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## **Part A:**

# **The nature, prevalence and impact of amphetamine-type stimulants**

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# Chapter 1. An introduction to amphetamine-type stimulants

## Introduction

- 1.1 Amphetamine-type stimulants (ATS) are a class of synthetic drugs that are related to the parent compound amphetamine, and include methamphetamine, amphetamine and MDMA, also known as ecstasy.
- 1.2 This chapter focuses on the nature and biological effects of ATS: what they are; how they affect the brain; the immediate effects of taking the drugs and drug dependence. It also describes the harms associated with ATS use.

## Common types of illicit ATS and their effects

**Figure 1.1: Class, types and forms of ATS<sup>1</sup>**

Class of drugs	Amphetamine-type stimulants									
Class of drugs	Amphetamines and methamphetamines						Phenethylamines			
Types of drugs	Amphetamine	Methamphetamine			Dexamphetamine	MDMA (ecstasy) MDA etc				
Forms of drugs	Powder, tablet	Powder	Crystal	Base	Tablet (e.g Ritalin)	Tablet	Powder	Capsule	Crystal	

### Amphetamine

- 1.3 Amphetamine can come in powder form, ranging in colour from white to brown, or as capsules and tablets. Amphetamine is usually swallowed, injected or smoked, but it can also be snorted.<sup>2</sup>
- 1.4 Its effects are felt immediately when injected or smoked, or up to 30 minutes later if snorted or swallowed.<sup>3</sup> Effects can include feelings of happiness and confidence, feeling energetic, enlarged pupils and dry mouth, fast heart rate and breathing, teeth grinding, reduced appetite and increased sex drive.<sup>4</sup>

### Methamphetamine

- 1.5 Methamphetamine is a more potent form of amphetamine, causing a powerful central nervous system response. It is commonly found in one of four forms: tablet; crystalline (often referred to as ice); paste (base) and powder (speed).<sup>5</sup>
- 1.6 Methods of taking methamphetamine include swallowing, snorting, smoking and injecting. Smoking or injecting methamphetamine produces an almost immediate euphoric sensation. If methamphetamine is snorted or swallowed, peak effects are felt in around five to 20 minutes.<sup>6</sup>
- 1.7 The immediate effects of methamphetamine consumption include feelings of pleasure and confidence, increased alertness and energy, fast heart rate and breathing, reduced appetite and increased sex drive.<sup>7</sup>

## Crystal methamphetamine

- 1.8 Crystal methamphetamine is the purest form of methamphetamine and provides the most intense high as well as the most intense come-down. It is also the most addictive form of methamphetamine.<sup>8</sup> Crystal methamphetamine overtook powder as the preferred form of the drug among people who took crystal methamphetamine in about 2013, a trend that continued up until at least 2016.<sup>9</sup>
- 1.9 Crystal methamphetamine usually comes as small, chunky and clear crystals that look like ice. It can also come as white or brownish crystal-like powder with a strong smell and bitter taste.<sup>10</sup> It is usually smoked or injected as these methods of administration provide the fastest and most intense high. It is sometimes swallowed or snorted.<sup>11</sup>
- 1.10 When crystal methamphetamine is smoked or injected, the effects can be felt in just three to seven seconds. It takes longer to feel the effects if swallowed (15 to 30 minutes) or snorted (three to five minutes).<sup>12</sup> Effects can include feelings of pleasure and confidence, increased alertness and energy, enlarged pupils and dry mouth, reduced appetite and increased sex drive.<sup>13</sup>
- 1.11 A witness described the experience of using crystal methamphetamine.

*'[W]ith this drug, the euphoria was so great and I felt invincible, and I felt I could connect, you know ... it actually solved the pain that I was feeling, and that's sort of the real psychological effect of the drug, apart from the physical – physical addiction of the drug.'*<sup>14</sup>

## MDMA

- 1.12 MDMA is a member of the phenethylamine family. MDMA and its chemical analogues such as 3,4-methylenedioxymphetamine (MDA) and 3,4-methylenedioxyethylamphetamine (MDEA) belong to the group of drugs commonly referred to as ecstasy-group substances.<sup>15</sup>
- 1.13 This group of drugs is also known as ectactogens or empathogens because of their ability to increase a person's feelings of empathy, good will and connection to others.<sup>16</sup> Other immediate effects include enlarged pupils, jaw clenching and teeth grinding, heightened senses (sight, hearing and touch), excessive sweating and skin tingles, reduced appetite, dehydration, heat stroke and drinking extreme amounts of water.<sup>17</sup>
- 1.14 MDMA usually comes as a tablet and is swallowed,<sup>18</sup> with initial effects reported after around 30 minutes and peak effects after 60 to 90 minutes.<sup>19</sup> If a person takes one dose of MDMA, the body eliminates 95% of the drug after about 40 hours. If a person takes multiple tablets in a short time, changes to metabolism result in far greater concentrations of MDMA in the blood and brain than would be expected, increasing risks to the person.<sup>20</sup>

## New psychoactive substances can mimic ATS

New psychoactive substances (NPS) are commonly defined as substances that are not covered by international drug controls but pose a public health threat comparable to illicit drugs.<sup>21</sup> NPS are designed to mimic illicit drugs such as cannabis, cocaine, heroin, LSD, MDMA (ecstasy) and methamphetamine.<sup>22</sup> Other names for NPS include research chemicals, analogues, legal highs, herbal highs, synthetic drugs, designer drugs and novel psychoactive substances.<sup>23</sup>

The term 'new' means 'newly misused' as opposed to newly invented. Most NPS substances were first synthesised many years ago.<sup>24</sup> The NPS market has grown rapidly in recent years. The United Nations Office on Drugs and Crime has identified about 900 NPS internationally and estimates that between 101 and 200 have been detected in Australia.<sup>25</sup> Synthetic cannabinoids are the most widely used NPS in Australia, followed by stimulant and psychedelic NPS.<sup>26</sup>

The Inquiry received evidence that NPS are an emerging issue in Australia,<sup>27</sup> and are a large and constantly growing group of substances.<sup>28</sup>

NPS are dangerous because they are often marketed as 'legal highs', implying they are safe to consume and use. Suppliers have marketed NPS under the names of harmless everyday products such as room fresheners, bath salts and herbal incenses.<sup>29</sup> However, the effects of NPS are not well known<sup>30</sup> and some have severe toxicities.<sup>31</sup>

The National Drug Strategy 2017–2026 has identified three key concerns about NPS: their toxicity is often not well understood; their chemical makeup (and associated toxicity) is constantly evolving; and new NPS are continually emerging.<sup>32</sup> The Strategy noted the use of NPS is often linked to health problems. People using NPS have frequently been hospitalised with severe intoxication and there have also been unexplained suicides associated with NPS use.<sup>33</sup>

Some pills sold as ecstasy may be made of NPS and contain only a small amount of MDMA or none at all.<sup>34</sup> Some of the more dangerous NPS that have been found in pills sold as MDMA include:<sup>35</sup>

- PMA (paramethoxyamphetamine), which is more toxic at lower doses than MDMA
- N-ethylpentylone, a cathinone that is much more potent than MDMA making it easier to take too much
- NBOMes (N-methoxybenzyl), which are more toxic at lower doses than other hallucinogenic drugs and can cause heart attack, renal failure and stroke.

1.15 Table 1.1 provides an overview of the effects of two common forms of ATS – those that are perceived positively (effects the person using the drug may be seeking) and those that are perceived negatively (effects the person may not be seeking).

1.16 The immediate effects of ATS vary, depending on factors including:<sup>36</sup>

- the person's size, weight and health
- whether they are used to taking the drug
- whether they take other drugs around the same time
- how much and how often they take the drug
- the strength of the drug.

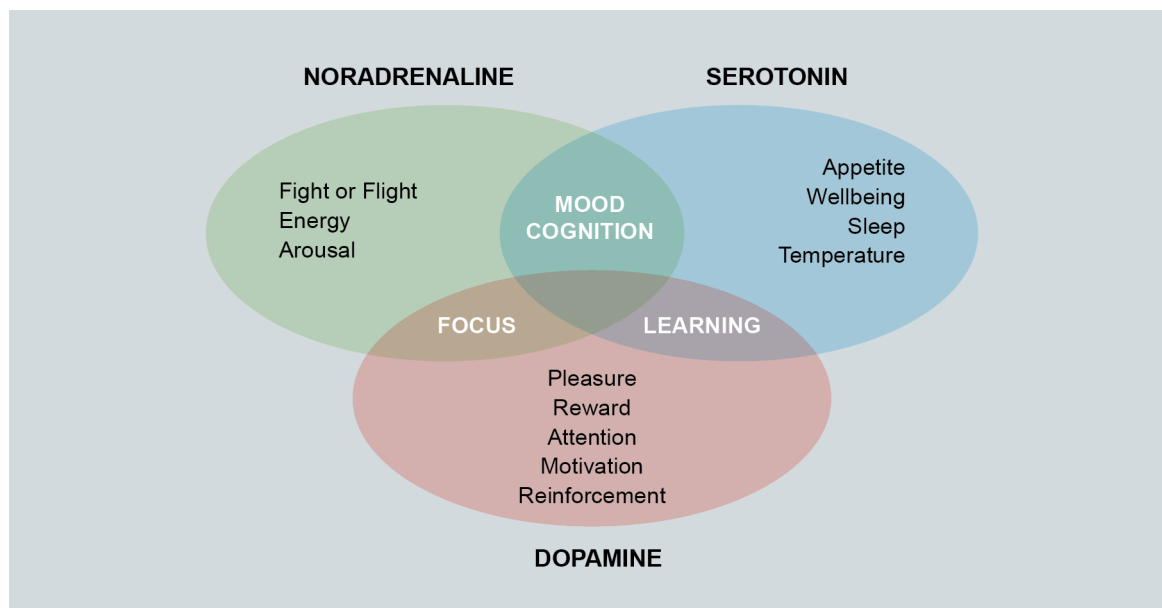
**Table 1.1: Immediate psychological and physical effects of ATS<sup>37</sup>**

Desired and/or positively rated/perceived effects	Negatively rated/perceived effects/adverse outcomes
<b>MDMA</b>	<b>MDMA</b>
euphoria	nausea
arousal	headache
enhanced mood	tachycardia (elevated heartrate)
increased sociability	bruxism (teeth grinding)
heightened perceptions	muscular rigidity and trismus (lockjaw)
inner peace	ataxia (impaired balance or coordination)
expanding consciousness	hyperthermia
mild hallucinogenic effects	lowering of mood (in the days after use)
<b>Methamphetamine</b>	<b>Methamphetamine</b>
euphoria	bruxism (teeth grinding)
increased stamina	agitation
increased energy	paranoia
heightened concentration and sexual drive	anxiety and depression
decreased appetite	psychosis
	formication (sensation of insects crawling on the skin)
	violent behaviour and aggression
	high-risk sexual activity
	risk of infectious diseases (through injecting)

## How ATS affect the brain

- 1.17 Neurotransmitters are chemical signals that send messages between brain cells. All ATS interfere with the activity of three neurotransmitters: dopamine, noradrenaline and serotonin. ATS trigger the release of a large amount of these neurotransmitters, and also block the recycling process that enables excess neurotransmitters to be stored for re-use (reuptake).<sup>38</sup> This process depletes the brain of these chemicals, which are important for normal brain functioning. It results in a significant increase in positive feelings during intoxication, but later flattens mood until the brain restores the depleted neurochemicals.<sup>39</sup> Although the brain can cope with occasional disruption to these systems and takes just a few days to restore normal functioning, regular use can disrupt these systems over the longer term.<sup>40</sup>
- 1.18 The actions of dopamine, noradrenaline and serotonin in normal brain function are interconnected. Figure 1.2 shows the broad functions associated with these neurotransmitters including where they potentially overlap.<sup>41</sup>

**Figure 1.2: Neurotransmitters involved in methamphetamine use**



## Dopamine

- 1.19 The dopamine system is the brain's reward pathway. Dopamine is responsible for sensations of pleasure and activities necessary to sustain life, such as eating, drinking and sexual behaviour. Under natural conditions, a pleasurable activity causes a release of dopamine, which is later taken back inside the brain cell and stored for later use. The release and recycle process makes it more likely that pleasant behaviour, such as eating food, will be repeated.<sup>42</sup>
- 1.20 Methamphetamine is highly addictive because of its ability to rapidly release a significantly higher amount of dopamine than any other pleasurable activity or psychoactive drug. The rate of dopamine falls very quickly in withdrawal from methamphetamine, leading to discomfort that encourages people to seek the drug again.<sup>43</sup>
- 1.21 In contrast, MDMA causes some additional release of dopamine, but its main mechanism of action involves serotonin. The reduced impact on the reward system may explain the self-limiting nature of MDMA use and the rarer occurrence of dependence compared with methamphetamine.<sup>44</sup>
- 1.22 The artificial release and depletion of dopamine disrupts normal brain functioning and may be partly responsible for longer-term effects of ATS use, such as poor memory, impaired attention and depressed mood. These effects are more evident among people who use methamphetamine than those who use MDMA.<sup>45</sup>
- 1.23 A witness with lived experience of crystal methamphetamine use told the Inquiry:

*'Ice numbed my feelings initially. It was great. It would distract my thoughts, but the rest of the time I would be down. After long-term use, it flattens you out, because you're not used to dealing with your emotions all the time. It becomes too much to deal with when you come off it.'*<sup>46</sup>

## Serotonin

- 1.24 Serotonin is a neurotransmitter found in the central nervous system and in the gut and blood vessels. It influences almost all brain cells in some way. It helps to maintain normal body temperature, regulate mood and control appetite and it is essential for normal sleep. It is also involved in sexual desire and function, and proper functioning of the endocrine system. A disruption in the serotonin system can lead to depression, anxiety and development of obsessive compulsive disorder.<sup>47</sup>
- 1.25 High levels of serotonin produce feelings of closeness to other people and increase feelings of wellbeing, happiness and optimism.<sup>48</sup> MDMA acts mainly on serotonin release and reuptake.<sup>49</sup>

## Noradrenaline

- 1.26 Noradrenaline, also known as norepinephrine, is one of the main neurotransmitters involved in responses to perceived danger. Noradrenaline controls pathways in the nervous system that prepare a person to respond rapidly to a physical threat, i.e. the 'fight, flight or freeze' response.<sup>50</sup>
- 1.27 Methamphetamine stimulates brain cells to release noradrenaline, causing an artificial state of arousal of the sympathetic nervous system and switching the brain and body to an 'on-guard' state.<sup>51</sup>

## Intoxication

- 1.28 Intoxication refers to how a drug changes perception, mood, thinking processes and motor skills.<sup>52</sup> ATS produce varying degrees of intoxication that have different effects:<sup>53</sup>
- Mild intoxication generally occurs with a low dose, producing the desired effects of increased confidence, alertness, energy and euphoria.
  - Moderate intoxication occurs when too much is taken, producing unwanted effects including unpleasant states of mind, such as racing thoughts and anxiety, and uncomfortable physical effects, such as teeth grinding, racing pulse and agitation.
  - Toxicity, or overdose, usually occurs when too much is taken at once. Acute toxicity can occur at any time and not only among people who use a large quantity regularly.
- 1.29 The effects of methamphetamine intoxication are set out in Table 1.2.

**Table 1.2: Effects of methamphetamine intoxication<sup>54</sup>**

Mild intoxication	Moderate intoxication	Toxicity (overdose)
Euphoria, sense of wellbeing	Nervousness	Chest pain, irregular heartbeat, blood clots, myocardial infarction (heart attack)
Increased energy	Agitation (may be extremely unpleasant)	Aggression
Improved attention, alertness, memory	Anxiety, may lead to panic	Tremor, seizure
Feelings of increased confidence	Jaw clenching, teeth grinding	Severe headache
Heightened sex drive	Nausea, vomiting	Unsteady walking
Reduced appetite	Headache	Difficulty breathing
	Hot and sweaty	Hot flushed, sweaty skin
	Racing pulse	Confusion, disorientation
		Muscle rigidity, spasm, jerking
		Severe agitation, panic, psychosis

1.30 Many factors influence how ATS affect an individual and the potential for serious or fatal consequences of intoxication, including:<sup>55</sup>

- How much is taken – dose can determine toxic effects as well as potential for dependence.
- Environmental conditions – the risk of toxicity can be increased by hot, noisy and overcrowded environments as well as through intense physical activity and too little or too much fluid intake.
- Individual characteristics – including a person's age, ethnicity and gender.
- Pregnancy – pregnant women are at risk of increased toxicity from ATS.
- Medical conditions – people who have conditions such as cardiorespiratory, inflammatory or infectious diseases, diabetes, kidney or liver failure and hypo/hyperthyroidism, are at risk of increased toxicity from ATS.
- Polydrug use – the unpredictable combination of different drugs can cause toxicity.
- Interactions with regular medications, such as antidepressants.
- Drug contaminants – ATS often contain dangerous contaminants or 'fillers'.

1.31 A witness with lived experience described the effects of crystal methamphetamine intoxication.

*'I guess it's an easier high, because – it is extremely high, but you don't go into a panic sort of high like cocaine does, whereas with ice it's just – you hit this level, and it's just – it's an internal confidence ... But the lows are extremely low, and that's why you're constantly chasing your tail, to get the next fix ... You're always chasing the first high, and it's never the same.'*<sup>56</sup>

## Neurotoxicity

- 1.32 Repeated use of ATS has been linked to neurotoxicity,<sup>57</sup> an adverse effect on the nervous system, which includes the brain, spinal cord and nerves.
- 1.33 Brain imaging studies in people who have used methamphetamine and MDMA for a long time show nerve damage and changes to neurotransmitters.<sup>58</sup> Changes in the serotonin system may be the cause of mood disturbances and impairments in memory and cognitive ability reported by people who use ATS. The effect of dopamine has been associated with psychotic symptoms of ATS use.
- 1.34 MDMA use increases the risk of serotonin syndrome, a potentially fatal condition that occurs when MDMA is used with other drugs that also raise serotonin levels, such as other ATS or antidepressants.<sup>59</sup> The symptoms of serotonin syndrome include confusion, agitation, sweating, increased heart rate and muscle spasms.<sup>60</sup>

## The 'come-down' or 'crash' and withdrawal

- 1.35 As the level of ATS in the brain decreases, dopamine levels quickly fall back to normal, and the pleasurable feelings fade, causing a 'crash' or 'come-down'. It is similar to a hangover from alcohol and can last one to three days.<sup>61</sup>
- 1.36 Typical symptoms of the ATS come-down include feeling flat and irritable, being unable to concentrate and excessive sleeping. MDMA come-down symptoms are related to a lack of sleep, the effects of excessive physical activity such as dancing, going without food and using other drugs (including alcohol).
- 1.37 Withdrawal symptoms can occur when a person who has used a drug for a long time reduces or stops using the drug. Withdrawal often leads to relapse into drug use or the use of other drugs<sup>62</sup> to relieve the symptoms of withdrawal.<sup>63</sup>
- 1.38 People withdrawing from ATS may experience profound fatigue and sleepiness, cravings, anxiety, depression and psychological distress.<sup>64</sup> The longer a person has used ATS, the more severe the withdrawal symptoms.<sup>65</sup> Withdrawal symptoms generally resolve in three weeks, but some may continue for months.
- 1.39 Withdrawal from ATS can exacerbate anxiety and depression in the short term,<sup>66</sup> and may continue for several months after the person has stopped using ATS.<sup>67</sup> Thoughts about suicide and suicide attempts have been reported during withdrawal from ATS.<sup>68</sup>

## Symptoms of withdrawal

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) lists typical psychological and physical symptoms of withdrawal from ATS as depression, anxiety or agitation, along with:<sup>69</sup>

- fatigue
- vivid, unpleasant dreams
- insomnia or hypersomnia (excessive sleeping)
- increased appetite
- psychomotor retardation (slowing down of thought and physical movements) or agitation.

Other possible withdrawal symptoms include:<sup>70</sup>

- stomach cramps
- aches
- nausea
- rapid heart beat
- hot and cold flushes
- chest pains
- weight loss
- cravings.

- 1.40 The Inquiry heard that withdrawal symptoms may change as a person passes through phases of crash and withdrawal. Dr Jonathan Brett, Staff Specialist in Clinical Pharmacology, Toxicology and Addiction Medicine, St Vincent's Hospital, told the Inquiry that people mainly want to sleep in the first 12 to 24 hours after heavy use of methamphetamine.

*'... They may have some cravings to use drugs, but generally they feel – they just want to lie in bed. They feel awful. After that, they can get a bit more agitated, restless, irritable, have very strong cravings, unstable mood, increased appetite, poor concentration and that can last for, you know, even two to four weeks. Possibly peaks about sort of, you know, day seven to 10.'*<sup>71</sup>

- 1.41 Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol Service, said withdrawal from ATS is not life-threatening and a person can withdraw in a suitable home environment.<sup>72</sup>

- 1.42 Lived experience witnesses told the Inquiry that the physical symptoms of withdrawal are tolerable.

*'I didn't go to any formal detox to get clean. I detoxed myself without any medical assistance. I stayed in a hotel room for 15 days while I was going through withdrawal .... During the first week of withdrawal, I was just sweating and trying to sleep it off.'*<sup>73</sup>

*'I found the hardest part of recovery was the social side of things. I didn't find the physical side of withdrawal too hard.'*<sup>74</sup>

## How ATS are used

### Some ATS have medical uses

- 1.43 ATS have a long history of medical use (see Chapter 2). Currently, ATS are used legally in Australia to treat attention deficit hyperactivity disorder (ADHD) in children and adults, and the sleep disorder narcolepsy.<sup>75</sup>
- 1.44 ADHD affects one in 20 Australian children.<sup>76</sup> The main symptoms of ADHD are inattention, impulsivity and hyperactivity.<sup>77</sup> In Australia, the psychostimulant medications mainly used to treat ADHD are dexamfetamine, methylphenidate and lisdexamfetamine.<sup>78</sup> ATS are thought to reduce the symptoms of ADHD by changing the availability of the neurotransmitters dopamine and noradrenaline in the parts of the brain involved with behaviour inhibition, impulse control, attention and memory. The exact way they work is not fully understood.<sup>79</sup>
- 1.45 There is interest in MDMA as a treatment for mental health conditions to support psychotherapy. MDMA is being trialled in the United States, United Kingdom and Europe to help people with post-traumatic stress disorder (PTSD)<sup>80</sup> to process memories of emotional trauma.<sup>81</sup> The trial results have been described as impressive, with PTSD symptoms clearing for up to six years without a further dose and with no chronic adverse effects.<sup>82</sup>

### Not all ATS use is harmful

- 1.46 It is important to acknowledge that, although all drug use has the potential to cause harm, not all drug use is harmful. The Inquiry received evidence and submissions noting that a large proportion of people in Australia use drugs at some time in their lives and most experience few adverse effects.<sup>83</sup>
- 1.47 Professor Alison Ritter, Director, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney, told the Inquiry that based on United States research, she estimated that a quarter of people who use crystal methamphetamine are likely to become dependent and the remaining 75% would not.<sup>84</sup>
- 1.48 Harmful use can occur across a spectrum of drug use (described in detail in Chapter 5). Use that is dependent and or intensive is more likely to be harmful, as is use of ATS with other drugs (polydrug use – discussed in Chapter 5). Non-harmful use is more likely to be concentrated at the end of the spectrum where people use drugs in an experimental and recreational way.
- 1.49 Dr Bronwyn Hudson, GP Registrar Visiting Medical Officer and Emergency Senior Medical Officer, Byron Central Hospital, said many people who use ATS will never have an encounter with the health system. She said people who seek treatment are at the more severe end of the spectrum of use.<sup>85</sup>
- 1.50 The Inquiry heard that some ATS use has positive effects. The NSW Users and AIDS Association observed the reasons for ATS use are diverse and specific to each individual, and that not all ATS use is dysfunctional.<sup>86</sup>
- 1.51 Surveys of people who use MDMA recreationally have reported positive effects of use, such as positively changing outlooks on life, having a better understanding of self, and improved relationships and sociability.<sup>87</sup>

- 1.52 The context of drug use can also determine the experience of harm. As discussed in Chapter 3, socioeconomic and demographic context can also play a role in determining to what extent drug use will affect a person's life.<sup>88</sup> The most serious and harmful use is often related to a range of complex social and health factors, such as socioeconomic disadvantage and trauma. Individuals who engage in harmful use are often polydrug users who have many social needs.<sup>89</sup>

### Dependence and ATS use

- 1.53 Drug dependence is a clinically recognised health condition that includes both a physical need or craving and psychological dependence, which is a perceived need to use the drug.<sup>90</sup>
- 1.54 The symptoms of ATS dependence include:<sup>91</sup>
- taking increasingly higher doses of the drug more frequently
  - continuing to use the drug despite adverse health effects
  - experiencing withdrawal symptoms when not under the influence of the drug.
- 1.55 Drug dependence changes the brain. It reinforces the limbic circuit, which controls reward pathways and dampens the frontal lobe, which is responsible for impulse control.<sup>92</sup> As Dr Brett, St Vincent's Hospital, noted: *'That's the nature of addiction... intense drive to do something, but without any control to stop yourself.'*<sup>93</sup>
- 1.56 A witness told the Inquiry about the addictive effects of crystal methamphetamine.
- 'After I tried ice, it snowballed into wanting more and more. I didn't really think about the addictive properties of ice at the time. I thought heroin was the only physically addictive drug out there. Even if I had of known it was addictive, I still would have tried it. It made me feel good and helped with the work I was doing [at] the time. It made me forget about everything. I wouldn't know if I still had my mental health and anxiety issues, as I felt great on ice.'*<sup>94</sup>
- 1.57 Dependence is a key risk factor for adverse health and social consequences from drug use.<sup>95</sup> One study estimated that people who experience drug dependence have a reduced life expectancy of almost 14 years.<sup>96</sup> Substance dependence regularly coexists with mental health conditions.<sup>97</sup> People who experience substance dependence are most likely to experience health harms requiring acute care.<sup>98</sup>
- 1.58 Genetic factors can significantly influence the development of drug dependence, accounting for 40 to 60% of an individual's vulnerability to developing dependence.<sup>99</sup> The type of ATS used also determines risk of dependence. People who use crystal methamphetamine are twice as likely to experience dependence compared to those who use other forms of methamphetamine.<sup>100</sup> Dependent use can develop within a year of regular use.<sup>101</sup>
- 1.59 A person with lived experience of crystal methamphetamine dependence told the Inquiry:

*‘... crystal-meth addiction is a progressive disease, and it brought me to my knees quickly, within a year. Life became unmanageable. I was highly emotional, short-tempered and my relationships disappeared. I became a harder, colder person. I didn’t care about other people or myself. Meth became my number one priority.’<sup>102</sup>*

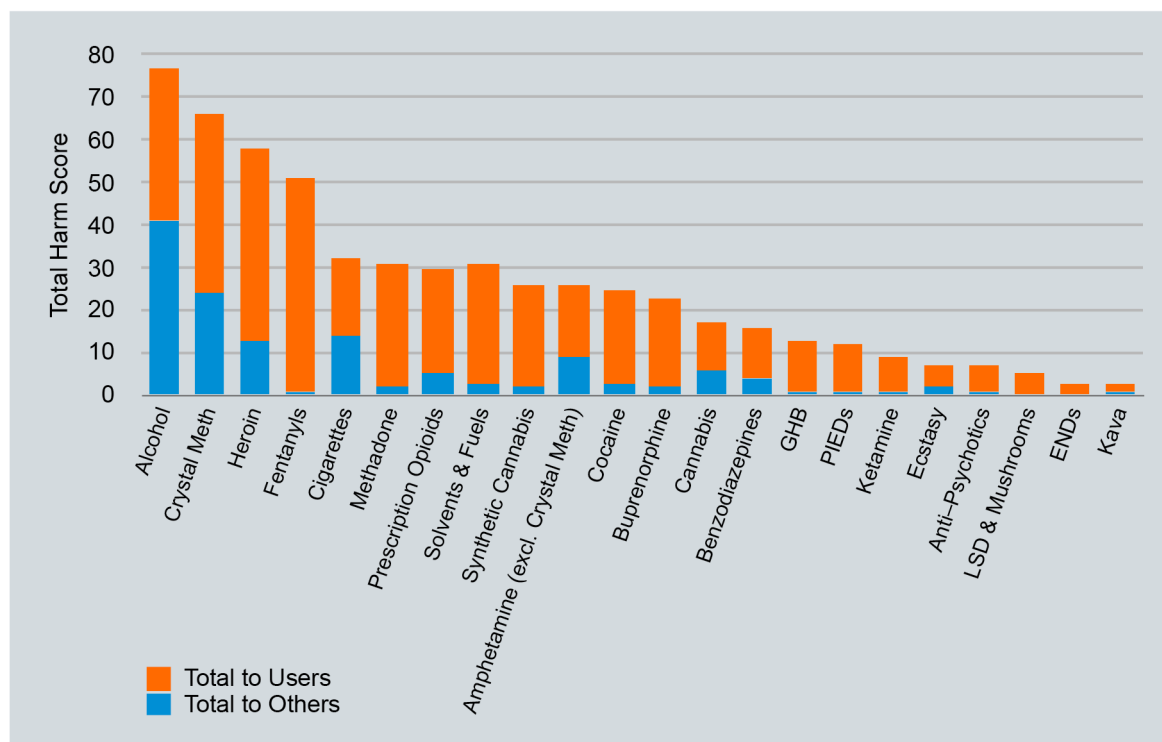
- 1.60 In contrast, regular use of MDMA is uncommon, and its frequency of use is lower than other illicit drugs.<sup>103</sup> Although evidence of MDMA dependence is limited, some studies have reported symptoms of dependence, primarily in people with heavy use.<sup>104</sup> Dr Brett, St Vincent’s Hospital, told the Inquiry he had not seen a case of MDMA dependence during his professional career.<sup>105</sup>
- 1.61 The method of taking a drug can also determine the risk of dependence, with those who inject crystal methamphetamine at greatest risk of becoming dependent.<sup>106</sup> People who smoke methamphetamine also more frequently report dependence above those who snort or swallow the drug.<sup>107</sup>

## The harms associated with ATS use

- 1.62 As well as the immediate effects of consumption described earlier in this chapter, ATS use can lead to a range of harms for both the individual using drugs, their families and communities.
- 1.63 Research has found clear evidence of the severity of individual and societal harms particularly of crystal methamphetamine use.<sup>108</sup> Submissions and witness evidence to the Inquiry mainly focused on the impact of crystal methamphetamine and the challenges of responding to higher levels of its use.
- 1.64 Associate Professor Rebecca McKetin, National Drug and Alcohol Research Centre (NDARC), UNSW Sydney, told the Inquiry that the key harms of methamphetamine use are mental health effects, cardiovascular risk and injuries from intoxication.<sup>109</sup>

*‘So regardless of how you take methamphetamine, if you take enough of it you will see dependence. You will see mental health harms, including elevated risk of psychosis, elevated risk of violence of suicidality and depression. If you use the drug enough, regardless of the route of administration, you’ll see elevated risk of cardiovascular problems and stroke, and you’ll see, if you inject it, specifically elevated risk of blood-borne virus transmission.’<sup>110</sup>*

- 1.65 Research has also emphasised the harms of methamphetamine use. An Australian study, replicating an earlier UK study,<sup>111</sup> ranked legal and illegal drugs according to 16 criteria: nine related to harms to the individuals who use drugs themselves and seven related to harms caused to others.<sup>112</sup> The study ranked crystal methamphetamine as highly harmful, and ecstasy at the less harmful end of the scale.<sup>113</sup> It found that ATS cause much greater harm to the person using the drug than to others.<sup>114</sup>
- 1.66 Figure 1.3 below summarises the drugs considered and their score against harms to users and others.

**Figure 1.3: Ranking of drug harms in Australia<sup>115</sup>**

1.67 The harms associated with ATS use are discussed in detail below. Strategies to reduce these harms are discussed in Chapter 15.

### Harms to users

#### Psychological harms

- 1.68 The relationship between ATS use, particularly methamphetamine use, and mental health is two way and complex. A person may use ATS as a way to manage their mental health symptoms, but ATS use can intensify mental health symptoms.<sup>116</sup>
- 1.69 The Inquiry received evidence that ATS can cause adverse mental health effects and exacerbate pre-existing mental health conditions. Dr Craig Sadler, Senior Staff Specialist Addiction Medicine, Director Alcohol and Drug Unit, Calvary Mater Newcastle Hospital, said mental health symptoms and conditions commonly associated with ATS use include anxiety, depression, perceptual disturbances, thought disorder, delusions, paranoia, hallucinations, psychosis, agitation and aggression. These symptoms may be transient, episodic or prolonged and may be the direct effects of ATS use or an exacerbation of pre-existing anxiety, mood or psychotic symptoms or disorders.<sup>117</sup>
- 1.70 A father described to the Inquiry how his daughter's use of crystal methamphetamine was *'inextricably linked to her mental health issues'*.<sup>118</sup> He said his daughter started taking crystal methamphetamine to ease the pain of mental health conditions including depression, anxiety, bipolar disorder and paranoia. The use of crystal methamphetamine alongside these mental health conditions led to a period of homelessness and an attempt at suicide.<sup>119</sup>
- 1.71 Shannon Speechley told the Inquiry he experienced adverse mental health effects after using crystal methamphetamine for a number of years: *'Over time my mental health was affected. I was diagnosed with type II bipolar, schizophrenia and drug-induced psychosis. I had suicidal thoughts and attempted to take my life ... I tried to take my life again several times.'*<sup>120</sup>

- 1.72 Surveys of people who use ATS have found that mental health symptoms of anxiety, depression, panic attacks, mood swings, aggression, hallucinations, depression, paranoia and psychosis can occur the first time ATS are used or when use becomes problematic.<sup>121</sup> A study of people who use amphetamine found the average time a person received a mental health diagnosis or treatment after the start of their regular amphetamine use was about two years.<sup>122</sup>
- 1.73 Factors that increase the risk of people who use ATS developing mental health symptoms are:<sup>123</sup>
- heavy and more frequent use, particularly over a longer period
  - increase in the severity of dependence
  - a history of mental health conditions
  - polydrug use (including legal substances, such as alcohol and benzodiazepines).

### Mental health and drug use

The relationship between mental health conditions and drug use can be viewed from three main perspectives:<sup>124</sup>

- Mental health problems are the primary problem and drug use occurs to relieve symptoms of the mental health condition.
- Drug use leads to the development of mental health symptoms through brain changes, by triggering an underlying condition or by exacerbating existing symptoms.
- There is a common but independent pathway, where the same conditions lead to both mental health issues and drug use.

### ATS and psychosis

- 1.74 Psychosis is a mental health condition in which a person is unable to distinguish what is real from what is not.<sup>125</sup> ATS use can induce psychosis that typically involves delusions and hallucinations, irrational hostile behaviour, exaggerated changes of mood and strong emotions.<sup>126</sup> Psychotic symptoms are more commonly associated with crystal methamphetamine. There is an association between psychotic symptoms and high-dose, long-term or dependent use of crystal methamphetamine.<sup>127</sup> The risk of psychosis is particularly great in people who have a personal or family history of mental health conditions.<sup>128</sup>
- 1.75 Psychotic symptoms can be transient (lasting for hours) or last days and weeks and require specialist mental health care. Transient episodes may still result in an admission to hospital and may indicate risk of developing a psychotic disorder.<sup>129</sup>
- 1.76 Adolescents, young adults, people from ethnic minority groups, and those with a history of a psychotic disorder are more likely to experience psychotic symptoms when taking ATS. Some of these characteristics are associated with indicators of socioeconomic disadvantage. Researchers have noted that the high prevalence of mental health conditions in people who use methamphetamine may be in part due to their background characteristics, and not solely their drug use.<sup>130</sup>
- 1.77 Dr Marcia Fogarty, Executive Director of Mental Health for Hunter New England Local Health District, described how crystal methamphetamine can affect a person with a pre-existing psychotic disorder, such as schizophrenia.

*‘... most of the antipsychotic drugs are dopamine blockers, and what the amphetamines actually do is blow the dopamine out into your brain ... So if you already have a damaged brain or if you already had a brain that is prone to psychotic symptoms and then you suddenly increase all the dopamine, you’re really at much higher dose of getting psychotic symptoms or showing psychotic symptoms because you’ve just used the ice.’<sup>131</sup>*

- 1.78 The Inquiry heard that around one-quarter of people who regularly use methamphetamine develop pre-psychotic symptoms, such as hearing voices occasionally, and around 10 to 15% of people develop psychosis.<sup>132</sup> Dr Grant Sara, Psychiatrist, Director of InforMH, NSW Health, said between a quarter and a half of people with drug-induced psychosis would go on to have a later diagnosis of schizophrenia.<sup>133</sup> Similar figures are reflected in the literature.<sup>134</sup>

- 1.79 Dr Brett, St Vincent’s Hospital, told the Inquiry that repeated psychosis fuels a ‘horrible cycle’ where people use more of the drug to deal with the stress of psychotic symptoms.<sup>135</sup> He said people may develop chronic psychosis, even after stopping amphetamine use, because their threshold for psychotic symptoms has been lowered to a point where stress alone can bring on psychosis.<sup>136</sup>

*‘[W]e see that about half of people who have had some psychosis will go on to have another episode. Generally, it’s because they keep using, but the more you’ve had it, the lower your threshold and the less likely you are to recover with prolonged abstinence.’<sup>137</sup>*

- 1.80 The Inquiry heard evidence from several individuals with lived experience of ATS-related psychosis and mental health conditions with psychotic symptoms. Sahra Hawkins described rapid and adverse effects on her mental health after she started to use methamphetamine, leading to her being charged with criminal offences committed while in active psychosis.<sup>138</sup> Another person described prolonged periods of psychosis related to crystal methamphetamine use:

*‘Now that I am clean, my mental health is a lot better. I really hit rock bottom when I was using ice. When I was using party drugs like MDMA, the comedowns were not as bad, but with ice my mental health deteriorated rapidly, and I would have had about 20 bouts of ice-induced psychosis.’<sup>139</sup>*

### **The effects of MDMA on mental health**

- 1.81 The effects of MDMA on mental health are different to those of methamphetamine. Many risk factors for developing mental health symptoms as a result of other ATS use – including injecting, frequent use and dependence – are generally not associated with MDMA use.<sup>140</sup>
- 1.82 Studies have shown only mild disruptions in movement and thinking ability after MDMA use.<sup>141</sup> Surveys of people who use ecstasy have reported that most adverse reactions are mild and generally short term and are often due to polydrug use. Studies of people who use ecstasy recreationally have not found quantifiable long-term impacts of such use on mental health.<sup>142</sup> However, there are reports of psychotic reactions to MDMA use in people who have a personal or family history of a mental health condition, suggesting that MDMA also has the potential to exacerbate an existing condition or genetic predisposition.<sup>143</sup>

## Physical health harms

- 1.83 ATS use can have a range of effects on a person's physical health and wellbeing, including reduced immunity to infections, skin problems, stomach cramps,<sup>144</sup> poor sleep quality,<sup>145</sup> heart palpitations and chest pain.<sup>146</sup> Injecting, more frequent use and dependence on methamphetamine are predictors of poor physical health.<sup>147</sup>
- 1.84 There are short- and long-term harms associated with ATS use. In the short term, people may experience insomnia, trembling, dehydration and increased blood pressure and heart rate. In the longer term, people may experience more significant physical health problems, such as gum disease, kidney, heart and lung problems, malnutrition and problems with their physical movement.<sup>148</sup>
- 1.85 ATS are associated with seizures, which typically occur within several hours of taking the drug. Liver damage, including acute liver failure, and kidney conditions have also been reported.<sup>149</sup> Smoking crystal methamphetamine also comes with the risk of acute and chronic lung problems, such as coughing and wheezing, difficult or laboured breathing and coughing up blood.<sup>150</sup>
- 1.86 Dr Anthony Gill, Addiction Medicine Specialist, Alcohol and Drug Centre, St Vincent's Hospital, described the medical conditions he has seen associated with ATS use.

*'Medical comorbidities commonly co-occurring with ATS-related diagnoses that I see include marked weight loss and poor nutritional state, skin lesions, cardiovascular disease, sexually transmitted infection, hepatitis C infections in injectors, and in hospital we see infective endocarditis, abscesses and cellulitis, and other injecting-related infections. Teeth problems and dental abscesses are also commonly seen in my clinical context.'*<sup>151</sup>

- 1.87 Witnesses with lived experience of ATS use described the impacts of that use on their physical health.

*'Well, I guess from not eating and not sleeping I got down to 58 kilos... I was extremely skinny, like ridiculously skinny. I was – I guess I was dying, slowly dying. I wasn't eating ... You lose your appetite, and so I would only eat when I would come into contact with people that would remind me to eat... You're definitely, slowly killing yourself.'*<sup>152</sup>

*'The worst period of my addiction lasted about 18 months ... I wasn't eating. I would faint. My mother said I looked grey and I got down to about 47 kilos. My ice use was a lot higher during this period.'*<sup>153</sup>

*'In terms of my physical health – I've got kidney damage, which came up two years into my recovery. My kidneys are damaged from all the drug use and the stress I was under.'*<sup>154</sup>

## Effects on the brain, heart and cardiovascular system

- 1.88 Methamphetamine use can lead to cardiovascular events including elevated blood pressure and heart rate,<sup>155</sup> and more severe complications such as stroke,<sup>156</sup> heart attack, cardiomyopathy, irregular heartbeat and enlargement and thickening of the walls of the heart.<sup>157</sup> Cardiovascular disease is a significant health concern for people who are dependent on methamphetamine.<sup>158</sup>
- 1.89 Cardiovascular problems have been reported in young people who use methamphetamine, even though these problems are generally uncommon in young people who do not use ATS.<sup>159</sup>

- 1.90 MDMA increases heart rate and blood pressure and has induced fatal arrhythmias (irregular heart beat) in people with an underlying natural disease.<sup>160</sup> It can also cause hyperthermia and low blood sodium levels.<sup>161</sup> There are still many unknowns about the harms of MDMA use, despite decades of research on this drug.<sup>162</sup>

### ***Method of administration***

- 1.91 Inhalation and injection are increasingly reported as methods of using methamphetamine, with frequent use associated with greater levels of harm, including potential for dependence.<sup>163</sup>
- 1.92 The Inquiry received evidence from Associate Professor McKetin, NDARC, that there is limited evidence comparing the risks associated with different routes of administration. However, the available evidence suggests that smoking may be related to less severe levels of dependence, although people who smoke methamphetamine consume it frequently and are just as likely to experience adverse health outcomes as those who inject it.<sup>164</sup>

### ***Infectious diseases***

- 1.93 People who use methamphetamine report that while intoxicated, they are more likely to engage in high-risk sexual activities. This, along with the sharing of injecting equipment, can increase the risk of blood-borne viral infections.<sup>165</sup> Injection also carries the risk of skin infections around the injection area, and bacterial infections of the heart, lungs and brain.<sup>166</sup>
- 1.94 Many people report re-using needles, with only a relatively small proportion using bleach to clean the needles before re-use.<sup>167</sup> People in rural areas who inject may be at further risk of harms due to limited health services, geographic isolation and higher levels of stigmatisation and discrimination.<sup>168</sup>

### ***Physical health harms of MDMA use***

- 1.95 The use of MDMA can result in physiological harms that differ from those relating to methamphetamine. As discussed in Chapter 7, many of the factors associated with methamphetamine use, including administration by injecting, frequent use, dependence or related psychosis, are not associated with the use of MDMA.<sup>169</sup>
- 1.96 The physiological harms of MDMA use depend on a variety of factors, including the context of its use, the components used to manufacture the drug and individual risk factors. Certain groups of people and contexts may result in high-risk use and an increase in associated harms. Evidence to the Inquiry suggests music festivals are associated with higher rates of MDMA use than occur in the general community,<sup>170</sup> and there has been an increase in the level of drug-related harm at music festivals in the past decade.<sup>171</sup>

### ***ATS-related deaths***

- 1.97 Understanding the contribution of ATS to drug deaths is complex as it is often difficult to directly attribute a death solely to a particular drug. However, a recent review suggests that mortality is substantially higher in people who use ATS. A global review of stimulant use, focusing on the use of cocaine and amphetamine, also found that stimulant use increases cardiovascular disease and deaths, and that suicide, overdose, accidental injuries (mainly motor vehicle accidents) and homicide are significant causes of death in people who use amphetamines.<sup>172</sup>
- 1.98 People who use illicit drugs or pharmaceutical drugs for non-medical purposes can place themselves at high risk of fatal and non-fatal overdose.<sup>173</sup>

## MDMA

- 1.99 Fatal overdoses from MDMA are relatively rare compared to the number of people who use MDMA. Most fatalities are a result of a combination of factors,<sup>174</sup> primarily where unexpectedly high doses are taken or where the substance taken contains unknown contaminants (including other more dangerous drugs). In the recent *NSW Coronial Inquest into Music Festival Deaths*, the Deputy State Coroner noted:

*‘The evidence heard in this inquest demonstrates that, while it is true that any individual can have an idiosyncratic reaction to a so-called “recreational” dose of MDMA, the cause of death in each of these cases was from the consumption of the drug MDMA at toxic levels, way above that required to produce the desired euphoric effect. These were not “idiosyncratic reactions”; their levels fall within a range that experts identify as toxic or potentially lethal.’<sup>175</sup>*

- 1.100 The Deputy State Coroner further noted that the environment within which drugs are taken is particularly important, noting that the six deaths occurred during summer music festivals. Research suggests that a recreational dose of MDMA may be fatal when combined with certain environmental and individual factors. People who use MDMA can develop a degree of tolerance after initial doses, meaning toxic effects may also vary between people. The Coroner said further research is required in this area.<sup>176</sup>
- 1.101 Dr Brett, St Vincent’s Hospital, told the Inquiry that the most common reason for deaths associated with MDMA is hyperthermia and the inability of the body to regulate temperature.<sup>177</sup> As noted by the Coroner, the environment in which MDMA is being used can further affect the body’s ability to regulate its temperature, for example, the use of MDMA at a party or music festival, combined with heat, crowded spaces, dancing and polydrug use.<sup>178</sup>
- 1.102 Another potentially fatal condition that can affect people who use MDMA is hyponatraemia, a condition where the blood has a low sodium level due to dilution with water. MDMA causes excessive thirst and water consumption but also inhibits urination. Low levels of sodium in the blood can lead to cerebral oedema, where the brain swells with water.<sup>179</sup>
- 1.103 ‘Binge’ MDMA use, where people take multiple pills or tablets in a single dose or session, is becoming more common in Australia and can increase the risk of harm or overdose.<sup>180</sup> A recent Australian study reported it was common among festival goers to take two MDMA tablets at once. As heard in the *NSW Coronial Inquest into Music Festival Deaths*, people may take multiple pills at once for fear of being caught in the possession of drugs.<sup>181</sup>
- 1.104 This practice – described as ‘*double dropping*’ – is risky due to the higher purity of MDMA on the market, contamination of drugs with adulterants, and the presence of new psychoactive substances. In Europe, there have been reports of high-dose ecstasy (over 100mg) and ‘super pills’ (up to 340mg) on the market. These higher doses increase risk of harm, including the risk of overdose.<sup>182</sup>

## Social harms

- 1.105 The Inquiry heard evidence about how the use of drugs can affect other aspects of an individual’s life, including straining their relationships with their families, affecting their employment or ability to be employed, and causing them to become involved in crime.<sup>183</sup>

## **Loss of relationships**

- 1.106 The Inquiry heard from many people about how their use of ATS affected their relationships.

*'When you are using ice, it isolates you. It takes away your friends, relationships with family, links to community, your character, everything. You are so alone because you have lost yourself. Isolation prevents you from accessing support, not wanting to be looked down upon for using drugs is also a barrier.'*<sup>184</sup>

*'My temper became reactionary. My brother and sister moved out of my mum's house because of my behaviour ... The topic of my drug use is still raw. I don't know whether my mum is the same after all of it. My dad started drinking a lot more. I can still see the damage in my family in some ways.'*<sup>185</sup>

- 1.107 The harms of ATS use, such as those described above, can occur as a result of behavioural changes and an associated chaotic lifestyle, stigma and disengagement from family and friends. Frequent use of ATS can lead to secretive behaviour, withdrawal from networks, reduced emotional wellbeing, behavioural disturbance and psychosis. These effects can lead to conflict with family and friends, contributing to family breakdown and a loss of positive connections.<sup>186</sup> They can also affect parenting capacity (discussed in Chapter 18).
- 1.108 Relationship breakdown and disconnection from social networks outside of drug-using peers is common among people who experience harmful or dependent ATS use.<sup>187</sup> This disconnection can lead people to increase their drug use to cope with the isolation resulting from relationship breakdown.<sup>188</sup>

## **Loss of jobs, housing and educational opportunities**

- 1.109 Exhaustion, depression, illness, poor concentration, irritability and paranoia caused by ATS use<sup>189</sup> can negatively affect a person's employment, housing and educational opportunities.<sup>190</sup> These effects can occur with occasional ATS use while more pervasive and significant impacts can occur as a result of long-term use.<sup>191</sup>
- 1.110 As one lived experience witness told the Inquiry: *'Within six months I was smoking enough that I had to resign from my private investigating job. I lost my relationship, my car. I was kicked out of home and lost everything I own.'*<sup>192</sup>
- 1.111 The loss of a job and the challenges of maintaining employment while using ATS can lead to increased drug use to cope with the associated stress.<sup>193</sup> Several lived experience witnesses described how ATS use affected their work.

*'I got sacked from my job after I took a week off sick to recover from a period of partying. I was consumed with shame and guilt. I knew that I was going to have to get help.'*<sup>194</sup>

*'Due to my meth use I couldn't work. Even though I stopped working to focus on my recovery, I couldn't actually work because I was using more. I would organise an interview and still be using at home at the time that I was meant to be there and would just call in sick.'*<sup>195</sup>

*'I was living a double life. By day I would work in a corporate environment and by night I was taking drugs and partying. I was not a very reliable employee around this time and some days I would not go to work if I could not get access to speed. I worked as a temporary employee for 10 to 15 years because I was so unreliable.'*<sup>196</sup>

## **Criminal activity**

- 1.112 The Inquiry heard from people with lived experience who had committed criminal offences to support their personal drug use.

*'In January 2015, I went to jail for drug possession and manufacturing charges. Since then I have been in and out of jail. All my offending was motivated by drugs including other offending like ... credit card fraud and counterfeit money.'*<sup>197</sup>

*'I got arrested for supplying, got an 18-month probation-supervised bond with parole ... There is a lot more violence when ice comes into play. I heard stories about home invasions, and a criminal element became a part of my life.'*<sup>198</sup>

- 1.113 Criminal offending can affect an individual's ability to reintegrate effectively back into the community, affecting their employment, education, financial dependence and relationships with family and other social networks.<sup>199</sup> People who have a criminal conviction relating to drug manufacture and/or drug supply are prohibited from accessing public housing in some areas.<sup>200</sup> Although this is aimed at enhancing community safety, it has implications for a person's access to housing, particularly in locations that may be closer to social support networks. Unstable housing is a critical risk factor associated with harmful drug use and is discussed further in Chapter 17.

- 1.114 The Inquiry heard how criminal records, often for low-level offences, can have damaging long-term implications. Challenges were identified in gaining clearances for Working With Children Checks, raising barriers to employment or mentorship with young people in the community.<sup>201</sup>

*'Most of our community have been profiled, stereotyped, put into incarceration, you know, and they don't get the chance to say, "Hey, I'm a better person than what I was back then. I've learnt, and from my learnings, I can teach somebody else not to go down that path".'*<sup>202</sup>

- 1.115 Some people who use ATS, particularly those who experience greater levels of marginalisation, including homelessness and mental health conditions, are also more likely to be victims of a crime.<sup>203</sup>

## **Harms to others**

### **Physical harms**

- 1.116 Use of ATS, particularly methamphetamine, can result in a range of behaviours that can harm others. This includes harms caused in road accidents<sup>204</sup> due to the driver's increased confidence, impulsivity, lethargy and exhaustion associated with their ATS use.<sup>205</sup> The social cost of these accidents includes property damage, loss of employment and physical injury.<sup>206</sup>
- 1.117 The World Health Organization has found that people who are under the influence of amphetamines are five times more likely to be involved in a fatal crash, more than six times more likely to be injured in a crash and more than eight times more likely to cause property damage from a crash.<sup>207</sup>

## **Social harms**

### ***Family adversity***

- 1.118 ATS use, particularly crystal methamphetamine use, can have a profound impact on families and friends of the person using.<sup>208</sup> The chronic stress and social isolation experienced by families as a result of a person's ATS use can affect their physical, emotional, social and economic wellbeing.<sup>209</sup>
- 1.119 Many witnesses gave evidence to the Inquiry about their experiences of the effects of dealing with their loved one's crystal methamphetamine use, including severe anxiety, trauma and post-traumatic stress.
- 1.120 Evidence to the Inquiry described how harmful use of drugs can expose family and friends to a range of harms, including stress and emotional strain, relationship conflict, family breakdown, physical violence, financial burden and intimidation because of unpaid drug debts.<sup>210</sup>

### ***Crime***

- 1.121 People in the community may become victims of crime committed as a result of a person's ATS use, including drug dealing, assaults, property crimes or other activities to fund drug use.
- 1.122 The Commonwealth Department of Health and Ageing and the European Monitoring Centre for Drugs and Drug Addiction have categorised criminal offences committed by people who use drugs as follows:<sup>211</sup>
- Psychopharmacological – antisocial and criminal behaviour resulting from a person being intoxicated. This type of crime is a significant concern when people use crystal methamphetamine. The Inquiry heard multiple stories and received multiple submissions on the violent behaviour of some people under the influence of crystal methamphetamine.
  - Economic compulsive – crimes committed to support drug use, typically by a person experiencing drug dependence. Submissions to the Inquiry observed that people may rely on various forms of theft and fraudulent activities to finance ATS consumption, including stealing from retail outlets, stealing food, breaking into cars and houses, and fraudulently claiming government welfare.<sup>212</sup>
  - Systemic – crimes of participating in the drug market. These include participation in the sale, importation, production, use and possession of ATS.

### ***Violence***

- 1.123 The link between violence and ATS use is complex. There is no evidence to show that ATS use directly causes violence, but there is considerable evidence that some people who use methamphetamine are at times violent. For example, in a UK study, 47% of people who used amphetamine interviewed for the study had committed a violent crime, and half of them associated the violence with their amphetamine use.<sup>213</sup> A study of detainees in WA found that detainees who used amphetamine were more likely than those who did not to commit property, robbery and weapons offences, but were no more likely to commit other violent offences.<sup>214</sup>
- 1.124 ATS use, particularly methamphetamine use, may make a person more prone to violent behaviour, whether or not this results in a criminal offence. While not all people who use methamphetamine will exhibit violent behaviour, a causal link has been established between methamphetamine use and behavioural effects including reduced inhibition, hyperawareness and hypervigilance that may result in physical aggression.<sup>215</sup>

- 1.125 In 2006, the NSW Bureau of Crime Statistics and Research (BOCSAR) and NDARC concluded that chronic methamphetamine use is associated with high levels of aggression, and a higher rate of violent offending compared to the general population.
- 'It is not clear, however, whether high levels of violent behaviour among methamphetamine users can be attributed to methamphetamine use per se, or whether they are related to factors that co-occur with methamphetamine use, such as the violence inherent in the drug market, polydrug use or pre-disposing personality.'*<sup>216</sup>
- 1.126 Not all research establishes a clear association between amphetamine use and violence. In 2009, BOCSAR studied whether an amphetamine charge increased the likelihood of a future charge involving violence. The research concluded that there was no evidence that being charged with an amphetamine offence increases the later risk of being charged with a violent offence. However, researchers noted the finding should not be regarded as a definitive test of the relationship between amphetamine use and violent behaviour.<sup>217</sup>
- 1.127 A range of factors influence the likelihood that a person using ATS will engage in violent behaviour, including how much and how often they take ATS, the presence of psychotic symptoms, a history of aggression and polydrug use.<sup>218</sup>
- 1.128 The Inquiry received evidence from a range of witnesses about the link between the use of ATS, particularly crystal methamphetamine, and violence.<sup>219</sup> Legal Aid NSW noted that its practitioners have seen many clients who use ATS become involved in violent offences, especially if their ATS use is compounded by mental health issues and/or other drug use.<sup>220</sup> Police officers said people who take crystal methamphetamine can be violent towards family and community members and the police.<sup>221</sup>
- 1.129 The Inquiry heard from a person with lived experience of crystal methamphetamine use that: *'Ice made me really angry and violent; no other drug has ever had that effect on me. Because I was using drugs so often, eventually they lost their effect, and I was constantly angry.'*<sup>222</sup>
- 1.130 The Inquiry also gathered a significant body of evidence that crystal methamphetamine is likely to increase the frequency and severity of domestic and family violence incidents, more so than other drugs. The effect of crystal methamphetamine on domestic violence is discussed in detail in Chapter 18.
- 1.131 The strongest evidence for a relationship between methamphetamine use and violent behaviour is when violence occurs in the context of methamphetamine-induced psychosis.<sup>223</sup> Frequent use of high doses of crystal methamphetamine may cause psychosis, leading to paranoid delusions, hallucinations and aggressive and violent behaviour.<sup>224</sup>
- 1.132 NDARC noted that a proportion of people experiencing methamphetamine psychosis will show hostile behaviour, and factors thought to influence this include polydrug use, impulsivity, a predisposition towards violence and circumstantial factors.<sup>225</sup>
- 1.133 The Inquiry received submissions that described interpersonal violence occurring from psychosis related to crystal methamphetamine use, with two councils reporting increased risks to council employees, and the wider public.<sup>226</sup> Northern Beaches Council described one example.

*'[A] murder of a young man by his friend using methamphetamine in a suburban street in 2018, was witnessed by many residents. Not only do these types of individual tragedies result in widespread trauma, they also result in increased fear and have a negative impact on the perception of safety amongst the wider community.'*<sup>227</sup>

- 1.134 In recent years in NSW, there have been reports of extreme cases where people intoxicated by crystal methamphetamine have caused significant harm to their family members.<sup>228</sup>

### **Environmental damage**

- 1.135 The production of ATS relies on a chemical process that uses highly flammable, very toxic and corrosive chemicals.<sup>229</sup> The process also produces a significant amount of waste, with an estimated 10kg of hazardous and toxic waste produced for each kilogram of pure methamphetamine produced.<sup>230</sup>
- 1.136 These toxic chemicals can pose serious long-term health risks to the public as they remain on surfaces long after the production process has finished. There is also an adverse environmental impact from the dumping of chemical waste into public spaces such as rivers, parks and roadsides.<sup>231</sup> The evacuation of affected areas, destruction of property and flow-on insurance costs can further affect local communities.<sup>232</sup> The national direct cost of assessment and remediation of contaminated sites is about \$10 million.<sup>233</sup>
- 1.137 In NSW, local councils have the regulatory responsibility for managing residual contamination and other hazards from the operation of illicit clandestine drug laboratories.<sup>234</sup> Laboratories producing ATS are mainly located in residential areas,<sup>235</sup> which has significant consequences on the local population.<sup>236</sup> Once a laboratory is identified, the local council has the power to issue a notice to the property owner to clean up the property and remove any harmful residue.<sup>237</sup>
- 1.138 Fire and Rescue NSW often supports NSW Police when responding to drug laboratories to address potential fires or explosions.<sup>238</sup> Fire and Rescue NSW told the Inquiry it assisted other governmental agencies in 109 drug-related incidents between March 2015 and January 2019.<sup>239</sup>

### **Economic harms**

#### **Business and workforce costs**

- 1.139 ATS use costs businesses and the wider economic productivity of NSW through reduced workforce productivity and safety, and poor health outcomes that affect work output.<sup>240</sup>
- 1.140 Research has established that amphetamine is one of the most commonly used illicit drugs at work.<sup>241</sup> People who use amphetamine are more likely to be absent from work or attend work under the influence of drugs compared to people who use other illicit drugs.<sup>242</sup>
- 1.141 A national estimate drawing from datasets on workplace compensation and injuries that resulted in work absenteeism estimated a cost of \$809 million from methamphetamine use in 2013–14.<sup>243</sup> In addition, absenteeism among people who use methamphetamine was estimated to cost workplaces about \$38.5 million.<sup>244</sup> A range of other workplace costs attributed to methamphetamine use were not quantified, such as staff turnover and employee wellbeing costs.<sup>245</sup>

- 1.142 The most severe impact on workforce productivity comes from deaths caused by ATS use. In 2013–14, this economic cost was estimated to be \$8.3 million a year or \$175 million over 30 years.<sup>246</sup> Other factors that increase costs for businesses include drug testing employees, reduced productivity from staff while coming down from a drug and absenteeism from education.<sup>247</sup>
- 1.143 The impact of ATS is more prominent in some industries and occupational groups.<sup>248</sup> For example, the hospitality, construction and transport industries have seen a much higher prevalence of methamphetamine use (9.5%, 5.4% and 5.4% respectively) compared to other industries.<sup>249</sup> There are also significantly different use patterns among different age groups, genders and in remote areas that may result in certain industries or occupations being more susceptible to these costs.<sup>250</sup> The occupational use of ATS is discussed in Chapter 8.

### ***Additional costs for government services***

- 1.144 ATS use can lead to substantial additional costs for government services. Generally, most of the costs of ATS use are driven by people experiencing harmful or dependent use.<sup>251</sup> These costs are incurred across various government agencies and cover:
- drug use prevention, harm reduction and treatment
  - health care (hospitals, GPs and ambulance)
  - crime (police, courts, prisons and victims)
  - child protection.<sup>252</sup>

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## Chapter 2. A history of drug use and policy in NSW

### Introduction

- 2.1 Throughout recorded history, people have used psychoactive substances to alter their consciousness. The cultural, social, political and legal contexts of drug use have evolved over time.
- 2.2 Public attitudes to drug use have also changed, and this has been reflected in policy and the law. Since at least World War II, Australia, in step with the international community, has adopted a punitive, prohibitionist approach to drug control. However, more recently those working in the AOD sector and international health and human rights organisations have advocated for a more compassionate, human rights and health-based approach.
- 2.3 ATS use and government responses to it in NSW should be considered against the historical background of drug use and drug policy in NSW over the past century. The lessons learned over time about the effectiveness of different responses to drug use can inform an effective response to ATS in NSW.
- 2.4 Although there are features of ATS use that make it different to use of other drugs, the challenges associated with harmful drug use are largely the same; NSW has dealt with these challenges before.

### Lessons from history

#### People have always used psychoactive substances

- 2.5 People have used psychoactive substances throughout recorded history in nearly all societies.<sup>1</sup> Alcohol was one of the earliest used psychoactive substances in most cultures, with records of such use dating back more than 5,000 years.<sup>2</sup> The consumption of psychoactive substances, including drugs such as marijuana, hashish and opium for cultural, medicinal and religious purposes, has been well documented.<sup>3</sup>
- 2.6 Psychoactive drugs have also played a significant role in historic shifts in politics, finance, geography and society. A notable example of the interplay of such factors is highlighted by the outcome of the First Opium War in the mid-19<sup>th</sup> Century between China and the United Kingdom. Tensions arose over the illicit opium trade into China, which the Chinese authorities sought to stop but which the British supported to fund trade that met their domestic demand for tea. As a result of the war, Hong Kong became a British colony and a number of Chinese cities were opened to British trade, including an active opium trade. China was opened to extensive Protestant missionary activity.<sup>4</sup>
- 2.7 In the Australian context, rum was used as a currency in colonial NSW from the late 18<sup>th</sup> Century due to a shortage of official currency, and it is believed that 19<sup>th</sup> Century white settlers used opium for medicinal purposes.<sup>5</sup>

## Different drugs have been of concern at different times in history

- 2.8 There have been social and political concerns about the recreational use of different drugs at different times in history.
- 2.9 NSW's first response to recreational drug use targeted the smoking of opium in the Chinese community in the mid-19<sup>th</sup> Century,<sup>6</sup> although the use of proprietary opium remedies among the European population was not restricted as it was regarded as 'medicinal'.<sup>7</sup> In an early example of the stigmatising effect of public discourse about drug use, commentary at the time concerning problematic drug use and the need for legal control was racist.<sup>8</sup>
- 2.10 The first drug law in colonial Australia was the *Act for granting a Duty of Customs on Opium 1857* (Vic), which imposed an import duty on opium. In the following years, other legislation was introduced imposing further tariffs on opium and banning smoking. Later that century, tariffs and duties were imposed on cannabis and morphia.<sup>9</sup>
- 2.11 In 1919, non-medical use of cocaine came to prominence in Australia following reports of its use by soldiers returning from World War I. In Sydney and Melbourne, cocaine use became associated with prostitution and the underworld. Despite evidence suggesting only small-scale use of cocaine in NSW and Victoria at the time, links between the perceived immorality of both the drug and the type of people that used it were factors that drove increased legislative controls in NSW and Victoria.<sup>10</sup>
- 2.12 Until the 1950s, heroin was widely used in medicine in Australia, including as an analgesic in obstetrics.<sup>11</sup> However, in the 1960s and 1970s, recreational use of heroin became problematic,<sup>12</sup> with a significant increase in the number of people with heroin dependence in Australia during the heroin 'epidemic' of the 1980s.<sup>13</sup>
- 2.13 Use of amphetamines has also been of concern at different times. Amphetamines were distributed in the early part of the 20<sup>th</sup> Century through the licit pharmaceutical industry in products marketed as relieving congestion, reducing appetite and treating depression.<sup>14</sup> Amphetamines were also used extensively during the 20<sup>th</sup> Century to address fatigue and increase alertness in both Allied and Axis forces during World War II.<sup>15</sup> Concerns about abuse and dependence arose from these cases of use, and in the 1970s amphetamines became subject to tightened controls following the development of international instruments such as the United Nations 1971 *Convention on Psychotropic Substances*.<sup>16</sup>
- 2.14 From the mid-1980s through the 1990s, MDMA was commonly used by young people attending dance parties,<sup>17</sup> and there has been increased media attention on deaths from MDMA of young people since 1995.<sup>18</sup>
- 2.15 Australian population data showed a significant increase in the number of people who used amphetamines between 1995 and 1998, doubling from 2 to 4% of the population.<sup>19</sup> This rise in use coincided with reports from the late 1990s of more potent forms of methamphetamine becoming available, as well as the detection by law enforcement of steadily increasing domestic production and record amounts of methamphetamine importation.<sup>20</sup>
- 2.16 By the mid-2000s, researchers and clinicians reported both an increase in methamphetamine-related harms and concern about the limitations of data sources.<sup>21</sup> These issues remain of concern today, and it is still not possible to reliably estimate the prevalence of use of ATS in NSW and the extent of associated harms. This is discussed in more detail in Chapter 7.

