

Ways to combat ice addiction in Queensland

Discussion paper



EXECUTIVE SUMMARY

The upsurge in the use of crystal methamphetamine (ice) in Australia has had a chaotic effect on many individuals, families and communities. Queensland has not been exempt from this growing national and international problem.

The growing prevalence of the drug's use, coupled with the disproportionate harm that this form of methamphetamine presents, means that **Queensland must act now** to tackle the problem and its causes.

On 23 July 2015, the Council of Australian Governments (COAG) considered an interim report from the National Ice Taskforce which identified six areas for action. COAG agreed that all jurisdictions would work together to develop the National Ice Action Strategy (based on the agreed six areas) for finalisation in late 2015.

In the meantime, it is important that Queensland takes immediate action to meet the challenges and pressing needs for Queensland. This will also place Queensland in a stronger position to respond to the National Ice Action Strategy when it is finalised.

This discussion paper has been developed to engage with key stakeholders and the broader community on options and solutions to address the emerging problem of ice in Queensland.

The paper discusses the use and prevalence of crystal methamphetamine in Queensland (and more broadly across Australia) as a way to provide accurate information about the problems that ice presents for Queensland. The paper also sets out what is currently being done to address the problem, by a range of agencies including Queensland Health, the Queensland Police Service, and the Ice Awareness Campaign recently launched by the Queensland Government.

A literature review has also been conducted of the evidence of what works to address ice use (see Attachment 1).

Strong policing responses are important, but cannot be the only response if the ice problem is to be effectively addressed. **Effective responses to ice, and its impact on the community, require evidence-based, multiple, targeted interventions focused on both prevention and treatment at an individual, family and community level.** Effective approaches also facilitate collaborative and cooperative partnerships that empower families and communities to deliver locally relevant prevention strategies.

We also need to explore innovative ways to allocate resources to fund these responses, including redirecting proceeds of organised crime, and other unexplained wealth funds under forfeiture of proceeds of crime legislation.

The discussion that follows is designed to generate debate and ideas about the **best way forward** to ensure Queensland is well placed to address this difficult problem.

There are a range of factors unique to Queensland that will need to be addressed. This includes:

- Queensland has a significant number of vulnerable populations including Aboriginal and Torres Strait Islander communities, youth and offender groups
- The geographic spread of Queensland raises the issue of how to effectively police and provide services across the state
- The size of Queensland's borders, including that an international border (with Papua New Guinea) which presents specific challenges.

A number of Queensland Government agencies are already engaged in a range of responses to address the impacts of drug and alcohol issues more broadly. For example, Queensland has committed to implementing actions to prevent and reduce the adverse impacts of alcohol and drugs on the health and wellbeing of Queenslanders through the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*.

A preliminary analysis of this work and the particular context of Queensland has identified a number of **potential areas for reform**. These include:

- Targeting use of forfeited money from unexplained wealth prosecutions to fund programs to respond to drug abuse
- Ways to effectively provide access to treatment in rural, regional and remote areas, including Indigenous communities
- Increased access to specific treatment facilities, including innovative, flexible options for detoxification and aftercare
- Better routes into treatment, including identifying particular barriers to treatment and critical enablers
- Contemporary, innovative treatment options for at risk groups including young people and parents who are primary carers for children
- Culturally appropriate interventions for Indigenous groups
- Support for families affected by ice
- Increased focus on criminal networks involved in the production and supply of illicit drugs (including ice) within Queensland and across interstate and international borders
- Increased focus on the underlying causes and determinants of drug use.

In the meantime, to address immediate priorities already identified, the Queensland Government is establishing additional service responses in Cape York (Cooktown), Gold Coast, Rockhampton and the South West (Charleville and Cunnamulla). These additional services will be tailored to be locally responsive and will address the particular needs of the local community by targeting population groups identified as vulnerable to ice use.

In addition, two Drug and Alcohol Brief Intervention Teams (DABIT) in the Emergency Departments (ED) of Logan Hospital and Townsville Hospital will be established, expanding upon already funded DABIT teams at Gold Coast University Hospital, Royal Brisbane and Women's Hospital. These teams support the work of ED staff by providing screening of all patients presenting, and where indicated brief, intervention and referral to AOD services.

Have your say

The consultation period for this paper is six weeks and Submissions are sought by 26 October 2015.

You can contribute to this discussion and provide the Government with your ideas on how we can address this problem by making a written submission to

The Department of the Premier and Cabinet
PO Box 15185, City East, Queensland 4002

or

email combat-ice@premiers.qld.gov.au

Note: If you are concerned about your own or someone else's drug use, visit www.qld.gov.au/ice or contact the Alcohol and Drug Information Service on 1800 177 833.

CONTEXT

What is Ice?

Ice is the commonly used name for the **crystalline** form of **methamphetamine**.

Methamphetamine is a particularly potent stimulant drug that comes in three main forms – powder ('speed'), paste (base), and crystal ('ice').

The euphoric feelings that many ice users experience are due to the rapid release of dopamine in the brain, with the effect intensified by smoking or injecting the drug. However, it can also be swallowed, snorted or inserted as a suppository¹.

Methamphetamine fits within the broader group of drugs known as amphetamine-type stimulants (ATS), which also includes drugs such as MDMA (ecstasy).

Prevalence of ice in Australia

Ice use is growing in Australia

The increased use of crystal methamphetamine in Australia is not unique, with the global market also having increased significantly in recent times. Criminal groups are producing crystal methamphetamine in more countries and in greater quantities than ever before. Since 2011, the weight of global seizures of amphetamine-type stimulants has grown by as much as 80% annually¹. And growth in the Australian market has outstripped the global trend.

The Australian Customs and Border Protection Service (ACBPS) reported that in 2013-14, ice made up 79% of the weight of amphetamine-type stimulants seized at the Australian border, compared with 41% in 2010-11².

In 2013, the National Drug Strategy Household Survey (NDSHS)³ found that 2.1% of Australians aged 14 years and older (400,000 people) had used meth/amphetamines at least once in the previous 12 months, and 2.3% of Queenslanders (approximately 87,000). Prevalence in Queensland was the fourth highest in Australia, after Western Australia, Northern Territory and Tasmania.

The Australian Crime Commission (ACC) and the NDSHS⁴ have also found that people using methamphetamines are more likely to use the crystal form (ice) than the powder form (speed). The use of ice by people who used methamphetamine has more than doubled, from 22% in 2010 to 50% in 2013, while the use of powder decreased significantly from 51% to 29%.

In addition, both purity and frequency of use have increased. Average purity of crystal methamphetamine increased from approximately 20% to 70%⁵, and from 2010 to 2013 the proportion of users taking methamphetamines daily or weekly increased from 9.3% to 15.5%. For ice users in particular this rose from 12.4% to 25.3%⁶.

1 UNODC 2014 Global Synthetic Drugs Assessment

2 ACBPS financial year drug detection data

3 National Drug Strategy Household Survey (NDSHS) 2013

4 ACC 2015; NDSHS 2013

5 ACC 2015

6 NDSHS 2013

Greater exposure to and use of ice in the community, combined with the increasing use of social networks to enable drug use, is contributing to the popularity and availability of the drug. Some research also indicates that the pervasive nature of social networks may be making ice more socially acceptable amongst young people, while making it harder for users to escape a culture of drug use.

A large proportion of ice users in Australia also use alcohol and other drugs at rates much higher than the general population, exposing them to a greater range of risks and harms.

Ice is causing disproportionate harm

While ice is used by a relatively small proportion of the population, the harms associated with ice are a danger, not just to the person using the drug, but to their families and the broader community. The ACC considers that ‘methamphetamine, and in particular crystal methamphetamine, poses the highest risk to the Australian community’⁷.

The adverse effects of ice also impact and challenge those involved in the delivery of front line services to the community such as police and ambulance officers, as well as health and community professionals working in government and non-government sectors⁸.

Overdose

If a large amount or a potent batch is used, it could also cause an overdose that could be fatal. Adverse symptoms associated with an overdose include⁹:

- Racing heart beat and chest pain
- Breathing problems
- Fits or uncontrolled jerking
- Extreme agitation, confusion, clumsiness
- Sudden, severe headache
- Unconsciousness
- Stroke, heart attack and death.

