LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: Use of crystal methamphetamine "ice" in the ACT)

Members:

MS K MacDONALD (The Chair)
MS M PORTER (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 9 MAY 2007

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

WITNESSES

The committee met at 9.36 am.

GALLAGHER, Ms KATY, Minister for Health
DELANY, MS HELENE, Manager, Alcohol and Other Drug Policy, Policy Division, ACT Health
TROMPF, MS LINDA, Acting Executive Director, Policy Division, ACT Health

THE CHAIR: I understand that Mrs Burke is caught in traffic so we will start.

Ms Gallagher: How unfortunate.

THE CHAIR: It takes me five minutes to read the card anyway.

The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.

Thank you very much for attending today, minister and officials. We are looking into the use of crystal methamphetamine—often known as ice—within the ACT. Minister, do you wish to make an opening statement?

Ms Gallagher: Thank you. I will just make a few comments. We welcome the opportunity to appear before the standing committee today and we are looking forward to the report once the standing committee has finished its deliberations and received evidence.

As you would be aware, the ACT government's approach to alcohol and other drug use is found in the ACT alcohol, tobacco and other drug strategy 2004-08. I am sure that if you do not have a copy of that policy document we can provide copies to you. We are making significant progress towards the implementation of that strategy; we can go into more detail around that if the committee wishes or we have time.

You will have seen the ACT government's submission to the standing committee that

we provided, I think back in March. ACT Health had the job of coordinating that submission across a range of agencies; I think you will agree that it is a very comprehensive submission about the state of play around the use of crystal methamphetamine in the ACT as best we know it.

The main thrust of the submission was that the use of methamphetamines—ice included—is a slowly increasing component of the work of both government agencies and non-government agencies, but is certainly not overwhelming those agencies. At the moment, it appears that we are managing within the current framework, but we are keeping our eye on it. Whilst the issue gets a lot of publicity, ice use and the effects of ice are a small but growing component of the work of some agencies, including our emergency services and health agencies.

Some of the data contained in the submission shows that the use of methamphetamine, including ice, in the ACT is slightly higher than the national average when that data is collected for people over the age of 14—at around 4.3 per cent or 11,500 people. That is slightly down on the 2001 data. That is data on methamphetamine, not necessarily just ice.

Another recent report concerned the 2006 illicit drug reporting system. There was a survey of only 100 injecting users, but it gives a snapshot. It showed that the proportion of injecting drug users in the ACT reporting recent use of crystal methamphetamine increased quite dramatically, from 62 per cent to 88 per cent, over the space of just one year. This increase was bigger than in other jurisdictions. It was the first year in which ice use amongst injecting drug users had exceeded heroin use. This could be attributable to the cost and the reduced availability of heroin, but we will certainly be watching that as well.

I will let the committee take the rest of the time, but from our point of view we are keeping an eye on it. A review of the ACT alcohol and drug service system will be conducted over the next three months, looking at how our services are responding to the environment and the climate in the ACT. That review will give us an opportunity to make sure that our approaches are responding as effectively as possible. There is some national work going on which we will be interested in following; and of course we will use the committee's report as part of our response in making sure that our services provide the most responsive approach they can within the framework of our policy document and in the framework of the strategy. We will particularly keep an eye on the levels of methamphetamine use and the impact of that use on our service system. I might just leave it there.

THE CHAIR: Thank you for that. I would like to put on the record the committee's thanks for such a comprehensive submission from ACT Health on behalf of health and the rest of the appropriate government agencies. I might just start by asking witnesses to state their name and the capacity in which they appear, before they speak.

We have a number of submissions. One submission, from Toora Women, who auspice both WIREDD and Lesley's Place, made the comment that they have done an anecdotal gathering of evidence from clients within their organisations and that Lesley's Place has done a small survey of some of its clients. They have talked about women becoming psychotic as one of the effects of ice. They also mentioned that

things can be misinterpreted: the actions of those who are going through an episode because of ice can be interpreted as being aggressive when they are not meant to be aggressive. They have made a suggestion that staff within Mental Health ACT need to be educated on the effects of ice, particularly on the importance of sensitive communications. Since this is of concern to the community, it leads me to the question of what information on this particular drug is being given to people who work within Mental Health ACT currently. Of course, ice is just one drug of many which people within Mental Health ACT would have to deal with, I would assume.

Ms Gallagher: Does your question concern whether people are incorrectly responded to or whether they are not people with a mental illness but are referred to services based on their behaviour as a result?

THE CHAIR: It is when they are actually within Mental Health ACT. I think it is appropriate that they are within the mental health system. They have made reference within their submission. They talk specifically about the need to educate users, specifically in terms of the side effects. One woman specifically said that it took her three psychotic episodes to realise that she was having these psychotic episodes as a result of taking ice in the first place. They also said:

> Communication had been difficult for both the women and health professionals. Both groups appeared to misinterpret defensive behaviour as aggression. One woman stated she was "very happy to see some fire fighters" and went to hug them, resulting in the police being called as it was seen that she was attacking them. While in hospital one of the women could not talk due to her paranoia which was interpreted as her not being cooperative.

Ms Gallagher: Yes, I see.

THE CHAIR: It is a difficult thing for health professionals to keep on top of the changing cocktail of drugs within our community, but I am just interested to know what information and what—

Ms Gallagher: What training for mental health?

THE CHAIR: What training is being done?

Ms Trompf: I probably cannot give you the exact details of what training is provided to staff working within Mental Health ACT specifically, but there is a comprehensive educational program, a lot of which is mandatory for all staff working in mental health. Certainly the issue of drugs and drug interactions, and the impact that that has on people's mental state and their behaviour, is part of that training.

If the committee would like me to get back to them with more details and with advice about what that training incorporates, I am happy to do that. But certainly all that information is provided. Up-to-date information on drug usage and changes in behaviour is made available to staff in mental health. There is an increasing awareness and working relationship between mental health and the alcohol and drug sector, to continue to try and build on that. That does not mean to say that incidents like the one that Toora has described do not occur, but there is a commitment to ensuring that staff do have the appropriate level of information and skills to provide care in an

appropriate fashion.

MS PORTER: It would be good if we could get that detail.

THE CHAIR: Yes, it would be good if you could follow up with that.

Ms Gallagher: Like the other agencies, Mental Health ACT are saying that this area of work is increasing and taking up more of their resources. Mental Health ACT need to respond to that for their staff, in terms of staff development. The other issue raised there is that the evidence supports that ice users do not see themselves as necessarily having a problem or needing to seek treatment based on that.

MRS BURKE: That is true.

Ms Gallagher: That is something that is a little unusual about this group. It is certainly supported by the data about people accessing drug and alcohol programs—support programs—and nominating amphetamines as their particular drug of concern. The figure is very low.

THE CHAIR: Do you want to talk about how that means that they end up, for other reasons, presenting—

Ms Gallagher: I guess that you can follow on from that to say that that there does appear to be an issue that, if ice or amphetamine is your particular drug of choice, perhaps you are not linking your behaviour or the need to get treatment to that use of drug. I think the data I had from health showed that only eight per cent of all treatment episodes were for clients with amphetamine as their principal drug of concern in the 2004-05 and 2005-06 years.

MRS BURKE: I think that is a really valid point. I will not give a name, but a family member is exactly in that situation. It is not they that have the problem, it is somebody else. I have just written something down here. You said—and I understand what you said, minister—that the increase is not overwhelming. Is it perhaps due to a lack of education about the impacts and the effects of the drug—as with any drug? But linked to that—maybe the chair needs to follow up—I have got another question on the federal government's committee report on illicit drug use that was put out in February. Do you want to ask your question first and I will come back to mine?

THE CHAIR: I am happy to. That is an issue. The federal government has, literally in the last few weeks, announced that it is going to be spending several million dollars on trying to find treatment for crystal methamphetamine users as well as law enforcement. I was wondering if any information had come through to ACT Health in regard to how we would be able to tap into some of that money and what will be involved. I know that quite a large component will be going on prevention through law enforcement.

Ms Gallagher: Yes.

THE CHAIR: Sorry, that is not much of a question. There is a question in there somewhere.

Ms Gallagher: There is. I attended an ice forum—that is a short name for it—in Sydney in December last year. Half the presentations were from law enforcement agencies. From my point of view as the health minister sitting there seeing things from a health point of view, I found it unusual to be listening to the federal police talk about what they are doing here, there and everywhere to stop illicit drugs coming in. People have their own views about that.

But there is some more information coming through. This was announced by the commonwealth a few weeks ago and then followed up in the budget. We are having a look at that now, but for the ACT I think it is probably more about support for the non-government sector here—for rehabilitation and all of that. And that is all welcome.

THE CHAIR: At the moment there are no treatment options. There is no equivalent to methadone for heroin users or people taking heroin. That is the case for methamphetamines in general, as far as I understand, not just for ice. But I understand there is—

Ms Gallagher: There are some national trials going on out there.

THE CHAIR: Yes.

Ms Gallagher: Some clinical trials. I will ask Helene to talk about that.

Ms Delany: That is correct. There are clinical trials currently under way. There is no intention that the ACT would conduct its own clinical trials in this area, but certainly we will be watching very closely for the outcomes of those trials, to look at the implications for the programs here in the ACT.

MRS BURKE: Can I ask something before you move on?

THE CHAIR: Yes. How far advanced are the clinical trials? Are they at a fairly early stage? Do they have much hope? I note that one of the submissions talks about the possible use of dexamphetamine as a method of dealing with the issue. And there is something else.

Ms Delany: I would need to come back to you on the actual time lines for when the trials will be completed. It is of note that, with the significant injection of funding that the Australian government are talking about, there has been no reference at all to pharmacotherapies. That is really interesting. At this time it is too early to say whether those clinical trials will actually provide a better option. It is still not known—in terms of the stage that those trials are at.

THE CHAIR: Mrs Burke, sorry; I kept interrupting you.

MRS BURKE: That is okay. Thank you. In relation to pharmacotherapy responses and the emerging issue with ice and dexamphetamine, and amphetamine use in general, I want to refer to recommendation 1 from a commonwealth government inquiry. If you do not have it in front of you, I will read it out. I will ask for a response

from you or the minister. The recommendation reads:

> The Committee recommends that the Australian Government and the states, the territories and their agencies standardise the terms being used to describe amphetamines and other synthetic drugs (AOSD), particularly for research and statistical purposes.

I wondered where the ACT was up to in relation to any of these recommendations, particularly that one. A view of mine is that a lot of it is about crime. This was the one that stood out: we do need to have a lot more research. Where are we up to with this recommendation from the federal government? Is this part of your work? Does recommendation 1 from the federal government dovetail into that?

Ms Gallagher: These national agreements are usually dealt with through the Ministerial Council on Drug Strategy. I think there is a view around arising from confusion about what you are talking about. People think that methamphetamine is ice, and everyone gets lumped in. There is a whole range of issues. I cannot tell you what stage of implementation that recommendation is at, but it would travel through the national ministerial council.

MRS BURKE: I just wondered if you are aware of it and whether—

Ms Gallagher: I did not know that that was recommendation 1, but I am aware of the conversation that has been had, and it is particularly from presentations that the ministerial council had from experts who, I guess, are getting a bit frustrated with, I sense, the focus on ice and not on other things, perhaps. Some of the feeling that I have picked up from people is that there is a lot of interest, particularly media interest, in ice, but you can't just shift your focus to one and not look at everything else and where it sits within the picture of other drugs, including alcohol, which remains one of the biggest problems that our community tries to deal with every year. It is not overtaking the drugs in our community that have been there in the past and the problems they cause. The ministerial council on drugs is to meet next Wednesday in Adelaide. The Attorney-General and I sit on that council and we take it in turns, so the Attorney-General and minister for police will be attending on my behalf next week.

