
Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants



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Report
Volume 4 of 4
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Part C:

Regional stories



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Introduction to the Inquiry's regional hearings

In recognition of the impacts of ATS use on communities in regional, rural and remote NSW, the Inquiry conducted hearings in six regional centres across NSW where crystal methamphetamine is seen to be a significant problem – Lismore, Nowra, Dubbo, East Maitland, Broken Hill and Moree.

In deciding which regional areas to visit, the Inquiry considered a number of factors:

- data relating to the level of prevalence and harms in various communities across NSW
- the need to visit towns and regions that represent the breadth of communities in different parts of NSW, for example, coastal communities and also isolated areas in the far west of the state
- regions with a higher proportion of Aboriginal people given that, statistically, 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.¹

Data show that people in remote and very remote areas are 2.5 times more likely to use methamphetamine and amphetamine than people who live in major cities.² According to wastewater analysis, the weight per capita of methamphetamine consumption has been higher in regional NSW than in Sydney in all reports since August 2016, and has shown a steady increase in regional NSW since 2017.³ (See Chapter 7)

Public and private hearings were held in each regional centre. Private roundtable discussions with members of the local Aboriginal communities were also held in Lismore, Nowra, Dubbo, East Maitland, Broken Hill, Wagga Wagga and Toomelah.

In public hearings, government and non-government service providers gave evidence about their experiences of the prevalence and harms associated with use of ATS, particularly crystal methamphetamine, and their efforts to respond to issues arising from the use of these drugs. Representatives from the justice, health and community services sectors were among those to appear before the Inquiry.

During private hearings, people with lived experience of crystal methamphetamine shared difficult stories of their own use, or the challenges of caring for family members or friends who use the drug.

The evidence gathered during the six regional hearings highlights that crystal methamphetamine use is having a profound effect in regional communities, often compounded by the chronic lack of available and accessible treatment services. For that reason, the Inquiry has identified people living in regional, rural and remote NSW as a priority population, requiring targeted policy and service responses to address ATS use.

Common themes emerged from the Inquiry's regional hearings.

- **Lack of services and facilities:** The lack of detoxification and rehabilitation facilities, and wait times for existing facilities, means that the important window of opportunity to get people into treatment is often missed.⁴ Vast distances between detoxification and rehabilitation facilities in rural areas present a major barrier to treatment. Regional service providers have ongoing difficulties in recruiting and retaining appropriately qualified staff to work in the AOD/mental health treatment sector.

- **Lack of continuity of care:** There is a lack of continuity of care for people moving from rehabilitation back into regional communities.⁵ There are also insufficient pathways between facilities, which particularly affects those leaving prison. The Inquiry heard that people often leave prison without receiving or engaging in ongoing care and support for AOD or other health issues.⁶ The Inquiry heard the lack of continuity of care between Corrective Services NSW and Justice Health means that inmates may be released from correctional facilities without Justice Health being aware that they are leaving.⁷ Often inmates are released into homelessness, without prescriptions for regular medication or referrals to support services, which greatly heightens the risk of their resuming substance use.⁸ (See Chapter 20)
- **Lack of service coordination:** The fragmentation of AOD service delivery in regional areas hinders service providers' ability to respond effectively to crystal methamphetamine use. The Inquiry heard coordination between government and non-government services or providers is often inadequate. (See Chapter 14)
- **Inequity and social disadvantage:** Rural and remote people experience greater health inequities and burden of illness than people in metropolitan and inner-regional locations.⁹ Drug use and dependence are often rooted in social disadvantage, which also compounds the harms associated with the use of crystal methamphetamine. (See Chapter 3)

The Inquiry has placed great importance on having meaningful and positive engagement with Aboriginal people to help develop its recommendations. During the roundtable discussions, Aboriginal people, service providers and stakeholders spoke candidly about the devastating effect of crystal methamphetamine on families and communities. As part of this process, the Inquiry met with about 100 people.

Regional Aboriginal community representatives told the Inquiry how intergenerational trauma contributes to the use of crystal methamphetamine and also compounds the difficulties involved for Aboriginal people in recovery.

The Inquiry heard that the legacy of the Stolen Generations is such that many Aboriginal people are reluctant to seek treatment for their use of crystal methamphetamine, often because they fear the Department of Communities and Justice might remove their children. The experience of racism is also a barrier to accessing treatment. One roundtable participant said that because of the racism they have endured, Aboriginal women tell her: *'I'm not going up to that hospital. I'm not going to see this person. I'm not going to see that person ...'*¹⁰

The lack of detoxification and rehabilitation facilities in regional locations means that Aboriginal people often need to leave Country and their family support networks for treatment, which they are reluctant to do. Aboriginal women, particularly, do not want to be separated from their children and are deterred from initiating the treatment process due to the lack of detoxification and rehabilitation facilities where Aboriginal families can heal together. (See Chapter 16)

The six regional areas described in the following stories are representative and the Inquiry accepts that many other regional centres in NSW are also confronted by the harms associated with ATS use. For this reason, the Inquiry has not made region-specific recommendations in the report but has sought to make recommendations that will benefit all people in need in NSW. The experiences of ATS use of people living in regional, rural and remote NSW, and the need for them to be considered as a priority population as part of AOD policy, are discussed further in Chapter 8.

Despite the many challenges related to ATS use highlighted during the Inquiry's regional hearings, the Inquiry also noted the hard work, dedication and resilience of the communities it visited. The Inquiry thanks the people of Lismore, Nowra, Dubbo, East Maitland, Broken Hill Moree, Wagga Wagga and Toomelah for their generosity in assisting the Inquiry.

References

- ¹ Australian Institute of Health and Welfare, Commonwealth, *Alcohol, and other drug treatment services in Australia 2016-17* (Report No 31, 2018) 26.
- ² Australian Institute of Health and Welfare, Commonwealth, *National Drug Strategy Household Survey 2016* (Report, 2017), 96.
- ³ Australian Criminal Intelligence Commission *National Wastewater Drug Monitoring Program – Report 8* (Report, August 2019) 42.
- ⁴ Moree Hearing, Sydney, 30 September 2019, TS 4614.33-40 (Superintendent Tanner).
- ⁵ East Maitland Hearing, East Maitland, Exhibit A, Tab 27, Statement of Joe Coyte, June 2019, [16].
- ⁶ East Maitland Hearing, East Maitland, Exhibit A, Tab 11, Statement of Dr Nick Ryan, 18 June 2019, [28].
- ⁷ Lismore Hearing, Lismore, 14 May 2019, TS 681.30-35 (Dr Wims).
- ⁸ Dubbo Hearing, Dubbo, 4 June 2016, TS 1492.10-21 (Dr Clark); East Maitland Hearing, East Maitland, 19 June 2019, TS2012.9-37.
- ⁹ Susan Nancarrow et al, 'Models of Care Involving District Hospitals: A Rapid Review to Inform the Australian Rural and Remote Context' (2015) 39(5) *Australian Health Review* 494-507.
- ¹⁰ Nowra Roundtable (Private), Nowra, 29 May 2019, TS 981.18-20 (Name Withheld).

SNAPSHOT: LISMORE

GEOGRAPHY

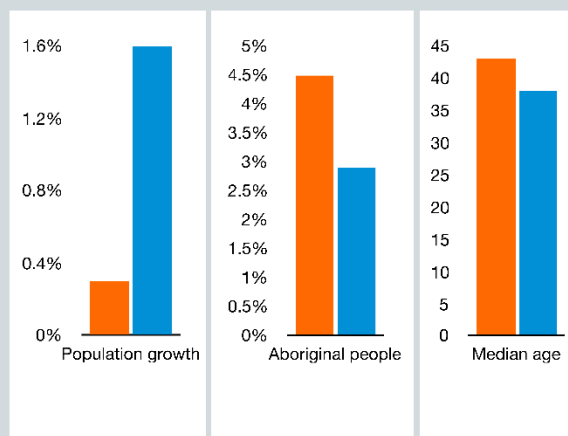


- **Local Health District (LHD):** The Northern NSW LHD services over 300,000 residents and spans an area of 20,732 square kilometres.
- **Primary Health Network (PHN):** The North Coast PHN covers approximately 32,047 square kilometres home to approximately 520,000 people.
- **Police District:** The Richmond Police District has fourteen police stations.

KEY DEMOGRAPHICS

6.1% of Lismore's population identifies as being an Aboriginal person.

■ Lismore ■ State average



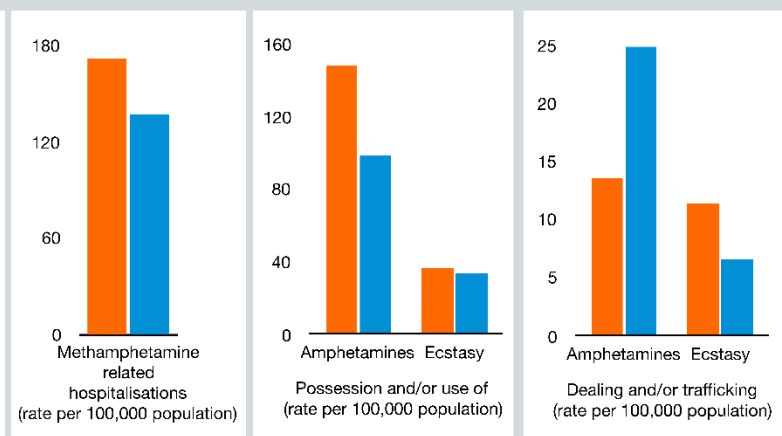
(NSW Dept. of Planning and Environment, 2015 to 2016, LHD)

(ABS, Census 2016, LHD)

(ABS, Census 2016, LHD)

HEALTH HARMS & CRIMINAL OFFENCES

Amphetamine related offences have remained stable within the Lismore local government area.



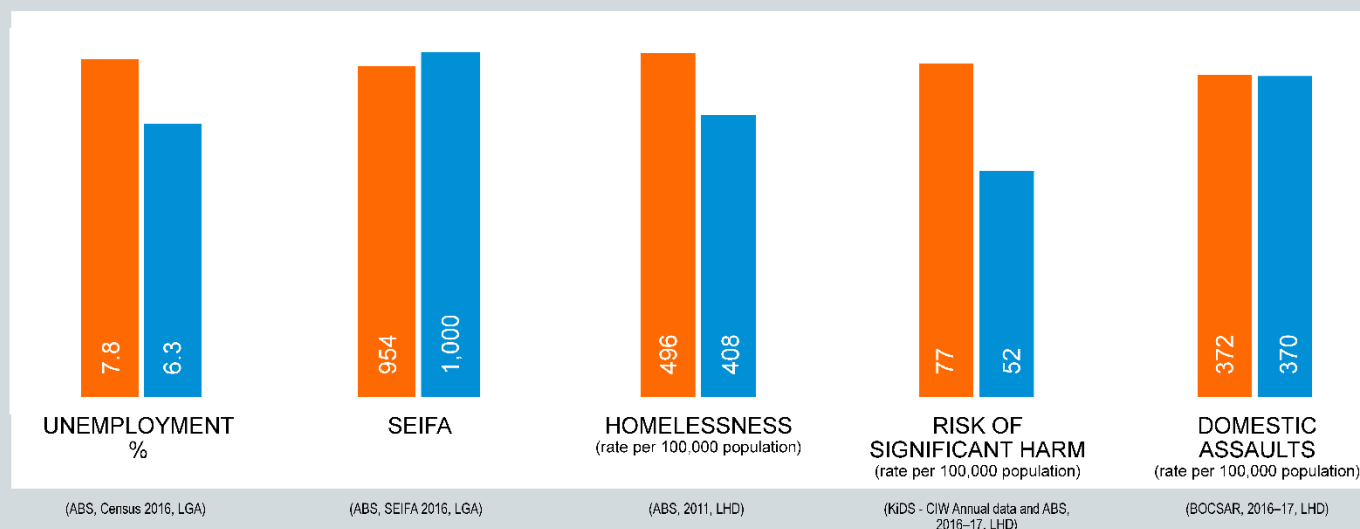
(HealthStats NSW, 2016-17, LGA)

(BOCSAR recorded criminal incidents, Oct 2018 to Sep 2019, LGA)

(BOCSAR recorded criminal incidents, Oct 2018 to Sep 2019, LGA)

KEY SOCIAL STATISTICS

■ Lismore ■ State average



(ABS, Census 2016, LGA)

(ABS, SEIFA 2016, LGA)

(ABS, 2011, LHD)

(KIDS - CIW Annual data and ABS, 2016-17, LHD)

(BOCSAR, 2016-17, LHD)

Chapter 23. The Lismore region

Introduction to the Lismore region

- 23.1 Lismore is a city in the Northern Rivers region of NSW, about 35km inland from the coastal town of Ballina. The Lismore Local Government Area (LGA) has a population of about 43,000.¹ Lismore is in the Northern NSW Local Health District (LHD), which stretches to the Queensland border and includes the Tweed Shire, Murwillumbah, Byron Bay, Nimbin, Casino and Grafton in the south.
- 23.2 The Inquiry held hearings in Lismore on 13 to 15 May 2019. Public and private witnesses and members of the region's Aboriginal communities spoke about their experiences of crystal methamphetamine in both the city and other areas of the region.
- 23.3 The 2018 North Coast Primary Health Network (PHN) Alcohol and Other Drug Treatment Needs Assessment reported that heroin and amphetamines have become increasingly prevalent over the past four years as the principal drugs of concern for people receiving treatment.² The 2018 North Coast PHN 'Speak Up' community survey found that 47.7% of all respondents across the PHN marked drug and alcohol use as one of the community health issues they are most concerned about. Lismore (59.5%), Byron Shire (58.5%) and Kempsey (55.2%) LGAs had the highest rates of concern.³
- 23.4 As the Needs Assessment noted, non-prescribed substance use has a strong relationship with social markers of disadvantage.⁴ According to the Department of Communities and Justice (DCJ), Northern NSW (Lismore LGA plus six surrounding LGAs) has a number of indicators of social disadvantage that are higher than NSW averages, including rates of young people involved in risk of significant harm reports or in out-of-home care; the percentage of one-parent families with children under 15 and with a weekly family income of less than \$650; and rates of homelessness and unemployment.⁵
- 23.5 Previous inquiries have also looked at AOD-related issues in the area.⁶ This Inquiry heard of community members' frustrations that despite repeated investigations, the region's concerns have not been addressed. For example, Edwina Lloyd, Councillor, Lismore City Council and Trial Advocate, Aboriginal Legal Service (ALS), gave evidence to the Inquiry that hope is '*dwindling*' among Aboriginal people in the region that anything will be done to address the issues in their communities that have a high social and economic cost.
- 'People have been members and given evidence at these committees for years and years and years and yet nothing has happened. So we are hoping that this Inquiry is going to lead to politicians putting their guns down and working together to address these very significant social issues that impact all of our community and cost us socially and economically.'*⁷
- 23.6 The traditional custodians of the Lismore region are the Widjabul people of the Bundjalung Nation. Aboriginal people represent 5% of the North Coast PHN's population, higher than the proportion for NSW (2.9%).⁸ Aboriginal people make up 7.2% of the population of the Richmond Valley LGA, centred on the town of Casino, 30km south-west of Lismore.⁹ The Inquiry heard that Aboriginal communities in the region are disproportionately affected by crystal methamphetamine use. More than half of people who are incarcerated in the Richmond Valley are Aboriginal.¹⁰

- 23.7 The Inquiry heard evidence about the difficulties people from the LGBTQI+ community in the Lismore region face compared to heterosexual people, particularly in relation to stigma and shame when trying to access AOD services. Michael Tizard, Regional Manager, ACON Northern Rivers, told the Inquiry that members of *'our community may well have experienced discrimination and stigma when trying to access mainstream services over the course of their lives'*.¹¹
- 23.8 Other issues of concern in the Lismore region include difficulties accessing residential rehabilitation services, of which there is a shortage, shortfalls in diversionary programs in the region and the impact of ATS on health workers assisting people presenting with ATS-related issues. For example, Dr Edward Wims, Clinical Director, Mental Health, Richmond Clarence, said he has observed a number of staff assaulted by patients intoxicated by ATS, resulting in physical injuries and mental health trauma.¹²

*'I've had nurses, you know, in tears ... telling me about explaining to their child why mummy had a bruise on their face. You know, why their clothing has been ripped ... I know husbands who worry about their wives going into work in this environment and asking why would you put yourself through this? And so it's – you've got your frontline workers who are extremely traumatised by it, who are worried about it in the back of their mind every day...'*¹³

Lismore's experience with ATS

Use of crystal methamphetamine by people involved in the justice system

- 23.9 Cr Lloyd, Lismore City Council and ALS, told the Inquiry that up to 99% of District Court cases dealt with by the ALS in the region are related to substance use, and most of these are specifically related to crystal methamphetamine.¹⁴ *'Very, very, very rarely you will come across a client that has not been using whilst they committed the crime.'*¹⁵
- 23.10 The Inquiry heard from Robert Lendrum, Senior Manager, Magistrates Early Referral into Treatment (MERIT), Northern NSW LHD, who said that 88 of the 167 clients (52.7%) who exited the program in 2018 identified crystal methamphetamine as their principal drug of concern, ahead of cannabis (70 people).¹⁶ He gave evidence that around 2014 to 2015, the most commonly used form of amphetamine transitioned to a crystal form.¹⁷ Mr Lendrum noted that pressures have increased on the MERIT program in the Lismore area because of the increasing number of clients presenting with ATS use.¹⁸

Presentations to health services

- 23.11 NSW Ministry of Health data for the Northern NSW LHD show increases in the rate of methamphetamine-related hospitalisations. Between 2013–14 and 2016–17, the rate trebled in the Northern NSW LHD. The rate of methamphetamine-related hospitalisations for people aged 16 and over in 2016–17 across all LHDs in NSW was 136.3 per 100,000 population. In the Northern NSW LHD it was 171.4 per 100,000 population.¹⁹
- 23.12 The Inquiry received evidence that the proportion of clients at the LHD's inpatient withdrawal unit at Riverlands Drug and Alcohol Service in Lismore reporting that methamphetamine was their primary drug of concern has risen significantly, from 3.1% in 2010–11 to 11.7% in 2014–15.²⁰

- 23.13 Nevertheless, doctors told the Inquiry they believe ATS-related presentations are stable. Dr Wims, Mental Health, Richmond Clarence, said he believed a recent law-enforcement success in seizing a large amount of amphetamine from a large distributor correlated with a reduction in admissions to the emergency department and acute admissions to the mental health inpatient unit.²¹
- 23.14 Dr Robert Davies, Emergency Director, The Tweed Hospital, observed that crystal methamphetamine-related presentations to the hospital peaked in 2016 and *'seem to have reduced and plateaued since that time'*. He said the emergency department manages about one aggressive and violent presentation for whom police or hospital security are called to assist weekly or fortnightly.²²
- 23.15 Dr Davies said ATS-related presentations to the emergency department are due to a range of factors including intoxication, mental health conditions or medical issues often related to longer-term use such as chest pain, heart failure or frontal lobe damage.²³ He said that while a patient's use of crystal methamphetamine might not be captured in the records if they present with heart failure, he believes current data provide a *'reasonably accurate'* picture of trends related to ATS use presentations.²⁴
- 23.16 He noted that music festival-related presentations are less frequent. He said festivals now have onsite medical facilities providing care from general practice to an onsite resuscitation facility.²⁵

Other service providers' observations about increases in ATS use

- 23.17 Mr Tizard, ACON Northern Rivers, told the Inquiry counselling staff have seen an increase in the number of clients reporting mood problems and depression linked to the use of crystal methamphetamine during 'chemsex'.²⁶ He said 32.4% of clients using ACON's Substance Support Service identified methamphetamine as their primary substance of concern, the same percentage as those who said alcohol was their main concern.²⁷
- 23.18 Leone Crayden, CEO of The Buttery, a not-for-profit drug and alcohol rehabilitation, addiction and mental health organisation near Bangalow, gave evidence of the increase in people seeking assistance for methamphetamine use, from 12% in 2014 to 24% in 2018.

Who is using crystal methamphetamine?

- 23.19 Superintendent Toby Lindsay, Commander of the Richmond Police District, NSW Police Force, told the Inquiry that Richmond Police District staff have observed that people who use crystal methamphetamine are often of low socioeconomic means. This is consistent with the evidence given by Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol Service, who stated that people using crystal methamphetamine are more likely to be younger, from poorer socioeconomic backgrounds, from more rural settings, and more likely to be homeless and identify as Aboriginal compared with patients presenting with other substance use disorders.²⁸
- 23.20 However, Dr Davies, The Tweed Hospital, told the Inquiry that the type of people presenting to the emergency department with ATS-related issues *'has completely changed'* over the past two decades. He said that previously, the typical sort of person was a 20 to 30 year-old male who had used 'speed'. Now, a diverse range of people present with crystal methamphetamine-related issues, including teenagers, people in their forties and fifties, and more women.²⁹ He said: *'... we see a lot of agitated, disordered, angry sort of females'*.³⁰ He noted that he is seeing people from *'the more impoverished side of the community'*, and people with histories of incarceration. However, he is also seeing people with *'regular jobs'*, for example, fly-in-fly-out workers.³¹

- 23.21 The Inquiry received evidence about the difficult histories of many people who use crystal methamphetamine. For example, Robert Lendrum, MERIT, said *‘the level of the trauma that these people have experienced is just astronomical’* and it is becoming *‘generational’*.³² He said people with issues related to crystal methamphetamine have a limited capacity to engage in rehabilitation programs due to the nature of the drug. *‘They struggle to attend appointments, follow through and engage’*.³³

*‘[W]e’re dealing with a whole lot of other complexities and it’s about engaging or having services to engage and provide support, as well, if you’re looking at a whole lot of childhood sexual assault, physical trauma, maybe a familial background with an enormous amount of domestic violence experienced.’*³⁴

- 23.22 Terry McGrath, Team Leader, Namatjira Haven Drug and Alcohol Healing Centre, stated that while alcohol is the predominant drug for which people seek treatment at the centre, the patient cohort generally has ‘multiple traumas and all sorts of complicated issues going on around them, and where even they might be treating themselves with their drug use’.³⁵ He said that many people’s issues with drugs relate to the disenfranchisement they feel in society. *‘[T]he gaps are widening to such an extent that there’s too many have-nots, and they’re feeling out of place, and they need something to relieve their – their inner anxieties, and that’s what they find in their drug use.’*³⁶
- 23.23 Dr Helliwell told the Inquiry that in the Northern NSW LHD, he commonly encounters patients in the Riverlands inpatient withdrawal unit, the Opioid Treatment Program, the hospital clinical liaison service and the MERIT program. He said these patients have more severe amphetamine substance use disorders, often with a history of presentations to hospital emergency departments, acute psychiatric services and involvement with police.³⁷ *‘We see patients with significant psychiatric comorbidity both as a driver and a consequence of amphetamine use disorders.’*³⁸ He noted that many patients have ‘significant comorbidity’ of blood-borne viruses such as hepatitis B, hepatitis C and to a lesser extent HIV as a result of sharing injecting equipment when using amphetamines.³⁹
- 23.24 Ms Crayden, The Buttery, told the Inquiry that, compared to people using other drugs, people presenting with ATS-related difficulties have a higher level of mental health issues. She said, *‘a lot of the people that are coming to us on crystal methamphetamine are also taking antidepressants as well’*.⁴⁰

Availability of ATS

- 23.25 Superintendent Lindsay told the Inquiry a ‘point’ of crystal methamphetamine in the Northern Rivers costs about \$50, or \$400 a gram.⁴¹ He said that people may escalate consumption of illicit drugs from cannabis, to cannabis laced with crystal methamphetamine, to crystal methamphetamine in its own right.⁴²
- 23.26 Dian Edwards, Manager, Namatjira Haven, a participant in the Lismore Roundtable, said that people seeking treatment say they would prefer to use cannabis but crystal methamphetamine is cheaper and readily available.⁴³

Impacts of ATS use in the Lismore region

- 23.27 Lismore City Council’s Social Justice and Crime Prevention Committee noted that drug-related crime and substance use disorder is a huge economic cost to the government and taxpayer, *‘but also comes at a social cost to our families and communities – a cost that can be difficult to quantify but easy to see’*.⁴⁴

Impact on crime and violence

- 23.28 The Committee noted that NSW Bureau of Crime Statistics and Research (BOCSAR) data show that drug-related crime in the Lismore region is two to three times the state average. It noted:

*'[T]he public perceive (and the Committee agrees) that the prevalence of methamphetamine (ice) misuse has become a significant challenge in our region and such misuse is too often sadly linked to violent behaviour and criminal offending.'*⁴⁵

- 23.29 BOCSAR data show that in 2018, two LGAs within the Northern Rivers area had significantly higher rates of incidents of possession and/or use of amphetamine than the NSW average (90.7 per 100,000 of the population): Lismore LGA (129.8) and Richmond Valley LGA (115.8).⁴⁶

- 23.30 Superintendent Lindsay told the Inquiry that detections of crystal methamphetamine and other ATS in the Lismore region, as recorded in the police operational data system WebCOPS, increased from 2014 and peaked sharply in 2016, coinciding with a period of increased overt and covert police investigative activities. He said there was anecdotal evidence of an 'ice drought' from 2017 before detections and legal action rates again increased during 2018. Excluding cannabis, crystal methamphetamine accounts for the majority of illicit drug detections in the police district.⁴⁷

- 23.31 Superintendent Lindsay said that Richmond police are aware of both current suspected crystal methamphetamine dealers and historically convicted dealers within the district.⁴⁸ He said they have been the subject of overt and covert police operations, such as Strike Force Deverill, which ran from mid to late 2018 and resulted in the seizure of 7kg of MDA, other drugs, weapons and cash.⁴⁹

- 23.32 He added that the NSW Police Force has limited data available about the effect of ATS on crime in NSW because the drug-related information in WebCOPS, NSW Police's operational system, is largely collected for detection/seizure incidents only.⁵⁰

- 23.33 The Superintendent told the Inquiry that in 2018 there were a number of approved and non-approved music festivals in the region and during that period there was an increase in detection rates of MDMA and 'other tablets'.⁵¹

- 23.34 In a statement to the Inquiry, William Bon, Field Officer, Lismore ALS, told the Inquiry that the service's clientele base has increased 'dramatically' in the past 10 years alongside a corresponding increase in the prevalence and seriousness of offending. He said: 'I believe the increase is directly related to the prevalence of crystal methamphetamine in our Aboriginal communities.'⁵² Cr Lloyd, Lismore City Council and ALS, told the Inquiry of the incidence of violent offences being committed by people using crystal methamphetamine, including break and enter with violence and domestic violence.⁵³

*'We have a lot of clients who are in great states of crisis ... presenting with a complex array of issues. Generally speaking, when we see a client in the cells, they can be aggressive, upset, sometimes in psychosis, and the fact sheets that go along with the offending generally reveals very unsophisticated and chaotic offending – impulsive, opportunistic and violent.'*⁵⁴

Impact on health services

23.35 Dr Davies, The Tweed Hospital, said that a challenge for health services is ‘*where best to care for these patients*’. He said emergency departments do not have separate areas for intoxicated patients so they might occupy acute beds in the department for prolonged stays. Patients are usually admitted to a mental health unit if there is ongoing psychosis or mental health issues but there are insufficient mental health inpatient beds so admissions can wait days in the emergency department.⁵⁵

23.36 The Inquiry heard of the impact people presenting with crystal methamphetamine-related aggression can have on staff. Dr Davies said the most common type of abuse is verbal abuse, but staff can also experience physical violence such as being punched or bitten or spat upon.⁵⁶

‘For healthcare workers, you know, we go into the profession to help people and to have a subset of patients, you know, that want to do you harm in the course of you trying to care for them is very confronting. And so some staff get very distressed and dismayed and very much want not to be part of the care of those patients ... some of these patients want to do harm and they tell you so in no uncertain terms. So – and it can be scary for a young nurse when they’re telling you that they’re going to come and find you in a few days’ time and find where you live and murder your family. So these are the levels of violence that staff are exposed to, and that is – can be very, very distressing for staff.’⁵⁷

23.37 There is a number of hospitals within the LHD including regional referral hospitals at Lismore Base Hospital and The Tweed Hospital.⁵⁸ These hospitals both have an inpatient mental health unit that receives ATS-related presentations. Dr Wims, Mental Health, Richmond Clarence, gave evidence that the LHD has policies for managing patients with acute behavioural disturbances in both emergency departments and acute inpatient units, but the policies do not specifically address patients using crystal methamphetamine or ATS. Dr Wims said patients are admitted to the inpatient mental health unit once the behavioural disturbance has been managed in the emergency department but sometimes, owing to the level of sedation required, a patient can only be safely managed in an intensive care unit (ICU), which places strain on already stretched ICUs.⁵⁹

23.38 Dr Wims told the Inquiry of the ‘*phenomenal*’ effect a severely behaviourally disturbed ATS-affected person can have on emergency department staff. He said staff are trained to be compassionate and caring, and it can be extremely traumatising to have to forcibly restrain and medicate someone, sometimes for prolonged periods of time. ‘*You’re left confronted with this individual who is basically saying “bring it on, I’m ready for you”.*’⁶⁰ Dr Wims also gave the example of a client who needed large doses of an anaesthetic that caused her to dissociate (disconnect with reality):

‘[W]e weren’t aware that that’s what her experience was; we just thought that she was continuing to kick out and lash out, so she ended up getting more sedative medication. But she was extremely traumatised by that experience and, you know, it caused a lot of distrust. So this whole cycle is just traumatising everybody, and it’s a dilemma about how do to it better.’⁶¹

23.39 Dr Helliwell, Riverlands Drug and Alcohol Service, said that while sometimes he felt the model of care provided is unsustainable and there is stigma attached to addiction medicine, he sees ‘*fantastic outcomes*’.⁶²

*'It gives me great joy working with people at the pointy end of society... I'll often get colleagues say, "Well, why do you work with those losers?" And I'd say, "well, actually, we get really good outcomes". We – you know, if we can engage people and get them into evidence-based treatment, then the outcomes are excellent and you see fantastic turnarounds in people's health.'*⁶³

Impact on other services

- 23.40 Superintendent Lindsay, Richmond Police District, said that the impact of crystal methamphetamine and other ATS on the community is of considerable concern to police. He said police and community members are often injured during interventions in response to people who use ATS. For example, in March 2019, two uniformed officers responded to community concerns about a man trespassing on properties in the township of Woodburn, about 7km inland from Evans Head. A *'violent confrontation'* occurred and two community members helped the officers restrain the man. The police officers and one of the community members was injured. Six hours later, the man could not recall his actions and said he had been on an *'ice bender'* for many days.⁶⁴ Superintendent Lindsay said: *'From my observations and operational policing experience, this incident is not isolated.'*⁶⁵

- 23.41 Cr Lloyd, Lismore City Council and ALS, said ALS staff are affected by the increase in crystal methamphetamine-related issues.

*'I guess we all can be a bit traumatised by some of the issues that our clients present with and we find it very frustrating because we can't get them the help that they need and we will see them in the cells and they're often not fit to give us instructions at all and yet they are bail refused in many cases and there are no beds available in local rehabilitation centres for them to go to.'*⁶⁶

Impact on children and families

- 23.42 Superintendent Lindsay gave evidence that Domestic Violence Liaison Officers believe crystal methamphetamine contributes to domestic and family violence. However, he said data are not available because when recording domestic and family violence-related incidents, there are no specific data fields relating to ATS use.⁶⁷
- 23.43 Mr Lendrum, MERIT, noted that people who have faced domestic and family violence offences are eligible for the program and *'a high number'* of MERIT clients would have domestic violence offences in their history.⁶⁸
- 23.44 Witnesses noted the effect of ATS disorders on families and friends. For example, Deirdre Robinson, General Manager, Northern NSW LHD, Mental Health and Drug and Alcohol Services, said that ATS use has a *'devastating impact on families, even when the user is somewhat high functioning'*. She said the impact is often in the social and psychological realm, *'with strained interpersonal relationships, financial pressures, domestic violence and neglect'*.⁶⁹

- 23.45 When asked about the support available for families, Dr Helliwell responded that:

*'There is a degree of public support through our overstretched drug and alcohol counsellors and case workers. It's yet another burden of care on top of caring for the patients. Apart from that, the only thing we really have across the State, of course, is Family Drug Support, run by Tony Trimmingham, which is an excellent service, but, you know, it is based in Sydney, again.'*⁷⁰

Impact on Aboriginal people

23.46 The Inquiry heard of the far-reaching effect crystal methamphetamine is having within Aboriginal communities.⁷¹ Mr Bon, Lismore ALS, told the Inquiry that *'crystal methamphetamine is breaking relationships, families and communities'*.⁷²

23.47 One participant at the Lismore Roundtable expressed her distress at how crystal methamphetamine has affected her daughter.

*'She doesn't own it, she doesn't see it, even though ... She still doesn't see that it's ruining her life. It's just so hard to deal with, especially when you know she's a beautiful, educated person. She was brought up with morals, she was brought up the right way, she had goals, aspirations for her life. She got in with her partner, who isn't the best person, and her life just took a downward turn from there, even after she had her daughter.'*⁷³

23.48 Cr Lloyd, Lismore City Council and ALS, noted the *'disgraceful statistics'*⁷⁴ relating to Aboriginal incarceration in the Lismore region. In NSW, Aboriginal people make up between 24 and 28% of the overall population of correctional facilities.⁷⁵ Cr Lloyd told the Inquiry that for example, in the Lismore LGA, 35 of the 79 people in correctional facilities (44.3%) were Aboriginal; in Richmond Valley LGA, of 48 people incarcerated, 32 were Aboriginal (66.6%).⁷⁶

23.49 Cr Lloyd also told the Inquiry that the lack of access to rehabilitation often results in her clients not being granted bail, and that there are no programs available to them while in custody or remand. She said:

*'I don't believe that their custodial environment is a proper place for people to start unpacking all of the trauma that may have led to their substance use disorder in the first place. It's not a safe – it's not therapeutic and that's why residential rehabilitation centres are so important.'*⁷⁷

23.50 The impact of ATS on Aboriginal people and communities is discussed further in Chapter 16.

Impact on the LGBTQI+ community

23.51 According to the 2018 North Coast PHN 'Speak Up' community survey, stigma was one of the three most commonly reported barriers to LGBTQI+ respondents accessing AOD services.⁷⁸ It noted:

*'[T]he most significant finding was that people identifying as LGBTIQ were 142% more likely to report stigma and shame was a challenge when trying to access AOD services, when compared to heterosexual respondents.'*⁷⁹

23.52 Mr Tizard, ACON Northern Rivers, also told the Inquiry that stigma, distrust and fear of discrimination are significant barriers for the LGBTQI+ community in accessing services.⁸⁰ ACON offers a community-led service for members of the LGBTQI+ community including for those identifying substance use issues and their friends and family members. It provides face-to-face counselling as well as phone and Skype counselling across other parts of the Northern Rivers and Mid North Coast. It also operates a needle and syringe program from its Lismore office.⁸¹

23.53 ACON provides up to 12 sessions of counselling and care coordination for LGBTQI+ clients with substance use issues, with additional sessions provided on an as-needs basis.⁸²

- 23.54 Derek Tys, Substance Support Counsellor, ACON Northern Rivers, said that the service's therapeutic approach includes motivational interviewing, narrative therapy, art therapy and acceptance and commitment therapy.⁸³ Many clients have had significant trauma in their lives.⁸⁴ Mr Tys said while they might be coming in for a substance-related issue, *'the reason it might be there will be quite multifaceted and this might be the first time that we might actually have an opportunity ... to begin addressing those – those issues'*. Mr Tys added that other issues might be related to the effects of chemsex, which can lead to *'paranoia and obsessiveness and ruminating and an inability to have them be reassured'*.⁸⁵
- 23.55 A lived experience witness told the Lismore Hearing how he first tried crystal methamphetamine in his early 40s out of curiosity during a sexual encounter with a man and it developed into a 'chemsex' party with six men. He detailed how his use of the drug spiralled out of control until eventually he was injecting it.⁸⁶ The witness agreed that stigma was an issue for him in seeking treatment. When he sought treatment from an AOD counsellor, it was to discuss his drinking, and it was some time before he felt able to talk about his use of crystal methamphetamine. He said he could *'handle the shame of alcoholism'* but not the shame and social stigma of being dependent on crystal methamphetamine.⁸⁷
- 23.56 He noted that after completing the nine-month rehabilitation program at The Buttery he decided to remain in the Northern Rivers region. *'I really like the feel of the country environment, it ensures that I'm protected from the triggers of my use in Sydney.'*⁸⁸

Local responses to ATS

- 23.57 Various responses specific to crystal methamphetamine have been developed in the Lismore region in recent years. For example, following the release of the National Ice Action Strategy in 2015, the Bulgarr Ngaru Aboriginal Medical Corporation and the North Coast PHN initiated and jointly funded the Crystal Methamphetamine Project (CMP). In response to community concerns about the impact of crystal methamphetamine on individuals, families, communities and services in the region, the CMP facilitates a stronger focus on improving the integration and coordination of AOD services to meet the needs of the community.⁸⁹
- 23.58 The final report of the CMP details outcomes achieved as part of the project, including the development of an AOD program with a lived experience component. The 'Working Together Project', developed with the Department of Education in consultation with headspace, the NSW Police Force and Tweed Shire Council, was piloted with 58 Year 9 and 10 students from Kingscliff and Tweed River High schools.⁹⁰
- 23.59 Cr Lloyd, Lismore City Council and ALS, told the Inquiry about the work of the Lismore City Council Social Justice and Crime Prevention Committee, which during 2018 investigated the demands, gaps and challenges faced in the AOD, justice and housing sectors. She said it was *'really our community's cry for help'*. Members of the Committee include the ALS, Legal Aid, Community Corrections, a Lismore representative of the Office of the Director of Public Prosecutions and a member from DCJ.⁹¹ The Committee's finding and recommendations are discussed below under 'Opportunities to strengthen local responses'.
- 23.60 A number of collaborative approaches in Lismore aim to prevent the use of illicit drugs, particularly focused on engaging at-risk young people. One police initiative is the RISEUP program, which targets disengaged and at-risk young people and aims to break youth association with crime. Superintendent Lindsay said Bundjalung Elders have joined police, youth case managers and community and Aboriginal liaison officers at the Lismore PCYC for activities.⁹²

*'So it's an opportunity where police identify these kids ... We collect them in the mornings once a week. We take them to PCYC, engage with them through fitness. We feed them breakfast, facilitate their attendance at school. Really positive outcomes.'*⁹³

- 23.61 Superintendent Lindsay told the Inquiry that there are 13 police stations in the Richmond Police District and the three main towns with 24-hour stations are Ballina, Casino and Lismore. There is a small drug unit.⁹⁴ He said the district uses supplementary funding sought through the Recovered Asset Pool program to contribute to the disruption of street and midlevel illicit drug supply.⁹⁵ Dob in a Dealer campaigns have been *'very effective in terms of information sharing'* and that there has been a *'significant amount of information the community has provided to us locally'*.⁹⁶

- 23.62 Superintendent Lindsay noted that the NSW Police Force is involved in Safety Action Meetings where representatives from multiple agencies and support services come together fortnightly to discuss high-risk domestic violence cases.⁹⁷ He said there is also a police and Aboriginal community consultative committee centred around Ballina, Lismore and Casino.

*'They're great opportunities to – for full and frank conversations with our local Aboriginal communities around their needs and also policing initiatives ... It's also an opportunity to problem solve with those communities.'*⁹⁸

- 23.63 The LHD provides several publicly funded services, including counselling, early intervention, hospital consultation, opioid treatment services and medical support and treatment. The main service sites are in Lismore and Tweed Heads, but community drug and alcohol counsellors are also located at other locations in the LHD. There is a 12-bed medically supervised inpatient detoxification unit at the Riverlands Drug and Alcohol Service in Lismore, but it is the only public inpatient withdrawal unit between Newcastle and Brisbane. Other services co-located with the detoxification unit include an outpatient Opioid Treatment Program, a drugs in pregnancy service, the MERIT program, an outpatient counselling and consultancy service and a specialist AOD service.⁹⁹

- 23.64 The Buttery (for adults) and Namatjira Haven (mainly for Aboriginal men) are the two key non-government residential rehabilitation services in the region.

- 23.65 Namatjira Haven, located at Alstonville, between Ballina and Lismore, offers the Gulgiwen Residential Program for Aboriginal men aged over 18, with 14 beds for non-Aboriginal men. The average stay is three months for justice referrals and six to eight weeks for those aged under 21. Men with complex substance use and related issues can stay for four to nine months.¹⁰⁰

- 23.66 The Buttery is a multiprogram facility that includes two residential addiction programs, one which lasts three months and the other three to nine months. It also includes a separate psychological wellbeing program. It operates community outreach programs across the Mid and Far North Coast of NSW. In 2018, The Buttery had 1,240 participants across its programs, including day rehabilitation, individual counselling, group therapy sessions, youth early intervention programs and wellness education. This was an increase of 20% from the previous year. At the time of the Hearing, The Buttery had a six-month wait for men and four-month wait for women for its residential rehabilitation program.¹⁰¹

- 23.67 Other AOD services in the Northern NSW region include Byron Private, which is a private residential facility in Byron Bay,¹⁰² and Rekindling the Spirit in Lismore. Rekindling the Spirit was created by Aboriginal people for Aboriginal people and offers assessment and referral, counselling and support. It is partnered with Lismore's Aboriginal medical service, Jullums.¹⁰³
- 23.68 Mr Tizard, ACON Northern Rivers, told the Inquiry that ACON has demonstrated some success in reducing the use of methamphetamine and that there have been improvements in clients' psychological wellbeing during their engagement with the service.¹⁰⁴ He said ACON volunteers support areas of the service's work such as the Rovers program at music festivals.

Opportunities to strengthen local responses

The need for improved access to treatment

- 23.69 Dr Wims, Mental Health – Richmond Clarence, told the Inquiry of issues for which effective responses need to be found.
- The lack of detoxification facilities. Dr Wims noted that Riverlands provides *'a fantastic service'* in Lismore but there is no such facility in Tweed or at the southern end of the LHD. He said access to rehabilitation *'is a huge problem; the time delay in accessing the rehabilitation is far too long.'*¹⁰⁵ He said that with increased resourcing there is potential for *'ambulatory rehabilitation'* so people could stay at home while they undergo rehabilitation, rather than having to leave their support networks.¹⁰⁶
 - A shortage of AOD clinicians within community mental health centres. *'At last count, we estimated we would probably need an extra 20 clinicians across the – the board.'*¹⁰⁷
 - The lack of a safe injecting facility in the region: *'I think everything that we can do towards harm minimisation for this client group is an opportunity ... to provide better health for [them] ... the ramifications across the community into their families, into their functioning, into their ability to be kind of pro-social and partake in society is increased with every single harm minimisation program we put in place.'*¹⁰⁸
 - Health responses are hindered by the fact that different jurisdictions, such as Hunter New England LHD and the Queensland system, use different forms of electronic medical records. *'Ours doesn't communicate with theirs.'* He said finding ways for multiple agencies to work together more effectively is important.¹⁰⁹
- 23.70 Dr Bronwyn Hudson, Byron Central Hospital, told the Inquiry that more efficient models of care could be provided if there were extra resources. She said one such example was ambulatory withdrawal management. *'Not all patients need to come into hospital to withdraw from certain substances'*¹¹⁰ Dr Hudson also noted that the inpatient withdrawal unit is under-resourced. She said it does not have a clinical director or funding for one.

*'The unit itself has run successfully and achieved good outcomes based on the work of a solo addiction specialist [Dr Helliwell] who is passionate and dedicated to his field. This is an unsustainable model as it is dependent on one person. If this person was to leave the LHD then the unit would be left without any clinical leadership.'*¹¹¹

23.71 Dr Hudson noted other shortfalls in service provision included:

- a lack of support services for people using ATS who are not in crisis but are not stable and in recovery
- no resource or facility for women with children or pregnant women to seek residential rehabilitation in the area
- no weekend or out-of-hours medical cover for the inpatient withdrawal unit
- limited clinical liaison services in the area
- limited or non-existent AOD counselling/outreach teams at all hospitals in the area, including in Byron Bay, where there are *'multiple daily substance-related presentations to ED'*.¹¹²

23.72 Witnesses identified a number of opportunities to improve healthcare service provision in the area. For example, Dr Hudson told the Inquiry that support is lacking for GPs managing patients who are not in an acute phase.¹¹³ Ms Robinson, Northern NSW LHD suggested that a colocation model using nurse practitioners would increase the capacity of GPs to undertake AOD work with patients. She said that colocation of nurse practitioners could provide support to GPs, and *'greater integration of speciality and primary health care services'*.¹¹⁴

23.73 The Inquiry also heard about the key role of clinical liaison nurses in the AOD field.¹¹⁵ However, a number of witnesses noted the paucity of these positions across the LHD, including out of hours.¹¹⁶ Dr Davies, The Tweed Hospital, observed that in his view, additional clinical nurse liaison positions would help engage some patients and reduce re-presentations.¹¹⁷ In addition, Dr Wims said:

*'[H]aving more drug and alcohol consultation liaison would be a great help, and that would help not just within mental health services, but across the rest of the general hospital, where our ATS users are on the medical wards, they're on the surgical wards, the orthopaedic wards, in maternity services. So it would allow much better coverage and a much more comprehensive way of dealing with these people.'*¹¹⁸

23.74 Further, the Inquiry heard about the assistance that technology could offer services to reach regional, remote and rural clients. Ms Robinson, Northern NSW LHD, said telehealth/telemedicine is something that *'... rural and regional areas ... have to embrace.'*¹¹⁹ She agreed that it is a tool that has the potential to enhance the reach of the LHD.¹²⁰

The need to improve diversionary programs

23.75 Circle Sentencing and the pre-trial MERIT program are available in the area but there are resourcing issues. A Drug Court is under consideration for the area.¹²¹

23.76 Mr Lendrum, MERIT, noted that distances in the region and poor transport options are an additional barrier to people seeking treatment for crystal methamphetamine-related issues.

23.77 Mr Lendrum told the Inquiry there was a period when MERIT in Grafton did not have a case manager and, given the two-hour drive from Lismore to Grafton, it was untenable to run it as an outreach program.¹²² But he said there had not been a suspension for *'a while'*.¹²³ Mr Lendrum added:

*'[W]hen you're running it at virtually capacity all the time, if there is – if we say, anecdotally, there was a police raid in the area and we had a big influx on top, we've already got full caseloads – then we would have to say, "We actually have to suspend receiving referrals for a period of somewhere between a month and six weeks".'*¹²⁴

23.78 Mr Lendrum told the Inquiry of extra resources that would assist the program.

- An increase in staffing levels across the district.¹²⁵
- Staff who have the capacity to drive an hour to collect someone and bring them in for treatment or visit them to provide the treatment in their home.¹²⁶
- An extension of the period MERIT can devote to clients with crystal methamphetamine as their primary substance of concern to six months. He said not everyone requires that much time but a *'quality intervention'* could prevent clients returning to court. *'It's saving court time, it's saving resources, it's saving health resources, so there is a benefit in the long term.'*¹²⁷

23.79 Cr Lloyd, Lismore City Council and ALS, said the MERIT program is an *'incredibly valuable'* resource for clients before the Local Court but when it is not available, clients lose the opportunity for MERIT-assisted rehabilitation and a magistrate might need to take a punitive rather than diversionary approach.¹²⁸ She also said that Circle Sentencing had not operated in the region for a few months due to a staffing issue.¹²⁹

23.80 In the Lismore City Council Social Justice and Crime Prevention Committee report, Cr Lloyd noted:

*'There are certainly enough adult and young Aboriginal persons before the courts in this region to support a Koori court that operates one day a week. Casino court operates on Wednesday and despite the Aboriginal population in Casino being about 7%, our clients make up about 70% of the court list on most Wednesdays, and that's just the Casino court experience.'*¹³⁰

23.81 The Committee determined the Lismore community has a need for:¹³¹

- a drug court, a youth and adult Koori court, and justice reinvestment initiatives
- an expansion of the MERIT program
- the return of the DCJ Life on Track program, which is designed for defendants in the Local Court who require assistance to address their complex needs and reduce their risk of reoffending.¹³²

23.82 Cr Lloyd added that Life on Track, managed by the Aboriginal owned and run Rekindling the Spirit, was superseded by the Mission Australia-operated Extra Offender Management Service, which has fewer staff and does not provide the same services.¹³³ She said Life on Track understood the needs of clients living in regional areas.

*'The workers were incredible. They worked outside of the box. They would pick up our clients at night and take them to meetings. They would pick them up early and drive them to therapy sessions. They really worked outside of the box and they worked in a holistic way which I think is really missing now. They worked with that individual on not just on their criminal needs but also all of the other social issues that have led to them becoming involved in substances and in committing criminal offences.'*¹³⁴

23.83 Superintendent Lindsay also supported the introduction of a dedicated drug court: *'The diversionary corrections and support pillars, as we understand the drug court that operates in Parramatta, [have] been very effective. We'd very much like to support that initiative in this district.'*¹³⁵

23.84 Superintendent Lindsay also noted the need for further coordination of effort across government and non-government agencies in relation to diversionary programs.¹³⁶

Need to support people leaving correctional facilities

- 23.85 Dr Wims, Mental Health – Richmond Clarence, said people leaving correctional facilities with mental health problems face the greatest challenges in the community. He said there are increases in deliberate self harm after release and keeping track of patients in custody is logistically challenging due to resourcing and sharing of information issues. He said that in his experience the collaboration between Justice Health and the Northern NSW LHD is ‘poor’.

‘[T]his seems to be exacerbated by the position Justice Health finds themselves in, within the correctional facility where they often do not know whether a prisoner is planned for imminent release or transfer. I believe it is essential to at least include Justice Health in these planning decisions, and ideally to include the LHD who will ultimately have responsibility for the individual upon their release from custody.’¹³⁷

- 23.86 Dr Wims said sometimes ‘you get a distressed phone call from a Justice Health colleague’ to say they do not know where someone has been released to. It could be to a boarding house or to a motel for two nights by Link2home, a homelessness information and referral service.¹³⁸ He said his team is attempting to keep track of patients who are in custody by ringing around various people within Justice Health, Community Corrections and the criminal justice system. Dr Wims gave an example of a recent case in which he tried to ensure continuity of care for a patient in the custodial system who ‘fell through the gaps’.

‘He was moved to Grafton. By the time I had organised the psychiatrist review in Grafton, he had then gotten moved onto Cessnock. Luckily, he did get seen by a psychiatrist in Cessnock, but before the treatment plan could be implemented, he was moved to Windsor. The mental health nurse at Windsor didn’t know anything about this individual or ... what the nature of his problems were, and then he got moved from there and I lost track until, eventually, we – we found him in another part of the corrections system.’¹³⁹

- 23.87 He said that for patients with comorbid mental health and ATS use issues, the inability to keep track of them within the custodial system means that they often go without medication or develop psychosis in a correctional facility.¹⁴⁰ He said it is also an issue when a person exits the system without the knowledge of Justice Health. Dr Wims said it is a ‘really important client group that we need to keep hold of’ so that when they are released, they’re not ‘out of sight, out of mind’ and when they return home health services can help set them ‘on a better trajectory’.¹⁴¹

‘[I]t’s a missed opportunity because if we – if we can’t intervene really quickly, if we can’t provide that – that cushion for them to come out of prison and to say, “We’ve got you. We’re here. We’re containing you. We realise that you have been through this experience. We don’t want you to go back to prison. You don’t want to go back to prison. Let’s work together and find a way of stopping that. Part of that may be stopping your ATS use, and part of that may be getting on medication. Let’s work together.” ... we’ve got a very short window where the individual is motivated to – to start maybe making some changes in their lives before their dealer finds them and says, “Welcome home. Here’s a free little bag just to get you back on track,” because if we can intervene before that happens, then we’ve got a chance, but the dealers are often quicker than we are, and they often know that somebody is out of prison before we do. So that’s a problem.’¹⁴²

23.88 The Lismore City Council Social Justice and Crime Prevention Committee also concluded the Lismore community has a need for:¹⁴³

- further rehabilitation services
- detoxification services for young people
- culturally and gender-appropriate residential services for Aboriginal women and children, for women and children generally and for individuals with a dual diagnosis.¹⁴⁴

23.89 The Inquiry heard evidence from Mr Tizard, ACON Northern Rivers, that to reduce the stigma and shame that act as barriers to LGBTQI+ people seeking treatment, training for mainstream services around inclusion and diversity is required.

‘So understanding what it is behind the acronym LGBTIQ and what that means. I’ve just done two training sessions for a program called Silver Rainbow, which is about training aged-care staff to responding appropriately to the LGBT community, and a lot of that is about understanding the history of discrimination that LGBT people have experienced. And times have certainly changed with things like marriage equality, but if you even look at the marriage equality plebiscite what it did was brought out the arguments from two sides: those for and those against. And those against certainly raised all the issues and the reasons why it shouldn’t happen: that LGBT behaviour is wrong, against moral values of society, those sorts of things. So it has retraumatised people, if you like, in terms of the experiences they’ve had throughout their lives.’¹⁴⁵

23.90 Mr Tizard noted the importance of interagency meetings, *‘sitting around the table with other programs, other drug services’*. He said ACON Northern Rivers has attended staff meetings at other AOD services including Riverlands Drug and Alcohol Service and The Buttery.¹⁴⁶ He said he believes there is a need for group treatment programs and provision for more than the current 12 sessions ACON is able to provide clients whose needs are more complex and require longer-term therapeutic intervention. He gave the example of a recent intake referral to ACON:

‘It was from an Aboriginal trans woman who was living under [a] building in Lismore, had been assaulted by another homeless person, and had been clean for eight days ... so you’re dealing with multiple issues in a case example like that, in terms of homeless, substance abuse issues, gender issues and trauma associated with assault. Very complex clients, some of them.’¹⁴⁷

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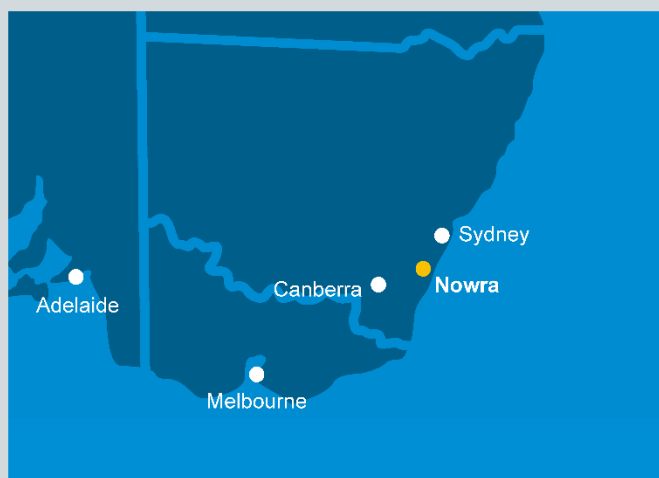
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- ²⁸ Lismore Hearing, Lismore, Exhibit LF, Tab 16, Statement of David Helliwell, 8 May 2019, [5].
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SNAPSHOT: NOWRA

GEOGRAPHY

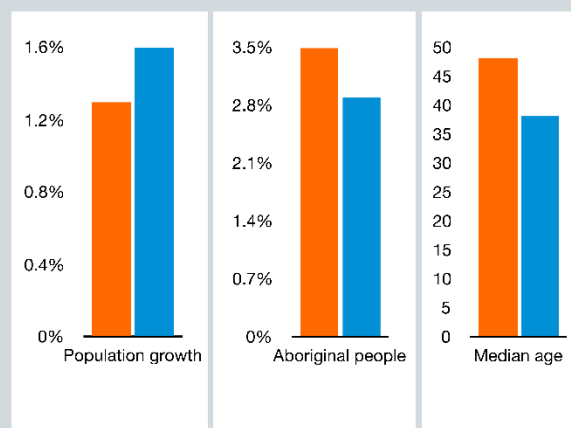


- The town of Nowra is a service centre for surrounding smaller townships lying to the north and south including Kangaroo Valley and Jervis Bay communities such as Huskisson and Hyams Beach.
- Local Health District (LHD): The Illawarra Shoalhaven LHD extends about 250 kilometres and has a population of more than 400,000 residents.
- Primary Health Network (PHN): The South Eastern NSW PHN supports more than 616,800 people across 11 Local Government areas and one Commonwealth Territory (Jervis Bay).
- Police District: The South Coast Police District has police stations in Berry, Huskisson, Ulladulla, Batemans Bay, Narooma, Bega, Merimbula and Eden.

KEY DEMOGRAPHICS

Across the LHD, there is a greater number of people identifying as being an Aboriginal person (3.5%) than the NSW average (2.9%).

■ Nowra ■ State average



(NSW Dept. of Planning and Environment, 2015 to 2016, LHD)

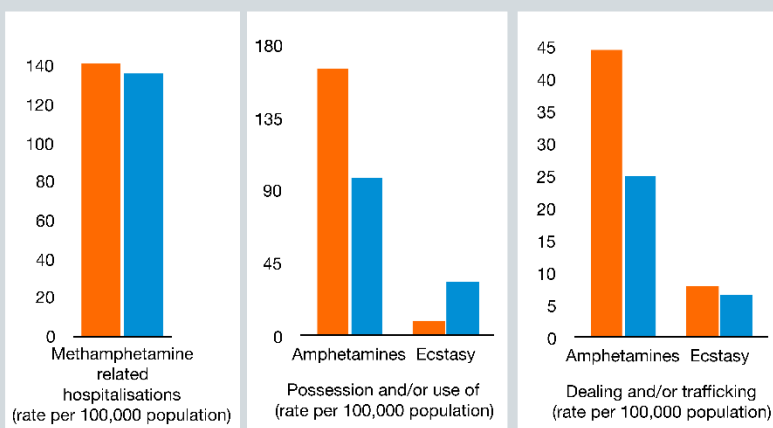
(ABS, Census 2016, LHD)

(ABS, Census 2016, LHD)

(HealthStats NSW, 2016-17, LGA)

HEALTH HARMS & CRIMINAL OFFENCES

The rate of possession and/or use of amphetamines in the Shoalhaven local government area has increased 13.8% annually over the past 5 years.

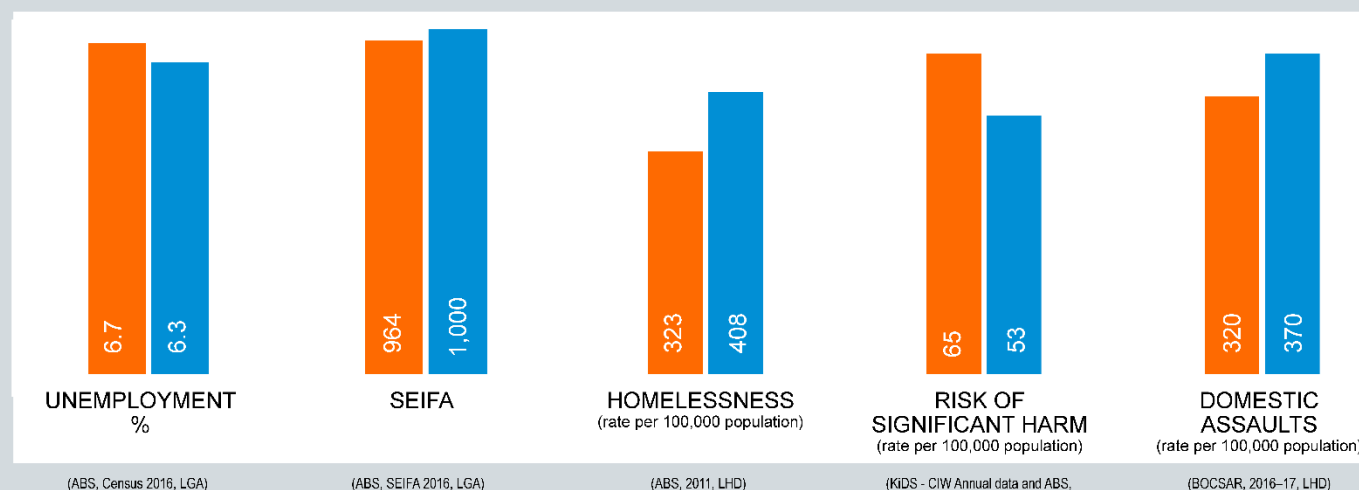


(BOCSAR recorded criminal incidents, Oct 2018 to Sep 2019, LGA)

(BOCSAR recorded criminal incidents, Oct 2018 to Sep 2019, LGA)

KEY SOCIAL STATISTICS

■ Nowra ■ State average



(ABS, Census 2016, LGA)

(ABS, SEIFA 2016, LGA)

(ABS, 2011, LHD)

(KIDS - CIW Annual data and ABS, 2016-17, LHD)

(BOCSAR, 2016-17, LHD)

Chapter 24. The Nowra region

Introduction to the Nowra region

- 24.1 The town of Nowra sits at the heart of the Illawarra, Shoalhaven and Eurobodalla areas on the Shoalhaven River about 170km south of Sydney. The town sits within the Shoalhaven Local Government Area (LGA), which has a population of approximately 99,650 people.¹ Nowra is a service centre for surrounding smaller townships to the north and south including Kangaroo Valley and the Jervis Bay communities of Huskisson and Hyams Beach. Smaller service towns include Ulladulla, Batemans Bay and Narooma.
- 24.2 The Inquiry conducted hearings in Berry and Nowra from 29 to 31 May 2019 to gather evidence about the impact of crystal methamphetamine and other ATS on people living in the region. During private hearings, the Inquiry heard compelling stories from people with lived experience of crystal methamphetamine use and from members of the local Aboriginal community. At the public hearing, government and non-government service providers gave evidence about local responses to ATS, including treatment and rehabilitation options.
- 24.3 The town of Nowra sits in the Yuin Nation, which stretches from north of Kiama, west towards Goulburn and south to Eden.² The Illawarra, Shoalhaven and Eurobodalla areas fall within the South Eastern NSW Primary Health Network, which encompasses two Local Health Districts (LHDs) – the Illawarra Shoalhaven and Southern NSW LHDs. Although there are pockets of affluence in coastal areas in the region, data show that the Illawarra, Shoalhaven and Eurobodalla areas generally experience higher levels of disadvantage than the NSW average.
- 24.4 Evidence before the Inquiry indicated that a greater number of people in the Shoalhaven LGA identify as Aboriginal (5.5%) than the NSW average (2.9%).³
- 24.5 The Inquiry heard evidence about a number of key issues affecting people in the Nowra region who use crystal methamphetamine, their families and communities and service responders.

Nowra's experience with ATS

Increasing use of crystal methamphetamine

- 24.6 Evidence the Inquiry received suggests that use of crystal methamphetamine and other ATS in the Nowra region has increased. There has been an increase in people presenting to AOD services who are using ATS.⁴ Acting Superintendent Kevin McNeil, Acting Commander, South Coast Police District, NSW Police Force, said he has observed an increase in the use of crystal methamphetamine in the south coast region since about 2009, and people have moved from using low-purity ATS to the higher-purity crystal methamphetamine.⁵ He said that as people start using purer forms of ATS, their behaviours become more *'violent, paranoid, agitated ... [and] unresponsive to police commands'*.⁶

Increasing presentations to health services

- 24.7 Health providers told the Inquiry that crystal methamphetamine is the most common illicit drug that they see evidence of in the Nowra region. Dr Simon Tucker, Interim Clinical Director, Department of Medicine, Shoalhaven District Memorial Hospital, Nowra, said the *'majority of recreational drug presentations'* to the hospital's emergency department are related to the use of crystal methamphetamine.⁷ James Pepper, Manager, Specialist Programs, Illawarra Drug and Alcohol Service, told the Inquiry that the data collected by his service as part of the Australian Institute of Health and Welfare's National Minimum Data Set show that, in the past two to three years, ATS have overtaken cannabis as the second most common cause of people seeking drug treatment from Illawarra Shoalhaven LHD Drug and Alcohol Services.⁸ Similarly, Ruth Power, Shoalhaven Drug and Alcohol Service Manager, informed the Inquiry that between 2017 and 2018, the number of clients across the Illawarra Shoalhaven Drug and Alcohol Service reporting ATS as their primary drug of concern increased from 52% to 63%.⁹
- 24.8 Mr Pepper oversees the outpatient Illawarra Shoalhaven LHD Stimulant Treatment Program, the Illawarra Shoalhaven LHD Drug and Alcohol Intake Service, Aboriginal Services and the Wollongong Magistrates Early Referral Into Treatment (MERIT) program.¹⁰ He said he has observed a *'significant increase'* in patients accepted into the MERIT program with ATS as their preferred primary substance. The Illawarra Shoalhaven Drug and Alcohol Service National Minimum Data Set data also shows that between 2009 and 2018, ATS use for people on Illawarra Shoalhaven LHD MERIT programs increased from 19% to 63%.¹¹
- 24.9 Dr Frank Cordaro, GP Staff Specialist, Illawarra Shoalhaven LHD, said that since he started working for the LHD's drug and alcohol services in 2015, crystal methamphetamine has always been the most common ATS used. *'Other ATS are encountered from time to time, but never in the context of daily, or near daily use, as is frequently the case with crystal methamphetamine use.'*¹²
- 24.10 Hospital admission data add weight to this evidence of an increase in the use of crystal methamphetamine. Between 2013–14 and 2016–17 in the Illawarra Shoalhaven LHD, the rate of methamphetamine-related hospitalisations for people aged 16 and over nearly doubled, from 77.8 per 100,000 population to 141.7. In the Southern NSW LHD, the rate more than doubled, from 43.1 per 100,000 population to 95.8. In 2016–17, across all LHDs in NSW, the rate of methamphetamine-related hospitalisations for people aged 16 and over was 136.3).¹³

Other service providers' observations about increase in ATS use

- 24.11 The Inquiry heard from service providers and witnesses in the family and community services sector who said they have witnessed an increase in ATS-related issues. For example, Amanda Jamieson, Manager Client Services, Nowra Community Services Centre (CSC), NSW Department of Communities and Justice (DCJ), said that in the past 10 years she has observed an increase in the number of families in the Nowra CSC affected by ATS use.¹⁴ She told the Inquiry that, of the 124 families the Nowra CSC was working with, 49 (39.5%) have ATS as a risk factor.¹⁵
- 24.12 Other service providers' observations are consistent with Ms Jamieson's evidence. Shirley Diskon, Manager, Hope House, which provides accommodation in Batemans Bay for men who experience homelessness after leaving correctional centres on bail or parole, said she had seen an increased use of crystal methamphetamine in the past three years. *'There is more criminal behaviour involved, more violence – more domestic and family violence.'*¹⁶

- 24.13 Rosa Coordinated Care, Shoalhaven Women's Resource Group, has also experienced an increase in the number of women who identify that they use ATS (65% of clients).¹⁷

Who is using crystal methamphetamine?