- 2.17 By 2006, media attention on crystal methamphetamine had increased, which coincided with significant policy activity.<sup>22</sup> In 2006, NSW amended the *Drug Misuse and Trafficking Act 1985* (NSW) to ban the sale, supply and display of 'ice' pipes,<sup>23</sup> and NSW Premier Morris Iemma called for a national leadership summit, culminating in the National Leadership Forum on Ice in 2006.<sup>24</sup>
- 2.18 The Forum brought together representatives from Australian state, territory and Commonwealth governments as well as the New Zealand Government to examine a range of issues including the prevalence of crystal methamphetamine, law enforcement responses and measures to increase the capacity of the health and social support systems to respond to the drug. The Forum produced a communique with a range of resolutions addressing interjurisdictional collaboration for ongoing strategies, law enforcement measures dealing with trafficking and manufacture, prevention and education, and treatment and other supports.<sup>25</sup> The Forum reported to the Ministerial Council on Drug Strategy, which had endorsed the development of a National ATS Strategy earlier in 2006.<sup>26</sup>
- 2.19 Since 2014 there has been another wave of concern over increases in methamphetamine use. The National Ice Taskforce, which reported in 2015, indicated concern regarding Australia's disproportionately high, and growing, use of methamphetamine compared to most other countries. The Taskforce made 38 recommendations to address a variety of issues arising in Australia as a result of the drug.<sup>27</sup> Although data show a significant and consistent reduction in the overall prevalence of meth/amphetamine use in Australia since 2001,<sup>28</sup> such concerns may be attributed to the shift towards the use of higher potency crystal methamphetamine among people who use any form of meth/amphetamine and their more frequent use.<sup>29</sup>

### Early attempts to prohibit drugs led to unintended consequences

- 2.20 In the late 19<sup>th</sup> Century, a thriving patent medicine industry was the primary source of the sale of drugs in Australia. It was subject to minimal regulation, although the early years of the 20<sup>th</sup> Century saw Australia move towards prohibition.<sup>30</sup> As is discussed in Chapter 11, prohibition can cause many unintended consequences and this was the experience of Australia's attempts during early Federation to prohibit some forms of drug use through drug laws.
- 2.21 At that time, public concern grew over the increasing use of opium in the Aboriginal community and the widespread harm it was causing. The sale of opium to Aboriginal people was banned in Queensland by the *Aboriginals Protection and Restriction of the Sale of Opium Act 1897* (Qld).<sup>31</sup> The *Opium Smoking Prohibition Act 1905* (Vic) prohibited the smoking, sale, manufacture and possession of opium in Victoria<sup>32</sup> and in 1895 SA introduced the *Opium Act 1895* (SA), prohibiting the supply of opium to Aboriginal people, a prohibition that was extended to non-Aboriginal people in 1906.<sup>33</sup> Similar legislation in the other states followed in subsequent years, with NSW passing the *Police Offences (Amendment) Act 1908* (NSW), which prohibited the sale, possession and smoking of opium and keeping a place for opium smoking.<sup>34</sup> Following Federation, the Commonwealth prohibited absolutely the importation of 'opium suitable for smoking'.<sup>35</sup>
- 2.22 The prohibition of opium led to the emergence of drug smuggling, a large increase in the price of illegal opium, the corruption of customs officers and adulteration of the product. One academic noted: '*In one step, the Commonwealth Government had established an underground market characterised by massive profit, corruption and impure product.*'<sup>36</sup> The Australian Comptroller-General of Customs reported to the Government of the time that prohibition of opium importation had not achieved the desired effect, that opium was still imported freely, and that gains made in price increases had in fact expanded the trade.<sup>37</sup>

## Illicit drugs including ATS have not always been illegal

- 2.23 It is important to note that the legal status of drugs is not necessarily related to their relative risk or harm.<sup>38</sup> Many drugs that currently carry criminal penalties, including MDMA and amphetamines, have been used as medicinal therapies and were often available over-the-counter at pharmacies and through licensed sellers.
- 2.24 A prime example of this are opioid medicines. In the late 19<sup>th</sup> Century, Australia boasted the world's largest per capita consumption of opium-based patent medicines,<sup>39</sup> used for a variety of purposes including as an infant sleeping aid and to treat pain and diarrhoea.<sup>40</sup>
- 2.25 As a consequence, Australia's early drug laws were largely regulatory or commercial in nature.<sup>41</sup> For example, the *Commerce (Trade Descriptions) Act 1905* (Cth) allowed for regulations to prohibit the importation of goods, including medicines, that did not have a suitable trade description to identify their contents.<sup>42</sup>
- 2.26 Amphetamine was first synthesised in the 1880s,<sup>43</sup> followed by methamphetamine and crystal methamphetamine, which were first synthesised in 1893 and 1918 respectively.<sup>44</sup> In 1912, MDMA was first mentioned in a patent certificate filed by the pharmaceutical company Merck, being a precursor chemical involved in a chemical method for synthesising a pharmaceutical coagulant drug, with the company discovering its potential psychoactive properties in 1927.<sup>45</sup>
- 2.27 From the early 1930s until the 1950s, amphetamines were widely available internationally as an over-the-counter inhaler with the brand name Benzedrine, marketed initially as a decongestant.<sup>46</sup> In 1937, the American Medical Association approved amphetamine tablets, marketed as Benzedrine Sulfate, for the treatment of narcolepsy, postencephalitic Parkinsonism and mild depression.<sup>47</sup> During World War II, there was widespread use of amphetamines among soldiers to reduce fatigue and delay sleep under combat conditions,<sup>48</sup> including in the United States and British military who supplied Benzedrine tablets to their servicemen.<sup>49</sup> From 1938, methamphetamine tablets were marketed by German pharmaceutical company Temmler as 'Pervitin', with numerous claims made for benefits including in recovery from surgery, treatment of asthma, hay fever, headaches, schizophrenia, depression and anxiety.<sup>50</sup> Methamphetamine tablets were also provided to servicemen by the German and Japanese militaries during World War II.<sup>51</sup>
- 2.28 The widescale use of amphetamines during World War II led to large increases in production and a consequent surplus of these drugs after the war, much of which became available on the black market.<sup>52</sup> Problems associated with widespread use of amphetamines became apparent in the post-war period. An early example of this was a severe epidemic of intravenous methamphetamine use in Japan following the war, where surplus stocks of injectable methamphetamine were made available on the domestic market and heavily promoted in over-the-counter sales. Up to 1.5 million people in Japan were estimated to be injecting methamphetamine, a problem that was brought to the attention of authorities due to psychiatric disorder presentations by people with problematic drug use. This prompted the Japanese Government to respond by heavily restricting the availability of methamphetamine and the introduction of penal sanctions for its use.<sup>53</sup>
- 2.29 From the late 1970s, some psychotherapists in the United States started to use MDMA as a psychotherapeutic tool after methylenedioxy-amphetamine (MDA), which had been investigated for the same purposes from the 1960s, was banned in 1970. The United States subsequently scheduled MDMA as a controlled substance in 1985.<sup>54</sup>

## Australia's response to drugs has been heavily influenced by an international punitive approach

- 2.30 The content of Australia's early drug laws prohibiting opium was similar to a number of state and municipal laws enacted in the United States since 1875 and to Canadian federal law. It has been suggested that these laws established a structure and precedent which have not been questioned since.<sup>55</sup>
- 2.31 The international community took an active position against the opium trade from the start of the 20<sup>th</sup> Century. In 1909, the United States convened a conference in Shanghai to combat the trade and use of opium. This was followed by a conference in The Hague in 1912 that resulted in the *International Opium Convention*, the first multilateral international drug control treaty.<sup>56</sup> The *International Opium Convention* articulated an emerging policy that opiates and other 'dangerous drugs' should be subject to international coordination and strict domestic regulation, to ensure only legitimate and medical use.<sup>57</sup>
- 2.32 In a move towards greater multilateral oversight over the 1912 *International Opium Convention*, in 1920 the League of Nations passed a resolution to establish the Advisory Committee on the Traffic in Opium and Other Dangerous Drugs. This Committee initially focused its efforts on gauging the extent of the world drug problem. As the United States was not a member of the League of Nations, the United Kingdom increasingly took the lead in promoting international drug control efforts in the interwar years.<sup>58</sup>
- 2.33 Following World War I, the *1925 Geneva Convention on Opium and Other Drugs*, ratified by Australia in 1926,<sup>59</sup> required parties to enact laws to limit the manufacture, import, sale, distribution, export and use of a range of drugs including opium, marijuana and morphine, except for scientific purposes.<sup>60</sup>
- 2.34 Under pressure from the Commonwealth ratification of the *Geneva Convention on Opium and Other Drugs* and growing concerns regarding cocaine use in the state, NSW introduced the *Police Offences Amendment (Drugs) Act 1927* (NSW). This legislation amended the law, making it an offence to possess a range of substances including morphine, cocaine, heroin and opium, except for medical use, with offenders subject to a maximum penalty of a fine of 250 pounds or to imprisonment for 12 months, with or without hard labour, or both.<sup>61</sup>
- 2.35 The *1931 Convention for Limiting the Manufacture and Regulating the Distribution of Narcotic Drugs*, ratified by Australia in 1934,<sup>62</sup> introduced the concept of 'drug scheduling', which applies different control measures to different drugs. Under the 1931 Convention, certain drugs were subject to stricter controls. For example, heroin was subject to a provision requiring parties to prohibit its export except in limited circumstances.<sup>63</sup>
- 2.36 Australia used heroin extensively for medical purposes in the early 20<sup>th</sup> Century, particularly during child birth. Following World War II, Australia continued such use in medical procedures, and Australia's domestic use of the drug doubled between 1946 and 1951. The United Nations, which succeeded the League of Nations, publicly criticised Australia for its rapid increase in heroin use, as did the World Health Organization.<sup>64</sup>
- 2.37 Although the National Health and Medical Research Council, the Royal Australian College of Physicians and the Royal College of Obstetricians and Gynaecologists advised against the abolition of medicinal heroin, the Commonwealth Government placed an outright ban on heroin in 1953. Complementary legislation was subsequently enacted in each Australian state and territory.<sup>65</sup>

- 2.38 During the 1950s, increasingly harsh drug laws were introduced in the United States. The ‘stepping-stone theory’ of the time held that use of cannabis led to use of heroin and resulted in highly punitive laws for cannabis possession and use. At the same time, a strong penal response emerged, with long prison sentences imposed for drug offences.<sup>66</sup>
- 2.39 At the insistence of the United States, international drug control treaties became increasingly prohibitionist through the 1950s.<sup>67</sup> In 1961, the *Single Convention on Narcotic Drugs* (Single Convention) was adopted and entered into force in December 1964.<sup>68</sup> The Single Convention superseded all previous international conventions, protocols and treaties and continues to be supported by the vast majority of United Nations member states. It remains, as amended,<sup>69</sup> one of three treaties that define the international drug control system.<sup>70</sup>
- 2.40 The preamble to the *Single Convention* states that the parties recognise ‘*that addiction to narcotic drugs constitutes a serious evil for the individual and is fraught with social and economic danger to mankind*’.<sup>71</sup> The implications of the use of such language have been examined in the literature,<sup>72</sup> and the broader implications of the international narcotics control regime for human rights have increasingly entered the focus of non-government organisations and human rights monitors.<sup>73</sup>
- 2.41 The key provision of the *Single Convention* is found in Article 4. This provides:
- ‘The parties shall take such legislative and administrative measures as may be necessary ... to limit exclusively to medical and scientific purposes the production, manufacture, export, import, distribution of, trade in, use and possession of drugs.’<sup>74</sup>*
- 2.42 The *Single Convention* pays little attention to the health harms associated with drug use and cemented a prohibitionist and law enforcement approach to the legal framework for drug control.<sup>75</sup>

### Social perceptions of drug use led to stigma and more punitive laws

- 2.43 In the late 1960s, American soldiers visiting Australia on leave during the Vietnam War introduced significant amounts of cannabis and heroin to Sydney.<sup>76</sup> The significant increase in drug use in Australia from the mid-1960s to the late 1970s coincided with such use becoming a defining element of the counterculture philosophy of the time.<sup>77</sup>
- 2.44 During that period, public opinion in Australia began to turn against recreational drug use.<sup>78</sup> The use of illicit drugs by the youth of Australia and other western nations provoked fears of social unrest and moral decay.<sup>79</sup> In 1967, Reverend Ted Noffs warned that LSD use was the fastest-growing drug problem in Sydney:
- ‘The hippies are hard to combat, because they have evolved a ‘moral’ drug-taking cult. LSD is the source of their religion, and they cannot be persuaded that it is morally bad ... these people are often immature. Quite often they are frustrated youngsters who have had no previous spiritual experience. They are confusing these drug-induced experiences with genuine spiritual feelings.’<sup>80</sup>*
- 2.45 The official response was increased emphasis on law enforcement and the passing of increasingly punitive laws to extend the range of drug offences and increase penalties. NSW introduced the *Poisons Act 1966* (NSW), which provided for a maximum penalty of \$2,000 or imprisonment for two years, with or without hard labour, or both for offences of manufacture, supply, use or possession of opium or marijuana, or for possession of other ‘drugs of addiction’ as defined in Schedule 8 of the Poisons list.<sup>81</sup>

- 2.46 In 1967, the Commonwealth Government enacted the *Narcotic Drugs Act 1967* (Cth) which restricted the manufacture and distribution of narcotic drugs with a strict system of licensing, in accordance with the *Single Convention*.<sup>82</sup> The same year, the *Customs Act 1901* (Cth) was amended to increase certain penalties for offences associated with unlawful importation of narcotic drugs.<sup>83</sup> In 1971, the *Customs Act* was further amended,<sup>84</sup> with certain offences involving a ‘trafficable quantity’ (as newly defined) of narcotic goods being made subject to significantly higher maximum penalties.<sup>85</sup>

### The ‘war on drugs’ and a shift towards a harm minimisation approach

- 2.47 In 1971, United States President Richard Nixon declared a ‘war on drugs’ stating that: ‘*Drug traffic is public enemy number one ...*’.<sup>86</sup> The ‘war’ was continued in 1972 in Nixon’s election campaign, which emphatically linked drug addiction with crime.<sup>87</sup>
- 2.48 The United States war on drugs prompted a further global shift in political responses to drugs. The United States proposed a new conference to agree on a number of additional drug control measures, which was held in Geneva in 1972 and resulted in a Protocol consisting of 22 amendments to the *Single Convention* intended to strengthen both supply and demand control efforts.<sup>88</sup> Under the new provisions, countries not only had a legal obligation to treat and rehabilitate people addicted to drugs, but also to take all practicable measures for the prevention of abuse of drugs, for the early identification of people involved, and their ‘social reintegration’. The Protocol also provided possible alternatives to incarceration.<sup>89</sup>
- 2.49 A new convention, the *1971 Convention on Psychotropic Substances*, came into force in Australia in 1982.<sup>90</sup> This convention covered a range of substances including ATS, hallucinogens such as LSD, sedative hypnotics and anxiolytics (benzodiazepines and barbiturates), analgesics and antidepressants. Additional substances were added in later decades.<sup>91</sup>
- 2.50 Although the *1971 Convention on Psychotropic Substances* requires parties to prohibit all use of substances listed in Schedule 1 except for scientific and very limited medical purposes by duly authorised people, this does not include ATS because amphetamine, dexamphetamine and methamphetamine are listed in Schedule 2. The *1971 Convention* requires party states to restrict the manufacture, trade and distribution of substances in Schedules 2, 3 and 4 subject to licence or other control measures, and also allows for the supply or dispensing of those substances for use by individuals pursuant to medical prescription.<sup>92</sup>
- 2.51 Article 22 of the *1971 Convention on Psychotropic Substances* requires parties to treat as a punishable offence any action contrary to a law or regulation adopted in pursuance of its obligations under the Convention. It requires that serious offences are liable to adequate punishment, particularly by imprisonment or other penalty of deprivation of liberty. Notwithstanding this provision, the Convention provides that when ‘abusers of psychotropic substances’ have committed offences, parties may provide for alternatives to conviction or punishment, including the provision of treatment, education, aftercare, rehabilitation or social reintegration.<sup>93</sup>
- 2.52 In response to the *1971 Convention on Psychotropic Substances* (1971 Convention), the Commonwealth Government enacted the *Psychotropic Substances Act 1976* (Cth). This Act approved Australia’s ratification of the 1971 Convention and imposed controls over certain psychotropic substances passing through Australia.<sup>94</sup>

- 2.53 In 1977, the *Customs Act* was amended to provide for the forfeiture of the proceeds of drug trafficking,<sup>95</sup> and in 1979 penalties for offences under this Act were increased. For example, the maximum penalty for offences pursuant to section 235 of the Act,<sup>96</sup> which prescribed penalties for a variety of offences in relation to narcotic goods, such as smuggling and prohibited importation,<sup>97</sup> was increased from 25 years imprisonment to imprisonment for life where the narcotic goods concerned were not less than the applicable commercial quantity.<sup>98</sup>
- 2.54 In the 1970s, a number of government inquiries were established to examine drug-related issues, including organised crime, drug trafficking and police corruption.<sup>99</sup> One key question was the treatment of cannabis in relation to other illicit drugs.
- 2.55 In 1973, a report by the US Commission on Marihuana [sic] and Drug Abuse concluded that the possession of small amounts of marijuana should be decriminalised. As a result, many US states relaxed controls on cannabis use in the 1970s.<sup>100</sup> Similarly, in the mid-1970s some Australian jurisdictions amended laws to distinguish cannabis from other illicit drugs. For example, in 1975, the ACT reduced the maximum penalty for possession of less than 25g of cannabis to \$100, and in 1977 the NT set the maximum penalty for a first offence of cannabis use or possession at \$500.<sup>101</sup>
- 2.56 Another important issue at the time was the link between drugs and organised crime. The 1973 *Royal Commission into Organised Crime* was established under Justice Athol Moffitt in response to political and police corruption in NSW between 1965 and 1976. The Commissioner was concerned that international heroin smuggling links would be forged in NSW. However, his recommendations were not acted upon.<sup>102</sup>
- 2.57 In 1977, the *NSW Royal Commission into Drug Trafficking* (more commonly known as the Woodward Royal Commission) looked at links between the mafia and police, and the nature of the trade in a range of drugs, including cannabis, heroin, amphetamines, cocaine and hallucinogens. It also reported on the treatment of drug offenders and the existing statutory provisions for dealing with drug offences. In his report, Mr Justice Woodward urged the NSW Government to increase the maximum penalty for serious drug trafficking offences, suggested that police investigating drug trafficking should have greater powers, and called for a new national crime intelligence unit ‘to coordinate the collection of data’. He said suggestions that people be allowed to grow small numbers of marijuana plants were ‘divorced from reality’.<sup>103</sup>
- 2.58 Other inquiries in this era included the 1971 *Commonwealth Senate Select Committee on Drug Trafficking and Drug Abuse*, the 1978 *NSW Joint Parliamentary Committee Upon Drugs* and the 1980 *Australian Royal Commission of Inquiry into Drugs*. A number of these inquiries distinguished between the harm caused by cannabis and narcotics such as heroin and supported the decriminalisation of personal use of cannabis.<sup>104</sup>
- 2.59 The 1980 *Australian Royal Commission of Inquiry into Drugs* recommended against decriminalisation. It concluded that this approach would be contrary to the *Single Convention* and would lead to calls for decriminalisation of other illicit substances. The Royal Commission recommended that consideration of cannabis use be delayed for 10 years during which time information on the drug be collected and analysed.<sup>105</sup>
- 2.60 In the 1980s, illicit production and trafficking of opium/heroin and coca/cocaine continued to rise, as did use of these drugs. At the same time, ATS were starting to be manufactured in clandestine laboratories in North America, Europe and south-east Asia. The 2008 *World Drug Report* stated that the situation at this time ‘was steadily and rapidly deteriorating and drug abuse was described as reaching epidemic proportions in many parts of the world’.<sup>106</sup>

- 2.61 In 1984, work began on a new multilateral treaty aimed at establishing a comprehensive set of laws and guidelines to combat illicit drug trafficking.<sup>107</sup> The 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* came into force in November 1990. It required signatories to establish as criminal offences, in domestic law, a comprehensive list of activities involved in or related to international drug trafficking. It required parties to cooperate in taking broad measures to suppress illicit drug trafficking internationally, and also to enact domestic laws to suppress the drug trade. The requirements included implementation of laws addressing money laundering, confiscation of assets, extradition, mutual legal assistance and trade in chemicals, materials and equipment used in the manufacture of controlled substances.<sup>108</sup>
- 2.62 One of the controversial aspects of the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* was that it required parties to make drug trafficking activities 'criminal offences'. The *Single Convention* had only obliged parties to make drug trafficking activities 'punishable offences'.<sup>109</sup> In addition, Article 3(2) established that possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption be criminalised. This provision stated:
- 'Subject to its constitutional principles and the basic concepts of its legal system, each Party shall adopt such measures as may be necessary to establish as a criminal offence under its domestic law, when committed intentionally, the possession, purchase or cultivation of narcotic drugs or psychotropic substances for personal consumption contrary to the provisions of the 1961 Convention as amended or the 1971 Convention.'*<sup>110</sup>
- 2.63 However, the 1988 *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances* did provide that, in relation to offences relating to the possession, purchase or cultivation of drugs for personal consumption:
- 'The parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence... measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender.'*<sup>111</sup>

### Australia led the world by moving towards harm minimisation

- 2.64 Australia's consistent commitment to a harm minimisation approach to drug use since 1985 has helped establish its reputation as relatively progressive in relation to drug policy.<sup>112</sup> Harm minimisation acknowledges that there will always be some people in society who use alcohol and other drugs. Harm minimisation policies aim to prevent or reduce drug-related harms.<sup>113</sup>
- 2.65 This approach followed a significant increase in the number of people with heroin dependence in Australia in the 1980s. The visibility of heroin use and property crime committed by people with heroin dependence led to a special Premiers' conference in 1985 which launched the National Campaign Against Drug Abuse (NCADA).<sup>114</sup> NCADA formed the basis of the first National Drug Strategy and the adoption of the harm minimisation framework that is still applied today.<sup>115</sup>
- 2.66 Two important developments added weight to NCADA. First, in 1984, Prime Minister Bob Hawke announced publicly that his daughter used heroin. Second, HIV/AIDS started to spread rapidly and people who injected drugs were identified as a key group at risk due to the sharing of injecting equipment.<sup>116</sup>

- 2.67 NCADA enjoyed bipartisan political support and was a cooperative venture between Commonwealth and state/territory governments and the non-government sector. It had a multi-drug approach, encouraged partnerships between sectors (health, law enforcement, government and non-government organisations) and supported methadone treatment programs.<sup>117</sup>

### Compassion has been an element of drug policy since the 1999 NSW Drug Summit

- 2.68 The 1990s saw a steep rise in opioid overdose deaths in Sydney and Melbourne. During this decade, the price of heroin in Sydney almost halved and the purity increased significantly.<sup>118</sup>
- 2.69 As contemporary drug policy and resourcing were perceived to not effectively address illicit drug use in NSW, Premier Bob Carr hosted the 1999 Drug Summit in an attempt to achieve bipartisan support for new and innovative strategies and approaches to address drug use and harms in NSW.<sup>119</sup>
- 2.70 The Summit approached problems associated with drug use from an holistic and community-focused perspective. It prioritised treatment and principles of harm reduction over a criminal justice response.<sup>120</sup> Former NSW Attorney-General Jeff Shaw commented several years after the Summit that it: *'introduced the concept of compassion into drug policy and ... emphatically embraced the concept of an evidence-based approach'*.<sup>121</sup>
- 2.71 Taking a bipartisan approach, the Summit produced 20 general principles and 172 resolutions covering a broad range of issues related to illicit drug use in NSW including prevention, education, the role of police and the criminal justice system.<sup>122</sup>

### Notable recommendations of the 1999 NSW Drug Summit

- That drug dependency and misuse be recognised as major health issues and integrated into daily health practice.
- The provision of basic drug and alcohol treatment services in local communities.
- The expansion of diversionary measures including formalisation of police discretionary powers to caution minor drug offenders, and the removal of jail penalties for certain minor cannabis related offences.
- That measures be taken to address the level of drugs in correctional facilities.
- That the Government support a trial of medically supervised injecting rooms in communities where there is local support for the initiative.
- That methadone clinics be regulated and that the quality of their services increase.
- The establishment of a Youth Drug Court as part of the Children's Court System.
- The expansion of school-based drug education programs.
- The promotion of the involvement of health care service providers, including GP, in drug and alcohol services.<sup>123</sup>

- 2.72 There was a degree of community backlash after the Summit, with conservative media commentators, church leaders, parents, councils and academics coming out against some of the recommendations, including active opposition to supervised injecting rooms.<sup>124</sup> However, the NSW Government accepted the majority of the Summit's recommendations and they formed the basis of the July 1999 Government Plan of Action on Drugs.<sup>125</sup>
- 2.73 The NSW Government committed \$176 million to implement the Government Plan of Action over four years.<sup>126</sup> This commitment was the most significant enhancement of funding for drug and alcohol and associated support services since the development of the 1985 National Drug Strategy.<sup>127</sup>

- 2.74 The Office of Drug Policy was established within the NSW Cabinet Office to coordinate implementation of the Government's investment. This was supported by an expert advisory committee chaired by drug policy expert Professor Ian Webster which reported directly to the Premier.<sup>128</sup>
- 2.75 In 2001, the Government reported on progress against the implementation of projects arising from the Drug Summit's 172 recommendations.<sup>129</sup> The progress report detailed programs aimed at expanding treatment, diverting offenders into treatment, supporting young people to aid in prevention of drug dependence, supporting families, workforce development, development of community partnerships, improving drug awareness, regional treatment development and evaluation measures.<sup>130</sup> Key funding allocations over four years were directed to health care and treatment (\$112.9 million), prevention and early intervention services for families and young people (\$25.5 million), law enforcement and the justice system (\$5.3 million), education and community action against drugs (\$9.3 million) and programs in correctional facilities including drug detection and treatment (\$23.6 million).<sup>131</sup>
- 2.76 Among many other significant programs established and funded since the Drug Summit, the progress report highlighted the establishment of the Magistrates Early Referral into Treatment (MERIT) program, that a trial Youth Drug Court had been established, and that as part of the General Practitioner Project 11 GP liaison workers had been employed to assist GPs and pharmacists to manage and treat people who were dependent on drugs across all area health services.<sup>132</sup>
- 2.77 Although many of the problems discussed at the Summit persist today, the Summit remains a landmark event in the history of drug policy in NSW. Bipartisan political support for the Summit allowed genuine consideration of the issues and evidence.<sup>133</sup> This resulted in agreement to reconceptualise the way that drug policy and law should be focused and implemented, shifting from a law and justice focus towards a health-focused response.

## Progress has stalled since the Drug Summit

- 2.78 Despite substantial developments in NSW policy following the 1999 Drug Summit, progress has stalled and, in some cases, gone backwards. For example, the Youth Drug Court closed in 2012 and has not been replaced with a youth-specific drug diversion program.<sup>134</sup> Despite evidence of the continued need to better support GPs,<sup>135</sup> the GP liaison service is no longer centrally funded and NSW Health advised the Inquiry that only a small number of local health districts maintain a GP liaison position.<sup>136</sup>

## NSW developments

- 2.79 Following the 1999 Drug Summit and the Government's response, NSW AOD policy has been guided in turn by the NSW Drug Treatment Services Plan 2000–2005<sup>137</sup> and the NSW Health Drug and Alcohol Plan 2006–2010.<sup>138</sup> This has not yet been replaced despite the National Drug Strategy requirement that each jurisdiction develop their own strategies detailing local priorities.<sup>139</sup>

- 2.80 The 2006–2010 Drug and Alcohol Plan cited the 2004 National Drug Strategy Household Survey, which indicated there had been a reduction in recent illicit drug use between 1998 and 2004. The Plan indicated that one of the key contributing factors to this reduction was a significant expansion of treatment services by the NSW Government between 1999 and 2005, including expansion and development of pharmacotherapy programs, a significant increase in residential rehabilitation beds and two new in-patient detoxification services.<sup>140</sup> The Plan listed a range of existing Government initiatives that arose from the 1999 Drug Summit and the 2003 Summit on Alcohol Abuse, including the establishment of 67 MERIT residential rehabilitation beds; eight drug and alcohol clinical nurse consultant positions to support the health workforce; 62 new residential rehabilitation beds, and a Comorbidity Steering Committee established by NSW Health to oversee projects related to comorbidity and supervise a systems-wide analysis of relevant services.<sup>141</sup>
- 2.81 In 2008, NSW Health published the Comorbidity Framework for Action as a basis for addressing the issues presented by concurrent problematic AOD use and mental health disorders. The Framework outlined priorities in workforce planning, infrastructure and systems development, responses in priority settings such as emergency departments, residential rehabilitation and rural areas for priority clients, and the improvement of prevention and early intervention strategies to address the challenges faced by health services in treating comorbidity in the AOD and mental health sectors.<sup>142</sup> The Framework identified people who use amphetamine and who are experiencing mental health disorders as priority clients requiring specific and immediate responses.<sup>143</sup>
- 2.82 Despite the development of the 2008 Framework, a 2015 review published by NSW Health about models of care for comorbid mental illness and illicit drug use indicated that single disorder treatment models remain dominant, as opposed to integrated care.<sup>144</sup>

### National developments

- 2.83 In 2006, the Ministerial Council on Drug Strategy initiated the development of the National Amphetamine-Type Stimulant (ATS) Strategy 2008–2011 (ATS Strategy). The ATS Strategy was developed in the context of the National Drug Strategy 2005–2009 and its harm minimisation approach. The ATS Strategy prioritised community awareness of ATS use, supply and use of ATS, problems associated with ATS use, and organisational and system capacity to prevent and respond to such problems.<sup>145</sup>
- 2.84 On 8 April 2015, the National Ice Taskforce was established to advise the Commonwealth Government on the development of a National Ice Action Strategy. Outlining the priority of the Commonwealth Government in combating crystal methamphetamine, the terms of reference establishing the National Ice Taskforce cited Australian Crime Commission reports that indicated significant growth in detection of importation, manufacture and supply of crystal methamphetamine despite increased investment in border protection.<sup>146</sup> The National Ice Taskforce produced a final report on 6 October 2015,<sup>147</sup> with the resulting recommendations informing the National Ice Action Strategy, which was signed by the members of the Council of Australian Governments on 11 December 2015.
- 2.85 The National Ice Action Strategy operates as a sub-strategy of the National Drug Strategy, and is aimed at reducing the prevalence of crystal methamphetamine use and resulting harms through prevention of use, assistance for stopping use, and harm reduction for people who use drugs and others in the community.<sup>148</sup> In response to Recommendation 32 of the National Ice Taskforce final report, the National Ice Action Strategy outlined the formation of the Ministerial Drug and Alcohol Forum, which was established to oversee the development, implementation and monitoring of Australia's national drug policy framework, including the National Ice Action Strategy, from 2016.<sup>149</sup>

## Previous inquiries

2.86 A number of recent inquiries in Australia have examined methamphetamine and drug law reform generally, the reports of which are referred to extensively throughout this report. These include the:

- 2017 NSW *Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW*<sup>150</sup>
- 2014 Victorian *Parliamentary Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria*<sup>151</sup>
- 2015 Commonwealth National Ice Taskforce<sup>152</sup>
- 2018 Victorian *Parliamentary Inquiry into Drug Law Reform*<sup>153</sup>
- 2018 Commonwealth *Parliamentary Inquiry into crystal methamphetamine (ice)*<sup>154</sup>
- 2018 Government of WA, *Methamphetamine Action Plan Taskforce*<sup>155</sup>
- 2019 WA *Parliamentary Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community*<sup>156</sup>

### ***The 2017 NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales***

2.87 In 2017, the Health and Community Services Committee of the NSW Legislative Council commenced an inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW and its final report was published in August 2018. The report included a suite of recommendations relating to the development of planning, resourcing and standards to better connect people living in non-metropolitan areas of NSW to drug treatment services.<sup>157</sup>

2.88 The report included recommendations to review the Drug Court and the MERIT program, including the feasibility of expanding them to additional regional areas; to extend the duration of non-government AOD service funding grant timeframes; to investigate the efficacy of a scheme to establish full-time local Aboriginal trainee positions alongside every skilled position recruited in areas with a significant Aboriginal population, and to trial adult and youth Koori Courts in various regional locations.<sup>158</sup> The NSW Government responded to the final report on 21 January 2019, indicating broad support for its recommendations.<sup>159</sup>

### ***The 2014 Victorian Parliamentary Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria***

2.89 In 2014, the Law Reform, Drugs and Crime Prevention Committee of the Parliament of Victoria held an Inquiry into the supply and use of methamphetamine, particularly crystal methamphetamine, in Victoria. A two-volume report was published in September 2014. It found that extra support was required in the areas of health, law enforcement, education and family support in Victoria.<sup>160</sup>

2.90 The report made 54 recommendations, which included support for the establishment of a Ministerial Council on Methamphetamine and the development of a Victorian state methamphetamine action plan; support for drug education and information provision, including for families; support for workforce development specifically relating to amphetamines across a range of workforce sectors; support for the expansion of the Drug Court of Victoria; support for the provision of culturally appropriate programs and resources on methamphetamine to the Aboriginal community; support for improved access to treatment for regional areas of Victoria; and support for improved data collection.<sup>161</sup>

- 2.91 The Victorian Government responded to the report on 17 March 2015, announcing that the Victorian Ice Action Taskforce, chaired by the Premier and comprised of Ministers and expert stakeholders, had developed an Ice Action Plan which had drawn heavily from the report's recommendations.<sup>162</sup> The Ice Action Plan had six objectives: a focus on prevention and early intervention; reducing the supply, manufacture and distribution of crystal methamphetamine; reducing the impact of crystal methamphetamine on individuals, families and communities; building workforce capacity; working together for better outcomes through local community action and tailored responses to meet the needs of Victoria's diverse communities; and strengthening the evidence base. The delivery of the Plan was supported by \$45.5 million in new funding across a range of initiatives relating to the Ice Action Plan's objectives.<sup>163</sup>

### ***The 2015 Commonwealth National Ice Taskforce***

- 2.92 The National Ice Taskforce was established to advise the Commonwealth Government on the development of the National Ice Action Strategy. In its final report, one of the key findings was that, despite law enforcement agencies' strong response to disrupt the supply of crystal methamphetamine, the market in Australia remained strong, with the drug being easily accessible and its price remaining stable.<sup>164</sup> The National Ice Taskforce made 38 recommendations that addressed support for families, communities and frontline workers; prevention; tailoring of service and support; strengthening of law enforcement; the improvement of governance and building a better evidence base.<sup>165</sup>
- 2.93 The Commonwealth Government responded to the National Ice Taskforce report in December 2015. The response indicated the formation of the National Ice Action Strategy and announced a package supported by almost \$300 million in new funding that would focus on empowering local communities and supporting families; targeting prevention and education to those most at risk; further investment in treatment and workforce support; focused law enforcement and better research, evidence and guidelines.<sup>166</sup> These focus areas also form the five areas of action for the National Ice Action Strategy.<sup>167</sup>
- 2.94 The National Ice Taskforce's recommendations informed a number of significant national policy developments. Recommendation 32 of the National Ice Taskforce report called for Commonwealth, state and territory governments to introduce a simplified governance model to support greater coordination of government sector responses to drug use. The National Ice Action Strategy responded to that recommendation by outlining the formation of the Ministerial Drug and Alcohol Forum (MDAF) to oversee the development, implementation and monitoring of Australia's national drug policy framework, including the National Ice Action Strategy, from 2016.<sup>168</sup>
- 2.95 The National Ice Taskforce also recommended that Commonwealth, state and territory governments should work together to develop an online curated toolkit of information and resources to support families and communities to better understand and respond to the problems caused by crystal methamphetamine.<sup>169</sup> This recommendation has since been realised through the development of the resource Cracks in the Ice, an online toolkit providing evidence-based information and resources about crystal methamphetamine for the Australian community.<sup>170</sup>
- 2.96 Another National Ice Taskforce recommendation stated that governments should work together to expand and improve data sources available for central analysis of illicit drug trends, including the establishment of a national wastewater analysis capability.<sup>171</sup> This recommendation has since been implemented through the Australian Criminal Intelligence Commission's ongoing National Wastewater Drug Monitoring Program.<sup>172</sup>

### ***The 2018 Victorian Parliamentary Inquiry into Drug Law Reform***

- 2.97 In 2015 the Law Reform, Road and Community Safety Committee of the Parliament of Victoria received terms of reference for an *Inquiry into Drug Law Reform*. The Committee started work on the Inquiry in February 2017 and produced a final report in March 2018. The Inquiry heard it was important to acknowledge the different types of drug use when developing strategies to prevent use and minimise harms. It also identified growing recognition among governments and the community that a greater balance between traditional law enforcement and health-based responses to drug use would have a broader positive effect on the health and safety of communities.<sup>173</sup>
- 2.98 The Inquiry's report made 50 recommendations, which included a recommendation to treat offences of personal use and possession for all illicit substances as a health issue rather than a criminal justice issue, including through removal of the discretion involved with current police drug diversion processes.<sup>174</sup> The Inquiry also recommended a review of harms (such as increased injecting use of methamphetamines and other drugs) arising as a result of current laws that prohibited or discouraged non-injecting routes of drug administration.<sup>175</sup>
- 2.99 A number of recommendations were also made relating to 'safe events', including for consideration of models for drug checking services with a view to a potential Victorian trial, and also a recommendation that Victorian Police commission an independent evaluation of the use of drug-detection dogs at music festivals and other public spaces to determine their effectiveness and any unintended consequences or risk of harm.<sup>176</sup>
- 2.100 The Victorian Government provided a response to the Inquiry in August 2018. The response outlined the Victorian Government's ongoing and future strategies as they related to three themes of better, earlier treatment; saving lives and preventing harm; and safer communities. Though the response was generally supportive of the Inquiry and its work, it indicated that the Victorian Government would maintain a clear position against changes such as pill testing and decriminalisation of drugs.<sup>177</sup>

### ***The 2018 Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)***

- 2.101 On 18 March 2015, the Commonwealth Parliamentary Joint Committee on Law Enforcement initiated an inquiry into crystal methamphetamine. The Committee tabled its first report on 6 September 2017 and a final report on 27 March 2018. The first report primarily examined law enforcement responses to crystal methamphetamine in Australia, the prevalence of crystal methamphetamine in Australia, and Australia's drug strategies.<sup>178</sup> The final report examined treatment and harm reduction measures, funding of treatment services as part of the National Ice Action Strategy, and the decriminalisation of illicit drugs.<sup>179</sup>
- 2.102 The first report made eight recommendations, the first of which was that progress reports and the midpoint review provided to the MDAF and Council of Australian Governments on the implementation of the National Drug Strategy 2017–2026 and the National Ice Action Strategy be made publicly available. Other recommendations of the first report related to implementation of law enforcement measures and legislation, expanding or implementing drug diversionary programs subsequent to review, expanding international collaboration in relevant international forums, and monitoring of availability, purity and price of illicit drugs to better determine the impact of law enforcement and other strategies on the illicit drug market.<sup>180</sup>

- 2.103 The Committee's final report made an additional 15 recommendations that primarily focused on improving access to and quality of treatment. The final report examined demand and treatment policies, at-risk communities, harm reduction measures, funding of AOD services and decriminalisation. The Committee concluded that the current approach to addressing methamphetamine use in Australia was not working, and that the focus should shift from methamphetamine as a law enforcement problem to a health issue within an environment where treatment and support are readily available and without stigmatisation.<sup>181</sup> The final report included recommendations that accorded with this conclusion, including recommendations to address stigma as a barrier to seeking support and treatment, and that the Commonwealth, state and territory governments rebalance AOD funding across the three pillars of the National Drug Strategy (supply, demand and harm reduction strategies).<sup>182</sup>
- 2.104 The Commonwealth Government has not provided a response to the Committee's reports.<sup>183</sup>

### ***The 2018 Government of WA, Methamphetamine Action Plan Taskforce***

- 2.105 Following a 2017 WA state election commitment, the WA Government established a state-wide Methamphetamine Action Plan (MAP).<sup>184</sup> On 26 June 2017, the Methamphetamine Action Plan Taskforce was established to provide advice to the WA Government and inform the implementation of the MAP. The Taskforce produced its final report in August 2018, making 57 recommendations.<sup>185</sup>
- 2.106 The Taskforce recommendations addressed a number of key themes that arose during its inquiry. These themes included that methamphetamine use is a health and community issue that cannot be solved by law enforcement alone; the need to provide better access to treatment; the need for prevention and early intervention; stigma as a barrier; the importance of harm reduction strategies; the special needs of particular groups, including those in regional areas, Aboriginal communities and justice populations; the need for ongoing support and aftercare; the need to find alternative models to regulate and control the use of drugs in the community; and the importance of leadership in implementing and tracking progress of actions arising from the report.<sup>186</sup>
- 2.107 Addressing the need to find alternate models for regulation, the Taskforce recognised the limitations of criminalisation and imprisonment of people who use drugs and concluded that there is a need for comprehensive public consideration of the ways in which illegal drugs are treated in the community. It consequently recommended that a WA Parliamentary Committee inquire into and report on alternative models for drug regulation, regulatory systems and controls in other jurisdictions.<sup>187</sup>
- 2.108 The report also made a number of recommendations addressing the needs of particular communities and groups in WA. Addressing regional investment, the report recommended the development of regional AOD plans to promulgate a local approach to planning, investment, delivery and evaluation of services.<sup>188</sup> The report also made several recommendations aimed at meeting service needs of Aboriginal communities, including for the development and delivery of culturally appropriate models of residential rehabilitation.<sup>189</sup> Recommendations also addressed the vulnerability of justice populations to high rates of methamphetamine use, including a recommendation that the Department of Health and Department of Justice introduce needle and syringe exchange programs in WA prisons.<sup>190</sup>

- 2.109 The WA Government provided a response to the Taskforce report on 26 November 2018, which was generally supportive of most of the recommendations, though the Government did not support the introduction of needle and syringe exchange programs in WA prisons.<sup>191</sup> The response noted that, as recommended, a Parliamentary Committee had been established to conduct an Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community.<sup>192</sup>

***The 2019 WA Parliamentary Inquiry into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community***

- 2.110 The WA Legislative Council established a Select Committee into Alternate Approaches to Reducing Illicit Drug Use and its Effects on the Community (the Committee) on 17 October 2018. The Committee tabled its final report containing 46 recommendations on 28 November 2019.
- 2.111 The report examined approaches to reducing harm relating to illicit drug use in a variety of jurisdictions and compared their effectiveness with approaches currently used in WA,<sup>193</sup> concluding that a variety of approaches to drug policy, both in Australia and internationally, had found success in reducing drug-related harms through shifting policy priorities from prohibition to health, prevention and harm reduction.<sup>194</sup>
- 2.112 The Committee summarised its recommendations as calling for the prioritisation of the protection of individuals and the community from drug-related harms; that drug use should be treated primarily as a health issue; that criminal penalties for drug use and possession be replaced with administrative penalties; that current practices are reviewed and continually improved in line with contemporary evidence; that people who need help for drug-related issues, including those in regional areas or prison, should be able to access that help; and that measures be in place to reduce harms for those who are unwilling or unable to stop their drug use.<sup>195</sup>
- 2.113 Recommendations supported the investigation, development and implementation of either an expanded police drug diversion program or an administrative decision-making body and associated process for dealing with drug use and possession; an independent evaluation of the efficacy and cost-effectiveness of using drug-detection dogs at music festivals; consideration of a trial drug checking service for optimising safety at music festivals and the establishment of an early warning system for dangerous substances; an investigation into the viability of needle and syringe programs in prisons; and that the next iteration of the WA Alcohol and Drug Interagency Strategy should be a 10-year strategy, which addresses priorities and recommendations put forward by the Committee and which is evaluated every two years.<sup>196</sup>
- 2.114 The WA Government is due to provide a response to the Committee report in early 2020.

## Conclusion

- 2.115 Examination of the past demonstrates that drug use has been a constant feature of human history and that attitudes towards drug use have varied across cultures and eras. A relatively laissez-faire attitude in 19<sup>th</sup> Century western culture was replaced by a more prohibitionist approach in the 20<sup>th</sup> Century, with the implementation of international conventions seeking to respond to an ever-increasing array of new psychoactive substances, as well as the more established illicit drugs.

- 2.116 The last quarter of the 20<sup>th</sup> Century saw the emergence and wide acceptance of harm minimisation approaches acknowledging that some drug use will inevitably occur yet seeking to minimise its harmfulness. In more recent times (as discussed in Chapter 11), international drug policy has undergone a profound transformation, and many states have expressed increasing concern that a strictly prohibitionist approach may, in fact, create more harms than it prevents. They have examined closely and in many instances introduced policies of diversion or decriminalisation for simple use and possession, prioritising health and treatment rather than punishment and its attendant harms and stigma. These trends can be seen in several of the Australian reports and inquiries described above, and in the 2019 Communique of the United Nations Chief Executive Board (also discussed in Chapter 11), which encourages member states to introduce policies of decriminalisation of simple use and possession of drugs.
- 2.117 The policy initiatives that were generated as a consequence of the 1999 NSW Drug Summit provide a good example of the benefit that can be gained from pragmatic drug policy being introduced under strong government leadership. However, this history has demonstrated that if insufficient momentum is maintained and drug policies are allowed to lapse or become outdated, new and extreme problems will inevitably emerge, as has been the case with ATS.

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## Chapter 3. Trauma and other social determinants of amphetamine-type stimulant use

### Introduction

- 3.1 It is well established that the development of harmful drug use is generally the result of a complex interaction of individual and environmental risk factors.<sup>1</sup> Drug prevention programs and approaches to drug treatment have traditionally centred on changing individual behaviours<sup>2</sup> through treatments such as cognitive behavioural therapy. However, efforts that are confined to a focus on the individual often have limited effect – successful strategies address the complex factors in people's lives and environment that influence them to use drugs in a harmful way.<sup>3</sup>
- 3.2 Different social factors can influence whether someone starts using ATS, how they use them, whether they continue to use and the harms that they might experience.<sup>4</sup> As detailed throughout this report, the Inquiry received a large volume of evidence showing that harmful and dependent drug use is often rooted in complex social, economic and psychological determinants such as socioeconomic disadvantage, unemployment, homelessness and trauma.
- 3.3 Factors such as higher education levels, maintaining employment, taking on family responsibilities and social supports and networks that support a positive approach to reducing drug use can each play a role in helping a person to stop using drugs.<sup>5</sup> Fundamental pragmatic factors such as homelessness and living in a remote location can reduce access to treatment that is necessary to support a person to stop using drugs.<sup>6</sup> This is discussed further in Chapter 17.
- 3.4 Understanding these social factors helps ensure that strategies to address drug use address the broader social and health needs of people who use drugs and their families, and so have a greater likelihood of success.

### ATS use occurs across all parts of the community

- 3.5 People who use ATS reflect the spectrum of Australian society,<sup>7</sup> but use of methamphetamine and MDMA typically varies according to levels of socioeconomic advantage.<sup>8</sup>
- 3.6 People who use methamphetamine tend to be of relatively low socioeconomic means. According to 2016 National Drug Strategy Household Survey (NDSHS) data, recent use of methamphetamine was highest in people living in the most disadvantaged areas.<sup>9</sup> Evidence to the Inquiry suggests that people who use methamphetamine come from all walks of life, although they are often young and from socially disadvantaged groups.<sup>10</sup>
- 3.7 In contrast, 2016 NDSHS data show that use of MDMA increases with the level of socioeconomic advantage.<sup>11</sup> The Inquiry also heard from police and addiction medicine specialists that people who use MDMA are mostly younger<sup>12</sup> and from middle to higher socioeconomic backgrounds.<sup>13</sup>

## The link between ATS use and broader social determinants of health

- 3.8 Health outcomes reflect a person's social environment. The World Health Organization describes social determinants of health as: *'the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies and politics'*.<sup>14</sup> The environmental and health characteristics that influence health outcomes include social factors such as culture, history, neighbourhood and community and individual characteristics including behavioural and genetic characteristics and pathological biomarkers.<sup>15</sup>
- 3.9 In general, people from lower socioeconomic backgrounds with less income, wealth and education are at greater risk of poor health than more advantaged people,<sup>16</sup> and socioeconomic disadvantage has long been associated with the development of harmful drug use.<sup>17</sup> The relationship between disadvantage and harmful drug use establishes a need for interventions to support access to housing, education and employment.<sup>18</sup>
- 3.10 Use of ATS, especially methamphetamine, typically occurs in the context of complex socioeconomic disadvantage affecting families across generations. These issues include poverty, unemployment, intergenerational trauma, complex grief, mental and physical ill health, disability, homelessness, issues with violence and aggression, interactions with the criminal justice system and the child protection system, social exclusion and stigma.<sup>19</sup>
- 3.11 As the Northern Rivers rehabilitation organisation, The Buttery, observed: *'Homelessness, trauma, physical ill health, incarceration, problem gambling and severe mental illness are more and more common. This is most prevalent in people who indicate methamphetamine and alcohol use as their drugs of concern.'*<sup>20</sup>
- 3.12 The 2016 NDSHS explored the social determinants of health (including remoteness, socioeconomic status and employment), at-risk populations and the use of ATS. It found that:<sup>21</sup>
  - People in remote and very remote areas were 2.5 times more likely to have used meth/amphetamine than those in major cities.
  - People who were unemployed were 3.1 times as likely to have used meth/amphetamine as people who were employed.
  - Aboriginal people were 2.2 times as likely to use meth/amphetamine as non-Aboriginal people.
  - Homosexual/bisexual people were 5.8 times as likely to use ecstasy and meth/amphetamine as heterosexual people.
  - Single people with dependent children were 4 times as likely to have used meth/amphetamine as couples with dependent children.
- 3.13 The relationship between socioeconomic disadvantage and drug use can be two way – that is, socioeconomic disadvantage can increase the risk of drug use and, to a lesser extent, the use of drugs can lead to socioeconomic disadvantage.<sup>22</sup>
- 3.14 Effective policy responses must engage with the social determinants of drug use to focus on the risk factors that lead people to harmful drug use and the protective factors that can prevent that from occurring.

## Trauma is linked to drug use

- 3.15 Trauma generally refers to an event or experience that is significantly distressing and overwhelms a person's ability to cope with the situation they are experiencing.<sup>23</sup> There is a strong association between trauma, particularly intergenerational trauma, and harmful drug use. Aboriginal people have particular experiences of trauma, which are discussed further in Chapter 16.

- 3.16 Throughout the hearings, the Inquiry heard from witnesses who spoke about a traumatic event in childhood or adulthood that led to their drug use or drug dependence. Both lived experience and expert witnesses said that events such as child sexual abuse,<sup>24</sup> witnessing domestic violence,<sup>25</sup> the death of a parent,<sup>26</sup> adoption<sup>27</sup> or a severe and debilitating accident<sup>28</sup> are factors that can lead to drug use.

- 3.17 Health and community service providers noted that many clients seeking treatment for harmful drug use have complex histories involving multiple traumas.<sup>29</sup> Teena Bonham, Principal Project Officer Estate Management Unit from the NSW Department of Family and Community Services (FACS, now Department of Communities and Justice (DCJ)), told the Dubbo Hearing about the link between trauma and harmful drug use.

*'[P]eople don't wake up and choose to be a drug addict. Most of the time, it's triggered by trauma of some sort from either intergenerational trauma or a traumatic experience that people have experienced, and they're self-medicating to deal with that.'*<sup>30</sup>

- 3.18 Importantly, trauma can be intergenerational and it can be experienced directly or indirectly. Direct experience of trauma includes abuse, neglect and exposure to violence. Secondary exposure to trauma means being exposed to the trauma of others.

- 3.19 If a person's trauma remains unresolved, it can directly affect the next generation.<sup>31</sup> Professor Helen Milroy, Professor of Child Psychiatry at the University of WA and a Commissioner with the National Mental Health Commission, explained how trauma can be transmitted physically from one generation to the next. For example, a pregnant woman who has experienced trauma throughout her own life can transmit trauma to the foetus through stress hormones, resulting in poor growth in-utero, low birthweight and developmental difficulties.

*'... so not only is the stress being experienced by the woman and ... the foetus, it's also being experienced on a cellular level for the next generation after that. So that can cause changes to different sorts of responses by genes, the impact on growth and development, and then that continues to cause disadvantage for that next generation.'*<sup>32</sup>

- 3.20 Professor Milroy said intergenerational trauma is not confined to physical transmission from mother to baby during pregnancy. Trauma can also affect a parent's ability to 'understand what love and normal relationships are with an infant and a child', affecting their attachment with their child.<sup>33</sup>

*'What we saw there was that for those Aboriginal children who were cared for by members of the Stolen Generation, they were much more likely to have social and emotional difficulties and be at high risk for those sorts of problems. And part of that was just the impact of the loss of parenting and attachment ...'*<sup>34</sup>

## Trauma in childhood

- 3.21 Early childhood trauma frequently leads to adverse health outcomes and behaviours, which may include drug dependence.<sup>35</sup> For example, childhood physical and sexual abuse has a strongly documented association with illicit drug use.<sup>36</sup> Childhood trauma is a risk factor for almost any adverse outcome in life, including drug use. It also increases the risk of mental health disorders, which are in turn also related to drug use.<sup>37</sup>
- 3.22 Research has consistently shown that adverse childhood experiences increase the risk of illicit drug use later in life.<sup>38</sup> A pivotal Adverse Child Experiences (ACE) study in 1998 studied seven categories of adverse childhood experiences, including psychological, physical or sexual abuse; violence against the mother; and living with household members who used drugs in harmful ways, or were mentally ill or suicidal.<sup>39</sup> It showed that people who had experienced four or more of the categories in childhood had a four to 12-fold increased risk of 'drug abuse' compared to those who had experienced none. The study also found childhood abuse, neglect and household dysfunction tended to occur together and that the effects of these disruptive childhood experiences were strong and cumulative.<sup>40</sup>
- 3.23 Professor Milroy described how trauma affects children.
- 'For a child, in particular, it may be the witnessing of an event, such as in a domestic violence situation when they ... witness the violence, perhaps, against their mother, and it's thought that during that process of trauma that the person may feel a sense of terror or feel a sense of helplessness, and that's part of what causes the psychological injury.'*<sup>41</sup>
- 3.24 Professor Milroy outlined the common pathways by which childhood trauma links directly to drug or alcohol use, including self-medication to cope with feelings of distress or shame or rage and 'acting out' behaviour that involves using drugs or alcohol as part of a rebellious period. Less commonly, survivors of trauma were introduced to alcohol or drugs as part of the abuse grooming process and they continued to use the drugs.<sup>42</sup>
- 3.25 The 'self-medicating' role of drug use to deal with trauma is well researched. Children and adolescents may respond to adverse childhood events with feelings of helplessness and have difficulty with emotional self-regulation. Drug use helps them to disconnect from the emotional pain associated with abuse and becomes a coping response for other stressful situations.<sup>43</sup>
- 3.26 The Inquiry heard from a number of witnesses about how childhood trauma led to their later drug use. Nicola Tillier, an AOD clinician at Odyssey House, described a childhood that included domestic violence and sexual abuse. She started using marijuana and drinking alcohol when she was 12 and was injecting speed by the time she was 14. Her boyfriend later introduced her to crystal methamphetamine.<sup>44</sup>
- 3.27 A witness told the Inquiry that her mother died when she was eight years old and she spent her childhood in foster care, where she was abused. She was homeless from age 12 to 23. She used drugs to suppress her '*inner torment and pain*'.<sup>45</sup> The witness said crystal methamphetamine had a '*rapid and adverse effect*' on her mental health. After her admission to a mental health facility, the Department of Community Services removed her children. '*I feared that my children would experience similar trauma to that which I experienced whilst in care.*'<sup>46</sup>

## 3.28 Another witness told the Inquiry:

*'I had a violent childhood and saw a lot of things that a kid shouldn't see. I was offered drugs at an early age and I was up for it. After taking drugs and drinking alcohol, I realised this numbed me and I didn't think about the horrors all around me. Drugs and alcohol eased the pain.'*<sup>47</sup>

### Trauma in adulthood

3.29 The Inquiry also heard from lived experience witnesses who described traumatic events in adulthood that led to drug use and dependence, including a debilitating injury that ended a promising sporting career,<sup>48</sup> and involvement in a road accident in which a person was killed.<sup>49</sup> One witness described how losing a baby to stillbirth triggered her drug use: *'I had to go into hospital to give birth to my stillborn child and arrange a funeral ... After losing my baby, I sort of self-destructed.'*<sup>50</sup>

3.30 As Ms Tillier noted, most residents she works with at Odyssey House started using drugs to cope with trauma experienced throughout their lives, or during their childhood. *'These people become addicted, and get stuck in the cycle of using, without dealing with the trauma which is at the root of their problems.'*<sup>51</sup>

## Implications for policy and service responses

### Services need to be integrated, holistic and address a person's full range of needs

3.31 The Inquiry received compelling evidence that effective policy and service responses for people affected by drug use need to be holistic and better integrated and to recognise the complex social determinants of harmful and dependent drug use.

3.32 St Vincent's Health Australia observed that improved links and coordination between health, education, employment, housing and other sectors will support people who are receiving treatment to reconnect with the community.

*'NSW and Australia need a systematic, integrated and coordinated long-term approach to the prevention of drug problems that has at its centre a social determinants focus.'*<sup>52</sup>

3.33 Submissions to the Inquiry also called for responses that focus on the circumstances of people who use drugs, and support harm reduction rather than criminal justice responses.<sup>53</sup>

3.34 The NSW Council of Social Service observed the nexus between drug use, poverty and disadvantage, and called for responses that look at the drivers of disadvantage, are comprehensive and culturally appropriate and incorporate holistic approaches such as wraparound support.<sup>54</sup>

3.35 The Inquiry's evidence points to the pressing need for a network of early intervention services to support the individual, families and communities when a person's drug use first becomes harmful. The Inquiry also heard that young people need support to address underlying issues such as mental health and alcohol and drug dependence. For this to happen, health, education, community services and the justice sectors need to work together.<sup>55</sup>

- 3.36 Policy responses also need to address the very serious and important issue of homelessness in NSW, which is both a cause and effect of harmful drug use.<sup>56</sup> Homelessness NSW called for a 'Housing First' approach – an approach that ensures that housing is secured as a first priority, after which a multidisciplinary team of support workers can address other needs, such as drug use.<sup>57</sup> (Homelessness is discussed further in Chapter 17.)
- 3.37 The Inquiry heard evidence of examples of integrated, holistic service responses that are working well to meet the needs of people who use ATS. For example, the Continuing Coordinated Care program provides intensive wraparound support for people with AOD issues and other needs.<sup>58</sup> The Ministry of Health funds three non-government organisations (NGOs) to provide the program across large areas of the state. The program helps with care coordination, intensive outreach support and access to other services, such as health, housing and education.<sup>59</sup>
- 3.38 Another example of a successful holistic response is the Kirketon Road Centre, which provides harm reduction services, medical and mental health services, housing assistance, counselling, outreach and a space for socialising.<sup>60</sup> The centre is an integrated primary healthcare service in Kings Cross, particularly targeting services to young people, people who inject drugs, people involved in sex work, people from the LGBTI communities, Aboriginal people and people experiencing homelessness.<sup>61</sup>
- 3.39 The need for integrated, holistic policy and service responses is further addressed in Chapter 10 and appropriate recommendations are made in that chapter.

### **Services working with people who use drugs must be trauma informed**

- 3.40 Trauma-informed practice recognises that many, if not all, people seeking treatment, especially for mental health and AOD issues, are likely to have had some exposure to trauma.<sup>62</sup> In this respect the need for trauma-informed practice may be near universal.<sup>63</sup> Trauma-informed practice is a systematic approach to understanding and responding to the impact of trauma on people's lives. It promotes recovery through providing a safe and empowering passage through services.<sup>64</sup> The Inquiry received evidence from a range of organisations on the need for services for people who use ATS to be trauma informed.<sup>65</sup>
- 3.41 The five main characteristics of trauma-informed services are:<sup>66</sup>
- Safety: factors including physical safety, confidentiality, reassurance and peer relationships.
  - Trust: comfort in sharing, staff availability, non-judgmental attitudes, positive relationships and caring attitudes.
  - Choice: helping people gain control over important elements of their treatment, such as goal management, length of stay and choice of interventions.
  - Collaboration: includes opportunities for feedback, planning, goal setting and support.
  - Empowerment: includes comfort in sharing, trigger management, trauma awareness and understanding.

- 3.42 Those characteristics were evident in services that gave evidence to the Inquiry about their trauma-informed practice. Mark Ferry, CEO, Ted Noffs Foundation, said 80 to 90% of the young people in its residential programs reported trauma, including sexual abuse, physical abuse and, in some cases, torture. He said the Foundation focused on creating a safe environment.

*'For the first time in their life, they feel like they've got a family ... They found somewhere where, you know, they feel that people love them. And to put them back into their community, for a lot of them, it's partly traumatic in and of itself, so it's – in a nutshell, it's probably the biggest thing we deal with.'*<sup>67</sup>

- 3.43 Catherine Hewett, CEO of Kamira Alcohol and Other Drug Treatment Services, described how trauma-informed practice informs every aspect of their service, which cares for women with trauma backgrounds who, for example, are often sensitive to noises and smells that might remind them of past environments that were traumatic. The service provides a warm, comforting and peaceful environment, paying attention to every detail, right down to the noise of closing doors.<sup>68</sup>
- 3.44 The Inquiry has also heard about the risks of not using a trauma-informed approach to service delivery, which has the potential to inflict further harm and trauma, as well as the risk that the person will disengage from the service.<sup>69</sup>

### NSW Government response should be trauma informed

- 3.45 The NSW Government submission to the Inquiry acknowledged that drug use cannot be considered in isolation from the context of broader social issues in which it occurs, including trauma.<sup>70</sup> The Government said it recognised the importance of holistic responses that *'are trauma informed, incorporate social and emotional wellbeing, and take employment, housing and education into account'*.<sup>71</sup>
- 3.46 The NSW Government response to the *Legislative Assembly Committee on Law and Safety Inquiry into the adequacy of youth diversionary programs in NSW* described recent actions to help services develop a trauma-informed practice approach.<sup>72</sup> These include:
- The Department of Communities and Justice (DCJ) is collaborating with the Centre for Excellence in Therapeutic Care, a service that provides expert advice and knowledge sharing around intensive therapy for children recovering from trauma.<sup>73</sup>
  - DCJ Psychological Services are developing a training package for caseworkers and carers on trauma-informed care.<sup>74</sup>
  - The NSW Police Force is continuing trauma-informed training and education for officers.<sup>75</sup>
  - DCJ's Their Futures Matter reform has two programs that use trauma-informed approaches to support children and young people living in statutory foster or kinship care and their relationships with their carers. These programs also support teachers to understand the impact of trauma on children's learning and behaviour.<sup>76</sup>
  - The Youth Justice Operational Training Unit is embedding trauma-informed practice in staff training programs.<sup>77</sup>
  - The Department of Education provides training in trauma-informed practice in schools.<sup>78</sup>

- 3.47 The Inquiry commends the NSW Government's efforts to improve the ability of services to engage with trauma-informed practice. However, evidence before the Inquiry suggests that there is a need to continue to build the capacity of all services interacting with people who use AOD and their families to be trauma informed.

**Recommendation 1:**

That the NSW Government ensure that all government employees and NGO partners be trained in trauma-informed practice. Such training should be co-designed and delivered by people with lived experience of trauma, including Aboriginal people.

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## Chapter 4. Current drug policy, funding and governance

### Introduction

- 4.1 Responding to illicit drug use is a shared responsibility of Commonwealth, state and territory governments. Australia's current legal and policy frameworks around drug use are somewhat at odds with each other. Australia's and NSW's current legal frameworks for responding to ATS sit within a prohibition framework whereas Australia's overarching drug strategy has formally been underpinned by a harm minimisation approach at both a national and state level since 1985, when the National Drug Strategy came into effect.
- 4.2 This chapter considers the outcomes that AOD policy seeks to achieve and examines the current national and NSW AOD policy and legal frameworks and governance mechanisms. It also details current AOD funding provided by the Commonwealth and by NSW.

### Why government seeks to respond to AOD use

- 4.3 Policymaking is a process that articulates actions required to meet a particular goal. Public policy most often refers to the decisions and actions of government. Policy is made in response to a problem that needs attention, or as a way to change or maintain the status quo.<sup>1</sup>
- 4.4 Public policy is related to the public interest.<sup>2</sup> A government intervenes in the activities or decision of individuals or organisations for a variety of reasons, such as to address market or regulatory failure, to achieve social and environmental benefits, or to change behaviours to improve health outcomes (like discouraging tobacco smoking).<sup>3</sup> However, there are many aspects of community life in which the government chooses not to intervene.
- 4.5 People are affected by policies in different ways. Most policies seem either benign or beneficial to most, and policies are unlikely to come to public attention unless issues arise.<sup>4</sup>
- 4.6 As Babor et al. describe in their book *Drug Policy and the Public Good*:
- 'The application of public policy to address drug-related problems ... reflects how governments and societies struggle with substances that can induce pleasure and aid the work of medicine, yet also cause enormous harms to the individuals and society.'*<sup>5</sup>
- 4.7 The policy set by a government alters the actions taken across the community to address drug use and its harms.
- 4.8 In a submission to the Inquiry, the Australasian College for Emergency Medicine commented:
- 'Leadership and direction by government is required to reframe the policy and public discourse, and change community perception, of methamphetamine use across NSW communities. Social change is required to see the "person" in the first instance, rather than seeing a "problem" that elicits criminal justice responses.'*<sup>6</sup>

- 4.9 Language influences how policy problems are constructed. Research has shown how changes in language in Australia's drug policy documents have shifted how drugs have been 'problematized' over the past three decades, leading to a gradual reorientation of the problem from drug 'harms' to drug 'use'. According to academic research, this has altered the community's conceptualisation of what harm minimisation means.<sup>7</sup>
- 4.10 Drug policy has a great symbolic significance in politics,<sup>8</sup> and drug policies are subject to much debate. Policy decisions are influenced and informed by stakeholders who have varying ideologies, interests, evidence and levels of power. These factors are accepted as central to democratic processes,<sup>9</sup> and research evidence is just one of the factors. Laws and policies prohibiting certain drugs and not others have predominantly been developed and entrenched over time because of historical, political and social factors, as distinct from evidence about drug-related harms. For example, harms associated with alcohol and tobacco are higher than for illicit drugs, yet in NSW, it is lawful for adults to purchase alcohol and tobacco, while they are prohibited from possessing, growing, manufacturing or supplying many other substances, including a range of ATS.

## Government drug policies change over time

- 4.11 Illicit drug policy is shaped by both government decisions and actions, and government indecision and inaction. Australia's AOD policy broadly comprises:
- formal statements such as the National Drug Strategy
  - legislative and regulatory levers to achieve policy objectives
  - the allocation of resources to drug-related treatment programs, research and justice responses.
- 4.12 The focus of Australia's approach to illicit drugs has shifted over time in line with changes in domestic and international policies, politics, markets, knowledge and community expectations.<sup>10</sup> Paradigms have oscillated from punitive to empathic, and to various other points in between. Contradictory approaches have often occurred simultaneously. Professor Adrian Dunlop, Director and Addiction Medicine Senior Staff Specialist, Drug and Alcohol Clinical Service, Hunter New England Local Health District (LHD), told the Inquiry:
- 'I think this is the history. Since there has been a focus on alcohol and drugs in Australia since the, you know, mid-60s on ... there's cycles of concern about different drugs and crescendos of interest and involvement, and planning and coordination, and escalation to senior ministers ... and priorities and then it drifts away; other things become more problematic ... we're in one of those cycles at the moment.'*<sup>11</sup>
- 4.13 Historically, as in much of the rest of the world, Australia's response to illicit drugs focused on law enforcement and incarceration. However, as in Canada and some western European countries, harm minimisation has been at the core of Australian and NSW policy frameworks since 1985.<sup>12</sup>
- 4.14 In 1984, following an election promise for a campaign against drug abuse, Prime Minister Bob Hawke established a national response to drugs. The Minister for Health, Dr Neal Blewett, established a workshop to develop proposals for a strategy. The workshop's report recommended:

*'The objective of a national policy on drug use should be to minimise the harmful consequences of the use of drugs to individuals, their families and the community as a whole including the needs of special groups. Therefore a national, comprehensive approach will be needed.'*<sup>13</sup>

- 4.15 This led to the establishment of the National Campaign Against Drug Abuse (NCADA) followed by Australia's first National Drug Strategy in 1985. The National Drug Strategy was one of the first drug policies in the world to articulate a harm minimisation approach. Both NCADA and the National Drug Strategy were created with bipartisan political support and involved cooperation between the Commonwealth, state and territory governments and the non-government sector.<sup>14</sup> It saw early government commitment and investment in harm reduction strategies such as the establishment of needle and syringe programs, which are estimated to have prevented tens of thousands of cases of HIV and saved the health system billions of dollars in treatment costs.<sup>15</sup>
- 4.16 NSW has been recognised internationally for its Medically Supervised Injecting Centre (MSIC), which has been operating in Kings Cross since 2001. Multiple evaluations have reported on its effectiveness in reducing overdose-related morbidity and mortality; reducing public injecting and discarded syringes; and providing a channel into drug treatment.<sup>16</sup>
- 4.17 Australia has also made a significant contribution to global multilateral forums on drug issues, and to supply control efforts at both a regional and international level. These contributions once earned Australia *'a high international reputation for its progressive, balanced and comprehensive approach to dealing with the problems posed by the use and misuse of drugs in the community'*.<sup>17</sup>
- 4.18 Yet, despite these positive outcomes, there was a shift back to a focus on law enforcement and supply reduction with the Commonwealth Government's Tough on Drugs approach launched in 1997.<sup>18</sup>
- 4.19 Scrutiny of Australia's drug policies has found, as in other countries, that the supply of drugs – and the harms caused by them – has not been reduced.<sup>19</sup> The NSW Crime Commission submitted *'that the current law enforcement response to the importation, supply and distribution of methyl amphetamine in NSW is not very effective in reducing the production and supply in the state'*.<sup>20</sup>
- 4.20 While previously a forerunner in international drug policy, it has been suggested that Australia has not capitalised on its past success and has fallen behind in innovative and progressive harm minimisation strategies.<sup>21</sup> This is discussed further in Chapter 2.