MRS BURKE: Would the committee be able to get some sort of feedback on that in terms of the recommendations?

Ms Gallagher: Yes, sure.

MRS BURKE: Is that all right, chair?

THE CHAIR: Yes.

Ms Gallagher: On recommendation 1 or all the recommendations?

MRS BURKE: Whatever you feel. I don't know how much you go through at these meetings.

Ms Gallagher: What are you reading from?

MRS BURKE: I am happy to show you.

THE CHAIR: For Hansard, it is the joint committee's inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs, or AOSD, in Australia.

MS PORTER: Minister, I go back to the staff issue and the support of staff. We have covered the training area, but my concern is for the support of staff in general throughout the whole of the health system because, obviously, this problem is different, although we should not ignore all those other problems and all those other drug issues that are coming through. As you rightly say, alcohol is one of our biggest challenges, but the people using this drug do present sometimes with what would appear to be quite violent behaviour—difficult behaviour, in any case—for staff to deal with.

From information that I get from organisations in the not-for-profit area, the staff in these various places are already under considerable stress when dealing with people that present with other drug issues, so this is coming on top of that. I know that you said that the number is small at the moment, but it is growing, and we seem to have, for whatever reason, a larger number than other places. But it is not so much the number as the different behaviour that is presenting, I think.

What are we doing to ensure that we have sufficient staff on hand to deal with people as they present and, importantly, to get these people onto treatment programs so that the problems do not compound? How do we debrief our staff? Have we got sufficient resources to be able to debrief our staff so that they have got the energy to carry on?

Ms Gallagher: That is an issue and I think it is the reason that makes ice attractive in terms of public discussion. It is about the result. The community perhaps wouldn't be so worried if the result of taking ice wasn't some of the behaviours that have been talked about. I think that is part of the focus on it. I could say from my involvement with ACT Health, but it would be harder for me to talk about policing. I think you would be better off asking the non-government agencies how they are dealing with some of that. I think this is something that we have to keep our eye on, but it is not unusual for aggressive and violent people to attend our health system for a number of different reasons or causes. That is not to say that we aren't looking at this.

I have been to the emergency department a number of times, and the good old days of the heroin overdose have been raised with me in the sense that those patients would come in and you could deal with them because they certainly weren't violent. If users of methamphetamine present at the emergency department, their behaviour can have quite an impact on the hospital particularly, but also from that first contact with the ambulance service. I know that the ambulance service has its own ways of dealing with people, particularly around calming them down.

The hospital has processes in place, including debriefing opportunities for staff, but, looking at the figures for the people that we would be talking about here, you are looking at 19 separations in 2005-06 in the emergency department. There would be by far more violent, aggressive people attending our hospital than that, and processes are

in place to deal with that. That is not to say that they are ideal, but it does come down to security. We do have security in place for this reason, but that is not to say that we are not continuing to monitor it and having a look at it. I do not know whether Helene wants to add to that in relation to alcohol and drug rehabilitation and what that means.

Ms Delany: There seem to be two components, if you like, to the comment in relation to workforce development. One could be about the specialised training in this particular area, and the other workforce issue is more generally what are the skills of the workforce. I am specifically talking about the alcohol and drug workforce, particularly the workforce employed by non-government organisations. It is an area that has been of concern and it is an area that we have invested in significantly.

Last year, in May 2006, we actually had a profile done of the alcohol and drug workforce across both the non-government and the government sectors to look at the skills, and we have now invested $200,000 in training to bring staff up to the minimum of a certificate IV in alcohol and drugs across the sector, a significant investment in those basic alcohol and drug skills. In terms of specialised knowledge in this particular area, we have not developed our resources locally, as you would expect. We are actually drawing on the resources developed under the national amphetamines training package. Much of that work had come through Turning Point, Victoria. We are utilising their resources here. Also, they have come to the ACT and worked with our staff doing train the trainer programs and the like.

In terms of incidents and debriefing of staff, this has also been of concern. It is a matter that has been discussed amongst the executive directors of all the alcohol and drug services that meet monthly in the ACT. We have looked at the practices that are in place in relation to the supervision across each of those services and how we can work more collaboratively to benefit from them, whether it is bringing in the same external person as a supervisor that we know is actually particularly good or sharing resources between our own services. Those are just a couple of initiatives in that particular area.

THE CHAIR: We are running out of time, but I will ask one final question because I think it is an important one. It is about an issue that has come up in a few of the submissions that I have looked through; that is, the issue of education. I know that within the government's submission—and we talked about it this morning—you talk about the fact that that they don't feel that there is an issue with their behaviour. You mention on page 35 of the submission that, given the reticence of many amphetamine users to present at alcohol and drug services, increasingly attention is being given to conveying information, education and support via internet-based media. I am curious to know how you use the internet-based media.

Also, within at least a couple of the submissions that I have read there has been a discussion about how people thought when they started taking the drug that they were fine on it and were unaware that if they kept topping up, which was one of the comments made in one of the submissions, this could have long-term negative effects on their health. How do we get that information out there and how are we currently getting information out into the community about the negative impact of not just ice but amphetamines and methamphetamines in general?

Ms Delany: A number of the alcohol and drug services are approached fairly regularly to come out and do community education by, for example, the construction industry and other areas, people actually seeking to be proactive in the workplace and in other areas to provide people with information relating to prevention, symptoms and things to look at, which picks up some of what you are saying there.

In terms of particular populations of people that are at risk, what we have done in the last 12 months is the ACT has been involved in a very exciting project with the National Drug and Alcohol Research Centre, the ecstasy and related drugs project, which has involved peers. It has involved the Youth Coalition working in partnership with the Red Cross, the save a mate program. It has actually targeted some of the dance scenes, the nightspots, and worked on the model of actually using peers—people that hopefully the people using these drugs and potentially at harm are more likely to relate to—to convey that information. That project is now coming to an end.

We are actually picking up on what we have learnt there. There has been a lot of learning that has come out of that. For example, feedback has gone back to the police about some of the information that the public have made available on it, with opportunities to strengthen it in terms of the language that is used and the type of information that is provided, based on the information that has come back from both the peers and the people that they have talked to. For the next 12 months we have just offered funding to the Red Cross save a mate program to extend this further, and are in discussions with the Youth Coalition. So it is about how we can pick up the learnings from that research trial that we have been involved in and how we can actually use the internet and other means that we know young people are tapping into for information to address this problem?

THE CHAIR: That's great. We will leave it at that because we are already running 10 minutes over time. Thank you very much for your time. If we do end up with further questions after hearing from other witnesses, we will let you know. We appreciate your making the time available today.

BUSH, MR WILLIAM MURDOCH, Member, Families and Friends for Drug Law Reform
LEY, MR JOHN FRANCIS, Vice President, Families and Friends for Drug Law Reform

THE CHAIR: I call to the table John Ley and Bill Bush from Families and Friends for Drug Law Reform. I think both of you gentlemen were present before when I read the card about privileges. You understood the contents? You do not need me to read it again?

Mr Ley: No, thank you very much.

THE CHAIR: Excellent. First of all, thank you very much for your very extensive submission which you put in to the committee. It is greatly appreciated that an organisation which is purely a voluntary organisation has taken the time to do so much research for us. Would you like to start by making a statement and addressing the submission that you made?

Mr Ley: I would, thank you. Families and Friends for Drug Law Reform is grateful for the opportunity to give evidence to this important inquiry into crystal methamphetamine. I will just give a summary of our main points. First, we believe there should be a focus on life and wellbeing in this inquiry. Families and Friends for Drug Law Reform asks you to have two principles as your guide: first, that the overriding objective of this inquiry should be the promotion of life and wellbeing for drug users and the whole community; and, secondly, that what you decide on to achieve that objective should be consistent with the best available evidence.

Crystal methamphetamine is the particular topic of your inquiry. It is a drug that is causing a lot of harm. Obviously it should be less available than it is, but the elimination of it and any other illicit drug should not become the objective that trumps the promotion of life and wellbeing. A measure focusing on abstinence that leads to drug users, their partners and their children catching a blood-borne virus is not a measure that promotes life and wellbeing. Using ecstasy is less harmful than ice, so steps that lead someone to use ecstasy in its place would promote wellbeing, even if not abstinence. The drugs themselves are not the only things that can harm life and wellbeing. The laws that parliaments pass and the policies that governments adopt can do so too. The cure should not add to the disease. Like the medical profession, politicians should do no harm.

The second major point is that not all illicit drugs are as dangerous as each other. This committee is investigating a particularly potent form of methamphetamine, its crystalline form. It is about 80 per cent pure. The oily base form is 21 per cent pure, three-quarters less pure. The powdered speed form is about 10 per cent pure, seven-eighths less than ice. The advent of crystal and base forms is associated with psychotic behaviour. To quote one study:

> Compared with a sample of longer-term, heavier, and predominantly injecting amphetamine users, crystal meth users appeared more likely to experience significant harms after a much shorter and lower level of use.

To promote wellbeing the committee must examine measures that shepherd users from the more potent to the less potent forms. Insistence on abstinence, as opposed to encouragement of the less potent forms, would be detrimental to the community's interests. All drugs may have their dangers but not all are equally dangerous, as a British study published just this March in the *Lancet* shows. It ranks 20 legal and illicit drugs according to their harm measured in the light of three parameters: physical harm, dependence and social harm. Amphetamine came in at No 8 and ecstasy at No 18. The committee should take on board such evidence.

The next point is to focus on the importance of different populations. The committee should devise different strategies for different user populations. The needs of the injecting poly drug user who may prefer heroin but who has turned to ice because of the scarcity of high-purity injectable heroin are not the same as those of the secondary school student who pops a couple of ecstasy pills containing mostly methamphetamine every month or so at a party. In particular, we urge the committee to pay particular attention to the distinct needs of a number of separate and specific groups.

First, secondary schoolchildren: national survey figures show some decline in amphetamine use and stable ecstasy use among them. The second group we refer to are children who drop out of school. These are not surveyed. Anecdotally, Families and Friends for Drug Law Reform understands that heavy methamphetamine use takes place in this population. The third group are tertiary students and working populations in their late teens and 20s. Annual surveys of ecstasy and related drugs provide an insight into this population. Judging by the median days of use, five in the past six months for ice addiction, it is not a particular problem for this population.

The next group are adult injecting poly drug users. This population surveyed to some extent by the annual illicit drugs survey demand particular attention. One deeply regrets that the prescription of heroin was vetoed 10 years ago. Evidence in Europe points to the fact that the chaotic life of these people would have been stabilised and free from methamphetamine-induced psychosis.

The final group, a group that are not often focused on, are those detained in ACT remand centres and those who will be detained in the new ACT prison. It is notorious that, in spite of all efforts, substantial quantities of drugs, including methamphetamine, circulate in corrective institutions throughout Australia and elsewhere. By virtue of the sharing of syringes these places are also hothouses for the spread of hepatitis C and other blood-borne diseases.

What is useful for one population may be of no benefit to another; thus testing of pills at parties, which the Parliamentary Joint Committee on the Australian Crime Commission recommended earlier this year should be considered, will be of considerable benefit for young adult population members who want to use ecstasy and not methamphetamine at a party. It will have no beneficial impact on the addicted injecting poly drug user seeking to binge on ice.

Then we have the really important issue of effectiveness of law enforcement. The effectiveness of drug law enforcement should be subject to continuous evaluation. Drug market indicators are collected which show whether law enforcement is

reducing supply. If law enforcement is having a positive effect, price should increase, purity should decrease and availability should reduce. That is not occurring. Available data for the ACT for 2006 indicates that the price for crystal methamphetamine is stable at $50, and 74 per cent of those surveyed said availability was easy to very easy.

