IMPACTS OF METHAMPHETAMINE IN VICTORIA

A Community Assessment

Report for the Victorian Department of Health
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1. Executive Summary

The amphetamine market, which includes crystal methamphetamine, in Victoria involves hundreds of millions of dollars in sales. The highly profitable, relatively cheap and easy-to-consume product is increasingly appearing throughout Victoria and has challenged even small communities. Increased availability of crystal methamphetamine, also known as ‘ice’, was becoming apparent at least as early as 2012, with the period of escalated frontline service awareness being around the September-October period of 2012. This is the same period in which ambulance attendances attributed to crystal methamphetamine began a sharp and steady rise. A feature of its presence is that it is being felt across a wide range of demographics.

This report is based on a literature review, analysis of secondary data sources, interviews and analysis of sewage. It is clear that frontline services, including health, justice and welfare, are being challenged by individual level, family level and community level consequences of problematic methamphetamine use.

Methamphetamine purity has risen in Victoria, from an approximately 20 per cent in the 2010-2011 reporting period to more than 75 per cent in the 2012-2013 period. This confirms that drug markets can shift quickly and dramatically. Police arrests and ambulance data indicate that methamphetamine incidents have surpassed what was previously regarded as the last ‘peak’, the 2005/2006 period. Judging by comments and secondary data analysis in this report, the impost of crystal methamphetamine upon the police, justice and health systems, such as the ambulance service and emergency departments, may be greater than has been recognised to date.

It is clear that alongside global flows of methamphetamine reaching our communities, Victorian production of methamphetamine also continues to be well established. Illicit drug markets do change, but it is not known if this period of increased purity and apparent availability is a short phase, or whether it may be more structural and hence long term.

Needle and Syringe Programs are already seeing increased number of clients who use ice, which is often used alongside other drugs (polydrug use). This has implications for future blood borne virus transmission environments.

People with many years experience working with people who use illicit drugs noted that there seemed be a particularly fast trajectory from occasional use to problematic and harmful methamphetamine use. Methamphetamine can affect people and their families quickly, and in many physical, psychological, legal and financial ways. There has been more than a 250 per cent increase in the number of fatal overdoses involving methamphetamine since 2010. Methamphetamine is now second to heroin as an illicit drug contributing to overdose deaths in this state.

There is a sense that response systems, on the whole, are not yet able to cope with the scale of the problem. This includes health, corrections, housing and family support. It is clear from ambulance call-out and police case data, as well as reports from frontline health and social services, that the impost of methamphetamine upon response systems is enormous.

The crystal methamphetamine issue is real, and genuinely alarming many communities and their members, who in areas such as Mildura, are looking for and driving forms of ‘local’ responses. The level of community concern is reflected in the thousands of people attending community information sessions, especially in regional areas. Frontline services, including police and health, as well as the members of the general community are seeking factual information rather than alarmist fear-based
communications interventions. Local and regional networking and collaboration has an important role to play in responses.

The Waste Water Analysis used in report suggests that on a population basis, there may be less methamphetamine consumed in rural and regional centres than in Melbourne overall. There is evidence in this report that there is more weekend methamphetamine use than during the week, supporting a view that there is a higher proportion of ‘occassional’ or regular recreational users than is the case with opioids. The urine analysis conducted in this assessment is revealing. It would indicate that how a community experiences the crystal methamphetamine issue – one that involves a variety of harmful impacts – can vary.

Therefore, with the behavioural consequences of crystal methamphetamine use, it does not require a large increase in a highly visible drug problem for its impact to be felt in regional or rural areas where networks are tight.

Because of the complexity of the issue, and its direct effects upon individual users and hence service systems, crystal methamphetamine appears to be a particularly draining substance when compared with heroin or other opiates, for example. So, in this sense, the issue may not only be whether or not there is more or less methamphetamine use in regional or rural areas compared with Melbourne, but rather, its actual and perceived impacts upon communities.


2. Background

Anex, now the Penington Institute, began receiving numerous reports from frontline health workers, particularly from regional and rural areas, about an apparent increase in methamphetamine use, from September 2012 onwards.

Since then, workforce and media reports indicate that the use of methamphetamine — particularly crystal methamphetamine or ‘ice’ — has increased in numerous Victorian communities.

In response to reported increased methamphetamine use across the state, the Victorian Government has been implementing a variety of initiatives and has substantially increased investment to support communities.

In 2013, the Minister for Mental Health, Community Services, Disability Services and Reform, the Hon. Mary Wooldridge MP, funded Anex (now Penington Institute) to conduct a community situational assessment of methamphetamine use, particularly crystal methamphetamine, commonly known as "ice" in selected metropolitan, regional and rural areas.

A high-level reference group advised the project. This included representatives from Department of Health, Department of Justice, Victoria Police, Ambulance Victoria, Magistrates’ Court of Victoria, the Commission for Children and Young People, the Australasian College of Emergency Medicine VACCHO, VAADA and Turning Point.

The assessment was based on Rapid Situational Assessment methodology [1, 2]. Its aim was to obtain information about methamphetamine use and the extent of its impact on individuals, families, services and Victorian communities.

This assessment addressed two main questions:
1. What is the level and nature of methamphetamine availability and use in Victoria?
2. What are the associated impacts for users and their families, services, communities?

The project’s objectives were to:

- Undertake a literature/desktop review
- Examine and review existing data sources relating to methamphetamine use
- Undertake a Waste Water Analysis in four Victorian communities (including measurement points for Melbourne) to measure and report on levels of crystal methamphetamine use
- Collect and Assess of data collected by community services regarding the drug use of their client group/s
- Undertake key informant interviews with representatives from a variety of services across regional and metropolitan Melbourne.
- Undertake interviews with people who use methamphetamines.

This report provides a snapshot of current methamphetamine use and relevant community responses. It documents relevant agencies’ and community members understanding and experiences of the reported increases in methamphetamine availability and use, and drug related harms associated with this.
3. Introduction

Methamphetamine is a synthetic drug, commonly available in tablet, powder (speed), crystal (ice) and ‘base’ forms [3]. In this report, the term methamphetamine encompasses the three main forms of this drug: crystal methamphetamine or ‘ice’; powder (also known as ‘speed’); and, less commonly, ‘base’. Methylamphetamine is another term for methamphetamine [4], and is used in the section concerning Victoria Police crime data.

The period of 2005/2006 is generally regarded as being the previous peak of crystal methamphetamine use in Victoria. In order to obtain more accurate information about the current situation, and its impact on individuals, their families, services and the community, Penington Institute was funded by the Victorian Department of Health to undertake a rapid community assessment (RCA) of methamphetamine use in selected metropolitan, regional and rural areas.

This report is a snapshot of methamphetamine use, and responses to use. It assesses the situation in a number of regions using available data as well as the innovative method, Waste Water Analysis (WWA). It also documents methamphetamine–related harms experienced by individuals, communities and families. Finally, it looks at some of the ways community services across Victoria are experiencing these harms.

4. Methodology

This project uses a rapid assessment and response (RAR) approach [5-8]. It is an approach to methodology rather than a set of specific methods. We have used four stages. First we reviewed literature. Second, through secondary data we gained a sense of the extent of use and harms, and the period in which it began to be apparent that methamphetamine was emerging as a significant issue warranting close attention. Third, we spoke to members of communities throughout Victoria to ascertain their sense of what is happening in relation to methamphetamine, and the needs of communities to better respond. In addition, we spoke to people who have direct experience of methamphetamine use in order to gain a better understanding of impacts of use. Finally, we conducted urine analysis of a number of populations. These stages are discussed in detail below.

Component One: Literature review

A literature review was conducted to provide background on the issue of methamphetamine use, guide the research and present the most up-to-date information on related harms. Additionally, the literature was reviewed in order to identify innovative community level responses to methamphetamine.

Both scientific and ‘grey’ literature were reviewed. Databases such as Science Direct, CINAHL, MEDLINE and PsychLit were used, as well as Google Scholar and Google (for grey literature). Various combinations of the following search terms were used: ‘methamphetamine’, ‘ice’, ‘speed’, ‘illicit stimulants’, ‘harm reduction’, ‘community response’, ‘community intervention’. Searches were conducted on other stimulants such as ‘crack’, cocaine and amphetamines more broadly. The literature review provided background on the issue of methamphetamine use and possible interventions and informed the interview questions.

Component Two: secondary data to assess prevalence and harms
Currently, although there is strong anecdotal evidence of increasing and problematic methamphetamine use across Victoria, up to date primary data are not available on prevalence of use. This stage was conducted in order to establish some sense of the scale of current methamphetamine use in Victoria, associated harms and at-risk populations. Relevant secondary data sources were reviewed in order to establish the prevalence of methamphetamine use in Victoria and at risk populations. Reviewed data included reports of use among specific drug using groups such as the Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drug Reporting System (EDRS), as well as law enforcement and emergency response data.

**Component Three: Perspectives on methamphetamine use and related harms, and the impact on communities and services - Interviews with key informants**

Key informants were interviewed in order to assess the impact of methamphetamine use on communities, and to identify ways in which services and communities were addressing this issue and any gaps in services, or service needs required. Key informants were interviewed individually or in small groups, from a range of services and locations. Interviews focused on the use of methamphetamine in the geographical areas in which the key informants work.

**Sampling and Recruitment of Key Informants**

Key informants were recruited from a range of areas across Victoria. These included Bacchus Marsh, Ballarat, Frankston, Mornington, Seymour, Wangaratta, Shepparton, Wodonga, Warnambool, Portland, Horsham and Morwell. They were recruited from a cross section of organisations and services including Hospital Emergency Departments, schools, AOD services (youth withdrawal unit, NSPs, AOD counsellors), youth services, out of home care providers, housing/homelessness services and family violence services. Services were contacted by telephone to recruit key informants. The researcher asked to talk to a representative of the service about the issue of methamphetamine in the community. Through a form of snow-balling, initial key informants suggested others who were then also contacted.

**Instruments**

Key informant interviews were conducted using a semi-structured interview schedule which elicited responses in relation to:

- Current knowledge of use and prevalence of ice in the community (including demographics of users, frequency of use, supply sources and patterns of distribution
- Variations in the above that have occurred in the previous 24 months (and explanation of variance)
- Current indicators of harm from methamphetamine use
- Adequacy of service system response to methamphetamine users and their families
- Strategies to improve responses
- Strategies to reduce harm

Interviews were either face-to-face or by telephone. Notes were taken and where permission was granted, were recorded. It was proposed to interview 30 people. However, the final number of interviews conducted was more than 40.
Component Four: In-depth interviews with people who use methamphetamine

Interviews were carried out with seven people who use methamphetamine, as well as one family member of a person who uses methamphetamine to gain a better understanding of people's experience of this drug.  

Sampling and Recruitment

People were recruited through the services approved by the Department of Health, Human Research Ethics Committee. Service workers made initial contact with individuals who, if willing to participate, were then contacted by a researcher.

Inclusion/exclusion criteria

Inclusion criteria for people who use methamphetamine:
- Aged 18 years or over.
- Regular use of methamphetamine (use at least twice weekly in the past 6 months).
- Able to give informed consent.

Inclusion criteria for family members of people who use methamphetamine:
- Aged 18 years or over.
- Has a close family member (partner or child) who is a regular use of methamphetamine (use at least twice weekly in the past 6 months).
- Able to give informed consent.

Instruments

1. People using methamphetamine and or family members of people using methamphetamine were interviewed using a semi-structured interview schedule.
2. They were provided a Participant Information and Consent Form (PICF). It included a statement written in non-technical language and which explained the study and detailing the requirements of participants. This statement included a section where participants signed their consent to participate in the research.

Analysis

Interviews were thematically analysed, which has guided the framework for the section of the report where interviews are discussed. Quantitative data provided by services/agencies as well as publically available data were analysed. Descriptive statistics only were generated.

In summary, the focus of these components has been on establishing a sense of the scale of use in Victoria, as well as obtaining data from affected groups, including service providers and people who use methamphetamine. We have sought to provide information on key issues related to this drug, including harms to individuals and families as well as the broader impacts for communities.

Component Five: Waste Water Analysis (WWA)

Penington Institute collaborated with the School of Pharmacy and Medical Sciences, at the University of South Australia, to test sewage treatment system water samples from Melbourne, two regional cities and a small country town. This is known as Waste Water Analysis (WWA), or "sewage epidemiology [9-11]. The purpose of this analysis was to examine, among other issues, the

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1 This component of the study was granted ethics approval by the Department of Health on the 16th December, 2013.
proposition that methamphetamine use was occurring in small towns, and that on a population level, its use may be higher in regional areas than in Melbourne. Samples were taken twice in a week, which enabled comparison of weekend versus mid-week drug consumption. The WWA methodology includes volume requirements, timing and frequency of sample collection, storage and reporting requirements, as well as population data that are to be provided by each site.

5. Component one – literature review

Methamphetamine is a variant of amphetamine. A stimulant, methamphetamine is made primarily from ephedrine or pseudoephedrine and is typically available in four forms; tablet, powder, base and crystal (ice) [12]. In the 1990s, methamphetamine replaced amphetamine as the dominant form of amphetamine available in Australia. Crystal methamphetamine, also known as ‘ice’ or ‘crystal’, is a crystalline form of higher purity methamphetamine [13].

The use of illicit stimulants in Australia rose in the 1990s, climbing from around an estimated two per cent of the Australian population aged 14 years or older in 1993, to a peak of almost four per cent (3.7 per cent) by 1998 [14]. This trend was argued to have occurred primarily because of the increased availability of imported crystal methamphetamine [15]. The shift to increased use of crystal methamphetamine encouraged a culture of smoking, via a glass pipe, or a ‘bong’-style water pipe, particularly among recreational users [16]. It also resulted in greater drug-related harms, and in higher numbers of people who primarily smoke methamphetamine seeking treatment [17]. Information on how to manufacture methamphetamine is easily accessed through the internet, and it is able to be covertly manufactured in a wide variety of locations at low cost [18, 19].

The most recent publication of the (Australian) National Drug Strategy Household Survey (NDSHS) was published in 2011 and measured population-level drug use in 2010 [20], well before the increased use since 2012.² The report indicated that, since 1998, prevalence of methamphetamine use in Australia as a whole had declined, from a peak of 3.7 per cent of people 14 years old or older recorded in the 1998 survey, to 2.1 per cent in the 2010 report. This reduction in use is thought to be related to a decrease in the initiation of use among young people [21]. Methamphetamine remains the fourth-most used illicit drug in Australia, following cannabis, MDMA (ecstasy) and pharmaceutical drugs [20].

In 2013 the Australian Bureau of Statistics Macro-Economics research unit has estimated the value of trade and profitability in certain illicit drugs in Australia. It estimated that Australians spent approximately $1.05 billion on crystal and non-crystal amphetamines in 2010, and that the profit within that sales volume was approximately $1.03 billion [22]. Based on a crude population-level split, the Victorian proportion of that approximate consumer spending would have been around $250,000,000 in 2010. The researchers who conducted this analysis, based on complex economic modelling, have told Penington Institute the estimates published were at the conservative end of the range. Amphetamine use is more widespread than heroin use [23]. The ABS drug market modellers have calculated that there were approximately 10 times more “occasional” users of methamphetamine than there are “heavy users”. This was not the case with heroin, where they estimate “heavy users” outnumber “occasional users” [24, 25]. This split between “heavy” and “occasional” should borne in mind when reading the Waste Water Analysis section of this report.

² The survey is due to be released in 2014 and measured the population in 2013.
That ABS analysis looked at 2010. It is quite likely, if not certain, that the size of the market has grown in Victoria substantially.