- 24.14 Witnesses gave evidence to the Inquiry about common characteristics shared by people using ATS. For example, Dr Cordaro, Illawarra Shoalhaven LHD, noted that he commonly observes the following characteristics among his patients:

*'... male, age 30–50, lower socioeconomic status, unemployed or unstable employment, accommodation provided by Department of Housing, fractured family structure (divorced, separated, limited contact with parents, children and siblings), previous traumatic life events (child abuse, sexual abuse), a concurrent mental health diagnosis (depression, bipolar affective disorder or psychotic disorder) and removal of children by Family and Community Services.'*¹⁸

- 24.15 Dr Tucker, Shoalhaven District Memorial Hospital, also gave evidence that people using ATS are generally aged under 50, and crystal methamphetamine is *'more prevalent among lower socioeconomic groups and those who are homeless'*.¹⁹ He said he has been surprised that he has seen more women than men presenting with issues related to crystal methamphetamine.²⁰ Dr Tucker noted that ATS use is commonly an incidental disclosure when emergency staff take the histories of patients who present asking for help for mental health issues or unrelated illnesses or injuries.²¹
- 24.16 However, Matthew Sterling, Paramedic, Bulli Ambulance Station, NSW Ambulance, said the people using drugs with whom he has contact in the South Coast region do not seem to be from a socioeconomically disadvantaged group. He said they tend to be in their early twenties to mid-thirties and report that crystal methamphetamine is the first drug they have used.²²

Impacts of ATS use in the Nowra region

Impact on crime and violence

- 24.17 Acting Superintendent McNeil, South Coast Police District, said he believed *'increased proactive and covert strategies'* deployed by police in the area have led to an increase in the detection of ATS²³ and that the purity levels of the ATS seized are higher.²⁴
- 24.18 NSW Bureau of Crime Statistics and Research (BOCSAR) statistics in evidence before the Inquiry show that in 2018 there were 130.1 incidents of use/possess amphetamines recorded per 100,000 of the population in the Shoalhaven LGA, having increased from a rate of 45.3 incidents per 100,000 of the population in 2014.²⁵ The statistics showed that while there were 14.6 recorded incidents of dealing/trafficking in amphetamines recorded per 100,000 of the population in the Shoalhaven LGA in 2018, this had decreased from a rate of 32.2 recorded incidents per 100,000 of the population in 2014.²⁶

- 24.19 Acting Superintendent McNeil said that since 2009, he has seen an increase in violence and behaviour similar to psychosis associated with the use of crystal methamphetamine, further stating:

*'My experience has been that ATS users would normally have a history of sustained drug use before developing such behaviours, however it appears to me that the drug "ice" reduces that timeframe. ... my experience is that the behaviour of individuals can be similar to paranoid, aggressive or psychotic.'*²⁷

- 24.20 Carol Thomas, South Coast and Tablelands Area Manager, Juvenile Justice (now Youth Justice NSW), gave evidence to the Inquiry that ATS use has been a factor in the offending behaviour of clients. Offences include stealing to buy drugs, break and enter, and assault.²⁸
- 24.21 Mr Sterling, NSW Ambulance, said the frequency of callouts to incidents that were initially described as 'behavioural disturbance' or 'mental health issues' but upon attendance apparently involved drugs has increased.²⁹ He said he has attended domestic violence incidents where the patient was the victim of a family member who was acting under the influence of ATS.³⁰
- 24.22 Waminda South Coast Women's Health and Welfare Aboriginal Corporation submitted to the Inquiry that, in cases where clients have been the victims of domestic violence, approximately 80% of the perpetrators have been under the influence of drugs and/or alcohol, and of those approximately seven out of 10 have used crystal methamphetamine.³¹
- 24.23 Acting Superintendent McNeil gave evidence that in his experience, ATS-related domestic violence occurs between husbands and wives or partners, and also between adult children and their parents. *'... sometimes the parents decide not to report whatever is going on at home and we've clearly seen some violent incidents ... where it's quite clear that the people have used ice.'*³²

Impact on health services

- 24.24 Health service providers told the Nowra Hearing about the challenges of caring for patients who present to health services with behavioural issues related to crystal methamphetamine use. For example, Mr Sterling, NSW Ambulance, said that where he is called to a behavioural disturbance and a patient has used crystal methamphetamine, *'it is more common than not that I would sedate and/or restrain them'*.³³ Mr Sterling further stated:

*'I have observed that these patients are aggressive and reluctant to attend hospital but in my opinion they are unsafe not to transport. The risk of the patient to themselves or to other people is high and they do not have the required capacity or competency to refuse transport.'*³⁴

- 24.25 Mr Sterling said there is a perception among paramedics that the increase in the use of ATS has affected their level of safety. He said his colleagues have a heightened sense of *'situational awareness'* and of the need to conduct a more thorough risk assessment when attending scenes. *'We've certainly had an ... increase in the number of paramedics who have been assaulted.'*³⁵

- 24.26 Dr Tucker, Shoalhaven District Memorial Hospital, told the Inquiry that patients presenting to the emergency department affected by ATS use sometimes lash out, kick equipment or knock things over.³⁶ He said he is *'aware of incidents where, you know, members of staff have felt threatened, have been spat at by patients presenting with mental health and recreational drug use'*.³⁷ He noted that junior staff may be warned about patients who present regularly that have previously been aggressive or violent to staff.³⁸
- 24.27 Dr Tucker said that about once a fortnight he involuntarily sedates a patient affected by ATS, but he said sedation is a last resort and it is better to try to *'negotiate, understand and communicate as a means of de-escalating a situation'*. He said such patients often need a mental health assessment and if they have been sedated they might not be suitable for an assessment for up to eight hours. *'That's a much longer period of time within the emergency department, waiting for that assessment.'*³⁹ He said occasionally patients might be delayed for up to 12 hours before they received a mental health assessment. He also noted the difficulties presented by patients who abscond.⁴⁰
- 24.28 The Inquiry heard that finding appropriate spaces in health facilities to treat people affected by crystal methamphetamine is an ongoing challenge. For example, Dr Tucker told the Inquiry that Shoalhaven District Memorial Hospital has a designated 'mental health room', but it is in a busy, stimulating area in the emergency department, which can contribute to an escalation of *'illness behaviours and increased disorientation for ATS users with cognitive impairment as a consequence of their use'*. He said a quieter location would help in *'de-escalating'* such patients.⁴¹ Dr Tucker said that under plans to redevelop the hospital, the emergency department will be rebuilt and provisional plans include *'a more sympathetically located mental health zone'* closer to security services and with increased capacity.⁴²
- 24.29 Dr Tucker noted that the hospital's mental health service does not operate 24 hours a day, seven days a week. Out of hours, it uses the on-call psychiatry team at Shellharbour Hospital who provide a district response.⁴³
- 24.30 Adam Bryant, Acting Director, Mental Health Illawarra Shoalhaven LHD, told the Inquiry that, in his experience, the most significant challenge for mental health services is finding an appropriate treatment location for patients acutely affected by ATS or withdrawing from the drug.⁴⁴ He said that, at times, these patients are treated in acute mental health facilities under the *Mental Health Act 2007 (NSW)* for *'brief psychotic experiences in the context of their ATS intoxication or symptoms related to their withdrawal'*. But he noted that such behaviour can affect other patients in the mental health unit.⁴⁵
- 24.31 Dr Cordaro, Illawarra Shoalhaven LHD, described the challenges AOD specialists face in trying to assist people using ATS who might be experiencing psychotic symptoms: *'They simply won't turn up or the cognition is simply not there to ... partake in counselling.'*⁴⁶
- 24.32 The Inquiry heard that service providers working in Nowra face risks due to crystal methamphetamine use in the community.
- 24.33 Ms Jamieson, Nowra CSC, told the Inquiry that generally two case workers are sent out on all initial home visits but with families in which ATS is an issue, all subsequent visits also require two case workers.⁴⁷ *'They may be compliant and engaging on one visit, but we don't know, from one visit to the next, whether that's going to be the case. And so workers have become fearful about going out on their own just in case.'*⁴⁸

- 24.34 Ms Jamieson said it is a drain on resources and, as a result, other children who have been reported as at risk of significant harm potentially might not be able to receive a service.⁴⁹ She added: *'It wouldn't matter how many staff we had. We will never be able to get to all the work that we need to get to.'*⁵⁰

Housing and homelessness

- 24.35 Submissions and research before the Inquiry indicate that homelessness or unstable housing are critical risk factors associated with harmful drug use.⁵¹ The Inquiry has also received evidence that people dependent on drugs, including crystal methamphetamine, often have complex, interrelated needs that require integrated multidisciplinary services. However, these needs cannot be properly addressed while housing is unstable.⁵² The association between homelessness and harmful drug use is discussed in Chapter 17.

- 24.36 Many witnesses at the Nowra Hearing spoke of the housing issues faced by people who use ATS. At the Nowra Roundtable, participants talked about the challenges of maintaining housing while undergoing rehabilitation. Corrina Faulkner, Family Litigation Unit, Legal Aid NSW, noted:

*'[W]hen you're talking about a mother ... how does she do that? How does she go, for example, to spend a year in Karralika in Canberra to try to deal with her drug addiction and maintain a relationship with the child and maintain housing? Because as soon as she does that, her Department of Housing ceases, and if you don't have housing, you can't have your child. So, there's a lot of problems with the connection of the systems...'*⁵³

- 24.37 Ruth Power, Nurse Manager, Shoalhaven Drug and Alcohol Service, and manager of the MERIT program, described the complexity of circumstances that people can face, including debt, a lack of money for public transport, mental health issues, family violence, DCJ involvement and homelessness, all of which can be barriers to clients committing to programs.⁵⁴ Ms Power further observed that:

*'[W]e do have a lot of clients who have significant issues with housing, temporary housing, moving around quite a bit. They'll often be trying to change their living situation if they want to remove themselves from where there's other people using ATS substances.'*⁵⁵

- 24.38 Ms Power added that when someone does not have secure housing, their immediate need is to feel safe and to find a home, so keeping weekly appointments or contact with an AOD service can be difficult.⁵⁶

- 24.39 Ms Diskon, Hope House, said men who used ATS often lose public housing for a range of reasons: *'It can be that they're depressed. ... there are mental health issues, so they don't look after the property ... they spend their money on the drugs and don't pay their rent – don't look after their properties ...'*⁵⁷

- 24.40 Even after treatment, finding stable housing is extremely difficult. Ms Diskon noted that every one of the 69 men who had been at Hope House since 2018 had applied for public housing during their stay but only two received it. She said that three rental references are required for public housing and providers do not like to put more than one single man in a property.⁵⁸ She noted that Hope House has no contact with community housing provider Southern Cross Housing and makes private housing applications for clients.⁵⁹ Of the men who had been at Hope House since 2018, 34 were placed in private rental housing.⁶⁰ Of the difficulty in securing stable housing for clients leaving Hope House, Ms Diskon noted:

*'[I]t's very limited, the rental properties – affordable rental properties in Batemans Bay to be able to place everybody, and there's a bit of a stigma attached for people with criminal behaviour, drug use, homelessness, that sort of thing, but we do our best to make sure that anybody who leaves has somewhere to go safe.'*⁶¹

- 24.41 Southern Cross Housing is the largest community housing provider in the Shoalhaven, Eurobodalla and Cooma-Monaro region.⁶² As a registered community housing provider, one of its performance outcome goals is to facilitate access to support for tenants who have complex needs.⁶³ Alex Pontello, CEO of Southern Cross Housing, gave evidence about the challenges involved in finding housing for such people, including those with AOD and/or mental health issues: *'[W]e are getting more and more complex clients. You know, the days of the mum and dad and a couple of kids just wanting a helping hand through social housing is tending to disappear ...'*⁶⁴
- 24.42 Mr Pontello noted there is a mismatch between the needs of clients and available housing stock. He said most people on the priority waitlist require one-bedroom accommodation but most available housing is *'the old-style three/four-bedroom-type accommodation'*.⁶⁵ He agreed that public housing is not readily available for men to share,⁶⁶ and said that men who have complex needs can present potential risks in terms of aggression if housed together.⁶⁷ Decisions about which person on the priority waitlist will receive housing are made based on suitability. He said if a man with complex issues or mental health issues is at the top of the list but the place available is in a unit complex of mostly women, the decision might be that it is inappropriate accommodation for him. That could mean the man might be on the list for a longer period of time.⁶⁸
- 24.43 Ms Forbes, Rosa Coordinated Care, told the Inquiry that housing is one of the biggest issues in the area.⁶⁹ In 2014, the Shoalhaven Women's Resource Group received funding to develop Rosa Coordinated Care to provide intensive case management for women over 18 returning to the area after time in custody or AOD rehabilitation. It gives priority to women who are experiencing homelessness or at risk of homelessness. Ms Forbes said barriers to women entering treatment include the fear they might lose access to their children or lose their public housing tenancy.⁷⁰
- 24.44 She noted that under a partnership between Rosa and Southern Cross Housing to support women with transitional accommodation, it took 18 months for one woman to be housed. *'We thought it was going to be six months.'*⁷¹ In relation to the significance of unstable housing or homelessness for the clients Rosa Coordinated Care works with, Ms Forbes told the Inquiry:

*'If a woman is couch-surfing or living in her car or whatever, there is all sorts of, perhaps, temptations or need to, or just a sense that nothing is going to be better, "I may as well use". They've got nowhere safe or comfortable where they can actually bunker down and ... shut the world out in a way. Unfortunately, we have had a couple of women who have felt that if they just did a petty crime and went back inside at least they would have somewhere to stay, and we just find that particularly tragic.'*⁷²

Case study

Michelle Preston shared the story of a relative who has used crystal methamphetamine for nine years. She said he suffered trauma as a child and has a troubled history including early drug use, time in juvenile detention and, later, adult correctional facilities. He has had multiple involuntary admissions to mental health facilities under the *Mental Health Act 2007* as a result of psychosis. Four years ago, he was diagnosed with schizophrenia.⁷³

*'[He] is homeless and camps 12km out of Narooma. He walks barefoot along the highway with his dog to attend brief mental health appointments. His dog is his security and comfort. He doesn't have a shower or anything to cook on. He has been on the public housing list for six years but still hasn't got a place.'*⁷⁴

When Ms Preston's relative leaves psychiatric care he is released into homelessness. He once walked along the middle of a highway at dusk to return to where he was camping. She said he is *'desperately unwell ... I don't think he is going to make it through winter'*.⁷⁵

Ms Preston told the Inquiry that homeless camps have sprung up along the south coast because of the lack of private rental accommodation and social housing and a high unemployment rate. She said there are *'clusters of people just living the best that they can'* at campgrounds, caravan parks and in parks along the south coast.⁷⁶

Impact on children and families

- 24.45 The Inquiry heard how an individual's use of crystal methamphetamine and other ATS can affect families and the wider community. For example, Acting Superintendent McNeil, South Coast Police District, said crystal methamphetamine contributes to greater violence in a family and can cause the breakdown of a family unit.⁷⁷ Mr Sterling, NSW Ambulance, gave evidence that he has attended a number of incidents in which parents have called emergency services to get assistance for their child's ATS use, further noting:

*'[W]hen I have spoken to the parents they report to me that they have difficulty finding the support their child requires and then, when they find the support, it is difficult to get the child to commit to rehabilitating. Many of the parents that I have met in these situations describe themselves as being at their "wit's end" and emotionally they are spent.'*⁷⁸

- 24.46 Ms Thomas, Juvenile Justice, gave evidence about the agency's work with young clients in the region. She said the South Coast and Tablelands Area staff supervise 81 clients (including 12 in custody), with the Nowra team supervising 28 clients (including six in custody).⁷⁹ Ms Thomas told the Inquiry that the majority of clients present with ATS use.⁸⁰
- 24.47 She said that most clients who use crystal methamphetamine have backgrounds of trauma and their lifestyles are difficult and chaotic as a result of using ATS.⁸¹ Conflict at home as a result of their drug use might mean they are not able to stay with their family, or it might be a difficult home environment from the outset, *'so they're often moving around and staying at different places and may not know where they're going to stay next'*.⁸² They might not have the stability or ability to attend school or jobs, or fulfil their obligations under their orders, which can result in breaches leading to a more significant or longer order, or custody.⁸³ On the problems posed by crystal methamphetamine to clients, Ms Thomas noted:

*'[B]y the time a young person comes to us, they've disengaged from school, sometimes for a long period. So they can't read and write particularly well. Employment is another issue; they're not able to find work. Motivation is huge, so even being motivated to look for employment is often not there. You know, motivation to even come and see us or counselling, get some AOD counselling, is also very difficult. Having structure in their lives ... Often their peers are using with them, so their peer group is really significant, especially to a young person. So that makes it even more complex.'*⁸⁴

- 24.48 Nowra CSC is responsible for delivering child protection and out-of-home care services to families in the Shoalhaven LGA, including responding to risk of significant harm reports made in relation to children living in the geographic area serviced by Nowra CSC.⁸⁵ Ms Jamieson, Nowra CSC Manager, told the Inquiry that 34 of the 52 children who entered care in Nowra between April 2018 and April 2019 were from a family in which one or both parents used ATS.⁸⁶
- 24.49 Ms Jamieson said she has observed instances of multigenerational ATS use in the Nowra area.⁸⁷ She said such use makes it more difficult to keep children connected to their families because kinship care might not be available if grandparents are also using ATS.⁸⁸ Ms Jamieson explained the impact on children of a carer who suffers from psychotic symptoms related to using crystal methamphetamine: *'... it's the unpredictable nature of the care that's being provided; it's the lack of routine; it's meeting their basic [sic] needs, but it's also exposing children to a parent who is displaying very erratic behaviour.'*⁸⁹

Impact on Aboriginal people

- 24.50 The Inquiry received evidence about the impact of ATS on Aboriginal communities in the south coast region and the additional barriers they face in accessing services.⁹⁰ Acting Superintendent McNeil, South Coast Police District, said crystal methamphetamine has had a *'devastating effect'* on Aboriginal families and communities.⁹¹

Elders care for children until they come of age

Waminda South Coast Women's Health and Welfare Aboriginal Corporation submitted to the Inquiry that in Aboriginal culture, family obligations extend beyond partners and children, so the impact of crystal methamphetamine is far reaching. If parents use crystal methamphetamine, family members often end up caring for nieces, nephews, grandchildren and cousins. Waminda gave an example of one Elder in its healing program who had become the full-time carer of her grandchildren, aged four and six. The children's parents were both using crystal methamphetamine.⁹²

*'She had to undergo several interviews and supervision to see how she was coping with the children and she fought hard to gain custody. Waminda were able to support her with accommodation until appropriate housing was found and she was supported by staff in transitioning to a full-time carer role. Her confidence in her ability to be a full-time carer and being the right person to care for her grandchildren was rocked due to the negativity she faced by FACS and she needed reassurance that she was going to be okay and that she was the right person to care for her grandchildren. While Dad is now back in the children's life and has occasional care and visits, Auntie is still their full-time carer.'*⁹³

The experience of Aboriginal communities is discussed in Chapter 16. The impact of ATS use on families and friends is also discussed in Chapter 18.

Local response to ATS

- 24.51 The Inquiry heard about a range of initiatives from service providers in the Illawarra, Shoalhaven and Eurobodalla areas. Acting Superintendent McNeil described the work of Safety Action Meetings (SAMs) during which agencies such as Health, Education, DCJ, Housing and Corrections come together with non-government agencies to share information about cases to *'prevent or lessen serious threats to the life, health or safety of domestic violence victims and their children'*. The Inquiry heard that if police or DCJ are aware that a perpetrator of domestic violence is dependent on crystal methamphetamine, this would be discussed at the SAM.⁹⁴ Acting Superintendent McNeil observed SAMs are: *'action-based and it is one of the most effective tools that I've seen since I've been a police officer that's come [in] for the interagency communication and relationships that have been built.'*⁹⁵
- 24.52 At the Nowra Roundtable, there was a consensus of opinion that Work and Development Orders (which allow for fines to be 'paid off' by engaging in other activities such as counselling) have been a success for Aboriginal people. This is because they are not only able to pay off the fines, but also receive appropriate support for other issues including ATS use.⁹⁶
- 24.53 Ms Thomas, Juvenile Justice, gave evidence about community-based programs and services utilised by young people involved in the criminal justice system from the Nowra region that assist in addressing ATS use. They include:⁹⁷
- The Alcohol and other Drug Education module in the Changing Habits and Reaching Targets (CHART) program, delivered by a caseworker during supervision with a young person on a community-based sentence. It is designed to help young people develop effective coping strategies to assist them to maintain behavioural change and prevent relapse.
 - The X-Roads program for young people on community-based orders who require extra intervention after completing the CHART program. It explores precursors to drug use, urges and cravings and provides strategies to stay on track. It also explores how good support systems and communication can help the young person manage triggers. It focuses on motivating behaviour change.
- 24.54 Some service providers told the Inquiry that they have shifted their efforts because of the increase in the number women identifying ATS use as an issue. Ms Forbes, Rosa Coordinated Care, said that initially the service focused on arranging for clients coming out of correctional facilities to go on housing lists, getting them identification documents and assisting with restoration of access to children, but ATS use has led to an increased complexity in the lives of clients and a change in the *'nature and breadth of services required'*.⁹⁸ Ms Forbes noted the expanded range of support required for Rosa Coordinated Care clients, stating:
- '[T]here has been an increase in need for mental health services, mental health support, drug and alcohol rehabilitation programs, drug and alcohol counselling. We've found an increase in financial debt ... and financial counselling need. Financial literacy is really difficult for a lot of people.'*⁹⁹

Hope House programs make clients ‘feel good about themselves’

The Inquiry was told of the work of Hope House, which has the capacity to care for eight men at a time for up to six months. It has supported 69 men since 1 January 2018, 78% of whom presented with ATS-related issues including homelessness, mental health issues and criminal behaviour.¹⁰⁰ In response to clients’ needs, it offers holistic, therapeutic rehabilitation programs. In addition to Alcoholics and Narcotics Anonymous and SMART (Self-Management and Recovery Training), programs include lifestyle skills, basic numeracy and literacy, computer basics and anger management.¹⁰¹

Ms Diskon, Manager of the service, said that 100% of clients have trauma in their past, including sexual assault, domestic violence, family breakdown, parental abandonment and homelessness.¹⁰² She said trauma-informed practice is essential and that mental health, dependence, criminal behaviour and homelessness are connected. She said that crystal methamphetamine has different effects on people compared to other drugs and alcohol, and Hope House has changed some of its programs to increase the focus on clients’ anger and trauma.¹⁰³ Ms Diskon observed:

‘The clients that are on crystal methamphetamine seem to be more anxious. Their mental health issues seem to be more exacerbated. ... It has impacted quite a lot on their actual life – their self-esteem, their self-worth, their physical health. They ... come to us about 60kg and, by the time they leave, they’re about 90kg. They’re just really down and out.’¹⁰⁴

Ms Diskon also noted that Hope House does not have the ‘strictness’ of other rehabilitation centres:

‘I like to make it like a family community place. Most of these men have been downtrodden. No one loves them. They’re all by themselves. They’ve got such low self-esteem. We try to make them – pick them up and make them feel good about themselves.’¹⁰⁵

- 24.55 In its submission to the Inquiry, Waminda described its Healing Framework which focuses on evidence-based practice and on an integrated and holistic approach to healing rooted in Aboriginal culture.¹⁰⁶
- 24.56 Waminda’s Nabu service works with DCJ and provides intensive family support and case management to high-risk families for periods of up to five years.¹⁰⁷ Waminda also runs a number of other facilities and services, including a gym, a respite house, a health centre and a farm.¹⁰⁸
- 24.57 The Inquiry heard from Gabriella Holmes, Program Manager of Mission Australia’s Triple Care Farm, a withdrawal management and residential rehabilitation program in the Southern Highlands for young people aged between 16 and 24 from around Australia.¹⁰⁹ The withdrawal management unit was a recent addition to Triple Care Farm, and was designed specifically to respond to the longer periods of withdrawal associated with ATS, allowing for up to 28 days of supported withdrawal.¹¹⁰ Ms Holmes told the Inquiry that, in 2018, more than 100 young people went through the 10-bed unit.¹¹¹

- 24.58 Ms Holmes gave evidence about the importance of Triple Care Farm's Aftercare Program. It has four support workers, including one based in the Illawarra Shoalhaven, and another in Campbelltown, the areas from which the largest numbers of referrals come. The support workers take clients to appointments, help them look for jobs, fund recreation and help them sustain accommodation and housing. Two other support workers are based at Triple Care Farm. One provides remote support using Skype or Facebook for clients who have come from farther afield.¹¹² Ms Holmes said:

*'[O]ne of the things we find is effective is that because the Aftercare worker is based at Triple Care Farm, that young person has got to know them really well while they're participating in the program. So, they have really good trust and rapport, so they can have really meaningful conversations when they're in the community. If they're having a difficult time, they can call in, have that support and then be connected to the support network that they established while they were at the farm.'*¹¹³

- 24.59 There are limited services providing residential drug treatment for young people in NSW.¹¹⁴ Ms Holmes told the Inquiry of the significant demand for Triple Care Farm's programs, noting that they received over 2,700 inquiries for their service in 2018 (up from 1,830 in 2012), with young people remaining on the wait list for the service for up to 17 weeks.¹¹⁵ Ms Holmes noted that on each occasion Triple Care Farm has advertised the program through media, they have been '*completely overwhelmed with inquiries for unmet need.*'¹¹⁶
- 24.60 The Inquiry also heard evidence that a local support group for families of people who use crystal methamphetamine was started in 2017 by two women with family members who use ATS.

Opportunities to strengthen local responses

- 24.61 In written and oral evidence to the Inquiry, witnesses noted a range of shortfalls in the response to crystal methamphetamine use in the Nowra region. Most commonly the Inquiry heard of a lack of detoxification and rehabilitation centres and the need for acute care facilities to manage AOD and mental health comorbidities.
- 24.62 Ms Thomas, Juvenile Justice, described how young people using ATS have difficulties accessing services in the Nowra region. Some key services for young people, especially detoxification and rehabilitation services, are difficult to access. Most frequently, young people from the Nowra region go to the Ted Noffs Foundation's Canberra residential centre, Program for Adolescent Life Management (PALM).¹¹⁷ On rare occasions, Shoalhaven clients have been sent to Mac River Rehabilitation Centre in Dubbo,¹¹⁸ which caters to young people aged between 13 and 18. Ms Thomas told the Inquiry that most young people under the supervision of Juvenile Justice are reluctant to travel for treatment.¹¹⁹
- 24.63 For young people in more remote areas of the region, issues with public transport can be a barrier to them travelling to towns to access community-based counselling and rehabilitation services.¹²⁰ Ms Thomas told the Inquiry that it can be difficult for young people to travel to the ACT to attend the PALM rehabilitation service. Sometimes Juvenile Justice staff are able to take them while other times public transport might be organised.¹²¹
- 24.64 Young people might also have trouble accessing such services because of long wait lists or because services have exclusion criteria (for example, excluding young people who have committed violent or sexual offences).¹²²

24.65 Ms Jamieson, Nowra CSC, also gave evidence that the lack of detoxification and rehabilitation services is the biggest challenge facing the centre in its work to help families with children affected by ATS use. Ms Jamieson told the Inquiry that *'[o]ur families need to travel to Wollongong, Canberra, Sydney; there's nothing locally.'*¹²³ She also confirmed that adolescents requiring treatment need to travel to Canberra or Sydney.¹²⁴

24.66 In evidence that echoed the experience of a number of regional areas, other witnesses also noted that the distances involved in the Nowra region and lack of public transport presents issues for people seeking treatment or trying to support family members in treatment. For example, Ms Preston, while sharing her experience of accessing services for a relative using ATS, noted:

*'Narooma has very limited services, and we have to travel up and down the highway to get to Moruya and Batemans Bay where there are hospitals and other services. There's no public transport in the area so if you don't have a car it is very difficult. If you have to get to Sydney there is only one morning bus which leaves at 4.30am.'*¹²⁵

24.67 At the Nowra Roundtable, participants also noted the need for local residential rehabilitation so people can stay on Country near their family, children and support networks. Katie Fox, Regional Coordinator, Waminda Drug and Alcohol Brokerage, said:

*'[T]hat's what's preventing a lot of our women from staying when they get into treatment. They miss their – they're so far away from Country ... so even the stress of actually accessing treatment is a lot stronger than the addiction.'*¹²⁶

24.68 The Inquiry heard that the implementation of telehealth models, including the use of video conferencing facilities in regional areas, can assist in overcoming the barriers to accessing services posed by the geographic size of the region. It was also noted that there are some issues in the implementation of such models, such as coverage and capacity, and that it is still preferable to see patients in person.¹²⁷

24.69 Mr Pepper, Illawarra Drug and Alcohol Service, told the Inquiry that there are inadequate services to manage people with significant mental health issues who also use ATS, and that clients often cannot afford private psychiatric treatment. He said providing increased access to psychiatric care before the patient requires acute hospital or emergency department admission could improve this problem.¹²⁸

24.70 Mr Bryant, Mental Health Illawarra Shoalhaven LHD, said the area would benefit from a facility like the Psychiatric, Alcohol and Non-Prescription Drug Assessment Unit (PANDA) at St Vincent's Hospital in Sydney,¹²⁹ which provides a multiservice process of medical and AOD services that can safely *'decrease the person's level of intoxication and engage the person in, hopefully, some treatment options, both ... in the here and now, but also post that episode of intoxication'*.¹³⁰

24.71 Mr Bryant said an ideal model of care for people with ATS-related presentations is a collaborative model, in which other services such as employment, housing and Legal Aid NSW are represented.¹³¹ He further stated:

*'[A]ll these sorts of concurrent issues are occurring for people who are using both our drug and alcohol services and people who are using ATS concurrently; maybe not the entire population, but definitely a significant proportion. And often if you can address some of those other things concurrently, the person's desire and engagement in ... that substance may even decrease over time. It gives them opportunities to engage in other activities. It's more than just a treatment for the ATS itself. It's often around helping them to build a life for themselves.'*¹³²

- 24.72 The Inquiry heard that there are opportunities to upskill GPs to respond to people using ATS. Dr Cordaro, Illawarra Shoalhaven LHD, noted that there is scope for greater educational awareness for GPs on how to screen specifically for substances such as amphetamines.¹³³ Dr Cordaro also highlighted the effectiveness of clinical support for GPs, informing the Inquiry that a clinical nurse specialist from the LHD currently sees AOD patients in a general practice for half a day each fortnight, observing that:

*'[Y]ou're essentially creating a little bit of a portal from the general practice to [the Illawarra Shoalhaven LHD drug and alcohol] service as well as providing support for the general practitioners in that practice. So those general practitioners are less likely to avoid treating those patients.'*¹³⁴

- 24.73 Opportunities to improve health services, including through more collaborative models of care, are discussed in Chapter 14.

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SNAPSHOT: DUBBO

GEOGRAPHY

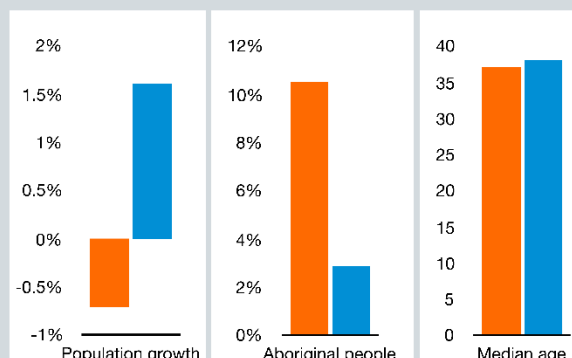


- Dubbo services a wider region including the townships of Bourke, Brewarrina, Lightning Ridge, Cobar, Nyngan, Warren, Trangie, Narromine, Coonamble and Walgett.
- Local Health District (LHD): The Western NSW LHD services an area of around 250,000 square kilometres.
- Primary Health Network (PHN): The Western NSW PHN is the largest in NSW, covering more than 430,000 square kilometres.
- Police District: The Orana-Mid Western Police District is responsible for an area of 85,000 square kilometres.

KEY DEMOGRAPHICS

Of people who live in the Western NSW PHN, 10.5% identify as an Aboriginal person, compared to the national average of 2.8%.

■ Dubbo ■ State average



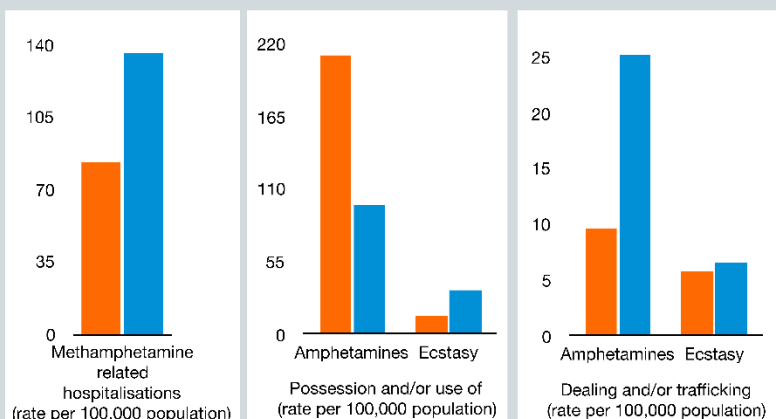
(NSW Dept. of Planning and Environment, 2015 to 2016, LHD)

(ABS, Census 2016, LHD)

(ABS, Census 2016, LHD)

HEALTH HARMS & CRIMINAL OFFENCES

The rate of possession and/or use of amphetamines in the Dubbo Regional local government area has increased 13.6% annually over the past 5 years.

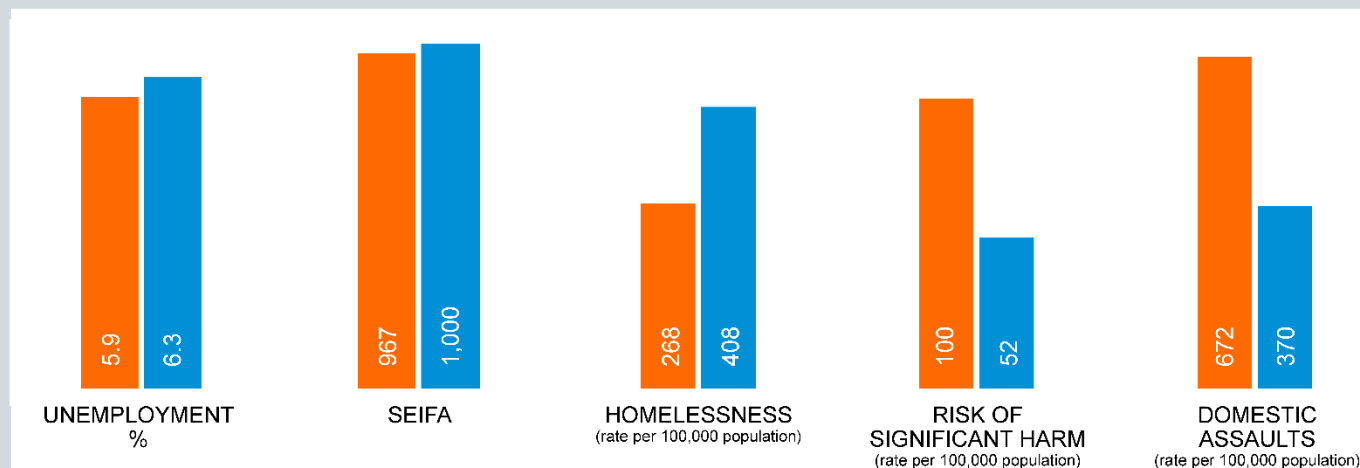


(BOCSAR recorded criminal incidents, Oct 2018 to Sep 2019, LGA)

(BOCSAR recorded criminal incidents, Oct 2018 to Sep 2019, LGA)

KEY SOCIAL STATISTICS

■ Dubbo ■ State average



(ABS, Census 2016, LGA)

(ABS, SEIFA 2016, LGA)

(ABS, 2011, LHD)

(KIDS - CIW Annual data and ABS, 2016-17, LHD)

(BOCSAR, 2016-17, LHD)

Chapter 25. The Dubbo region

Introduction to the Dubbo region

- 25.1 The Dubbo Regional Council Local Government Area (LGA), formerly the Western Plains Regional LGA, was recorded as having a population of 50,077 in the 2016 census.¹ Dubbo services a wider region including the townships of Bourke, Brewarrina, Lightning Ridge, Cobar, Nyngan, Warren, Trangie, Narromine, Coonamble and Walgett.
- 25.2 The Inquiry held hearings in Dubbo from 4 to 6 June 2019 during which witnesses gave evidence about the increase in both the use and harms of crystal methamphetamine in the region.
- 25.3 As in other regional areas, witnesses at the Dubbo Hearing spoke of the inadequacy of data gathered on the prevalence of crystal methamphetamine. One witness said he believes available data do not reflect the full extent of crystal methamphetamine use in western NSW.²
- 25.4 Evidence received at the Dubbo Hearing reinforces that crystal methamphetamine use occurs in the context of broader socioeconomic disadvantage. People who use crystal methamphetamine include younger people, those from low socioeconomic backgrounds, and those who are marginalised from community and disengaged from education.
- 25.5 According to the Department of Family and Community Services (FACS) (now Department of Communities and Justice) statistics tendered before the Inquiry, the rate of young people involved in risk of significant harm reports in 2016–17 in Western NSW (including Dubbo) was nearly double the state average. The statistics also indicate that the rate of young people in out-of-home care was more than double the state average.³
- 25.6 More than 30,000 Aboriginal people live within the bounds of the Western NSW Primary Health Network (PHN), or 10.5% of the total PHN population, significantly higher than the NSW average of 2.1%.⁴ While Dubbo sits within the traditional lands of the Wiradjuri Nation,⁵ the Western NSW Local Health District (LHD) encompasses other nations including the Kamilaroi Nation and multiple language groups.⁶
- 25.7 As is the case across the areas in regional NSW the Inquiry visited, evidence was given of the impact of crystal methamphetamine use on Aboriginal communities. Teena Bonham, Principal Project Officer for FACS, Western Region, told the Dubbo Hearing that Aboriginal people tell her that the drug is crippling their communities and *'taking their young people'*.⁷ Ms Bonham is Aboriginal, and she told the Inquiry that most drug use is triggered by trauma, either intergenerational or a traumatic experience.⁸
- 25.8 The Inquiry consistently heard of the region's need for detoxification and rehabilitation services and of the community's frustration that repeated calls for government support have not been answered despite previous investigations, including the *2017 NSW Parliamentary Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW*.

Dubbo's experience with ATS

Increase in ATS use among young people in contact with the criminal justice system

- 25.9 The Inquiry heard evidence in Dubbo that ATS use is increasing. Cindy Wilson, Nursing Unit Manager at Orana Juvenile Justice Centre, said successive 'Young People in Custody Health Surveys' conducted by Juvenile Justice and the Justice Health and Forensic Mental Health Network have indicated 'a rapid rise' in the use of crystal methamphetamine and other ATS over the 15 years.⁹ In 2003, only 16% of young people in custody reported amphetamine use. That increased to 47% in 2009 (with 17.7% specifying the use of crystal methamphetamine) and 73.8% in 2015 (with 55.1% specifying the use of crystal methamphetamine and 31.6% describing at least weekly use).¹⁰
- 25.10 Ms Wilson told the Inquiry that Orana is the only centre for young people in custody in Western NSW; its clients are primarily males aged between 11 and 19 and on average 85% are Aboriginal. Many have backgrounds of homelessness and significant trauma. Ms Wilson said:

*'Most of the young people that come through Orana are the most marginalised and disadvantaged children in the state. A lot of children have parents in custody; parents with major issues with alcohol and other drugs; and children have often been in and out of out-of-home care and FACS involvement.'*¹¹

Increase in presentations to health services

- 25.11 Evidence given to the Inquiry by health workers, and hospital data in relation to emergency department presentations and mental health emergency care, also indicate an increase in use of crystal methamphetamine in the Dubbo region. A senior nursing staff member at Dubbo Base Hospital's emergency department told the Inquiry that presentations relating to crystal methamphetamine have increased by 50% in the two years he has been at the hospital.¹² He noted a 'huge prevalence' of ATS use across a range of age and demographic groups.¹³
- 25.12 According to Dr Ian Spencer, a GP and Visiting Medical Officer at Wellington District Hospital, Wellington Hospital has about three drug-related presentations a week, of which he believes more than 75% relate to crystal methamphetamine.¹⁴ He said that while patients who have overdosed on opioids are 'quite sedated' when they present, people using amphetamines are often intoxicated: 'They're aggressive, violent and very difficult to manage.'¹⁵
- 25.13 Jason Crisp, Director, Integrated Mental Health, Drug and Alcohol Services, Western NSW LHD, provided statistics for Mental Health Emergency Care, a telephone and video conferencing service that establishes a link between emergency departments and patients. The service recorded a total of 2,445 patients presenting after hours to emergency departments across Western NSW LHD and Far West LHD in a 12-month period. Of these, 3% of males (74) and 1% of females (25) presented 'after admitting methamphetamine use related disorganised behaviours'.¹⁶
- 25.14 Mr Crisp believed the figures are likely to be higher given that emergency departments do not generally complete a drug screen and many people do not disclose their use of crystal methamphetamine due to a combination of shame, fear, concern about legal ramifications and general stigma around using the drug. Mr Crisp said that, particularly in regional and remote areas of the LHD, as well as in the north-west area of the LHD, his own experience and feedback from clinicians suggests the use of crystal methamphetamine is more prevalent than data show.¹⁷

- 25.15 Hospital admission data add weight to health workers' evidence about the harms of crystal methamphetamine use in the Dubbo region. Data show that between 2013–14 and 2016–17, the rate of methamphetamine-related hospitalisations in the Western NSW LHD (for people aged 16 years and over) more than doubled.¹⁸

Increase in use of crystal methamphetamine among people who use drugs

- 25.16 Other AOD service providers also gave evidence about the increase in crystal methamphetamine use. Madeleine Baker, Clinical Services Coordinator, Mac River Adolescent Drug and Alcohol Rehabilitation Centre, Mission Australia, noted a significant increase in the number of young people using crystal methamphetamine referred to the Centre. Between 2017 and 2018, the proportion of clients who reported crystal methamphetamine use increased from 36 to 63%. Ms Baker said prevalence was particularly high among young Aboriginal people, with 84% of Aboriginal clients reporting crystal methamphetamine use.¹⁹
- 25.17 The Inquiry heard from Alan Bennett, CEO, Orana Haven Aboriginal Corporation, who said he has observed increased use of crystal methamphetamine in the region over the past three years: *'Walgett used to be fentanyl, Brewarrina used to be cannabis and Bourke used to be oxys – oxycodones – but now there's ice right throughout the place. It's taken over.'*²⁰

Who is using crystal methamphetamine in Dubbo?

- 25.18 Witnesses gave evidence about the categories of people who are more likely to use crystal methamphetamine. They include people aged between 13 and 40, people from rural and remote communities, people from low socioeconomic backgrounds and Aboriginal people.²¹
- 25.19 Evidence received at the Dubbo Hearing echoes other evidence received by the Inquiry that drug use occurs in the context of broader socioeconomic complexity (see Chapter 3). Witnesses noted some of the issues faced by people using crystal methamphetamine include marginalisation, isolation from family, disengagement from education, unemployment, poor peer association and an increased risk of offending to support drug use.²² Norm Henderson, Senior Drug and Alcohol Worker, Weigelli Centre Aboriginal Corporation, near Cowra, said many of Weigelli's clients are involved in legal matters or on parole. A *'very, very high percentage that never really had any employment, very low in literacy and numeracy levels.'*²³
- 25.20 Dr Scott Clark, Clinical Director, Mental Health and Drug and Alcohol Services, Western NSW LHD, stated that some people who use ATS could also be undergoing opioid substitution treatment and have a history of hospital-based psychiatric unit admissions.²⁴
- 25.21 The Western NSW PHN *Drug and Alcohol Needs Assessment 2017* identified Aboriginal and Torres Strait Island people, young people aged 12 to 25 years, males aged 25 to 45 years, people with ongoing at-risk alcohol use, people who use cannabis regularly and people using methamphetamines as priority groups that required access to drug and alcohol treatment.²⁵

- 25.22 Witnesses also told the Inquiry about crystal methamphetamine use in the mining and trade industries.²⁶ Christopher Waters, Clinical Nurse Consultant, Dubbo Base Hospital emergency department, gave evidence that fly-in fly-out workers are among those who make ATS-related presentations to the hospital.²⁷ Mr Henderson said many shearers use crystal methamphetamine to get up for work in the morning and then use cannabis to sleep at night.²⁸ He said truck drivers also use ATS:

‘With the truck drivers, it’s because their deadlines are pretty full on. They’ve got to be in a certain space – certain place at a certain time, and they don’t get much downtime. So, they’re running two or three log books and using methylamphetamine.’²⁹

Impacts of ATS use in the Dubbo region

- 25.23 The Inquiry heard a large body of evidence that the use of crystal methamphetamine is having deep and devastating effects on many people in the Dubbo region. The Western NSW PHN *Drug and Alcohol Needs Assessment 2017* supports evidence received by the Inquiry about the complex and multiple co-occurring issues facing people who use ATS in the Dubbo region:

‘The use of methamphetamines (ice) was raised as a significant concern in most communities. In particular its addictiveness and impact on health, functioning and relationships was highlighted across communities. The impact of ice was perceived to have increased significantly in recent years.’³⁰

Impact on crime

- 25.24 Crime data tendered at the Dubbo Hearing show that police detections of crystal methamphetamine and other ATS have increased. NSW Bureau of Crime Statistics and Research statistics for the Dubbo LGA show an increase of 66.1% in the rate of use and possession of amphetamines over the two years to July 2018. It is more than twice the NSW rate (197.7 per 100,000 of the population compared to 90.7 for NSW).³¹
- 25.25 Superintendent Peter McKenna, District Commander of the Orana-Mid Western Police District, NSW Police Force, told the Inquiry that in 2018 there were 183 legal actions for methamphetamine and 22 legal actions for MDMA.³² He said the use of ATS also contributes to other types of criminal offending. He said that offenders who go on ‘crime sprees’ are often intoxicated:

‘It might be a number of pursuits, aggravated break and enters, might be armed robberies and we’re chasing the same offenders. When we finally do apprehend them, when they’re debriefed, it’s not uncommon for them to (a) be under the influence of a type of drug and, when we finally get to the bottom and we’re speaking with them, whether they’re on the record or off the record, it’s not uncommon for them to say they had just been taking ice for days on end. They don’t really remember what they did and they’ve just been bingeing themselves. It’s not uncommon for them to say “I haven’t slept for three days”...’³³

Comorbidities

25.26 Comorbidities are common for people who use crystal methamphetamine. Rhiannon McMillan, Clinical Nurse Consultant, Western NSW LHD, Orange and Region, observed that people using crystal methamphetamine commonly present with co-occurring psychiatric conditions, medical issues such as infected injecting sites, abscesses and dental decay, and demonstrate a lack of self-care and hygiene. She said they often exhibit impulsivity and risky behaviour such as sharing injecting equipment and tend to lose track of days.³⁴ The evidence received in this region in relation to comorbidities was a theme that arose frequently across the Inquiry's hearings. Treating comorbidities is discussed further in Chapter 14.

25.27 Lucy Rolek, Registered Nurse, Team Leader, Acute and Continuing Care Team for the Community Mental Health Team Dubbo and North, North-West Region, observed:

*'In the last 12 months, the most common comorbidities I have seen are psychosis, trauma, schizophrenia, depression, impulsivity and polysubstance abuse. In my experience, many patients are trying to manage past trauma with drugs. It has also been my experience that Indigenous people in particular tend to present with trauma as a comorbidity leading to their ATS use. Use of ATS to manage trauma can trigger psychosis.'*³⁵

25.28 Cindy Wilson, Orana Juvenile Justice Centre, said mental health and drug use comorbidity is significant. She said the young people she sees who use ATS have other issues such as first episode psychosis, which can often progress to schizophrenia, high rates of depression and anxiety and intellectual disability.³⁶ She said that 85% of young people in Orana have a diagnosis of ADHD.³⁷ Mr Waters, Dubbo Base Hospital, told the Inquiry that: *'In just the past two weeks, two known ice users under the age of 35 have passed away due to overdose and comorbidities'*.³⁸ He added: *'I've been in the position for two years and I would say 25 people that I first met when I moved to Dubbo are now dead, and it's specifically from ice.'*³⁹

Treatment challenges

25.29 The Inquiry heard it can be challenging to provide services to people presenting with issues related to crystal methamphetamine. Mr Waters said each week about six people presenting to Dubbo Base Hospital's emergency department are acutely behaviourally disturbed due to drug use and require immediate sedation.⁴⁰ He gave one example of the difficulties faced by police and emergency department staff:

*'Last Thursday, seven police were required to hold down a gentleman, probably 80kg, and that would take myself, three or four nursing staff, away from the positions they've been allocated during the day, and they would have to come and assist – plus [a] mental health clinician as well.'*⁴¹

25.30 Dr Spencer, Wellington District Hospital, noted the difficulty presented to staff when both AOD and mental health issues are present, and said that staff often question which problem is the priority to treat.⁴²

*'When a patient is brought in who is affected by methamphetamines, the mental health team will often say the person does not fall under their guidelines. The mental health team considers drug-induced psychosis as a "drug issue" not a "mental health issue", whereas the police will tell us the patient needs to be scheduled. The mental health team does not see it as their business to do alcohol and other drug (AOD) treatment.'*⁴³

- 25.31 Dr Spencer said he has seen young people who have used amphetamines and also have a psychotic illness.

*'It's hard to say whether the psychosis was underlying all along, or whether it was brought out by the drug. ... amphetamine psychosis I think in some ways damages something. A number of people who experience psychosis will ultimately end up with a diagnosis of schizophrenia.'*⁴⁴

Impact on communities and families

- 25.32 Witnesses gave evidence to the Inquiry about the severe impact of crystal methamphetamine on communities and families in the Dubbo region. Service providers have noted a correlation between the use of crystal methamphetamine and domestic and family violence, as discussed in Chapter 18. For example, Dr Spencer said he sees patients at least once a week who have been involved in amphetamine-related domestic violence incidents.

*'Either the victim or their partner will be brought into the emergency department by police. The domestic violence is related to drugs about 70% of the time. There seems to be more domestic violence these days caused by amphetamines. The victim will say to us "he's on drugs", which in 2019 can be presumed to mean "he's on ice".'*⁴⁵

- 25.33 The Inquiry heard similar evidence from other witnesses. Ms Bonham, FACS, said people in the communities she works with tell her that crystal methamphetamine use drives much of the domestic violence.⁴⁶

*'[People are] telling me that ice is crippling their communities, that they've never seen anything like this before. They've seen other drugs and alcohol and other things come and go, but ice, they're saying, is the one that's taking their young people and their families away at a very fast rate.'*⁴⁷

- 25.34 She said that historically the area's social housing estates were a 'place of community', but that is no longer the case.

*'People are isolating themselves. There's an increase of violence between households – different family groups and households and individuals. We've had riots in some of the estates and ... there's no evidence, but what people and community are telling me is that, you know, this was an ice retaliation, you know, through dealers and individuals owing. And ice, there has also been an increase in domestic violence in some of those households ... families are telling us that, you know, "He's not normally violent. It's the ice", and then there's ... brawls. And there has been houses burned out, where the – I guess the word in the community is that it was an ice debt retaliation.'*⁴⁸

- 25.35 Ms Rolek, Community Mental Health Team, noted the impact of parental ATS use on children. She said the use of crystal methamphetamine and other ATS can result in children either being neglected or removed from their parents. *'This in turn affects the mental health of the child involved and can create an awful cycle.'*⁴⁹

- 25.36 At the Dubbo Roundtable, participants noted their distress at the problems caused by crystal methamphetamine and other ATS in their communities and also their frustration at the difficulties faced by people who use ATS in accessing services.⁵⁰

Local responses

25.37 The Inquiry heard of the significant efforts undertaken by multiple organisations and service providers in the Dubbo region to assist people using ATS as well as affected families and communities. The work covers a range of areas, including justice and health responses, peer support, social housing estate Place Plans, partnerships between organisations and relationship building between Aboriginal communities and service providers such as NSW Police Force. Witnesses, especially those at the Dubbo Roundtable, made it clear that communities in the Dubbo region are strong and have a great capacity for resilience, despite the issues associated with ATS use.

25.38 Superintendent McKenna, NSW Police Force, said he believes the increase in the rate of possession and/or use of amphetamine is due to more proactive policing activity.⁵¹ In 2017, Superintendent McKenna established a formal drug team comprising four officers to target major drug suppliers in the police district. Previously, a drug strike force was run on an as-needed basis.⁵²

25.39 Superintendent McKenna noted the police district's efforts to strengthen relationships with local Aboriginal communities and Aboriginal youth, including a 'Fit for Life' program. About 30 children ranging in age from eight to 15 are picked up by buses, given a cooked breakfast and involved in a structured exercise program. A packed lunch is provided for children who do not have one and children are taken to school. Superintendent McKenna stated: *'I've seen the relationship that we've built with those kids to be immense.'*⁵³

25.40 He described the ceremony that was held recently to mark the first time the Aboriginal flag has been raised at Dubbo Police Station, at which a well-known Elder spoke:

*'[I]t was only the other day that he was walking down the street and he saw three young fellas from his community sitting at the rotunda down on the main street, not doing anything wrong, and he said, "And I saw this police car pull up ... And I saw the kids run over to the car, like they wanted to see the police officer", and they actually got in the car, and he drove them somewhere ... and this Elder said that he walked away smiling because the kids aren't scared of the police. The kids actually wanted to be with that police officer, and that's what I'm seeing. So, we really are making some inroads.'*⁵⁴

25.41 At the Dubbo Roundtable, the Inquiry heard about the grassroots 'Dob in a dealer' campaign in Wellington. A participant said there is a historical distrust of police in the community, which means people are reluctant to contact police with information. He believed that attitude has to change:

*'The campaign in Wellington is to Dob in a Dealer. I think something like that needs to be expanded. We all still have the distrust of police and are reluctant to, I suppose, dob on someone or dob in the dealers, but that has to change as well, I think. I think once, you know, dealers know it's not okay or the community doesn't accept it, that's going to be a positive, because as it is now, I think we do accept it, wilfully or not. Sometimes we turn a blind eye, and that can be just as bad as well, so, look, the dob in a dealer program, if you haven't come across it, I think that should be expanded.'*⁵⁵

- 25.42 The Inquiry received evidence about the emerging field of ‘justice reinvestment’ and the work of Maranguka Justice Reinvestment in Bourke, which is discussed in Chapter 12. Sarah Hopkins, Managing Solicitor, Justice Projects, Aboriginal Legal Service NSW/ACT, and Chair of Just Reinvest NSW, said justice reinvestment is an holistic and integrated approach that involves redirecting resources away from prisons and into addressing the causes of offending in communities that have high rates of contact with the criminal justice system.⁵⁶ Ms Hopkins said the Maranguka scheme is the first example of such a project in Australia. She said it has established a database of information about the Bourke community to identify ‘*what was relevant to a young person’s trajectory into the criminal justice system*’.⁵⁷

‘[I]t’s an example of ... an innovative process which is really providing some solutions in terms of how to get the right set of supports to people when they need it and at the right time, because the way that operates is that information is shared about what’s happened in the last 24 hours in that community, and then a discussion is had around what sort of supports that person and their family might need, and the – and a plan is made to make sure that – that those supports are provided.’⁵⁸

- 25.43 Mr Crisp, Western NSW LHD, gave further evidence about Western NSW PHN’s 24-hour emergency telehealth and mental health information service, Mental Health Emergency Care (MHEC), which has access to video links to assess patients in all emergency departments in the LHD.⁵⁹

‘[W]e’ve seen really good evidence of MHEC preventing people being admitted, because they’re able to engage the appropriate services in the community of origin. One of the things that I’m incredibly passionate about is keeping people as close to home and as close to support, where that support is appropriate, as possible.’⁶⁰

- 25.44 The Inquiry also heard evidence about AOD rehabilitation facilities in the Dubbo region. The closest AOD rehabilitation centre for adults is Lives Lived Well (LLW, formerly Lyndon NSW), based nearly two hours away from Dubbo in Orange. The facility provides in-community programs in Wellington and Dubbo.⁶¹ Other rehabilitation facilities are: Mac River Adolescent Drug and Alcohol Rehabilitation Centre, operated in conjunction with Youth Justice; Orana Haven, the Aboriginal Corporation’s AOD rehabilitation facility at Brewarrina; and Weigelli Centre Aboriginal Corporation near Cowra, which also has an Aboriginal focus.⁶² Improving access to AOD services is explored in Chapter 14.

- 25.45 Ms Baker, Mac River Adolescent Drug and Alcohol Rehabilitation Centre, told the Inquiry how the facility is adapting to harmful crystal methamphetamine use by taking a more holistic approach in its programs and looking at how best to meet the physical and psychological needs of clients, their families and community. Ms Baker said it is also important to make sure young people leaving the facility have ‘*the right supports wrapped around that young person returning home*’.⁶³ Her evidence about the need for a trauma-informed perspective echoed that of other service providers:

‘[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 therapies they need to support them through their journey.’⁶⁴

- 25.46 Orana Haven takes single males over the age of 18 in a 90-day program. It offers TAFE courses such as mechanics, carpentry and welding.⁶⁵ It is in the process of setting up a detoxification facility.⁶⁶ Weigelli Centre Aboriginal Corporation has 18 beds and offers a three-month program. It is the only Aboriginal residential rehabilitation facility in NSW that takes couples and one of only two to take Aboriginal women.⁶⁷ Mr Henderson said Weigelli has conducted trials of home detoxification services, and it works well in regional areas but not in smaller and more remote locations where homes are less safe.⁶⁸ He gave evidence about Weigelli's partnership with Orana Haven, which forms an Aboriginal hub funded by the PHN and aims to close gaps between pre-rehabilitation and aftercare treatment.

*'We've sort of turned it into more of a support, supporting people on the ground. We actually go out to the riverbank with people who are drinking and put a barbecue on and get them in and take them into the AMS [Aboriginal Medical Service] or take them up to the hospital if they need to go to the hospital. We go to places and mix with people that no one else seems to want to go out and do because of all the risk assessment and all that sort of stuff going around. So, we do things a little differently, because predominantly we're dealing with Aboriginal people, so there is a difference in dealing with Aboriginal people.'*⁶⁹

- 25.47 The Inquiry heard of other positive outcomes in AOD services and treatment, including the not-for-profit group Lives Lived Well (LLW), which runs community and residential programs across Queensland and NSW. Michele Campbell, Group Manager Clinical Services, NSW LLW, told the Inquiry of LLW's withdrawal management and rehabilitation programs in Orange, outreach services in Orange and Dubbo, and the Roadmaps Mobile Day Program, which provides a mobile six-week day relapse prevention program.⁷⁰ It has visited Dubbo, Wellington, Gilgandra and Warren and is looking to extend its reach. Evaluations have found it has *'had some good outcomes for people that haven't accessed services before'*.⁷¹
- 25.48 Ms Bonham, FACS, described to the Inquiry her work with social housing estates experiencing socioeconomic disadvantage under the FACS Future Directions' Place Plans Program. Under the program, staff work with community and the broader service sector to identify key priority areas for a community, develop initiatives and implement programs⁷² with a focus on Aboriginal healing.⁷³
- 25.49 Ms Bonham described *'beautification programs'* run by FACS in an effort to break down the stigma people feel about living in certain social housing areas that have a reputation for the presence of drugs.⁷⁴ Under the programs, residents in some estates built parks and sporting facilities while learning skills:

*'[P]overty drives a lot of the disadvantage ... one of our greatest priorities is opportunities and pathways which is education, training and employment. ... we've had 61 people employed through our social housing estates through different initiatives that we've done. We've created social enterprises where – in one community, we've got catering where women – where community members have been trained in food handling and – and got qualifications to do a catering service, and they get catering when we have meetings or people engage them for catering. Another community, we've got – a couple of the communities, we've got yard maintenance and handyman. This is running – so residents are getting actual work experience.'*⁷⁵

- 25.50 In some instances, FACS engaged with Corrective Services and TAFE to implement a program in which young people could sign up for the Work and Development Order scheme and simultaneously reduce their fines: *'We did a park, a children's playground area, where 15 participants from the estate collectively had \$250,000 worth of fines where we were able to reduce those by \$40,000.'*⁷⁶

- 25.51 Another local response to crystal methamphetamine is Brothers 4 Recovery, a registered not-for-profit charity founded by Stephen Morris. He told the Inquiry that, after rehabilitation from drug dependence, he decided he could help people in his community *'get clean'*.⁷⁷ Mr Morris, who is also a Peer Workforce Manager at Bloomfield Hospital in Orange, said Brothers 4 Recovery has travelled to hundreds of schools, communities and correctional centres across Australia to provide information on addiction and share experiences about recovering from addiction so people do not *'feel alone'*.⁷⁸

*'We also run camping trips for people experiencing issues with drugs or alcohol. We take around 15 men to the river and do fishing and camping with them. It helps to get people out of the environment where they use drugs or alcohol, even for only 48 hours. It gets them thinking. At night, everyone sits around a campfire and shares their journey. People are encouraged to open up about their own experiences with drugs and alcohol. The men love the opportunity to talk openly about these issues, because they do not usually get a chance to hear stories about beating addiction. Often, the men who attend the camp will follow up with each other afterwards and support each other in their journey to beat their addiction.'*⁷⁹

- 25.52 Ms Bonham, FACS, told the Inquiry that Brothers 4 Recovery ran seminars as part of the Place Plans Program. *'We even had drug users there to talk about their story and to give people hope and light at the end of the tunnel.'*⁸⁰ She gave evidence that the seminars led to Brothers 4 Recovery running early intervention programs in schools. *'The kids were coming home talking about that, and so it has opened up that conversation.'*⁸¹

Opportunities to strengthen local responses

- 25.53 A strong message to emerge from evidence received at the Dubbo Hearing is the community's need for an holistic rehabilitation facility with the capacity to assist people through detoxification.

- 25.54 Since 2013, organisations and community representatives in Dubbo and the wider Western region have lobbied the NSW and Commonwealth governments about the need for appropriate AOD detoxification and rehabilitation services in the region.⁸² In 2018, the Health and Community Services Committee of the NSW Legislative Council visited Dubbo as part of its *Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW*.⁸³ The Committee heard from a number of people who called for 'multipurpose' detoxification and rehabilitation services.⁸⁴ For example, in his evidence, Dubbo Regional Councillor Stephen Lawrence said:

*'NSW Health does not provide detoxification facilities at major hospitals in regional, rural and remote NSW. Persons admitted for other reasons may incidentally receive it, but there are no dedicated beds and services in our region for this. Lastly in the list of issues of gaps in service provision, Dubbo does not have a drug court. The need for a drug court has long been recognised. ... A rehabilitation centre and specialist detoxification facilities for that purpose are a key component of such a project. Council is strongly advocating for a suite of all three services so that we can have a drug court in Dubbo that works closely with a rehabilitation centre and withdrawal facilities.'*⁸⁵

- 25.55 In its final report, the Legislative Council Committee recommended that the NSW Government pilot a drug court in Dubbo in parallel with an increase in rehabilitation services for the area.⁸⁶ In its response to the report, the NSW Government said it supported the recommendation in principle and would consider expanding the NSW Drug Court to regional areas including Dubbo. It noted that any expansion of the NSW Drug Court would require *‘a commensurate increase in treatment services’*. The NSW Government supported the Committee’s recommendation that the NSW Ministry of Health implement a population-based planning tool to determine what rehabilitation services and how many beds were required throughout NSW.⁸⁷ The expansion of the NSW Drug Court is discussed in Chapter 11.
- 25.56 Evidence the Inquiry received about inadequacies in service responses, including for detoxification and rehabilitation, is supported by the Western NSW PHN *Drug and Alcohol Needs Assessment 2017*. It identified issues in service provision for high-needs populations, including:
- Most communities said AOD rehabilitation services are a high-priority need.
 - There is the perception that few communities have access to specialist AOD services, including addiction specialists, and where they do exist they often operate on a fly-in-fly-out/drive-in-drive-out basis with limited access.
 - Support for early intervention approaches is widespread and GPs are seen to play a key role, but their capacity to do so is *‘perceived to be limited by time, skills and attitudes’*.
 - Options for AOD detoxification are limited across the region. *‘The skills, capacity and attitudes of GPs to provide home-based detoxification was perceived as limiting more home-based detoxification.’*⁸⁸
- 25.57 The Dubbo Regional Council submitted to the Inquiry that *‘consultation with close to 150 stakeholders across the LGA suggests the absence of a residential rehabilitation facility in the area is a key contributing factor to the impacts of AOD on the Dubbo community’*.⁸⁹
- 25.58 The Inquiry also heard of circumstances in which people needing access to health and emergency services, detoxification and rehabilitation face barriers and inadequate pathways between services. For example, Craig Biles, Area Manager, Central West, Western Region, Juvenile Justice, noted issues with access to treatment:
- ‘Young people may experience difficulties accessing alcohol and other drugs [sic] or addiction specialists as there are often long waiting lists. The services that are available in the community may also have exclusion criteria, including offence-based criteria (excluding young people who have committed violent or sexual offences for example), and they may not accept a young person if they are actively using drugs. Access to detoxification services in a rural setting is difficult. Stable and appropriate accommodation may also be a consideration for inclusion into residential programs ...’*⁹⁰
- 25.59 Dr Spencer, Wellington District Hospital, gave evidence that the hospital has difficulty managing patients with acute behavioural issues and usually does not admit them or transfer them to Dubbo. *‘They haven’t got the staff or the resources. The patients then are not complying and the follow-up that we’ve got planned for them doesn’t happen. So we don’t admit and we don’t transfer.’*⁹¹
- 25.60 Dr Spencer agreed that some people needing assistance can fall through the gaps because they choose to leave hospital once they have gone through the acute crisis phase in emergency, which usually lasts some hours.⁹² He said it can be a day or two before drug and alcohol liaison workers can come from Dubbo, by which time *‘we’ve lost contact with the patient’*.⁹³

- 25.61 Ms Rolek, Community Mental Health Team, said that sometimes the opportunity to get a patient into treatment is lost because they may change their mind about rehabilitation in the time it takes for a facility in another area to have a position available.⁹⁴ Ms Rolek noted there is also a lack of referral pathways for people being released from correctional facilities and that about 50% of clients in that situation are using crystal methamphetamine.

*'People who are released from correctional facilities are a vulnerable group of people and knowing where to initially seek assistance is not always easy for them. A clear referral pathway between the correctional centre and community mental health and drug and alcohol services is necessary. In my opinion this is a gap in the system.'*⁹⁵

- 25.62 An Aboriginal participant at the Dubbo Roundtable identified difficulties associated with people using crystal methamphetamine who have regular involvement with the correctional system. She said the point at which a person enters custody can be pivotal.

*'[T]here's often a real rush of desire to change their life at that point in time, and that's the point in time that we have to harness, because we all know it doesn't work to try and impose treatment upon people who are struggling with addiction if they don't want it. If they want it, and when they want it, that's when the help needs to be available, but there's a disconnect, because you can't get people into rehab necessarily at the time a bed is available. There are so few beds. You have to be – you have to have some incredible coincidence of the time at which they have that lightbulb moment, the progress of their matter through the courts and a bed available in rehab, and it just – it doesn't happen, and ... we miss that moment when we could change things. And then we just spend money for the next 20, 30 years paying for them to go in and out of jail.'*⁹⁶

- 25.63 People without stable housing also face challenges accessing rehabilitation services, according to evidence the Inquiry received. (The importance of housing is discussed in Chapter 17). Ms McMillan, Western NSW LHD, noted that detoxification services will not accept patients who do not have a residential address and housing services will not approve a person for emergency housing until they have detoxified.⁹⁷

*'We've actually put a hospital address to get a patient into treatment ... a few of the services now will not accept homeless patients into their care because of the concerns of duty of care post-discharge. Where does that person go? We're sending them back into the reality that they've ... come from, in a sense.'*⁹⁸

- 25.64 The Inquiry heard of the significant challenges service providers and people seeking treatment for ATS face due to distance and remoteness in the Dubbo region. These distances can present a significant barrier to treatment⁹⁹ and to the recruitment and retention of skilled staff. Efforts to expand the geographical reach of services in regional areas are discussed in Chapter 14.