Submitting drug users to the criminal process can cause much more harm than the drug itself. An adventurous or curious teenager prosecuted for possession of even enough methamphetamine for personal use can have his or her employment prospects blighted. In light of such documented dangers of user-level law enforcement, we urge the committee to reject intensified law enforcement at that level. Public health approaches do work—measures like shepherding users to less harmful drugs, increasing services and improving treatments for those dependent on methamphetamines and improving the capacity to respond to methamphetamine-induced psychoses.

One further point we would like to emphasise is in relation to ice pipes. Our organisation is alarmed by the chorus of calls to ban ice pipes. They are of course a means of producing a quick and intense high from inhaling vaporised methamphetamine crystals. While any consumption of ice is cause for concern, it is imperative that the committee closely examine the consequences of a ban. The competing means of producing a similar effect is by injection, and that is a much more dangerous means of administration. Wellbeing is promoted by discouraging that practice in the context of policy that discourages ice use, not by a policy that encourages switching from a means of administration that of itself causes minimal harm to one that is perilous; that is, injecting. It is of grave concern that in an environment of political panic the reasons for introduction of syringe programs two decades ago are forgotten.

MS PORTER: You mentioned the correctional services in that presentation, you mentioned the remand centre and you mentioned the upcoming Maconochie centre and your concern around that. Would you like to enlarge on that a little bit? I looked through the list of recommendations and—I might be missing it—I did not see a recommendation about the correctional centres.

Mr Ley: Right. We have presented a supplementary submission just today.

MS PORTER: Is there a recommendation on that in there as well at all?

Mr Ley: Is there a recommendation in there, Bill? No?

Mr Bush: No, there is not one specifically on that.

MS PORTER: I realise it is a concern of yours and I was just wondering if you would like to enlarge on that a little bit.

Mr Ley: Yes. We are very concerned that in the new prison the health program be as close as possible to the health program that is available to members of the community outside and that there be a needle program in the prison so as to minimise the spread of blood-borne diseases in the prison, which is a major problem in corrective institutions throughout Australia. We are concerned that the chief health officer, who

will be responsible for the health of inmates, have strong authority to implement proper programs in the health interests of all inmates as a group, particularly in relation to having a proper needle program and in relation to individuals who have particular problems.

Mr Bush: Just to add to that, we have concern about the drug and alcohol strategy that has been published for ACT corrections. It has an enormous emphasis on abstinence and, as John has just said, it does not give effect to the principle of equivalence—that what is available in the community should be available to people in corrections. Also the bill that is before the Assembly has a provision that makes health the responsibility of the corrections authorities, the Department of Justice and Community Safety, and this is against the consistent practice in the ACT for its correctional institutions to date and it is inconsistent with the practice that exists in New South Wales. It is inconsistent with the recommendation of the Senate committee on mental health, an important committee that put down its recommendation. So there are some concerns.

MRS BURKE: Thank you for your addendum to your original submission. I was just looking on page 7 at figure 6, which shows the method of consumption of crystal methamphetamine by ACT ecstasy users between 2003 and 2006, and I was correlating that back to a comment made by Bill about the pipes ban. Obviously it seems there has been an exponential increase anyway in the use of injection as a method of consumption from 2003 to 2006. It is probably a side question. Even if a ban were to go ahead it would seem that it is like shutting the stable door after the horse has bolted to some extent. Needle usage has increased to such a level that would banning pipes really have a big impact given that the use is exponentially rising?

Mr Bush: One does not want to encourage use of crystal methamphetamine. So in a sense at one level it is very understandable that you want to stop pipes, because in a sense it makes it easier to do it. The best answer I can give is the question that you will pose. We see that needle use is increasing—

MRS BURKE: But pipes are still available at this stage readily, so I—

Mr Ley: Basically, it will make the situation worse if that is—

MRS BURKE: Do you think so? It is already on the increase. This may be a moot point in a sense because the activity is still happening, and far more dangerously from what you tell us.

Mr Ley: But, clearly, if you ban pipes, people are going to go to injecting even more so.

MRS BURKE: Right. I have another quick question on page 10 of your addendum, which was surrounding data collection. I note that we have the pharmacy guild next and they have Project Stop, which is the internet based tracking system of pseudoephedrine. You are saying that there is a lack of important information gathering on the composition of illicit drugs and it is not routinely gathered in the ACT. I am not sure whether these are two different things and I am hopeful that the pharmacy guild can say if that is what it is going to be doing to help this whole issue

that you have got here.

Your recommendation says that the government should analyse and regularly publish the contents of synthetic illicit drugs—maybe the pharmacy guild would gather that information; I do not know—and prompt public warnings of drugs being passed off as less dangerous ones; I guess presumably from the information that you gather. Do you want to talk a bit more about that?

Mr Bush: That recommendation really came out of the very good forum that you kindly arranged, and particularly because you had present some people from the ACT analytical laboratory there. But the point is that if you look at the published data on drugs that are seized—let us say ecstasy—it tells you the amount of ecstasy in the tablet, and it is not that much. In order to get good policy around that you need to know the other active ingredients that are put in this.

I recall the minister saying—and we were very pleased to hear it—that potentially warnings are being considered by police about dangers that may arise because of a particularly bad batch and things like this. But you cannot know that unless you analyse it. According to the people from the analytical laboratory, this is not done methodically; it is only done at the particular behest of the police for particular prosecutorial purposes, so not a representative sample is ever submitted and some of the information that does go to the police is not necessarily, as we know, published regularly. So there is an information gap here which it would seem could be filled with minimal difficulty.

MRS BURKE: Thank you.

MS PORTER: So it is about the recommendation to develop medical treatment for ice—I cannot say the other word at this time of the day or any other time of the day.

THE CHAIR: Crystal methamphetamine.

MS PORTER: Yes. You can say it perfectly; I cannot. We heard before when the minister was here that we are awaiting what is happening federally with regard to finding some form of medical treatment. So I guess that might well be a frustration of yours, to wait for that and the slowness of that, because you are saying you want it to be fast-tracked but obviously it is taking a while. You also say that we should be alert to what is ahead and that we are just reacting at the moment to this particular fad or fashion; I think you put that in your submission. How can we be aware of what we do not know about, what might be around the corner?

Mr Bush: One can only look at history, and by looking at history we will hopefully avoid the mistakes of history. Ice and all the things that are happening now with ice were forecast by the criminal intelligence people from as early as 1995-96; that these were being manufactured and circulating in a big way in South-East Asia and that they would certainly come to Australia. That has happened. In 1999-2000 a base first appeared in the Gold Coast area, south of Brisbane area. The medical people there and the police issued warnings of psychoses, violence, difficulties in emergency departments. It is like deja vu; this was eight years ago—longer ago than that insofar as these methamphetamines were in South-East Asia from the early nineties at least,

these synthetic drugs. We have had plenty of time. I am sorry to—

MS PORTER: No, that is all right.

Mr Bush: Impatience and that sort of thing. These things do not happen. They are businesses; they are big and profitable businesses and there is ramp-up time, and the ramp-up time, I am afraid, is now in full bloom. It is now fairly much a mature industry and we are seeing evidence of it reaching a plateau.

MS PORTER: Thank you.

THE CHAIR: I am going to have to stop you there. Thank you very much for attending today. If we have any further questions we will get back in contact with you, but thank you once again for your extensive submission and recommendations.

REID, MR PATRICK, President, Pharmacy Guild of Australia, ACT Branch

THE CHAIR: Mr Reid, the committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing.

If you could start by stating your name and the capacity in which you appear today, Mr Reid.

Mr Reid: Thanks, madam chair. Pat Reid, President of the Pharmacy Guild of Australia, ACT Branch.

THE CHAIR: I thank you for your submission and the attached exhibit, which was a submission to the Australian parliamentary joint committee on AOSD. Would you like to make an opening statement before we go to questions?

Mr Reid: Madam chair, I know we are under some time pressures here, so I will take those reports as read and you will have a copy there. I will direct you, though, to page 11 of that report to the Australian Crime Commission. There are four recommendations which were held within that report. As to the main one that we wish to tackle today, I do acknowledge that the ACT government, as of several weeks ago, has committed to legislate for the implementation of Project Stop, which is the internet based recording of sales for pseudoephedrine based products. I have tabled some documents there which outline the process and the application of Project Stop in pharmacies for your recognisance.

To give you some statistics on Project Stop, to give some background, 90 per cent of the pharmacies in Queensland have voluntarily taken up this tool over the last 12 months. There have been in excess of 30,000 entries made on the system during the pilot phase, and currently, as I said, about 90 per cent of those pharmacies are entering. Of that, more than 6,000 sales of pseudoephedrine have been refused. That is where a product or a supply has been refused, which is about one in five.

As a direct result of Project Stop in Queensland there have been a number of outcomes. One has been that there have been 35 arrests and more than 250 charges

laid since the system has been utilised. These charges include multiple counts of trafficking, producing and supplying of a dangerous drug. At least seven illicit drug laboratories have been located, otherwise known as clan labs or meth labs, and several people have been referred to the Australian Crime Commission under that federal jurisdiction. The Queensland police currently have more than 250 active case files generated from information contained within Project Stop.

To give you some background, pharmacy is seen as purely a supply aspect in the methamphetamine problem, given that the precursor drug is normally pseudoephedrine. Of course, our role, we believe, is more primary health care based as well. We do see a range of substance users. They are also contained in our treatment programs, such as methadone and buprenorphine. So we do see a combination of people within the pharmacy who may be affected by this. It is a commonplace thing for heroin and methamphetamine to be used together. So we do often see patients who have multiple substance abuse problems, not just simply heroin or its precursors.

The other thing to be aware of is that pseudoephedrine is not the only precursor of note. The other ingredients that go into the methamphetamine process, such as iodine crystals and those sorts of things, also have to be made part of this legislation, we believe. It means that where we do sell iodine crystals in the pharmacy or potassium permanganate, which can also be used in this process, they should be a recordable item as well. So I take that on note.

I do refer you to recommendations 1, 2, 3 and 4. Given a lot of our battle to this point—and we presented some information to the health select committee a couple of years ago now around Project Stop—it is worth while to note that we are hoping for legislation to be in before this cold and flu season. Obviously, that is the core time for these particular medications.

I would also point you to an issue around pseudoephedrine and its banning which has been highlighted recently; that is, that phenylephrine, a substitute for this particular drug, has a very low bio-availability. It also has what is called a high first pass metabolism in the body. So for the majority of people who take this particular drug it doesn't do a lot for their colds and flu. The upshot of that, of course, is that they normally appear at a doctors surgery at some point for further treatment.

I would like to make the point that this is more than just a supply issue. It is also a primary health care issue, keeping people out of emergency departments and also helping people with their colds and flu, the traditional lurgies at this time of year. But also, we do have a role in the assistance of patients who may have multiple substance abuse problems that we do see in pharmacy.

THE CHAIR: I will start the ball rolling. I note that in recommendation 4 you talk about a national awareness campaign. Do you see the pharmacy guild being involved in terms of the potential side effects of taking methamphetamines?

Mr Reid: Yes, we have had a couple of programs run under the pseudo watch program, which is also mentioned in this particular paper, which have highlighted the issues around methamphetamine use, obviously the main ones being downstream

psychosis and other outcomes. Of course, the one thing with methamphetamine, as opposed to some other drugs, is that its timeline from initial use to these sorts of things is greatly shortened. So, again, it is an issue where people may deteriorate quite quickly and, as a primary health care provider in the community, we often see these people more often than their GP or other health providers, unless they present at the emergency department. So it is certainly something where we do see pharmacy having a dual role here; as I said, primary health care but also in supply.