It has been felt that methamphetamine use is more prevalent amongst certain occupations. Roche and colleagues (2008) found that:

“The hospitality industry, an industry that traditionally attracts large numbers of young workers, had the largest proportion of workers who used methamphetamine. Male workers, transport industry workers, construction industry workers, tradespeople and unskilled workers also reported high prevalence of methamphetamine use [26: 338].”

Higher use in work areas that involve hard physical labour and long hours which may be related to the drug’s ability to maintain alertness and energy is not surprising. It should be noted that these data are now at least six years old.

**The cultural contexts of methamphetamine use**

There is a body of qualitative research that examines the cultural context of methamphetamine use in Australia. This work documents some of the social environments of methamphetamine consumption, providing insight into why and how people use methamphetamine, how people manage methamphetamine-related harms, methamphetamine and poly-drug use and the role that physical and cultural factors play in shaping methamphetamine use.

Slavin [27, 28] researched gay men in Sydney, finding that for some, methamphetamine plays a key role in social events. Methamphetamine was commonly used among his participants to enhance sex, but also as part of a party culture. At the same time, he documents how some gay men manage the drug (and its related harms) more successfully than others. He argues that for his participants, methamphetamine use was considered acceptable, whereas other drug use – such as heroin use – was not. Further, he documents a reluctance by some of his participants to use harm reduction services such as NSP because they do not want to identify as ‘junkies’.

Pennay has demonstrated that, for some young people, methamphetamine has become ‘normalised’ and shows the way in which young people use this drug in the context of a ‘big night out’; that is, a period of more than 24 hours spent ‘partying’ [29]. Her documentation of methamphetamine use shows that rather than being a drug that makes people ‘out of control’, her participants used methamphetamine to ‘sober up’ in order to facilitate their entry into mainstream nightclubs. This is illustrated in the following quote from a participant in Pennay’s research:

“If we’re too pissed we’d usually have it [methamphetamine] to straighten us out. I never go anywhere without my little vial, just in case. If someone gets too f**ked on ecstasy or too pissed or something I always carry it around, like an emergency, to straighten them out.”

(Interview: December, 2006) [29: 413-414].

Similarly, in research with young people from Perth [30], found that methamphetamine was a drug people considered kept them ‘in control’ rather than a drug such as ‘ecstasy’ that could cause the user to appear extremely intoxicated through facial spasms and so on. One of Green’s participants said of methamphetamine:

“I find that the rock [crystal methamphetamine] just doesn’t affect my emotions at all. The E [MDMA] affects your emotions and that’s not what I was after. I wanted to be in full control of what I was doing, what I was feeling” [30: 406].
Such research provides insight into the way in which young people in Australia think about and use methamphetamine. It shows that for some, the use of methamphetamine is not associated with violence and extreme behaviour, but is a drug they use to maintain self-control. Moreover, use of this drug is socially acceptable among these young individuals. These ethnographic explorations of methamphetamine use are a valuable tool for public health professionals in formulating education around this drug. They demonstrate the need to couch messages in the experience of young people — and other populations among whom methamphetamine use is high — so that they remain credible and relevant [31].

5.1.1. Effects and harms

The immediate effects of methamphetamine can be intensely pleasurable. These include feelings of euphoria, well-being, self-esteem, alertness/wakefulness, increased sex drive and reduced appetite [32]. Research conducted by the Penington Institute asked crystal methamphetamine users to describe the both the positive and negative effects of crystal methamphetamine [33]. Amongst the effects described were: “Increased arousal when used for sex”, “long sex sessions”, “the perceived freedom from inhibition and physical limitations, especially the need to sleep”, “improved feeling about self, energy”, “dopamine rushes are really nice. Amphetamines are great for energy and stamina”, and I get my cleaning done. It's better than drinking”.

However, methamphetamine consumption can also produce a variety of severe adverse effects which include: stomach cramps, increased blood pressure, teeth clenching and/or grinding, cardiac arrhythmia, stroke and psychological effects including paranoia and anxiety [32].

Individual harms

Harm associated with methamphetamine use does not affect all users equally. Harms associated with higher frequency of use, higher potency forms and riskier routes of administration, particularly intravenous injection [13]. Additionally, binge use and poly-drug use are associated with greater harms [32, 34] as are long-term use, smoking methamphetamine and the use of crystal methamphetamine [35]. While dependent use has been associated with injecting methamphetamine, smoking is also associated with a high level of harm [35]. Thus, while there is a relatively small population of people who engage in frequent (i.e., weekly or more) methamphetamine use [36], this type of use is of concern as it is associated with the majority of methamphetamine-related harms [13, 37]. It should also be noted that occasional use can also be associated with harm. Methamphetamine use can also impact on day-to-day functionality of individuals. Henry et al [38] examined measures of everyday function in people who were previously methamphetamine-dependent. These authors assessed functionality over a number of areas such as comprehension, finances, communication, transportation and medication management. They found that people who had been methamphetamine-dependent performed worse than healthy control subjects of comparable age and education on almost all indices of daily function.

5.1.2. Physiological harms

A range of physical harms have been documented in relation to methamphetamine use. These tend to be exacerbated by methods of ingestion, such as injecting [32], and patterns of use such as binge use, or using methamphetamine with a combination of other drugs [34, 35].

In terms of overall physical health, Australian research with 309 methamphetamine users found that people dependent on methamphetamine and over the age of 24 years have significantly poorer physical health than the general population [39]. The research stated that it is not possible to
attribute poor health status to the use of methamphetamine, or any other drug, due to the cross sectional nature of the study [39].

Toxicity and overdose are severe physical harms that can occur as a result of methamphetamine use [40]. Methamphetamine overdose and/or toxicity is characterised by symptoms such as agitation, dilated pupils, elevated heart beat and high blood pressure. Other symptoms may be experienced such as shivering, chest pain, and renal failure. In rare cases, coma or seizures may occur [41]. Death may occur from methamphetamine overdose and is typically related to seizures, cardiac arrhythmias or respiratory failure. Cardiovascular complications are the primary reason behind most methamphetamine-related fatalities [40]. Fatal overdoses have also occurred after taking methamphetamine because of brain haemorrhages, renal failure and stroke [40]. Men in their mid-30s who are long term methamphetamine users are at greatest risk of fatal methamphetamine overdose. However methamphetamine toxicity has also been reported by first time users and is not necessarily related to dose amount, frequency of use or route of administration [40].

Other physical harms associated with the long term use of methamphetamine include dependence [42], with people who inject methamphetamine at greatest risk of dependence [43]. Methamphetamine dependence is defined by tolerance, withdrawal and inability to discontinue use of the drug despite significant social, physical and psychological consequences [40]. Withdrawing from methamphetamine can result in disturbed sleep and depressed mood and anxiety [41]. Other symptoms may include disturbed sleep, craving and a lack of energy. Methamphetamine is also known to be cardiotoxic, increasing heart rate and blood pressure [41]. Research suggests methamphetamine withdrawal — and symptoms such as depression and anxiety — peak at 2-3 days after methamphetamine cessation, with gradual improvement over 7-10 days [41].

Use of methamphetamine is related to cardiac pathology such as hypertension, tachycardia, ischaemic stroke [44]. Repeated methamphetamine use may lead to chronic conditions, including coronary heart disease and cardiomyopathy [41].

Other physical harms that may result from long term, heavy methamphetamine use include poor oral/dental health [45]. This may be the result of dry mouth from methamphetamine intoxication and teeth grinding when heavily intoxicated [41]. It could also be related to lifestyle factors associated with long term illicit drug use such as poverty and homelessness. Skin infections have also been related to methamphetamine use. This may be a result of skin picking and formication (the feeling that something is crawling on your skin) that can sometimes occur during methamphetamine use [41].

Neurotoxicity

There has also been a significant body of research assessing whether methamphetamine use results in cognitive impairment; that is, detrimental changes to the brain that impact on brain functioning. This research finds that long-term dependent methamphetamine use can result in cognitive deficits, especially to memory, attention and executive function, possibly from neurotoxicity [46, 47]. An extensive review of this body of evidence found that the research is inconclusive, and argued that the field of neuroscience has generally over-interpreted the severity of cognitive problems in methamphetamine dependence [48]. A response to this review notes that Hart et al [48] bring to light a number of important methodology and data interpretation problems in neurological research and suggest that a more critical and careful approach to neurological research is taken in future studies. Other researchers argue that the few longitudinal studies around this issue mean that, at present, it is not possible to determine the long-term cognitive impact of methamphetamine and the permanence of purported neural effects [32].
5.1.3. **Psychological and mental health harms**

There can be extensive psychological harms associated with frequent and long-term use of methamphetamine, and regular users of the drug are characterised by a high prevalence of psychological co-morbidity [49, 50]. The most recent population-level data find that people who had used methamphetamine in the previous 12 months were more than twice as likely as non-users to have been diagnosed with or treated for a mental illness in this period (25.6% compared with 11.7%) [51]. These may include mental health problems such as anxiety, panic attacks, paranoia, mood swings, mania, hallucinations, aggression, suicidal thoughts and depression [34, 52].

Many people using methamphetamine experience mild psychotic symptoms such as visual and auditory hallucinations and suspicious thoughts [53], with these typically easing after cessation of methamphetamine use [54]. More severe psychotic reactions have been found to be dose-dependent and associated with increased use of methamphetamine. Research has found the psychosis experienced by methamphetamine users is similar to acute paranoid schizophrenia, which is characterized by persecutory delusions. Symptoms can last from hours to days, and recede once the drug's effects have worn off [55].

This relatively high level of psychiatric co-morbidity among people who use methamphetamine is concerning given its impact on treatment efficacy. Research has found that those people experiencing psychological issues have poorer retention in treatment and treatment outcomes [56, 57]. Nonetheless, research also indicates that people who use drugs and also have mental health issues can benefit from treatment, and that treatment can lessen mental health symptoms [58, 59].

5.1.4. **Family and community level harms**

*Violence*

There is a great deal of research that documents methamphetamine-related harm to individuals, but less is formally known about methamphetamine-related harm to others and to the wider community. This would appear to be a significant gap in the research.

There is, however, recent research that found there is a dose-related increase in violent behaviour during periods of methamphetamine use. This increase was largely independent of the violence risk associated with psychotic symptoms [54]. The research also found pre-existing psychotic symptoms and alcohol use further increased the risk of violent behaviour while an individual was using methamphetamine. The researchers concluded that there was a causal relationship between methamphetamine and violence, but that it was not possible to determine the direction of the relationship; that is, whether methamphetamine use increased violent behaviour, or whether violence increased methamphetamine use. Further, the authors cautioned that their findings were only applicable to chronic methamphetamine users. All the individuals they studied were classified as dependent on methamphetamine. Thus the findings of the research are not able to be generalised to other populations of methamphetamine users, such as those who use it occasionally.

While dose is important, it should also be noted that other factors may play a role in violent events. These include the social context, an individual's pre-existing propensity to violence, and other drug use such as alcohol [60-62]. Moreover, involvement in the illicit drug market itself is associated with elevated levels of exposure to violence and perpetration of violence, although research has found that methamphetamine users are reportedly more likely to perpetuate violence than heroin users [62].
**Family relationships**

Methamphetamine use by children, siblings or parents can be damaging to families, impacting on internal and external family relationships. While sometimes challenging, maintaining internal relationships is important, as families can support the individual to make safer choices about their methamphetamine use [34]. US research also indicates that connectedness to family is a protective factor against drug use among young people [63].

External relationships are also important in assisting families to deal with methamphetamine use. Research with Australian families found that families with children using drugs felt a lack of support from the wider community [64]. This can result in isolation and exclusion of people using methamphetamine and their families at a time when they are at their most vulnerable and in most need.

Families are also at risk when a parent uses methamphetamine. Most obviously, children are particularly vulnerable in this situation. Drug intoxication and withdrawal can result in reduced ability to care for children and engagement in the illicit drug market can expose children to violence and illegal activities [65]. Psychological effects associated with the use of methamphetamine such as depression, anxiety and psychosis are not conducive to good parenting and may impact on the wellbeing of children. Importantly, parental illicit drug use is often part of a more complex picture of disadvantage, including poverty, and social isolation [65]. This suggests that a multifaceted approach to parental drug use is required.

**Treatment**

Australian researchers have written that “specialised treatment options for methamphetamine use in Australia are scarce, a picture that is not dissimilar to most other parts of the world” [66]. Further, writing in "Principles of Addiction", McKetin and colleagues have stated that “despite the extent of methamphetamine use, and resulting harms, no specialized treatment options for this drug have been proved to be effective” [4]. There are various form of non-specialist treatment available for methamphetamine use, including counselling, outpatient and inpatient detoxification and residential rehabilitation.

National treatment data from the Australian Institute of Health and Welfare provide an indication of levels of treatment seeking for methamphetamine use. Treatment is measured by completed episodes of care, so does not measure cases were people start but do not finish treatment. Recent data indicate that amphetamines (including methamphetamine) were the fourth most common principal drug of concern for which treatment was sought in 2010–11 (nine per cent of episodes). This is a slight increase compared with 2009–10 (seven per cent) [17]. However, consistent with research that finds methamphetamine is typically used concurrently with other drugs [66] when amphetamine use reported in treatment episodes for other principal drugs of concern was included, 19 per cent of all treatment episodes during 2010-2011 involved amphetamines. Similar to previous years, counselling was the most common main treatment type, with about half (48 per cent) of episodes where amphetamines were the principal drug of concern reporting this treatment [17].

Treatment outcomes for methamphetamine use have been found to be time-limited, in that the benefits are apparent only during the individual's time in treatment [67]. These findings highlight the chronic relapsing nature of methamphetamine dependence and the need for a treatment approach with a more sustained impact [67].
As with other drugs, including alcohol, treatment for methamphetamine use is also complicated by issues of comorbidity [50]. For instance, clinical levels of depression are very high among people entering treatment for methamphetamine use [52]. Nonetheless, treatment can assist people to reduce their use as well as improve their mental health [66].

Another complicating issue with regards to methamphetamine treatment is that professionals may feel out of their depth in addressing methamphetamine, and many are pessimistic about the outcomes of methamphetamine treatment [68]. In the case of withdrawal treatment for methamphetamine, it has been argued that:

\[
\text{treatment services should consider improving withdrawal protocols, educating clinicians and reconsidering entry criteria to better respond to methamphetamine users who have made the important first step into withdrawal treatment [68].}
\]

It is also argued that improved treatment responses are needed to address methamphetamine use including the issues of poly-drug use and mental health comorbidity within this population [52].

**Community approaches to tackling methamphetamine-related harms**

*General principles*

There is not a great deal of documentation, let alone evidence, on the ways in which communities have addressed the issue of methamphetamine use. For instance, Walker and colleagues (2008) report on a community initiative with Indigenous groups in the US aimed at preventing methamphetamine use. These researchers note that there are no documented or demonstrated community driven practices as an outcome of this project [69]. The lack of outcomes is due to a number of reasons including lack of clarity around the actual extent of methamphetamine use in communities and agreement on outcomes, as well as poor involvement and documentation of the process [69].

Allsop [70] argues that in lieu of evidenced-based community-level initiatives that address methamphetamine use, it is worth looking at areas that are relatively well documented, such as community interventions around alcohol use. Here, community capacity to address drug use has been developed. Successful community level approaches that address alcohol use are typically multifaceted and include:

- Raising awareness of existing policy and ways to use policy approaches to reduce risk (e.g. enforcement of liquor and drink driving legislation)
- The engagement of diverse stakeholders (police, health service and community organisations)
- Targeting specific at-risk groups and behaviours (e.g. young people and drink driving) [70].

