Rural & Regional Affairs and Transport Legislation Committee

ANSWERS TO QUESTIONS ON NOTICE

Hearing into Transport Security Amendment (Serious or Organised Crime) Bill 2016

Infrastructure and Regional Development

Question no./reference: Consultation

Program: NA
Division/Agency: Office of Transport Security
Topic: Transport Security Amendment (Serious or Organised Crime) Bill 2016 [Provisions]
Proof Hansard Page: 10, 12, 13, 14, 19

Questions raised by Acting Chair, Senator Sterle, Glenn, and Senator Rice, Janet

1. **Senator Sterle** asked the Department of Infrastructure and Regional Development (the Department) to provide:
   a. a comprehensive list of consultation (page 10);
   b. membership of the Maritime Industry Security Consultative Forum (page 12);
   c. confirmation of whether the Maritime Union of Australia raised any issues with the serious and organised crime policy during consultation (pages 13, 14); and
   d. membership of the Oil and Gas Security Forum (page 19).
2. **Senator RICE** asked how many stakeholders are involved in the industry forums (page 14).

Answer:

1. **Attachment A** outlines industry consultation on discussion papers reviewing the aviation and transport security identification cards (ASIC and MSIC) eligibility criteria.

2. **Attachment B** outlines details of the consultative forums, including membership, where the proposal to amend the ASIC and MSIC eligibility criteria was the subject of formal discussion.

3. **Attachment C** outlines consultation the Department has conducted with the Maritime Union of Australia to review the ASIC and MSIC eligibility criteria, feedback received and any action by the Department in response to this feedback.

Attachments
Attachment A – Policy development consultation
Attachment B – Transport security forums
Attachment C – Maritime Union of Australia consultation

Policy development consultation

Industry Discussion Papers

- December 2012: *Assessment of relevant offences in the ASIC and MSIC Schemes: Discussion paper*.
- January 2014: *Assessment of relevant offences in the ASIC and MSIC Schemes: Options paper*.
- March 2014: *Comparison between proposed and current list of Aviation Security Relevant Offences and Maritime Security Relevant Offences*.

Discussion papers where issued via email to members of the various industry consultative forums, including:

- aviation specific forums such as the Aviation Security Advisory Forum (ASAF) and Regional Industry Consultative Meetings (RICM); and
- maritime specific forums such as the Maritime Industry Security Consultative Forum (MISCF); and the Oil and Gas Security Forum (OGSF).

Please refer to Attachment B for membership of each consultative forum.

Discussion paper consultative forums

The Department held two ASIC and MSIC consultative forums to specifically discuss recommendations identified by the 2011 Parliamentary Joint Committee and Australian National Audit Office Report reports[1], and proposals presented in the Department's 2012 discussion paper, *Assessment of relevant offences in the ASIC and MSIC Schemes*. Attendees are noted overleaf.

ASIC/MSIC Stakeholder Forum (this forum is no longer active)		
Date	**Location**	**Attendees**
19 February 2013	Perth	26
1 March 2013	Sydney	30*

* Attended by representative of the Maritime Union of Australia.

Outcomes from these forums noted:

- The discussion paper and eligibility criteria did not represent a final policy position. Consultation would be ongoing.
- The ASIC and MSIC schemes would maintain their original purpose of prevention of unlawful interference with aviation and maritime transport.
- Review of the eligibility criteria was aimed at establishing targeted criteria to improve security outcomes for the aviation and maritime industries.
- It was noted the eligibility criteria (as provided in the discussion paper) would likely result in a reduction of people found ineligible due to the removal of some irrelevant and minor offences, and the introduction of a minimum sentence threshold.
- Agreement was made to distribute material that highlights the exact differences between the current and proposed eligibility criteria.
- Other key discussion outcomes noted:
    - There was general support for the proposal to harmonise the ASIC eligibility criteria with the MSIC eligibility criteria;
    - there was general support for the proposal to align the appeal processes for both schemes;
    - there was a general understanding of the tiers of offences, and that these tiers should be targeted to identify relevant offences. Some participants queried the necessity of a tiered approach (presented initially by four tiers). It was discussed that reducing the number of tiers would lead to relatively minor offences creating ineligibility–this was not a preferred outcome from a revised criteria;
    - it is important to ensure eligibility criteria are clear, refined and targeted to preventing unlawful interference with aviation and maritime transport;
    - there was general agreement to remove the pattern of criminality test from the Aviation Transport Security Regulations 2005 or revisit the parameters of this test, and also agreement that the MSIC eligibility criteria should continue to not involve a pattern of criminality component; and
    - the comments from the forums will be taken into consideration and included in a further options paper.

After 1 March 2013, consultation continued via the Department's established sector specific consultative forums e.g. ASAF, RICM, MISCF and OGSF. No further policy specific forums were conducted.

[1] Australian National Audit Office Report, 2011, *The Management of the Aviation Security Identification Card and Maritime Security Identification Card Scheme*;
Parliamentary Joint Committee on Law Enforcement, 2011, *Inquiry into the adequacy of aviation and maritime security measures to combat serious and organised crime*

Attendance to ASIC/MSIC Stakeholder Forum (February & March 2013)	
Industry	Newcastle Airport
Airport Security	NT Airports
Asciano	Nth Qld Airports
Australia Marine Services	Patrick
Australian Shipowners' Association	Perth Airport
Australian Workers' Union	Port of Brisbane
Ballina Airport	Ports Australia
Board of Airline Representatives of Australia	Qantas
Brisbane Airport	Queensland Airports
Broome Airport	Rio Tinto
Canberra Airport	Shipping Australia
Chubb Fire & Security	Skywest Airlines
Dampier Port Authority	Sydney Airport
DP World	Sydney Ports
Esperance Port	Teekay Shipping
Fremantle Ports	Toll Priority
Geraldton Airport	Transport Workers Union
Geraldton Port Authority	United Voice
Gold Security Group	Veritas
Hobart Airport	Woodside Energy
Hutchinson Ports	**Government**
Maritime Union of Australia	AusCheck – Attorney General's Department
Melbourne Airport	Office of Transport Security – Department of Infrastructure and Regional Development
Multicard	

ATTACHMENT B

Transport security consultative forums

The Department of Infrastructure and Regional Development holds a range of consultative forums attended by industry and government agencies. Forums are held on a regular or semi-regular basis and are used to ensure consistent and comprehensive stakeholder engagement. The forums listed below are those for which the aviation and maritime security identification card eligibility criteria – or associated policy – was listed as a formal agenda item.

Date	Forum	Location	Attendees
Aviation Security Advisory Forum (ASAF) – Aviation			
22 March 2012	ASAF	Gold Coast	41
12 July 2012	ASAF	Sydney	47
25 October 2012	ASAF	Melbourne	46
20/21 March 2012	ASAF	Hobart	44
11 July 2013	ASAF	Brisbane	43
3 December 2013	ASAF	Sydney	50
8 April 2014	ASAF	Perth	45
24 July 2014	ASAF	Canberra	40
1-2 December 2014	ASAF	Sydney	47
25 February 2015	ASAF	Victoria	45
30 July 2015	ASAF	Adelaide	43
17 November 2015	ASAF	Brisbane	46
8 March 2016	ASAF	Canberra	46
Issuing Body Forum (IB Forum) – ASIC and MSIC Issuing Bodies			
21 to 22 May 2015	IB Forum	Brisbane	34
26 June 2015	IB Forum	Perth	26
19 November 2015	IB Forum	Perth	19
4 December 2015	IB Forum	Sydney	30
Maritime Industry Security Consultative Forum (MISCF) – Maritime			
16 February 2012	MISCF	Brisbane	58
25 July 2012	MISCF	Adelaide	50*
27 March 2013	MISCF	Sydney	49*
29 October 2013	MISCF	Melbourne	55*
26 March 2014	MISCF	Brisbane	48*
24 September 2014	MISCF	Adelaide	41*
25 March 2015	MISCF	Melbourne	42*
23 September 2015	MISCF	Fremantle	45*
Offshore Oil and Gas Forum (OGSF) – Oil and Gas			
15 May 2013	OGSF	Canberra	53*
19 November 2013	OGSF	Melbourne	54*
17 June 2014	OGSF	Darwin	43*
25 June 2015	OGSF	Perth	52
4 - 5 November 2015	OGSF	Brisbane	51
Regional Industry Consultative Meetings (RICM) – Aviation			
12 November 2012	RICM	Melbourne	50
24 August 2012	RICM	Sydney	51
19 April 2012	RICM	Adelaide	57
8 August 2013	RICM	Perth	35
18 April 2013	RICM	Brisbane	41
12 December 2013	RICM	Melbourne	47
10 April 2014	RICM	Adelaide	47
7 August 2014	RICM	Canberra	40
13 November 2014	RICM	Canberra	50
26 February 2015	RICM	Victoria	41
25 August 2015	RICM	Adelaide	49
10 December 2015	RICM	Brisbane	44

*Attended by representative of the Maritime Union of Australia.

Membership of transport security consultative forums

Attendance to each of these forums is subject to availability. As such, some members may not attend all meetings. All members, regardless of attendance, are issued with agenda papers prior to each meeting, and are sent copies of meeting outcomes and any material presented during each forum (i.e. presentations slides).

Other government departments or agencies may attend by request or invitation.