- 25.65 Dr Clark, Western NSW LHD, said the *'earlier in a career you can find someone to work in a rural area, the more likely they will stay in the area'*.¹⁰⁰ He said that psychiatry trainees are rotated to Dubbo and Bloomfield Hospital as part of their training¹⁰¹ and agreed there could be benefits in a program to rotate staff from the city to remote areas.¹⁰² He also suggested clinical liaison services could assist GPs in remote areas to increase their specialist knowledge and offer general support, and an AOD case manager could be called on if a GP had a question, issue or problem that was beyond their normal experience: *'[Someone] the general practitioner knows, can call and develop a relationship with and trusts ... that would make many more general practitioners feel comfortable taking on more of these patients.'*¹⁰³
- 25.66 Other witnesses noted the difficulties of recruiting staff. For example, Mr Crisp, Western NSW LHD, said a recent position in Lightning Ridge was advertised *'half-a-dozen times without any interest'*.¹⁰⁴ Mr Crisp said it was important to be creative in developing solutions,¹⁰⁵ noting a Western NSW LHD partnership with Charles Sturt University in Wagga Wagga that delivered a dedicated mental health degree for Aboriginal clinicians.¹⁰⁶ Mr Crisp said he has targets to increase the number of Aboriginal employees to ensure *'we have a workforce that's representative of our organisation'*.¹⁰⁷ Workforce implications for the health system are considered further in Chapter 14.
- 25.67 Mr Crisp also noted there could be benefits in training people for a Certificate IV qualification. He said that limiting training to people with degree qualifications leads to *'a situation whereby we don't always get the best'*.¹⁰⁸ He also said there was an opportunity to use *'a vast network of telehealth facilities'*, which would allow smaller regional and remote hospitals to be supported by major hospitals with AOD Mental Health Hospital Consultation Liaison and allow their services to be extended outside business hours.¹⁰⁹
- 25.68 Evidence before the Inquiry referred to the importance of culture and of Aboriginal people healing on Country. Ms Bonham, FACS, said it is difficult to articulate what spirituality means to Aboriginal people but offered the example of a man who used crystal methamphetamine and spent time in a correctional centre.
- '... when he come back to Dubbo – and he's a traditional descendant from this area – he had gone to the river and ... he said, "I have been at the river for three hours and sat in that water, and feeling that water run through my body was something. I felt my old people with me at that point in time." And he said, "And I haven't had – I've separated from that for a long time."'*¹¹⁰
- 25.69 Ms Bonham told the Inquiry that FACS has cultural awareness training for all staff, but this could be further developed. She said communities want to play a role in developing cultural awareness training for themselves, because *'every community and nation group is different'*.¹¹¹ The importance of cultural awareness training is considered in Chapter 16.

- 25.70 The Inquiry heard from multiple witnesses that a Youth Koori Court should be established in Dubbo. Superintendent McKenna, NSW Police Force, noted:

*'They look at the root cause of why that child is offending. They look at what it is that needs to be done to keep that child out of the criminal justice system. ... they come up with an action plan to actually get to the root cause, as opposed to what we're doing now, and that is we're either cautioning, using one of our other diversion strategies or putting them into the courts. You know, there's nothing saying what's going on at home. What are they going back to? What's the lifestyle like that is causing them to do this? And that's where that Koori Court really makes a difference, in the research that I've looked at.'*¹¹²

- 25.71 Mr Biles, Juvenile Justice, also gave evidence that a Youth Koori Court for Dubbo could be valuable for Aboriginal young people. He said Aboriginal people saw the traditional court system as adversarial and alienating. He said a Youth Koori Court was *'about the client and the rehabilitation, and the wraparound services that the community as a whole can provide to support that young person create a change'*.¹¹³ A more detailed discussion about expanding the Youth Koori Court is in Chapter 16.

References

- 1 Dubbo Hearing, Dubbo, Exhibit A, Tab 1, 'ABS Census QuickStats – Western Plains Regional LGA'.
- 2 Dubbo Hearing, Dubbo, Exhibit A, Tab 11, Statement of Jason Crisp, 15 May 2019, [13]; Dubbo Hearing, Dubbo, 5 June 2019, TS1653-1655 (Crisp).
- 3 Dubbo Hearing, Dubbo, Exhibit A, Tab 1, FACS Statistics – Western NSW Dashboard – FACS Clients.
- 4 Dubbo Hearing, Dubbo, Exhibit A, Tab 2, Western NSW PHN Health Profile 2018.
- 5 'Dubbo', Aboriginal Housing Office (Web Page), <<https://www.aho.nsw.gov.au/applicants/era/about/chapters/locations/dubbo>>.
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- 8 Dubbo Hearing, Dubbo, 6 June 2019, TS 1712.42-45 (T Bonham).
- 9 Cindy Wilson, Submission No 8 (18 April 2019) 1.
- 10 Cindy Wilson, Submission No 8 (18 April 2019) 1.
- 11 Dubbo Hearing, Dubbo, Exhibit A, Tab 20C, Statement of Cindy Wilson, 30 May 2019, [16].
- 12 Dubbo Hearing, Dubbo, 4 June 2019, TS 1445.45-46 (Waters).
- 13 Dubbo Hearing, Dubbo, Exhibit A, Tab 20B, Statement of Christopher Waters, 28 May 2019, [6]-[7].
- 14 Dubbo Hearing, Dubbo, 4 June 2019, TS 1442.21 (Dr Spencer); Dubbo Hearing, Dubbo, Exhibit A, Tab 20, Statement of Ian Spencer, 27 May 2019, [7].
- 15 Dubbo Hearing, Dubbo, 4 June 2019, TS 1443.27-29 (Dr Spencer).
- 16 Dubbo Hearing, Dubbo, Exhibit A, Tab 11, Statement of Jason Crisp, 15 May 2019, [4]-[5].
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- 18 Tendered in Chambers on 13 December 2019, Exhibit Z, Tab 127, Response of NSW Health dated 6 September 2019 to request for information dated 16 August 2019, 'Response to additional questions received by DPC', Attachment C, 5.
- 19 Dubbo Hearing, Dubbo, Exhibit A, Tab 30A, Statement of Madeleine Baker, 29 May 2019, [3].
- 20 Dubbo Hearing, Dubbo, 6 June 2019, TS 1775.11-13 (Henderson).
- 21 Dubbo Hearing, Dubbo, Exhibit A, Tab 14, Statement of Jenny Taylor, 15 May 2019, [8].
- 22 Dubbo Hearing, Dubbo, Exhibit A, Tab 15, Statement of Dr Scott Clark, 17 May 2019, [6]; Dubbo Hearing, Dubbo, Exhibit A, Tab 24, Statement of Craig Biles, 13 May 2019, [8].
- 23 Dubbo Hearing, Dubbo, 6 June 2019, TS 1776.26-27 (Henderson).
- 24 Dubbo Hearing, Dubbo, Exhibit A, Tab 15, Statement of Dr Scott Clark, 17 May 2019, [6].
- 25 Dubbo Hearing, Dubbo, Exhibit A, Tab 8, *Western NSW Drug and Alcohol Needs Assessment* (Report, 2017) 14-15.
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- 27 Dubbo Hearing, Dubbo, Exhibit A, Tab 20B, Statement of Christopher Waters, 30 May 2019, [10]; Dubbo Hearing, Dubbo, 4 June 2019, TS 1448.17-25 (Waters).
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- 52 Dubbo Hearing, Dubbo, 5 June 2019, TS 1573.5-9 (Superintendent McKenna).
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- 104 Dubbo Hearing, Dubbo, 5 June 2019, TS 1674.46 (Crisp).
- 105 Dubbo Hearing, Dubbo, 5 June 2019, TS 1675.7 (Crisp).
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SNAPSHOT: EAST MAITLAND

GEOGRAPHY

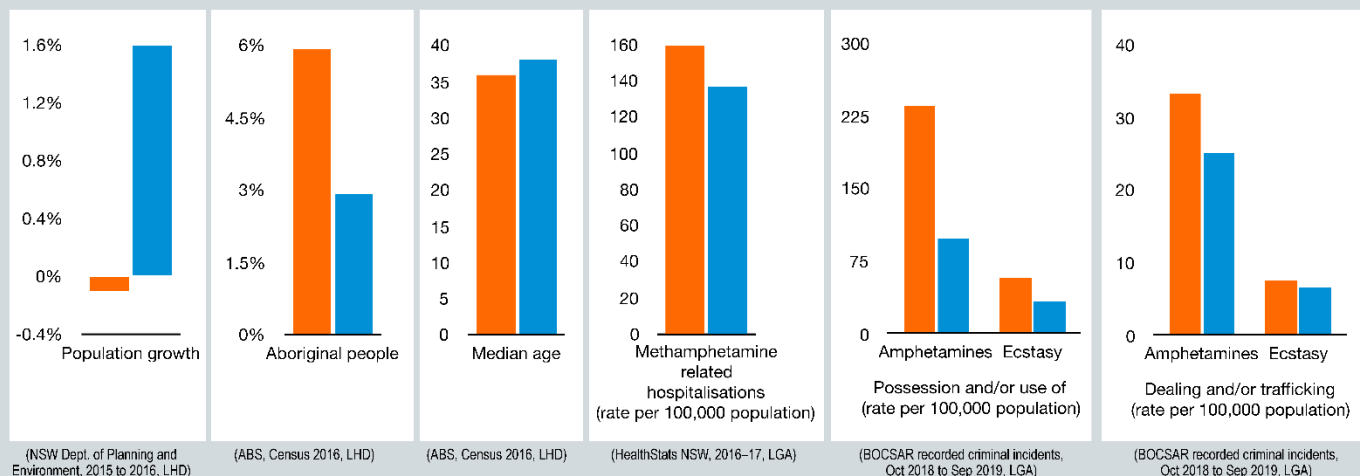


- The PHN covers 23 Local Government Areas comprised of a mix of metropolitan, regional and rural locations.
- Local Health District (LHD): The Hunter New England LHD covers an area of around 131,785 square kilometres and includes Maitland, Newcastle, Cessnock, Moree, Narrabri and Armidale.
- Primary Health Network (PHN): The Hunter New England and Central Coast PHN is the second-largest in NSW and stretches to the Queensland border to the north and is bordered by the Hawkesbury River in the south.
- Police District: The Port Stephens Hunter Police District covers five Local Government areas and services a population of around 164,000 people.

KEY DEMOGRAPHICS

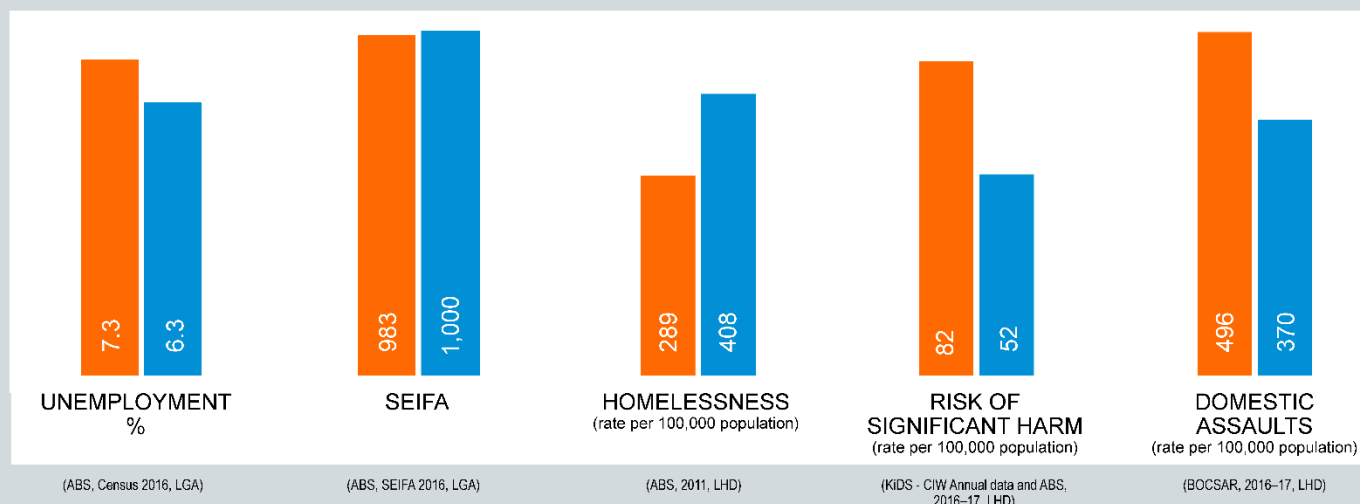
Some Local Government Areas within the region have high Aboriginal populations (over 10%), including; Gunnedah, Liverpool Plains, Moree Plains, Narrabri and Tamworth Regional LGAs.

■ East Maitland ■ State average



KEY SOCIAL STATISTICS

■ East Maitland ■ State average



LGA-Local Government Area ATS-Amphetamine Type Stimulants SEIFA-Social Economic Index for Areas

Chapter 26. The East Maitland region

Introduction to the East Maitland region

- 26.1 The Inquiry held a hearing in East Maitland from 18 to 21 June 2019 to gain an understanding of issues related to the use of crystal methamphetamine and other ATS in the region. East Maitland is within the Hunter New England and Central Coast Primary Health Network (PHN), and the region includes both the Hunter New England and Central Coast Local Health Districts (LHDs) and the towns of Gosford, Woy Woy, Wyong, Newcastle, Maitland, Cessnock, Moree, Narrabri and Armidale.
- 26.2 Data tendered before the Inquiry from the Department of Family and Community Services (FACS, now the Department of Communities and Justice (DCJ)) indicates that the Hunter New England region contains 12% of the population of NSW.¹ Evidence before the Inquiry also shows that there are a number of Local Government Areas (LGAs) in the Hunter New England region with Aboriginal populations which are significantly higher than the state average (2.9%), such as Maitland LGA (5.3%), Cessnock LGA (7.2%) and Narrabri LGA (12.2%).² Aboriginal Nations in the region include the Anaiwan and Nganyaywana, Awabakal, Biripi, Darkinjung, Dunghutti, Geawegal, Kamilaroi, Kuring-gai, Ngarabal, Wonnaru and Worimi Nations.³
- 26.3 Key issues that emerged during the hearings included the effects on children resulting from parental use of crystal methamphetamine. One witness said: *'We see a lot of really stressed little children. You can see it on their faces.'*⁴
- 26.4 Other witnesses gave evidence about an increase in intergenerational drug use. As a result, the Inquiry heard instances of children becoming desensitised to drug use and engaging in risky behaviours.⁵ One mental health executive noted that a trial AOD treatment program for under 18s had started in Newcastle. *'They're getting flooded with kids; they're just coming out of the woodwork.'*⁶
- 26.5 The Inquiry also heard from Wyong-based Kamira Alcohol and Other Drug Treatment Services about the increasing number of pregnant women seeking assistance for ATS-related issues, often midway or late in the term of their pregnancy, and the shortfall in rehabilitation services for these women. This can result in an inability to meet DCJ requirements and the removal of babies.⁷
- 26.6 Participants at the East Maitland Roundtable talked about communities' experiences of crystal methamphetamine. John Manton, Aboriginal Health Access Manager, Hunter New England and Central Coast PHN, said it was *'everywhere'*, including in Taree and Maitland. *'You can't get away from it.'*⁸ Another participant noted:
- 'My home town ... may as well be out in the middle of the desert; that's how – that's how remote it is from a – you know, 40 minutes from a major town. But the ice epidemic up there is every second person on that mission is using.'*⁹
- 26.7 Other Roundtable participants talked about children being taken into care, with Vicki Cosgrove, Aboriginal Cultural Educator, describing it as a *'second round of stolen generation'*.¹⁰ Ms Cosgrove said the issues arising from the 1997 report of the *National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families (Bringing them Home)*¹¹ have not been addressed and now there is another layer of trauma on the communities. *'So, for us, in terms of our communities, the impact is everything that has been part of our history is now part of our future as well.'*¹²

East Maitland's experience with ATS

Increasing use of crystal methamphetamine

- 26.8 At the East Maitland Hearing, witnesses from sectors including health, police, family and community services and other local service providers told the Inquiry of their increasing fears about the prevalence of crystal methamphetamine and other ATS in their communities.¹³ Cessnock City Council also expressed concern about the prevalence of crystal methamphetamine.¹⁴ At a meeting in 2018, Cessnock City Council made a commitment to investigate the prevalence of crystal methamphetamine in the community along with treatment and support services available in the Cessnock LGA. The findings of the investigation were tabled at a meeting of the Council on 6 February 2019.¹⁵ The report found there was a lack of accessible treatment options and support services in the Cessnock LGA, including inpatient withdrawal and rehabilitation, and that there are barriers to accessing such services, including distance, privacy and fear of stigma and marginalisation.¹⁶ The report recommended that Cessnock City Council continue to lobby for increased provision and improved access to treatment and support services for people who use methamphetamine and their families across the Cessnock LGA.¹⁷
- 26.9 The *Hunter New England Central Coast PHN Needs Assessment 2019–2022* noted that the use of substances, including increasing methamphetamine use, is an issue of concern for the Central Coast. The report also stated that the use of drugs is a key contributing factor to the poorer health status of Aboriginal people in the PHN.¹⁸
- 26.10 Superintendent Craig Jackson, Commander, Port Stephens Hunter Police District, NSW Police Force, told the Inquiry that the use of crystal methylamphetamine and other ATS is prevalent across all locations in the district. He said methamphetamine is second only to cannabis in rates of possession.¹⁹ He noted that the use of ATS crosses demographics, including age, socioeconomic status and employment status,²⁰ and that methamphetamine has become more prevalent in the past five to 10 years.²¹
- 26.11 Superintendent Jackson said MDMA is used by a different demographic, generally people under the age of 30 who take it at music and dance festivals and '*in the pub scene*'.²² He said the police district is the location for two large music festivals, Groovin' the Moo and Subsonic, and there is a marked increase in detections during the festivals.²³

Use of crystal methamphetamine by people in contact with the justice system

- 26.12 The Inquiry heard evidence about the use of crystal methamphetamine among people who have had contact with the justice system. For example, in the 2018 financial year, 71.3% of participants in the Southern Sector of the Hunter New England Magistrates Early Referral Into Treatment (MERIT) Program reported crystal methamphetamine was their principal drug of concern compared to the state-wide average of 53.8%.²⁴
- 26.13 Cessnock Correctional Centre,²⁵ Tamworth Correctional Centre²⁶ and Glen Innes Correctional Centre²⁷ are located in the region. Susan Walton, Community Corrections District Manager, Maitland Community Corrections, told the Inquiry that offenders being supervised in the community who have AOD issues are referred to specialist local providers such as the Broadmeadow-based SMART (Self Management and Recovery Training) program. In a local example of an issue explored in Chapter 20, she said the program reported that they see many Community Corrections clients who say crystal methamphetamine and buprenorphine use in correctional centres is widespread. Ms Walton said SMART recovery clients are drug tested when they enter temporary supported accommodation and 40% are found to have amphetamines in their system.²⁸

- 26.14 Crystal methamphetamine is also an issue for young offenders. David Lowe, Area Manager, Juvenile Justice NSW (now Youth Justice NSW), works across the Maitland, Muswellbrook and Tamworth Juvenile Justice community offices. He said that about 28% of the service's clients – 42 young people on supervised orders and six in custody²⁹ – use ATS and most present with varying levels of other drug use. He said that, based on his experience, ATS use among clients is stable.³⁰

Increasing health presentations

- 26.15 Similar to the experience throughout the regional hearings, health sector witnesses gave evidence that shows an increase in the rate of ATS presentations over the past decade to health services.
- 26.16 Between 2013–14 and 2016–17, the rate of methamphetamine-related hospitalisations for people aged 16 years or over more than trebled in the Hunter New England and Central Coast LHDs. In both cases, the rate of people aged 16 years or over hospitalised for methamphetamine-related issues in 2016–17 was significantly higher than the state average.³¹
- 26.17 The Inquiry heard evidence from health professionals in the region. Dr Arvind Kendurkar, Senior Staff Specialist, Drug and Alcohol Services, Hunter New England LHD, noted that 181 patients who sought help from community-based services in 2009 said amphetamines were their primary drug of concern. In 2018, the figure was 696.³²
- 26.18 Dr Craig Sadler, Senior Staff Specialist Addiction Medicine, Director Alcohol and Drug Unit, Calvary Mater Newcastle Hospital; Clinical Director Withdrawal Services Hunter New England LHD, noted that in 2009–10, ATS presentations made up 5.4% of all episodes of care in the unit but by 2017–18, they were 17.2%, an increase of about 300%.³³ He told the Inquiry that in the same period there was a 700% increase in the number of people admitted to Lakeview Inpatient Withdrawal Unit at Belmont District Hospital with amphetamine as their primary drug of concern.³⁴
- 26.19 Dr Sadler noted that the accuracy of data gathered about admissions can be variable because emergency department presentations and hospital admissions are a large and complex dataset that might not demonstrate the contribution of ATS.³⁵ He said presentations are coded by diagnostic-related groups (DRGs).
- ‘So that might be their pancreatitis, or their surgical operation or their – whatever has happened to them. And while ATS use may be part of that, or a contributing factor or a comorbidity, it may not necessarily be listed in the list of DRGs. So that’s an example of how it’s – how it’s missed.’³⁶*
- 26.20 The difficulties arising from the way in which ATS-related data is collected within NSW Health are addressed further in Chapter 14.
- 26.21 Dr Sadler said people taking crystal methamphetamine and ATS come from all demographics, but there are generally more males than females and Aboriginal people are overrepresented in the cohort.³⁷

- 26.22 Dr Nick Ryan, Director of the Emergency Department, Tamworth Rural Referral Hospital, also gave evidence that data might not reveal the full extent of ATS use. He said patients presenting with acute behavioural disturbance or mental health issues are often unwilling or unable to answer questions about drug use and ATS presentations are not captured on the emergency department database.³⁸ He said this is an issue across the Hunter New England LHD and without good data it is hard to quantify the impact of ATS.³⁹ Dr Ryan said that, based on his observations and discussions with colleagues in his department, the incidence of ATS-related presentations appears to be increasing. He said crystal methamphetamine is the principal drug involved in presentations⁴⁰ and appears to be replacing 'speed'.⁴¹
- 26.23 The Inquiry heard from William Robertson, Health Services Manager, Southern Psychosocial Unit, Hunter New England LHD, who manages AOD clinical services including the MERIT Program and the Stimulant Treatment Program. He said that in the past five years he had seen a significant increase in people seeking treatment for methamphetamine use and a shift from injecting to smoking.⁴² Mr Robertson said 18 to 20% of participants in the Stimulant Treatment Program are Aboriginal people and there has been an increase in participants from regional areas including Cessnock and Raymond Terrace.⁴³
- 26.24 The Inquiry heard evidence from Dr Sujatha Venkatesh, Clinical Director, Psychiatric Emergency Service, Hunter New England Mater Mental Health, which comprises the four-bed Psychiatric Emergency Care Centre and the eight-bed Psychiatric Intensive Care Unit, co-located with the Calvary Mater Newcastle Hospital. Dr Venkatesh told the Inquiry that ATS-related presentations to her services have increased in the past two years.⁴⁴ She said most referrals come through the general hospital's emergency department and are related to psychiatric symptoms known to be associated with ATS use.⁴⁵ Dr Venkatesh said that on average, the Psychiatric Emergency Care Centre and the Psychiatric Intensive Care Unit see between eight and 10 people a week with acute behavioural disturbances.⁴⁶
- 26.25 Margaret Terry, Mental Health and Substance Use Service Director, Hunter New England Mental Health, Senior Clinical Psychologist, told the Inquiry she has observed a substantial increase in the number of patients presenting intoxicated or suffering withdrawal from ATS with comorbid psychiatric disorders such as psychosis, mood disturbances and complex trauma histories, some with an associated personality disorder diagnosis.⁴⁷ She said she has also observed an increase in the number of patients presenting with longer-term and chronic ATS use and associated methamphetamine psychosis.⁴⁸
- 26.26 Dr Venkatesh and Ms Terry agreed that ATS is the primary drug of concern for about 60% of patients admitted. Ms Terry said crystal methamphetamine is the drug most likely to cause drug-induced psychosis or exacerbate an underlying psychosis.⁴⁹ Dr Venkatesh said it was her impression that ATS have become stronger and she is also seeing increased impairment from polysubstance use and impurities in drugs.⁵⁰
- 26.27 Dr Venkatesh said people who present using ATS are commonly from a socioeconomically disadvantaged background, aged 18 to 25 and have mental illness comorbidity. She said a common feature is a lack of social and family support or a dysfunctional family situation. She said use is high among Aboriginal people.⁵¹

Crystal methamphetamine use by pregnant women

- 26.28 The Inquiry heard from several witnesses about an increase in the number of pregnant women in the East Maitland region who use ATS and present to health services. William Robertson, Health Services Manager, Southern Psychosocial Unit, Hunter New England LHD, who manages the Stimulant Treatment Program in that LHD, observed a recent increase in the number of pregnant women referred to the service by DCJ and antenatal treatment programs,⁵² although the number has lessened since the establishment of the new Substance Use in Pregnancy and Parenting Service (SUPPS) program.⁵³
- 26.29 Gail Hartley, Clinical Nurse Consultant, SUPPS, Central Coast LHD, told the Inquiry that 11 out of 18 families (61%) of the SUPPS' current intensive home visiting program identify methamphetamines as their main drug of concern.⁵⁴ Over the past 12 months, about 40% of women referred to SUPPS had ATS or stimulants as their principal drug of concern.⁵⁵ She added that the service has had to adapt to a demand that is '*well in excess*' of what is possible under current funding.⁵⁶
- 26.30 Ms Hartley noted that women who misuse substances during pregnancy have a range of complex needs. They are usually single mothers, engage in polydrug use, smoke tobacco and frequently misuse prescription drugs to manage anxiety, pain, depression and trauma experiences. They often have histories of homelessness and domestic violence, mental health issues, a lack of family support, previous child removals, legal issues and debts. A third of women referred to SUPPS in the past 12 months were Aboriginal.⁵⁷
- 26.31 Catherine Hewett, CEO, Kamira Alcohol and Other Drug Treatment Services, said the number of pregnant women seeking assistance has increased by 500% over two years.⁵⁸ Kamira is a 22-bed facility in the Wyong Hospital grounds that has provided residential AOD treatment for 35 years to women, pregnant women and women with dependent children up to the age of eight.⁵⁹ Ms Hewett said nearly all the pregnant women referred to the service have crystal methamphetamine as a primary drug of concern.⁶⁰
- 26.32 Ms Hewett gave evidence that the use of ATS has likely increased the demand for Kamira's services. She noted a 50% increase in the number of requests for service in the past financial year, from about 420 requests to 605.⁶¹ Two years ago, ATS overtook alcohol to become the primary drug of concern for Kamira's clients and this year it is the primary drug of concern for 60% of Kamira's clients.⁶² She said clients have usually experienced a psychotic episode related to ATS use before admission.⁶³ The importance of services for pregnant women is considered in Chapter 18.
- 26.33 Ms Hewett said many clients are aged between 25 and 35 and have children who have been placed in out-of-home care or who are at risk of being removed. Thirty per cent of clients are Aboriginal.⁶⁴ She said there has been an increase in the number of women with tertiary qualifications who have become involved in a cycle of domestic violence that led to drug use.⁶⁵ She said all clients have backgrounds of significant and complex trauma, including domestic and family violence.⁶⁶

Children's experience of ATS

- 26.34 The Inquiry also heard how crystal methamphetamine is impacting the lives of children in the region. Anne-Marie Connelly, Manager, Client Services, NSW Department of Family and Community Services, said a decline in the price of crystal methamphetamine in the Hunter area has made it more accessible. She said the drug appears to have increased its presence in schools and is used by schoolchildren.⁶⁷

- 26.35 Jacqueline Hornery, Brighter Futures Program Coordinator, Samaritans, told the Inquiry about the program's work with families and children under nine years old, about whom a risk of serious harm report has been made to DCJ. Ms Hornery noted that the number of families in the program affected by crystal methamphetamine and other ATS has increased.⁶⁸ She said that Brighter Futures received 103 referrals in 2018, of which 25 specified crystal methamphetamine use as one of the reasons for referral and another 25 listed the referral reason as AOD generally.⁶⁹ She said it is sometimes difficult to tell whether a person is under the influence of ATS if they have been using the substance for a longer period, because they might be reasonably coherent.⁷⁰
- 26.36 Ms Hornery said 90% of referrals come from DCJ and 10% come from the community. She noted that most families in Brighter Futures have some form of vulnerability, including AOD use, mental health issues, intellectual disability or domestic violence.⁷¹ Samaritans works with families that often come from areas with a high prevalence of crystal methamphetamine use and associate with *'a cohort of people in similar circumstances to them, often with a generational history of child protection involvement, a lack of housing and an experience of trauma'*.⁷²
- 26.37 Ms Hornery told the Inquiry that she has observed a change in the patterns of drug use in the past five years. People who use 'speed' might do so only on weekends but people who use crystal methamphetamine seem to do so consistently *'as a means of escaping'*. She noted that, unlike heroin, it is more common for both parents to use the drug.⁷³
- 26.38 The Inquiry heard evidence from Cigdem Watson, Executive Manager, Personal Helpers and Mentors Program and the Youth Drug and Alcohol Services (YDAS) at Centacare, Narrabri. She stated that YDAS was established in 2018 to work with children between the ages of 10 to 19 because it was apparent that people in the area were developing AOD issues from an early age. She said crystal methamphetamine first started to appear about five years ago and has become much more accessible, particularly in the past two years. She said amphetamines are the principal drug of concern for about 16% of young people using the service and more than 50% of the young people using the service have comorbid AOD and mental health issues.⁷⁴

Impacts of ATS use in the East Maitland region

- 26.39 Cessnock City Council submitted that the growing issue of crystal methamphetamine use, alongside gaps in service provision, is putting pressure on GPs, hospital emergency departments, ambulance, mental health services and police.⁷⁵

Impact on crime

- 26.40 NSW Bureau of Crime Statistics and Research (BOCSAR) statistics in evidence before the Inquiry show that between 2014 and 2018, there has been an increase in recorded incidents of 'use/possess' amphetamines in the Maitland LGA, with a reduction in the rate of recorded 'dealing/trafficking' amphetamine incidents.⁷⁶ During the same period, Narrabri LGA saw a reduction in recorded incidents of 'use/possess' amphetamine with rates of recorded 'dealing/trafficking' amphetamine incidents remaining stable.⁷⁷ The statistics indicate stable rates in the Newcastle LGA of recorded incidents of both 'use/possess' and 'dealing/trafficking' in amphetamines between 2014 and 2018.⁷⁸

- 26.41 Superintendent Jackson, NSW Police Force, told the Inquiry that police are responding to an increasing number of calls to people suffering the effects of methamphetamine and ATS and are often called to assist NSW Ambulance. He said patients are taken to Maitland Hospital or Calvary Mater Hospital.⁷⁹ He noted multiple challenges police face when responding to callouts for people affected by crystal methamphetamine, including the need to make quick decisions with minimal or anecdotal information about what drug the person is using.⁸⁰ He said responding to these situations can require multiple police resources because people affected by ATS can be aggressive, strong and slow to tire. *'Instead of sending one car crew to, to a job like that, we might send two or three.'*⁸¹

Impact on health services

- 26.42 Health providers also gave evidence about the pressures on service provision from the increasing use of crystal methamphetamine. Dr Marcia Fogarty, Executive Director of Mental Health, Hunter New England LHD, gave evidence to the Inquiry that ATS-related admissions spike on weekends when junior doctors are more likely to be rostered on and other services such as AOD or social work are generally not available.⁸² Dr Venkatesh, Hunter New England Mater Mental Health, said it is a *'huge strain'* on staff trying to care for these patients. *'The staff do get burnt out in this process, and I think, as a service, we are seeing a lot of assaults, and a lot of staff moving out of intensive care units.'*⁸³
- 26.43 In evidence that echoed a theme heard throughout the regional hearings, Dr Ryan, Tamworth Rural Referral Hospital, gave evidence about the pressures involved when treating patients with ATS-related problems in a regional hospital emergency department. He said that in cases of acute behavioural disturbance, including psychosis and agitation, patients are first assessed by an emergency department or mental health clinician or following a telephone discussion with an admitting psychiatrist. They are then moved to a mental health ward. However, he said the mental health service is reluctant to admit patients if they believe drug or alcohol intoxication is the cause of their presentation. He said in such situations, the patients remain in the emergency department until they are no longer intoxicated, which strains already limited resources.⁸⁴ He also noted that many of the patients needing more resources arrive at the department between midnight and 7am when decreased numbers of staff are available.⁸⁵
- 26.44 Dr Ryan said there are several presentations a week by people using ATS who are intoxicated, creating difficulties for staff.
- 'People with acute behavioural disturbance likely to be due to ATS use have punched staff members (at least two documented cases of which I am aware), spat on and bitten staff, threatened staff with used syringes, and threatened and attempted other physical violence. It usually occurs early in their ED stay before their full circumstances are known. Being a busy mixed ED, these patients also pose a threat to children and other vulnerable patient groups.'*⁸⁶
- 26.45 He said that where it is apparent a person is a risk to themselves or to staff and verbal de-escalation is unsuccessful, both physical and chemical restraint are usually used.⁸⁷ When it is determined someone needs to be restrained, a minimum of eight people is required. *'I won't undertake that process unless I've got those numbers, because I think it's dangerous to do so.'*⁸⁸ Dr Ryan said that when there are limited numbers of emergency department staff he calls on security staff, wards people, porters and nursing staff for assistance.⁸⁹ Such incidents occur a couple of times a week.⁹⁰ Improvements to health services are examined in Chapter 14.

Impact on children and families

- 26.46 Witnesses told the Inquiry how parental use of crystal methamphetamine can affect children. For example, Ms Connelly, FACS, told the Inquiry she has observed a steady increase in the number of risk of serious harm reports in which the use of crystal methamphetamine and other ATS was the primary reported issue and was linked to issues of chronic child neglect.⁹¹ Between 1 July 2018 and 31 May 2019, approximately 143 children entered care in the Hunter District. The parents of 55 of the children (38%) had issues related to crystal methamphetamine. It should be noted that this is not official DCJ data and was drawn manually from DCJ 'Entry into Care' records and is indicative only.⁹²
- 26.47 Ms Connelly said children are being exposed to ATS use from a young age and third and fourth generations of the same families are coming to the attention of child protection services.⁹³ She noted that young people are engaging in risky behaviours.⁹⁴
- 26.48 She said she knew of three or four cases in the past year in which adults groomed young people into crystal methamphetamine dependence, then held them in situations of psychological captivity. She said in the worst-case scenarios, young men and women were seriously physically and sexually assaulted.⁹⁵
- 26.49 The Inquiry heard evidence from witnesses about how a person's use of crystal methamphetamine or other ATS can affect their family. For example, Ms Hornery, Brighter Futures, said that often the service meets families that are not functioning.⁹⁶ They might have become known in the community because of an incident of domestic violence or children's non-attendance at school. Rent and bills might not have been paid and there might be conflict with neighbours and friends. Ex-partners or family members might be incarcerated.⁹⁷ She said 67 of the 103 referrals Brighter Futures received in 2018 included domestic violence as one of the reasons for referral. She noted a perception among case workers that domestic violence associated with crystal methamphetamine use tends to be more physical and frequent than in situations where the drug is not present.⁹⁸ The association between ATS and domestic violence is considered in more detail in Chapter 18.
- 26.50 Participants at the East Maitland Roundtable discussed the impact of crystal methamphetamine on communities. Tara Dever, CEO, Mindaribba Local Aboriginal Land Council, said that some people claim they are using marijuana, but it is clear they are concealing the use of crystal methamphetamine:
- '[W]e know the rents aren't being paid; your mortgages aren't being paid. There's no one going to work. The children aren't going to school, or they are going to school, they shut up. Kids stop. Anyone who is, you know, from the Aboriginal experience ... knows you shut up. If you're hungry, if everything is going wrong at home, they're not the kids at school going, "I haven't got anything to eat." They are not. They will be quiet. They will not tell you there is nothing to eat.'*⁹⁹
- 26.51 Ms Dever said that in one area children aged between eight and 14 were in trouble for stealing bags of shopping and nappies. *'You know, kids that age don't steal those things unless they have to provide for a small child at home'*.¹⁰⁰
- 26.52 The impact of crystal methamphetamine on Aboriginal communities is explored in Chapter 16.

Local responses

- 26.53 The Inquiry heard of the substantial efforts from both government and non-government providers to respond to the use and impacts of crystal methamphetamine in the East Maitland region. It received evidence of collaboration between services in an effort to provide wraparound supports. Agencies noted that Youth Action Meetings, Safety Action Meetings and Complex Case Coordination meetings are effective in reducing risks.¹⁰¹
- 26.54 Superintendent Jackson, NSW Police Force, told the Inquiry that police make every effort to identify drugs during music festivals but also take a harm minimisation approach.¹⁰² He said police know drugs get into festivals, but they want to make sure they don't 'lose' an attendee. He said it was important for young people to let police know if they or someone with them was suffering ill effects from a drug. He stated drug use was not just a law-enforcement issue but also a health issue. *'We're trying to keep these ... kids safe.'*¹⁰³ Superintendent Jackson agreed police could exercise discretion in deciding whether to search someone for drugs who had taken an unwell friend to police and would also need to have reasonable cause to carry out a search.¹⁰⁴
- 26.55 Superintendent Jackson agreed he is aware that if music festival patrons see a police presence either at the gate or inside the festival, they might decide to take all at once the drugs they originally planned to take gradually through the festival, thereby increasing the health risk.¹⁰⁵ He said he is also aware of the unsafe practice of 'pre-loading', whereby people take a larger quantity of drugs before a festival.¹⁰⁶
- 26.56 Superintendent Jackson also gave evidence about the district's implementation of the RISEUP strategy, developed by the NSW Police Commissioner, to connect disengaged young people aged 15 to 18 to workplace opportunities. District police work with staff at three Police Citizens Youth Clubs in Maitland, Nelson Bay and Raymond Terrace on RISEUP programs including Fit for Life and Fit for Work.¹⁰⁷
- 26.57 Mr Lowe, Juvenile Justice NSW, told the Inquiry that Juvenile Justice's community-based programs to assist young people using ATS include the Alcohol and Other Drug Education module in the Changing Habits and Reaching Targets (CHART) program; the X-Roads program; the Dthina Yuwali program based on cultural learning; and the Junaa Buwa! Rural Residential Service based in Coffs Harbour.¹⁰⁸
- 26.58 Noting that domestic and family violence is a common feature among clients,¹⁰⁹ Mr Lowe also gave evidence about a partnership with Dr Tamara Blakemore, a Senior Social Work lecturer at the University of Newcastle, that developed a program called 'Name, Narrate, Navigate'.¹¹⁰ It was created to address the need for early-intervention services and supports for young people who perpetrate violence in their relationships with partners, parents and carers. The trauma-informed and culturally sensitive program was recently piloted in the Hunter region.¹¹¹
- 26.59 Mr Lowe also told the Inquiry about the recently established multiagency Youth Action Meetings in Cessnock chaired by the NSW Police Force.¹¹² He said the approach has two streams – a welfare stream where it has been identified that a young person and their family have welfare needs, and an offending behaviour stream to look at what supports are required for a young person who continues to reoffend.¹¹³

- 26.60 Health services gave evidence about local facilities available for those needing assistance with mental health and AOD issues. Dr Fogarty, Hunter New England LHD, told the Inquiry that Newcastle's Mater Hospital is the hub facility in the LHD where most ATS presentations are taken and where most adult mental health beds are located. Other hubs are Maitland, Tamworth, Taree and Armidale.¹¹⁴ She said emergency departments in smaller hospitals, including Gunnedah and Singleton, have out-of-hours access to mental health video conferencing. Mental health clinicians based at James Fletcher Hospital in Newcastle carry out assessments and offer diagnostic and treatment advice via video conference. She said it is a good service¹¹⁵ but not useful in the case of people who are acutely intoxicated and uncooperative.¹¹⁶
- 26.61 Dr Fogarty said it is not always possible to make appropriate referrals for children and families affected by ATS and that, until recently, drug and alcohol centres only saw people over 18.¹¹⁷ But she said a trial treatment program for under 18s has started in Newcastle.¹¹⁸
- 26.62 In an example of how health services have attempted to better address the issue of comorbid mental health and AOD issues, Ms Terry, Hunter New England Mental Health, told the Inquiry that the Mental Health and Substance Use Service includes a 22-bed acute inpatient unit, the Mental Health and Substance Use Unit (MHSUU), also on the Mater campus, and a community team.¹¹⁹ She said she believes the MHSUU is the only inpatient unit in NSW with designated integrated care for people with serious co-occurring mental health and substance use issues.¹²⁰ Admission is through the Psychiatric Emergency Care Centre.¹²¹ She noted that most people admitted to the unit have a history of trauma. Unit staff adopt a trauma-informed approach to treatment and look at mental health and substance use together.¹²² The MHSUU also takes a 'stage of change' approach to patients, assessing clients' readiness to address their mental health and AOD issues. Depending on the stage they are at, they might be offered information, education or access to relapse-prevention programs.¹²³
- 26.63 Dr Sadler, Calvary Mater Hospital, gave evidence about the hospital's Alcohol and Drug Unit. He said it is a small, multidisciplinary unit with 5.5 full-time equivalent staff. It services the emergency department and the general medical hospital and provides a multidisciplinary outpatient service that includes follow-up counselling programs and outpatient withdrawal.¹²⁴ Dr Sadler said cultural awareness training is mandatory. The Calvary Mater Newcastle has an Aboriginal liaison staff member and there are several Aboriginal-specified staff positions in Hunter New England AOD services.¹²⁵ He also noted that in some cases there is strong interagency collaboration. For example, the Lakeview Inpatient Withdrawal Unit at Belmont District Hospital has an arrangement with Centrelink under which staff visit patients in the unit to help them deal with payment issues.¹²⁶
- 26.64 In another example of a local response to experiences of AOD use, in January 2019, the Hunter New England LHD service started the Youth Drug and Alcohol Clinical Services (YDACS). The Inquiry heard from Dr Krista Monkhouse, Paediatric Staff Specialist for YDACS, which provides clinical interventions to young people aged up to and including 18 years who have a moderate to severe substance use problem, with a focus on those with high-risk comorbidities such as mental health conditions.¹²⁷ Dr Monkhouse said the service currently has about 71 clients, most aged between 15 and 18. Dr Monkhouse said adequate data about the proportion of YDACS clients with crystal methamphetamine or other ATS as their principal drug of concern is not available, but she believes it is less than 20% (based on Minimum Data Set information about 31 patients).¹²⁸

- 26.65 Dr Monkhouse said the YDACS clinical hub is in Newcastle but provides support to young people in rural and regional locations via telehealth appointments, or indirectly through a consultation and liaison process with the clinician working with the young person. YDACS is also piloting a clinic in Cessnock that runs one day a fortnight.¹²⁹ Team members provide consultant liaison services to John Hunter Children's Hospital.¹³⁰ The use of telehealth and related services to improve services in regional areas is considered in Chapter 14.
- 26.66 Referrals to the service come from hospitals, the Child and Adolescent Mental Health Service and GPs. Dr Monkhouse said that YDACS will soon hold an information session at a Hunter Postgraduate Medical Institute night that caters to about 200 GPs in the area. She said YDACS has done '*a lot of networking*' in Tamworth, Narrabri and Moree to spread information about the service. As a result, non-government organisations (NGOs) and counsellors are starting to contact the service asking for consultations for young people.¹³¹
- 26.67 Dr Monkhouse offered an example of how the consultation has worked for a case in Moree. She said an NGO in western NSW contacted YDACS about a 16-year-old Aboriginal girl. Dr Monkhouse said she established an initial rapport with the girl during a phone psychosocial assessment. The following week, Dr Monkhouse joined in a video conference session with the girl, her mother, the NGO counsellor, a registered nurse and an adult fly-in fly-out AOD addiction medicine specialist who had travelled to Moree for the conference. They assessed the girl and established she would benefit from an opiate agonist treatment program. Since then, using video conferencing, YDACS has been able to support the girl on a weekly basis, connecting with a GP in the area and the pharmacy providing the treatment. The addiction medicine specialist visits Moree on a monthly basis.¹³²
- 26.68 The Inquiry heard that most young people presenting to YDACS have some form of trauma in their background¹³³ and about a third identify as Aboriginal.¹³⁴ Dr Monkhouse said culturally appropriate and trauma-informed service delivery is essential to ensure that no further harm is caused.¹³⁵
- 26.69 The Inquiry heard that YDACS takes a harm minimisation approach and includes education, physical and health screening, sleep and nutrition information and advice about minimising risks when taking drugs, such as using glass instead of plastic when smoking from a bong, not injecting drugs and hydrating when taking MDMA.¹³⁶
- 26.70 Witnesses gave evidence about programs to help pregnant women who use crystal methamphetamine. Ms Hartley, SUPPS, told the Inquiry that the service started in 2017 to improve outcomes for pregnant and postnatal women and their children whose lives are affected by AOD use.¹³⁷ SUPPS provides consultation and liaison services to the maternity ward and special care nursery (births of high-risk pregnancies) at Gosford Hospital; consultation and treatment for pregnant women with substance issues at Gosford and Wyong Hospital antenatal services; consultation to clients of the Aboriginal health services Ngiyang, Nunyara and Yerin; and an intensive home visiting program.¹³⁸
- 26.71 She said the service works with women to prevent relapse, to address health issues such as nutrition, dental care and hepatitis C,¹³⁹ to help them build strong and secure attachments with their babies, and to encourage them to engage in wider community-based support and health services such as child and family health clinics.¹⁴⁰ Ms Hartley noted that AOD work with pregnant women is slow and steady and it can be problematic to address trauma too quickly, especially with Aboriginal women. '*We can, you know, push them away very easily and quickly, so it has to be really slow, steady.*'¹⁴¹

- 26.72 Ms Hartley said the lack of housing in the Central Coast region is a major issue. She said many SUPPS clients try to find private housing because of the ‘dramas’ they experience in public housing, but available private housing is often inadequate.¹⁴² She said some clients stay in controlling or violent relationships because appropriate housing is unavailable.¹⁴³ Concerns about housing are not unique to the Maitland area and were also reported in other regions.
- 26.73 SUPPS works with Kamira to ‘provide a bridge between Kamira and maternity services at Gosford and Wyong Hospital’.¹⁴⁴ Kamira’s Ms Hewett said the relationship with SUPPS and the expertise its staff offered is ‘invaluable’.¹⁴⁵
- 26.74 Ms Hewett told the Inquiry that Kamira admitted five pregnant women for treatment in the past year.¹⁴⁶ She said some women who contact the centre but whose babies are due within four months are not even assessed for admission because of Kamira’s four-month waitlist.¹⁴⁷ Ms Hewett said if a pregnant woman is not able to access residential rehabilitation, DCJ will remove her baby and place the baby in out-of-home care. She agreed that the limitations on the number of women Kamira can admit mean more women are likely to have babies removed from their care.¹⁴⁸
- 26.75 Ms Hewett said that, at any one time, the service treats only a small number of pregnant women because of the complex nature of their presentations. She said some women who use ATS and who have prior FACS (now DCJ) involvement might delay accessing antenatal treatment because they fear they will have another child removed.¹⁴⁹ This means in some cases women arrive at Kamira after 20 weeks of pregnancy and it might be their first contact with a health service. At the same time as the service tries to stabilise a client’s mental health, she must attend prenatal appointments. Additional complexities might include potential brain and physical development issues for the baby, risks connected to the birth and babies born with high needs in the short or long term, DCJ involvement after the birth, and a lack of housing availability or support when the woman leaves Kamira.¹⁵⁰
- 26.76 Ms Hewett said there is emerging evidence about the importance of attachment-based programs.¹⁵¹ She said if a mother can form a strong attachment with a baby, it might contribute to preventing her relapse. She described Kamira’s infant massage group during which a facilitator helps mothers to bond with their babies.

‘[O]ften they haven’t had this experience in their own childhood, so how can we expect them to be able to just switch that switch on and deliver it to this child, so generationally, this is where we can have the most impact, by building this strong secure attachment. They touch their baby. Their baby has eye contact with them, and this amazing thing happens in their brain. The baby is attached to the mother. They know that they’re safe. They know that they can trust, and this is the – this is the beginning of growing into an adult that can develop strong healthy secure attachments with other adults and put them at lower risk of entering chaotic lifestyles of drug use, violence, etc.’¹⁵²

- 26.77 Ms Hewett added that Kamira clients have complex trauma backgrounds and chaotic lifestyles but may not understand they have experienced trauma.

‘[It] saddens me to – when you sit with them and you hear their trauma and that’s normal. It has been normalised because it’s what happened in their environment as a child; it’s what happened with their mother, with their sisters in their relationships. That’s just a normalised thing.’¹⁵³

- 26.78 She told the Inquiry that people with such backgrounds have poor mood regulation and are sensitive to noise, smell, touch and sensations and it can be difficult for them to live with other women in a facility. She said Kamira uses trauma-informed and culturally appropriate practices; its environment is warm and comforting and has quiet spaces. Staff are aware of closing doors quietly and the tones of their voices.¹⁵⁴
- 26.79 Other supports for children and families affected by ATS in the Hunter New England region include:
- **The Samaritans Brighter Futures program:** The program has teams in Newcastle and Lake Macquarie and works with 98 families at a time.¹⁵⁵ The program collaborates with other services including Mercy Services AOD outreach programs, Staying Home Leaving Violence and Circle of Security, and works closely with schools and preschools.¹⁵⁶ Case workers usually attend Safety Action Meetings convened by Police.¹⁵⁷
 - **Their Futures Matter reform:** This aims to deliver services and support to prevent children entering care and to keep families together. In the Hunter region, Their Futures Matter is in Edgeworth, Mayfield, Charlestown, Raymond Terrace, Cessnock, Maitland, Wyong and Gosford.¹⁵⁸ Ms Connelly, Cessnock Community Services, said the Their Futures Matter model is the first in NSW to deliver evidence-based, in-home therapeutic service for families. She said there is a high rate of underlying trauma in the parents of the families involved, including experiences of serious physical harm, sexual abuse and childhoods characterised by parental drug use.¹⁵⁹
 - **Education Department interventions:** The Inquiry heard evidence from Debborah Beckwith, Network Specialist Facilitator, NSW Department of Education and Tony Gadd, Director, Educational Leadership for the Maitland Principal Network. Ms Beckwith explained she provides support to 140 schools in the area between Muswellbrook, Port Stephens and Taree. She said that responding to the educational needs of some students can involve multiple services and she provides an access point for other agencies to connect with schools about young people with complex matters.¹⁶⁰ Mr Gadd, who supervises 21 principals in the Maitland region, said there is a range of interagency meetings in his network, including the Rutherford Complex Case Coordination Committee, initiated in partnership with Maitland DCJ staff and attended by government departments including the NSW Police Force and NSW Health's Child and Adolescent Mental Health Service.¹⁶¹
- 26.80 The Inquiry heard of the limited options for residential drug rehabilitation in the region. Apart from Kamira (which is restricted to women), in Cessnock there is the We Help Ourselves four- to six-month residential program for men and women aged over 18, and The Glen, a culturally appropriate residential rehabilitation facility for Aboriginal men aged over 18 on the Central Coast.
- 26.81 Joe Coyte, CEO, The Glen, said the centre has 37 beds: 15 for clients transitioning from the program back into the community and 22 allocated to a 12-week program (two of those are bunks in the television room, 'overflow beds', and are nearly always full). Up to 30 men are waiting for a bed at any one time. In 2018, the facility treated 131 clients, 73 of whom nominated methamphetamine as their primary drug of concern. Mr Coyte said that five years ago, alcohol followed by heroin were the primary drugs of concern.¹⁶² He also stated that The Glen is seeing more clients with mental health issues and has changed its policy to accept men with a medicated mental illness.¹⁶³ He said most clients are self-referred and that, increasingly, family members are involved in referrals, particularly for clients in prison. He said Corrective Services staff no longer do referrals for inmates which is difficult '*when many of our clients can't read or write*'.¹⁶⁴

- 26.82 Mr Coyte said The Glen works with employment partners such as Bunnings, Lendlease and Multiplex to assist vulnerable clients to secure employment.¹⁶⁵ The Glen's program includes engagement with local Aboriginal Elders, art and painting lessons, tours on Country, storytelling and smoking ceremonies *'to help cleanse negativity and create positive energy'*. Recently, The Glen's dance group performed in front of 25,000 people at a Knights versus Roosters game.¹⁶⁶

*'The cultural aspect of The Glen program is very important. Previous clients have reported that without the cultural elements of the program, they would not be clean and sober. Connecting spiritually can give clients more confidence and show men how to have a good time without drugs and/or alcohol.'*¹⁶⁷

- 26.83 The Inquiry heard that The Glen recently received \$9 million of funding to establish a culturally appropriate AOD rehabilitation service for women.¹⁶⁸ Mr Coyte said The Glen considers clients *'to be sick people who need help to get well, not bad people who need to learn how to be good people'*.¹⁶⁹
- 26.84 Helen Fielder-Gill, Unit Service Manager, Alcohol and Drugs, Samaritans, gave evidence about Friendship House, which provides transitional accommodation for people coming out of correctional centres. The Samaritans run the Ice SMART program from a hub called Recovery Point in Broadmeadow, Newcastle and in Hamilton South.¹⁷⁰ The program modifies the usual SMART recovery program by including elements that are designed to better engage with people who use methamphetamine.

Opportunities to strengthen local responses

- 26.85 The Inquiry heard of shortfalls in resources and processes that hinder the region's response to the impact of crystal methamphetamine and other ATS. Witnesses shared with the Inquiry ideas to ensure an increase in the effectiveness of responses and strategies.
- 26.86 Cessnock City Council submitted that a multifaceted approach to reducing ATS use and its related harms should be implemented. It said treatment and support services that meet the needs of regional and rural communities should have a visible presence in those communities. Cessnock City Council also noted that a register of AOD services, including information about waiting periods and referral pathways for people who use ATS and their families, might help to address a range of issues associated with service coordination and awareness.¹⁷¹
- 26.87 Ms Hewett, Kamira, said the demand from pregnant women across the state is so great that Kamira could fill 20 additional beds.¹⁷² She said that, since 2009, she had reported and provided evidence at state and Commonwealth government levels about the lack of pregnancy-specific treatment to meet demand.¹⁷³ She said there has not been political interest or a government funding opportunity to provide that support.¹⁷⁴

*'An immediate improvement to access of treatment is required for pregnant women using ATS who are at risk of removal of their newborn into out-of-home care. Denying pregnant women access to treatment that works has far-reaching physical, emotional, mental and social effects on herself, her baby and the greater community. Kamira has a specialist program that works but is only limited by its capacity.'*¹⁷⁵

- 26.88 The Inquiry heard from witnesses about the lack of continuity of care for people being released from correctional centres and the need for collaborative treatment planning between Justice Health and Corrective Services. For example, Dr Sadler, Calvary Mater Hospital, said that in the post-release period, individuals returning to drugs face a higher risk of overdose because they might have had less exposure to drugs in correctional facilities.¹⁷⁶ He observed that greater resources for the Connexions program for people leaving facilities would be beneficial.¹⁷⁷ (Connexions is a Jesuit Social Services counselling program for young people with a dual diagnosis of mental illness and substance misuse).¹⁷⁸
- 26.89 Dr Fogarty, Hunter New England LHD, gave evidence that former detainees face significant barriers to being reintegrated into the community. She said they are often abruptly released without funds and are not given medication or scripts for any regular medication, referrals to health services or follow-up with other services. On release, an individual usually has no job or income source, which increases the chance they will resume risk-taking behaviours.¹⁷⁹
- ‘We have had a couple of catastrophic instances in the last two years where people have been abruptly released from prison. Within a couple of weeks, they become acutely psychotic because they haven’t got any medication, plus or minus have taken substances and have either ended up dead or quite catastrophically ending up in hostage, siege situations that just end very badly for all concerned.’¹⁸⁰*
- 26.90 Dr Fogarty said that when these cases are reviewed afterwards, Justice Health often do not know the person has been released.¹⁸¹ She said there should be a system so a prisoner’s medications, appointments and follow-up treatments can be organised ahead of release.¹⁸² She noted that Local Coordinated Multiagency offender management, part of the Premier’s Priority Offender reform to reduce adult reoffending,¹⁸³ has recently started in Newcastle. It involves collaboration between the NSW Police Force, DCJ, NSW Health and sub-agencies including Corrective Services, Justice Health, Housing and AOD services to assist Community Corrections clients with mental health or substance use issues to access the help they need.¹⁸⁴
- 26.91 Other witnesses gave evidence about the absence of pathways for people leaving correctional facilities. For example, Dr Ryan, Tamworth Rural Referral Hospital, noted the presence of the Tamworth Correctional Centre across the road from the hospital and said his department sees people who have recently left the facility but have either not received or not engaged with ongoing care and support for AOD and other health problems.¹⁸⁵
- 26.92 Dave Johnstone, AOD Support Case Worker, a participant in the East Maitland Roundtable, said he has met people who entered correctional facilities medicated for conditions such as schizophrenia or borderline personality disorder and who have later been released unmedicated and without living skills. *‘By then, they’ve turned to self-medication. Ice is cheap and nasty and available everywhere in Newcastle. ... there’s no escaping it; it’s absolutely everywhere.’¹⁸⁶* Mr Johnstone noted that some people go into a correctional facility without an issue with drugs but come out with one, while others *‘go in with the habit and they get the habit worse’*.¹⁸⁷

- 26.93 Others noted the lack of continuity of care for people moving from detoxification to rehabilitation facilities or from rehabilitation back into the community. For example, Mr Coyte, The Glen, said clients need to be fully detoxified before starting The Glen's program and often need to travel, sometimes by public transport or overnight, from detoxification facilities in other parts of the state to reach The Glen. He said about two clients a month do not start the program because they relapse during the trip. He said it would be helpful if there were detoxification services closer to the Central Coast.¹⁸⁸ Ms Connelly, Cessnock Community Services, said there are no transitional housing programs in the Hunter district to support people after rehabilitation, which can mean a person must return to the area where they previously lived and be exposed to old networks and suppliers.¹⁸⁹
- 26.94 The Inquiry also heard about the lack of specialist units to manage people who are experiencing acute behavioural disturbance and drug-induced psychosis. Dr Fogarty, Hunter New England LHD, noted that it can take up to 48 hours to safely detoxify a person who has taken amphetamines,¹⁹⁰ which affect heart rate and breathing.¹⁹¹ She gave evidence that there is a need for specialist detoxification beds *'in a secure ward which is fully equipped with piped gases and monitoring equipment'*. It would need to be staffed by a specialist team in mental health, toxicology and resuscitation.¹⁹² She said such an approach would enable trials to build more effective evidence-based treatments and contribute to expertise in a multidisciplinary field.¹⁹³
- 26.95 Dr Venkatesh noted that Hunter New England Mater Mental Health is co-located with the general hospital, Calvary Mater Hospital. She said the hospital would benefit from a common and separate space where emergency department staff, AOD staff and mental health staff could work together to manage both the security risk and a patient's needs during the acute intoxication phase.¹⁹⁴
- 26.96 Witnesses from health services also gave evidence about a shortage of addiction medicine specialists and consultation liaison services to meet the needs of people presenting at hospitals with ATS-related issues. Dr Sadler, Calvary Mater Hospital, said the LHD would greatly benefit from more consultation liaison and AOD staff in hospitals and in mental health inpatient units.¹⁹⁵ He gave evidence about a AOD consultation liaison service's capacity to interact with patients in the emergency department and successfully work them back into community-based services:

*'If someone doesn't need admission, we try to identify that early. We try to work with ED with the four-hour situation, and we have a process to link that person into outpatient follow-up in our clinic set up, you know, the next day. We have a process where that can – that care can continue straightaway.'*¹⁹⁶

- 26.97 Dr Sadler observed that the more rural the area, the fewer AOD staff there are.¹⁹⁷ He said resources are also an issue in relation to GP provision of AOD services. He noted that models are in place for AOD specialists to visit general practices to assist GPs to provide intervention and withdrawal services, but there are insufficient staff.¹⁹⁸ Dr Fogarty also gave evidence that the AOD service is very small, comprising between 150 and 200 staff across the LHD, most in community teams and clinics.¹⁹⁹ In relation to consultation liaison services, Dr Fogarty said:

*'And so for each hospital they may only have one person to do the consult liaison for the whole hospital. So those guys are super busy. And they will certainly come and be very helpful where they can, but there's a lot of demands on them and we probably need to multiply them by 10 to be effective.'*²⁰⁰

- 26.98 Dr Venkatesh noted that an AOD service performs outpatient assessments at Calvary Mater Hospital but is limited to weekday business hours. She said an Addiction Consultant is the only one able to consult with patients on the mental health ward, which can lead to significant delays in offering services.²⁰¹ She said that an AOD nurse practitioner based in the emergency department who could offer AOD services to the Psychiatric Emergency Care Centre and the Psychiatric Intensive Care Unit would be valuable in assessment and in determining pathways for patients.²⁰² Dr Venkatesh said delay in access to services contributed to poor outcomes because patients again went through *'the cycle of being homeless and going through the same ... disadvantages they've been living through'*.²⁰³ She said quality of care could be improved with more housing options, more rehabilitation programs, and 'step down' residential programs after discharge from acute care.²⁰⁴
- 26.99 Dr Ryan said the Tamworth Rural Referral Hospital emergency department does not have access to an AOD consultation liaison service.²⁰⁵ He said there is a community health AOD service based in Tamworth but noted the lack of a local inpatient detoxification facility and that no psychiatrists live in the town. He also observed that crisis housing is in short supply and access to social workers is limited to business hours. *'If these services were available, they may help to get some people out of the chaotic environment that seems to fuel their substance use.'*²⁰⁶ Dr Ryan also said there is a need for:²⁰⁷
- extra training for emergency department staff about AOD-related treatment and referral options
 - more senior medical and nursing staff trained to deal with ATS-affected patients in the department
 - more security staff in the department
 - more data to assist staff be more proactive with intervention to prevent recurrent crisis presentations.
- 26.100 Dr Monkhouse, YDACS, told the Inquiry that the physical location of the service is a barrier to young people wanting to access the service. It is co-located with an adult community health centre²⁰⁸ and is a *'large, overwhelming, very clinical building [that] is very scary for them'*.²⁰⁹ She said the service is forming a youth advisory committee made up of former clients that will gather information about how to create a more inviting service. She added that co-locating YDACS with other adolescent services such as the Child and Adolescent Mental Health Service would be a better use of resources given that many clients visited both.²¹⁰
- 26.101 One participant at the East Maitland Roundtable reinforced the need for youth-friendly services:
- 'I know when my nephew was going through it, his mum was trying to get him counselling and the only option he had was to go and present at the office of where that counsellor was and he just couldn't do it. If they had been flexible enough to organise a coffee shop or something, he may have accessed a service.'*²¹¹

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- 202 East Maitland Hearing, East Maitland, Exhibit A, Tab 12, Statement of Sujatha Venkatesh, 18 June 2019, [23].
- 203 East Maitland Hearing, East Maitland, 19 June 2019, TS 1990.44-46 (Dr Venkatesh).
- 204 East Maitland Hearing, East Maitland, Exhibit A, Tab 12, Statement of Sujatha Venkatesh, 18 June 2019, [20].
- 205 East Maitland Hearing, East Maitland, Exhibit A, Tab 11, Statement of Nick Ryan, 28 May 2019, [20].
- 206 East Maitland Hearing, East Maitland, Exhibit A, Tab 11, Statement of Nick Ryan, 28 May 2019, [21]-[22].
- 207 East Maitland Hearing, East Maitland, Exhibit A, Tab 11, Statement of Nick Ryan, 28 May 2019, [34]-[35].
- 208 East Maitland Hearing, East Maitland, Exhibit A, Tab 14A, Statement of Krista Monkhouse, 17 June 2019, [17].
- 209 East Maitland Hearing, East Maitland, 20 June 2019, TS 2096.3-4 (Dr Monkhouse).
- 210 East Maitland Hearing, East Maitland, 20 June 2019, TS 2096.11-18 (Dr Monkhouse).
- 211 East Maitland Roundtable (Private), East Maitland, 21 June 2019, TS 2319.10-13 (Cosgrove).

SNAPSHOT: BROKEN HILL

GEOGRAPHY

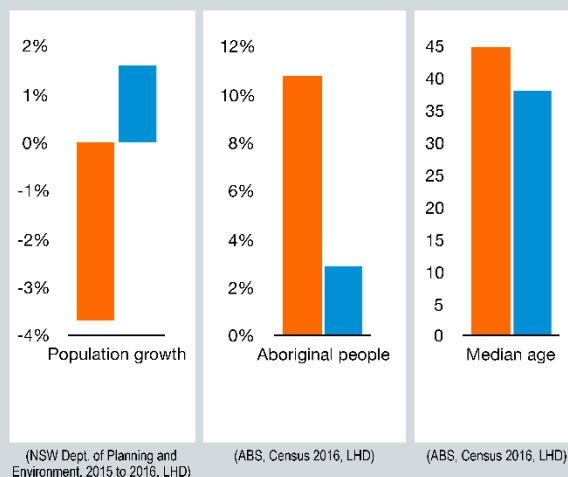


- Broken Hill is closer to Adelaide (520km) than it is to Sydney (over 1,100km).
- Local Health District (LHD): the Far West LHD covers an area of about 195,000 square kilometres, making it the second largest LHD in NSW and the most sparsely populated.
- Primary Health Network (PHN): The Western NSW PHN is the largest in NSW, covering more than 430,000 square kilometres.
- Police District: The Barrier Police District covers about 20% of the land mass of NSW.

KEY DEMOGRAPHICS

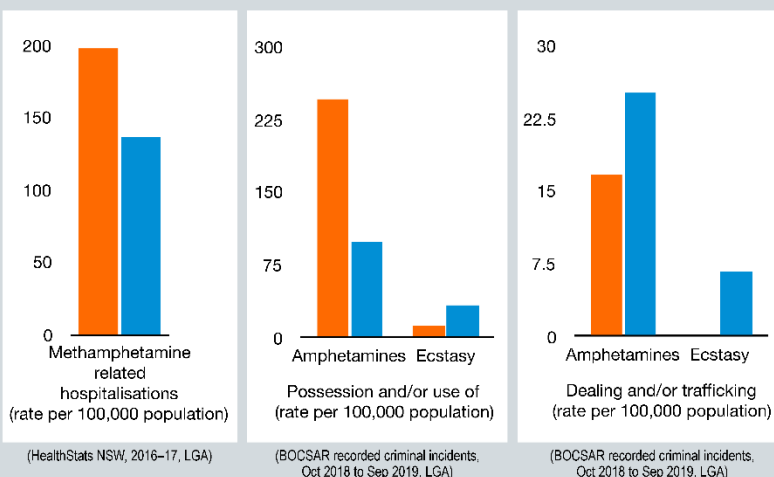
The LHD's population is about 30,000, with Broken Hill home to about 62% of residents.