Allsop [70] also discusses the 2008 work from Birckmayer and colleagues [71] who argue that these principles could work with drugs such as methamphetamine. These authors propose an approach that includes:

- Community mobilisation and education targeted towards at-risk groups to increase support of prevention efforts and raise awareness of key issues
- Use of law enforcement approaches, but in combination with the broad range of other interventions
Development of coalitions of support and action across a broad range of organisations and individuals (police, health, media, education,) consistent with the broad range of issues to be addressed [70].

Young people are an important consideration in the delivery of methamphetamine community-level interventions given that use is relatively high among this population. Yet there are few, in any, targeted on-going methamphetamine education programs delivered to young people in Australia. In the US, there have been reports that universal abstinence-based programs with young people through schools have had a significantly positive impact on young people’s methamphetamine use. However, critiques of this work assert that these claims should not be made and are analysis dependent [72]. Based on these critical evaluations, US scholars have argued for a move away from abstinence-based programs, more rigorous evaluations of programs delivered to school children, and programs that more accurately reflect the context of young people’s experiences with drugs [72].

In Australia, research with young people using methamphetamine and party drugs has argued that responses to drug use need to take into account the meaning that specific drugs have to young people and the context within which they use and experiment with drugs [31, 73]. The normalisation of drug use among some groups of young people suggest that abstinence-only approaches, and approaches that use extreme examples of drug use, would be ineffective as they would not reflect young people’s experiences.

Moreover, while there are broad principles that can be applied to drug education for young people, there are some specific issues in relation to methamphetamine. Many people use methamphetamine in public spaces, and do not access traditional sites of drug education such as NSPs or drug treatment. New types of information and education strategies may be required in specific ‘drug use settings’ such as bars and nightclubs, the workplace, schools and universities. This might involve the development of more effective ‘peer to peer’ education and information strategies in which the practical benefits of methods to reduce harms might be communicated to young people in a way that resonates with their own experiences [74].
6. Component two – prevalence and harms

This section reviews a variety of secondary data sources to give an overview of trends in seizures, police case data, ambulance attendances and drug trend tracking studies/projects.

6.1. Supply side indications

There has been a steady increase in the number of clandestine methamphetamine labs detected and seized by Australian law enforcement agencies each year [75]. The ACC releases an annual Illicit Drug Data Report (IDDR), which brings together a range of state, territory and federal data sets to give an overview of national illicit drug markets. It is usually released in May, and reports on the previous financial year. The ACC reported that in 2011-2012 Victoria reported the largest percentage increase in the detection of clandestine labs [76], with a further increase in 2012-2013 [77].

Table 1: Clandestine laboratory detections, by state and territory, 2002–03 to 2012–13.

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002–03</td>
<td>47</td>
<td>19</td>
<td>171</td>
<td>34</td>
<td>36</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>314</td>
</tr>
<tr>
<td>2003–04</td>
<td>61</td>
<td>20</td>
<td>189</td>
<td>48</td>
<td>33</td>
<td>1</td>
<td>6</td>
<td>0</td>
<td>358</td>
</tr>
<tr>
<td>2004–05</td>
<td>45</td>
<td>31</td>
<td>209</td>
<td>25</td>
<td>44</td>
<td>3</td>
<td>21</td>
<td>3</td>
<td>381</td>
</tr>
<tr>
<td>2005–06</td>
<td>55</td>
<td>47</td>
<td>161</td>
<td>50</td>
<td>58</td>
<td>5</td>
<td>12</td>
<td>2</td>
<td>390</td>
</tr>
<tr>
<td>2006–07</td>
<td>49</td>
<td>72</td>
<td>132</td>
<td>51</td>
<td>37</td>
<td>9</td>
<td>1</td>
<td>5</td>
<td>356</td>
</tr>
<tr>
<td>2007–08</td>
<td>51</td>
<td>76</td>
<td>121</td>
<td>69</td>
<td>30</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>356</td>
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<tr>
<td>2008–09</td>
<td>67</td>
<td>84</td>
<td>148</td>
<td>65</td>
<td>78</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>449</td>
</tr>
<tr>
<td>2009–10</td>
<td>82</td>
<td>113</td>
<td>297</td>
<td>71</td>
<td>118</td>
<td>1</td>
<td>12</td>
<td>0</td>
<td>694</td>
</tr>
<tr>
<td>2010–11</td>
<td>87</td>
<td>63</td>
<td>293</td>
<td>75</td>
<td>171</td>
<td>11</td>
<td>2</td>
<td>1</td>
<td>703</td>
</tr>
<tr>
<td>2011–12</td>
<td>90</td>
<td>99</td>
<td>379</td>
<td>58</td>
<td>160</td>
<td>15</td>
<td>7</td>
<td>1</td>
<td>809</td>
</tr>
<tr>
<td>2012–13</td>
<td>105</td>
<td>113</td>
<td>330</td>
<td>56</td>
<td>136</td>
<td>9</td>
<td>8</td>
<td>0</td>
<td>757</td>
</tr>
</tbody>
</table>

Source Australian Crime Commission 2014

Of the 809 labs detected across Australia in 2011-12, 552 were ATS labs (excluding MDMA). 70.6 per cent of labs were located in residential areas, and 3.1 per cent were located in rural areas [76].

The IDDR reported increased purity of methamphetamine seized in Victoria. The mean purity across the year in Victoria jumped from around 20 per cent in 2010-2011 to 60 per cent in 2011-2012, and 76.1 per cent in 2012-2013, which was higher than average purity level in Australia overall.
Table 2: Annual median purity of methylamphetamine samples, 2002–03 to 2012–13.
Source Australian Crime Commission 2014

<table>
<thead>
<tr>
<th>Year</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002–03</td>
<td>8.6</td>
<td>20.4</td>
<td>19.4</td>
<td>21.5</td>
<td>18</td>
<td>12.2</td>
<td>--</td>
<td>11.5</td>
</tr>
<tr>
<td>2003–04</td>
<td>11</td>
<td>23.5</td>
<td>16.9</td>
<td>19.8</td>
<td>32</td>
<td>16.9</td>
<td>--</td>
<td>19.7</td>
</tr>
<tr>
<td>2004–05</td>
<td>18</td>
<td>19</td>
<td>17.3</td>
<td>11.6</td>
<td>23</td>
<td>32.3</td>
<td>--</td>
<td>24.3</td>
</tr>
<tr>
<td>2005–06</td>
<td>13</td>
<td>13.7</td>
<td>12.9</td>
<td>14.8</td>
<td>21</td>
<td>13.1</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2006–07</td>
<td>18.5</td>
<td>14.3</td>
<td>11.4</td>
<td>21.6</td>
<td>20</td>
<td>12.4</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2007–08</td>
<td>9.8</td>
<td>14.8</td>
<td>11.9</td>
<td>14.7</td>
<td>18</td>
<td>8.5</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2008–09</td>
<td>9</td>
<td>7.2</td>
<td>8.2</td>
<td>13.29</td>
<td>12</td>
<td>9.2</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2009–10</td>
<td>8</td>
<td>9.7</td>
<td>6.8</td>
<td>6.9</td>
<td>17</td>
<td>4.4</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2010–11</td>
<td>9.5</td>
<td>19.6</td>
<td>13.9</td>
<td>31.7</td>
<td>32</td>
<td>9.3</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2011–12</td>
<td>19.5</td>
<td>60</td>
<td>34.2</td>
<td>43.3</td>
<td>47</td>
<td>7.9</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>2012–13</td>
<td>68</td>
<td>76.1</td>
<td>52.6</td>
<td>54.6</td>
<td>50</td>
<td>64</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Source Australian Crime Commission 2014

The ACC Illicit Drug Data reports also purity, as reported by Victoria Police, on a quarterly basis. Compiling these quarterly figures from the past three annual reports provides an insight into the period of time that purity levels of methamphetamine began to rise sharply [75-78].
Table 3: Methamphetamine purity levels reported as quarterly measurements reported to Australian Crime Commission by Victoria Police.

As Table 3 shows, purity levels were rising steadily during 2011 and the rose sharply from early 2012 onwards [75–78]. This gives weight to the view that methamphetamine being consumed by Victorians was of a far higher purity during 2012 than just two years earlier.

The ACC also reports on ATS seizures. Victoria showed a 60.6 per cent increase in the number of seizures (1394) in the 2011-2012 report, and a further 73.7 per cent increase in the 2012-2013 report [76, 77]. The number of seizures in New South Wales, Western Australia and Queensland were 5772, 3401 and 3350 seizures respectively. The 2011-2012 reported noted that Victoria also posted the greatest percentage change in the weight (gm) of ATS seized, with an increase of 1279.6 per cent, and the increasing volume of ATS continued to rise throughout the 2012-2013 period (See Table 4).

Table 4: Number, weight and percentage change of national ATS seizures, 2011–12 and 2012-13.

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>Number 2011–12</th>
<th>Number 2012–13</th>
<th>% change</th>
<th>Weight (grams) 2011–12</th>
<th>Weight (grams) 2012–13</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>5 772</td>
<td>8 762</td>
<td>51.8</td>
<td>882 916</td>
<td>4 403 788</td>
<td>398.8</td>
</tr>
<tr>
<td>Victoria</td>
<td>1394</td>
<td>2 422</td>
<td>73.7</td>
<td>580 063</td>
<td>1 850 879</td>
<td>219.1</td>
</tr>
<tr>
<td>Queensland</td>
<td>3 350</td>
<td>4 172</td>
<td>24.5</td>
<td>41 266</td>
<td>58 053</td>
<td>40.7</td>
</tr>
<tr>
<td>South Australia</td>
<td>539</td>
<td>346</td>
<td>-35.8</td>
<td>14 155</td>
<td>53 359</td>
<td>277.0</td>
</tr>
<tr>
<td>Western Australia</td>
<td>3 401</td>
<td>4 580</td>
<td>34.7</td>
<td>29 578</td>
<td>74 688</td>
<td>152.5</td>
</tr>
<tr>
<td>Tasmania</td>
<td>258</td>
<td>241</td>
<td>-6.6</td>
<td>4 683</td>
<td>5 199</td>
<td>11</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>328</td>
<td>350</td>
<td>6.7</td>
<td>19 450</td>
<td>7 032</td>
<td>-63.8</td>
</tr>
<tr>
<td>ACT</td>
<td>149</td>
<td>183</td>
<td>22.8</td>
<td>517</td>
<td>738</td>
<td>42.7</td>
</tr>
<tr>
<td>Total</td>
<td>15 191</td>
<td>21 056</td>
<td>38.6</td>
<td>1 572 628</td>
<td>6 453 736</td>
<td>310.4</td>
</tr>
</tbody>
</table>

a) The term amphetamine-type stimulants (ATS) encompasses drugs included under both the amphetamines and phenethylamines groupings. b) Includes seizures by state/territory police and the AFP for which a valid seizure weight was recorded. Source Australian Crime Commission 2014
Victoria accounted for the greatest number of ATS arrests (an increase of 50.5 per cent), closely followed by New South Wales and Queensland (see Table 5). Note that this increase was on top of a 45 per cent increase reported in the previous reporting period [76].

**Table 5: Number and percentage change of national ATS arrests, 2010–11 and 2011–12.** Source Australian Crime Commission 2014

<table>
<thead>
<tr>
<th>State/Territory</th>
<th>2011–12</th>
<th>2012–13</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>4451</td>
<td>5905</td>
<td>32.7</td>
</tr>
<tr>
<td>Victoria</td>
<td>4494</td>
<td>6762</td>
<td>50.5</td>
</tr>
<tr>
<td>Queensland</td>
<td>4188</td>
<td>4941</td>
<td>18</td>
</tr>
<tr>
<td>South Australia</td>
<td>1049</td>
<td>1312</td>
<td>25.1</td>
</tr>
<tr>
<td>Western Australia</td>
<td>2347</td>
<td>2870</td>
<td>22.3</td>
</tr>
<tr>
<td>Tasmania</td>
<td>161</td>
<td>125</td>
<td>-22.4</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>14</td>
<td>169</td>
<td>1107.1</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>124</td>
<td>105</td>
<td>-15.3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16,828</strong></td>
<td><strong>22,189</strong></td>
<td><strong>31.9</strong></td>
</tr>
</tbody>
</table>

a. The term amphetamine-type stimulants (ATS) encompasses drugs included under both the amphetamines and phenethylamines groupings. For further details see the Statistics chapter.
b. The arrest data for each state and territory include Australian Federal Police data

The above data show significant increase in detection and arrests for methamphetamine in 2011-2012 and 2012-2013.

**Victoria Police Crime Statistics (2013)**

Victoria Police’s crime statistics include reports of (unspecified) drug offences by Local Government Area (LGA) and Police Service Area (PSA) and state-wide reports of specific drug offences.

Throughout the media, there have been statements issues by spokespeople for the Victoria Police, which link a number of assaults and armed robberies to methamphetamine. For example:

> “Police figures show that... there were 3218 amphetamine-related assaults and 3990 burglaries”[^3]

> “Police said in at least 12 murders committed or tried by courts over the past two years, crystal methamphetamine was used by the killer or was otherwise a suspected factor in the crime”[^4]

Updated in December 2013, but not disaggregated by LGA or PSA, Victoria Police Crime Statistics show that in Victoria during the 2012/2013 period, there were 1335 cases of “traffick methylamphetamine” recorded.[^5] This represents a 90.2 per cent increase over 2011/2012 when there were 702 such cases. In 2010/2011 there were 448 cases of “trafficking methamphetamine”.

[^5]: Methylamphetamine is the term used in this dataset.
With regards possession of methylamphetamine offences, there were 1176 such recorded offences in 2012/2013, compared with 491 in 2011/2012. This was a 139.5 per cent increase. Furthermore, the 2012/2013 statistics compare with 147 cases of possession in 2010/2011 [79].

By comparison, statistics relating to “trafficking amphetamine” in the period 2010/2011 to 2012/2013 show the following: 407, 365, 324. This reveals a small decline in the number of amphetamine trafficking cases recorded, but a large increase in the number of methylamphetamine trafficking cases. This directly overlaps with the period in which reports of increased methamphetamine use in Victoria began, and has continued to occur.

These figures provide an indicator of what contributes to increased availability, and of course, increased police attention to the methamphetamine supply.

Table 6 shows methylamphetamine and amphetamine trafficking and possession cases in Victoria over a decade.

Table 6: Victorian methylamphetamine and amphetamine offences.

**Detainee testing including at Footscray Police Station**

Another source of relevant data is the Drug Use Monitoring in Australia (DUMA) program. DUMA collects information on results of drug tests among people detained by police at nine police stations in Australia, including Footscray which is the only Victorian site in the survey. In 2009-2010, nationally DUMA recorded its lowest level of methamphetamine use (15 per cent) since the program’s inception in 1999 [80].

However, with regards to results from the Footscray police station samples, it was noted that: “the main exception to this [national trend] was a substantial increase in the detection of methamphetamine, which rose by 15 percentage points in 2010 (up to 26 per cent)” [80].

**Prison population**

In Victoria, in 2013 the overall prison population increased nine per cent (456 prisoners) to 5340 (as at the prison census). The (crude) imprisonment rate increased from 112 per 100,000 to 120 per 100,000 in 2013. The next estimate of numbers will not occur until later this year, but it is known that
methamphetamine-related offences have increased, and is likely to be contributing to what the Auditor-General has described as dangerously over-crowded prisons [81].

The above data would indicate that on the supply side at least, conditions appear conducive to increased availability of methamphetamine in Victoria. The next section will look at published data that assists us to understand whether or not there may be increased use, at least amongst populations regularly studied as part of on-going surveillance and research in Australia.