Coming down

It can take several days to ‘come down’ from using ice with difficulty sleeping, exhaustion, headaches, dizziness, blurred vision, paranoia, hallucinations, confusion, irritability and feeling down. Using depressant drugs such as alcohol, benzodiazepines or cannabis to help with the ‘come down’ effects may result in a cycle of dependence on both types of drugs¹⁰.

Long term effects

With regular use, ice may eventually cause:

- Extreme weight loss due to reduced appetite
- Restless sleep
- Dry mouth and dental problems
- Regular colds or flu
- Trouble concentrating
- Breathlessness
- Muscle stiffness
- Anxiety, paranoia and violence
- Depression
- Heart and kidney problems
- Increased risk of stroke
- Needing to use more to get the same effect
- Dependence on ice
- Financial, work or social problems
- Risk of HIV or Hepatitis C from injecting.

Ice psychosis

7 ACC 2015

8 Scott, N Caulkins, JP Ritter, A & Dietze, P. 2015

9 Qld Health www.druginfo.adf.org.au/drug-facts/

10 Qld Health

High doses of ice and frequent use may also cause 'ice psychosis'. A recent Australian study concluded that 'users of ice are five times more likely to suffer psychotic symptoms while taking the drug than when they were abstinent'¹¹. This condition is characterised by paranoid delusions, hallucinations and bizarre, aggressive or violent behaviour.

Dependence

People who regularly use ice can quickly become dependent on the drug. They may feel they need ice to go about their normal activities like working, studying and socialising, or just to get through the day.

Mental health problems

Some people who regularly use ice may start to feel less enjoyment with everyday activities. They can get stressed easily and their moods can go up and down quite quickly. These changes can lead to longer term problems with anxiety and depression. People may feel these effects for weeks or months after they give up ice.

Mixing ice with other drugs

The effects of taking ice with other drugs – including over-the-counter or prescribed medications – can be unpredictable and dangerous, and could cause:

- *Ice + speed or ecstasy*: enormous strain on the heart and other parts of the body, which can lead to stroke
- *Ice + alcohol, cannabis or benzodiazepines*: enormous strain on the body, and more likely to overdose. The stimulant effects of

ice may mask the effects of depressant drugs like benzodiazepines and can increase the risk of overdose.

Withdrawal

Giving up ice after using it for a long time is challenging because the body has to get used to functioning without it. Withdrawal symptoms generally settle down after a week and will mostly disappear after a month. Symptoms can include:

- Cravings for ice
- Increased appetite
- Confusion and irritability
- Aches and pains
- Exhaustion
- Restless sleep and nightmares
- Anxiety, depression and paranoia.

Impact on family and friends

Having a family member or friend who uses ice may place that person or someone they know under immense strain. It can make family members and friends feel frustrated, anxious, desperate and helpless. This is exacerbated if the person using ice is paranoid, being aggressive or violent, or are involved in crime to support their ice dependency. The ACC has found that ice users are more likely to neglect parenting responsibilities, and that children in the homes of ice users are at greater risk of ingesting unsafe chemicals¹².

Crime

Involvement in a range of criminal activity is frequently associated with ice use including property offences, money laundering, firearms trafficking and violence¹³.

¹¹ ACC 2015

¹² ACC 2015

¹³ ACC 2015

Prevalence of Ice in Queensland

Overview: market in Queensland

The Crime and Corruption Commission (CCC) has identified the illicit methamphetamine market in Queensland as posing the highest and fastest growing threat to Queenslanders. This assessment is based on the harms caused by methamphetamine and in particular ice, the prevalence of methamphetamine in Queensland and the extent to which organised crime is involved.

An analysis of survey data from the Illicit Drug Reporting System (IDRS) and the Ecstasy and Related Drugs Reporting System (EDRS) reveals an increase in the reported use of methamphetamine in Queensland since 2009¹⁴.

General usage in Queensland

The IDRS reported ice usage in Queensland had increased four-fold in a 12-month period, from 8% in 2010 to 32% in 2011. From 2010-11 to 2011-12, the number of amphetamine-related hospital admissions increased from 121 admissions per million persons to 184 admissions per million persons.

The Queensland Police Service (QPS) has advised that arrests in Queensland for methamphetamine related offences rose by 18% from 2011-2012 to 2012-2013. In Queensland in 2012-13, there were 4,941 total arrests. In 2013-14, the number of offences increased by 37.1% with a total of 6,772 arrests.

Anecdotal evidence from rural QPS districts indicates an increased prevalence and adverse impacts of methamphetamines on communities in rural and regional Queensland.

Results from the Entox wastewater project¹⁵ also support an increase in methamphetamine

use in Queensland. Analysis of samples for the period January 2011 to May 2012 identified significantly higher methamphetamine chemical run-off in wastewater than MDMA and cocaine.

The Queensland Ambulance Service (QAS) also noted an increase in attendances at overdose cases where the primary substance was recorded as 'amphetamine', from 132 cases in 2009-2010 to 149 cases in 2010-2011. In the following two years, the QAS attended 265 such incidents (in 2011-12) and 282 (in 2012-13).

Health services¹⁶

Inpatient treatment episodes in any Queensland hospital where ice is the 'principal diagnosis' increased from 10 episodes in 2009-2010 to 78 episodes in 2013-2014^{17 18}.

Data taken from the Consumer Integrated Mental Health Application (a tool used by clinical practitioners and administrative

¹⁴ The IDRS and the EDRS are annual voluntary surveys of injecting drug users (IDUs) and regular ecstasy user (REUs).

¹⁵ The Entox researchers' estimate of a typical dose of illicit methamphetamine is based on median consumption amounts reported in survey studies from Queensland and purity of analysed seizures from Queensland in the same year (Prichard et al. 2012).

¹⁶ The health services data is a measure of service utilisation and not prevalence. Furthermore, the data has a number of limitations, including that it reflects only those who seek treatment, those that do are seeking it from the public health system and in some circumstances 'ice' must be the diagnosis which limits the number of cases that appear in the results. Further, most of the data sources only record the broad category of methamphetamine rather than the sub-types of base, speed or ice.

¹⁷ The codes used here to examine trends in amphetamine-related hospital separations only included the ICD-10-AM T436 Poisoning by psychostimulants (excluding cocaine) diagnosis (Qld Health).

¹⁸ Qld Health data.

personnel) indicates that two diagnoses of ice were made in 2012-2013 and 10 were made during 2014-2015.¹⁹

Rural impacts

Anecdotal information has been received from some rural centres regarding increased prevalence and adverse impacts of methamphetamine on local communities. This is especially prevalent where mining/resources operations have resulted in population growth in the community or as a result of transient (fly-in, fly-out) workforces.

Currently there is little quantitative research available regarding the extent of the ice problem in rural Queensland communities. The QPS is progressing the collection of intelligence from rural policing divisions to better understand the impact of methamphetamine in these areas.

Indigenous communities

Anecdotal advice from QPS districts indicates that whilst there has been an increased availability of methamphetamine in the area, there is little concrete evidence of increased uptake by Aboriginal and Torres Strait Islander (ATSI) groups in and around the major centres at this stage²⁰.

Police have suggested that the cost of methamphetamine in these areas may be beyond the financial means of some within the ATSI community. It is believed that these factors may be delaying widespread uptake of methamphetamine in discrete rural communities in north Queensland, however there is little research available to support or negate the advice.

Anecdotal information from a hospital and health service in an Indigenous Queensland community is that there has not been any presentation for amphetamine-induced psychosis in any of its facilities, nor has there been a large increase in referrals at alcohol and drug services for amphetamines.

However, a recent ACC study found that illicit drug use is of concern in Indigenous communities throughout Australia, particularly for methamphetamine use. According to available data on self-reported use of illicit substances, methamphetamine is the third most common illicit substance used in Indigenous communities, with 5% indicating amphetamines/speed use in the 12 months prior to survey²¹. Another study found that ice was not a significant concern for Indigenous communities²².

In any event, any change in the current situation around the price of methamphetamine in the area, as well as the vulnerability in Indigenous communities to substance abuse, means that ice represents a significant potential risk to rural and remote Indigenous communities.

Community services impacts

Anecdotal feedback in Queensland indicates some growing concern for service delivery provision brought about by increasing use of ice in the community. This includes impacts on individuals, parents and families. The issues of concern raised by service providers include violence/aggression, complex mental health issues, and disengaged and vulnerable youth.²³

¹⁹ Qld Health data.