■ Broken Hill ■ State average



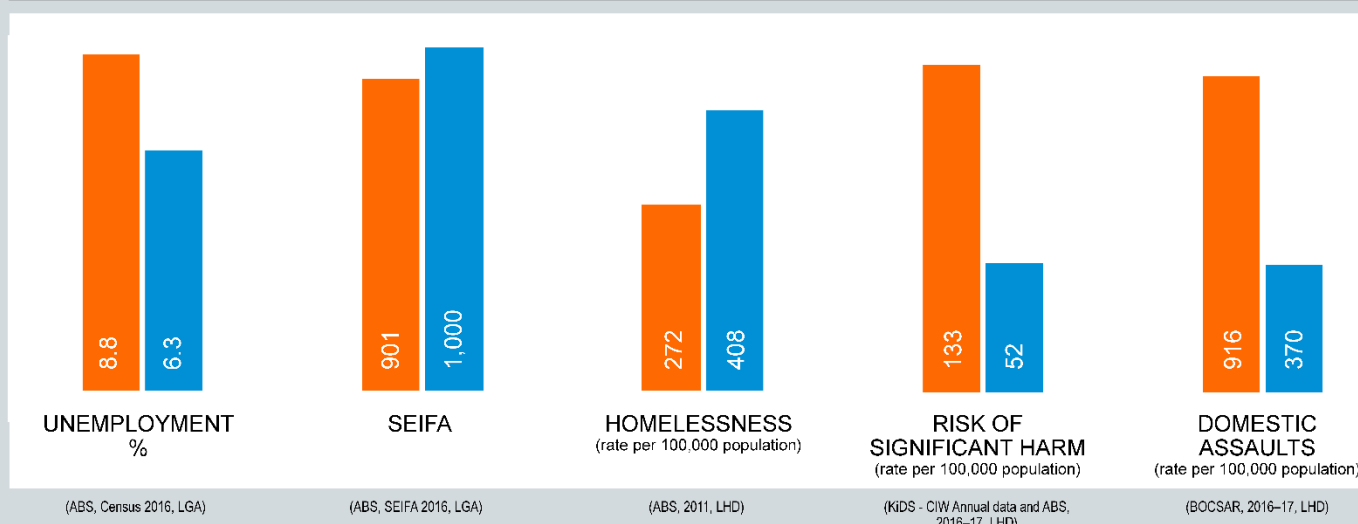
HEALTH HARMS & CRIMINAL OFFENCES

In the Western NSW PHN, there was a six-fold increase in the rate of methamphetamine-related hospitalisations for people aged 16 years and over between July 2012 and June 2017.



KEY SOCIAL STATISTICS

■ Broken Hill ■ State average



Chapter 27. The Broken Hill region

Introduction to the Broken Hill region

- 27.1 The city of Broken Hill is the largest in the Far West of NSW. It is about 50km from the SA border and is closer to Adelaide (520km) than it is to Sydney (more than 1,100km). It has a population of 17,708 people, about 62% of the population of the Far West Local Health District's (LHD) population of about 30,000.¹ Smaller communities in the region include Wilcannia, Menindee and Ivanhoe.
- 27.2 The Inquiry held hearings in Broken Hill from 15 to 18 July 2019. Witnesses in public and private hearings and participants in the Broken Hill Roundtable spoke of the increasing use of crystal methamphetamine in both the city and other remote communities in the region.
- 27.3 Witnesses from Juvenile Justice (now Youth Justice) and the Community Restorative Centre (CRC) gave evidence that large numbers of offenders use crystal methamphetamine and that use is increasing because the drug is commonly available.² Police evidence shows that police operations on major highways running through Broken Hill have increased the detection rate of drugs.³
- 27.4 The Inquiry heard about the destructive impact of crystal methamphetamine on individuals and families. One health worker said children are growing up to see that drug use is *'the norm'*.⁴ A service provider gave evidence that among the increase in risky behaviours clients engaged in, some had engaged in prostitution for drugs.⁵ A Broken Hill solicitor practising in the areas of criminal and family law said crystal methamphetamine is almost always a factor in child protection matters.⁶
- 27.5 The Inquiry heard that service providers face challenges due to crystal methamphetamine use, adding to difficulties recruiting and retaining staff due to the region's isolation.
- 27.6 The Broken Hill Hearing confirmed evidence heard in other regions about the complex connection between crystal methamphetamine and social disadvantage. There are pockets of deep disadvantage in the city of Broken Hill and surrounding remote areas. Statistics from the Department of Communities and Justice (DCJ) in evidence before the Inquiry show that, compared to the NSW average, there was nearly triple the rate of young people involved in risk of significant harm reports in the far west of NSW in 2016-17, and nearly double the rate of children in out-of-home care.⁷ The statistics in evidence also show that the far west region has an average annual personal wage and salary income of \$53,333 compared to the state average of \$62,813.⁸
- 27.7 As with other regional hearings, the Inquiry heard that crystal methamphetamine use disproportionately affects Aboriginal communities. DCJ statistics before the Inquiry indicate that 10.8% of the population of the far west of NSW are Aboriginal, compared to the state average of 2.9%.⁹ The traditional custodians of the land of the Broken Hill LGA are the Wilyakali People of the Barkandji Nation.¹⁰

27.8 Aboriginal people told the Inquiry about the difficulties they have experienced accessing health, justice and housing services, including:

- a lack of trust in institutions, which Aboriginal people have historically seen as racist¹¹
- feelings of shame about drug use, which sometimes deter people from seeing Aboriginal AOD workers¹²
- fear of travelling for treatment away from their land, culture and kinship and being ‘locked up in institutions’¹³
- fear of children being removed and placed in out-of-home care.¹⁴

27.9 During the Broken Hill Roundtable, Murray Butcher, Senior Project Officer, Kalypi Paaka Mirika Healing Program, Maari Ma Health, spoke of embedded trauma:

‘It’s not the first time ... our community’s been traumatised. We’ve been traumatised by alcohol. We’ve been traumatised by violence. We’ve been traumatised by racism ... We’ve got people walking around with lost identities, people who are scarred and traumatised, probably even genetically handed down trauma because trauma changes [the way] genes ... work Ice is just the only latest thing impacting on our community.’¹⁵

27.10 The Inquiry also heard from witnesses about the cultural and spiritual significance of the Darling River, an hour from Broken Hill at Menindee, and the impact of drought and water depletion from irrigation. Terina King, Transition Worker, Broken Hill CRC, said during the Roundtable: *‘I mean, that’s everything that our people have lived on, you know. Everyone goes camping, fishing, weekend swimming – whatever – you know. There’s none of that anymore.’¹⁶*

27.11 Denise Hampton, Aboriginal Community Development and Health Education Officer, Broken Hill University Department of Rural Health, told the Inquiry of the practical and spiritual importance of the river. Its ill-health means people can no longer swim or fish, which has reduced recreational activities and traditional hunting and gathering opportunities.

‘[W]e’re Barkandji people; we belong to the river. We refer to the river as our “barka”. ... We’ve seen this over many years, where particularly our communities along the river experience high crime rates when there’s issues ... surrounding the river, you know. You see high crime rates, less attendance at school; people’s social and emotional wellbeing is impacted heavily, because the river is seen as our lifeblood. It’s part of us, you know. Our connection to country, and the river, is really important and significant to Aboriginal people ...’¹⁷

Broken Hill’s experience with ATS

27.12 Broken Hill was a focus area for the NSW Legislative Council’s 2017 *Inquiry into the Provision of Drug Rehabilitation Services in Regional, Rural and Remote NSW*,¹⁸ which heard evidence about the community’s deep and ongoing concerns about the increasing prevalence of crystal methamphetamine and other ATS in the region.

27.13 Broken Hill Mayor, Darriea Turley, stated in a submission to the Inquiry that crystal methamphetamine is not just an issue for Broken Hill but also for communities across the Far West including Wilcannia, Menindee and White Cliffs.¹⁹ She said Broken Hill is a major drug corridor because it is at the centre of a number of major highways linking SA, Victoria and Queensland.²⁰

Increase in ATS use

- 27.14 The Inquiry heard from witnesses who described a worrying increase in the use of crystal methamphetamine in Broken Hill. For example, the CRC, Far Western NSW, provides support in Broken Hill and Wilcannia to Aboriginal clients aged over 18 who are transitioning from prison back into the community.²¹ Ian Harvey, Team Leader of Transition Programs, CRC, Far Western NSW, said that in the past two years the number of clients using crystal methamphetamine has increased and now exceeds the number of people using cannabis and alcohol.²² He noted his office sees 90 to 100 clients a year, about 95% of whom have a substance use disorder. Crystal methamphetamine is the primary drug of concern for 85 to 95% of that group.²³
- 27.15 Michelle Kelly, former Manager, Client Services, NSW Department of Family and Community Services (FACS, now the NSW Department of Communities and Justice (DCJ)), gave evidence to the Inquiry about her work overseeing child protection and out-of-home care in the Far West District. Ms Kelly stated that the District has seen a '*significant rise*' in the use of crystal methamphetamine in most communities.²⁴ Leigh Sutcliffe, Community Corrections Manager, Broken Hill, said she has observed an increase in the use of ATS in the Broken Hill region, particularly in Aboriginal communities. She said that around three-quarters of offenders use AOD, including ATS.²⁵ Ms Sutcliffe observed that more than half of the offenders under supervision have a history of some significant trauma,²⁶ and some have a low rate of literacy.²⁷
- 27.16 Greg Edwards, Area Manager Far West, Juvenile Justice (now Youth Justice), coordinates and manages a large multidisciplinary, community-based team that works to reduce the reoffending of young offenders and enhance their functioning and reintegration into the community.²⁸ He told the Inquiry his team supervises 36 clients and about a third use ATS. He said ATS use is increasing because they are commonly available in communities.²⁹ The prevalence of ATS throughout NSW more generally is discussed in Chapter 7.

Increasing presentations to health services

- 27.17 NSW Ministry of Health data for the Far West LHD show increases in the rate of methamphetamine-related hospitalisations. In 2016–17, the rate of methamphetamine-related hospitalisations for people aged 16 and over was the highest of any LHD in NSW (198.2 per 100,000 population, compared to 136.3 per 100,000 population for all LHDs in NSW). In 2013–14, the rate of methamphetamine-related hospitalisations in the Far West LHD was 118.2 per 100,000 population.³⁰
- 27.18 A range of health service providers gave evidence that there has been an increase in the use of crystal methamphetamine and other ATS. The Inquiry heard from Jodie Miller, Acting Director, Mental Health, Drug and Alcohol Services, Far West LHD, who said her staff have reported an increase in crystal methamphetamine-related presentations to the emergency department, the Mental Health Inpatient Unit at Broken Hill Hospital and the Community Mental Health Drug and Alcohol Service in Broken Hill and Dareton.³¹
- 27.19 Tracey Munro, a mental health nurse with Broken Hill Hospital, described a steady increase in crystal methamphetamine use since 2010 with a marked increase from 2012 onwards and a '*plateau of usage in the past year or so*'.³² She said that in the past six months, 24% of admissions to the Broken Hill Mental Health Inpatient Unit were related to crystal methamphetamine.³³

- 27.20 Dr Peter Vaux, Clinical Director, Community Mental Health Team, said that over the five years he has worked at Broken Hill there have been more presentations involving methamphetamine *'with peaks occurring with availability and when the drug has been imported into Broken Hill'*.³⁴ At the *'problematic end'*, the demographic of people using ATS is skewed towards people who are unemployed and those with traumatic backgrounds who are more susceptible to using substances to deal with the trauma and its secondary effects.³⁵
- 27.21 Vanessa Latham, Mental Health Manager, Royal Flying Doctor Service (RFDS), Broken Hill, said she has observed an increase over the past three to five years in the number of presentations of people with ATS-induced psychosis and/or aggressive behaviour, with her observations based on information from frontline clinicians through handover and assessment processes.³⁶
- 27.22 GP Dr Steven Grillett, Maari Ma Health Aboriginal Corporation, said there has been an increase in the number of patients disclosing their use of crystal methamphetamine and other ATS. In 2012, about one patient a month disclosed use of ATS for the first time; now patients disclose use of ATS and ask for medical support about twice a week.³⁷
- 27.23 Dr Andrew Olesnicky, Medical Director, Broken Hill Hospital Emergency Department,³⁸ said statistics related to methamphetamine-related hospitalisations are likely an underestimate.³⁹ The department sees many people with antisocial behaviours, or with minor injuries, but *'they don't wear on their sleeve the fact that crystal methamphetamine or ATS have been in any way involved in their presentation'*.⁴⁰
- 'This morning I went in to work and I was handed over a patient with a lacerated wrist, who had put his hand through a plate glass window, and we had to organise to get him into theatre and get that repaired, and he was a known schizophrenic on antipsychotic medication ... then it was admitted to us that he, the night before, had used crystal methamphetamine, and so if he had – if he had come in with perhaps a more minor injury that was sorted locally and didn't require consent and didn't require all that, there perhaps would not have been that same degree of delving into what he had used the night before that may have been responsible for his wrist laceration.'*⁴¹
- 27.24 The impact of ATS use on the health system is discussed further in Chapter 14.

Methods of administering ATS

- 27.25 The Inquiry heard that people using ATS in the Broken Hill region use a range of methods to administer drugs, including smoking, injecting and ingesting.⁴² During the Broken Hill Roundtable, Des Jones, Independent Chairperson, Murdi Paaki Regional Assembly, noted that energy-saving light globes are used to make pipes from which to smoke ATS.⁴³
- 27.26 Paramedic Jamie Peetz, Broken Hill Ambulance, stated it is not uncommon for people in their late teens and early twenties to take ATS in the form of tablets referred to as 'pingers' (the street name for MDMA)⁴⁴ because *'they believe it is nothing like injecting "ice" and not as addictive'*.⁴⁵ Mr Peetz said he has seen an increase in people using ATS recreationally on holidays, weekends, days off and special events.⁴⁶

ATS use related to specific occupations

- 27.27 The Inquiry heard evidence of an increase in ATS use by young men working in trades.⁴⁷ For example, Ms Miller, Far West LHD, told the Inquiry her teams have recently seen an increase in ATS use among shift workers, mineworkers and truck drivers. *'Clinicians report ATS is used on days off due to regular drug and alcohol tests in the workplace.'*⁴⁸
- 27.28 Another witness told the Inquiry of numerous cases in which miners working rosters with multiple days on, then multiple days off, go *'hard on ice for the first couple of days and then go off it leading up to being back on shift due to compulsory, or random, drug testing upon attendance at work'*.⁴⁹
- 27.29 Occupational use of ATS is discussed further in Chapter 8.

Impacts of ATS use in the Broken Hill region

- 27.30 The use of crystal methamphetamine and other ATS has had devastating effects on communities, individuals and families in the Broken Hill region and has challenged the capacity of service providers.
- 27.31 A report by Western NSW Primary Health Network (PHN), *The Western NSW PHN Drug and Alcohol Needs Assessment – 2017*, supports evidence submitted to the Inquiry. It noted that in most Western NSW communities the use of methamphetamines has been raised as a significant concern. *'[I]ts addictiveness and impact on health, functioning and relationships was highlighted across communities. The impact of ice was perceived to have increased significantly in recent years'*.⁵⁰

Impact on crime

- 27.32 Superintendent Paul Smith, Barrier Police District (which covers 20% of the land mass of NSW),⁵¹ noted that data for the police district showed that methamphetamine is the predominant ATS detected, with a 30% annual average increase in detections from 2014 to 2018. Between 2017 and 2018, there was a 91% increase in incidents of methamphetamine detection (47 incidents in 2017 followed by 90 in 2018).⁵²
- 27.33 Superintendent Smith stated that between 2017 and 2018, ATS detections associated with Aboriginal and Torres Strait Islander offenders increased from eight incidents to 16 in 2018.⁵³ He gave evidence that police data do not provide information about the contribution of crystal methamphetamine to other crimes.⁵⁴ Improvements to the way the NSW Police Force collects data are explored further in Chapter 19.

Pressure on health services

- 27.34 The Inquiry heard evidence about how ATS-related issues increase pressure on health services. For example, Dr Olesnicky, Broken Hill Hospital, said 10 to 20% of people who present acutely under the influence of ATS are admitted to the Mental Health Inpatient Unit or a general medical unit.⁵⁵ Dr Olesnicky stated that people presenting with ATS-related conditions generally have comorbidities including trauma, infection, social issues such as homelessness and poverty, and mental health conditions, such as psychosis.⁵⁶

- 27.35 Dr Vaux, Community Mental Health Team, also described a ‘significant amount of morbidity’ associated with the use of ATS. *‘[It] creates more psychiatric presentations and more difficult to manage psychiatrist presentations, and those numbers would not be high, but they represent a particularly difficult group to deal with.’*⁵⁷
- 27.36 There are ‘peaks and troughs’ in ATS-related presentations, according to Susan Thomas, Nursing Unit Manager, Broken Hill Hospital emergency department, possibly due to different batches of drugs. *‘If there is a bad “batch”, we see more difficult presentations, with increased psychotic episodes.’*⁵⁸
- 27.37 Witnesses also gave evidence about how the isolation of Broken Hill increases the difficulty of attracting and retaining a professional health workforce.⁵⁹ For example, Dr Olesnicky told the Inquiry that outside business hours, the department runs mostly on locums who are employed on short-term contracts, *‘usually on a FIFO-type basis for a couple of days a week, a couple of weeks’*.⁶⁰
- 27.38 Dr Vaux described problems recruiting and retaining clinical staff in the region, particularly in psychiatry, where it is important a client forms a good relationship with a single person and noted this only comes *‘with steady connection over time’*.⁶¹ Workforce implications for the health system are considered further in Chapter 14.

Impacts on families

- 27.39 Rachel Storey, a Broken Hill solicitor, provided a statement to the Inquiry that noted for the past five years she has observed the increasing use of crystal methamphetamine and the impact of that use on clients, families and government services in the Broken Hill area.⁶² She has seen family law matters where a family member’s use of crystal methamphetamine has led to a deterioration in their contribution to family and society.⁶³ She said crystal methamphetamine is almost always a factor in child protection matters⁶⁴ and about 80% of criminal matters are related to crystal methamphetamine.⁶⁵
- 27.40 Ms Miller, Far West LHD, said she has observed an increase in distressed family members or carers asking for help for a family member using ATS.⁶⁶ She said there has been a number of occasions when patients affected by ATS have been admitted to the Mental Health Inpatient Unit and their aggressive or violent behaviour has affected other patients. She said the unit is not a mental health intensive care unit, does not have quiet rooms, has two staff per shift who could be agency or new graduate nurses, and is unsuitable for people who are highly agitated.⁶⁷
- 27.41 The Inquiry’s Broken Hill Hearing heard evidence about the range of ATS-related impacts on young people in the region. For example, Corina Kemp, Aboriginal Mental Health Drug and Alcohol Clinical Leader, Far West LHD, said children are growing up to see that drug use is *‘the norm’*.⁶⁸
- 27.42 Ms Kelly, FACS, gave evidence to the Inquiry about her work overseeing child protection and out-of-home care in the Far West LHD. Between 1 January 2018 and 15 May 2019, she said the Broken Hill Community Service Centre had removed 17 children where crystal methamphetamine was identified as the reason for the entry into care. A further four children were removed for drug use, type not identified.⁶⁹ Ms Kelly agreed it is possible that crystal methamphetamine could have been the drug used in the four removal situations where the drug type was not identified.⁷⁰ Of the 21 children who were removed from families, only one was from an Aboriginal family.⁷¹ Ms Kelly agreed that this is consistent with the reluctance of Aboriginal families to report ATS use for fear of children being removed.⁷²
- 27.43 Ms Kelly told the Inquiry that harms in families where crystal methamphetamine and ATS are an issue include violence, criminal activity, a lack of food in the home, inadequate clothing and educational neglect.⁷³

27.44 The way that ATS is affecting families is considered in detail in Chapter 18.

Impacts on communities

27.45 Participants of the Broken Hill Roundtable also told the Inquiry of the devastating impact of crystal methamphetamine and other ATS on communities in the region. Ms King, CRC, said it is easier to get crystal methamphetamine in Broken Hill Aboriginal communities than cigarettes, and it is *'cheaper than a pack of smokes'*.⁷⁴ This evidence is consistent with evidence explored in Chapter 16.

27.46 David Doyle, Primary Health Care Worker, Royal Flying Doctor Service South Eastern Section, described the impact of ATS on community activities, including a sharp fall in football teams in the area between the 2018 and 2019 seasons. *'When I asked the communities why there weren't the teams, they said, "Because everyone is using ice".'*⁷⁵

27.47 Roundtable participants noted the connection between ATS use and issues that disproportionately affect Aboriginal communities, such as separated families, early school leaving and long-term unemployment. One stated: *'I've got a family member that is addicted to ice; when you're talking about your family structure, it just tears your family apart. Literally tears your family apart.'*⁷⁶

27.48 Ms King, CRC, said older generations face challenges when a family member uses ATS. She noted:

*'They don't want to be reporting the people. They don't want the kids taken away, you know, so [it] is easier for the Elders to step in and take their grandkids rather than the kids being taken away, because that still happens.'*⁷⁷

27.49 In some cases, grandparents are raising children, but there is no support for them, financial or otherwise.⁷⁸ The Inquiry heard of the *'hurdles to meet the criteria'* that are involved in registering as a foster parent or carer, which is required to obtain a kinship allowance.⁷⁹

27.50 Broken Hill Roundtable participants noted an increase in violence as a result of ATS use, which often has flow-on effects. Mr Harvey, CRC, stated:

*'[I]f they're in social housing, for example, they're damaging property ... They're getting in trouble for it. You know, they don't care. But then at the end of the day, they're going to be homeless because they're going to be kicked out of their property because they've caused damage, and they can't afford to fix the damage. They're going to have huge debts.'*⁸⁰

27.51 Mr Harvey spoke of clients' difficulties in accessing housing. Those unable to find housing often have no choice but to return to environments where there is drug use and domestic violence, which compounds their offending behaviour.⁸¹

Housing and homelessness

27.52 Mr Harvey said that when people try to access crisis accommodation through the NSW Government's Link2Home information, assessment and referral service,⁸² there is often none available in the Broken Hill area. As a last resort people are offered a swag or a tent. *'[They] are told to go and pitch it somewhere where they feel safe. It could be in a relative's backyard.'*⁸³ He said about 15 swags have been handed out in Wilcannia, and the Salvation Army has provided about five to CRC clients in Broken Hill.⁸⁴

- 27.53 Mr Harvey outlined the story of a CRC client who had been in rehabilitation and made a big effort to turn her life around:

*'She has two young children but is homeless and unable to get housing because she has been blacklisted by all the real estate agents in town. She has a history of systemically damaging property and not paying rent. Her best hope is to move out of town. I believe there needs to be a second-chance program for people like her who have demonstrated that they are not using anymore.'*⁸⁵

- 27.54 Ms King, CRC, described the difficulties of providing a service in a small community. If CRC team members accompany clients to real estate agents, agents would know that the client might have a criminal history. Ms King said for that reason it is better to send clients to agencies on their own *'but then the struggle is a lot of our clients can't read and write. So, you know, they're not supported ...'*⁸⁶

- 27.55 Broken Hill Roundtable participants also discussed issues relating to housing, noting levels of homelessness and *'couch-surfing'*,⁸⁷ long waiting lists for social housing⁸⁸ and racism encountered at private real estate agents.⁸⁹ Mr Harvey said: *'We're still getting people coming out of custody that are homeless and we're setting them up for failure straightaway.'*⁹⁰

- 27.56 Further evidence and recommendations in relation to housing are considering in Chapter 17.

Cultural impacts

- 27.57 Ms King told the Inquiry of the significant increase in drug and alcohol use in Aboriginal communities when a death occurs.

*'[T]he whole family comes together for sorry business. Funerals affect the whole community. I have seen it with my own family. As soon as a death occurs, people can fall off the radar, sometimes for six weeks ... I have had clients tell me they "really hit the gear hard over that time". There is nothing to support them through that. We can go in there and see them, but there is nothing to help them when they are withdrawing and processing grief and loss.'*⁹¹

- 27.58 During the Broken Hill Roundtable, Mr Butcher, Maari Ma Health, spoke of how ATS affect Elders' capacity to practise and deliver culture to the next generation.

*'Such is the craving for this drug for those ones who are on it and who are caught up with it that we're losing them culturally, we're losing them as family members, we're losing them as community members ... you know, it prevents them from connecting with country, connecting to their identity, connecting to their stories ... so that's another impact ... the cultural aspect – what it's doing to our culture.'*⁹²

- 27.59 The work carried out by this Inquiry in relation to Aboriginal people and communities is considered in more detail in Chapter 16.

Local responses

- 27.60 The Inquiry heard evidence from witnesses working in a range of areas including emergency services, health, justice and diversionary programs, community services, education and child protection about the Broken Hill region's response to the impact of crystal methamphetamine and other ATS.
- 27.61 Superintendent Smith, Barrier Police District, gave evidence about initiatives to disrupt the supply and distribution of drugs in the district. He said police operations on major highways running through Broken Hill, including the Barrier and Silver City Highways, plus an increase in random drug-testing capabilities, have increased drug detections.⁹³
- 27.62 Superintendent Smith said that since a senior police force officer and CATCH (Crime and Traffic Connecting on our Highways) trainer had transferred to Broken Hill, police operations on seizures, especially movement of currency, firearms and contraband along major roads, had increased dramatically and included a major seizure of 20kg of crystal methamphetamine at Balranald on the Sturt Highway.⁹⁴
- 27.63 Superintendent Smith also noted the following points.
- The work of Safety Action Meetings in the Barrier Police District; through collaboration across agencies they aim to prioritise responses to domestic violence victims at serious threat of harm.⁹⁵
 - Preliminary consultations about a pilot Justice Reinvestment Project for Wilcannia based on Bourke's successful Maranguka Justice Reinvestment Project (which is discussed in Chapter 12).⁹⁶
 - The work of Police and Aboriginal Community consultative committees in communities including Broken Hill, Wilcannia, Menindee, Ivanhoe, Balranald, Dareton (Wentworth and Buronga). Engagement strategies include youth training excursions, school visits, movie nights and the RISEUP program (a strategy developed by the NSW Police Commissioner, connecting disengaged young people to workplace opportunities).⁹⁷ At Wilcannia, RISEUP has just started running out of the police station and community hall.⁹⁸
- 27.64 NSW Police Force initiatives aimed at improving relationships with local Aboriginal communities are discussed in Chapter 16.
- 27.65 The Inquiry heard evidence about the Magistrates Early Referral Into Treatment (MERIT) program in the area. The Far West LHD Mental Health Drug and Alcohol Service partners with the Broken Hill Local Court, the NSW Police Force, local legal teams and health services to support and deliver the MERIT Program.⁹⁹
- 27.66 Melissa McInnes, Drug and Alcohol Clinical Nurse Consultant, Far West LHD, who provides clinical supervision and review of cases to MERIT clinicians as part of her role, said that completion levels for the 12-week MERIT Program vary. In 2018, just over half of clients (52.9%) with ATS as their primary drug of concern completed the MERIT program, compared to 70% with alcohol as their primary drug and 38.9% with cannabis.¹⁰⁰ (Across NSW, in 2018, the MERIT completion rate was 58% for clients with ATS as their primary drug of concern compared to 69% for clients with a primary drug of concern other than ATS).¹⁰¹ Expansion of the MERIT program to regional areas is dealt with in Chapter 11.

- 27.67 The Inquiry heard evidence about the work of the CRC in Broken Hill. The CRC provides transitional support to clients affected by, or at risk of being affected by, the criminal justice system.¹⁰² Mr Harvey said the CRC works on an holistic basis with clients to reduce recidivism,¹⁰³ with most referrals coming from Community Corrections and inmates soon to be released. Broken Hill Correctional Centre is a medium- and minimum-security correctional centre for male and female offenders.¹⁰⁴ The minimum-security Ivanhoe/Warakirri Correctional Centre for male offenders is about 300km south-east of Broken Hill.¹⁰⁵
- 27.68 About 95% of CRC clients have a substance use disorder, with crystal methamphetamine the primary drug of concern for 85 to 95% of that group.¹⁰⁶ An AOD clinician from the RFDS works at the CRC's Broken Hill premises one day a week.¹⁰⁷
- 27.69 Mr Harvey told the Inquiry that the CRC prioritises housing and AOD treatment and referrals for clients, *'but we look at basically everything within their life'*.¹⁰⁸ He said that if suitable housing can be found for a client, they are less likely to reoffend. The CRC takes a harm minimisation approach because of an increase in risky behaviour such as needle sharing and unprotected sex. *'So we're looking at ways in which we can support our clients and not have them feel shame.'*¹⁰⁹
- 27.70 CRC's harm reduction initiatives include providing Fitpacks and needle containers.¹¹⁰ Ms King, CRC, said that before the centre obtained Fitpacks, she collected them for clients from Broken Hill Base Hospital's Needle and Syringe Program, which is in full view of the emergency department waiting room and her clients had not wanted to go themselves for fear of being judged.¹¹¹ Improving outcomes for those in custody is discussed in Chapter 20.
- 27.71 The Inquiry received evidence about the Western NSW PHN's funding of AOD services in the region, including the GP Psychiatry Support Line, which provides information to help GPs manage mental health consumers.¹¹² The PHN is also delivering a Mobile Day Rehabilitation Program as a 12-month trial funded through to 31 March 2019 with a possible extension to 30 June 2019. The six-week intensive non-residential rehabilitation program, funded through the National Ice Action Strategy, rotates around communities in western NSW and has a strong Aboriginal focus.¹¹³
- 27.72 The Inquiry heard of service providers' work to provide holistic, integrated care in the Broken Hill region. For example, Mission Australia offers the Alcohol and Other Drugs Continuing Coordinated Care Program, which provides care coordination and wraparound services for people who require substantial psychosocial supports that *'may have an impact on their health and wellbeing and ability to engage in AOD treatment'*.¹¹⁴
- 27.73 Ms Latham, RFDS, said the RFDS provides services to 24 rural and remote locations across western and far west NSW,¹¹⁵ including a Mental Health and Drug and Alcohol Service in a colocation arrangement with headspace, the CRC and the Broken Hill GP Super Clinic. An AOD clinician works from a consulting room in each location on regular days of the week.¹¹⁶
- 27.74 Ms Latham said colocation allows services to work collaboratively *'or in a consortium-type model, to make it easier for the client to receive the right support, at the right time, from the right service'*.¹¹⁷ Collaboration between service providers is considered further in Chapter 14.

- 27.75 Andrew House, AOD clinician, RFDS, South Eastern Section, provides AOD education and counselling to clients, works with medical, nursing and other health professionals to treat patients with AOD issues, and develops, implements and appraises education strategies.¹¹⁸ Mr House has about 50 clients, many in remote areas. Clinics can be held weekly, fortnightly, monthly or every six weeks.¹¹⁹ He said it can take a long time to build relationships and engage with communities because a clinician may only see someone for an hour a fortnight.¹²⁰

*'[W]e're able to meet people where they're at. So, we're not dictated to by a certain model, so to speak. We're – we can actually ... talk to some guys just walking up and down the street in the main street of Tibooburra, you know. You might go and sit under a tree somewhere.'*¹²¹

- 27.76 Mr House gave evidence about his own history of drug use and dependence and how it has given him insight into the problems people using crystal methamphetamine and other ATS face. *'I just think you need that personal touch, and I think because the nature of the disorder, it is a lonely disorder.'*¹²² This is an example of the importance of a peer workforce that is discussed in Chapter 14.

- 27.77 The Inquiry received evidence from other health service providers, including the Far West LHD Mental Health Drug and Alcohol Service. The LHD's services include a six-bed Mental Health Inpatient Unit at Broken Hill Base Hospital; the 10-bed Far West Mental Health Recovery Centre in Broken Hill managed by Neami National; community Mental Health and Drug and Alcohol Services in Broken Hill and Dareton; and the MERIT program.¹²³

- 27.78 Ms Miller, Far West LHD, said the Broken Hill Base Hospital has the capacity to help people requesting alcohol or benzodiazepine detoxification, but there is a gap in health services in the region for people detoxifying from crystal methamphetamine and other ATS.¹²⁴ She said the hospital's general medical or surgical wards are not appropriate for people presenting with acute issues related to ATS.¹²⁵

- 27.79 Dr Vaux, Community Mental Health Team, who is responsible for the Broken Hill Base Hospital's six-bed inpatient unit and the Far West Mental Health Recovery Centre, said there are no ATS-related detoxification services in the health district, and it is only when a person has an acute presentation such as ATS-related psychosis that they are admitted while going through withdrawal.¹²⁶ He said that although the centre is dedicated to improving outcomes for people with mild mental health conditions and some with minor substance issues, it does not have formal programs to address AOD issues.¹²⁷ The provision of adequate detoxification services is explored in Chapter 14.

- 27.80 The Inquiry heard evidence about the importance of culturally appropriate and safe services for people who might have suffered trauma. For example, Ms Hampton, Broken Hill University Department of Rural Health, gave evidence about the department's collaboration with the Far West LHD to provide cultural education to health professionals and social service and welfare-sector agencies in the region. She said the Cross Cultural Perspectives in Aboriginal Health – Respecting the Difference training package looks at a range of subjects including history, the impacts of colonisation and contemporary issues for Aboriginal communities. *'It also highlights the need for change to address those disparities that we're seeing in Aboriginal health.'*¹²⁸

- 27.81 Ms Hampton said it is important that services treat Aboriginal people in a culturally appropriate manner *'because of the racism that does exist – whether we like it or not'*.¹²⁹ She agreed that even if a service provider has received cultural awareness training, it is still important they know about the communities' needs and priorities.¹³⁰ This topic is discussed in detail in Chapter 16.

- 27.82 She described work in the Far West LHD to investigate and improve issues that affect Aboriginal people's access to services. For example, a project to identify why Aboriginal people leave emergency departments before they are seen for treatment resulted in discussions with local communities.¹³¹ Ms Hampton noted there were huge improvements after small and inexpensive changes were made, such as better communication around wait times.¹³² In 2015, a committee called Bulleera Mala was established to create a network in the Far West LHD to give Aboriginal staff input into the design of health service policies relating to Aboriginal people.¹³³ Participants looked at a range of issues and solutions.¹³⁴
- 27.83 The Inquiry also heard evidence about the Maari Ma Aboriginal Health Service, which works with mainstream agencies to improve the health of Aboriginal people in seven communities – Broken Hill, Ivanhoe, Balranald, Menindee, Wilcannia, Wentworth Shires and Tibooburra. The Aboriginal board of directors is committed to an approach that includes physical, emotional, spiritual, cultural and environmental dimensions.¹³⁵ Maari Ma has more than 120 staff, 60% of whom are Aboriginal. Clinical services are based around a GP-led multidisciplinary model of care.¹³⁶
- 27.84 Dr Debra Jones, Director, Primary Health Care, Broken Hill University Department of Rural Health, told the Inquiry about the Far West LHD program 'Embedding Health', which started in 2018 and places registered nurses within schools. Embedding Health's main focus is primary schools, but it includes a program for secondary schools called 'Save a Mate' in which the nurses talk to students about drug and alcohol use.¹³⁷
- 27.85 In the program, five registered nurses provide services to seven primary and two secondary schools.¹³⁸ The nurses focus on three areas: understanding the health needs of the child and youth population; health promotion and literacy activities, including arranging for other health professionals to visit the schools; and supporting chronic and complex care. This can involve helping parents to navigate health systems and engage with the school. Julie Roberts, Nurse Manager, Primary Health Care Registered Nurses in Schools Service, said:
- 'Some families haven't engaged with the school very well and since we've had nurses in the schools, we have found that there are some parents that have come on board, engaged with a nurse and, therefore, have engaged with education as well about their child.'*¹³⁹
- 27.86 Dr Jones told the Inquiry that Embedding Health challenges some service models, including those who believe GPs should drive health care. She said well-qualified registered nurses have a '*distinct and significant role to play*'.¹⁴⁰
- '[W]here a nurse is functional in these spaces, they actually contribute to better coordinated care, not fragmented care. ... Historically, schools and health have been two separate systems in NSW. So we're actually challenging how these systems engage with each other.'*¹⁴¹

Opportunities to strengthen local responses

- 27.87 Witnesses overwhelmingly identified the need for holistic, wraparound treatment services for Broken Hill, including a detoxification and rehabilitation facility. The Inquiry heard a substantial body of evidence about the lack of detoxification and rehabilitation services in the Far West LHD. The closest rehabilitation centre to Broken Hill is the Wiimpatja Healing Centre, about 70km from Wentworth and more than 332km from Broken Hill. It has eight treatment beds that are only for Aboriginal men.¹⁴²

- 27.88 Mr Harvey, CRC, said the centre has an increased focus on trying to access detoxification and rehabilitation services for clients,¹⁴³ but there are no beds for ATS detoxification in Broken Hill.¹⁴⁴ In the past year, CRC has made about 30 applications for clients to go into rehabilitation with only three people placed, each in locations far from Broken Hill.¹⁴⁵ Mr Harvey said there are no rehabilitation beds for people with offences of a sexual nature. He knows of two clients in that category, one of whom has complex mental health issues and an acquired brain injury, and both continued to use ATS because there was *'nowhere for them'*.¹⁴⁶ He said that detoxification is a 'roadblock':

*'The client needs to actually be detoxed before they go into rehab ... and then, of course, the next barrier is a financial barrier ... who's going to pay for them to actually get to the location, who's going to support them with what they need ... in terms of maybe some personal care items ... Some of our clients don't even have clothing or they wouldn't have toiletries and stuff like that. They wouldn't even have a bag.'*¹⁴⁷

- 27.89 Ms King, CRC, said there is a lack of services available to take advantage of windows of opportunity when a client might be ready to go into rehabilitation. If a client is unable to stop using when a bed is available and disappears, the bed might not be available when they return and rehabilitation services may be reluctant to offer them a bed in the future.¹⁴⁸ Ms King gave the example of one client she had attempted to get into rehabilitation who had overdosed more than five times in one year.¹⁴⁹
- 27.90 Ms King also noted that rehabilitation centres limit a client's contact with family members, which is difficult for Aboriginal people for whom family is so important. *'They need connection with country as well. A lot of people don't like to go too far off country. Some clients who go away to rehab haven't lasted. One client lasted two days.'*¹⁵⁰
- 27.91 Mr Harvey observed that if CRC had the funding, there would be a demand for services for non-Aboriginal clients. *'I hear all the time from the gaol, "I wish you would work with white fellas."*'¹⁵¹
- 27.92 Ms Storey, Broken Hill solicitor, told the Inquiry that in 2017 she was a member of a working group into AOD use in the Far West that lobbied the 2017 *NSW Parliamentary Inquiry into the Provision of Drug Rehabilitation Services in Regional, Rural and Remote NSW*. She said it was disappointing that no recommendations arose from the Inquiry to assist Broken Hill specifically.¹⁵²
- 27.93 The working group's submission to the Parliamentary Inquiry noted there is a lack of rehabilitation and detoxification beds in the Far West and insufficient counselling services for people affected by crystal methamphetamine and other ATS.
- 27.94 There is also ongoing difficulty attracting appropriately qualified professionals to the Far West: *'[I]n some instances, people with lesser qualifications are providing services.'*¹⁵³
- 27.95 The working group's submission noted long the waiting times and prohibitive costs of rehabilitation services outside the region and restrictions preventing clients who are leaving correctional facilities entering rehabilitation facilities (or those with certain criminal offences in their backgrounds). It said Broken Hill City Council was committed to working with any rehabilitation provider looking to establish a facility in the city.¹⁵⁴

27.96 Ms Latham, RFDS, suggested to the Inquiry that measures to improve services for people needing assistance with ATS-related issues should include: easier access to detoxification beds in hospitals and on Country rehabilitation opportunities; a rehabilitation service in Far West NSW or a supervised medical detoxification community service; and improved partnerships with other services such as Mission Australia to ensure the best coordination and support for individuals. Ms Latham also called for increased funding for day treatment and rehabilitation under a *'consortium and wellbeing model'* with a non-clinical atmosphere to support *'whole-of-person recovery and support before, during and post-treatment'*.¹⁵⁵ She said it should include both clinical and non-clinical services, and *'psychosocial elements'* such as housing, finance and arts and cultural opportunities.¹⁵⁶

27.97 Ms Miller, Far West LHD, told the Inquiry that residential rehabilitation is a great concern for the community.¹⁵⁷ A new strategic plan for Mental Health, Drug and Alcohol is being developed and a residential rehabilitation facility is being considered.¹⁵⁸ Ms Miller also spoke of the potential benefits of an integrated model of holistic care in which services were located together.¹⁵⁹ She said that often clinicians find it hard to *'navigate these complex drug and alcohol service streams'*,¹⁶⁰ and wondered how someone using ATS or their family found their way through the system.

*'So, one of the things I was thinking about is perhaps a headspace model ... that perhaps is an integration of the LHD, the RFDS, Mission Australia, so a hub that [comprises] all community drug and alcohol specific services, Aboriginal medical services. It could be that you do have a GP there, in terms of, you know, community-based detox.'*¹⁶¹

27.98 Ms Miller said GPs could help to provide community-based detoxification if they received education and support from the LHD.¹⁶² She noted however, that getting an immediate appointment with a GP is difficult: *'GPs come, GPs go. It's my understanding some of our patients can't afford to attend GP services ... There's a lot of barriers to why people don't have access to GPs.'*¹⁶³ She added that nurse practitioners can be used in community-based detoxification.¹⁶⁴

27.99 Broken Hill Mayor Cr Turley also spoke about the need for new models of care that break down traditions in drug detoxification and rehabilitation and are culturally sensitive. She said pre-entry conditions that a person must have undergone detoxification before gaining access, or that a person who has been convicted of serious criminal offences is not eligible for treatment, should be reconsidered. *'This will be a complex model. But it is a model that can be achieved.'*¹⁶⁵

27.100 Participants in the Broken Hill Roundtable said there is a need for rehabilitation services on Country so people can heal as a family. Mr Butcher, Maari Ma Health, said:

*'[T]hose people that are going out seeking help, they are forced to go out off Country to unfamiliar places where there's no support system there that they're familiar with ... That, in itself, in our culture, has a detrimental effect on our spirituality and our whole wellbeing because it's not just our physical health. This is our mental health. It's our emotional health. All that needs to be taken care of.'*¹⁶⁶

27.101 The Inquiry heard evidence that communications between services needed strengthening. For example, Dr Vaux, Community Mental Health Team, said information is not regularly and easily exchanged because different services use different forms of medical records. Better sharing could improve coordinated responses to clients, especially those in remote areas.¹⁶⁷

- 27.102 Dr Vaux also said GPs could better identify and support people who use drugs such as crystal methamphetamine.¹⁶⁸ He suggested engagement could improve if GPs could spend time working with the Mental Health Team, *'seeing how our service works, talking our language, understanding the extent of the problems and how we deal with them'*.¹⁶⁹
- 27.103 Witnesses gave evidence to the Inquiry about limitations of the MERIT system. For example, Ms McInnes, Far West LHD, said MERIT only went to Wilcannia once a week,¹⁷⁰ but client numbers there were not high, sometimes up to five people.¹⁷¹ She said the 12-week duration of MERIT was too short for clients using ATS, because of the prolonged withdrawal phase, and suggested that six months would be more useful.¹⁷² The expansion of appropriate services to regional and remote communities is considered further in Chapter 11.
- 27.104 Ms Kemp, Far West LHD, told the Inquiry that the availability of tablet technology to facilitate remote conferencing between Aboriginal communities and specialist clinicians would work well, but they do not have access to such technology.¹⁷³ Ms Latham, RFDS, agreed that such technology would be a useful tool in remote communities.¹⁷⁴
- 27.105 Ms McInnes, Far West LHD, told the Inquiry that AOD clinical nurse consultants being available to support general practices could assist to upskill general practice and that this could significantly improve existing services.¹⁷⁵

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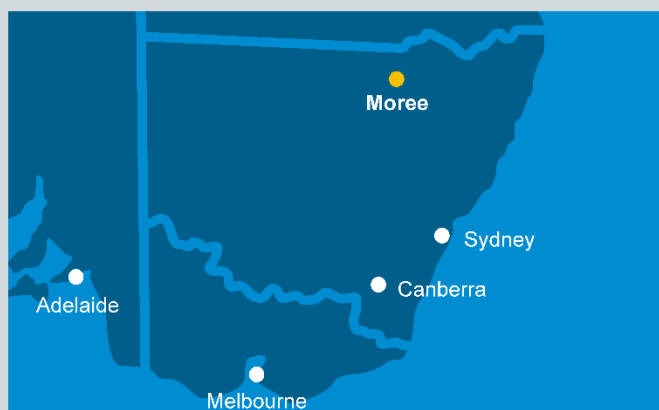
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SNAPSHOT: MOREE

GEOGRAPHY

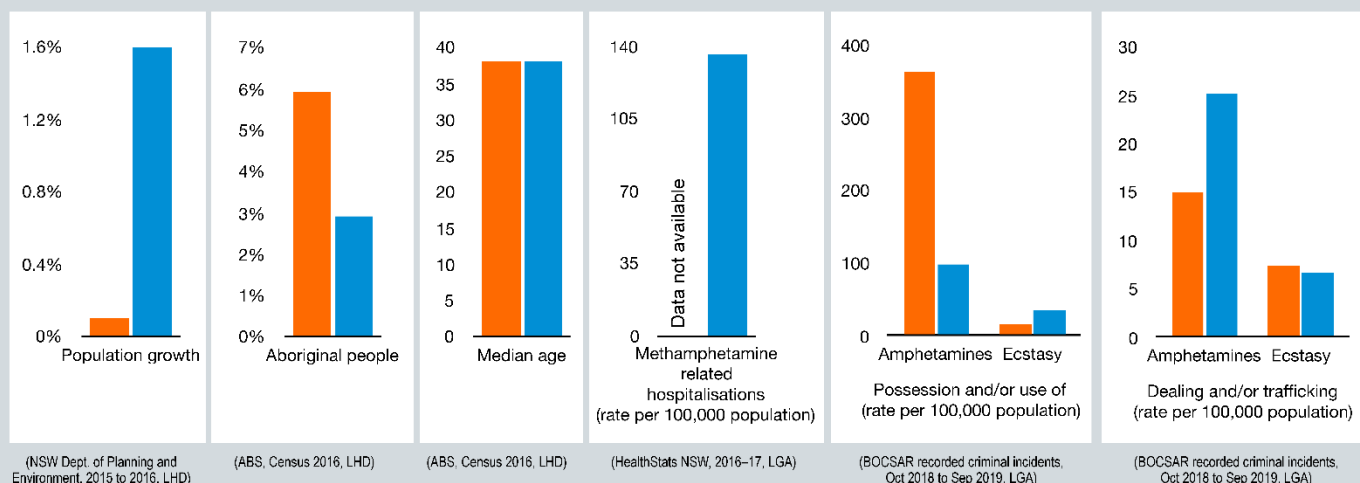


- Moree is an agricultural service town of about 10,000 people on the banks of the May River.
- Local Health District (LHD): The Hunter New England LHD covers an area of around 131,785 square kilometres and includes Maitland, Newcastle, Cessnock, Moree, Narrabri and Armidale.
- Primary Health Network (PHN): The Hunter New England and Central Coast PHN is the second-largest in NSW and stretches to the Queensland border to the north and is bordered by the Hawkesbury River in the south.
- Police District: The New England Police District covers about 53,000 square kilometres.

KEY DEMOGRAPHICS

21.5% of Moree's population identifies as being an Aboriginal person.

Moree State average

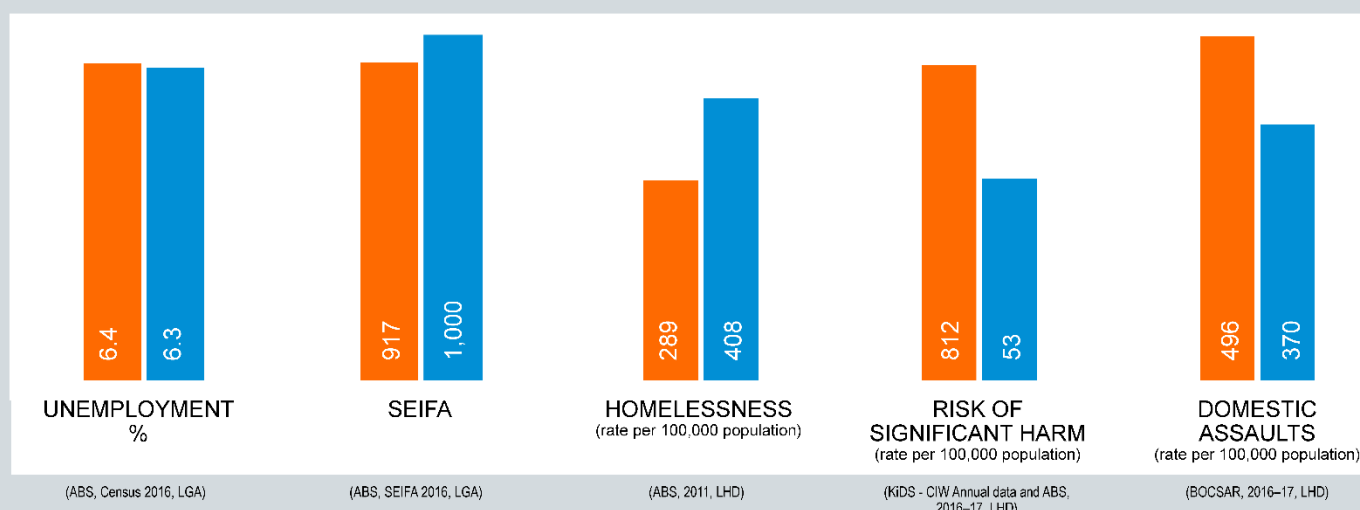


HEALTH HARMS & CRIMINAL OFFENCES

Amphetamine related offences have remained stable within the Moree Plains local government area.

KEY SOCIAL STATISTICS

Moree State average



Chapter 28. The Moree region

Introduction to the Moree region

- 28.1 Moree is an agricultural service town of about 10,000 people¹ on the banks of the May River. About 13,000 people live in the Moree Plains Shire Local Government Area (LGA). The area is characterised by extensive broadacre farming and has been a centre for cotton production since the mid-1970s.²
- 28.2 The Inquiry held hearings in Moree on 15 and 16 August 2019 and in Sydney on 30 September 2019 to learn from local service providers, lived experience witnesses and community members about issues relating to the use of crystal methamphetamine and other ATS in the region.
- 28.3 Aboriginal people make up 21.6% of the population of Moree Plains Shire,³ compared to the NSW average of 2.9%.⁴ For the Aboriginal people of the Kamilaroi Nation, the second largest nation on the eastern coast of Australia,⁵ the region has a difficult history of segregation, racism and disadvantage. Through the 1950s and 1960s, those issues received national attention: a 1955 Moree Council ordinance banned anyone with Aboriginal blood from using the town's Memorial Hall or Baths. The ban was rescinded in 1965 after University of Sydney students led by Charles Perkins on the 'Freedom Ride' protested in Moree.⁶
- 28.4 The region's Aboriginal people continue to face considerable challenges. As part of the Inquiry's examination of the issues in the Moree region, an Aboriginal community meeting was held in Toomelah, near the NSW/Queensland border. The meeting heard about generations of trauma suffered by Aboriginal people in the area.⁷
- 28.5 Witnesses told the Inquiry that people are reluctant to seek help for issues relating to the use of crystal methamphetamine for fear that their children might be removed.⁸ Others noted the stigma attached to the drug. The Moree Plains Shire Council submitted that many of the people who use ATS in the Moree area have '*gone underground*' and lack the confidence to seek treatment.⁹
- 28.6 NSW Bureau of Crime Statistics and Research (BOCSAR) statistics in evidence before the Inquiry show that in 2018 there were 304.8 incidents of use/possess amphetamines recorded per 100,000 of the population in the Moree Plains Shire LGA, having increased from a rate of 223.8 incidents per 100,000 of the population in 2014.¹⁰ On the other hand, the statistics showed that whilst there were 29.7 recorded incidents of dealing/trafficking in amphetamines recorded per 100,000 of the population in the Moree Plains Shire LGA in 2018, this had decreased from a rate of 57.7 recorded incidents per 100,000 of the population in 2014.¹¹ The statistics before the Inquiry also show that in the year to March 2019, Moree Plains Shire LGA had a significantly higher rate of recorded incidents of malicious damage to property (3,932.8 incidents per 100,000 of the population) when compared to the state average (737.8 incidents per 100,000 of the population).¹²
- 28.7 As with other remote areas, Moree struggles to recruit and retain appropriately skilled people for significant and specialist positions. For example, the Inquiry heard of multiple roles for registered psychologists that have been vacant, one for up to two years. As a result, in some service areas, counsellors are no longer available for client referrals.¹³

Moree's experience with ATS

- 28.8 Superintendent Scott Tanner, District Commander, New England Police District, NSW Police Force, gave evidence to the Inquiry that his experience working in rural NSW has led him to believe that Moree has no greater prevalence or availability of crystal methamphetamine than any other similar-sized community.¹⁴ He said data show that men aged between 20 and 40 comprise the largest group using of ATS, and he has observed that people from a disadvantaged socioeconomic background who identify as Aboriginal are more likely to use crystal methamphetamine and other ATS.¹⁵
- 28.9 Superintendent Tanner said the price of a 'point of ice' in Moree ranges from \$20 to \$100, and it is sometimes cheaper than in other regional areas.¹⁶ He said crystal methamphetamine is so cheap that someone can receive unemployment benefits and still be dependent on the drug.¹⁷ The price and availability of ATS across NSW is explored further in Chapter 6.

Increasing prevalence of use

- 28.10 David Kelly, Manager of Community Health Programs for Wellington Aboriginal Corporation Health Service and manager of the Maayu Mali Aboriginal Residential Rehabilitation Centre in Moree, gave evidence that the prevalence of crystal methamphetamine has increased over the past five years.¹⁸ He said the Australian Institute of Health and Welfare's national minimum data set shows that 45% of clients report amphetamines as their primary drug of concern, with 20% reporting alcohol and 16% reporting cannabis. He noted that while the data indicate trends in drug use, it is limited due to the use of self-reporting.¹⁹
- 28.11 Mr Kelly said the age range of people using crystal methamphetamine varies. He knows of a nine-year-old boy in the community who has started to use the drug, as well as a woman now in her mid-sixties who started to use crystal methamphetamine in her fifties.²⁰ He noted that about 50% of Maayu Mali clients are under 25 years of age.²¹
- 28.12 Cigdem Watson, Executive Manager, Centacare, Narrabri, told the Inquiry that crystal methamphetamine has become increasingly accessible, especially in the past two years. Ms Watson oversees the Youth Drug and Alcohol Service based in Narrabri, which works with children between the ages of 10 and 19 and provides complex case management, psychosocial support, mentoring and care coordination.²² Over the past year, the service had seen 85 young people in Tamworth and 30 in Narrabri, and about 16% of them, including some as young as 10, disclosed amphetamines as their primary drug of concern.²³
- 28.13 Ms Watson said that more than 50% of young people using the service are Aboriginal and more than 50% have comorbid AOD and mental health issues.²⁴ She also observed that many people prefer to inject crystal methamphetamine '*due to the cost and the effectiveness of using the drug in that way*'.²⁵

Impacts of use in the Moree region

- 28.14 Superintendent Tanner gave evidence that the difference between Moree and other communities is the impact of ATS use on families and on domestic violence. He said that while people who use crystal methamphetamine can be high functioning and *'hold down a job, hold down a family and continue to use ice'*, in Moree however, people who use crystal methamphetamine are more likely to be unemployed.²⁶

*'[Y]ou don't have those other outside releases, ice becomes more of an issue. Your usage increases because you don't have to get up the next day to go to work. You don't have to get the kids to school because they're not going to school.'*²⁷

Impact on crime

- 28.15 Superintendent Tanner gave evidence that much of the town's criminal offending, including break-ins and domestic violence, is linked to crystal methamphetamine. The New England Police District records some of the highest domestic violence conviction rates in NSW and Moree has a more heightened experience of it than other communities, recording 3,101 domestic and family violence incidents in the past two years.²⁸
- 28.16 BOCSAR figures support Superintendent Tanner's evidence. The rate of incidents of domestic assault in Moree in the year to March 2019 was more than three times the NSW rate (1360.5 per 100,000 of the population compared to 382.4 for NSW).²⁹
- 28.17 Superintendent Tanner said he believed that, while data link only a few incidents of domestic violence to the use of crystal methamphetamine, it is involved in at least 60% of offending behaviour.³⁰ The Superintendent's observations are consistent with evidence heard in the Sydney (General) Hearing from Ms Mary Baulch, CEO, Domestic Violence NSW, who noted it is the experience of domestic and family violence service providers that the use of crystal methamphetamine and other ATS increases the frequency and severity of domestic and family violence.³¹ The association between ATS and domestic violence is discussed further in Chapter 18.
- 28.18 The Inquiry heard that, as in other small rural communities, Aboriginal people are reluctant to report domestic violence, which presents challenges for police trying to protect community members at risk. Superintendent Tanner said:

*'There is a fear ... if they do report it that their children will be removed which is – historically you've heard the damage that that causes. There's also the shame associated with it, and there's also the intimidation factor. So if family members know that, you know, John is going back to jail because of what Mary has told the police, well, then there's that fear factor that comes in for retribution and things like that.'*³²

- 28.19 Superintendent Tanner also gave evidence to the Inquiry about rates of police detection of crystal methamphetamine and other ATS. He said that over the past five years the detection rate for ATS had increased by 3.7% annually but in the past two years the increase was 13%.³³ BOCSAR data show that the rate of incidents of use/possess amphetamines, while stable over two years, was nearly three times the NSW rate at 267.6 per 100,000 of the population in the year to March 2019, compared to 92.1 for NSW.³⁴
- 28.20 He said that most offenders in Moree are dependent on more than one substance and alcohol is the largest contributor, followed by ATS.³⁵ He noted that while with alcohol there are *'happy drunks'*, *'sleepy drunks'* and some aggressive drunks, when people are using crystal methamphetamine, their behaviour is frequently unpredictable and aggressive.³⁶

Public housing and drug use

- 28.21 Superintendent Tanner also told the Inquiry about how problems with public housing are associated with drug use. He said that 53 public housing properties in south Moree were destroyed by fire in 2017.³⁷ He said the burned-out homes played on young people's mental welfare. *'I mean, if you're walking around your community and you're seeing, you know, a dozen homes that are burnt to the ground or burnt out as shells, it gives a ghetto look.'*³⁸ He said the removal of the homes from the public housing stock contributes to the shortage of housing in Moree.³⁹
- 28.22 Additionally, he said people go to the burned-out houses to inject crystal methamphetamine and other drugs.⁴⁰ Superintendent Tanner said Housing NSW boards up houses that are vacant but there are no subsequent checks to ensure they are still secure.⁴¹

Impacts on children and young people

- 28.23 The Inquiry heard evidence from Binnie Carter, Manager, Casework Child Protection/Triage, Moree Community Services Centre (CSC), Department of Communities and Justice (DCJ). The Moree CSC forms part of the New England DCJ District, which stretches north to the town of Boggabilla and the Toomelah community, east to Gravesend, south to Bellata and north-west to Mungindi and Boomi.⁴² Ms Carter said that from attending community meetings, it is clear that people in Moree and Toomelah are worried about the effect of crystal methamphetamine on young people.⁴³ Ms Carter said many reports regarding young people are about antisocial behaviour.

*'... so they're out on the streets; they're out late at night; they're committing some form of crime. The reports we get from family members are concerns about our young mums and dads that are having children at a young age, but they have drug-related issues and not able to care for those children.'*⁴⁴

- 28.24 Ms Carter said she believed that 50 to 60% of risk of significant harm (ROSH) reports received mention some form of drug or crystal methamphetamine use.⁴⁵ However, she said DCJ did not have data on the number of ROSH reports where ATS use was a factor in reports, nor on the number of children removed from families because of ATS use.⁴⁶ She added that most ROSH reports referring to drug use do not identify the type of drug used.⁴⁷
- 28.25 She told the Inquiry that Moree CSC receives 60 to 80 ROSH reports on families each month,⁴⁸ of which 98% are Aboriginal families.⁴⁹ The primary reported concern can be emotional, psychological or sexual abuse, neglect, lack of supervision or medical care, domestic violence, homelessness or drug use.⁵⁰ She stated that an accumulation of such issues, rather than drug use alone, is the reason children enter care.⁵¹ The age range of people using crystal methamphetamine is between 18 and 30 years,⁵² but she has observed in the past 18 months that people using the drug have become younger.
- 28.26 Ms Watson, Centacare, Narrabri, said the intergenerational use of crystal methamphetamine raises issues of child protection because there is no safe place for children in families using drugs. In the past when the Department of Family and Community Services (FACS, now Department of Communities and Justice) became involved in a family situation, children could be placed with grandparents, but with grandparents starting to use the drug, it is becoming more of a challenge.⁵³

- 28.27 Roslyn Laws, Chair of the Moree Community Drug Action Team and Local Drug Action Team, told the Inquiry she has seen a range of impacts from crystal methamphetamine on the Moree community. At monthly roundtable meetings with 26 services in Moree and 15 to 20 in Boggabilla, she heard reports that people using crystal methamphetamine are becoming increasingly difficult to manage.⁵⁴ She said the manager of the Moree waste department told a meeting that 50,000 needles were found in the collected waste in 2018.⁵⁵
- 28.28 Superintendent Tanner told the Inquiry that children in Moree are often in the streets because they don't feel safe at home.⁵⁶
- 28.29 The impacts of ATS on families is discussed in detail in Chapter 18.

Stigma and treatment

- 28.30 The Inquiry heard that the use of crystal methamphetamine can be a hidden issue, and some people do not seek help for their issues because of the stigma attached. Mr Kelly, Maayu Mali Aboriginal Residential Rehabilitation Centre, noted that because Moree is such a small community, people using crystal methamphetamine can be deterred from accessing services.

*'I'm conscious that people, particularly for residential services, people do choose to leave Moree to access residential services in other towns to ... have some privacy and space to deal with that. And I'm also conscious that we, vice versa, have lots of people who come from out of town who would prefer to receive their treatment in Moree for exactly the same reason.'*⁵⁷

- 28.31 He added that because people are unwilling to seek help at an early stage of their use of AOD, in most cases Maayu Mali clients are admitted after their children had been removed or after they had ended up in custody.⁵⁸
- 28.32 Ms Watson, Centacare, Narrabri, also identified stigma as an issue, especially in relation to the Needle and Syringe Program, which is run from an anteroom area in the emergency department of Narrabri Hospital. There is also a needle and syringe dispensary at the hospital entrance.⁵⁹

*'This is not ideal as people need to ring the buzzer and say they want to access to the area for that purpose. We are a small community, so there is shame and stigma that results when people known to others say they are wanting to access syringes.'*⁶⁰

- 28.33 The evidence received in Moree in relation to stigma is consistent with that received in other regions. Stigma is explored more generally in Chapter 9.

Local responses

- 28.34 The Inquiry heard of the police district's success in interrupting the supply of ATS to the Moree region. Superintendent Tanner said that Strike Force Sassafras has been the most notable of a number of strike forces created in the past four years to investigate and successfully prosecute ATS dealers. He said it dismantled a significant distribution network with links to the Sydney metropolitan area.⁶¹
- 28.35 Superintendent Tanner said the police relationship with the Moree community is 'at the forefront of my mind' and he continues to develop opportunities to increase police understanding of and commitment to the community.⁶² He gave evidence about existing police measures to address ATS-related issues in Moree and engage with the community:

- There are two Aboriginal Community Liaison Officers stationed in Moree, one in Boggabilla, one in Inverell and one in Armidale.⁶³
- Police are involved in Safety Action Meetings, a NSW Government domestic violence reform that facilitates the sharing of information between service providers *'to prevent or lessen serious threats to the life, health or safety of domestic violence victims and their children'*.⁶⁴
- In April 2018, an Aboriginal police officer who was born in Moree returned to be Moree's Youth Liaison Officer.⁶⁵
- The Police Commissioner's RISEUP strategy is implemented in Moree at the PCYC and includes the Fit for Life, Fit for Work and Fit for Service programs.⁶⁶
- Police have links with the SHAE (Sports, Health, Art, Education) Academy, an Aboriginal organisation that works with young people and families to reduce their involvement in crime, provide opportunities for education and employment, and includes a men's group program.⁶⁷
- Police are engaged with the new justice reinvestment program in Moree. Superintendent Tanner said he thought it could be a *'game changer'* for the town.⁶⁸
- New police officers arriving in Moree spend a day with the Aboriginal Community Liaison Officers and are educated in local cultural issues. They visit sacred sites with Elders and *'get a grasp of what the culture is about'*.⁶⁹

Drop-in program reduces youth crime rates

Superintendent Tanner said a Saturday night drop-in program was started by the Officer in Charge of Moree, Inspector Martin Burke, in conjunction with the Moree PCYC, in response to issues of social dysfunction on Friday and Saturday nights.

The Saturday night program is aimed at youth aged 10 to 17 and runs from 9pm to 1am. Volunteers from the NSW Police Force, Aboriginal Legal Service, the Miyay Birray Youth Service, and community members work to provide a safe environment. Visitors to the program have included Wallabies Tim Horan and Justin Harrison, and boxer and rugby league star Anthony Mundine. All participants are given a meal, with Miyay Birray Youth Service and Woolworths donating food.⁷⁰ On some nights the program has catered for 120 young people. Young people are driven home at the end of the night.

Superintendent Tanner said the program has reduced the number of young people wandering the streets on a Saturday night and increased the level of respect between police and young people. He said rates of youth crime on Saturday nights have decreased dramatically.⁷¹

- 28.36 Superintendent Tanner told the Inquiry there is a group of good, strong, young Aboriginal leaders aged between 15 and 25 years emerging in Moree. *'I think that's where our strength will lie.'*⁷² He also noted the importance of having an Aboriginal police officer who grew up in Moree on his team.⁷³

*'And he can actually speak to the kids and say, "Well, hang on. You know, I grew up in a mission out here. This doesn't have to be the way you go". ... So it's just using his life experience. I mean, he's only still a young guy but, you know, just the impact that I've seen him have on young people is incredible.'*⁷⁴

- 28.37 Other initiatives implemented by the NSW Police Force in other regions to improve relationships with Aboriginal communities are discussed in Chapter 16.