## Current national policy framework: the National Drug Strategy

- 4.21 The National Drug Strategy is Australia's main national drug policy.<sup>22</sup> Harm minimisation has been embedded as the overarching framework of the Strategy since its inception in 1985.<sup>23</sup> The current iteration of the National Drug Strategy covers a 10-year period (2017–26) and provides a national framework for a bipartisan, consistent approach to alcohol, tobacco and other drug policy and was endorsed by the national Ministerial Drug and Alcohol Forum (MDAF) in 2017.<sup>24</sup> The aim of the National Drug Strategy is: *'To build safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social, cultural and economic harms among individuals, families and communities.'*<sup>25</sup>

- 4.22 The current National Drug Strategy recognises Australia's long-standing and ongoing commitment to the underpinning principle of harm minimisation and equivalence of endeavour aimed at health and law enforcement approaches.<sup>26</sup> Harm minimisation is defined in the current National Drug Strategy as a principle that '*considers the health, social and economic consequences of drug use on individuals, families and communities as a whole*'.<sup>27</sup> The National Drug Strategy states that a:

*'[H]arm minimisation policy approach recognises the clear recognition that drug use carries substantial risks, and that drug users require a range of supports to progressively reduce drug-related harm to themselves and the general community, including families. This policy approach does not condone drug use.'*<sup>28</sup>

- 4.23 Professor Alison Ritter, Director, Drug Policy Modelling Program (DPMP), Social Policy Research Centre, UNSW Sydney, told the Inquiry that the National Drug Strategy aims to minimise harms through three pillars of supply reduction, demand reduction and harm reduction, noting that this '*has become an enormously stable, bipartisan approach to alcohol, tobacco and illicit drugs in Australia*'.<sup>29</sup>

- 4.24 In an evaluation undertaken of the 1993–1997 National Drug Strategy by Professors Eric Single and Timothy Rohl, harm minimisation was found to be fundamental to the Strategy's success.<sup>30</sup> The authors considered that harm minimisation had been misinterpreted and misunderstood by some as denoting a '*soft on drugs*' approach.<sup>31</sup> However, while the National Drug Strategy acknowledges that illicit drug use does occur, it does not condone drug use.<sup>32</sup> Single and Rohl said:

*'Harm minimisation should be viewed as the middle ground where persons with widely differing views on drug policy can agree with one another regarding practical, immediate ways to reduce drug-related harm, even though they may disagree about major policy approaches to the prevention of use per se.'*<sup>33</sup>

- 4.25 In the current National Drug Strategy, harm minimisation is based on the following considerations:<sup>34</sup>

- Drug use occurs across a continuum, from occasional use to dependent use.
- A range of harms is associated with different types and patterns of drug use.
- The response to these harms requires a multifaceted approach.

### National Drug Strategy priorities for attention

- 4.26 The National Drug Strategy also prioritises particular actions, populations and substances, some of which inform sub-strategies that sit under the National Drug Strategy targeting specific concerns. States and territories are expected to develop local strategic frameworks based on the National Drug Strategy to implement its aims and objectives.

- **Priority actions:** enhance access to evidence-informed, effective and affordable treatment services and support; develop and share data and research, measure performance and evaluate outcomes; develop new and innovative responses to prevent uptake, delay first use and reduce alcohol, tobacco and other drug problems; increase participatory processes; reduce adverse consequences; restrict and/or regulate availability; and improve national coordination.
- **Priority populations:** Aboriginal and Torres Strait Islander people; people with comorbid mental health conditions; young people; older people; people in contact with the criminal justice system; culturally and linguistically diverse populations; and people identifying as lesbian, gay, bisexual, transgender and/or intersex.

- **Priority substances:** methamphetamines and other stimulants; alcohol; tobacco and nicotine; cannabis; non-medical use of pharmaceuticals; opioids including heroin; and new psychoactive substances.<sup>35</sup>

### Sub-strategies under the National Drug Strategy

The following sub-strategies have been developed under the National Drug Strategy:

- National Aboriginal and Torres Strait Islander People Drugs Strategy 2014–2019
- National Alcohol and other Drug Workforce Development Strategy 2015–2018
- National Tobacco Strategy 2012–2018
- Consultation Draft National Alcohol Strategy 2018–2026
- National Fetal Alcohol Spectrum Disorder Strategic Action Plan 2018–2028
- National Ice Action Strategy 2015

### The pillars of the National Drug Strategy

- 4.27 The 2017–2026 National Drug Strategy, like its predecessors, recommends a balanced approach across three pillars of supply reduction, demand reduction and harm reduction, each of which adds to the collective strength of the strategy. The interrelationship of harm minimisation with the three pillars of supply reduction, demand reduction and harm reduction is visualised in Figure 4.1.

**Figure 4.1: Pillars of the National Drug Strategy<sup>36</sup>**



## Supply reduction

- 4.28 Supply reduction aims to reduce the availability of drugs and make them more difficult to obtain. In relation to licit drugs, such as alcohol, tobacco and pharmaceuticals, supply reduction strategies may entail regulating access to these substances.
- 4.29 Reducing the supply of illicit drugs in Australia is primarily controlled through prohibition, policing and law enforcement measures. These include police operations that may target border detections, domestic seizures and dismantling or disrupting distribution networks.<sup>37</sup> Supply reduction strategies target all aspects of the illicit drug supply chain, from production through to consumption.<sup>38</sup> Specific policing strategies relating to reducing the supply of ATS are described further in Chapter 19.

- 4.30 However, despite significant and sustained supply reduction efforts, the illicit drug market has adapted. It has been documented that the supply of crystal methamphetamine is resilient to supply reduction levers. This creates a significant challenge for governments.<sup>39</sup>

### Demand reduction

- 4.31 Demand reduction focuses on preventing non-users from ever trying drugs, delaying the first use of drugs and reducing the use of drugs by those who already use.
- 4.32 Preventing the uptake of alcohol, tobacco or drug use is a demand reduction measure. Prevention is considered '*more cost-effective than treating established drug-related problems*' as it averts the expense to the community of drug-related harms and government responses to them.<sup>40</sup>
- 4.33 Education and early intervention are central, including school and community-based programs, public awareness campaigns, family support, early intervention programs, diversion programs, coordination of primary and specialist care, and building resilient and inclusive communities.<sup>41</sup> As adolescence and early adulthood are periods in life when drug use is likely to begin, early intervention and prevention initiatives are often youth-focused.<sup>42</sup> A more detailed discussion about prevention of drug use is in Chapter 12.
- 4.34 Law enforcement can reduce demand by deterring people from using drugs through the threat of criminal sanctions, as well as through reducing the availability of drugs and making them more expensive or harder to obtain.<sup>43</sup>
- 4.35 Another important way of reducing demand is effectively targeting and engaging with individuals who currently use drugs, and supporting them to decrease or cease their use, as well as preventing the uptake of more harmful behaviours. Attracting and retaining individuals who use drugs into effective treatment is central to reducing their demand for drugs.<sup>44</sup> Programs that support social engagement and development of protective factors are also important in demand reduction.<sup>45</sup>

### Harm reduction

- 4.36 Grounded in principles of human rights and justice, harm reduction policies and programs aim to reduce the harms caused by drugs, rather than reducing drug use.<sup>46</sup> Strategies aim to encourage safer practices and reduce preventable risk factors.<sup>47</sup>
- 4.37 Central to harm reduction is a recognition that individuals use drugs despite the array of measures in place to prohibit and restrict use.<sup>48</sup> Harm reduction should be achieved through coordination across health, law enforcement and prevention strategies<sup>49</sup> that have practical, rather than idealised, goals.<sup>50</sup>
- 4.38 Examples of drug harm reduction measures in place in NSW include the MSIC in Kings Cross, needle and syringe programs across the state and opioid substitution programs. More information on harm reduction is in Chapter 15.

### National Ice Action Strategy 2015

- 4.39 The National Ice Action Taskforce developed the National Ice Action Strategy, which was released in 2015. Commonwealth, state and territory governments are all signatories to the Strategy, which has the goal of reducing the prevalence of crystal methamphetamine use and associated harms. Governments are responsible for implementing and monitoring the strategy, with MDAF providing oversight and reporting to the Council of Australian Governments (COAG).<sup>51</sup>

- 4.40 The National Ice Action Strategy describes five priority areas to reduce the harm that may be caused by problematic use of crystal methamphetamine.<sup>52</sup>
- support for families and communities
  - targeted prevention
  - investment in treatment and workforce
  - focused law enforcement
  - better research and data.
- 4.41 Each priority area has a list of specific actions; however, there are no timelines or measures of success included in the document.

### Current NSW policy framework

- 4.42 NSW does not have an alcohol and drug strategy in place to support or guide implementation of the National Drug Strategy or AOD policy more broadly. This has been the case since 2010. This is despite an expectation that all Australian jurisdictions will have such a strategy, as specified in the National Drug Strategy.<sup>53</sup>
- 4.43 The implications of a lack of a strategy in NSW were articulated in submissions and evidence to the Inquiry, including that it has created service delivery gaps<sup>54</sup> and has led to a lack of clearly articulated strategic aims, priority populations and objectives for the NSW AOD sector.<sup>55</sup> The Royal Australasian College of Physicians submitted that NSW needs an AOD strategy that comprehensively addresses drug demand, supply and harm minimisation, in consultation with health professionals, noting that:
- '[W]ith rapid changes in illicit drug supply markets and increasing use of crystal methamphetamine among methamphetamine users, there is a risk that without a comprehensive strategy and supporting cooperative relationships between police, health professionals and community workers, drug-related deaths and harms could rise.'*<sup>56</sup>
- 4.44 The Inquiry heard during the Health Service Responses Roundtable that the lack of a state-level drug and alcohol strategic plan was the '*elephant in the room*' when discussing service delivery and service gaps in the health sector.<sup>57</sup>
- 4.45 In response, NSW Health's representative indicated that there had been work to prepare such a state-wide plan for the health sector, but this had not yet concluded, partly to allow this Inquiry to complete its work.<sup>58</sup> Nevertheless, a significant amount of time has passed since there was an official AOD policy or strategy in place for the health sector in NSW, and it is clear from the evidence before the Inquiry that this has resulted in a lack of clarity and direction for AOD health service delivery.
- 4.46 In other evidence provided to the Inquiry, the NSW Police Force noted that an illicit drug strategy for NSW Police was currently in a draft phase.<sup>59</sup> The current draft sets out a number of strategies and initiatives such as diversion of drug offenders and efforts to disrupt supply.<sup>60</sup>
- 4.47 The development of these sector-specific strategies are an important part of drug policy and action in NSW. However, there remains a lack of a coordinated whole-of-government response to AOD at a state level. This is discussed further in Chapter 10.

## Current legal framework

- 4.48 Legislation is one mechanism to achieve policy outcomes. Australia's legal framework for illicit drugs is largely framed by international conventions to which Australia became a signatory 50 years ago, as well as Commonwealth legislation from a similar period. This is discussed in Chapter 2.
- 4.49 The Australian legal framework consists of a range of Commonwealth, state and territory laws that regulate and restrict the production, supply and use of drugs. In evidence to the Inquiry, Professor Ritter, DPMP, and Professor Kate Seear, Associate Professor in Law, Monash University, expressed the view that such laws are 'repressive'<sup>61</sup> and 'punitive'.<sup>62</sup> The Inquiry heard that laws in NSW and Queensland are particularly repressive as there are criminal penalties associated with use and possession offences, whereas other jurisdictions have depenalised use and possession of drugs, including crystal methamphetamine and ecstasy.<sup>63</sup>

## Commonwealth legal framework

- 4.50 Within Australia's federal system of government, most criminal laws are enacted and enforced by the states. However, several laws and standards have been adopted at the Commonwealth level for Australia to meet its international obligations and achieve policy outcomes. These laws aim to strictly regulate drugs being imported or manufactured for legitimate medical and research purposes, and to punish those who traffic, sell, import, manufacture and possess drugs (or their precursor chemicals) for other purposes.
- 4.51 Commonwealth laws include the:
- *Customs Act 1956* (Cth) and *Customs (Prohibited Imports) Regulations 1956* (Cth), which prohibit the importation of drugs and other prohibited substances except in accordance with strict importation requirements. This includes narcotics, psychotropic drugs and precursor chemicals.
  - *Narcotics Drugs Act 1967* (Cth), which establishes a national framework both to prevent abuse and diversion of controlled narcotics and to ensure the availability of such drugs for medical and research purposes, in accordance with the 1961 *Single Convention on Narcotic Drugs*.<sup>64</sup>
  - *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act 1990* (Cth), which provides that certain Commonwealth Government drug offences have extraterritorial effect, and also provides for specific drug offences that are committed on board Australian aircraft and ships. It also incorporates the *Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988*.<sup>65</sup>
  - *Commonwealth Criminal Code Act 1995* (Cth), which prohibits trafficking, selling, importing, the commercial manufacture and possession of controlled drugs and precursor chemicals in Australia, and contains a range of offences relating to the procurement of children for, or harming of children during, the commission of such offences.<sup>66</sup>
  - The *Proceeds of Crime Act 2002* (Cth), which provides a scheme to trace, restrain and confiscate the proceeds of crime against Commonwealth law. In some circumstances it can also be used to confiscate the proceeds of crime against foreign or state law (if the proceeds have been used in a way that contravenes Commonwealth laws). It also provides a scheme that allows confiscated funds to be used to prevent and reduce the harmful effects of crime in Australia.<sup>67</sup>
  - The *Poisons Standard 2019* is a Commonwealth legislative instrument that provides classification of medicines and poisons into Schedules for inclusion in the relevant legislation of the states and territories. The Poisons Standard also includes model provisions about containers and labels, a list of products recommended to be exempt from these provisions, and recommendations about other controls on drugs and poisons.<sup>68</sup>

## NSW legal framework

- 4.52 Consistent with the international and Commonwealth legal frameworks, NSW legislation proscribes certain drugs and drug-related activities, in particular those not associated with specific medical and research purposes.
- 4.53 A key piece of legislation is the *Drug Misuse and Trafficking Act 1985* (NSW) (*DMT Act*). Schedule 1 of the *DMT Act* lists more than 240 prohibited plants and drugs, including a range of ATS, and outlines the threshold quantity of each drug used to determine the relative seriousness of the offending behaviour. Table 4.1 below sets out the current threshold quantities in the *DMT Act* for amphetamine, methylamphetamine and MDMA, noting these are currently under review.

**Table 4.1: *Drug Misuse and Trafficking Act 1985* (NSW), Schedule 1 (excerpt)**

Prohibited plant or prohibited drug	Traffickable quantity	Small quantity	Indictable quantity	Commercial quantity	Large commercial quantity
Amphetamine	3.0g	1.0g	5.0g	250.0g	1.0kg
Methylamphetamine	3.0g	1.0g	5.0g	0.25kg	0.5kg
3,4 Methylenedioxymethylamphetamine	0.75g	0.25g	1.25g	0.125kg	0.5kg

- 4.54 Section 29 of the *DMT Act* provides that, except in certain circumstances, if a person has in his or her possession an amount of a prohibited drug which is not less than the traffickable quantity, he or she shall be deemed to have the prohibited drug in his or her possession for supply.
- 4.55 In NSW, threshold quantities are also applied to determine whether particular drug charges can be proceeded against summarily (at the Local Court) or on indictment (typically tried in the District Court), and whether a person is required to show cause as to whether he or she is to be granted bail when charged for certain drug offences.<sup>69</sup>

4.56 The box below outlines some of the key provisions in the DMT Act.

### Key provisions in the *Drug Misuse and Trafficking Act 1985 (NSW)*

#### Summary offences

Part 2, Division 1 of the *DMT Act* sets out the summary offences under the Act which shall be prosecuted before the Local Court. These include:

- possession of a prohibited drug (s 10(1))
- possession of equipment for administration of prohibited drugs (this does not apply in respect of a hypodermic syringe or needle) (s 11(1)-(1A))
- sale; supply; or display, in or in connection with a shop, of waterpipes and ice pipes (s 11A)
- possession of a tablet press or drug encapsulator (s 11B)
- possession of a document that contains instructions for the manufacture or production of a prohibited drug (s 11C)
- self-administration of prohibited drugs (s 12)
- administration of prohibited drugs to others (s 13)
- permitting another to administer you prohibited drugs (s 14)
- forging prescriptions, obtaining prescriptions or prohibited drugs by false representation, or failing or refusing to provide required information to medical practitioners, nurse practitioners or midwife practitioners with intent to deceive them (ss 15-18)
- advertising or holding out that premises are available for use for unlawful administration of prohibited drugs (s 18A)
- manufacture, production, possession or supply of certain substances listed in Schedule 9 of the Poisons Standard (s 18B)
- aiding and abetting the commission of Division 1 offences within NSW (s 19)
- aiding and abetting the commission of offences corresponding to Division 1 offences outside of NSW (s 20).

The penalty for offences under Division 1 is a fine of 20 penalty units (\$2,200), or imprisonment for a term of two years, or both.

#### Indictable offences

Part 2, Division 2 of the *DMT Act* sets out the offences under the Act to be prosecuted on indictment. These include:

- offences relating to the cultivation, supply and possession of prohibited plants, including offences relating to enhanced indoor cultivation of prohibited plants in the presence of children (ss 23–23A)
- manufacture and production of prohibited drugs, possession of precursors and certain apparatus for manufacture or production of prohibited drugs, and possession of prohibited drug precursors (ss 24–24B)
- supply of prohibited drugs, and supply of prohibited drugs on an ongoing basis (ss 25–25A), including deemed supply where a person has in their possession not less than the traffickable quantity of the prohibited drug (s 29)
- conspiring to commit, and aiding and abetting the commission of Division 2 offences within NSW (ss 26–27)
- conspiring to commit, and aiding and abetting the commission of offences corresponding to Division 2 offences outside of NSW (s 28).

Particular indictable offences under Division 2 may be dealt with summarily although this is limited to offences relating to less than the commercial quantity of the prohibited substance concerned. Where Division 2 offences are dealt with summarily, maximum penalties depend on the quantity of prohibited plants or drugs concerned in the commission of the offence. For example:

- When dealing with not more than a small quantity of the prohibited plant or drug, if the offence is dealt with summarily, the maximum penalty for an offence is a fine of 50 penalty units (\$5,500) or imprisonment for two years, or both (s 30).
- When dealing with not more than an indictable quantity of the prohibited plant or drug, and the offence is dealt with summarily, the maximum penalty is a fine of 100 penalty units (\$11,000) or imprisonment for two years or both (s 31).

Where Division 2 offences are dealt with on indictment:

- The maximum penalty is a fine of 2,000 penalty units (\$220,000) or imprisonment for a term of 15 years, or both (s 32).
- Where the offence relates to cannabis plant or cannabis leaf, the maximum penalty is a fine of 2,000 penalty units or imprisonment for 10 years or both (s 32(h)).

For particular Division 2 offences involving commercial quantities or cultivation for a commercial purpose the penalties are higher:

- Where the offence involves less than the applicable large commercial quantity the maximum penalty is a fine of 3,500 penalty units (\$385,000) or imprisonment for 20 years, or both (s 33(2)(a)); or where the offence relates to cannabis plant or leaf, a maximum penalty of a fine of 3,500 penalty units or imprisonment for 15 years, or both (s 33(2)(b)).
- Where the offence involves not less than the applicable large commercial quantity the maximum penalty is a fine of 5,000 penalty units (\$550,000) or imprisonment for life, or both (s 33(3)(a)); or where the offence relates to cannabis plant or leaf, a maximum penalty of a fine of 5,000 penalty units or imprisonment for 20 years, or both (s 33(3)(b)).

### Offences involving drug premises

A range of offences exist in relation to 'drug premises', being any premises that are used for the unlawful supply or manufacture of prohibited drugs and/or the unlawful commercial cultivation of prohibited plants by enhanced indoor means (s 36TA).

For example, it is an offence to enter, or be on, drug premises without lawful purpose or excuse (s 36X), to knowingly allow premises to be used as drug premises (s 36Y), and to organise or conduct drug premises (s 36Z). Penalties for the latter two offences are higher if the offender knows that a child has access to the premises and, as a consequence the child is exposed to a prohibited plant or drug, or a drug supply process, or equipment capable of being used to administer a prohibited drug (ss 36Y(2); 36Z(2)).

- 4.57 Laws have also been enacted in NSW which prohibit activities associated with harmful drug use or supply. This includes, for example, driving under the influence of drugs, and, more recently, drug supply causing death.<sup>70</sup> The *Poisons and Therapeutic Goods Act 1966* (NSW) provides for the regulation, licensing, control and prohibition of the supply and use of poisons, drugs of addiction and certain dangerous drugs and therapeutic goods.

## Governance

- 4.58 Governance refers to the processes and mechanisms by which policies and actions are directed, controlled and held to account. Governance is an important function in determining how decisions are made, who is involved in decision-making and balancing power and accountability.<sup>71</sup> Governance of complex social policy issues involves many layers of government, non-government and community organisations and individuals. Good governance can be articulated in many ways. In relation to illicit drug policy, key principles have been described as participation; consensus-orientation; accountability; transparency; responsiveness; equity and inclusiveness; effectiveness and efficiency and following the rule of law.<sup>72</sup> Good governance is important in improving social conditions for the population and is critical to shaping the strategic direction of AOD policy.

### Intergovernmental AOD governance mechanisms

- 4.59 As noted above, the Commonwealth Government established a National Ice Taskforce in 2015 to report on actions needed to address crystal methamphetamine use in Australia. The National Ice Action Strategy was endorsed by COAG in December 2015 with the goal of reducing the prevalence of crystal methamphetamine use and resulting harms across the Australian community.
- 4.60 Responding to the National Ice Action Strategy is the responsibility of all Australian governments, recognised by the establishment of MDAF in 2016 to oversee the development, implementation and monitoring of Australia's national drug policy framework, including the National Ice Action Strategy.<sup>73</sup>
- 4.61 The MDAF comprises health and justice Ministers with responsibility for alcohol and drug policy and justice or law enforcement from each jurisdiction.<sup>74</sup> The MDAF reports directly to COAG and also provides information which may be of assistance to the COAG Health Council and the COAG Law, Crime and Community Safety Council.<sup>75</sup> Its functions are to:
- oversee the work to develop, implement and monitor Australia's national drug policy framework
  - direct, advise and report to other councils and committees
  - report each year to COAG.<sup>76</sup>

### NSW AOD governance mechanisms

- 4.62 As detailed in Chapter 2, following the Drug Summit in 1999, an Office of Drug Policy was established within the NSW Cabinet Office, and the associated Government Plan of Action was overseen by a Cabinet Committee on Drugs.<sup>77</sup> At that time, governance of state-wide drug policy and actions was centralised and enabled coordinated action and clear accountability.
- 4.63 Currently, there is no such mechanism or structure of state-level oversight and governance of AOD strategy or policy. Certain cluster-specific strategies<sup>78</sup> refer to actions relating to illicit drug use and harm, but the responsibility for the implementation of these lies predominantly with individual agencies, which have internal governance mechanisms and are ultimately accountable to different Ministers.
- 4.64 NSW illicit drug policy entails a broad range of actions that cross many areas of government. A number of Ministers have responsibility over portfolios that require policy responses to address drug use and harm, including the Attorney-General, the Minister for Health and Medical Research, the Minister for Police and Emergency Services, the Minister for Education and Early Childhood Learning, the Minister for Mental Health, Regional Youth and Women, the Minister for Families, Communities and Disability Services, and the Minister for Counter Terrorism and Corrections.

- 4.65 As discussed in Chapter 10, there is currently no centralised planning and coordination of responses to illicit drug use in NSW nor is there regular reporting to the community on action on illicit drug use.

## Funding

- 4.66 The complexity of funding means it is difficult to obtain a complete picture of AOD funding in NSW.<sup>79</sup> This complexity arises for two main reasons.
- 4.67 First, alcohol and other drugs are part of the fabric of life in Australia, making AOD responses complex. These involve health, justice, policing, education and many other parts of government, and many different aspects of each of those parts. For many government-funded services, responding to AOD is part of their core business, and is not reported separately.
- 4.68 Secondly, funding comes from both the Commonwealth and NSW Governments, as well as from philanthropic investment and personal expenditure. Funding flows through multiple entities, government and non-government, and is spent on, for example, service delivery, research or policy development. These pathways have been described as ‘*convoluted*’.<sup>80</sup> For example, specialist AOD services can receive government funding from at least four sources: directly from the Commonwealth Government, indirectly from the Commonwealth Government through Primary Health Networks (PHNs), directly from the NSW Government, and indirectly from the NSW Government through LHDs. As well, there is limited clarity about the roles and responsibilities of the Commonwealth and state governments (further discussed in Chapter 14).
- 4.69 These complexities made it very difficult for the Inquiry to determine the total amount of funding being spent on AOD responses in NSW. This was partly because many AOD responses are provided by agencies through their business-as-usual funding, discussed further below, so it is not possible to quantify accurately the funding associated with AOD-specific work. The Commonwealth’s response to the Inquiry’s request for funding information provides another example of some of the difficulties faced by the Inquiry in this context, in that the data it provided did not capture AOD-relevant items under the Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme or details of funding provided to hospitals through Activity-Based Funding and block funding.
- 4.70 The only clear picture that emerges from the Inquiry’s work relates to funding of targeted AOD health and justice responses. This evidence was gathered through specific requests to government departments and agencies, rather than from publicly available information.

## Funding of targeted AOD health responses

4.71 According to evidence to the Inquiry, in 2018–19 the combined Commonwealth and NSW Government expenditure on AOD specialist health responses in NSW was \$346.2 million.<sup>81</sup> The allocation of these funds across the various services available is outlined below.

### Commonwealth funding of targeted AOD health responses in NSW

4.72 In 2019–20, the Commonwealth Department of Health directly funded various targeted AOD responses in NSW as follows:<sup>82</sup>

- \$6.8 million for prevention and early intervention
- \$9.1 million for research and data (not NSW-specific)<sup>83</sup>
- \$1.6 million for grant funding to Local Drug Action Teams (between 2016–17 and 2019–20)
- \$15.9 million for residential rehabilitation<sup>84</sup> and withdrawal treatment services
- \$6.5 million for the Community Health and Hospitals Program.

4.73 The Commonwealth Department of Health also allocated \$27.2 million to PHNs in 2019–20 to commission AOD services.<sup>85</sup>

### Indirect funding through PHNs

4.74 Funding from the National Ice Action Strategy is allocated primarily to PHNs. This allocation is based on a model that targets high-risk populations, the degree to which there are rural and regional populations, an assessment of socioeconomic disadvantage and the proportion of Aboriginal and Torres Strait Islander populations.<sup>86</sup> All PHNs in NSW (apart from the Murrumbidgee PHN) received an increase in National Ice Action Strategy funding in 2019–20.<sup>87</sup> (See Table 4.2)

**Table 4.2: Commonwealth Department of Health AOD funding of PHNs<sup>88</sup>**

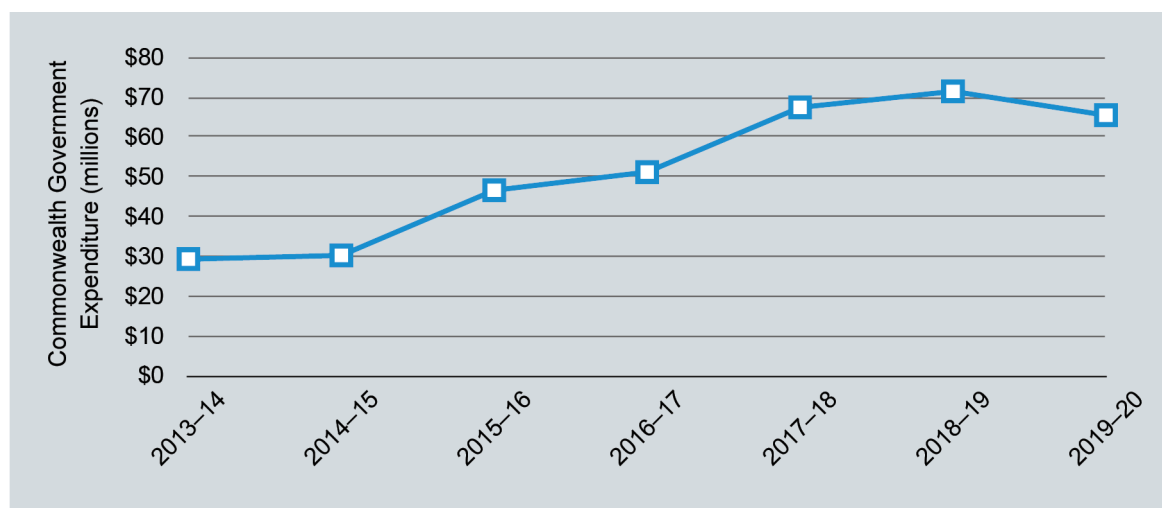
TOTAL NSW	Non-NIAS	NIAS	Total PHN Allocation
2016–17	\$657,839	\$18,433,434	\$19,091,273
2017–18	\$7,302,900	\$18,433,434	\$25,736,334
2018–19	\$7,302,900	\$18,433,434	\$25,736,334
2019–20	\$7,725,665	\$19,430,525	\$27,156,190
2020–21	\$7,725,665	Not yet allocated	\$7,725,665
2021–22	\$7,725,665	Not yet allocated	\$7,725,665
Total	\$38,440,633	\$74,730,826	\$113,171,459

Note: NIAS refers to the National Ice Action Strategy

4.75 The Inquiry heard from witnesses that National Ice Action Strategy funding is allocated annually, creating significant operational issues for service providers that are further discussed in Chapter 14.

### Changes over time

4.76 Commonwealth funding of targeted AOD health responses (including funding provided to PHNs) has increased since 2013–14.<sup>89</sup> (See Figure 4.2)

**Figure 4.2: Commonwealth investment in AOD specialist services in NSW<sup>90</sup>**

### NSW Government funding of targeted AOD health responses

4.77 In 2018–19, NSW Health provided targeted AOD health funding as follows:<sup>91</sup>

- \$172.4 million to LHDs to commission AOD services
- \$11.0 million to the Justice Health and Forensic Mental Health Network
- \$34.3 million for NSW Health Research Grants and staffing
- \$57.1 million to non-government organisations for commissioned work.

### LHD funding

4.78 The funding allocated to LHDs is shown below. These data have been compared to the population of each LHD and are provided in Table 4.3.

**Table 4.3: NSW Health AOD program funding by LHD (\$m)<sup>92</sup>**

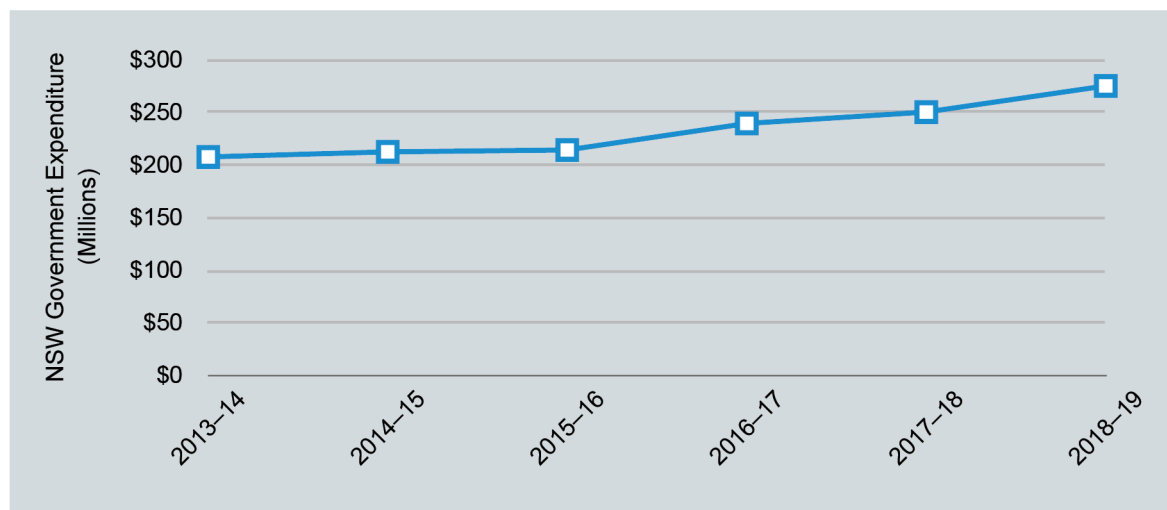
Local Health District	AOD Program Budget (\$m)			Budget Per Person			Region
	2014	2015	2016	2014	2015	2016	
Central Coast	\$6.8	\$7.2	\$7.1	\$21.0	\$22.0	\$21.0	Metropolitan
Far West	\$1.2	\$1.4	\$1.8	\$40.0	\$47.0	\$60.0	Rural and regional
Hunter New England	\$13.4	\$14.1	\$14.6	\$15.0	\$16.0	\$16.0	Rural and regional
Illawarra Shoalhaven	\$8.4	\$8.4	\$9.1	\$21.0	\$21.0	\$22.0	Metropolitan
Mid North Coast	\$5.8	\$6.1	\$6.6	\$27.0	\$29.0	\$31.0	Rural and regional
Murrumbidgee	\$2.4	\$2.5	\$2.6	\$10.0	\$10.0	\$11.0	Rural and regional
Nepean Blue Mountains	\$9.0	\$9.0	\$10.3	\$25.0	\$25.0	\$28.0	Metropolitan
Northern NSW	\$8.1	\$8.0	\$8.6	\$28.0	\$27.0	\$29.0	Rural and regional
Northern Sydney	\$10.6	\$10.7	\$10.9	\$12.0	\$12.0	\$12.0	Metropolitan
South Eastern Sydney	\$11.0	\$11.5	\$11.5	\$12.0	\$13.0	\$13.0	Metropolitan
South Western Sydney	\$13.1	\$13.7	\$15.1	\$14.0	\$15.0	\$16.0	Metropolitan
Southern NSW	\$2.7	\$2.8	\$2.9	\$14.0	\$14.0	\$14.0	Rural and regional
Sydney	\$12.2	\$14.3	\$14.0	\$19.0	\$23.0	\$21.0	Metropolitan
Western NSW	\$10.2	\$10.2	\$9.7	\$37.0	\$37.0	\$35.0	Rural and regional
Western Sydney	\$11.9	\$11.6	\$12.0	\$13.0	\$13.0	\$13.0	Metropolitan

- 4.79 Table 4.3 shows that the distribution of AOD funding across metropolitan and rural and regional areas varies significantly. In 2016, the rural and regional budget ranged from \$11 to \$60 per person, and the metropolitan budgets ranged from \$12 to \$29 per person.
- 4.80 The differences in per person funding can be partly attributed to specific state-wide programs. For example, Northern NSW LHD's higher expenditure per person is partly due to an investment in the Riverlands Drug and Alcohol Service, which take clients from outside its home LHD.<sup>93</sup>
- 4.81 However, many of the AOD health programs are available across all LHDs. For example, most LHDs received funding for the MERIT (Magistrate's Early Referral Into Treatment) program and most LHDs received funding for opioid treatment or substitution programs.
- 4.82 The relative consistency of programs across LHDs suggests that differences in per person funding to each LHD may be related to factors other than program availability. For example, differences in funding may be driven by local demand for services (met and unmet demand), population within an LHD, equity of accessibility and service utilisation.

### **Changes over time**

- 4.83 Investment in NSW Government-funded AOD specialist health responses in NSW has increased since 2013–14. (See Figure 4.3)

**Figure 4.3: NSW Health investment in specialist AOD services<sup>94</sup>**



## Funding of targeted AOD justice responses

- 4.84 The NSW Government's Department of Communities and Justice (DCJ) received approximately \$11.7 million in targeted AOD funding in 2018–19.<sup>95</sup> Nearly half of this funding was received by Corrective Services NSW.
- 4.85 In 2018–19 the following DCJ agencies received specific AOD funding:
- Juvenile Justice received \$3.2 million
  - Corrective Services NSW received \$5.8 million
  - NSW Crime Commission received \$0
  - NSW Police Force received \$0.5 million
  - Family and Community Services received \$2.3 million.
- 4.86 However, many other programs and initiatives are delivered through these agencies without specific AOD funding. These programs are funded through agencies' business-as-usual functions, with staff contributing to projects and initiatives as part of their normal duties and responsibilities. For example, NSW Police staff contribute to the drug courts as part of their duties and responsibilities without receiving funding specific to the initiative.

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- <sup>82</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 102, Response of the Commonwealth Department of Health dated 6 August 2019, to Request for Information dated 8 July 2019.
- <sup>83</sup> Research and data activities are delivered on a national basis, not solely in NSW. Only a small portion of the funding amounts contributes to activities in NSW.
- <sup>84</sup> Commonwealth funding for non-residential alcohol and other drug treatment services was transitioned to PHNs from 2017-18.
- <sup>85</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 102, Response of the Commonwealth Department of Health dated 6 August 2019, to Request for Information dated 8 July 2019.
- <sup>86</sup> Parliamentary Joint Committee on Law Enforcement, Commonwealth, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) 100.
- <sup>87</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 102, Response of the Commonwealth Department of Health dated 6 August 2019, to Request for Information dated 8 July 2019.
- <sup>88</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 102, Response of the Commonwealth Department of Health dated 6 August 2019, to Request for Information dated 8 July 2019.
- <sup>89</sup> Parliamentary Joint Committee on Law Enforcement, Commonwealth, *Inquiry into crystal methamphetamine (ice)* (Final Report, March 2018) 23, 101.
- <sup>90</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 102, Response of the Commonwealth Department of Health dated 6 August 2019, to Request for Information dated 8 July 2019.
- <sup>91</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 92, Response of NSW Health dated 23 August 2019, to Request for Information dated 8 July 2019, Attachment A, 'Funding Data for NSW Local Health District Programs'.
- <sup>92</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 92, Response of NSW Health dated 23 August 2019, to Request for Information dated 8 July 2019, Attachment A, 'Funding Data for NSW Local Health District Programs'.
- <sup>93</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 92, Response of NSW Health dated 23 August 2019, to Request for Information dated 8 July 2019, Attachment A, 'Funding Data for NSW Local Health District Programs'.
- <sup>94</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 92, Response of NSW Health dated 23 August 2019, to Request for Information dated 8 July 2019, Attachment A, 'Funding Data for NSW Local Health District Programs'.
- <sup>95</sup> Tendered in Chambers on 13 December 2019, Exhibit C, Tab 14, Response of NSW Department of Communities and Justice dated 7 August 2019, to Request for Information dated 8 July 2019.



## Chapter 5. The spectrum of amphetamine-type stimulant use and implications for policy and services

### Introduction

- 5.1 People use drugs, including ATS, in different ways, which can be considered as broad categories or types of use, such as experimental use and dependent use. One drug may be associated more with a particular type of use than another, such as MDMA, which is often used recreationally and rarely in a dependent way. The types of drug use outlined in this chapter are also associated with varying degrees and types of harms.
- 5.2 Different types of ATS use require different service and support responses.<sup>1</sup> For example, although there are some similarities in the use of crystal methamphetamine and MDMA, there are also significant differences in terms of the people who use them, how and where they use them, and the harms they experience.<sup>2</sup> Responses to young people who use MDMA at music festivals need to be different to responses to people who regularly inject crystal methamphetamine.<sup>3</sup>
- 5.3 People who use ATS will be amenable to interventions at different stages of their use, at different locations and in different settings. Policy and service responses, such as education and diversionary programs, must be designed in such a way that they recognise and appropriately respond to the different levels of harms implicit in different categories of use.<sup>4</sup>

### Drug use occurs across a spectrum

- 5.4 ATS use occurs across a spectrum and is associated with a range of different harms.<sup>5</sup> While it is common for a person's drug use to change over time, it is not the case that one stage leads inevitably to another.<sup>6</sup> The Alcohol and Drug Foundation describes a spectrum of drug use that is made up of different categories. These are experimental use, recreational use, situational use, intensive use or 'bingeing' and dependent use.<sup>7</sup> Each of these categories is examined further below.
- 5.5 The Inquiry is of the view that it is important to consider people who do not use drugs (non-users) as a separate target audience of drug policy, given that a large proportion of the population do not use illicit drugs and a key objective of drug policy is to prevent them from doing so, or to delay their first use.<sup>8</sup>
- 5.6 Available data illustrate the diversity in types of ATS use (see Table 5.1). The 2016 National Drug Strategy Household Survey (NDSHS) reported the following data on how often people who reported recent (past year) use of meth/amphetamine or ecstasy used the drugs.<sup>9</sup>

**Table 5.1: Frequency of illicit drug use, recent users aged 14 years or older (%)<sup>10</sup>**

	Amphetamine or methamphetamine		Ecstasy	
	Australia	NSW	Australia	NSW
Weekly or more frequent use	20.4%	22.0%*	1.9%*	n.a.
Monthly use	10.6%	17.7%*	13.8%	14.8%*
Every few months	24.7%	19.0%*	32.9%	30.9%
Once or twice a year	44.3%	41.3%	51.5%	54.3%

\* Estimate has a relative standard error of 25% to 50% and should be used with caution.

## Types of ATS use

- 5.7 Amphetamine and methamphetamine are associated with all types of use but particularly with intensive and/or dependent use. In contrast, MDMA is mainly associated with recreational/social use.<sup>11</sup>

### People who do not use drugs

- 5.8 The 2016 NDSHS found that most Australians (57%) had never used an illicit drug in their lifetime. A very large proportion said they had never used ATS, with 94% of respondents saying they had never used methamphetamine or amphetamine and 89% saying they had never used ecstasy.<sup>12</sup>
- 5.9 The most common reason people gave for not having tried illicit drugs is that they were not interested (73%). Other reasons provided for never trying illicit drugs are of significance when considering interventions to prevent drug use.<sup>13</sup>
- 43% cited concerns over health or becoming addicted (see Chapter 1).
  - 31% were worried about legal consequences and not wanting to break the law (see Chapter 11 and Chapter 19).
  - 25% did not want to feel out of control.
  - 23% cited religious or moral reasons.
  - 19% thought it would not be enjoyable.
  - 18% had a fear of death.

### Where people use ATS<sup>14</sup>

The 2016 NDSHS reports that of people who reported use of amphetamine and methamphetamine in the previous 12 months, 78.1% reported use in a private home, 37.3% at a private party, 22.6% at a rave/dance party, and 21.7% at a public establishment including pubs and clubs.

Of people who reported use of MDMA in the previous 12 months, 48.2% reported use in a private home, 57.4% at a private party, 65.3% at a rave/dance party, and 44.8% at a public establishment.

### Experimental use

- 5.10 Experimental use is defined as trying a drug once or twice out of curiosity.<sup>15</sup> Experimental use is motivated by the desire to experience new feelings or moods, may occur alone or in the company of friends who are also experimenting, and often involves a single instance of use or use that is short term.<sup>16</sup>

- 5.11 The 2016 NDSHS found that around 65% of people who used an illicit drug did so because they were curious, and 50% reported trying it for the first time because a friend or family member was using or offered them the drug.<sup>17</sup>
- 5.12 The Inquiry heard from witnesses who said they experimented with ATS to fit in with friends. One witness said she tried marijuana at age 14 and speed and ecstasy at age 17 because her friends were using the drugs. She also started using crystal methamphetamine because her boyfriend was using it.<sup>18</sup> Another witness described how he started using speed with his friends for the adrenaline rush of trying something new.<sup>19</sup>
- 5.13 As Matt Noffs, CEO of the Ted Noffs Foundation, told the Inquiry: *'drugs will be something that most of our kids experiment with, and I think that's an important realisation to come to'*.<sup>20</sup>

### Case study: experimental use

Melissa\* started using crystal methamphetamine just before she turned 18. She said one of the reasons she started experimenting with drugs was because other people were doing it. *'Some of my friends in Year 12 smoked pot and still do to this day. Some experimented with ecstasy and my boyfriend at the time was using ice and that's how I was introduced to it. I would use it together with him.'*<sup>21</sup>

### Recreational use

- 5.14 Recreational use refers to when a person uses drugs on specific social occasions (for example, using MDMA at dance parties), and they know what drug suits them and in what circumstances.<sup>22</sup> The type and amount of drug taken varies according to the social situation.<sup>23</sup>
- 5.15 Most people start using ATS for social reasons, using in the company of others. They are attracted to the effects of methamphetamine and MDMA such as reduced inhibition, enhanced confidence, increased sociability, energy, alertness and heightened physical sensations.<sup>24</sup> The desire to enhance experiences is the most common reason for continuing drug use among people who use illicit drugs.<sup>25</sup>
- 5.16 Most people who use ATS fall into the recreational category of use, and they use ATS very infrequently. Research has found that this group is able to set and maintain clear boundaries to control their use and prevent the risk of developing dependence.<sup>26</sup>
- 5.17 Research has found that young people mainly use MDMA for social and recreational reasons such as at parties, music and dance events and music festivals.<sup>27</sup> This is consistent with evidence to the Inquiry, with participants at the Inquiry's Youth Roundtable explaining that MDMA is generally used at a party or a festival.<sup>28</sup>
- 5.18 Evidence to the Inquiry suggested that people also use crystal methamphetamine as a recreational drug.<sup>29</sup>
- 5.19 People may use crystal methamphetamine to enhance their sexual experiences.<sup>30</sup> Although 'chemsex' may occur among people who use ATS regardless of their sexual orientation, there is evidence of higher rates of crystal methamphetamine use among gay men, and this can occur in the context of chemsex.<sup>31</sup> ATS in this context has been shown to lead to risky sexual behaviours and place individuals at greater risk of HIV and other sexually transmitted infections.<sup>32</sup>

\* A pseudonym

### Case study: recreational use

Jess\* uses a variety of drugs recreationally, including MDMA, dexamphetamine and cannabis at festivals. At other times, she uses LSD and cocaine. Jess said using drugs *‘changes your mind frame’* and enhances experiences with friends. *‘I’ve had some really memorable experiences with friends when we’ve all been on that level, which I’ve really enjoyed and I’ve found to be, yes, pretty priceless.’*<sup>33</sup>

### Situational use

- 5.20 Situational use is the use of drugs to help perform a task or to cope with the demands of a situation.<sup>34</sup> This type of use is often limited to the duration of the task or situation, for example, when studying for exams or during a work shift.<sup>35</sup>
- 5.21 Methamphetamine is associated with situational use as it can increase a person’s confidence, alertness, energy, concentration and stamina.<sup>36</sup> Situational use of ATS occurs in skilled and unskilled professions, including trades and construction, long-distance driving, hospitality, sex work, IT, finance, health, fly-in fly-out industries, miners and shearers.<sup>37</sup>
- 5.22 The Sex Workers Outreach Project (SWOP) explained that some sex workers might be drawn to crystal methamphetamine to deal with 12-hour late-night shifts.<sup>38</sup> SWOP also noted that drugs such as crystal methamphetamine *‘can seem an attractive workplace aid to people in careers where there is a requirement for engaged, enthusiastic connection, especially on days you’re not feeling it’*.<sup>39</sup>
- 5.23 Research indicates that people who use methamphetamine to cope with a situation are less likely than people who use recreationally to acknowledge the illicit nature of their use. They are more likely to see their use as a *‘means to an end’*.<sup>40</sup> The occupational use of ATS is discussed further in Chapter 8.

### Case study: situational use

Ryan\*, who formerly used crystal methamphetamine, initially had no interest in the drug. He heard it was so strong that people would stay awake for three or four days after just one use and he could not understand why anyone would want to stay awake for that long. Later, Ryan began working 12-hour carpentry shifts that started at 5.30am. He told the Inquiry: *‘One of the employees was smoking ice and he told me he was using it to sustain energy ... This guy was like a machine. He used to just get the work done ... He was unstoppable.’* Ryan changed his mind about crystal methamphetamine. *‘I thought, “To get more energy out of the day, I will smoke with him.” That was it.’*<sup>41</sup>

### Intensive use or bingeing

- 5.24 Intensive use, also known as bingeing, means taking a large amount of drugs over a short period of time and/or using drugs continuously over days or weeks.<sup>42</sup> Intensive use is often linked to stress relief or the need to meet performance targets. Episodes of intense use can occur once or repeatedly.<sup>43</sup> Intensive use can occur across a range of different drugs, with an Australian study reporting that one in 10 young adults who use MDMA indicate binge use of the drug.<sup>44</sup>
- 5.25 Rhiannon McMillan, an AOD Clinical Nurse Consultant, described her observation of the binge use of crystal methamphetamine: *‘So [patients] might use for three or four days in a row, multiple injections in that period of time, and then they’ll just stop using, and they may not use for another month or two.’*<sup>45</sup>

\* a pseudonym

- 5.26 Intensive or binge use is often associated with significant harms. Police in regional towns gave evidence to the Inquiry about the effects of binge crystal methamphetamine use, including increased violence, antisocial behaviour and criminal offending.<sup>46</sup> Superintendent Scott Tanner, New England Police District, NSW Police Force, described several ‘*public order incidents*’ in Moree involving binge use of ATS and alcohol.<sup>47</sup>
- 5.27 Superintendent Peter McKenna, District Commander of the Orana Mid-Western Police District, told the Inquiry:

*‘Anecdotally it has been observed that offenders who go on crime sprees, including stolen motor vehicles, break, enter and steal, and robbery or serious domestic violence offences, are often heavily bingeing on methamphetamine at the time. Often offenders will admit to not remembering offences or that a spree was to support a binge.’<sup>48</sup>*

### Case study: Intensive use or bingeing

Joshua\* remembered a time in his life when he ‘*connected with other people through drugs*’. ‘*I was still partying on the weekends, drinking, using speed and pills, meeting people and chasing girls,*’ he told the Inquiry. Then he tried methamphetamine (meth). ‘*Meth put me in a different world and changed my way of thinking,*’ he said. Joshua said he first started using on Friday and Saturday nights. ‘*Then it was just about ... extending the party and I was using Friday, Saturday, Sunday. Then it was Thursday, Friday, Saturday, Sunday. Then I was using full time. At one time I think I was awake for three weeks.*’<sup>49</sup>

### Dependent use

- 5.28 People who are dependent on drugs are not able to stop using them without significant mental and/or physical distress.<sup>50</sup> Drug use is a central element of their daily life and they feel compelled to take drugs despite the damaging effects on many aspects of their life including their work, health, family, relationships and finances.<sup>51</sup>

### Substance use disorder

Substance use disorder is a complex medical condition with two sets of internationally recognised criteria used to inform diagnosis: the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD) system.<sup>52</sup> Both the ICD-11 and the DSM-V define a substance use disorder as comprising a strong drive to use the substance that results in a variety of problematic behaviours and symptoms.<sup>53</sup>

- 5.29 Dr Jonathan Brett, staff specialist in clinical pharmacology, toxicology and addiction medicine, St Vincent’s Hospital, said addiction is a primal urge to take a drug that overrides all reason. ‘*[W]e really overestimate in general the amount of agency people have in their actions and what they choose to do or not to do because of ... the damage to their brain through addiction.*’<sup>54</sup>
- 5.30 A witness with experience of dependent use described the personal impact of loss of control: ‘*I was totally powerless over what was happening to me. My addiction was running the show, and what I wanted was irrelevant ... It’s not a lifestyle that anyone chooses. It was living hell.*’<sup>55</sup>

\* a pseudonym

- 5.31 Dependent use is more commonly associated with methamphetamine and amphetamine than other types of ATS. In the 2016 NDSHS, 20% of people who used methamphetamine and amphetamine used the drugs weekly or more,<sup>56</sup> and 12.7% of people who used methamphetamine and amphetamine were unable to stop or reduce their intake.<sup>57</sup> There is limited research on the percentage of people who use crystal methamphetamine and develop dependent patterns of use. However, Professor Alison Ritter, Director of the Drug Policy Modelling Program, UNSW Sydney, drawing on US research into rates of dependent use of heroin and cocaine, estimated that about 25% of people who use crystal methamphetamine will go on to develop dependent patterns of use.<sup>58</sup>
- 5.32 In contrast, dependent use of MDMA is rare. The 2016 NDSHS found that 2% of people who used MDMA used it weekly or more,<sup>59</sup> and 1.7% of people who used MDMA were unable to stop or reduce their intake.<sup>60</sup> Dr Brett said he had not seen any cases of addiction to MDMA in his professional career.<sup>61</sup>

### Case studies: dependent use

Shannon Speechley, now an AOD counsellor, said he used crystal methamphetamine for years, despite serious impacts on his mental health and family relationships. *'I fell in love with the drug,'* he said. He became homeless and lived out of his car, turning to crimes such as stealing. Shannon said he *'fell into a very dark place'*, making several attempts to take his own life. He was hospitalised after his first suicide attempt. *'I woke up in Penrith Hospital from an induced coma not knowing what day of the week it was. I pulled out the tubes and left the hospital and started using again.'*<sup>62</sup>

Sean\* was aged about 50 when he was exposed to crystal methamphetamine through the gay community. *'My friends were able to stop, but I couldn't,'* he told the Inquiry. *'I kept and kept going. There's always a line you cross when you're an addict, but you don't realise that you've crossed it until it's too late.'* Sean said addiction to crystal methamphetamine brought him *'to his knees'* within a year. *'It's hard not to crave it,'* he said. *'I think about it, and think about it, because I have enmeshed the activities of sex and meth.'* Sean said life became unmanageable. *'I didn't care about other people or myself. Meth became the number one priority.'*<sup>63</sup>

### Patterns of use may change but are not predictable

- 5.33 People's use of drugs, including ATS, may vary over time, but one type of use does not necessarily lead to another.<sup>64</sup> The Inquiry received a substantial amount of evidence that ATS use does not inevitably lead to dependence.<sup>65</sup> The Australasian Chapter of Addiction Medicine of the Royal Australasian College of Physicians (RACP) noted that in the clinical experience of its doctors, most people who use crystal methamphetamine are not dependent on the drug, and that not all people who used crystal methamphetamine become dependent.<sup>66</sup>
- 5.34 Among people who use methamphetamine in Australia, most use irregularly and for a short period in their lives.<sup>67</sup> According to the 2016 NDSHS, lifetime use of methamphetamine was around 6.3%, but use in the past year was only around 1.4%. Lifetime use of MDMA was 11% in Australia, whereas use in the past year was only around 2%.<sup>68</sup>
- 5.35 A recent study that tracked people who used methamphetamine over five years found four trajectories of methamphetamine use for the study's cohort: consistently non-dependent (27%), persistent dependence (23%), transition from dependence to non-dependence (30%), and transition from non-dependence to dependence (13%).<sup>69</sup>

\* a pseudonym

- 5.36 Dr Brett, St Vincent's Hospital, gave evidence that problematic use develops more quickly with amphetamines than it does with other drugs, developing over weeks or months rather than years.<sup>70</sup> He also told the Inquiry that, in his experience, there is a five-year gap between when a person develops problematic use and when they seek treatment.<sup>71</sup>
- 5.37 Factors that affect the risk of dependence include what drug is taken, how much is taken and how it is taken. Social determinants of drug use, such as poverty, trauma and social disadvantage, can also increase the risk of dependent drug use.<sup>72</sup> Risk factors for drug dependence are discussed further in Chapter 1.
- 5.38 Many people who use amphetamine will reduce or stop using the drug on their own. For example, amphetamine use is highest when people are aged in their mid-twenties but declines substantially by their mid-thirties.<sup>73</sup> There is also evidence that most young adults who use MDMA use it relatively infrequently and that their use declines before they reach their mid-twenties.<sup>74</sup>
- 5.39 An Australian study that looked at amphetamine use from adolescence to adulthood over a 20-year period showed how use declines with age. The study found:
- Most (83.7%) participants reported no use of any amphetamine.<sup>75</sup>
  - 14.5% were considered occasional users of amphetamine. Of these, 50% and 60% reported using amphetamine infrequently at 24 and 29 years respectively, but this proportion dropped to 30% by 35 years.<sup>76</sup>
  - Only 1.8% were considered regular users of amphetamine. More than 70% of regular users reported weekly use at 24 years, dropping to 60% at 29 years and 20% at 35 years.<sup>77</sup>

## Polydrug use

- 5.40 Polydrug use involves using more than one type of drug, either at different times or at the same time,<sup>78</sup> and includes the use of licit and illicit AOD.<sup>79</sup> Polydrug use can occur across the spectrum of types of use,<sup>80</sup> and it is common among people who take ATS.
- 5.41 Polydrug use occurs among people who use ATS to manage or enhance the effects of ATS intoxication, or to reduce withdrawal symptoms. The drugs most commonly used with ATS are benzodiazepines, cannabis, opiates and alcohol.<sup>81</sup> As a lived experience witness told the Inquiry: *'Mushrooms, acid, heroin, pills, barbiturates were around then when we were using ... my goal was to get the next drug ... So, I wasn't really fussy what it was, but amphetamines were a big part.'*<sup>82</sup>
- 5.42 The Inquiry's evidence is consistent with the 2016 NDSHS, which reported use of other drugs at the same time as ecstasy or meth/amphetamines in the past 12 months as shown in Table 5.2.

**Table 5.2: Concurrent drug use, recent<sup>(a)</sup> drug users aged 14 years or older, 2016 (%)<sup>83</sup>**

Drug/behaviour	Ecstasy	Meth/amphetamines <sup>(b)</sup>
Cannabis	78.5	73.7
Ecstasy	n.a.	40.1
Meth/amphetamines <sup>(b)</sup>	25.5	n.a.
Cocaine	48.7	32.2
Hallucinogens	28.0	17.5
Inhalants	11.9	8.7
Heroin	*1.8	7.6
Synthetic Cannabinoids	*2.7	*4.9
New and emerging psychoactive substances	8.6	8.3
Pharmaceuticals <sup>(b)</sup>	29.9	37.8
Did not illicitly use any other drug	6.1	10.1
Daily smoker	27.5	52.1
Risky drinker (lifetime) <sup>(c)</sup>	55.8	52.5
Risky drinker (single occasion at least monthly) <sup>(d)</sup>	83.8	73.4

\* Estimate has a relative standard error of 25% to 50% and should be used with caution.

(a) Used in the previous 12 months.

(b) For non-medical purposes.

(c) On average, had more than 2 standard drinks per day.

(d) Had more than 4 standard drinks on one occasion at least once a month.

## Harms of polydrug use

- 5.43 Polydrug use can significantly increase the risk of a broad range of harms resulting from drug use.<sup>84</sup> It can enhance or mask the effects of another drug, reduce a person's level of control over their actions, including their drug use, and increase the risk of dependence<sup>85</sup> and health problems.<sup>86</sup> ATS may mask the intoxicating effects of alcohol or prescription benzodiazepines, increasing the risk of overdose, accident and injury.<sup>87</sup>
- 5.44 As the Australasian Chapter of Addiction Medicine, RACP observed: *'By using multiple drugs, these users not only can cause harm to themselves, but also can potentially impact on every level of society.'*<sup>88</sup>
- 5.45 The Royal Australian and New Zealand College of Psychiatrists noted a combination of drugs could lead to *'serious harm and an increase in the likelihood of unprecedented effects'*, and that polydrug use increased psychotic symptoms, particularly in people with schizophrenia.<sup>89</sup>
- 5.46 Research shows how polydrug use can increase the harms of ATS use:
- Using alcohol and methamphetamine at the same time increases blood pressure, increasing cardiovascular risks.<sup>90</sup>
  - The use of cannabis and ATS can worsen psychotic symptoms for some people, particularly those who have schizophrenia.<sup>91</sup>
  - The use of multiple ATS together, or a combination of ATS and some depressants, can increase the risk of overheating and seizures.<sup>92</sup>

## Implications for policy and service responses

- 5.47 It is essential that drug policy and service responses recognise the different categories of drug use, and target interventions to meet the specific needs of different groups of people who use ATS according to their category of use.
- 5.48 The NSW Aboriginal Land Council observed: *‘Drawing a distinction between the different categories of user is necessary as the support and treatment needs among these three different groups will vary.’*<sup>93</sup>

## Policy responses tailored to different types of use

- 5.49 Response objectives need to be determined taking into account the motivations and other subjective features of the individual. However, these response objectives should include the following types of use:
- **Non-use:** preventing or delaying first use and ensuring that if a person does use, they understand how to do so in the safest manner.
  - **Experimental and recreational use:** reducing the harms and risk behaviours associated with use, which may include preventing a person’s use from becoming more regular and creating safer settings for use.
  - **Situational use:** reducing the harms and risk behaviours associated with use, which may include preventing a person’s use from becoming more regular, and also addressing the demands of particular situations which may be contributing to a person’s use.
  - **Intensive use or bingeing:** reducing the harms and risk behaviours associated with use, which may include preventing a person’s use from become more regular, reducing the amount they use, creating safer settings for use, and creating opportunities for engagement with primary care and specialist providers to assist with contemplation of changes in use behaviour.
  - **Dependent use:** supporting people to recover from drug-related problems, which may include ceasing or reducing their use and reducing harms and risk behaviours associated with use.
- 5.50 Where there is dependent use, the appropriate support and treatment for each person may need to be more intensive and last longer than for other types of use. Holistic wraparound services that support a person to stop using drugs and avoid relapse may be required, recognising the importance of addressing a person’s health and social needs (including access to housing, education, employment and community connections) to support recovery. Policy and service responses should also develop strategies to reduce the harm associated with dependent drug use by creating safer settings for use, such as needle/syringe exchange and safe disposal facilities. Such services are considered in Chapter 15.

## The goals of policy and service responses to ATS use in NSW

- 5.51 Preventing drug use and harm minimisation are key objectives of the legal and policy frameworks for responding to ATS use in NSW. Across the spectrum of drug use described in this chapter, policy and service responses should focus on preventing uptake of drug use, preventing people moving to more harmful use, and reducing harms associated with drug use.

5.52 Consistent with the National Drug Strategy, effective policy and service responses to people who use ATS aim to:<sup>94</sup>

- **Prevent uptake and delay first use:** preventing uptake reduces the harms associated with drug use for individuals, their families and communities. Delaying first use also reduces the risk of harm, including mental and physical harm to the individual using drugs, and reduces the risk of continued drug use.
- **Reduce harmful use:** reducing harmful consumption over time, or the amount taken on a single occasion, can reduce harms. Harmful use can arise due to the amount of drug taken and how often it is used, the nature of the drug, the way it is used, context of use and individual risk factors such as health and age.
- **Reduce risk behaviours:** harms can result from taking a drug, as well as from risky behaviours associated with drug use. Strategies that encourage safer behaviours reduce harms to individuals, families and communities.
- **Create safer settings:** environmental changes can reduce the impact of drug use. Examples include chill-out spaces, providing food and free water at licensed venues, and facilities for the safe disposal of needles and syringes.
- **Support people to recover from drug-related problems:** treatment and support services are highly effective in reducing risky drug use and harms associated with drug use. A range of services is needed, from community-based support to intensive specialist treatment services. Holistic and integrated treatment and support services are needed to support people to recover from drug use. It is also important to have approaches that bolster protective factors and address social determinants of health.

### Implications of polydrug use for policy and service responses

5.53 The high prevalence of polydrug use among people who use ATS has significant implications for policy and service responses to ATS use. It creates a need to respond holistically – at a systemic and individual level – to the harms associated with use of the illicit drugs occurring in tandem with ATS use.

5.54 Holistic responses to ATS use are more difficult where polydrug use is involved.<sup>95</sup> Engaging with a person who is under the influence of a number of different drugs may be more complex for medical, law enforcement and other services. Polydrug use is also likely to complicate the identification of appropriate treatment or other referral options.<sup>96</sup>

5.55 According to the European Monitoring Centre for Drugs and Drug Addiction, policy and service responses that target only a specific type of drug are often less effective for people who engage in polydrug use.<sup>97</sup> Australian researchers have stated that these responses can ‘*artificially segment users, ignore common contributors to use and harm, and create divisions of care*’.<sup>98</sup>

- 5.56 The need for policy and service responses to ATS to consider and address polydrug use was outlined in a number of submissions to the Inquiry.<sup>99</sup> St Vincent's Health Australia argued that:

*'Failure to recognise the prevalence and patterns of polydrug use can have significant consequences for public health, law enforcement and community safety programs. A single drug strategy can prove counterproductive if the use of one drug type is inextricably linked to the use of other drugs within the local drug market.'*<sup>100</sup>

- 5.57 Polydrug use among people who use ATS and the need for holistic responses to ATS use require that policy and service responses draw on an understanding of broader patterns of alcohol and drug use generally, while still being tailored to the problems that are specific to ATS. The implications of this for NSW's drug policy framework and service responses are discussed in subsequent chapters.

## References

- 1 Sydney (General) Hearing, Sydney, 9 May 2019, TS 248.10-4 (Dr Brett).
- 2 Harm Reduction Hearing, Sydney, 23 September 2019, TS 4163.33-42 (Professor Ritter).
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## Chapter 6. Supply and availability of amphetamine-type stimulants

### Introduction

- 6.1 The ATS market in NSW is supplied through both domestic production and the importation of precursor chemicals and finished product from international sources.<sup>1</sup> Transnational crime networks are attracted to Australia because the market for ATS is lucrative and demand is high.<sup>2</sup> Additionally, precursor chemicals used to produce ATS are relatively cheap in other countries compared to domestically, making their importation more profitable.<sup>3</sup> Recent literature suggests Australia has the highest rate of amphetamine dependence in the world, and amphetamine dependence is associated with a substantially higher proportion of excess mortality in Australia compared to other regions.<sup>4</sup>
- 6.2 The weight of ATS detected at the Australian border increased significantly in 2017–18 to one of the highest levels ever recorded.<sup>5</sup> The Inquiry was informed that approximately \$7.3 billion worth of crystal methamphetamine is consumed per year in Australia.<sup>6</sup> This market is now entrenched and is likely to continue to grow in the medium term.<sup>7</sup> Ninety-four per cent of the 4,178kg of crystal methamphetamine detected at the Australian border between 2018 and 2019 was intended for importation to NSW.<sup>8</sup>
- 6.3 As discussed in Chapter 4, supply reduction is one of the three pillars of the National Drug Strategy 2017–26, which outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply and harm reduction strategies. In NSW, the supply of ATS is primarily controlled through prohibition, policing and law enforcement measures. The role to be played by supply reduction within a whole-of-government AOD policy for NSW is discussed in Chapter 10.
- 6.4 The Australian Criminal Intelligence Commission (ACIC) informed the Inquiry that there has been an increase in seizures of methamphetamine and its precursors and a drop in the price of crystal methamphetamine. The NSW Crime Commission stated that the current law enforcement response to the importation, supply and distribution of methamphetamine in NSW is not very effective in its aim of reducing production and supply in NSW.<sup>9</sup> Similarly, the Global Commission on Drug Policy said there is little evidence that detecting, arresting and incarcerating people involved in international illicit drug markets is reducing drug-related harms or deterring others from engaging in the market.<sup>10</sup> The effectiveness of current law enforcement measures in the context of a prohibitionist model of regulating the use and possession of ATS is further explored in Chapter 19.