²⁰ QPS Submission.

²¹ ACC 2015

²² Clough, AR Fitts, & Roberstson J 2015

²³ Department of Communities, Child Safety and Disability Services Submission.

Vulnerable young people

A 2015 snapshot profile undertaken by Youth Justice, Department of Justice and Attorney-General (DJAG), of 1,603 young people under a supervised youth justice order, found that 9% (140 young people) identified as misusing ice either on its own or in combination with other drugs. The highest concentration of users was found in the North Brisbane region at 19% of all reported users.

Young people are required to report any drug use during their medical assessment upon admission to a youth detention centre. Anecdotal reports indicate that ice use is becoming a significant issue for young people entering youth detention. Anecdotally, it has also been reported that the age of young people who report using ice when entering detention has decreased, with the majority of use reports in the 13-15 years age bracket.

Data taken from specialised alcohol and other drug services in Queensland, indicates that 843 treatment episodes related to situations where the client has identified ice as their primary drug of concern. Of these, 318 users were in the 18-≤25 years age bracket and 395 users were in the 26-≤39 years age bracket.²⁴

Probation and parole

Probation and parole offices across Queensland have reported a significant increase in ice use since 2012, demonstrated by an increase in positive drug tests for methamphetamines and amphetamines, and disclosures by offenders regarding their use of ice.

There was also an increase in the number of parolees suspended for methamphetamine use during 2012-13 in Queensland.

Methamphetamine has continued to be the primary drug related to parolee suspensions since this time.

In some locations, 30-40% of parole suspensions (for any reason) were due to urine tests for methamphetamine/amphetamines. If focused solely on suspensions for positive drug tests, over 70% of parole suspensions in some areas were due to methamphetamine/amphetamines.

These findings concur with the Drug Use Monitoring Australia (DUMA) detainee data gathered by the Australian Institute of Criminology (AIC). This data indicates that self-reported amphetamine use by detainees increased by 23.3%, from 39.6% in 2012-13 to 48.9% in 2013-14²⁵. Further, the proportion of detainees testing positive for methamphetamine was the highest reported in the last decade – rising from 25.9% in 2012-13 to 33% in 2013-14²⁶.

Production

Methamphetamine is both imported and produced domestically and the Queensland market is not reliant on the international importation of the end product. Worryingly, since 2012 there has been an increase in the international importation of ice to Australia, but no corresponding drop in domestic production²⁷.

The QPS also recognises an increase in the prevalence and purity of ice across the state. Since 2010, the weight of police seizures of methamphetamines in crystal form has increased by more than 100%. Conversely, seizures of methamphetamines in powder

²⁴ Qld Health data.

²⁵ AIC DUMA data cited in the Australian Crime Commission, Illicit Drug Data Report 2013-14.

²⁶ AIC DUMA data cited in the Australian Crime Commission, Illicit Drug Data Report 2013-14.

²⁷ CCC Submission; ACC 2015

form have decreased by half for the same period.²⁸

The QPS also notes that the median purity of methamphetamine has increased from 10-12% to 70-72% between 2010 and 2015²⁹. The ACC reports that the average price per gram has also increased, however when the significant improvement in purity is taken into account, the overall price has declined³⁰. The QPS has also observed an increase in organised criminal activity in the last one to two years around the importation, trafficking, supply, manufacture and possession of methamphetamine in the state.

The ACC's intelligence highlights that serious and organised crime groups have become entrenched in all levels of the Australian methamphetamine market with no one group dominant, and that more than 60% of the entities on the National Criminal Target List are involved in the methamphetamine and/or precursor market³¹.

Queensland has the largest number of clandestine drug laboratory detections across Australia. There were 219 clandestine laboratories detected in 2010-2011 and 340 detected in 2013-2014. Of the 340 detections in 2013-2014, 270 of these were for amphetamine-type substances (excluding MDMA)³².

Since 2000-01, Queensland has accounted for the greatest proportion of national detections of amphetamine-type substance (excluding MDMA) clandestine laboratories, accounting for 44.4% in 2013-14³³. This is in part because of the large number of small scale laboratory seizures.

The QPS reports that the Queensland clandestine drug laboratory seizures have decreased in the past 12 months by 30%. This may indicate demand for methamphetamines in Queensland is increasingly being met by the importation of ice from interstate and overseas, as opposed to local production.

In Northern Queensland, clandestine drug laboratory detections have remained stable when compared to other reporting periods and the decrease in clandestine laboratory detections is predominately contained to the south east corner of the state.

Both the CCC and the QPS note trafficking and importation of precursor chemicals as a significant trend in the Queensland market. The detection of amphetamine type stimulant precursors at Queensland borders have increased fivefold from 2009-2011.

²⁸ QPS Submission.

²⁹ QPS Submission: Summary. NOTE: 2014-215 stats are based on raw data and not centrally verified. 2014-2015 data is not complete. These stats do not include approximately 30% of seizures of methamphetamine which fall under the 2 gram weight. Seizures under 2 grams are not quantified. The purity of seizures under 2 grams would give a strong indication of street

level purity however due to work load and no requirements by the courts they are not quantified.

³⁰ Clough, AR Fitts, & Roberstson J 2015

³¹ ACC 2015

³² ACC Illicit Drug Data Report 2012-2013.

³³ ACC Illicit Drug Data Report 2013-14.

National Ice Taskforce

The Commonwealth established the National Ice Taskforce (Taskforce) to work with the states and territories to develop a National Ice Action Strategy which builds on existing efforts in all jurisdictions to address the demand, supply and harm associated with ice.

The Taskforce comprising the chairperson, Mr Ken Lay (former Chief Commissioner of Victoria Police), Professor Richard Murray (Dean of the College of Medicine and Dentistry at James Cook University) and Doctor Sally McCarthy (Director of the Emergency Care Institute and a senior emergency physician at the Prince of Wales Hospital) was announced on 8 April 2015.

On 23 July 2015, the Taskforce presented its interim report on the use and impacts of crystal methamphetamine on the Australian community to the COAG, providing leaders with the Taskforce's initial analysis of this complex issue, an overview of existing gaps and efforts to tackle the problem, and advice about what more needs to be done.

The interim report was developed following more than 1,300 submissions, seven targeted community consultations and input from experts in drug treatment, health care, education, research and law enforcement to gain a better understanding of this drug and how it is causing harm.

The Taskforce has identified six areas for action where they believe more work needs to be done by all governments, and where the greatest benefits can be gained to assist ice users, their families, communities and the workforce to tackle this complex problem.

These six areas are:

- 1. Target primary prevention**
- 2. Improve access to early intervention, treatment and support services**
- 3. Support local communities to respond**
- 4. Improve tools for frontline workers**
- 5. Focus law enforcement actions**
- 6. Improve and consolidate research and data**

The six areas will form the basis for the next phase of activity, as the Taskforce completes its final report to the Prime Minister and works with all governments to develop the National Ice Action Strategy (the Strategy).

The Queensland Government will continue to work collaboratively with all other Australian governments to develop the Strategy. The Strategy will comprise detailed initiatives under each of these areas, and will be brought back to COAG for endorsement before the end of this year. The areas of reform identified in this paper are consistent with the key areas for action identified by the Taskforce.

Current Queensland Government Responses to Drug Use in Queensland

The Queensland Government takes a **holistic approach** to addressing the problems associated with crystal methamphetamine, focusing not just on law enforcement, but also on education, treatment and support programs.

The summary of activities currently undertaken by Queensland Government agencies set out below are not exhaustive, but provide an overview of strategies and services aimed at reducing the demand, supply and harms associated with ice and other drug and alcohol use in Queensland.

Queensland Police Service

The QPS's strategic plan identifies major and organised crime, particularly in relation to drugs, as a significant priority.

The QPS is committed to not only targeting the production of drugs at its very source, including monitoring the trade and use of precursor chemicals, but also detecting and dismantling the criminal networks at the core of this market.

Emphasis is placed on operational collaboration and partnerships with external law enforcement partners to maximise joint operational targeting opportunities with respect to all drugs, but with particular emphasis on methamphetamine.

The QPS Drug and Serious Crime Group, through the Chemical Diversion Desk, maintains an effective working relationship with the precursor chemical and equipment industry. This is for the purpose of monitoring the sales of precursor chemicals, which could potentially be diverted to the domestic production of methamphetamine in clandestine drug laboratories.