- 28.38 Bernadette Terry, Assistant Manager, Moree Youth Justice NSW, gave evidence about a range of measures to respond to clients with ATS-related problems but noted difficulties with staff recruitment and retention. For example, she said the office has advertised for a psychologist for two years but has not been able to fill the role. The human resources unit has developed an ‘innovative’ recruiting plan to attract staff that will soon be rolled out.⁷⁵ Ms Terry said that in the absence of a staff psychologist, Youth Justice clients in Moree are referred to outside services such as Child and Adolescent Mental Health Services, Centacare and headspace. Alternatively, clients are referred to a visiting child psychologist at Pius X Aboriginal Medical Service, although it often has a waiting list.⁷⁶ Ms Terry also said ‘trust issue[s]’ can make it difficult for clients to engage with other providers.⁷⁷

‘As soon as you mention counselling, they don’t want to do it. So if we’ve got to take them to an external service, sometimes it’s difficult to get them there, but if it was to our office where they have already got a trusting relationship developed with our caseworkers, it’s much easier to get them through the door.’⁷⁸

- 28.39 Ms Terry told the Inquiry of her team’s level of engagement with clients. For example, officers travel to Boggabilla, 100km away, to take a client to an appointment in Moree.⁷⁹ One of the first things Youth Justice does with clients is arrange an appointment with their school to start the process of re-engaging them in education, even if their attendance is only partial.⁸⁰ She said the Joint Support Program funds caseworkers to support clients. For example, for a period they might pick up a young person to take them to school, sit in the classroom with them, then take them home.⁸¹

- 28.40 Ms Carter, Moree CSC, told the Inquiry the service has five trained case workers and one who is completing training. She also gave evidence about the difficulty of finding skilled staff and said DCJ has an ongoing, localised recruitment program to fill caseworker and manager roles.⁸² She said there are two vacancies for child protection roles, one of which has been vacant for 12 months.⁸³

‘I know that working in community is hard for some people, because it’s such a small community and everybody knows everybody. Part of it could be the reputation of coming out to Moree. Like, I know when I came out here, it was, you know, “It’s going to be hard out there for you”, because of the things that we encounter out this way.’⁸⁴

- 28.41 She told the Inquiry that the difficulty in securing staff has multiple effects, including increasing pressure on staff who have large caseloads, reducing the number of families that can be visited after ROSH reports, and reducing the time caseworkers can spend with families.⁸⁵ She said that at one meeting to allocate reports to staff, 12 families were discussed but only six were allocated.⁸⁶

- 28.42 Ms Carter added that Aboriginal families in Moree are still reluctant to disclose they are using ATS for fear of DCJ potentially removing their children.⁸⁷ She said some people refer to caseworkers as ‘the welfare’.⁸⁸

- 28.43 Ms Carter noted that Moree CSC works with the Benevolent Society’s Brighter Futures program, which case manages families who have ROSH reports.⁸⁹ It works intensively with a family for up to two years on issues and includes counselling, supporting a family to attend health appointments, and advice on matters including financial management, parenting, routine and transport.⁹⁰ Moree CSC also works with Moree Family Support, Rural Referral Service and the Maayu Mali Aboriginal Residential Rehabilitation Centre.

- 28.44 Maayu Mali provides an intensive, 12-week residential rehabilitation program for Aboriginal men and women over the age of 18. It has 18 beds, 14 for men and four for women, which are currently the only Aboriginal specific women's beds in NSW. It promotes individual and community wellbeing and reduces substance abuse through the provision of culturally appropriate AOD prevention, education, treatment, rehabilitation and aftercare services for Aboriginal people. Before being admitted, eligible individuals must have gone through detoxification.⁹¹
- 28.45 Mr Kelly, Maayu Mali Aboriginal Residential Rehabilitation Centre, told the Inquiry the service also accommodates people with a comorbid mental health condition. He said the Moree service sector is small but *'close-knit'*⁹² and because Maayu Mali does not have nurses, psychologists or social workers on staff, it relies on other services, particularly Pius X Aboriginal Medical Service in Moree. He said: *'We're providing really strong wraparound psychosocial support, and when we need medical support, we're accessing it from elsewhere.'*⁹³ However, Mr Kelly noted that often other services are not available. *'Sometimes you're very lucky and it all falls into place very quickly, and sometimes not.'*⁹⁴
- 28.46 Ms Watson, Centacare, Narrabri, said many clients using the Youth Drug and Alcohol Service are involved with Juvenile Justice and DCJ. Some are being raised by grandparents due to AOD-related family dysfunction.⁹⁵ Given the complex issues young clients face, it can take time to build rapport with a young person and establish even a part of their story.⁹⁶

*'Once we can work with the young person and can stabilise them in various areas, their drug use will often come down as well, even if it was not one of their priorities to address. When you start addressing the dysfunction in the family or homelessness status, the drug use does decrease.'*⁹⁷

Case study

The Inquiry heard of the Youth Drug and Alcohol Service's support for a young woman under the age of 18. Her family has a history of intergenerational trauma, substance use and incarceration. One of her siblings is in a correctional facility and others have significant mental health issues and histories of using crystal methamphetamine.

The young woman is ambitious and has a good record of school attendance but *'for tragic reasons turned to using ice, bupe [buprenorphine] and injecting heroin'*. She has now been through the service's 12-week program three times and recently entered a pharmacotherapy program while she is also attempting to study.⁹⁸

Ms Watson, Centacare, Narrabri, said the program has been a *'life and game changer'* for the young woman.⁹⁹ *'[W]e're starting to see some significant changes. So the young person is now feeling more empowered; reengaged in school; looking at career opportunities.'*¹⁰⁰

Ms Watson said the Youth Drug and Alcohol Service had taken the young woman to Moree for a face-to-face pharmacotherapy consultation with a visiting Hunter New England Local Health District (LHD) addiction specialist. Subsequent appointments are through a telelink service.¹⁰¹ The service does not have the funding to accompany the young woman to Newcastle to undergo detoxification from the pharmacotherapy, so she has elected to take the train on her own.¹⁰²

- 28.47 Ms Watson noted that removing Aboriginal people from Country was not ideal. *'They're away from their kinship. They're away from everything. Makes it really difficult.'*¹⁰³ She gave an example of one young mother who was using crystal methamphetamine and felt she was not able to travel to Newcastle for treatment. As a result, FACS (DCJ) had removed her children and she was working towards recovering in the community.¹⁰⁴

Opportunities to strengthen local responses

- 28.48 Witnesses told the Moree Hearing of the multiple barriers people with problematic crystal methamphetamine and ATS use face when attempting to access treatment services. For example, Ms Terry, Youth Justice NSW, told the Inquiry that for the past 12 months *'there have not been a lot of AOD services available in Moree'*.
- 28.49 Ms Terry noted other issues that make it difficult to respond to issues of young people's ATS use in Moree, including surrounding detoxification. She said Youth Justice has had problems with clients with heavy use of ATS who were refused entry to residential rehabilitation services because they had not undergone detoxification. Another was forced to leave residential rehabilitation because they were not properly detoxified. One client was sent to a Sydney hospital for detoxification but *'young people in Moree are reluctant to travel long distances away from their families and homes'*.¹⁰⁵ Additionally, there are no rehabilitation facilities in Moree for young people.
- 28.50 Ms Carter gave evidence about a lack of access to services. The closest detoxification facility is the four-bed Freeman House in Armidale, more than 250km away.¹⁰⁶ She said this had a significant impact on Aboriginal people because it took them off Country for their healing.¹⁰⁷ Only one person Moree CSC has worked with in the past year has gone into a rehabilitation program.¹⁰⁸ Ms Carter said that DCJ continues to work with people who have not had rehabilitation or refers them to other services such as Brighter Futures, but often their children become 're-reports' and the result can be that children enter care.¹⁰⁹
- 28.51 The Inquiry heard that detoxification might occur in custody, but young people then return to the same environment and socialise with the same peers for whom drug use is normalised.¹¹⁰ Ms Terry, Youth Justice NSW, said Moree would benefit from a local detoxification service¹¹¹ and halfway accommodation that gives a client returning to the community 24/7 support, a caseworker to help them access services and ongoing relapse-prevention counselling.¹¹²
- 28.52 Mr Kelly, Maayu Mali Aboriginal Residential Rehabilitation Centre, said there is a need to *'rethink withdrawal management'*.¹¹³ He explained that the current hospital-based regime of detoxification support was established to manage people's detoxification from heroin, alcohol and benzodiazepines, which can be medically dangerous for several days and includes seizures. The detoxification process is longer with crystal methamphetamine – it can take weeks for *'the mind to clear'* but the physical danger is much less. Mr Kelly suggested that a new form of withdrawal management for people using crystal methamphetamine could be residential support with the involvement of a medical practitioner.¹¹⁴ Access to withdrawal and detoxification has been an issue for a number of regional communities. Rethinking withdrawal management and detoxification are considered further in Chapter 14.
- 28.53 Ms Carter, Moree CSC, noted issues that hindered an effective local response and for which solutions need to be found. For example, the Moree CSC has not had a psychologist to support case workers and families for 18 months.¹¹⁵

- 28.54 Mr Kelly said he believed the situation for people leaving correctional facilities has deteriorated. He no longer receives notification of someone being released. *‘There’s no transitional care at all.’*¹¹⁶ Mr Kelly added that the provision of mental health support in regional NSW is of a *‘particularly low standard. There’s no such thing as early intervention and prevention, and there is little community-based mental health support’*.¹¹⁷ He believes a set of protocols is needed to improve the lack of continuity of care and the lack of coordination of care for people who use crystal methamphetamine and other ATS.¹¹⁸ Options to improve outcomes for those exiting custody are explored further in Chapter 20.
- 28.55 Superintendent Tanner told the Inquiry he supports the idea of a halfway house or safe house where children could go if they felt unsafe at home.¹¹⁹ He said police have suggested that funding could be sought for one of the burned-out houses to be cleaned up and restored for that purpose.¹²⁰
- 28.56 Ms Watson, Centacare, Narrabri, told the Inquiry of limitations on the Youth Drug and Alcohol Service. The Centacare geographical area covers around 99,100km² and includes outreach into small communities including Boggabilla and Toomelah.¹²¹ She said there is only 0.6 of a full-time equivalent staff member in Narrabri and 0.8 in Tamworth, and that the service has told the funding body (the NSW Ministry of Health) that it cannot meet demand for services.¹²² She said there are potential workers who could start with the service immediately, but there is no funding to employ them.¹²³ Ms Watson said her office goes *‘above and beyond’* to meet the needs in the area but she was unsure how long her office could continue to do so.¹²⁴
- 28.57 Moree Local Court is not in a Magistrates Early Referral into Treatment (MERIT) catchment area, but there is strong community support for MERIT. In 2015, a petition signed by more than 3,000 residents was tabled in NSW Parliament, requesting its introduction.¹²⁵ One of the women who launched the petition told the ABC: *‘We saw close family members going through the revolving doors of incarceration time after time because of their drug offending and criminal behaviour we thought “There’s got to be a better way”’*.¹²⁶
- 28.58 Ms Terry, Youth Justice NSW, accepted that if there were more options in the Moree community to assist young people deal with drug use, Youth Justice might be more successful in achieving its aim of reducing reoffending.¹²⁷ She said Moree could benefit from a Drug Court or a Youth Koori Court.¹²⁸
- 28.59 Superintendent Tanner said Moree would benefit from a Youth Koori Court in which there is a wraparound service involving an Elder or respected community member. He said he has observed the success of cultural camps run by Moree’s Aboriginal Community Liaison Officers and the Youth Liaison Officer.¹²⁹
- ‘[T]hey thrive on it ... I think that is probably the hidden gem to getting these kids involved. You know, we’ve normally seen that sport is the thing that will get kids involved in things, whereas now I think it’s culture. A lot of kids aren’t playing sport any more for a variety of reasons, but the Youth Koori Court brings all that together.’*¹³⁰
- 28.60 Expansion of diversionary programs including the MERIT program and the Youth Koori Court are discussed in Chapter 11.

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- 4 Moree Hearing, Moree, Exhibit A, Tab 1, Aboriginal Affairs NSW, Community Portrait: Moree Plains LGA, 2016, [5].
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- 122 Moree Hearing, Moree, Exhibit A, Tab 8, Statement of Cigdem Watson, 14 June 2019, [22]-[23].
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Appendices

Appendix 1: Letters Patent, 28 November 2018

NEW SOUTH WALES

ENTERED on the Record by me in Register of Patents No. 72 Page 260, this 28th day of November 2018.

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

Professor Daniel Howard SC

GREETING

By these our Letters Patent, made and issued in Our name by Our Governor on the advice of the Executive Council and under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) and every other enabling power, We hereby authorise you as Commissioner to inquire into and report to Our Governor of the said State on:

- A. The nature, prevalence and impact of crystal methamphetamine ("ice") in NSW.
- B. The adequacy of existing measures to target ice in NSW.
- C. Options to strengthen NSW's response to ice, including law enforcement, education, treatment and rehabilitation responses.

AND hereby establish a Special Commission of Inquiry for this purpose.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 31 January 2019, consult with communities and other stakeholders on detailed terms of reference for the conduct of your inquiry for consideration by the Premier.

AND OUR further will and pleasure is that you do, as expeditiously as possible, but in any case on or before 30 September 2019 deliver your final report in writing of the results of your inquiry to the offices of the Premier and Our Governor in Sydney.

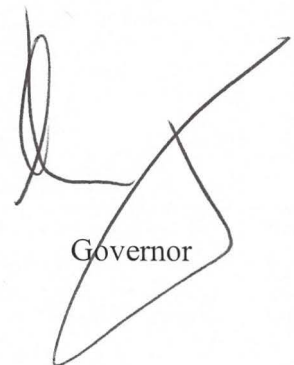
IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.


DEPARTMENT OF PREMIER AND CABINET
SECRETARY



WITNESS His Excellency General The Honourable David Hurley,
Companion of the Order of Australia, Distinguished Service Cross,
(Retired), Governor of the State of New South Wales in the
Commonwealth of Australia.

Dated this 28th day of November 2018.



Governor

By His Excellency's Command,



Premier.

Appendix 2: Letters Patent, 30 January 2019

NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

Professor Daniel Howard SC

GREETING

WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 28 November 2018, We authorised you as sole Commissioner to inquire into and report to Our Governor of the said State on issues concerning crystal methamphetamine in New South Wales,

AND WHEREAS it is desirable that the Letters Patent of 28 November 2018 be altered and varied to provide additional time for the consultation on detailed terms of reference for the conduct of your inquiry for consideration by the Premier,

NOW THEREFORE, by these Our Letters Patent, made and issued in Our name by Our Governor on the advice of the Executive Council and under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) and every other enabling power, We hereby alter and vary the Letters Patent of 28 November 2018 by omitting "31 January 2019" in the first paragraph beginning "AND OUR further will" and inserting instead "8 February 2019".

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.

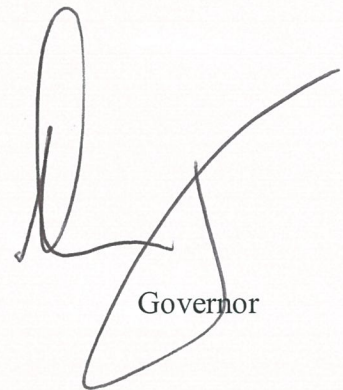
ENTERED on the Record by me in Register of Patents No. 92 Page 294, this 30th day of January 2019.

DEPARTMENT OF PREMIER AND CABINET
SECRETARY



WITNESS His Excellency General The Honourable David Hurley,
Companion of the Order of Australia, Distinguished Service Cross,
(Retired), Governor of the State of New South Wales in the
Commonwealth of Australia.

Dated this 30th day of January 2019.



Governor

By His Excellency's Command,



Premier.

Appendix 3: Letters Patent, 28 February 2019

NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

Professor Daniel Howard SC

GREETING

WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 28 November 2018, We authorised you as sole Commissioner to inquire into and report to Our Governor of the said State on issues concerning crystal methamphetamine in New South Wales,

AND WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 30 January 2019, We altered and varied the Letters Patent of 28 November 2018 by omitting "31 January 2019" in the paragraph beginning "AND OUR further will" and inserting instead "8 February 2019",

AND WHEREAS it is desirable that the Letters Patent of 28 November 2018 be further altered and varied to incorporate detailed terms of reference for the conduct of your inquiry, to amend the date by which you are to report, and to confer upon you certain powers under the *Special Commissions of Inquiry Act 1983* (NSW),

NOW THEREFORE, by these Our Letters Patent, made and issued in Our name by Our Governor on the advice of the Executive Council and under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) and every other enabling power, We hereby alter and vary the Letters Patent of 28 November 2018 by omitting the paragraphs marked "A", "B" and "C" and inserting instead the following:

"A. The nature, prevalence and impact of crystal methamphetamine ('ice') and other illicit amphetamine type stimulants ('ATS').

B. The adequacy of existing measures to target ice and illicit ATS in NSW.

C. Options to strengthen NSW's response to ice and illicit ATS, including law enforcement, education, treatment and rehabilitation responses.

D. In conducting the inquiry the Commissioner will:

1. Establish and consult with an expert advisory panel, including:
 - a. At least one member with expertise in health, drug addiction, treatment and rehabilitation,
 - b. At least one member with expertise in drug education and harm minimisation,
 - c. At least one member with expertise in law enforcement,

ENTERED on the Record by me in Register of Patents No. 92 Page 296, this 28th day of February 2019.

DEPARTMENT OF PREMIER AND CABINET

For SECRETARY



- d. At least one member who represents an Aboriginal organisation or community group, and
 - e. Such other members as the Commissioner considers would be of assistance.
2. Consider any drug-related recommendations from any NSW inquest held during the course of the inquiry.
 3. Consider relevant NSW and Commonwealth reports, the findings of past inquiries and other relevant existing material.
 4. Consider relevant international literature (including reports, research, and other materials), experience and practice.
 5. Prepare and publish as soon as practicable an issues paper and to call for public submissions on the issues paper to be made in good time so as to allow the Commissioner to complete the final report.
 6. Consult and/or meet various stakeholders and others.
 7. Conduct formal hearings in public and, if appropriate, in private, to examine witnesses and other interested persons to take place in Sydney and elsewhere, including some of the particular regions where the drug 'ice' is identified as being a significant issue.
 8. Prepare and deliver a final report that considers the information, submissions and evidence, and which makes appropriate findings and recommendations under the terms of reference."

AND hereby alter and vary the Letters Patent of 28 November 2018 by omitting the first paragraph beginning "AND OUR further will",

AND hereby alter and vary the Letters Patent of 28 November 2018 by omitting "30 September 2019" in the second paragraph beginning "AND OUR further will" and inserting instead "28 October 2019".

AND pursuant to section 21 of the *Special Commissions of Inquiry Act 1983* (NSW) it is hereby declared that sections 23 and 24 shall apply to and in respect of the Special Commission issued to you by Our Letters Patent.

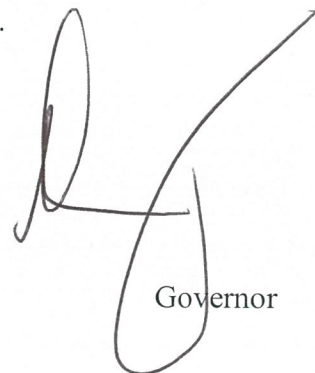
AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.



WITNESS His Excellency General The Honourable David Hurley,
Companion of the Order of Australia, Distinguished Service Cross,
(Retired), Governor of the State of New South Wales in the
Commonwealth of Australia.

Dated this 28th day of February 2019.



Governor

By His Excellency's Command,



Premier.

Appendix 4: Letters Patent, 11 July 2019

NEW SOUTH WALES

ELIZABETH THE SECOND, by the Grace of God Queen of Australia and Her other Realms and Territories, Head of the Commonwealth:

TO

Professor Daniel Howard SC

GREETING

WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 28 November 2018, We authorised you as sole Commissioner to inquire into and report to Our Governor of the said State on issues concerning crystal methamphetamine in New South Wales,

AND WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 30 January 2019, We altered and varied the Letters Patent of 28 November 2018 by omitting "31 January 2019" in the paragraph beginning "AND OUR further will" and inserting instead "8 February 2019",

AND WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 28 February 2019, We altered and varied the Letters Patent of 28 November 2018 by omitting the paragraphs marked "A", "B" and "C" and inserting instead the following:

"A. The nature, prevalence and impact of crystal methamphetamine ('ice') and other illicit amphetamine type stimulants ('ATS').

B. The adequacy of existing measures to target ice and illicit ATS in NSW.

C. Options to strengthen NSW's response to ice and illicit ATS, including law enforcement, education, treatment and rehabilitation responses.

D. In conducting the inquiry the Commissioner will:

1. Establish and consult with an expert advisory panel, including:
 - a. At least one member with expertise in health, drug addiction, treatment and rehabilitation,
 - b. At least one member with expertise in drug education and harm minimisation,
 - a. At least one member with expertise in law enforcement, At least one member who represents an Aboriginal organisation or community group, and
 - b. Such other members as the Commissioner considers would be of assistance.
2. Consider any drug-related recommendations from any NSW inquest held during the course of the inquiry.

ENTERED on the Record by me in Register of Patents No. 92 Page 420, this 11th day of July 2019.

DEPARTMENT OF PREMIER AND CABINET

For SECRETARY


3. Consider relevant NSW and Commonwealth reports, the findings of past inquiries and other relevant existing material.
4. Consider relevant international literature (including reports, research, and other materials), experience and practice.
5. Prepare and publish as soon as practicable an issues paper and to call for public submissions on the issues paper to be made in good time so as to allow the Commissioner to complete the final report.
6. Consult and/or meet various stakeholders and others.
7. Conduct formal hearings in public and, if appropriate, in private, to examine witnesses and other interested persons to take place in Sydney and elsewhere, including some of the particular regions where the drug 'ice' is identified as being a significant issue.
8. Prepare and deliver a final report that considers the information, submissions and evidence, and which makes appropriate findings and recommendations under the terms of reference.”

AND WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 28 February 2019, We altered and varied the Letters Patent of 28 November 2018 by omitting the first paragraph beginning “AND OUR further will”,

AND WHEREAS, by Letters Patent, made and issued in Our name by Our Governor of Our State of New South Wales on 28 February 2019, We altered and varied the Letters Patent of 28 November 2018 by omitting “30 September 2019” in the second paragraph beginning “AND OUR further will” and inserting instead “28 October 2019”,

AND WHEREAS it is desirable that the Letters Patent of 28 November 2018 be further altered and varied to amend the date by which you are to report under the *Special Commissions of Inquiry Act 1983* (NSW),

NOW THEREFORE, by these Our Letters Patent, made and issued in Our name by Our Governor on the advice of the Executive Council and under the authority of the *Special Commissions of Inquiry Act 1983* (NSW) and every other enabling power, We hereby alter and vary the Letters Patent of 28 November 2018 by omitting “28 October 2019” in the paragraph beginning “AND OUR further will” and inserting instead “28 January 2020”.

AND IT IS FURTHER DECLARED that these Letters Patent are to be read with the Letters Patent constituting your Commission.

IN WITNESS, We have caused these Our Letters to be made Patent and the Public Seal of Our State to be hereunto affixed.



WITNESS Her Excellency the Honourable Margaret Beazley, Officer of the Order of Australia, Queen's Counsel, Governor of the State of New South Wales in the Commonwealth of Australia.

Dated this 11th day of July 2019.

Margaret Beazley Governor

By ^{Her} Excellency's Command,

Premier.

Appendix 5: Expert Advisory Panel

Panel members

Professor Steve Allsop
Peter Bodor QC
Howard Brown OAM
Nicholas Cowdery AO QC
Dr Nadine Ezard
Professor Michael Farrell
Veronica Ganora
Dr Simon Longstaff AO
Associate Professor Richard Matthews AM
Martin Nean
Garth Popple
Andrew Scipione AO APM
Dr Jeff Snars
Dr Bruce Westmore
Dr Hester Wilson
Judge Dina Yehia SC

Biographies of panel members

Professor Steve Allsop, National Drug Research Institute, Curtin University

Professor Steve Allsop has been involved in prevention, treatment and policy research and practice and service management for almost 40 years, working in both government and academic positions. He has been the Director of two national drug research centres, the National Centre for Education and Training on Addiction until 2000 and the National Drug Research Institute until 2016. Professor Allsop has worked with the Western Australian Government Drug and Alcohol Office and was its Executive Director from 2003 to 2005.

Professor Allsop has chaired national expert groups on responses to alcohol and coexisting mental health and drug problems, and contributed to national clinical practice guidelines and national, state and territory drug strategies.

Other recent and current roles include Chair, WA Network of Alcohol and Drug Agencies; Deputy Chair, Australian National Advisory Council on Alcohol and Drugs; member, Child Death and Domestic Violence Review Panel, Ombudsman (WA), and Mental Health Advisory Group Australian Defence Force; and Deputy Regional Editor for the journal *Addiction*.

In 2015 he received the Senior Scientist Award from the Australasian Professional Society on Alcohol and other Drugs and in 2017 was the winner of the National Honour Roll as part of the 2017 Alcohol and Drug Excellence and Innovation Awards.

Mr Peter Bodor QC, Assistant Commissioner (Legal), NSW Crime Commission

Mr Peter Bodor QC was admitted as a barrister in 1976 and was appointed Queen's Counsel in 1988. He has represented individuals, corporations and governments throughout Australia and internationally. His practice included advising and appearing in jury and judge alone trials (criminal and civil), Royal and Special Commissions of Inquiry, ICAC, tribunals, inquests and Crime Commissions.

Relevant to this Inquiry, whether prosecuting or defending for over 40 years as a specialist criminal lawyer, Mr Bodor QC frequently and intimately encountered all forms of the illicit drugs milieu through the accused and the impacts on victims and/or end users.

Mr Bodor QC holds a statutory appointment as Assistant Commissioner (Legal) of the NSW Crime Commission. He primarily exercises statutory coercive investigative functions and conducts compulsory hearings into organised and serious crime that frequently involve the importation, distribution and the sequelae to the community of the drug trade, including ATS. He acted as Commissioner of the NSW Crime Commission for a period of 12 months in 2017–2018.

Mr Howard Brown, Victims Advocate

Mr Howard Brown OAM became an advocate for victims of crime after the murder of a friend in 1988. He became a committee member of the Victims of Crime Assistance League in 1989, before establishing the Sydney arm of the organisation in 1991. He now works as an independent advocate for victims of crime.

Mr Brown is a member of the Victims Advisory Board and the NSW Sentencing Council. He was also a member of the DNA Review Panel. He has provided assistance to the Homicide Victims Support Group, Enough is Enough, Mission Australia, Stand Together Against Sexual Abuse and the Homicide Victims Association, and participates in many other organisations and committees.

Mr Brown is a victims' advocate before the Mental Health Review Tribunal and State Parole Authority NSW. He was engaged in restorative justice programs through the Department of Juvenile Justice and was a victims' representative in the trial of the Forum Sentencing scheme at Liverpool Court.

Mr Brown was awarded the Order of Australia Medal in 2004 for his work with victims of crime and was made an Honorary Fellow of the University of New South Wales in 2011 for his work with the university and for victims of crime.

Mr Nicholas Cowdery AO QC, Former NSW Director of Public Prosecutions

Mr Nicholas Cowdery AO QC was admitted as a barrister in 1971 and commenced practising as a public defender in Papua New Guinea in the same year. Mr Cowdery entered private practice as a barrister in Sydney in 1975 where he remained until 1994. He was appointed Queen's Counsel in 1987 and served as an Associate Judge of the District Court for periods between 1988 and 1990.

Mr Cowdery was appointed the Director of Public Prosecutions for NSW in 1994 and ended his 16-year tenure in 2011. He also served as President of the International Association of Prosecutors from 1999 to 2005 and as inaugural Co-Chair of the Human Rights Institute of the International Bar Association from 1995 to 2001.

Mr Cowdery was appointed a Member in the Order of Australia in June 2003, and an Officer in the Order in June 2019 in recognition of his distinguished service to the law, to the protection of human rights, to professional legal bodies and to the community. He has received numerous awards in Australia and internationally.

Mr Cowdery was awarded with an Honorary Doctor of Laws from the University of Wollongong in 2011 and, since his retirement as public prosecutor, has held several honorary academic positions and has been engaged in teaching at universities. He is also involved in various criminal law research and other projects and in criminal law reform.

Mr Cowdery serves on various criminal law and human rights committees and was elected President of the NSW Council for Civil Liberties in October 2019. He is the author of *Getting Justice Wrong: Myths, Media and Crime* (Allen & Unwin, 2001) and *Frank and Fearless* (NewSouth Publishing, 2019), and co-edited the International Association of Prosecutors' *Human Rights Manual for Prosecutors*.

Dr Nadine Ezard, Clinical Director, Alcohol and Drug Service, St Vincent's Hospital; Director, National Centre for Clinical Research on Emerging Drugs

Dr Nadine Ezard is the Director of the National Centre for Clinical Research on Emerging Drugs and Clinical Director of the Alcohol and Drug Service at St Vincent's Hospital, Sydney, home to one of NSW's first specialist stimulant treatment programs.

Dr Ezard has an MBBS in Medicine and Surgery and BA in History and Philosophy of Science from the University of Melbourne, a Masters of Public Health from Harvard School of Public Health and a PhD in Public Health from the London School of Hygiene and Tropical Medicine.

Dr Ezard has more than 25 years' experience in the addiction medicine field and over that time has received multiple accolades including a Commonwealth Scholarship and recognition as one of the *Australian Financial Review's* 100 Women of Influence.

Her body of peer-reviewed research involves building the evidence base for improved health interventions for marginalised populations. Dr Ezard's current research focuses on working with people who use stimulants, to develop new and effective interventions.

Dr Ezard is a registered medical practitioner and Fellow of the Australasian Chapter of Addiction Medicine of the Royal Australasian College of Physicians. She has previously worked for the World Health Organization, the United Nations High Commissioner for Refugees and the United Nations Office of Drugs and Crime.

Professor Michael Farrell, Director, National Drug and Alcohol Research Centre

Professor Michael Farrell has been the Director of the National Drug and Alcohol Research Centre since 2011. Prior to that he worked in London for over 20 years as a consultant addiction psychiatrist in the Maudsley Hospital and as a Professor of Addiction Psychiatry at the Institute of Psychiatry, Kings College London.

His research interests include treatment evaluation, including the development of the National Treatment Outcomes Profile, and national and international drug policy. He is the Chair of the International Consortium for Health Outcome Measurement Working Group on Substance Use and Editor of the Cochrane Drug and Alcohol Group.

Professor Farrell has a long-standing interest in drug dependence, comorbidity and drugs within the criminal justice system. He has been a member of the World Health Organization (WHO) Expert Committee on Drug and Alcohol Dependence since 1995 and chaired the WHO External Evaluation of the Swiss Heroin Trial.

Professor Farrell chaired the Scientific Advisory Committee of the European Monitoring Centre on Drugs and Drug Abuse in 2008 for three years.

Ms Veronica Ganora, Consumer Representative

Ms Veronica Ganora holds a Bachelor of Arts from the University of Sydney and has qualifications in adult education, human and community services and consumer advocacy.

She brings to the Expert Advisory Panel a lived experience of substance use and treatment, including treatment for crystal methamphetamine use. She has wide-ranging experience as a consumer of AOD treatment services and extensive experience in navigating the mental health system as a service user, advocate and support worker.

Ms Ganora has been active in consumer advocacy, peer education and consumer research since 2015. She is currently employed by NSW Health as a Consumer Representative/Health Education Officer with South Eastern Sydney Local Health District Drug and Alcohol Services.

Ms Ganora has also worked as a casual peer educator with the South Eastern Sydney Recovery College since 2017, co-writing, developing and reviewing mental health and AOD education for consumers and staff of the Local Health District. She has planned, co-written and co-facilitated courses on AOD use and wellbeing, opioid medications and recovery, challenging stigma, and systemic advocacy, among others.

Ms Ganora contributed to a Consumer Participation Pilot Project for the Network of Alcohol and other Drugs Agencies (NADA) in 2018 and 2019, developing, reviewing and co-facilitating training materials and workshops for staff and consumers at AOD residential rehabilitation and detoxification services across NSW. She helped evaluate the project in early 2019.

Ms Ganora is a founding member of the Alcohol and Other Drugs Branch Consumer Reference Committee at the NSW Ministry of Health, Centre for Population Health, where she has been co-developing a Consumer Engagement Framework to assist the Ministry's work with consumers, carers and families of service users.

Dr Simon Longstaff AO, Executive Director, The Ethics Centre

Dr Simon Longstaff is Executive Director of The Ethics Centre, a position he has held since 1991. Dr Longstaff is an Honorary Professor at the Australian National University and is a Fellow of CPA Australia, the Royal Society of NSW and the Australian Risk Policy Institute.

In 2013, Dr Longstaff was made an Officer of the Order of Australia for distinguished service to the community through the promotion of ethical standards in governance and business, to improving corporate responsibility and to philosophy.

Associate Professor Richard Matthews AM, School of Psychiatry, UNSW Sydney

Associate Professor Richard Matthews AM is a National Director of Calvary Healthcare, a Director of Mind Gardens Research and Medical Advisor – Clinical Governance to GEO Prison Services.

He holds a conjoint associate professorship at the Faculty of Medicine, UNSW Sydney. He graduated from Medicine at the University of New South Wales in 1975.

Associate Professor Matthews was a general practitioner for 20 years. He developed an interest in drug and alcohol treatment and worked for many years in the outpatient department in St Vincent's Hospital, Sydney, in this discipline. He worked in prison health in NSW for 20 years, serving as Director of Drug and Alcohol, Director of Clinical Services and Chief Executive of Justice Health NSW from 1999 until 2005.

He served for eight years as Deputy Director General at NSW Health with responsibility for State-wide Services Development, Mental Health, Drug and Alcohol, Primary and Community Health, Maternity Services, Child Health and Child Protection as well as Intergovernment and Funding Strategies Relations.

In 2011 he was appointed a Member of the Order of Australia for services to mental health, drug and alcohol and prison health

Mr Martin Nean, Aboriginal Health Representative

Mr Martin Nean is Manager of Aboriginal Drug and Alcohol Clinical Services at Hunter New England Local Health District and Chair of the Aboriginal Drug and Alcohol Network (ADAN) Leadership Group.

Established as a result of the Drug Summit in 2002, the ADAN membership includes Aboriginal drug and alcohol workers from Aboriginal Community Controlled Health Services, Aboriginal Residential Rehabilitation Services, Local Health Districts and other non-government organisations. The ADAN Leadership Group, which is a nominated group of ADAN members, represents the network at a state level and engages with key stakeholders regarding policy development and state-wide projects aimed at the Aboriginal drug and alcohol sector.

Mr Garth Popple, Executive Director, We Help Ourselves

Mr Garth Popple has been working in the AOD non-profit sector since 1980 and in executive management roles since 1986. Mr Popple has held honorary committee and board positions as well as serving on various State Ministerial committees for NSW Health and on a National Council that directly reported to the Prime Minister.

As Executive Director of We Help Ourselves, Mr Popple oversees six residential AOD therapeutic communities and four day programs across NSW and Queensland. He is Chairperson and past President of the Australasian Therapeutic Communities Association and Deputy President of the World Federation of Therapeutic Communities.

Mr Popple is an Honorary Fellow of the University of Western Sydney and in 2007 received the National Honour Roll Award for people who have made a significant contribution, over a considerable time period, to the drug and alcohol field. He received the Prime Minister's Award at the 2010 National Drug and Alcohol Awards, recognising an individual as having made a significant commitment and contribution to reducing the impact and negative effects of drug and alcohol use.

Mr Popple's past board memberships and associations include past President of the International Federation of NGOs, past Co-Chair and Executive Member of the Australian National Council on Drugs, past President and board member of the Network of Alcohol and other Drugs Agencies and member of the International Council of Alcohol and Addictions.

Mr Andrew Scipione AO APM, Former Commissioner of the NSW Police Force

Former Commissioner Andrew Scipione AO APM joined the NSW Police Force in 1980 and held a range of positions and appointments before his promotion to the rank of Detective Inspector in 1992. Mr Scipione was appointed Detective Superintendent (Commander) in 1995 and a Senior NSW Police Counter Terrorist Advisor from 1992 to 1998. Further advancements as Chief of Staff to the NSW Police Commissioner, Assistant Commissioner in charge of Special Crime and Internal Affairs and Deputy Commissioner preceded his appointment as Commissioner of the NSW Police Force in 2007.

Mr Scipione's academic achievements include postgraduate qualifications in Management, Police Management and Security Management. He is a Fellow of the Australian Institute of Management, a Member of the Australian Institute of Company Directors and a Graduate of the FBI National Executive Institute.

Mr Scipione was awarded an Honorary Doctor of Letters from Macquarie University in 2013 and an Honorary Doctor of Letters from Western Sydney University in 2018. He was appointed Adjunct Professor at Western Sydney University from 2008 to 2011, and again in 2015 until September 2018. Macquarie University named Mr Scipione Alumnus of the Year In 2018 for his public and community service.

Mr Scipione is a recipient of the Australian Police Medal, the National Medal and the Order of Australia.

Dr Jeff Snars, Concord Centre for Mental Health

Dr Jeff Snars has worked in both inpatient and community mental health settings in the NSW public psychiatric system for 38 years. Dr Snars was Westmead Hospital's first Chairman of the Department of Psychological Medicine, Director of Mental Health Services at St George Hospital and Director of Clinical Services at Rozelle Hospital. He was responsible for the continuity of care in the relocation of clinical services from Rozelle Hospital to the Concord Centre for Mental Health, where he has been Director of Clinical Services and Medical Superintendent for 10 years. He established the Collaborative Centre for Cardiometabolic Health in Psychosis with Professor Tim Lambert and Associate Professor Roger Chen in 2009.

Dr Snars has made major contributions to three of Sydney's metropolitan mental health services, leading enduring improvements in systems of care and day-to-day clinical practice. He has established several new psychological services and programs, working to integrate medical and psychiatric care. Dr Snars' particular interests include acute mental health cases, the psychiatric aspects of epilepsy and the medical vulnerabilities of people with schizophrenia.

Dr Snars has taught undergraduate medical students and supervised psychiatry registrars throughout his career.

The Royal Australian and New Zealand College of Psychiatrists awarded Dr Snars the Ian Simpson Award in 2009 for his outstanding contribution to clinical psychiatry through service to patients and the community.

Dr Bruce Westmore, Forensic Psychiatrist

Dr Bruce Westmore is a practising psychiatrist with extensive expertise in the areas of alcohol, drug and other addictions, obsessive compulsive disorders, autism spectrum disorders, brain injuries and forensic psychiatry.

Dr Westmore is a former Director of Forensic Psychiatry in Queensland and former official adviser to the Government of New Zealand, assisting in organising and developing a national forensic psychiatry service.

Dr Westmore has been a visiting consultant to various private hospitals and held long-term teaching commitments with postgraduate and undergraduate students. Dr Westmore has had extensive experience as an expert witness.

Dr Hester Wilson, Chair, Specific Interests Addiction Medicine Network, Royal Australian College of General Practitioners

Dr Hester Wilson is a Fellow of the Australasian Chapter of Addiction Medicine within the Royal Australasian College of Physicians and a Fellow of the Royal Australian College of General Practitioners (RACGP) with a Masters in Mental Health. Dr Wilson is Chair of the National Faculty of Specific Interest in Addiction within the RACGP. She is a conjoint lecturer at the UNSW Sydney and is chairing the scientific committee for the biannual international Medicine in Addiction Conference in 2021.

Dr Wilson has worked in primary care settings for more than 25 years and has a special interest in women's health, sexual health, mental health, behaviour change, addiction medicine and providing care for people with chronic complex issues.

As well as working in a mixed billing general practice in inner metropolitan Sydney, Dr Wilson is a staff specialist in addiction in the public health system in Sydney. Dr Wilson is currently undertaking a PhD focused on primary and specialist care and health issues associated with tobacco, alcohol and other drug use. She is a keen teacher and has facilitated many training sessions for multidisciplinary teams over the past 20 years.

Judge Dina Yehia SC, Judge of the District Court of NSW

Judge Dina Yehia SC began her legal career working for the Western Aboriginal Legal Service. She later worked as a solicitor advocate with the Legal Aid Commission, before being called to the Bar in 1999. She spent 14 years as a Public Defender, taking silk in 2009. She became the first female Deputy Senior Public Defender in 2013.

Her practice in the Supreme Court of NSW included murder trials and a year-long terrorism trial at Parramatta in 2009. Subsequently, she appeared in the High Court in *Bugmy v The Queen* in 2013 and in the Special Leave application in *Honeysett v The Queen*.

Judge Yehia was appointed as a District Court Judge in May 2014. She is the Chairperson of the Walama Court Working Group and sits on numerous committees and working groups.

Terms of Reference for Expert Advisory Panel

1. Purpose

The New South Wales Government has established a Special Commission of Inquiry into Crystal Methamphetamine ('Ice') ('the Commission').

As part of the process of the Inquiry, an Expert Advisory Panel ('the Panel') is being established to inform the Commission on priority issues and assist with progressing the Inquiry methods and outcomes.

2. Role of the Panel of Experts

The Panel will be asked to provide advice to the Commissioner and other Commission staff on the issues raised by the Terms of Reference of the Commission, including:

- advice on the nature, prevalence and impact of crystal methamphetamine on the NSW community
- advice on the adequacy of existing measures to target ice in NSW
- advice on options to strengthen NSW's response to ice, including law enforcement, education, treatment and rehabilitation responses.

There is a possibility that the terms of reference may be expanded to include amphetamine-type stimulants (ATS) generally.

The Panel will be asked to provide advice regarding:

- identifying relevant issues for the Commission to examine
- identifying stakeholders
- the contents of an 'issues & discussion' paper that the Commission proposes to publish to accompany an invitation for public and stakeholder submissions to the inquiry
- effective engagement with stakeholders in relation to reform options
- evidence gathering
- the content of the Commission's final report and recommendations.

3. Membership

The Panel is to consist of members including:

- i. At least one member with expertise in health, drug addiction, treatment and rehabilitation
- ii. At least one member with expertise in drug education and harm minimisation
- iii. At least one member with expertise in law enforcement
- iv. At least one member who represents and Aboriginal organisation or community group
- v. Such other members as the Commissioner considers would be of assistance to the Inquiry as members of the Expert Advisory Panel.

It is expected that the Panel will comprise between 14 and 20 individuals. The Panel will be chaired by the Commissioner.

4. Meeting Details

The Panel is expected to meet on at least three occasions throughout the course of the Commission's work. It is also expected that individual members may be contacted from time to time to provide ad-hoc advice on particular matters raised during the evidence-gathering and consultation process.

It is anticipated that the first formal meeting will be held in February 2019, and the final meeting in August 2019. Secretariat support to the Panel will be provided by staff of the Commission.

5. Payment and expenses

Members of the Panel will not be paid, but the Commission will cover the reasonable travel expenses of members of the Panel attending meetings.

Expert Advisory Panel sitting dates

4 March 2019

27 September 2019

26 November 2019

Appendix 6: First Nations Advisory Committee

Committee members

James Beaufile
Alan Bennett
Christopher Bloxsome
Janelle Clarke
Duran Cox
Bob Davis
Aunty Pat Field
Tony Hunter
Kristy Kennedy
Emma Langton
Louise Lynch
Peta Macgillivray
Jinny-Jane Smith
Emma Walke
Lloyd Walker
Lisa Wellington

Terms of Reference for First Nations Advisory Committee

1. Purpose

The New South Wales Government has established a Special Commission of Inquiry into Crystal Methamphetamine ('Ice') ('the Commission').

As part of the process of the Inquiry, a First Nations Advisory Committee ('the Committee') is being established to inform the Commission on best practice on engaging with Aboriginal and Torres Strait Islander people and their communities.

2. Role of the Committee

The Committee will be asked to provide advice to the Commissioner and other Commission staff on the following:

- ways to engage and work with Aboriginal Torres Strait Islander communities in a respectful way
- assist with promoting/advertising the work of the Commission within Aboriginal Torres Strait Islander communities
- assist with the identification of stakeholders who may wish to make submissions to the Commission
- facilitate engagement with members of specific communities who may be able to assist the Commissioner with the Inquiry.

There is a possibility that the Inquiry may be expanded to include amphetamine-type stimulants (ATS) generally.

The Commissioner recognises that Committee members do not speak on behalf of all Aboriginal and Torres Strait Islander people or the organisation that they come from.

3. Membership

The Committee is to consist of Aboriginal and Torres Strait Islander people who have experience:

- i. in the criminal justice system
- ii. in the health system particularly in drug treatment
- iii. working with young people
- iv. working with Elders
- v. such other members as the Commissioner sees fit.

In selecting Committee members, it is a goal of the Commission to ensure that individuals selected can have a combination of the experiences as outlined above and come from several different communities throughout metropolitan and regional NSW. The Commission will endeavour to ensure an appropriate gender and age balance amongst the membership.

It is expected that the Committee will comprise between 10 and 14 individuals.

4. Meeting details

The Committee is expected to meet on at least two occasions throughout the course of the Commission's work. It is also expected that individual members may be contacted from time to time to provide ad-hoc advice on specific matters raised during the evidence-gathering and consultation process.

It is anticipated that the first formal meeting will be held in March 2019, and the final meeting in August 2019. Secretariat support to the Panel will be provided by staff of the Commission.

5. Payment and expenses

Members of the Committee will not be paid, but the Commission will cover the reasonable travel expenses of members of the Committee attending meetings. Lunch and other appropriate refreshments will be provided.

First Nations Advisory Committee sitting date

11 March 2019

Appendix 7: Staff of the Inquiry

Counsel Assisting

Sally Dowling SC
Nicholas Kelly
Damian Beauflis
Louise Beange
William de Mars

Chief Operating Officer

David McGrath

Communications

Kim Arlington
Julia Carlisle

Editors

Marge Overs
Helen Signy
Stephanie Wood
Mark Ragg

Personal Assistant to Commissioner

Susan Kent

Policy and Research

Megan Smith
Lauren Hogarth
Kate Smithers
Jennifer Chalmers
Stephen Kendall
Lexi Buckfield
Solange Frost
Dr Karin Lines
Joel Murray
Thomas Wallace
Elena Walsh
Claudine Lyons
Kath Vaughan-Davies
Clea Viney
Emma Hunt
Melissa Cavallo
Erin Halligan

Solicitor Assisting

NSW Crown Solicitor

Staff of the NSW Crown Solicitor's Office

James Herrington
Tracey Howe
Ellyse McGee
Gareth Martin
Hugh Gillespie
Susan Ellicott
Grace Forster
Connie Livanos
Nadezna Wilkins
Tonette Leedham
Isabelle Sarmiento
Irene De Raya
Sean Hawkins
Pranay Jha
Nina Britton Dillon
Chris Gopinath

Appendix 8: Preliminary submissions received in response to the Inquiry's proposed Terms of Reference

1. Eve Kiernan
2. Not published
3. Nicholas Cowdery AM QC
4. Anonymous
5. Not published
6. Anonymous
7. Narrandera Shire Council
8. Gilgandra Shire Council
9. Ballina Shire Council
10. City of Sydney Council
11. Australian Health Practitioner Regulation Agency
12. Harm Reduction Australia
13. His Honour Judge Roger Dive, Senior Judge, Drug Court of New South Wales
14. Grant Mistler
15. Port Macquarie Hastings Council
16. Bathurst Regional Council
17. Waverley Local Council
18. Northern Sydney Local Health District
19. Professor Ian Coyle
20. Not published
21. Eurobodalla Shire Council
22. Mental Health Coordinating Council
23. Jonathan Harms
24. Marrin Weejali Aboriginal Corporation
25. Not published
26. His Honour Judge Richard Cogswell SC, President of the Mental Health Review Tribunal
27. Liverpool City Council
28. Lloyd Babb SC, Director of Public Prosecutions
29. Alcohol and Drug Foundation
30. Glen Innes Severn Council
31. National Drug Research Institute (NDRI)
32. Network of Alcohol and other Drugs Agencies (NADA)
33. Coffs Harbour City Council
34. Dubbo Regional Council
35. Central Darling Shire Council

36. Anonymous
37. Oberon Council
38. Drug and Alcohol Nurses of Australasia (DANA)
39. Brian Hill
40. Anonymous
41. Rhonda Danylenko
42. Northern Beaches Council
43. Royal Flying Doctor Services South Eastern Section
44. Royal Australian College of General Practitioners (RACGP)
45. Not published
46. Western Sydney University
47. South Eastern Sydney Local Health District (SESLHD)
48. Tweed Shire Council
49. Cessnock City Council
50. John Malouf
51. NSW Farmers Association
52. His Honour Judge Graeme Henson AM, Chief Magistrate of the Local Court
53. National Centre for Education and Training on Addiction (NCETA)
54. The Matilda Centre, University of Sydney
55. Australasian College for Emergency Medicine (ACEM)
56. Byron Shire Council
57. New South Wales Crime Commission
58. New South Wales Nurses and Midwives Association
59. Aboriginal Health & Medical Research Council of NSW (AHMRC)
60. Wagga Wagga City Council
61. Aboriginal Legal Service and Just Reinvest NSW
62. Shellharbour City Council
63. Geoff Pritchard OAM
64. Inner West Council
65. Not published
66. New South Wales Department of Education
67. Faye Westwood
68. Community Legal Centres NSW
69. Ronald Churchill
70. Liverpool Plains Shire Council
71. His Honour Judge Peter Johnstone, President of the Children's Court of New South Wales
72. Surry Hills Community Drug Action Team
73. National Centre for Clinical Research on Emerging Drugs (NCCRED)
74. New South Wales Bar Association

75. The Public Defenders
76. Department of Home Affairs
77. Police Association of New South Wales
78. ACON
79. University of Newcastle
80. Adele House Limited
81. Cowra Shire Council
82. Australian Paramedics Association NSW
83. The Royal Australian New Zealand College of Psychiatrists (RANZCP – NSW Branch)
84. Dr David Outridge
85. Australasian Chapter of Addiction Medicine (AChAM) of the Royal Australasian College of Physicians (RACP)
86. Lithgow City Council
87. Country Women's Association of NSW
88. Australian Medical Association NSW
89. Department of Justice
90. NSW Health
91. The Honourable Peter Dutton MP, Minister for Home Affairs
92. Legal Aid NSW
93. Burwood Council
94. Not published
95. Corrective Services of NSW

Appendix 9: Submissions received in response to the Inquiry's Issues Papers

1. Cheryl Whiteman
2. Not published
3. Anonymous
4. Drug Free Australia
5. Dr Peter Foltyn
6. Not published
7. Anonymous
8. Cindy Wilson
9. George
10. Mental Health Review Tribunal
11. Not published
12. The Public Defenders
13. Not published
14. Not published
15. Not published
16. Griffith Aboriginal Medical Service
17. Not published
18. Not published
19. James Stewart
20. Broken Hill City Council
21. Anonymous
22. Anonymous
23. Anonymous
24. Office of the Director of Public Prosecutions
25. Drug and Alcohol Nurses of Australasia
26. Not published
27. Anonymous
28. Michael Balderstone
29. "Ben"
30. Anonymous
31. Cessnock City Council
32. The Royal Australian and New Zealand College of Psychiatrists
33. Homelessness NSW
34. Not published
35. Anonymous
36. Lismore Soup Kitchen

37. Harm Reduction Australia
38. Nigel Baker
39. Not published
40. David Burt
41. Not published
42. Dayle Rees
43. Lismore City Council Social Justice and Crime Prevention Committee
44. Goulburn Mulwaree Council
45. Anonymous
46. Anonymous
47. The Royal Australasian College of Physicians
48. National Drug Research Institute
49. Anonymous
50. Grahame Gee
51. Waminda South Coast Women's Health and Welfare Aboriginal Corporation
52. Australasian College for Emergency Medicine
53. Northern Beaches Council
54. NSW Council of Social Services
55. Leeton Shire Council
56. Penington Institute
57. Drug Policy Modelling Program, UNSW Sydney
58. Not published
59. Not published
60. Not published
61. Australian Bureau of Statistics
62. Upper Hunter Mental Health Interagency
63. Children's Court of New South Wales
64. Dubbo Regional Council
65. Centre for Social Research in Health, UNSW Sydney
66. Mission Australia
67. University of Sydney Policy Reform Project
68. Tim Sheehan
69. Ben Mostyn
70. NSW Council of Civil Liberties
71. Odyssey House
72. Moree Plains Shire Council
73. Hope House Community Life Batemans Bay
74. Matilda Centre for Research in Mental Health and Substance Use, University of Sydney and The Priority Research Centre for Brain and Mental Health, University of Newcastle
75. Tweed Shire Council

76. Mental Health Carers NSW
77. ACON
78. Alcohol and Drug Foundation
79. Network of Alcohol and Other Drugs Agencies
80. Commonwealth Department of Health
81. National Drug and Alcohol Research Centre
82. Positive Life NSW and HIV/AIDS Legal Centre
83. Sex Workers Outreach Project
84. Matt Jones
85. Andrew Kroehn
86. Not published
87. Simone Henrikson
88. Not published
89. Dr Elyse Methven
90. Orana Haven Aboriginal Corporation
91. South Western Sydney Primary Health Network
92. The Shopfront Youth Legal Centre
93. MindM8 Ventures
94. Anonymous
95. Uniting NSW/ACT
96. Literacy for Life
97. New South Wales Bar Association
98. Country Women's Association of NSW
99. Veronica Rawlinson
100. Justice Action
101. His Honour Judge Roger Dive, Senior Judge, Drug Court of New South Wales
102. Not published
103. Not published
104. Not published
105. The Buttery
106. Kamira Alcohol and Other Drug Treatment Services
107. NSW Crime Commission
108. Anonymous
109. Not published
110. The National Centre for Education and Training on Addiction
111. Law Society of New South Wales
112. Not published
113. Not published
114. Blacktown City Council
115. Anonymous

116. Aboriginal Legal Service (NSW/ACT)
117. Uniting Medically Supervised Injecting Centre
118. NSW Aboriginal Land Council
119. Mental Health Commission of New South Wales
120. Liverpool City Council
121. Australian Medical Association (NSW)
122. Youth Action NSW
123. National Centre for Clinical Research on Emerging Drugs
124. NSW Young Lawyers Criminal Law Committee
125. Anonymous
126. Health Services Union
127. St Vincent's Health Australia
128. Directions Health Services
129. What Can Be Done Steering Committee
130. Not published
131. Not published
132. Acting State Coroner, Domestic Violence Death Review Team
133. Barnardos Australia
135. Not published
136. Legal Aid NSW
137. NSW Users and AIDS Association
138. Ethnic Communities' Council of NSW
139. Drug and Alcohol Multicultural Education Centre
140. Tony Trimmingham, Family Drug Support
141. Commonwealth Department of Home Affairs
142. Not published
143. NSW Government
144. Not published
145. Not published
146. Robyn Lewis
147. Anonymous
148. Positive Life and HIV/AIDS Legal Centre (supplementary submission)
149. Australian Criminal Intelligence Commission
150. Australian Institute of Criminology
151. Stephen Russell
152. Ralph Seccombe
153. Not published
154. SMART Recovery Australia
155. Maari Ma Health Aboriginal Corporation
156. Dr Thalia Anthony

- 157. Not published
- 158. Riverina Murray Regional Alliance
- 159. Nicholas Cowdery AO QC

Appendix 10: Stakeholder meetings and consultations

10 January 2019	The Hon. Gladys Berejiklian, MP, Premier of NSW
17 January 2019	Associate Professor Anthony Schembri, Dr Nadine Ezard, Dr Tony Gill, David Hedger – St Vincent's Hospital, Sydney
17 January 2019	Larry Pierce, Gerard Byrne, Garth Popple, Gabriella Holmes – Network of Alcohol and Other Drugs Agencies
18 January 2019	Elizabeth Koff, Secretary, and Dr Kerry Chant PSM, Chief Health Officer – NSW Health
30 January 2019	The Hon. Michael Daley MP, Leader of the Opposition, the Hon Walt Secord MP, Shadow Minister for Health
31 January 2019	Associate Professor Richard Matthews, School of Psychiatry, UNSW Sydney
05 February 2019	The Hon. Bradley Hazzard MP, Minister for Health
07 February 2019	Commissioner Michael Fuller APM, Assistant Commissioner Stuart Smith, Superintendent Scott Whyte APM – NSW Police Force
08 February 2019	Dr Donald Weatherburn, Director, NSW Bureau of Crime Statistics and Research
13 February 2019	Matt Noffs, Mark Ferry – Ted Noffs Foundation (Youth Rehabilitation)
18 February 2019	Nathan Martin, Aboriginal Affairs NSW
19 February 2019	Nicolas Parkhill, Karen Price, Sarah Lambert – ACON
22 February 2019	Board members of the Aboriginal Legal Service
25 February 2019	Dr Marianne Jauncey, Medical Director, Uniting Medically Supervised Injecting Centre (MSIC)
27 February 2019	Judge Roger Dive, Senior Judge, Drug Court of New South Wales
8 March 2019	Professor Nicholas Lintzeris and Professor Adrian Dunlop, addiction medicine specialists
12 March 2019	The Hon. Mark Speakman MP, Attorney General
18 March 2019	Professor Alison Ritter, Director, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney
19 March 2019	Dr Tobias Mackinnon, Dr Jeremy Resnick, Dr Jonathon Adams, Dr Nicholas Burns, forensic psychiatrists
20 March 2019	Dr Alex Wodak AM, The Hon. Hal Sperling QC, Associate Professor Richard Matthews

27 March 2019	Commissioner Peter Severin, Dr Anne Marie Martin, Mark Wilson PSM, Kevin Corcoran PSM, Jeremy Tucker – Corrective Services NSW
1 April 2019	Dr Alex Wodak AM, addiction medicine specialist
3 April 2019	Dr Marcia Fogarty (Hunter New England Local Health District), Jason Crisp (Western NSW Local Health District), Dr Victor Storm (Sydney Local Health District)
10 April 2019	Acting Superintendent Michael Cook, Patricia Ward – NSW Police Force
24 April 2019	Professor Eileen Baldry, Professor of Criminology, UNSW Sydney, and Matt Noffs, Mark Ferry – Ted Noffs Foundation
30 April 2019	Women's Legal Service NSW, Aboriginal Women's Consultation Group and Indigenous Women's Legal Program
15 May 2019	Judge Graeme Henson AM, Chief Magistrate of the Local Court of NSW
12 June 2019	Alessandro Pirona, Thomas Seyler, Joao Matias – European Monitoring Centre for Drugs and Drug Addiction
26 June 2019	Cigdem Watson, Executive Manager of the Personal Helpers and Mentors Program and Youth Drug and Alcohol Service, Centacare
26 June 2019	Thiyama-Li Family Violence Prevention Service, Moree
26 June 2019	Superintendent Scott Tanner and Inspector Martin Burke, Moree Police
26 June 2019	Pius X Aboriginal Corporation, Moree
2 July 2019	Russell Maynard, Portland Hotel Society, Vancouver, Canada
3 July 2019	Cedric Charvet, International Network of Drug Consumption Rooms
4 July 2019	Dr Manuel Cardoso, Deputy General-Director of the Intervention on Addictive Behaviours and Dependencies, Lisbon, Portugal
8 July 2019	Justice Derek Price AM, Chief Judge of the District Court of NSW
10 July 2019	Daan van der Gouwe, Drugs Information and Monitoring System, Trimbos Instituut, the Netherlands
22 July 2019	David Laffan, Phoebe Crosbie – Commonwealth Department of Health
24 July 2019	Magistrate Sue Duncombe, Children's Court of New South Wales and Youth Koori Court
26 July 2019	Professor Thomas Kerr, British Columbia Centre on Substance Use, Vancouver, Canada

26 July 2019	Dr John Lewis, consultant toxicologist, member of The International Association of Forensic Toxicologists, Chairman of Standards Australia Committee CH-036
9 August 2019	Dr Mary Harrod, Chief Executive Officer, NSW Users and AIDS Association
12 August 2019	Magistrate Harriet Grahame, Deputy State Coroner
19 August 2019	Stacey Bourque, Executive Director, ARCHES, Lethbridge, Canada
6 September 2019	Kwanmanas Jitraskoul and Jeremy Douglas – United Nations Office on Drugs and Crime
9 October 2019	Sarah Hopkins and Jenny Loveridge – Justice Reinvestment

Appendix 11: Site visits

17 January 2019	Medically Supervised Injecting Centre, Kings Cross
27 February 2019	Drug Court of NSW, Parramatta
4 April 2019	Marrin Weejali Aboriginal Corporation, Blackett
4 April 2019	Ted Noffs Foundation, The Street University, Mount Druitt
8 April 2019	Odyssey House, Redfern and Eaglevale
30 April 2019	Calvary Riverina Drug and Alcohol Centre, Wagga Wagga
30 April 2019	Pathways Murrumbidgee, Wagga Wagga
16 May 2019	Balund-a (Tabulam) Transitional Centre, Tabulam
21 May 2019	Intensive Drug and Alcohol Treatment Program, Outer Metropolitan Multi-Purpose Correctional Centre, John Morony Correctional Complex
21 May 2019	Dillwynia Correctional Centre
3 June 2019	Kamira Alcohol and Other Drug Treatment Services, Wyong
24 June 2019	Compulsory Drug Treatment Correctional Centre, Parklea Correctional Complex
24 June 2019	Cobham Juvenile Justice Centre, Werrington
29 July 2019	St Vincent's Hospital Emergency Department, Darlinghurst
30 July 2019	Calvary Riverina Drug and Alcohol Centre, Wagga Wagga
12 August 2019	Bolwara Transitional Centre, Emu Plains
28 August 2019	Involuntary Drug and Alcohol Treatment Program, Royal North Shore Hospital
11 September 2019	Family Drug Treatment Court, Melbourne
11 September 2019	The Bridge Centre, Melbourne
2 October 2019	Behavioural Assessment Unit, Royal Melbourne Hospital, Melbourne

Appendix 12: Public Roundtables and participants

Public Roundtables held

Health Service Responses, 20 August 2019

Decriminalisation, 18 September 2019

Youth Diversionary Programs, 2 October 2019

Health Service Responses Roundtable

Jason Crisp, Director, Integrated Mental Health, Drug and Alcohol Services, Western NSW Local Health District

Dr Adrian Dunlop, Director and Addiction Medicine Senior Staff Specialist, Drug and Alcohol Clinical Service, Hunter New England Local Health District

Mariam Faraj, General Manager, Clinical Services, Central and Eastern Sydney Primary Health Network

Veronica Ganora, Consumer Representative

Debbie Kaplan, Manager, Drug and Alcohol Clinical Policy, Centre for Population Health, NSW Health

Anita McRae, Senior Manager, Mental Health, Drug and Alcohol, Murrumbidgee Primary Health Network

Jolene Mokbel, Psychologist and Clinical Coordinator, Salvation Army Youthlink AOD/Mental Health Programs

Larry Pierce, Chief Executive Officer, Network of Alcohol and other Drugs Agencies (NADA)

Gael Rao, General Manager, Drug and Alcohol Service, Nepean Blue Mountains Local Health District

Dr Grant Sara, Psychiatrist, Director of InforMH, NSW Health

Mary Wahhab, Clinical Nurse Educator, South Western Sydney Local Health District

Dr Hester Wilson, Chair of the Specific Interests Addiction Medicine Network, Royal Australian College of General Practitioners

Decriminalisation Roundtable

Professor Geoffrey Gallop AC, Commissioner, Global Commission on Drug Policy (former Premier of Western Australia)

Dr Caitlin Hughes, Associate Professor in Criminology and Drug Policy; Senior Research Fellow at the National Drug and Alcohol Research Centre; Matthew Flinders Fellow, Centre for Crime Policy and Research, Flinders University

Cr Edwina Lloyd, Chair, Lismore City Council Social Justice and Crime Prevention Committee; Trial Advocate for the Aboriginal Legal Service

Annie Madden AO, founding member, Harm Reduction Australia (formerly Chief Executive Officer of the Australian Injecting & Illicit Drug Users League)

Stephen Odgers SC, Co-Chair, Criminal Law Committee of the New South Wales Bar Association

Professor Alison Ritter, Director, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney

Andrew Scipione AO APM, Former Commissioner of NSW Police Force

Professor Kate Seear, Associate Professor in Law, Monash University; Adjunct Research Fellow, National Drug Research Institute

Dr Donald Weatherburn PSM, Adjunct Professor, University of Sydney Law School (formerly Director, NSW Bureau of Crime Statistics and Research)

Dr Alex Wodak AM, President, Australian Drug Law Reform Foundation

Youth Diversionary Programs Roundtable

Katie Acheson, Chief Executive Officer, Youth Action NSW

Belinda Edwards, Director Statewide Services, Department of Communities and Justice

Ron Frankham, Solicitor in Charge, Children's Legal Service, Legal Aid NSW

Andrew Johnson, Advocate, Office of the NSW Advocate for Children and Young People

His Honour Judge Peter Johnstone, President of the Children's Court of New South Wales

Jacki Maxton, Senior Solicitor, The Shopfront Youth Legal Centre

Nada Nasser, State Director NSW/ACT/VIC, Mission Australia

Anthony Shannon, Director, Inclusion and Early Intervention, Department of Communities and Justice

Paul Simpkins, Acting Superintendent, Youth and Crime Prevention Command, NSW Police Force

Carol Thomas, Area Manager, South Coast and Tablelands, Juvenile Justice, Department of Communities and Justice

Karly Warner, Chief Executive Officer, Aboriginal Legal Service NSW/ACT

Appendix 13: Private Roundtables

1 April 2019	Youth Roundtable
4 April 2019	Western Sydney Roundtable (Aboriginal community)
30 April 2019	Wagga Wagga Roundtable (Aboriginal community)
13 May 2019	Lismore Roundtable (Aboriginal community)
29 May 2019	Nowra Roundtable (Aboriginal community)
3 June 2019	Dubbo Roundtable (Aboriginal community)
21 June 2019	Maitland Roundtable (Aboriginal community)
27 June 2019	Toomelah Roundtable (Aboriginal community)
15 July 2019	Broken Hill Roundtable (Aboriginal community)
10 September 2019	Education Roundtable (NSW Department of Education)
12 September 2019	Education Roundtable (The Association of Independent Schools of NSW)
16 September 2019	Planning and Funding of Treatment Services
20 September 2019	Education Roundtable (Sydney Catholic Schools)

Appendix 14: Public Hearings and witnesses

Hearings

28 March 2019	Directions hearing and opening address
7 to 10 May 2019	Sydney (General)
14 to 15 May 2019	Lismore
30 to 31 May 2019	Nowra
4 to 6 June 2019	Dubbo
18 to 20 June 2019	East Maitland
16 to 18 July 2019	Broken Hill
15 to 16 August, 30 September 2019	Moree
2 to 5 and 26 September, 9 October 2019	Custodial Services and Community Corrections
23 to 25 September 2019	Harm Reduction
30 September to 1 October 2019	Diversionary Programs

Sydney (General) Hearing, 7 to 10 May 2019, Sydney

Day 1

Professor Michael Farrell, Director, National Drug and Alcohol Research Centre

Dr Jackie Fitzgerald, Acting Executive Director, NSW Bureau of Crime Statistics and Research

Dr Sarah Thackway, Executive Director, Centre for Epidemiology and Evidence, NSW Ministry of Health

Dr Michelle Cretikos, Director, Clinical Quality and Safety Centre for Population Health, NSW Ministry of Health

Detective Acting Superintendent Michael Cook, Acting Commander, Drug and Firearms Squad, NSW Police Force

Day 2

Professor Helen Milroy, Professor of Child Psychiatry, University of Western Australia;
Commissioner with the National Mental Health Commission