Aviation Security Advisory Forum (ASAF) – Aviation	
Industry	Queensland Airports
Adelaide Airport	Regional Aviation Association of Australia
Australian Airports Association	Regional Express
Australia-Pacific Airports Corporation	Sydney Airport Corporation
Board of Airline Representatives of Australia	Tigerair
Brisbane Airport	Virgin Australia
Cairns Airport	**Government**
Canberra International Airport	Airservices Australia
Cobham Aviation Services	AusCheck – Attorney General's Department
FedEx International Security	Australian Border Force
Gold Coast Airports	Australian Federal Police
Hobart International Airport	Civil Aviation Safety Authority
Northern Territory Airports	Department of Agriculture
Perth Airport	Department of Immigration and Border Protection
Qantas	Office of Transport Security – Department of Infrastructure and Regional Development

Issuing Body Forum (IB Forum) – ASIC and MSIC Issuing Bodies	
Industry	Multicard
1-Stop Connections	Newcastle Airport
Adelaide Airport	Perth Airport
Aerodrome Management Services	Pilbara Ports Authority
Airport Security Pty Ltd / Security ID	Port of Brisbane
Alice Springs Airport	Programmed Marine
Asciano / Patrick	Programmed Marine
Ballina Shire Council	Qantas
Brisbane Airport	Royal Flying Doctor Service
Broome International Airport	Security ID - Airport Security
Canberra International Airport	Shire of East Pilbara
Chubb Electronic Security	Southern Ports Authority - Port of Albany
City of Greater Geraldton	Southern Ports Authority - Port of Bunbury
Clientview	Southern Ports Authority - Port of Esperance
Darwin International Airport	Sunshine Coast Airport
DP World Australia	Sydney Airport
Fremantle Ports	Toll
Gladstone Ports Corporation	Veritas Engineering
Gold Coast Airport	Virgin Australia
Gold Security Group	Whitsunday Regional Council
Hobart Airport	**Government**
Hutchison Ports Australia	AirServices Australia
Identiv Australia (Multicard)	AusCheck – Attorney General's Department
Kalgoorlie-Boulder Airport	Australian Border Force (formerly Australian Customs & Border Protection)
Mackay and Cairns Airports	Civil Aviation Safety Authority
Melbourne Airport	Office of Transport Security – Department of Infrastructure and Regional Development
Midwest Ports Authority	

Maritime Industry Security Consultative Forum (MISCF) – Maritime	
Industry	Gippsland Ports
Asciano	Gladstone Ports Authority
ASP Ship Management Group	Inpex Australia
Australian Shipbuilding & Repair Group	Kimberley Ports
Australian Shipowners Association	L-3 Oceania
Australian Submarine Corporation	Maritime Industry Australia
Caltex Australia	Maritime Union of Australia
Carnival Australia	**Government**
Chevron Australia	Attorney-General's Department
Darwin Port Corporation	Department of Agriculture and Water Resources
DP World	Department of Immigration and Border Protection
Flinders Ports	Department of Infrastructure and Regional Development
Fremantle Ports	Maritime Border Command – Australian Border Force
Geelong Ports	Office of Transport Security – Department of Infrastructure and Regional Development

Oil and Gas Security Forum (OGSF) – Oil and Gas	
Industry	Vermilion Oil and Gas Australia
AGL Energy	Viva Energy Australia
Arrow Energy	Woodside Energy
Australian Petroleum Production and Exploration Association	**Government**
Beach Energy	Attorney-General's Department
BHP Billiton	Australian Border Force
BP Australia	Australian Federal Police
Buru Energy	Australian Maritime Safety Authority
Caltex Australia	Department of Defence
Chevron Australia	Department of Industry, Innovation and Science
ConocoPhillips Australia	Department of Infrastructure and Regional Development
Darwin Port Corporation	Department of the Prime Minister and Cabinet
ExxonMobil	National Offshore Petroleum Safety and Environmental Management Authority
GDF SUEZ Bonaparte	NT Department of Mines and Energy
GLNG Operations	NT Department of the Chief Minister
INPEX	QLD Department of Energy and Water Supply
JKC Australia LNG	Queensland Police Service
Oil Search	VIC Department of Economic Development, Jobs, Transport and Resources
Origin Energy	Victoria Police
QGC	WA Department of the Premier and Cabinet
Quadrant Energy	WA Department of Transport
Santos	Western Australia Police
Shell Australia	Office of Transport Security – Department of Infrastructure and Regional Development
Teekay Shipping (Australia)	

Regional Industry Consultative Meetings (RICM) – Aviation	
Industry	Longreach Airport
Adelaide Airport Limited	Mackay Airport
Aerodrome Management Services	Maranoa Regional Council**
Airlines of Tasmania	Melair - Launceston Airport
Albury Airport	Mid-Western Regional Council**
Albury City Council**	Mildura Airport
Alliance Airlines	Moranbah Airport / BHP Billiton Mitsubishi Alliance
Argyle Diamonds	Mount Isa Airport
Armidale Regional Airport	MSS Security

Australian Airports Association	Network Aviation - A Qantas Group Airline
Avalon Airport Australia	Newcastle Airport
Ayers Rock Resort	Nhulunbuy Corporation
Ballina Shire Council	Norfolk Island Airport
Bankstown Airport	Northern Territory Airports
Barcaldine Regional Council**	Orange City Council**
Bathurst Regional Council**	Paraburdoo - Aerodrome Management Services
BHP Billiton	Paraburdoo Airport
Brisbane Airport Corporation	Parkes Shire Council**
Broome International Airport	Perth Airport
Bundaberg Regional Council**	Port Augusta City Council**
Burnie Airport	Qantas
Busselton Airport	Queensland Airports
Cairns Airport	Regional Airport Security
Ceduna Shire Council**	Regional Express (Rex)
Central Highlands Regional Council**	Rio Tinto
Christmas Island Airport	Rockhampton Regional Council**
City of Albany	Shire of Carnarvon
City of Greater Geraldton	Shire of East Pilbara
City of Kalgoorlie-Boulder	Shire of Esperance
Clarence Valley Council**	Shire of Exmouth
Cloncurry Shire Council**	Shire of Jerramungup
Cobham Aviation Services	Shire of Meekatharra
Coffs Harbour City Council**	Shire of Ravensthorpe
Coffs Harbour Regional Airport	Skippers Aviation
Devonport Airport	Skytrans
Devonport Airport / Tasmanian Ports Corporation	Skywest Airlines
District Council of Coober Pedy	SNP Security
District Council of Lower Eyre Peninsula	Startrek Express
Dubbo City Council**	Sunshine Coast Airport
Eurobodalla Shire Council**	Tamworth Regional Airport
Flinders Council**	Tamworth Regional Council**
Forte Airport Management	Toll
Fraser Coast Council**	Town of Port Hedland Council**
Gladstone Regional Council**	Townsville Airport
Greater Taree City Council**	Vincent Aviation Australia
Hamilton Island	Wagga Wagga City Council**
Hawker Pacific	Warrnambool City Council**
Horn Island Airport	Warrumbungle Shire Council**
Inverell Shire Council**	Wellcamp Airport
ISS Facility Services	Westralia Airports Corporation
Jandakot Airport Holdings	Whitsunday Regional Council**
Karratha Airport	Whyalla Council**
Katherine Town Council**	Wiluna Shire
King Island Council**	**Government**
Kununurra Airport	Australian Federal Police – national representative
Launceston Airport	Australian Federal Police – state specific representative
Learmonth Airport	Airservices Australia
Lismore City Council**	Office of Transport Security

** As airport owners, local government are listed as industry.

Maritime Union of Australia (MUA) consultation

Preliminary MUA and Departmental meeting - 2011

On 29 November 2011, the Department met with Dean Summers and Aaron Neal from the MUA in Sydney and discussed the government's response to the Parliamentary Joint Committee and Australian National Audit Office reports.[2]

It was noted at the meeting that further policy work would be undertaken and this required ongoing consultation, including establishing an industry consultative forum.

While appreciating that each of the policy/review projects would be considered on merit and that no decision had been made on any of the matters under review, the MUA's views were as follows:

- any expansion of the *Maritime Transport and Offshore Facilities Security Act 2003* to cover serious and organised crime would be a matter of concern;
- the MUA had reservations about the notion of the MSIC becoming a "smart card" due to the potential for intrusive oversight by port facility operators;
- the MUA would be sympathetic to the use of biometrics on cards provided it was in line with International Maritime Organisation standard 147;
- the MUA was concerned about off-port facilities (such as where containers are filled and then sealed with no further examination) and suggested such areas should be subject to the MSIC regime;
- the MUA expressed concerns about some off-port maritime industry employees (HR, IT, planning and the like) who would not be subject to the MSIC scheme; and
- in particular the MUA noted that, the list of maritime security relevant offences had recently been expanded and further tightening would not be in line with the security risk to the maritime industry.

As the MUA wished to formalise their views on the strength of the current MSIC scheme, the MUA was encouraged to write to the Secretary of the Department, particularly to emphasise their view that following the recent MSIC eligibility criteria changes, they considered the scheme robust for its counter-terrorism role.

Details of subsequent consultation and issues raised by the MUA is outlined below.

Consultation on discussion papers

Discussion paper - Assessment of relevant offences in the ASIC and MSIC Schemes: Options (December 2012)		
Option	Response received	Relevant OTS action as at April 2016
1. The criminal assessment components of the ASIC and MSIC background check are aimed at identifying people who may constitute a threat to transport security due to one, or more, of the following factors: • Their convictions demonstrate that they have committed acts that constitute unlawful interference with aviation/maritime transport or offshore facilities; • Their convictions demonstrate that they have committed serious acts comparable to unlawful interference, including terrorism and high level offences against the state such as treason; • Their convictions demonstrate that they have conducted activity that if repeated could compromise the preventive security regimes set out in the ATSA and MTOFSA; • Their convictions may demonstrate that they have disregard for human life and well-being; • Their convictions may demonstrate that they have a high level of disregard for private or public property; • Their convictions are of a nature that might be exploited by terrorists; • Their convictions constitute a public stigma that might leave them open as trusted insiders vulnerable to coercion; • Their convictions are acts that are often committed in support of terrorist activity.	The MUA understand the intentions of the statements however have concerns about several of the descriptors which could be considered subjective and open to interpretation and make clear articulation of the security outcomes very hard to achieve.	Noted, these components were used to establish which offences would be included as an Aviation Security Relevant Offences (ASRO) and Maritime Security Relevant Offences (MSRO). No further action is required.