The QPS, through the Drug and Alcohol Coordination Unit, is also working with Queensland Health (QH) and other government and non-government agencies to develop effective responses to address harms associated with the misuse of illicit drugs including methamphetamine. The Police

recognise that all strategies designed to address the current demand and use of methamphetamine need to incorporate a whole-of-government approach which incorporates law enforcement, treatment and education as complementary key objectives within the National Drug Strategy 2010-15.

Crime and Corruption Commission

The CCC is responsible for investigating major crime referred to it by the Crime Reference Committee. The CCC has a standing referral to investigate organised crime and related criminal activity.

To fight major crime, the CCC utilises multidisciplinary investigation teams including investigation, intelligence, forensic computing, law, information technology, forensic accounting, and surveillance and technical disciplines. The CCC also utilises coercive hearings powers to investigate serious activities, such as networks involved in drug trafficking, and has criminal proceeds confiscation powers.

A case study of a CCC operation is Operation Juliet Wave. This was a two-year operation by the CCC, in partnership with the QPS, which dismantled a major organised crime network that was trafficking ice and other drugs between Sydney and Brisbane. The operation resulted in a total of 62 people charged with 430 offences. Drugs with an estimated value of

\$2.9 million were also seized including crystal and liquid ice estimated at over \$2 million.

The CCC also publishes declassified intelligence and research reports to inform the community of current issues in law enforcement and crime prevention. This includes 'Illicit drug markets in Queensland' – a strategic intelligence assessment profiling the main illicit drug markets currently operating in Queensland, and the extent of organised crime involvement in them.

The CCC's Proceeds of Crime Team has been responsible for the restraint and forfeiture of funds and property of individuals and groups engaged in the supply and trafficking of methamphetamine in Queensland. Proceeds of crime action removes the financial gain and incentive associated with methamphetamine supply and prevents reinvestment in further illegal activity.

Methamphetamine is identified as a high priority in the CCC Intelligence Collection Priorities (ICP) which ensures ongoing intelligence focus on collection against identified information gaps. The ICP ensures that the resources of the CCC are aligned with highest priority crime issues impacting Queensland.

Department of Justice and Attorney-General

DJAG is responsible for a range of government services including the administration of justice in Queensland, including youth justice and custodial, probation and parole services.

DJAG (through the Attorney-General) is responsible for the *Drugs Misuse Act 1986* (DMA), which provides criminal sanctions to persons who unlawfully produce, supply, possess or traffic in dangerous drugs. The *Drugs Misuse Regulation 1987* (DMR) divides dangerous drugs into more serious drugs, which are listed in schedule 1 and attract

higher maximum penalties for a number of offences, and schedule 2, which lists other dangerous drugs. Methamphetamine (which includes 'ice') is prescribed in schedule 1 of the DMR. As well as the regulation of dangerous drugs, the DMA and DMR also regulate drug precursors and apparatus.

The DMA and DMR are constantly under review to ensure that the legislation remains responsive to changing trends in drug culture. A Queensland Inter-Departmental Working Group on Drugs (IDWG) meets several times a year to discuss emerging trends and issues in dangerous drugs and changing trends in the illicit drug culture. This will include, for example, consideration of the recent *National Control Framework for Precursor Chemicals and Equipment* developed by the Precursor Advisory Committee. The IDWG is chaired by the DJAG and includes members from the Department of the Premier and Cabinet, QH and the QPS.

The Queensland Government has also committed to reinstating specialist courts including those dealing with people who are affected by drugs. The Government is currently researching and analysing the available evidence of what works best and delivers the most effective outcomes. A framework will be developed that will build on the current Queensland Courts Referral Program and will recognise the links between offending, drug and alcohol abuse as well as child protection and domestic violence.

Commission of Inquiry into organised crime in Queensland

The recently established Commission of Inquiry into organised crime in Queensland will ascertain the extent and nature of organised crime and its impacts on the economy and society in general. The Commission of Inquiry, headed by Michael Byrne QC, commenced on 1 May 2015. One of the key areas of focus included in the Terms of Reference for the

Commission is consideration of the high threat illicit drug and/or precursor markets, including methamphetamine. The Commission is due to report to the Premier by 30 October 2015.

Youth justice

Current practice within youth justice to address substance misuse, including ice use by young people, include undertaking risk assessments, comprehensive case planning, and referrals to service providers. For young people in detention there are also onsite health services and a *Forensic Adolescent Mental Health Alcohol and Other Drug Programs* unit.

Queensland Corrective Services

Queensland Corrective Services runs a number of programs within both custodial and community based corrections aimed at addressing and managing issues relating to substance abuse. An Immediate Risk Needs Assessment is completed for prisoners upon admission to identify any risks or needs that require immediate action. This includes, but is not limited to, immediate substance abuse needs. For prisoners serving in excess of 12 months custodial imprisonment, an assessment of general rehabilitation needs is also conducted to establish rehabilitation goals and identify needs including, but not limited to, substance abuse.

Similarly, an Immediate Risk Assessment is also undertaken to provide a 'snapshot' of immediate risk factors for offenders supervised in the community and identifies any issues requiring immediate intervention.

Specific custodial programs aimed at addressing substance abuse include the *Pathways: High Intensity Substance Abuse Program* and the *Positive Futures Program*.

The Pathways: High Intensity Substance Abuse Program uses cognitive behavioural therapy to change antisocial thinking and behaviour

associated with offending and substance abuse. The 126 hour program targets cognitive, emotional and behavioural skills which are known to reduce future offending and substance abuse.

The *Positive Futures Program* is a culturally sensitive 'strength based program' targeting anger and violence, alcohol and drug abuse, power and control, jealousy, trust and fear, family and community and parenting. This 36 hour program has been specifically developed for Indigenous men.

Queensland Health

QH funds a range of government and non-government services including ambulance, hospital, and other treatment services to tackle drug use and its consequences. QH's primary focus is on the prevention, early intervention and treatment of alcohol and other drug issues.

Treatment services include multidisciplinary team approaches to substance use. These services offer counselling/psychosocial interventions, outpatient withdrawal support and management, replacement therapies, relapse prevention, and referral to other services.

Speciality services are also provided, such as preventative teams working within the community, homeless health outreach teams, and the provision of sterile injecting equipment and health interventions through the Needle and Syringe Program.

Other specialty services include the Queensland Opioid Treatment Program which provides opioid replacement therapy (e.g. Suboxone or Methadone) for people who are dependent on opioids such as heroin, morphine and oxycodone, as well as Dovetail, which is a dedicated service to support youth drug and alcohol professionals.

The Alcohol and Drug Information Service (ADIS) is a telephone service for people concerned about their own or someone else's substance use.

The Queensland Mental Health Commission (QMHC) is currently driving ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health, drug and alcohol system. The QMHC will be responsible for leading a cultural change in the way that mental health, and alcohol and other drug services, are planned and delivered in Queensland.

Queensland has committed to implementing actions to prevent and reduce the adverse impacts of alcohol and drugs on the health and wellbeing of Queenslanders through the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014–2019*.

The Queensland Mental Health Commission is leading this work and is partnering with government, non-government agencies, people who have experience of problems related to alcohol and drug use, their families and support people to develop the Action Plan. The Action Plan aims to prevent and reduce the adverse impact of drugs and alcohol on the health and wellbeing of Queenslanders and a discussion paper titled *Reducing Alcohol and Other Drug Impacts in Queensland* was released on 18 August 2015 to seek the views of Queenslanders and key stakeholders on the actions to be taken.

QH has previously undertaken initiatives to deal with ice in Queensland including the *Queensland Ice Breaker Strategy*. This whole-of-government strategy was implemented in 2006 to target ice use in Queensland. The campaign featured education, treatment and drug law enforcement programs. It was overseen by a high-level taskforce reporting directly to the Minister for Health. Specifically, the Strategy involved:

- Development of a state-wide education campaign targeting young people about the dangers of the drug
- Enhancement of alcohol and other drug treatment services for vulnerable young people, including drug withdrawal services, outpatient counselling and residential rehabilitation services
- Review of public and non-government alcohol and other drug treatment facilities and other interventions available across Queensland
- Working with pharmacies to restrict the sale of pseudoephedrine medicines to those who have a genuine need as required by new controls
- Working closely with general practitioners to ensure appropriate prescribing of pseudoephedrine medicines.