6.2. Indicators of levels of demand/use


Australia’s National Drug Strategy Household Survey (NDSHS), conducted every three years, provides an indication of levels of methamphetamine use and is particularly interesting in relation to young people. Due to the stigmatizing and illegal nature of methamphetamine use, as well as its methodology, significant under-reporting is likely.

Nationally, the 2010 NDSHS found that meth/amphetamines use was high among unemployed people (4.8 per cent), homosexual and bisexual people (7.1 per cent), those who had never been married (3.8 per cent), and single people without children (3.4 per cent). Further, four per cent of 18 and 19 year olds and 5.9 per cent of people aged between 20-29 years had used methamphetamine in the previous 12 months [20]. This compares with 3.4 per cent of 30-39 year olds and 0.5 per cent of those aged over 40 years. Other available data find that among particular populations of young people use may be higher. A recent study from South Australia found that around 20 per cent of young nightclub goers (N=457) were using methamphetamine [82].

The NDHS does not produce state/territory breakdowns in any drug category. The survey was conducted again last year, and the report is expected later in 2014.

6.2.2. IDRS and EDRS

The Illicit Drug Reporting System (IDRS) is a national annual survey of people who inject drugs, capturing various aspects of their drug use such as types of drugs consumed and methods of consumption [15]. Similarly, the Ecstasy and Related Drugs Reporting System (EDRS) reports on the drug use of regular ecstasy users in Australia [83]. Both the IDRS and the EDRS report on the drug use of experienced and ‘sentinel’ groups of drug use, and in Victoria conduct the research in Melbourne only. The data collected are not considered representative of drug use in the general population, but may predict drug use trends and act as an early warning system.

The most recent IDRS and EDRS surveys indicate the use of methamphetamine in all forms among these established drug user populations may be trending down. The IDRS reports that in Victoria, 61 per cent of respondents used methamphetamine in the previous six months in 2013, down from 67 per cent in 2012 [84]. The EDRS reports that 71 per cent of Victorian respondents had used methamphetamine in the previous six months in the 2013 survey, down from 84 per cent of respondents in 2012 [85].

The 2013 data indicated that use of crystal methamphetamine among these populations was less than reported in 2012. The 2013 IDRS reports that 55 per cent of participants in Victoria had used crystal methamphetamine in the past six months compared to 59 per cent in 2012. The EDRS reports that, in 2013, 45 per cent of Victorian participants had used crystal methamphetamine in the past six months compared to 48 per cent in 2012. However, while these data suggest use of this form of
methamphetamine is declining; 2013 rates of use are much higher than in 2010. In 2010, only 36 per cent of IDRS and 18 per cent of EDRS participants had used crystal methamphetamine in the past six months [84, 85].

6.2.3. Trends in analysis of the annual NSP survey data

The annual Australian NSP Survey is a form of serological and behavioural surveillance that is used to indicate, among other things, trends in illicit drugs being injected across Australia. The highest percentage of Victorian respondents who reported methamphetamine/amphetamine as being the last drug injected was 35 per cent, recorded in 2006. As can be seen from the data below, published data for the past five years suggests a level of stability regarding methamphetamine as last drug injected [86]. Forthcoming data from the 2013 survey will show a rise to 21 per cent [87].

Table 7: Number of Victorians who list methamphetamine as last injected drug (2008-2012)

<table>
<thead>
<tr>
<th>Year</th>
<th>N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>N = 308</td>
</tr>
<tr>
<td>2009</td>
<td>N = 334</td>
</tr>
<tr>
<td>2010</td>
<td>N = 445</td>
</tr>
<tr>
<td>2011</td>
<td>N = 506</td>
</tr>
<tr>
<td>2012</td>
<td>N = 463</td>
</tr>
<tr>
<td>2008</td>
<td>55 (18)</td>
</tr>
<tr>
<td>2009</td>
<td>45 (13)</td>
</tr>
<tr>
<td>2010</td>
<td>57 (13)</td>
</tr>
<tr>
<td>2011</td>
<td>91 (18)</td>
</tr>
<tr>
<td>2012</td>
<td>82 (18)</td>
</tr>
</tbody>
</table>

6.2.4. The Earlier Identification of Drug Harms Project

The Earlier Identification of Drug Harms Project (EIDHP) is a surveillance system coordinated by the Victorian Department of Health. It collects “anecdotal information and observations” from approximately 30-40 alcohol and other drug agencies in Victoria [88]. The bi-monthly report provides information on drug use patterns. They have indicated that services in metropolitan and regional areas were reporting rises in methamphetamine use since during 2012. For example, in the November 2008 EIDHP report, the majority of regional services reported that few clients were using methamphetamine. In early 2011, EIDHP found that most metropolitan and regional agencies (83 per cent and 80 per cent respectively) reported that few/some clients used methamphetamine during the February-March 2011 reporting period [89].

The September/October 2012 report, in the section regarding responses from metropolitan services, noted that “reports have remained relatively consistent since November 2008,” but did observe that six services reported an increase in methamphetamine use amongst clients [90]. However, of the 15 regional services that took part in the survey, 10 reported “increased levels of use during the two months preceding the data collection” [90]. The October-November 2012 survey found that six of 15 metropolitan services, and six of 13 regional services, were noting increased methamphetamine use amongst clients [91]. Amongst metropolitan services, eight reported that “half” of clients and two reported “most” of clients used methamphetamine. In the regional services, the corresponding numbers were five and two (amongst 15 services). The same report noted that a number of metropolitan services reported an increase in psychosis among clients, some of which was attributed to the use of methamphetamine. Metropolitan and regional services also reported increased violence among clients sometimes resulting in police attendance and withdrawal of services, during this period.

In the June-July 2013 EIDHP report, the majority of regional services stated that most of their clients used methamphetamine, with these agencies reporting increased use or stable use among clients [92]. By late 2013, 12 of the 17 metropolitan services were reporting “half” or “most” clients using methamphetamine, while in the regional areas it was eight of 13 [93].
6.2.5. **Data from Ambulance Victoria, reported in the “Ambo Project”**

The Ambo Project, a collaboration between Ambulance Victoria and Turning Point for the Victorian Department of Health, measures trends in non-fatal alcohol and drug-related ambulance attendances in Victoria [94]. The report from the project is published annually. Monthly data is provided on an ongoing basis. Published annually, it is a method of monitoring drug-related harms across the state. In the past it has published data from metropolitan call-outs, but as of the 2013 report (for 2011-2012 period) it has also included data from the rest of Victoria.

Examination of the reports over time show a clear increase in the number of ambulance call-outs involving methamphetamine. For example, the 2011 report examining call-outs for the 2009-2010 period noted increased ambulance call-outs related to methamphetamine, describing it as an upward trend. At that stage, the peak per month during 2010 was approximately 19 callouts in all of Melbourne, in February and March [94].

The 2012 report for 2010-2011 noted that the 2006 peak had been surpassed, and that there was, by that stage, a “pronounced upward trend” [95]. The following reporting period, 2011-2012, showed an even more dramatic increase in the number of methamphetamine-related ambulance call-outs, again noting a “pronounced upward trend” [96].

As the graph below shows, the most recent report – covering the 2012-2013 period - shows a dramatic increase in the number of callouts related to methamphetamine, in both metropolitan and regional areas [97]. Looking at the most recent and previous reports it reveals that there was a 10-fold rise during the five years to mid-2013. The rise in regional Victoria is dramatic, but it should be borne in mind that on a population basis, the rate of crystal methamphetamine ambulance callouts was lower in regional Victoria that in metropolitan Melbourne.
By compiling the 2012-2013 monthly reports and past monthly figures produced in previous reports, it is possible to see the month by month fluctuations as well as the period of time in which the ambulance crystal methamphetamine ambulance callouts began to rise substantially. It is evident from this graph that the substantial rise began just after the previous reporting period ended, and by late 2012 and early 2013 it was clear that something was happening in the community that was leading to larger numbers of people being responded to by paramedics due to crystal methamphetamine. The 2012-2013 report again shows that there are far more crystal methamphetamine ambulance callouts recorded that during the period previously regarded as being the high-point of ice use, the 2005-2006 period [97].

It is useful to again examine the methamphetamine purity data graph when looking at the ambulance data timelines.

This 2012-2013 increase also coincides with the Victoria Police data discussed earlier, and also the period of time that Penington Institute began receiving numerous reports from the harm reduction workforce. In addition, it coincides with patterns that began to emerge in the early warning system, the EIDHP.

As Table 8 shows, analysis of 2011/2012 data shows a lower population-level rate of ambulance callouts to methamphetamine in metropolitan compared with regional Victoria.
<table>
<thead>
<tr>
<th>Substance</th>
<th>Metro Melbourne N (rate)</th>
<th>Regional Victoria N (rate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>11,159 (2665.9)</td>
<td>3692 (2559.9)</td>
</tr>
<tr>
<td>Benzdiazepines</td>
<td>3159 (754.6)</td>
<td>808 (560)</td>
</tr>
<tr>
<td>All Heroin</td>
<td>1901 (454)</td>
<td>102 (70.9)</td>
</tr>
<tr>
<td>Other analgesics</td>
<td>1584 (378.5)</td>
<td>603 (418.1)</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>1221 (291.6)</td>
<td>487 (337.6)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>1145 (273.5)</td>
<td>425 (294.7)</td>
</tr>
<tr>
<td>Cannabis</td>
<td>1416 (338.2)</td>
<td>554 (384.2)</td>
</tr>
<tr>
<td>Crystal methamphetamine</td>
<td>1112 (265.7)</td>
<td>231 (159.8)</td>
</tr>
<tr>
<td>Opioid analgesics</td>
<td>711 (169.8)</td>
<td>350 (242.4)</td>
</tr>
<tr>
<td>GHB</td>
<td>578 (138.1)</td>
<td>42 (29)</td>
</tr>
<tr>
<td>Other amphetamines</td>
<td>282 (67.4)</td>
<td>82 (56.8)</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>230 (54.9)</td>
<td>104 (72.1)</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>306 (73.1)</td>
<td>54 (37.4)</td>
</tr>
<tr>
<td>Inhalants</td>
<td>122 (29.1)</td>
<td>31 (21.5)</td>
</tr>
<tr>
<td>Cocaine</td>
<td>122 (29.1)</td>
<td>10 (6.9)</td>
</tr>
</tbody>
</table>

Within the ambulance call-out data analysis there is information regarding the time at which attendances occur. This has implications for impacts on police and the health system, including hospital emergency departments. The 2011/2012 data indicates that in metropolitan areas, police co-attended with the ambulance 19 per cent of the time for methamphetamine-related callouts, whereas in regional areas it was only seven per cent of the time [96]. This had risen to 27 per cent in metropolitan Melbourne and 22 per cent in regional areas during 2012-2013 [97].

Heroin-related ambulance overdoses tend to occur during the day, particularly the afternoon. In Victoria in the 2011/2012 period, 35 per cent of metropolitan Melbourne heroin-related attendances resulted in transportation to hospital [96], which had risen to 43 per cent by 2012-2013. The regional rate was 50 per cent.

By comparison, in metropolitan Melbourne 87 per cent of crystal methamphetamine attendances resulted in transportation to hospital during 2012-2013, and in regional Victoria the rate was 90 per cent. So while there may be more heroin-related ambulance attendances than crystal methamphetamine, far more crystal methamphetamine callouts result in a trip to a hospital.

Note that the peak times for such ambulance attendances and subsequent transportation to hospitals, is late at night and early morning, particularly on the weekends [96].

Victorian Coroners Court data

Data within a recent Victorian Coroners Court inquest [98] indicate a steady increase in cases where methamphetamine was a contributing factor to a fatal overdose. In 2013, amongst illicit drugs (not including illicit use of pharmaceutical drugs), only heroin contributed to more overdose deaths than methamphetamine. The number of overdose deaths involving methamphetamine were: 14 in 2010, 29 in 2011, 34 in 2012 and 50 in 2013. The Coroners Court has not coded records for methamphetamine prior to 2010.
7. Component four – qualitative research results

This section outlines and discusses key themes identified in the interviews with key informants. Interviews focused on the prevalence of methamphetamine use and related harms, as well as how services and communities were responding to this issue. Interviews also sought to identify gaps in services and needs of communities in relation to methamphetamine use.

7.1. Prevalence and availability of methamphetamine

*Increased reports of methamphetamine use*

A person who uses crystal methamphetamine has described the ease of access to it. It is "cheap, reliable, readily available. And always a good rush. It is easy to get and addictive. I’m smoking it whilst doing this survey" [33].

The most constant theme in interviews with key informants was the strong impression that there has been increased availability of crystal methamphetamine in their areas. Key informants based this assessment on their direct experience working with clients, internal statistics from services and knowledge obtained from networks within their community. Statements such as the following were common among key informants:

“... prevalent everywhere. Constantly, it’s all I hear from all my clients” (Youth worker, Hume region)

“Flooding through small towns... slowly and insidiously wiping out communities” (AOD worker, Grampians)

“My understanding is its fairly rampant throughout the communities in Gippsland” (Community worker, Gippsland region)

Increasing availability had led services to have a greater number of methamphetamine users as clients. For instance, an outer metropolitan Melbourne harm reduction (including NSP worker) noted methamphetamine use had increased from one or two clients who were accessing the service at any time, to 80-90 per cent of all clients accessing the service.

“If we go back a couple of years ago most of our clients- we have an older age group... weren’t using ice... however, the transition to ice has been fairly dramatic, [nearly] all our clients now are using ice”

While overall it was noted that availability had increased, specific reports of the availability of methamphetamine in towns differed and some areas were not seeing ice use at the same problematic levels as other communities. For instance, youth workers in two different parts of the Hume region told researchers:

“There is an increase, but they’re not coming through our doors”; and

“It’s not that predominant, it’s mainly cannabis and alcohol...”
A homelessness worker in the Hume region, acknowledging reports of increases, but not having witnessed this directly, said they were bracing for a wave of methamphetamine use in their community.

“Local police say we haven’t seen anything yet ... the word is it’s going to get worse”

While not all key informants reported significantly high level of crystal methamphetamine use in their client groups, overall the sense was that many areas in Victoria were experiencing higher than usual levels of crystal methamphetamine use.

CASE STUDY: a regional community health service

By mid last year the service was confronting increased methamphetamine use amongst clients, both in the treatment and needle and syringe programs. From July to September saw 248 new referrals to our programs. They conducted a quick audit of their data late last year, and the emergent statistics are revealing.

There have been 812 clients that have received treatment in the ATOD program September 2012 to September 2013.

There has been 1018 Episodes of care delivered to those clients. There were 282 active clients within treatment at our service in the Month of September 2013. In September 2013, 114 clients nominated Methamphetamines as their drug of choice (DOC) or one of their drugs of choice, being 40.43% of all clients currently in treatment. This is a significant increase from the data reported in the Victorian Drug Statistics Handbook: Patterns of drug use and related harm in Victoria for the period July 2009–June 2010 of 9%.

At the same period of time, 45 clients identified as Aboriginal or Torres Strait Islander. Of that 45, 36 clients nominated Methamphetamines as their DOC, being 80% of all Indigenous clients in treatment.