[2] Australian National Audit Office Report, 2011, *The Management of the Aviation Security Identification Card and Maritime Security Identification Card Scheme*;
Parliamentary Joint Committee on Law Enforcement, 2011, *Inquiry into the adequacy of aviation and maritime security measures to combat serious and organised crime*

NOTE - Convictions relevant to these factors may also be relevant to the prevention of serious and organised crime.		
2. Amend the ASIC and MSIC schemes so that they have identical relevant offences and processes for determining a person's eligibility for a card.	The MUA suggest that any attempt to harmonise the ASIC and MSIC schemes needs to take into account their different origins and that the MSROs has been subject to greater scrutiny by industry, unions and government.	Noted, having non-identical relevant offences creates vulnerabilities and opportunities to circumvent the system. Further consultation was undertaken to develop the harmonised criteria.
3. Assuming Option 2 (Amend the ASIC and MSIC schemes so that they have identical relevant offences and processes for determining a person's eligibility for a card) is supported, people who hold either an ASIC or MSIC may apply for the other card without undergoing an additional background check.	Support in general but suggest that further consultation between industry, unions and government should be undertaken. The list of MSRO and ASRO shouldn't be broadened but rather rationalised and any redundant MSRO/ASRO should be removed. The Dept. should rely on 12 years + data to examine this issue.	Noted. An assessment of the likely risk an individual might pose with certain convictions was conducted when setting imprisonment thresholds under the revised eligibility criteria. As a result, the proposed thresholds are proportionately tiered to the risk to unlawful interference or the facilitation of criminal activities in the aviation or maritime secure environments.
4. Any revised list of relevant offences should be informed by a clearly articulated statement about each offence's relevance to the prevention of unlawful interference with aviation and maritime transport.	Support – this should be fully articulated with the notion of natural justice as a reference point.	Noted. The MUA's notion of natural justice has been adopted in how offences are tiered – placing relevance on the findings of the court.
5. Where relevant offences may also assist in the prevention of serious and organised crime, this should be clearly articulated	Support – this should be fully articulated with the notion of natural justice as a reference point.	Noted. No further action required.
6. The lists of offence categories should be grouped into the four tiers outlined at Attachment A.	Oppose The MUA opposes the creation of a 4 tier system of MSRO as the current system has served the process well. They acknowledge that the proposed 4 tier format will provide the Dept. with a broader view of an applicant's criminal background but strongly oppose any system which could be construed as a 'pattern of criminality'.	Noted. Further consultation identified that the four tier approach was not feasible and potentially limiting for applicants. A five tier approach creates greater proportionality for determining the severity of offences.
7. The consequences of a conviction should relate to the tier from which the offence category comes.	The MUA suggest that this is not clearly articulated and ask 'What would the different consequences for each tier be?'	Noted. Further consultation and assessment of relevant convictions was conducted. This reinforced the need to consider sentencing handed down by the courts as an indication of the seriousness of specific offences.
8. Disqualifying offences and other offences likely to constitute acts of unlawful interference with aviation and maritime transport, and offshore facilities should be exempt from the spent convictions scheme.	The Spent Convictions Scheme should not be extended to Tier 2 offences. IPs and IBs should not be consulted with regards to an applicant who has tier 2 convictions because industrial and employment decisions may be influenced by this disclosure to the detriment of the applicant.	Agreed. Disqualifying offences (Tier 1) will not be considered under the Spent Conviction Scheme. Spent convictions are not considered by Tiers 2 to 5.
9. Where an applicant's conviction clearly falls into more than one category, the more serious offence category should take precedence.	The MUA suggests that this is not clearly articulated. All MSROs/ASROs are taken into consideration when determining the suitability of an applicant.	Noted. Further consultation was undertaken to clarify where a person is convicted of an offence in a higher tier, this would take priority over other convictions in lower tiers.
10. In considering applications for discretionary cards, the Secretary should consider the offence tier(s) from which the applicant's conviction(s) come.	The MUA suggests that this is not clearly articulated. The Secretary has enough flexibility and discretion to allow or deny a card based on the already expanded list of convictions.	Noted. No further action required. The Secretary is entitled to consider all available options in considering and exercising their powers to issue a discretionary card.
11. The ASIC and MSIC schemes should have identical processes for assessing relevant offences.	The MUA suggest that any attempt to harmonise the ASIC and MSIC schemes needs to take into account their different origins and that the MSROs has been subject to greater scrutiny by industry, unions and government.	Noted, having non-identical relevant offences creates vulnerabilities and opportunities to circumvent the system. Further consultation was undertaken to develop the harmonised criteria.
12. Subject to the adoption of the proposed approach regarding tiers of offence categories outlined at Attachment A, the current arrangements for the pattern of criminality should be removed from the ASIC scheme.	The MUA opposes the creation of a 4 tier system of MSRO as the current system has served the process well. They acknowledge that the proposed 4 tier format will provide the Dept. with a broader view of an applicant's criminal background but strongly oppose any system which could be	Noted. The pattern of criminality element has been removed. However, consultation identified the tiered approach would provide greater benefit to applicants as this enables the findings of a court to be taken into consideration when determining the

	construed as a 'pattern of criminality'.	seriousness of convictions.
13. In considering an application for a discretionary ASIC or MSIC, the Secretary must consider any pattern of criminality in the criminal record of the applicant - this pattern could include relevant offences and other offences.	The MUA opposes the concept of 'pattern of criminality'. It has the potential to be seen as a denial of justice in this proposal and is contracted in the Options Paper. The Aviation industry has called for this to be included even though it is agreed it will provide no security outcomes. The ASIC scheme is ill-considered and a 'pattern of criminality' has clearly not worked in the Aviation sector and has not been required in the Maritime sector and so is rejected in any form.	Noted. The pattern of criminality element has been removed. However, the Secretary is entitled to consider all available options in considering and exercising their powers to issue a discretionary card.
14. ASIC IBs should no longer receive criminal history information about applicants.	Support This identifies another flaw in the ASIC scheme. The potential for an IB or employer to misuse 'sensitive information' is too great.	Noted. Under the proposed criteria, there are only to be three background check outcomes; eligible, adverse, or disqualified. No information is relayed to IBs other than the outcome of the background check.
15. The regulations should be amended to require the Secretary to specifically consider any convictions under transport security legislation, or the AusCheck legislation, irrespective of whether they constitute a relevant offence for discretionary card applicants.	The MUA doesn't understand the rationale behind some of the convictions. Some specific crimes (e.g. gambling) have been subjectively linked to ASIC/MSIC scheme. The convictions list is already extensive and the MSIC process of background checking against those relevant offences has been established. Legislation MUST NOT direct the Secretary to check against all of AusCheck and transport legislative crimes.	Noted. Further consultation and an assessment of the likely risk an individual might pose with certain convictions was conducted.
16. 'Rising of a court' should be removed from the definition of 'imprisonment' in the ASIC and MSIC schemes.	Supports	Noted. Consultation identified the tiered approach would provide greater benefit to applicants as this enables the findings of a court to be taken into consideration when determining the seriousness of convictions. 'Rising of a court' remains as a term of imprisonment.
17. The definition of a relevant offence should be harmonised and should capture all criminal acts associated with an offence under the criteria.	The MUA REJECTS this Option outright. To include the threat to cause EVERY offence is too expansive and no case has been made to broaden the convictions to these threats.	Noted. Following further consideration, this was amended so that the definition of a relevant offence will refer to offences listed by schedule in the regulations.
Other	-The MUA has concerns about the use of foreign labour operating under 988 MCV and 457 VISA conditions. They suggest that the staff operating under these conditions are difficult to background check and are consequently a possible security risk. -The MUA are concerned about staff within organisations who control HR and don't actually go into secure zones and thus don't require MSICs. They suggest that this is a security risk. -The MUA is concerned about transient workers in container packing yards which are outside of secure zones. They suggest this is a security risk. -The MUA is concerned about Flag of Convenience shipping with high consequence/dangerous goods cargo and staff on MCVs. They suggest this is a security risk. -The MUA is concerned about a lack of skilled resources within the domestic maritime industry and suggest that the reliance on foreign resources is a security risk.	Noted. No further action taken, however, this is outside the scope of the proposed new eligibility criteria. The Department continues to work to address vulnerabilities associated with maritime security zones.

Industry forums attended by the MUA

Date	Forum	Location	Outcomes
25 July 2012	MISCF	Adelaide	• A new Aviation and Maritime Advisory Forum to discuss serious and organised crime matters has been proposed and an initial meeting was held in Sydney on 18 July 2012. • Members were provided an overview of the PJC and ANAO reports and subsequent activity underway. • Meeting outcomes noted MUA support for measures related to enhanced security of the waterfront.