In addition to the areas of reform identified in this paper, in order to address immediate priorities, the Queensland Government is establishing additional service responses in Cape York (Cooktown), Gold Coast, Rockhampton and the South West (Charleville and Cunnamulla). These additional services will be tailored to be locally responsive and will address the particular needs of the local community by targeting population groups identified as vulnerable to ice use.

Two Drug and Alcohol Brief Intervention Teams (DABIT) in the Emergency Departments (ED) of Logan Hospital and Townsville Hospital will also be established, expanding upon already funded DABIT teams at Gold Coast University Hospital, Royal Brisbane and Women's Hospital. These teams support the work of ED staff by providing screening of all patients presenting, and where indicated brief, intervention and referral to AOD services.

Education

Education helps create healthy attitudes toward drug and alcohol use. Through education, responsible behaviour and social expectations can be examined to reduce drug and alcohol-related violence and anti-social behaviour and address safety issues.

Schools provide opportunities for students to learn through alcohol and other drugs education. The *Alcohol and other drugs education program*³⁴ for Year 7 and 12 students supports young Queenslanders to develop a greater awareness and understanding of the impacts and consequences of alcohol and other drug use.

Based on the principles of harm minimisation, the program takes a preventative approach to encourage non-use; reduces risks associated with use; and promotes healthier, alternative behaviours. The Alcohol and other drugs education program increases students' capacity to make responsible, safe and informed decisions.

The *Alcohol and other drugs education program* also integrates with the *Learning and Wellbeing Framework* to assist schools develop a school-wide positive learning culture that enhances student mental health and emotional and social wellbeing.

Alcohol and other drugs education is also a focus of the National Curriculum to be implemented in state schools from 2016.

Department of Communities, Child Safety and Disability Services

The Department of Communities, Child Safety and Disability Services (DCCSDS) aims to enable vulnerable Queenslanders to improve their lives by investing, providing and partnering in

effective and innovative services. These services include child safety services, community services, disability services, women's services and Multicultural Affairs Queensland.

DCCSDS provides a range of child and family support services that support vulnerable families including intensive family support.

DCCSDS also funds a number of counselling and other support services to assist vulnerable individuals with a wide range of issues, including family and relationship issues, coping with chronic illness, and personal crisis and trauma-related conditions.

To support young people, the Department invests in youth development and leadership programs and support services targeting Queensland's most vulnerable young people. Youth programs include Youth Support, and the Youth Housing and Reintegration Service, and After Care Services.

Queensland Government Ice Awareness Campaign

The Queensland Government Ice Awareness Campaign began on 19 July 2015. The campaign focuses on the factual and credible health and social impacts of ice use, providing contact details for a telephone helpline (ADIS) in Queensland. The campaign also includes information about the criminal aspects of the drug, including details for Crime Stoppers.

The campaign targets regional and rural areas of Queensland, in response to the growing concern about ice in these areas.

³⁴ www.education.qld.gov.au/curriculum/alcohol-drug-education/index.html

The campaign comprises three elements: (1) print advertising (6 weeks, state-wide), linking to Crime Stoppers and the ADIS hotline; (2) social and online media promotion; and (3)

awareness packages that provides information and tools via community networks including general practitioner (GPs) and health clinics.

Addressing the challenges now – and a new approach for the future

While Queensland will continue to work collaboratively with all other Australian governments to develop the National Ice Action Strategy, it is important that Queensland examines current gaps in service delivery to meet the growing challenges associated with ice. **We cannot afford to sit back and wait.**

Specific challenges facing Queensland

Like all other Australian jurisdictions, the problems associated with ice and other substance abuse is growing, putting pressure on individuals, families and communities as well as government and non-government service providers. However, some factors are unique to Queensland and will need to be addressed within this context.

Vulnerable Populations

Queensland has a significant number of vulnerable populations, including Aboriginal and Torres Strait Islander communities, youth and offender groups.

Although there has been an increased availability of methamphetamine in some Aboriginal and Torres Strait Islander communities, the high cost and known associated harms of ice may have prevented a significant increase in its usage at this stage. However, as Aboriginal and Torres Strait Islander communities often have a higher incidence of drug and alcohol abuse, action needs to be taken to ensure that ice does not become entrenched in these communities.

Youth offenders and adult offenders have seen an increase in the prevalence of ice when entering detention and in the community. For young offenders in particular, drug use is a known risk factor for offending, which if not addressed, can lead to long-term involvement in the justice system.

Geographic Size of Queensland

The geographic spread of Queensland raises the issues of how to adequately police and provide appropriate services across the state in response to this issue.

Similar challenges exist for health and community service providers (government and non-government) to provide education, treatment, support and rehabilitation programs in all areas of the state that may require them.

State and International Border Size and Access

The size of Queensland's borders also raise importation, policing and customs issues. As the only Australian jurisdiction to have an international border (Papua New Guinea), Queensland has both domestic and international border issues to consider when attempting to restrict the supply of ice.

How resources are to be distributed, and what resources are appropriate for which sections of the border, must be adequately analysed.

Literature review of what works to tackle methamphetamine use

The literature review (Attachment 1) emphasises the need for law enforcement strategies to be coupled with evidence-based, multiple, targeted interventions focussed on both prevention and treatment at an individual family and community level. Effective approaches also facilitate collaborative and cooperative partnerships that empower families and communities to deliver locally relevant prevention strategies.

A variety of levels of intervention were identified including primary interventions (media campaigns, education programs, family support and community-led initiatives), secondary interventions (early interventions for drug users and unique populations), tertiary interventions (treatment avenues for drug abusers) and harm reduction strategies.

Immediate actions: additional service responses

Based on the analysis undertaken to date and to address immediate priorities while further reforms are considered, the Queensland Government is establishing additional service responses in Cape York (Cooktown), Gold Coast, Rockhampton and the South West (Charleville and Cunnamulla). These additional services will be tailored to be locally responsive and will address the particular needs of the local community by targeting population groups identified as vulnerable to ice use.

In addition, two Drug and Alcohol Brief Intervention Teams (DABIT) in the Emergency Departments (ED) of Logan Hospital and Townsville Hospital will be established, expanding upon already funded DABIT teams at Gold Coast University Hospital, Royal Brisbane and Women's Hospital. These teams support the work of ED staff by providing screening of all patients presenting, and where indicated brief, intervention and referral to AOD services.

Potential areas for reform

There remain many opportunities for better coordination between departments and service providers – for example between QH funded services, and those funded by DCCSDS and DJAG (Youth Justice Services).

The Queensland Government also supports a continued focus on the criminal aspects of the drug, in particular the links to organised crime. These links are being specifically pursued by the Commission of Inquiry into organised crime. However, the following issues have been identified as potential areas for reform, based on the results of the literature review and the particular context of Queensland.

Targeted use of forfeited money from unexplained wealth prosecutions

The Queensland scheme

In Queensland, the *Criminal Proceeds Confiscation Act 2002* (the CPCA) enables the state to recover proceeds of crime and unexplained wealth. The proceeds of crime can include money or property: gained from criminal activity; used in committing an offence; belonging to serious drug offenders; or where individuals have wealth and are unable to explain how they lawfully acquired it (referred to as 'unexplained wealth').

The primary object of the CPCA is to remove the financial gain and increase the financial loss associated with illegal activity. Confiscation of proceeds of crime is a key strategy for disrupting criminal activity, particularly serious and organised crime.

All confiscated funds go back into Queensland's Consolidated Revenue Fund, excluding: any costs associated with criminal defence and/or civil confiscation defence (for example by the Public Trustee of Queensland or Legal Aid Queensland); or where the Court makes a particular order for payment. The value of restraints and forfeitures will vary across years dependent on a number of factors.

The net funds available from the Queensland scheme are further reduced once additional Office of the Director of Public Prosecutions and CCC costs are accounted for.

The Commonwealth scheme

The Commonwealth Government takes action under its *Proceeds of Crime Act 2002* (POCA) to recover proceeds of crime derived from breaches of Australian laws. All confiscated money or funds derived from the sale of confiscated assets are placed into the 'Confiscated Assets Account'.

Under the POCA, the relevant Minister has the power to approve a program funded out of the Confiscated Assets Account funds. This expenditure can be approved for one or more of the following purposes: crime prevention measures; law enforcement measures; measures relating to treatment of drug addiction; and diversionary measures relating to illegal use of drugs.