MRS BURKE: Thank you for appearing before the committee today and thank you very much for your comprehensive information, which is really useful. On page 10 of your submission to the Australian Crime Commission you talk about what needs to be done. You say that community pharmacies need the continuous support of the relevant government agencies and consumer organisations to assist them by developing and implementing campaigns for dealing with this issue without hindering their business practice or creating secondary impacts by diverting the criminals et cetera.

What is it at the moment that is hampering that perhaps better understanding and working relationship between not just non-government agencies but the government itself? Are there blockages there that you may want to advise the committee of so that we can make recommendations to the government about unblocking or not hindering anything you are doing?

Mr Reid: I think the primary blocker which now should be removed with legislation is the privacy aspect of sharing this information amongst the jurisdictions of police and so on. That, hopefully, will be removed by this particular legislation.

The other issue, I guess, is that, given that people will have a higher level of interaction when they are purchasing these medicines because of the necessity for it to be recorded, that does create some tension at the pharmacy-patient interface. That is something, I think, for education campaigns as to why. We found in our trials and pilots that when people are educated around why they are being asked the extra questions—it is also good quality use of medicines to ask those questions—they are more than happy to comply. It is when it is done without any reason or rhyme, just asking a series of questions which may seem intrusive, that they do get upset.

So those sorts of consumer awareness campaigns are very important to the success of these programs, and we have done a little bit of that in the ACT. Obviously, with the role of this legislation, we will need to do more. That is certainly something where consumers, the government and pharmacists themselves need to be active in that area for consumer awareness.

In terms of the other blockages that we see, I guess the main one that I do perceive is that we are seen purely as a supply portal; we are not seen as a primary health care provider. When you consider that people see us, on average, every six weeks, whereas they may only see their GP twice a year, we are the most accessible health professional in the community, and we don't feel that often we are regarded in that respect. We are seen purely as a supply role, which is possibly not our best use of resources, given the level of education that our pharmacists and their staff do have.

They are probably the two main ones, but I certainly do think that we can be utilised

much more effectively for primary health care purposes and also consumer awareness, given our locations and proximity to the community.

MRS BURKE: Are there any moves under way to do that within the ACT at this stage with the pharmacy guild?

Mr Reid: Yes, we have been very active in agitating with the various agencies about our role in community health. I will say that we have recently been added to the primary health care committee as a member of that committee, so that is very positive for pharmacy. I also note that we have been invited to a number of other jurisdictional meetings in the last six months. I have been president for eight years and it has taken 7½ years to get to that position, but I must say that it is nice now to be involved at that level, and we are seeing some gains there.

We do have a committee meeting coming up with the divisions of general practice and other jurisdictions around methadone and buprenorphine care, which we haven't had before. So, as one of the primary interfaces for that, apart from the hospitals and with the local GPs, that is a very positive thing. So I do congratulate us and the jurisdictions on coming together on those issues.

MRS BURKE: Finally, you said that you are a primary health care provider. In terms of your core business, what impacts are all this data collection, liaising and memorandums of understanding having on your industry?

Mr Reid: It has really been an issue of making sure that we do continue best practice. One of the things we strive very hard for in the ACT around this type of area is to make sure that we do lead the country. We have the highest penetration of addiction care services in community pharmacy—50 per cent in the ACT—and that in no small part is due to the ACT government funding those patients to half a level.

We do have a very good understanding now of the environment in which we are working with methamphetamine and diversion through our work with the AFP and other areas. A lot of the strictures and problems we had at the practical side have been addressed by this particular tool, so we are hoping that that won't impact on us too much in our care provision but also won't impact on our patients.

MRS BURKE: I couldn't see Woolworth's doing that. Sorry, I had to add that.

Mr Reid: That is true.

MRS BURKE: You don't need to comment.

THE CHAIR: Mr Reid, you talked earlier about the other drugs that are precursors. Where are they accessed from? They are not generally accessed from the local pharmacist, are they?

Mr Reid: The solvents et cetera are accessible at places like hardware stores. Also, they access those sorts of things from pharmacies. Some of the other precursors, such as iodine, are primarily pharmacy based, although they can be accessed in some gardening stores, those sorts of things. The AFP has worked quite hard, I think, on

constraining them within those other industries.

The issue, I guess, for us is that they are not notifiable in any way, shape or form. In that case, it means that they may slip through the net a little bit. If they do get the main precursor, which is pseudoephedrine, then you can constrain it further by making sure that these other precursors are limited or unavailable. They are normally low-impact things. People normally use iodine in very low doses for various medical needs, but it is unusual for them to need crystal iodines and those sorts of things, unless there is a specific purpose that they need to be notified for. I think the Australian Crime Commission has actually spoken with the chief pharmacists of each state and territory around these precursors.

MS PORTER: I have a concern buzzing around in my head. It is probably not really a concern, but this emphasis on catching people doing the wrong thing is not going to pick up some unintended consequences with young people who just think that maybe if they buy some cold tablets they will get a high or something and then they end up caught up in the criminal system, with obviously very detrimental impacts on them. We have heard from previous witnesses about how important it is that we don't cause further harm through what we are trying to do to control this particular drug.

Mr Reid: Yes. We have been very careful that, in terms of the design of this particular system, it is only on multiple purchase or attempted multiple purchase. So, if they are only taking one pack to see whether a can of coke and half a dozen cold tablets give them a high, it is not important. If they are buying more than three packs within a specified time frame, then it will come to the notice of the AFP.

THE CHAIR: That is a myth, isn't it?

Mr Reid: Yes, it is. It's like coke and aspirin.

MS PORTER: But, whether it is a myth or not, young people may believe it.

THE CHAIR: I was just checking.

MS PORTER: What about the legitimate purchaser who goes to a discount pharmacy, for instance, and knows that if you buy three packs of something you get a discount?

Mr Reid: Currently, it is illegal to buy more than one pack in any state or territory. So, if they are doing that, please let me know.

MS PORTER: No, I don't know at all.

Mr Reid: The second issue is that we have been very careful to make sure that we are not breaching anybody's privacy so that legitimate users aren't, as you say, caught in the net of unwarranted issues. Their information is purged after a suitable time frame. So, at a normal dosage rate for a normal person, after I think 2½ days or three days of treatment their information is then purged from the system. The average cold does last 10 days, if not a little bit longer at the moment. If you need multiple packs over that length of time, as long as you are not buying them one after the other, you should be okay in the system.

It is relying on people to take a normal dosage. It is also incumbent on the pharmacist and that health care interface to ensure that they are telling them what the correct dosage is and that after three days they can safely buy another pack without fear of being labelled a criminal, a runner or anything else. No, we have been very careful on that aspect.

MRS BURKE: I have a very quick final question, as we are running out of time, with regard to the Stop Program. Surely it needs to be one in, all in to overcome some of the things you say. What stops people from going from one chemist to another and then another in one day?

Mr Reid: I guess the issue is still an issue of practicality, of everybody having a computer and everybody being able to access the internet. If you are in some of our newer suburbs, getting internet access isn't all that easy.

MRS BURKE: Yes. I hope Telstra is listening.

Mr Reid: The 90 per cent take-up in Queensland is excellent, but the other 10 per cent still have to record in some form, whether it is paper based or something else. The issue is that this system is the only one that has comparative data on where people are buying and how often they are buying, if they are a true runner. But in the ACT we do have nearly every pharmacy on broadband because of the federal government's broadband initiative. Again, this does have reporting to say whether people are not recording. So, if there is a hole in the system, then this can also pop that up, and that means that people like the chief pharmacist of the ACT can ask them why they are not recording and things like that. It really is designed to make sure that those people are adhering to the program, that they are doing what is required.

The other thing is that I wear another hat. I am on the pharmacy board of the ACT. The board has unreservedly backed this particular initiative, which means that, if it is a board edict that you must concord and you must follow this through, then not to do that is actually professional misconduct and you can be brought to bear before the board. The board's role is to protect the consumer, not to protect the pharmacist. So, if you do misbehave and it has an impact on the average person, then the board has every right to ask you to account for that.

THE CHAIR: Thank you very much for your time today.

Mr Reid: My pleasure.

THE CHAIR: If we have further questions, we will get in contact with you. Thank you for bringing along the further information about Project Stop.

Meeting adjourned from 10.54 am to 11.19 am.

CONNELLY, COMMANDER SHANE, Deputy Chief Police Officer, Investigations and Support, ACT Policing

THE DEPUTY CHAIR: I will read the card for the chair while she is gone.

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While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of the evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing. Did you understand that?

Cmdr Connelly: I understood that.

MRS BURKE: You can come up for air now.

THE CHAIR: I would like to think that that was a good way for me to get out of reading the card again!

MS PORTER: It is all right.

THE CHAIR: I welcome Commander Connelly. Before we commence, I am sure the committee would want me to place on the record its appreciation for the work of the late Audrey Fagan, the former Chief Police Officer.

MRS BURKE: Hear, hear!

MS PORTER: Hear, hear!

THE CHAIR: In particular, she made her time available for the community forum that we had back in March. We are all still shocked about her death. I wanted to put that on the record. Would you like to make an opening statement?

Cmdr Connelly: Yes. Thank you. Firstly, on behalf of ACT Policing, I would like to thank you all for your condolences in relation to Chief Police Officer Fagan. I would like to acknowledge the Ngunnawal people whose land we are currently talking on. I

would like to acknowledge you, Karin, Mary and Jacqui, members of the Legislative Assembly. I appreciate your taking the opportunity to ask us questions in relation to this important community issue. I will run through a few of the issues and then be open to questions.

Firstly, I want to touch on the policing arrangement for the ACT. ACT Policing is a business unit in the Australian Federal Police. A formal policing arrangement between the commonwealth and the ACT government sets out how policing services are to be delivered in the ACT. This arrangement was renewed in 2006 for a period of five years. An annual purchase agreement between the Chief Police Officer and the ACT Minister for Police and Emergency Services sets out the key performance indicators for policing in the ACT and how these are to be measured. This is a unique arrangement within Australia. The purchase agreement includes 36 key performance indicators, covering areas of community interest such as the level of crime, fear of crime, police responsiveness, public confidence, road safety, support for the judicial process and crime prevention.

The first area I would like to talk about is crystal methamphetamine, which is more commonly known as ice because of its appearance. Crystal methamphetamine is a high purity form of methamphetamine. It retains a form as large clear crystals. Crystal methamphetamine is methamphetamine that is of high purity—generally 80 per cent pure. "Pure" is a word I hesitate to use, because there is nothing really pure in crystal methamphetamine; it is a combination of a number of substances, varying according to the way it is cooked—"cooked" being the term used by the people who manufacture it to create the drug in the first place.

There are reports that, on the whole, crystal methamphetamine appears to be imported into Australia. I say that with caution because, it being an illicit market, we do not know how much is produced within Australia and how much is imported. On the whole, it would appear that the bulk of it is imported. However, there are reports of crystal methamphetamine being manufactured within Australia.

At this time, that crystal methamphetamine may be of a lower purity. Often it is amphetamine in a crystalline form, but is not crystal methamphetamine. That amphetamine in a crystalline form appears to be ice or crystal methamphetamine but is of a lower purity—and sometimes has a purity of about 50 per cent. This may lead to individuals increasing the dosage. They take a lower purity of this ice-like substance and then get the true crystal methamphetamine; that can cause substantial health problems or, in some cases, death.