Management of the service has said: “This is one of the most concerning trends of misuse that we are seeing. XX has one of the largest Aboriginal populations in Victoria and the emergence of ice as a Drug of Choice to a population that is already dealing with health and social consequences of long term substance misuse, is devastating. Our service has 2 ATOD clinicians that work within the Aboriginal Community and provide assistance to the XX Koori court. The Koori Court has both Elders and Respected Persons assisting the Magistrate. In recent sittings, the Elders and Respected Persons have expressed their lack of understanding about the social impact, health consequences and Community responses to the ice use amongst their community. They have requested more training and this is imperative if the community is to have any informed response to this crisis. This trend towards ICE varies greatly from the previous DOC for this community, which predominately has been alcohol and cannabis (these are still problematic, however).

Injecting Drug Users: The service has the Needle Syringe program (NSP) and a brief snapshot of injecting drug users that access our service for clean injecting equipment was gained when all participants were asked if they would be prepared to nominate their DOC for intravenous use.

Of the 80 clients that acquired clean injecting equipment over the period from 26/09/13 to the 01/10/13 (2 business days only) 36 nominated ICE as their DOC, being 45% of participants. This is a massive increase (31%) in the number of people using ICE in our communities (using the 9% from the 2009-2010 data) and without a coordinated response by both government and local service providers, treatment options will became more difficult to access, through the sheer weight of numbers of people affected.

*This case study was provided to this report. It is an amended section of the service’s submission to the Victorian Parliamentary Inquiry into methamphetamine use in Victoria.
Reasons for increased use

Key informants were asked to identify reasons for increased use of crystal methamphetamine in their communities. A number of factors were considered relevant, and these are outlined below.

“Other drugs becoming scarce or having reduced quality”

A number of workers believed that changes in the availability and quality of other illicit drugs had led clients to begin using methamphetamine.

Workers in regional areas noted they were seeing people who had a history of using speed (either recently or historically), but were now using crystal methamphetamine. An AOD worker in Barwon South West region noted:

“It’s the only thing available, there’s no speed anymore.”

Another worker stated that in Melbourne heroin had become more expensive and less pure and this had driven people to use crystal methamphetamine:

“... there was a lack of access to a high grade cheap heroin... then there was a change to people using bupe [buprenorphine] and injecting it, and I think because bupe and methadone was such a leveller it became ‘I can use ice, because it gives me a good buzz”-- (AOD worker, metropolitan Melbourne)

Increased availability and accessibility

Driving the increased use of methamphetamine was its increased availability and increased accessibility. A regional youth worker noted:

“A client [said] ‘I haven’t had it in three months, but I could go to 13 different houses now in [this regional centre] and they’d give it to me without money, because they know I’m a frequent flyer’... and she’s from Melbourne.”

In a small town, a youth worker reported that the number of people dealing methamphetamine had increased:

“It was one, but now there’s multiple [dealers].”

There was a sense that, in the past, when there was a single dealer, accessibility of methamphetamine was limited to a smaller, vulnerable group. However, with a higher number of dealers it was much more available to a wider range of people.

Most workers interviewed for the project said they were able to identify some local locations of both methamphetamine manufacturing and distribution points. This intelligence was obtained through discussions with clients, their own family members or local networks.

A small number of people interviewed linked increasing levels of methamphetamine with Outlaw Motorcycle Gangs (OMCG).
Methamphetamine becoming cheaper:

All sources reported that methamphetamine was becoming cheaper, and price was a key driver of increased use.

“The accessibility is phenomenal and the affordability is phenomenal” (Team Leader, Youth Services, Hume Region)

Some participants noted that it was cheaper, or better value, than alcohol, meaning:

“... for $100 a point, for a recreational user, $100 bucks for a weekend, to have that euphoria, compared to spending $200 bucks on the booze – it is a cheaper option”.

This is consistent with comments from a crystal methamphetamine consumer who has said it “feels great, you have interesting crazy conversations, helps you last through a big weekend” [33].

The issue of cost effectiveness compared with alcohol was reiterated by another Hume region, youth homelessness worker who said:

“A night on ice can last for days... drinking lasts a few hours.”

However, for those with a lower tolerance to methamphetamine, a smaller amount could get you through a night. In Gippsland, a youth worker reported:

“As of a few weeks ago, for as little as $10 you could buy enough to get you through”

In summary, key informants reported increased use of crystal methamphetamine among their clients and their wider communities. Key reasons for increased availability were that the drug was accessible, available and relatively cheap.

This is consistent with comments from a Victorian who has used methamphetamine and who said: “It’s the strongest possible amphetamine stimulant in the world and it’s cheap compared to heroin. I was addicted for seven months at 18” [33].

7.2. Patterns of use and social context

Nature of use

Crystal methamphetamine was reportedly the most common form of methamphetamine being used at all sites surveyed for this report. It was most commonly being reported as being smoked (particularly amongst young people and new initiates), however in some areas they noted that, from an AOD service perspective, they were seeing a 50-50 split with injecting and smoking. There were less frequent reports of young people snorting ice. Injecting methamphetamine users tended to be people who had already been injectors, but there were also reports of new injectors.
Methamphetamine use becoming normalised

There was a sense, despite the widespread reported harms of crystal methamphetamine, that its use had become normalised within some sub-populations. That is, it was less likely to be viewed as a dangerous drug, and was seen as acceptable to use it socially. For example, one person has said it gives "increased energy, confidence, increased libido, able to stay awake all night partying, drinking lots of alcohol without getting drunk", while another others have said it was "it's fun and social. It gives you more energy. It makes you feel good" and "the feeling it gives and always makes for a fun night" [33].

The sense of “normalisation” of ice was particularly reported to have occurred among young people. For instance, a worker in the Gippsland region stated:

“... it’s been going on 2-3 years in this area fairly heavily, the ones who were 17 and are now 20 have a mentality that’s it’s just a normal thing, people do it, people survive, people function. They have the mentality that there’s one unlucky one who can’t control it, who ends up in a bad place... they think it’s normal, it’s out there, it’s everywhere”.

Poly drug use

Poly-drug use is frequent among most people using drugs, and research shows that problematic methamphetamine users often have high levels of other drug use [42]. Reflecting this research, key informants reported that methamphetamine was frequently used with alcohol or cannabis. In the case of cannabis, workers reported that clients had told them:

“It complements the pot use.“

“It goes hand and hand with pot... you find that the ones who use every day are the ones who get into ice or have been involved in ice.”

In relation to alcohol, it was noted by one worker that methamphetamine was able to prolong a drinking session.

“I don’t think they see alcohol as an issue a lot of the time... and it’s quite expensive. People use ice and alcohol a lot.”

In a group of construction workers using methamphetamine in Gippsland, it was reported by a key information that:

“Ninety per cent of the time it’s combined with binge drinking... then they get onto the chronic cannabis to ease coming down.”

In addition, some services reported that people were illegally buying prescription medications to ease comedown symptoms.

Faster route to problematic use
Compared with other substances, a number of people with years of experience working with people who use illicit drugs noted that, in their opinion, there seemed to be a particularly fast trajectory from occasional use to problematic and harmful methamphetamine use.

“It happens rapidly... I think the associated behaviours and emotions are so exaggerated...”

The trajectory of harms impacting on relationships, finances, legal issues and the like occurred rapidly, according to some workers. For example a nurse said:

“I think about my clients... generally those things were medium to long term consequences of substance use, but with ice it happens very quickly” [Nurse].

Another worker noted:

“You see a perfectly ‘normal’ individual – [they] have children, working, have a partner, no history whatsoever – [then they] get stuck into ice then everything goes belly up... it’s a really sneaky drug, it’s really insidious”.

A parent has written:

"It is killing my son from the inside out .I’m losing him. There is no help out there for parents this drug which is killing our kids. Where do we turn to get help?” [33].

A person with direct experience has also commented on the short time in which use can become problematic:

"There is nothing good about using it from either the point of view of someone who is effected by another persons use of it and the person who is using it. They may start out thinking it is great, but, that great feeling doesn't last too long at all from my experience. In a very short time life is chaotic for them and all concerned” [33].

An NSP worker told the story of a family losing everything:

“They were working, they had kids ... everything was going really well. He was kicking goals. Both of them [a couple] were on the methadone program, doing really well. Then they discovered ice. Within two weeks they had lost the housing, they’d lost their children ... everything blew up. Twelve months later they’re coming around ... now they’re using recreationally – doing it when they get paid. They’ve just managed to secure housing, he’s trying to find a job and they’re on the road to trying to get their children back. When I talk to them they acknowledge... it was the ice.”

A youth AOD worker said when clients moved from cannabis to methamphetamine, the effects of the drugs and their behaviour was often something young people were not prepared for. This worker described how, on cannabis, his clients would stay at home, inside for a weekend playing computer games, and when they moved to methamphetamine, would be awake for days or weeks at a time, on a 'bender'.

There was a belief from some workers that
“... it’s more addictive and [users are] more dependent quicker” (Barwon South West).

A key concern for some workers was that with changes in purity in their area, young people were unsure how to reduce harms associated with use, or understand how changes to purity would affect them.

“A certain standard came through, then the price went up and the purity went up. Then it has dropped again, the quality is quite bad, so people are using more and more. But trying to get clients to understand that process - a higher grade comes in, they’ve been on a lower grade.”

7.3. Populations at risk

While some people interviewed could see increases in particular demographic groups presenting, such as young people, in many areas different forms of disadvantage or vulnerability placed people at heightened risk of problematic methamphetamine use. However, it was also evident that the ‘normalisation’ of methamphetamine means that diverse groups were at risk, with some workers stating that use was problematic among a wide range of people including active sportspeople (eg: football players), office workers using amphetamine for weight loss/maintenance and trade apprentices. To gain a sense of why crystal methamphetamine may be gaining popularity, note the following overview:

"It gives you a heap of confidence and you find that it’s much easier to have a conversation to someone new. It pretty much blocks out reality for a while if you’re going through a rough time, for girls it’s a good way to lose weight quick and easy and just pretty much makes you feel on top of the world and invincible as if you can accomplish absolutely anything you put your mind to” [33].

Recent initiates

Across the state, services are noting a trend for younger people to start experimentation using crystal methamphetamine and bypassing experimentation with alcohol or cannabis.

“The new kids on the block usually pick up with the ice.”

“We’re seeing a lot of young people who start off on meth ... it’s immediate and at high levels.”

Services were also seeing increases in recent initiates over 25 years, who, while potentially having been occasional users in the past, are now presenting at services for treatment, including counselling.

“We’re starting to see a group of people who have a lot of protective factors... employment, family and friends.”

Another worker in the Grampians region noted,

“I’m seeing people who had [protective factors]... but lost the employment, relationships...”

Young people
Many people noted that methamphetamine use was high in young people. Crystal methamphetamine was now seen as a party drug among many young people, and young people would use what was available to them at the time within their social network.

“It’s still seen as recreational... it’s a party drug” (Youth Worker, Hume region)

“It seems like I have a percentage of clients who are taking [methamphetamine] to party. Mostly on the weekend, they’d be taking GHB, ice, ecstasy, cocaine, ketamine, and that would be in the context of going out and partying.”

Another worker believed their young clients found methamphetamine as socially acceptable as cannabis:

“In their heads it’s the same as pot, ‘it’s casual, it makes me feel better, I don’t think about my problems’. It’s hard to get kids to acknowledge it as a problem ... it’s looked at as cool, a quick cheap high” (Youth Worker.)

An ambulance officer noted that:

“I’d hate to think that there is a level of normalisation now... but there is a different party mode now. [Young people] don’t go out till late, and it’s very expensive to go out... I could see that people would stay at home till late, then crank up on a bit of meth, then go out.”

A youth AOD worker estimated that around 95 per cent of his service’s young clients had a history of physical or sexual abuse. Another youth worker noted the use was potentially linked to the history of disadvantage and trauma:

“They’re self medicating I would say”

Another worker, whose clients were young people in out-of-home care, reported:

“I have 20 clients, and I can honestly say probably 14 of them have a history with it, and currently use”

Of these clients with a history of vulnerability or trauma, client perceptions of problematic use varied. A Hume youth worker noted:

“Do they identify it as a problem? Not necessarily. But they do disclose they use regularly”.

Those working with young people in the out-of-home care sector, and youth homelessness programs noted that there was substantial use in their client groups. In some instances, particularly within residential units, younger residents were being exposed to methamphetamine by older residents.

“We can probably track the younger age groups [through] residential housing... they seem to be going in younger... going into residential care at 13. We are seeing more use at 13, because they are exposed to ice by the older kids”
Workers noted that young people would present, like other cohorts, when in crisis – such as when they had run out of money, or when they were coming down after days without sleep. Workers experienced challenges in keeping them engaged to consider their methamphetamine use once the crisis had passed. When clients were approaching services in financial crisis, workers saw what one described as a “rinse and repeat” cycle:

“[there has been] an increase of young people coming in seeking emergency relief - food vouchers, fuel vouchers, Myki funds to get them to and from their appointments. That in itself impacts people’s capacity to pay their rent and their food...we’re supporting them to that next pay day, at which time they will disengage [from us]”

This financial crisis seen in young people using methamphetamine was linked to their existing vulnerability.

“They have a small amount of life skills, so when they get their money, they’re falling straight into that trap and spending all their money on that one thing.”

A few services noted a marked increase in the number of tradespeople who were using methamphetamine, consistent with media reports. Use within construction workers was not limited to weekend occasional or social use. This group used crystal methamphetamine to get through long and demanding shifts.

“...they do 12 hour shifts, or they do extended late nights... they’re probably on the fence between functional and dependent” (who and what type said this?)

A Hume AOD worker said his client group was:

“Primarily male. Quite a few tradesman, those guys would be completing apprenticeships or [who had] qualified in the past two years.”

One NSP worker noted that far from being hidden use by tradespeople, it was highly visible, with workers coming in to collect syringes in work clothes, and in groups. Furthermore, the use of crystal methamphetamine for work performance was being modelled to apprentices.

“It’s definitely a culture... and I’ve heard from parents... the older ones are often responsible for teaching the younger ones.”

Aboriginal Communities

Reports from communities across the state, local media and data published in reports shows that Victorian Aboriginal communities are being particularly affected by methamphetamine use. One worker noted:

“Indigenous communities are hard hit, the prevalence is high”

Key informants reported that small Aboriginal communities particularly were feeling profound effects of increased methamphetamine use. The researchers were told by one worker that young people in particular were not accessing services, as they did not have anonymity within the community, or they may have a family member working at the service.

A common theme that has emerged is that there is a sense that many Aboriginal communities, including in rural Victoria, feel deeply affected by methamphetamine and that is touching negatively on the lives of grandparents’ generations as well as younger people. There is a sense, described by many, that it is “killing” the community. The case study of a regional service on Page 33 provides indications that strongly suggested methamphetamine use is well within populations of Aboriginal drug injectors, as well as non-injectors.

*Football/netball clubs as example of a social setting*

In a few towns, there was local knowledge that football players were using crystal methamphetamine socially on the weekends. This knowledge came from working with young people who experienced problematic crystal methamphetamine use, and other networks – such as the adult children of workers telling them it was rampant.

A Grampians AOD worker stated:

“We’re hearing it from say, footy club players ... they say it’s everywhere in footy in the social circles... it’s the transition from being a behind-closed-doors drugs to being out in the open and socially acceptable ... that happened over the last six months I think ... you can buy it openly at the pub”.

Another worker reported that they had been told young footballers used methamphetamine to counter weight gain. It was noted however, that use of methamphetamine eventually negatively impacted on their sporting performance.