Possible reforms

The Queensland Government could explore options for how confiscated funds could be used to fund new initiatives aimed at addressing current gaps in service delivery to meet the growing challenges associated with ice. Instead of the revenue from proceeds of crime being returned to Queensland's Consolidated Fund, consideration could be given to utilising a component of this revenue for particular purposes (such as drug treatment), similar to the Commonwealth scheme.

This could be achieved through legislative amendment, which would send a clear message of the Government's policy to target proceeds of crime to address this issue. Alternatively, this could be achieved administratively for specific crimes where there are clearly identifiable assets that are of a significant size to warrant this targeted approach.

Queensland will also continue to work with the Commonwealth and other jurisdictions to investigate a national, cooperative unexplained wealth scheme.

There is currently inter-governmental consideration being given by the COAG Law, Crime and Community Safety Council (LCCSC) on a possible national cooperative scheme on unexplained wealth. At the last meeting of the LCCSC (which is composed of Attorneys-General and Police Ministers throughout Australia), Ministers noted the importance of cooperative approaches to using unexplained wealth laws to disrupt and undermine serious and organised crime in Australia. Ministers also agreed to continue to work together to develop the proposed national cooperative scheme on unexplained wealth.

Queensland is continuing to work with the Commonwealth and other jurisdictions to consider how best to achieve benefits to Queensland over and above what our current unexplained wealth scheme delivers.

Health Services

Due to the increase in the use of ice and the significant detrimental harms associated with this particular drug, the need for effective health service responses is critical. Effective responses cannot simply rely on a criminal justice response to this problem.

Treatment options across a broad spectrum

Effective solutions need to be across the broadest treatment spectrum, which includes information, counselling, drug withdrawal services, outpatient counselling, as well as residential treatment rehabilitation services. Aftercare and follow-up are essential components of successful treatment programs.

Funding for these treatment services is largely a joint responsibility of the Federal and State / Territory governments under the National Drug Strategy. Maintaining, and where possibly expanding, these funding streams is essential to an effective national response to drug related harms.

Rural, regional and remote access

Given the size and regional spread of Queensland there is a need to ensure adequate access to alcohol and drug treatment services, especially to those who live in regional and remote areas of Queensland.

There is only one publicly funded medical detox facility in Queensland (located in Brisbane at the Hospital Alcohol Drug Service in the Royal Brisbane and Women's Hospital), with 16-18 beds. Some hospitals are also able to provide this service, but this depends on capacity and other priorities. Whilst this is not the only treatment option, it is an effective response in some specific cases.

Building and operating standalone, purpose-specific medical inpatient detox facilities in every location that may need them is not feasible, affordable or timely. Innovative, flexible options need to be explored. Options, including home-based and community out-client facilities, may offer alternatives that will enable timely support and detox services to be provided across the state.

Building on existing partnerships with non-government community care providers will be key to providing better access to drug and alcohol treatment services.

There is long standing debate regarding the best place for services targeting problematic substance use to be located, as there will never be enough specialist alcohol and drug treatment services to meet demand. Often, even when people are engaged with specialist alcohol and drug services, they will also need access to primary healthcare providers for other medical concerns and ongoing care.

Integrated and coordinated models that operate across primary health and specialist alcohol and drug services are needed to simplify referral pathways between services and improve patient outcomes. Primary healthcare also has a role to play in the detection of risky substance use.

Better routes into treatment

Attempts in the past have been made to increase GP engagement in alcohol and drug service provision; however, barriers still exist. Primary healthcare practitioners are sometimes reluctant to question patients about their substance use, or offer treatment that is unfamiliar or unsupported. More research is needed to identify particular barriers to treatment, and what are the critical enablers for people to seek help.

Effective treatment for at risk groups

Contemporary, innovative treatment options are also needed to address specific 'at risk' groups.

While a number of these groups are known, further work is needed to better understand what other groups are at risk, particularly where no effective interventions are currently being provided.

Specific services that may be beneficial include:

- treatment options for young people
- treatment for mothers/fathers who are primary carers of small children (no options currently exist for residential services for this group)
- dedicated culturally appropriate interventions for Aboriginal and Torres Strait Islander people
- services and options to address the treatment needs of people living in regional and rural communities.

We already know that there is limited access to withdrawal management and support facilities for young people.

One option could be to establish trial sites for innovative treatment options for those people falling through the gaps in metropolitan, regional, rural and Indigenous communities.

Poly-drug use

Many people who use ice are poly-drug users where two or more drugs are used at the same time or on the same occasion. Accordingly, treatment options for ice need to form part of the broader strategy to address alcohol and other drugs.

Family support

It is evident that families affected by ice abuse require support, and that adequate family support can help to prevent continued abuse³⁵.

There is very little published evidence demonstrating that specific stand-alone family support programs successfully reduce amphetamine abuse in the community. Nevertheless, it should be noted that family education and support were key components of the *Tackling Methamphetamine National Action Plan*³⁶ which has achieved great success in New Zealand.

The New Zealand Action Plan established two websites 'MethHelp' and 'DrugHelp' which seek to educate families/whānau and users about effects of methamphetamine and how to access treatment through a centralised web resource. In addition, the Action Plan oversaw the creation of 'Education Guidelines' and online resources, and Police School Community Services education programmes were provided to increase the reach of school community interventions targeted to at-risk youths and families to reduce use.

Increased targeting of domestic production and supply

Any move by the Commonwealth Government to increase their focus on border protection targeting international importations would see a likely displacement effect, leading to an increased demand for domestically produced illicit drugs including ice.

³⁵ NIDA, 2015

³⁶ Department of Prime Minister and Cabinet New Zealand, 2007

The QPS and other law enforcement agencies will continue to build on existing approaches to target domestic production and supply of illicit drugs in parallel to the increased focus on border importations. This could include increasing inter-agency intelligence sharing capacity and operational responses to target domestic production and supply of methamphetamine within the state and across state borders.

Increased focus on the underlying causes and social determinants of drug use

The National Drug and Alcohol Research Centre (NDARC) found that despite significant expenditure on drug prevention, problematic drug use has increased and new drug-related problems have emerged.

The NDARC also found that a variety of factors contribute to drug use and other problem outcomes, both individual and environmental. While drug prevention and treatment programs have traditionally focused on changing individual behaviours, these efforts can have only limited impact when changes are not made to the environment, that is, to the social determinants of drug use.

Alcohol and other drug abuse can develop across a person's lifespan as a result of environmental conditions, particularly those within that person's family and local community. Family, social networks, and peer pressure are key influencers of substance abuse among young people.

Exposure to ice through friends and siblings has been claimed to be a primary determinant of its expanding use. Understanding these factors is key to reducing the number of people who abuse drugs and alcohol.

Socio-economic disadvantage and cultural factors shape patterns of drug use and drug related harm. Our policy responses to the serious harms caused by ice use need to acknowledge this context as we work with the community and with service providers to reduce the supply of and demand for this drug.

Attachment 1

Literature review - Tackling methamphetamine use: what works?

Brief overview of the literature

In addition to law enforcement strategies, an effective response to methamphetamine use and abuse, and its impact on the community, requires evidence-based, multiple, targeted interventions focused on both prevention and treatment at an individual, family and community level.

In this brief overview of the literature, we explore those strategies found to be effective or show promise in responding to methamphetamine use and abuse, and those strategies found to be ineffective. We have structured the review around the following levels of intervention:

- Primary interventions, including media campaigns, education programs, family support and community-led initiatives
- Secondary interventions, including early interventions for drug users and unique populations
- Tertiary interventions, including treatment avenues for drug abusers
- Harm reduction strategies.

From this overview it is possible to conclude:

- To be effective, primary interventions, which seek to prevent first time use: should be targeted towards specific high risk groups; should be timely, factual, realistic, credible, non-judgemental, balanced, honest, culturally and linguistically appropriate; and should prioritise messaging that seeks to reduce the harms associated with ice abuse, such as health safety messaging. Effective approaches also facilitate collaborative and cooperative partnerships that empower families and communities to deliver locally-relevant prevention strategies.
- Secondary interventions, which seek to identify and discontinue abuse early, are effective when they provide training and education to frontline services providers (e.g., general practitioners (GPs)) who are most likely to come into contact with methamphetamine users, as these groups are best positioned to recognise use and abuse and put in place strategies to minimise risk and harm, and impart information about the effects of drug use in the short and long term. Innovative approaches to engaging methamphetamine users, such as online forums and support programs, are also showing some promise in encouraging users to seek treatment.
- Tertiary interventions, which seek to treat the medical consequences of continued abuse, require further exploration due to the limited available evidence of success of current methods including pharmacological responses, detoxification programs and community based treatment programs. Residential rehabilitation programs that provide intensive, sustained treatment approaches, with particular emphasis on follow-up care and relapse prevention, are most likely to be effective in providing tertiary care to methamphetamine abusers.