I would like to touch on the issue of clandestine laboratories in the ACT. Most of the amphetamine consumed in Australia is produced in Australian or locally manufactured processes or clandestine laboratories. Methamphetamine is reported as the most common amphetamine type stimulant to be processed in Australia, due to easier accessibility to the precursor chemical pseudoephedrine compared with amphetamine type substance precursors which are more complex. There have been few clandestine laboratories detected in the ACT. Over the past two years, only three have been detected, with one classed as category C—that is, a clandestine laboratory where the equipment is there but it is not being used—and two as category A—that is, laboratories that are active.

The manufacturing of amphetamine type stimulants presents a substantial risk of injury and even death from contamination, toxic gases and fire explosion to those who live in or nearby the "clan" labs. It is a toxic substance, it is a heavy pollutant and it is highly volatile and dangerous. Due to the highly toxic and volatile nature of the chemicals used in production, these laboratories present a considerable risk to the public. The larger the laboratory, the larger is the risk.

ACT Policing is working with ACT Health and the pharmacy guild to initiate Project Stop, which I believe you have spoken about today, to reduce the amount of pseudoephedrine that is diverted into the illicit drug market from the legitimate pseudoephedrine market for people with health needs for it. Project Stop is a web-based program which allows pharmacies to report more accurately on exactly what medications are being targeted and where this activity is taking place. In addition to ensuring that pseudoephedrine products are being sold to legitimate customers, Project Stop has enabled law enforcement agencies to track and identify "pseudo runners", which is the name we give to people who are basically out there shopping for pseudoephedrine.

Another issue of particular concern is the increasing incidence of poly drug use. Poly drug use occurs when two or more drugs are used at the same time or on the same occasion. Rarely are either amphetamines or methamphetamines used exclusively. Poly drug use, including the use of methamphetamine, cannabis and/or alcohol or other drugs in combination, is increasingly common amongst drug users, whether through the use of several drugs in succession over a period of time or, more worryingly, through the use of a wide repertoire of drugs at the same time. I cannot emphasise enough that part of the concern is the excessive use of alcohol with the use of these drugs.

In 2004, participants in the national drug strategy household survey on recent users of methamphetamine were asked whether any other drugs were used on at least one occasion at the same time as this drug. Approximately nine in 10 people—87 per cent—of those aged 14 and over had consumed alcohol and methamphetamine on at least one occasion—that is, together. Next most commonly, 68 per cent of recent users had used marijuana/cannabis and 49 per cent had used ecstasy at the same time as using methamphetamine. There is acknowledgment in the health profession that poly drug use does have significant higher risks than using methamphetamine alone. Poly drug use often carries with it more risks than the use of a single drug, due to an increase in side effects and unique chemical interactions.

The biggest problem to overcome is that many drug users are not sufficiently aware of the dangers of various drug combinations. Stimulants when combined with other stimulants greatly increase the associated side effects, causing a greater false sense of confidence and risk-taking behaviour. A depressant combined with another depressant dangerously increases the associated side effects, drastically slowing reaction times and distorting the person's perception. I say this particularly in the context of drug driving.

In one incident in February 2007 three ACT residents topped off a night of drinking by consuming a quantity of gamma hydroxybutrate, commonly known as fantasy.

They had had a big night of drinking; then they decided to take the fantasy and methamphetamine. In a short time, one of them collapsed and began fitting. His friends placed him in the recovery position before they too succumbed to the effects of the drugs they had consumed and also fitted. One managed to make a 000 call but could not speak due to hyperventilation. Ambulance and police attended. We were able to track the phone call through the 000 network, and attended. It was really through the lifesaving activity of the ACT ambulance personnel that the three young people were saved. All of them were admitted to hospital in a serious condition. One had aspirated vomit and was seriously ill. All three recovered but were seriously shaken by the incident. I think it is fair to say—I will not go into the personal identities—that these were three normal young people in a good demographic. These were not long-term drug users. They were just people whom some would call part of the party scene.

Let me turn to the impact on users and responders. Problems with crystal methamphetamine include that it is relatively cheap—around $50 for a half point, 0.05 of a gram, or $80 for a full point—as well as being highly addictive. Crystal methamphetamine, through its very nature and the episodes of violence resulting from its use, has a direct impact on the safety and security of public and police responding to incidents involving users. Unlike heroin users—who typically become stupefied or, in layman's terms, tend to go home and go to sleep—crystal methamphetamine users usually become very aggressive after use and are capable of committing violent or criminal behaviour.

A particular concern for my officers dealing with the users is the difficulty in distinguishing between people experiencing mental health psychosis problems and drug intoxication related psychosis. For medical personnel also the care and treatment of people affected by methamphetamine or crystal methamphetamine can be very difficult because of their tendency to be violent or paranoid. This issue is going to present a challenge for all of our community for some time to come.

Under the auspices of the national drugs strategy, police and health professionals nationally are developing guidelines for dealing with people affected by psycho-stimulant toxicity. At this time ACT Policing has guidelines in relation to dealing with people who are mentally ill, and those are what are applied. This harm reduction strategy is in addition to strategies to disrupt the manufacture and supply of amphetamine type stimulants.

I turn to use in the ACT. Despite the knowledge we have around the effects of these drugs, the 2004 national drug strategy household survey found that 3.2 per cent of the general Australian population aged 14 years and over had used amphetamine, including methamphetamine, for non-medical purposes in the 12-month period prior to the survey. In the ACT the figure was 4.3 per cent, which was the second highest in any jurisdiction. The highest recorded usage was in WA, which had 4.5 per cent. ACT Policing has charged numerous offenders—for criminal offences—who admitted recent use of crystal methamphetamine or stated that they committed offences to support their drug addiction. I do not want you to be confused that we are charging crystal methamphetamine users for using crystal methamphetamine; this is for other crimes.

Whilst historically the link between drug use and property crime has been well established, we need to also deal with the fact that theft to support addiction is not the only crime committed by users of this new generation of drugs. In the ACT we have seen offenders who have admitted that, whilst under the influence of crystal methamphetamine, they have committed assaults, including some very violent assaults, domestic violence, traffic offences, road rage, extremely dangerous driving and other breaches of the peace, along with burglaries and stealing motor vehicles.

Officers in the ACT have arrested users who were in possession of weapons, including knives, a hunting slingshot, extendable police style batons, syringes, firearms and, more recently, Tasers. This creates an extremely dangerous situation for our officers and members of the public when you consider the volatile behaviour associated with the use of crystal methamphetamine.

I turn to police powers. Another issue faced by police in the ACT is that we have no power to obtain blood samples from offenders in such incidents—with the exception of traffic offences—in order to determine whether their toxicology indicates that the offender is acting under the influence of drugs such as crystal methamphetamine. ACT Policing is able to take samples of blood from a person involved in a motor vehicle accident. At this time, however, ACT Policing cannot conduct roadside drug testing; thus the influence of drugs such as crystal methamphetamine and drug use behaviour such as the incidence of driving in a manner dangerous or road rage cannot be accurately measured in the absence of admissions by offenders.

In 2004 the Victorian government introduced random roadside saliva testing to detect drivers under the influence of cannabis and methamphetamines. Since Victoria started testing for cannabis and methamphetamine in December 2005, more than 400 drivers out of approximately 20,000 screened have tested positive for methamphetamine based drug use: one in 49 drivers tested positive.

In May 2005 legislation was introduced in the ACT which established a serious drug offence component—chapter 6 of the Criminal Code 2002 and amendments to the Drugs of Dependence Act 1989. One of the more significant amendments contained in this legislation was the inclusion of offences with respect to precursors. We welcome that legislation. Essentially, precursors are the raw chemical components of a controlled drug. Many precursors are present in products that are readily available off the shelf in pharmacies, supermarkets and hardware stores, and are commonly extracted in backyard laboratories to manufacture controlled drugs, including amphetamines.

Chapter 6 includes a range of offences to deal with those who manufacture controlled drugs. Prior to its introduction there was no offence for possession of precursors—in particular, pseudoephedrine—in the ACT. Since this legislation was introduced, the ACT Policing drug intelligence and drug investigations team have had considerable success in apprehending manufacturing and supplies of illicit drugs. This includes a 321 per cent increase in the amount of amphetamines—I stress that it is the amount, not the number of seizures—seized in 2005-06 compared to the previous year. This has shown that our targeted approach to disrupting the supply of illicit drugs in the ACT is working.

I would like to conclude this presentation by acknowledging the excellent work of our investigators and our intelligence staff, along with the ACT Policing general duties patrols, our beat teams and the public, who, through Crime Stoppers, provide us with valuable information in relation to the fight against illicit drug use, particularly crystal methamphetamine. On that note, I am happy to take questions.

THE CHAIR: Thank you for that, Commander Connelly. You have talked about Project Stop, and Mr Reid from the pharmacy guild talked about that in quite some detail as well. You have briefly mentioned some of the precursors that are available, not just through pharmacies but also through hardware stores. Can you elaborate a little bit on what the answer might be in terms of dealing with some of the precursor chemicals which are found in places like hardware stores?

Cmdr Connelly: That is a very good question, and a tough one. A lot of these precursors—and I would prefer not to go into the precursors, for obvious reasons.

THE CHAIR: Yes.

Cmdr Connelly: All of these precursors have a legitimate usage in everyday society. Some of them may be cleaning agents; some of them may be alcohol based substances. The key to Project Stop is that it takes the critical ingredient of pseudoephedrine out of the amphetamine process, which makes the manufactured substance a useless one. There may be other chemicals that provide a vital role; I am not aware of those. But I am a firm believer that, if you try the strategy of Project Stop and the inappropriate use continues, you need to have a look at other angles. I would not want to limit the options in relation to other precursor material, but I would say that at this stage, given that Project Stop is a new project, it is probably worth waiting and seeing the impacts of that.

MRS BURKE: I want to reflect quickly on the fact that obviously we are dealing with a couple of issues running parallel. One is the criminal aspect and the other one is the primary health care. You mentioned and touched on the power to take blood samples not being available in the ACT; perhaps you could elaborate on that. From your intel, would you say that that is the way we should be heading? Are you calling loudly for it and asking this inquiry to look into that as a means or way of trying to monitor, protect or assist?

Cmdr Connelly: Rather than calling for it, I would prefer the inquiry to keep an open mind on the potential use of that.

MRS BURKE: Okay.

Cmdr Connelly: Because it is an illicit market, it is hard to determine the size of the market, the impacts of the market in relation to health effects and the public policy that should be formed to deal with those. There is some very interesting research that has just been released in South Australia.

I am the chair of the National Drug Law Enforcement Research Fund. It is a commonwealth funded fund; every state and territory police force is represented, as are officials from health, the Attorney-General's Department and the Australian

Customs Service.

A Dr Griggs in South Australia has done some research that we funded in relation to trauma toxicology. It was looking at people presenting to hospitals after things like being assaulted, being in a car accident and so on. It was properly structured research on that basis. I will not start quoting figures without having them in front of me, but they were quite amazing figures—in terms of the percentages of people that were showing signs of amphetamine usage, for instance, and were involved in some sort of trauma incident, be it a car accident, an assault or as a victim of crime. From having the ability to test blood—maybe just in the hospital setting by practitioners—there is a potential to gauge the size of the problem and the potential impacts of the problem on society.

MRS BURKE: I think we do not know about it at this stage. What we are hearing about this morning is sketchy and patchy data collection in terms of the effects. Users will say that there is nothing wrong with them. I was talking to some people from pharmaceutical drug law reform, and it is "I do not have the problem; you do." Some of these people do not even know the effects of the drug on them as human beings.

Cmdr Connelly: That is why, to my mind, keeping that open as a potential—

MRS BURKE: Yes.

Cmdr Connelly: Particularly if there was, for instance, a rise in motor vehicle accidents or motor vehicle trauma.

MRS BURKE: Yes.