An AOD counsellor said:

‘This is definitely not exclusive to males, no way. They probably form the majority of users, but no means the vast majority. For example, I’ve got a client now, a woman in her mid 20s, middle class and works in retail, and she was using for partying. She’s gone too far, and she’s has said ‘Nope, this is not who I want to be’. So we’re trying to help her. And this girl is a netballer, a good one. So when we hear of footy clubs, it’s important to remember that they are football and netball clubs ... the primary use of ice is recreational, a social setting, to party on. And in country and regional areas, football/netball clubs are the heart of the town. They are the social hub of the town.’"
Summary

The interviews with key informants showed significant diversity in the groups considered at risk of problematic methamphetamine use. Present in this were more traditional populations such as young people and people with a history of disadvantage. However less obvious populations were also seen to be presenting, such as football players and tradespeople. This may reflect key informants’ perceptions of both normalisation of methamphetamine, as well as its affordability and availability.

7.4. Individual Harms

Key informants reported a wide range of harms to the individual as a result of methamphetamine use. These are reported below.

Physical health

Individuals with problematic methamphetamine use were reported to suffer a range of harms to their health including poor nutrition, weight loss, dental issues and skin issues.

“One person who everyone knows really well... he was our main ice user. He turned into a skeleton... it was like off a zombie movie.”

Mental health

A key harm identified by many people in the interviews was the increase in mental health issues for people using methamphetamine. One worker noted:

“Particularly over the last six to eight months maybe, we’ve seen very messy people.”

These ranged from agitation, erratic behaviour, to self-harm and psychosis.

“Their thought processes don’t connect at all... they can be standing there talking to you for 20 minutes and you have no idea what they’re saying”

“They’re all over the shop. They come in and out; they’re speaking half sentences... I refer to it as talking in tongues.”

One youth worker told the study:

“I think a lot of drug use in general, and ice [in particular], is masking emerging mental health issues”

Another said:

“It’s chicken or egg. Is it self-medication for the mental health? Or is it a drug-induced psychosis? Often our clients are so complex you can’t separate it out.”

Housing
Services noted that methamphetamine was having an effect on housing stability. This was linked to women escaping family violence, people being unable to hold down jobs, relationship breakdowns, and financial impacts of problematic methamphetamine use.

“My last few clients who came through the door were affected by ice. [They’re] in private rental... [they] got a Notice to Vacate because they haven’t paid their rent. The drug is the issue. They’re spending on the drug rather than their rent” (Hume region, homelessness worker)

Another worker, linked to a community health service noted:

“There’s a couple of clients who’ve been sleeping in cars, and couch surfing.”

Problematic methamphetamine use was seen to have a direct impact on housing stability. One housing support worker noted:

“Generally, [our clients are] using any money that they’ve got on those drugs. Money that should be used for bills and rent. So, they end up in rental arrears, a lot of people come to us in that situation when they’re behind in their rent a month... Those that don’t come to us end up losing their rental home, or they get their home that they own – have a mortgage on – taken away, because they can’t make repayments”

Financial

As with housing, people told the study stories of people with problematic methamphetamine use having:

“Financial breakdowns...they’re unable to commit to work or study” (Gippsland).

There were reports from another region of:

“a small group of clients who cycle around Centrelink payment...It’s weekly. One week parenting payment, one week Centrelink payment” (Grampians Region).

A youth worker told the study that she had heard reports that

“as soon as they get [Centrelink] they get walked to the ATM by their dealer on their pay day... and it’s gone by Monday”.

Another youth worker said:

“It’s really hard to work with [youth] holistically to find housing and other things when you can’t look at budgeting... it’s really challenging” (Youth Worker, Loddon Mallee).
Summary

It was evident from key informant reports that the harms experienced by people using methamphetamine were wide ranging. These harms presented challenges to workers due to clients’ erratic behaviour, and the rapid impact of methamphetamine use on areas such as finance and health.

7.5. Community harms

In addition to individual level harms, there were widespread reports of community level harms. These mainly centred on violence, including family violence.

Violence

Reports from Victoria Police, note that frontline officers were experiencing high levels of aggression and violence as a direct result of methamphetamine use. One worker relayed this information about local police:

"The cops told me...normally every year there are 14 armed robberies... they’re usually kids nicking phones off other kids. In the last 12 months they had 44 armed robberies, 30 something of them were people on ice or looking for ice. And 15 of them were the first time in trouble with the cops”.

Paramedics spoken to for the study also noted the increase in violence, noting that while responding to illicit drug was a low percentage of their work overall, methamphetamine use was:

"The most dangerous thing we do... the most dangerous thing we see."

This paramedic spoke of violent attacks in the back of ambulances, with those who were substance affected being “stronger than in normal situations”. Often users were unable to be restrained.

Violence was also reported by some inner-Melbourne Emergency Departments, as patients with drug-induced psychosis had:

"...no insight into potential for harm to self or others ... in this state people are more impulsive and more violent”

The hospital reported a large number of assaults on staff, which had the flow-on effect of staff burn-out, and increased staff sick leave.

In general, people interviewed said that while violence increased and was more severe when people were on methamphetamine, this occurred most frequently in people who had a prior propensity to violence.

However, this was not always the case. A few workers told the researchers that clients with no history of aggression had become violent after using methamphetamine.

“There are lot of people that I’ve been really surprised have been ... perpetrating violence.”

The methamphetamine created what one worker explained as:

“...an artificial fight or flight response.”
An AOD worker noted that, in relation to methamphetamine, violence was exacerbated due to long periods without sleep:

“I believe with drug use, that people do have less control over their temper... like you might be violent only when alcohol affected. It’s the same thing in lots of ways... Any drug is mind or mood altering... then on top of that [with ice, it’s] sleeplessness, and the sense of paranoia” - (Grampians region).

Youth workers noted violence between friends and acquaintances violence when young people were using methamphetamines:

“There’s a lot of threats amongst themselves” - (Hume Region).

Another said:

“There was a spate last year... there was an altercation and a stabbing. My client stabbed the other person” - (Hume Region).

The severity of the violence experienced could be extreme. A number of workers in Southern Melbourne talked about the spate of very violent crime when methamphetamine first became commonly used by their clients.

“[There were]...bizarre acts of violence, keeping people tortured... murders” - (Metropolitan Melbourne)

Another worker in the same region spoke of:

“... hitting people with iron bars... holding them captive for days or weeks”

7.6. Impacts on families and communities

Thousands of Victorians have been attending a range of public meetings, forums and workshops to better understand methamphetamine. For example, one event Shepparton, where Penington Institute was invited to present, attracted more than 200 people. Another, in Moama, was attended by more than 500 people. More than 120 people attended a community forum instigated by Aboriginal elders in Robinvale, and that event was on a Saturday night. Among the most common themes that have emerged is that there is a sense of frustration and powerlessness, and that methamphetamine misuse is impacting families, including not just children, but parents, grandparents, aunties and uncles.

A person with a sibling using crystal methamphetamine has said “there is nothing good about meth. My brother is tearing our family apart. He has stolen a large amount of money from my father and he is out of control” [33].

Key informants report that problematic methamphetamine use is having a significant effect on family members. Intake forms for non-AOD services do not usually ask explicitly about which substance is being used or misused. Instead, these data would be held in case notes. Penington Institute worked with a family violence service which volunteered to add a question to the intake forms, to capture
methamphetamine use in their clients. This subsequent data showed that in November 2013, 38 per cent of perpetrators were methamphetamine users, and in December 2013, 44 per cent of perpetrators were users. The organisation told Penington Institute that in the previous six months, as many women were referred to refuges as had occurred in the previous 18 months – which shows the extremity of the risk to women when violent perpetrators were using methamphetamine.

A woman has described her experience:

"My husband smashed up the house, tried to abduct children, threw knives at me and threatened to kill me with a power saw. [He] Smashed me in the head with a milk crate. Had road rage and drove into a pole" [33].

Services in many regions report families are increasingly seeking help and support. One worker reported that they are noticing an increase in calls to their health centre from families requesting more information about methamphetamine, describing “huge increases in concerned family members calling”.

In another area, an AOD worker who works primarily with families has said they have experienced, "Lots of families calling up for help – extremely worried".

Workers noted that in families with existing and significant inter-generational AOD issues, people who normally would normally tend to deal with problematic substance use between themselves were now unsure of what to do, and many were seeking help.

The direct harms to families were well known, with a community health worker noting that parents and families were “stuck between a rock and a hard place”. The worker noted:

“[It’s desperate families ... it’s just been horrific, they’re forced to kick their young people out because their behaviour has become unbearable. One family had to Section 10 their son three times]."

Another worker reported an example of a father attempting to prevent his son from accessing methamphetamine, saying:

“One father desperately trying to hold his son back from this world and these people... he nailed his windows shut, disables the car, so [the son] smashes windows and walks”

There were reports from several service types that in situations where couples were using, or had a history of substance use, the impacts of methamphetamine were very negative. For some it resulted in relationship breakdown, for others it resulted in involvement with police and child protection.

One AOD worker from the Barwon South West Region told the study that ice was causing harms in long-term user relationships, saying:

“They tell me at the NSP that they’re really scared about [ice]... you suddenly see relationships break up... these relationships have weathered the storm of abuse and

7 Under Section 10 of the Victorian Mental Health Act (1986), police officers are able to apprehend a person who they believe is mentally ill and poses a serious risk of bodily harm to themselves or others.
drug and alcohol stuff and the deprivations of it, the effects... but the partner’s use of ice is causing them to break up or causing concerns or threats and other behaviours”

Another in the Grampians region noted that:

“Couples [use methamphetamine] together... [leading to] increased reports of child protection. [Before] they hadn’t come to the attention of services. It’s a change in the trend. They might have had a [substance use] history going back a fair way, but not come to or had problems and ended up in hospital or with police involved or child protection involved”

Impacts on children

A number of workers interviewed for the study noted that they were seeing increases in children being unable to stay at home with parents who were using methamphetamine. This could result from Child Protection involvement, or through informal care arrangements.

Another Gippsland worker noted:

“We work with a few grandparents who now have custody of their grandchildren due to ice. They had to face the ‘Ok, this is what I have to do – this person is not going to like me, but my own child I’ll have to make an enemy of to protect my grandchild’... and that’s heartbreaking”

A housing worker said that informal care arrangements were more common in her area:

“It’s difficult to get Child Protection involved so it’s usually informal...grandparents and siblings.”

This worker went on to explain how challenging reunification of children and parents could be when methamphetamine was involved:

“You’ll have a small percentage where [getting their children back] will be a big focus –and getting their lives together. But, when you come to helping them with all their other issues to ... get the kids back – they just want the house. They don’t want to look at the other problems. So it doesn’t go any further than that”

Family violence

The issue of family violence in relation to methamphetamine use emerged as a key theme. Of concern, was the increase in both the intensity and the incidence of violence, with workers using terminology such as “unprecedented” and “prolific” levels of methamphetamine use involved in family violence. This is reported to have increased over the last two years.

An inner Melbourne Emergency Medicine Specialist noted they had anecdotally seen an increase in family violence incidents related to methamphetamine use by the perpetrator. This was a "socially complex situation", where the victim would not want to involve police, but needed to be held in safety in the Emergency Department until business hours, when they could be referred to social workers and crisis accommodation services.
Family violence was not only being identified in the family violence sector, but also with those working in housing, homelessness and youth work. An AOD worker noted:

“While we’re not a family violence focused service, we have a large proportion of people affected by family violence. People [who use methamphetamine] come in ... reporting violent behaviour in their relationships.”

While a youth worker noted that they:

“...turn up to do an outreach for a young person and they’re just tearing up the house ... in the process they will threaten, push or throw an object at their partner.”

Workers in various family violence services noted that they were seeing much more severe injuries, including:

“...broken jaws, broken arms, women hit with babies in their arms”; and

“...really serious assaults... choking, knife threats, smashing a head into a wall.”

However, all but two people interviewed believed that this level of violence and assault tended to happen amongst people who had a pre-existing propensity to violence, as one explained:

“I would tend to think that those people would already be violent or have the potential to be violent... the types of people, who if really drunk would have the propensity to violence.”

A few people noted that the violence appeared to occur while the perpetrator was affected by methamphetamine, and during the come-down. With what one worker described as:

“...when they’re coming down they are physically and violently having an outburst and hurting the people they love.”

Beyond the physically escalating violence, there were increases in reports of “verbal, financial and emotional abuse”. Another person reported that “We’re seeing the destruction of property”.

Family violence was also not limited to intimate partners, but also child to parents and elder abuse by an adult child.

Services reported seeing "lots of physical altercations with parents”. One worker noted:

“Family members that have a user living at home... that’s the biggest trauma... it’s the verbal abuse, some fairly small numbers where the users are getting physically abusive.”

Another said: “Parents have had to call police... then to protect other children they have to take out intervention orders.”
7.7. Impacts on service systems

**Police**

This report has already documented the sharp increase, at a statewide level, in the number of cases of amphetamine/methamphetamine possession and trafficking. Discussions with police highlighted that officers are responding to a range of issues related to methamphetamine use including enforcing drug laws, responding to clandestine labs, trafficking and possession, as well as providing a response to users who are a danger to themselves and/or others. This can include assaults, homicide, family violence incidents, responding to fire-arms reports, property damage, placing someone under a Section 10\(^8\) to get them psychiatric care, etc.

Police report that officers on the ground are experiencing high levels of violence when confronting methamphetamine users with psychosis. This places significant demand on police resources, and places officers at significant risk.

**Paramedics**

Paramedics spoken to for this report noted variance in levels of methamphetamine use across the regions. While methamphetamine call outs were seen as an “increasing problem” (Metro region), and “trending upwards” (Hume Region), there was a view that the prevalence of methamphetamine was higher in Melbourne than in regional areas. Within regional areas, prevalence was highest in regional centres and larger towns. The level of prevalence reported was seen as directly “driven by the size of the city... and what the teams see”.

In areas where there were tourist hot-spots – particularly those offering activities for (predominantly) younger people (skiing, snowboarding, water skiing etc) - methamphetamine call outs were higher during tourist seasons. One paramedic spoken to noted that these areas attract a lot of people from other capital cities – including, but not only Melbourne. This was also reported in areas that held festivals as well. As, one worker noted it takes “one event to skew data”.

Looking at methamphetamine call outs in general, use was higher on the weekends than during the week. This was seen as challenging, because, especially in regional areas, resources were already stretched. In addition, in many cases it became a multi-agency issue, involving police, and emergency departments also. In particularly bad situations one case could take out all resources for a region all night. One person interviewed, however, noted that in smaller communities services were more connected and therefore responding to a person with methamphetamine issues could also include referring them onto ongoing support.

While some individual paramedics did not see a pattern in demographics of people presenting, some believed it was more common to attend to individuals were likely to be under 35,

“the bullet proof age profile”. One paramedic noted “there is a different party mode now. [Young people] don’t go out to late, and it’s very expensive to go out...I could see that people would stay at home till late, then crank up on a bit of meth, then go out”

When paramedics attend, they face “a degree of uncertainty of a situation”. Another paramedic noted that people were “predictably unpredictable”. One paramedic noted that in the overall context of their

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\(^{8}\) Under Section 10 of the Victorian Mental Health Act (1986), police officers are able to apprehend a person who they believe is mentally ill and poses a serious risk of bodily harm to themselves or others.
work, “illicit drugs are a low percentage of work for us”, however he described methamphetamine call outs as the “most dangerous thing we do - the most dangerous thing we see”.

Another paramedic noted that in instances where the affected individuals would call an ambulance themselves, this was easier to respond to. More commonly, a person would call paramedics for a friend or family member who was combative or violent - to themselves or others. These individuals could become violent in the back of an ambulance, posing extreme risk to the safety of paramedics.

**Hospital Emergency Departments**

There were variations in reports from emergency services interviewed for the report with some smaller hospitals contacted reporting it is not significantly impacting their urgent care and emergency staff. A senior emergency department worker in the Barwon South West region said:

“That type of presentation is very rare to us... we may see one a month, two a month maybe. It’s certainly not a weekly occurrence for us.”