- Harm reduction programs, which seek to minimise the harms associated with methamphetamine or 'ice' abuse have been proven to be effective in Australia and overseas. Examples of harm reduction programs that show promise include needle/syringe programs and safer injection or 'drug consumption rooms'.

Primary prevention strategies

Primary prevention programs aim to reduce the likelihood of individuals commencing drug use. Examples include mass media campaigns, school-based drug education programs, and approaches targeted towards families or communities (Pennay & Lee, 2008). Primary prevention strategies may or may not be targeted to specific drugs.

Despite their popularity, there is little evidence to show that mass media campaigns, on their own, are effective in preventing the uptake or reducing the use of illicit drugs (Pennay & Lee, 2008; Department of Prime Minister and Cabinet (DPMC), New Zealand, 2014). That said, they can be an important element in changing attitudes or increasing knowledge more broadly across the community (Proctor & Babour, 2001). For this reason, media campaigns should only ever be one element of a broader drug strategy or wellbeing strategy (Penington Institute, 2015).

Primary prevention approaches that are thought to be effective focus on:

- Providing messages aimed at reducing potential drug-related harms, in particular health promotion, rather than drug prevention (Pennay & Lee, 2008)
- Are specific and targeted towards groups who are most at risk, particularly given methamphetamine use appears to be concentrated within specific sub-populations as opposed to being a widely used drug, like alcohol or tobacco (Degenhardt et al., 2008; Ministerial Council on Drug Strategy, 2011)
- Are timely, factual, realistic, credible, non-judgmental, balanced and honest (Pennay & Lee, 2008)
- Center on reducing risk factors that may lead someone to use drugs, and augmenting the protective factors that may stop the uptake of drug use (Law Reform, Drugs and Crime Prevention Committee, 2014)
- Include materials and programs that are appropriate for people from culturally and linguistically diverse backgrounds (Pennay & Lee, 2008).

Evidence regarding the effectiveness of school-based education programs is mixed. Programs that focus on promoting abstinence are thought to be particularly ineffective as they fail to take into account the presence of risk taking behaviour and experimentation that is part of normal adolescent development (Pennay & Lee, 2008). Peer-delivered education messages are often advocated in primary prevention initiatives, although there is also a limited evidence-base to support this approach (Pennay & Lee, 2008).

To be effective, school-based programs should aim to be realistic and credible and take into account participants' own or peer experiences of drug use (Mallick & Watts, 2007). School-based programs that are well-designed, incorporated into the school program on an ongoing basis, and delivered by trained teachers in the classroom setting are most likely to be successful (DPMC, New Zealand, 2014).

There may also be some value in funding after-school programs designed to provide young people with a safe, supervised, structured environment in which to engage in prosocial activities and development. Research shows that students who participate in extracurricular activities are less likely to develop substance abuse problems, less likely to engage in other dangerous behaviour, and perform better at school (Penington Institute, 2015).

Beyond its impact at the individual level, drug dealing and use causes great harm to families and communities. There is evidence to suggest that providing families with adequate support can help to prevent continued abuse among drug users (NIDA, 2015). Furthermore, it has been shown that communities can help to remove the stigma associated with amphetamine use and abuse, so people feel confident enough to seek help and know where and how to get it (VIC Government, 2015).

Family education and support are key components of the '*Tackling Methamphetamine National Action Plan*' which has achieved great success in New Zealand (NZ). In particular, the Action Plan has succeeded in reducing methamphetamine use from 2.2% of the total NZ population in 2007-08 to 1% in 2014 (DPMC New Zealand, 2014).

Under the Action Plan, two websites were established, 'MethHelp' and 'DrugHelp,' which seek to educate families/whānau and users about effects of methamphetamine and how to access treatment through a centralised web resource. In addition, a series of 'Education Guidelines', online resources and Police School Community Services education programs were developed under the Action Plan. These aimed to increase the reach of school community interventions targeted to at-risk youths and families and to reduce drug use among these groups (DPMC New Zealand, 2007).

Efforts were also made to strengthen best practice community programs under the Action Plan. One example is the Community Action Youth and Drugs (CAYAD), a national project to reduce harm to young people and families/whānau from illicit drugs and alcohol. CAYAD coordinators and communities are funded by the Ministry of Health to find innovative and inspiring ways to make a difference for young people and their families/whānau. The CAYAD program aims to (CAYAD, 2015):

- Increase informed community discussion and debate about issues related to alcohol and other drugs
- Adopt effective policies and practices to reduce alcohol and other drug related harm
- Increase local capacity to support young people in education, employment and recreation
- Reduce the supply of alcohol and other drugs to young people.

The Ministry of Health undertook to evaluate a number of innovative local approaches that demonstrate promise for reducing demand for methamphetamine. Unfortunately, the evaluations do not appear to have been made publicly available but may be worthy of further consideration should they be released.

The approach taken under CAYAD is consistent with findings from the Inquiry into the supply and use of Methamphetamine in Victoria (LRDPC, 2014). The Inquiry found that holistic approaches that require government, service providers and communities to work collaboratively and cooperatively to deliver prevention strategies are likely to be more successful than those which narrowly restrict drug and life skills education to the school classroom.

Secondary prevention strategies

Secondary prevention strategies refer to uncovering potentially harmful substance use prior to the onset of overt symptoms or problems. Secondary prevention strategies are important in the case of amphetamine use because of the more serious harms associated with its use (Penington Institute, 2015). Research suggests, however, that methamphetamine users are often reluctant to enter treatment and may be suspicious of its effectiveness (Pennay & Lee, 2008). Clinicians and other front-line staff engaging with methamphetamine users are therefore most likely to be effective when they have experience in treating methamphetamine use, strong communication skills, and an understanding of the mental and other health problems that lead individuals to use (Pennay & Lee, 2008). For this reason it is important that frontline staff receive appropriate training and support to know how to identify potential users and how to respond.

GPs in particular are in a strong position to identify the early signs of methamphetamine use and put in place strategies to minimise risk and harm, and impart information about the effects of drug use in the short and long term (Bloch, 2008). When properly trained and resourced, GPs can also act as key linkage points into specialist treatment, and provide aftercare and support to prevent relapse (Pennay & Lee, 2008).

The Inquiry into the supply and use of methamphetamines in Victoria (LRDCPC, 2014) discussed the need for greater training and workforce development to increase awareness, understanding and an ability to respond to ice users. The Inquiry considered that the provision of such training can positively influence worker wellbeing and worker effectiveness and recommended that the Victorian Government in conjunction with relevant Victorian Alcohol and Other Drug agencies, provide intensive tailor-made training on methamphetamine for frontline workers.

A key component of New Zealand's *'Tackling Methamphetamine National Action Plan'* has been the raising of the alcohol and other drug workforce capacity and capability to respond effectively to methamphetamine. This has occurred through an increase in the number of internships for new workforce, and training existing workforces to help users into treatment. Additionally, GPs have been trained to screen and provide brief interventions, such as motivational interviewing techniques to channel users into treatment, and the Ministry of Health has provided guidance to service providers regarding expected approaches to methamphetamine use (DPMC, New Zealand 2014).

In addition to improving training for frontline staff, there are ways in which it might be possible to encourage methamphetamine users to participate in early treatment, for example using online approaches.

The Australian National University is currently exploring the effectiveness of a self-guided web-based intervention (breakingtheice.com.au) for amphetamine-type stimulants users (Tait et al., 2015). Early research has used a randomised control trial to compare a waitlist control group and a treatment group exposed to a fully automated intervention. The intervention contains three modules derived

from cognitive behaviour therapy and motivational enhancement which have proven effective in responding to drug users. The research measured self-reported amphetamine use in the three months prior to the intervention, and compared this to three and six month follow-ups. The study also explored participants' self-reported help seeking behaviour. Early results suggest that web-based intervention may encourage help seeking associated with amphetamine use, but does not reduce amphetamine use. It is important to note that 37% of the intervention group did not complete the program. The authors conclude that web-based programs may provide a means of engaging some sections of difficult to reach groups and encouraging them to seek treatment, although this approach is far from perfect and a substantial minority remain disengaged.