Cmdr Connelly: Drug testing for motor vehicles. We have been doing alcohol testing on motor vehicle drivers for many years, with a significant impact on the road trauma statistics as a result of the introduction of random breath testing many years ago. I do not think we should close our minds to it. Equally, I think we need to be alert to the wider issues in relation to those things and ensuring that, if you were, for instance, to go to taking blood samples, there was protection of the rights of the victims or the offenders.

MRS BURKE: Yes.

MS PORTER: A couple of times in your presentation to us, you mentioned the importance of education. I wondered whether that was one of those 36 key indicators—the emphasis on education. You do not have to answer that immediately, but you can in a minute. I would also like to hear your thoughts on what else we can do around educating the public and users about the differences. As you said, it is not necessarily pure; there could be other things that are contained in things that they are taking and people may not be aware of the danger. We have heard from various people beforehand. Also, you were talking about the education of your staff and the development of guidelines. You were saying that currently you are using the guidelines with regard to working with people who are affected by mental health issues. You said that you were developing additional guidelines, and I wonder when those guidelines might be available.

Cmdr Connelly: In answer to your first question, definitely education forms part of our KPIs in relation to crime prevention. We have a strong crime prevention education program which deals with everything from road safety to drug use. The suburban policing strategy, which I think is a legacy of former Assistant Commissioner Audrey Fagan, was really much directed at taking that education process into the high schools and re-engaging with the high school community—particularly youth, who are probably most at risk in relation to these drugs. So we do have a strong education and crime prevention element. We work very closely with the ACT department of health in relation to that process and also with schools.

We have had a very successful program for many years—I think it is a benchmark program in Australia—in the Kenny Koala program, which is aimed at primary school children. That does not have a strong drug message; it is really more of a crime prevention message in relation to road safety, stranger danger and things like that. But I think there is room for development in relation to drug education at the high school level—not so much about the drug itself but particularly about the manufacturing process, the risks involved in how the drug is manufactured, and that you are getting not a licit drug properly produced but an illicit drug that may be produced by someone of any character. There is room to move there.

The second part of your question was in relation to mental illness. It is impossible at this stage—and I think it probably always is going to be impossible—to distinguish between someone who is suffering from a psychotic episode because of mental illness and someone who is suffering from a psychotic episode that is induced by the taking of a drug that has brought on a psychotic effect. When I say that our members have guidelines in relation to mental illness—if they see the signs of the psychosis, they would use those guidelines as the basis to be informed as to how to treat the people.

We are trying—I think the whole law enforcement community is endeavouring—to see if we can reach out to get guidelines that are more specific to psychosis from the point of view of people who are not mentally ill but who are psychotic because of the drug. This is a very, very difficult task. It may well inform the way we can treat people if they are detained, because obviously there are special needs if they are detained and they have taken drugs. Again, though, people will not readily admit to what they have taken unless they are in trouble. We had two deaths last year that I am aware of. Both people were admitted to hospital, both of them admitted to friends that they had taken ice and both of them subsequently died.

One of the problems with ice is this. I do not want to compare ice to heroin, but in many ways, with a person who has died of a heroin overdose, it is easier from a toxicology and post-mortem perspective to determine what they died of. With ice it is not quite that easy, particularly when you get into the realms of poly drug use, where they may have a cocktail of drugs and alcohol that may have subsequently caused their death. So there are issues there.

We are looking to improve our guidelines all the time. At this stage there is no way an untrained constable can determine why a person is acting in a psychotic manner, so they deal with them as they are psychotic.

THE CHAIR: Ms Porter had another question.

MS PORTER: Yes. It is in relation to what you said before about the three young people that were, fortunately, assisted. We have heard from other witnesses how important it is that people, particularly our young people, do not get caught up in this and end up in the criminal system rather than ending up in the health system, which is where they should rightly be situated, because this is a health problem for these young people. As you said, it seemed that this was possibly a one-off—but who knows? From what you have said, I guess that your emphasis is on actually capturing or pursuing people who are manufacturing and trafficking rather than pursuing people who are using, and that your emphasis for people who are using is to assist them and to get medical attention for them. Is that what I am hearing?

Cmdr Connelly: That is correct. And, whilst I do not condone the activity of the three young people, it goes back to our oath in relation to serving the ACT: that we will in the ACT, whilst serving as a police officer in the ACT, serve the community and protect lives. Our primary objective in that particular case was the protection of their lives. There was no criminal action taken against those three young people. Our job is to reduce the harm of these drugs and to disrupt the supply. That is our primary objective. If you look at our drug statistics in relation to drug seizures, you will see that the bulk of those are in relation to the supply of—

MS PORTER: How do we get that message out to our young people? You said that they are not likely to admit what they have taken because they are frightened of maybe getting caught up in the criminal system. For me, that begs a question: if young people are not going to tell you what they are taking because they are scared, how can we get over that?

Cmdr Connelly: That is a very good question. I would say to you that many young people do talk to us about what they have taken, too, so we need to find balance in the debate there. The counter is also true when a drug user has taken a drug and realises that they have been ripped off or been provided with something that they did not ask for. Quite often in drug use you may ask for ecstasy and get GBH. What you see is not what you always get. They do provide us with information. I think you have got to find a balance in that. The education process is part of that. It is about open and frank debates like this one today and it is about people being more aware of what is in the drugs and knowing full well what the likely impacts of those drugs are. Without good research, we will not know that. We can speculate, but we will not know.

I cannot put my hand on my heart and tell you whether there is more ice than amphetamine or normal amphetamine in Canberra. I can tell you that I believe there is more amphetamine than ice at this time, but last week we had a significant arrest with quite an amount of ice. So it can change. At this time I believe, through my reading of our cases, that it is more a case of amphetamine. But what does concern me is the amount of poly drug use; that is where they take anything that they can get their hands on. And—I reinforce this; I will say this till I go blue—it is the alcohol as well.

MS PORTER: Yes.

MRS BURKE: Yes.

Cmdr Connelly: We cannot forget the alcohol in this, because there is such a nexus between the alcohol and the drug and the impacts on their health—the impacts or potential impacts on the health of the public when you mix alcohol and the drug. This is a cocktail that can lead to serious road trauma; it can lead to serious violent crime. I think the word "cocktail" is a good word to use.

MS PORTER: Thank you.

MRS BURKE: I have a very quick question; it is a related issue. It has come to my attention that the psyche of some users—obviously users can be very cunning—leads them to try to use the opt-out mental health defence as a way of not proceeding through the courts. Are you aware of that?

Cmdr Connelly: I would say—obviously I could not or should not comment on the defences raised or matters before the court.

MRS BURKE: No, no.

Cmdr Connelly: What I can say is in general terms: any defence worth their salt will look for the best outcome for their client.

MRS BURKE: I am saying that this is amongst young people. This seems to be feedback I have had from certain young people. It is broader than just ice, of course.

THE CHAIR: Can I interrupt here. It might be an issue. We are going into an area which is off the terms of reference. You might like to raise that in estimates. I think we do need to finish now.

MRS BURKE: Okay. Thank you very much.

MS PORTER: Thank you very much.

THE CHAIR: Thank you, Commander Connelly, for coming along, making your time available and giving us an extensive presentation. It is much appreciated. If we have any further questions, we will be back in contact with you. We will get the transcript to you in the next week or so.

Cmdr Connelly: Thank you for your time.

WIGGINS, MS NICOLE, Coordinator, Canberra Alliance for Harm Minimisation and Advocacy

THE CHAIR: I welcome Ms Wiggins from CAHMA, and will read the card. The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

Before the committee commences taking evidence, let me place on the record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding the publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing. Do you understand all of that?

Ms Wiggins: Yes.

THE CHAIR: Thank you, Ms Wiggins, for making your time available today and also I would like to thank you and CAHMA for putting in an extensive submission to the committee. Would you like to start by addressing the submission that you have made?

Ms Wiggins: Yes, thank you. CAHMA would like to thank you for giving us this opportunity to speak today to the inquiry. CAHMA is the Canberra Alliance for Harm Minimisation and Advocacy. We are an ACT peer based drug user organisation representing illicit drug users on issues of relevance and significance to their lives. CAHMA is auspiced by the Australian Injecting and Illicit Drug Users League, which is the peak national organisation for state and territory drug user organisations in Australia. As a peer based organisation CAHMA is run by and for illicit drug users and for this reason represents an important perspective in relation to this inquiry. CAHMA is currently operating in an unfunded capacity but regardless of this we recognise the importance of contributing the perspective of illicit drug users to this inquiry.

For ease of reference, I have split the submission into a number of areas. The first area is peer education. Peer education has been used in many areas of public health. However, it is in the areas of HIV, hepatitis C and drug use that it has been most widely used, and increasingly so in the past few decades. In Australia peer education is endorsed by both the national HIV-AIDS strategy, the national hepatitis C strategy and locally by the ACT alcohol and tobacco and other drugs strategy, and increased

and improved support for peer based models of service delivery, support and advocacy and community development are a priority action area in the ACT drug strategy.

CAHMA lost its ACT funding at the end of June 2006 and this has left the ACT community without a peer organisation to represent the interests, needs and concerns of illicit and injecting drug users. The ACT is now in a situation where there is a large gap in the provision of peer based services to provide support, information, referral, advocacy and representation for drug users. Our mainstream services, alcohol and drug services, cannot provide the unique style and service delivery and support that is offered by peer organisations. This inquiry into methamphetamine use further highlights this gap and the urgent need for a funded, peer based, drug user organisation.

It is essential that illicit drug users, and in particular methamphetamine users, have input into this inquiry so as to ensure that their voices are heard and that their particular needs are met. During the operation of CAHMA's drop-in centre and education services we were able to work closely with the methamphetamine users to address and assist with their needs, and this close collaborative relationship, based on mutual respect, trust and honesty, ensured that CAHMA's staff were able to gain an insight into and relevant up-to-date information on changing trends and needs of methamphetamine users. Unfortunately, due to the current unfunded position these links have been broken.

In harm reduction, the recurring success of Australian public health strategies has been due to the involvement of affected communities in the planning, delivery and evaluation of education and prevention programs, services and policies and through partnership activities with governments, researchers and health professionals. This strength must be acknowledged, and strategies to work towards achieving partnerships articulated, in the formulation of any ACT amphetamine strategy. Structural and social changes are necessary to engage people who inject drugs and others who use illicit drugs. An enabling environment, including a supportive legal and policy framework, is required to complement harm reduction education and prevention activities.

In February 2007 the Parliamentary Joint Committee on the Australian Crime Commission released their report on the manufacture, importation and use of amphetamines and other synthetic drugs in Australia. CAHMA believes the committee's findings should be drawn upon in the development of any amphetamine strategy in the ACT. In the context of CAHMA's submission focusing on harm reduction we would like to reinforce the inquiry's recommendations 5 and 6 as pertinent to any ACT amphetamine strategy. Recommendation 5 states:

> The Committee recommends that public education and demand-reduction campaigns for illicit drugs be factual, informative and appropriately targeted. The Committee also recommends that such campaigns seek input from young people, and take account of user experiences of amphetamines and other synthetic drugs …

Recommendation 6 states:

> The committee recommends that, in the execution of the National Drug Strategy, harm-reduction strategies and programs receive more attention and resources.

Harm reduction campaigns to raise awareness of drug treatment options should be made available to front-line workers, including needle and syringe program workers. CAHMA endorses this recommendation and calls for leadership on the continued support and adequate resourcing of needle and syringe programs. This strategy has had a significant effect in preventing the transmission of blood-borne viruses amongst people who inject drugs in Australia, including amphetamine users.