1 March 2013	ASIC/MSIC Stakeholder Forum	Sydney	• Industry and the Department recognised the need to reinforce the message of the purpose of the ASIC and MSIC schemes through a series of factors that determine whether an offence should be added to the list of relevant offences. • The MUA did not support the list of factors distributed in the eligibility criteria paper. • There was general agreement that better articulation of why offences are relevant was necessary. The MUA requested the factors be developed in consistency with the principles of International Civil Aviation Organization and International Ship and Port Facility Security Code.
27 March 2013	MISCF	Sydney	• The Chair noted that the Department and Attorney-General's Department (AGD) were currently finalising a further ASIC/MSIC eligibility criteria options paper, which would include a comparative table of the current and proposed eligibility criteria for both schemes. • Meeting outcomes noted MUA requested confirmation that the MSIC/ASIC eligibility criteria list would be provided to industry for consideration. • Agreed – Members were advised this was the intention of the Department.
29 October 2013	MISCF	Melbourne	• The Department continues to respond to PJCLE recommendation that offences that would disqualify an individual from obtaining an MSIC be toughened by looking to ensure that there were more targeted offence categories. It is currently anticipated that an options paper on this matter will be distributed to industry participants in the first quarter of 2014. • Meeting outcomes noted MUA noted that a number of discussion papers had been discussed during the meeting and requested that a list of current papers under development be circulated to all MISCF members. • Agreed – noting that some papers may not be progressed but the list would provide an indication on proposed engagement.
26 March 2014	MISCF	Brisbane	• The Department circulated an options paper on the *Assessment of Relevant Offences in the ASIC and MSIC Schemes*. • The following response was provide to questions raised by members – ineligible MSIC applicants will continue to have access to the discretionary card process, except where the original rejection was based on a serious offence.
25 March 2015	MISCF	Melbourne	• Update provided on strengthening eligibility requirements for both the ASIC and MSIC schemes to better target serious criminal offences and reduce the impact of less serious offences. • Member-led questions included discussion on the harmonisation and tiering of eligibility criteria, and particularly the role sentencing would play in indicating severity.
23 September 2015	MISCF	Fremantle	• Update provided on strengthening eligibility requirements with discussion outlining initial analysis indicates the revised eligibility criteria will provide positive employment outcomes and significantly reduce the number of discretionary card applications

Policy development consultation

Industry Discussion Papers

- December 2012: *Assessment of relevant offences in the ASIC and MSIC Schemes: Discussion paper*.
- January 2014: *Assessment of relevant offences in the ASIC and MSIC Schemes: Options paper*.
- March 2014: *Comparison between proposed and current list of Aviation Security Relevant Offences and Maritime Security Relevant Offences*.

Discussion papers where issued via email to members of the various industry consultative forums, including:

- aviation specific forums such as the Aviation Security Advisory Forum (ASAF) and Regional Industry Consultative Meetings (RICM); and
- maritime specific forums such as the Maritime Industry Security Consultative Forum (MISCF); and the Oil and Gas Security Forum (OGSF).

Please refer to Attachment B for membership of each consultative forum.

Discussion paper consultative forums

The Department held two ASIC and MSIC consultative forums to specifically discuss recommendations identified by the 2011 Parliamentary Joint Committee and Australian National Audit Office Report reports[1], and proposals presented in the Department's 2012 discussion paper, *Assessment of relevant offences in the ASIC and MSIC Schemes*. Attendees are noted overleaf.

ASIC/MSIC Stakeholder Forum (this forum is no longer active)		
Date	**Location**	**Attendees**
19 February 2013	Perth	26
1 March 2013	Sydney	30*

* Attended by representative of the Maritime Union of Australia.

Outcomes from these forums noted:

- The discussion paper and eligibility criteria did not represent a final policy position. Consultation would be ongoing.
- The ASIC and MSIC schemes would maintain their original purpose of prevention of unlawful interference with aviation and maritime transport.
- Review of the eligibility criteria was aimed at establishing targeted criteria to improve security outcomes for the aviation and maritime industries.
- It was noted the eligibility criteria (as provided in the discussion paper) would likely result in a reduction of people found ineligible due to the removal of some irrelevant and minor offences, and the introduction of a minimum sentence threshold.
- Agreement was made to distribute material that highlights the exact differences between the current and proposed eligibility criteria.
- Other key discussion outcomes noted:
    - There was general support for the proposal to harmonise the ASIC eligibility criteria with the MSIC eligibility criteria;
    - there was general support for the proposal to align the appeal processes for both schemes;
    - there was a general understanding of the tiers of offences, and that these tiers should be targeted to identify relevant offences. Some participants queried the necessity of a tiered approach (presented initially by four tiers). It was discussed that reducing the number of tiers would lead to relatively minor offences creating ineligibility–this was not a preferred outcome from a revised criteria;
    - it is important to ensure eligibility criteria are clear, refined and targeted to preventing unlawful interference with aviation and maritime transport;
    - there was general agreement to remove the pattern of criminality test from the Aviation Transport Security Regulations 2005 or revisit the parameters of this test, and also agreement that the MSIC eligibility criteria should continue to not involve a pattern of criminality component; and
    - the comments from the forums will be taken into consideration and included in a further options paper.

After 1 March 2013, consultation continued via the Department's established sector specific consultative forums e.g. ASAF, RICM, MISCF and OGSF. No further policy specific forums were conducted.

[1] Australian National Audit Office Report, 2011, *The Management of the Aviation Security Identification Card and Maritime Security Identification Card Scheme*;
Parliamentary Joint Committee on Law Enforcement, 2011, *Inquiry into the adequacy of aviation and maritime security measures to combat serious and organised crime*

Attendance to ASIC/MSIC Stakeholder Forum (February & March 2013)	
Industry	Newcastle Airport
Airport Security	NT Airports
Asciano	Nth Qld Airports
Australia Marine Services	Patrick
Australian Shipowners' Association	Perth Airport
Australian Workers' Union	Port of Brisbane
Ballina Airport	Ports Australia
Board of Airline Representatives of Australia	Qantas
Brisbane Airport	Queensland Airports
Broome Airport	Rio Tinto
Canberra Airport	Shipping Australia
Chubb Fire & Security	Skywest Airlines
Dampier Port Authority	Sydney Airport
DP World	Sydney Ports
Esperance Port	Teekay Shipping
Fremantle Ports	Toll Priority
Geraldton Airport	Transport Workers Union
Geraldton Port Authority	United Voice
Gold Security Group	Veritas
Hobart Airport	Woodside Energy
Hutchinson Ports	**Government**
Maritime Union of Australia	AusCheck – Attorney General's Department
Melbourne Airport	Office of Transport Security – Department of Infrastructure and Regional Development
Multicard	

ATTACHMENT B

Transport security consultative forums

The Department of Infrastructure and Regional Development holds a range of consultative forums attended by industry and government agencies. Forums are held on a regular or semi-regular basis and are used to ensure consistent and comprehensive stakeholder engagement. The forums listed below are those for which the aviation and maritime security identification card eligibility criteria – or associated policy – was listed as a formal agenda item.

Date	Forum	Location	Attendees
Aviation Security Advisory Forum (ASAF) – Aviation			
22 March 2012	ASAF	Gold Coast	41
12 July 2012	ASAF	Sydney	47
25 October 2012	ASAF	Melbourne	46
20/21 March 2012	ASAF	Hobart	44
11 July 2013	ASAF	Brisbane	43
3 December 2013	ASAF	Sydney	50
8 April 2014	ASAF	Perth	45
24 July 2014	ASAF	Canberra	40
1-2 December 2014	ASAF	Sydney	47
25 February 2015	ASAF	Victoria	45
30 July 2015	ASAF	Adelaide	43
17 November 2015	ASAF	Brisbane	46
8 March 2016	ASAF	Canberra	46
Issuing Body Forum (IB Forum) – ASIC and MSIC Issuing Bodies			
21 to 22 May 2015	IB Forum	Brisbane	34
26 June 2015	IB Forum	Perth	26
19 November 2015	IB Forum	Perth	19
4 December 2015	IB Forum	Sydney	30
Maritime Industry Security Consultative Forum (MISCF) – Maritime			
16 February 2012	MISCF	Brisbane	58
25 July 2012	MISCF	Adelaide	50*
27 March 2013	MISCF	Sydney	49*
29 October 2013	MISCF	Melbourne	55*
26 March 2014	MISCF	Brisbane	48*
24 September 2014	MISCF	Adelaide	41*
25 March 2015	MISCF	Melbourne	42*
23 September 2015	MISCF	Fremantle	45*
Offshore Oil and Gas Forum (OGSF) – Oil and Gas			
15 May 2013	OGSF	Canberra	53*
19 November 2013	OGSF	Melbourne	54*
17 June 2014	OGSF	Darwin	43*
25 June 2015	OGSF	Perth	52
4 - 5 November 2015	OGSF	Brisbane	51
Regional Industry Consultative Meetings (RICM) – Aviation			
12 November 2012	RICM	Melbourne	50
24 August 2012	RICM	Sydney	51
19 April 2012	RICM	Adelaide	57
8 August 2013	RICM	Perth	35
18 April 2013	RICM	Brisbane	41
12 December 2013	RICM	Melbourne	47
10 April 2014	RICM	Adelaide	47
7 August 2014	RICM	Canberra	40
13 November 2014	RICM	Canberra	50
26 February 2015	RICM	Victoria	41
25 August 2015	RICM	Adelaide	49
10 December 2015	RICM	Brisbane	44

*Attended by representative of the Maritime Union of Australia.

Membership of transport security consultative forums

Attendance to each of these forums is subject to availability. As such, some members may not attend all meetings. All members, regardless of attendance, are issued with agenda papers prior to each meeting, and are sent copies of meeting outcomes and any material presented during each forum (i.e. presentations slides).

Other government departments or agencies may attend by request or invitation.