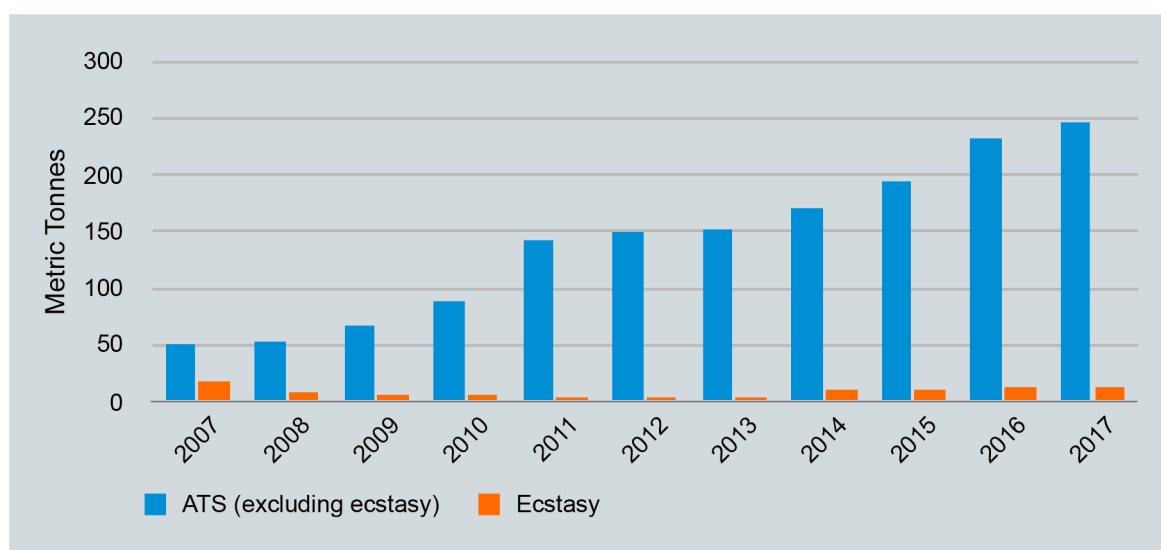
### Supply of ATS

#### The global ATS market has been growing

- 6.5 The size of the global ATS market can be estimated through the number and volume of seizures of ATS and its chemical precursors. Although this measure does not represent the whole market, it does suggest that the market for ATS has been progressively growing over the past two decades, particularly since 2009.<sup>11</sup> It should be noted that the markets for amphetamine and MDMA (ecstasy) operate very differently. The global increase in ATS has been predominantly driven through an increase in methamphetamine and not MDMA.<sup>12</sup>

- 6.6 According to the United Nations Office on Drugs and Crime (UNODC), while the number of countries reporting total ATS seizures remained relatively stable at about 100 countries in each of the periods 2003–07 and 2013–17, the number of countries reporting seizures of methamphetamine rose by 50% in the last decade.<sup>13</sup> The largest quantities of methamphetamine seized in 2017 were recorded in the United States, followed by China, Thailand and Mexico.<sup>14</sup> Australia detected the 11<sup>th</sup> greatest weight of ATS seized (excluding MDMA) at 6,121kg (or 2% of the total global weight).<sup>15</sup> North America and east and south-east Asia together accounted for 91% of the quantity of methamphetamine seized over the period 2013–17.<sup>16</sup>
- 6.7 The weight of global seizures of ATS (excluding MDMA) grew from 50 metric tonnes in 2007 to 247 metric tonnes in 2017.<sup>17</sup>

**Figure 6.1: Global seizures of ATS<sup>18</sup>**



- 6.8 The increase in global methamphetamine seized in recent years has been attributed to both an increase in global law enforcement activities and a growing market for methamphetamine, particularly in North America, east and south-east Asia and Oceania.<sup>19</sup>
- 6.9 In contrast, the total weight of ecstasy seized globally is significantly lower than that of other ATS (see Figure 6.1).

### **There has been significant growth in ATS supply from east and south-east Asia**

- 6.10 Global methamphetamine trafficking primarily takes place in two regions, east and south-east Asia and North America.<sup>20</sup> Seizure reports indicate that methamphetamine is trafficked extensively between countries in these regions and is primarily destined for Asia or North America.<sup>21</sup>
- 6.11 Unlike drugs that rely on plant-based ingredients cultivated under certain climatic conditions, ATS are made from chemical precursors and production processes can be undertaken anywhere.<sup>22</sup> As at June 2019, the manufacture of methamphetamine had been identified in 50 countries.<sup>23</sup>

- 6.12 There has been significant recent growth in ATS supply from east and south-east Asia. UNODC data show that between 2013 and 2016, crystal methamphetamine seizures almost tripled in east and south-east Asia.<sup>24</sup> This increase is partly due to law enforcement efforts in China that have forced drug producers to move production into neighbouring countries,<sup>25</sup> predominantly into remote areas where conditions for drug production are favourable.<sup>26</sup> For example, there has been significant growth in seizures in Myanmar, Laos, Thailand, Cambodia, Vietnam, Malaysia and Indonesia.<sup>27</sup>
- 6.13 Another factor supporting growth of international production has been a lack of regional precursor control strategies and a lack of capacity at a national level to consistently enforce existing laws.<sup>28</sup> This has allowed transnational organised crime groups to facilitate the supply of large quantities of ATS throughout east and south-east Asia.<sup>29</sup>
- 6.14 Between 2013 and 2017, a total of 31 countries dismantled about 35,000 clandestine methamphetamine laboratories.<sup>30</sup> A large majority (90%) were in North America, mostly in the United States, followed by Mexico and Canada.<sup>31</sup> There have also been recent reports of the closure of industrial-scale methamphetamine laboratories in Myanmar<sup>32</sup> and the Philippines.<sup>33</sup> Australia and New Zealand accounted for a limited share (approximately 1%) of the global number of methamphetamine laboratories dismantled.<sup>34</sup> Available information suggests ephedrine and pseudoephedrine remain the main precursors used in the manufacture of methamphetamine in Africa, Asia, Europe and Oceania.<sup>35</sup>

### Australia imports ATS from many different countries

- 6.15 Fifty countries were identified as embarkation points for ATS (excluding MDMA) detected at the Australian border in 2017–18.<sup>36</sup> Measured by weight, the United States has overtaken China as the primary embarkation point of ATS (excluding MDMA) coming to Australia. This may be due to the high price of methamphetamine in Australia compared to in the United States (US\$456 per gram in Australia in 2017 compared to US\$75 per gram in the United States), making the smuggling of methamphetamine from countries in North America highly profitable.<sup>37</sup> Other key embarkation points by weight include Thailand, Malaysia, the United Arab Emirates, Canada, Mexico, Lebanon, Vietnam and India.<sup>38</sup>
- 6.16 ATS often transit through several countries before finally reaching Australia.<sup>39</sup> For example, methamphetamine produced by Iranian and West African organised crime groups is usually shipped through a complex traffic flow through south-east Asia to Australia.<sup>40</sup> These complex trafficking flows are shown in Figure 6.2 below.

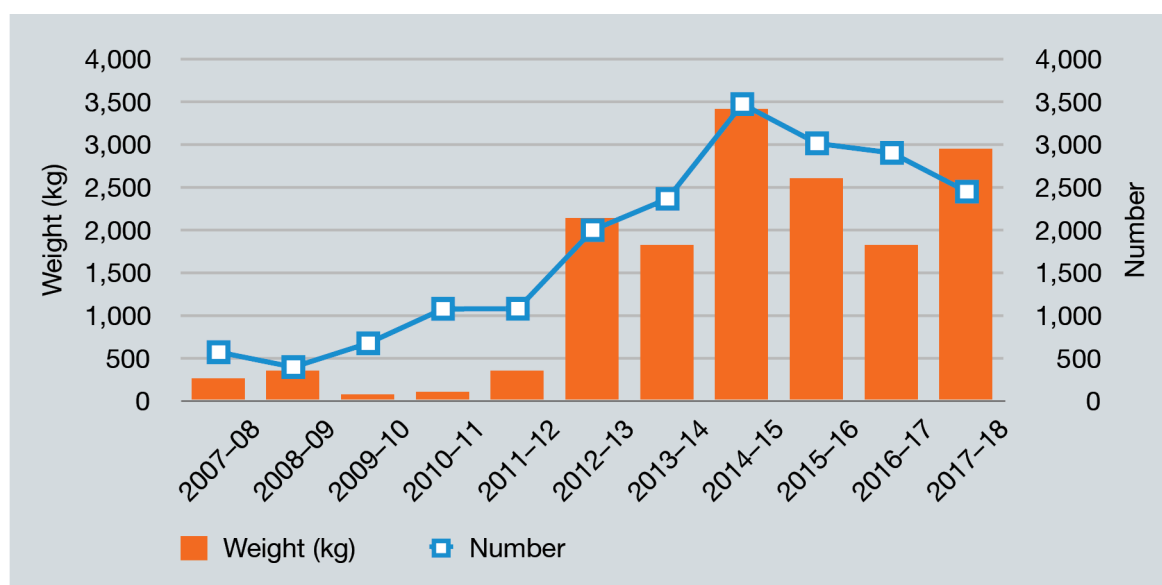
**Figure 6.2: Perceived crystal methamphetamine trafficking flows in east and south-east Asia, 2016–18<sup>41</sup>**



- 6.17 It has been recently reported that Pacific nations including Fiji, Vanuatu, Papua New Guinea, Tonga and New Caledonia are emerging as significant transit points in global methamphetamine trafficking routes.<sup>42</sup>
- 6.18 The production and export of MDMA is significantly different to methamphetamine, with most imported from European countries. In 2017–18, 32 countries were identified as embarkation points for MDMA detected at the Australian border. The Netherlands was the primary embarkation point by weight.<sup>43</sup> Other key embarkation points by weight included Germany, France, Spain, the United Kingdom, Belgium, China, Austria, Switzerland and Italy.<sup>44</sup>

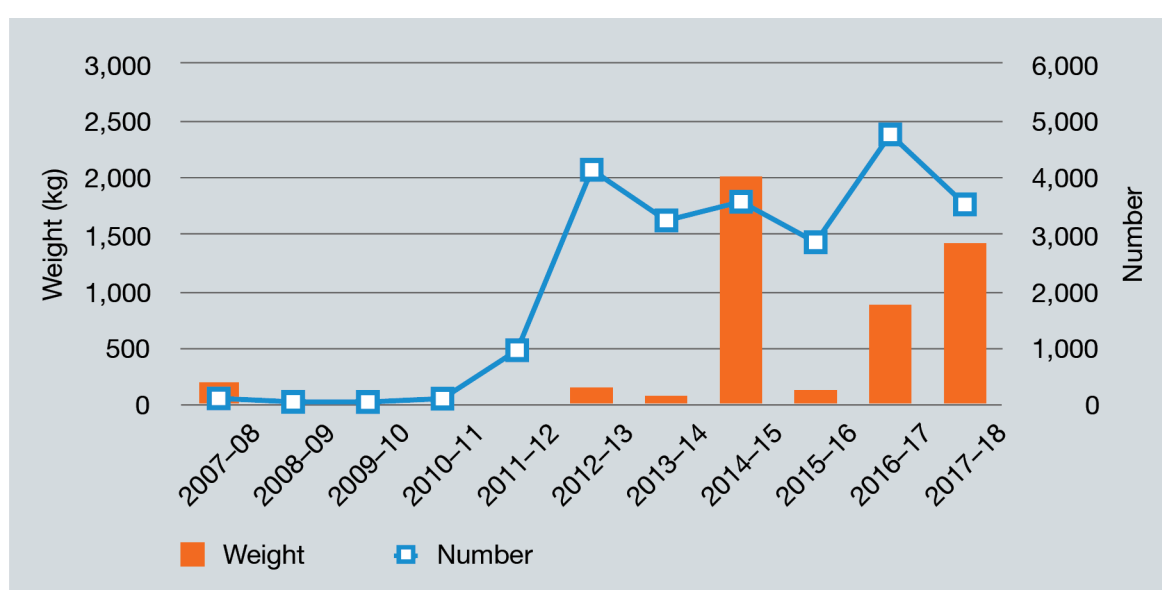
#### The weight of ATS (excluding MDMA) detected at the border has increased recently

- 6.19 While the number of ATS (excluding MDMA) detections at the Australian border decreased in 2017–18 compared to the previous reporting period, the weight detected increased by 61% to 2,952kg in the same period – the second highest detected weight on record.<sup>45</sup> (See Figure 6.3)

**Figure 6.3: Number and weight of ATS (excluding MDMA) detections at the Australian border, 2007–08 to 2017–18<sup>46</sup>**

6.20 The Department of Home Affairs informed the Inquiry that seizures of ATS accounted for 32.9% of the number of illicit drug seizures nationally in 2016–17 and 27.5% of the weight of illicit drugs seized nationally.<sup>47</sup> Between 1 January 2018 and 31 March 2019, the weight of ATS detected by the Australian Border Force at the Australian border was 4,258kg. Of this, crystal methamphetamine comprised 4,178kg, with 94% intended for importation to NSW.<sup>48</sup>

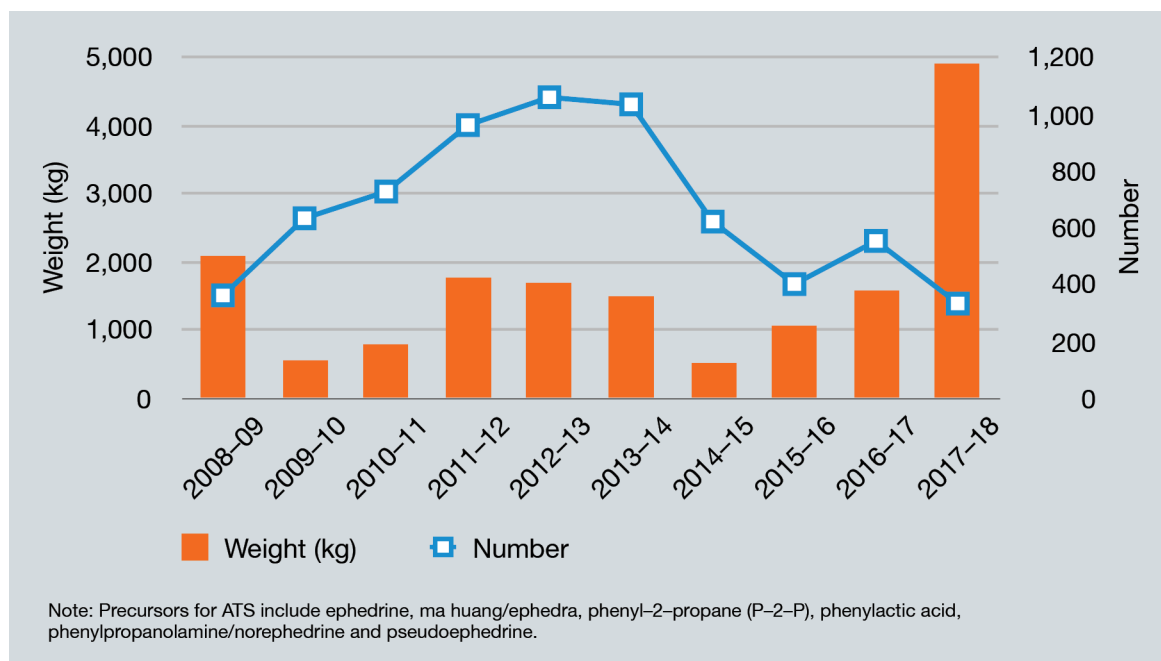
6.21 Seizure data indicate that the MDMA market in Australia is smaller than the crystal methamphetamine market. In 2017–18, the weight of MDMA detected at the Australian border increased by 59.6% compared to the previous reporting period, to 1,420kg, which is the second highest weight of MDMA detected in the last decade.<sup>49</sup> (See Figure 6.4)

**Figure 6.4: Number and weight of MDMA detections at the Australian border, 2007–08 to 2017–18<sup>50</sup>**

## There has been a significant increase in detections of precursor chemicals used in the manufacture of ATS

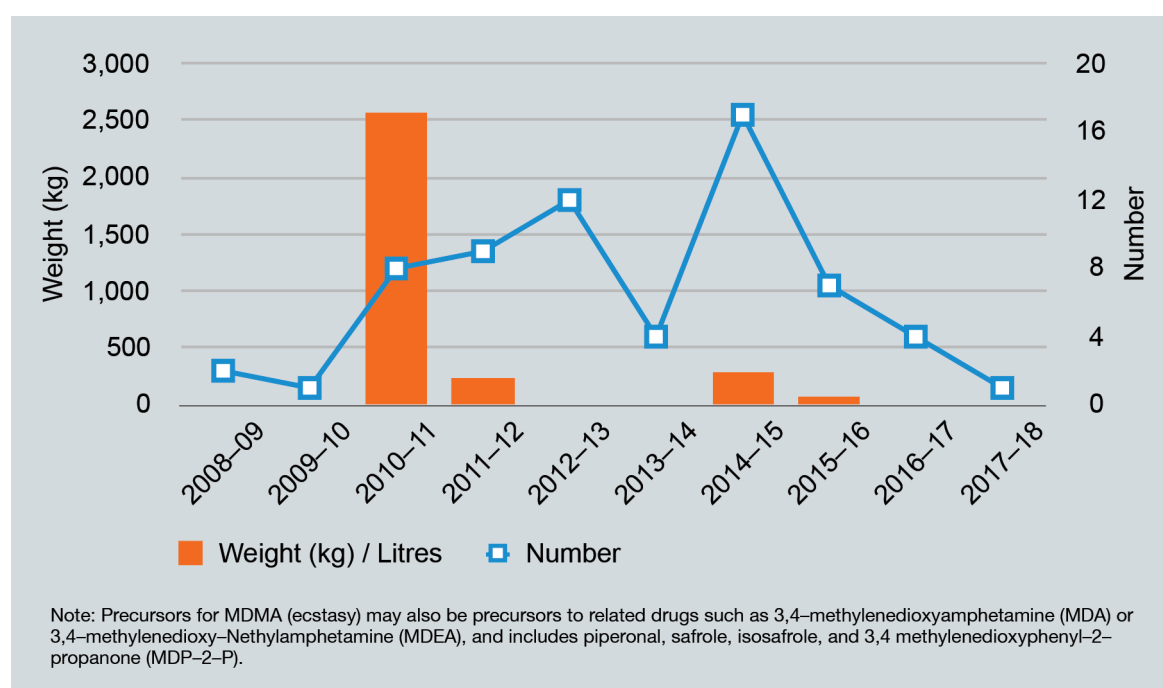
- 6.22 In NSW, it is a criminal offence under the *Drug Misuse and Trafficking Act 1985* (NSW) to possess precursor chemicals capable of being used to manufacture a prohibited drug, unless the person in possession can establish a legitimate purpose or reasonable excuse for possessing such precursors.<sup>51</sup> At Commonwealth level, the *Commonwealth Criminal Code 1995* prohibits importation and exportation of border controlled precursors.<sup>52</sup> There are penalties associated with the importation of precursor chemicals used in the manufacture of ATS of up to 25 years imprisonment for importing commercial quantities,<sup>53</sup> with a commercial quantity of ephedrine and pseudoephedrine being 1.2kg.<sup>54</sup> The chemicals industry also has a voluntary code of conduct that aims to ‘*protect against the diversion of chemicals and scientific apparatus into illicit production of drugs*’.<sup>55</sup>
- 6.23 Many of the precursor chemicals used to produce ATS are common chemicals used by legitimate industries and are not prohibited either internationally or domestically.<sup>56</sup> The manufacture of ATS is not dependent on any single chemical precursor or method of production. Different production methods use different precursors, and producers are therefore able to adapt methods based on the availability and price of precursors as well as the skill of the people manufacturing the drugs.<sup>57</sup>
- 6.24 The Inquiry heard there has been a significant increase in detected importations of precursor chemicals used in the illicit manufacture of methamphetamine.<sup>58</sup> According to the 2017–18 *Illicit Drug Data Report*, the weight of ATS (excluding MDMA) precursors detected at the Australian border increased from 1,584kg in 2016–17 to 4,912kg, the highest detected weight on record.<sup>59</sup> Drug profiling data of analysed border and domestic seizures indicate ephedrine and pseudoephedrine remain the predominant methamphetamine precursors.<sup>60</sup> (See Figure 6.5)

**Figure 6.5: Number and weight of ATS (excluding MDMA) precursor detections at the Australian border, 2008–09 and 2017–18<sup>61</sup>**



- 6.25 In 2017–18, by weight Thailand was the primary embarkation point for ATS (excluding MDMA) precursor detections at the Australian border.<sup>62</sup> Other key embarkation points by weight during this reporting period included China (including Hong Kong), the United Kingdom, the Republic of Korea, the United States, Malaysia, New Zealand, India, Singapore and Vietnam.<sup>63</sup>
- 6.26 Most ATS precursor detections are made through international mail, but these detections account for a small proportion of the total weight. In 2017–18, more than half of the total number of ATS (excluding MDMA) precursor border detections were from international mail, representing only 7.4% of the total weight of precursor detections.<sup>64</sup> This may reflect increased use of the ‘scatter imports’ method of importation, which involves sending large volumes of postal items, each containing small amounts of chemicals, to multiple addresses or post box numbers.<sup>65</sup> Most of the weight of ATS (excluding MDMA) precursor detections were from sea cargo, which accounted for 85.4% of detections by weight in 2017–18.
- 6.27 A very small number of MDMA precursor imports have been detected in the past decade. There was one detection in the 2017–18 reporting period, with a weight of 5g.<sup>66</sup> The majority of detections in the 2016–17 reporting period occurred through international mail (75%) with the remainder being detected in air cargo.<sup>67</sup>

**Figure 6.6: Number and weight of MDMA precursor detections at the Australian border, 2008–09 and 2017–18<sup>68</sup>**



- 6.28 Precursors and equipment are used legally by legitimate businesses including hospitals and other medical settings, waste destruction facilities, pharmacies and chemical companies.<sup>69</sup> They can be diverted in a variety of ways, including through stealing, doctor-shopping, disguising imported precursor chemicals as non-controlled products, exploiting contacts within these facilities, internet sales or establishing a seemingly legitimate business as a cover.<sup>70</sup>

- 6.29 The ACIC told the Inquiry that, based on the operational reporting and significant increases in detected importations of precursor chemicals used in the illicit manufacture of methamphetamine, it suspected a '*tangible undetected large-scale domestic manufacture of methylamphetamine*'.<sup>71</sup> In recognition of this, the ACIC has instigated a High Risk and Emerging Drugs Special Operation to investigate illicit drug markets affecting Australia, with a focus on the methamphetamine market and the related market for precursor chemicals.<sup>72</sup>

### End user declaration system

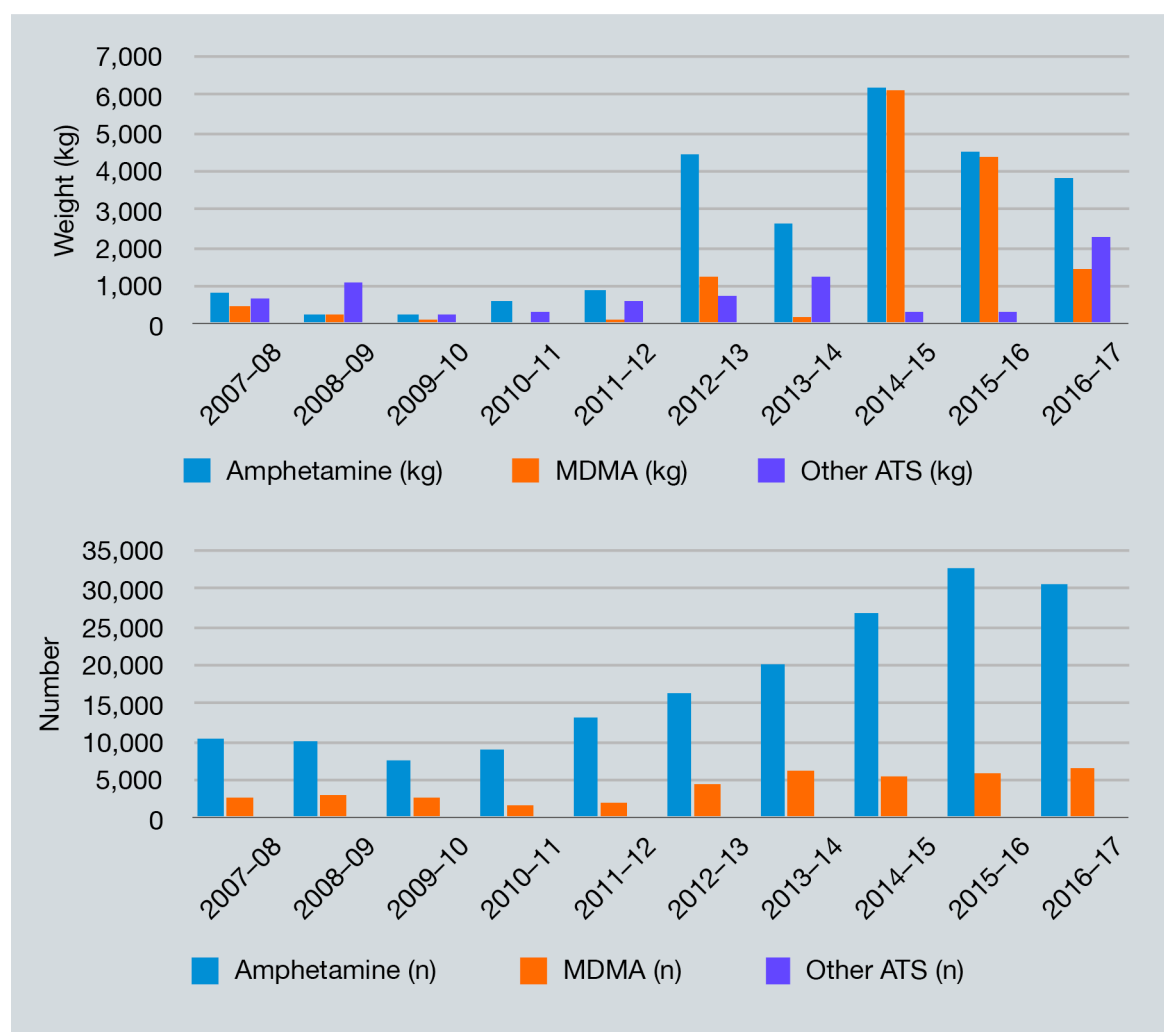
- 6.30 In an attempt to prevent the purchase of precursor chemicals for the purpose of manufacturing illicit drugs, all states and territories in Australia have in place an end user declaration (EUD) system, whereby suppliers are required to record details of sales of specified chemicals and equipment.<sup>73</sup> A purchaser is required to provide identification and make a declaration that the chemicals will not be used for the manufacture of prohibited drugs.<sup>74</sup>
- 6.31 The Police Association of NSW said that Commonwealth and state governments should consider whether the current system is adequate, or whether further improvements are required, including in relation to the ability of law enforcement to monitor in real time the sale, movement and status of chemicals and equipment.<sup>75</sup>
- 6.32 Detective Acting Superintendent Michael Cook, Acting Commander, Drug and Firearms Squad, NSW Police Force, told the Inquiry that although each state and territory has an EUD system in place, each system differs slightly and relates to different chemicals and equipment. In recognition of this, the NSW Police Force are working closely with the Therapeutic Goods Administration to develop a standardised national real-time EUD system to alert authorities when certain chemicals or combinations of chemicals or equipment are ordered.<sup>76</sup> The development of this real-time national EUD is a current priority for the Drug and Firearms Squad.<sup>77</sup>

### The number of ATS seizures has increased in NSW

- 6.33 A significant proportion of ATS in Australia is produced domestically using chemicals and equipment diverted from legitimate purposes, although the full extent of domestic production is unknown. The size of the market is generally estimated through the number and size of clandestine laboratories detected and the number and weight of precursor drugs detected.

### National seizures

- 6.34 The ACIC informed the Inquiry that the number and weight of national amphetamine seizures increased substantially in 2012–13 and has not reverted to levels seen before that year. The ACIC said there was little change in the number of national MDMA seizures in the same period, but the weight of MDMA seized nationally increased significantly in 2014–15 and 2015–16.<sup>78</sup> (See Figure 6.7)

**Figure 6.7: National ATS seizures, by ATS drug type, number and weight, 2007–08 to 2016–17<sup>79</sup>**

'Other ATS' includes ATS drug forms other than crystalline, powder or tablet and includes seizures for which the drug form was not known or was inadequately described. The numbers of seizures of 'other ATS' were too low to be visualised on the scale of this graph.

## NSW seizures

6.35 The NSW Police Force provided the Inquiry with seizure data for 2014–19, which demonstrated that the number of ATS seizures has increased gradually since 2014–15.<sup>80</sup> Conversely, the weight of ATS seizures peaked in 2014–15 at 3,196kg, and has remained under 1,000kg since that year (see Table 6.1). This peak may be attributable to a small number of very large detections of ATS at the Australian Border in Sydney in 2014–15, including:<sup>81</sup>

- four large detections of MDMA at the Australian border in Sydney, which accounted for approximately 96.4% of the weight of national detections of MDMA at the Australian border for that reporting period
- five large detections of ATS (excluding MDMA) at the Australian border in Sydney, which accounted for approximately 40.4% of the weight of national detections of ATS (excluding MDMA) at the Australian border for that reporting period.

**Table 6.1: Number and weight of seizures in NSW since 2014–15<sup>82</sup>**

Seizures	ATS total		MDMA		Crystal Methamphetamine		Methamphetamine (excluding Crystal)	
	Number of seizures	Total weight of seizures (kg)	Number of seizures	Total weight of seizures (kg)	Number of seizures	Total weight of seizures (kg)	Number of seizures	Total weight of seizures (kg)
2014–15	9,879	3,197	2,597	2,036	4,945	1,022	2,346	139
2015–16	11,441	499	2,930	172	5,985	216	2,544	111
2016–17	11,510	475	3,363	67	5,879	255	2,276	66
2017–18	11,458	990	3,461	348	5,937	529	2,060	113
2018–19	12,693	643	3,770	320	6,628	249	2,295	74

6.36 Despite these seizures, it is clear from evidence before the Inquiry that ATS remain readily available in NSW, and supply continues to meet demand. This is reflected in a comparison between national wastewater and seizure data, which indicates the weight of MDMA seized exceeded the estimated amount needed to meet national demand by 175%. The weight of amphetamines seized (of which the majority was methamphetamine) was equivalent to 51% of the estimated total amount consumed during the 2017–18 reporting period (see Table 6.2).

**Table 6.2: Comparison of the weight of methylamphetamine, cocaine, MDMA and heroin seized nationally in 2017–18 and estimated consumption<sup>83</sup>**

Drug	Estimated consumption (kilograms per annum) <sup>[a]</sup>	2017–18 national seizures (gross kilograms)	Percentage of total estimated consumption seized (%)
Methylamphetamine	9,847	5,064 <sup>[b]</sup>	51
Cocaine	4,115	1,970	48
MDMA	1,162	2,033	175
Heroin	750	229	31

[a] Consumption estimates are based on data derived from Year 2 of the National Wastewater Drug Monitoring Program

[b] At this time it is not possible at a national level to provide a further breakdown of drugs within the amphetamines category. As such national seizure figures reflect the weight of amphetamines seized. Amphetamines include amphetamine, methylamphetamine, dexamphetamine and amphetamines not elsewhere classified. Based on available data, methylamphetamine accounts for the majority of amphetamines seized.

### Clandestine laboratory detections have declined nationally but have increased recently in NSW

6.37 Clandestine laboratories range from crude, small scale, makeshift operations using simple processes, to highly sophisticated operations using technically advanced processes, equipment and facilities. They can be found across a wide range of locations, including houses and apartments, cars, rental storage, motorhomes and even public toilets. Irrespective of their size and level of sophistication, the corrosive and hazardous nature of many of the chemicals used in the manufacture of ATS make clandestine laboratories a risk, both to the health of those undertaking the manufacturing process and the community more broadly.<sup>84</sup>

6.38 Submissions to the Inquiry stated that methamphetamine is relatively easy to manufacture, requiring unsophisticated laboratories and limited training and equipment.<sup>85</sup> The National Drug and Alcohol Research Centre (NDARC) noted the methods used to manufacture ATS can vary greatly, depending not only on the availability of certain precursors but also on the availability of skilled labour.

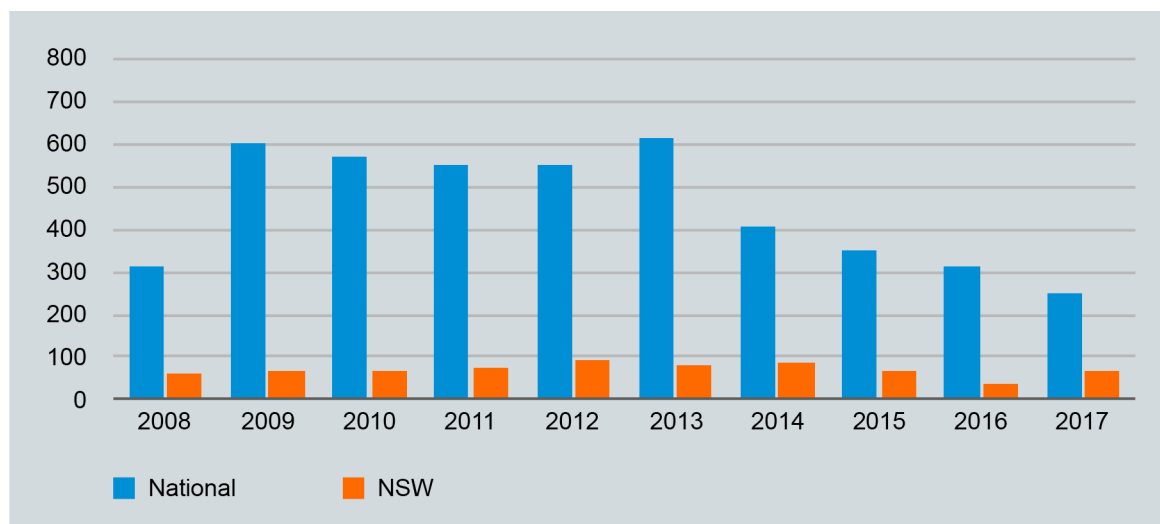
*‘... when a few ‘cooks’ are imprisoned, their preferred methods are no longer common, but the processes can resurface when cooks with specialised knowledge and skills are released from prison’.*<sup>86</sup>

6.39 Nationally, the total number of detections of clandestine laboratories manufacturing ATS has more than halved over the past five years, from a peak of 611 detections in 2013–14 to 253 detections in 2017–18.<sup>87</sup> Detections in NSW have also decreased, although not as markedly, from a peak of 96 detections in 2012–13 to a low of 35 detections in 2016–17. The number of detections rose again to 68 in 2017–18 (see Figure 6.8).

6.40 Almost three-quarters of the clandestine laboratories manufacturing methamphetamine detected in NSW in 2017–18 used the ‘hypophosphorous’ method of production, compared to half of laboratories detected nationally. This method is comparatively simple as it uses readily available basic equipment and precursors, with pseudoephedrine and ephedrine the most common precursors used.<sup>88</sup>

6.41 Twenty clandestine laboratories were detected manufacturing MDMA in Australia in 2017–18, half of which were located in NSW. This represents the highest number detected in the past decade and the second highest number on record.<sup>89</sup>

**Figure 6.8: Number of ATS clandestine laboratory detections in NSW and nationally 2008–17<sup>90</sup>**



6.42 The NSW Crime Commission noted that the reduced number of detections does not necessarily indicate reduced output.<sup>91</sup> Several factors influence output levels, including the size of reaction vessels, amount and type of precursors used, skill of people involved and the method of manufacture.<sup>92</sup>

- 6.43 Detective Acting Superintendent Cook, NSW Police Force, gave evidence that there has been an increase in the production capacity of clandestine laboratories uncovered in NSW.<sup>93</sup>

*‘... we are seeing more MDMA-manufacture processes, labs in the last couple of years than we have seen before. The manufacture of MDMA is a more complex process than the manufacture of methylamphetamine. It requires a larger range of chemicals and more specialist chemicals and equipment and a higher degree of knowledge in the manufacture process. At the same time we are seeing more of those laboratories.’<sup>94</sup>*

- 6.44 The UNODC categorises clandestine laboratories into four categories depending on their size: addict-based, other small scale, medium scale and industrial scale. In 2017–18, about half of all clandestine laboratories manufacturing illicit drugs detected in Australia were addict-based, while approximately one-quarter were classified as other small scale. Medium laboratories constituted approximately 20% of detections, while industrial-scale laboratories constituted only 1.6%.<sup>95</sup>
- 6.45 Detective Acting Superintendent Cook stated that while the numbers of clandestine laboratories detected have dropped, there has been an increase in larger-scale operations detected.<sup>96</sup> He noted that drug manufacturers were increasingly looking for isolated locations where trucks transporting equipment could operate without alerting neighbours. He said most laboratories detected are able to produce multiple kilograms of crystal methamphetamine or MDMA in a single manufacture process.<sup>97</sup> (See Table 6.3)
- 6.46 Conversely, the Inquiry heard from the NSW Police Force during regional hearings that clandestine laboratory detections in their police districts were not common, with only a few having been detected in recent years.<sup>98</sup>

**Table 6.3: NSW Police Force detections of clandestine ATS labs<sup>99</sup>**

MDMA	Total	Size (number)				Location (number)					
		Addict-based	Other small	Medium	Industrial	Residential	Vehicle	Other	Commercial	Public Place	Rural
2014–15	10	–	3	7	–	4	–	–	3	–	3
2015–16	9	–	–	9	–	1	–	–	3	–	5
2016–17	2	–	–	2	–	–	–	–	2	–	–
2017–18	10	–	4	2	4	3	–	–	2	–	5
2018–19	4	–	1	2	1	1	–	–	–	–	3

Crystal Methamphetamine	Total	Size (number)				Location (number)					
		Addict-based	Other small	Medium	Industrial	Residential	Vehicle	Other	Commercial	Public Place	Rural
2014–15	76	–	54	22	–	42	4	2	7	5	16
2015–16	57	–	31	26	–	45	3	2	1	–	6
2016–17	40	1	30	9	–	28	1	–	5	–	6
2017–18	58	–	35	22	1	43	6	–	1	–	8
2018–19	40	–	20	20	–	31	2	–	5	–	2

## Crime groups play a significant role in the supply and distribution of ATS

- 6.47 The illicit supply of drugs remains the largest and most profitable criminal enterprise in east Asia and the Pacific. In 2012, more than US\$35 billion per year was generated from the illicit drug market (including pharmaceuticals) in the east Asian and Pacific regions, representing over one-third of total transnational organised crime enterprises.<sup>100</sup>
- 6.48 ATS are a profitable commodity for serious and organised crime, which is deeply entrenched in the importation, manufacture and distribution of methamphetamine in Australia. In 2019, the illegal methamphetamine sector was worth an estimated US\$11.1 billion across Australia and New Zealand.<sup>101</sup> The NSW Crime Commission told the Inquiry it was aware of information indicating that *'organised criminal syndicates only need one in seven of their drug importations to be successful in order to make their business profitable'*, demonstrating the scale and volume of the operations undertaken by organised criminal syndicates.<sup>102</sup>
- 6.49 To support the international supply chain, it is not unusual for various criminal organisations to collaborate at different stages.<sup>103</sup> For example, Mexican and South American crime cartels are known to engage with Chinese and African crime groups to obtain and trade cheap precursor chemicals for the ATS market while supplying cocaine and other contraband.<sup>104</sup> Outlaw motorcycle gangs in Australia and New Zealand have links with Canadian, North American, Thai, Indonesian and Scandinavian crime groups and operate as importers and financiers of the illegal drug trade.<sup>105</sup> This increase in the size and scope of the illicit drug market affecting Australia reflects the globalisation and economic growth of countries, especially within Asia.<sup>106</sup>
- 6.50 Organised crime groups are also increasingly involved in the importation and trafficking of precursor chemicals and are adept at developing new manufacturing techniques to avoid sales controls over key precursors.<sup>107</sup> Australian organised crime groups are attracted to importing illicit precursor chemicals as they are cheaper and can be brought in larger volumes offshore. Precursors and equipment used in the domestic production of ATS are imported from countries where they are freely available, such as China or India, which have large legitimate chemical and pharmaceutical industries, or in partnership with crime groups from those countries.<sup>108</sup>
- 6.51 Detective Acting Superintendent Cook, NSW Police Force, said the primary groups involved in large-scale drug supply in NSW are Middle Eastern organised crime groups and outlaw motorcycle gangs.<sup>109</sup> The Department of Home Affairs stated that two-thirds of targets on the National Criminal Target List are reportedly involved in the sale and distribution of crystal methamphetamine and its precursors.<sup>110</sup>
- 6.52 The ACIC told the Inquiry that available data on estimated drug consumption and seizures in Australia suggest organised crime groups are able to respond rapidly to large seizures and quickly resupply the market, noting that high demand and profit margins justify the risk to crime groups. It further noted that repeated seizures at a national and state level can have a short-term impact on the NSW methamphetamine market, particularly in Sydney, but if seizures are not sustained, availability reverts to previous levels.<sup>111</sup>

- 6.53 Evidence before the Inquiry suggests organised crime groups are becoming more sophisticated and professional in drug supply activities, largely facilitated by technology and encrypted communications.<sup>112</sup> Detective Acting Superintendent Cook said organised crime groups are increasingly using encrypted communications devices and apps<sup>113</sup> and sophisticated electronic ‘hides’ or ‘secret compartments’ in motor vehicles to conceal activities surrounding the supply of illicit drugs and firearms.<sup>114</sup> He noted that increased use of technology has given criminal groups more confidence in transporting drugs.<sup>115</sup> At the same time, the Inquiry heard the NSW Police Force must work within the constraints of limited funds and resources to counter these activities.<sup>116</sup>
- 6.54 It is estimated there are 39 outlaw motorcycle gangs with more than 5,000 members in operation in Australia.<sup>117</sup> Although it is not possible to estimate the proportion of outlaw motorcycle gangs affiliated with ATS supply or the part they play in ATS-related crime,<sup>118</sup> it is evident that many of these organisations have become significantly involved in the domestic supply of ATS, particularly crystal methamphetamine.<sup>119</sup> For example, in late 2014 the Comanchero outlaw motorcycle gang was linked to a seizure of 32kg of methamphetamine in Sydney.<sup>120</sup> In June 2017, a joint operation between the NSW Police Force and the Australian Federal Police led to the seizure of more than 1.4 tonnes of ephedrine that had been trafficked from China, and the arrest of 14 people including members of the Rebels outlaw motorcycle gang.<sup>121</sup>
- 6.55 The 2017 *Commonwealth Parliamentary Inquiry into Crystal Methamphetamine (ice)* and the 2014 *Victorian Parliamentary Inquiry into the Supply and use of methamphetamine in Victoria* heard that the significant role of outlaw motorcycle gangs in the Australian ATS market is enabled by easy access to precursor chemicals, established drug distribution networks, the use of violence, access to weapons and the use of specialised money laundering services.<sup>122</sup>
- 6.56 Increased law enforcement attention on outlaw motorcycle gangs in Australia has resulted in the expansion of their chapters throughout east and south-east Asia. The UNODC anticipates that outlaw motorcycle gangs may further expand their involvement in the methamphetamine and precursor trade from south-east Asia to Australia, given the low price per kilogram and increased quantities of methamphetamine manufactured and available in the region.<sup>123</sup>

## Money laundering

- 6.57 Money laundering refers to the processing of illicit profits to disguise their origins, which enables criminals to transform the proceeds from criminal activity into seemingly legal revenue from seemingly legal sources.<sup>124</sup> Criminals such as drug traffickers use money laundering for a range of reasons, including to legitimise illegitimate earnings, hide and accumulate wealth, avoid prosecution, evade taxes and increase profits through reinvestment that can be used to fund further criminal activity.<sup>125</sup> ‘Professional facilitators’, including lawyers, accountants, financial and tax advisers, registered migration agents, stockbrokers, real estate agents and customs brokers, contribute to the drug market by facilitating money laundering.<sup>126</sup>
- 6.58 Recently, the NSW Crime Commission has targeted networks involved in professional money laundering activities, which on many occasions has led to identification of people also involved in drug importation and distribution. In relation to investigations the Commission was involved in, there were a total of 163 charges for money laundering in NSW in 2017–18, compared to 97 drug-related charges. Money laundering charges have overtaken drug charges for three years in a row. Several of the money laundering investigations have led to successful drug prosecutions.<sup>127</sup>

- 6.59 AUSTRAC oversees Australia's anti-money laundering and counterterrorism financing regime. AUSTRAC provided information to the Inquiry that the primary money laundering channels used by individuals and groups engaging in criminal enterprises are as follows:<sup>128</sup>
- The banking system: This sector has a large customer base, substantial financial flows and a diversity of product offerings that provide an opportunity for criminal groups to conceal and mix licit and illicit activity.
  - The remittance (money transfer) sector: Service providers accept instructions from customers to transfer money or property to a specified recipient. This sector is often used to facilitate the transfer of funds overseas.
  - The gaming sector: This sector includes licensed casinos, electronic gaming machine venues, totalisators and sports betting. This sector is used in the placement (moving, dispersing or disguising funds) and layering (reinvesting funds) stages of the money laundering cycle.
  - High-value goods and services: The purchase of high-value goods provides a mechanism to reinvest or conceal proceeds of crime. Individuals or groups may seek to store and hide value in goods, or transfer value to a third party.
- 6.60 Given the relationship between illicit drug supply and money laundering, effective strategies for regulating and controlling the flow of money should continue to be a priority for government to address the supply of ATS.

### Online illicit drug markets

- 6.61 Cryptomarkets are online marketplaces located in the dark web that enable people who use illicit drugs to buy and sell them, exchange information about drug availability and purity, and obtain recipes for their manufacture, among other things.<sup>129</sup> Payment is commonly facilitated through the use of cryptocurrencies such as bitcoin and drugs are distributed to buyers via mail.<sup>130</sup> The supply of illicit drugs online via cryptomarkets is becoming increasingly common due to the anonymity of both sellers and buyers, which reduces the risk of detection by law enforcement.<sup>131</sup>

### Definitions

**Surface web, clear web and deep web:** The 'surface' or 'clear' web is the part of the internet that can be accessed through search engines such as Google. The 'deep' web is not accessible through standard search engines and can only be accessed by searching in a particular website.

**Dark web or dark net:** This is a part of the deep web that is intentionally hidden and inaccessible via standard web browsers. It can only be accessed via a Tor browser or similar software. Tor (an acronym for 'The Onion Router') is free browsing software that obscures the IP address of a user's computer, providing anonymity and protecting the personal privacy of the user. It is the part of the internet most commonly used for illicit activities such as the supply of illicit drugs.

**Cryptomarkets:** Cryptomarkets are online forums located in the dark web and are accessible via Tor. They facilitate the exchange of goods and services between people who use digital encryption to conceal their identities. One of the largest and most well-known cryptomarkets was Silk Road, a large illicit online drug retail market established in February 2011 and dismantled by the US Federal Bureau of Investigation in October 2013.<sup>132</sup>

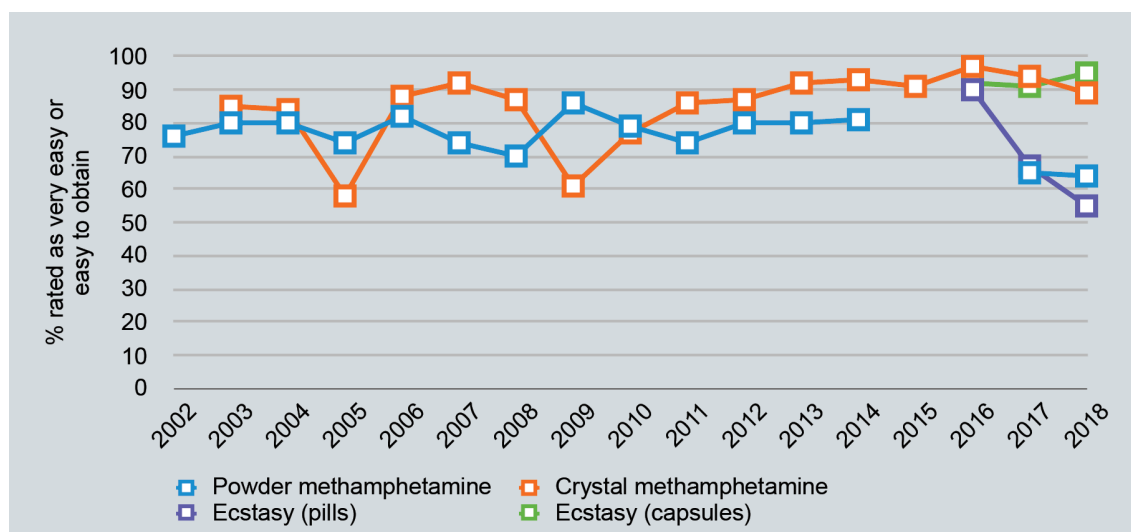
- 6.62 Cryptomarkets resemble legitimate online marketplaces such as eBay or Amazon. They bring together a range of vendors in one location, each listing products for sale, enabling users to compare products and shop.<sup>133</sup> Like licit online marketplaces, users are prompted to provide feedback on sellers, including comments and ratings.<sup>134</sup> This ensures that dealers who provide low-quality services or products are quickly rejected by the cryptomarket community. A participant at the Youth Roundtable convened by the Inquiry said that sellers on the dark web do not last long if they are selling low-quality drugs or the drugs are not being received by users.<sup>135</sup> *'I would probably trust the reliability of dark net market drugs more than I would of any other type of drugs.'*<sup>136</sup>
- 6.63 As a portion of the global drug trade, it is likely that cryptomarkets represent a very small fraction of overall sales. The dark web market appears to be most commonly used for mid- or low-volume sales directly to consumers, with sales of large volumes of substances relatively uncommon.<sup>137</sup> The NSW Crime Commission told the Inquiry: *'Sales numbers are not significant when compared to the more established distribution networks operated by organised crime throughout Australia.'*<sup>138</sup>
- 6.64 A regional analysis of cryptomarkets published by the Australian Institute of Criminology identified 150 online drug vendors based in Australia in 2016, out of a total 1,838 vendors operating worldwide, representing the second highest number of drug vendors per capita globally.<sup>139</sup> Australian vendors accounted for 27% of total methamphetamine transactions and 9% of total ecstasy/MDMA transactions worldwide.<sup>140</sup> This research also identified that a very high percentage of Australian vendors sold products within Australia only. Youth Roundtable participants told the Inquiry that purchasing illicit drugs domestically reduced the chances of seizure by customs officials.<sup>141</sup> Another factor contributing to this trend may be Australia's geographic isolation, meaning there are long postal delivery times to potential international customers. The relatively high price of drugs sold by Australian vendors also makes sales by Australian vendors significantly less attractive, compared to their international competitors.<sup>142</sup>
- 6.65 The NSW Crime Commission told the Inquiry that online ATS markets are not currently considered a significant threat, and that the Commission does not investigate dark net activities. However, it highlighted the challenges experienced by law enforcement in investigating criminal syndicates who use encrypted communication platforms, noting that a significant amount of time and resources are required to gather sufficient intelligence to identify individuals who *'operate under this cloak of anonymity'*.<sup>143</sup>
- 6.66 A limitation in the growth of cryptomarkets is the fact that drugs must be sent through the postal system, risking detection and seizure by law enforcement and customs officials.<sup>144</sup> In an effort to counter this, cryptomarkets provide advice to sellers on how to avoid detection.<sup>145</sup> Detective Acting Superintendent Cook, NSW Police Force, told the Inquiry that some suppliers offer warranties on the delivery of their illicit products. He further noted that many dark web suppliers no longer provide warranties on drugs being sent to WA, due to the success of WA police in intercepting drugs in the mail.<sup>146</sup> He said a current focus of the Drug and Firearms Squad is new and emerging routes of distribution including online and by post.<sup>147</sup>

*'The dark web relies on the use of a postal service to deliver those drugs between the seller and the buyer. Different jurisdictions in Australia have had a range of success, using equipment to identify illicit drugs in the postal stream. Additionally larger and larger quantities of prohibited drugs are coming in through international mail, the postal stream. So it's an area where we are looking at expanding our capabilities so that we can better identify drugs that are in transit.'*<sup>148</sup>

- 6.67 Research suggests that the use of online illicit drug marketplaces may result in a reduction in drug-related harms. Anonymised user forums permit information sharing between buyers about drug effects and harm reduction strategies that may reduce the risk of serious harm or illness.<sup>149</sup> Feedback and ratings systems enable buyers to make informed decisions on what to purchase and from whom, and to avoid more dangerous batches of drugs.<sup>150</sup> Literature also suggests that violence associated with the physical purchase of illicit drugs, including street-level crime and gang-related conflicts, are avoided through online transactions.<sup>151</sup>
- 6.68 Online drug forums also allow researchers to gather information and data that would be difficult to collect using other methods, for example on patterns of use of emerging drugs, motivations and harms.<sup>152</sup> NDARC noted that its analysis of illicit online drug markets identified that MDMA was the third most commonly available substance on the major cryptomarkets from January to July 2017 (according to the number of vendors listing this substance for sale) and methamphetamine was the fifth most commonly sold substance. It highlighted potential opportunities for further reporting and monitoring:
- ‘While identification of actual purchasing and receipt of drugs from cryptomarkets in Australia is challenging to ascertain, there is the opportunity with some of these marketplaces to analyse information presented on where drugs are shipped from, and can be shipped to, to give Australian-relevant data.’<sup>153</sup>*
- 6.69 There is scope in NSW to consider broadening this monitoring to systematic evaluation of other online sources to integrate with surveillance efforts, including surface web marketplaces, discussion forums, social media and search engine trend data.

## Availability of ATS

- 6.70 ATS are highly accessible across Australia. In 2018, national surveys of people who regularly inject drugs and those who regularly use ecstasy found all forms of ATS were easy to source. Ninety-four per cent of participants of both surveys found crystal methamphetamine ‘easy’ or ‘very easy’ to obtain. Most people also reported that speed and ecstasy were ‘easy’ or ‘very easy’ to obtain.<sup>154</sup> However, ecstasy, especially in powder form, was reported as being less easy to obtain than in the previous year.
- 6.71 People who use ATS in NSW also consider them easy to source. The 2014–15 Drug Use Monitoring in Australia survey of police detainees in Bankstown and Surry Hills stations rated the availability of methamphetamine as 8 out of 10, with 1 being ‘extremely hard’ to source and 10 being ‘readily available’ or ‘overabundant’.<sup>155</sup> Evidence received by the Inquiry is consistent with this perception.<sup>156</sup> NDARC cited research demonstrating two-thirds of consumers reported powder methamphetamine to be very easy or easy to obtain (similar to previous years), and over three-quarters of consumers reported crystal methamphetamine was very easy or easy to obtain.<sup>157</sup> (See Figure 6.9)
- 6.72 The Inquiry received evidence at its regional hearings that crystal methamphetamine is readily available.<sup>158</sup> One participant at the Nowra Roundtable likened the local dealer to a pizza delivery man: *‘One of the communities out at home ... one of the fellas delivers ice like he’s the pizza man. The whole community sees the car drive in. People walk out, collect it like it’s a pizza, and he just drives away.’<sup>159</sup>*
- 6.73 A participant at the Broken Hill Roundtable said it was both easier and cheaper to obtain crystal methamphetamine than it was to buy a packet of cigarettes over-the-counter at a store.<sup>160</sup>

**Figure 6.9: Current perceived availability of ATS<sup>161</sup>**

Note: There are no available data for availability of powder methamphetamine in 2014 and 2015.

## Sources of ATS

6.74 Data and Inquiry evidence show that most people who use ATS in NSW source their drugs from friends. Participants of the Youth Roundtable told the Inquiry that they were most likely to buy from known networks or using platforms such as Wickr, an instant messaging app that allows users to exchange encrypted messages.<sup>162</sup> However, data from the Australian Institute of Health and Welfare indicate a larger proportion of people sourced ATS from a person outside their friendship group in 2013–16. (See Table 6.4)

**Table 6.4: Usual source of methamphetamine supply, recent<sup>(a)</sup> users aged 14 or older, NSW and Australia, 2004 to 2016 (%)<sup>163</sup>**

Source	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Friend	70.4	64.9	52.5	66.3	*34.4*	69.9	65.9	60.1	57.4	54.7
Dealer	23.8	26.5	39.1	27.9	58.6*	22.7	27	32.7	30.6	33.4
Other <sup>(b)</sup>	*5.8	*8.6	*8.3	*5.8	**7.0	7.4	*7.1	7.2	12	11.9

\* Estimate has a relative standard error of 25% to 50% and should be used with caution.

\*\* Estimate has a high level of sampling error (relative standard error of 51% to 90%), meaning that it is unsuitable for most uses.

\* Statistically significant change between 2013 and 2016.

n.p. Not published because of small numbers, confidentiality or other concerns about the quality of the data.

(a) Used in the previous 12 months for non-medical purposes.

(b) Includes 'Relative', 'Partner', 'Doctor shopping/forged script', 'Prescription for medical condition', 'Internet', 'Stole/steal it' and 'Other' in 2016. Response options have changed over time, so trends should be interpreted with caution.

Note: Base is users of meth/amphetamines in the previous 12 months.

## Price of ATS

6.75 Despite recent decreases in the price of ATS, prices in Australia remain among the highest in the world.<sup>164</sup> This is partly due to the high seizure rate in Australia<sup>165</sup> as well as the large distances required to traffic drugs and their precursors into Australia involving multiple traffickers, each of whom adds a cost for their services.<sup>166</sup>

- 6.76 Across Australia, the average 'street' price of ATS (per 0.1g, or 'point') varies considerably. Price is influenced by availability, supply, demand, purity and other market factors, such as location and relationship with supplier.<sup>167</sup> In 2017–18, the price for an MDMA tablet ranged between \$15 to \$45 across Australia.<sup>168</sup> The price of a point of crystal methamphetamine (referred to in Table 6.5 below as 'ice') ranged between \$20 and \$100 in different states and territories in 2017–18.<sup>169</sup>

**Table 6.5: ATS prices by state and territory 2017–18<sup>170</sup>**

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	National
MDMA tablet	\$15–\$35	\$20	\$20–\$40	\$25	\$25–\$35	\$20–\$40	\$30–\$45	\$20–\$30	\$15–\$45
Ice (0.1g)	\$20–\$50	\$20–\$50	\$50–\$100	\$50	\$50–\$100	\$80–\$100	\$100	\$50–\$100	\$20–\$100

- 6.77 The Inquiry heard that the price of ATS has decreased significantly in NSW in recent years.<sup>171</sup> The NSW Crime Commission submitted that this indicates current law enforcement responses are not reducing supply and have not correlated with an increase in product price.<sup>172</sup>
- 6.78 Detective Acting Superintendent Cook, NSW Police Force, said the price of crystal methamphetamine had roughly halved since 2011.

*'I've been at the drug squad and then the drug and firearms squad since 2011. I have seen in that time the price of crystal methylamphetamine or ice drop significantly. When I first started working in that area, a kilogram of – ice sold for between 180 and 220 thousand dollars for a kilo ... I've seen a decrease in the price over time, and at the moment a kilogram of ice is available for purchase for between 80 and 100 thousand dollars.'*<sup>173</sup>

- 6.79 Detective Acting Superintendent Cook reported a similar trend in relation to MDMA, noting that a kilogram of MDMA sold for up to \$60,000 in 2013, but it is now possible to purchase it for \$20,000.<sup>174</sup>

**Table 6.6: Trend in ATS price (NSW) 2014–15 to 2018–19<sup>175</sup>**

	NSW					National			
	2014–15	2015–16	2016–17	2017–18	2018–19	2014–15	2015–16	2016–17	2017–18
MDMA tablet	\$25–\$50	\$20–\$50	\$15–\$45	\$15–\$35	\$20–\$30	\$10–\$50	\$20–\$50	\$4–\$50	\$15–\$45
MDMA (1kg)	–	\$27,000 – \$50,000	\$37,000– \$44,000	\$37,000– \$44,000	\$35,000– \$44,000	–	\$27,000 – \$60,000	\$30,000 – \$60,000	\$37,000 – 80,000
Ice (0.1g)	\$50–\$150	\$20–\$150	\$30–\$150	\$20–\$50	\$30–\$75	\$50–\$150	\$20–\$200	\$17–\$150	\$20–\$100
Ice (1g)	\$250– \$600	\$150– \$600	\$250– \$600	\$150– \$400	\$200– \$450	\$250– \$1,200	\$150– \$1,200	\$250– \$1,000	\$150– \$1,000
Ice (1kg)	\$120,000 – \$20,000	\$90,000 – \$150,000	\$80,000 – \$140,000	\$75,000– \$110,000	\$80,000 – \$145,000	\$120,000 – \$280,000	\$75,000 – \$280,000	\$50,000 – \$280,000	\$75,000– \$300,000
Powder/paste/ base (0.1g)	\$20–\$100	–	–	–	–	\$20–\$150	\$30–\$150	–	–

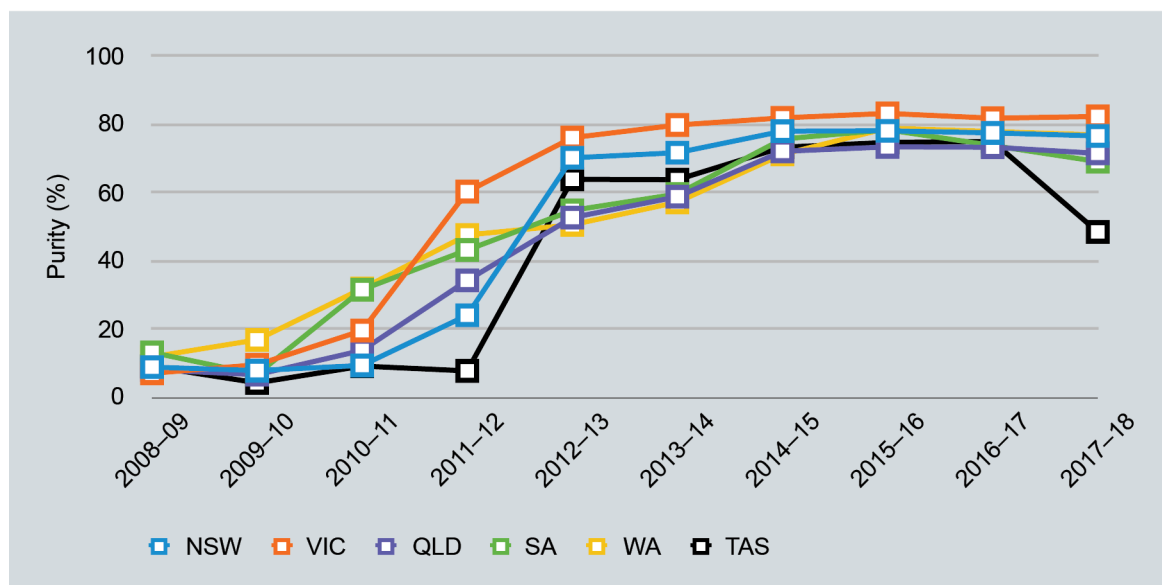
- 6.80 Prices of ATS fluctuate in NSW Police districts. The evidence obtained by the Inquiry from the NSW Police Force in relation to the current price of crystal methamphetamine and MDMA is summarised in Table 6.7. The evidence shows that some police districts experience a large range in the street price of crystal methamphetamine and MDMA. One police district reported that the price of crystal methamphetamine ranges from \$20 to \$100, which was linked to 'market forces' with times of abundance and times of limited supply.<sup>176</sup>

**Table 6.7: Price of ATS across NSW in 2019<sup>177</sup>**

NSW Police District	Hearing location	Crystal methamphetamine		MDMA	
		Point (0.1g)	Gram	Tablet	Gram
Barrier Police District	Broken Hill	\$50	n.a	n.a	n.a
Campbelltown City Police Areas Command	Sydney	\$50	\$300	n.a	n.a
New England Police District	Moree	\$20 – \$100	\$100 – \$300	\$15 – \$30	n.a
Orana Mid Western Police District	Dubbo	\$50	\$350 – \$500	\$20 – \$30	n.a
Port Stephens Hunter Police District	East Maitland	\$50	\$300 – \$400	n.a	n.a
Richmond Police District	Lismore	\$50	\$400	\$15 – \$30	n.a
South Coast Police District	Nowra	\$50 – \$100	\$300 – \$500	\$20 – \$40	n.a
Sydney City Police Area Command	Sydney	\$25 – \$50	\$150 – \$400	n.a	\$180 – \$350

### Purity of ATS

6.81 In 2017–18, the purity of methamphetamine remained high across all states and territories in Australia, except Tasmania.<sup>178</sup> In NSW, median purity increased slightly from 76% in 2016–17 to 77.5% in 2017–18 (see Figure 6.10).

**Figure 6.10: Median purity of methamphetamine samples<sup>179</sup>**

6.82 Data provided to the Inquiry by the NSW Police Force highlighted a significant increase in purity in 2018–19, particularly in relation to seized amphetamine samples. Crystal methamphetamine has remained the purest form, with purity levels fluctuating from 70 to 78%.<sup>180</sup> (See Table 6.8)

**Table 6.8: Purity of seized ATS<sup>181</sup>**

Purity	Phenethylamine (median purity, %)			Amphetamine (median purity, %)			Crystal methamphetamine (median purity, %)		
	<=2 gms	>2 gms	total	<=2 gms	>2 gms	total	<=2 gms	>2 gms	total
2014–15	45.0	21.0	23.0	4.5	8.5	8.5	78.5	78.0	78.0
2015–16	71.5	27.0	62.0	–	5.7	5.7	78.0	78.0	78.0
2016–17	63.5	38.5	52.5	–	6.2	6.2	77.7	77.5	77.5
2017–18	60.0	29.8	54.7	–	3.6	3.6	71.7	69.5	70.2
2018–19	64.2	60.2	61.2	60.0	68.3	67.2	75.9	72.6	73.7

6.83 NDARC drew the Inquiry's attention to significant changes in the ecstasy market reported by the Ecstasy and Related Drugs Reporting System. It said the use of pills has declined and use of capsules and crystal ecstasy has increased. The survey found consumers perceived ecstasy capsules and crystal to be of higher purity than pills and powder. The street price of pills and powdered ecstasy has declined and these forms are reported by consumers to be easy or very easy to access.<sup>182</sup>

6.84 There is an important relationship between purity and price of drugs. Generally, a higher price signals to buyers that purity is higher.<sup>183</sup> However, this does not seem to be the case in the Sydney market, as the street price of crystal methamphetamine has remained relatively stable while the purity and availability of the drug has increased.<sup>184</sup>

6.85 The Inquiry heard that increases in drug purity are linked to an increase in drug-related harms. One drug and alcohol treatment provider told the Inquiry that the manufacture of crystal methamphetamine has become cheaper and easier, while potency has increased.