Nicolas Parkhill, Chief Executive Officer, ACON

Karen Price, Deputy Chief Executive Officer, ACON

Dr Mary Harrod, Chief Executive Officer, NSW Users and AIDS Association

Sahra Hawkins, lived experience witness

Shannon Speechley, lived experience witness

Nicola Tillier, lived experience witness

Witnesses with lived experience

Day 3

Dr Jonathan Brett, Staff Specialist in Clinical Pharmacology, Toxicology and Addiction
Medicine, St Vincent's Hospital, Sydney

Angus Skinner, NSW Police Association

Elaine Thomson, Director of Practice of Quality Control and Clinical Support, Office of the
Senior Practitioner, NSW Department of Family and Community Services

Azure Green, Manager Client Services, St Marys, NSW Department of Family and
Community Services

Day 4

Gerard Byrne, State Manager, Alcohol and Other Drug Services (NSW/ACT/QLD), The
Salvation Army

Garth Popple, Executive Director, We Help Ourselves

Jennifer Frendin, Program Manager, Community Services, Odyssey House

Mark Ferry, Chief Operating Officer, Ted Noffs Foundation

Matt Noffs, Chief Executive Officer, Ted Noffs Foundation

Melinda Bonham, Team Leader, Marrin Weejali Aboriginal Corporation

Mary Baulch, Chief Executive Officer, Domestic Violence NSW

Lismore Regional Hearing, 14 to 15 May 2019, Lismore

Day 1

Superintendent Toby Lindsay, Commander, Richmond Police District, NSW Police Force

Edwina Lloyd, Councillor, Lismore City Council; Trial Advocate, Aboriginal Legal Service
(Northern Region)

Dr Robert Davies, Emergency Director, The Tweed Hospital

Dr Edward Wims, Clinical Director, Mental Health, Richmond Clarence

Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol
Service

Dr Bronwyn Hudson, General Practitioner, Registrar Visiting Medical Officer, Emergency
Senior Medical Officer, Byron Central Hospital

Day 2

Dr David Helliwell, Clinical Lead, Alcohol and Other Drugs, Riverlands Drug and Alcohol Service

Dr Bronwyn Hudson, General Practitioner, Registrar Visiting Medical Officer, Emergency Senior Medical Officer, Byron Central Hospital

Deidre Robinson, General Manager Northern NSW Local Health District, Mental Health and Drug and Alcohol Services

Paul Millard, Paramedic, NSW Ambulance

Michael Tizard, Regional Manager, Northern Rivers ACON

Derek Tys, Substance Support Counsellor, Northern Rivers ACON

Judith Townsend, Manager Practice Support, NSW Department of Family and Community Services

Leone Crayden, Chief Executive Officer, The Buttery

Robert Lendrum, Senior Manager, MERIT, Northern NSW Local Health District

Nowra Regional Hearing, 30 to 31 May 2019, Nowra

Day 1

Acting Superintendent Kevin McNeil, Acting Commander, South Coast Police District, NSW Police Force

Matthew Sterling, Paramedic, NSW Ambulance

Dr Simon Tucker, Interim Clinical Director, Department of Medicine, Shoalhaven District Memorial Hospital

Wade Norrie, Director of Nursing, Mental Health, Illawarra Shoalhaven Local Health District

Dr Adam Bryant, Acting Director Mental Health, Illawarra Shoalhaven Local Health District

James Pepper, Manager, Specialist Programs, Illawarra Drug and Alcohol Service

Dr Frank Cordaro, GP Staff Specialist (AOD), Illawarra Shoalhaven Local Health District

David Reid, Director Drug and Alcohol Service, Illawarra Shoalhaven Local Health District

Ruth Power, Nurse Manager, Shoalhaven Drug and Alcohol Service

Day 2

Amanda Jamieson, Manager Client Services, NSW Department of Family and Community Services, Nowra

Carol Thomas, Area Manager, South Coast and Tablelands, Juvenile Justice

Dean Straughan, Networked Specialist Facilitator, NSW Department of Education

Graeme Sutherland, Director, Educational Leadership, NSW Department of Education

Shirley Diskon, Manager, Hope House

Alex Pontello, Chief Executive Officer, Southern Cross Housing

Gabriella Holmes, Program Manager, Triple Care Farm, Mission Australia

Patricia Forbes, ROSA Co-ordinated Care, Shoalhaven Women's Resource Group, Nowra

Dubbo Regional Hearing, 4 to 6 June 2019, Dubbo

Day 1

Isaac Graham, Paramedic, NSW Ambulance

Dr Ian Spencer, General Practitioner and Visiting Medical Officer, Wellington Hospital

Christopher Waters, Clinical Nurse Consultant, Emergency Department, Dubbo Base Hospital

Dr Scott Clark, Clinical Director Mental Health and Drug and Alcohol Services, Western NSW Local Health District

Sarah Hopkins, Managing Solicitor of Justice Projects, Aboriginal Legal Service (NSW/ACT) Ltd; Chair, Just Reinvest NSW

Alistair Ferguson, Founder and Executive Director, Just Reinvest NSW

Day 2

Rhiannon McMillan, Alcohol and Other Drugs Clinical Nurse Consultant

Superintendent Peter McKenna, Commander, Orana Mid-Western Police District, NSW Police Force

Craig Biles, Area Manager, Central West, Western Region, Juvenile Justice

Cindy Wilson, Nursing Unit Manager, Orana, Justice Health and Forensic Mental Health Network

Jenny Taylor, Team Leader, MERIT

Jason Crisp, Director, Integrated Mental Health, Drug and Alcohol Services, Western NSW Local Health District

Day 3

Teena Bonham, Principal Project Officer, Estate Management Unit, NSW Department of Family and Community Services

Bianca Smith-Bates, Networked Specialist Facilitator, NSW Department of Education

Madeleine Baker, Clinical Services Coordinator, Mac River Adolescent Drug and Alcohol Rehabilitation Centre

Norm Henderson, Senior Drug and Alcohol Worker, Weigelli Centre Aboriginal Corporation

Alan Bennett, Chief Executive Officer, Orana Haven Aboriginal Corporation

Michele Campbell, Group Manager, Clinical Services, Lives Lived Well

East Maitland Regional Hearing, 18 to 20 June 2019, East Maitland

Day 1

Anne-Marie Connelly, Manager Client Services, Hunter Adolescent Services, NSW Department of Family and Community Services

Deborah Beckwith, Networked Specialist Facilitator, NSW Department of Education

Tony Gadd, Director, Educational Leadership, NSW Department of Education

Susan Walton, District Manager, Community Corrections

David Lowe, Area Manager, Hunter New England Juvenile Justice

Day 2

Superintendent Craig Jackson, Commander, Port Stephens Hunter Police District, NSW Police Force

Dr Sujatha Venkatesh, Clinical Director, Psychiatric Emergency Service, Hunter New England Mater Mental Health

Margarett Terry, Mental Health and Substance Use Service Director, Senior Clinical Psychologist

Dr Marcia Fogarty, Executive Director of Mental Health, Hunter New England Local Health District

Dr Nick Ryan, Director, Emergency Department, Tamworth Rural Referral Hospital

Dr Craig Sadler, Senior Staff Specialist Addiction Medicine; Director Alcohol and Drug Unit, Calvary Mater Newcastle Hospital; Clinical Director, Withdrawal Services, Hunter New England Local Health District

William Robertson, Health Services Manager, Southern Psychosocial Unit, Hunter New England Local Health District

Day 3

Dr Krista Monkhouse, Paediatric Staff Specialist, Youth Drug and Alcohol Clinical Services, Hunter New England Local Health District

Gail Hartley, Clinical Nurse Consultant, Substance Use in Pregnancy and Parenting Service, Central Coast Local Health District

Catherine Hewett, Chief Executive Officer, Kamira Alcohol and Other Drug Treatment Services

Brydie Jameson, Senior Project Officer, Everymind

Jacqueline Hornery, Brighter Futures Program Coordinator, Samaritans

Broken Hill Regional Hearing, 16 to 18 July 2019, Broken Hill

Day 1

Andrew House, lived experience witness

Terina King, Transition Worker, Community Restorative Centre, Broken Hill

Ian Harvey, Team Leader, Transitional Program, Community Restorative Centre, Broken Hill

Superintendent Paul Smith, Commander, Barrier Police District, NSW Police Force

Leigh Sutcliffe, District Manager, Community Corrections, Broken Hill

Day 2

Dr Andrew Olesnicky, Medical Director, Emergency Department, Broken Hill Hospital

Dr Peter Vaux, Clinical Director, Community Mental Health Team, Broken Hill Hospital

Joanne Lenton, Clinical Nurse Consultant, Broken Hill Health Service

Melissa McInnes, Drug and Alcohol Clinical Nurse Consultant

Jodie Miller, Acting Director, Mental Health Drug and Alcohol Service, Far West Local Health District

Day 3

Michelle Kelly, Manager Client Services, NSW Department of Family and Community Services

Dr Debra Jones, Director, Primary Health Care, Broken Hill University Department of Rural Health

Julie Roberts, Nurse Manager, School-Based Nurse Program 'Embedding Health'

Denise Hampton, Aboriginal Community Development and Health Education Officer, Broken Hill University Department of Rural Health

Corina Kemp, Clinical Leader, Aboriginal Mental Health Drug and Alcohol, Far West Local Health District

Vanessa Latham, Mental Health Manager, Royal Flying Doctor Service

Moree Regional Hearing, 15 to 16 August 2019 (Moree), 30 September 2019 (Sydney)

Day 1

Binnie Carter, Casework Manager, Child Protection/Triage, Moree Community Service Centre, Department of Communities and Justice

Bernadette Terry, Assistant Manager, Moree Youth Justice, NSW Department of Communities and Justice

David Kelly, Manager, Community Health Programs, Maayu Mali Residential Rehabilitation Centre

Day 2

Cigdem Watson, Executive Manager, Personal Helpers and Mentors Program and Youth Drug and Alcohol Services, Centacare

Day 3

Superintendent Scott Tanner, Commander, New England Police District, NSW Police Force

Custodial Services and Community Corrections Hearing, 2 to 5 September, 26 September, 9 October 2019, Sydney

Day 1

Opening address of Senior Counsel Assisting

Day 2

Gary Forrest, Chief Executive, Justice Health and Forensic Mental Health Network

Dr Jillian Roberts, Clinical Director, Drug and Alcohol, Justice Health and Forensic Mental Health Network

Dr Yolisha Singh, Child, Adolescent and Forensic Psychiatrist, Justice Health and Forensic Mental Health Network

Day 3

PG, lived experience witness

Dr Anne Marie Martin, Assistant Commissioner, Offender Services and Programs, Corrective Services NSW

Nicole Jess, Chairperson, Prison Officers Vocational Branch

Dr Sarah Gray, National Director, Rehabilitation and Reintegration, The GEO Group Australia

Day 4

Dr Anne Marie Martin, Assistant Commissioner, Offender Services and Programs, Corrective Services NSW

Day 5

Jeremy Tucker, Director, Corrections Strategy and Executive Services, Corrective Services NSW

Scott Brideoake, General Manager, Junee Correctional Centre, The GEO Group Australia

Jason Hainsworth, Director, Strategy, Community Corrections, Corrective Services NSW

Linda Smith, Director, Compulsory Drug Treatment Correctional Centre, Corrective Services NSW

Day 6

Mike Wheaton, Director, Policy and Practice, Youth Justice NSW

Dr Mindy Sotiri, Program Director, Advocacy, Policy and Research, Community Restorative Centre

Harm Reduction Hearing, 23 to 25 September 2019, Sydney

Day 1

Professor Alison Ritter, Director, Drug Policy Modelling Program, Social Policy Research Centre, UNSW Sydney

Associate Professor Rebecca McKetin, National Drug and Alcohol Research Centre, UNSW Sydney

Gino Vumbaca, President and Co-Founder, Harm Reduction Australia; Convenor of Pill Testing Australia

Dr David Caldicott, Emergency Consultant, Calvary Hospital Emergency Department, Canberra; Clinical Lead, Pill Testing Australia

Dr Marianne Jauncey, Medical Director, Uniting Medically Supervised Injecting Centre

Day 2

Dagmar Hedrich, Lead Scientist – Harm Reduction, Public Health Unit, European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)*

Alessandro Pirona, Principal Scientific Analyst, EMCDDA*

Dr Nadine Ezard, Director, National Centre for Clinical Research on Emerging Drugs; Clinical Director, Alcohol and Drug Service, St Vincent's Hospital, Sydney

Dr Mary Harrod, Chief Executive Officer, NSW Users and AIDS Association

Daan van de Gouwe, Trimbos Instituut, Drug Monitoring & Policy, Drugs Information and Monitoring System (DIMS), the Netherlands*

Dr John Lewis, Consultant Toxicologist, Member of the International Association of Forensic Toxicologists and Chairman of Standards Australia Committee CH-036

Dr Phillip Read, Director, Kirketon Road Centre, NSW Ministry of Health

Day 3

Cedric Charvet, Drug Consumption Room Coordinator, De Regenboog Groep, Amsterdam*

Stacey Bourque, Executive Director, ARCHES Lethbridge, Alberta, Canada*

Dr Thomas Kerr, Associate Director and Director of Research, British Columbia Centre on Substance Use, Vancouver, Canada*

Dr Kerry Chant, Chief Health Officer and Deputy Secretary Population and Public Health, NSW Ministry of Health

Russell Maynard, Community Engagement Lead, Portland Hotel Society, Vancouver, Canada*

Diversionary Programs Hearing, 30 September to 1 October 2019, Sydney

Day 1

Dr Caitlin Hughes, Associate Professor of Criminology and Drug Policy; Matthew Flinders Fellow, Centre for Crime Policy and Research, Flinders University

Magistrate Gregory Levine, Magistrates' Court of Victoria

Matthew Wilson, Statewide Program Manager, Family Drug Treatment Court, Victoria

Day 2

Detective Acting Superintendent Michael Cook, Acting Commander, Drug and Firearms Squad, NSW Police Force

Alexandra Young, Manager, Major Reforms, Community Corrections, Corrective Services NSW

Steven Childs, Psychologist and Manager, Drug and Alcohol Service and HIV and Related Programs, Central Coast Local Health District

Jared Sharp, Churchill Fellow

Magistrate Sue Duncombe, Children's Court of New South Wales and Youth Koori Court

* Evidence provided by pre-recorded video presentation

Appendix 15: List of people who provided statements but were not called as witnesses

Sydney (General) Hearing, 7 to 10 May 2019, Sydney

Larry Pierce, Chief Executive Officer, Network of Alcohol and other Drugs Agencies
Dr Beth Kotze, Executive Director Mental Health, Western Sydney Local Health District
Margaret Murphy, Clinical Nurse Consultant, Westmead Hospital
Nick Miles, Clinical Nurse Practitioner, Northern Sydney Local Health District
Dr Anthony Gill, Chief Addiction Specialist, NSW Ministry of Health
Dr Kerry Chant PSM, Chief Health Officer and Deputy Secretary, Population and Public Health
Dr James Edwards, Acting Director, Emergency Department, Royal Prince Alfred Hospital
Associate Professor Richard Cracknell, Director of Emergency Medicine, Campbelltown and Camden Hospitals
Jordan Emery, Zone Manager, Western Sydney and Nepean Blue Mountains Sector, NSW Ambulance
Dr Viktoria Sundakov, Psychiatrist, Director of Psychiatry, Royal Prince Alfred Hospital
Superintendent Wayne Benson, Commander, Campbelltown City Police Area Command, NSW Police Force
Superintendent Trent King, Commander, Blacktown Police Area Command, NSW Police Force
Acting Superintendent John Maricic, Crime Manager, Sydney City Police Area Command, NSW Police Force

Lismore Regional Hearing, 14 to 15 May 2019, Lismore

William Bon, Field Officer, Aboriginal Legal Service ACT/NSW
Mitch Dobbie, Service Manager, Tweed Ballina Drug and Alcohol Service
Rodney Chenhall, Community Corrections Director, North West District, Corrective Services NSW
Jodie Scott, Area Manager, Far North Coast, Juvenile Justice
Frank Potter, Executive Director, School Performance, NSW Department of Education
Trish Kokany, Networked Specialist Facilitator, NSW Department of Education

Nowra Regional Hearing, 30 to 31 May 2019, Nowra

Dr William Pratt, Physician, Shoalhaven District Memorial Hospital
Katherine Ruperto, District Emergency Nurse Educator, Illawarra Shoalhaven Local Health District
Mark McLean, Clinical Nurse Consultant (AOD), Illawarra Shoalhaven Local Health District
William Craig Flanagan, Community Corrections Director, West District, Corrective Services NSW

Cathy Bland, Community Corrections Manager, Nowra Community Corrections, Corrective Services NSW

Craig Smith, Governor, Metropolitan Reception and Remand Centre, Silverwater Correctional Complex, Corrective Services NSW

Mark Buckingham, Chief Executive Officer, Kedesh Rehabilitation Services

Will Temple, Chief Executive Officer, Watershed Drug and Alcohol Rehabilitation and Education Services

Dubbo Regional Hearing, 4 to 6 June 2019, Dubbo

Lucy Rolek, Registered Nurse, Team Leader Acute and Continuing Care Team, Community Mental Health Team, Dubbo and North, North-West Region

Andrew Walden, Needle and Syringe Program Coordinator, Western NSW Local Health District Northern Sector

Margaret Crowley, Nurse Unit Manager, Dubbo Sexual Health Service, Western NSW Local Health District Northern Sector

Andrew Harvey, Chief Executive Officer, Western Health Alliance Limited

Melinda Wit, Community Corrections District Manager, Dubbo Office, Corrective Services NSW

Lyndon Davis, Program Coordinator, Local Coordinated Multiagency Program, Community Corrections, Dubbo

Fiona McLean, Senior Project Officer, Local Coordinated Multiagency Program, Community Corrections, Dubbo

Adelia Fuller, Director, Educational Leadership, NSW Department of Education

Luke Butcher, Area Manager, Western NSW and Special Projects, Mission Australia

Steven Morris, Founder, Brothers4Recovery; Peer Workforce Manager, Bloomfield Hospital

East Maitland Regional Hearing, 18 to 20 June 2019, East Maitland

Dr Arvind Kendurkar, Senior Staff Specialist, Drug and Alcohol Clinical Services, Hunter New England Local Health District

Thomas McPherson, Paramedic, Hunter New England Sector, NSW Ambulance

Melinda Benson, Clinical Coordinator, Youth Drug and Alcohol Clinical Services, Hunter New England Local Health District

Karen Ingram, Inspector, Personal Development, Health and Physical Education, NSW Education Standards Authority

Sara Bartlett, Project Lead, Mindframe Project, Everymind

Tracy Jackson, Community Services Manager, Samaritans

Joe Coyte, Chief Executive Officer, The Glen Drug and Alcohol Rehabilitation Centre

Helen Fielder-Gill, Unit Service Manager, Alcohol and Drugs, Samaritans

Broken Hill Regional Hearing, 16 to 18 July 2019, Broken Hill

Keira Boxsell, Nurse Consultant Recovery Coordinator, Far West Local Health District

Vanessa Smith, Manager, Mental Health Drug and Alcohol Service, Broken Hill
Tracy Munro, Mental Health Nurse, Broken Hill Hospital
Susan Thomas, Nursing Unit Manager, Broken Hill Hospital Emergency Department
Jamie Peetz, Paramedic, NSW Ambulance, Broken Hill
Amanda Gasmier, Nurse Unit Manager, Broken Hill and Ivanhoe Health Centres, Justice Health and Forensic Mental Health Network
Dr Steven Grillett, General Practitioner, Maari Ma Health
Professor Alan Rosen, Clinical Psychiatrist, Academic Psychiatrist
Greg Edwards, Area Manager, Far West, Juvenile Justice
Lynette McLachlan, Acting Manager, Client Services, NSW Department of Families and Community Services, Broken Hill Office
Robert Dyson, Networked Specialist Facilitator, NSW Department of Education, Broken Hill
Peter Macbeth, Director Educational Leadership, NSW Department of Education
Jenna Bottrell, Program Manager, Mission Australia
Anne Te Kawa, Alcohol and Other Drug Clinician, Royal Flying Doctor Service, South Eastern Section
Andrew House, Alcohol and Other Drug Clinician, Royal Flying Doctor Service, South Eastern Section
Rachel Storey, Solicitor and President of the Far West Law Society

Moree Regional Hearing, 15 to 16 August, Moree

Roslyn Laws, Chair, Moree Community Drug Action Team and Local Drug Action Team

Custodial Services and Community Corrections Hearing, 2 to 5 September, 26 September, 9 October 2019, Sydney

Cindy Moore, Regional Support Manager, Corrective Services NSW
Sandra King, Co-Existing Disorder Project Coordinator, Corrective Services NSW
Maureen Wilson, Co-Existing Disorder Project Coordinator, Corrective Services NSW
Kevin Corcoran PSM, Assistant Commissioner, Custodial Corrections, Corrective Services NSW
Carlo Scasserra, Assistant Commissioner, Governance and Continuous Improvement, Corrective Services NSW
Melanie Hawyes, Executive Director, Youth Justice NSW
Lacretia Campbell, Unit Manager, Youth Justice NSW
Jamie Duggan, Custodial Caseworker, Youth Justice NSW
Jennifer Galousiz, Director, Corrections Research, Evaluation and Statistics, Corrective Services NSW
Kathie Gowan, Alcohol and Other Drug Counsellor, Youth Justice NSW
Gino Di Candilo, Industrial Officer/Regional Organiser, Public Service Association of NSW
Fiona Rafter, Inspector of Custodial Services, NSW

Kerry Cassells, Clinical Nurse Specialist, Justice Health and Forensic Mental Health Network

Richard Laws, General Manager, The GEO Group Australia

Paul Baker, Governor, Parklea Correctional Centre

John Eyre, Chief Executive Officer, arbias

Teegan Tomkins, Aboriginal Family Liaison Officer, Junaa Buwa! Centre for Youth Wellbeing, Mission Australia

Professor Basil Donovan, Program Head, Sexual Health Program, The Kirby Institute

David Johnstone, Alcohol and Other Drugs Caseworker, Wandiyali, Newcastle

Harm Reduction Hearing, 23 to 25 September 2019, Sydney

Dr Ingrid van Beek AM, Conjoint Professor, Viral Hepatitis Epidemiology and Prevention Program, The Kirby Institute; founding Medical Director, Medically Supervised Injecting Centre

Dr Kean-Seng Lim, President, Australian Medical Association (NSW)

Dr David Martyn Lloyd-Jones, President, Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians

Dr Chris Trethewy, Chair of NSW Faculty of the Australasian College for Emergency Medicine

Diversionary Programs Hearing, 30 September to 1 October 2019, Sydney

Jackie Fitzgerald, Acting Executive Director, NSW of Bureau of Crime Statistics and Research

Appendix 16: Consideration of drug-related recommendations made in NSW inquests

The Inquiry's Letters Patent require it to consider 'any drug-related recommendations from any NSW inquest held during the course of the Inquiry'.

Recommendations related to drugs were made in five NSW inquests held between 28 November 2018 and 28 January 2020. These inquests were:

1. Inquest into the death of DB, JD, DC, RG, AH and AB
2. Inquest into the death of Rebecca Maher
3. Inquest into the death of Ossama Al Refaay
4. NSW Coronial Inquest into Music Festival Deaths
5. Inquest into the death of Amaru Bestrin

Inquest into the death of DB, JD, DC, RG, AH and AB

Hearing dates: 7 to 10 May, 31 October to 1 November, 26 November 2018 before Deputy State Coroner Grahame

Date of findings: 1 March 2019

Overview: The inquest examined the deaths of six people following accidental opiate overdoses.

Recommendation	Consideration
To the Department of Premier and Cabinet	
1. That the Department of Premier and Cabinet facilitate and host a NSW Drug Summit, bringing together experts in the field of health, drug addiction and drug law reform, with members of State Parliament, law enforcement, sociologists, researchers, parents, current and former drug users, family support groups and community leaders, to develop drug policy, that is evidence and human rights based, and focused on minimising harm to users, their families, and the community.	<p>This Inquiry has consulted extensively with stakeholders, including experts in the field of health, drug addiction and drug law reform, law enforcement, current and former drug users, family support groups and community leaders.</p> <p>The recommendations of this Inquiry provide a detailed strategy by which the NSW Government can immediately respond to drug use and the harms it causes, including the development of a whole-of-government AOD policy. This is discussed in detail in Chapter 10.</p>

<p>2. The ambit of the Drug Summit should be wide and should give full and genuine consideration to:</p> <ul style="list-style-type: none"> a) Ways of reducing deaths by drug overdose in NSW b) The best evidence from countries outside Australia as to what works to minimise the risk of deaths by drug overdose c) Decriminalising personal use of drugs, as a mechanism to reduce the harm caused by drug use d) Ways of improving and expanding treatment for drug users e) Reducing the stigma and shame currently associated with drug use f) The availability of alternative non-pharmaceutical pain management options, including, for example, physiotherapy, hydrotherapy, and counselling. g) The availability of support mechanisms for family and friends of drug users 	<p>As above</p>
<p>3. That, following from the Drug Summit, a new 'Plan of Action' be developed with a comprehensive 'whole of government' and 'whole of community' approach to the management of illicit drug use and the care of users and their families.</p>	<p>Evidence considered by the Inquiry demonstrates the need for the implementation of a whole-of-government policy and Drug Action Plan. This is discussed in detail in Chapter 10. The Inquiry makes recommendations consistent with this recommendation.</p>

To NSW Health	
4. Noting that on 2 October 2018, the Therapeutic Goods Association registered naloxone 1.8mg nasal spray as an antidote to opioid overdose, and that stock is anticipated to be available from early 2019, NSW Health should support the immediate distribution of the nasal spray to: a. NSW Ambulance officers and paramedics for use in the treatment of those suffering an overdose b. NSW Police force members for use in the treatment of those suffering an overdose 42 c. General practitioners working in areas where there is a high prevalence of overdose, for the free supply to those at risk. d. Emergency Departments, for the distribution to drug users suspected of having an overdose, and to their families and friends.	This recommendation falls outside of the Inquiry's Terms of Reference.
5. That NSW Ambulance officers be trained to leave naloxone at the scene of a suspected overdose.	This recommendation falls outside of the Inquiry's Terms of Reference.
6. That Triple 0 operators receive training on how and when to advise callers about the administration of naloxone to callers themselves or to an individual they are with who is suspected of having an overdose.	This recommendation falls outside of the Inquiry's Terms of Reference.
7. That further support be given to the expansion of the ORTHN (Overdose Response and Take Home Naloxone) project, providing for the distribution of naloxone, and training, to members of the community most likely to come into contact with those at risk of an opiate overdose, in particular that efforts be made to expand the trial to rural areas.	This recommendation falls outside of the Inquiry's Terms of Reference.
8. That consideration be given to increasing funding to organisations like NUAA (NSW Drug Users Association), for harm reduction outreach in rural areas, and within specific communities of interest (e.g exiting prison populations, brothels) to distribute naloxone free to users.	This recommendation falls outside of the Inquiry's Terms of Reference.

<p>9. That attention is given to the introduction of Real Time Prescribing (RTP) in NSW, which includes private scripts as well as drugs provided pursuant to the Pharmaceutical Benefits Scheme (PBS). In this respect, a critical review of operation of the RTP scheme currently in operation in Tasmania may be instructive.</p>	<p>This recommendation falls outside of the Inquiry's Terms of Reference.</p>
<p>10. That urgent attention is given to improving the affordability of drugs substitution programs (methadone and Buprenorphine) for all drug addicted persons wanting to access them. This should include covering the dispensing fee and other associated costs.</p>	<p>This recommendation falls outside of the Inquiry's Terms of Reference.</p>
<p>11. That consideration be given to the availability of alternative drug substitution programs for a small group of persons who have not been suited to traditional programs, including low dose mobile methadone, long acting Buprenorphine and pharmaceutical heroin substitution for a minority who are severely dependent and treatment resistant.</p>	<p>This recommendation falls outside of the Inquiry's Terms of Reference.</p>
<p>12. That consideration be given to additional venues for the medically supervised injection of opiates, including the smaller consumption room model and/or additional medically supervised injection rooms (MSIR), in areas where there are many drug overdoses and where the community supports the establishment of MSIR.</p>	<p>The evidence considered by the Inquiry has demonstrated the need for a similar recommendation. The amendment of existing legislation to allow for the provision of additional service licences for drug consumption rooms based on local need is discussed in Chapter 15.</p>
<p>13. That support be given for a program of opiate monitoring to be available at venues, including the Medically Supervised Injection Centre (MSIC) and the NUAA. This will provide data for planning, implementation and evaluation of public health practise.</p>	<p>The evidence received by the Inquiry suggests that there is a need for better monitoring and data collection concerning use and harms of ATS and other drugs and recommendations have been made accordingly. Monitoring and data collection are discussed in Chapters 7, 14, 20, 21</p>
<p>14. That funding be allocated to Family Drug Support Australia and/or any similar support groups, to increase the number and availability of support services for the family and friends of drug users in NSW.</p>	<p>Evidence considered by the Inquiry has demonstrated that there is a need for the expansion of support for family and friends of people affected by drug use and recommendations have been made accordingly. The need for support for family and friends is discussed in Chapters 9, 14 and 18.</p>

15. That, following a study of unmet need for drug treatment facilities in NSW, resources be committed to increasing the number and type of facilities available to assist drug users to address health and related concerns.	The Inquiry has received substantial evidence demonstrating the unmet demand for drug treatment services and recommendations have been made accordingly. This issue is discussed throughout this report.
16. That support be provided to increase the availability and accessibility of non pharmaceutical pain management strategies, including hydrotherapy, counselling, physiotherapy and mindfulness training. Further research should also be undertaken into the use of medicinal cannabis in chronic non-cancer pain as an overdose prevention strategy.	This recommendation falls outside of the Inquiry's Terms of Reference.
17. That consideration be given to developing and piloting a system of plain speaking discharge summaries for all persons admitted for a condition related to problematic drug consumption, which contains reference to support hotlines, their next appointment and harm reduction measures.	Measures to ensure effective linkages between treatment responses, including the promotion and availability of support hotlines, assertive follow up and communication between treatment providers are discussed in Chapter 14.
To the NSW Police	
18. That consideration be given to providing NSW Police officers with naloxone nasal spray for use in the treatment of those suffering an overdose.	This recommendation falls outside of the Inquiry's Terms of Reference.
19. That consideration be given to providing NSW Police with training on the use of naloxone, particularly nasal spray naloxone as it becomes available in 2019.	This recommendation falls outside of the Inquiry's Terms of Reference.
20. That consideration be given to training NSW Police to leave naloxone at the scene of a suspected overdose.	This recommendation falls outside of the Inquiry's Terms of Reference.
21. That consideration be given to how best to collect and consider data on the involvement of opiates, particularly Fentanyl, in the overdose deaths of NSW citizens.	This recommendation falls outside of the Inquiry's Terms of Reference.

To the NSW Department of Justice – Office of the Attorney General	
<p>22. That the legislation governing the supply of prescription drugs be amended so that:</p> <ul style="list-style-type: none"> a) Family and friends of drug users can obtain a supply of naloxone from their General Practitioner on prescription. b) persons cannot be penalised for providing naloxone to a person suspected of having an overdose (the so called ‘good Samaritan laws’). 	<p>This recommendation falls outside of the Inquiry’s Terms of Reference.</p>
<p>23. That the Act and Regulations governing authority to prescribe drugs of addiction be reviewed for the purpose of:</p> <ul style="list-style-type: none"> a) simplifying the wording of the legislation to make it more easily understood by doctors and pharmacists b) considering whether Fentanyl should be reclassified, for the purpose of <i>the Poisons and Therapeutic Goods Act</i> and the <i>Therapeutic Goods Regulation</i>, so that it is subject to stricter regulation before it can be supplied. 	<p>This recommendation falls outside of the Inquiry’s Terms of Reference.</p>

To the Royal Australian College of General Practitioners and NSW/ACT State Faculty of Royal Australian College of General Practitioners	
<p>24. That consideration be given by the Royal Australian College of General Practitioners and NSW/ACT State Faculty of the Royal Australian College of General Practitioners to the design and delivery of a combination of training methods for General Practitioners about:</p> <ul style="list-style-type: none"> a) how to care for vulnerable drugs users b) The risk assessment to be done before prescribing pain killers c) The use of alternatives to prescription pain killers d) The interpretation and implementation of opioid and benzodiazepine Prescribing Guidelines developed by the College - including summary documents to guide busy practitioners 	<p>The Inquiry has considered the role of GPs in the provision of care in response to the use of ATS. The Inquiry has also identified that GPs may need additional training and support in relation to managing patients with substance use or dependence and made recommendations accordingly. The role of GPs is discussed in Chapter 14.</p>
<p>25. That consideration be given to mandating training in the RACGP in this area so that General Practitioners are required to complete the training as part of the Continuing Professional Development (CPD) triennium cycle.</p>	<p>As above.</p>
To the Pharmacy Guild of Australia	
<p>26. That The Pharmacy Guild of Australia consider what educational activities could be developed for pharmacists on naloxone, its safe use, importance of stocking in community pharmacies, and the availability of nasal spray naloxone from early 2019.</p>	<p>This recommendation falls outside of the Inquiry's Terms of Reference.</p>

Inquest into the death of Rebecca Maher

Hearing dates: 4 to 15 March before Acting State Coroner O'Sullivan (as she then was)

Date of findings: 5 July 2019

Overview: Rebecca Maher died on 19 July 2016 in a cell at Maitland police station in NSW. Ms Maher's death occurred accidentally while she was detained by officers of the NSW Police Force as an intoxicated person, medical attention not having been sought on her behalf. The medical cause of death was respiratory depression after loss of consciousness caused by mixed drug toxicity (involving alprazolam, methadone and other substances, but not ATS) and possibly aspiration of vomit.

Recommendation	Consideration
To the NSW Police Force	
<p>2. That the NSWPF consider improvements to its education and training of police officers as to circumstances which call for persons detained as intoxicated to be searched, in particular circumstances where the person may be intoxicated with prescription drugs and might have such drugs on them when detained.</p>	<p>The evidence considered by the Inquiry supports the need for this recommendation. Data indicate there is a high proportion of people entering police custody intoxicated by alcohol or drugs.</p>
<p>3. That the NSWPF consider the implementation of a requirement that all police officers who perform duty as custody manager at police stations undertake the Safe Custody Course, which would include education and training as to:</p> <p>a. The duty in respect of a person detained under Part 16 of LEPR to make all reasonable efforts to identify and locate a "responsible person"; and</p> <p>60</p> <p>b. Content of the NSWPF poster entitled "Safe Custody: Medical Risks" including that, when managing a person detained as intoxicated, it is dangerous and inappropriate to take the approach that the person will or can "sleep it off".</p>	<p>The evidence considered by the Inquiry supports the need for this recommendation. Data indicate there is a high proportion of people entering police custody intoxicated by alcohol or drugs and who start withdrawing or detoxifying in custody. Withdrawal and detoxification involve serious health risks that should be the subject of education and training for custody managers.</p>

<p>4. That the NSWPF consider modification to the CMS to require the custody manager:</p> <ol style="list-style-type: none"> when making entries for inspections to record, where the detainee is intoxicated, (1) what occurred when the custody manager attempted to rouse the detainee, and (2) the custody manager's assessment of the detainee's level of consciousness; and to record the efforts they have made to identify and locate a "responsible person", including consulting previous CMRs. 	As above
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Inquest into the death of Ossama Al Refaay

Hearing dates: 14 to 16 October, 25 October 2019 before Deputy State Coroner Ryan

Date of findings: 25 October 2019

Overview: Mr Al Refaay was an inmate at Long Bay Hospital at Long Bay Correctional Centre. He died on or about 11 April 2016 as a result of acute methamphetamine toxicity after a balloon or balloons filled with methylamphetamine which he had swallowed burst or dissolved inside his abdomen.

Recommendation	Consideration
To Corrective Services NSW	
<p>1. In circumstances where there is evidence of an attempt by a visitor to smuggle contraband to an identifiable inmate, formalising the process of notification:</p> <ul style="list-style-type: none"> by requiring notice in writing to be provided to the relevant intelligence office of that attempt; and by requiring that an alert notification be placed on the inmate's Inmate Profile Document concerning the attempt. 	<p>The Inquiry has considered the prevalence of ATS use in prisons in NSW and notes the ready availability of drugs in custodial settings (see Chapter 20). The Inquiry has recommended that the NSW Government immediately commission an independent review of the supply and availability of drugs in correctional centres and the efficacy of efforts to interdict supply. The Coroner's recommendation should be considered as part of any such review.</p>

2. Increasing the period of time at Long Bay Hospital within which CCTV footage of the visiting area is retained, from 15 days to 30 days.	As above.
3. Trialling the use of a low dose body scanner for adult visitors visiting inmates at Long Bay Hospital, having due regard for any relevant statutory and privacy considerations.	As above.

NSW Coronial Inquest into Music Festival Deaths

Hearing dates: 18 to 19 July, 10 to 13 September, 19 to 20 September before Deputy State Coroner Grahame

Date of findings: 8 November 2019

Overview: This inquest examined the deaths of six young people who died during or just after attending music festivals in NSW during a 13-month period from December 2017 to January 2019. In each case, post mortem toxicology results showed that an amount of MDMA was found in their blood at a toxic level, and in one case, mixed drug toxicity (MDMA and cocaine) was recorded as the cause of death.

Recommendation	Consideration
A: To the NSW Department of Premier and Cabinet	
1. That the Department of Premier and Cabinet permits and facilitates Pill Testing Australia, the Loop Australia, or another similarly qualified organisation to run front of house medically supervised pill testing/drug checking at music festivals in NSW with a pilot date starting the summer of 2019–20.	In Chapter 15, the Inquiry sets out the evidence demonstrating the benefits of a clinically supervised substance testing service and recommends the introduction of a state-wide, fixed-site substance testing service and the trial of an on-site service at a music festival.
2. That the Department of Premier and Cabinet, working with NSW Health and NSW Police, fund the establishment of a permanent drug checking facility, similar to the Dutch model known as the Drug Information Monitoring System (DIMS).	As above.
3. That the Department of Premier and Cabinet, working with NSW Health, research and support the development of technology to allow for the most sophisticated and detailed drug analysis to be made available on site at music festivals.	As above.

4. That the Department of Premier and Cabinet, working with NSW Health, research and support the development of early warning systems at music festivals generally and arising from front of house and/or back of house drug checking.	The Inquiry has not made a specific recommendation consistent with this recommendation, but supports it as part of the recommendations that this Inquiry has made relating to substance testing.
5. That the Department of Premier and Cabinet, working with the NSW State Coroner, NSW Police, FASS and NSW Health, develop protocols for the open sharing of information between these agencies regarding drug trends and monitoring of drug deaths.	In Chapter 21 the Inquiry recommends that the NSW Government establish a process to facilitate the sharing of data between agencies to inform timely responses and better understanding of drug trends at a state and regional level. This recommendation is supported.
6. That the Department of Premier and Cabinet facilitate a regulatory roundtable with the involvement of relevant State and Local government and key industry stakeholders, including the Department of Health, private health providers such as EMS Event Medical, NSW Ambulance and NSW Police, the Australian Festivals Association, harm minimisation experts and promoters, to ensure appropriate minimum standards for policing, medical services and harm reduction are mandated at music festivals.	The Inquiry notes that the NSW Parliament passed the <i>Music Festivals Act 2019</i> (NSW) in November 2019, which requires the responsible Minister to establish a music festival roundtable with government and industry stakeholders to meet at least four times a year.
7. That in developing any new music festival regulations the Department of Premier and Cabinet, working with the Australian Festivals Association and other relevant stakeholders, give consideration to the submissions of the family of Joshua Tam (MFI-C).	The Inquiry does not express a view concerning this recommendation.
8. That the Department of Premier and Cabinet facilitate the holding of a NSW Drug Summit to develop drug policy that is evidence-based and focused on minimising harm to users and the community (previously recommended in the Opiates Inquest examining six deaths – findings delivered on 1 March 2019), the Department should give full and genuine consideration to, among other issues: a. The development of a best practice model of and guidelines for drug checking/pill testing including for front of house operations at music festivals and fixed site services operating in the community.	As above.

<ul style="list-style-type: none"> b. Targeted education programs, designed for different age groups, with a focus on harm minimisation with respect to stimulant drugs at music festivals. c. Decriminalising personal use of drugs, as a mechanism to reduce the harm caused by drug use. d. Expanded regulation of certain currently illicit drugs. e. Redefining illicit drugs as primarily a health and social issue rather than primarily a law enforcement issue, and the implementation of law and policy that best achieves that goal. 	
B: To the NSW Department of Health	
<p>1. That the NSW Department of Health research and support evidence-based strategies that are most useful to maximise the chance of reducing harm and saving lives in the event of drug-related illness at music festivals including, for example, giving consideration to the use of ice baths and/or routine use of rectal thermometers to ascertain core temperature and/or ice vests.</p>	<p>This recommendation is supported.</p>
<p>2. That the NSW Department of Health consider evidence from the inquest that might supplement or improve the NSW Ministry of Health Guidelines “Pre-Hospital Guideline: Illicit Substance-Induced Hyperthermia” including, for example, the “Treatment Guidelines for Drug Induced Hyperthermia” (annexure DH-2 to statement of Dr Dorothy Habrat - Exhibit 62).</p>	<p>This recommendation is supported.</p>
<p>3. That the NSW Department of Health consider researching the metabolism of MDMA and whether there is a genetic risk factor for MDMA toxicity, for example in poor CYP2C19 metabolisers.</p>	<p>This recommendation is supported.</p>

<p>4. That the NSW Department of Health continues to fund and expand appropriate peer-delivered harm prevention and reduction services that are well received by patrons, for example, DanceWize.</p>	<p>The benefit of peer-delivered harm prevention and reduction services are discussed in Chapter 12 and recommendations have been made accordingly.</p>
<p>5. That the NSW Department of Health contributes to the Emerging Drugs Network of Australia (EDNA) by sharing the information that is obtained through NSW Health's enhanced surveillance in ED and ICU settings.</p>	<p>The benefit of surveillance of illicit drugs is discussed in Chapters 14 and 20. This recommendation is supported.</p>
<p>6. That the NSW Department of Health establishes and coordinates a group of key stakeholders, including State and Local government and key industry stakeholders, including the Department of Health, private health providers such as EMS Event Medical, NSW Ambulance and Police, the Australian Festivals Association, harm minimisation experts and promoters to allow for the annual review of <i>NSW Health Guidelines for Music festival Event Organisers: Music Festival Harm Reduction</i>.</p>	<p>The benefit of stakeholder engagement in the development of illicit drug policy is discussed in Chapter 9. This recommendation is supported.</p>
<p>7. That the <i>NSW Health Guidelines for Music festival Event Organisers: Music Festival Harm Reduction</i> be amended to advise of an appropriate time frame and protocol for a private medical service provider to conduct a full evaluation, preferably with an independent consultant, in the event of a fatality involving a patient who they have treated.</p>	<p>This recommendation is supported.</p>
<p>8. That the Department of Health working with organisations such as Family Drug Support Australia and drug educators such as Paul Dillon of Drug and Alcohol Research and Training (DARTA), develop resources for parents about talking to their children about stimulant drugs consumed at music festivals, focused on harm prevention and reduction.</p>	<p>Prevention and education are discussed in Chapters 12 and 13. This recommendation is supported.</p>

<p>9. That the Department of Health continues to promote music festival guidelines that encourage the following initiatives, by explaining their significance in reducing the risk of drug-related harms and death:</p> <ul style="list-style-type: none"> a. Free cold water at multiple stations throughout festivals. b. Well ventilated chill out spaces and the regular checking of ambient temperatures. c. Additional activities to music to encourage chill out (particularly for longer festivals). d. Involvement of artists in harm reduction messages. 	<p>This recommendation is supported.</p>
<p>C: To the NSW Police Force</p>	
<p>1. That, given the evidence of a link between the use of drug dogs and more harmful means of consumption (including panic ingestion, double dosing, pre-loading, and insertion in a vaginal or anal cavity) the model of policing at music festivals be changed to remove drug detection dogs.</p>	<p>This recommendation is supported. The evidence in support of a change to policing practices relating to drug detection dogs is discussed in Chapter 19.</p>
<p>2. In order to address the harm potentially caused by the current practice of police strip searching for possession of drugs (including more harmful means of consumption and secretion and adversely affecting the relationships between patrons and police meaning it may be less likely that patrons will seek help from Police), the NSW Police Commissioner issue an operational guideline and/or amend the relevant police handbook such that strip searches should be limited at music festivals to circumstances where:</p> <ul style="list-style-type: none"> a) There is a reasonable suspicion that the person has committed or is about to commit an offence of supply a prohibited drug, and b) There are reasonable grounds to believe that the strip search is necessary to prevent an immediate risk to personal safety or to prevent the immediate loss or destruction of evidence, and 	<p>The evidence in support of a change to policing practices relating to strip searches is discussed in Chapter 19. The Inquiry has recommended that this recommendation be accepted, extended to strip searches in the field generally, and implemented.</p>

<ul style="list-style-type: none"> c) The reasons for conducting the search are recorded on Body Worn Video before the search commences. d) No less invasive alternative is appropriate in the circumstances. 	
<p>3. That, in the event of pill testing/drug checking facilities being operational at NSW Music festivals, the Police Commissioner issue an operational guideline providing clear guidance to operational police as to how they are requested to exercise their discretion in regard to illicit drug use and possession at festivals. Such a Guideline should:</p> <ul style="list-style-type: none"> a. Identify the role of police as one of support and protection for otherwise law-abiding festival goers. b. Request police not to take punitive action against people in possession of drugs for personal use, and to concentrate their operations on organised drug dealing, social disorder and other crimes. c. Emphasise that while a primary part of policing at music festivals involves crowd control and enforcement of laws, it is part of good policing, and an objective at music festivals, to engage positively with festival goers wherever possible, to provide support and comfort where needed and to act to reduce or minimise harm. 	This recommendation is supported.
<p>4. That training for attendance at police operations at music festivals be developed and implemented within NSW Police and that such training be a pre-requisite for those police assigned to or wishing to perform police operations at music festivals. Regardless of the policing model in place, that training should:</p> <ul style="list-style-type: none"> a. Instruct police not to take punitive action against people in possession of drugs for personal use, and to concentrate their operations on organised drug dealing, social disorder and other crimes. 	This recommendation is supported.

<p>b. Emphasise that while a primary part of policing at music festivals involves crowd control and enforcement of laws, it is part of good policing, and an objective at music festivals, to engage positively with festival goers wherever possible, to provide support and comfort where needed and to act to reduce or minimise harm.</p>	
<p>D: To the Department of Premier and Cabinet, the NSW Police Force, the NSW Department of Health and the NSW Department of Communities and Justice</p>	
<p>1. That in the event personal possession remains a criminal offence, a group of relevant decision makers from each of the above stakeholders is convened in order to organise the funding, and installation of drug amnesty bins at music festivals. Drug harm reduction groups are to be consulted as to where to place those bins to maximise use and minimise harms.</p>	<p>The Inquiry notes that the NSW Government has agreed to a trial of amnesty bins in response to this recommendation.</p>
<p>2. That in the event personal possession remains a criminal offence, a group of relevant decision makers from each of the above stakeholders is convened to develop strategies to limit strip searches to those individuals suspected of supplying illicit drugs, rather than those in possession for personal use. That should involve consideration of the need to amend legislation, policy and/or procedural guidelines.</p>	<p>This recommendation is supported.</p>
<p>E: To the Australian Festivals Association</p>	
<p>1. That the Australian Festivals Association promote music festival guidelines that encourage:</p> <ul style="list-style-type: none"> a) Free cold water at multiple stations throughout festivals. b) Well ventilated chill out spaces and the regular checking of ambient temperatures. c) Additional activities to music to encourage chill out (particularly for longer festivals). d) Involvement of artists in harm reduction messages. 	<p>This recommendation is supported.</p>

2. That the Australian Festivals Association consider promoting novel harm reduction strategies identified during the inquest including new technologies and ideas raised by family of Joshua Tam.	This recommendation is supported.
F: To the NSW Education Standards Authority (NESA)	
1. That in the High School curriculum consideration be given to a learning module dedicated to deaths at music festivals with a particular focus on: <ul style="list-style-type: none"> a. The effects of MDMA in particular of high doses. b. Other factors that can increase your risk to having an adverse reaction to MDMA including temperature, exercise, weight, prescription medication, and mixing with other drugs and alcohol. c. Having a sober friend, warning signs to look out for, and seeking medical help. 	The Inquiry has noted the current review of the NSW curriculum and made a specific recommendation in relation to a review of the Life Ready Course. The Inquiry has also made a recommendation that a whole-of-government education strategy be developed to improve community understanding of the harms associated with ATS, how to reduce such harms and how to access services and supports to manage drug use.
2. That NESA commission a review from a recognised expert in drug education and harm reduction, such as Paul Dillon, Drug and Alcohol Research and Training (DARTA) to obtain advice on how best to protect young people from the potential harm posed by amphetamine type stimulants, particularly in the music festival environment, in a way that minimises harm that would include advice on the type of education appropriate for different age groups.	This Inquiry recognises the importance of providing age-appropriate education for young people, including information about harm reduction. The recommendation by Deputy Coroner Grahame is consistent with the Inquiry's recommendation in relation to Life Ready.
G: To EMS Event Medical	
1. That EMS Event Medical develop a review protocol so that in the event of another fatality, an independent consultant is engaged to assist with a full evaluation of the circumstances of the death and the adequacy of medical care, and that there be a clear time frame to initiative and complete the report.	The Inquiry did not consider evidence in relation to this matter and does not express a view on this recommendation.

Inquest into the death of Amaru Bestrin

Hearing dates: 19 June 2018, 25 October 2018, 21–23 October 2019 before Deputy State Coroner Grahame

Date of findings: 17 December 2019

Overview: Mr Bestrin collapsed in a toilet at Liverpool Hospital as a result of combined drug and alcohol toxicity. He was not found for many hours.

Recommendation	Consideration
To NSW Health	
3. That Liverpool Hospital notify General Health Services, the manager of General Services, the General Manager of Drug Health Services and the Harm Reduction Manager regarding any incidents entered in the central register involving a collapse or death in a publicly accessible or clinical toilets involving drugs.	This recommendation falls outside of the Inquiry's Terms of Reference.
9. That Liverpool Hospital undertake an overall risk assessment of its publicly accessible toilets, which includes consultation with cleaning and security staff, the General Manager of Drug Health Services and the Harm Reduction Manager.	This recommendation falls outside of the Inquiry's Terms of Reference.
13. That Liverpool Hospital provide: (a). First Aid training to all cleaners and security staff, with a particular focus on how to respond in the event of an overdose and, at a minimum training include identifying an overdose and use of the recovery position.	This recommendation falls outside of the Inquiry's Terms of Reference.
14. That Liverpool Hospital train all cleaners and security staff in the use of Naloxone nasalspray and that upon completion of the training, all cleaning and security staff are provided with Naloxone nasal spray, in order for it to be used in the event of a suspected overdose.	This recommendation falls outside of the Inquiry's Terms of Reference.

<p>15. That NSW Health, in consultation with Liverpool Hospital, undertake a feasibility study regarding a supervised injecting space within the grounds of Liverpool Hospital.</p>	<p>The Inquiry has made a recommendation in Chapter 15 that the current restriction of the number of supervised injecting centres that can be licensed under the <i>Drug Misuse and Trafficking Act 1985</i> (NSW) should be removed, and that such services should be provided based upon local need.</p> <p>This is discussed in Chapter 15.</p>
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Appendix 17: Unpublished data from the National Drug Strategy Household Survey (NDSHS)

As explained in Chapter 7, the National Drug Strategy Household Survey (NDSHS) is a representative survey about knowledge of, attitudes towards and behaviour in relation to drug use in the Australian non-institutionalised civilian population. To complement the published data, the Australian Institute of Health and Welfare provided the Inquiry with further detailed NSW and comparable national data.

Use of ATS

Table A17.1: People who recently^(a) used meth/amphetamine by age, NSW and Australia, 2004 to 2016 (%)

	New South Wales						Australia				
Age	2004	2007	2010	2013	2016		2004	2007	2010	2013	2016
14–19	5.7	*1.2	**1.0	*1.0	n.p.		4.4	1.6	1.6	*2.0	*0.8
20–29	9.2	5.7	3.9	3.5	*1.4 [#]		10.7	7.3	5.9	5.7	2.8 [#]
30–39	3.8	3.2	3.0	2.5	*1.0 [#]		4.1	3.9	3.4	3.1	2.4
40–49	*1.6	*0.9	*1.2	*1.2	*1.1		1.2	1.0	1.1	1.4	2.0
50+	**<0.1	*0.1	*0.1	*0.2	*0.3		*<0.1	*0.1	0.2	0.2	0.3

* 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.

Table A17.2: People who recently^(a) used ecstasy by age, NSW and Australia, 2004 to 2016 (%)

	NEW SOUTH WALES						AUSTRALIA				
Age	2004	2007	2010	2013	2016		2004	2007	2010	2013	2016
14–19	4.4	5.8	*2.3	*2.6	*2.9		4.3	5.0	2.8	3.0	3.2
20–29	12.0	9.8	9.1	8.0	6.0		12.0	11.2	9.9	8.6	7.0
30–39	4.3	5.0	4.5	2.9	*2.0		4.0	4.7	3.9	2.6	2.6
40–49	*1.4	*1.4	1.5	*1.1	*0.9		0.9	1.5	1.2	0.9	1.0
50+	**<0.1	**0.2	**<0.1	*0.3	*0.3		*<0.1	*0.1	*0.1	*0.2	*0.2

* 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.

Table A17.2: Proportion of people aged 14 or older who recently^(a) used meth/amphetamine, by social characteristics, NSW and Australia, 2004 to 2016 (%)

	New South Wales					Australia				
Characteristic	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Persons	3.1	1.8	1.6	1.4	0.7 [#]	3.2	2.3	2.1	2.1	1.4 [#]
Education^(b)										
Year 12 or less (includes Certificate I and II)	n.a.	n.a.	n.a.	1.0	*0.6	n.a.	n.a.	n.a.	1.8	1.2 [#]
Certificate III or IV	n.a.	n.a.	n.a.	3.1	2.0	n.a.	n.a.	n.a.	4.0	2.3 [#]
Diploma	*2.3	*1.7	*1.5	*1.1	n.p.	2.1	*2.1	2.1	1.6	1.5
Bachelor degree or higher	*2.4	*1.2	*1.0	*1.2	*0.3 [#]	2.7	1.6	1.4	1.4	1.0
Main employment status										
Currently employed	3.5	2.1	2.1	1.7	0.9 [#]	3.9	2.8	2.6	2.3	1.5 [#]
Unemployed/Looking for work	7.0	*4.6	*3.4	*2.3	*2.4	8.6	6.0	4.8	5.6	4.6
Other ^(c)	2.5	1.2	*0.5	*0.9	n.p.	2.0	1.4	0.9	1.2	0.7 [#]
Socioeconomic area										
First quintile (most disadvantaged)	2.4	*2.2	1.9	*1.8	*1.1	2.8	2.4	2.4	2.2	1.8
Second quintile	3.1	*1.8	*1.8	*1.2	*1.0	2.9	1.9	2.1	2.1	1.5
Third quintile	2.9	*1.8	*1.7	*1.3	*0.5	3.2	2.6	2.1	2.4	1.4 [#]
Fourth quintile	2.1	*1.8	*1.2	*1.5	n.p.	3.1	2.3	1.8	1.8	1.4
Fifth quintile (most advantaged)	4.4	*1.7	1.4	*1.1	*0.5	4.1	2.3	2.0	1.8	0.9 [#]
Remoteness										
Major cities	3.6	2.0	1.5	1.4	0.6 [#]	3.7	2.5	2.0	2.1	1.4 [#]
Inner regional	2.2	*1.3	1.6	*1.4	*1.2	2.2	1.7	2.0	1.6	1.2
Outer regional, remote and very remote	n.p.	n.p.	n.p.	n.p.	n.p.	2.3	1.9	2.1	2.6	2.0
Indigenous status[^]										
Indigenous	n.p.	n.p.	n.p.	n.p.	n.p.	*5.5	*2.6	*3.6	*3.1	*3.1
Not indigenous	3.1	1.7	1.5	1.4	0.6 [#]	3.2	2.2	1.9	2.0	1.4 [#]
Household composition										
Mothers with dependent children	n.a.	*1.4	1.1	*1.2	*0.4 [#]	n.a.	1.7	1.3	1.6	0.9 [#]
Other households	n.a.	1.9	1.6	1.5	0.8 [#]	n.a.	2.4	2.2	2.3	1.6 [#]
Sexual orientation										
Heterosexual	n.a.	1.6	1.4	1.3	0.6 [#]	n.a.	2.1	1.9	1.9	1.2 [#]
Homosexual/Bisexual	n.a.	*10.0	*6.6	*6.4	*5.4	n.a.	12.2	7.1	8.6	6.9
Not sure/Other	n.a.	n.p.	n.p.	n.p.	n.p.	n.a.	n.p.	*2.4	*2.1	*1.4
Mental health										
Diagnosed or treated for mental health condition ^(d)	6.9	*2.7	3.8	3.3	*2.6	6.5	4.6	4.5	4.6	4.1
Level of psychological distress^(e)										
Low	2.0	1.5	1.1	0.7	*0.3 [#]	2.1	1.6	1.6	1.3	0.8 [#]
Moderate	4.7	2.6	2.8	2.7	*0.8 [#]	5.1	3.6	3.0	3.2	1.9 [#]
High to very high	8.8	*3.7	3.0	*3.5	*3.4	8.0	5.9	4.6	5.6	4.7

* 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.

[^] Due to the small sample sizes for Aboriginal and/or Torres Strait Islander people, estimates should be interpreted with caution.

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

(b) Prior to 2013, the 'highest qualification obtained' question did not differentiate between Certificate levels. Data for categories below 'Diploma' in earlier years are not comparable, and have not been reported.

(c) Includes 'Solely engaged in home duties', 'A student', 'Retired or on a pension', 'Volunteer/charity work', 'Unable to work' and 'Other'.

(d) Includes depression, anxiety disorder, schizophrenia, bipolar disorder, an eating disorder and other form of psychosis.

(e) Low: K10 score 10–15, Moderate: 16–21, High: 22–29, Very high: 30–50. Data are for people aged 18 or older

Notes:

1. 2004 socioeconomic quintiles were calculated using the 2001 Census of Population and Housing. 2007 and 2010 socioeconomic quintiles were calculated using the 2006 Census of Population and Housing. From 2013, socioeconomic quintiles are calculated using the 2011 Census of Population and Housing. These data are considered comparable but trends should be interpreted with caution.

2. From 2013, Remoteness Areas were defined using the 2011 Australian Statistical Geography Standard (ASGS). Prior to this, relevant Australian Standard Geographical Classification (ASGC) editions were used. These data are considered comparable but trends should be interpreted with caution.

3. Base is New South Wales and Australian population.

Table A17.3: Proportion of people aged 14 or older who recently^(a) used ecstasy, by social characteristics, 2004 to 2016 (%)

	New South Wales					Australia				
Characteristic	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Persons	3.5	3.4	2.9	2.4	1.9	3.4	3.5	3.0	2.5	2.2
Education^(b)										
Year 12 or less	n.a.	n.a.	n.a.	1.5	1.3	n.a.	n.a.	n.a.	2.0	2.0
Certificate III or IV	n.a.	n.a.	n.a.	3.5	3.2	n.a.	n.a.	n.a.	3.5	3.0
Diploma	*2.2	*2.2	*2.8	*2.1	n.p.	2.8	3.5	2.6	2.3	1.4
Bachelor degree or higher	5.4	3.7	3.5	3.4	2.3	4.4	3.9	3.2	2.9	2.3
Main employment status										
Currently employed	4.3	4.1	3.8	3.1	2.7	4.4	4.4	3.8	2.9	2.9
Unemployed/Looking for work	*8.8	*4.2	*3.7	n.p.	n.p.	8.0	8.2	4.1	5.1	2.9
Other ^(c)	2.3	2.3	1.8	1.5	*0.8	1.8	2.1	1.7	1.5	1.1
Socioeconomic area										
First quintile (most disadvantaged)	*1.1	*2.3	1.9	*1.9	*1.0	1.6	2.6	1.9	1.6	1.2
Second quintile	2.1	*2.2	1.8	*1.6	*1.7	2.5	2.4	2.5	2.0	1.8
Third quintile	3.1	*2.9	1.7	*1.9	*1.7	3.2	3.8	2.7	3.0	2.3
Fourth quintile	2.6	3.3	2.9	3.5	3.1	3.1	3.7	3.1	2.8	3.1
Fifth quintile (most advantaged)	6.8	4.8	4.9	2.8	2.2	5.9	4.7	4.4	2.9	2.7
Remoteness										
Major cities	4.4	3.7	3.2	2.7	1.9	4.2	4.0	3.3	2.9	2.5
Inner regional	1.6	2.6	2.2	*1.5	*2.2	1.5	2.5	2.0	1.5	1.5
Outer regional, remote and very remote	n.p.	n.p.	n.p.	n.p.	n.p.	1.9	2.4	2.6	1.6	1.3
Indigenous status[^]										
Indigenous	*3.0	*5.7	*5.5	n.p.	n.p.	*3.0	4.1	*3.0	**1.1	*1.8
Not indigenous	3.6	3.2	2.9	2.5	1.9	3.4	3.5	3.0	2.5	2.2
Household composition										
Mothers with dependent children	n.a.	*1.7	1.3	*0.8	*0.4	n.a.	1.8	1.3	1.1	0.6*
Other	n.a.	3.7	3.4	2.7	2.2	n.a.	3.9	3.4	2.9	2.6
Sexual orientation										
Heterosexual	n.a.	2.8	2.7	2.3	1.6	n.a.	3.2	2.8	2.2	1.9
Homosexual/Bisexual	n.a.	23.9	14.3	*10.1	*10.2	n.a.	19.8	10.8	12.8	11
Not sure/Other	n.a.	*4.2	*3.6	n.p.	n.p.	n.a.	*4.3	*4.7	*4.2	*2.5
Mental health										
Diagnosed or treated for mental health condition ^(d)	*6.6	4.6	5.0	3.4	3.1	5.5	5.6	4.2	3.6	3.9
Level of psychological distress^(e)										
Low	2.7	2.7	2.4	1.7	1.5	2.5	2.6	2.5	1.9	1.6
Moderate	5.5	4.3	4.7	4.1	*2.1*	5.4	5.3	4.4	3.8	2.8*
High to very high	7.2	6.0	3.8	4.3	4.9	6.4	7.1	4.8	4.7	5.2

* 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 Due to the small sample sizes for Aboriginal and/or Torres Strait Islander people, estimates should be interpreted with caution.

(a) Used in the previous 12 months.

(b) Prior to 2013, the 'highest qualification obtained' question did not differentiate between Certificate levels. Data for categories below 'Diploma' in earlier years are not comparable, and have not been reported.

(c) Includes 'Solely engaged in home duties', 'A student', 'Retired or on a pension', 'Volunteer/charity work', 'Unable to work' and 'Other'.

(d) Includes depression, anxiety disorder, schizophrenia, bipolar disorder, an eating disorder and other form of psychosis.

(e) Low: K10 score 10–15, Moderate: 16–21, High: 22–29, Very high: 30–50. Data are for people aged 18 older

Notes:

1. 2004 socioeconomic quintiles were calculated using the 2001 Census of Population and Housing. 2007 and 2010 socioeconomic quintiles were calculated using the 2006 Census of Population and Housing. From 2013, socioeconomic quintiles are calculated using the 2011 Census of Population and Housing. These data are considered comparable but trends should be interpreted with caution.

2. From 2013, Remoteness Areas were defined using the 2011 Australian Statistical Geography Standard (ASGS). Prior to this, relevant Australian Standard Geographical Classification (ASGC) editions were used. These data are considered comparable but trends should be interpreted with caution.

3. Base is New South Wales and Australian population.

People who use ATS

Table A17.5: Average age of initiation^(a) for people aged 14 or older who used the drug in their lifetime^(b), NSW and Australia, 2004 to 2016 (years)

Drug/behaviour	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Ecstasy	23.4	22.8	22.4	21.8	21.4	22.8	22.6	22.2	21.7	21.7
Meth/amphetamine ^(c)	21.1	21.0	21.0	21.9	21.9	20.8	20.9	20.9	21.6	22.1 [#]

^{*} The margin or error (width of a 95% confidence interval) was between 1.5 and 2.5 years and should be used with caution.

^{**} The margin or error (width of a 95% confidence interval) was between 2.5 and 3 years, 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) Age first tried/used drug.

(b) Used the specified drug at least once in their lifetime.

(c) For non-medical purposes.

Note: Base is users of the specified drug in the previous 12 months.

Table A17.4: Years since first use for people aged 14 or older who recently^(a) used the drug, NSW and Australia, 2004 to 2016 (%)

Years since first use	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Methamphetamines^(b)										
0-3 years	37.6	24.8	23.1	27.9	*21.3	36.6	27.1	26.9	33.7	21.7 [#]
4-6 years	26.1	*13.3	20.0	*17.3	*17.9	24.4	20.8	19.2	14.1	13.7
7-10 years	14.4	26.5	21.9	17.7	*23.9	16.1	23.0	20.1	19.1	16.6
11-19 years	15.1	25.4	22.8	*20.1	*15.7	17.0	22.0	23.3	22.3	29.1
20 years or more	*6.8	*9.9	12.2	17.0	*21.2	5.9	7.2	10.5	10.9	18.9 [#]
Mean number of years since first use	6.9	9.1	[*] 10.0	[*] 9.8	n.p.	6.9	8.3	9.3	8.7	12.1 [#]
Ecstasy										
0-1 years	25.1	20.5	14.0	17.7	*12.2	26.3	21.1	15.3	19.2	20.4
2-3 years	19.6	17.2	22.7	*14.5	*21.0	20.8	19.0	20.4	16.0	18.2
4-6 years	26.1	23.1	15.4	*18.2	*17.0	29.3	23.9	23.0	17.6	14.3
7-10 years	17.3	21.4	21.8	22.2	*16.3	15.0	19.7	20.4	23.8	17.0 [#]
11-19 years	11.7	15.6	22.4	22.3	21.0	8.4	14.2	17.8	19.8	22.9
20 years or more	n.p.	*2.2	*3.6	*5.1	*12.5	**0.2	*2.1	3.0	3.6	7.1 [#]
Mean number of years since first use	5.0	6.1	7.2	7.7	[*] 8.9	4.5	5.9	6.6	6.9	7.8

* 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.

^{*} The margin or error (width of a 95% confidence interval) was between 1.5 and 2.5 years and should be used with caution.

^{**} The margin or error (width of a 95% confidence interval) was between 2.5 and 3 years, 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.

Note: Base is users of the specified drug in the previous 12 months.

(a) Used the specified drug in the previous 12 months.

(b) For non-medical purposes.

Table A17.5: Usual source of meth/amphetamine supply for people aged 14 or older who recently^(a) used the drug, NSW and Australia, 2004 to 2016 (%)

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 ^(b)	*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.