In Melbourne, however, emergency departments often see the “drama-end” of methamphetamine use, and acknowledged that presentations were just the “tip of the iceberg”.

An inner-city Melbourne emergency department noted that they had daily presentation of people with psychotic symptoms affected by methamphetamine. It was slightly higher on the weekends.

People presenting at emergency departments often require a psychiatric assessment and some form of chemical sedation – ranging from valium for agitation to Olanzapine®, or other anti-psychotic medication. The hospital has a policy to intervene in the least restrictive manner possible. However quite often people require a higher level of supervision and longer duration of care following methamphetamine-related psychosis.

A leading emergency department specialist said:

“Most often this involved agitation and psychosis, although injuries and domestic violence is also seen. Most commonly a psychotic patient is brought in by the police or the ambulance, a full assessment is made, and then treatment and/or sedation is undertaken. These patients may have no insight and potentially may be of harm to themselves or other people in the community.”

Considering the level of care required – patients presenting with methamphetamine-related psychosis placed a significant strain on emergency department staff, as

“They need resources such as highly trained nurses... a number of staff are needed to respond to someone in this state”.

Hospitals had to make careful decisions about when to sedate a patient, as “sedation is a danger in itself”. Individuals requiring full medical sedation must be placed in a high dependency cubicle and require constant monitoring by a highly trained emergency nurse. It was reported that this was impacting staff capacity:

“The associated exposure to violent patients has been associated with staff burn-out and increased sick leave for hospital staff.”
A leading addiction specialist based in a hospital said that although rare, in the past two years there have been some cases of extraordinary levels of “agitated/excited delirium” (a clinical term), so intense that sedation and admission to an Intensive Care Unit was required:

“In nearly 30 years of practice I can’t remember ever seeing a person so agitated that it required restraint that necessitated transfer to ICU ... the drugs that we normally use and the strategies we normally use are unable to be effective.”

In these cases, urine analysis had detected methamphetamine presence but due to not having access to more detailed toxicological testing it was not possible to examine whether or not other drugs were involved and therefore possibly a factor.

It was noted that emergency departments are now being encouraged under the National Emergency Access Targets (NEAT) to have people triaged and then either admitted for treatment or discharged within four hours [99, 100]. Difficult methamphetamine presentations could present challenges, because there may not be a place in psychiatric care ward warranted or available, but discharging (within the four hour target) a person who remained in a state of agitation may present a risk to themselves or others.

One department had introduced a ward where people can stay for a period of 24 hours (as opposed to the four-hour rule operational across Victoria). The “short stay” approach was deemed to have potential.

An emergency medicine specialist noted that people presenting quite often had a history of pre-existing psychosis, however the remainder could be white-collar workers, for example, who used methamphetamine on the weekend and began experiencing symptoms. Many patients’ psychosis tends to dissipate or disappear after 24 hours, at which point psychiatric units may not admit a person for extended care or conduct a psychiatric assessment for outpatient case management. Responding to methamphetamine-related psychosis involves drug and alcohol workers, as well as psych teams [where they exist].

This was reiterated by an NSP worker, talking about the need for psychiatric treatment for methamphetamine users having a psychotic episode:

“Whether [just] drug induced or ongoing... if you’re using ice, very rarely will you get admitted. And when they are in there, they are exited as a drug user, not someone who has a mental health issue”.

In a situation where a code grey event occurs (hospital-wide internal security response to aggressive behaviour), patients are placed in a secure room, with security staff from the hospital present, and specialist doctors and nurses. Each code grey could last 30 minutes to an hour, meaning those resources were unavailable for anyone else in the hospital.

It was suggested that in regional areas, where there were smaller hospitals and fewer staff, frequent presentations (either currently occurring, or if they did occur) could "take an entire staff to calm an agitated patient". Here, even a small number of presentations could “throw a small system [into chaos]”.

**Which services are people accessing?**

Looking at the reported increases in people seeking treatment, counselling and support for methamphetamine use, it is important to note how people are accessing services. Some individuals
are accessing a service through court orders or prior to sentencing. An AOD counsellor told researchers:

“[Most] clients are either mandated through corrections orders, or they might have been caught with drugs, and have a court date, and their lawyer advised them it would be better for them if they were doing AOD...”.

While acknowledging an increase in methamphetamine users from 10 per cent of clients in 2008, to 15 per cent in 2013, the worker reported that these clients saw themselves as occasional users, and did not see their use as problematic.

Workers in non-AOD sectors also noted that when a person presents to a service, the onus is on the client to reveal whether they or their family members are using methamphetamine. As such, the actual number of people accessing services in crisis with problematic methamphetamine use, or as a result of problematic methamphetamine use (from a family member) may be hidden.

Challenges in accessing AOD services

Many young people were reluctant to access AOD services, a youth homelessness worker noted:

“If I went through my last 50 clients, I can probably say only one of them I’ve got to go to an AOD counsellor...”

Another Grampians region youth homelessness worker noted:

“Not many of our clients are accessing drug and alcohol services”

Both youth and adult services noted that clients often presented in crisis, and if they were unable to be seen immediately, they would leave and may not engage with services again.

Particularly in smaller towns, workers noted that people without a history of substance misuse issues were reluctant to present for treatment, due to the stigma associated with drug use. This potentially masks the level of problematic methamphetamine use within communities.

Another key concern was that many people (particularly young people) accessing services were forced to leave their town or region in order to seek treatment. This could mean people travelling from regional areas to Melbourne for treatment, or between region to region, and leaving existing support structures behind (including family, friends, partners and children). In some instances this was a deterrent for seeking or accessing services.

Detoxification/Withdrawal:

Workers from a range of sectors noted that waiting times for treatment meant it was hard to keep clients committed to breaking their dependence. As a Hume Region youth worker noted, a client may say:

“’OK I’ll go to rehab’, well I can’t get you into rehab for six weeks, and you have to detox first, but I can’t get you into detox for eight weeks”
Services noted that it was often hard to treat methamphetamine withdrawal. One AOD worker noted:

“There’s not much we can do for them, except symptomatic treatment... there’s no pharmacotherapy.”

The above quote focused on the longer-term challenges of staying off methamphetamine. However, many workers noted that a period in a withdrawal unit tended to be a positive circuit breaker. Initially, clients may be offered a tricyclics anti-depressant to reduce racing thoughts and help them sleep in the first few days in treatment. A big focus is building the therapeutic relationship in a relatively short period of time.

“In the second week the work gets done dealing with core issues and triggers such as abuse, bullying, grief and loss and the family dynamic”.

A withdrawal service offered supports to their clients after release including encouraging them and their families to contact after-hours if they needed support or were in crisis. Upon being discharged, the service ensured young people had access to wrap around supports (youth workers, AOD counsellors) within their local region.

**Summary**

Many services spoke to felt challenged by the high levels of methamphetamine use within communities. Services providing a response to methamphetamine related crisis (such as psychosis), were particularly overwhelmed.
7.8. Component five – discussions with methamphetamine users

Current use patterns

Of the eight people interviewed, five reported no longer using methamphetamine, but had experienced problematic use in the previous 12 months. These people had very little positive to say about their experience with methamphetamine, saying “it’s just a waste of money”, and “ice fries your brain, while speed just gives you a really big buzz.”

Of the three people who were currently using methamphetamine, one described himself as addicted – but tried now to only use on the weekends. Another said he was a frequent user, and Tasha, 42, described her use as “regularly occasionally - or occasionally regularly”. Five of the eight had injected methamphetamine.

Reasons for using ice

Methamphetamine users and their families were asked a series of questions relating to why they used/had used ice, including any perceived benefits.

Changes in availability of other drugs

Most said that ice had replaced speed, with Jordon, 37, saying ice was ‘so much better than the speed we used to get, you just don’t know what’s in speed. Ice ... you know what you’re getting... it’s always good. It’s just strong, it’s got no cutters in it’.

Methamphetamine’s ability to keep people awake, and increase productivity were listed as beneficial, for example:

“You get more bang for your buck, it lasts longer... [compared to speed]... you can get focused, are able to do a lot of jobs and achieve a lot. I do believe I have some form of ADHD so it focuses me... you can stay on task... it will prolong awareness (sic) if required” Tasha, 42.

William, 20, said it helped him stay and “you can keep doing more things“, and along with Xavier, 18, noting it was an escape from reality and a “no fear drug”.

History of substance use

Both young men from regional Victoria people interviewed for the study had a history of poly drug use. William said that before using methamphetamine he:

“dabbled in all the [drugs] I can think of. I’ve dabbled in cocaine, used ice, heroin based pills, ecstasy, cannabis... and if I was using party drugs I’d be drinking heavily”

It was a similar story for Xavier who had tried cocaine, MDMA and a range of other drugs. Predominantly however, he:

“Smoked dope and [had] taken pills... and drinking pretty heavily... I’ve used heroin before... smoked it.”
One of the respondents said he generally only used methamphetamine, but for the others polydrug use was, not surprisingly, common. William said he would sometimes use high-quality cocaine, and then cannabis to help him sleep when he was coming down. Xavier and Tasha also spoke of using valium and Xanax.

**Changes in availability in community**

Xavier, from country Victoria, noted that in his area there was a sudden change from using cannabis to using ice around two years ago.

"When I was younger, everyone loved the dope and they were all getting into that. Then all of a sudden me and my social networks, we called it ‘the ice age’ – which erupted over the last few years."

For William, as outlined above, his exposure to methamphetamine was directly related to moving into a household with dealers.

Tasha believes that in the last two years in her community there is less use of ice, but she did wonder if that could be just within her network because “a lot of my friends have had kids now and are using a whole lot less”.

**Changes in personal use**

Two young people interviewed for the project noted that their use patterns – or the move from occasional to problematic use, happened quickly.

"I went from smoking 3 times a week to daily use in about three or four weeks... I was going great, going really good... making money, as well as getting more and more to smoke, then all of a sudden I'd have a shit day, something would happen in my life and it would bring me back down. I'd get really angry, and more determined to go out and get more” – Xavier.

William had a constant supply available, and over a six week period he started using heavily.

"When I first started smoking ice ... I’d only have a point or two, then it moved to three grams a week between me and a mate... it was quite heavy usage.”

It’s accessibility and free supply made it a constant temptation.

“When it was sold, we had leftover amounts, which were sizeable amounts... whatever was left we had for personal use”

Tasha who lived just out of Melbourne, said her use had decreased in the past three months, following a challenging time last year related to ice,

"we were using too much... it put a strain on our relationship... our brains weren’t functioning properly. It was too easy to point the finger, rather than look at your own contribution to a situation. We wanted to make a healthier change. New Year, new start”. 

Xavier went from using three of four times a week to every day in “about three our four weeks”, and was because of its masking effects; it helped block out mental pain.

**Networks of users**
Xavier said he had a network of around 100 peers who used methamphetamine, and 40 per cent of those used regularly. Of these peers, most were smoking.

“I’d get the odd few injecting, but I prefer smoking... so I tried to surround myself with people who smoked it”

Xavier spoke about the high prevalence of methamphetamine in his rural community, saying "A meth addict can pick another meth addict”.

“It got to a point where we’d walk around off our head and look at everyone, and when you’re on it you can just read people, and tell other people who are on it, or if they’re coming down... or if they’re flying.”

Brodie, 20, said of all people she knew, “maybe a thousand people were using ice”. Jordan said 50 per cent of his friends were using methamphetamine. While living interstate two years ago, most of his friends injected ice, but in Victoria, he said, more people generally smoked it.

William only used methamphetamine with his housemates. His extended peer group did not use methamphetamine, but were using cannabis heavily, so progressively he tended to socialise more with people he could use methamphetamine with.

**Use associated problems**

**Health**

William, noted that the lost significant levels of weight on methamphetamine very rapidly.

“I lost about 40 kilos, I was 120kgs when I started smoking, I’d always had issues with my weight... I knew weight loss was included in using, so I used it as a weight loss plan in about a month and a half... just incredible weight loss... you don’t feel hungry”

But for Tasha,

“I’ve suffered some fatigue at times... if I’ve been up too many days... I eat more chocolate! But that’s about it. I haven’t had any health implications”

**Mental health**

They discussed mental health issues both while on methamphetamine and after stopping use.

Issues ranged from minor anxiety, to more pronounced depression and anxiety, as well as drug-induced psychosis. Some individuals noted that the mental health issues appeared most pronounced after periods of not sleeping, but dissipated after rest. Others, who were no longer used ice, spoke of ongoing mental health issues.

Brodie said she was “more anxious, not so trusting” and noted that she became more paranoid while using. She believed however, that it did settle down when she had slept. Broadie had been off ice for 12 months, however she started using heavily again. Already diagnosed with Borderline Personality Disorder, she says she started using because she “wanted to feel good” again.
For both young men it was the escalating mental health issues which lead them to seek help.

William described a psychotic episode after more than a week without sleep.

“I’d been awake a bit over nine days, and I didn’t know whether I was awake or asleep... I hated the person I’d become through my ‘friends’ at that point. And I looked at them all and they were all off their guts, and I thought ‘Nah, fuck ‘em’, and I went into the kitchen and grabbed a knife and threatened to stab them all. I took a lunge at a mate. Nothing actually hit, but it was pretty trippy, and uncomfortable ... it scared the shit out of me because I didn’t know what was going on – I thought I was asleep. And to wake up two days later after sleeping and just losing it because I was coming down. There were a lot of holes in that room after that.”

Beyond the psychotic episode William had while on methamphetamine, he has had an ongoing challenge with regulating his moods since he stopped using methamphetamine:

“That one of the things I’ve struggled with – dealing with the extremities of the emotions – I find that really difficult. I can self-moderate before it gets to that extent – but when it happens it’s very hard to stop.”

Broadie was placed in a psychiatric ward after close to two weeks awake on methamphetamine.

“They put me in the psych ward [for] nine days... [I was awake] just shy of two weeks, so it was eleven days... I was paranoid”

Tasha, who said methamphetamine was every bit as dangerous as was sometimes made out in the media, explained the physical exhaustion she experienced:

“When you go for a two week bender, and you don’t sleep. You probably get four hours sleep out of two weeks, and your are not eating properly. You are just run down. I don’t know how to explain it, you’re withdrawing.”

Self-harm and assaults

Two of the young men spoke about self-harm including suicide attempts.

“T’ve tried overdosing, hanging myself, gassing myself and cutting” - Brodie

Xavier said hurting himself and trying to kill himself were turning points,

“I’d been up for two and a half weeks and me and my dealer had a falling out... the next day I felt really guilty and tried to knock myself [off]... I realised how alone I was, how wrong it was – everything I’ve been doing. Some of the memories of the things I’ve done while being on it ... for me it was either get back on the right track or I was too scared I wouldn’t make it.”.

Both young men had experienced an assault or an attempted assault on methamphetamine.

“If the wrong person triggered me, it wouldn’t be a good outcome”
William threatened to stab his housemates. He also noted that after this episode, while he was still using, he found ways of letting off his frustration in what he saw as more socially acceptable ways – such as at concerts.

“We’d smoked in the public toilet. [And] just go off our rocker at the gig... It was a metal gig so you could throw yourself around, hit people without copping serious blame for it or having repercussions – it was a good way to vent”

*Relationships with family and friends*

Relationships for both young men were harmed due to methamphetamine use. This was caused by isolating themselves from family and friends who didn't use and because of arguments had while they were on methamphetamine.

It has taken time to rebuild relationships with family members, which William, in part, worries is related to his ongoing mood swings.