Aviation Security Advisory Forum (ASAF) – Aviation	
Industry	Queensland Airports
Adelaide Airport	Regional Aviation Association of Australia
Australian Airports Association	Regional Express
Australia-Pacific Airports Corporation	Sydney Airport Corporation
Board of Airline Representatives of Australia	Tigerair
Brisbane Airport	Virgin Australia
Cairns Airport	**Government**
Canberra International Airport	Airservices Australia
Cobham Aviation Services	AusCheck – Attorney General's Department
FedEx International Security	Australian Border Force
Gold Coast Airports	Australian Federal Police
Hobart International Airport	Civil Aviation Safety Authority
Northern Territory Airports	Department of Agriculture
Perth Airport	Department of Immigration and Border Protection
Qantas	Office of Transport Security – Department of Infrastructure and Regional Development

Issuing Body Forum (IB Forum) – ASIC and MSIC Issuing Bodies	
Industry	Multicard
1-Stop Connections	Newcastle Airport
Adelaide Airport	Perth Airport
Aerodrome Management Services	Pilbara Ports Authority
Airport Security Pty Ltd / Security ID	Port of Brisbane
Alice Springs Airport	Programmed Marine
Asciano / Patrick	Programmed Marine
Ballina Shire Council	Qantas
Brisbane Airport	Royal Flying Doctor Service
Broome International Airport	Security ID - Airport Security
Canberra International Airport	Shire of East Pilbara
Chubb Electronic Security	Southern Ports Authority - Port of Albany
City of Greater Geraldton	Southern Ports Authority - Port of Bunbury
Clientview	Southern Ports Authority - Port of Esperance
Darwin International Airport	Sunshine Coast Airport
DP World Australia	Sydney Airport
Fremantle Ports	Toll
Gladstone Ports Corporation	Veritas Engineering
Gold Coast Airport	Virgin Australia
Gold Security Group	Whitsunday Regional Council
Hobart Airport	**Government**
Hutchison Ports Australia	AirServices Australia
Identiv Australia (Multicard)	AusCheck – Attorney General's Department
Kalgoorlie-Boulder Airport	Australian Border Force (formerly Australian Customs & Border Protection)
Mackay and Cairns Airports	Civil Aviation Safety Authority
Melbourne Airport	Office of Transport Security – Department of Infrastructure and Regional Development
Midwest Ports Authority	

Maritime Industry Security Consultative Forum (MISCF) – Maritime	
Industry	Gippsland Ports
Asciano	Gladstone Ports Authority
ASP Ship Management Group	Inpex Australia
Australian Shipbuilding & Repair Group	Kimberley Ports
Australian Shipowners Association	L-3 Oceania
Australian Submarine Corporation	Maritime Industry Australia
Caltex Australia	Maritime Union of Australia
Carnival Australia	**Government**
Chevron Australia	Attorney-General's Department
Darwin Port Corporation	Department of Agriculture and Water Resources
DP World	Department of Immigration and Border Protection
Flinders Ports	Department of Infrastructure and Regional Development
Fremantle Ports	Maritime Border Command – Australian Border Force
Geelong Ports	Office of Transport Security – Department of Infrastructure and Regional Development

Oil and Gas Security Forum (OGSF) – Oil and Gas	
Industry	Vermilion Oil and Gas Australia
AGL Energy	Viva Energy Australia
Arrow Energy	Woodside Energy
Australian Petroleum Production and Exploration Association	**Government**
Beach Energy	Attorney-General's Department
BHP Billiton	Australian Border Force
BP Australia	Australian Federal Police
Buru Energy	Australian Maritime Safety Authority
Caltex Australia	Department of Defence
Chevron Australia	Department of Industry, Innovation and Science
ConocoPhillips Australia	Department of Infrastructure and Regional Development
Darwin Port Corporation	Department of the Prime Minister and Cabinet
ExxonMobil	National Offshore Petroleum Safety and Environmental Management Authority
GDF SUEZ Bonaparte	NT Department of Mines and Energy
GLNG Operations	NT Department of the Chief Minister
INPEX	QLD Department of Energy and Water Supply
JKC Australia LNG	Queensland Police Service
Oil Search	VIC Department of Economic Development, Jobs, Transport and Resources
Origin Energy	Victoria Police
QGC	WA Department of the Premier and Cabinet
Quadrant Energy	WA Department of Transport
Santos	Western Australia Police
Shell Australia	Office of Transport Security – Department of Infrastructure and Regional Development
Teekay Shipping (Australia)	

Regional Industry Consultative Meetings (RICM) – Aviation	
Industry	Longreach Airport
Adelaide Airport Limited	Mackay Airport
Aerodrome Management Services	Maranoa Regional Council**
Airlines of Tasmania	Melair - Launceston Airport
Albury Airport	Mid-Western Regional Council**
Albury City Council**	Mildura Airport
Alliance Airlines	Moranbah Airport / BHP Billiton Mitsubishi Alliance
Argyle Diamonds	Mount Isa Airport
Armidale Regional Airport	MSS Security

Australian Airports Association	Network Aviation - A Qantas Group Airline
Avalon Airport Australia	Newcastle Airport
Ayers Rock Resort	Nhulunbuy Corporation
Ballina Shire Council	Norfolk Island Airport
Bankstown Airport	Northern Territory Airports
Barcaldine Regional Council**	Orange City Council**
Bathurst Regional Council**	Paraburdoo - Aerodrome Management Services
BHP Billiton	Paraburdoo Airport
Brisbane Airport Corporation	Parkes Shire Council**
Broome International Airport	Perth Airport
Bundaberg Regional Council**	Port Augusta City Council**
Burnie Airport	Qantas
Busselton Airport	Queensland Airports
Cairns Airport	Regional Airport Security
Ceduna Shire Council**	Regional Express (Rex)
Central Highlands Regional Council**	Rio Tinto
Christmas Island Airport	Rockhampton Regional Council**
City of Albany	Shire of Carnarvon
City of Greater Geraldton	Shire of East Pilbara
City of Kalgoorlie-Boulder	Shire of Esperance
Clarence Valley Council**	Shire of Exmouth
Cloncurry Shire Council**	Shire of Jerramungup
Cobham Aviation Services	Shire of Meekatharra
Coffs Harbour City Council**	Shire of Ravensthorpe
Coffs Harbour Regional Airport	Skippers Aviation
Devonport Airport	Skytrans
Devonport Airport / Tasmanian Ports Corporation	Skywest Airlines
District Council of Coober Pedy	SNP Security
District Council of Lower Eyre Peninsula	Startrek Express
Dubbo City Council**	Sunshine Coast Airport
Eurobodalla Shire Council**	Tamworth Regional Airport
Flinders Council**	Tamworth Regional Council**
Forte Airport Management	Toll
Fraser Coast Council**	Town of Port Hedland Council**
Gladstone Regional Council**	Townsville Airport
Greater Taree City Council**	Vincent Aviation Australia
Hamilton Island	Wagga Wagga City Council**
Hawker Pacific	Warrnambool City Council**
Horn Island Airport	Warrumbungle Shire Council**
Inverell Shire Council**	Wellcamp Airport
ISS Facility Services	Westralia Airports Corporation
Jandakot Airport Holdings	Whitsunday Regional Council**
Karratha Airport	Whyalla Council**
Katherine Town Council**	Wiluna Shire
King Island Council**	**Government**
Kununurra Airport	Australian Federal Police – national representative
Launceston Airport	Australian Federal Police – state specific representative
Learmonth Airport	Airservices Australia
Lismore City Council**	Office of Transport Security

** As airport owners, local government are listed as industry.

Maritime Union of Australia (MUA) consultation

Preliminary MUA and Departmental meeting - 2011

On 29 November 2011, the Department met with Dean Summers and Aaron Neal from the MUA in Sydney and discussed the government's response to the Parliamentary Joint Committee and Australian National Audit Office reports.[2]

It was noted at the meeting that further policy work would be undertaken and this required ongoing consultation, including establishing an industry consultative forum.

While appreciating that each of the policy/review projects would be considered on merit and that no decision had been made on any of the matters under review, the MUA's views were as follows:

- any expansion of the *Maritime Transport and Offshore Facilities Security Act 2003* to cover serious and organised crime would be a matter of concern;
- the MUA had reservations about the notion of the MSIC becoming a "smart card" due to the potential for intrusive oversight by port facility operators;
- the MUA would be sympathetic to the use of biometrics on cards provided it was in line with International Maritime Organisation standard 147;
- the MUA was concerned about off-port facilities (such as where containers are filled and then sealed with no further examination) and suggested such areas should be subject to the MSIC regime;
- the MUA expressed concerns about some off-port maritime industry employees (HR, IT, planning and the like) who would not be subject to the MSIC scheme; and
- in particular the MUA noted that, the list of maritime security relevant offences had recently been expanded and further tightening would not be in line with the security risk to the maritime industry.

As the MUA wished to formalise their views on the strength of the current MSIC scheme, the MUA was encouraged to write to the Secretary of the Department, particularly to emphasise their view that following the recent MSIC eligibility criteria changes, they considered the scheme robust for its counter-terrorism role.

Details of subsequent consultation and issues raised by the MUA is outlined below.

Consultation on discussion papers

Discussion paper - Assessment of relevant offences in the ASIC and MSIC Schemes: Options (December 2012)		
Option	Response received	Relevant OTS action as at April 2016
1. The criminal assessment components of the ASIC and MSIC background check are aimed at identifying people who may constitute a threat to transport security due to one, or more, of the following factors: • Their convictions demonstrate that they have committed acts that constitute unlawful interference with aviation/maritime transport or offshore facilities; • Their convictions demonstrate that they have committed serious acts comparable to unlawful interference, including terrorism and high level offences against the state such as treason; • Their convictions demonstrate that they have conducted activity that if repeated could compromise the preventive security regimes set out in the ATSA and MTOFSA; • Their convictions may demonstrate that they have disregard for human life and well-being; • Their convictions may demonstrate that they have a high level of disregard for private or public property; • Their convictions are of a nature that might be exploited by terrorists; • Their convictions constitute a public stigma that might leave them open as trusted insiders vulnerable to coercion; • Their convictions are acts that are often committed in support of terrorist activity.	The MUA understand the intentions of the statements however have concerns about several of the descriptors which could be considered subjective and open to interpretation and make clear articulation of the security outcomes very hard to achieve.	Noted, these components were used to establish which offences would be included as an Aviation Security Relevant Offences (ASRO) and Maritime Security Relevant Offences (MSRO). No further action is required.