*'Ice has been around for decades but not in the quantity or potency it is these days. I have had comment from men who have used Ice for up to 20 years who have said that it is only recently they have found its use problematic. These men have stated they do not know why it suddenly is an issue but increased potency and toxicity is the likely reason.'*<sup>185</sup>

6.86 Professor Michael Farrell, Director, NDARC, told the Inquiry that from 2007 to 2010, the purity of ecstasy declined significantly, and so too did death rates. However, he noted that since 2011, the purity of ecstasy increased significantly again, which had a correlative impact on the number of deaths from drug toxicity. He interpreted the significance of these data as indicating a role for considering drug toxicity in MDMA-related deaths.<sup>186</sup> Further discussion on the link between purity and harms have been outlined in Chapter 1.

## Conclusion

6.87 In the past decade, the purity of ATS available in NSW has increased while the price has decreased. As the global market continues to expand and domestic production of ATS continues to grow, Commonwealth and state law enforcement agencies recognise that current law enforcement strategies are unable to stop the supply of ATS and are having little impact on demand. These realities need to be considered in the design of whole-of-government AOD policies to achieve the overarching aim of minimising the harms associated with illicit drug use, which is discussed in more detail in Chapter 10.

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## Chapter 7. Prevalence of amphetamine-type stimulant use and harms

### Introduction

- 7.1 An effective policy response to ATS use in NSW is dependent on a comprehensive understanding of the problem and how it is changing over time. The nature of drug use is complex and there are barriers to understanding it. Professor Michael Farrell, Director of the National Drug and Alcohol Research Centre (NDARC), UNSW Sydney, told the Inquiry:

*'In trying to understand the nature of this problem, it's a bit like trying to put a jigsaw puzzle together, and sometimes the bits fit and sometimes the bits don't fit, but we've got a number of data sources and surveillance systems ... [it] is very important for us to pull together to understand the nature of the problem and the nature of trends.'*<sup>1</sup>

- 7.2 The Inquiry heard there are limitations in data currently available on ATS use in NSW. Based on available data, it appears there was a decline in recent use of methamphetamine in NSW between 2013 and 2016, following periods of relative stability.<sup>2</sup> The data also show a decline in recent use of ecstasy.<sup>3</sup>
- 7.3 However, evidence received by the Inquiry suggests these data may not reflect the true nature or size of the problem in NSW. The Inquiry heard that harms related to ATS use have increased in recent years, particularly those harms relating to crystal methamphetamine use.<sup>4</sup> Based on available data and evidence, it is possible to summarise the prevalence of ATS use and associated harms as described below.
- 7.4 **Methamphetamine is a comparatively low prevalence drug:** Only a small proportion of people report that they use methamphetamine in NSW, and rates of reported use in NSW are below the national average. National Drug Strategy Household Survey (NDSHS) data suggest there has been a consistent reduction in the population prevalence of methamphetamine use in NSW.<sup>5</sup>
- 7.5 **MDMA (ecstasy) is far less problematic than methamphetamine:** More people use MDMA/ecstasy than use methamphetamine.<sup>6</sup> However, they are using a small amount or are using infrequently.<sup>7</sup> People who use MDMA rarely develop dependence, with 2% accessing treatment.<sup>8</sup> The frequency of ecstasy use has decreased in the past decade.<sup>9</sup> However, there has been a recent increase in MDMA-related deaths in the context of music festivals in NSW.<sup>10</sup>
- 7.6 **People who use methamphetamine are doing so in a way that is more likely to cause harm:** There has been a shift in NSW towards use of the purer form of methamphetamine, crystal methamphetamine.<sup>11</sup> There is more regular and dependent use of methamphetamine, reflected in a shift towards more frequent use<sup>12</sup> and an increase in the proportion of people who smoke or inject the drug.<sup>13</sup> Most people who use methamphetamine also use alcohol and other drugs.<sup>14</sup>
- 7.7 **Methamphetamine use is associated with socioeconomic disadvantage:** The prevalence of methamphetamine use is higher in disadvantaged areas than in advantaged areas. By contrast, ecstasy use is more prevalent among those living in areas of higher socioeconomic advantage.<sup>15</sup>

- 7.8 **People are more likely to use ATS in their twenties:** People are most likely to use both methamphetamine and ecstasy in their twenties. The second most likely age group to use methamphetamine is people aged 30 to 39. The second most likely age group to use MDMA is people aged 14 to 19. The age of initiation of methamphetamine use is increasing, whereas the age of initiation of ecstasy use is falling.<sup>16</sup>
- 7.9 **ATS use harms the broader community:** Crystal methamphetamine is associated with high levels of harm to families including domestic and family violence<sup>17</sup> and children at risk of harm.<sup>18</sup> Community concern about methamphetamine has increased.<sup>19</sup>
- 7.10 The Inquiry heard issues of concern are:
- **Health harms:** Methamphetamine-related emergency department presentations<sup>20</sup> and hospital admissions<sup>21</sup> stabilised but remained high in 2017–18 after a period of rapid increase.
  - **Mental health harms:** Half of people who inject methamphetamine have a current or lifetime psychotic disorder.<sup>22</sup> NSW Health reports that 35% of primary methamphetamine-related admissions to hospital in 2017–18 had a recorded diagnosis of psychosis due to methamphetamine.<sup>23</sup>
  - **Deaths:** Deaths related to ATS are increasing in NSW. Evidence suggests the number of deaths associated with psychostimulants in NSW was four times higher in 2016 than in 2010.<sup>24</sup>
  - **Crime:** More people are being convicted of amphetamine-related offences in NSW, and the number of people sentenced to custody has more than doubled since 2006, from 221 to 514.<sup>25</sup> Recorded incidents relating to possession and use of amphetamines<sup>26</sup> are increasing at a faster rate than offences related to dealing and trafficking.<sup>27</sup> There has been a significant increase in drug-driving detections since 2008.<sup>28</sup> The prevalence of ATS-related non-drug offences is not well understood but appears high.
  - **Use in regional areas:** The prevalence of crystal methamphetamine use in regional NSW is higher than in cities. Methamphetamine-related harms in these areas are exacerbated by a scarcity of access to treatment and rehabilitation services.

## Current approaches to understanding the problem of ATS in NSW

- 7.11 The Inquiry formed the view based on numerous submissions and witness evidence that, to develop a comprehensive understanding of ATS use to inform policy responses, in addition to prevalence of use, it is important to consider patterns of use (including the method and frequency of use) and prevalence of harms associated with use (i.e. the impacts on individuals who use and the broader community).<sup>29</sup> A focus on the prevalence of harms is also consistent with Australia's stated policy of harm minimisation.<sup>30</sup>
- 7.12 The Centre for Social Research in Health submitted that a focus on population prevalence as a primary outcome measure to assess drug policy does not recognise the complexity of patterns of use. That is, not all drug consumption is harmful and drug-related harms may increase among specific groups or in certain geographic locations without there necessarily being any increase in prevalence of use at a whole-of-population level.<sup>31</sup> The submission argued that a focus on population prevalence will not direct resources to where they are most needed, and warned that framing methamphetamine as a population-wide problem could lead to sensationalised political and media debate and increased stigma.<sup>32</sup>

- 7.13 Professor Alison Ritter, Director, Drug Policy Modelling Program (DPMP), Social Policy Research Centre, UNSW Sydney, raised concerns that current drug policy is focused more on prevalence of use than associated harms.

*'We sort of circle back to what's the problem here that we're trying to solve. Is the problem that we're trying to solve ... the number of people who are using crystal methamphetamine or is the problem that we are trying to solve the harms associated with that use?'*<sup>33</sup>

- 7.14 Although it is unclear how the NSW Government currently conceptualises the problem of ATS use in its policy development and service planning, the Inquiry heard it is informed by a range of data sources, not limited to prevalence of use data. For example, the NSW Police Force told the Inquiry that it uses *'all available relevant data sources and research in developing drug policy, identifying emerging issues and informing program development'*.<sup>34</sup> Similarly, NSW Health said that policy and planning are informed by *'a range of national and state data'*.<sup>35</sup>
- 7.15 NSW Health publishes a surveillance report that draws on a variety of data sources to identify trends in methamphetamine use and related harms in NSW. These sources include the NDSHS, the Illicit Drug Reporting System (IDRS, a national survey of people who inject drugs) and the Ecstasy and related Drugs Reporting System (EDRS, a national monitoring system consisting of interviews with people who regularly use ecstasy and other stimulants) as well as NSW Health data.<sup>36</sup>
- 7.16 The Australian Criminal Intelligence Commission submitted that *'all surveys have roles to play in describing aspects of drug markets, but they have some limitations and do not collectively or individually provide a comprehensive picture of the markets'*.<sup>37</sup>

### Data sets for understanding prevalence and patterns of ATS use

- 7.17 Australia uses 'direct' and 'indirect' methods to measure prevalence of drug use. Direct approaches are useful, but they have limitations. Indirect approaches can be used to supplement direct approaches. Data used to understand prevalence and patterns of ATS are discussed in more detail in Chapter 21.

#### Direct estimates

- 7.18 Direct estimates of population prevalence are based on surveys of self-reported use. They include the NDSHS, a national population survey held every three years that provides the only available data on general population prevalence. Another survey is the Australian Secondary Schools Alcohol and other Drug (ASSAD) survey of secondary school children aged 12 to 17.
- 7.19 Self-report surveys are limited by under-reporting of drug use by survey participants, under-representation of marginalised populations including people who regularly use methamphetamine,<sup>38</sup> and small sample sizes in some parts of the country.<sup>39</sup> People experiencing homelessness, those who are institutionalised and young people who are not in school are excluded from the NDSHS and ASSAD surveys.<sup>40</sup>
- 7.20 In addition to population surveys, it is possible to measure patterns of use and harms via surveys of sentinel groups such as the IDRS and EDRS.

## Indirect estimates

7.21 Indirect estimates use different sources of data to indirectly estimate the total number of people who use drugs. This approach is used widely internationally and uses a range of data sources other than population surveys, such as treatment and arrest data.<sup>41</sup> Data sets available to form indirect estimates include:

- National Minimum Data Set, which reports on treatment presentations in government-funded services
- Australian Needle and Syringe Program Survey (ANSPS)
- NSW Bureau of Crime Statistics and Research (BOCSAR) statistics
- Drug Use Monitoring in Australia (DUMA) study of some people arrested and detained by police
- Australian Criminal Intelligence Commission's (ACIC) Illicit Drug Data Report.

## Wastewater analysis

7.22 Wastewater analysis undertaken by the ACIC offers a way to broaden understanding of direct estimates and indirect estimates of use. Wastewater analysis measures concentrations of drug metabolites excreted into the sewer system after consumption and uses these to estimate the weight of drugs used in a population.<sup>42</sup> It cannot estimate how many people are using drugs or measure the level of harm caused by drug use.<sup>43</sup> The Inquiry received evidence from several sources that, while wastewater analysis is a useful measure when taken in conjunction with other data sources,<sup>44</sup> its limitations include variation in sampling methods and inability to distinguish between licit and illicit substances or estimate dose.<sup>45</sup>

## Prevalence of harm should also be considered

7.23 To develop a comprehensive understanding of the problem of ATS in NSW, it is necessary to collect data on the prevalence of harms and changes in prevalence trends over time. This will allow for a better understanding of the policy problems to be solved, the targeting of programs and services to better address the harms experienced, and a foundation on which to judge the effectiveness of responses to ATS.

7.24 In describing the prevalence of harm, the Inquiry has considered the following data:

- **Health harms:** NSW Health collects and publishes some data on health harms associated with ATS. These include ATS-related emergency department presentations and hospital admissions, admissions to public hospitals for methamphetamine-related psychosis, psychostimulant-induced deaths and deaths where methamphetamine was detected.<sup>46</sup> The Inquiry heard that harms associated with ATS use, particularly use of crystal methamphetamine, may be under-reported due to the way in which data are collected and coded<sup>47</sup> and patients' reluctance or inability to self-report ATS use.<sup>48</sup>
- **Social harms:** Even though recent research found that crystal methamphetamine was overall the second most harmful drug to others, after alcohol,<sup>49</sup> there is a scarcity of data on the prevalence of social harms caused by ATS use, either to the individual or to others. There are some data collected on drug-related offences such as possession, deal/traffic and manufacture of illicit drugs, but no data are collected on the involvement of drugs in other types of offences such as property offences or assaults. Similarly, data collected by the Department of Communities and Justice (DCJ) about the use of alcohol or other drugs in child protection reports does not disaggregate by drug type.

- **Harms to others:** The Inquiry heard that current data collection on the prevalence of harms associated with ATS use contains limited recognition of the indirect harms of ATS use. Based on areas where evidence before the Inquiry suggests harms are most prevalent, it would be helpful to consider data on the association of ATS with domestic and family violence, children reported at risk of significant harm or removed into out-of-home care, non-drug criminal offences and the cost to government of responding to ATS use.
- **Economic harms:** It is not possible to quantify the full costs to government of health and social harms related to ATS use. However, the Inquiry heard it is likely to be significant. An estimate provided by the National Drug Research Institute (NDRI) did not consider costs associated with decreased productivity and reinforcement of marginalisation and disadvantage that can accompany illicit drug use. Further, some costs are non-quantifiable, such as costs associated with social and personal impacts of illicit drug use.

## Bringing the data together: a picture of ATS use in NSW

- 7.25 ATS use in Australia is predominantly measured by reference to NDSHS data, consistent with the approach in Europe where similar population surveys are used for the same purpose.<sup>50</sup> The most recent NDSHS available to the Inquiry is the 2016 survey. Metabolites in wastewater are also analysed and extrapolated to identify trends in illicit drug use across geographic areas in NSW and Australia.
- 7.26 In referencing NDSHS and wastewater data in this chapter and throughout this report, the Inquiry acknowledges their limitations. However, as described above, the NDSHS is the only population representative survey on AOD use in Australia, and it is therefore the principal available source of information on prevalence of use.
- 7.27 Caution should be taken in relying on NSW-specific data from the 2016 NDSHS. The Australian Institute of Health and Welfare (AIHW) custom analysis at Appendix 17 indicates the majority of estimates have a relative standard error of 25% to 50%. Further, some estimates were not published due to concerns about the quality of the data, including small numbers, confidentiality or other concerns.<sup>51</sup>

## ATS are comparatively low prevalence drugs

- 7.28 According to results from the 2016 NDSHS, 1.4% of Australians disclosed methamphetamine use in the past year (i.e. all forms of amphetamines, including illicit use of prescription amphetamines) and 2.2% disclosed ecstasy use. Reported use of both drugs has significantly declined over more than a decade.<sup>52</sup> In 1998, approximately 4% of Australians disclosed recent methamphetamine use,<sup>53</sup> and ecstasy use appears to have reached its peak in 2007, when approximately 3.4% of Australians disclosed recent use.<sup>54</sup>
- 7.29 To put this in context, the 2016 NDSHS indicated that around 43% of people in Australia aged 14 or older had used an illicit drug in their lifetime, 16% in the last 12 months and 6% in the last week. The most common illicit drug used in the past year was cannabis (10.4%). Rates of recent use (in the previous 12 months) of any illicit drug were slightly lower in NSW at 14.7%, compared to the national average of 15.6%.<sup>55</sup>
- 7.30 There was a decline in recent use of methamphetamine in NSW between 2013 and 2016, following periods of relative stability.<sup>56</sup> Population prevalence of methamphetamine use in NSW declined from 1.4% in 2013 to 0.7% in 2016, which is lower than the national rate.<sup>57</sup> Ecstasy use in NSW was lower than the national average (1.9% compared to 2.2%) and was declining consistent with the national trends.<sup>58</sup>

### More people use MDMA than use methamphetamine

- 7.31 Combined data from the NDSHS and wastewater analysis show how use of methamphetamine and MDMA differs in Australia. Wastewater analysis has found the weight of methamphetamine used in Australia is far greater than the weight of MDMA used.<sup>59</sup> However, the NDSHS indicated more people use MDMA than use methamphetamine.<sup>60</sup> Taken together, these data suggest that, although a larger number of people are using MDMA, they are using a small amount or are using infrequently. By contrast, a smaller number of people are using a larger amount of methamphetamine or are using more frequently.
- 7.32 Wastewater analysis showed that in December 2018, the estimated consumption of methamphetamine across all sites in Australia was less than 45 doses /1,000 people per day, slightly above the August 2016 level. This represents a relatively low rate of use compared to, for example, alcohol at more than 1,150 doses (standard drinks)/1,000 people per day.<sup>61</sup> In contrast, the estimated consumption of MDMA across Australia was less than 5 doses/1,000 people per day. According to this measure, MDMA is the least consumed illicit drug in Australia.<sup>62</sup>

### The frequency of methamphetamine use has increased, but the frequency of ecstasy use has decreased

- 7.33 The NDRI submitted that, while overall methamphetamine prevalence remains stable, there appears to be more frequent use within populations that already use drugs.<sup>63</sup>
- 7.34 The NDSHS indicated that methamphetamine is used more frequently than ecstasy. Using methamphetamine more than weekly is associated with dependence.<sup>64</sup> Just over one-fifth of people who recently used methamphetamine in NSW used it at least once per week or more in 2016 – an increase since 2010. However, due to small sample sizes, the increase was not statistically significant.<sup>65</sup>
- 7.35 In contrast, most people who recently used ecstasy in NSW only used it once or twice per year in 2016. Although around 15% used it once a month or more in 2016, this was far fewer than in 2007 when the proportion was around 25%.<sup>66</sup> Very few people who use MDMA experience long-term problems, with 2% of people presenting for drug treatment in Australia due to MDMA.<sup>67</sup> Data collected on publicly funded AOD treatment services indicate the proportion of closed treatment episodes where clients listed ecstasy as their principal drug of concern has remained stable at up to 1% since 2008–09, but as an additional drug of concern it decreased from 6% of episodes in 2008–09 to 2% in 2017–18. Most MDMA-related problems are acute harms, including psychosis, heart attack and stroke.<sup>68</sup>

### The age people are first using methamphetamine is increasing; the age they are first using ecstasy is decreasing

- 7.36 Up until 2010, people were more likely to try methamphetamine at a younger age than ecstasy. However, the average age at which people first try ecstasy is falling gradually, while the age people first try methamphetamine is increasing slightly.<sup>69</sup>
- 7.37 Between 2013 and 2016, there was a reduction in the proportion of people in Australia who used methamphetamine who had started their use in the last three years, which may indicate an increased reluctance to start using methamphetamine. By contrast, in the same period there was little change in the proportion of people who recently used ecstasy who first used it within the last three years.<sup>70</sup>

- 7.38 Despite there being a trend of people first trying ecstasy at a younger age, the group of people who reported recently using ecstasy was ageing; that is, there was a greater proportion of people who first tried ecstasy 11 or more years ago and even 20 or more years ago who reported recent use.<sup>71</sup>
- 7.39 Professor Farrell, NDARC, explained that these data suggest people with less engagement with methamphetamine have identified it as being potentially problematic and have avoided it, whereas people with more concerted and in-depth problems have become more deeply entrenched in its use.<sup>72</sup> He noted that an NDARC analysis of NSW Health data sets found a sharp increase in first-time stimulant admission between 2010 and 2013, including among those aged 18 to 24.<sup>73</sup>

### The rate of use of methamphetamine is low in young people

- 7.40 The 2017 ASSAD survey showed that the rate of amphetamine use among secondary school aged children (12 to 17 years) nationally was very low, with 1 to 2% reporting use in the past year.<sup>74</sup> In NSW the rate was similar at 1.8%.<sup>75</sup> The ASSAD definition of amphetamine is similar to the NDSHS definition of methamphetamine.<sup>76</sup> The 2016 NDSHS showed that the rate of methamphetamine use nationally was less than 1% for people aged 14 to 19.<sup>77</sup>
- 7.41 However, 5% of secondary school children surveyed by ASSAD in Australia reported ecstasy use in the past year.<sup>78</sup> In NSW, the rate was lower, at 4.0%.<sup>79</sup> The 2016 NDSHS put the figure lower at 3.2% nationally and 2.9% in NSW of 14 to 19 year-olds.<sup>80</sup>

### People are more likely to use ATS in their twenties

- 7.42 The 2016 NDSHS showed recent use of methamphetamine and MDMA in the past year was highest among people in their twenties (2.8% and 7% respectively). However, there was a statistically significant reduction in recent methamphetamine use in that age group compared to the 2013 survey results. In all age groups, except those who were 50 or older, recent methamphetamine use was lower in NSW than nationally.<sup>81</sup> Recent ecstasy use was also highest for people in their twenties in NSW and nationally in every year since 2004.

### The use of ATS varies by location

- 7.43 Existing data sets suggest ATS use varies by location in NSW. The Inquiry heard that according to the ACIC's wastewater analysis, MDMA use has recently increased in Sydney while there has been a longer-term steady increase in methamphetamine consumption in regional areas of NSW.<sup>82</sup>
- 7.44 Wastewater analysis showed the weight of methamphetamine use has been higher in regional NSW than in Sydney in all reports since August 2016. Regional methamphetamine use reached a record level of about 2,000mg/1000 people per day in April 2019.<sup>83</sup>
- 7.45 Nationally, wastewater analysis indicates that average consumption of MDMA is similar across regional and capital city sites, compared to other stimulants.<sup>84</sup> Wastewater analysis further indicated that use of MDMA in Sydney in April 2019 was double the recorded levels in 2017, at almost 300mg/1,000 people per day. Regional use of MDMA increased to more than double historical levels, at almost 700mg/1,000 people per day in April 2019.<sup>85</sup>
- 7.46 The 2016 NDSHS could not show clear patterns in NSW. Nationally, it indicated that there was a higher proportion of people who recently used methamphetamine in outer regional and remote areas compared with capital cities.<sup>86</sup>

- 7.47 NDSHS data showed the rate of recent ecstasy use was highest in major cities and lowest in outer regional areas nationally. In 2016, recent use in NSW was higher in inner regional locations than in major cities, although AIHW noted the estimate for inner regional locations has a relative standard error of 25 to 50% and should be used with caution.<sup>87</sup>

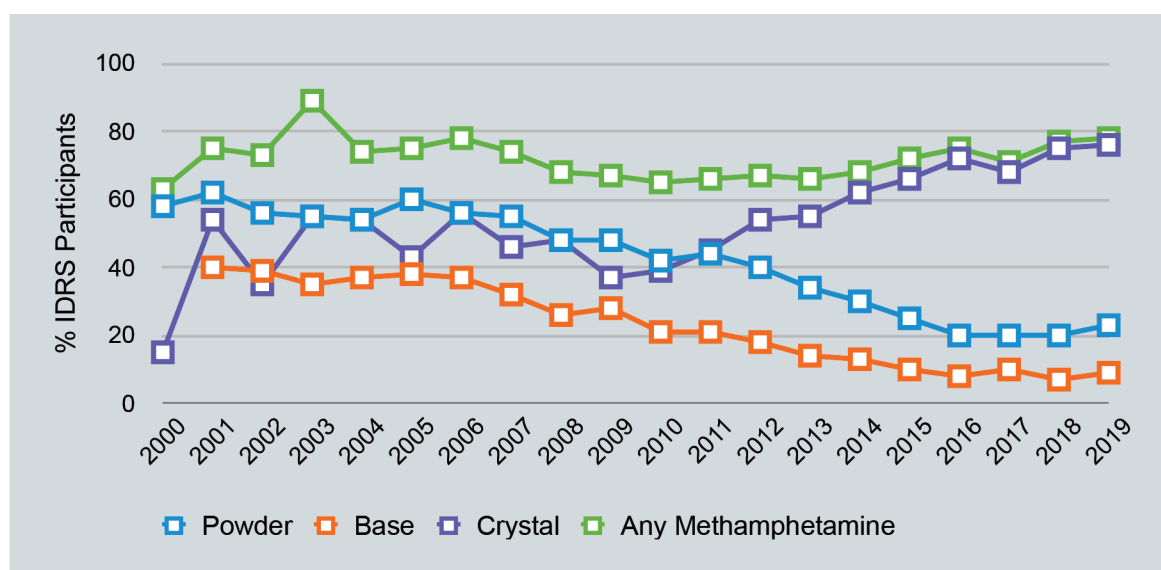
### **Methamphetamine is more likely to be used by people in disadvantaged areas**

- 7.48 In 2004, recent methamphetamine use was most prevalent among people living in areas with the highest level of advantage. However, since 2007 recent use has been highest in people living in the most disadvantaged areas and has decreased as the level of advantage increases. In contrast, ecstasy use tended to increase with the level of advantage of a person's address.<sup>88</sup>
- 7.49 The Inquiry heard anecdotal evidence about the level of advantage of people who use crystal methamphetamine. Superintendent Toby Lindsay, NSW Police Force, told the Lismore Hearing that there is '*no one identifiable user group*', although people detected tend to be '*of low socioeconomic means*'.<sup>89</sup> Isaac Graham, paramedic, Wellington, similarly noted that people who use ATS in the Western Local Health District are commonly from socioeconomically disadvantaged groups.<sup>90</sup>

### **The type of methamphetamine used is becoming more harmful**

- 7.50 While the 2016 NDSHS showed people who used methamphetamine in the past year reported using multiple forms, there was a change nationally in use from the lower strength powder form to the higher strength crystal form. In 2010, powdered methamphetamine was the form mainly used by 51% of people who recently used methamphetamine, while 22% mainly used crystal methamphetamine. By 2016, only 22% mainly used powder and 57% mainly used crystal methamphetamine.<sup>91</sup> This shift towards use of crystal methamphetamine was also recorded in NSW between 2010 and 2016. In 2016, a quarter of people who recently used methamphetamine mainly used powder and 55% mainly used crystal methamphetamine. The comparable 2010 figures were 52% and 15% respectively.<sup>92</sup>
- 7.51 The use of more potent forms of methamphetamine is associated with increases in health and social harms,<sup>93</sup> dependence and treatment demand.<sup>94</sup> Professor Farrell, NDARC, noted that, depending on the purity and the method of administration, the harmfulness of use of crystal methamphetamine can increase substantially in terms of toxicity, its impact on mental health and the addictive potential of the drug.<sup>95</sup> Dependence rates are higher among those who use crystal methamphetamine.<sup>96</sup>
- 7.52 Professor Farrell said NDARC's analysis indicated regular and dependent use of crystal methamphetamine increased markedly from 2010 until 2013, with some evidence to support a continued increase up until about 2017 or 2018. He further noted that there is some uncertainty around how to interpret the most recent upward trend, and that it is unclear whether more people are using, or whether the people who are using are incurring more harm, suggesting it is probably both.<sup>97</sup>

**Figure 7.1: Past six-month use of any methamphetamine, powder, base and crystal nationally, 2000–2019<sup>98</sup>**



7.53 Professor Farrell and others noted in a recent article published in *The Lancet* that, globally, the prevalence of use of amphetamines is highest in North America, followed by Oceania.<sup>99</sup> Australia has the highest estimated prevalence of amphetamine dependence in the world per 100,000 people, followed by high income North American countries,<sup>100</sup> suggesting that use may be more likely to lead to dependence in Australia.

#### Methods of use of methamphetamine are becoming more harmful

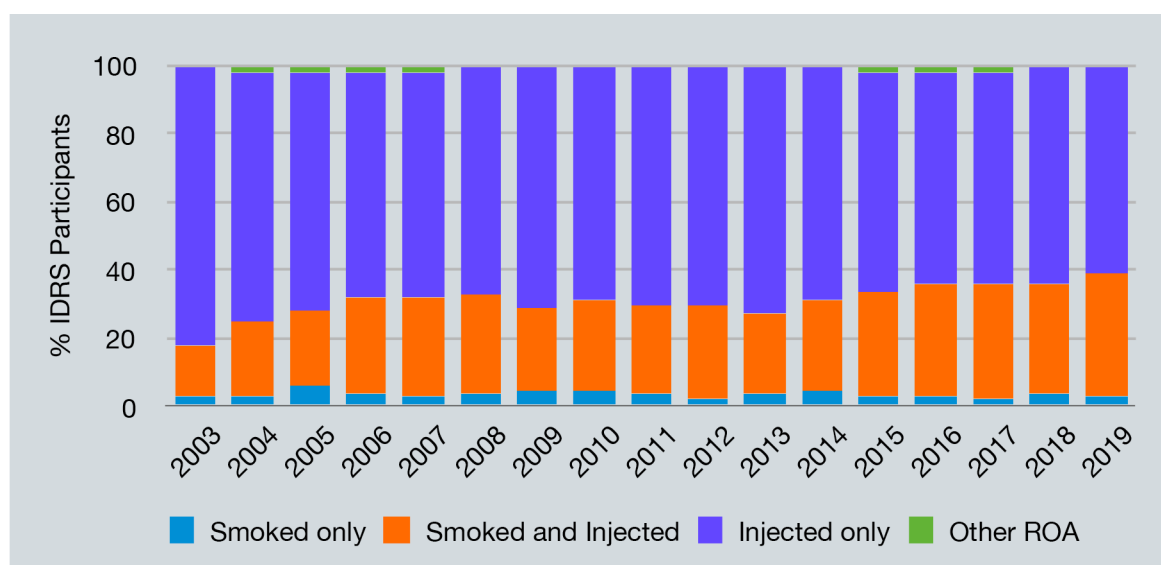
7.54 The powder form of methamphetamine is usually snorted or swallowed, and crystal methamphetamine is usually smoked or injected. NDSHS data show the rate of smoking has increased from 19% in 2010 to 42% in 2016, reflecting the shift towards use of crystal methamphetamine, which is more amenable to smoking. There has also been a decline in snorting and swallowing.<sup>101</sup>

7.55 2016 NDSHS data note that most people who report recent use of methamphetamine report doing so via smoking (67.6%) as compared to injection (19.2%).<sup>102</sup> Dr Marianne Jauncey, Medical Director, Uniting Medically Supervised Injecting Centre, and Dr Phillip Read, Director, Kirketon Road Centre, NSW Ministry of Health, confirmed to the Inquiry that '*most ATS is not injected in NSW. It's smoked*'.<sup>103</sup> The Inquiry heard evidence that these cohorts are not mutually exclusive: while most people who smoke methamphetamine will not inject, a significant number of people who inject also smoke methamphetamine.<sup>104</sup>

7.56 The literature shows that both smoking and injecting methamphetamine are harmful. One study found that, although people who smoked methamphetamine were less dependent than those who injected, they took the drug as often and had similarly high levels of psychological distress, poor physical and mental health, psychotic symptoms, risky sexual behaviour and criminal involvement.<sup>105</sup>

7.57 The IDRS illustrates that between 2003 and 2019, there was a decrease in people who reported methamphetamine use by injection only, and an increase in those who reported both smoking and injecting. Rates of people who report injection only are decreasing, reflecting the increases in people using mixed modes of administration.<sup>106</sup>

**Figure 7.2: Routes of administration among people who use crystal methamphetamine in national IDRS sample, 2003–2019<sup>107</sup>**



- 7.58 Dr Read, NSW Ministry of Health, told the Inquiry that the context of use and psychosocial factors increase the likelihood a person will start injecting: ‘... *those people who end up being the most marginalised often end up gravitating towards the injecting end of the spectrum*’.<sup>108</sup>
- 7.59 Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol Service, told the Inquiry that although they do not collect information on the mode of use, he had the impression that in Lismore: ‘*less than 50% are injecting. A lot of people are smoking crystal methamphetamine*’. In his opinion, smoking and injecting have a similar rapidity of onset. He noted that people who attend a dance party are more likely to smoke whereas people in the opioid treatment program are more likely to inject.<sup>109</sup>
- 7.60 The Inquiry notes that there is a discrepancy in the data regarding the most recently injected drug in NSW. According to the 2014–18 Australian Needle and Syringe Program Survey, methamphetamine was the most commonly reported drug last injected in NSW by people who visit needle and syringe programs, representing 35% of those sampled in 2018. Methamphetamine was only slightly more popular than heroin, which was the drug last injected by 30% of the sample.<sup>110</sup> In contrast, the 2018 NSW Needle and Syringe Program Enhanced Data Collection Survey reports that opiates were the most frequently injected drug reported in NSW, and stimulants were the second most frequently injected drug, with 34% of people reporting stimulants as the most recent drug injected in 2018, up from 26% in 2013.<sup>111</sup> Notwithstanding the discrepancy, the Inquiry notes that both surveys demonstrate an increase in the injecting of methamphetamine. The Inquiry notes that this is consistent with the evidence of Professor Farrell, NDARC, who told the Inquiry that analyses of national data from the IDRS showed an increase in the number of people who injected methamphetamine alongside reductions in the number of people reporting use.<sup>112</sup>
- 7.61 Among people who inject drugs in NSW, use of methamphetamine has been gradually increasing since monitoring began in 2000. In 2019, three in four IDRS participants in NSW (76%) reported recent use of methamphetamine. Of those who had reported recent use of methamphetamine, almost all had used crystal methamphetamine (97%) and a 18% reported using powder.<sup>113</sup>

### Most people who use ATS also use alcohol and other drugs

- 7.62 The Inquiry heard that most people who use methamphetamine tend to also use other drugs.<sup>114</sup> According to the 2016 NDSHS, around three-quarters of people who used methamphetamine in Australia used alcohol at the same time. Around 70% used tobacco at the same time, around half used cannabis and around one-quarter used ecstasy. The proportions were similar in NSW.<sup>115</sup>
- 7.63 An important trend was a marked drop in the proportion of people who used both methamphetamine and ecstasy at the same time in NSW, which peaked in 2007 at 54% and decreased to approximately 26% in 2016.<sup>116</sup> This appears to have coincided with what the ACIC has described as '*a major worldwide shortage in the availability of MDMA*', resulting in movement in Australia '*away from the use of MDMA to a range of other drugs, including drug analogues and methylamphetamine*'.<sup>117</sup>
- 7.64 Despite the resurgence in the supply of ecstasy in recent years,<sup>118</sup> people who recently used methamphetamine were no more likely to use it together with ecstasy.<sup>119</sup> This may indicate a change in the population of people who use methamphetamine. It is consistent with changes in the patterns of recent methamphetamine use and socioeconomic advantage described above; that is, while ecstasy use is more prevalent among those with socioeconomic advantage, methamphetamine use is more prevalent among those with socioeconomic disadvantage (whereas until 2004 methamphetamine use was more prevalent among those living in areas of highest socioeconomic advantage).<sup>120</sup>
- 7.65 As another potential indicator of polydrug use, the 2016 NDSHS showed that people who had recently used methamphetamine were very likely to have used cannabis in the past 12 months (66.2% in NSW and 73.7% nationally). Nationally, recent use of ecstasy and hallucinogens in the past 12 months declined between 2013 and 2016; recent ecstasy use also declined among people who recently used meth/amphetamines in NSW. Approximately 79% of NSW survey respondents who reported recent use of meth/amphetamine also reported using at least one other illicit substance in the past 12 months.<sup>121</sup> NSW Health told the Inquiry that, based on their analysis of the NDSHS, 75% of NSW survey respondents who reported recent methamphetamine use also reported risky drinking.<sup>122</sup>
- 7.66 In 2016, around 97% of people in NSW who used ecstasy used another drug at the same time. Almost 90% used alcohol and half used tobacco. Almost 60% reported using an illicit drug at the same time. Cannabis was the illicit drug most likely to be used at the same time, with close to one-quarter having used cocaine. Consistent with the trends in polydrug use for methamphetamine, there has been a reduction since the mid-2000s in the likelihood that people who recently used ecstasy also used methamphetamine at the same time, to only about 9% in NSW.<sup>123</sup> People who had recently used ecstasy were very likely to have used cannabis in the past 12 months, even more so than people who recently used methamphetamine. They were next most likely to have used cocaine and then hallucinogens.<sup>124</sup>
- 7.67 NSW Health told the Inquiry that, based on its analysis of the 2018 IDRS, 31% of people who injected drugs in NSW reported using a combination of opioids, stimulants or benzodiazepines on the day preceding the interview, with the most common combination being opioids and stimulants (20%) followed by opioids and benzodiazepines (9%). The vast majority (96%) of people who reported regular use of ecstasy and other stimulant drugs in NSW in 2018 reported concurrent use of other substances the last time they used a stimulant. The most commonly used substances were tobacco (66%), alcohol (63%), cannabis (58%), LSD (19%), nitrous oxide (17%) and ketamine (17%).<sup>125</sup>

### The prevalence of ATS-related harms is high, although not always well understood

- 7.68 Although overall prevalence of use has remained relatively stable, as described above, the harms associated with ATS, including both methamphetamine and MDMA, have increased in recent years. The increase in consumption of the more potent form of the drug, crystal methamphetamine, among people who recently used methamphetamine<sup>126</sup> can have greater impacts on toxicity, mental health and the potential for dependence.<sup>127</sup>
- 7.69 An Australian study published in 2016 estimated the number of people who are dependent and regularly use methamphetamine by using indirect prevalence estimation methods. The study estimated that in 2013–14, there were 268,000 people who used methamphetamine regularly (at least monthly) and 160,000 people dependent on methamphetamine aged between 15 and 54. This equates to population rates of 2.09% for regular use and 1.24% for dependent use, higher than estimates from earlier years. The highest rates of use were in the 25 to 34 year age group, and over time there have been increases in dependent use in the 15 to 24 year age group.<sup>128</sup>
- 7.70 The Royal Australian and New Zealand College of Psychiatrists submitted that more regular and dependent use of ATS and increases in problematic use were resulting in greater prevalence of harms.

*‘While prevalence of ATS use is falling, we are not seeing a corresponding decrease in rates of hospitalisation and possess/use of this particular drug... One possible conclusion that can be drawn from the data on ATS use is that while prevalence in NSW may be declining, we may be seeing more regular and dependent use of ATS and increases in problematic use of this particular drug.’<sup>129</sup>*

- 7.71 A submission from the NSW Government described how ATS-related harms in NSW have increased, demonstrated by increases in emergency department presentations, hospitalisations, deaths and contact with the criminal justice system.<sup>130</sup>

### Mental health harms

- 7.72 Australian studies report that around half of people who inject methamphetamine have a current or lifetime psychotic disorder,<sup>131</sup> and more than 16% of Australians with a first hospitalisation for psychosis are also using amphetamines – 10 times the rate of the age-matched Australian population.<sup>132</sup> A review of methamphetamine-associated psychosis reported that its prevalence varies widely, from 15 to 23% in recreational or community settings to 60% in those with methamphetamine dependence in treatment settings.<sup>133</sup> An Australian study found that those who inject crystal methamphetamine are significantly more likely to self-report a psychotic illness than other people who inject drugs.<sup>134</sup> NSW Health reports that 35% of primary methamphetamine-related admissions to hospital in 2017–18 had a recorded diagnosis of psychosis due to methamphetamine.<sup>135</sup>
- 7.73 One study on crystal methamphetamine-related harms in Australia found that a shift to the more potent crystal form of methamphetamine, as well as more frequent use among people who already use methamphetamine, was accompanied by an increase in amphetamine-related hospital and mental health unit admissions.<sup>136</sup> NSW Health provided the Inquiry with data about patients admitted from emergency departments to hospital wards across the state between 2014–15 and 2017–18. The data indicate that admission to psychiatric wards from emergency departments was much higher for patients with ATS-related diagnoses than those without: 51% of the patients with ATS-related diagnoses were admitted to psychiatric wards, compared to 2.2% of patients with non-ATS-related diagnoses.<sup>137</sup>

## ATS use is associated with a substantial number of matters coming before the Mental Health Review Tribunal

- 7.74 There is a lack of robust data about the association between ATS use and people coming before the civil and forensic divisions of the NSW Mental Health Review Tribunal. In recognition of this, the Inquiry asked the Tribunal to conduct a survey at these hearings for a two-week period from 2 to 13 September 2019 (see Appendix 19).
- 7.75 The total number of hearings for which information was received was 594, of which 171 were Mental Health Inquiries, 385 were other civil division hearings and 38 forensic division hearings. The survey results were accompanied by a note advising that some tribunal members had only recorded matters where ATS was a contributing factor. Accordingly, it was not possible to determine what percentage of total matters during the period involved patients with a history of ATS use.
- 7.76 Tribunal members indicated that the following numbers of cases in each hearing category involved patients with a history of ATS use:
- 62 of the Mental Health Inquiries
  - 128 of the other civil division hearings
  - 22 of the forensic division hearings.
- 7.77 Tribunal members further indicated that the following number of cases in each division involved patients where ATS use was a contributing factor to their mental health condition:
- 47 of the Mental Health Inquiries
  - 97 of the other civil division hearings
  - 10 of the forensic division hearings.

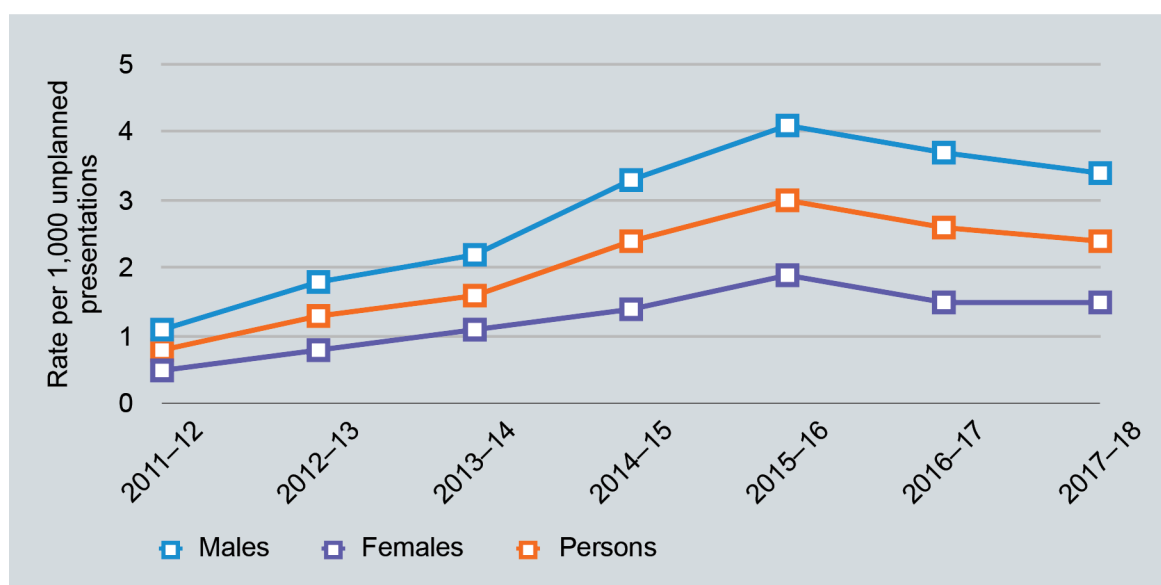
## Health harms

- 7.78 Methamphetamine-related emergency department presentations and hospital admissions stabilised in 2017–18, after a period of rapid increase.

### ***Emergency department presentations***

- 7.79 The rate of methamphetamine-related emergency department presentations in NSW increased from 0.8 per 1,000 presentations in 2011–12, to a peak of 3.0 per 1,000 presentations in 2015–16. The rate then stabilised at 2.4 per 1,000 presentations in 2017–18.<sup>138</sup> This pattern was evident in both men and women, and across all age groups, with the majority of the burden in the 25 to 34 and 35 to 44 year age groups.<sup>139</sup>

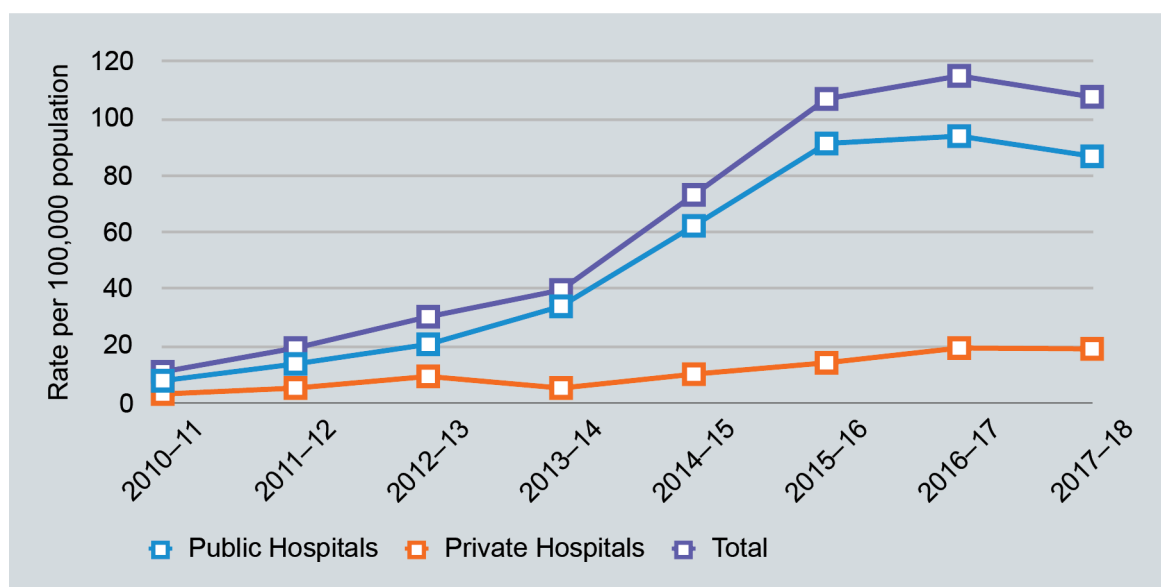
**Figure 7.3: Rate of methamphetamine-related emergency department presentations in people aged 16 years and over, by gender, NSW, 2011–12 to 2017–18<sup>140</sup>**

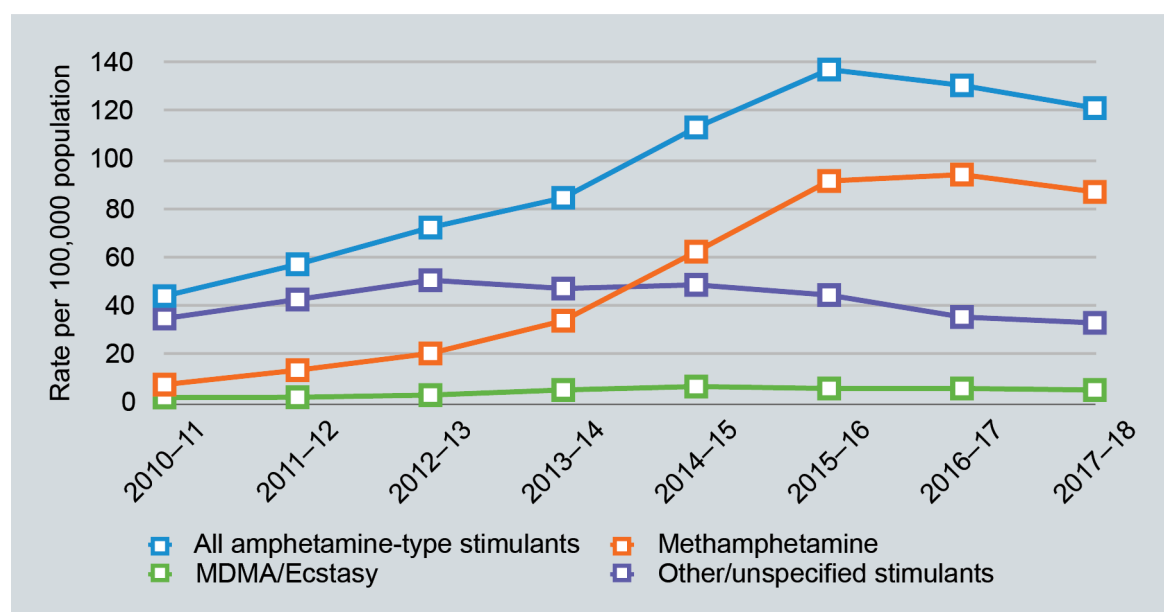
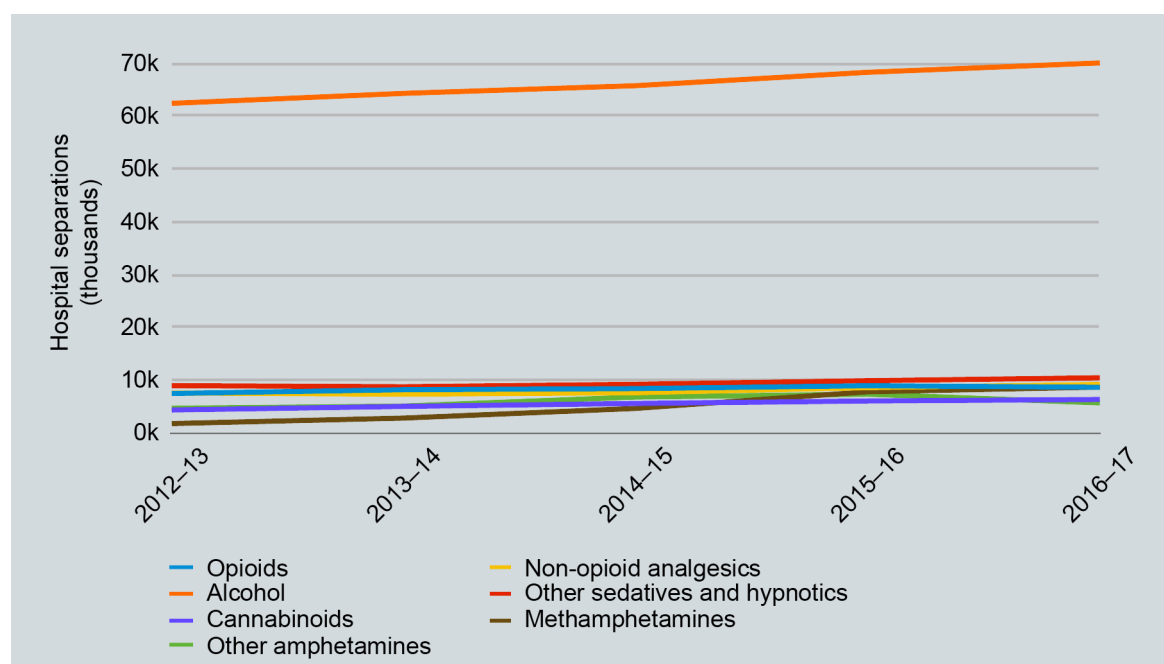


### **Hospital admissions**

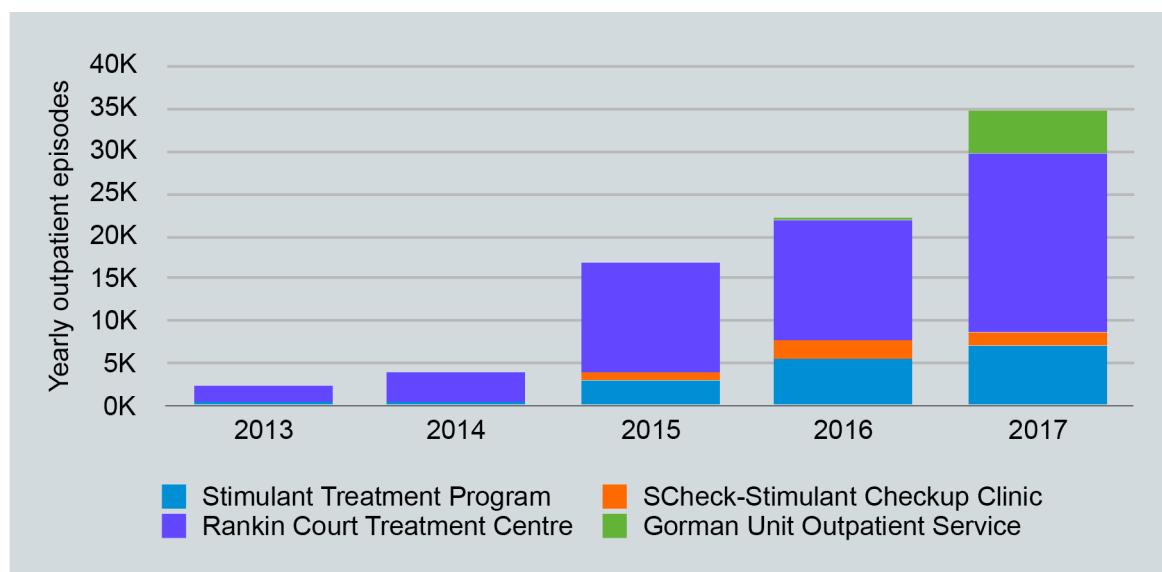
7.80 Based on data from NSW Health, methamphetamine-related hospital admissions increased rapidly between 2010–11 and 2016–17 but stabilised at high levels in 2017–18.<sup>141</sup> (See Figure 7.4 and Figure 7.5)

**Figure 7.4: Rate of methamphetamine-related hospitalisations to public and private hospitals, NSW, 2010–11 to 2017–18<sup>142</sup>**



**Figure 7.5: Rate of amphetamine-type stimulant hospitalisation to public hospitals, by substance, NSW, 2010–11 to 2017–18<sup>143</sup>****Figure 7.6: Hospital separations by selected drug-related principal diagnosis, number, Australia, 2012–13 to 2016–17<sup>144</sup>**

7.81 St Vincent's Health Australia submitted that over the past five years, St Vincent's Hospital in Sydney experienced the highest total number of emergency department presentations related to alcohol, drug abuse and drug-induced mental disorders compared with similar hospitals in NSW. The submission highlighted that outpatient episodes increased significantly between September 2013 and September 2018, partly driven by the introduction of new services, including the Gorman Unit Outpatient Service and Assertive Case Management Program. However, the total number of outpatient episodes at existing services (Stimulant Treatment Program and Rankin Court) also increased significantly during this time,<sup>145</sup> suggesting an increased demand for drug and alcohol treatment and support. (See Figure 7.7)

**Figure 7.7: Total yearly outpatient episodes 2013–17, St Vincent’s Hospital Sydney<sup>146</sup>**

7.82 St Vincent’s Health Australia noted three-quarters of active clients (as at October 2018) were male, and the average age of clients was 45 years.<sup>147</sup>

### MDMA-related harms at music festivals

7.83 Many of the risk factors for harms associated with methamphetamine use are not associated with MDMA use, including administration by injecting, frequent use, dependence or related psychosis.<sup>148</sup> However, the use of MDMA can result in physiological harms.

7.84 While the overall recent use of MDMA in NSW by people over the age of 14 is decreasing, certain demographics are experiencing high-risk use and an increase in associated harms.

### Demographics and contexts of use

7.85 The evidence indicates that music festivals are associated with higher rates of illicit drug use, particularly MDMA, than the general community.<sup>149</sup> A survey conducted in 2016 at an Australian music festival of people aged 18 to 30 found that 60% of respondents reported using MDMA in the previous 12-month period.<sup>150</sup>

7.86 This is consistent with evidence provided to the Inquiry. Dr Brett, St Vincent’s Hospital, gave evidence that MDMA use tends to occur in the context of partying or clubbing, and by a demographic of people who are of higher socioeconomic status, younger, educated and without a previous history of substance dependence.<sup>151</sup> Dr Brett noted that the social effects of MDMA make it a drug of preference for these contexts of use. *‘They give you a sense of connection with other people ... a oneness and a sort of emotional openness ... they can make people more talkative or chatty.’*<sup>152</sup>

7.87 Dr Bronwyn Hudson, GP Registrar Visiting Medical Officer, Emergency Senior Medical Officer, Byron Central Hospital, told the Inquiry that, in her experience, MDMA use was common in people who attend music festivals and as a weekend party drug.<sup>153</sup>

7.88 Participants at the Inquiry’s Youth Roundtable identified pleasure, increased social and community interaction, and enhanced experiences as reasons for consuming MDMA, particularly in music festival settings.<sup>154</sup>

## MDMA-related deaths at music festivals

7.89 The Inquiry notes that in the recent *NSW Coronial Inquest into Music Festival Deaths*, the Deputy State Coroner found that:<sup>155</sup>

- four of the deceased died of MDMA toxicity
- one died of MDMA and cocaine toxicity
- one died of complications of MDMA use.

7.90 Dr Kerry Chant, NSW Chief Health Officer, stated to the Inquest that there were five deaths associated with music festivals in NSW from September 2018 to January 2019. She noted this was an increase within a short period, with only 12 deaths associated with music festivals across Australia in the previous decade.

*‘In addition to these deaths, a number of people who attended music festivals developed serious illness requiring hospital admission and intensive care management for drug-related toxicity... there were 29 hospital pre-intubations, 25 drug-related intensive care admissions, and at least an additional 23 drug-related hospital admissions.’<sup>156</sup>*

7.91 The Inquest found that most MDMA consumed in Australia is imported, and likely to follow European drug trends. It found that in recent years Europe has experienced an increase in high purity and highly contaminated MDMA.<sup>157</sup>

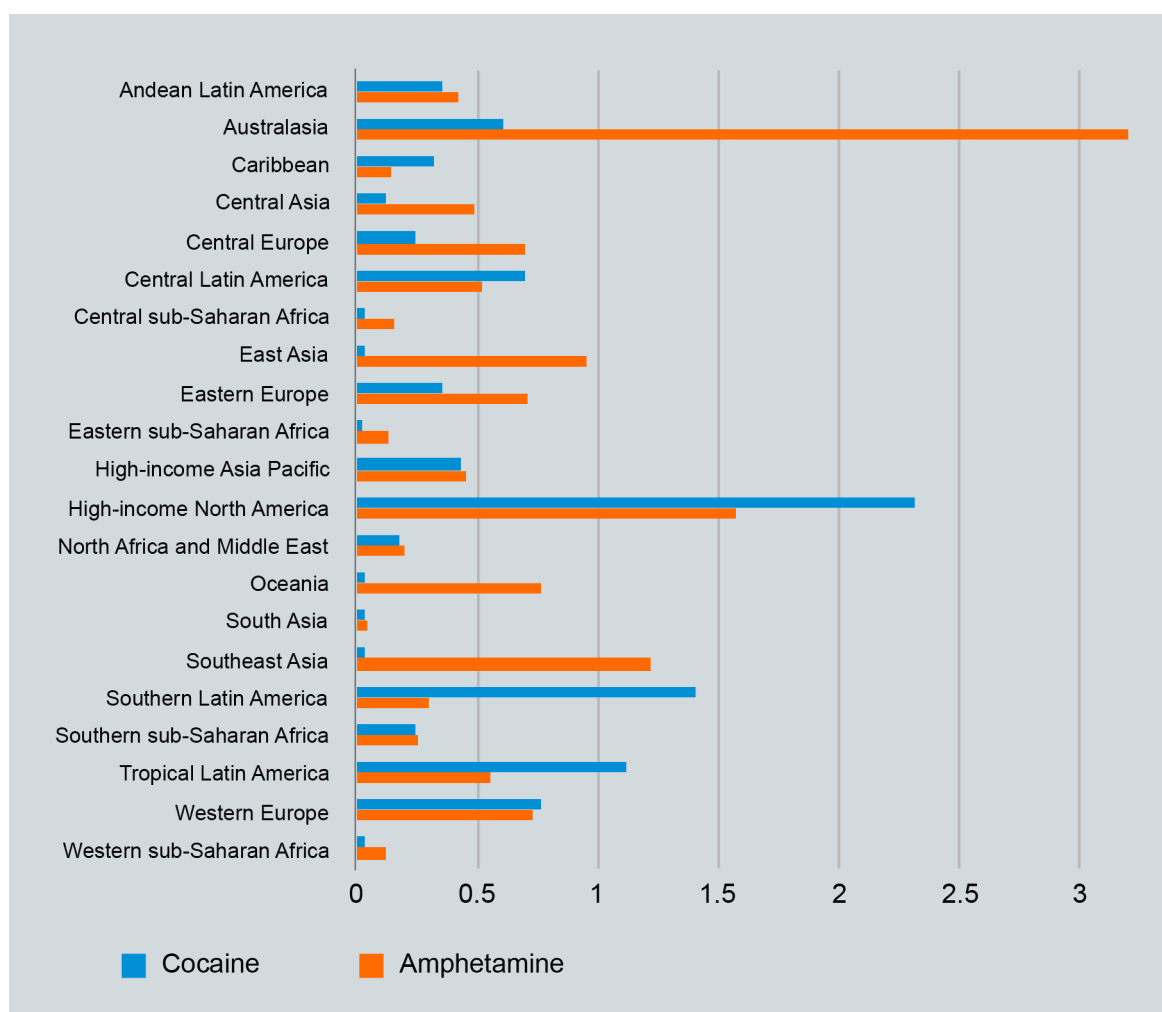
7.92 The risk of MDMA-related harms is increased in music festival environments due to a patron demographic of people aged 18 to 29 who report higher rates of MDMA use, the genre of music played, high temperatures, dehydration and continuous dancing over a prolonged time.<sup>158</sup>

## Deaths related to ATS

7.93 As noted in Chapter 1, understanding the contribution of ATS to drug deaths is complex as it is often difficult to directly attribute a death solely to a particular drug. Deaths from drug use are categorised as ‘drug-induced’ if directly attributable to drug use or ‘drug-related’ where drugs contributed to the death.<sup>159</sup>

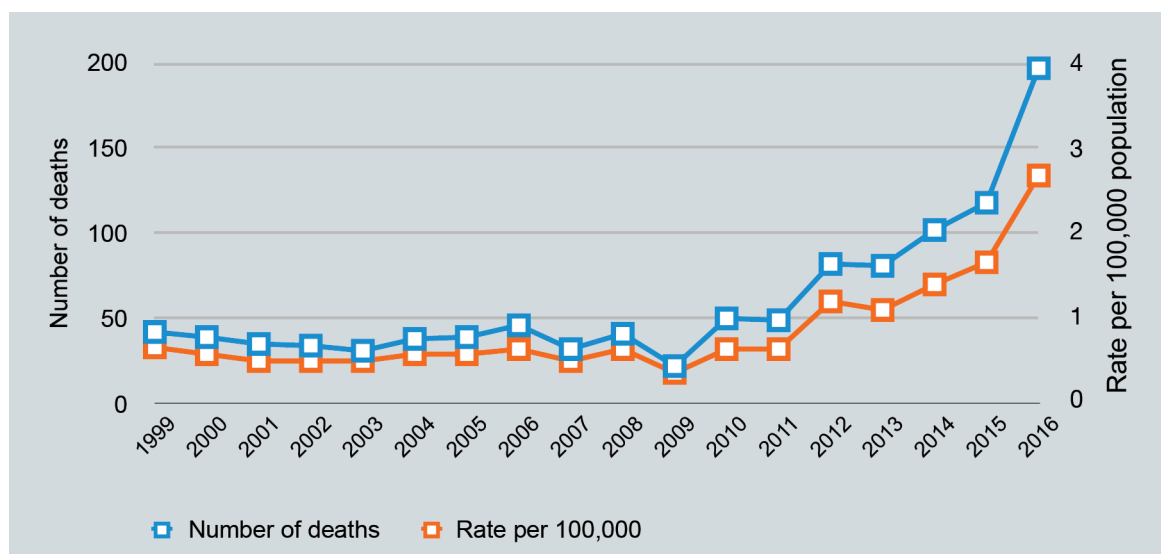
7.94 It is estimated that deaths associated with amphetamine dependence account for 0.58% of all deaths globally. Amphetamine dependence was associated with a substantially higher proportion of ‘excess’ deaths in Australasia than in other regions in 2017. The fraction of all-cause deaths associated with amphetamine dependence was around 3% in Australasia, followed by high income North America at about 2%.<sup>160</sup>

**Figure 7.8: Fraction of regional all-cause deaths associated with cocaine and amphetamine dependence in 2017<sup>161</sup>**



7.95 Deaths involving methamphetamine and other ATS including MDMA are increasing in NSW. NSW Health data report a rapid increase in psychostimulant-induced deaths excluding cocaine in NSW from 51 deaths in 2010 to 197 deaths in 2016.<sup>162</sup> Of these, 76 deaths had psychostimulants recorded as the only drug class associated with the death, while 121 had at least one other non-psychostimulant drug class also recorded.<sup>163</sup>

**Figure 7.9: Psychostimulant-induced deaths (excluding cocaine) as underlying or associated cause of death by number of deaths (left axis) and rate of deaths per 100,000 population, NSW, 1999–2016**<sup>164</sup>



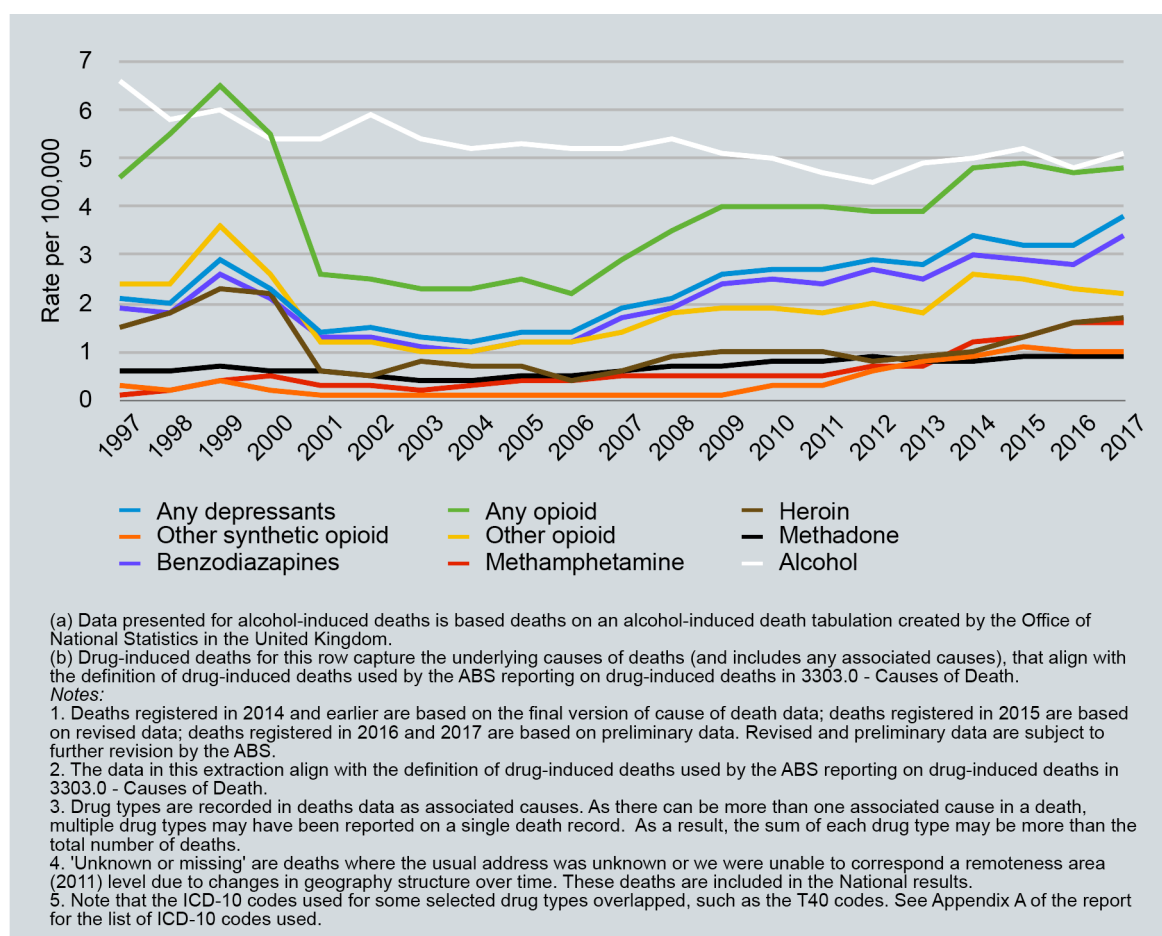
7.96 The Australian Bureau of Statistics (ABS) provided the Inquiry with data from the National Mortality Dataset showing that in NSW in 2017, psychostimulants were a factor in 6.5% of all accidental deaths and 5.2% of deaths due to intentional self-harm (including suicide).<sup>165</sup> It is important to note that the ABS, Australian Institute of Health and Welfare and NDARC use the terminology of drug-induced deaths to define those deaths that are directly attributable to drug use, while the Penington Institute uses the term drug-related deaths despite defining these deaths as directly attributable to drug use.