“I have flip outs... I get really angry for no reason and emotional for no reason. I couldn’t control the extremities”

Brodie said only two friends had expressed concern at her levels of use,

"because they don’t know who I am anymore... I’m not the same person as I was when I’m substance affected... not in the same frame of mind... I’m more anxious. Not so trusting”

“I’ve been using for over 21 years, over the years I’ve lost so many friends... I’ve learnt to not to be so open and honest. I keep it pretty hush hush. Down here ... I would be mortified if a few of my social crowd found out. They know I’m a bit of a speed freak, but they’d be mortified if they knew [I was using ice].” - Jordan

“...the person I became was well known... everywhere I’d go people would know me for the wrong reasons”.

While for William, it was from his family.

“I obtained the stigma of the junkie of the family, by my outer family not just my immediate family.”

He has been off methamphetamine for some months, and credits fighting this stigma as motivating him.

“I was determined to change their perception of me, and I think I’ve done pretty good with that so far”
Deciding to seek help

For both Xavier and William, long term and regular methamphetamine use resulted in them hitting a crisis point and deciding to seek help. For Xavier, deep depression and suicidality led him to self-harm.

“I spent Christmas alone, and that brought me into a very suicidal place. I hit the ice really bad and tried to hurt myself in different ways. I’d cut myself up, if I was bleeding I’d bandage myself, and if it got too serious I’d pour alcohol on it to take out the infection and bandage that up.”

After staying awake for two and a half weeks, he had an altercation with his dealer, which resulted in a suicide attempt.

“I realised how alone I was, how wrong it was – everything I’ve been doing. Some of the memories of the things I’ve done while being on it…”

This ended up being the catalyst to seek help.

“For me it was either get back on the right track or I was too scared I wouldn’t make it…”

Both young men were referred to a residential withdrawal service, William through a local AOD worker, and Xavier had previously been there to withdraw from cannabis. The service provides residential withdrawal for young people aged up to 22, for between 10-14 days. It provides a holistic environment for young people, where they have access to therapeutic counselling, specialist AOD workers, and social and recreational programs (including art spaces, weights room, massage etc).

They describe the treatment process as hard. William, who has been off methamphetamine for months notes:

“I think people with a meth addiction, different strategies need to be put in place about how they go about kicking it … If you’re seeing a counsellor about it, things have to be done differently… explaining ways to quit, not just you’ve got to stop… For me, I’d do what I did, focus on the two things that before you used you loved most in the world… and use that as leverage to get out of that hole”

He noted that after withdrawal, there was a lot of work to do:

“I think any meth addict who goes to see a counsellor needs to be warned, if you want to quit, they will, but it’s the hard yards. Don’t ever expect that it will be a smooth ride to stop using because it’s not.”

“You get a lot of issues arise, because you’re not using, but you need to find other ways of dealing with them rather than going back to using. Because, ultimately, you’re going to feel just as shit as you were.”
Jordan was planning over a number of years to stop using altogether, having mainly restricted to weekends.

"I have a plan in mind, I've given myself 'X' amount of years to wean myself off it, if I get to a certain point and it hasn't happened, you try this you try that, but if all things didn't go to plan in a time frame, I will have to do whatever I need to get off it.”

Both young men were optimistic about being able to stay off methamphetamine. They were linked into ongoing mental health and personal supports, and Xavier was a few months away from securing stable housing for the first time in four years.

Summary

The accounts of the former and current crystal methamphetamine users are consistent with other key informants’ accounts concerning the reduced availability of speed and increase availability of ice. This is also consistent with police purity data also discussed earlier. In addition, they describe the period from using it several times a week, for example, to daily use as happening quite quickly. Poly drug use is obviously a feature, as is injection. The account from Xavier, who is from rural Victoria, points to – at least in his impression – as the increased availability of crystal methamphetamine being about two years ago. Trauma is a common underlying factor in their drug use, which in their cases, involved destructive consequences including alienation from family and many friends.
8. Drug testing populations: Waste Water Analysis

8.1. Introduction

It is evident thus far that there is a general view that with regards methamphetamine use in Victoria over the past two years is concerned, the issue is being felt more in regional, and perhaps rural areas, than it is in Melbourne.

This section of the report introduces an approach to estimating drug use prevalence that has not been used in Victoria before. It enables comparison of methamphetamine levels between Melbourne, Geelong, Wodonga on the Murray River and the small Wimmera town of Warracknabeal.

8.2. The approach

Working with the School of Pharmacy and Medical Sciences, University of South Australia, we undertook an innovative method of assessing prevalence of drug use called Waste Water Analysis (WWA). WWA, also referred to as “sewage epidemiology” [101, 102], involves analysis of sewage water for indicators of illicit drug consumption in a population. It is a promising monitoring tool to estimate illicit drug consumption at the community level [10].

WWA can be used to detect changes in drug use over time, with analysis confirming ‘spikes’ over weekends and/or around special events (such as festivals or sporting events) [103]. WWA has demonstrated potential to usefully supplement information gathered by current drug monitoring systems [11]. While used in Europe for a number of years, WWA is relatively new to Australia [10, 104, 105]. It is now being routinely used by the Department of Health in South Australia. At least one Australian jurisdiction is using WWA to test drug use levels amongst an overall prison population.

Researchers test wastewater for urinary biomarkers of illicit drugs and together with data on treatment plant flow rates and population levels, estimates are made about illicit substance use among the general population, or used to compare communities. The analysis can also be used to monitor effectiveness or otherwise of drug misuse prevention programs. As a research methodology, it eliminates potential bias in user self-report. However, while showing changes in levels and differentiations between levels, it does not show deeper information such as user cohorts. Nonetheless, WWA is viable source of information concerning levels of methamphetamine use.

Nine Victorian water treatment plants were approached to participate in the analysis, of which five agreed. Those that participated were:

- Grampians, Wimmera, Mallee Water - Warracknabeal Plant
- North East Water - Wodonga Plant
- Black Rock treatment plant - covering much of the Geelong population.
- Melbourne Water Eastern Treatment Plant (ETP)
- Melbourne Water Western Treatment Plant (WTP)

Waste water sampling was conducted on Sunday and Wednesday. The Sunday sampling detects substances consumed on a weekend, while Wednesday is an early-in-the-week sampling period.

This is relevant as it can be used as a guide concerning ‘weekend’ versus more regular drug use. Table 8 allows comparison between plants and of the scale of methamphetamine use in the plant
catchment area. This is achieved by displaying drug use with the units of dose (so one can compare drugs which have different potency or dosage size) per day, per 1000 people (to allow comparisons between catchments of different size). These units of doses/day/1000 people reflect the total amount of methamphetamine use within that area.

Therefore this allows insights into the number of users within that area, and the rate that the community – as a whole - uses the drug.

### 8.3. Key findings by location

Table 8: Summary of Waste Water Analysis for methamphetamine use across all plants, showing weekend and mid-week results.

<table>
<thead>
<tr>
<th>Treatment (Population)</th>
<th>Plant</th>
<th>Doses per 1000 people (Sun)</th>
<th>Doses per 1000 people (Wed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warracknabeal (2355)</td>
<td></td>
<td>5.47</td>
<td>6.05</td>
</tr>
<tr>
<td>West Wodonga (35, 200)</td>
<td></td>
<td>18.2</td>
<td>12.5</td>
</tr>
<tr>
<td>Black Rock (236, 000)</td>
<td></td>
<td>17.6</td>
<td>14.7</td>
</tr>
<tr>
<td>Melb Eastern Treatment (1,500,000)</td>
<td></td>
<td>25.1</td>
<td>22.4</td>
</tr>
<tr>
<td>Melb Western Treatment (1,600,000)</td>
<td></td>
<td>51.4</td>
<td>38.8</td>
</tr>
</tbody>
</table>

Table 9: Average consumption of licit and illicit drugs (Average of the two days analysed)

<table>
<thead>
<tr>
<th></th>
<th>Black Rock</th>
<th>ETP</th>
<th>WTP</th>
<th>Warracknabeal</th>
<th>West Wodonga</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine</td>
<td>16</td>
<td>24</td>
<td>45</td>
<td>5.8</td>
<td>15</td>
</tr>
</tbody>
</table>

A measure of doses/day may be appropriate if a crude determination of user numbers is to be made (there would be a minimum and maximum number of doses used by one person in one day, especially for prescription drugs). The results from table 8 are presented as doses per day in Table 9. It is important to note that the number of heavy users within each population is unknown. As heavy/binge drug users may use many more than one dose per day, it is advisable to interpret the results with caution (one dose/day does not = 1 user, though it does give some indication). A result of less than one dose per day may be due to a drug being taken a day or so before the WWA sampling day, as the drug may be excreted by a person for up to several days.
Table 10: Number of doses consumed at Victorian WWTPs (average of the two days analysed)

<table>
<thead>
<tr>
<th></th>
<th>Black Rock</th>
<th>ETP</th>
<th>WTP</th>
<th>Warracknabeal</th>
<th>West Wodonga</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine</td>
<td>3,800</td>
<td>36,000</td>
<td>72,000</td>
<td>14</td>
<td>530</td>
</tr>
</tbody>
</table>

Adelaide comparison:

A wastewater analysis of the Adelaide metropolitan area (four metro wastewater treatment plants is completed for one week every second month on a continuing basis, since December 2011.)

The wastewater analysis research group at the University of South Australia is contracted to supply drug use data directly to the South Australian Department of Health. Due to contractual obligations, only proportional values can be described when comparing Adelaide with Victoria.

Table 11: Scaled methamphetamine use in Victoria compared with Adelaide metropolitan treatment plants. **

<table>
<thead>
<tr>
<th>Drug use In Victoria compared to Adelaide (doses/1000 people/day)</th>
<th>Black Rock</th>
<th>ETP</th>
<th>WTP</th>
<th>Warracknabeal</th>
<th>West Wodonga</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methamphetamine Lower, Low to Similar to Higher to Lower, less than half Lower</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Low = at low end of WWTPs in Adelaide, Lower = lower than recorded at WWTPs in Adelaide, etc.

8.4. Interpretation

The days sampled across the five plants may not be representative of the average use throughout the whole year. The University of South Australia has found that the use of stimulants can vary dramatically throughout the year in Adelaide, according to supply or police activity. As such, and as a measure of drug use over time, it is difficult to determine the accuracy of the results presented in the WWA. In terms of errors, there are site-specific errors which are not considered when presenting these results, as this project is considered more of a drug “spot check” rather than long term trend analysis. Errors could range from inherent variation within the flow meter, auto sampler or cold storage within the plant and also differences in the population size within the catchment (some of these estimates were very crude). There can also be errors/variation within the extraction and analysis methods. Therefore, results are presented as a single value without an error as this is largely unknown. A conservative estimate for the uncertainty of each measurement might be ± 25%.

Due to sampling constraints, Wednesday and Sunday representative samples were collected (as the 24 hour composite sample finishes on the Monday and Thursday it prevents operators attending over the weekend). The Wednesday sample represents a mid-week, or “low” usage time and the Sunday represents the “high” usage time (many stimulants are used mostly on weekends). It is possible that
the use of these drugs may (or may not) have been higher on the Friday or Saturday. In addition, there is the possibility that dumping (i.e. drugs dumped into the toilet/drain if there was a police raid) could have contributed to the results obtained.

Consistent with research in Adelaide [105], the Victorian WWA found that methamphetamine use in the regional and rural areas sampled was generally lower than that in metropolitan areas. Irving et al [105] also found that methamphetamine use seems to be more consistently used throughout the week with a slight increase on the weekend. The Victorian sites seemed to follow similar trends to these, with the exception of Warracknabeal.

The WWA shows us that prevalence of methamphetamine use in regional and rural areas is lower than in metropolitan Melbourne. Unsurprisingly, use was higher on the weekends than during the week in all areas. Finally, WWA analysis indicates that while levels of use are higher in metropolitan areas, methamphetamine is certainly present in regional and rural areas.

9. Discussion and conclusion

This report shows that there is an increase in the availability, purity and use of methamphetamine across the state, with it emerging as a more noticeable issue during the second half of 2012. There is little doubt that this is related to trends in the extremely profitable Victorian illicit drugs market, and judging by many respondents’ observations, a form of normalisation of crystal methamphetamine use. While heroin tends to be scarce outside of Melbourne or large regional centres (such as Geelong), this is certainly not the case with methamphetamine.

Interviews with key informants highlighted that harms associated with problematic methamphetamine, including increasing numbers of people injecting it. Methamphetamine is placing a significant burden on individuals, families and communities. In smaller towns in particular, harms such as theft and violence may feel concentrated, with even a small number of users having a noticeable effect on communities. Aboriginal communities are not immune to the overall methamphetamine use issues, including the stresses upon family structures.

All problematic substance use is known to cause a burden to society in relation to demand on emergency services (police, hospitals and ambulance), demand on services such as treatment, counselling and support, as well as harms associated with lack of housing, health issues and damage to families. The increased ambulance callouts related to methamphetamine, and the fact that a high proportion of the callouts end up with the patient being transported to hospital, quite possibly in an agitated state, is but one indication that methamphetamine presents qualitatively different challenges than do the opioids for which our health systems, including Needle and Syringe Programs, are more familiar.

There was a sense from the consultations that the harms trajectory associated with methamphetamine use was short compared with other drugs. This meant that problematic methamphetamine use tended to impact the individual, families and community much faster, and suggests the heightened importance of early intervention. This would require greater awareness of the effects of the drug and its various impacts on health and wellbeing, particularly for young people and their parents and carers. Greater knowledge of ‘how’ and ‘what works’ in terms of how to short-circuit methamphetamine use and get treatment is needed across communities.

Responding to problematic drug use within a community requires a coordinated effort from a range of individuals, businesses and services. As outlined in the regional health service case study, with reports of high levels of methamphetamine use in cohorts already disadvantaged, or at-risk, the
provision of wrap around services being in place to support individuals and families is particularly important.

It is apparent that strategies for communities to better understand this, particularly those in rural areas, need to be evidence based, but be operationalised locally in a real and meaningful sense. This also applies to the need for local-led formal responses, such as counselling and treatment and necessary inter-agency referrals.

It is essential that communities have access to evidence-based information that encompasses the spectrum of methamphetamine-related harm from occasional use to problematic use. Workers who spoke about the needs of families noted that a range of supports were required to assist them to help their loved one, as well as supporting them in making decisions, such as involvement of child protection.

Collaboration was essential for effectively responding, in a timely fashion, to client and families’ needs. This is especially true when a drug use is outside of an agency’s core business, reinforcing the need for local level task-forces that consider alcohol and drug use more broadly and have flexibility to focus on a matter such as methamphetamine as early as possible.

The Waste Water Analysis showed that prevalence of methamphetamine use in the regional and rural areas sampled was lower, on a population basis, than in metropolitan Melbourne, and higher on weekends. However, methamphetamine was certainly present in regional and rural areas. This finding highlights the possibility that effects of problematic methamphetamine use may be more visible and felt upon regional and rural communities than in Melbourne. Again, this is most likely another qualitative difference between a methamphetamine ‘problem’ than the more customary opioid misuse.

WWA has the potential to be used across Victoria to monitor and show changes in licit and illicit drug use over time. For this to be most effective sampling would need to occur more frequently and potentially across more sites.

This assessment presents an important question concerning methamphetamine. Is the apparent increased availability, and attractiveness to many people, just a drug market trend, or is it more structural and perhaps longer term? If it is to be longer term, and there is a possibility it may be, then fundamental structural changes to response systems predominantly geared for alcohol, cannabis and opiates need to be made.
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