[2] Australian National Audit Office Report, 2011, *The Management of the Aviation Security Identification Card and Maritime Security Identification Card Scheme*;
Parliamentary Joint Committee on Law Enforcement, 2011, *Inquiry into the adequacy of aviation and maritime security measures to combat serious and organised crime*

NOTE - Convictions relevant to these factors may also be relevant to the prevention of serious and organised crime.		
2. Amend the ASIC and MSIC schemes so that they have identical relevant offences and processes for determining a person's eligibility for a card.	The MUA suggest that any attempt to harmonise the ASIC and MSIC schemes needs to take into account their different origins and that the MSROs has been subject to greater scrutiny by industry, unions and government.	Noted, having non-identical relevant offences creates vulnerabilities and opportunities to circumvent the system. Further consultation was undertaken to develop the harmonised criteria.
3. Assuming Option 2 (Amend the ASIC and MSIC schemes so that they have identical relevant offences and processes for determining a person's eligibility for a card) is supported, people who hold either an ASIC or MSIC may apply for the other card without undergoing an additional background check.	Support in general but suggest that further consultation between industry, unions and government should be undertaken. The list of MSRO and ASRO shouldn't be broadened but rather rationalised and any redundant MSRO/ASRO should be removed. The Dept. should rely on 12 years + data to examine this issue.	Noted. An assessment of the likely risk an individual might pose with certain convictions was conducted when setting imprisonment thresholds under the revised eligibility criteria. As a result, the proposed thresholds are proportionately tiered to the risk to unlawful interference or the facilitation of criminal activities in the aviation or maritime secure environments.
4. Any revised list of relevant offences should be informed by a clearly articulated statement about each offence's relevance to the prevention of unlawful interference with aviation and maritime transport.	Support – this should be fully articulated with the notion of natural justice as a reference point.	Noted. The MUA's notion of natural justice has been adopted in how offences are tiered – placing relevance on the findings of the court.
5. Where relevant offences may also assist in the prevention of serious and organised crime, this should be clearly articulated	Support – this should be fully articulated with the notion of natural justice as a reference point.	Noted. No further action required.
6. The lists of offence categories should be grouped into the four tiers outlined at Attachment A.	Oppose The MUA opposes the creation of a 4 tier system of MSRO as the current system has served the process well. They acknowledge that the proposed 4 tier format will provide the Dept. with a broader view of an applicant's criminal background but strongly oppose any system which could be construed as a 'pattern of criminality'.	Noted. Further consultation identified that the four tier approach was not feasible and potentially limiting for applicants. A five tier approach creates greater proportionality for determining the severity of offences.
7. The consequences of a conviction should relate to the tier from which the offence category comes.	The MUA suggest that this is not clearly articulated and ask 'What would the different consequences for each tier be?'	Noted. Further consultation and assessment of relevant convictions was conducted. This reinforced the need to consider sentencing handed down by the courts as an indication of the seriousness of specific offences.
8. Disqualifying offences and other offences likely to constitute acts of unlawful interference with aviation and maritime transport, and offshore facilities should be exempt from the spent convictions scheme.	The Spent Convictions Scheme should not be extended to Tier 2 offences. IPs and IBs should not be consulted with regards to an applicant who has tier 2 convictions because industrial and employment decisions may be influenced by this disclosure to the detriment of the applicant.	Agreed. Disqualifying offences (Tier 1) will not be considered under the Spent Conviction Scheme. Spent convictions are not considered by Tiers 2 to 5.
9. Where an applicant's conviction clearly falls into more than one category, the more serious offence category should take precedence.	The MUA suggests that this is not clearly articulated. All MSROs/ASROs are taken into consideration when determining the suitability of an applicant.	Noted. Further consultation was undertaken to clarify where a person is convicted of an offence in a higher tier, this would take priority over other convictions in lower tiers.
10. In considering applications for discretionary cards, the Secretary should consider the offence tier(s) from which the applicant's conviction(s) come.	The MUA suggests that this is not clearly articulated. The Secretary has enough flexibility and discretion to allow or deny a card based on the already expanded list of convictions.	Noted. No further action required. The Secretary is entitled to consider all available options in considering and exercising their powers to issue a discretionary card.
11. The ASIC and MSIC schemes should have identical processes for assessing relevant offences.	The MUA suggest that any attempt to harmonise the ASIC and MSIC schemes needs to take into account their different origins and that the MSROs has been subject to greater scrutiny by industry, unions and government.	Noted, having non-identical relevant offences creates vulnerabilities and opportunities to circumvent the system. Further consultation was undertaken to develop the harmonised criteria.
12. Subject to the adoption of the proposed approach regarding tiers of offence categories outlined at Attachment A, the current arrangements for the pattern of criminality should be removed from the ASIC scheme.	The MUA opposes the creation of a 4 tier system of MSRO as the current system has served the process well. They acknowledge that the proposed 4 tier format will provide the Dept. with a broader view of an applicant's criminal background but strongly oppose any system which could be	Noted. The pattern of criminality element has been removed. However, consultation identified the tiered approach would provide greater benefit to applicants as this enables the findings of a court to be taken into consideration when determining the

	construed as a 'pattern of criminality'.	seriousness of convictions.
13. In considering an application for a discretionary ASIC or MSIC, the Secretary must consider any pattern of criminality in the criminal record of the applicant - this pattern could include relevant offences and other offences.	The MUA opposes the concept of 'pattern of criminality'. It has the potential to be seen as a denial of justice in this proposal and is contracted in the Options Paper. The Aviation industry has called for this to be included even though it is agreed it will provide no security outcomes. The ASIC scheme is ill-considered and a 'pattern of criminality' has clearly not worked in the Aviation sector and has not been required in the Maritime sector and so is rejected in any form.	Noted. The pattern of criminality element has been removed. However, the Secretary is entitled to consider all available options in considering and exercising their powers to issue a discretionary card.
14. ASIC IBs should no longer receive criminal history information about applicants.	Support This identifies another flaw in the ASIC scheme. The potential for an IB or employer to misuse 'sensitive information' is too great.	Noted. Under the proposed criteria, there are only to be three background check outcomes; eligible, adverse, or disqualified. No information is relayed to IBs other than the outcome of the background check.
15. The regulations should be amended to require the Secretary to specifically consider any convictions under transport security legislation, or the AusCheck legislation, irrespective of whether they constitute a relevant offence for discretionary card applicants.	The MUA doesn't understand the rationale behind some of the convictions. Some specific crimes (e.g. gambling) have been subjectively linked to ASIC/MSIC scheme. The convictions list is already extensive and the MSIC process of background checking against those relevant offences has been established. Legislation MUST NOT direct the Secretary to check against all of AusCheck and transport legislative crimes.	Noted. Further consultation and an assessment of the likely risk an individual might pose with certain convictions was conducted.
16. 'Rising of a court' should be removed from the definition of 'imprisonment' in the ASIC and MSIC schemes.	Supports	Noted. Consultation identified the tiered approach would provide greater benefit to applicants as this enables the findings of a court to be taken into consideration when determining the seriousness of convictions. 'Rising of a court' remains as a term of imprisonment.
17. The definition of a relevant offence should be harmonised and should capture all criminal acts associated with an offence under the criteria.	The MUA REJECTS this Option outright. To include the threat to cause EVERY offence is too expansive and no case has been made to broaden the convictions to these threats.	Noted. Following further consideration, this was amended so that the definition of a relevant offence will refer to offences listed by schedule in the regulations.
Other	-The MUA has concerns about the use of foreign labour operating under 988 MCV and 457 VISA conditions. They suggest that the staff operating under these conditions are difficult to background check and are consequently a possible security risk. -The MUA are concerned about staff within organisations who control HR and don't actually go into secure zones and thus don't require MSICs. They suggest that this is a security risk. -The MUA is concerned about transient workers in container packing yards which are outside of secure zones. They suggest this is a security risk. -The MUA is concerned about Flag of Convenience shipping with high consequence/dangerous goods cargo and staff on MCVs. They suggest this is a security risk. -The MUA is concerned about a lack of skilled resources within the domestic maritime industry and suggest that the reliance on foreign resources is a security risk.	Noted. No further action taken, however, this is outside the scope of the proposed new eligibility criteria. The Department continues to work to address vulnerabilities associated with maritime security zones.

Industry forums attended by the MUA

Date	Forum	Location	Outcomes
25 July 2012	MISCF	Adelaide	• A new Aviation and Maritime Advisory Forum to discuss serious and organised crime matters has been proposed and an initial meeting was held in Sydney on 18 July 2012. • Members were provided an overview of the PJC and ANAO reports and subsequent activity underway. • Meeting outcomes noted MUA support for measures related to enhanced security of the waterfront.