Education materials designed for amphetamine users must be culturally relevant and accurately targeted. In order to have maximum effect on risk behaviours and the context of drug use, explicit language and images are warranted for effective communication. Campaigns must be community and/or network driven, developed by the people for whom the message is intended. Peer education involves drug-using peers supporting and educating users to reduce the potential harms associated with drug use. Such an approach builds community capacity and knowledge within specific communities, enabling accurate information to be disseminated in a snowballing manner within the communities. This is a strong argument for the use of peer education, the importance of identity and identification of marginalised populations and the credibility that is generally accorded with both the messenger and the message.

Peer education provides a way to access hidden populations, which is crucial for amphetamine users, given the diversity of communities using these drugs; for example, students, professionals, weekend party-goers, people who have switched from opiate use to amphetamine use et cetera. Each group has its own setting or context of use and knowledge of harm reduction strategies. Other barriers to accessing and educating amphetamine users stem from the illicit nature of drug use and media sensationalism in reporting on amphetamine use. In these instances peer educators are able to engage with and educate their peers in their own settings. It is again a strong argument for the support of peer education as a harm reduction strategy.

On treatment and support issues, the overwhelming lack of access to treatment services, in particular replacement pharmacotherapies for amphetamine users, is a significant issue. Compounding the difficulties in accessing service is the common occurrence of discrimination, poor treatment and service delivery and a general lack of understanding of the needs of drug users.

The 2004 report of the commonwealth Department of Health and Ageing, *Barriers and incentives to treatment for illicit drug users*, highlighted numerous issues that act as barriers to drug users accessing treatments. Illicit users were found to be ill informed about available treatment options, along with having limited information on what services were available in their local area. Information provision by peers, including drug treatment experience of peers, is regarded as an important and credible source of information on drug treatments for drug users. This research again highlights the importance of peer services and provides further argument for the need for a funded peer organisation in the ACT.

The frequent and common experience of discrimination faced by illicit drug users creates a significant barrier to accessing services. The New South Wales inquiry into

hepatitis C related discrimination, the "c-change" report of 2001, found that health professionals and health services were common places for hepatitis C positive drug users to find themselves being discriminated against. Providing peers as front-line workers in services makes a significant contribution to combating discrimination, breaking down barriers between service providers and service users.

Peer organisations and their peer workers assist with dispelling myths and stereotypes of drug users and demonstrate that drug users, as a section of the community, have an important and useful contribution to make in improving health outcomes for themselves and their drug-using peers. Positive treatment experiences by peers can be communicated to those drug users who have never been in treatment and assist in actively encouraging those treatment-naive drug users to enter into treatment.

Once drug users enter into treatment regimes, ongoing support and advocacy provided by peers can again provide positive encouragement and support to increase retention. The support needs of methamphetamine users can be extremely complex and require the experience and understanding of peers who have similar experiences. This intimate knowledge and understanding of the issues that affect drug users can provide the required extra support and empathy that is lacking from those health professionals whose only knowledge of the issues is learnt through the academic environment.

Drug users are particularly sensitive and aware of the difference between health professionals with personal experience and knowledge and those without, and these relations have a dynamic where there is a power imbalance, an "us and them" mentality, influencing the construction of invisible walls that impact on interactions. Drug-using peers have the extra credibility, trust and respect that cannot be established in the usual client-health worker relationship and, although there are many extremely professional, knowledgeable and experienced health professionals in the ACT, they cannot achieve this standard of rapport, trust, mutual respect and empathy that is the core feature of a peer interaction.

The support and treatment needs of methamphetamine users need to be established by conducting a thorough research project that can identify what is and is not needed for methamphetamine users in the ACT. There is no one-size-fits-all model that can be implemented as there is no one type of methamphetamine user. A survey to establish evidence based priority needs of users, while identifying the differing groups that use methamphetamines, needs to be given priority. This evidence can then be used to establish programs and projects that can meet the needs of these priority groups. Many of these methamphetamine users are hidden populations, and peer networks are the only way to access these groups. Additionally, drug users can be suspicious of surveys and questionnaires, so utilising established networks of peers can offer support, information and advocacy in order to facilitate participation in research by methamphetamine users.

On law enforcement, law enforcement activities and associated legislative changes must occur with due regard to unintended consequences, anecdotal reporting as appropriate and evidence based policy and research. For example, it is important that any discussion around the removal of smoking implements acknowledges the practice as a safe alternative to the means of administering the drug; the potential shift from smoking to injecting; the risk of blood-borne virus transmission and other injecting

related harms; the use of police sniffer dogs at night clubs, et cetera, and the detrimental effect to harm reduction strategies in that people who use these illicit drugs may place themselves at an increased risk of overdose by consuming all their drugs in one go before attending the night club or swallowing all their drugs in one go while a raid is in progress.

On workforce development, the different social and health issues encountered by methamphetamine users need to be well understood and effectively dealt with by the ACT drug and alcohol sector and by the ACT mental health sector. The current situation appears to reflect a very poor understanding by many health professionals of the health and social needs of this particular group of drug users. The use of amphetamines and methamphetamines is not a new phenomenon, as these drugs have been used illicitly for many years. The major difference over the last few years is in the changes in market forces where availability of different forms of amphetamines and methamphetamines has changed.

The other significant factor is the response by the media with the agenda of creating a crisis and drama for the purpose of selling newspapers. Research has shown that there has not been the dramatic increase in use that is being portrayed in the media, and there has not been a significant rise in presentations of psychosis related to methamphetamine use. It is important that health professionals working in the sector do not fall into the trap of believing these exaggerated reports and indulge in the emotive language being used by the media. These types of response do nothing to improve the situation or assist those affected by the overuse or problematic use of the drug. Exaggerated or emotive language only serves to further isolate and stigmatise users and their families.

Workforce development for front-line workers should be focusing on the very basic skills of communication with drug users. Integral to communicating effectively with drug users is challenging personal prejudice and stereotypes that individual health workers may have towards drug users. Having developed these skills, the many other skills needed and training requirements will follow on. Communicating with and showing understanding, empathy and respect for methamphetamine users follows the same basic principles as with interactions with any other type of illicit drug user. It is unfortunate that many AOD workers seem to have limited skills in this area of communicating with illicit drug users. The skills and knowledge needed to work with methamphetamine users have many similarities with those needed to work with users of other drugs.

Due to the negative mental health consequences for methamphetamine users of overuse or extended use, AOD workers need a good understanding of basic mental health first aid, which is offered as a training for workers in this sector in the ACT. Given the strong relationship between drug use and mental health issues, or co-morbidity, it would seem necessary that this again would be a basic requirement for AOD workers, regardless of the types of drugs used by their clients. Rather than just looking at the lack of skills or training in the area of methamphetamines for AOD workers, it should be looked at as a lack of overall skills and training needed to deal with all drug-using clients regardless of the drugs they use.

Of course, additional information on basics such as the pharmacological effects of

methamphetamines, health consequences particular to methamphetamine use and the available, or lack of, treatments should be offered in training to front-line workers. But the bigger issue and need is that AOD staff are not well trained or skilled to address the needs of drug users in general. Training and information sessions provided in the past by CAHMA to AOD service providers have proved very successful and well received, with numerous requests for future sessions.

More importantly and more difficult to address are the inherent prejudice and discriminatory attitudes that are unfortunately held by AOD workers in many agencies in the ACT. These beliefs and attitudes need to be challenged and changed in order for AOD workers to increase their skills and knowledge in areas such as improved communication. Consumers and peer organisations are ideally placed to provide training and skills development in assisting AOD workers to recognise and address ingrained discriminatory attitudes.

Therefore, in working with challenging amphetamine users, workers in front-line services, including needle and syringe programs, require training or retraining on defusing potentially difficult situations, basic communication skills to assist workers to identify the ways to engage with those with chaotic use, the correlation between amphetamine use and mental health concerns, and treatment options, including interactions and adverse reactions.

THE CHAIR: Thank you for that.

MS PORTER: I have just a quick question; I know we are running late.

THE CHAIR: I think the next witnesses are running late as well.

MS PORTER: That is good then. I just want to go right back to what you were saying about education, because education has been quite a theme during the hearings. You mentioned that education material needed to be culturally appropriate. Could you enlarge on that a bit more, please?

Ms Wiggins: Okay—an understanding of the context that people are using drugs in; an understanding of the different cultural groups that use methamphetamines and the reasons people are using them; that there is such a diverse group of methamphetamine users from professionals to students, to people bingeing just on weekends, to people with chaotic or problematic use; so to be appropriate and targeted at all those different groups.

THE CHAIR: Following on from that, how would you like to see the education campaigns targeted? You have talked about peer based education that they are aware of. Can you give me and the committee some ideas on ways that that can be done?

Ms Wiggins: Sure, involving affected communities; the messenger is the same person who the message is intended for; having amphetamine users as part of the process of developing those education messages so that they are specifically targeted and understood by amphetamine users, that they use the language that amphetamine users understand and they are put into the context that amphetamine users understand; so, basically, developed by drug-using peers for drug-using peers.

THE CHAIR: I appreciate that. Evidence was given earlier today, however, and has been talked about quite a bit, that users of methamphetamines, and I think to a lesser extent amphetamines, do not see that they have a problem, so they are not presenting to medical facilities. If they do not think that they have a problem, why would they be inclined to go and speak to other users about the concerns with methamphetamines and ways to reduce the potential harm from it if they do not believe that there is any potential harm from it? How do we get that message across, I suppose?

Ms Wiggins: I disagree that people do not see that they have a problem. People who are injecting, particularly, are well aware of the harms associated with injecting and the blood-borne virus risk. We are convening a group next week of 10 amphetamine users to discuss developing an education message and poster, and they were really quite easy to round up. They are very interested in being part of developing that education message. Perhaps people who have problematic use are not necessarily admitting that they have a problematic use, but they do recognise that not sleeping, not eating very well and being suspicious and paranoid represent a problem.

We have had numerous successes in the past of getting those people involved in at least campaigns around giving advice on reducing use, how to deal with not sleeping well or what foods people can eat if they are binge using and they are not eating very much. People have been very eager to participate in those, to give suggestions of what they have done in the past, what sort of foods they can eat that are not heavy on their stomach and that are healthy. Also, amphetamine users who are not necessarily problematic amphetamine users but occasional users are interested in being part of developing messages around blood-borne viruses.

MS PORTER: So, given all of that and you think you have got people that would be willing to develop, or are currently developing, those messages, what route would you suggest is the best route? You talked about a poster, but what other ways would you see as effective to use to put the message out there?

Ms Wiggins: Information pamphlets and resources can be developed. Workshops are a really effective way to get health education messages across. It is a good way of engaging with people in an informal environment where you set it up like a lunch and as part of that you also have health education messages. So it is not just specifically focused on "this is somewhere where you're coming along to learn" and they do not have "do not use drugs" messages rammed down their throats or whatever—people can be suspicious of that—but workshops where you have a lunch and informal discussions.

THE CHAIR: So you are talking about the harm minimisation messages, rather than abstinence messages, which is understandable, given the setting.

Ms Wiggins: Yes, and it can be both. But people are suspicious if you start talking about abstinence. They are concerned that that is going to be the aim of the workshop or the pamphlet and people are not even going to pick it up or attend. But if you can have an education message in whatever format, or a workshop, that is focusing on just health messages—healthy eating, getting some sleep, strategies to reduce use—from that people can move further down the line towards thinking about abstinence.

MRS BURKE: Thank you very much, Nicole, for the comprehensive presentation today. Just on a practical note, you say that you are not being funded any more by the government. All this valuable information—are you feeding it to anybody? Are you tapping into, say, the federal government's non-government organisation treatment grants program, because they are keen for NGOs to be involved?