Tertiary interventions

Tertiary prevention involves treating the medical consequences of drug abuse and facilitating entry into treatment so further disability is minimised.

There are a range of challenges associated with providing treatment to dependent or chronic users of methamphetamine:

- The drug has a complex action in the brain, meaning longer and more complex treatment interventions are required when compared to other illicit drugs
- There is a limited range of psychological and pharmacological therapy available to users
 - There are few specific programs for methamphetamine users (LRCPC, 2014).

When methamphetamine users do enter treatment, they do so from a variety of avenues. Multiple options for treatment and entry are recommended given the heterogeneous nature of the client group. In particular, strong collaboration and cooperation between emergency/primary care services and specialist treatment services are required to ensure access to effective and consistent treatment for a range of methamphetamine users (Pennay & Lee, 2008).

Treatment for methamphetamine addiction is typically provided in detoxification centres, one-on-one counselling, group sessions and residential treatment (DPMC, New Zealand, 2014). Treatment is similar to that provided for alcohol and other drugs.

In 2006, the Methamphetamine Treatment Evaluation Study was established to determine whether existing community-based drug treatment approaches reduced methamphetamine use and related harms (McKetin et al., 2010). A cohort from Sydney was followed-up at three months, 12 months and three years post treatment, and compared to a non-treatment comparison group. The study found that after participating in treatment, methamphetamine users showed sustained reductions in methamphetamine use and related harms compared to a non-treatment comparison group. These positive outcomes were largely due to ongoing treatment exposure. The single baseline episode of drug treatment was found to have only short-term benefits.

Furthermore, poorer outcomes were observed across groups for heavier injecting methamphetamine users, and those with psychotic symptoms and high levels of psychological distress on entry to treatment. Of the around one-third of methamphetamine users who recovered without further drug treatment, positive outcomes were particularly likely following exposure to longer and more intensive

treatment programs. This study highlights the need for intensive, sustained treatment approaches, with particular emphasis on follow-up care and relapse prevention.

A subsequent study found that community-based detoxification programs did not reduce methamphetamine use at any follow-up relative to the control group (McKetin et al., 2012). Resident rehabilitation produced large reductions in the frequency of methamphetamine use at three months, compared to both the community-based detoxification and control groups. The authors concluded that community-based residential rehabilitation may produce a time-limited decrease in methamphetamine use, while detoxification alone does not appear to produce sustainable changes in behaviour.

As stated previously, methamphetamine use is not restricted to any single group in society. For this reason it is important to consider the needs of different groups when exploring the effectiveness of tertiary intervention programs. The Inquiry in to the supply and use of Methamphetamine in Victoria (LRDCPC, 2014) found that insufficient attention has been paid to the specific treatment requirements of particular sub-groups of people who use methamphetamine. However, where research has been undertaken, it suggests tailoring drug treatment programs to the unique needs of specific groups is likely to be more effective than delivering standardised treatment programs. This includes: supporting culturally appropriate healing centres and therapeutic communities for Indigenous Australians; providing family therapy and assertive after-care to respond specifically to the needs of young people; and providing additional resources to remote and regional locations to help them appropriately manage and respond to the problem in their local community.

Harm reduction programs

Beyond treatment, there may be opportunities to explore harm reduction programs. Harm reduction measures aim to minimise the health risks associated with drug use, and are usually employed alongside other measures which are aimed at reducing the incidence of drug use (Home Office UK, 2014). The rationale behind harm reduction is that there are greater risks posed to individual and public health by the spread of disease, than are posed by drug use. In other words, the health of the individual and the community should be prioritised over preventing drug use.

Harm reduction policies are supported by the fact that there is very little evidence that effective interventions which can exert a primary prevention effect on illicit drug use exist (Hunt et al., 2010). As such, greater emphasis should be placed on more immediate, achievable goals relating to the many harms associated with drug use, that is, harm reduction.

There are two harm reduction programs most relevant to methamphetamine abuse, each with varying levels of success. These include:

- Needle and syringe programs
- Safer injection or 'drug consumption room'.

Needle/syringe programs

The primary goal of needle/syringe programs ('NSPs') is to prevent the transmission of HIV/AIDS and other blood-borne viral infections that are spread between intravenous drugs users through the sharing of injecting equipment. NSPs also attempt to limit sexual transmission of HIV between injecting drug users as well as to the wider, non-injecting population (Moss, 1987). The majority of

NSPs aim to increase the number of syringes in circulation, and encourage their return and safe disposal, so that each syringe is used fewer times, thereby reducing the chances of viral transmission (Home Office UK, 2014).

Additionally NSPs frequently take advantage of contact with drug users to:

- Provide information and education, such as how best to disinfect used syringes/needles
- Provide easier access to addiction treatment, health and social services
- Use outreach methods to make contact with hidden populations (WHO, 2002).

NSPs have many different forms, and are shaped by the local and national context in which they occur. Some of these include: pharmacy exchange schemes; standalone syringe exchanges; exchanges attached to specialist drug services; community outreach schemes; and mobile services. A review by Coffin (2000) identifies a further range of modalities for preventing HIV by ensuring good availability of sterile equipment including: pharmacy sales; injector- specific packs; mass distribution; and vending machines (cited in Hunt et al., 2010).

Since the 1980s, there have been many investigations concerning the impact of NSPs on risk behaviours and the viral status of people who use them. In 2001, a review by Gibson appraised a vast majority of studies to address the question ‘are needle and syringe program effective at reducing HIV risk behaviours and HIV infection among injecting drug users?’ Of the 42 studies appraised, 28 found positive effects and 14 found either no association or a combination of positive and negative effects. Overall, this provides strong evidence of the positive impact of NSPs on HIV risk behaviour and HIV infection and gives good justification for their implementation (cited in Hunt et al., 2010).

Safer injection or ‘drug consumption rooms’

‘Drug consumption rooms (‘DCR’s’) are facilities into which drug users can bring their own drugs for consumption under supervision in a clinical, hygienic setting, away from public spaces’ (Home Office UK, 2014). The primary common aim of a DCR is to reduce the public health and social impacts of drug use by reducing rates of overdose and infection, avoiding the safety risks associated with hasty public injections, and minimising public nuisance. Secondary aims include connecting users with treatment, advice and social services (Home Office UK, 2014).

In 2013, the European Monitoring Centre for Drugs and Drug Addiction reviewed evidence from a range of studies on DCR’s from across Europe, Canada and Australia. The resulting report considered that there was sufficient evidence to conclude that DCRs are ‘generally successful in meeting their primary aims (to provide an environment for safer drug use, to improve the health status of the target group and to reduce public disorder) without incurring serious risk’ (Home Office UK, 2014).

A number of evaluations of a ‘Medically Supervised Injecting Centre’ (‘MSIC’) set up in Sydney in 2007 have made similar positive findings. Of note, there is broad consensus that the MSIC has successfully treated a substantial number of overdoses which may otherwise have occurred in public places and without medical support, thereby increasing the risks to drug users and others (Thomas, 2010). One source stated that ‘in its first 10 years of operation this centre managed 4400 overdoses without a single fatality’ (Pryor, 2015). There has also been a significant decrease in the number of needle syringes collected in the King’s Cross area since the MSIC commenced operations, and community

surveys of local residents and businesses indicate that there has been an increase in support for the MSIC over the period in which it has been operating³⁷.

There is significant evidence that a range of operational models for DCRs are possible, and these can successfully serve differing populations and local needs. 'In line with their objectives, consumption rooms have demonstrated an ability to attract more marginalized and vulnerable drug users. There are indications that they are likely to have an impact on overdose deaths and may reduce risk behaviours for blood-borne viruses. However, these cannot yet be well-quantified. Beyond this, they can provide access to a range of drug treatment, health and social care services. As yet, the cost-effectiveness of consumption rooms is uncertain. Whilst they show some promise, further research is required to clarify their overall impact and value for money' (Hunt et al., 2010).

³⁷http://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/FlagPost/2010/September/Sydneys_Medically_Supervised_Injecting_Centre

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