1 March 2013	ASIC/MSIC Stakeholder Forum	Sydney	• Industry and the Department recognised the need to reinforce the message of the purpose of the ASIC and MSIC schemes through a series of factors that determine whether an offence should be added to the list of relevant offences. • The MUA did not support the list of factors distributed in the eligibility criteria paper. • There was general agreement that better articulation of why offences are relevant was necessary. The MUA requested the factors be developed in consistency with the principles of International Civil Aviation Organization and International Ship and Port Facility Security Code.
27 March 2013	MISCF	Sydney	• The Chair noted that the Department and Attorney-General's Department (AGD) were currently finalising a further ASIC/MSIC eligibility criteria options paper, which would include a comparative table of the current and proposed eligibility criteria for both schemes. • Meeting outcomes noted MUA requested confirmation that the MSIC/ASIC eligibility criteria list would be provided to industry for consideration. • Agreed – Members were advised this was the intention of the Department.
29 October 2013	MISCF	Melbourne	• The Department continues to respond to PJCLE recommendation that offences that would disqualify an individual from obtaining an MSIC be toughened by looking to ensure that there were more targeted offence categories. It is currently anticipated that an options paper on this matter will be distributed to industry participants in the first quarter of 2014. • Meeting outcomes noted MUA noted that a number of discussion papers had been discussed during the meeting and requested that a list of current papers under development be circulated to all MISCF members. • Agreed – noting that some papers may not be progressed but the list would provide an indication on proposed engagement.
26 March 2014	MISCF	Brisbane	• The Department circulated an options paper on the *Assessment of Relevant Offences in the ASIC and MSIC Schemes*. • The following response was provide to questions raised by members – ineligible MSIC applicants will continue to have access to the discretionary card process, except where the original rejection was based on a serious offence.
25 March 2015	MISCF	Melbourne	• Update provided on strengthening eligibility requirements for both the ASIC and MSIC schemes to better target serious criminal offences and reduce the impact of less serious offences. • Member-led questions included discussion on the harmonisation and tiering of eligibility criteria, and particularly the role sentencing would play in indicating severity.
23 September 2015	MISCF	Fremantle	• Update provided on strengthening eligibility requirements with discussion outlining initial analysis indicates the revised eligibility criteria will provide positive employment outcomes and significantly reduce the number of discretionary card applications

Rural & Regional Affairs and Transport Legislation Committee

ANSWERS TO QUESTIONS ON NOTICE

Hearing into Transport Security Amendment (Serious or Organised Crime) Bill 2016

Infrastructure and Regional Development

Question no./reference: Statistical analysis

Program: NA
Division/Agency: Office of Transport Security
Topic: Transport Security Amendment (Serious or Organised Crime) Bill 2016 [Provisions]
Proof Hansard Page: 13

Question raised by Acting Chair, Senator Sterle, Glenn

1. **Senator Sterle** asked the Department of Infrastructure and Regional Development (the Department) to provide details of the statistical modelling.
2. **Supplementary question** (received by phone request 7 April 2016 from Committee Secretariat, Craft, Nick), can the Department provide background detail on how many aviation and maritime security identification cards are in use, the number of annual applications and the length of time the background check is valid for.

Answer:

Statistical analysis

1. Aviation and maritime security identification card (ASIC and MSIC) applications received between April and June 2014 were modelled against both existing and proposed new criteria. This three month sample[1] included 18,629 ASICs and 13,231 MSICs, totalling 31,860 applications.

2. Under the existing eligibility criteria:
   - 184 of this sample group were found adverse and would be considered ineligible on first application (57 ASICs and 127 MSICs). These applicants have the option to apply to the Secretary of the Department of Infrastructure and Regional Development for a discretionary assessment.

3. Under the proposed new eligibility criteria:
   - 111 applicants in this sample group would be found adverse (19 ASICs and 92 MSICs). These applicants have the option to apply for a discretionary assessment.
   - Due to the change in criteria, seven applicants who would previously have received a card would be adverse under the new criteria (0 ASICs and 7 MSICs). The existing rights of appeal remain open to these applicants.
   - Under the new criteria, 80 applicants (38 ASICs and 42 MSICs) will no longer be required to apply for a discretionary card, as they will initially be eligible for an ASIC or MSIC. This equates to an estimated 320 applicants per year who would no longer require a discretionary assessment to be issued an ASIC or MSIC.

Background

4. As at 31 March 2016 there were 254,455 valid ASICs and MSICs in use (138,825 ASICs and 115,630 MSICs).

5. Annual application figures are (at 31 March 2016):

Calendar Year	ASIC Applications	MSIC Applications[2]	Total Transport Security Card Applications
2010	75,231	20,834	96,065
2011	77,677	50,693	128,370
2012	75,683	38,799	114,482
2013	82,749	43,889	126,638
2014	74,568	40,336	114,904
2015	80,073	55,264	135,337
2016 YTD	20,348	10,395	30,743

6. Background checks are valid for two years only. ASICs are valid for a maximum of two years from the date the background check is completed. MSICs can be valid for two or four years. However, the four year MSIC requires a background check two years from the date the initial background check is completed.

[1] The proportion of cards can fluctuate throughout the year; this sample is considered a point in time analysis.
[2] This does not disaggregate two year and four year MSICs.

Rural & Regional Affairs and Transport Legislation Committee

ANSWERS TO QUESTIONS ON NOTICE

Hearing into Transport Security Amendment (Serious or Organised Crime) Bill 2016

Infrastructure and Regional Development

Question no./reference: ICE Taskforce

Program: NA
Division/Agency: Office of Transport Security
Topic: Transport Security Amendment (Serious or Organised Crime) Bill 2016 [Provisions]
Proof Hansard Page: 16

Question raised by Senator Rice, Janet

1. **Senator Rice** asked when the National Ice Taskforce's recommendations were made.

Answer:

1. The National Ice Taskforce delivered its Final Report to the Prime Minister of Australia on 9 October 2015 (**Attachment A**).

2. A whole of government response to the final report was made publicly available on 6 December 2015.

Attachments
Attachment A – ICE Taskforce Final Report 2015

FINAL REPORT OF THE

NATIONAL ICE TASKFORCE

2015

Final Report of the National Ice Taskforce

978-1-925237-92-4 Final Report of the National Ice Taskforce (DOCX)

978-1-925237-93-1 Final Report of the National Ice Taskforce (PDF)

978-1-925237-94-8 Final Report of the National Ice Taskforce (Hardcopy)

Dear Prime Minister

It is my pleasure to present the Final Report of the National Ice Taskforce.

The Taskforce has undertaken an extensive consultation and research process to inform its findings, travelling around Australia to listen to people share their views of and experiences with this drug. We received over 1,300 written submissions from organisations and members of the public, and spoke to numerous experts spanning the health, law enforcement and community sectors, and Commonwealth, state, and territory government agencies. What we heard from Australians was—in many cases—sad, confronting and challenging: ice is a drug like no other, and is causing a great deal of harm across our community.

Ice use is not a problem we can solve overnight, and not something we can simply arrest our way out of. Nevertheless, we believe we can do more to reduce the use of this drug, and the harm it is causing, enhancing the already significant efforts being taken by governments, communities and individuals.

The Taskforce's Final Report is founded on a strong evidence base and is informed by a wide range of expert advice, research, as well as local and international experience in dealing with ice. We are most grateful for the valuable input received from various Commonwealth agencies and from all state and territory governments, who have been closely involved in the development of this report. We would particularly like to thank the members of the Australian National Advisory Council on Alcohol and Drugs for their valuable assistance and expert advice. I have greatly benefited from the advice of the Council's Chair, Mrs Kay Hull AM.

It has been a privilege and a great pleasure to work with my fellow Taskforce members, Professor Richard Murray and Associate Professor Sally McCarthy. I thank them for their hard work, extensive contributions and sage advice.

I also acknowledge the excellent support and advice provided to the Taskforce by the Secretariat in the Department of the Prime Minister and Cabinet.

Yours sincerely

Ken Lay APM
Chair

6 October 2015

EXECUTIVE SUMMARY

Ice use in Australia is at high levels and is increasing

Proportionally, Australia uses more methamphetamine than almost any other country, and the number of users continues to grow. More than 200,000 Australians reported using the crystalline form of methamphetamine (commonly known as 'ice') in 2013, compared with fewer than 100,000 in 2007. These figures are conservative and already dated. Today, evidence suggests there are well over 200,000 users.

Its use creates a distinct problem for society

Unlike cannabis and heroin, ice is an extremely powerful stimulant. For some people, it can trigger psychological disturbances or violent and aggressive behaviour. Long term use may damage the brain and cause impaired attention, memory and motor skills. The distress ice causes for individuals, families, communities and frontline workers is disproportionate to that caused by other drugs.

Law enforcement agencies have responded strongly to disrupt the supply of the drug

The quantity of ice seized at the Australian border has increased dramatically in recent years. In 2014, customs intercepted more than 50 times as much ice by weight than in 2010. In 2013-14 there were over 26,000 arrests related to the distribution or possession of amphetamine-type stimulants, including ice.

But the market remains strong

Despite the efforts of law enforcement agencies, the market for ice remains strong. Ice is still easy to get and its price remains stable.

The lack of any discernible market response to the efforts by Australian law enforcement agencies to prevent the supply of ice is greatly concerning. In most markets—legal or not—the significant shock to supply caused by a large seizure of product, should at the very least push up prices, particularly when demand is so strong. It is remarkable that despite very large seizures there has been no increase in the street price of the drug.

The resilience of the market for ice reflects the drug's unique nature

There are factors that, in combination, make ice unlike other illicit drugs that have commonly been used in Australia:

- Ice is manufactured from chemicals, not produced from plants, and can be mass produced in industrial scale labs offshore for export into Australia, so any seized product can be quickly replaced.
- Methamphetamines, including ice, are the only illicit drug that is both imported and locally manufactured in significant quantities, increasing complexity of the required response from law enforcement agencies.
- Ice is easily concealed and trafficked. For example it can be dissolved in oil and reconstituted as crystals.

- Ice is also a dangerous drug for new users, offering the promise of euphoria, confidence and enhanced sexual pleasure at a relatively cheap price. At $50 per dose in some parts of Australia, it can be cheaper than a night out drinking alcohol.
- The effects of ice can be achieved through smoking, not just through injecting, making its use appear safer and more socially acceptable.
- Ice is more likely to cause dependence than other drugs, and has a very long withdrawal and recovery phase. Prolonged heavy use can impair cognitive functioning for months after giving up the drug. Relapse is understandably common.