7.97 ABS data show that across Australia in 2016:<sup>166</sup>

- Psychostimulants were involved in 20.1% of drug-induced deaths, most of which involved methamphetamine, making it the third most common category of drug-induced deaths after benzodiazepines and other opioids (excluding heroin, fentanyl and methadone).
- The presence of meth/amphetamines in a drug-induced death was approximately five times higher in 2016 than it was in 1999.

7.98 The rate of drug-induced deaths across Australia has risen at a faster rate in regional and remote areas, up 41% between 2008 and 2017 compared with a 16% increase in major cities. During this same period, drug-induced deaths were more likely to be due to prescription drugs than illegal drugs, and there was a substantial rise in the number of deaths with a prescription drug present.<sup>167</sup>

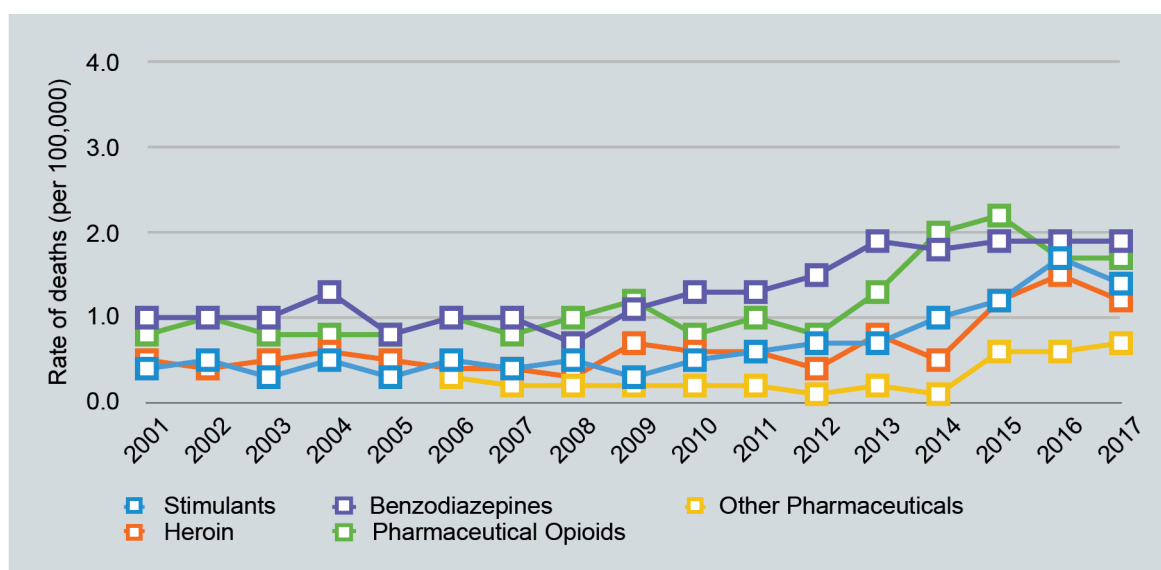
**Figure 7.10: Cause of death by alcohol and common drug types, rate per 100,000 population, Australia, 1997–2017**<sup>168</sup>



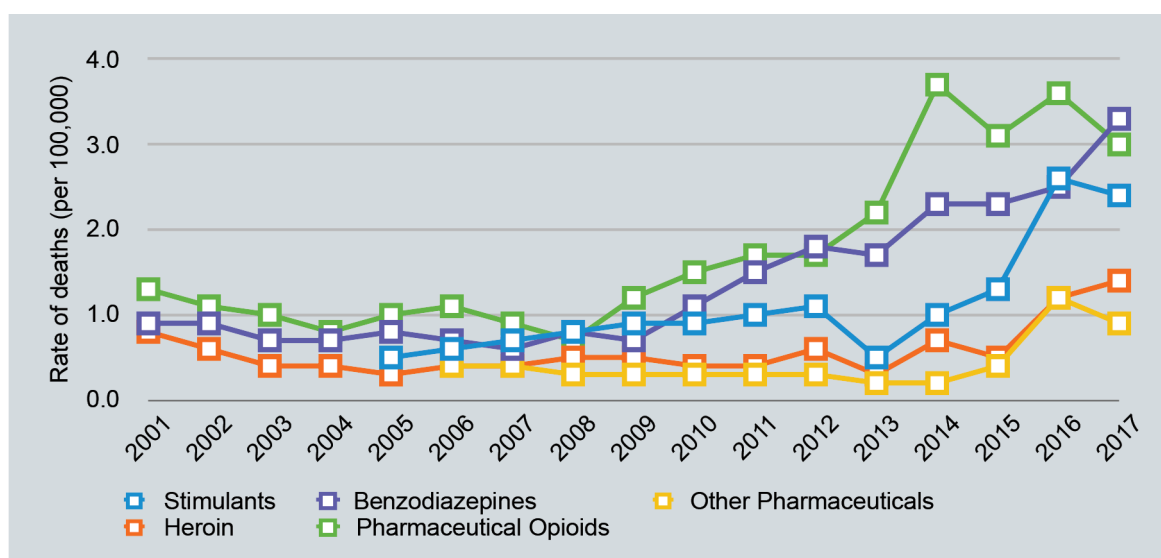
7.99 The Pennington Institute produces an annual overdose report that provides analysis on different drug types, patterns in demographic and socioeconomic status, and spatial trends. The latest report showed that unintentional drug overdoses continued to rise across the country, with incidence highest in the 30 to 59 year age bracket. Overall prevalence was higher in men. Aboriginal people were more than three times more likely to die from overdose compared to non-Aboriginal people.<sup>169</sup> Opioids continued to be the most commonly identified drug group in unintentional drug deaths, but there were significant increases in deaths involving stimulants. Polydrug use was a factor in many of these deaths, with dramatic increases in deaths where four or more substances were involved.<sup>170</sup>

7.100 In NSW, the rates of unintentional drug-induced deaths were higher in regional areas. Benzodiazepines and pharmaceutical opioids remained the most common drugs involved and increases in stimulant deaths were evident.<sup>171</sup>

**Figure 7.11: Unintentional drug-induced deaths by drug type in greater Sydney, 2001–17, rate per 100,000 population<sup>172</sup>**

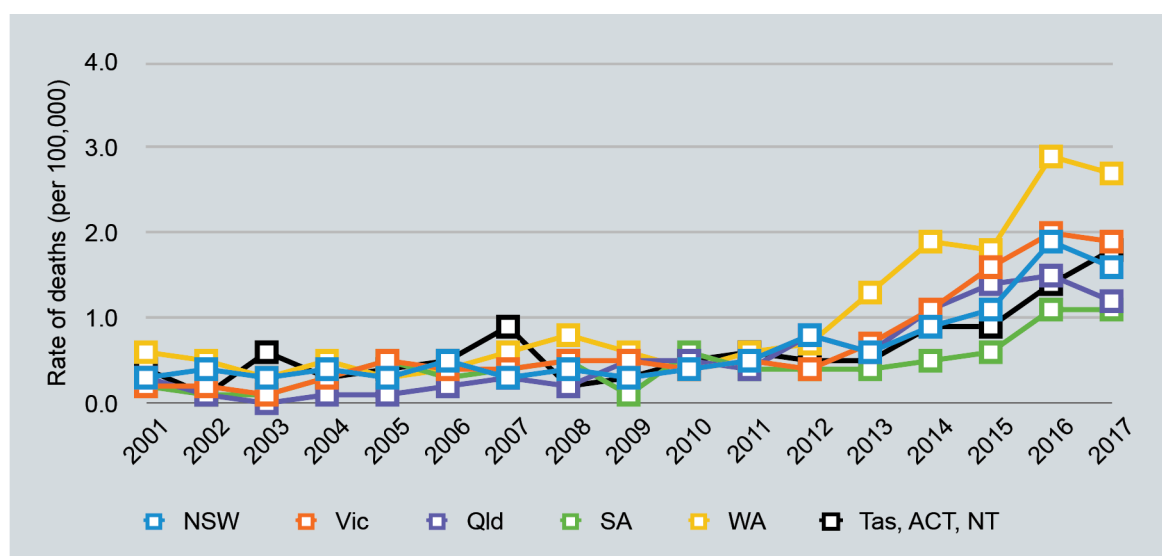


**Figure 7.12: Unintentional drug-induced deaths by drug type in regional NSW, 2001–17, rate per 100,000 population<sup>173</sup>**



7.101 Trends of stimulant-related unintentional deaths are similar across Australia, as shown in Figure 7.13.

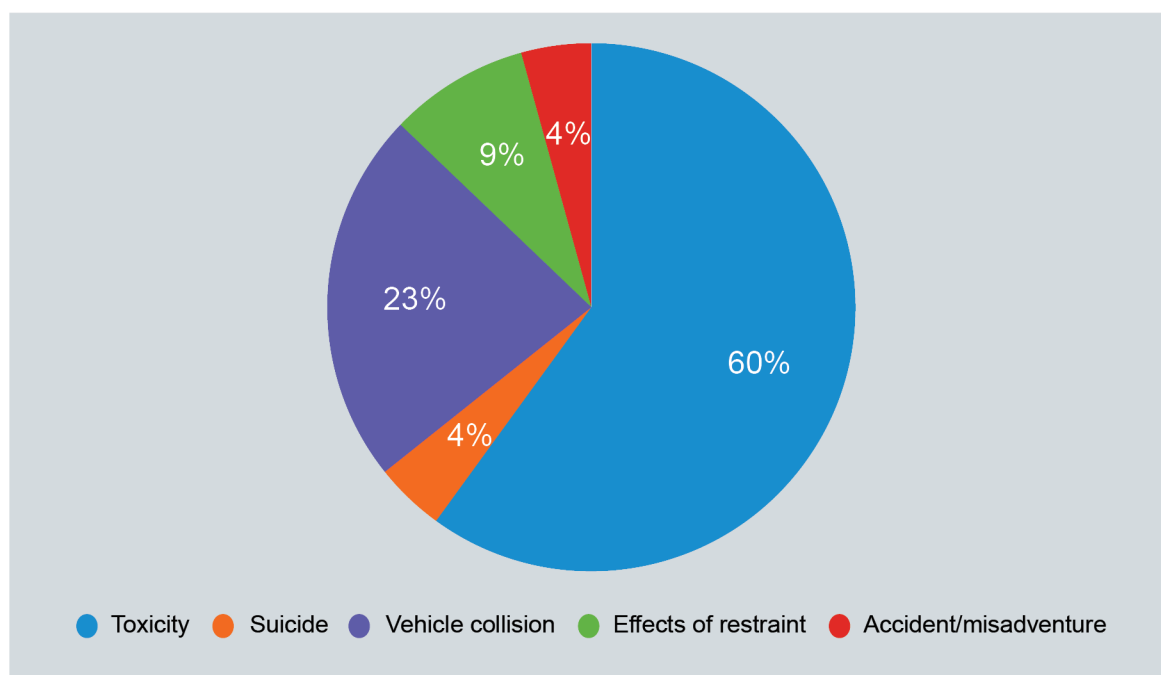
**Figure 7.13: Unintentional drug-induced deaths involving stimulants by state and territory 2001–17, rate per 100,000 population<sup>174</sup>**



### NSW Coronial Inquest findings

- 7.102 The Inquiry issued a request for information to the National Coronial Information System (NCIS) seeking details of all NSW coronial findings and recommendations for the past five years where ATS use or drug overdose was a contributing factor to the death.
- 7.103 The NCIS provided the Inquiry with coronial findings for 57 deaths in NSW delivered between 19 July 2011 and 31 December 2018, where ATS was identified in its 'drug' coding fields.<sup>175</sup> These included cases where detailed findings had been handed down, or where an inquest was dispensed with without discursive findings or recommendations. Four of these deaths were excluded from further consideration by the Inquiry on the basis that the involvement of ATS was unclear. The Inquiry also considered a further 12 deaths involving ATS use for which coronial findings have been issued since 31 December 2018.
- 7.104 These 65 deaths constitute those deaths that have been the subject of findings by the Coroner since July 2012 but are unlikely to represent the total number of deaths relating to ATS use in NSW during that period. Of the 65 ATS-related deaths:
- Approximately 65% of cases (42 deaths) involved drug toxicity leading directly to death (including in cases of polydrug use). Five deaths involved MDMA toxicity. One death was attributed to '*complications as a result of MDMA use*', and one death to mixed MDMA and cocaine toxicity. Six deaths occurred in the context of music festivals (see above).
  - Approximately 25% of cases (16 deaths) involved motor vehicle accidents where either the deceased had ATS present in their system at the time of the accident (of which six involved police pursuits) or where the deceased was killed in an accident where a driver had used ATS.
  - Approximately 10% of cases (six deaths) involved the use of restraint in a manner that contributed to the deceased's death in the course of managing the deceased's severe behavioural disturbance while under the influence of ATS. Of these, five involved restraint by NSW Police officers.

**Figure 7.14: NSW Coronial Inquest findings in which ATS were a principal or contributing cause of death 8 July 2012 to 8 November 2018**



7.105 Similar statistics have been published in the literature. A study published in 2017 showed that methamphetamine-related death rates in Australia doubled between 2009 and 2015. Toxicity was the most frequent cause, while natural disease, suicide and accident accounted for more than half of the deaths.<sup>176</sup>

### Crystal methamphetamine is associated with high levels of harm to families

7.106 The Inquiry heard from numerous witnesses with lived experience, health workers and in submissions that use of crystal methamphetamine has a profound and lasting impact on families.<sup>177</sup>

7.107 Comprehensive data are not kept on the number of people affected by their loved one's use of ATS. However, available information suggests a high rate of harms to families associated with use of crystal methamphetamine, including domestic and family violence and child protection matters. Harms to families are discussed in more detail in Chapter 18.

### Domestic and family violence

7.108 The Inquiry heard evidence from numerous witnesses that there is an association between use of ATS and domestic and family violence. While robust data on the prevalence of ATS-associated domestic and family violence are lacking, there is sufficient evidence before the Inquiry to suggest that this warrants further investigation.

7.109 A recent Australian synthesis of previous studies on the association between methamphetamine and domestic and family violence offending reported a high prevalence of domestic violence offending among people who use methamphetamine, although the rates of offending quoted in the studies included in the synthesis varied markedly.<sup>178</sup> The synthesis found that people who use methamphetamine made up a small proportion of domestic and family violence offenders overall.<sup>179</sup>

- 7.110 In a written statement provided to the Inquiry, Mary Baulch, CEO, Domestic Violence NSW, presented the findings of a survey of that association's members' experiences of working with people experiencing domestic and family violence where crystal methamphetamine or other ATS are being used. Ms Baulch reported that 33 of the 37 members who responded to the survey (89%) stated that, in their view, ATS use increases the frequency and severity of domestic violence, making it more erratic, unpredictable and explosive.<sup>180</sup>
- 7.111 This is consistent with evidence provided to the Inquiry by DCJ workers, who noted that instances of domestic and family violence are high among people who use crystal methamphetamine in the communities they service. For example, s Elaine Thomson, Director of Practice of Quality Control and Clinical Support, Office of the Senior Practitioner, FACS (now DCJ), reported that three-quarters of all crystal methamphetamine-related clinical consults involved domestic and family violence.<sup>181</sup> Teena Bonham, Principal Project Officer Estate Management Unit, FACS (now DCJ), told the Dubbo Hearing that the communities she works with have reported a large increase in crystal methamphetamine use in Dubbo over the past four to five years,<sup>182</sup> and they believe that much of the domestic and family violence there is driven by crystal methamphetamine use.<sup>183</sup>

### **Children at risk of significant harm and removed into out-of-home care**

- 7.112 Most people who use ATS do not abuse or neglect their children,<sup>184</sup> but evidence before the Inquiry suggested there is a significant association between children being at risk of significant harm and parental use of crystal methamphetamine.
- 7.113 Witness estimates of the prevalence of ATS in statutory child protection and out-of-home care cases varied.<sup>185</sup> Several witnesses from DCJ told the Inquiry they had observed an increase in crystal methamphetamine use in families and communities in recent years.<sup>186</sup>
- 7.114 In recognition of the lack of robust data about the extent to which ATS are associated with child protection matters, the Inquiry asked DCJ to conduct a survey of its Managers Client Services across the state about the matters managed by their Community Services Centre over the last year. Managers Client Services are senior practitioners who provide oversight and direction of other child protection case workers. A total of 42 Managers Client Services responded to the survey,<sup>187</sup> representing approximately 50% of all Managers Client Services, with the following results:
- The majority of respondents estimated that ATS was a primary or secondary factor in more than half of the risk of significant harm reports received in the last year, at 63% and 66% respectively.
  - Just under half of respondents estimated that ATS was a primary or secondary reason in more than half of the cases of children and young people entering out-of-home care in the past year, at 46% and 49% respectively.

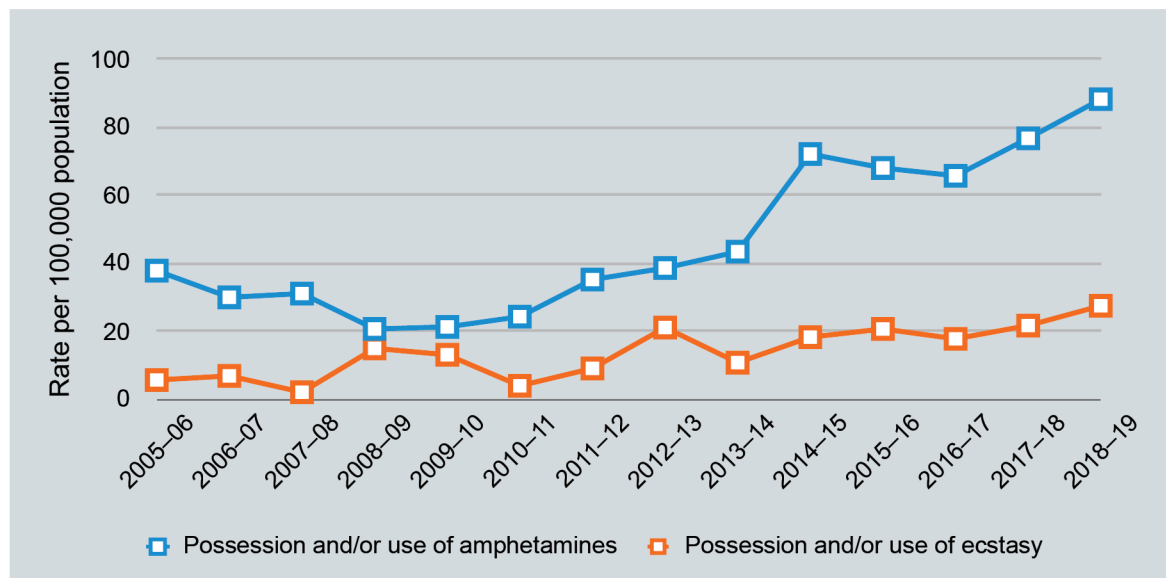
The methodology and limitations of this survey are discussed at Appendix 19.

- 7.115 This is consistent with evidence received by the Inquiry at each of its regional hearings. For example, DCJ witnesses at the Lismore and Sydney (General) Hearings suggested around half of the risk of harm reports in their Community Services Centre involved crystal methamphetamine.<sup>188</sup> In Broken Hill, this figure was 100%.<sup>189</sup> In 2017–18, positive tests for meth/amphetamines were returned by 11% of drug screens of families with alcohol and drug concerns being case managed by DCJ, second only to cannabis at 33%.<sup>190</sup>

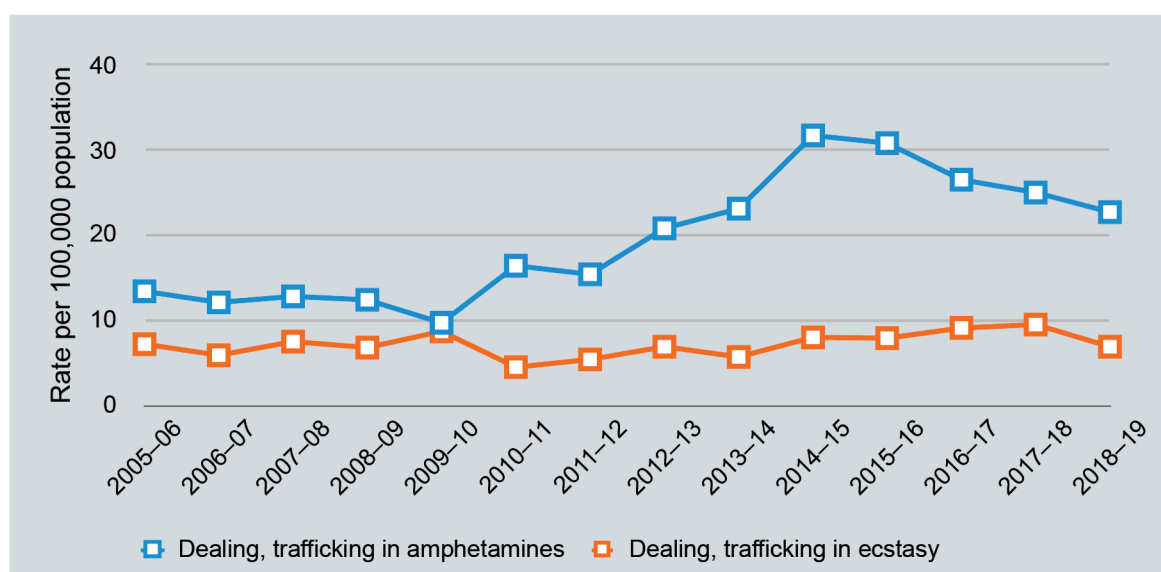
### Recorded incidents for amphetamine-related charges are increasing in NSW

- 7.116 Recorded incidents relating to possession and use of amphetamines are increasing. NSW crime statistics show that the rate of recorded incidents of use or possession of amphetamines in NSW (per 100,000 individuals in the NSW population) has more than tripled over the past 13 years, from 31.7 in the financial year ending June 2006, to 95.1 for the financial year ending June 2019.<sup>191</sup> Rates of recorded incidents of dealing or trafficking over this same period have also increased, but less significantly. They have almost doubled from 13.4 in the financial year ending June 2006 to 22.7 for the financial year ending June 2019.<sup>192</sup>
- 7.117 A similar trend may be observed when combining rates for amphetamines and ecstasy. The rate of recorded use or possession of these drugs has tripled over the same period, from 43.2 per 100,000 population for the financial year ending 2006 to 132 for the financial year ending 2019.<sup>193</sup> In comparison, the rate of recorded incidents of dealing or trafficking has increased from 20.6 per 100,000 population in the financial year ending 2006 to 29.6 for the financial year ending 2019.<sup>194</sup>

**Figure 7.15: Recorded incidents of possess/use of amphetamine and ecstasy per 100,000 population, July 2005 to June 2019**<sup>195</sup>



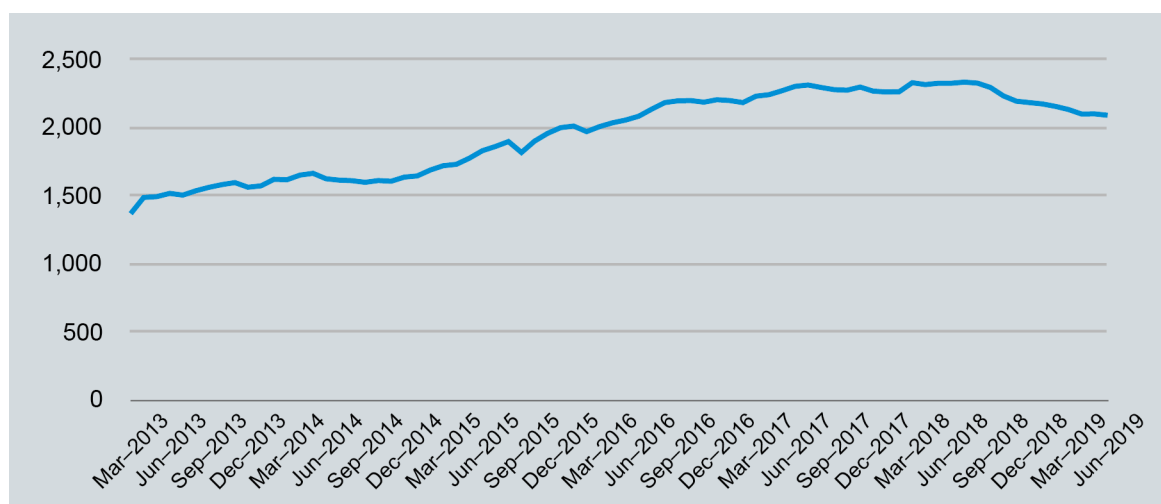
**Figure 7.16: Recorded incidents of deal/traffic in amphetamine and ecstasy per 100,000 population, July 2005 to June 2019<sup>196</sup>**



**More people are being sentenced for amphetamine-related charges, and more people are going to prison for drug-related offences**

7.118 The number of people sentenced to custody for amphetamine-related charges is increasing, from 221 in the financial year ending June 2006 to 514 in the financial year ending June 2019.<sup>197</sup> The total number of people incarcerated for drug offences has also increased, from 1,369 in March 2013 to 2,091 in June 2019.<sup>198</sup>

**Figure 7.17: NSW Prison population incarcerated for a drug offence (all drug types), March 2013 to June 2019<sup>199</sup>**



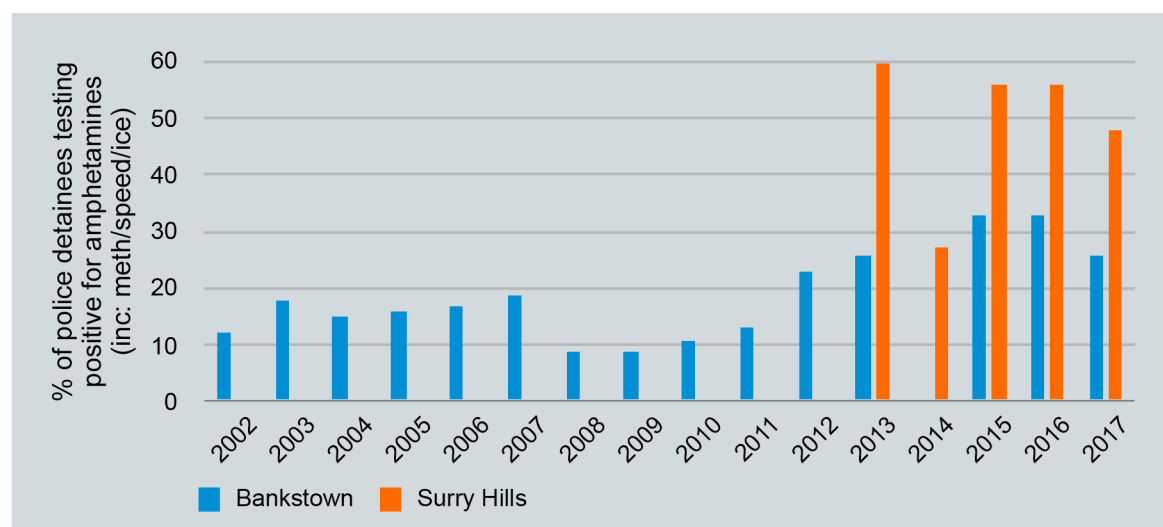
**Prevalence of ATS-related non-drug offences is not well understood, but appears high**

7.119 Data are not kept on the prevalence of ATS-related non-drug offences. ATS-related non-drug offences refer to crimes associated with an individual's drug use. They include assaults, property crimes or other activities to fund their drug use.

7.120 BOCSAR data show that, while amphetamine-related offending has been increasing in NSW, the long-term trend for property offences has not mirrored this trajectory. In fact, there have been significant downward trends recorded since 1990 for robbery, robbery with a firearm, burglary and motor vehicle theft.<sup>200</sup>

- 7.121 According to the 2016 NDSHS, 3.1% of people who recently used illicit drugs said they had created a disturbance or damaged property or stolen goods, 2.8% had verbally abused someone and 0.6% had physically abused someone. Almost 10% of people who had recently used illicit drugs reported having been a victim of an incident related to their drug use.<sup>201</sup>
- 7.122 Currently, the DUMA study is the only source of routinely collected data that provides evidence of the extent to which people who commit an offence may be under the influence of illicit drugs. This self-report survey of people in police custody, including voluntary urinalysis, provides an objective measure for corroborating reported recent drug use (within 48 hours of arrest).
- 7.123 DUMA asks detainees to what extent they think methamphetamine/speed/ice has contributed to the incident that led to their detention. In 2013, DUMA found that people detained for drug offences in Australia who tested positive to methamphetamine were more likely than other offenders to report that the drug they had taken had contributed to their current offending (64%).<sup>202</sup> Methamphetamine, speed and crystal methamphetamine also contributed to violent offending (58%), property offending (50%) and breach offences (44%).<sup>203</sup> These crimes included activities to help fund drug use and crimes resulting from an altered mental state after taking methamphetamine.<sup>204</sup> Figure 7.18 below shows that the rate of police detainees testing positive for methamphetamine/speed/crystal methamphetamine has been increasing, according to the DUMA surveys conducted in Bankstown and Surry Hills.

**Figure 7.18: Police detainees testing positive for amphetamines, 2002–17<sup>205</sup>**



- 7.124 The DUMA report shows that 72% of the 255 detainees in Sydney who provided a urine sample in 2015–16 tested positive to at least one type of drug. Positive test rates were highest for amphetamines (48%), followed by cannabis (43%), opiates (32%) and benzodiazepines (21%).<sup>206</sup>
- 7.125 Eighteen per cent (73) of detainees surveyed reported having gained an income in the 30 days before detention through illegitimate sources that included sex work, shoplifting, drug dealing or other drug crime, and other crimes (such as theft, fraud, burglary or robbery). Twenty-five per cent of Surry Hills detainees reported an illegitimate income in the 30 days before detention compared with 13% of Bankstown detainees.<sup>207</sup>

- 7.126 To better understand the prevalence of ATS-related non-drug criminal offending, the Inquiry worked with the Judicial Commission to conduct a survey of Local Court magistrates and District Court judges about their experience and perceptions of the extent to which crystal methamphetamine is used by people committing 'non-drug criminal offences' (i.e. criminal offences other than possess/supply/manufacture drugs, such as domestic and family violence, personal violence, theft and related offences, public order offences, unlawful entry/break and enter offences and driving offences). Twenty-seven per cent of the Local Court magistrates invited to participate in the survey did so. In comparison, 21% of the invited District Court judges responded. The methodology and limitations of these surveys are discussed in Appendix 19.
- 7.127 Of the 45 Local Court magistrates who completed the survey:<sup>208</sup>
- 40% reported that for at least half of the defendants in the non-drug criminal matters that had come before them in the last 12 months, there was information to suggest that the defendant was under the influence of crystal methamphetamine during the commission of the offence.
  - 53% reported that there was information to suggest that at least half of the defendants who had come before them in the last 12 months were people who had used crystal methamphetamine.
- 7.128 Of the 22 District Court judges who completed the survey:<sup>209</sup>
- 45% reported that for at least half of the defendants in the non-drug criminal matters that had come before them in the last 12 months, there was information to suggest that the defendant was under the influence of crystal methamphetamine during the commission of the offence.
  - 59% reported that there was information to suggest that at least half of the defendants who had come before them in the last 12 months were people who had used crystal methamphetamine.
- 7.129 Magistrates and judges were asked to identify the types of non-drug criminal offences in which crystal methamphetamine use was most often a factor. Common responses included offences of violence (including domestic violence and sexual violence), break and enter, robbery, driving, fraud and property offences. Most magistrates and judges reported that they had seen an increase in the use of crystal methamphetamine as a factor associated with the commission of non-drug criminal offences over the last five years.

### **A significant proportion of people driving while under the influence of drugs have used ATS**

- 7.130 Research undertaken by the NSW Centre for Road Safety found that drug-driving is now as much a factor in driver fatalities as drink driving.<sup>210</sup> The 2016 NDSHS found that 15.1% of people who used illicit drugs recently admitted to having driven while under the influence of drugs in the past 12 months.<sup>211</sup> According to the NSW Roads and Transport *Drug Driving Trauma Trends* Report, 44% of cases where the driver tested positive for an illicit substance in relation to a fatal crash between 2010–11 and 2015–16 involved amphetamine or crystal methamphetamine, and 4% involved MDMA.<sup>212</sup>
- 7.131 The Inquiry heard that more people are driving under the influence of ATS in NSW. The NSW Government outlined to the Inquiry the analysis of the Random Drug Testing Unit results undertaken by the Forensic and Analytical Science Service, which highlighted an increase in the frequency and concentration of methamphetamine in driving under the influence offences in February/March 2015 compared to February/March 2008.

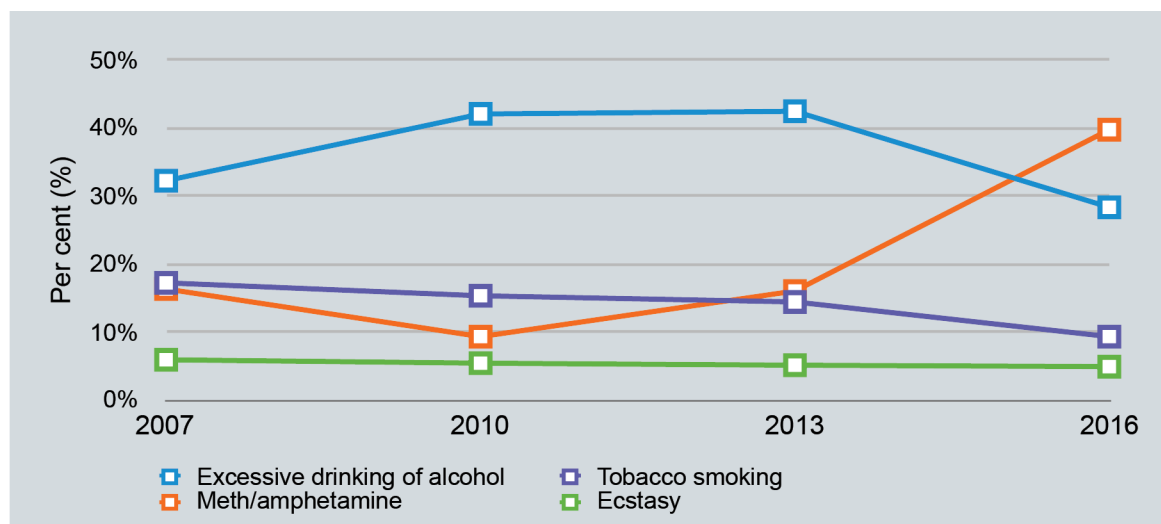
*‘... the frequency of methamphetamine in DUI driving rose from an average involvement of 22 in 65 events per month to 70 in 110 events. At the same time the concentration levels rose on average from 40% with a concentration level of more than 0.1 MG/L to 68% at the same toxicity level of more than 0.1 MG/L. This indicates a sharp rise in use and concentration.’<sup>213</sup>*

- 7.132 Between July 2016 and June 2018, a total of 13,665 people were sentenced in the NSW Local Court for an offence of ‘*drive with presence of prescribed illicit drug*’ under s 111 of the *Road Transport Act 2013*. Of these, 11,471 people were sentenced for a first offence and 2,194 people were sentenced for a second or subsequent offence. Similarly, in 2015, a large majority of convictions under s 111 of the *Road Transport Act 2013* (NSW) were first offences (92.4%).<sup>214</sup>
- 7.133 Data provided by the NSW Government on the number of people found guilty of drug-driving offences by principal offence type indicate that most offences do not include a recorded drug type, making it difficult to assess the actual prevalence of ATS drug driving in NSW. Of the 7,404 people found guilty of driving with an illicit drug present or under the influence of alcohol/drugs from July 2017 to June 2018, only 34 incidents had a recorded drug type, of which 24 were amphetamines.<sup>215</sup>

### Community concern about methamphetamine has increased

- 7.134 The Inquiry heard that there is a strong perception in the general community that use of ATS, particularly crystal methamphetamine, reduces safety. Whereas historically the NDSHS has found that excessive drinking of alcohol is the primary community concern, the number of respondents who rated methamphetamine and amphetamine as the most serious concern more than doubled from 16.1% in 2013 to 39.8% in 2016, overtaking alcohol as the most concerning overall.<sup>216</sup> (See Figure 7.19)

**Figure 7.19: Drug thought to be of most concern for the general community (National, aged 14 years or older) 2007–16**<sup>217</sup>



- 7.135 In comparison, the NDSHS showed that community concern about ecstasy had remained consistent and low. Between 2007 and 2016, the percentage of people rating ecstasy as the drug of most concern fell slightly from 5.5% to 5%.
- 7.136 Results varied across age groups. For example, people in their thirties were more concerned about methamphetamine than teenagers (45% compared to 26%), while people over 70 years were more concerned with excessive alcohol compared to 18 to 24 year-olds (32% compared to 23%).<sup>218</sup>

### **Economic harms associated with ATS are not well understood, but are likely to be high**

- 7.137 The Inquiry has not been able to determine the amount that the government spends on responding to ATS. However, it is apparent that the economic harms of ATS to government as well as the broader community are significant and need to be better understood.
- 7.138 According to the NDRI, in 2016 the greatest costs of methamphetamine were related to crime, including costs of policing, courts, corrections and victims of crime (\$3,244.5 million), followed by premature death (\$781.8 million) and workplace costs (\$289.4 million).<sup>219</sup>
- 7.139 The actual current cost of ATS is expected to be higher than the figures estimated in the NDRI report for several reasons. These include that NDRI did not look at all ATS; there have been changes in prevalence of use and the level of harmful use since 2013–14; and harms associated with ATS have increased since this time.

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## Chapter 8. Priority populations

### Introduction

- 8.1 The use of ATS, and the harms it can cause, differs across groups in the community. Certain groups use ATS more frequently and in riskier ways. Some groups face barriers when accessing treatment and supports that are not encountered by others. Understanding the needs of different sections of the community is essential if AOD policies and treatment services are to reach as many people as possible.
- 8.2 The stigma faced by individuals who use drugs may be compounded by judgment or discrimination they may experience because they belong to a particular group. As Drug and Alcohol Nurses of Australasia noted in their submission: *'Discrimination and stigma associated with alcohol and other drug use is exacerbated when issues of substance use are discussed with populations who may be already marginalised or judged.'*<sup>1</sup> Stigma is discussed in detail in Chapter 9.
- 8.3 The Inquiry examined ATS use among a number of population groups. It has identified the following as priority populations whose ATS use requires careful analysis in the formulation of policy and service responses:
- young people
  - people identifying as lesbian, gay, bisexual, transgender, queer or intersex (LGBTQI+)
  - people in contact with the criminal justice system
  - people in particular occupations
  - culturally and linguistically diverse communities
  - people with mental health conditions
  - people with cognitive impairment
  - people living in regional, rural or remote NSW
  - Aboriginal people and communities
  - people experiencing homelessness
  - pregnant women.
- 8.4 Many of the above groups are recognised as being 'priority populations' by the National Drug Strategy. While the National Drug Strategy also recognises older people (aged over 60) as a priority population,<sup>2</sup> evidence considered by the Inquiry suggests that ATS use by older people is low relative to other age groups.<sup>3</sup> As people who use ATS age and continue to use, that may change. Recent data show that methamphetamine-related emergency department presentations and hospitalisations for people over the age of 55 increased overall in the period 2011–12 to 2017–18.<sup>4</sup>

### Young people

- 8.5 Young people are not all at equal risk of using drugs,<sup>5</sup> and not all drug use during adolescence will lead to dependence.<sup>6</sup> National surveys of drug use have found that young people who use drugs are more likely to use alcohol, cannabis and tobacco than ATS.<sup>7</sup> The Inquiry also considered the recreational use of MDMA by young people in social settings and at music festivals.<sup>8</sup>

- 8.6 Not all ATS use by young people, however, is a result of recreational or experimental choices. Young people may also resort to drug use in response to difficult circumstances in their lives. This was highlighted by Mark Ferry, Chief Operating Officer of the Ted Noffs Foundation, in his evidence to the Inquiry:

*‘Let’s just remember that most of us have the privilege of choice. Most of our kids will drown in choices. Their anxiety will come from not knowing all the different things they want to do – whether they want to be a doctor or a lawyer or a social media expert. The young people that we see don’t have the privilege of choice. So the notion of them making a bad choice is a mistake on our behalf.’<sup>9</sup>*

- 8.7 As this chapter will outline, young people are particularly vulnerable to the harms related to drug use. Mr Ferry told the Inquiry of the trajectory that use of methamphetamine by young people can take:

*‘I think, especially with ice, that young people who already have a load of things against them – and it’s the trauma and everything we’ve talked about – once they start using ice – and let’s be quite frank. They describe their first time using ice as wonderful. It’s a very pleasurable experience. It accelerates quite quickly.’<sup>10</sup>*

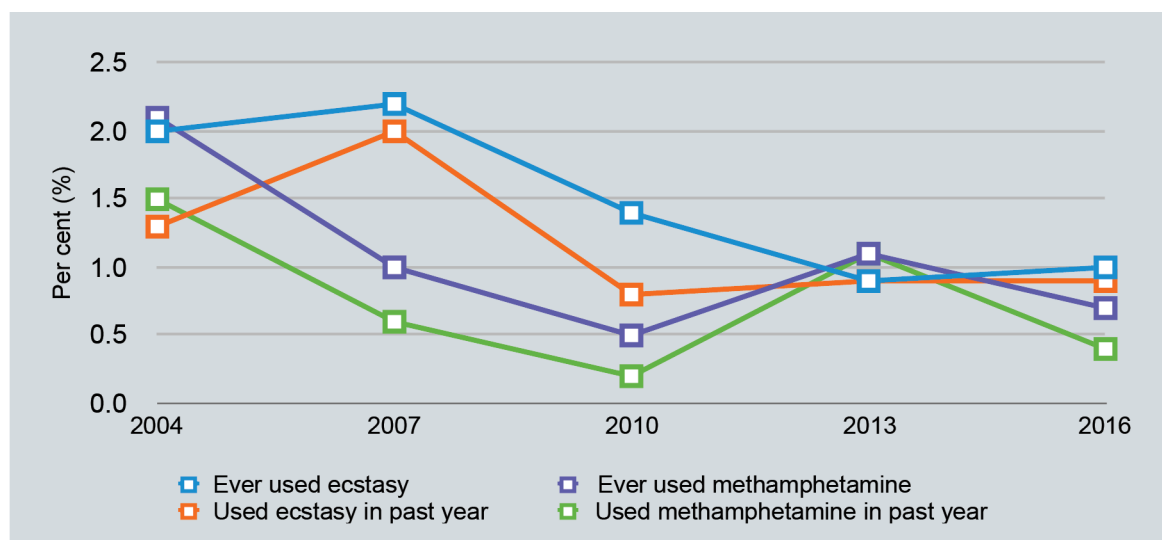
- 8.8 Adolescence is a critical risk period for the start of drug use.<sup>11</sup> Many of the lived experience witnesses who gave evidence to the Inquiry said that they, or their children, had begun using ATS in their teenage years or early adulthood.<sup>12</sup> Data suggest that nationally, the average age at which people over 14 first used an illicit drug was 19.8.<sup>13</sup> For those who began using illicit substances between the age of 14 and 29, the average age of their first use was 16.7.<sup>14</sup> Noting the potential for the harms of drug use by young people to become entrenched,<sup>15</sup> young people ought to be accorded special consideration in the design of treatment and service responses.
- 8.9 This section will focus on young people aged 10 to 24, consistent with the definition of young people adopted in the National Drug Strategy.<sup>16</sup>

### ATS use by young people

#### Young people aged 12 to 17

- 8.10 The 2016 National Drug Strategy Household Survey (NDSHS) suggested that lifetime use of ecstasy among young people aged 12 to 17 fell between 2004 and 2013 but increased slightly in the period 2013 to 2016.<sup>17</sup> Ecstasy use reported in the past 12 months increased among that cohort from 2010 to 2016.<sup>18</sup>
- 8.11 Data provided by the NDSHS concerning the use of methamphetamine by young people aged 12 to 17 are based on small figures. For this reason, the survey does not assist to establish an accurate measure of the likely proportion of people who use methamphetamine in that age range and ought to be approached with caution.<sup>19</sup>

**Figure 8.1: National Drug Strategy Household Survey (NDSHS) ecstasy and amphetamine use among people in Australia, age 12 to 17, 2004–16 (as a percentage)<sup>20</sup>**



## 2016 National Drug Strategy Household Survey

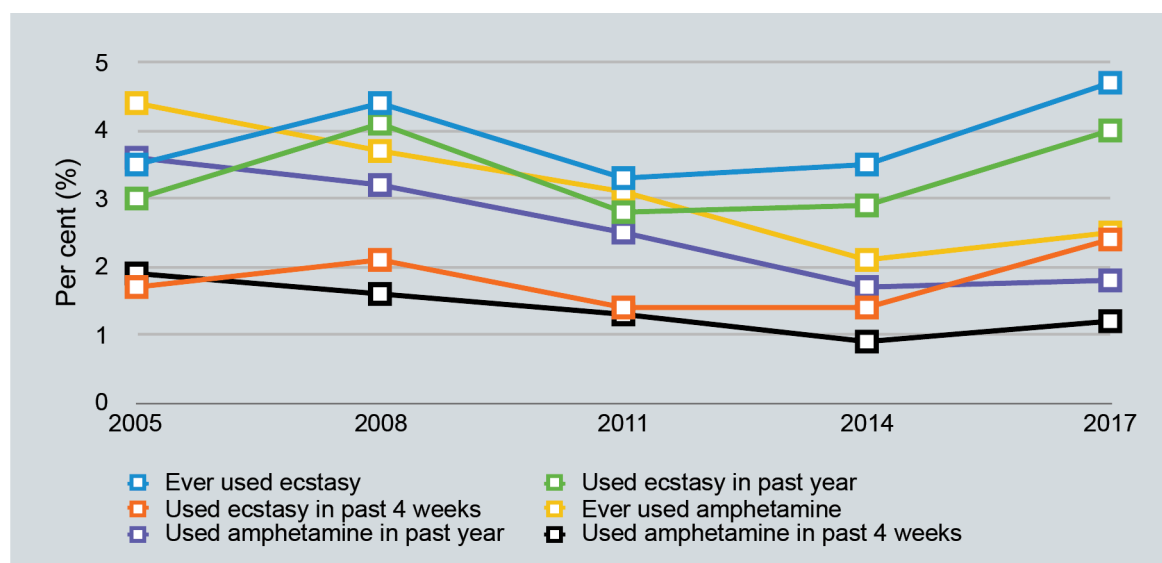
### Young people aged 18 to 24

8.12 Use of ecstasy by people aged 18 to 24 declined in the period 2004 to 2016 according to the NDSHS, with 8% of respondents nationally reporting recent use in 2016.<sup>21</sup>

8.13 The proportions of people aged 18 to 24 who reported ever having used methamphetamine, and those reporting recent use, both fell considerably in the period 2004 to 2016.<sup>22</sup>

## Australian School Students National Alcohol and Drug (ASSAD) survey

**Figure 8.2: ASSAD: Ecstasy and amphetamine use among secondary students in NSW, age 12 to 17, 2005–17 (as a percentage)<sup>23</sup>**



### Use of MDMA/ecstasy

- 8.14 The Australian School Students National Alcohol and Drug (ASSAD) survey is a survey of secondary school children aged 12 to 17. According to the 2017 NSW ASSAD results, in 2017, most school students aged 12 to 17 (95%) reported never having used ecstasy. Four per cent reported having used it in the year before the survey, with 2.5% reporting use in the month before the survey.<sup>24</sup> Nationally, almost half (47%) of students who reported recent use of ecstasy also reported having used it once or twice. Young men were more likely to have used ecstasy compared with their female peers.<sup>25</sup> Lifetime use of ecstasy increased between 2011 and 2017 in the NSW ASSAD sample.<sup>26</sup> This finding is consistent with the upward trend identified in the 2016 NDSHS.

### *Use of amphetamine and methamphetamine*

- 8.15 The 2017 NSW ASSAD survey found that only 2.5% of students aged 12 to 17 reported ever using amphetamine for non-medical reasons, with 1.8% reporting use in the year before the survey and 1.2% reporting use in the month before the survey.<sup>27</sup>
- 8.16 As is apparent from a comparison of the graphs in Figure 8.1 and Figure 8.2 above, the NSW ASSAD survey shows increases in use of amphetamines between 2014 and 2017. This increase is not reflected in the NDSHS data available up to 2016. This may point to an increase in ATS use by young people in the period since the last NDSHS in 2016. Results of the 2019 of the NDSHS are not yet available.

### Increase in young people seeking treatment for methamphetamine use

- 8.17 It has been argued that the NDSHS and ASSAD survey are not useful to determine changes in rates of drug use for drugs that have an already low prevalence of use among young people, such as methamphetamine.<sup>28</sup> A study examining drug use among adolescents in residential drug treatment in the ACT and NSW, which was conducted between 2009 and 2014 and involved 865 young people aged 14 to 19, found an increase in methamphetamine reported as the primary drug of concern among service participants (from 10.8% to 48.9%) and an increase in methamphetamine use at the time of admission (from 28.8% to 59.4%).<sup>29</sup> Although these data do not suggest increases in methamphetamine use among all young people, they do indicate that some young people who use methamphetamine have experienced increases in harms that have led to seeking treatment.
- 8.18 Evidence given at the Inquiry's hearings by a number of youth AOD treatment providers indicated that substantial proportions of young people currently in their services use methamphetamine.<sup>30</sup>

### Polydrug use

- 8.19 The Inquiry heard evidence that there is often polydrug use among young people.<sup>31</sup> A survey by the Ted Noffs Foundation of its clients suggested they used on average two or more different substances.<sup>32</sup> Gabriella Holmes, the Program Manager of the Triple Care Farm, a service that provides AOD treatment programs to young people aged 16 to 24, told the Inquiry that 70% of that service's clients reported using five or more different drugs.<sup>33</sup>

## Harms of drug use for young people

8.20 Young people are particularly vulnerable to the harms of drug use, given drug use may interfere with the important and formative processes that take place at this stage of a person's life. A young person may be more vulnerable to developing dependence compared with an adult because the parts of the brain that are associated with decision-making and self-regulation do not fully develop until early adulthood.<sup>34</sup> Use of licit and illicit drugs during adolescence may inhibit the development of important skills, such as behavioural regulation.<sup>35</sup> A higher intensity of use (such as daily or chronic use) will have a greater adverse effect on brain development.<sup>36</sup>

8.21 Young people who use illicit drugs are at higher risk of developing mental health conditions such as anxiety, depression and conduct disorders compared with peers who do not use illicit drugs.<sup>37</sup> The presence of a mental health condition and concurrent drug use in adolescence increases the likelihood of problematic use in adulthood.<sup>38</sup> The Royal Australian and New Zealand College of Psychiatrists noted:

*'ATS use can have harmful effects on the mental and physical health of young people and in some cases can have lethal consequences with higher rates of suicide and overdoses among young people. While ATS use is of concern for the general population, earlier initiation and polydrug use are of significant concern throughout the phase of adolescent development. The prevalence of mental illness amongst young people also adds to concern as any pre-existing mental health issues are likely to be greatly exacerbated by ATS use.'*<sup>39</sup>

8.22 The Inquiry heard that drug use in early life can lead to chaotic circumstances in the life of a young person, leading to an increased likelihood of their involvement in high-risk situations and affecting their long-term development.<sup>40</sup> Young people may become disengaged with schooling as a result of drug use.<sup>41</sup> The Inquiry also heard evidence of youth homelessness associated with ATS use.<sup>42</sup> Research suggests that young people who inject drugs are more likely to be at risk of blood-borne viruses and other injecting-related harms compared to older people who inject drugs.<sup>43</sup> This is due to their underuse of needle and syringe programs<sup>44</sup> and high rates of unsafe injecting.<sup>45</sup>

8.23 Dependent use in combination with mental health conditions in young people may lead to family breakdown, stigma and discrimination (for the young person and their family), shame and guilt, homelessness, contact with the juvenile or criminal justice system, and disengagement from education and/or employment.<sup>46</sup>

## Why young people use ATS

The Inquiry heard that young people may use ATS, in particular MDMA, for social reasons.<sup>47</sup> At a Youth Roundtable convened by the Inquiry, young people explained their reasons for using drugs:

*'It makes music sound awesome, like, for one. Yeah, it just feels good to dance.'*<sup>48</sup>

*'I find they open up my mind. I create new ideas. I create or do art.'*<sup>49</sup>

*'It changes your mind frame.'*<sup>50</sup>

- 8.24 Dr Mary Harrod, CEO, NSW Users and AIDS Association, described ATS use among young people attending festivals:

*'If you look at the festival community ... there's a common shared experience that everyone is heavily invested in in terms of travel and expense and bonding with their friends and drug use is ... a social interaction and a means of socialising and ... connecting with people. Not just with the feelings that you get through drug use, but the act itself ... it's a way to connect with people.'*<sup>51</sup>

- 8.25 However, motivations beyond a desire to socialise or experiment will also cause young people to use drugs. The Centre for Social Research in Health, UNSW Sydney outlined other factors in relation to methamphetamine use by young people: *'For these young people, their substance use is often tied up with disadvantages such as volatile family history, poverty and mental ill health.'*<sup>52</sup>

- 8.26 The Inquiry heard how trauma sustained in a variety of circumstances, from neglect to emotional and sexual trauma, tends to be a common feature among young people whose drug use is harmful.<sup>53</sup>

- 8.27 Studies on risk factors for drug use among young people have mainly focused on cannabis and/or alcohol; few Australian studies focus specifically on methamphetamine use in this cohort. The following risk factors for drug use by young people have been drawn from studies whose focus was not solely on alcohol or cannabis use:

- low levels of education<sup>54</sup>
- peers' use of drugs in late childhood and early adolescence<sup>55</sup>
- family breakdown early in a young person's life<sup>56</sup>
- child neglect and abuse<sup>57</sup>
- low participation in community activities (including organised sport) involving adults
- involvement in 'delinquent behaviour' (vandalism, school truancy, physical fighting, petty theft, carrying a weapon and driving a car without permission) at age 13 and 14<sup>58</sup>
- personality and behavioural factors, such as:
  - rated as 'aggressive' at ages five to six, seven to eight, 11 to 12<sup>59</sup>
  - less shy in approaching strangers,<sup>60</sup> and more reactive and less persistent at tasks than peers<sup>61</sup>
  - less agreeable, less conscientious and less neurotic<sup>62</sup>
  - low emotional control at age 13 and 14<sup>63</sup>
  - interested in thrill-seeking activities.<sup>64</sup>

- 8.28 Research finds no consistent pattern between the various indicators of socioeconomic status and illicit drug use among young people.<sup>65</sup> However, young people who use illicit drugs and have a lower socioeconomic status are at risk of experiencing greater harms than their peers who have a higher socioeconomic status.<sup>66</sup>

- 8.29 Parental or familial drug use may also lead young people to use drugs. The Inquiry was told how children whose parents use methamphetamine may have an increased risk of using the drug. Anne-Marie Connelly, the Manager of Client Services at Cessnock Community Services Centre, NSW Department of Family and Community Services (FACS, now NSW Department of Communities and Justice (DCJ)), provided her observations of methamphetamine use among adolescents in her service in this regard:

*'The exposure to parents using has ... desensitised young people and children to the consequences, the negative consequences, of that [methamphetamine use], ...it appears that there's a higher likelihood of a young person using ice because of that intergenerational effect.'*<sup>67</sup>

- 8.30 Jacqueline Hornery, Brighter Futures Program Coordinator, Samaritans, outlined her service's observations of intergenerational use among young people.<sup>68</sup> The Inquiry also heard how use of drugs within a family can desensitise younger siblings to drug use and lead to their own experimentation with drugs.<sup>69</sup>

### Service needs and responses for young people

- 8.31 The treatment needs of young people are different to those of adults who use ATS. Mr Ferry told the Inquiry how the Ted Noffs Foundation's treatment approaches for young people recognise a range of challenges and look at the young person as a whole:

*'[Y]oung people are going through puberty, they're going through growing up, they're finding their way in the world. It is a stressful time and a difficult time for any young person, let alone those facing the challenges of drug and alcohol and the associated issues going along with it. So the [treatment] model is much more intensive. It's also very much a holistic program ... we're also dealing with homelessness, with mental health, with schooling, with education...'*<sup>70</sup>

- 8.32 Youth-specific programs may need to be tailored to cater to those with lower levels of literacy and numeracy. This might mean, for example, delivering shorter program sessions or having assistance available to support young people to complete tasks.<sup>71</sup> Links with other services appear vital to provide holistic care and support, including facilitating access for young people to a GP or to engage with mental health or grief support services.<sup>72</sup> Madeleine Baker, Clinical Services Coordinator, Mac River Adolescent Drug and Alcohol Rehabilitation Centre, said empathy and understanding support young people through their treatment.

*'[U]nderstanding and acknowledging where the young people have come from, what their history is, so that then we can put the right services in place for them, and what – what therapies they need to support them through their journey.'*<sup>73</sup>

- 8.33 It is also necessary to address the various practical barriers that can hinder young people accessing services. Active and assertive follow up by service workers to ensure young people remain engaged with the service may be crucial.<sup>74</sup> The involvement of family members or carers in a young person's treatment was described to the Inquiry as the 'gold standard'.<sup>75</sup> A focus on harm minimisation is important in order to minimise both the physical risks of substance use and also the longer-term development risks associated with harmful drug use in early adolescent years.<sup>76</sup> The Inquiry heard there is a need to assist young people with practicalities such as explaining the location of the service, parking and public transport arrangements, as clients may have varying abilities to negotiate such issues.<sup>77</sup>

- 8.34 The Inquiry was able to consider the programs provided by the Youth Drug and Alcohol Service (YDAS) of the Hunter New England Local Health District (LHD). YDAS is a tertiary-based service that provides clinical interventions to young people aged up to and including 18 years who have a moderate to severe substance use problem.<sup>78</sup> Dr Krista Monkhouse, Staff Specialist at the service, emphasised the need for mental health support and wraparound services for young people.<sup>79</sup> Dr Monkhouse also provided the Inquiry with her views as to what other features are desirable in an AOD service for young people. These include the co-location of child and adolescent mental health and other services in a similar space that is youth-friendly, non-clinical in appearance and which operates during hours more amenable to young people's daily routines. Such co-location of services would allow better case management of a young person across services.<sup>80</sup>
- 8.35 The Inquiry heard in evidence and submissions that there is a lack of youth-specific AOD services across the state, creating a significant barrier to treatment and support for young people. Although NSW Health advised the Inquiry of various initiatives it had funded from the 2016 Drug Package for youth treatment,<sup>81</sup> evidence given at the regional hearings suggests there is a need for greater provision of services for young people. The closest youth detoxification facility in western NSW, for example, is at Nepean Hospital in Sydney's west.<sup>82</sup> The need to leave family and other supports to access treatment causes both physical and emotional stress.
- 8.36 The Inquiry was told that there are no detoxification beds across the state for young people aged under 16.<sup>83</sup> Witnesses from western and northern NSW indicated the need for youth detoxification facilities in their local region.<sup>84</sup> Lismore City Council's Social Justice and Crime Prevention Committee identified the need for such a service in the Lismore area.<sup>85</sup> A submission from the NSW Council of Social Services outlined there are insufficient or no supports for young people with drug and alcohol dependence in the Hunter New England area, with Coffs Harbour and Dubbo being the closest rehabilitation facilities for young people in Tamworth.<sup>86</sup> The Inquiry also heard that there are no community-based withdrawal, detoxification and rehabilitation services for young people in the Nowra region.<sup>87</sup> The lack of a youth detoxification facility in Moree, and the difficulties this causes for youth in contact with the criminal justice system there, was the subject of evidence at the Moree Hearing.<sup>88</sup> Another witness at that hearing noted the absence of youth-specific AOD services in many other northern NSW towns, including Armidale, Walgett, Gunnedah, Inverell and Glen Innes.<sup>89</sup>

## Lesbian, gay, bisexual, trans and queer and intersex people

- 8.37 The lesbian, gay, bisexual, trans, queer and intersex (LGBTQI+) communities make up a diverse group of individuals. There is research evidence that people who identify as lesbian, gay, bisexual and/or trans have a higher prevalence of use of alcohol and other drugs compared with the general Australian population.<sup>90</sup>
- 8.38 Evidence concerning ATS use (and other illicit drug use) predominantly focuses on gay, bisexual and queer men.<sup>91</sup> There is considerably less evidence about ATS use among lesbian, bisexual and queer women,<sup>92</sup> and even less evidence regarding trans, gender diverse people and non-binary people.<sup>93</sup> The Inquiry has not been able to identify any reliable evidence concerning the use of ATS by intersex people.<sup>94</sup>

- 8.39 Nicolas Parkhill, CEO, ACON, described the diversity of the LGBTQI+ community and said drug use among LGBTQI+ individuals differs to that of the general population.

*'I think it's important to make note that drug use for our communities ... is significantly higher for our communities than the general population. And the way that use occurs is contextual and culturally very, very different to how it occurs in the broader community as well. It's also, I think, important to note that, within that broad framing around lesbian, gay, bisexual, transgender and queer framing, there are very diverse populations within that collective, if you like, and so how a gay man of the age of 45 might use drugs will be very different to how a lesbian may use drugs at the age of 20.'*<sup>95</sup>

### ATS use by LGBTQI+ people

#### Lesbian, bisexual and queer women

- 8.40 Lesbian, bisexual and queer women tend to use drugs at higher rates than the general population. The prevalence of lifetime and recent use of ecstasy and methamphetamine are greater among lesbian and bisexual women compared with other women. One analysis of the 2013 NDSHS showed that among lesbian and bisexual women, in the 12 months before the survey, 8% recently used ecstasy and 4.7% recently used methamphetamine. This compares to 1.6% (ecstasy) and 1.3% (methamphetamine) for women in the general community.<sup>96</sup>
- 8.41 The Sydney Women and Sexual Health (SWASH) survey is a comprehensive study conducted every two years about the sexual health and wellbeing of lesbian, bisexual and queer women in NSW. In 2018, the SWASH survey found that in the six months before the survey, use of ecstasy (16.3%) and methamphetamine (12.1%) was higher than reported in the NDSHS.<sup>97</sup> The higher rates among the SWASH sample may be because the study specifically targets lesbian, bisexual and queer women, rather than a general population survey where some participants identify as lesbian, bisexual or queer.
- 8.42 The use of ecstasy and methamphetamine among lesbian, bisexual and queer women mainly happens in social settings (in private homes, or at public parties), with most use occurring at public venues or parties.<sup>98</sup> A small number of lesbian, bisexual and queer women (less than 10%) use ecstasy and methamphetamine in the context of sex.<sup>99</sup>
- 8.43 There is little other evidence on the patterns of ATS use among lesbian, bisexual or queer women in Australia.

#### Gay, bisexual and queer men

- 8.44 Gay, bisexual and queer men have higher rates of drug use compared with the general community.<sup>100</sup> There is a large amount of research evidence on drug use among gay, bisexual and queer men in Australia. Research in this area has largely been framed around sexual health risk and HIV transmission.
- 8.45 The Flux Study is an online survey that explores licit and illicit drug use among gay and bisexual men in Australia. In 2017, Flux found that 20.4% of respondents reported using ecstasy and 13.4% reported using crystal methamphetamine. Rates among men in the general community are much lower at around 2.5% for both ecstasy and methamphetamine.<sup>101</sup>

- 8.46 While ATS use is higher in gay and bisexual men, this does not equate to higher levels of dependence or harms compared with other groups. In its submission, the Centre for Social Research in Health at UNSW Sydney noted that:

*‘There is a risk of inflating the “problem” of crystal methamphetamine use by equating the prevalence of use with crystal-related harm. This would be a mistake, particularly for a population (like gay and bisexual men) who are stigmatised for other reasons (such as sexuality or risk of HIV infection) and could present a barrier to help seeking.’<sup>102</sup>*

- 8.47 Gay, bisexual and queer men use drugs in a variety of settings, including to ‘chill out’ (54.0%), at dance parties (29.8%), clubs (30.8%) and with friends (45.8%) (multiple responses were allowed).<sup>103</sup>

- 8.48 Gay men described to the Inquiry their experiences of using ATS in social settings.

*‘I was involved in the party scene ... taking MDMA and other social experience enhancing drugs, as well as smoking meth socially and very infrequently.’<sup>104</sup>*

*‘My social network would use ecstasy sporadically mostly at dance parties or on a Saturday night and they used more often than I did. I first used ecstasy because I was curious about it and I wanted to fit in with the gay community. I actually didn’t really like ecstasy. I didn’t enjoy the sense of not being in control and found it hard to let go.’<sup>105</sup>*

- 8.49 In 2017, most respondents to the Flux Study who reported having used ecstasy (77.2%) said they had used it only once or twice in the previous six months and 22% had used it monthly.<sup>106</sup>

- 8.50 Just over half (51.5%) of respondents who reported having used methamphetamine had used it once or twice in the previous six months. Around one-third (32.8%) had used methamphetamine monthly, 11.1% had used it weekly and 4.6% had used it daily.<sup>107</sup> More frequent use may be associated with dependent types of use. (Types of drug use are discussed in Chapter 5.)

### Trans and gender diverse people

- 8.51 There is little evidence available about ATS use among trans and gender diverse people in NSW. The NDSHS does not include estimates for people identifying as trans.<sup>108</sup> However, other studies suggest trans people may have higher rates of drug use compared with the general community.

- 8.52 The First Australian National Trans Mental Health Study was designed to look at the mental health and wellbeing of trans people in Australia.<sup>109</sup> In 2013, participants in the study were around twice as likely to have used an illicit drug than the general population in the past 12 months. Trans men were more likely than trans women to report using ecstasy and methamphetamine.<sup>110</sup>

- 8.53 The 2018 Australian Trans and Gender Diverse Sexual Health Survey is the largest study undertaken in Australia about trans and gender diverse people, with 1,632 people completing the survey.<sup>111</sup> In 2018, 15.8% reported illicit drug use in the context of sex in the 12 months before the survey and 18.2% reported lifetime use of illicit drugs in the context of sex (more than 12 months before the survey).<sup>112</sup> There was a higher rate of use of illicit drugs in the context of sex among non-binary people compared with trans men and trans women.<sup>113</sup>

### Injecting drug use among LGBTQI+ people

Evidence indicates a higher prevalence of injecting drug use among LGBTQI+ people than in the general population (in NSW, the population prevalence of injecting drug use in 2014 was estimated to be 0.73%).<sup>114</sup>

The SWASH survey reported that 7% of respondents had 'ever injected' drugs.<sup>115</sup>

The Gay Community Periodic Survey is an annual sexual health survey about gay, bisexual and queer men. In 2018, the Sydney survey found that 3.6% of respondents reported injecting drugs in the six months before the survey.<sup>116</sup>

The Flux Study found that 4.9% of respondents reported injecting 'crystal' in the six months before the survey.<sup>117</sup>

The 2018 Australian Trans and Gender Diverse Sexual Health Survey found that 1.5% of respondents reported injecting drug use within the year prior to the survey and 5.1% reported lifetime injecting drug use (more than 12 months before the survey).<sup>118</sup>

Use of crystal methamphetamine by injecting is associated with increased toxicity, greater adverse effects on mental health and greater potential to establish dependent patterns of use.<sup>119</sup> Policy and service responses aimed at LGBTQI+ people should take into account the higher prevalence of injecting use among this population and the particular patterns of harms to which it may lead.