Table A17.6: Drugs used at the same time when using meth/amphetamines^(a), people aged 14 or older who recently^(b) used the drug, NSW and Australia, 2004 to 2016 (%)

Drug	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Alcohol	84.1	84.6	87.1	80.5	83.3	87.2	84.5	88.2	86.0	74.7 [#]
Tobacco	n.a.	n.a.	73.6	66.9	74.7	n.a.	n.a.	70.6	68.1	68.8
Marijuana/cannabis	65.9	66.7	48.0	50.0	51.3	67.6	65.6	54.1	49.8	53.5
Cocaine	11.4	21.5	*14.3	*17.6	*18.3	13.6	20.5	18.3	14.6	13.4
Ecstasy	44.5	54.0	39.8	*24.5	*25.8	49.4	55.4	44.1	29.8	23.7
Ketamine	*9.3	*7.9	**2.6	*9.1	*14.4	9.2	5.3	3.7	5.8	7.3
Pain-killers/pain relievers and opioids ^(a)	*6.3	*10.9	*5.8	*7.4	*9.1	6.8	12.2	8.7	8.3	16.0 [#]
Pharmaceuticals ^(a) (excluding pain-killers/pain relievers and opioids)	8.2	*16.0	*4.4	*12.2	**5.9	11.3	18.8	9.5	9.6	7.0
Other	*4.6	*16.0	*7.7	*6.3	*13.7	8.7	16.3	13.5	11.2	13.9
Illicit drugs used at same time (excludes alcohol and tobacco) ^(b)	80.3	85.3	69.8	66.4	63.4	81.6	86.2	74.1	64.8	71.0
Not used any of the above	*4.5	**3.3	n.p.	**6.9	n.p.	3.8	*2.7	*2.5	*4.2	*3.5

* 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) For non-medical purposes.

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

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

Table A17.7: Places where people aged 14 or older who recently^(a) used the drug usually use meth/amphetamines, NSW and Australia, 2004 to 2016 (%)

	New South Wales					Australia				
Location	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
In my own home	40.6	46.0	48.2	42.6	57.3	46.7	53.9	47.1	46.5	52.0
At a friend's house	45.5	52.5	38.1	55.7	56.6	52.4	51.9	53.5	59.0	54.2
At a private party	54.0	48.3	52.4	41.9	38.9	49.0	52.5	50.4	46.9	37.3 [#]
At a rave/dance party	47.5	31.9	37.1	27.8	*32.4	45.6	39.0	35.3	26.8	22.6
At licenced premises (e.g. pubs/clubs)	49.4	33.7	35.1	21.3	*18.0	46.2	39.9	39.6	25.0	21.7
In a car	16.3	*15.8	*14.4	*10.7	**8.7	18.1	21.0	16.1	15.6	14.7
Somewhere else	18.6	36.2	*16.2	*8.3	*13.9	21.3	26.0	17.4	16.6	17.1

* 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.

Notes:

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

2. Respondents could select more than one response.

Table A17.8: Proportion of people aged 14 or older who recently^(a) used meth/amphetamine who also reported using other illicit drugs in the previous 12 months, NSW and Australia, 2004 to 2016 (%)

	New South Wales					Australia				
Drug also used	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Cannabis	82.0	84.2	69.5	76.13	66.2	82.0	77.4	73.1	72.7	73.7
Ecstasy	59.3	69.1	61.0	54.8	29.2 [#]	61.1	68.1	59.2	53.0	40.1 [#]
Cocaine	17.8	31.9	44.7	51.2	35.1	19.9	32.2	41.5	39.5	32.2
Hallucinogens	*12.6	*16.5	24.2	22.3	n.p.	15.8	15.4	28.3	26.4	17.5 [#]
Inhalants	*7.0	*8.2	*8.2	*10.6	*10.6	6.7	*5.4	8.6	13.9	8.7
Ketamine	*7.1	*8.0	*5.9	**7.8	*11.3	6.9	6.2	6.6	5.6	8.7
Injected drugs ^(b)	*8.7	16.8	16.8	*12.9	n.p.	12.2	16.3	15.2	11.3	15.1
Pain-killers/pain relievers and opioids ^(c)	*10.0	23.6	17.8	22.6	*15.2	14.1	21.0	22.7	25.8	29.9
Pharmaceuticals ^(c) (excluding pain-killers/pain relievers and opioids)	*12.0	22.9	24.9	23.7	*18.7	12.4	24.0	23.7	19.2	18.5
Did not use any other illicit	7.8	**3.4	*6.8	*5.7	*21.3	6.7	*5.8	7.9	7.9	10.1

* 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) Not prescribed to inject.

(c) For non-medical purposes.

Notes:

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

2. Drug categories have changed over time, so trends should be interpreted with caution.

Table A17.9: Proportion of people aged 14 or older who recently^(a) used ecstasy who also reported using other illicit drugs in the previous 12 months, NSW and Australia, 2004 to 2016 (%)

Drug also used	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Cannabis	81.4	71.1	69.2	79.0	77.7	79.3	71.6	74.3	76.8	78.5
Meth/amphetamines	52.2	38.0	31.8	28.4	*10.8 [#]	58.3	44.0	40.6	42.0	25.5 [#]
Cocaine	23.8	38.4	49.2	60.8	63.6	22.7	32.0	45.1	44.9	48.7
Hallucinogens	10.1	12.8	21.6	25.3	24.1	14.5	12.2	29.3	31.5	28.0
Inhalants	*7.3	*6.3	*7.4	*10.3	*16.6	7.3	5.4	8.3	14.6	11.9
Ketamine	*7.4	*6.8	*6.4	*7.6	*13.4	6.9	4.5	6.1	7.9	11.5
Injected drugs ^(b)	*4.0	*6.3	*4.9	*5.7	n.p.	6.3	6.5	5.9	*4.0	*2.7
Pain-killers/pain relievers and opioids ^(c)	*10.9	14.2	11.4	*12.1	*13.6	13.6	12.7	14.4	15.8	20.5
Pharmaceuticals ^(c) (excluding pain-killers/pain relievers and opioids)	*11.6	14.9	12.6	17.6	*9.8	11.3	16.2	16.3	16.2	15.7
Did not use any other illicit	*9.0	*11.8	11.7	*6.0	*4.1	9.7	12.5	9.7	8.3	6.1

* 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) Not prescribed to inject.

(c) For non-medical purposes.

Notes:

1. Base is users of ecstasy in the previous 12 months.

2. Drug categories have changed over time, so trends should be interpreted with caution.

Table A17.10: Frequency of drug use, people aged 14 years or older who recently^(a) used the specified drug, NSW and Australia, 2010 to 2016 (%)

Frequency of use	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Ecstasy										
At least once a month or more	20.9	25.8	13.5	*6.9	*14.8	21.2	25.0	15.5	13.9	15.7
Every few months	35.8	33.3	27.9	32.4	30.9	31.3	28.9	31.4	32.4	32.9
Once or twice a year	43.3	40.9	58.6	60.7	54.3	47.5	46.1	53.1	53.7	51.5
Meth/amphetamines^(b)										
At least once a week or more	*5.7	*18.4	*7.6	*15.2	*22.0	10.8	14.2	9.3	15.5	20.4
About once a month	18.3	15.8	*13.8	*10.0	*17.7	16.1	21.5	15.6	16.6	10.6 [#]
Every few months	31.1	22.7	29.2	*20.2	*19.0	29.2	26.6	26.3	19.8	24.7
Once or twice a year	44.8	43.2	49.3	54.6	41.3	43.9	37.7	48.8	48.0	44.3

* 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 the specified drug in the previous 12 months.

(b) For non-medical purposes.

Note: Base is users of the specified drug in the previous 12 months.

Table A17.11: Proportion of people aged 14 years or older who recently^(a) used the specified drug, that couldn't stop or cut down even though they wanted to, by drug type, NSW and Australia, 2001 to 2016 (%)

Drug type	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Ecstasy	*2.6	*3.7	n.p.	n.p.	n.p.	3.1	*4.0	*2.5	*2.6	*1.8
Meth/amphetamines^(b)	*3.7	*15.1	*3.9	*12.5	*13.4	5.4	13.3	5.5	11.7	12.9

* 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 the specified drug in the previous 12 months.

(b) For non-medical purposes.

Note: Base is users of the specified drug in the previous 12 months.

Table A17.12: Forms of ecstasy used by people aged 14 years or older who recently^(a) used the drug, NSW and Australia, 2016 (%)

Form of ecstasy	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Main form used										
Pills/Tablets	n.a.	n.a.	n.a.	n.a.	42.6	n.a.	n.a.	n.a.	n.a.	51.2
Capsules	n.a.	n.a.	n.a.	n.a.	40.7	n.a.	n.a.	n.a.	n.a.	33.4
Crystals/Rock	n.a.	n.a.	n.a.	n.a.	*12.4	n.a.	n.a.	n.a.	n.a.	11.6
Powder	n.a.	n.a.	n.a.	n.a.	n.p.	n.a.	n.a.	n.a.	n.a.	*3.8
Forms ever used										
Pills/Tablets	n.a.	n.a.	n.a.	n.a.	85.0	n.a.	n.a.	n.a.	n.a.	90.1
Capsules	n.a.	n.a.	n.a.	n.a.	78.9	n.a.	n.a.	n.a.	n.a.	69.2
Crystals/Rock	n.a.	n.a.	n.a.	n.a.	47.0	n.a.	n.a.	n.a.	n.a.	41.8
Powder	n.a.	n.a.	n.a.	n.a.	42.4	n.a.	n.a.	n.a.	n.a.	42.1

* 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.

n.a. Not available. These questions were not asked prior to 2016.

Note: Base is users of ecstasy in the previous 12 months.

(a) used the specified drug in the previous 12 months.

Table A17.13: Main method of meth/amphetamines use, people aged 14 years or older who recently^(a) used meth/amphetamines, NSW and Australia, 2010 to 2016 (%)

	New South Wales						Australia				
Method of use	2004	2007	2010	2013	2016		2004	2007	2010	2013	2016
Smoked	n.a.	*12.3	*8.3	36.4	45.8		n.a.	16.6	19.1	40.9	41.8
Snorted	n.a.	28.1	39.8	24.4	*13.6		n.a.	32.9	34.2	22.6	16.3
Swallowed	n.a.	41.8	39.1	29.6	*31.9		n.a.	34.7	36.0	26.5	28.6
Injected	n.a.	*17.2	*12.8	*8.3	*8.7		n.a.	15.7	10.6	9.5	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.

Notes:

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

2. This question was not asked in the 2004 NDSHS.

Table A17.14: Frequency of meth/amphetamine use, people aged 14 years or older who recently^(a) used the drug, by form of meth/amphetamines used, NSW and Australia, 2004 to 2016 (%)

	New South Wales						Australia				
Frequency of use	2004	2007	2010	2013	2016		2004	2007	2010	2013	2016
All recent meth/amphetamine users											
Once a month or more	24.1	34.1	21.5	25.2	39.7		26.9	35.7	24.9	32.1	31.0
Every few months	31.1	22.7	29.2	*20.2	*19.0		29.2	26.6	26.3	19.8	24.7
Once or twice a year	44.8	43.2	49.3	54.6	41.3		43.9	37.7	48.8	48.0	44.3
Main form of meth/amphetamine used - crystal/ice											
Once a month or more	n.a.	*55.2	*39.4	*34.6	51.4		n.a.	47.5	29.9	45.5	40.1
Every few months	n.a.	n.p.	n.p.	n.p.	*21.5		n.a.	*20.7	*23.1	14.3	22.6
Once or twice a year	n.a.	*35.9	*48.8	57.2	*27.1#		n.a.	31.8	47.0	40.2	37.3
Main form of meth/amphetamine used - powder/speed											
Once a month or more	n.a.	n.p.	n.p.	n.p.	n.p.		n.a.	30.6	16.6	18.8	21.7
Every few months	n.a.	33.3	34.0	*21.2	n.p.		n.a.	31.7	29.0	20.0	26.6
Once or twice a year	n.a.	42.1	57.1	68.3	*50.2		n.a.	37.7	54.4	61.2	51.7

* 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.

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

Table A17.15: Average quantity of meth/amphetamines and ecstasy usually consumed by people aged 14 or older who recently^(a) used the specified drug, 2004 to 2016

	New South Wales					Australia				
Amount	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Methamphetamines^(b)										
Average number of grams usually consumed	0.7	0.5	0.6	0.5	0.4	0.5	0.4	0.5	0.4	0.3
Ecstasy^(c)										
Average number of tablets/pills	1.6	1.6	2.0	2.0	n.a.	1.5	1.6	1.9	1.8	n.a.
Ecstasy^(c) (amount of main form used)										
Average number of tablets/pills	n.a.	n.a.	n.a.	n.a.	2.2	n.a.	n.a.	n.a.	n.a.	2.0
Average number of capsules	n.a.	n.a.	n.a.	n.a.	2.0	n.a.	n.a.	n.a.	n.a.	1.7
Average number of grams	n.a.	n.a.	n.a.	n.a.	n.p.	n.a.	n.a.	n.a.	n.a.	0.7

^{*} The margin of error (width of a 95% confidence interval) was between 0.3 and 0.6 units and should be used with caution.

^{**} The margin of error (width of a 95% confidence interval) was between 0.6 and 1.0 units, 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 the specified drug in the previous 12 months.

(b) For non-medical purposes.

(c) In 2016, people were asked to indicate the forms of ecstasy that they had ever used, the main form that they use, and how much ecstasy (per form) they typically used. Due to discrepancies in these questions, quantities are only reported for the main form that the respondent used. Prior to 2016, people were only asked how many tablets or pills they typically used, and were not asked about the main form that they used. This represents a break in the time series, and trend results should not be interpreted beyond 2013.

Table A17.16: People aged 14 years or older who recently^(a) used meth/amphetamine, by social characteristics, NSW and Australia 2004 to 2016 (%)

	New South Wales					Australia				
Characteristic	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Persons	100	100	100	100	100	100	100	100	100	100
Education^(b)										
Year 12 or less	n.a.	n.a.	n.a.	31.8	*32.7	n.a.	n.a.	n.a.	39.1	38.1
Certificate III or IV	n.a.	n.a.	n.a.	35.5	47.4	n.a.	n.a.	n.a.	34.7	29.7
Diploma	*7.8	*10.9	*10.0	*8.1	n.p.	6.1	10.0	10.0	8.2	11.5
Bachelor degree or higher	15.7	17.2	*15.9	24.6	*12.4	16.3	17.5	16.1	18.0	20.6
Main employment status										
Currently employed	60.6	63.2	76.4	64.3	66.1	67.9	68.6	71.9	64.4	58.9
Unemployed/looking for work	*6.3	*7.3	*11.2	*9.0	*19.0	6.5	6.3	10.8	13.8	20.6
Other ^(c)	33.1	29.5	*12.3	26.8	*15.0	25.6	25.0	17.3	21.8	20.5
Socioeconomic area										
First quintile (most disadvantaged)	10.9	*17.9	22.7	*24.1	36.5	13.7	18.0	21.3	18.8	26.0
Second quintile	19.5	*16.4	19.6	*17.5	*25.5	17.0	14.5	18.6	20.3	21.7
Third quintile	18.0	*15.2	*18.7	*14.7	*14.9	19.6	20.8	20.3	22.9	20.1
Fourth quintile	13.3	23.5	*14.7	*23.1	n.p.	21.5	22.7	19.5	19.2	19.4
Fifth quintile (most advantaged)	38.3	27.0	24.3	*20.6	*17.2	28.2	23.9	20.3	18.8	12.8
Remoteness										
Major cities	82.0	79.1	67.9	78.0	62.5	77.9	75.0	68.2	72.3	68.6
Inner regional	16.7	*13.1	24.1	*19.6	34.5	14.1	15.3	20.3	13.2	15.6
Outer regional, remote and very remote	n.p.	n.p.	n.p.	n.p.	n.p.	8.0	9.8	11.4	14.6	15.8
Indigenous status[^]										
Indigenous	n.p.	n.p.	n.p.	n.p.	n.p.	*2.3	*1.5	*3.2	*2.9	*6.0
Not indigenous	98.6	97.3	94.4	97.2	90.2	97.7	98.5	96.8	97.1	94
Household composition										
Mothers with dependent children	n.a.	*13.3	13.8	17.6	*10.2	n.a.	12.3	12.6	15.4	11.0
Other	n.a.	86.7	86.2	82.4	89.8	n.a.	87.7	87.4	84.6	89.0
Sexual orientation										
Heterosexual	n.a.	84.8	87.7	86.5	72.8	n.a.	88.1	89.6	87.7	81.6
Homosexual/Bisexual	n.a.	*13.4	*10.6	*10.8	*24.6	n.a.	10.7	8.0	10.2	15.7
Not sure/Other	n.a.	n.p.	n.p.	n.p.	n.p.	n.a.	**1.2	*2.5	*2.1	*2.7
Mental health										
Diagnosed or treated for mental health condition ^(d)	19.4	*15.5	27.0	29.1	50.3 [#]	18.1	21.4	25.4	29.0	43.4 [#]
Not diagnosed or treated	80.6	84.5	73.0	70.9	49.7 [#]	81.9	78.6	74.6	71.0	56.6 [#]
Level of psychological distress^(e)										
Low	41.9	53.0	45.8	35.5	*28.1	43.0	44.7	51.2	41.7	35.7
Moderate	31.0	28.3	35.0	40.9	*21.5 [#]	33.2	31.7	28.0	31.8	27.1
High to very high	27.1	18.7	19.2	*23.6	50.4 [#]	23.7	23.6	20.8	26.6	37.2 [#]

* 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.

[^] Due to the small sample sizes for Aboriginal and/or Torres Strait Islander people, estimates should be interpreted with caution.

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

(b) Prior to 2013, the 'highest qualification obtained' question did not differentiate between Certificate levels. Data for categories below 'Diploma' in earlier years are not comparable, and have not been reported.

(c) Includes 'Solely engaged in home duties', 'A student', 'Retired or on a pension', 'Volunteer/charity work', 'Unable to work' and 'Other'.

(d) Includes depression, anxiety disorder, schizophrenia, bipolar disorder, an eating disorder and other form of psychosis.

(e) Low: K10 score 10–15, Moderate: 16–21, High: 22–29, Very high: 30–50. Data are for people aged 18 or older.

Notes:

1. 2004 socioeconomic quintiles were calculated using the 2001 Census of Population and Housing. 2007 and 2010 socioeconomic quintiles were calculated using the 2006 Census of Population and Housing. From 2013, socioeconomic quintiles are calculated using the 2011 Census of Population and Housing. These data are considered comparable but trends should be interpreted with caution.

2. From 2013, Remoteness Areas were defined using the 2011 Australian Statistical Geography Standard (ASGS). Prior to this, relevant Australian Standard Geographical Classification (ASGC) editions were used. These data are considered comparable but trends should be interpreted with caution.

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

Table A17.17: People aged 14 years or older who recently^(a) used ecstasy, by social characteristics, NSW and Australia 2004 to 2016 (%)

	New South Wales					Australia				
Characteristic	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Persons	100	100	100	100	100	100	100	100	100	100
Education^(b)										
Year 12 or less	n.a.	n.a.	n.a.	27.2	30.0	n.a.	n.a.	n.a.	36.0	39.2
Certificate III or IV	n.a.	n.a.	n.a.	22.3	30.0	n.a.	n.a.	n.a.	24.4	24
Diploma	*6.6	*7.7	9.3	*8.9	n.p.	7.7	10.6	8.5	9.4	6.8
Bachelor degree or higher	30.5	29.1	28.6	41.6	39.5	25.0	27.0	24.6	30.3	30
Main employment status										
Currently employed	66.1	66.3	70.3	68.4	79.9	72.6	70.1	71.7	66.1	72.8
Unemployed/Looking for work	*7.0	*3.6	*6.2	n.p.	n.p.	5.8	5.6	6.2	10.3	8.1
Other ^(c)	26.9	30.2	23.5	24.6	*16.8	21.6	24.3	22.1	23.5	19.1
Socioeconomic area										
First quintile (most disadvantaged)	*4.5	*10.1	12.0	*14.7	*12.7	7.6	12.7	11.4	11.6	11.1
Second quintile	11.7	*10.9	10.8	*13.2	*16.1	13.9	11.5	16.0	15.6	16.5
Third quintile	17.2	*13.4	10.1	*12.4	*17.3	19.1	19.7	17.8	23.4	20.7
Fourth quintile	14.7	23.6	19.6	30.0	25.1	20.7	24.1	23.2	24.7	27.5
Fifth quintile (most advantaged)	52.0	42.0	47.5	29.8	28.7	38.6	32.0	31.6	24.8	24.3
Remoteness										
Major cities	88.3	81.3	78.5	83.7	75.1	84.2	77.4	76.3	82.0	80.1
Inner regional	10.7	14.7	18.0	*12.5	23.5	9.5	14.7	13.8	10.3	13.3
Outer regional, remote and very remote	n.p.	n.p.	n.p.	n.p.	n.p.	6.4	8.0	9.8	7.7	6.6
Indigenous status[^]										
Indigenous	n.p.	n.p.	n.p.	n.p.	n.p.	*1.2	*1.5	*1.8	**0.8	*2.2
Not indigenous	99.0	97.5	96.1	99.3	97.9	98.8	98.5	98.2	99.2	97.8
Household composition										
Mothers with dependent children	n.a.	*8.5	8.3	*7.3	*3.9	n.a.	8.6	8.0	8.9	5.0 [†]
Other	n.a.	91.5	91.7	92.7	96.1	n.a.	91.4	92	91.1	95.0 [†]
Sexual orientation										
Heterosexual	n.a.	80.4	85.3	88.1	78.9	n.a.	86.8	88.8	84.0	80.9
Homosexual/Bisexual	n.a.	17.2	11.7	*9.7	17.8	n.a.	11.2	8.1	12.5	16.0
Not sure/Other	n.a.	n.p.	n.p.	n.p.	n.p.	n.a.	*2.0	*3.1	*3.5	*3.1
Mental health										
Diagnosed or treated for mental health condition ^(d)	16.3	14.3	19.4	17.5	22.4	14.7	17.0	16.4	18.9	27.1 [†]
Not diagnosed or treated	83.7	85.7	80.6	82.5	77.6	85.3	83.0	83.6	81.1	72.9 [†]
Level of psychological distress^(e)										
Low	49.4	54.8	54.9	48.6	51.4	48.5	49.5	55.9	51.4	47.8
Moderate	31.3	27.4	31.9	35.1	21.3 [†]	33.4	31.3	28.9	30.7	25.7
High to very high	19.2	17.8	13.2	16.3	27.3	18.0	19.2	15.1	18.0	26.6 [†]

* 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.

[^] Due to the small sample sizes for Aboriginal and/or Torres Strait Islander people, estimates should be interpreted with caution.

(a) Used in the previous 12 months.

(b) Prior to 2013, the 'highest qualification obtained' question did not differentiate between Certificate levels. Data for categories below 'Diploma' in earlier years are not comparable, and have not been reported.

(c) Includes 'Solely engaged in home duties', 'A student', 'Retired or on a pension', 'Volunteer/charity work', 'Unable to work' and 'Other'.

(d) Includes depression, anxiety disorder, schizophrenia, bipolar disorder, an eating disorder and other form of psychosis.

(e) Low: K10 score 10–15, Moderate: 16–21, High: 22–29, Very high: 30–50. Data are for people aged 18 or older.

Notes:

1. 2004 socioeconomic quintiles were calculated using the 2001 Census of Population and Housing. 2007 and 2010 socioeconomic quintiles were calculated using the 2006 Census of Population and Housing. From 2013, socioeconomic quintiles are calculated using the 2011 Census of Population and Housing. These data are considered comparable but trends should be interpreted with caution.

2. From 2013, Remoteness Areas were defined using the 2011 Australian Statistical Geography Standard (ASGS). Prior to this, relevant Australian Standard Geographical Classification (ASGC) editions were used. These data are considered comparable but trends should be interpreted with caution.

3. Base is users of ecstasy in the previous 12 months.

Table A17.18: Drugs used at the same time when using ecstasy, by people aged 14 or older who recently^(a) used ecstasy, NSW and Australia, 2004 to 2016 (%)

Drug	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Alcohol	77.5	84.2	91.0	91.9	90.0	82.6	85.4	94.0	92.3	88.2
Tobacco	n.a.	n.a.	59.7	59.8	50.2	n.a.	n.a.	60.8	60.8	56.5
Marijuana/cannabis	55.0	48.9	42.3	49.2	49.5	56.8	49.2	41.0	44.7	52.8 [#]
Cocaine	15.2	22.3	28.0	36.0	25.7	13.5	18.5	23.9	23.1	26.1
Meth/amphetamines ^(b)	37.8	21.2	11.9	*15.7	*9.1	38.5	28.7	20.3	24.1	14.8 [#]
Ketamine	*11.6	*5.4	*6.0	*7.8	*7.2	8.6	5.0	5.8	6.5	8.0
Hallucinogens	n.a.	n.a.	*6.5	*7.6	*11.7	n.a.	n.a.	8.4	9.1	13.0
Pharmaceuticals ^(b)	*7.9	*5.6	*5.1	*9.0	**4.8	7.2	8.8	6.4	6.2	6.7
Other	**5.5	14.1	*3.9	*4.0	**4.4	6.7	10.2	*3.9	4.5	*2.7
Illicit drugs use at same time (excludes alcohol and tobacco) ^(c)	69.7	62.7	56.4	64.0	58.5	70.8	65.3	56.9	58.7	62.8
Not used any of the above	*10.0	*6.1	**1.1	**5.1	**2.8	7.1	5.2	*1.8	*3.0	*3.3

* 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.

(b) For non-medical purposes.

(c) Tobacco was not included as a response option in 2004 or 2007

Notes:

1. Base is users of ecstasy in the previous 12 months.

2. Response options have changed over time, trends should be interpreted with caution.

Patterns of use

Table A17.19: Use of prescription amphetamines for non-medical purposes, people aged 14 or older who recently used meth/amphetamines,^(a) NSW and Australia, 2010 to 2016 (%)

Behaviour	New South Wales			Australia		
	2010	2013	2016	2010	2013	2016
Used prescription amphetamine ^(a) in their lifetime	*11.0	*17.7	*26.4	15.1	14.1	28.3 [#]
Used prescription amphetamine ^(a) in the last 12 months	n.a.	n.a.	*12.8	n.a.	n.a.	15.9
Used prescription amphetamine ^(a) as their main form in the last 12 months	**3.3	**6.1	*12.8	6.8	*3.0	11.1 [#]

* 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 for non-medical purposes.

Note: Base is people who used meth/amphetamines in the last 12 months.

Table A17.20: Lifetime use of meth/amphetamines for non-medical purposes by remoteness area, people aged 14 or older, NSW and Australia, 2010 to 2016 (%)

Remoteness	New South Wales			Australia		
	2010	2013	2016	2010	2013	2016
Major cities	6.7	6.0	5.2	7.2	6.9	6.3
Inner regional	5.9	5.4	5.2	6.3	6.3	5.3
Outer regional, remote and very remote	*4.1	3.8	*7.3	7.2	8.1	8.1

* 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.

Table A17.21: Lifetime use of ecstasy by remoteness area, people aged 14 or older in NSW and Australia, 2010 to 2016 (%)

Remoteness	New South Wales			Australia		
	2010	2013	2016	2010	2013	2016
Major cities	11.4	11.5	11.8	11.1	11.5	12.0
Inner regional	8.6	8.9	9.6	8.1	8.8	8.6
Outer regional, remote and very remote	5.1	6.1	*9.7	9.4	10.1	10.5

* 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.

Table A17.22: Lifetime use of meth/amphetamines for non-medical purposes, by gender and age, people aged 14 or older, NSW, 2010 to 2016 (%)

Age	Males				Females				Persons		
	2010	2013	2016		2010	2013	2016		2010	2013	2016
14–19	**1.1	—	—		**1.5	*2.1	—		*1.3	*1.0	—
20–29	12.1	13.3	*5.8 [#]		11.4	6.7	7.4		11.7	10.0	6.6 [#]
30–39	14.4	14.2	13.3		14.1	9.2	9.8		14.3	11.7	11.5
40–49	9.4	7.8	9.1		6.2	7.2	6.9		7.7	7.5	8.0
50+	1.4	2.1	3.4		0.7	1.4	1.6		1.0	1.8	2.5

* 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.

— Estimate is nil or has been rounded to zero

(a) Used at least once in lifetime for non-medical purposes.

Table A17.23: Main form of meth/amphetamines used by main method of use, people aged 14 or older who have recently^(a) used meth/amphetamines, NSW, 2010 to 2016 (%)

Method of use	Mainly used powder				Mainly used crystal (ice)				Recent meth/amphetamine users		
	2010	2013	2016		2010	2013	2016		2010	2013	2016
Smoked	n.p.	n.p.	n.p.		n.p.	n.p.	n.p.		*8.3	36.4	45.8
Snorted	63.4	n.p.	n.p.		n.p.	n.p.	n.p.		39.8	24.4	*13.6
Swallowed	*27.3	n.p.	n.p.		n.p.	n.p.	n.p.		39.1	29.6	*31.9
Injected	**8.3	n.p.	n.p.		n.p.	n.p.	n.p.		*12.8	*8.3	*8.7

* 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 last 12 months for non-medical purposes.

Note: 'Other' method of use has been excluded from this table.

Table A17.24: Main form of meth/amphetamines used by main method of use, people aged 14 or older who have recently^(a) used meth/amphetamines, Australia, 2010 to 2016 (%)

Method of use	Mainly used powder			Mainly used crystal (ice)			Recent meth/amphetamine users		
	2010	2013	2016	2010	2013	2016	2010	2013	2016
Smoked	*6.4	**4.3	*12.2	61.4	78.0	67.6	19.1	40.9	41.8
Snorted	56.8	64.7	51.1	*9.1	*5.3	*4.2	34.2	22.6	16.3
Swallowed	27.8	27.0	32.8	*15.2	*7.3	*7.3	36.0	26.5	28.6
Injected	*9.0	*4.0	**2.3	*14.4	*9.4	19.2 [#]	10.6	9.5	11.9
Other	—	n.p.	n.p.	—	n.p.	**1.8	—	**0.5	**1.3

* 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.

— Estimate is nil or has been rounded to zero

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

Note: This table was published in the Illicit Drugs Chapter in the 2016 NDSHS detailed findings (Table 5.47).

Table A17.25: Main form of meth/amphetamines used by main method of use, people aged 14 or older who have recently^(a) used meth/amphetamines by age, Australia, 2010 to 2016 (%)

Method of use	Mainly used powder			Mainly used crystal (ice)			Recent meth/amphetamine users		
	2010	2013	2016	2010	2013	2016	2010	2013	2016
Aged 14-29									
Smoked	*10.8	**6.5	n.p.	67.5	87.2	84.5	25.7	49.2	44.6
Snorted	62.5	69.5	n.p.	**11.2	**6.3	**6.6	35.5	22.4	20.1
Swallowed	21.2	*24.0	n.p.	*14.5	**3.2	**2.2	32.8	24.6	31.9
Injected	**5.5	n.p.	n.p.	**6.8	**3.2	**3.6	*6.0	**3.1	**1.8
Aged 30-49									
Smoked	**1.6	n.p.	*14.6	45.2	61	60.5	9.6	30.1	42.8 [#]
Snorted	51.5	59	42.6	n.p.	**4.0	**2.5	33.8	21.7	14
Swallowed	33.6	29.5	36.1	*18.9	*14.6	*10.6	39.3	28.6	24
Injected	*13.3	*9.5	**3.4	*33.0	*20.4	25.6	17.3	19.7	18
Aged 50+									
Smoked	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	*21.5
Snorted	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	**11.5
Swallowed	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	*41.9
Injected	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	n.p.	*23.2

* 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 last 12 months for non-medical purposes.

Note: 'Other' method of use has been excluded from this table.

Attitudes and perceptions

Table A17.26: Drug first nominated when asked about a specific drug problem, people aged 14 years or older, NSW and Australia, 2004 to 2016 (%)

Drug first nominated	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Alcohol	10.5	10.9	6.6	7.8	7.0	10.0	10.5	6.5	7.8	6.3 [#]
Tobacco	3.4	2.7	2.7	2.6	1.9 [#]	3.3	2.6	2.2	2.3	2.0
Cannabis	27.2	23.2	23.1	21.9	13.8 [#]	29.2	25.2	23.9	22.8	14.6 [#]
Ecstasy	2.4	4.6	3.6	3.8	3.5	2.6	4.2	3.8	3.4	3.1
Meth/amphetamine ^(a)	3.9	14.6	13.4	17.6	40.9 [#]	5.5	16.4	16.3	21.9	46.4 [#]
Cocaine	7.3	7.4	11.7	12.6	9.5 [#]	6.7	7.1	11.6	11.0	8.1 [#]
Heroin	42.0	33.1	34.0	28.3	17.0 [#]	39.4	30.3	31.0	25.6	14.0 [#]
Pain killers/analgesics/opioids ^(a,b)	0.4	0.4	1.3	1.4	1.7	0.5	0.4	1.1	1.4	1.5
Steroids ^(a)	*0.2	*0.3	*0.1	*0.2	*0.3	0.2	0.3	*<0.1	0.2	0.2
Methadone/buprenorphine ^(a)	n.a.	n.a.	*0.2	*0.2	*0.4	n.a.	n.a.	0.2	0.3	0.4
Drugs other than listed	*<0.1	0.2	*<0.1	*0.3	0.8 [#]	*<0.1	0.2	0.1	0.3	0.6 [#]
None/can't think of any	0.7	1.2	1.6	3.3	3.2	0.6	1.1	1.6	3.0	2.8
Drugs listed prior to 2013 ^(c)	1.9	1.4	1.6	n.a.	n.a.	2.0	1.6	1.7	n.a.	n.a.

* 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) For non-medical purposes.

(b) Over-the-counter pain killers, prescription pain killers and other opioids were separated prior to 2013.

(c) For 2010, this includes tranquilisers/sleeping pills, inhalants, hallucinogens, GHB, ketamine and kava. For 2007, this includes caffeine, barbiturates, tranquilisers/sleeping pills, inhalants, hallucinogens, GHB, ketamine, zanthanols and kava. For 2004 this includes tea/coffee/caffeine, barbiturates, tranquilisers/sleeping pills, inhalants, hallucinogens, GHB, ketamine and kava.

Table A17.27: Drug thought to be of most concern for the general community, people aged 14 years or older, NSW and Australia, 2004 to 2016 (%)

Drug	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Excessive drinking of alcohol	32.1	33.8	42.9	43.8	30.2 [#]	30.9	32.3	42.1	42.5	28.4 [#]
Tobacco smoking	23.6	17.6	16.3	15.7	9.8 [#]	23.9	17.3	15.4	14.5	9.4 [#]
Cannabis	6.0	5.8	4.3	3.7	2.3 [#]	6.7	5.7	4.5	3.8	2.6 [#]
Ecstasy ^(b)	6.5	6.4	5.3	5.4	5.3	7.4	6.0	5.5	5.2	5.0
Meth/amphetamine ^(a)	1.6	14.5	8.1	13.4	35.9 [#]	2.8	16.4	9.4	16.1	39.8 [#]
Cocaine	5.5	8.4	6.2	4.1	3.8	5.0	8.3	6.1	3.6	3.3
Heroin	22.1	10.8	12.4	10.4	8.9 [#]	19	10.5	11.4	10.7	7.5 [#]
Painkillers/analgesics/opioids ^(a)	0.6	*0.4	1.3	2.1	1.7	0.6	0.6	1.5	2.2	2.0
Steroids ^(a)	**<0.1	*0.2	**<0.1	*0.2	*0.3	<0.1	0.2	*<0.1	0.3	0.3
Methadone/buprenorphine ^(a)	n.a.	n.a.	*0.2	0.4	0.5	n.a.	n.a.	0.2	0.3	0.5 [#]
None of these	*0.4	*0.5	0.4	0.9	1.3	0.3	0.3	0.4	0.8	1.2 [#]
Other ^(c)	1.5	1.8	2.6	n.a.	n.a.	3.1	2.5	3.3	n.a.	n.a.

* 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) For non-medical purposes.

(b) Included 'designer drug use' in 2004.

(c) The list of response options has changed over time. In 2004 and 2007, barbiturates, tranquillisers, sniffing glue/petrol/solvents/rush, and hallucinogens were listed as separate response options. In 2010, tranquillisers/sleeping pills, sniffing petrol/glue/aerosols/solvents, hallucinogens/LSD/magic mushrooms, GHB, ketamine, and kava were listed as separate response options. These were removed in subsequent survey waves and have been grouped under 'Other' in this table. Comparisons should be interpreted with caution.

Table A17.28: Support^(a) for actions taken against people found in possession of selected illicit drugs for personal use, people aged 14 years or older, NSW and Australia, 2004 to 2016 (%)

Drug/action	New South Wales					Australia				
	2004	2007	2010	2013	2016	2004	2007	2010	2013	2016
Ecstasy										
A caution/warning or no action	9.8	9.0	11.5	13.2	17.0 [#]	8.8	8.5	10.7	12.5	14.8 [#]
Referral to treatment or education program	40.1	48.9	35.8	36.1	36.9	41.1	48.9	37.1	37.4	38.8 [#]
Fine	24.0	19.6	23.5	24.0	22.1	24.6	20.8	24.8	24.5	22.9 [#]
Community service or weekend detention	10.3	7.1	12.4	11.7	9.6 [#]	9.4	6.3	10.7	10.3	8.7 [#]
Prison sentence	14.6	13.9	15.2	13.4	12.7	14.8	13.9	15.2	13.7	13.0
Some other arrangement	1.3	1.5	1.6	1.6	1.6	1.2	1.5	1.6	1.5	1.7
Meth/amphetamines^(b)										
A caution/warning or no action	5.5	10.6	4.2	4.2	4.6	4.8	10.5	4.3	4.3	4.2
Referral to treatment or education program	42.5	52.5	43.9	43.5	45.3	42.5	52.7	42.9	43.1	45.7 [#]
Fine	19.3	17.7	16.8	18.1	14.7 [#]	19.7	18.9	18.7	18.6	15.2 [#]
Community service or weekend detention	10.9	7.6	13.0	12.7	9.9 [#]	10.3	6.6	11.7	11.4	8.9 [#]
Prison sentence	20.1	10.1	19.7	19.0	23.0 [#]	20.8	9.7	20.1	20.3	23.5 [#]
Some other arrangement	1.8	1.6	2.6	2.5	2.4	1.9	1.5	2.3	2.3	2.6

* 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) Includes those who selected 'support' or 'strongly support'. Calculations based on those respondents who were informed enough to indicate their level of support.

(b) For non-medical purposes.

Appendix 18: Data from the NSW Bureau of Crime Statistics and Research (BOCSAR)

The NSW Bureau of Crime Statistics and Research (BOCSAR) is a statistical and research agency within the Department of Communities and Justice that:

- develops and maintains statistical databases on crime and criminal justice in NSW
- conducts research on crime and criminal justice issues and problems
- monitors trends in crime and criminal justice
- provides information and advice on crime and criminal justice in NSW.¹

In response to a request for information by the Inquiry, in August 2019 BOCSAR provided the Inquiry with data about amphetamine and ecstasy-related incidents, offences, court and custody statistics.²

NSW recorded crime statistics July 2005 to June 2019

Table A18.1: Rate per 100,000 population of recorded incidents of possess/use amphetamines or ecstasy in NSW

Drug type	Jul 2005 – Jun 2006	Jul 2006 – Jun 2007	Jul 2007 – Jun 2008	Jul 2008 – Jun 2009	Jul 2009 – Jun 2010	Jul 2010 – Jun 2011	Jul 2011 – Jun 2012	Jul 2012 – Jun 2013	Jul 2013 – Jun 2014	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Amphetamines	31.7	38.1	36.4	32.2	30.4	37.8	47.9	53.4	61	83.2	96	89.6	87.6	95.1
Ecstasy	11.5	14.3	17.9	26	26.1	16.6	17	26.1	23.5	27.8	31.5	35.3	36.5	36.9

Table A18.2: Rate per 100,000 population of recorded incidents of deal/traffic amphetamines or ecstasy in NSW

Drug type	Jul 2005 – Jun 2006	Jul 2006 – Jun 2007	Jul 2007 – Jun 2008	Jul 2008 – Jun 2009	Jul 2009 – Jun 2010	Jul 2010 – Jun 2011	Jul 2011 – Jun 2012	Jul 2012 – Jun 2013	Jul 2013 – Jun 2014	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Amphetamines	13.4	12.1	12.8	12.4	9.7	16.4	15.4	20.8	23.1	31.7	30.8	26.5	25	22.7
Ecstasy	7.2	5.9	7.5	6.8	8.7	4.5	5.4	6.9	5.7	8	7.9	9.1	9.5	6.9

Table A18.3: Rate of incidents of possess/use amphetamines recorded by the NSW Police Force by Statistical Area and % change over past 10 years

Statistical Area	Jul 2005 – Jun 2006	Jul 2006 – Jun 2007	Jul 2007 – Jun 2008	Jul 2008 – Jun 2009	Jul 2009 – Jun 2010	Jul 2010 – Jun 2011	Jul 2011 – Jun 2012	Jul 2012 – Jun 2013	Jul 2013 – Jun 2014	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019	10 Yr % Change
Coffs Harbour Grafton	28.2	24.1	25.4	13	12.1	12.7	34	28	71	82.9	112.1	96.2	125.7	125.7	938.8%
Far West And Orana	40.9	71.8	60.7	29	31.4	34.7	46.8	64.8	54.6	120.5	137.9	111.4	152.6	224.6	615.3%
Southern Highlands And Shoalhaven	20.2	30.6	21.4	17.5	18.7	26.3	23.9	38.3	41.4	67.5	87.5	119.4	104.3	118	531.0%
Central Coast	24.2	28.7	18.3	11.8	15.5	25	19.5	23.4	47.9	75.1	90.3	98	83.1	97.6	529.7%
Riverina	25.8	30.3	29.5	20.2	30.4	39.9	50.1	64	67.5	121.2	111.7	123	106.8	169.3	456.9%
Hunter Valley Exc Newcastle	31.3	36.6	35.1	35	33.6	35.5	46.1	49.3	85.5	111.1	156.1	120	145.7	181.3	439.6%
Murray	39.3	56.9	72.5	33.6	29.9	61.5	80.8	83.9	111.9	124.7	158.9	125.5	125.3	150.6	403.7%
Mid North Coast	34.1	38.1	29.1	22.3	24	25.2	32.7	46.7	55.9	65.3	103.1	96.7	110.4	113.6	373.3%
Sydney – South West	20.8	30.9	28.3	29.9	27.7	40.3	48.1	66.6	76.1	114.1	118.4	106.5	98.7	130.4	370.8%
New England And North West	18.1	23.8	23.1	32	19.5	25.9	37.8	38.2	51.7	78	112.9	80.3	84.3	86.5	343.6%
Richmond Tweed	29.5	41.6	26.7	31.2	28.7	28.1	31.7	57.1	69.9	103.3	111.5	96.9	108.3	120.3	319.2%
Capital Region	37.8	30	31.1	20.7	21.3	24.3	35.2	38.6	43.4	72.1	68	65.7	76.7	88.2	314.1%
Sydney Blacktown	37.2	51.9	35.5	34.3	21.5	31	51.8	57.1	46.4	71.4	85	72.7	76.1	88.9	313.5%
Sydney Outer South West	21.5	24.5	39.8	22.6	27.2	27.8	50.9	47.7	64	84.1	121	98.7	84.8	98.9	263.6%
Sydney Inner West	11.6	17	18.2	11.8	15.5	16.8	20.1	36.6	29.9	35.6	50.6	44.2	49.7	54.2	249.7%
Sydney North Sydney And Hornsby	13.4	13.1	12.1	9	5.7	11.3	19	17	13.6	19.5	19.2	16.1	16.2	18.8	229.8%
Sydney Parramatta	34.9	40	37.4	29.4	28.7	43.3	53.2	61.5	68.4	86.8	95.5	90	82.1	94.2	228.2%
Central West	31.9	47.3	40.4	40.1	34.1	28.8	62.9	61.5	75.6	82.3	111.5	94.2	82.9	109.4	220.8%
Newcastle And Lake Macquarie	23.6	33.8	27.7	34.3	28	28.8	46.4	52	69.6	88.5	101.3	103.4	106.1	88.9	217.5%
NSW	31.7	38.1	36.4	32.2	30.4	37.8	47.9	53.4	61	83.2	96	89.6	87.6	95.1	212.8%
Sydney Inner South West	18.3	22	19.1	22.1	19.1	22.3	22.1	36	43.7	53.5	56.2	59.5	52.1	51.6	170.2%
Sydney Outer West And Blue Mountains	24.2	27	27.1	26.4	32.6	36.5	42.6	54.9	59.5	85.8	109.8	105.6	106	85.3	161.7%
Sydney Northern Beaches	11.2	13.3	16	15	9	12.9	15.9	14.2	13.2	23.9	30.8	25.2	21.6	22.7	152.2%
Illawarra	48.5	46.2	47.9	40.5	38.5	49.2	57.8	81.8	63.7	85	118.8	135.7	107.3	92.3	139.7%
Sydney Sutherland	19	21.8	19.8	17.6	23.8	26.9	32.3	45.3	45.5	64.5	59.7	62.4	73.1	51.5	116.4%
Sydney City And Inner South	119.1	137.6	169.8	147.6	124.8	172	186.8	222.7	259.7	317.9	297.7	264.8	246.9	242.3	94.2%
Sydney Ryde	7.5	12.5	4.9	10.9	10.2	3.5	8.2	12	11.2	11	17.8	14.8	13.9	16.5	61.8%
Sydney Baulkham Hills And Hawkesbury	22.8	21	8.7	8.5	9.8	8.8	6.9	6.8	9.8	19.8	18.6	14	12.9	14.1	43.9%
Sydney Eastern Suburbs	23.6	30.3	27	33.9	52.4	51.7	59.3	60.8	37.5	52.4	54.4	59.1	51.1	56	6.9%

Note: The types of offences shown tend to be those detected by police rather than reported. Therefore the trends shown may be more indicative of policing operations rather than the incidence of those particular offences.

Table A18.4: Rate of incidents of possess/use ecstasy recorded by the NSW Police Force by Statistical Area and % change over past 10 years

Statistical Area	Jul 2005 – Jun 2006	Jul 2006 – Jun 2007	Jul 2007 – Jun 2008	Jul 2008 – Jun 2009	Jul 2009 – Jun 2010	Jul 2010 – Jun 2011	Jul 2011 – Jun 2012	Jul 2012 – Jun 2013	Jul 2013 – Jun 2014	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019	10 Yr % Change
Sydney North Sydney And Hornsby	16.1	16.6	16.7	10.9	6.5	10.5	8.6	7.8	13.6	22.4	37.2	44.1	42	39.7	510.8%
Coffs Harbour Grafton	3.9	9.3	10.8	10.7	2.3	1.5	5.2	2.2	7.3	7.3	13	15.8	17.1	12.1	426.1%
Capital Region	6	14.7	9.2	8.6	5.2	4.2	9.7	11	8.7	14.1	18.9	15.6	13.3	26.1	401.9%
Murray	9.8	9.8	20.3	15	7	1.8	10.5	19.2	20.8	24.9	35.9	35.6	32	27.8	297.1%
Sydney Outer South West	3.5	3.9	9.5	6.4	4.6	2.9	4.1	8.9	8.7	16	17.1	15.6	16.3	17.4	278.3%
Mid North Coast	5.1	6.6	12.5	9.4	7.4	7.3	5.8	6.7	6.2	11.8	14.5	29.2	36.2	26.1	252.7%
Illawarra	5.5	5.9	13.8	12.9	8.1	4.2	5.9	13.8	12.3	13.5	13.7	10.9	11.4	26.4	225.9%
Riverina	6	11.9	8.5	18.9	5.2	1.9	4.5	9.6	9.6	8.2	13.9	8.2	11.9	15.6	200.0%
Central Coast	13.9	13.9	13.1	9.9	12.3	6.9	3.7	3.7	9.2	8.8	19.5	20.2	33.6	32.4	163.4%
Newcastle And Lake Macquarie	13.3	7.7	6.4	11.2	8.6	4.8	2.8	5.3	9.7	9	14.7	22.2	16.7	21.2	146.5%
Sydney Parramatta	18.5	38.6	25.5	38	26.4	31	30	47	49.5	48.8	47	37.5	66.7	62.2	135.6%
Hunter Valley Exc Newcastle	5.7	6.9	2.1	15	13.1	4	9.1	21.1	10.8	18.3	20.7	17.8	21.7	27.5	109.9%
Central West	2.6	7.2	10.2	16.3	9	9.4	5.9	3.9	7.3	10.6	12.4	17.1	14.2	16.6	84.4%
Sydney Inner West	4.8	5.9	4.6	6.4	8.1	3.3	3.2	13.4	16.2	21.5	17.5	10.1	16.9	14.0	72.8%
NSW	11.5	14.3	17.9	26	26.1	16.6	17	26.1	23.5	27.8	31.5	35.3	36.5	36.9	41.4%
Sydney Northern Beaches	8.6	6.8	6.3	7.5	6.1	8.9	5.2	8.3	8.9	7.3	14.1	6	10.4	8.6	41.0%
Sydney City And Inner South	74.3	72.5	116.5	165.9	160.4	84.9	104.7	204.5	179	221.3	224.3	214.1	185.3	214.2	33.5%
Sydney Blacktown	2.5	4.6	4.9	12.6	4.6	4.5	2.9	20.6	3.1	4.5	6.4	6.6	7.5	5.8	26.1%
Richmond Tweed	9.8	22.6	20.6	44.2	81.5	11.1	8.5	57.9	40	45.5	54.1	95.3	93.4	101.0	23.9%
Sydney Inner South West	6.4	5.5	6.2	6.4	4.6	3.8	6.3	3.9	7.2	5.4	7	7.4	6.9	5.6	21.7%
Sydney Eastern Suburbs	15.1	26.6	62.3	138.7	156.8	132.9	114.5	144.5	120	128.2	127.2	208.5	200.7	172.7	10.1%
Sydney South West	4.3	6.3	11.6	7.8	5.7	4.6	4	5.7	5.9	5.3	9.8	8.6	11.6	6.2	8.8%
Far West And Orana	5.1	4.3	5.1	11.1	7.6	0.8	4.3	7.7	5.1	6	7.7	9.4	9.4	7.7	1.3%
Sydney Sutherland	7.1	9	11.3	15.3	10.5	4.6	8.7	10	9	14.8	20.5	17.3	11.9	10.6	1.0%
Sydney Baulkham Hills And Hawkesbury	11.9	7.3	8.7	10	15.4	10.1	4.1	4.1	4	5.3	7.8	13.6	9.5	13.3	-13.6%
Southern Highlands And Shoalhaven	6	6	7.4	11.7	10.8	2.1	4.9	9.1	5.5	5.5	11.4	6	11.1	8.5	-21.3%
New England And North West	0.6	2.8	3.9	4.5	12.2	2.7	2.2	6.5	2.2	4.9	8.1	10.8	7	8.1	-33.6%
Sydney Ryde	5.7	7.5	3.1	17.6	7.2	1.2	4.1	5.1	3.4	3.3	4.3	4.7	6.2	4.1	-43.1%
Sydney Outer West And Blue Mountains	4.2	6.7	9	10.3	40	22	23.2	23.6	20.4	23.1	18.9	20.6	17.9	17.2	-57.0%

Note: The types of offences shown tend to be those detected by police rather than reported. Therefore the trends shown may be more indicative of policing operations rather than the incidence of those particular offences.

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Table A18.5: Number of persons of interest^ (POIs) proceeded against by the NSW Police Force for a possess/use amphetamines or ecstasy offence by gender and age

Drug type	Age	Male	% Total	Female	% Total	Unknown	Total
Amphetamines	Under 18	43	1%	17	0%	0	60
	18 – 29	1,300	22%	560	10%	5	1,865
	30 – 39	1,636	28%	492	8%	2	2,130
	40 – 49	1,060	18%	297	5%	1	1,358
	50 and over	397	7%	76	1%	0	473
	Total	4,436	75%	1,442	24%	8	5,886
Ecstasy	Under 18	69	3%	42	2%	0	111
	18 – 29	1,406	56%	607	24%	17	2,030
	30 – 39	213	9%	40	2%	0	253
	40 – 49	54	2%	23	1%	0	77
	50 and over	17	1%	1	0%	0	18
	Total	1,761	71%	713	29%	17	2,491

^ Persons of interest (POIs) are suspected offenders recorded by police in connection with a criminal incident. Some POIs are formally proceeded against to court and some are proceeded against other than to court whilst others are not proceeded against. The POIs included in the table above have all been proceeded against. POIs are not a count of unique offenders. Where an individual is involved in multiple criminal incidents throughout the year they will appear as a POI multiple times. Correspondingly, no person of interest information will be recorded for criminal incidents in which there is no known suspect. This is very common among incidents of property crime which have a low clear up rate.

Table A18.6: Number of persons of interest^ (POIs) proceeded against by the NSW Police Force for a possess/use amphetamines or ecstasy offence by gender and Indigenous status

Drug type	Indigenous Status	Male	% Total	Female	% Total	Unknown	Total
Amphetamines	Indigenous	563	10%	196	3%	0	759
	Non-indigenous	3,286	56%	1,037	18%	8	4,331
	Unknown	587	10%	209	4%	0	796
	Total	4,436	75%	1,442	24%	8	5,886
Ecstasy	Indigenous	24	1%	9	0%	1	34
	Non-indigenous	1,435	58%	582	23%	14	2,031
	Unknown	302	12%	122	5%	2	426
	Total	1,761	71%	713	29%	17	2,491

^ Persons of interest (POIs) are suspected offenders recorded by police in connection with a criminal incident. Some POIs are formally proceeded against to court and some are proceeded against other than to court whilst others are not proceeded against. The POIs included in the table above have all been proceeded against. POIs are not a count of unique offenders. Where an individual is involved in multiple criminal incidents throughout the year they will appear as a POI multiple times. Correspondingly, no person of interest information will be recorded for criminal incidents in which there is no known suspect. This is very common among incidents of property crime which have a low clear up rate.

Table A18.7: Number of persons of interest[^] (POIs) proceeded against by the NSW Police Force for a possess/use amphetamines or ecstasy offence by prior amphetamine charges

Drug type	Prior charge	Male	% Total	Female	% Total	Unknown	Total*
Amphetamines	No priors	2,245	39%	834	14%	5	3,084
	Has priors	2,122	37%	585	10%	3	2,710
	Total	4,367	75%	1,419	24%	8	5,794
Ecstasy	No priors	1,682	68%	695	28%	17	2,394
	Has priors	62	3%	12	0%	0	74
	Total	1,744	71%	707	29%	17	2,468

[^] Persons of interest (POIs) are suspected offenders recorded by police in connection with a criminal incident. Some POIs are formally proceeded against to court and some are proceeded against other than to court whilst others are not proceeded against. The POIs included in the table above have all been proceeded against. POIs are not a count of unique offenders. Where an individual is involved in multiple criminal incidents throughout the year they will appear as a POI multiple times. Correspondingly, no person of interest information will be recorded for criminal incidents in which there is no known suspect. This is very common among incidents of property crime which have a low clear up rate.

Table A18.8: Number of persons of interest[^] (POIs) proceeded against by the NSW Police Force for a deal/traffic amphetamines or ecstasy offence by gender and age

Drug type	Age	Male	% Total	Female	% Total	Unknown	Total
Amphetamines	Under 18	5	0%	6	0%	0	11
	18 – 29	288	17%	121	7%	7	416
	30 – 39	479	28%	229	14%	1	709
	40 – 49	308	18%	85	5%	0	393
	50 and over	134	8%	19	1%	0	153
	Total	1,214	72%	460	27%	8	1,682
Ecstasy	Under 18	28	5%	7	1%	0	35
	18 – 29	407	70%	60	10%	2	469
	30 – 39	50	9%	11	2%	0	61
	40 – 49	17	3%	1	0%	0	18
	50 and over	1	0%	0	0%	0	1
	Total	503	86%	79	14%	2	584

[^] Persons of interest (POIs) are suspected offenders recorded by police in connection with a criminal incident. Some POIs are formally proceeded against to court and some are proceeded against other than to court whilst others are not proceeded against. The POIs included in the table above have all been proceeded against. POIs are not a count of unique offenders. Where an individual is involved in multiple criminal incidents throughout the year they will appear as a POI multiple times. Correspondingly, no person of interest information will be recorded for criminal incidents in which there is no known suspect. This is very common among incidents of property crime which have a low clear up rate.

Table A18.9: Number of persons of interest^ (POIs) proceeded against by the NSW Police Force for a deal/traffic amphetamines or ecstasy offence by gender and Indigenous status

Drug type	Indigenous Status	Male	% Total	Female	% Total	Unknown	Total
Amphetamines	Indigenous	136	8%	65	4%	0	201
	Non-indigenous	1054	63%	388	23%	8	1,450
	Unknown	24	1%	7	0%	0	31
	Total	1,214	72%	460	27%	8	1,682
Ecstasy	Indigenous	20	3%	4	1%	1	25
	Non-indigenous	466	80%	66	11%	1	533
	Unknown	17	3%	9	2%	0	26
	Total	503	86%	79	14%	2	584

^ Persons of interest (POIs) are suspected offenders recorded by police in connection with a criminal incident. Some POIs are formally proceeded against to court and some are proceeded against other than to court whilst others are not proceeded against. The POIs included in the table above have all been proceeded against. POIs are not a count of unique offenders. Where an individual is involved in multiple criminal incidents throughout the year they will appear as a POI multiple times. Correspondingly, no person of interest information will be recorded for criminal incidents in which there is no known suspect. This is very common among incidents of property crime which have a low clear up rate.

Table A18.10: Number of persons of interest^ (POIs) proceeded against by the NSW Police Force for a deal/traffic amphetamines or ecstasy offence by prior amphetamine charges

Drug type	Prior charge	Male	% Total	Female	% Total	Unknown	Total*
Amphetamines	No priors	261	30%	95	11%	0	356
	Has priors	413	47%	107	12%	2	522
	Total	674	77%	202	23%	2	878
Ecstasy	No priors	270	63%	54	13%	1	325
	Has priors	92	21%	13	3%	1	106
	Total	362	84%	67	16%	2	431

^ Persons of interest (POIs) are suspected offenders recorded by police in connection with a criminal incident. Some POIs are formally proceeded against to court and some are proceeded against other than to court whilst others are not proceeded against. The POIs included in the table above have all been proceeded against. POIs are not a count of unique offenders. Where an individual is involved in multiple criminal incidents throughout the year they will appear as a POI multiple times. Correspondingly, no person of interest information will be recorded for criminal incidents in which there is no known suspect. This is very common among incidents of property crime which have a low clear up rate.

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Table A18.11: Number of amphetamines offences recorded by the NSW Police Force by whether legal proceedings commenced in 90 days of reporting* July 2009 to March 2019**

	Proceeded against with 90 days	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4
Possession and/or use of amphetamines	Yes	308	329	427	418	416	430	507	526	538	532	627	637	723	709
	No	126	114	142	121	140	165	164	149	218	170	216	255	265	308
	% proceed against	71.0	74.3	75.0	77.6	74.8	72.3	75.6	77.9	71.2	75.8	74.4	71.4	73.2	69.7
	Total	434	443	569	539	556	595	671	675	756	702	843	892	988	1,017
Dealing, trafficking in amphetamines	Yes	99	124	104	166	229	196	147	153	175	153	207	195	192	344
	No	26	30	36	48	95	95	98	68	54	102	65	74	154	144
	% proceed against	79.2	80.5	74.3	77.6	70.7	67.4	60.0	69.2	76.4	60.0	76.1	72.5	55.5	70.5
	Total	125	154	140	214	324	291	245	221	229	255	272	269	346	488

	Proceeded against with 90 days	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	2015 Q3	2015 Q4
Possession and/or use of amphetamines	Yes	718	638	723	762	873	949	1,068	1,096	1,177	1,349	1,399	1,343
	No	260	276	310	271	279	347	361	371	429	396	434	403
	% proceed against	73.4	69.8	70.0	73.8	75.8	73.2	74.7	74.7	73.3	77.3	76.3	76.9
	Total	978	914	1,033	1,033	1,152	1,296	1,429	1,467	1,606	1,745	1,833	1,746
Dealing, trafficking in amphetamines	Yes	195	257	419	311	254	294	537	438	287	403	360	374
	No	104	127	89	86	176	83	206	195	202	109	313	112
	% proceed against	65.2	66.9	82.5	78.3	59.1	78.0	72.3	69.2	58.7	78.7	53.5	77.0
	Total	299	384	508	397	430	377	743	633	489	512	673	486

	Proceeded against with 90 days	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1
Possession and/or use of amphetamines	Yes	1,410	1,454	1,451	1,366	1,183	1,200	1,223	1,272	1,343	1,404	1,391	1,345	1,418
	No	427	439	471	458	401	402	425	393	425	405	429	451	440
	% proceed against	76.8	76.8	75.5	74.9	74.7	74.9	74.2	76.4	76.0	77.6	76.4	74.9	76.3
	Total	1,837	1,893	1,922	1,824	1,584	1,602	1,648	1,665	1,768	1,809	1,820	1,796	1,858
Dealing, trafficking in amphetamines	Yes	368	450	443	373	325	292	402	312	268	428	381	235	291
	No	222	145	161	181	129	145	154	153	193	55	94	157	153
	% proceed against	62.4	75.6	73.3	67.3	71.6	66.8	72.3	67.1	58.1	88.6	80.2	60.0	65.5
	Total	590	595	604	554	454	437	556	465	461	483	475	392	444

* Note: This includes incidents where a person was either proceeded against to court or proceeded against other than to court (by way of Youth Justice Conference, Caution Young Offenders Act, Cannabis Caution, Other Drug Caution, Criminal Infringement Notice, or Infringement Notice or Warning)

**Data is available up until March 2019 as a period of 3 months is required after an incident is reported to allow for proceedings within 90 days to commence.

Note: The types of offences shown tend to be those detected by police rather than reported. Therefore the trends shown may be more indicative of policing operations rather than the incidence of those particular offences.

Table A18.12: Number of ecstasy offences recorded by the NSW Police Force by whether legal proceedings commenced in 90 days of reporting* July 2009 to March 2019**

	Proceeded against with 90 days	2009 Q3	2009 Q4	2010 Q1	2010 Q2	2010 Q3	2010 Q4	2011 Q1	2011 Q2	2011 Q3	2011 Q4	2012 Q1	2012 Q2	2012 Q3	2012 Q4
Possession and/or use of ecstasy	Yes	469	300	419	268	145	262	348	173	151	225	373	235	407	366
	No	83	65	55	44	32	51	48	38	28	37	31	51	71	71
	% proceed against	85.0	82.2	88.4	85.9	81.9	83.7	87.9	82.0	84.4	85.9	92.3	82.2	85.2	83.8
	Total	552	365	474	312	177	313	396	211	179	262	404	286	478	437
Dealing, trafficking in ecstasy	Yes	140	76	138	99	71	62	70	44	56	65	52	87	56	85
	No	77	11	16	9	14	23	7	6	19	24	11	46	10	21
	% proceed against	64.5	87.4	89.6	91.7	83.5	72.9	90.9	88.0	74.7	73.0	82.5	65.4	84.9	80.2
	Total	217	87	154	108	85	85	77	50	75	89	63	133	66	106

	Proceeded against with 90 days	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1	2015 Q2	2015 Q3	2015 Q4
Possession and/or use of ecstasy	Yes	579	268	283	406	553	223	367	520	602	288	390	584
	No	91	55	77	67	80	54	77	92	85	56	89	89
	% proceed against	86.4	83.0	78.6	85.8	87.4	80.5	82.7	85.0	87.6	83.7	81.4	86.8
	Total	670	323	360	473	633	277	444	612	687	344	479	673
Dealing, trafficking in ecstasy	Yes	101	140	55	66	112	106	121	112	101	130	97	159
	No	74	19	15	15	39	15	17	71	36	16	32	26
	% proceed against	57.7	88.1	78.6	81.5	74.2	87.6	87.7	61.2	73.7	89.0	75.2	86.0
	Total	175	159	70	81	151	121	138	183	137	146	129	185

	Proceeded against with 90 days	2016 Q1	2016 Q2	2016 Q3	2016 Q4	2017 Q1	2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1
Possession and/or use of ecstasy	Yes	631	374	510	657	756	374	529	540	866	441	541	557	837
	No	138	101	85	114	143	94	120	121	153	96	87	119	159
	% proceed against	82.1	78.7	85.7	85.2	84.1	79.9	81.5	81.7	85.0	82.1	86.2	82.4	84.0
	Total	769	475	595	771	899	468	649	661	1,019	537	628	676	996
Dealing, trafficking in ecstasy	Yes	147	94	111	178	136	122	137	197	149	86	103	115	158
	No	26	21	17	71	24	48	40	37	71	28	24	33	24
	% proceed against	85.0	81.7	86.7	71.5	85.0	71.8	77.4	84.2	67.7	75.4	81.1	77.7	86.8
	Total	173	115	128	249	160	170	177	234	220	114	127	148	182

* Note: This includes incidents where a person was either proceeded against to court or proceeded against other than to court (by way of Youth Justice Conference, Caution Young Offenders Act, Cannabis Caution, Other Drug Caution, Criminal Infringement Notice, or Infringement Notice or Warning)

**Data is available up until March 2019 as a period of 3 months is required after an incident is reported to allow for proceedings within 90 days to commence.

Note: The types of offences shown tend to be those detected by police rather than reported. Therefore the trends shown may be more indicative of policing operations rather than the incidence of those particular offences.

NSW Criminal Court Statistics July 2018 to June 2019

Table A18.13: Number of amphetamines and ecstasy charges finalised in court by offence type and jurisdiction NSW Criminal Court Statistics July 2018 to June 2019

Drug type	Offence type	Higher Court	Local Court	Children's Court	Total
Amphetamines	Import or export illicit drugs	59	0	0	59
	Deal or traffic in illicit drugs - commercial quantity	301	0	0	301
	Deal or traffic in illicit drugs - non-commercial quantity	811	773	11	1,595
	Manufacture or cultivate illicit drugs	46	5	1	52
	Possess and/or use illicit drugs	249	6,231	57	6,537
	Other illicit drug offences	3	23	0	26
	Total	1,469	7,032	69	8,570
Ecstasy	Import or export illicit drugs	8	1	1	10
	Deal or traffic in illicit drugs - commercial quantity	103	0	4	107
	Deal or traffic in illicit drugs - non-commercial quantity	469	357	51	877
	Manufacture or cultivate illicit drugs	10	0	0	10
	Possess and/or use illicit drugs	121	2,479	60	2,660
	Other illicit drug offences	0	0	0	0
	Total	711	2,837	116	3,664

NOTE: The data above provides no information on the number of persons who were charged with these offences; it only provides information on the number of charges finalised in Court for these offences.