We have got your evidence today, which is great, but obviously you can see a future for where you are going. I am just wondering, particularly in relation to ice and the dynamic of that, what your position is in terms of CAHMA and how you are going to continue on to do the work and research.

Ms Wiggins: We are currently working with volunteers. We are negotiating a small funding contract with ACT Health for the next financial year, but it is not going to be enough to restart the organisation. But, yes, we certainly are busy writing submissions and investigating different funding sources.

MRS BURKE: Did you know about the federal government's non-government organisation—

Ms Wiggins: Yes, we did actually have funding through that. CAHMA had funding through that.

MRS BURKE: Okay. It is just that you are working so hard out there and—

Ms Wiggins: Yes. There are numerous funding sources that we are investigating and we have madly been writing lots of submissions.

MRS BURKE: Thank you for taking a very balanced approach.

THE CHAIR: Okay. I understand our next lot of witnesses have arrived, so I once again thank you for your extensive submission and also for giving up your time to appear today. You have provided some valuable input and we appreciate that. If we have any further questions we will get back in contact with you. Also, for your information, the transcript of evidence will be sent to you in the next three days, so that you can just check it to make sure that you have been recorded correctly and that you have not been quoted incorrectly.

HELLEC, MS PAULINA, Coordinator, Women's Information, Resources and Education on Drugs and Dependency, Toora Women Inc
TRAJKOVSKI, MS BRANKA, Coordinator, Toora Women Inc—Lesley's Place

THE CHAIR: While you are taking your seats, I will start reading the card.

The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request, the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing. Do you understand all that?

Ms Hellec: Perfectly.

Ms Trajkovski: Yes.

THE CHAIR: Excellent. Can you start by stating your names and the capacity in which you appear today.

Ms Hellec: I am Paulina Hellec and I work at WIREDD, Women's Information, Resources and Education on Drugs and Dependency. I am the coordinator there.

Ms Trajkovski: I am Branka Trajkovski. I work at Lesley's Place, which is a service part of a large organisation, Toora Women Inc. I am coordinator there.

THE CHAIR: I start by placing on record the committee's thanks for your submission. It was certainly an interesting submission to read, especially from the perspective of women using drugs, specifically crystal methamphetamine. I should say that, while this inquiry is looking at the issue of ice, we have looked into issues about methamphetamines and amphetamines generally. That came up in our earlier discussions today. Would you like to start by making a statement or do you wish to go straight to questions?

Ms Hellec: We would like to make a statement.

THE CHAIR: Sure.

Ms Hellec: The reason why we are here, as you already said, is that we want to give a voice from women, and especially talk about some very small research done in women that is gender specific. There is Toora Women Inc and the two drug and alcohol services in the ACT. Basically, one may provide a service just for gender specific drug and alcohol and other dependencies. That is the reason we are here and that is the reason we want to set up a voice for women. We just have inquired of a few women. Most of the women do not want to fill in surveys and all that stuff. Most of the things have been done anecdotally—and a little bit of a survey. Do you want to say anything else, Branka?

Ms Trajkovski: I agree with what Paulina said.

THE CHAIR: Mrs Burke has to leave at 12.30.

MRS BURKE: Yes, and I apologise for that.

THE CHAIR: So I might ask her to start the questions.

MRS BURKE: Thank you, chair. You raise a very important issue in regard to gender specificity—not that we want to exclude men, but we really do have to look at the impacts on males as opposed to females. That is a really good point that you make today, and it is one which probably has not been made by other groups—that the effects will be different; hormonally we are different.

I was interested in talking to you about your outreach support and a few things to do with that: the numbers of people that are coming through your particular organisations; the age group; single, married or otherwise—what sort of category they are in. That is just trying to get a handle on where there seems to be the biggest problem or issue. Do you know of any causal problems the women users are turning to ice for? And then, out of that bit of doom and gloom, you also offer an excellent outreach support for people wanting to rehabilitate and get back onto the straight and narrow. Would you like to make any comments on that?

Ms Hellec: Yes. Maybe we will talk differently.

Ms Trajkovski: Yes.

Ms Hellec: WIREDD is not residential; it is a kind of drop-in centre. It is close here in Civic because this is where most of the drug use is happening and people are coming to use or buy. The women who access us around a year—the drop-in is around 2,000 women, but not all of them come to use ice; it is different stages. We work in harm minimisation, so women come to WIREDD in any state, usually attending intoxicated—whatever they want to do. We work with that frame of the philosophy of a feminist organisation and we are aware where women are at. We work with women and what the women want at that time—if for them it is the work, or they need to do something with ice, or they want to do something about their trauma. The way we work is—trauma impacts a lot of women's lives. This is most of the reason why women use this. Ninety per cent of the women who come to access us

have been incest survivors—

MRS BURKE: Sorry, they are?

Ms Hellec: Sexual incest survivors. And also 80 per cent of the women have experienced domestic violence. That is mostly the way we work. The reason why women use is mostly about the trauma they have experienced in their lives.

MRS BURKE: What sort of age group?

Ms Hellec: The age group is around—the youngest one maybe who comes to our door has been 16 and the oldest one has been 75. The way we work is also that we work with women who—someone in their families has a problem, or friends. Some come not because they have a problem but because their partner, their children or their friends have a dependency. With the ice, we only have a few women who acknowledge—who disclose to us they have been using ice. Most of them said it was a problem with lack of information—they did not have enough knowledge before they start using. Because it was very cheap and easy to get, they just switched from heroin or speed to ice. I do not know if I have answered your question.

MRS BURKE: You did, thank you. I have a second one, if I may. In your submission you talked about education, support and treatment for users. Backing onto what you have just said, it was revealed, and it therefore is necessary that we do more education, that women thought the consequences were minimal—that there was no information on how to use it safely and no mention of possible mental health effects. Is that what you are finding on the street and around the traps—that the message being sent about ice is that it is okay to use it, that it will not do you much harm? Is that what women are believing? Is that how they are being sold it? Do you know that?

Ms Hellec: Women are believing it is easy, cheaper. That is a fact—it is cheaper to use. And, yes, they were not aware—and also of the consequences.

MRS BURKE: They were not aware of the consequences?

Ms Hellec: No.

MRS BURKE: Thank you.

THE CHAIR: Do you want to add to that?

Ms Trajkovski: Yes. I would agree with that. When women started using, they thought, "This is not going to have such a consequence as the other drugs."

MRS BURKE: Why did they believe that? Were they told that or did they just assume?

Ms Trajkovski: They believed it is like that. When I did the survey with a few of the women who said that this was their problem, they were saying that actually there was not much information there available. I could just add that women that I spoke with had a poly drug problem; it was not just ice as an issue. When one is using whatever

and cannot get their drug of preference, you will try whatever is available and see how you go. Basically there was no information that you might end up in psychosis. It was difficult for them to even recognise that what was going on was actually psychosis. One of the women said that it took three psychoses for her to realise, "Oh, this is actually drug related."

MRS BURKE: Not good.

Ms Trajkovski: To realise, "I am not going mad."

MRS BURKE: So none of them asked the question before they purchased the drug—as to the effects of the drug?

Ms Hellec: Maybe because also there was not much information before.

Ms Trajkovski: Yes.

Ms Hellec: Now it is the media—"ice is dangerous"; ice is this and that. It is just—

MRS BURKE: More awareness.

Ms Hellec: It turns us to panic—"People are using ice; maybe it is not okay to treat this person." But it is not that way. There is not clear information of the consequences and effects.

Ms Trajkovski: Sorry, could I interrupt. I remember talking with one of the women who said that it would be beneficial if there were available stories of others who have been using—about how it affected them.

MRS BURKE: Yes.

Ms Trajkovski: So people can recognise "this might actually happen to me" or "this is actually what did happen to me".

MRS BURKE: So informed choices.

Ms Trajkovski: Yes, just to have the stories about how ice is affecting people.

THE CHAIR: In your submission you talked about more information going out there. So stories of—

Ms Trajkovski: Other users.

THE CHAIR: Stories of others' experiences would be one way.

Ms Trajkovski: Yes.

MRS BURKE: Testaments, yes.

THE CHAIR: But the issue has come up—we talked about this with the last witness,

who did not actually agree, but it was the submission that we received from the government—that a lot of people using ice and methamphetamine do not think that they have a problem.

MRS BURKE: Yes.

THE CHAIR: So the problem is how we actually get that information out there to them in the first place—for people who do not necessarily believe that there is a problem with using this particular drug.

Ms Trajkovski: Well—

THE CHAIR: What ideas do you have? What inspiration do you have for us?

Ms Trajkovski: Just from talking to a few of the women, obviously there are consequences—and affecting physical and mental health. I have information here from the alcohol and drug council of Australia that statistically shows that the increase in methamphetamine usage is huge and that quite a big percentage of people end up in the psych wards due to psychosis. I have a copy of this I can give to you.

THE CHAIR: Yes.

MS PORTER: Thank you.

Ms Trajkovski: That supports that this is happening. Maybe people are not—I do not know; are they realising that their mental health is affected by the drugs or is it previous mental health issues? The data says that 10 per cent of people who are using dexamphetamine—of those who ended up in hospital, 10 per cent did have prior mental illness, but the rest did not. I think data like that—out in a really easily readable form—can say that it is affecting mental health, that people might get a feeling of persecution or a feeling that you are untouchable. One woman said that when she used—when she was on a high—she was at Northbourne Avenue near Civic and she felt that she could just close her eyes and cross the street without looking. It is that kind of feeling.

THE CHAIR: She thought she was immune to being injured.

Ms Trajkovski: Basically, but you can get killed. Another one said that once when she was on a high she was at home and started having obsessive thoughts about doing armed robbery. She had not done one in her life, but this was going on in her head. As prevention, she just locked herself in the house and spent hours sitting staring at the TV—and prevented herself from getting out and doing what was going on in her head. She was the one who said to me that she went through this experience three times to realise that it was actually drug related, that she was not going mad. The first thing is to think, "I'm really going mad."

Ms Hellec: And there is also the fact that in any drugs the people are in different stages. There are people who always said, "I do not have a problem with the drug." How we work with those women is to engage them, so they feel like they have a place where, if they have a problem, they can come and we are not going to be judgmental.

There is support; there are ways. You do not need to fill out thousands of forms to be part of our system and our organisation. That is the way we explore with the women where they said, "I do not have a problem with this. I just come." That is okay. "Today you feel like that, but when you are telling me that your life is becoming unmanageable and you are feeling that, that is part of what is happening with any drugs anyway." That is another way. We see with women it works really well when you work with them—you do not have much of an agenda—to just give all the support—"You need to change your life and you have the problem"—just coming from themselves.

MS PORTER: You said in your submission that one of the things that you think there is a need for is a safe place for women when they need to be admitted to hospital. Are you saying that it is not safe at the moment?

Ms Hellec: In the ACT there is not a detoxification place just for women. It is safe in that way. It is safe, but women feel safer if there is an only-women kind of space. Also, women sometimes do not want to go to any place. If they have children, with whom will the children stay? If there is a place where women can go and have a place they can trust to leave their children at, that will be a very good way to start. Some of the women who access us do not go to the other services because sometimes their partners or their ex-partners are there. They feel like having us away with only women—they feel that it is safe itself. That is what women express.

THE CHAIR: Thank you. I do not have any further questions. As I said before, thank you very much for putting the effort in and also, particularly, for taking time out of what I am sure is a very busy day for you both. We do appreciate the fact that you have come in and spoken to us today. If we have any further questions, we will get back to you. In the next two to three days you should receive a copy of the transcript, which you should check to see that you have not been misquoted.

Ms Hellec: Okay.

THE CHAIR: Hansard do their best, but sometimes they do not pick up on the words, especially when I mumble.

The committee adjourned at 12.37 pm.