### Why LGBTQI+ people use ATS

- 8.54 Members of the LGBTQI+ community may use ATS for similar reasons to the general population, including for its desired effects in social settings.<sup>120</sup> However, factors unique to LGBTQI+ populations may contribute to higher use of ATS or put them at greater risk of dependence when using some forms of ATS.
- 8.55 Karen Price, Deputy CEO of ACON, described to the Inquiry a range of drivers for ATS use among LGBTQI+ people, which are reflected in the literature, including:
- 'minority stress'<sup>121</sup> (stress from stigma due to being within sexual and gender minorities)<sup>122</sup>
  - mental health<sup>123</sup> (there are higher rates of mental health conditions among LGBTQI+ people)<sup>124</sup>
  - a high likelihood of peers who use drugs<sup>125</sup> (also known as social acceptability, whereby favourable or positive attitudes exist towards illicit drug use, including through engagement in social and sexual subcultures)<sup>126</sup>
  - easy access to drugs<sup>127</sup>
  - a history of criminalised sexuality<sup>128</sup>
  - trauma<sup>129</sup>
  - discrimination.<sup>130</sup>
- 8.56 One witness described how trauma associated with sexuality was a driver of their ATS use:

*'I underwent extreme conversion therapy to change my sexuality when I was 17 and 20. My parents initiated a lot of this, but I feel as though people really didn't understand about homosexuality at that time ... I can look back now on this with forgiveness and compassion but it was traumatic.'*<sup>131</sup>

## Sexualised drug use ('chemsex')

8.57 Sexualised drug use is the practice of using certain illicit drugs to enhance sexual pleasure, adventure and enjoyment.<sup>132</sup> Also known as 'chemsex', 'party and play' or 'PnP', sexualised drug use is both a feature and driver of ATS use in some subgroups of LGBTQI+ communities. Chemsex occurs among people who use ATS regardless of their sexual orientation, but it is particularly common in the LGBTQI+ community.

8.58 The Centre for Social Research in Health cautioned about making generalisations about sexualised drug use.

*'Not all gay and bisexual men who use methamphetamine in sexual settings report problematic use, yet the relatively small proportion that do often become representative of 'chemsex' practices more generally, and the harms they experience become attributable to all men who engage in practices that combine drugs and sex.'*<sup>133</sup>

8.59 The use of ATS, particularly crystal methamphetamine, for sex can have a disinhibiting effect, which can lead to higher-risk choices such as not using condoms. Sexualised drug use may increase the risk of sexually transmitted infections and blood-borne viruses including HIV and hepatitis C.<sup>134</sup>

8.60 Some data show an association between crystal methamphetamine use and sexual risk behaviours, which could lead to HIV transmission.<sup>135</sup> However, the risk of HIV transmission during sexualised drug use may be reduced due to increased testing for HIV, high rates of uptake and adherence to HIV treatment, and use of HIV pre-exposure prophylaxis among people at risk of HIV.<sup>136</sup>

8.61 One witness told the Inquiry of their use of methamphetamine in a sexual context.

*'I became involved in the chemsex community, which involved using drugs, including meth, at sex parties. My meth use escalated and became sexualised as I established [neural] pathways that associated drug use with sex.'*<sup>137</sup>

## Impact of ATS use on LGBTQI+ people

8.62 Varying levels of social acceptability of different ATS within the LGBTQI+ community may influence an individual's use of them. For example, in one study of Australian gay, bisexual and queer men, 57.8% of respondents indicated that using ecstasy was 'very' or 'somewhat' socially acceptable among their peers, while 61.9% reported crystal methamphetamine use was 'not at all' socially acceptable among their peers.<sup>138</sup> This may mean that LGBTQI+ people who use methamphetamine are stigmatised by peers who do not use it, though their peers might use other ATS. Such stigma can be a barrier to help-seeking behaviour.<sup>139</sup>

8.63 Some gay, bisexual and queer men may associate higher levels of social connectedness with drug use. This may lead to an apprehension that reducing or stopping their use may risk their becoming socially isolated.<sup>140</sup>

- 8.64 Although the association between drug use and intimate partner violence is not unique to LGBTQI+ people, intimate partner violence between same-sex attracted couples is often hidden within broader discussions about domestic violence. In its submission to the Inquiry, ACON described an association between some forms of drug use and intimate partner violence.

*‘A more recent study of women in same-sex relationships found that women with a history of intimate partner abuse were prone to more drug and alcohol-related problems than were women who had not experienced IPV [intimate partner violence].’<sup>141</sup>*

- 8.65 A detailed discussion about ATS and domestic and family violence is in Chapter 18.

### Service needs and responses for LGBTQI+ people

- 8.66 ACON’s submission outlined the need for inclusive, sensitive, culturally appropriate and non-judgmental treatment services and harm reduction messages provided by an adequately trained workforce.<sup>142</sup> The Centre for Social Research in Health acknowledged the importance of developing culturally appropriate treatment options for LGBTQI+ people, noting that not all people using ATS need treatment.<sup>143</sup>

- 8.67 In their joint submission, Positive Life NSW and the HIV/AIDS Legal Centre noted that stigma is a barrier to providing information about safer injecting practices to gay, bisexual and queer men.<sup>144</sup> A lack of access to needle and syringe programs, harm reduction information and safer injecting practices education could lead to an increased risk of injecting-related harms, particularly among a group of people where there are higher rates of injecting compared with the general community.<sup>145</sup>

- 8.68 The Inquiry also received a submission from a member of the LGBTQI+ community who raised concerns about how a person’s use of ATS can affect partners and friends.

*‘The negative aspect of other people’s ice use encroaches on my life as a gay man in Sydney ... Partners and friends have been damaged by their use of ice ... The motivation to make this submission comes from personal grief as well as genuine concern for my community.’<sup>146</sup>*

- 8.69 A broader discussion about the impact of ATS use on families is discussed in Chapter 18.

## People living with HIV

People living with HIV have a diverse range of sexualities and genders and include people from the LGBTQI+ community. However, gay, bisexual and queer men are over-represented among people with HIV in NSW.

National data show that some people living with HIV have higher prevalence of ATS use compared with the general population and compared with their HIV-negative peers.<sup>147</sup> Although people with HIV use drugs for similar reasons as other groups,<sup>148</sup> the use of ATS among some people with HIV may be because of simultaneous experiences of stigma relating to HIV,<sup>149</sup> being a part of a sexual, gender or racial minority,<sup>150</sup> or stigmatised occupations, such as sex work,<sup>151</sup> in combination with drug use.

The Inquiry received evidence that ATS use, particularly crystal methamphetamine, occurs at a higher rate among people with HIV in NSW than the rest of the community.<sup>152</sup> Positive Life NSW and the HIV/AIDS Legal Centre noted that HIV-positive gay, bisexual and queer men are more likely to report using crystal methamphetamine than HIV-negative men (27.4% versus 8.7% in 2018).<sup>153</sup>

This point is reflected in a national survey of people with HIV in Australia, HIV Futures 9, which reported that 12.3% of respondents used methamphetamine occasionally, 5.2% used methamphetamine once a month and 4.5% used methamphetamine at least weekly.<sup>154</sup> While most people who reported using drugs for 'non-medical purposes' were not worried about their drug use, 21.8% 'agreed or strongly agreed that they were worried about their drug use'.<sup>155</sup>

Both the Gay Community Periodic Survey and the Flux Study found that gay, bisexual and queer men with HIV were more likely to report injecting drug use compared with their HIV-negative peers.<sup>156</sup> This finding is consistent with the results of HIV Futures 9, which found that 14.2% of respondents reported injecting drugs in the past 12 months and a further 16.8% indicated they had previously injected drugs, but not within the 12 months prior to the survey.<sup>157</sup>

One witness described how a HIV diagnosis had led to their use of methamphetamine:

*'In 2014, I was diagnosed HIV-positive. This came as a shock and was very traumatic for me. Because of the stigma of being HIV-positive, I carried a lot of internalised shame. I did not think that I could tell the people that I knew, and so I withdrew from friendship circles... the people I knew who took meth were non-judgmental about my HIV status. I started to use meth as a means of escape from the internalised shame and trauma of being HIV-positive.'*<sup>158</sup>

## People into contact with the criminal justice system

- 8.70 The Inquiry heard evidence of the high frequency of ATS use by people who have become involved with the criminal justice system at various junctures, from initial interactions with police, to people serving sentences of imprisonment, to those in the community on community orders.

- 8.71 The Inquiry notes, for example, the Drug Use Monitoring in Australia study (discussed in Chapter 7), which provides evidence of substantial rates of ATS use among people who have been detained by police.<sup>159</sup> Surveys conducted by the Inquiry of Local Court magistrates and District Court judges, discussed in detail in Chapter 7, have also provided a picture of the extent to which people who use ATS come before the courts in relation to non-drug criminal offending. The Inquiry has also extensively considered ATS use in custodial settings, including by people on remand or serving sentences, and transitioning into and out of custody (discussed in detail in Chapter 20).
- 8.72 People who come into contact with the criminal justice system often come from backgrounds of economic and social disadvantage which suggest they have high needs. The Justice Health and Forensic Mental Health Network *2015 Network Patient Health Survey Report*, which surveyed people in custody, showed that inmates surveyed frequently had the following characteristics:
- histories of family break up, placement in out-of-home care<sup>160</sup>
  - parents who were incarcerated during the inmate's childhood<sup>161</sup>
  - contact with the criminal justice system as a juvenile
  - low education attainment<sup>162</sup> and low levels of literacy and numeracy skills<sup>163</sup>
  - higher levels of mental health conditions<sup>164</sup> and high levels of trauma<sup>165</sup>
  - higher rates of homelessness (compared with the general population) before<sup>166</sup> and after incarceration<sup>167</sup>
  - high rates of drug use before entering custody,<sup>168</sup> during custody<sup>169</sup> and after leaving custody.
- 8.73 The Inquiry considers that each point at which a person who uses ATS can come into contact with the criminal justice system presents an opportunity for intervention, such that careful analysis of this population group as a whole is needed when AOD policies and service responses are formulated. Interventions at each stage of the criminal justice system may assist to prevent a person's further progression within it. Although intensive AOD treatment and services are required for many inmates who have entered the custodial system, those who have not yet reached that point may also have complex needs and should also be the subject of interventions. As a witness whose ATS use led them to criminal offending told the Inquiry:
- 'People need to be given the same support opportunities when they first come up on the radar with drug issues. That would be better than after they have been through the system already.'*<sup>170</sup>
- 8.74 This report considers a number of possible interventions that can take place at the different points of a person's trajectory within the criminal justice system. Initial contact between police and people who use ATS may be an appropriate point to invoke diversionary processes and referral pathways leading to involvement of health services. These are discussed in Chapter 11. The prevalence of people who use ATS appearing before the courts suggest that diversionary pathways at that stage are warranted (also discussed in Chapter 11). Effective policy and service responses to people in custody and subject to community supervision who use ATS are considered Chapter 20.

## People employed in particular occupations

- 8.75 The prevalence of ATS use is higher in certain industries and occupations than it is in the Australian general population.<sup>171</sup> ATS have a greater prevalence in occupations where heavy or continuous labour, or late shifts and long hours are required.<sup>172</sup> For example, the hospitality, construction and transport industries have a much higher prevalence of methamphetamine use (9.5%, 5.4% and 5.4% respectively) compared to other industries.<sup>173</sup> The Inquiry also heard witness evidence of ATS use by miners.<sup>174</sup>
- 8.76 Literature suggests that ATS are used in an occupational setting to improve performance on the job or to change the experience of work, including to complete a task more quickly, to improve focus and concentration and to improve confidence and stamina.<sup>175</sup> This kind of ATS use is referred to as 'situational' or 'functional' use. For some people, functional use may become dependent use.<sup>176</sup> Some individuals may already use ATS before entering an occupation, and in some cases find their drug use is '*accepted, overlooked or encouraged*'.<sup>177</sup>
- 8.77 Norm Henderson, Senior Drug and Alcohol Worker at the Weigelli Centre Aboriginal Corporation in Woodstock, told the Inquiry that many shearers use methamphetamine to get up to work in the morning and take cannabis to sleep at night, '*playing havoc with their mental health*'.<sup>178</sup>
- '[W]hen I was younger, ... it was mainly alcohol in the sheds then, but lately the shearers that we do get coming through Weigelli are using methamphetamines. Truck drivers too. We're getting a few ex-truck drivers coming through who've been using a lot of methamphetamines, and it does have a significant effect on their mental health.'*<sup>179</sup>
- 8.78 Research has found that people who use methamphetamine in an occupational context are less inclined to recognise the illicit nature of their drug use compared with those who use the drug socially.<sup>180</sup> They give themselves permission to use methamphetamine '*justifying it as a way to get the job done*'.<sup>181</sup> This can have implications for health promotion, harm reduction (including needle and syringe program use), targeting of interventions and risk of dependence.

## Occupations where ATS use occurs more prevalently

- 8.79 The Inquiry heard evidence about the range of occupations where ATS are used to enhance performance on the job, including miners<sup>182</sup> and hospitality workers.<sup>183</sup> Melissa McInnes, Drug and Alcohol Clinical Nurse Consultant for the Far West LHD, described how the Far West LHD services had come into contact with tradespeople who were known to be using ATS:

*'We've had ... an increase in tradespeople, particularly doing roofs for Broken Hill, over the last two to three years, as a direct result from the hailstorm that we had and so that brought a lot of trades people into our area ... the feedback that we're getting from some clients who are known to be using ATS, [is that] they're actually getting [ATS] from some of the tradespeople ... We've had a couple of tradespeople come in as well, either in withdrawal or seeking some assistance with their use.'*<sup>184</sup>

## Sex workers

- 8.80 Research evidence shows that injecting drug use occurs more among sex workers compared to the general community. A national sexual health surveillance network, ACCESS, records data on the health of sex workers using de-identified information from the clinical records and laboratory results of 32 sexual health clinics in NSW.<sup>185</sup> The data showed that, compared with peers who were not sex workers, male sex workers were 3.5 times more likely to report injecting drug use and female sex workers were 2.1 times more likely to report injecting drug use.<sup>186</sup>
- 8.81 The Inquiry received a submission from the Sex Workers Outreach Project, the peer-based sex workers' organisation in NSW, which noted that sex workers can come from already marginalised groups in the community, and face yet further stigma as a result of their occupation. The dual experience of stigma can be correlated with drug-seeking behaviour.<sup>187</sup>
- 8.82 There is little research specifically focused on other drivers of ATS use among sex workers in NSW or Australia. The Sex Worker Outreach Project submission noted sex workers may use crystal methamphetamine to:<sup>188</sup>
- combat fatigue from late-night shifts that may last up to 12 hours
  - increase levels of energy, engagement and connection
  - satisfy the demands of clients, who may think drug use is acceptable in settings where sex work occurs
  - deal with the impact of intersecting marginalised identities and behaviours, including LGBTQI+ identities, living with HIV and/or injecting practices
  - deal with the impact of stigma and discrimination relating to sex work
  - manage complex trauma.
- 8.83 The Sex Worker Outreach Project further submitted:
- 'Along with other Australian workers who work in the night-time industries ... sex workers often work 12-hour shifts late at night. Staying awake and functional as a night-shift worker, contrary to the body's circadian rhythms can be hard, particularly if you want to participate in life outside of work during the same daylight hours as your friends and family.'*<sup>189</sup>

## Long-haul truck drivers

- 8.84 Long-haul truck drivers in Australia and other countries have used a variety of stimulants for decades.<sup>190</sup> Stimulants refers to prescription, over-the-counter and illicit drugs and include weight loss pills, medication for attention deficit hyperactivity disorder, amphetamine and caffeine.
- 8.85 The NSW Injury Risk Management Research Centre at UNSW Sydney surveyed long-haul truck drivers in 1991, 1998 and 2005. The survey results estimated that 20 to 30% of respondents used stimulants on the job.<sup>191</sup> The findings were consistent across the three surveys.
- 8.86 Factors that may lead to ATS use among long-haul truck drivers mostly involve workplace conditions, such as time on the road and downtime between shifts, as well as the type of employment, age and experience of the driver.<sup>192</sup> Employer and worker acceptance of ATS use, as well as the availability of ATS among truck drivers, may lead a long-haul driver to use ATS while working.<sup>193</sup> Dependence may be also be a strong reason for ATS use among some drivers.<sup>194</sup>

- 8.87 Mr Henderson, Weigelli Centre Aboriginal Corporation, noted the pressures on long-haul truck drivers that motivated their use of ATS:

*'It's predominantly the younger cohort of people. With the truck drivers, it's because their deadlines are pretty full on. They've got to be in a ... certain place at a certain time, and they don't get much downtime. So they're running two or three log books and using [methamphetamine].'*<sup>195</sup>

### Impact of ATS use on people in particular occupations

- 8.88 Patterns of use among workers can move between functional and dependent use. There are greater effects on the health of people whose use is dependent compared to those who use ATS less frequently or less intensely.
- 8.89 While these effects are not unique to workers, workers may be particularly vulnerable to dependence, as described by one participant in a study on stimulant use among truck drivers. *'You get to a stage where you can't tell if you're taking [stimulants] for necessity or just because you like it, or your body craves it. It's easiest and least stressful to just tell yourself you need it to do the miles.'*<sup>196</sup>
- 8.90 Workplace culture, social acceptability and attitudes to drugs may make it more difficult for some people to change their ATS use.<sup>197</sup> ATS use may have perceived benefits on worker productivity in the short term. However, there is evidence of lost productivity due to absenteeism from ATS use, and a risk to self and others in the workplace due to incidents and injuries.<sup>198</sup> In addition, for long-haul truck drivers, there is an association between stimulant use and a higher risk of fatal crashes.<sup>199</sup> One study that analysed fatal road crashes in Australia found truck drivers who were under the influence of stimulants more likely to be at fault compared to drivers who were not under the influence of drugs.<sup>200</sup>
- 8.91 A witness to the Inquiry described how their use of methamphetamine recommenced in the occupational setting:

*'Then at 38 I had a relapse and started smoking meth – what I call crystal methamphetamine. At that time, I was living in Glebe, doing 12-hour carpentry shifts on site from 5.30 am. One of the employees was smoking ice and he told me he was using it to sustain energy. I thought to get more energy out of the day I will smoke with him. That was it. I used for three years. I did three months. I was smoking daily, and my boss found out. I lost my job and started selling ice in order to live.'*<sup>201</sup>

### Culturally and linguistically diverse people

- 8.92 Culturally and linguistically diverse (CALD) is an umbrella term to describe people who originate from countries where English is not the principal language.<sup>202</sup> The term does not include Aboriginal and Torres Strait Islander people.<sup>203</sup>
- 8.93 People from CALD communities are not always included in research, so there is a lack of literature that reports the experiences of CALD communities in NSW in relation to illicit drug use.<sup>204</sup> For example, people who do not speak English as their first language are under-represented in population-based surveys, such as the NDSHS.<sup>205</sup> The lack of research makes it difficult to quantify the extent that drug use affects people from CALD communities.
- 8.94 The National Drug Strategy has identified CALD groups as a priority population, noting that some populations *'have higher rates of, or are at higher risk of, alcohol, tobacco and other drug problems'*.<sup>206</sup>

### ATS use by CALD people

- 8.95 The Drug and Alcohol Multicultural Education Centre (DAMEC) conducts community-based research focusing on alcohol and other drug use among CALD communities. In 2004, DAMEC conducted research into the attitudes, knowledge and behaviour of six cultural and language groups in relation to alcohol and other drugs. The groups were from among the Vietnamese community, Spanish-speaking communities, Pasifika communities, Italian community, Chinese community and Arabic-speaking communities.<sup>207</sup> In all six of the cultural and language groups, lifetime use and recent use of amphetamines were well below that of the NSW general population.<sup>208</sup>
- 8.96 A more recent study that analysed data from the 2013 NDSHS also indicated a lower prevalence of meth/amphetamine and ecstasy use among CALD community respondents compared with non-CALD respondents.<sup>209</sup>
- 8.97 The Ethnic Communities' Council submitted to the Inquiry that drug use among CALD communities may be hidden due to stigma and different cultural norms: *'It is crucial and necessary to recognise the shame and taboo that is associated with the drug 'Ice' in certain CALD community groups.'*<sup>210</sup>
- 8.98 Increased stigma contributes to a risk of greater harm and a barrier to accessing support and health services among CALD people who use ATS.<sup>211</sup>

### Why people from CALD communities use ATS

- 8.99 There is little research focusing on the drivers of illicit drug use among CALD communities. It is also acknowledged that there are significant differences in the experiences between and within CALD communities. However, in its submission, DAMEC identified factors that may contribute to AOD use by people from CALD communities, including:<sup>212</sup>
- the loss of economic, family or social identity and disruption to traditional parenting relationships, which can affect the ability to discipline young people
  - adaptation to Australian settings where certain substances may be more widely available and tied to social practices
  - experiences of alienation and structural racism.
- 8.100 Trauma may be a risk factor for dependent or harmful use for people who have been refugees and/or have been held in detention. Submissions by the Ethnic Communities Council and DAMEC described pre-migration experiences of forced displacement and torture, and unresolved trauma as potential drivers of ATS use among some people who came to Australia as refugees.<sup>213</sup>

### Impact of ATS use on CALD people

- 8.101 Cultural and language barriers to prevention, health promotion, harm reduction and treatment services can influence how ATS use affects CALD communities. DAMEC raised the issue of the potential greater risk of blood-borne viruses (and other injecting-related harms) among CALD communities due to a lack of culturally relevant health promotion resources and campaigns about safer injecting practices.<sup>214</sup>

- 8.102 Services which are insufficiently culturally sensitive or culturally informed can be a significant barrier for people who are dependent on drugs or alcohol and are seeking support.<sup>215</sup> Approaches such as counselling may not always be an obvious starting point for someone from a CALD community,<sup>216</sup> as there may often be a lack of knowledge about the role of counsellors.<sup>217</sup> For some CALD communities, individual needs are less important than the collective needs of the family or community.<sup>218</sup> Another significant barrier is the difficulty in translating mainstream AOD concepts and frameworks into languages other than English.<sup>219</sup>
- 8.103 Stigma and discrimination play a large role in how CALD communities interact with ATS use and access support services. People from CALD communities who use illicit drugs may not disclose their drug use to other family members due to feelings of shame.<sup>220</sup> Non-disclosure can lead to greater harms than not being able to ask for help, such increased risk of blood-borne viruses among those who inject drugs.
- 8.104 Many people from CALD communities simply do not know what services are available or how to navigate the AOD, mental health and justice systems.<sup>221</sup> Difficulty in navigating the healthcare system is a common experience for many members of CALD communities, not just those seeking support for ATS use.
- 8.105 Moree Plains Shire Council described the impact on people from CALD communities, especially in rural areas:

*'In rural areas the impact on families, LGBTQI, Indigenous, CALD and other listed communities can be insurmountable. Families are affected socially, economically, emotionally and can be 'damaged' for many years. For example, in rural areas where there are CALD users, they often do not have a big circle of community to fall back on and become reliant on their own smaller circle of family and friends, and depending on their culture, can be shunned from this inner circle, which could lead to more mental health and drug use.'*<sup>222</sup>

## People with a mental health condition

- 8.106 People with a mental health condition are vulnerable to significant harms associated with illicit drug use, and they are overrepresented in some of the priority populations discussed in this chapter (including among members of the LGBTQI+ community and people in custody).<sup>223</sup> ATS use and mental health conditions frequently occur comorbidly, including where a person's pre-existing mental health condition occurs in conjunction with, but is not necessarily caused by ATS use.<sup>224</sup> People with such underlying mental health conditions are the focus of the following discussion.
- 8.107 Dr Craig Sadler, Senior Staff Specialist Addiction Medicine, and Director, Alcohol and Drug Unit, Calvary Mater Newcastle Hospital; Clinical Director Withdrawal Services Hunter New England LHD, described the complexity of needs among people with comorbid mental health conditions and drug dependence.

*'Wherever there's mental health comorbidity, which is common, with substance use, then it adds complexity to the patient and what the patient requires and the patient's ability to follow the treatment options and paths that might be presented or put forward to them.'*<sup>225</sup>

## ATS use by people with a mental health condition

- 8.108 The use of drugs among people with a mental health condition is common.<sup>226</sup> The Inquiry heard how this can frequently become harmful because, while people with a mental health condition might use drugs to help relieve the symptoms of their condition, use of ATS in turn may exacerbate those symptoms.<sup>227</sup>

- 8.109 According to the 2016 NDSHS, among people who had used any illicit drug in the past 12 months, 27% reported they had been diagnosed or treated for a mental health condition.<sup>228</sup> Among people who used methamphetamine or amphetamine and MDMA, the rate of self-reported mental health diagnosis or treatment was 42% and 27%, respectively.<sup>229</sup> According to the survey, the rates of mental health conditions among people who have used illicit drugs has increased significantly since 2013.<sup>230</sup>
- 8.110 Research into the relationship between mental health conditions and drug use has shown:
- For people with schizophrenia, drug abuse can increase after the onset of the symptoms of the condition.<sup>231</sup>
  - Some mental health conditions are more frequent among people who experience multiple drug dependence (associated with polydrug use) compared to people who experienced alcohol dependence.<sup>232</sup>
  - Higher levels of MDMA use were associated with young adults with antisocial personality disorder and attention deficit hyperactivity disorder.<sup>233</sup>
  - A diagnosis of some personality disorders in early adolescence was associated with an increased risk of dependent illicit drug use (other than cannabis) in late adolescence or adulthood.<sup>234</sup>

### Why people with a mental health condition use ATS

- 8.111 People with a mental health condition may use drugs to enjoy the effects of intoxication, or to deal with stress, in much the same way as people in the general population.<sup>235</sup> Other drivers of substance use described in the literature include:
- to mitigate the isolating impacts of some mental health conditions<sup>236</sup>
  - to facilitate social interactions<sup>237</sup>
  - to relieve the symptoms of a mental health condition.<sup>238</sup>
- 8.112 Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol Service, said that patients who have psychiatric conditions such as schizophrenia may turn to methamphetamine to counteract the 'blunting' effect of medications.<sup>239</sup> Dr Helliwell also noted:

*'We know that patients with depression may often start to use methamphetamine and find it gives them a lift initially, but we also, obviously, see consequences of methamphetamine use too. So we see drug-induced psychosis. We see – a lot of patients seem to develop quite significant anxiety disorders after prolonged crystal methamphetamine use and, obviously, depression and suicidal ideation too.'*<sup>240</sup>

- 8.113 A witness told a private hearing of the Inquiry how she turned to crystal methamphetamine because of her mental health.

*'I was sad all the time and I didn't know why ... I saw a family doctor who said I had a bit of depression and anxiety. I wasn't doing too well and I wanted to not feel sad and depressed all the time. The doctor gave me antidepressants and Xanax for anxiety. This wasn't the best for me, as it made me feel a bit high, so I wanted to get more of that... After I tried ice, it snowballed into wanting more and more... It made me forget about everything. I wouldn't know if I still had my mental health and anxiety issues, as I felt great on ice.'*<sup>241</sup>

### Impact of ATS use on people with a mental health condition

- 8.114 The Inquiry heard evidence of the difficulties that comorbid substance use can cause for those with underlying mental health disorders. Dr Sadler, Calvary Mater Newcastle Hospital, told the Inquiry that the stabilisation of a person's mental health treatment was challenging in patients who use ATS.<sup>242</sup> Dr Viktoria Sundakov, Director of Psychiatry at the Royal Prince Alfred Hospital, explained ATS use worsens underlying psychotic or mood disorders and can increase the length of treatment a person requires for them.<sup>243</sup> She stated that use of crystal methamphetamine can destabilise previously stable patients and lead to an increase in violence.<sup>244</sup>
- 8.115 A person's ATS use may make treating their mental health condition more difficult; equally, a person's mental health condition may complicate the treatment they require for their drug use. The Royal Australian and New Zealand College of Psychiatrists submitted that people who use ATS and experience mental health issues often *'fall through the gaps of the healthcare system'*.<sup>245</sup> A mental health nurse employed by the Calvary Riverina Drug and Alcohol Centre in Wagga Wagga (one of a very few such positions in AOD services in NSW), told the Inquiry how people with underlying mental health conditions may encounter stigma in conventional AOD treatment settings due to their condition and its associated symptoms, including in residential rehabilitation facilities.<sup>246</sup>
- 8.116 The adverse effects of ATS use on an individual's treatment course in the short term can result in poorer overall outcomes in the longer term. Research suggests that the use of ATS by a person with a mental health condition can lead to further social disadvantage, particularly for conditions like schizophrenia.<sup>247</sup> The Matilda Centre for Research in Mental Health and Substance Use emphasised that *'people with comorbid substance use and mental health issues also generally experience worse overall health and wellbeing compared to people experiencing these problems in isolation'*, noting that comorbid mental health issues and substance use often interact in ways that maintain one another.<sup>248</sup> Mental Health Carers NSW also noted the association between comorbid mental health and substance use disorders with higher rates of financial problems, unstable housing and suicide (among other things) than in individuals who have with solely drug dependence or mental illness.<sup>249</sup> In addition, the use of ATS among these individuals in some cases can contribute to antisocial behaviour such as criminal activity<sup>250</sup> and increased levels of social conflict.<sup>251</sup>

### Service needs and responses for people with a mental health condition

- 8.117 The provision of treatment to people with comorbid substance use and mental health disorders is discussed in detail in Chapter 14.

### Forensic mental health patients

Forensic mental health patients differ from other people in contact with the criminal justice system.<sup>252</sup> They are more likely to have 'severe' mental health conditions,<sup>253</sup> including more than one co-occurring mental health condition, very high levels of trauma,<sup>254</sup> and high levels of cognitive impairment.<sup>255</sup>

A person may come to be treated in a forensic mental health setting if:

- the court has found them not guilty by reason of mental illness and they are to be detained in a prison or hospital or conditionally released into the community
- they are unfit to stand trial and are to be detained in a correctional centre or mental health facility
- they are a correctional patient transferred for involuntary treatment
- they are in a custodial setting under a Forensic Community Treatment Order.

In 2016, the Justice Health and Forensic Mental Health Network conducted research and published the 2016 Forensic Mental Health Patient Survey (FMHPS). It found that patterns of ATS use in this cohort, while still higher than in the general community, are noticeably different to that of the population in other custodial settings. There is a higher occurrence of drug use or dependence among forensic mental health patients compared with people in other custodial settings (38% and 30.4%, respectively).<sup>256</sup>

Around half of participants in the 2016 FMHPS had ever used methamphetamine and amphetamine and around one-third had ever used ecstasy.<sup>257</sup>

The Inquiry received little conclusive evidence regarding forensic patients. However, a review into the Mental Health Review Tribunal noted that forensic patients:<sup>258</sup>

- typically come from disadvantaged backgrounds
- have often experienced trauma earlier in life
- are commonly diagnosed with a psychotic illness, and comorbidity, particularly drug use disorders.

### People with cognitive impairment

8.118 There is little research about the use of drugs among adults and adolescents with a cognitive impairment.<sup>259</sup> Within the available studies, few explore the use of stimulants.<sup>260</sup> The lack of research on prevalence and drivers of use makes it difficult to assess the extent to which ATS use is an issue among this group.<sup>261</sup>

8.119 In addition, there are inconsistencies in definitions of cognitive impairment between the law, social and medical researchers and the community, which makes researching this group of people difficult.<sup>262</sup>

### ATS use by people with cognitive impairment

8.120 Although prevalence of illicit drug use may be low among people with a cognitive impairment,<sup>263</sup> there is potential for greater drug-related harm and dependence compared with other people who use drugs.<sup>264</sup> Among people with a cognitive impairment, young people and people who are, or have been, in custody may be particularly vulnerable to drug use.<sup>265</sup>

- 8.121 People with a cognitive impairment tend to start using drugs at an older age, use fewer drugs and less often than those without cognitive impairment.<sup>266</sup> Those who do use illicit drugs display fewer symptoms of dependence but face harms leading to treatment at a faster rate compared with those who use illicit drugs in the general community.<sup>267</sup>
- 8.122 It has been suggested that patterns of use among people with cognitive impairment are varied, but that there is an association between the severity of a cognitive impairment and patterns of use.<sup>268</sup> Because of their greater physical and financial independence and access to drugs in the community,<sup>269</sup> the incidence of harmful drug use increases among those with less severe forms of cognitive impairment.

### Why people with cognitive impairment use ATS

- 8.123 Drivers of illicit drug use among people with a cognitive impairment are similar to those of the general community. However, there are vulnerabilities that come from living with a cognitive impairment that may drive illicit drug use among this group of people. Factors leading to illicit drug use may include:
- exclusion, isolation and/or feeling different with a desire to fit in<sup>270</sup>
  - symptoms of intoxication may mimic some symptoms of intellectual disability or hide differences<sup>271</sup>
  - trauma because of exploitation (sexual, physical, psychological and financial)<sup>272</sup>
  - reducing the negative affect associated with their condition.<sup>273</sup>

### Impacts of ATS use on people with a cognitive impairment

- 8.124 People with a cognitive impairment or intellectual disability may have characteristics that place them at risk of harm and dependence. Factors include:<sup>274</sup>
- not having the skills to decline the offer of drugs from others
  - not understanding the potential negative consequences of drug use
  - a lack of knowledge about drug effects and potential interactions with prescribed medications.
- 8.125 Illicit drugs may increase the severity of behavioural and emotional problems for people with mild to borderline intellectual disability, compared to those with disability who do not use drugs. One study described the following impacts on emotions and behaviour:<sup>275</sup>
- increased anxiety and depression
  - increased aggression and rule breaking behaviours
  - more intrusive thoughts
  - increased antisocial personality problems, hyperactivity and externalising problems.

### Service needs and responses for people with cognitive impairment

- 8.126 Dr Mindy Sotiri, Program Director, Advocacy, Policy and Research, Community Restorative Centre, noted the lack of suitable treatment services for people with a cognitive impairment who use ATS and who have had contact with the criminal justice system. *‘There is in the community a general absence of programs designed to work with clients who also have intellectual disability or other forms of cognitive impairment.’*<sup>276</sup>

### Case studies drawn from the UNSW Mental Health Disorders and Cognitive Disability in the Criminal Justice System Databank

Professor Eileen Baldry and Dr Ruth McCausland provided to the Inquiry six case studies of people with mental health disorders and cognitive disability in the criminal justice system in NSW who have histories of amphetamine use.<sup>277</sup> These case studies highlight the multiple and complex needs that can exist in a person's life, and how these can compound the challenges associated with their ATS use.

One case study concerned 'Roy'<sup>278</sup> an Aboriginal man with borderline intellectual disability, a personality disorder and a long history of problematic drug use and interaction with the criminal justice system. Roy's contact with police started at age 13 and his first substantial period in custody was at age 17. His offending, significantly related to the presence of his intellectual disability, escalated after this time and he also began to be hospitalised for substance use disorder and self-harm. Roy is noted to have continued to cycle in and out of custody in the last 10 years, including in relation to amphetamines.<sup>279</sup>

The authors of the case studies note they demonstrate '*the ways that disability, disadvantage and illicit drug use are routinely criminalised*',<sup>280</sup> concluding that drug rehabilitation services do not cater for people with cognitive disability, while disability services '*rarely cater for people who use drugs*'.<sup>281</sup> The studies highlight the need for specialist services and early intervention to prevent people with cognitive impairment from becoming entrenched within the criminal justice system.

## People living in regional, rural and remote NSW

- 8.127 People living in remote and very remote areas are 2.5 times more likely to use methamphetamine and amphetamine than those in major cities,<sup>282</sup> yet physical access to AOD services is limited outside of metropolitan areas. This raises distinct issues for individuals, families and communities in rural, regional and remote NSW.
- 8.128 In recognition of the effects of ATS use on these communities, the Inquiry conducted hearings in regional locations on almost half of its public hearing days. The Inquiry held public and private hearings in Lismore, Nowra, Dubbo, East Maitland, Broken Hill and Moree and met with service providers and Aboriginal stakeholders in Wagga Wagga to hear directly from people affected. A detailed account of the issues raised in the Inquiry's regional hearings is provided in the Regional Stories in Part C of this report.

### ATS use by people living in regional, rural and remote NSW

- 8.129 The 2016 NDSHS found that people who live in regional, rural and remote areas may have slightly different patterns of use of both meth/amphetamine and ecstasy compared with people who live in major cities. For example, people who live in remote and very remote areas of Australia were more likely to have used crystal methamphetamine compared to people in other areas.<sup>283</sup> These findings may not be consistent when analysing NSW-specific data from the NDSHS, due to the low sample size in remote/very remote areas.

- 8.130 One factor that affects patterns of use outside major cities is the availability of drugs. For some people living in regional, rural and remote areas of NSW, their choice of drug may be opportunistic, based on what is available. Melissa McInnes, Drug and Alcohol Clinical Nurse Consultant, Far West LHD, told the Inquiry:

*'It's more about supply and demand, or the supply ... it depends on what is actually becoming available in the town. So sometimes ... it is speed; sometimes it's ice. Other times those are difficult to get, and it may be cannabis or something other like that. There has been a couple of reports of heroin coming into the town as well.'*<sup>284</sup>

- 8.131 Dr Harrod, NSW Users and AIDS Association, described the nature of ATS use among fly-in fly-out (FIFO) workers, particularly in regional and rural NSW.

*'One of the things that we've seen is that there are communities in rural NSW who are serviced by ... the FIFO workforce, or they're on truck routes, and drugs are brought into the community ... because people are using them for work reasons, they're also selling them within those communities, and it's our experience that a lot of Aboriginal communities in rural and remote NSW are particularly hard hit by ... that sort of set of circumstances, and where there might not have been a lot of methamphetamine ... 10 or 20 years ago, it's coming in through [the FIFO workforce].'*<sup>285</sup>

- 8.132 The Inquiry has heard that Aboriginal Australians are more likely to have used methamphetamine than the non-Aboriginal population, and to have received treatment where amphetamine was the primary drug of concern.<sup>286</sup> The regions where the Inquiry held hearings had a higher proportion of Aboriginal people, ranging from 5% of the population in the Lismore Local Government Area to 21.6% in the Moree Plains Local Government Area, compared with the NSW average of 2.9%.<sup>287</sup> The Inquiry heard from police, health witnesses and service providers at all regional hearings that ATS use was prevalent in their Aboriginal communities, with serious consequences.<sup>288</sup> Chapter 16 discusses ATS use in relation to Aboriginal people and communities.

### Why people living in regional, rural and remote NSW use ATS

- 8.133 Factors that may increase the risk of drug use, including use of ATS, for people in regional, rural and remote areas include:

- lack of employment opportunities resulting in fewer people in full-time work, more people in part-time work and higher rates of unemployment compared to the NSW state average<sup>289</sup>
- reduced access to health services<sup>290</sup>
- lower levels of completion of year 12 than in urban areas<sup>291</sup>
- higher rates of mental health conditions and socioeconomic disadvantage than in urban areas and geographic isolation.

- 8.134 A witness described aspects of life in Broken Hill that may lead to ATS use there:

*'This is not a growth town. This is a three-speed economy. You've got the FIFO workers, the miners – and a lot of the miners use... You've got people who don't work on the mines. You've got a – 50% of people are receiving some Centrelink benefit and then you've got the Aboriginal people. It's not a growth town. It has dropped ... 7,000 [population] ... since I've been here ... and there's nothing ... there's just nothing for people to do here, so they turn to ice as well. There is nothing to do, especially not for people entering young adulthood.'*<sup>292</sup>

- 8.135 A mother made the following statement to the Inquiry in Moree about her son's struggle with ATS use:

*'There are no services out here. Most of the young people are on youth allowance, which is \$250 a fortnight. There is also no opportunity for young people to get further education out here... There's also no work out here. Nothing for our youth.'*<sup>293</sup>

- 8.136 There may be additional risk factors for ATS use in regional, rural and remote communities relating to discrimination. Issues of racism, homophobia, transphobia and stigma (relating to drug use or other marginalised identities) can compound both the risk of ATS use and the impacts of use. Submissions received from stakeholders in regional, rural and remote NSW noted that many of the priority populations identified by the Inquiry also make up a part of regional and rural communities.<sup>294</sup>

### Impacts of ATS use on people living in regional, rural or remote NSW

- 8.137 While each rural community faces its own challenges in dealing with the impact of ATS use, the same issues arose repeatedly at the Inquiry's regional hearings:

- lack of accessible detoxification facilities and AOD treatment, rehabilitation and support services
- barriers presented by people having to travel for treatment
- difficulty in recruiting and retaining appropriately qualified staff
- stigma that people who use ATS and their families face.

### Lack of accessible detoxification facilities and AOD treatment, rehabilitation and support services

- 8.138 The Inquiry consistently heard that people in regional, rural or remote NSW are not receiving treatment for ATS use when they need it, meaning crucial opportunities to break the cycle of drug use and reduce the associated harms are missed. One woman with experience of ATS use told the Inquiry: *'As for my experience, in that moment when you reach out for help, it is a very, very short window that you will take the help, as once you have got high again, the cycle repeats.'*<sup>295</sup>

- 8.139 Dr Sadler, Calvary Mater Newcastle Hospital, said a shortage of staff increases waiting times.

*'[T]here's only a handful of staff that work in drug and alcohol in Tamworth ... So that leads to waiting times, basically, if you've only got one person in a particular town who's the designated person for drug and alcohol assessments, drug and alcohol counselling follow up, then there's a limit to how many people they can see.'*<sup>296</sup>

- 8.140 Amanda Jamieson, Manager Client services, NSW Department of Family and Community Services (now Department of Communities and Justice), said the biggest challenge was the lack of local detoxification and rehabilitation centres, with families needing to travel to Wollongong, Canberra and Sydney. Ms Jamieson said if there are no places available at the few centres that take people needing treatment as well as their children, *'You stay at home and keep using until they can get you in.'*<sup>297</sup>
- 8.141 In a statement to the Inquiry, Jenny Taylor, Magistrates Early Referral into Treatment (MERIT) Team Leader, summarised the difficulties she has experienced:

*'In my experience, there is a lack of rehabilitation and detoxification services, even in larger towns such as Dubbo. I have experienced instances where patients have been unable to attend services due to issues including long waitlists, difficulties with travel and lack of funds. These issues can be particularly difficult for patients who live in more regional areas, especially if there are limited beds and they need to travel long distances to attend rehabilitation or detoxification services.'*<sup>298</sup>

- 8.142 Ms Taylor told the Inquiry that people who use ATS who want help and cannot get it lose motivation to attend:

*'[T]hey want the detox and rehab now, and then you're getting told there's a waiting list, and, you know, you try and engage the client, keep them engaged into that process, and then they're using ... on top of that again, then it's impacting on their families, it's impacting the community.'*<sup>299</sup>

- 8.143 One witness told the Inquiry he had to wait six months to get into residential rehabilitation, saying: *'In six months I could have been dead.'*<sup>300</sup>

- 8.144 In a statement to the Inquiry at Broken Hill, Keira Boxsell, Clinical Nurse Consultant Recovery Coordinator, Far West LHD, said: *'Problematic ATS use is not well catered for in the Far west. It has small sites scattered across a large area... There is no provision for a "detox" bed in Broken Hill and there are no residential rehabilitation centres in Broken Hill.'*<sup>301</sup>

- 8.145 Dr Andrew Olesnicky, Medical Director, Broken Hill Hospital emergency department, described the impact of lack of access to AOD treatment.

*'From an emergency department perspective, there are many instances where patients present voluntarily, seeking assistance with drug addiction (including ATS) however lack of immediate access to dedicated AOD assessment and treatment following primary contact and assessment can and does lead to relapse and disengagement from available services.'*<sup>302</sup>

- 8.146 Witnesses at the Moree Hearing told the Inquiry about the lack of treatment services in that region, particularly for young people. David Kelly, Manager of Community Health Programs, Maayu Mali Aboriginal Residential Rehabilitation Centre, said: *'There's certainly nothing even vaguely resembling a rehab, even a day program rehab, for young people anywhere within hundreds of kilometres of here.'*<sup>303</sup>

- 8.147 Cigdem Watson, Executive Manager, Centacare, Narrabri, oversees its Youth Drug and Alcohol Service. She told the Moree Hearing there is a lack of resources across local communities to assist people experiencing crystal methamphetamine dependence.

*'[I]f someone is using ice in our communities or any other drug, for example, in Narrabri we don't even have a resident doctor in the hospital. We don't have designated detox facilities, those kinds of things. We don't have any of those ... So if you've got someone who's having, let's say, a psychotic episode using ice, they – they get taken to ED. What happens then is those nurses, they don't have the training for a start to deal with a complex presentation such as drug and alcohol. They don't have specialties in that. And then they don't have designated beds. They don't have access to a specialist drug addiction – like, a professor or something like that ... It puts a lot of strain back on to the local service providers.'*<sup>304</sup>

## Barriers presented by the need to travel for treatment

8.148 The Inquiry heard long travel distances create barriers to treatment due through extra costs, a lack of transport and the need to leave home and support networks.

8.149 Madeleine Baker, Clinical Services Coordinator, Mac River Adolescent Drug and Alcohol Rehabilitation Centre in Dubbo, stated that if clients are aged over 16, the services refer them to Nepean Hospital in Sydney for detoxification.

*‘... which is obviously a long way away for our young people, so often it’s quite a scary process, particularly if they’re coming from rural areas like Bourke, Coonamble, anything like that, because it’s a big travel for them to go to Sydney ... it’s a big process for a young person to go there and then come back to us.’<sup>305</sup>*

8.150 Craig Biles, Area Manager, Central West, Juvenile Justice (now Youth Justice), described in evidence to the Dubbo Hearing the situation faced by many seeking access to treatment:

*‘They’re not rich. They don’t have access to motor vehicles, and they don’t have access to public transport networks. If you live in one of the satellite communities and ... you miss the appointment, that ... sometimes offers the opportunity to disengage.’<sup>306</sup>*

8.151 A witness told the hearing how travelling for treatment for her son had affected her family.

*‘I drove [my son] to the rehab centre [in Coffs Harbour], which was a seven-hour drive.... After three weeks in rehab, he said he couldn’t do it ... we don’t currently have a rehab centre in Dubbo, so there’s nowhere we can go to speak with someone who has drug and alcohol expertise. There are drug abuse counsellors at Community Health, but when you want to book an appointment you can be waiting two weeks to see someone.’<sup>307</sup>*

### **NSW Legislative Council inquiry into the provision of drug rehabilitation services in regional, rural and remote New South Wales**

A recent NSW Parliamentary Inquiry examined the provision of drug rehabilitation services in regional, rural and remote NSW. The Parliamentary Inquiry delivered its final report in August 2018.

The Legislative Council Inquiry received 43 submissions and held eight public hearings in six regional locations: Nowra; Batemans Bay; Dubbo; Broken Hill; Grafton and Lismore. The terms of reference of the Inquiry included a specific instruction to ‘examine rehabilitation services for those with amphetamine and methamphetamine (“ice”) addictions’.<sup>308</sup>

To avoid duplicating the work of the Parliamentary Inquiry, and in light of its scope and terms of reference, this Inquiry did not further enquire into access to drug rehabilitation services in regional NSW.

However, evidence before the Inquiry reiterates the urgency of these issues. This Inquiry considers that the Parliamentary Inquiry’s recommendations ought to be implemented as a matter of urgency.

The Inquiry made 12 recommendations:<sup>309</sup>

1. That the NSW Ministry of Health implement, as a matter of urgency, a population-based planning tool, such as the Drug and Alcohol Service Planning model, to ascertain what rehabilitation services and how many beds are required throughout NSW, and in which regions.
2. That the NSW Government significantly increase funding to drug and alcohol-related health services, and use the data gathered through the population-based planning tool as outlined in recommendation 1, to:
  - tender for the establishment of more residential rehabilitation services throughout regional New South Wales, including facilities for women and children, Aboriginal people and young people including those aged 13 to 16
  - tender for the establishment of more detoxification services throughout regional NSW, including facilities for Aboriginal people and young people
  - investigate the benefits of establishing multipurpose facilities in regional areas that provide detoxification, residential rehabilitation and outpatient services
  - fund local social services and Aboriginal Medical Services in regional, rural and remote NSW to assist in transporting patients to and from drug and alcohol treatments
  - provide incentives for qualified drug and alcohol professionals to relocate to regional areas and to upskill workers based in regional areas
  - work with universities, in collaboration with the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists, on initiatives to develop more specialists in the drug and alcohol field
  - investigate the efficacy of subsidising beds in regionally-based private, for-profit residential rehabilitation facilities to ensure more people from regional areas can access rehabilitation.
3. That the NSW Ministry of Health, as a matter of urgency, establish a central register for NSW of all available beds and facilities for drug and alcohol rehabilitation, which includes real-time data concerning wait lists and wait times; encompasses private health and medical services; and is publicly available as a resource for service providers, legal professionals and the community.
4. That the NSW Government conduct a review of the Drug Court and the Magistrates Early Referral Into Treatment program, including the feasibility of establishing them in additional regional areas.
5. That the NSW Government pilot a Drug Court in Dubbo in parallel with an increase in rehabilitation services for the area.
6. That the NSW Government:
  - commit to providing funding grants to non-government drug and alcohol-related service providers that run for a minimum of three years, with the option for a two year extension
  - advocate through the Council of Australian Governments for the Australian Government to commit to the same practice.
7. That the NSW Government establish a standards framework for the private, for-profit residential rehabilitation industry.
8. That the NSW Government ensure that public housing tenants who undertake residential drug rehabilitation or detoxification, not exceeding 12 months, do not lose their housing while undergoing treatment.

9. That the NSW Government:

- acknowledge the health, social and economic benefits of prevention of drug and alcohol abuse
- investigate the efficacy of implementing a state-wide school nurse program which includes targeting young people with preventative action and support.

10. That the NSW Ministry of Health report to the NSW Parliament annually on the progress of the implementation and outcomes of the Good Health – Great Jobs: Aboriginal Workforce Strategic Framework 2016-2020 in regards to the drug and alcohol rehabilitation sector.

11. That the NSW Government investigate the efficacy of establishing a scheme to establish a full-time local Aboriginal trainee position alongside every skilled position recruited in areas with a significant Aboriginal population.

12. That the NSW Government:

- trial adult and youth Koori Courts in various regional NSW locations for a period of 12 months
- then conduct a comprehensive review to determine the appropriateness and need for further Koori Courts in other locations in regional NSW.

The NSW Government noted in its response to the Parliamentary Inquiry that it supported (or supported in principle) recommendations 1–11, and ‘noted’ recommendation 12.<sup>310</sup>

### Difficulty in recruiting and retaining appropriately qualified staff

8.152 Clinicians and government services witnesses described difficulties in recruiting and keeping qualified staff, affecting the level of services that can be provided to patients and clients.

8.153 Dr Edward Wims, Clinical Director, Mental Health, Richmond Clarence, said community mental health services in the Lismore area would need an extra 20 clinicians for the ‘*kind of robust clinically responsive service that we would like to provide*’,<sup>311</sup> but even if the funds were available, it was questionable as to whether those positions could be filled. ‘*[U]nfortunately, in regional and particularly rural areas, despite the beauty of where we live, it is challenging finding clinicians to move into the area.*’<sup>312</sup>

8.154 The emergency department at Broken Hill Hospital’s relies on locums, with the Department’s Medical Director, Dr Olesnicky, telling the Inquiry:

*‘[W]e run mostly on locums ... outside of regular business hours, most of the medical staff, staff in our emergency department, are employed on short-term contracts, usually on a FIFO type basis for a couple of days a week, a couple of weeks ... if we were able to recruit and retain permanent staff, we would happily put them on after-hours.’*<sup>313</sup>

- 8.155 Bernadette Terry, Assistant Manager, Moree Youth Justice, gave evidence that a psychologist position had been unfilled for two years, affecting young clients.

*'We have been recruiting for that position unsuccessfully ... We've done a lot of research into it and we feel that it's due to the remoteness of Moree; that the level of skills the psychologist needs to have, we're not getting those types of people applying. So we want registered psychologists, and ... I don't believe they get enough incentives to come to a town like Moree.'*<sup>314</sup>

### Increased impact of stigma

- 8.156 The stigma that people who use ATS experience can be acute in smaller communities, affecting people's willingness to seek treatment.
- 8.157 Considerable media attention is given to the impact of crystal methamphetamine on regional, rural and remote communities in NSW. Perceptions of the impact of crystal methamphetamine in rural NSW are influenced by media reporting including the misinterpretation of data.<sup>315</sup> Media reporting tends to depict the notion of a 'rural ideal' and overemphasises the criminal nature of crystal methamphetamine use, rather than focusing on the underlying causes of dependence.<sup>316</sup>
- 8.158 Negative media portrayals add to the stigma of drug use in rural areas, according to Dr Bronwyn Hudson, GP registrar, Visiting Medical Officer, Emergency Senior Medical Officer, Byron Central Hospital. Dr Hudson said there were often *'sensationalised headlines around "ice-ravaged Lismore" or other such headlines, which paint this picture of crystal methamphetamine users as being criminals'*.<sup>317</sup>
- 8.159 Another factor that may drive this stigma is that drug-related problems can be more visible in smaller communities than in urban areas. The issue of confidentiality and anonymity in smaller communities can affect access to health promotion, harm reduction,<sup>318</sup> treatment and support services. Confidentiality is important because of the stigma associated with drug use, particularly for crystal methamphetamine and injecting drug use. A person who seeks services relating to their drug use needs to know their use will not be disclosed to others. For example, a person may not feel comfortable disclosing their drug use to the local GP if family members are seeing the same doctor. As a witness told a private hearing: *'The stigma attached to drug use is pretty horrendous. Dubbo is a small town, and everybody knows everybody.'*<sup>319</sup>
- 8.160 Confidentiality concerns may also deter people in regional, rural and remote NSW from accessing harm reduction services. There is the risk of being 'outed' as a person who injects drugs when accessing primary needle and syringe programs and electronic dispensing machines. Secondary needle and syringe programs that are part of a health service are more discreet, but there can be a risk of lack of confidentiality and discretion from staff within the health service, depending on the location and process of accessing sterile injecting equipment.
- 8.161 Submissions from a variety of stakeholders raised the issue of lack of anonymity and confidentiality as a concern for people who use drugs in regional, rural and remote NSW that can act as a barrier for harm reduction.<sup>320</sup> Clinical Nurse Consultant Joanne Lenton stated to the Broken Hill Hearing that, in her experience working within the Far West LHD, clients are concerned about the stigma and discrimination with illicit drug use and are fearful of being seen in their local community accessing a needle and syringe program.<sup>321</sup>

- 8.162 In evidence to the Moree Hearing, Ms Terry, Department of Communities and Justice, described the impact of confidentiality concerns in a small town.

*‘And because it’s such a small town, we’ve had cases where clients have said, “I don’t want to go to that service, because I know a person that works there”, or, “I’m related to a person that works there”, and they don’t want that person to know their story.’<sup>322</sup>*

- 8.163 Possible solutions to provide greater provision of AOD services in rural and remote areas are considered in detail in Chapter 14.

### **Aboriginal people and communities**

- 8.164 Aboriginal people and communities are considered in Chapter 16.

### **People experiencing homelessness**

- 8.165 People experiencing homelessness are considered in Chapter 17.

### **Pregnant women**

- 8.166 The needs of pregnant women are discussed in Chapters 14, 15 and 20.

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- <sup>2</sup> Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026* (2017) 28.
- <sup>3</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Report, 2017) 68; NSW Health Stats, 'Methamphetamine related emergency department presentations' (Web Page, 3 September 2019) [http://www.healthstats.nsw.gov.au/Indicator/beh\\_illimethed/beh\\_illimethed\\_age\\_trend?&topic=Drug%20misuse&topic1=topic\\_illi&ode=beh\\_illi](http://www.healthstats.nsw.gov.au/Indicator/beh_illimethed/beh_illimethed_age_trend?&topic=Drug%20misuse&topic1=topic_illi&ode=beh_illi); Sydney (General) Hearing, Sydney, Exhibit B, Tab 20, Jackie Fitzgerald, NSW Bureau of Crime Statistics and Research, *Submission to the Special Inquiry into the Drug ICE* (Presentation, 1 May 2019), [13].
- <sup>4</sup> NSW Health Stats, 'Methamphetamine related emergency department presentations' (Web Page, 3 September 2019) [http://www.healthstats.nsw.gov.au/Indicator/beh\\_illimethed/beh\\_illimethed\\_age\\_trend?&topic=Drug%20misuse&topic1=topic\\_illi&ode=beh\\_illi](http://www.healthstats.nsw.gov.au/Indicator/beh_illimethed/beh_illimethed_age_trend?&topic=Drug%20misuse&topic1=topic_illi&ode=beh_illi); NSW Health Stats, 'Methamphetamine related hospitalisations' (Web Page, 3 September 2019) [http://www.healthstats.nsw.gov.au/Indicator/beh\\_illimethos/beh\\_illimethos\\_age\\_trend](http://www.healthstats.nsw.gov.au/Indicator/beh_illimethos/beh_illimethos_age_trend).
- <sup>5</sup> United Nations Office on Drugs and Crime, *Drugs and age: Drugs and associated issues among young people and older people* (Report, June 2018) 15.
- <sup>6</sup> John Howard, Matt Stubbs and Anthony Arcuri, 'Comorbidity: coexisting substance use and mental disorders in young people' (2007) 11(3) *Clinical Psychologist* 89.
- <sup>7</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Report, 2017) 12; Nicola Guerin and Victoria White, *ASSAD 2017 Statistics and trends: Australian secondary students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances* (Report, December 2018) 32.
- <sup>8</sup> See, for example, Harm Reduction Hearing, Sydney, 23 September 2019, TS 4216.40-4246.35 (Vumbaca and Dr Caldicott); 24 September 2019, TS 4315.11-4321.16 (Dr Harrod).
- <sup>9</sup> Sydney (General) Hearing, Sydney, 10 May 2019, TS 389.12-22 (Ferry).
- <sup>10</sup> Sydney (General) Hearing, Sydney, 10 May 2019, TS 386.19-24 (Ferry).
- <sup>11</sup> United Nations Office on Drugs and Crime, *Drugs and age: Drugs and associated issues among young people and older people* (Report, June 2018) 15, 25.
- <sup>12</sup> See, for example, Sydney (General) Hearing, Sydney, 8 May 2019, TS 193.1-11 (Tillier); TS 198.32-35 (SG1); Lismore Hearing (Private), Lismore, 13 May 2019, TS 467.10-16 (Name Withheld); TS 481.45-6; TS 482.9-22 (Name Withheld); Dubbo Hearing (Private), Dubbo, 3 June 2019, TS 1306.8-16 (Name Withheld); TS 1345.10-35 (Name Withheld); East Maitland Hearing (Private), East Maitland, 21 June 2019, TS 2243.34-6 (Lewis); East Maitland Roundtable (Private), East Maitland, 21 June 2019, TS 2277.45-2278.16 (Name Withheld).
- <sup>13</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Report, 2017) 58.
- <sup>14</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Report, 2017) 58.
- <sup>15</sup> Sydney (General) Hearing, Sydney, 10 May 2019 TS384.39-47 (Ferry).
- <sup>16</sup> Commonwealth of Australia (Department of Health), *National Drug Strategy 2017-2026*, (2017) 27.
- <sup>17</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Supplementary Tables, 2017) Tables 5.35, 5.36.
- <sup>18</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Supplementary Tables, 2017) Tables 5.35, 5.36.
- <sup>19</sup> See explanatory note to Tables 5.41 and 5.42, Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Supplementary Tables, 2017).
- <sup>20</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Supplementary Tables, 2017) Tables 5.35, 5.36, 5.41, 5.42.
- <sup>21</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Supplementary Tables, 2017) Table 5.36.
- <sup>22</sup> Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016: detailed findings* (Supplementary Tables, 2017) Tables 5.41, 5.42.
- <sup>23</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 703, Response of NSW Health dated 3 October 2019, to Summons to Produce dated 4 September 2019.
- <sup>24</sup> Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 703, Response of NSW Health dated 3 October 2019, to Summons to Produce dated 4 September 2019.
- <sup>25</sup> Nicola Guerin and Victoria White, *ASSAD 2017 Statistics and trends: Australian secondary students' use of tobacco, alcohol, over-the-counter drugs, and illicit substances* (Report, December 2018) 74.
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- <sup>28</sup> Sally Nathan et al, 'Trends in drug use among adolescents admitted to residential treatment in Australia' (2016) 204(1) *Medical Journal of Australia* 149.
- <sup>29</sup> Sally Nathan et al, 'Trends in drug use among adolescents admitted to residential treatment in Australia' (2016) 204(1) *Medical Journal of Australia* 149.
- <sup>30</sup> Sydney (General) Hearing, Sydney, 8 May 2019, TS 153.31-47 (Professor Milroy); 10 May 2019, TS 376.3 (Noffs); TS 376.11 (Ferry); Nowra Hearing, Nowra, 31 May 2019, TS 1258.28-44 (Holmes); Dubbo Hearing, Dubbo, 6 June 2019, TS 1753.39 (Baker); East Maitland Hearing, East Maitland, Exhibit A, Tab 27B, Statement of Cigdem Watson, 14 June 2019, [37].
- <sup>31</sup> East Maitland Hearing, East Maitland, 20 June 2019, TS 2092.27 (Dr Monkhouse).
- <sup>32</sup> Sydney (General) Hearing, Sydney, 10 May 2019, TS 376.37-45 (Ferry).
- <sup>33</sup> Nowra Hearing, Nowra, Exhibit LF, Tab 31, Statement of Gabriella Holmes, 14 May 2019, [41].
- <sup>34</sup> Dan Lubman, Murat Yücel and Wayne Hall, 'Substance use and the adolescent brain: A toxic combination?' (2007) 21(8) *Journal of Psychopharmacology* 792; East Maitland Hearing, East Maitland, 20 June 2019, TS 2100.15-43 (Dr Monkhouse).

- 35 East Maitland Hearing, East Maitland, 20 June 2019, TS 2100.25-9 (Dr Monkhouse).
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## Chapter 9. Stigma

### Introduction

9.1 The damaging and pervasive impact of stigma cannot be overstated. AOD use is one of the most stigmatised activities in the world,<sup>1</sup> and ATS are some of the most socially stigmatised drugs.<sup>2</sup> Stigma stops people from seeking help from others including from health services.<sup>3</sup> Stigma has also been identified as a significant barrier to drug policy reform.<sup>4</sup> It makes it more difficult to recruit people to participate in research<sup>5</sup> and affects data collection by discouraging people from disclosing their drug use.<sup>6</sup>

9.2 The Inquiry received a significant amount of evidence about the stigma experienced by people who use crystal methamphetamine and other ATS from those with lived experience,<sup>7</sup> representative organisations,<sup>8</sup> clinicians and service providers<sup>9</sup> and in numerous submissions.<sup>10</sup> Stigma was described as entrenched, profound, damaging<sup>11</sup> and a major barrier to people seeking help.<sup>12</sup> One witness told the Inquiry:

*‘... from my personal and professional experience, the judgment, stigma and discrimination associated with ice and meth is a very real and disempowering barrier to seeking help for people who might benefit from counselling and peer support.’<sup>13</sup>*

9.3 Stigma surrounding ATS use affects both the people who use ATS and their families.<sup>14</sup> Drug-related stigma causes discrimination, marginalisation, social exclusion and poor health and social outcomes. It is a critical barrier to drug treatment and other services. People often continue to experience stigma and its detrimental effects long after they have stopped using drugs.<sup>15</sup>

9.4 Stigma is also a barrier to reducing drug harms and improving treatment. Professor Alison Ritter, Director, Drug Policy Modelling Program (DPMP), Social Policy Research Centre, UNSW Sydney, stated:

*‘Stigma and discrimination is a major barrier to almost all of what we do in the drug policy area, whether it’s harm reduction services, whether it’s treatment services, whether it’s prevention programs. It is powerful and pervasive. It is supported by a media that wants to report ... shocking stories, tragedies.’<sup>16</sup>*

9.5 Multiple factors give rise to stigma – lack of public education and understanding,<sup>17</sup> gaps in health professionals’ training,<sup>18</sup> criminalisation of drug use/possession,<sup>19</sup> media portrayals of people who use drugs<sup>20</sup> and the framing of drug campaigns.<sup>21</sup>

9.6 Reducing stigma is vital to meeting the needs of people who use ATS.<sup>22</sup> Responses to stigma require a sustained and comprehensive approach that addresses these factors. Of particular significance to that approach are addressing media portrayals of people who use drugs, and ensuring the involvement of people with lived experience of drug use in the development of drug education, prevention and harm reduction campaigns.

## What is stigma?

### Defining stigma

- 9.7 Stigma is a complex phenomenon that has been defined in many different ways.<sup>23</sup> One of the most influential definitions comes from US sociologist Erving Goffman, who argued stigma arises when society marks a person for having ‘*an attribute that is deeply discrediting*’ and reduces them ‘*from a whole and usual person to a tainted, discounted one*’.<sup>24</sup>
- 9.8 Stigma can be distinguished from discrimination in that stigma is the negative beliefs that society holds about a group of people, whereas discrimination is unfair or detrimental treatment of people belonging to a certain group.<sup>25</sup> The World Health Organization has identified stigma as a major cause of discrimination and exclusion.<sup>26</sup>
- 9.9 Stigmatisation is a multilevel process occurring at both individual and societal levels, often as a result of power, structures and institutions.<sup>27</sup> A report on reducing stigma and discrimination for people experiencing problematic AOD use for the Queensland Mental Health Commission identified stigma as being the labelling and stereotyping of difference at an individual and societal level that leads to status loss, and that relies on social structures that facilitate and create the conditions for their operation.<sup>28</sup>

### Types of stigma

- 9.10 The Inquiry heard that stigma has different forms, including social or public stigma, structural stigma and self-stigma.<sup>29</sup> Social stigma describes ‘*the phenomenon of large social groups endorsing stereotypes about and acting against a stigmatised group*’.<sup>30</sup> Structural stigma refers to the ‘*rules, policies and procedures of institutions that restrict the rights and opportunities for members of the stigmatised groups*’.<sup>31</sup> Self-stigma is the fear of being discriminated against and internalising negative thoughts and feelings as a result of identifying with a stigmatised group.<sup>32</sup>
- 9.11 The literature also identifies enacted stigma (the direct experience of discrimination and rejection by members of society) and perceived stigma (the belief that others in society hold negative stereotypes about you, whether or not they actually do).<sup>33</sup>
- 9.12 The stigma many people experience due to their drug use is frequently compounded by the interaction of sexism, racism and social disadvantage.<sup>34</sup> The Inquiry received a range of evidence about the effects of multiple stigmas. Drug and Alcohol Nurses of Australasia noted that stigma associated with AOD use is exacerbated in populations who may already be marginalised or judged, including people living in rural and remote communities, people with mental health issues, Aboriginal people, people in contact with the criminal justice system, pregnant women and LGBTQI+ people.<sup>35</sup> ACON stated that drug use, including the use of methamphetamine, has been linked to increased trauma, stigma and discrimination in LGBT communities.

*‘For more than 30 years, LGBT populations and people living with HIV have already been victims of systemic and individual discrimination, fear and hatred. Research has shown there is a correlation between men who are HIV-positive and increased use of crystal methamphetamine.’<sup>36</sup>*

- 9.13 ACON noted stigma around crystal methamphetamine use in LGBTQ+ communities creates barriers to both formal and informal help seeking.<sup>37</sup> Positive Life NSW (Positive Life) and the HIV/AIDS Legal Centre (HALC) submitted that the stigma around injecting drug use and hepatitis C infection in gay social scenes may mean many gay men who inject methamphetamine and other drugs during sex may not be exposed to harm reduction and peer education provided by needle and syringe programs as they do not identify culturally with these messages.<sup>38</sup>

9.14 Mark Ferry, Chief Operating Officer of the Ted Noffs Foundation, told the Inquiry that young people experience double discrimination for being a young person and a person who uses drugs.<sup>39</sup>

9.15 Stigma can be compounded in rural areas, where the Inquiry heard people who use ATS experience multifaceted stigma.

*'They are perceived as the 'low life' of towns as often their usage is noted by the community. Many users in our area have 'gone underground' therefore lack the confidence to seek help for their addictions.'*<sup>40</sup>

9.16 The Ethnic Communities Council submitted that it is crucial to recognise the shame and taboo associated with crystal methamphetamine use in certain culturally and linguistically diverse (CALD) community groups and suggested prevalence is often masked in these groups.<sup>41</sup>

## Stigma is a common experience for people who use ATS

9.17 The Inquiry received numerous submissions and heard from many witnesses that people who use ATS, particularly those who use crystal methamphetamine, are heavily stigmatised.<sup>42</sup> Many witnesses who gave evidence to the Inquiry of their experience with ATS spoke of their experience of stigma.