NSW Criminal Court Statistics July 2004 to June 2019

Table A18.14: Trends in the number of amphetamines and ecstasy charges finalised in court by offence type and financial year

Drug type	Offence type	Jul 04 – Jun 05	Jul 05 – Jun 06	Jul 06 – Jun 07	Jul 07 – Jun 08	Jul 08 – Jun 09	Jul 09 – Jun 10	Jul 10 – Jun 11	Jul 11 – Jun 12
Amphetamines	Import or export illicit drugs	1	2	6	10	10	29	16	30
	Deal or traffic in illicit drugs - commercial quantity	113	83	100	98	91	113	102	161
	Deal or traffic in illicit drugs - non-commercial quantity	458	442	527	580	591	533	530	750
	Manufacture or cultivate illicit drugs	49	54	61	28	25	35	46	60
	Possess and/or use illicit drugs	1,576	1,537	1,797	1,827	1,819	1,669	2,017	2,563
	Other illicit drug offences	12	33	95	131	102	68	19	34
	Total	2,209	2,151	2,586	2,674	2,638	24,47	2,730	3,598
Ecstasy	Import or export illicit drugs	23	21	6	8	1	10	1	1
	Deal or traffic in illicit drugs - commercial quantity	38	58	69	63	65	58	62	65
	Deal or traffic in illicit drugs - non-commercial quantity	258	300	344	381	486	541	387	338
	Manufacture or cultivate illicit drugs	2	6	5	10	9	10	13	15
	Possess and/or use illicit drugs	562	586	770	983	1,542	1,864	1,399	1,297
	Other illicit drug offences	0	0	2	0	4	4	3	14
	Total	883	971	1,196	1,445	2,107	2,487	1,865	1,730

Drug type	Offence type	Jul 12 – Jun 13	Jul 13 – Jun 14	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Jul 17 – Jun 18	Jul 18 – Jun 19
Amphetamines	Import or export illicit drugs	24	39	69	58	72	63	59
	Deal or traffic in illicit drugs - commercial quantity	188	145	200	262	270	295	301
	Deal or traffic in illicit drugs - non-commercial quantity	827	1,419	1,362	1,493	14,94	1,852	1,595
	Manufacture or cultivate illicit drugs	58	68	66	52	77	71	52
	Possess and/or use illicit drugs	2,993	3,584	4,841	6,215	6,379	5,880	6,537
	Other illicit drug offences	20	33	33	31	35	20	26
	Total	4,110	5,288	6,571	8,111	8,327	8,181	8,570
Ecstasy	Import or export illicit drugs	1	2	2	8	7	10	10
	Deal or traffic in illicit drugs - commercial quantity	34	45	60	59	70	98	107
	Deal or traffic in illicit drugs - non-commercial quantity	363	428	471	612	669	728	877
	Manufacture or cultivate illicit drugs	5	8	6	3	7	7	10
	Possess and/or use illicit drugs	2,051	1,801	2,147	2,372	2,887	2,902	2,660
	Other illicit drug offences	0	2	1	1	0	1	0
	Total	2,454	2,286	2,687	3,055	3,640	3,746	3,664

NOTE: The data above provides no information on the number of persons who were charged with these offences; it only provides information on the number of charges finalised in Court for these offences.

NSW Higher, Local and Children's Criminal Courts July 2018 to June 2019

Table A18.15: Charges and defendants charged in finalised court appearances for amphetamines offences

Offence		Charges			Defendants charged		
		Charges finalised	Charges proven	% proven	Defendants with a finalised charge	Defendants with a proven charge	% proven
Import or export illicit drugs	Import illicit drugs	58	42	72.4	43	35	81.4
Deal or traffic in illicit drugs	Deal or traffic in illicit drugs - commercial quantity	301	263	87.4	219	209	95.4
	Deal or traffic in illicit drugs - non-commercial quantity	1,591	979	61.5	1,105	785	71
	Total	1,892	1,242	65.6	1,234	958	77.6
Manufacture or cultivate illicit drugs	Manufacture illicit drugs	52	44	84.6	44	42	95.5
Possess and/or use illicit drugs	Possess illicit drugs	6,488	5,721	88.2	5,935	5,305	89.4
	Use illicit drugs	37	35	94.6	37	35	94.6
	Total	6,525	5,756	88.2	5,951	5,323	89.4
Other illicit drug offences	Other illicit drug offences, other	26	22	84.6	24	22	91.7
Total		8,553	7,106	83.1	6,796	6,228	91.6

Table A18.16: Charges and defendants charged in finalised court appearances for ecstasy offences (NSW Higher, Local and Children's Criminal Courts July 2018 to June 2019)

Offence		Charges			Defendants charged ^(a)		
		Charges finalised	Charges proven	% proven	Defendants with a finalised charge	Defendants with a proven charge	% proven
Import or export illicit drugs	Import illicit drugs	10	9	90	9	8	88.9
Deal or traffic in illicit drugs	Deal or traffic in illicit drugs - commercial quantity	108	99	91.7	83	78	94
	Deal or traffic in illicit drugs - non-commercial quantity	876	598	68.3	686	518	75.5
	Total	984	697	70.8	738	581	78.7
Manufacture or cultivate illicit drugs	Manufacture illicit drugs	10	7	70	9	7	77.8
Possess and/or use illicit drugs	Possess illicit drugs	2,647	2,398	90.6	2,587	2,365	91.4
	Use illicit drugs	3	2	66.7	3	2	66.7
	Total	2,650	2,400	90.6	2,589	2,367	91.4
Other illicit drug offences	Other illicit drug offences, other	0	0	0	0	0	0
Total		3,654	3,113	85.2	3,111	2,909	93.5

NSW Criminal Court Statistics July 2018 to June 2019

Table A18.17: Prior offending in the previous five years for people convicted of an amphetamines or ecstasy charge as their principal offence* (NSW Criminal Court Statistics July 2018 to June 2019)

Drug type	Offence type	Any prior proven court appearance		Prior proven DV conviction		Prior custodial sentence		Total persons found guilty
		No.	%	No.	%	No.	%	
Amphetamines	Possess and/or use illicit drugs	1,969	74.33%	578	21.82%	587	22.16%	2,649
	Deal or traffic in illicit drugs - commercial quantity	118	64.84%	23	12.64%	40	21.98%	182
	Deal or traffic in illicit drugs - non-commercial quantity	503	84.11%	128	21.40%	209	34.95%	598
Ecstasy	Possess and/or use illicit drugs	240	12.99%	29	1.57%	14	0.76%	1,848
	Deal or traffic in illicit drugs - commercial quantity	25	39.68%	6	9.52%	3	4.76%	63
	Deal or traffic in illicit drugs - non-commercial quantity	172	42.89%	29	7.23%	23	5.74%	401

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Note: This table shows proven court appearances. Individuals can have multiple court appearances in a single year and across years. Such individuals will be counted multiple times in these data – every time they have a court appearance.

Table A18.18: Prior offending in the previous five years for people convicted of an amphetamines charge as their principal offence* by Indigenous Status and Offence Type

Indigenous status	Violent prior offending		Property prior offending		Drug prior offending		Total
	No prior offending	Prior offending	No prior offending	Prior offending	No prior offending	Prior offending	
Indigenous	400	320	362	358	337	383	720
Non-Indigenous	2,126	576	1,891	811	1,462	1,240	27,02
Unknown	89	0	88	1	87	2	89
Total	2,615	896	2,341	1,170	1,886	1,625	3,511

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Note: This table shows proven court appearances. Individuals can have multiple court appearances in a single year and across years. Such individuals will be counted multiple times in these data – every time they have a court appearance.

Table A18.19: Prior offending in the previous five years for people convicted of an ecstasy charge as their principal offence* by Indigenous Status and Offence Type

Indigenous status	Violent prior offending		Property prior offending		Drug prior offending		Total
	No prior offending	Prior offending	No prior offending	Prior offending	No prior offending	Prior offending	
Indigenous	36	15	44	7	36	15	51
Non-Indigenous	1,929	82	1,941	70	1,835	176	2,011
Unknown	262	0	262	0	260	2	262
Total	2,227	97	2,247	77	2,131	193	2,324

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Note: This table shows proven court appearances. Individuals can have multiple court appearances in a single year and across years. Such individuals will be counted multiple times in these data – every time they have a court appearance.

NSW Criminal Court Statistics July 2004 to June 2019

Table A18.20: Trends in prior offending in the previous five years for people convicted of an amphetamine or ecstasy charge as their principal offence* (NSW Criminal Court Statistics July 2004 to June 2019)

Drug type	Offence type	Prior offending measure	Jul 04 – Jun 05	Jul 05 – Jun 06	Jul 06 – Jun 07	Jul 07 – Jun 08	Jul 08 – Jun 09	Jul 09 – Jun 10	Jul 10 – Jun 11	Jul 11 – Jun 12
Amphetamines	Possess and/or use illicit drugs	% Any prior proven court appearance	54.75	56.82	57.52	57.11	56.56	54.63	54.94	60.67
		% Prior custodial sentence	10.47	12.02	14.23	14.12	14.09	11.76	11.86	14.98
	Deal or traffic in illicit drugs - commercial quantity	% Any prior proven court appearance	75.32	70.18	67.57	69.74	65.75	68.49	48.57	53.47
		% Prior custodial sentence	14.29	17.54	18.92	21.05	24.66	27.40	12.86	24.75
	Deal or traffic in illicit drugs - non-commercial quantity	% Any prior proven court appearance	61.65	62.83	66.39	67.19	68.94	65.98	69.41	72.00
		% Prior custodial sentence	20.87	15.18	25.63	23.05	24.62	20.33	17.81	21.09
Ecstasy	Possess and/or use illicit drugs	% Any prior proven court appearance	30.83	32.44	28.76	27.91	26.40	21.68	22.62	22.56
		% Prior custodial sentence	1.39	2.68	2.04	1.89	1.59	1.28	0.81	1.19
	Deal or traffic in illicit drugs - commercial quantity	% Any prior proven court appearance	29.17	52.27	44.23	47.62	60.00	62.50	48.72	54.55
		% Prior custodial sentence	4.17	13.64	7.69	7.14	7.50	2.50	12.82	0.00
	Deal or traffic in illicit drugs - non-commercial quantity	% Any prior proven court appearance	41.38	39.86	44.83	47.70	47.00	48.88	47.16	38.13
		% Prior custodial sentence	5.17	3.62	4.02	3.45	5.99	6.73	4.55	4.32

Drug type	Offence type	Prior offending measure	Jul 12 – Jun 13	Jul 13 – Jun 14	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Jul 17 – Jun 18	Jul 18 – Jun 19
Amphetamines	Possess and/or use illicit drugs	% Any prior proven court appearance	61.02	63.89	66.02	67.36	70.07	72.07	74.33
		% Prior custodial sentence	14.84	15.82	16.00	16.24	20.73	23.11	22.16
	Deal or traffic in illicit drugs - commercial quantity	% Any prior proven court appearance	58.26	64.29	57.14	57.71	65.29	59.34	64.84
		% Prior custodial sentence	16.52	19.39	15.13	19.43	21.76	23.08	21.98
	Deal or traffic in illicit drugs - non-commercial quantity	% Any prior proven court appearance	72.15	74.34	71.78	76.40	74.67	82.33	84.11
		% Prior custodial sentence	24.16	24.60	24.09	27.85	29.61	29.50	34.95
Ecstasy	Possess and/or use illicit drugs	% Any prior proven court appearance	17.67	18.07	17.83	16.80	14.54	13.61	12.99
		% Prior custodial sentence	0.89	1.19	0.57	1.09	1.13	0.80	0.76
	Deal or traffic in illicit drugs - commercial quantity	% Any prior proven court appearance	50.00	67.74	47.50	51.35	40.00	47.54	39.68
		% Prior custodial sentence	5.00	16.13	5.00	13.51	2.22	13.11	4.76
	Deal or traffic in illicit drugs - non-commercial quantity	% Any prior proven court appearance	43.03	46.89	39.15	45.16	44.82	45.54	42.89
		% Prior custodial sentence	7.88t	3.95	2.83	2.87	6.72	6.85	5.74

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Note: This table shows proven court appearances. Individuals can have multiple court appearances in a single year and across years. Such individuals will be counted multiple times in these data – every time they have a court appearance.

NSW Criminal Court Statistics July 2018 to June 2019

Table A18.21: Penalties for persons convicted of an amphetamines or ecstasy charge as their principal offence*

Drug type	Penalty	Possess and/or use illicit drugs	Deal or traffic in illicit drugs
Amphetamines	Custody - Number sentenced	62	363
	Custody - Average duration (in months)	3	20.8
	Supervised Community Sentence	221	360
	Unsupervised Community Sentence	432	48
	Fine - Number sentenced	1,733	8
	Fine - Average fine amount (in \$)	\$473	\$888
	Other	201	1
	Total	2,649	780
Ecstasy	Custody - Number sentenced	1	81
	Custody - Average duration (in months)	3	19.4
	Supervised Community Sentence	24	260
	Unsupervised Community Sentence	1,244	111
	Fine - Number sentenced	380	10
	Fine - Average fine amount (in \$)	\$471	\$1,020
	Other	199	2
	Total	1,848	464

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Table A.18.22: Number of persons sentenced to custody* where their principal offence was an amphetamines or ecstasy charge by non-parole period (NSW Criminal Court Statistics July 2018 to June 2019)**

Drug type	Sentence length (non-parole period)	Possess and/or use illicit drugs	Deal or traffic in illicit drugs
Amphetamines	Up to 1 year	61	168
	>1 and up to 2 years	1	106
	>2 and up to 3 years	0	39
	>3 and up to 4 years	0	13
	>4 and up to 5 years	0	18
	>5 and up to 6 years	0	9
	>6 and up to 7 years	0	5
	>8 and up to 9 years	0	2
	>9 and up to 10 years	0	1
	>10 and up to 11 years	0	2
	Total	62	363
Ecstasy	Up to 1 year	1	32
	>1 and up to 2 years	0	26
	>2 and up to 3 years	0	13
	>3 and up to 4 years	0	8
	>4 and up to 5 years	0	1
	>5 and up to 6 years	0	1
	Total	1	81

*Prison and juvenile detention

**Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

NSW Criminal Court Statistics July 2004 to June 2019

Table A18.23: Number persons sentenced to custody* where their principal offence was an amphetamines or ecstasy charge**

Drug type	Jul 04 – Jun 05	Jul 05 – Jun 06	Jul 06 – Jun 07	Jul 07 – Jun 08	Jul 08 – Jun 09	Jul 09 – Jun 10	Jul 10 – Jun 11	Jul 11 – Jun 12	Jul 12 – Jun 13	Jul 13 – Jun 14	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Jul 17 – Jun 18	Jul 18 – Jun 19
Amphetamines	221	202	297	292	288	255	208	287	294	366	489	579	619	629	514
Ecstasy	64	98	95	95	92	95	65	54	34	60	49	60	99	93	95

*Prison and juvenile detention

**Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Table A18.24: Number and % of persons sentenced to custody* where their principal offence was an amphetamines or ecstasy charge**

Drug type	Measure	Offence type	Jul 04 – Jun 05	Jul 05 – Jun 06	Jul 06 – Jun 07	Jul 07 – Jun 08	Jul 08 – Jun 09	Jul 09 – Jun 10	Jul 10 – Jun 11	Jul 11 – Jun 12
Amphetamines	Number sentenced to custody	Import or export illicit drugs	0	1	6	5	9	15	11	20
		Deal or traffic in illicit drugs - commercial quantity	62	47	68	65	63	68	64	92
		Deal or traffic in illicit drugs - non-commercial quantity	83	72	104	124	114	115	83	105
	% sentenced to custody	Import or export illicit drugs	–	100.0	100.0	83.3	100.0	100.0	84.6	95.2
		Deal or traffic in illicit drugs - commercial quantity	80.5	82.5	91.9	85.5	86.3	93.2	91.4	91.1
		Deal or traffic in illicit drugs - non-commercial quantity	40.3	37.7	43.7	48.4	43.2	47.7	37.9	38.2
Ecstasy	Number sentenced to custody	Import or export illicit drugs	15	18	6	6	1	9	1	1
		Deal or traffic in illicit drugs - commercial quantity	15	36	43	36	34	36	34	27
		Deal or traffic in illicit drugs - non-commercial quantity	25	33	30	36	39	34	20	19
	% sentenced to custody	Import or export illicit drugs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
		Deal or traffic in illicit drugs - commercial quantity	62.5	81.8	82.7	85.7	85.0	90.0	87.2	81.8
		Deal or traffic in illicit drugs - non-commercial quantity	21.6	23.9	17.2	20.7	18.0	15.3	11.4	13.7
Drug type	Measure	Offence type	Jul 12 – Jun 13	Jul 13 – Jun 14	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Jul 17 – Jun 18	Jul 18 – Jun 19	
Amphetamines	Number sentenced to custody	Import or export illicit drugs	11	30	50	31	51	44	35	
		Deal or traffic in illicit drugs - commercial quantity	100	82	103	148	151	149	128	
		Deal or traffic in illicit drugs - non-commercial quantity	114	158	205	265	260	267	235	
	% sentenced to custody	Import or export illicit drugs	78.6	96.8	98.0	100.0	98.1	100.0	100.0	
		Deal or traffic in illicit drugs - commercial quantity	87.0	83.7	86.6	84.6	88.8	81.9	70.3	
		Deal or traffic in illicit drugs - non-commercial quantity	38.3	41.8	49.9	51.3	48.4	45.8	39.3	
Ecstasy	Number sentenced to custody	Import or export illicit drugs	0	1	1	3	6	7	6	
		Deal or traffic in illicit drugs - commercial quantity	14	28	25	30	38	47	42	
		Deal or traffic in illicit drugs - non-commercial quantity	17	23	16	24	48	30	39	
	% sentenced to custody	Import or export illicit drugs	0.0	50.0	50.0	75.0	100.0	70.0	75.0	
		Deal or traffic in illicit drugs - commercial quantity	70.0	90.3	62.5	81.1	84.4	77.1	66.7	
		Deal or traffic in illicit drugs - non-commercial quantity	10.3	13.0	7.6	8.6	13.5	8.9	9.7	

*Prison and juvenile detention

**Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

NSW Custody Statistics March 2013 to June 2019

Table A18.25: Prison population incarcerated for a drug offence (all drug types)

Prison population	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13		
Drug offence	1,369	1,488	1,494	1,518	1,505	1,537	1,562	1,582	1,597	1,563		
Prison population	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
Drug offence	1,573	1,621	1,618	1,652	1,665	1,625	1,615	1,611	1,599	1,612	1,607	1,637
Prison population	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Drug offence	1,646	1,689	1,721	1,731	1,776	1,831	1,862	1,898	1,818	1,901	1,958	2,000
Prison population	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Drug offence	2,012	1,971	2,008	2,036	2,056	2,084	2,136	2,184	2,197	2,199	2,187	2,205
Prison population	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Drug offence	2,199	2,184	2,231	2,242	2,271	2,303	2,313	2,295	2,279	2,275	2,298	2,268
Prison population	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Drug offence	2,262	2,264	2,330	2,316	2,326	2,326	2,334	2,327	2,295	2,233	2,194	21,84
Prison population	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19						
Drug offence	2,174	2,156	2,133	2,100	2,101	2,091						

NSW Recorded Crime Statistics July 2018 to June 2019

Table A18.26: Number of incidents of possess/use or deal/traffic amphetamines or ecstasy offences recorded by the NSW Police Force by premises type

Offence	Premises	Amphetamines	Ecstasy
Possession and/or use of amphetamines	Adult Entertainment	12	3
	Business/Commercial	305	33
	Carpark	221	31
	Education	18	7
	Health	79	2
	Industrial	13	3
	Law Enforcement	428	31
	Licensed Premise	206	1,158
	Marine Transport	1	0
	Outdoor/Public Place	4,659	1,276
	Public Transport	302	68
	Recreation	15	134
	Religious	2	131
	Residential	1,184	3
	Unknown	4	16
	Utilities	2	1
	Vehicle	29	1
	Total	7,480	2,898
Dealing, trafficking in amphetamines	Adult Entertainment	2	12
	Business/Commercial	45	10
	Carpark	60	2
	Health	2	1
	Industrial	1	1
	Law Enforcement	72	4
	Licensed Premise	65	113
	Outdoor/Public Place	550	248
	Public Transport	19	13
	Recreation	1	12
	Residential	890	115
	Unknown	67	4
	Utilities	8	9
	Vehicle	6	1
	Total	1,788	545

Note: The types of offences shown tend to be those detected by police rather than reported. Therefore the trends shown may be more indicative of policing operations rather than the incidence of those particular offences.

Table A18.27: Persons convicted of an amphetamines or ecstasy charge as their principal offence* by plea

Drug type	Offence type	Guilty Plea	Not Guilty Plea	No Plea Entered	Plea Unknown/ Not stated	Total
Amphetamines	Import or export illicit drugs	25	10	0	0	35
	Deal or traffic in illicit drugs - commercial quantity	168	14	0	0	182
	Deal or traffic in illicit drugs - non-commercial quantity	525	50	22	1	598
	Manufacture or cultivate illicit drugs	31	1	0	1	33
	Possess and/or use illicit drugs	1,622	71	953	3	2,649
	Other illicit drug offences	1	0	3	0	4
	Total	2,372	146	978	5	3,501
Ecstasy	Import or export illicit drugs	7	1	0	0	8
	Deal or traffic in illicit drugs - commercial quantity	63	0	0	0	63
	Deal or traffic in illicit drugs - non-commercial quantity	379	16	6	0	401
	Manufacture or cultivate illicit drugs	6	0	0	0	6
	Possess and/or use illicit drugs	1,716	6	125	1	1,848
	Other illicit drug offences	0	0	0	0	0
	Total	2,171	23	131	1	2,326

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Table A18.28: Number of people sentenced to a supervised community sentence for their principal penalty* for an amphetamine or ecstasy offence

Drug type	Offence	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Jul 17 – Jun 18	Jul 18 – Jun 19
Amphetamines	Import or export illicit drugs	1	0	1	0	0
	Deal or traffic in illicit drugs	155	188	210	255	360
	Manufacture or cultivate illicit drugs	5	4	7	5	7
	Possess and/or use illicit drugs	172	229	226	226	221
	Other illicit drug offences	5	1	1	1	0
	Illicit drug offences	338	422	445	487	588
Ecstasy	Import or export illicit drugs	1	1	0	3	0
	Deal or traffic in illicit drugs	117	133	188	171	260
	Manufacture or cultivate illicit drugs	0	1	0	1	1
	Possess and/or use illicit drugs	18	20	26	24	24
	Other illicit drug offences	0	0	0	0	0
	Illicit drug offences	136	155	214	199	285

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

NSW Recorded Crime Statistics July 2014 to June 2019

Table A18.29: Number of persons proceeded against by the NSW Police Force for s111 of the *Road Transport Act 2013* (NSW), relating to driving with an illicit drug or morphine in the blood or urine

Legislation	Jul 14 – Jun 15	Jul 15 – Jun 16	Jul 16 – Jun 17	Jul 17 – Jun 18	Jul 18 – Jun 19
s111 of the <i>Road Transport Act 2013</i> (NSW)	3,480	10,170	8,937	8,713	8,249

Table A18.30: Number of people appearing in finalised court appearances for a charge under s 111 of the *Road Transport Act 2013* (NSW), relating to driving with an illicit drug or morphine in the blood or urine by outcome, gender, age or Indigenous status

Category	Value	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Total finalised charges under s111 of the <i>Road Transport Act 2013</i> (NSW)		2,239	8,796	8,087	8,294	8,157
Outcome	Guilty	2,172	8,694	7,966	8,166	8,054
	% Guilty	97.0%	98.8%	98.5%	98.5%	98.7%
	Not guilty	56	73	98	101	79
	Other	11	29	23	27	24
	Total	2,239	8,796	8,087	8,294	8,157
Gender	Female	406	1,814	1,872	1,968	1,936
	Male	1,833	6,982	6,215	6,326	6,221
Age	Under 18	9	53	56	54	50
	18 to 29	919	3,802	3,256	3,065	3,012
	30 to 39	629	2,607	2,539	2,677	2,486
	39 to 49	478	1,662	1,617	1,737	1,759
	50 and over	204	672	619	761	850
Indigenous status	Indigenous	305	1,490	1,499	1,535	1,392
	Non-Indigenous	1,607	6,075	5,658	5,944	5,846
	Unknown	327	1,231	930	815	919

Table A18.31: Number of people who were charged with a first offence under s 111 of the *Road Transport Act 2013* (NSW), relating to driving with an illicit drug or morphine in the blood or urine

Charge	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
First offence	2,127	7,853	6,742	6,708	6,421
% first offence	95.0%	89.3%	83.4%	80.9%	78.7%
Total charged	2,239	8,796	8,087	8,294	8,157

Note: A first offence is determined based on the lawpart

Table A18.32: Number of people who pleaded guilty under s 111 of the *Road Transport Act 2013* (NSW), relating to driving with an illicit drug or morphine in the blood or urine

Plea	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Pleaded guilty	1,686	6,498	6,007	6,147	6,064
% pleaded guilty	75.3%	73.9%	74.3%	74.1%	74.3%
Total charged	2,239	8,796	8,087	8,294	8,157

Table A18.32A: Number of people sentenced under s 111 of the *Road Transport Act* (NSW), relating to driving with an illicit drug or morphine in the blood or urine by penalty type and average non-parole period (NPP) or fine amount

Penalty	Jul 2014– Jun 2015	Jul 2015– Jun 2016	Jul 2016– Jun 2017	Jul 2017– Jun 2018	Jul 2018– Jun 2019
Custody	4	1	7	4	1
Average penalty duration (NPP) - months (excl Life)	3.8	4.1	5.9	11.8	4
Custodial alternatives	0	1	2	0	3
Non-custodial community based orders	34	50	54	55	158
Fines	1,519	5,505	5,206	5,482	5,310
Average penalty amount - fine	\$492	\$492	\$499	\$513	\$507
Conviction only	48	279	335	433	481
Conditional release without conviction	528	2,517	2,196	1,997	1,947
No conviction recorded	39	339	164	194	151
Other	0	2	2	1	3
No penalty	67	102	121	128	103

NSW Recorded Crime Statistics July 2005 to June 2019

Table A18.33: Number of persons of interest for police person search incidents by whether drugs or implements were detected and drug type

Search	Drug type	Jul 2005 – Jun 2006	Jul 2006 – Jun 2007	Jul 2007 – Jun 2008	Jul 2008 – Jun 2009	Jul 2009 – Jun 2010	Jul 2010 – Jun 2011	Jul 2011 – Jun 2012
Total person searches		87,875	128,970	160,464	189,660	212,319	242,156	218,164
Total with drugs or implements found		1,480	1,933	2,397	2,683	2,287	2,146	2,178
Drugs found	Cocaine	9	15	40	32	45	29	31
	Crack	0	1	2	0	0	0	0
	Cannabis	663	852	1,178	1,282	893	646	665
	MDMA (ecstasy)	34	65	75	140	118	43	48
	Hallucinogen	2	1	3	10	9	3	8
	Heroin	25	24	45	78	43	24	33
	Methadone	24	32	25	25	21	22	36
	Sedative	30	44	49	55	80	67	62
	Methyl/amphetamine	115	188	200	234	125	126	183
	Steroid	5	3	8	10	9	18	16
	Stimulant	3	3	5	7	9	11	9
	Khat	0	0	1	0	0	0	0
	Opium	1	2	6	3	5	4	3
	Other drug	98	138	192	214	266	329	354
	Precursor	2	0	4	6	4	7	2
	Counterfeit drug	1	0	1	0	2	1	0
	Gamma hydroxybutyrate(ghb)/related compd	0	0	14	5	7	9	3
	NPS (synthetic cannabis)	0	0	0	0	0	0	10
	NPS (synthetic other)	0	0	0	0	0	0	0
	Pharmaceutical drug	0	0	0	0	0	0	0
	LSD	0	0	0	0	0	0	0
Drug implement only		468	565	549	582	651	807	715

Search	Drug type	Jul 2012 – Jun 2013	Jul 2013 – Jun 2014	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Total person searches		243,708	257,791	262,127	258,369	241,387	239,987	239,446
Total with drugs or implements found		2,686	2,797	3,161	3,511	3,507	3,410	3,638
Drugs found	Cocaine	31	46	68	87	122	176	178
	Crack	0	0	0	0	0	0	0
	Cannabis	742	762	806	978	1,020	1,016	930
	MDMA (ecstasy)	96	113	120	184	181	193	194
	Hallucinogen	7	1	0	0	0	0	0
	Heroin	31	37	44	34	47	40	54
	Methadone	33	29	26	25	21	22	16
	Sedative	78	10	0	0	0	0	0
	Methyl/amphetamine	273	307	423	421	494	463	471
	Steroid	15	12	15	10	16	13	8
	Stimulant	7	0	0	0	0	0	0
	Khat	0	0	0	0	0	0	0
	Opium	6	2	2	0	3	5	4
	Other drug	402	172	96	105	115	97	124
	Precursor	4	0	2	0	0	2	2
	Counterfeit drug	1	0	0	0	1	1	1
	Gamma hydroxybutyrate(ghb)/related compd	9	5	9	16	18	21	43
	NPS (synthetic cannabis)	39	26	13	13	9	5	4
	NPS (synthetic other)	0	2	5	2	4	4	2
	Pharmaceutical drug	0	289	295	288	270	310	399
	LSD	0	5	9	10	14	14	12
Drug implement only		912	979	1,228	1,338	1,172	1,028	1,196

NOTE: If more than one type of drug was involved in an incident, the most serious was selected.

NSW Criminal Court Statistics July 2014 to June 2019

Table A18.34: Number persons sentenced to a fine where their principal offence* was an amphetamines or ecstasy charge

Drug type	Offence type	Measure	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Amphetamines	Import or export illicit drugs	Fine - Number sentenced	0	0	0	0	0
		Fine - Average fine amount (in \$)	na	na	na	na	na
	Deal or traffic in illicit drugs - commercial quantity	Fine - Number sentenced	0	0	0	0	0
		Fine - Average fine amount (in \$)	na	na	na	na	na
	Deal or traffic in illicit drugs - non-commercial quantity	Fine - Number sentenced	5	10	7	6	8
		Fine - Average fine amount (in \$)	\$970	\$850	\$807	\$892	\$888
	Manufacture or cultivate illicit drugs	Fine - Number sentenced	0	0	0	0	0
		Fine - Average fine amount (in \$)	na	na	na	na	na
	Possess and/or use illicit drugs	Fine - Number sentenced	1,432	1,708	1,632	1,477	1,733
		Fine - Average fine amount (in \$)	\$480	\$498	\$493	\$498	\$473
	Other illicit drug offences	Fine - Number sentenced	3	5	1	2	4
		Fine - Average fine amount (in \$)	\$290	\$430	\$300	\$1,000	\$333
	Total	Fine - Number sentenced	1,440	1,723	1,640	1,485	1,745
		Fine - Average fine amount (in \$)	\$481	\$500	\$494	\$501	\$474
Ecstasy	Import or export illicit drugs	Fine - Number sentenced	0	0	0	0	1
		Fine - Average fine amount (in \$)	na	na	na	na	\$250
	Deal or traffic in illicit drugs - commercial quantity	Fine - Number sentenced	0	0	0	0	0
		Fine - Average fine amount (in \$)	na	na	na	na	na
	Deal or traffic in illicit drugs - non-commercial quantity	Fine - Number sentenced	6	7	5	5	10
		Fine - Average fine amount (in \$)	\$745	\$1,121	\$1,110	\$1,020	\$1,020
	Manufacture or cultivate illicit drugs	Fine - Number sentenced	0	0	0	0	0
		Fine - Average fine amount (in \$)	na	na	na	na	na
	Possess and/or use illicit drugs	Fine - Number sentenced	408	498	547	544	380
		Fine - Average fine amount (in \$)	\$412	\$416	\$429	\$437	\$471
	Other illicit drug offences	Fine - Number sentenced	0	1	0	0	0
		Fine - Average fine amount (in \$)	na	\$400	na	na	na
	Total	Fine - Number sentenced	414	506	552	549	391
		Fine - Average fine amount (in \$)	\$417	\$426	\$436	\$443	\$485

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

NSW Recorded Crime Statistics July 2014 to June 2019

Table A18.35: Number of persons proceeded against by the NSW Police Force for s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs for amphetamines

Legislation	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
s11 of the Drug Misuse and Trafficking Act 1985	166	200	163	100	148

Table A18.36: Number of people appearing in finalised court appearances for a charge under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs by outcome, gender, age or Indigenous status for amphetamines

Category	Value	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Total finalised charges under s11 of the Drug Misuse and Trafficking Act 1985		14	14	26	15	21
Outcome	Guilty	13	14	26	14	21
	% Guilty	92.9%	100.0%	100.0%	93.3%	100.0%
	Other	1	0	0	1	0
	Total	14	14	26	15	21
Gender	Female	5	6	9	4	5
	Male	9	8	17	11	16
Age	Under 18	0	0	0	0	0
	18 to 29	7	7	8	3	9
	30 to 39	3	5	11	8	8
	40 to 49	4	2	5	3	2
	50 and over	0	0	2	1	2
Indigenous status	Indigenous	3	3	1	2	3
	Non-Indigenous	11	11	25	13	17
	Unknown	0	0	0	0	1

Table A18.37: Number of people who were charged with a first offence under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs for amphetamines

Charge	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
First offence	11	14	24	14	17
% first offence	78.6%	100.0%	92.3%	93.3%	81.0%
Total charged	14	14	26	15	21

Note: A first offence is determined based on the lawpart

Table A18.38: Number of people who pleaded guilty under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs for amphetamines

Plea	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Pleaded guilty	12	11	15	7	16
% pleaded guilty	85.7%	78.6%	57.7%	46.7%	76.2%
Total charged	14	14	26	15	21

Table A18.39: Number of people sentenced under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs by penalty type and average non-parole period (NPP) or fine amount for amphetamines

Penalty	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Custody	0	0	2	0	1
Average penalty duration (NPP) - months (excl Life)	0	0	9.5	0	3
Custodial alternatives	0	0	0	0	0
Non-custodial community based orders	2	1	5	3	2
Fines	6	9	14	9	10
Average penalty amount - fine	\$238	\$383	\$280	\$517	\$282
Conviction only	3	4	4	1	8
Conditional release without conviction	2	0	1	1	0
No conviction recorded	0	0	0	0	0
Other	0	0	0	0	0
No penalty	1	0	0	1	0

NSW Recorded Crime Statistics July 2014 to June 2019

Table A18.40: Number of persons proceeded against by the NSW Police Force for s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs for ecstasy

Legislation	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
s11 of the <i>Drug Misuse and Trafficking Act 1985</i> (NSW)	0	1	0	1	0

Table A18.41: Number of people appearing in finalised court appearances for a charge under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs by outcome, gender, age or Indigenous status for ecstasy

Category	Value	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Total finalised charges under s111 of the Road Transport Act 2013		0	1	0	1	0
Outcome	Guilty	0	1	0	1	0
	% Guilty	0.0%	100.0%	0.0%	100.0%	0.0%
	Not guilty	0	0	0	0	0
	Other	0	0	0	0	0
	Total	0	1	0	1	0
Gender	Female	0	0	0	1	0
	Male	0	1	0	0	0
Age	Under 18	0	0	0	0	0
	18 to 29	0	1	0	0	0
	30 to 39	0	0	0	1	0
	40 to 49	0	0	0	0	0
	50 and over	0	0	0	0	0
Indigenous status	Indigenous	0	0	0	0	0
	Non-Indigenous	0	1	0	1	0
	Unknown	0	0	0	0	0

Table A18.42: Number of people who were charged with a first offence under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs for ecstasy

Charge	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
First offence	0	1	0	0	0
% first offence	0.0%	100.0%	0.0%	0.0%	0.0%
Total charged	0	1	0	1	0

Note: A first offence is determined based on the lawpart

Table A18.43: Number of people who pleaded guilty under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs for ecstasy

Plea	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Pleaded guilty	0	0	0	1	0
% pleaded guilty	0.0%	0.0%	0.0%	100.0%	0.0%
Total charged	0	1	0	1	0

Table A18.44: Number of people sentenced under s 11 of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to possession of equipment for administering prohibited drugs by penalty type and average non-parole period (NPP) or fine amount for ecstasy

Penalty	Jul 2014– Jun 2015	Jul 2015– Jun 2016	Jul 2016– Jun 2017	Jul 2017– Jun 2018	Jul 2018– Jun 2019
Custody	0	0	0	0	0
Average penalty duration (NPP) - months (excl Life)	0	0	0	0	0
Custodial alternatives	0	0	0	0	0
Non-custodial community based orders	0	0	0	1	0
Fines	0	1	0	0	0
Average penalty amount - fine	\$0	\$400	\$0	\$0	\$0
Conviction only	0	0	0	0	0
Conditional release without conviction	0	0	0	0	0
No conviction recorded	0	0	0	0	0
Other	0	0	0	0	0
No penalty	0	0	0	0	0

NSW Recorded Crime Statistics July 2014 to June 2019

Table A18.45: Number of persons proceeded against by the NSW Police Force for s 11A of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to selling a drug implement or displaying a drug implement in a shop

Legislation	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
s11A of the <i>Drug Misuse and Trafficking Act 1985</i> (NSW)	0	0	0	0	0

Table A18.46: Number of people appearing in finalised court appearances for a charge under s 11A of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to selling a drug implement or displaying a drug implement in a shop by outcome, gender, age or Indigenous status for amphetamines

Category	Value	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Total finalised charges under s11A of the <i>Drug Misuse and Trafficking Act 1985</i> (NSW)						
Outcome	Guilty	1	7	1	0	0
	% Guilty	100.0%	77.8%	50.0%	0.0%	0.0%
	Not Guilty	0	1	1	2	1
	Other	0	1	0	0	0
	Total	1	9	2	2	1
Gender	Female	1	2	1	0	1
	Male	0	7	1	2	0
Age	Under 18	0	0	0	0	0
	18 to 29	0	4	0	0	0
	30 to 39	0	0	1	0	0
	40 to 49	0	1	0	1	1
	50 and over	1	4	1	1	0
Indigenous status	Indigenous	0	0	0	0	0
	Non-Indigenous	1	9	2	2	1
	Unknown	0	0	0	0	0

Table A18.47: Number of people who were charged with a first offence under s 11A of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to selling a drug implement or displaying a drug implement in a shop for amphetamines

Charge	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
First offence	1	8	2	2	1
% first offence	100.0%	88.9%	100.0%	100.0%	100.0%
Total charged	1	9	2	2	1

Note: A first offence is determined based on the lawpart

Table A18.48: Number of people who pleaded guilty under s 11A of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to selling a drug implement or displaying a drug implement in a shop for amphetamines

Plea	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Pleaded guilty	1	7	0	0	0
% pleaded guilty	100.0%	77.8%	0.0%	0.0%	0.0%
Total charged	1	9	2	2	1

Table A18.49: Number of people sentenced under s 11A of the *Drug Misuse and Trafficking Act 1985* (NSW), relating to selling a drug implement or displaying a drug implement in a shop by penalty type and average non-parole period (NPP) or fine amount for amphetamines

Penalty	Jul 2014 – Jun 2015	Jul 2015 – Jun 2016	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Custody	0	1	0	0	0
Average penalty duration (NPP) - months (excl Life)	0	3	0	0	0
Custodial alternatives	0	0	0	0	0
Non-custodial community based orders	1	0	1	0	0
Fines	0	3	0	0	0
Average penalty amount - fine	\$0	\$883	\$0	\$0	\$0
Conviction only	0	0	0	0	0
Conditional release without conviction	0	3	0	0	0
No conviction recorded	0	0	0	0	0
Other	0	0	0	0	0
No penalty	0	2	1	2	1

NSW Criminal Court Statistics January 2017 to June 2019

Table A18.50: Number of charges under s 10(1) of the *Drug Misuse and Trafficking Act 1985* (NSW) involving amphetamines or ecstasy finalised in selected courts by month

Local Court	Festival Name	Drug type	2017 Jan	2017 Feb	2017 Mar	2017 Apr	2017 May	2017 Jun	2017 Jul	2017 Aug	2017 Sep	2017 Oct	2017 Nov	2017 Dec	2018 Jan	2018 Feb	2018 Mar	2018 Apr	2018 May	2018 Jun	2018 Jul	2018 Aug	2018 Sep	2018 Oct	2018 Nov	2018 Dec	2019 Jan	2019 Feb	2019 Mar	2019 Apr	2019 May	2019 Jun
Byron Bay	Bluesfest	Amph	0	2	4	0	1	1	0	2	3	3	3	1	2	2	5	1	1	0	3	2	5	2	0	2	1	2	1	0	1	3
		Ects	2	3	3	0	2	6	4	50	21	5	3	2	3	1	0	2	0	3	2	1	72	3	4	2	4	33	34	5	8	7
Penrith	Defqon 1	Amph	19	22	23	14	29	24	29	27	27	22	27	25	13	22	23	26	26	16	19	16	20	19	20	14	18	21	22	20	14	19
		Ects	2	3	0	2	0	7	0	2	2	23	6	4	2	4	4	4	2	5	1	0	1	2	29	7	4	3	1	1	0	0
Byron Bay	Falls Festival	Amph	0	2	4	0	1	1	0	2	3	3	3	1	2	2	5	1	1	0	3	2	5	2	0	2	1	2	1	0	1	3
		Ects	2	3	3	0	2	6	4	50	21	5	3	2	3	1	0	2	0	3	2	1	72	3	4	2	4	33	34	5	8	7
Port Macquarie	Festival of the Sun	Amph	1	6	9	8	7	9	2	3	4	6	9	6	4	1	2	6	2	5	1	1	2	2	2	4	9	3	6	13	6	4
		Ects	2	12	1	0	1	2	4	0	1	0	5	1	14	3	2	0	1	2	0	1	2	0	1	1	2	10	5	1	2	1
Sydney Downing Centre	Field Day	Amph	39	57	56	38	64	39	45	46	31	63	43	31	37	62	67	48	57	46	46	48	62	43	43	24	60	58	55	50	64	67
		Ects	138	217	107	88	69	81	79	44	53	51	60	28	77	194	108	64	102	73	77	35	56	48	65	56	153	118	82	47	61	47
Maitland	Groovin's the Moo – Maitland	Amph	7	8	16	2	10	12	5	9	6	4	13	5	6	3	5	10	9	8	12	9	11	3	7	9	10	11	9	10	14	10
		Ects	0	2	0	1	0	19	3	2	2	2	2	0	1	1	2	2	2	6	9	1	2	0	1	2	0	0	2	2	2	1
Sydney Downing Centre	Mardi Gras	Amph	39	57	56	38	64	39	45	46	31	63	43	31	37	62	67	48	57	46	46	48	62	43	43	24	60	58	55	50	64	67
		Ects	138	217	107	88	69	81	79	44	53	51	60	28	77	194	108	64	102	73	77	35	56	48	65	56	153	118	82	47	61	47
Waverley	Mardi Gras	Amph	6	12	10	5	14	12	14	5	6	7	8	7	5	9	5	3	7	7	9	10	9	11	5	7	10	14	11	8	8	12
		Ects	23	53	99	13	13	4	5	3	6	14	39	12	5	57	50	15	10	2	7	2	1	40	21	2	11	13	14	3	8	3
Waverley	St Jeromes Laneway Festival	Amph	6	12	10	5	14	12	14	5	6	7	8	7	5	9	5	3	7	7	9	10	9	11	5	7	10	14	11	8	8	12
		Ects	23	53	99	13	13	4	5	3	6	14	39	12	5	57	50	15	10	2	7	2	1	40	21	2	11	13	14	3	8	3
Gosford	Lost Paradise	Amph	9	6	16	9	7	10	9	10	10	11	13	6	10	3	13	18	9	9	14	10	6	10	7	10	8	10	11	2	17	3
		Ects	1	4	20	5	0	1	5	3	6	3	0	0	17	12	30	7	3	0	1	3	4	2	3	2	6	33	9	1	5	1
Byron Bay	Splendour in the Grass	Amph	0	2	4	0	1	1	0	2	3	3	3	1	2	2	5	1	1	0	3	2	5	2	0	2	1	2	1	0	1	3
		Ects	2	3	3	0	2	6	4	50	21	5	3	2	3	1	0	2	0	3	2	1	72	3	4	2	4	33	34	5	8	7
Deniliquin	Strawberry Fields	Amph	1	3	1	1	0	2	1	0	0	1	2	4	3	2	2	0	2	1	0	1	1	1	1	3	1	1	0	2	2	5
		Ects	0	0	1	0	1	2	1	0	2	0	2	1	0	0	0	0	0	2	0	0	0	0	0	0	1	0	0	0	1	0
Dungog	Subsonic	Amph	0	0	0	0	0	0	0	0	0	0	0	0	3	0	2	0	1	0	0	0	0	0	0	2	0	0	0	0	0	0
		Ects	5	0	0	0	1	0	0	0	0	0	0	0	4	0	8	0	0	0	0	0	0	0	0	0	7	0	0	0	0	0

Amph = Amphetamines Ects = Ecstasy

	Month before the festival
	Month of the festive
	Two months post festive

NOTE: The data above provides no information on the number of persons who were charged with these offences; it only provides information on the number of charges finalised in Court for these offences.

NSW Criminal Court Statistics July 2016 to June 2019

Table A18.51: Number of persons found guilty whose principal offence* was a charge under s 10(1) of the *Drug Misuse and Trafficking Act 1985* (NSW) involving amphetamines or ecstasy by sentence type

Drug type	Penalty	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Amphetamines	Custody	76	87	61
	Supervised Community Sentence	224	225	219
	Unsupervised Community Sentence	432	425	429
	Fine	1,625	1,476	1,726
	Other	197	188	200
	Total	2,554	2,401	2,635
Ecstasy	Custody	5	4	1
	Supervised Community Sentence	26	24	24
	Unsupervised Community Sentence	1,181	1,333	1,242
	Fine	545	543	380
	Other	283	217	199
	Total	2,040	2,121	1,846

Source: NSW Bureau of Crime Statistics and Research

Reference: sr19-17881 *Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Table A18.52: Number of persons found guilty whose principal offence* was a charge under s 10(1) of the *Drug Misuse and Trafficking Act 1985* (NSW) involving amphetamines or ecstasy by age of offender

Drug type	Offender's age	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Amphetamines	Under 18	13	8	7
	18 – 19	70	56	81
	20 – 24	326	271	317
	25 – 29	456	402	420
	30 – 39	910	821	875
	40 – 49	593	629	674
	50 – 59	161	190	231
	60 – 65	19	22	26
	Over 65	5	2	3
	Total	2,554	2,401	2,635
Ecstasy	Under 18	23	23	19
	18 – 19	368	374	411
	20 – 24	955	973	859
	25 – 29	437	483	349
	30 – 39	204	194	156
	40 – 49	46	55	45
	50 – 59	7	17	6
	60 – 65	0	2	1
	Total	2,040	2,121	1,846

Table A18.53: Number of persons found guilty whose principal offence* was a charge under s 10(1) of the *Drug Misuse and Trafficking Act 1985* (NSW) involving amphetamines or ecstasy by prior convictions

Drug type	Measure	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Amphetamines	Any prior proven court appearance	1,790	1,730	1,959
	% Any prior proven court appearance	70.1%	72.5%	74.4%
	Total	2,554	2,401	2,635
Ecstasy	Any prior proven court appearance	296	289	240
	% Any prior proven court appearance	14.5%	13.6%	13.0%
	Total	2,040	2,121	1,846

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

Table A18.54: Number of persons found guilty whose principal offence* was a charge under s 10(1) of the *Drug Misuse and Trafficking Act 1985* (NSW) involving amphetamines or ecstasy by plea

Drug type	Plea	Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 – Jun 2019
Amphetamines	Guilty Plea	1,566	1,526	1,613
	Not Guilty Plea	65	86	70
	No Plea Entered	922	789	949
	Plea Unknown/Not stated	1	0	3
	Total	2,554	2,401	2,635
Ecstasy	Guilty Plea	1,803	1,949	1,714
	Not Guilty Plea	14	6	6
	No Plea Entered	222	166	125
	Plea Unknown/Not stated	1	0	1
	Total	2,040	2,121	1,846

*Where a person has been found guilty of more than one offence, the offence which received the most serious penalty is the principal offence.

References

- ¹ NSW Bureau of Crime Statistics and Research, *About us* (Web page) <https://www.bocsar.nsw.gov.au/Pages/bocsar_aboutus.aspx>.
- ² Tendered in chambers, 13 December 2019, Exhibit Z, Tabs 47 and 56, Responses of Department of Communities and Justice dated 30 August 2019 to request for information dated 23 July 2019.

Appendix 19: A technical note on surveys conducted by the Inquiry

In its examination of the prevalence and impact of ATS in NSW, the Inquiry encountered areas where research and data do not exist or are insufficient. To address these shortcomings in the data, the Inquiry conducted or had conducted on its behalf a number of surveys, including:

- a survey of Department of Family and Community Services (FACS) practitioners, in relation to the association between ATS and child protection matters
- a survey of Local Court Magistrates and District Court Judges, in relation to the association between ATS and non-drug criminal offending
- a survey of Mental Health Review Tribunal (MHRT) Members, in relation to the association between ATS and matters coming before the tribunal
- a survey of residential rehabilitation providers and withdrawal management providers, in relation to models of care, wait lists, eligibility for entry into programs and funding sources.

The methodological and measurement limitations of these surveys are discussed below. They reflect the constraints on time and resources the Inquiry faced in completing its task.

Due to the limitations on the data collected, the Inquiry has not made findings or conclusions based on the survey findings. However, the data collected from the FACS, MHRT and Local and District Court surveys support the need for further, more robust data and research collection in relation to the association between ATS and child protection matters, non-drug criminal offending and matters coming before the MHRT.

Department of Family and Community Services (FACS) survey

This survey was undertaken to collect information from FACS (now known as the Department of Communities and Justice (DCJ)) about the prevalence and impact of ATS use on families coming into contact with the child protection system. The results of this survey are discussed in Chapter 7 and Chapter 18.

Procedure

The survey was conducted by FACS on behalf of the Inquiry in July and August 2019. FACS sent the survey to their Managers Client Services at each Community Services Centre (CSC). Managers Client Services are senior practitioners who provide oversight and direction of other case workers.

Six questions, listed below, were asked. The first two refer to risk of significant harm (ROSH) reports. A child or young person is considered to be at ROSH if the circumstances that are causing concern for the safety, welfare or wellbeing of the child or young person are present to a significant extent. This means the concern is sufficiently serious to warrant a response by a statutory authority (such as the NSW Police Force or FACS) irrespective of a family's consent.¹

1. In the last 12 months, what proportion of ROSH reports transferred into your CSC included Amphetamine Type Substances [sic] as the primary issue? Practitioners were given the choice of nominating 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%.
2. In the last 12 months, what proportion of ROSH reports transferred into your CSC included Amphetamine Type Substances as a contributing issue? Practitioners were given the choice of nominating 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%.
3. In the last 12 months, what proportion of children did your CSC enter into Out of Home Care (OOHC) primarily due to Amphetamine Type Substances? Practitioners were given the choice of nominating 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%.
4. In the last 12 months, what proportion of children did your CSC enter into OOHC where Amphetamine Type Substances was present but it was not the primary reason for entry into OOHC? Practitioners were given the choice of nominating 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%.
5. What, if any, trends have you observed in relation to the use of 'ATS' as a factor associated with child protection matters in your CSC over the last five years?
6. What complexities exist (if any) when working with families impacted by ATS?

The survey results were compiled and analysed by FACS and provided to the Inquiry.

Sample

A total of 42 participants completed the survey (although one of these only answered question 6). FACS advised that this represents a 52% response rate, based on the number of Managers Client Services distributed across the state.

Managers Client Services representing the following geographic areas responded:

- Hunter New England District: Cessnock, Glen Innes, Inverell, Maitland, Mayfield, Muswellbrook, Moree, Narrabri, Raymond Terrace, Tamworth
- Illawarra Shoalhaven District: Nowra, Ulladulla
- Western District: Cootamundra, Broken Hill, Dubbo
- Northern District: Clarence Valley, Lismore, Ballina, Grafton
- Sydney/South West/ Eastern Districts: Macarthur, Fairfield, Ingleburn, Lakemba, Central Sydney, Eastern Sydney, Chatswood, Burwood, Pennant Hills
- Western Sydney District: Blacktown, Mount Druitt, Penrith, Lithgow, Parramatta, St Marys.

Limitations

There are a number of important qualifications in relation to the interpretation and usage of the data.

- It is unclear which illicit substances respondents considered 'amphetamine type substances'.
- Since each Manager Client Services deals with a different number of ROSH reports, child protection matters, entrants to out-of-home care, etc, the survey results cannot be extrapolated as indicative of the prevalence of ATS in all ROSH reports.

- Participation in the survey was voluntary and Managers Client Services were required to rely on their varying professional experience to answer questions. As such, the responses may be subject to both confirmation and recall bias. The extent of these biases cannot be understood without a comprehensive review of all ROSH reports.
- A Manager Client Services is not required to review all of the ROSH reports that are transferred into a CSC and thus the answers provided in this survey likely only represent a sample of higher level ROSH reports that a Manager Client Services would review. Furthermore, in undertaking this survey, Managers Client Services were not required to review their CSC ROSH reports or entries into OOHC to definitively determine the prevalence of 'Amphetamine Type Substances'.
- Child protection work is complex and it can be difficult to single out one issue as the 'primary issue' of risk to children. This survey only sought to understand the perceptions of the Managers Client Services regarding the prevalence of 'amphetamine type substances'. Caution should therefore be taken when interpreting the data as other complicating factors that led to a ROSH report or entry into OOHC may not have been considered.
- Verified data provided by DCJ about the proportion of ROSH reports where *Alcohol or Other Drugs* (AOD) were identified as the primary or secondary issue provide an accurate depiction of the prevalence of all drugs and alcohol for all ROSH reports and remains DCJ's primary source of truth about the prevalence of drugs and alcohol for children in ROSH reports. DCJ is unable to extract administrative data about the prevalence of specific drug types.

Local Court Magistrates and District Court Judges survey

The purpose of this survey was to collect information from magistrates and judges to assist the Inquiry to better understand the extent to which the use of crystal methamphetamine ('ice') is associated with non-drug criminal offences.

Non-drug offences were defined for the purposes of the survey as criminal offences other than possess/supply/manufacture drugs; for example, domestic violence, personal violence, theft and related offences, public order offences, unlawful entry/break and enter offences and driving offences.

Procedure

Invitations to participate in an online survey, hosted on the Judicial Commission's electronic survey platform, were sent by:

- i. the Chief Magistrate to 169 magistrates or acting magistrates in the Local Court and Children's Court on 27 June 2019
- vi. the Inquiry to 105 judges in the District Court on 5 August 2019.

Survey responses were collated by the Judicial Commission and returned to the Inquiry.

Five survey questions were developed by the Inquiry, in consultation with the NSW Judicial Commission, the Chief Magistrate and the Chief Judge, District Court:

1. In the last 12 months, in the non-drug criminal matters before you, approximately how often was there information to suggest that the defendant was under the influence of 'ice' during the commission of the offence? Please estimate to the nearest 10%. Respondents were given the choice of nominating 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%.

2. In the last 12 months, in the non-drug criminal matters before you, approximately how often was there information to suggest the defendant was a user of 'ice'? Please estimate to the nearest 10%. Respondents were given the choice of nominating 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%.
3. In your experience, in what types of non-drug criminal offences is 'ice' use most often a factor?
4. What, if any, trends have you observed in relation to the use of 'ice' as a factor associated with the commission of non-drug criminal offences over the last given years?
5. Are there any other comments you would like to make about 'ice' use as a factor associated with non-drug criminal offences?

Sample

Responses were received from 45 (26.6%) magistrates and 22 (20.95%) judges.

Limitations

The response rates are relatively low and the Inquiry cannot be confident whether the respondents are representative of the broader cohort of magistrates and judges. It is possible that judges and magistrates dealing in non-drug criminal charges with 'ice' were more motivated to respond. Since each respondent will deal with different numbers of non-drug criminal matters, the findings are not a reliable basis on which to draw conclusions as to the prevalence of 'ice' involvement in non-drug criminal matters before the Local and District Courts.

Mental Health Review Tribunal survey

The purpose of this survey was to elicit information from members of the Mental Health Review Tribunal (MHRT) about their experience and perceptions of the extent to which ATS use may be a factor in the admission of people to health or mental health facilities and who subsequently appear before the Tribunal.

Procedure

The Registrar of the MHRT circulated a short questionnaire to members, asking questions about each patient/consumer that came before the Tribunal within a two-week period commencing 2 September 2019. Members were advised that their responses should be based only on information presented to the hearing, and that no additional questions should be asked to elicit any information for the purposes of the survey.

Members were asked to complete the following in relation to each patient/consumer.

- Age in years
- Hearing or application type
- Sex (M or F)
- Aboriginal and Torres Strait Islander Status (Yes/No)
- History of ATS use? (Yes/No)
- Was ATS a contributing factor? (Yes/No)
- Brief description of mental health condition

Questionnaires completed by each Member were compiled by the Registrar of the Tribunal and returned to the Inquiry. In his cover letter the Registrar noted:

- There was some confusion about the 'ATSI' column, with some Members confusing it with the 'ATS' column and using it to record ATS information not ATSI information. He cautioned it may therefore be safer to disregard all information in the ATSI column.
- While Members were asked to complete one line on the survey for each hearing conducted, some members only completed a line where ATS was a contributing factor.

Sample

The total number of hearings for which information was received was 594, of which 385 were from civil hearings, 171 were from Mental Health Inquiries and 38 from the forensic division.

In 2018–19, there were 18,549 hearings and mental health inquiries: 17,006 civil hearings and 1,543 forensic hearings.² Over a two-week period, assuming the hearing and mental health inquiries are run over 50 weeks that year, there would have been on average 742 hearings per fortnight. Assuming hearings and inquiries were undertaken at much the same rate over the survey period, this suggests that information was received from approximately 80% of the hearings and inquiries held in the survey period.

Limitations

The response rate and the fact that some respondents only included hearings where ATS was a contributing factor mean that the survey is not a census of all hearings, as was intended, and may give an inflated result as to prevalence of ATS involvement in hearings.

Residential Rehabilitation Provider Survey

This survey was undertaken to obtain information regarding models of care, wait lists, eligibility for entry into programs and funding sources as they related to residential rehabilitation service providers.

Procedure

The Inquiry emailed invitations to participate in an online survey to the executives and managers of 25 residential rehabilitation providers listed on the NSW Health website as receiving NSW Health funds,³ and nine further providers identified through research as receiving some form of NSW or Commonwealth funding.⁴ The survey was open between 15 July and 9 September 2019.

The survey asked the following 14 questions.

1. Name of residential rehabilitation service
2. What are the funding source(s) of your residential rehabilitation service, and the approximate proportion of funding they provide? (please select all that apply):
 - a. NSW Ministry of Health
 - b. Local Health District
 - c. Primary Health Network
 - d. Commonwealth
 - e. Philanthropy
 - f. Fundraising
 - g. Other (please specify)

3. What is the approximate proportion of funding per source?
4. What is the typical length of time that an ATS affected individual spends in residential rehabilitation provided by your organisation? (please select one):
 - a. <1 month
 - b. 1-3 months
 - c. 3-6 months
 - d. 6-9 months
 - e. 9-12 months
 - f. 12+ months
5. What models of care or specific programs are provided?
6. What is the typical length of time an individual will spend on a wait list before being able to access a residential rehabilitation place?
 - a. Less than 2 weeks
 - b. Less than 1 month
 - c. 1 month to 2 months
 - d. 2 months to 3 months
 - e. 3 months to 6 months
 - f. More than 6 months
7. Are there any processes in place for prioritising the wait list? (please select all that apply):
 - a. Clinical need
 - b. Pathway into residential care (e.g. through a partnership with a withdrawal management provider)
 - c. Patient able to self-fund a place
 - d. Access to a designated funded bed (e.g. through the MERIT program)
 - e. Other (please specify)
8. Are there reasons why your service may remove an individual from the wait list (e.g. not maintaining contact regarding entry)?
9. Are any supports provided to individuals to assist them in maintaining their place on the wait list?
10. Are there any exclusion criteria for entry into a residential rehabilitation program offered by your organisation?
 - a. Yes
 - b. No
11. (If answered yes to Q10) What are the exclusion criteria? (please select all that apply):
 - a. Not applicable
 - b. Gender
 - c. Indigenous status
 - d. Age
 - e. Children
 - f. Current pregnancy
 - g. Criminal offence history
 - h. Violent criminal or sexual offence history
 - i. Currently on opioid substitution therapy
 - h. Require pharmacological treatment for mental health issue, such as depression or anxiety (e.g. daily tablet for depression)
 - j. Require pharmacologic treatment for severe mental health issues, such as schizophrenia or psychosis (e.g. daily antipsychotic medication)
 - k. Other (please specify)

12. Are risk assessments undertaken that may facilitate entry for someone who meets one or more of the exclusion criteria for the program? (N/A if not applicable)
13. In the past 2 years, how many people have been refused entry based on the program's exclusion criteria? (N/A if not applicable)
14. Upon discharge or exit from the residential rehabilitation program, what (if any) type of aftercare or follow-up is provided, including linking with 'step-down' community programs?

Sample

Of the 34 services invited to respond to the survey, 29 responses were received (~85%).

Limitations

The Inquiry endeavoured to invite participation from all publicly-funded residential treatment providers, although some may have been missed.

Withdrawal Management Provider Survey

This survey was undertaken to obtain information regarding models of care, wait lists, eligibility for entry into programs and funding sources as they related to withdrawal management service providers.

Procedure

The Inquiry emailed invitations to participate in an online survey to the executives and managers of eight withdrawal management services that were identified through research as receiving some form of NSW or Commonwealth funding. The survey was open between 15 July 2019 and 12 August 2019.

On 18 July 2019 the Inquiry sent a request for information to NSW Health including the provision of survey questions and a request for a response to the survey from all withdrawal management services operated by the NSW Health. NSW Health subsequently provided a response from 18 withdrawal management providers on 27 August 2019.

The online survey asked the following 14 questions. The request for information addressed to NSW Health omitted the first three questions.

1. Name of withdrawal management service
2. What are the funding source(s) of your withdrawal management service, and the approximate proportion of funding they provide? (please select all that apply):
 - a. NSW Ministry of Health
 - b. Local Health District
 - c. Primary Health Network
 - d. Commonwealth
 - e. Philanthropy
 - f. Fundraising
 - g. Other (please specify)
3. What is the approximate proportion of funding per source?

4. What is the typical length of time that an ATS affected individual spends in withdrawal management provided by your organisation? (please select one):
 - a. <1 week
 - b. 1-2 weeks
 - c. 2-3 weeks
 - d. 3-4 weeks
 - e. 4+ weeks
5. What models of care, interventions, or specific programs are provided?
 - a. Inpatient
 - b. Ambulatory/patient's home
 - c. Community setting
 - d. Other (please specify)
6. What is the typical length of time an individual will spend on a wait list before being able to access a withdrawal management bed/place?
 - a. Less than 2 weeks
 - b. Less than 1 month
 - c. 1 month to 2 months
 - d. 2 months to 3 months
 - e. 3 months to 6 months
 - f. More than 6 months
7. Are there any processes in place for prioritising the wait list? (please select all that apply):
 - a. Clinical need
 - b. Pathway into withdrawal management (e.g. through a partnership with another inpatient or community care provider)
 - c. Patient able to self-fund a place
 - d. Other (please specify)
8. Are there reasons why your service may remove an individual from the wait list (e.g. not maintaining contact regarding entry)?
9. Are any supports provided to individuals to assist them in maintaining their place on the wait list?
10. Are there any exclusion criteria for entry into the withdrawal management program offered by your organisation?
 - a. Yes
 - b. No

11. (If answered yes to Q10) What are the exclusion criteria? (please select all that apply):
- a. Not applicable
 - b. Gender
 - c. Indigenous status
 - d. Age
 - e. Children
 - f. Current pregnancy
 - g. Criminal offence history
 - h. Violent criminal or sexual offence history
 - i. Currently on opioid substitution therapy
 - j. Require pharmacological treatment for mental health issue, such as depression or anxiety (e.g. daily tablet for depression)
 - k. Require pharmacologic treatment for severe mental health issues, such as schizophrenia or psychosis (e.g. daily antipsychotic medication)
 - l. Other (please specify)
12. Are risk assessments undertaken that may facilitate entry for someone who meets one or more of the exclusion criteria for the program? (N/A if not applicable)
13. In the past 2 years, how many people have been refused entry based on the program's exclusion criteria? (N/A if not applicable)
14. Upon discharge or exit from withdrawal management, what (if any) type of aftercare or follow-up is provided, including linking with 'step-up or step-down' services such as residential rehabilitation or community programs?

Sample

All eight of the services the Inquiry invited to respond to the online survey provided a response (100%). It is assumed that all withdrawal management services operated by NSW Health responded as well.

Limitations

The Inquiry endeavoured to invite participation from all publicly-funded withdrawal management providers, although some may have been missed.

Reference

- ¹ <https://www.facs.nsw.gov.au/providers/children-families/interagency-guidelines/child-protection-report>
- ² Mental Health Review Tribunal, 2018.19 Annual Report (30 September 2019) 20, 21.
- ³ NSW Health, 'Withdrawal management and residential rehabilitation services', *NSW Government – Health* (Web page, 12 December 2018) <<https://www.health.nsw.gov.au/aod/Pages/wmrs-contact.aspx>>.
- ⁴ Noting that in their response to the survey, Foundation House indicated that they are in fact funded solely through construction industry contributions.

Appendix 20: Resources for the community

The following services are available to anyone who needs support related to the use of ATS in NSW.

Breaking the Ice

A suite of online information resources about crystal methamphetamine produced by NSW Health in collaboration with the Alcohol and Drug Foundation and local agencies. Resources include online education modules, videos, factsheets and where to find further support.

www.breakingtheice.org.au

Counselling online

A program funded by the Commonwealth Government's Department of Health and operated by Turning Point, it provides assistance to Australian residents concerned about alcohol and other drugs. The primary service is online text-based counselling for people concerned about their own drinking or drug use. The service is also available to people concerned about a family member, relative or friend. The service provides support by email, tools such as self-assessments and self-help modules, an SMS service and an online community forum.

www.counsellingonline.org.au

Cracks in the Ice – Community Ice Toolkit

A website and app funded by the Commonwealth Government to provide information about the impacts of crystal methamphetamine in Australia. The website contains tools such as fact sheets, brochures, booklets and PowerPoint presentations, an online counselling resource for people experiencing problems with crystal methamphetamine and/or other drugs, an online wellbeing and resilience program for families, and a training program for health workers.

www.cracksintheice.org.au

Family Drug Support Australia

A website and 24/7 phone line providing support for families throughout Australia to deal with alcohol and drug issues.

www.fds.org.au or call 1300 368 186

Positive choices

An online portal to help school communities access accurate, up-to-date drug education resources and prevention programs.

www.positivechoices.org.au

St Vincent's Stimulant Treatment Line

A NSW state-wide telephone service providing education, information, referral, crisis counselling and support for people affected by use of stimulants.

Sydney Metropolitan: (02) 9361 8088; regional and rural NSW: Free call 1800 10 11 88

The Alcohol Drug Information Service (ADIS)

A NSW service providing a 24-hour support line for people experiencing issues with alcohol or other drugs, or who are concerned about someone else's use.

1800 250 015

The National Alcohol and Other Drug hotline

A hotline providing free and confidential advice about alcohol and other drugs. It directs callers to their state or territory Alcohol and Drug Information Service.

1800 250 015

Your Room

A directory funded by NSW Health that provides information and education resources about drugs, including methamphetamine.

www.yourroom.com.au