9.18 The Network of Alcohol and other Drugs Agencies (NADA) described how stigma is experienced by people who use illicit drugs:

*'They are very often considered as not part of 'normal' society and are commonly labelled as deviants, diseased, unemployed, uneducated and criminals. Stigma involves processes of labelling, stereotyping, social ostracism, exclusion and extrusion and are all essential ingredients for discrimination. Experiencing stigma, over any time period can have devastating effects.'*<sup>43</sup>

9.19 The 2013 national Illicit Drug Reporting System data showed that nearly half of respondents (47%) reported experiencing discrimination in the past 12 months.<sup>44</sup> The Australian Injecting and Illicit Drug Users League's 2015 survey also found survey participants commonly experienced discriminatory treatment related to their drug use or health status.<sup>45</sup>

9.20 A 2018 study of people who use drugs and alcohol in Queensland found stigma and discrimination were common everyday experiences.<sup>46</sup> Professor Kate Seear, Associate Professor in Law at Monash University, told the Inquiry that her research identified that people who use drugs in Queensland experienced significant and sustained stigma in a wide range of settings, particularly in health care, employment and within the family. She said this stigma can last a lifetime.<sup>47</sup>

9.21 This experience is consistent with research from around the world. The World Health Organization rates dependence on illegal drugs as the most stigmatised health condition.<sup>48</sup> Other research confirms that the level of stigma attached to problem drug use is higher than that ascribed to most other stigmatised groups,<sup>49</sup> including people with mental illness who have been traditionally very stigmatised by society.<sup>50</sup> This drug-related stigma is even more intense for people who inject drugs.<sup>51</sup>

9.22 Of all illegal drugs, crystal methamphetamine is one of the most stigmatised substances. In a 2018 Australian survey about the National Drug Campaign, respondents most commonly identified crystal methamphetamine as the most dangerous drug (65%) compared to ecstasy (11%) and MDMA (4%).<sup>52</sup>

- 9.23 In relation to crystal methamphetamine use, the Centre for Brain and Mental Health Research and Matilda Centre for Research in Mental Health and Substance Use (Centre for Brain and Mental Health and Matilda Centre) reported to the Inquiry the results of an online community survey, which showed stigmatising attitudes to people who use crystal methamphetamine are common in Australia.<sup>53</sup> The study surveyed a large sample of Australian residents, including people who use crystal methamphetamine, their family and friends, health professionals and general community members. The survey found that 45 to 65% of respondents judged people who use crystal methamphetamine negatively. The survey also identified that 70% of people who use crystal methamphetamine at least once a month or more said they had experienced some form of discrimination because of their use.<sup>54</sup>
- 9.24 US research with people who use methamphetamine found almost all participants (96%) agreed or strongly agreed that people hold negative stereotypes of people who use methamphetamine and will treat someone differently if they are found to use methamphetamine (92%). More than two-thirds of participants (69%) reported family members treated them differently and more than half (56%) said they had lost friends because of their methamphetamine use.<sup>55</sup>
- 9.25 Stigma is not confined to the person using drugs.<sup>56</sup> A survey by the Australian Injecting and Illicit Drug Users League showed that partners, children, other family members, colleagues and friends had been affected by stigma and discrimination in relation to their relative or friend's drug use.<sup>57</sup> Research by the Drug and Alcohol Multicultural Education Centre noted that fears about consequences of shame and stigma related not only to the individual but extended to their whole family.<sup>58</sup> The Inquiry also heard evidence that stigma can extend to residents of housing communities that have a reputation for drug use.<sup>59</sup>
- 9.26 Stigma can also extend to treatment and support services for those who use drugs.<sup>60</sup> Dr Marianne Jauncey, Director, Uniting Medically Supervised Injecting Centre, told the Inquiry the reality is that '*... anything to do with drugs, drug treatment or drug use is still very much a stigmatised activity and one that is associated with much shame*'.<sup>61</sup> Several health professionals pointed out that staff who work in AOD services with people who use ATS also experience stigma and this could be a reason for difficulties in recruiting staff to the sector, particularly in regional and rural areas.<sup>62</sup>

## The impact of stigma

- 9.27 The Inquiry received powerful evidence from many lived experience witnesses about the impact of ATS-related stigma on their lives.<sup>63</sup> One witness said:

*'Stigma is a major issue. It took me two years after finding out about drug issues before talking to anyone about it. Stigma makes it hard to engage with services because you don't want local workers to know what is going on [sic] your family. Pushing through the stigma is so hard, people judge you negatively for what they know nothing about. I now hold my head high in my small community but in the past, I avoided social situations just so I didn't have to explain my world. The media add to the stigma with the continual sensationalising of ice users. Not all ice users are violent and nasty, many are high functioning members of society that eventually see their use catch up with them.'*<sup>64</sup>

- 9.28 Annie Madden, founding member of Harm Reduction Australia and former CEO of the Australian Injecting and Illicit Drug Users League, described how stigma affects people who use drugs.

*'And worse, stigma kills people. It is not only a lifelong, you know, affliction that people live with, you know, that they find very hard to engage as a member of society ... it kills – people die in a room next to someone else from drug-related overdoses because they're too ashamed to tell someone who loves them that they've got an issue.'*<sup>65</sup>

- 9.29 Many submissions to the Inquiry described how stigma affects people who use ATS. The Inquiry heard that stigma has been shown to worsen stress, reinforce differences in socioeconomic status, delay or impede help seeking and lead to premature termination of treatment.<sup>66</sup> Stigma affects people's mental health and self-esteem<sup>67</sup> and can make people feel worthless or hopeless, in turn triggering them to use AOD.<sup>68</sup>

- 9.30 There is general agreement in the literature that the effects of stigma on people who use drugs, including those who use ATS, are profound, multiple and long-lasting.<sup>69</sup> Stigma and discrimination negatively affect people who are often already marginalised and vulnerable in society.<sup>70</sup> The literature describes how stigma leads to discrimination, rejection and ridicule,<sup>71</sup> with '*powerful expectations of rejection*' eroding confidence and impairing social and occupational functioning.<sup>72</sup> The harmful effects of stigma can persist after drug use has stopped.<sup>73</sup>

- 9.31 These effects are also demonstrated in Australian research. An Australian study found that stigma has a substantial impact on the lives of people who use drugs and affects how they see themselves and the world around them.<sup>74</sup> Participants in the study reported that drug-related stigma and discrimination made them feel degraded, ashamed and angry.<sup>75</sup> The Australian Injecting and Illicit Drug Users League's 2015 survey of people who use drugs or have a blood-borne virus concluded that experiencing stigma in the long term or even for a short period of time can have devastating effects.<sup>76</sup>

- 9.32 The literature consistently highlights how stigma can adversely affect the physical and mental health of people who use drugs and their families.<sup>77</sup> The mental health impacts of drug-related stigma include chronic stress,<sup>78</sup> internalised blame,<sup>79</sup> low self-esteem<sup>80</sup> and depression.<sup>81</sup> The Australian Injecting and Illicit Drug Users League's research showed stigma wears people down, isolates them and can often lead people to feel suicidal.<sup>82</sup> The debilitating effect of stigma on the mental health of people who use drugs is a key obstacle to their recovery.<sup>83</sup>

- 9.33 Several studies suggest the adverse effects of stigma on the mental wellbeing of people who use drugs can further contribute to their drug use. Participants in a 2018 Australian drug and alcohol study talked about how stigma and discrimination triggered feelings of worthlessness and hopelessness, which led them to give up on seeking change and continue to use drugs.<sup>84</sup> Evidence to the Inquiry also identified that stigma can perpetuate drug use.<sup>85</sup>

*'[W]here you're criminalised and where you're stigmatised very broadly in society and the media, you internalise that and it will – you know, that in itself will feed drug use, because the drugs give you a temporary respite from that pervasive kind of thing that you feel.'*<sup>86</sup>

## Stigma is a barrier to treatment and services

- 9.34 One important impact identified by a number of witnesses and submissions is that stigma prevents people from seeking help.<sup>87</sup> One witness described how stigma prevented them from accessing help earlier.

*‘Although I don’t present as the typical drug addict, the stigma is generally out there ... because of the stigma associated with addiction... you don’t ask for help ... reducing that stigma enough to be honest and saying, “This is who I am” and “This is what I do” without judgment allows me to get help. So it’s – it really is a lot of the stigma around just the word “addict”.’<sup>88</sup>*

- 9.35 This experience is also consistent with the academic literature. An Australian systematic review of methamphetamine and amphetamine treatment barriers found stigma or embarrassment was the most commonly cited barrier across all studies.<sup>89</sup> The person who uses drugs is reluctant to seek help due to internalised stigma,<sup>90</sup> or they are reluctant to disclose their drug use when they do access services due to fear of judgment and discrimination from service providers.<sup>91</sup>

- 9.36 The Inquiry received a large body of evidence, including submissions and oral evidence from lived experience witnesses and service providers, that showed how ATS-related stigma adversely affects people’s access to treatment.<sup>92</sup> Directions Health Services submitted to the Inquiry that stigma makes it hard for people who use ATS and their family members to seek help.

*‘ATS users are often reluctant to seek treatment not only because of the negative stereotyping of ice users, per se, but compounded by the negative perceptions of injecting drug use practices, frequently by the healthcare professionals they seek assistance from.’<sup>93</sup>*

- 9.37 At the Moree Hearing, David Kelly, Manager, Community Health Programs, Wellington Aboriginal Corporation Health Service, said the combination of ATS-related stigma and living in a small community meant people had to leave their town to access residential AOD treatment services with privacy.<sup>94</sup>

- 9.38 Cessnock City Council identified through community consultation that:

*‘People were hesitant to seek treatment and support because of stigma that was associated with different types of services. A fear of consequences such as losing custody of children or accommodation options acted as a barrier for some groups in accessing AOD services. In particular, parents were hesitant to acknowledge dependence or refer themselves to services because of a fear of losing custody of their children and homeless young people felt their accommodation options became limited when they indicated they were regular users.’<sup>95</sup>*

- 9.39 Edwina Lloyd, Councillor, Lismore City Council, described to the Inquiry how stigma creates a barrier to seeking treatment.

*‘I know this because that’s actually what happened to me. I spent many years living in shame experiencing substance use disorder. And I was too embarrassed to ask for help. I felt like a bad person, I felt like a criminal. And now I know I was experiencing a chronic health issue. And I’m one of the lucky ones who was able to make it out the other side to tell the tale.’<sup>96</sup>*

## Stigma in healthcare settings

- 9.40 The Inquiry also heard that stigma affects the way people are treated in healthcare settings. Dr Mary Harrod, CEO, NSW Users and AIDS Association (NUAA), stated that in her organisation's experience *'drug users are frequently treated very poorly in hospital, clinic and general practice settings'*.<sup>97</sup> Lived experience witness Robyn Lewis told the East Maitland Hearing (Private):

*'Over the years, I had been to drug and alcohol counselling with counsellors that had no lived experience of ice ... I was also seeing a gambling counsellor ... She wasn't very receptive of me and judged me for my ice use. The counsellors didn't have any lived experience and acted like I had leprosy or I was someone to be feared. She said things that made me really uncomfortable, so I only went a few sessions and then stopped going. I didn't seek any more help from her or from the other counselling groups in the area for about 12 months.'*<sup>98</sup>

- 9.41 Ms Madden, Harm Reduction Australia, told the Inquiry that: *'... the only reason ... someone accesses the healthcare system is because they need help, and the best our healthcare system can do is to say, "You're a piece of rubbish. Go away. We are not interested."*'<sup>99</sup> Odyssey House submitted that its clients who present to general health services or other non-AOD-specific services experience stigma from both professional and non-professional individuals, which affects their access to services.<sup>100</sup>

- 9.42 The Inquiry heard evidence from numerous healthcare professionals that stigma against people who use ATS is present in hospitals<sup>101</sup> and other health settings such as general practice.<sup>102</sup> Many health professionals acknowledged to the Inquiry that stigma exists among healthcare professionals and is a barrier to the person accessing treatment.<sup>103</sup> Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol Service, said:

*'I think stigma is one of the most difficult things that our patients encounter in engaging with treatment... They're barely keeping their noses above water, as far as their lives are concerned, yet they're seen as some sort of, you know, burden on the system, whereas, in fact, this cohort of patients carry a high degree of morbidity and mortality.'*<sup>104</sup>

- 9.43 Dr Bronwyn Hudson, GP Registrar Visiting Medical Officer, Emergency Senior Medical Officer, Byron Central Hospital, suggested fear of stigma and discrimination is part of the reason people who use ATS do not access healthcare services for their drug use.<sup>105</sup>

*'[W]hen my patients suggest to me that they won't go to an emergency department in an emergency for fear of stigma and discrimination, that concerns me because there's nowhere else for them to go, and the perceived stigma for them is a real barrier to attending emergency departments.'*<sup>106</sup>

9.44 This is consistent with the literature, with many studies showing that negative attitudes and beliefs about people who use drugs are common among health professionals. This stigma can mean people who use drugs receive lesser quality care<sup>107</sup> and may even be denied treatment in some instances.<sup>108</sup> These discriminatory experiences discourage people from seeking help in the future.<sup>109</sup> Research notes that not all people who use drugs have negative encounters with health professionals, and most tend to have a mix of positive and negative experiences. Studies indicate that people with drug dependence can be difficult to deal with in a hospital setting, but this largely arises from the poor behaviour of a minority. The literature suggests stigma tends to reflect a lack of staff training in treating this group.<sup>110</sup>

9.45 The Inquiry heard from a range of health professionals about the possible causes of drug-related stigma in healthcare settings. Dr Ian Spencer, a GP and Visiting Medical Officer at Wellington Hospital, said stigma in emergency departments is often linked to a combination of the person's challenging behaviour while under the influence of crystal methamphetamine and under-resourced and stressed hospital staff.<sup>111</sup> Dr Adrian Dunlop, Director and Addiction Medicine Senior Staff Specialist, Drug and Alcohol Clinical Service, Hunter New England Local Health District (LHD), suggested stigma was due to the pressures of the environment.

*'[W]e talked before about the issue of stigma and, unfortunately, it's very common in medical and nursing staff, especially in acute hospital settings, that to some degree are like pressure-cooker settings a lot of the time. There's the ED four-hour target to be met. There's discharge targets to be met. There's bed efficiency targets to be met all of the time, so it is a high-pressure environment.'*<sup>112</sup>

9.46 Rhiannon McMillan, an AOD Clinical Nurse Consultant, told the Inquiry's Dubbo Hearing that she had witnessed cases where patients presented to the emergency department with a fractured bone but were not given pain relief because they injected drugs.<sup>113</sup> She said this discriminatory treatment was primarily due to a lack of understanding and education. *'When I did my undergrad nursing degree we were given an hour's drug and alcohol education in that. It's not enough, so it's not necessarily people being nasty or – it's just that they don't know.'*<sup>114</sup>

9.47 Dr Marcia Fogarty, Executive Director of Mental Health for Hunter New England LHD, said she believes stigma comes from some health professionals' beliefs that the person is responsible for their drug use, unlike someone with a mental health issue.

*'[W]ith substance use, I think sometimes people feel, well, you've actually caused this yourself. You've chosen to take these drugs that are causing this, and particularly when people continue to do it. Like, you can understand somebody taking something once that they think is a party drug and all their mates say, "Yes, this is a good thing", and it has this effect on them, but when they do it again two weeks later you think, "What are you doing?"'*<sup>115</sup>

9.48 Several medical witnesses said stigma is not a barrier to health treatment,<sup>116</sup> because they believe it does not affect the way they provide services<sup>117</sup> or they are not aware of stigma as a barrier to treatment.<sup>118</sup> Dr Scott Clark, Clinical Director, Mental Health and Drug and Alcohol Services, Western NSW LHD, said he is not aware that stigma is a barrier to accessing drug treatment or mental health services and that he has not observed discrimination when people present for treatment.<sup>119</sup> *'I actually would say that our staff work very hard to be objective, caring and accepting, sometimes in very, very difficult and challenging circumstances.'*<sup>120</sup>

- 9.49 The Inquiry also heard of positive experiences with health professionals that helped to overcome the effects of stigma. One witness told the Inquiry:

*'I found it hard to reach out to services because I didn't want to be judged. I didn't want anyone to know. I always tried to look like I never used because it was embarrassing ... On the other hand, hospitals were always good with me even though they knew I was using. I would feel embarrassed and I wouldn't want to show them my arms for things like blood tests, but they told me it was okay.'*<sup>121</sup>

- 9.50 These varying experiences and perspectives demonstrate much of the complexity in addressing stigma. However, the balance of the evidence is that stigma continues to be a barrier to health treatment. Professor Daniel Fatovich, Professor of Emergency Medicine at the University of WA and Director of Research at Royal Perth Hospital, observed that even perceived stigma can act as a barrier to treatment.<sup>122</sup>

### Stigma affects efforts to respond to drug use

- 9.51 Stigma can be a significant barrier to drug policy reform.<sup>123</sup> Research has found that stigma affects people in multiple ways,<sup>124</sup> and has the potential to adversely affect all aspects of a person's life.<sup>125</sup> Studies emphasise several areas where stigma may produce negative outcomes for people who use drugs, including in securing employment,<sup>126</sup> housing,<sup>127</sup> accessing justice,<sup>128</sup> and social inclusion.<sup>129</sup> Evidence provided to the Inquiry indicates that stigma affects the ability of parents to have children restored to them<sup>130</sup> and it makes it difficult to access social services, including employment services and housing.<sup>131</sup> Several of these matters are explored further in other chapters, including Chapters 17 and 18.

- 9.52 As the UK Drug Policy Commission observed, these broader impacts of drug-related stigma have serious consequences for government policy. Stigma undermines efforts to help people who use drugs to tackle their condition, recover and reintegrate into society.<sup>132</sup>

*'Key policies seeking greater reintegration and recovery, moving people from benefits into work, and a focus on public health will not succeed while stigmatising attitudes are pervasive ... people will be reluctant to acknowledge their problems and seek treatment, employers will not want to give them jobs, landlords will be reluctant to give them tenancies and communities will resist the establishment of treatment centres. As a result, drug problems will remain entrenched rather than overcome.'*<sup>133</sup>

- 9.53 Dr Alex Wodak AM, President, Australian Drug Law Reform Foundation, told the Inquiry that stigma not only damages people, it damages health and social systems that are struggling to help people with drug problems, for example by leading to reduced funding and difficulty in recruiting staff.<sup>134</sup> Stigma was also identified as negatively affecting the ability of people who use drugs to speak up on their own behalf.<sup>135</sup>

- 9.54 Associate Professor Rebecca McKetin, National Drug and Alcohol Research Centre (NDARC), UNSW Sydney, identified that the stigma around drug use makes it more difficult to recruit people to participate in research<sup>136</sup> and affects data collection by discouraging people from disclosing their drug use.<sup>137</sup> Australian researchers found stigma may impede the reliable measurement of prevalence of drug use as it increases the tendency for people to under-report their lifetime use of drugs. This makes it difficult to rely on household surveys to observe trends in patterns of use.<sup>138</sup> As is discussed further in Chapter 7 and Chapter 21, accurate and reliable information about drug use is an important tool in drug policy.

## What gives rise to stigma?

### Stigma comes from many sources

- 9.55 Drug-related stigma comes from multiple sources, including family members, friends, neighbours, co-workers, media and service providers.<sup>139</sup> Various studies highlight the negative attitudes of health professionals towards patients with substance use disorders.<sup>140</sup> People who use drugs may also stigmatise people who use other drugs based on the relative social acceptability of different drugs.<sup>141</sup>
- 9.56 Consistent with the evidence to the Inquiry, recent research has identified that stigma and discrimination are commonly experienced in health care/public health, welfare and support services, police and criminal law and in the wider society.<sup>142</sup> Studies have identified other situations where stigma and discrimination are experienced, including in employment,<sup>143</sup> and in interactions with family.<sup>144</sup>

### Social norms

- 9.57 Stigma about drugs and the people who use them occurs due to societal norms characterising the use of illicit drugs as bad or deviant.<sup>145</sup> These norms are reflected in pejorative labels often attributed to people who use drugs, such as ‘addict’, ‘junkie’, ‘deviant’, ‘delinquent’ and ‘criminal’.<sup>146</sup>
- 9.58 Society’s attitudes to drugs and particular types of drug are constantly shifting.<sup>147</sup> While all illegal drugs are stigmatised to varying degrees, there is broad consensus that the level of stigma differs according to the type of drug.<sup>148</sup> At different times, certain drugs have been viewed as more or less socially acceptable.<sup>149</sup> As has been identified already, methamphetamine is particularly stigmatised.
- 9.59 Dr Jonathan Brett, Staff Specialist in Clinical Pharmacology, Toxicology and Addiction Medicine, St Vincent’s Hospital, described to the Inquiry anecdotal reasons for stigma around people who use drugs, particularly people who use amphetamines. He said people who use ATS are often more visible as they may be active, disruptive and unable to control their impulses.

*‘I think things are changing slowly, but the general public perception – well, in addiction medicine we are where we were maybe 10 or 20 years ago with mental health, as in, [people think] this is your fault ... Attributing blame to the person who is using.’<sup>150</sup>*

- 9.60 The method of drug administration also influences the level of social acceptance and stigma. Research has shown that taking drugs in a pill form is less stigmatised than injecting drugs,<sup>151</sup> and that people who inject drugs are one of the most stigmatised groups in society.<sup>152</sup> The Inquiry received evidence that people who inject drugs experience compounded stigma that is significantly greater than those who take drugs by other means.<sup>153</sup>

### Public misunderstanding and misinformation

- 9.61 There is evidence that stigma is related to widespread public attributions of blame and perceived danger.<sup>154</sup> Surveys of community attitudes repeatedly link negative attitudes about people who use drugs with notions of personal responsibility.<sup>155</sup>
- 9.62 Stigma comes from the perception that drug use is within a person’s control and therefore they are responsible for their condition.<sup>156</sup> Drug use is believed to be a moral failing and people who use drugs are seen as morally weak, despite the complex biological, cultural, social and political–economic factors that shape drug use.<sup>157</sup> The importance of social determinants of drug use is explored further in Chapter 3.

- 9.63 Dr Mary Harrod, NUAA, described the impact of *'pervasive stigma'*.

*'As the leader of a community of people who use drugs, I often hear the reasoning of "they did it to themselves, they put the pill in their mouth" which to me equates to "they deserve to die". Imagine saying this for any other chronic health condition or only funding type 1 diabetes or the treatment of childhood cancer? We can't because it's outrageous.'*<sup>158</sup>

- 9.64 Work in Britain in 2010 noted that there is limited public understanding of the complex and interrelated causes of drug dependence,<sup>159</sup> which is consistent with the evidence before the Inquiry about the need to understand the journeys of people with lived experience to better comprehend the nature of the problem in Australia.<sup>160</sup> Dr Helliwell, Riverlands Drug and Alcohol Service, said *'we need to keep educating the public'* to address issues of stigma.

*'I think we need to always be reminding the public that treatment does work, with time, and I think we need to improve people's understanding that substance dependency is not a lifestyle choice. It's often a consequence of quite significant childhood trauma and other traumas during people's lives.'*<sup>161</sup>

### Criminalisation contributes to stigma

- 9.65 The Inquiry heard evidence that the criminalisation of drug use and possession contributes to stigma.<sup>162</sup> Cr Lloyd, Lismore City Council, said stigma begins with the criminalisation of illicit substances.<sup>163</sup>

*'[A]s long as substances are criminalised, people using them will be stigmatised, alienated and they'll suffer more harm. For many people, though, using substances does not lead to experiencing substance use disorder and they're not actually harming anyone, yet arresting and charging, convicting, we're causing more harm, we're reducing their employment prospects, we're disrupting their lives, their relationships, alienating them, stigmatising them and separating them from community.'*<sup>164</sup>

- 9.66 Positive Life NSW and HALC submitted that the criminalisation of ATS use, especially the charge of possession of small amounts of ATS and other drugs, increases stigma and harm to people who use drugs. They cited police policy and tactics, such as strip searching, as a source of stigma.<sup>165</sup> This is consistent with the work of Australian drug policy researchers that has linked drug-related stigma to laws prohibiting drugs and law enforcement practices.<sup>166</sup> Drug-related law enforcement practices may disproportionately target certain groups through the selective or exclusionary targeting of specific populations.<sup>167</sup>
- 9.67 Prohibiting certain drugs is inherently stigmatising because it conveys a message that certain drugs are bad and therefore so are the people who use them. Dr Don Weatherburn, Adjunct Professor, University of Sydney Law School and former Director of the NSW Bureau of Crime Statistics and Research, said there is no question that prohibition generates stigma: *'That's what every criminal offence does.'*<sup>168</sup> Cr Lloyd identified that criminalising activities such as drink driving has value as a public deterrent, but this approach does not work for people with substance use disorders, who will continue to use drugs whether or not they are legal due to the nature of their dependence.<sup>169</sup>

- 9.68 Research has found that the criminalisation of substance use increases the level of stigma associated with drugs and further marginalises and excludes people who use illegal drugs from society.<sup>170</sup> A 2018 review found a number of Queensland laws had the potential to stigmatise and/or discriminate against people who use drugs due to the nature and wording of the provisions.<sup>171</sup> The potential impact of criminalisation on the stigma experienced by people who use drugs is further discussed in Chapter 11.

### Media and public messages about ATS provoke fear and stigma

- 9.69 Numerous researchers, professionals and organisations gave evidence to the Inquiry about the damaging impact of negative public messaging and media reporting of ATS use.<sup>172</sup> This evidence was also reflected in submissions to the Inquiry that identified the impact of media reporting and language. The Centre for Brain and Mental Health Research (CBMHR) and the Matilda Centre submitted to the Inquiry that messages conveyed by news media and government advertising can play a considerable role in the nature of public beliefs and attitudes regarding alcohol and other drugs.<sup>173</sup>
- 9.70 In particular, submissions and evidence to the Inquiry noted the impact of language associated with ATS use. St Vincent's Health Australia argued that the mainstream media is one of the greatest sources of stigma associated with ATS use: *'Largely, the media representation of stimulant use promotes a climate of fear. The use of terms like "scourge" and "threat to society" are anti-public health and stigmatising.'*<sup>174</sup>
- 9.71 The DPMP also noted that people who use crystal methamphetamine are particularly vulnerable to stigma and discrimination, given extensive media portrayal of these people as *'dangerous'* and *'psychotic'*.<sup>175</sup> Everymind, a not-for-profit national institute working to reduce mental ill health and suicide and improve wellbeing, developed the Mindframe media guidelines to support safe media reporting, portrayal and communication about these issues. Brydie Jameson, Everymind's Senior Project Officer, said media reporting of crystal methamphetamine in Australia is inflammatory. *'Research indicates that negative reporting can contribute to poor community attitudes, poor public perception of those who use AOD and may impact help-seeking behaviours for those who need it.'*<sup>176</sup>
- 9.72 The Inquiry heard that the slang term 'ice' for crystal methamphetamine could increase stigma. Dr Helliwell, Riverlands Drug and Alcohol Service, said crystal methamphetamine use is sensationalised and rarely associated with positive headlines.<sup>177</sup> Robyn Lewis, a witness with lived experience, told the Inquiry: *'The word "ice" scares people. They see things on the TV, like people smashing up hospitals. People are fearful of anyone on ice. Not everyone on ice is a bad person ...'*<sup>178</sup>
- 9.73 Multiple submissions identified that inaccurate or dramatic portrayals of crystal methamphetamine use may prevent people from seeking help or engaging with harm reduction messages.<sup>179</sup> The Sex Workers Outreach Project argued that successive media scare campaigns that demonised people who use drugs have turned them off to messages about drug harm.<sup>180</sup> ACON said inaccurate and dramatic media portrayal of people who use crystal methamphetamine can lead to people distancing themselves from the messaging.

*'[A] vast majority of people who use drugs, including ice, do not "look like" the images portrayed in the media, leading to a sense from users that their use is "not that bad" or that only people acting like "that" need to seek assistance ...'*<sup>181</sup>

- 9.74 Professor Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Health Australia, provided a direct observation of this effect, stating:

*'When we talk to our clients, they say, "I didn't come earlier because I didn't recognise myself in those images. I didn't feel I was that severe. Therefore, I wasn't worthy of treatment, or that isn't me." Therefore, you're not offering anything for me. So anecdotally, that actually prevented people coming forward for treatment, and we know there's an up to 10-year gap between when people first start having problems related to methamphetamine and when they seek treatment, and that's a long time in which harms can accumulate to that individual, their families and their communities.'*<sup>182</sup>

- 9.75 The Inquiry evidence is consistent with research literature, which has found that public messaging about drugs in the media, and from governments and other institutions, is a significant factor contributing to drug-related stigma.<sup>183</sup>
- 9.76 The role of media in shaping public opinion and policy making is well documented, with evidence that public concern about drug use is more influenced by the media than actual changes in reported incidence or severity of the problem.<sup>184</sup> Many studies highlight the media's sensationalist and often negative framing and reporting of drugs, which can lead to the stigmatisation of the people who use them.<sup>185</sup>
- 9.77 A 2018 Everymind review of studies of Australian media reporting of drug and alcohol found consistent evidence of alarmist reporting. The authors observed that the reported rise of drug use was often disproportionate to the actual size of the problem and was frequently inconsistent with the evidence. This exaggerated framing inaccurately shapes public perceptions and anxiety about particular drugs, contributing to '*moral panic*'<sup>186</sup> and does not allow a wider discussion of health, social and socioeconomic issues associated with drug use.<sup>187</sup> The review observed that news articles about amphetamine emphasised 'crisis' and conveyed negative value judgments of people who use amphetamine. In contrast, news articles about ecstasy focused on the damaging health consequences.<sup>188</sup> It also found that reporting of crystal methamphetamine was out of proportion to the social reality of the issue. From 2010 to 2013, Australian media reported an 'ice epidemic' while use of crystal methamphetamine remained relatively stable.<sup>189</sup> The *Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)* noted that media coverage was a contributing factor to crystal methamphetamine overtaking alcohol as the drug most people were concerned about in 2016 despite a decline in use.<sup>190</sup>
- 9.78 Other research has found that methamphetamine has been consistently and broadly constructed in the media as a 'scourge'.<sup>191</sup> Numerous publications show that the media is much more likely to negatively and disproportionately report crystal methamphetamine compared to other drugs.<sup>192</sup> NADA stated:

*'[I]t could well be argued that the media has created a "drugs crisis" through reporting of inaccuracies, unnecessary dramatisation of issues and stereotypical representations of illicit drug users. Headlines such as 'Our ice epidemic,' Western Australian, 5 April 2018; 'Ice hits schools: Our ice scourge,' Herald Sun, 18 January 2015; and 'Ice plague: Victorian-first, tests reveal alarming spread of deadly drug,' Herald Sun, 3 September 2014 all reflect a manufactured drama which conflicts with evidence.'*<sup>193</sup>

## Drug prevention campaigns can fuel stigma

- 9.79 The Inquiry heard that negative mass media and public campaigns designed to prevent drug use contribute to stigma and discrimination experienced by those who use ATS.<sup>194</sup> NADA submitted that the campaigns kept people away from treatment and made families more concerned about ATS and its harmful effects.<sup>195</sup> AOD workers observed the negative impact of a recent government mass media campaign:

*'I think many of us were quite distressed with the last lot of Commonwealth Government's television advertisements in relation to methamphetamine use. We see many users who don't fall into those categories, and I think that, you know, that actual campaign probably stigmatised our users and had more of a negative effect on them than it had in terms of a public health outcome.'*<sup>196</sup>

*'[T]hey've got the ads on at the moment where an ice user is in the emergency department and they get the stool and they smash the window ... But the problem with those is the person that [has] just started using ice or hasn't got to that stage thinks, "Well, I'm not that bad. I don't need help and I'm going to keep going with it."'*<sup>197</sup>

- 9.80 ACON also emphasised the public health impact of such campaigns, arguing in its submission that fear-based awareness campaigns stigmatise people who use drugs, feed fear in the broader community, and most significantly are more likely to drive people who use drugs away from treatment resulting in poor health outcomes. ACON referred to the evaluation findings of the National Drugs Campaign (Phase 7) and suggested that such mass campaigns are not reaching the audiences who need the information.<sup>198</sup>
- 9.81 The literature also shows that mass media drug prevention campaigns can be highly stigmatising to people who use drugs, resulting in isolation, low self-esteem and reduced access to treatment.<sup>199</sup> Campaigns are often shock based, reinforcing negative stereotypes and creating fear to deter drug use.<sup>200</sup> Mass media campaigns make worst-case scenarios seem routine and exaggerate consequences.<sup>201</sup>
- 9.82 The 2017 *Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)* noted the 'Ice Destroys Lives' campaign stigmatised people who use drugs in their portrayal of people being highly intoxicated and violent.<sup>202</sup> A 2017 study of the same campaign found it reinforced negative stereotypes of people who use ATS as dangerous and discouraged people from seeking help.<sup>203</sup> A recent evaluation of the subsequent phase of the National Drug Campaign found messaging about how to get help for crystal methamphetamine was more effectively communicated.<sup>204</sup>

## Improving efforts to address ATS-related stigma

- 9.83 The Inquiry considered a substantial amount of evidence supporting a range of strategies to reduce ATS-related stigma. This evidence indicated a need for coordinated action to address misinformation and support efforts to counteract stigmatising attitudes and behaviours. As Professor Helen Milroy, Professor of Child Psychiatry, University of WA, told the Inquiry:

*'Hopefully the more understanding we are as a society and as a treatment system, as a service system, then the better we are able to combat stigma. I think we will always have stigma, though. I think these sometimes are issues that are really difficult to manage.'*<sup>205</sup>

9.84 The body of literature on the experiences and effects of drug-related stigma has grown in recent years,<sup>206</sup> but there has been comparatively less research into effective interventions to address the causes and effects of drug-related stigma, including ATS-related stigma. Literature reviews observe the research in this area is largely inconclusive and studies do not consider the long-term effectiveness of the interventions under consideration.<sup>207</sup> However, consistent with the evidence received by the Inquiry, a 2018 literature review on reducing drug-related stigma concluded stigma-reducing interventions must be:<sup>208</sup>

- multilevel to address both the structural causes of stigma as well as individuals' discriminatory attitudes and behaviours
- multifaceted to address the wide variety of mechanisms and contextual factors that produce discriminatory outcomes
- universal or targeted and delivered in particular settings.

9.85 While the lack of research makes it difficult to definitively identify the type of interventions likely to be effective,<sup>209</sup> interventions have been found to show promise<sup>210</sup> or are supported by comparison with other health-related fields, including mental health and HIV/AIDS.<sup>211</sup> These include:

- motivational interviewing<sup>212</sup>
- encouraging community participation and greater community contact with people who use drugs,<sup>213</sup> or communicating positive stories of people with substance use disorders<sup>214</sup>
- education for both professionals and the public,<sup>215</sup> such as contact-based training and education programs for professionals, and education for the public on drug dependence<sup>216</sup>
- protest or advocacy<sup>217</sup>
- removing stigmatising legislative provisions<sup>218</sup>
- supporting and promoting self-help and mutual aid bodies.<sup>219</sup>

### NSW needs a greater focus on comprehensive strategies to address stigma

9.86 The Inquiry received a number of submissions calling for a national strategy to reduce stigma. The NSW Branch of the Royal Australian and New Zealand College of Psychiatrists and St Vincent's Health Australia argued for a sustained and comprehensive stigma-reduction strategy that would improve community and health service understanding and attitudes, as well as enable people who use ATS to seek treatment and help.<sup>220</sup> Ms Madden, Harm Reduction Australia, said there is a need for a comprehensive stigma reduction and elimination program or strategy that targets everyone involved in ATS, including the general community.<sup>221</sup> NUAA called for serious investment to address stigma and discrimination in partnership with people who use drugs.<sup>222</sup>

9.87 The Inquiry received a body of evidence that indicated stigma is a pervasive issue that is experienced in interactions with the general population, the media and a range of government agencies including health. Such complexity requires a coordinated response that engages relevant agencies and provides a consistent approach to addressing and reducing stigma.

9.88 The National Drug Strategy 2017–2026 recognises that reducing stigma and promoting help seeking is important to reducing demand for drugs, but it does not outline any specific stigma-reduction measures.<sup>223</sup> The National Ice Action Strategy 2015 does not include any reference to ATS-related stigma or strategies to address it.<sup>224</sup> In NSW, there are no specific statewide strategies or policies to address ATS or other drug-related stigma.

- 9.89 In its response to the Inquiry's request for information about current anti-stigma initiatives, NSW Health provided advice that it is undertaking a stigma and discrimination project to understand the beliefs, attitudes and practice of health staff about AOD consumers, and develop strategies to address stigma and discrimination towards people with AOD issues.<sup>225</sup> The goals of the project are to:
1. contribute to reducing the stigma and discrimination that create a barrier to accessing AOD treatment and support services
  2. consistently enable the provision of high-quality alcohol and other drug treatment and care, free of stigma and discrimination
  3. enable people at risk of AOD-related harms to provide direct and timely feedback on their health outcomes and experience.
- 9.90 Initiatives related to the first goal are under way. These include conducting research with health professionals and support staff about how they work with people who have illness or injury associated with AOD use. The research aims to understand how to improve the system to support people experiencing harms from AOD to access person-centred, safe, high-quality care in NSW. This research will inform NSW Health's strategy to engage with GPs, pharmacists and clients involved in the justice and corrections system.<sup>226</sup>
- 9.91 The Inquiry supports the goals of this project. However, while a focus on reducing stigma in providing AOD services is important, it needs to be supported by a more comprehensive approach that also considers the other contexts in which stigma is experienced (for example, in other service settings and the community) and includes strategies that reflect these.
- 9.92 It is the view of the Inquiry that an holistic approach to stigma should be developed. The various aspects of that response to ATS are explored in more detail in the remainder of this chapter.

## Recommendation 2:

That NSW Health develop and implement a project to reduce stigma, including:

- a public education campaign about ATS and people who use ATS, with a focus on raising awareness and dispelling myths
- the dissemination of existing best practice communication guidelines to government and non-government agencies that come into frequent contact with people who use ATS
- the development and implementation of anti-stigma training resources for government and non-government health workers
- appropriate community-based strategies
- the involvement of people with lived experience of drug use in the development and implementation of the project.

## Law reform is needed to reduce harms of stigma

- 9.93 The Inquiry heard from several witnesses and experts that stigma and its harmful effects will remain while there are criminal penalties for drug use.<sup>227</sup> Professor Kate Seear, Associate Professor in Law, Monash University, told the Inquiry that, based on her research in the field, she believed it was not possible to address drug-related stigma while maintaining a punitive approach to drug use and possession.<sup>228</sup> Professor Ritter, DPMP, cited Germany's approach of removing the criminal penalties for drug use and possession by law without any additional requirements. She said this has resulted in more people voluntarily accessing treatment and harm reduction services largely because of the reduction in stigma.<sup>229</sup> Cr Lloyd, Lismore City Council, said politicians from all sides of politics need to agree to recognise ATS use as a health issue and stop criminalising people who use ATS and other drugs:

*'... politicians really need to take leadership in this area and call it for what it is and accept that the war on drugs is over, put the guns down and come to some agreement – bipartisanship – on this issue and avoid stigmatising and demonising and criminalising and punishing people...'*<sup>230</sup>

- 9.94 Associate Professor McKetin, NDARC, noted the severe stigma and legal consequences of using methamphetamine mean that people are reluctant to seek help or identify that they use drugs while they are still employed or parenting.

*'The way we get around this would be to reduce the adverse legal consequences associated with being someone who consumes the drug, to help people who consume the drug and services/community manage and reduce stigma (as done with depression), to use methods of communication and interaction that are more anonymous and generally lower threshold (e.g., internet/phone vs face-to-face), and to make sure that face-to-face services are discrete (e.g. location and branding don't flag illicit substance use; records are not shared with other services).'*<sup>231</sup>

- 9.95 The Inquiry heard it is important not to over-pathologise people in considering whether or not to decriminalise drug use and possession.<sup>232</sup> Professor Seear, Monash University, observed that people use drugs for a wide range of reasons, and treating drug use as either a criminal problem or a medical problem is inaccurate and stigmatising in itself. She said this binary approach can often lead to other harms, particularly where it becomes a logic to support compulsory or mandated drug treatment.<sup>233</sup> A detailed discussion on the question of decriminalisation or depenalisation of illicit drugs, including the effects of that on stigma, is in Chapter 11, in which the Inquiry recommends decriminalisation of personal use and possession of illicit drugs.

- 9.96 However, it is important to note that decriminalisation alone is not sufficient to address stigma associated with ATS use. Dr Don Weatherburn, Adjunct Professor, University of Sydney Law School, said he believed decriminalisation of drug use/possession would reduce but not eliminate stigma. He cited ongoing stigma associated with dependence on legal drugs such as alcohol and nicotine (cigarettes).<sup>234</sup> Ms Madden observed that decriminalisation would not immediately eliminate stigma and the process would take time. *'... just because you decriminalise things, it's not magically going to take away stigma and discrimination overnight. We've spent a long time building that story. So, it's going to take some deconstruction.'*<sup>235</sup>

- 9.97 Dr Caitlin Hughes, Associate Professor and Matthew Flinders Fellow, Centre for Crime Policy and Research, Flinders University, told the Inquiry that law reform needed to be accompanied by other measures.

*‘But changing a law in and of itself is barely going to be sufficient. It’s a good – but if you really want to see the benefits from changing the response, is increasing investment in treatment, harm reduction responses is really important, as well as new messaging about – to address the stigma and discrimination that has been occurring in society.’<sup>236</sup>*

- 9.98 The need for a range of measures to address stigma is consistent with the picture provided by other evidence to the Inquiry. As is clear throughout this chapter, the issue of stigma is multifaceted and requires a range of responses.

### Raising awareness and dispelling myths

- 9.99 The Inquiry received a range of evidence about the need for public awareness campaigns to change attitudes around ATS.<sup>237</sup> CBMHR and Matilda Centre noted that their online community survey of Australian residents showed community support for the need to change attitudes towards people who use crystal methamphetamine. They said the results showed about 42% of respondents believed people who use crystal methamphetamine are mistreated in society and 46% believed people should be more empathetic and understanding to people who use crystal methamphetamine.<sup>238</sup> Providing trusted, evidence-based, supportive information about drugs such as crystal methamphetamine is an important step to overturning the stigma surrounding these drugs. They noted the public space is often cluttered by alarmist, stigmatising and incorrect information.<sup>239</sup>

- 9.100 The Inquiry heard it is important to remind the public that drug dependence is often a consequence of significant trauma,<sup>240</sup> and that campaigns need to emphasise that drug use is a health issue, not a moral issue.<sup>241</sup>

- 9.101 Submissions and lived experience witnesses also called for positive campaigns that ‘humanise’ people who use drugs. For example, a member of the community wrote to the Inquiry stating:

*‘A person is a human being with many facets and dimensions. My son was not just a “drug addict”, he is my son, he is a brother, he is a friend, he is a lover of animals. He is a giver of love; he is a portent for change. The humanising of a person who has resorted to drug use would go a long way to discuss the damage to life and future without further stigmatising the ATS user and their families who are predominantly silent victims.’<sup>242</sup>*

- 9.102 Several Australian websites share individual stories of people who use drugs as a way to challenge negative stereotypes and promote public understanding. These include the university research-based *Lives of substance* website<sup>243</sup> and the *Breaking the Ice* website. Some information and drug-related stigma education resources are available on the *Breaking the Ice* website.<sup>244</sup> The website includes videos from people affected by crystal methamphetamine and an interactive online learning tool with a short module on reducing stigma to educate individuals and communities.<sup>245</sup>

- 9.103 Evidence in the literature supports positive public campaigns and communication strategies as an effective way to counter public fears about people who use drugs and address misconceptions about drug use and drug dependence.<sup>246</sup> Researchers highlight the importance of promoting positive stories and messaging about people who use drugs.<sup>247</sup> They say public figures talking about their personal experiences has been influential in the mental health field and this could be applied to counter drug-related stigma.<sup>248</sup>
- 9.104 The WA Methamphetamine Taskforce recognised the value of sharing positive stories to challenge ATS-related stigma. The Taskforce recommended the WA Mental Health Commission promote positive personal stories of successful treatment to the general public and to those experiencing dependent use of methamphetamine to address both social and self-stigma and promote help seeking behaviour. The WA Government accepted the recommendation.<sup>249</sup> The UK Drug Policy Commission notes the success of mental health campaigns in the UK, such as *Time to Change* and *See Me*, which promoted more positive images of people with mental health problems and improved public attitudes.<sup>250</sup>
- 9.105 The Inquiry has also noted that, in addition to addressing the individual and structural causes of stigma, the literature recognises the need for interventions to address the personal impact of stigma on people who use ATS. Several Australian reviews have recommended programs and services to address internalised drug-related stigma.<sup>251</sup> US research similarly concluded strategies to cope with stigma may be an important component of drug treatment programs for people who use methamphetamine.<sup>252</sup> Group-based acceptance and commitment therapy is one such method that has been found to significantly decrease internalised stigma among people with substance use disorders.<sup>253</sup> Campaigns addressing stigma should similarly consider the impact of internalised stigma.

### Improving communication, public messaging and media reporting

- 9.106 The media and government's ability to shape public attitudes about drugs through messaging and language presents a significant opportunity to reframe the public discourse and reduce drug-related stigma.<sup>254</sup> Several studies have recommended educating the media about responsible reporting on drug-related issues, including how to encourage a balanced portrayal and how to avoid stigmatising representations.<sup>255</sup>
- 9.107 The Inquiry received a range of evidence about the importance of accurate, balanced media reporting to address stigma and discrimination.<sup>256</sup> CBMHR and Matilda Centre submitted that the NSW Government, media outlets and workforce must use evidence-based, non-stigmatising language when communicating with the Australian public about drug use and related harms, and in particular about crystal methamphetamine.<sup>257</sup>
- 9.108 The media can also be an effective platform for messages about harm reduction. The Inquiry received evidence from the *NSW Coronial Inquest into Music Festival Deaths*, at which clinical psychologist Dr Stephen Bright said the media could provide important harm reduction information about drug use, rather than '*sensationalising the way in which drugs are portrayed and consequently young people tune off to the media*'.<sup>258</sup>
- 9.109 Evidence to the Inquiry also emphasised the need for government and health services to use non-stigmatising language.<sup>259</sup> NSW Health's *Your Room* website acknowledges that language and the terminology used to describe people experiencing drug and alcohol dependence is powerful. It recommends using terms such as 'person with a drug dependence' instead of 'addict', 'junkie', 'druggie' or 'alcoholic'.<sup>260</sup>

- 9.110 Several submissions to the Inquiry recommended the NADA *Language Matters* resource,<sup>261</sup> which guides drug and alcohol workers on person-centred language to avoid stigma and to show respect for the person's agency, dignity and worth.<sup>262</sup> ACON noted that while *Language Matters* does not address messaging around ATS use, the guiding principles are suitable to inform approaches to ATS messaging.<sup>263</sup>

### Guidelines for media reporting

- 9.111 Mindframe, on behalf of the Commonwealth Department of Health, has recently developed national guidelines for the reporting and portrayal of AOD in the Australian media. The guidelines were launched in March 2019 and follow the 2017 *Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)* recommendation for the Australian Press Council to develop and implement media reporting standards for coverage of drug use.<sup>264</sup>
- 9.112 Mindframe and the Cracks in the Ice online toolkit have also developed a resource for best practice media reporting on crystal methamphetamine, expected to be launched in early 2020. The resource, *Crystal methamphetamine in the media: A guide to non-stigmatising and accurate reporting* highlights the importance of portraying crystal methamphetamine use as a public health issue and reporting on it the same way as any other health condition. A webinar previewing the resource noted that the media are often the primary source of information on methamphetamine and alarmist media representations 'can initiate spontaneous, ill-advised policy reactions'.<sup>265</sup>

#### Mindframe guidelines for communicating about someone who uses alcohol and other drugs

- Characterising a person by their AOD use is unhelpful and stigmatising. Instead use person-centred language. For example, instead of referring to someone as a 'cannabis user' describe the person as 'a person who uses cannabis'.
- Negative representation of people who use AOD can lead to further stigma and reduce help seeking.
- When communicating about a person who uses drugs and who has broken the law, or about a drug-related crime, ensure that the information conveyed is factual and accurate and that sensationalist content is omitted.
- Be sensitive and remember that the way in which a person who uses AOD is portrayed can potentially have an impact on their life and the lives of their families and significant others. This includes high-profile individuals and celebrities.
- Where possible, remind the audience that the subject is not only a person who uses drugs, but someone who has other traits. Most people who use AOD function well as parents, partners, participants in the workforce and members of their community.
- Portraying AOD dependence as a treatable condition may contribute to improved understanding and reduced stigma among the general public, who are accustomed to unhelpful stereotypical media portrayals.

- 9.113 The Mindframe guidelines aim to positively influence the quality of media reporting on alcohol and other drugs, improve community attitudes towards people living with drug and alcohol issues and increase help-seeking behaviour.<sup>266</sup> There is a lack of published evidence about the media's uptake of the guidelines or effectiveness in reducing drug-related stigma,<sup>267</sup> although it can be anticipated that the guidelines may have a similar outcome to previous guidelines issued by Mindframe in relation to suicide and mental health. Ms Jameson, Everymind, told the Inquiry that Mindframe intends to conduct a study to monitor any change in the behaviour of the Australian media in response to its AOD guidelines, as it did with its earlier media guidelines on reporting of suicide.<sup>268</sup> It found the suicide reporting guidelines have positively contributed to changes in the quality of reporting of suicide and mental health conditions.<sup>269</sup> However, the review noted these improvements can only be sustained with the ongoing collaboration of the media and continued reinforcement of the guidelines.<sup>270</sup> The new Mindframe AOD guidelines are not binding and there are no supporting industry standards as there are for suicide and mental health reporting, such as the Australian Press Council's Specific Standards on Coverage of Suicide.<sup>271</sup>
- 9.114 NADA referred the Inquiry to guidelines for the responsible reporting of issues relating to AOD that were originally developed in 2004 and strengthened in 2014. It noted the guidelines are not mandatory and '*it has been suggested that the media are reluctant to consider them, if they are aware of them at all*'.<sup>272</sup> NADA stated there are opportunities to strengthen the guidelines, including the development and active endorsement of media kits on best practice journalism in relation to reporting on drugs and people who use drugs that could include the guidelines and other resources.<sup>273</sup>
- 9.115 In its submission to the Inquiry, the Alcohol and Drug Foundation referenced existing guidelines that provide recommendations for journalists and media professionals in how to present information about AOD use and people who use AOD. These are:
- *Mindframe for Alcohol and Other Drugs* guidelines (2019)
  - *AOD Media Watch* guidelines (2017)
  - Global Commission on Drug Policy: *The World Drug Perception Problem* (2017)
  - UK Drug Policy Commission: *Dealing with the stigma of drugs: a guide for journalists* (2012).<sup>274</sup>

### Best practice in media reporting

The Alcohol and Drug Foundation said that common best-practice themes in guidelines about reporting AOD use are:<sup>275</sup>

- using the Mindframe (2019), UK Drug Policy Commission (2017) and Global Commission on Drug Policy (2017) language guidelines to avoid using stigmatising terminology when reporting
- not repeating stereotypes about AOD use or using stigmatising images (e.g. people passed out)
- being sensitive to the fact that the person in any story is someone's child, parent or friend and the way they are reported on can affect lives. This includes story informants whose lives can also be affected by reporting
- shifting reporting to frame people experiencing AOD-related issues as having an illness and needing help as opposed to being self-indulgent or hedonistic
- seeking out reputable key informants who will provide accurate and evidence-based information
- contextualising new drug trend reporting (e.g. 'emerging' drugs) within existing AOD use patterns.

- 9.116 Several submissions, including those from the Alcohol and Drug Foundation,<sup>276</sup> NADA<sup>277</sup> and CBMHR and Matilda Centre<sup>278</sup> expressed the view that there are opportunities to support improved media reporting. The Inquiry heard that governments can play an important stewardship role in addressing stigmatising media reportage<sup>279</sup> and that there is a significant opportunity for the NSW Government to show leadership by avoiding stigmatising terminology in its own materials to the press. DPMP recommended implementing guidelines for government departmental and ministerial communication about AOD issues.<sup>280</sup> Without limiting other opportunities to strengthen and support improved communication and reporting of AOD issues, the Inquiry notes that the Mindframe guidelines provide a reputable set of existing guidelines which could be adopted as the first step in such efforts.

### Recommendation 3:

That the NSW Government work with the Commonwealth, other state and territory governments and the Australian Press Council to strengthen the implementation of the Mindframe media guidelines, including monitoring of media reporting that may contribute to stigma.

### Training for health professionals

- 9.117 The Inquiry heard that nursing staff have benefited from ongoing training and support to decrease the stigma associated with substance use,<sup>281</sup> and that more training for nursing and medical staff at the undergraduate level in relation to AOD issues, stigma and trauma would help to reduce stigma.<sup>282</sup> Dr Peter Vaux, Clinical Director, Community Mental Health Team, Broken Hill, told the Inquiry: *'You address it through education and training and your own use of language around these issues, so that there's – a sense of compassion is there alongside with care.'*<sup>283</sup>
- 9.118 Dr Hester Wilson, Chair of the Specific Interests Addiction Medicine Network, Royal Australian College of General Practitioners, told the Inquiry's Health Responses Roundtable that she believes there needs to be a bigger training stream in illicit drugs at the undergraduate medical level. However, she acknowledged the challenge that the curriculum is already busy and AOD is a cross-cutting issue.<sup>284</sup>
- 9.119 DPMP recommended the implementation of anti-stigma awareness training across relevant workforces. It noted that awareness training provides an opportunity to challenge stigma and its impacts. It referred to existing awareness programs developed by peer-based organisations for people who used drugs that could be used or adapted, including the Australian Injecting and Illicit Drug Users League's online training module for health professionals and NUAA's stigma and discrimination training.<sup>285</sup> DPMP recommended identifying key workforces and undertaking a needs assessment of those workforces before working with peer-based organisations for people who use drugs and consumers to devise appropriate anti-stigma training.<sup>286</sup>
- 9.120 NUAA noted it has developed and started to roll out RACGP-accredited training to support GPs to work with people who use drugs.

*'Similar training needs to be mandated across multiple professional groups including non-clinical hospital staff such as reception and security as well as work done to incorporate training into our medical and nursing schools. Target heads of LHD drug and alcohol services with intensive workshops so they can better lead change from the top.'*<sup>287</sup>

- 9.121 The ADF is working on a project to produce a guide and training materials for health professionals to address drug-related stigma and discrimination. The project is funded by the Victorian Department of Health and Human Services. The ADF's partners on the project are the Penington Institute, Harm Reduction Victoria and the Association of Participating Service Users.<sup>288</sup>
- 9.122 The literature supports the need to increase the knowledge and skills of health professionals and other professionals who come into regular contact with people who use drugs.<sup>289</sup> Researchers suggest more specific drug education and training for health professionals,<sup>290</sup> and note that educating medical students about substance use problems is likely to decrease stigmatising attitudes.<sup>291</sup> The literature also supports interventions at the structural level to address stigma and discrimination in healthcare settings.<sup>292</sup> While acknowledging the importance of interventions to change the attitudes and behaviour of healthcare workers at the individual level, workplace education without organisational support is ineffective.<sup>293</sup>
- 9.123 The National Ice Taskforce recommended that ATS education and training be included in medical curriculums, foundation qualifications and continuing professional development programs for frontline health workers.<sup>294</sup> The NSW Health Education and Training Institute offers a stigma, discrimination and injecting drug use eLearning module for NSW Health staff, which aims to improve health outcomes and experiences of people who inject drugs in healthcare settings.<sup>295</sup>
- 9.124 In addition to the eLearning module for health staff, the NSW Government submitted that agencies have put in place a range of training and resources for Department of Community and Justice child protection practitioners. This includes the NSW Practice Framework, which recognises the impact of professionals' language on client relationship and outcomes, and the AOD online practice kit to improve responses to families where drugs and/or alcohol feature.<sup>296</sup>

### Education works best when combined with interpersonal contact

- 9.125 The ADF highlighted that stigma research focused on other health conditions, particularly mental illness and HIV/AIDS, shows that education alone is not effective to address prejudice and discrimination. However, educational approaches combined with contact-based approaches that facilitate positive interactions between the public and people with those health conditions can improve attitudes to stigmatised people.<sup>297</sup>
- 9.126 Health-related stigma research also suggests education and training interventions can be made more effective if they are delivered in conjunction with contact-based approaches.<sup>298</sup> These facilitate interaction between people who live with stigmatised health conditions and the broader community. They are based on the premise that people who have exposure to other people with a stigmatised condition have greater understanding and more positive attitudes.<sup>299</sup>
- 9.127 Professor Ritter, DPMP, said that hearing about personal experiences enables others to look at the problem with compassion and an understanding about its complexity.

*'One of the reasons policy is so hard in this area is because people (politicians and the public) have ill or misinformed images of drugs, drug use and people who use drugs, partly informed by the media. It is only when people connect with the problem of drug use in [a] personal way that they can actually see alternative solutions and different ways of thinking about it.'*<sup>300</sup>

- 9.128 The UK Drug Policy Commission's survey of public attitudes about people who use drugs showed people who had lived, worked or were friends with someone with a history of drug dependence had fewer negative attitudes than people who had not.<sup>301</sup> Such steps are unlikely, alone, to wholly remove stigma since stigma persists in communities even when most people know someone who uses ATS, according to David Kelly, Manager of Community Health Programs, Wellington Aboriginal Corporation Health Service. Mr Kelly told the Inquiry's Moree Hearing:

*'[I]t's an interesting situation in a small town like Moree where there is still stigma attached to drug use, particularly use of methamphetamine, and yet virtually everybody in town knows somebody or is related to somebody that – that has these issues ... it's an interesting thing that there could be stigma for something that is so prevalent.'*<sup>302</sup>

- 9.129 However, the research supports including personal engagement as a part of responding to stigma. A 2013 systematic review found that health professionals who had more contact with patients with substance use disorders expressed more positive attitudes.<sup>303</sup> Another systematic review in 2011 found contact-based training and education programs targeting medical students were effective at reducing drug-related stigma.<sup>304</sup> The WA Methamphetamine Taskforce recommended the state's Mental Health Commission involve people with lived experience of methamphetamine and their families in frontline workforce education and training to reduce stigma.<sup>305</sup>

### Lived experience of drug use must inform drug policy

- 9.130 Several submissions to the Inquiry stressed the importance of involving people with lived experience of drug use in drug policy, education and public awareness campaigns to counteract stigma and discrimination.<sup>306</sup>
- 9.131 The DPMP recommended consumer participation in policy, planning and service delivery to reduce stigma and discrimination. It stated that consumer participation provides opportunities to disrupt the routine dehumanisation faced by people who use drugs.<sup>307</sup> CBMHR and Matilda Centre recommended the NSW Government involve people with lived experience wherever possible in policy making and service provision.<sup>308</sup>

*'Involving people with lived experience in policy making and service provision, is critical to reduce stigma produced by systemic factors that are exacerbated when those most affected by ice use and related harms do not have a voice.'*<sup>309</sup>

- 9.132 ACON stated that all messaging about ATS use should be developed using a co-design process that meaningfully includes people who use ATS.<sup>310</sup> Similarly, Professor Kate Seear, Monash University, told the Inquiry she believes any educational material should be developed with the involvement of peer experts, including organisations such as NUAA and Harm Reduction Australia.<sup>311</sup> NUAA cited its Consumer Academy program, which aims to build consumer confidence and capacity to participate in health care. Program participants have taken places on the NSW Ministry of Health Consumer Advisory Council.<sup>312</sup>
- 9.133 The literature supports involving people with lived experience of AOD use in policy and practice to challenge stigma and discrimination. Consumer participation not only increases interpersonal contact but enables the views and lived experiences of people who use drugs to inform policies and services, so they are more responsive to their needs.<sup>313</sup> Research suggests consumer participation should be a key component of treatment services, health services and other social support services that regularly have contact with people experiencing problematic drug and alcohol use.<sup>314</sup>

## Education, campaigns and resources should be developed with people with lived experience

9.134 The Inquiry heard that drug education and awareness campaigns need to be targeted and developed with input from people who use drugs.<sup>315</sup> NUAA stated that best practice is to involve people who use ATS in developing messaging. Appropriate consultation is the only way to reduce stigma and reach the people that need to be reached.<sup>316</sup> The Sex Workers Outreach Project similarly submitted that peer-led community responses to crystal methamphetamine have been much more successful than negative media campaigns at engaging people who use drugs by using lived experience to solve the problems of drug use.<sup>317</sup> Such approaches are already identified by NSW Health in other contexts.<sup>318</sup>

9.135 The DPMP noted a large body of international research shows that mass media campaigns have no effect on drug use behaviour and can compound stigma and marginalisation, such as that which occurred with two anti-methamphetamine campaigns in the US, *Faces of Meth* and *The Meth Project*.<sup>319</sup> DPMP stated that campaigns that target specific at-risk groups using community-based organisations have demonstrated at least some impact on health-seeking and risk-reduction behaviours, for example in HIV prevention, while avoiding stigma-related language.<sup>320</sup> It suggested that:

*'In coordination with consumer groups, the NSW Government should explore and find the best communication approaches that will be credible among target sub-populations of people who use ATS in order to increase awareness of potential harms and treatment options to encourage help seeking. Any dedicated funds for future mass marketing campaigns in NSW targeting people who use ATS should be diverted into targeted communication campaign strategies.'*<sup>321</sup>

9.136 NDRI also recommended using targeted strategies to reach sub-populations, encourage treatment seeking and avoid the negative stereotypes and stigma caused by negative mass media drug prevention campaigns.<sup>322</sup>

9.137 ACON argued that tailored messaging approaches should be developed for the diverse communities of people who use ATS. It referred to ACON's 12 campaigns since 2013 to educate and mobilise gay men to end the HIV epidemic, noting independent evaluation results have demonstrated the campaigns' success and that gay men engage and respond to community messaging that is embedded in community, empowering and informative.<sup>323</sup>

9.138 A 2017 study of the Commonwealth Government's media campaign '*Ice Destroys Lives*' similarly recommended targeted evidence-based prevention strategies focusing on high-risk groups rather than generalist mass media campaigns that further stigmatise people who use ATS.<sup>324</sup>

9.139 This approach was endorsed by the *Commonwealth Parliamentary Inquiry into crystal methamphetamine (ice)* in 2018. It recommended the Commonwealth Government ensures future public awareness campaigns engender compassion towards people who use drugs and target those people with the objective of encouraging them to seek treatment and support.<sup>325</sup>

- 9.140 Involving people with lived experience of alcohol and drug use in the development and implementation of policy also enables their lived experience to be taken into account.<sup>326</sup> The evidence and submissions before the Inquiry, along with international experience, make clear the importance of this involvement.

**Recommendation 4:**

That the NSW Government include people with lived experience of drug use and their representative organisations in the development and implementation of all future drug education, prevention and harm reduction campaigns.

## References

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- <sup>2</sup> Kari Lancaster, Kate Seear and Alison Ritter, *Reducing Stigma and Discrimination for people experiencing problematic alcohol and other drug use* (Drug Policy Modelling Program, UNSW Sydney, Monograph No 26, August 2018) 62.
- <sup>3</sup> East Maitland Hearing, East Maitland, Exhibit A, Tab 23, Statement of Brydie Jameson, 11 June 2019 [10]; Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3971.15-16 (Lloyd); NSW Branch of the Royal Australian & New Zealand College of Psychiatrists, Submission No 32 (7 May 2019) 8-9; Decriminalisation Roundtable, Sydney, 18 September 2019, TS 4006.16-17 (Professor Ritter); Lismore Hearing, Lismore, 15 May 2019, TS 723.1-11 (Dr Hudson); Sydney (General) Hearing, Sydney, 8 May 2019, TS 179.31-45 (Dr Harrod); Dubbo Hearing, Dubbo, Exhibit A, Tab 13, Statement of Rhiannon McMillan, 14 May 2019 [35]; Broken Hill Hearing, Broken Hill, 16 July 2019, TS 2514.29-45 (House).
- <sup>4</sup> Harm Reduction Hearing, Sydney, 23 September 2019, TS 4160.30-7 (Professor Ritter).
- <sup>5</sup> Harm Reduction Hearing, Sydney, 23 September 2019, TS 4205.8-41 (Professor McKetin).
- <sup>6</sup> Sydney (General) Hearing, Sydney General Exhibit B, Tab 42, Statement of Anthony Gill, 6 May 2019, [30]; East Maitland Hearing, East Maitland, Exhibit A, Tab 8, Statement of Craig Sadler, 28 May 2019, [74]; Dubbo Hearing, Dubbo, 5 June 2019, TS 1658.3-10 (Crisp); Moree Plains Shire Council, Submission No 72 (undated, received 7 May 2019) [1.1.4]; Lismore Hearing, Lismore, Exhibit LF, Tab 12, Statement of Bronwyn Hudson, 10 May 2019 [18]-[19]; Dubbo Hearing, Dubbo, Exhibit A, Tab 11, Statement of Jason Crisp, 15 May 2019, [5]; National Drug & Alcohol Research Centre, UNSW Sydney, Submission No 81 (7 May 2019) 2.
- <sup>7</sup> Sydney (General) Hearing, Sydney, Exhibit K, Statement of SG1, 3 May 2019, [15].
- <sup>8</sup> ACON, Preliminary Submission No 78 (31 January 2019) 3; Lismore Hearing, Lismore, Exhibit LF, Tab 24, Statement of Michael Tizard, 13 May 2019, [21]; Sydney (General) Hearing, Sydney, 8 May 2019, TS 183.16 (Dr Harrod).
- <sup>9</sup> Sydney (General) Hearing, Sydney, 9 May 2019, TS 265.18-34 (Dr Brett); Lismore Hearing, Lismore, Exhibit LF, Tab 7, North Coast Primary Health Network - Alcohol and Other Drug Treatment - Needs Assessment, [13]-[23]; Dubbo Hearing, Dubbo, Exhibit A, Tab 28, Statement of Norm Henderson, 21 May 2019, [26].
- <sup>10</sup> Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 4; Cessnock City Council, Submission No 31 (2 May 2019) 4.
- <sup>11</sup> Sydney (General) Hearing, Sydney, Exhibit B, Tab 20, Statement of Mary Harrod, 30 April 2019, [9]; Harm Reduction Hearing, Sydney, 23 September 2019, TS 4160.31 (Professor Ritter); Decriminalisation Roundtable, Sydney, 18 September 2019, TS 3973.40-4 (Madden); Lismore City Council Social Justice and Crime Prevention Committee, Submission No 43 (May 2019) 9; Broken Hill Hearing, Broken Hill, 17 July 2019, TS 2694.36-41 (Dr Vaux).
- <sup>12</sup> Matilda Centre for Research in Mental Health and Substance Use, the University of Sydney and the Priority Research Centre for Brain and Mental Health, the University of Newcastle, Submission No 74 (7 May 2019) 12.
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