Ice's unique factors have created a perfect opportunity for organised crime—a growing demand for a highly attractive and addictive substance, which can be sold at a high price in Australia.

The market's resiliency must shape our response

Australia's response must be designed to address the uniquely complex characteristics of the problem we face. The demonstrated buoyancy of the ice market suggests this is not a problem that can be solved overnight.

Our first priority must be supporting families, workers and communities to better respond to people affected by ice

Families, frontline workers and communities are struggling to respond to the growing number of dependent ice users around the country. Our immediate priority must be to support those Australians who are most affected by ice use.

Families need advice on how to help their relatives who are struggling as a consequence of their ice use.

Frontline workers need guidance on how to engage with ice users, and those in crisis, in particular where aggressive behaviour or violence is present.

We need to enable communities to play their part

Communities also need help to take action. Communities are key to sending strong messages against ice use, supporting users who want to get off the drug, and working with police and other services to keep local communities safe from ice.

Efforts to reduce demand for ice must be strengthened

We must balance our efforts in law enforcement with action to curtail the demand for ice.

This means reducing the number of ice users by providing effective support to help current users quit and preventing people from starting to use the drug through well designed and targeted prevention activities.

Ice users need treatment and support services that cater to their needs

While giving up ice is difficult, it is achievable. Many accomplish it without formal treatment or support. For others, well designed treatment services, including detoxification, counselling, rehabilitation and follow-up services can be effective.

Yet Australia's current treatment and support system is not particularly well designed to respond to ice use. Many services are designed for other types of drugs—for example, some detoxification services don't cater well for the comedown associated with stimulants, and some services lack appropriate follow-up for the extended withdrawal period associated with ice.

Residential services should give priority to those with significant social disadvantage or other coexisting health issues. There needs to be more accessible and cost-effective counselling services available to ice users when they need it.

Planning for treatment and support services to help people get off ice needs to take account of local needs. Local communities need to be involved in determining the right mix of services for their area.

And we must take steps to prevent people using in the first place

Young people experimenting with ice tend to be exposed to drugs through networks of their trusted peers. Education and information about ice needs to be broadly disseminated, including through schools, but we must also design credible prevention messages that resonate with particular at-risk groups.

Efforts to disrupt supply must be more coordinated and targeted

Disrupting the ice supply chain through seizures and arrests of key players in importing and trafficking networks remains a critical part of the response to ice.

There are maturing collaboration and coordination arrangements between Commonwealth, state and territory law enforcement agencies. Despite these, challenges remain in ensuring a unified response and the timely exchange of intelligence in relation to ice. An enhanced focus on the supply chain is required, particularly offshore. International cooperation and improved intelligence offer the best opportunities to tackle the supply of ice.

Domestically, there is an opportunity to make precursor controls more comprehensive and responsive, so they keep pace with changes in supply and production methods. It is also necessary to remove any potential for infiltration of air and sea ports by organised crime. And the growing use of ice in regional Australia must be recognised and appropriately addressed.

And better data, more research and regular reporting will strengthen Australia's response and keep it on track

The unique complexities of the ice problem and the current gaps in our understanding of the market for the drug highlight the critical need for better data, more research and regular nationally consistent reporting. Enhanced up-to-date data needs to be accessible to all stakeholders. Better data on illicit drug use will enable emerging trends to be identified and help governments to direct resources to priority areas. Further research can strengthen responses across all services.

There should also be regular reporting on progress to ensure all efforts remain on track.

RECOMMENDATIONS

Support families, communities and frontline workers

Recommendation 1

The Commonwealth, state and territory governments should work together to develop an online curated toolkit of information and resources to support families and communities to better understand and respond to the problems caused by ice.

Recommendation 2

The Commonwealth, state and territory government should provide additional funding to communities to empower them to develop locally-based solutions to ice and other illicit drug issues.

For example, this could be facilitated through existing community capacity building programmes such as the Commonwealth's Good Sports Programme, to avoid duplication of existing mechanisms.

Identification of appropriate, high-priority communities should be done collaboratively between governments, particularly where there are existing planning frameworks in place, to avoid inefficiencies or overlap of investment.

Recommendation 3

The Commonwealth, state and territory governments should work together to improve coordination between community-based alcohol and other drug services, and support referral pathways between local health, support, employment and other programmes.

This should build on existing coordination and governance mechanisms where possible, and involve Commonwealth, state and not-for-profit services to establish cross-service networks and provide better support for people seeking help for alcohol and other drug problems.

Recommendation 4

The Commonwealth, state and territory governments should engage expert leadership to provide evidence-based information for frontline workers on how to deal with methamphetamine in a variety of sectors and settings.

This should be done by updating existing national guidelines for frontline workers or developing new guidelines for frontline worker sectors and settings where national guidelines do not already exist. The guidelines should have a nationally consistent basis, but be flexible enough to take account of relevant differences in each state and territory.

Recommendation 5

The Commonwealth, state and territory governments should work with relevant accreditation associations and training organisations for various frontline workers (including general practitioners, regional and remote health workers, Indigenous health workers, nurses, psychologists, psychiatrists, paramedics and police) to ensure that education and training relevant to ice and other psychostimulant use is included in the medical curricula and foundation qualifications and in continuing professional development programmes.

As the first step, the Commonwealth Government should work through the General Practice Mental Health Standards Collaboration to strengthen stimulant-specific content in mental health skills training for general practitioners relevant to both the urban and the regional and remote context and in the continuing professional development of general practitioners.

Recommendation 6

Under the National Drug Strategy framework, the state and territory governments should review the availability of Certificate IV alcohol and other drug qualifications and take action to address placement shortages as a matter of priority.

Recommendation 7

The Addiction Medicine Medical Benefits Scheme items approved by the Medical Services Advisory Committee in August 2013 should be implemented as a matter of priority.

Future consideration should also be given to the following enhancements to the Medical Benefits Scheme items:

- diagnoses must be consistent with Diagnostic and Statistical Manual of Mental Disorders, 5th Edition or International Classification of Diseases 11th Revision criteria
- source of referral should be narrowed to include general practitioners and nurse practitioners only
- items should include requirements for assessment and management of patients within the primary care setting, with communication exchange between the specialist and primary care provider.

Recommendation 8

The Commonwealth, state and territory governments should work together to develop workforce development pathways and career options for more Indigenous Australians in the alcohol and other drug sector, including strategies to ensure the workforce is appropriately supported and sustainable over the long term.

Target prevention

Recommendation 9

Building on existing efforts, the Commonwealth, state and territory governments should work together to ensure that ice and other methamphetamine-specific resources are available to support and inform teachers, parents, families and students. The resources should:

- be endorsed by alcohol and other drug experts and the education sector
- incorporate a range of information and educational materials across risk and age groups
- include specific resources that are relevant for regional and remote and Indigenous communities
- be made readily available online and linked with the existing online school web resources and the online curated toolkit.

Recommendation 10

The Commonwealth should develop a comprehensive, evidence-based two-year prevention communication plan, in consultation with expert bodies (including the Australian National Advisory Council on Alcohol and Drugs), that focuses specifically on ice.

The communications activities should include:

- a follow-up national public awareness campaign that is informed by robust evidence and promotes the treatment and support options available for users and their families
- targeted communication activities for at-risk groups to be delivered through different mediums, including social media and (if appropriate) peer-to-peer methods. These activities should capture people living in regional and remote areas, Indigenous communities, young people and lesbian, gay, bisexual, transgender and intersex people.

The communications plan should be comprehensively evaluated after two years, including effectiveness in reaching target audiences and impact on ice use. This should then inform the development of future communication activities relevant to ice.

Recommendation 11

The Commonwealth should partner with state and territory governments and industry groups to develop a pilot workplace prevention programme to roll-out across high-risk industries.

This pilot programme should:

- be developed in consultation with alcohol and other drug and industry expertise
- be rolled-out across multiple high-risk industries over an appropriate length of time to monitor outcomes
- incorporate a robust evaluation methodology to inform future workplace prevention activities.

Recommendation 12

The Commonwealth, state and territory governments should agree to take a whole-of-government approach to prevention, with a focus on vulnerable populations, including Indigenous Australians.

This should include two key elements:

- working in partnership with vulnerable groups and communities to address the risk factors that lead to drug misuse
- working in partnership to enhance the roll-out of parenting and early childhood programmes aimed at developing resilience in young children, particularly in disadvantaged communities.

Tailor services and support

Recommendation 13

The Commonwealth Government should improve access to online interventions by funding the development and delivery of ice-specific counselling and self-help online options, and by commissioning an evaluation of uptake and outcomes resulting from these initiatives to help build the evidence base around these forms of support.

Recommendation 14

The Commonwealth, state and territory governments should work together to ensure users and families affected by ice have ready access to a single, national hotline where they can receive information, counselling and other support services.

This hotline must be resourced with the appropriate expertise to respond effectively to ice across a broad range of issues—this includes ensuring support is available for families when they need it.

Recommendation 15

The Commonwealth, state and territory governments should work with sector experts to roll out a national training programme to improve delivery of alcohol and other drug screening and brief interventions for:

- primary care workers, including general practitioners
- emergency department nurses and physicians and paramedics
- community workers.

The roll out of this programme should occur in consultation with professional bodies and the Australian National Advisory Council on Alcohol and Drugs.

Recommendation 16

The Commonwealth Government should review and enhance the Better Access Initiative to ensure that individuals with a diagnosed alcohol and other drug misuse disorder have greater access to appropriate treatment and care through their general practitioner.

This should include improving referral pathways for alcohol and other drug-specific psychosocial intervention, and enhancing associated training through the General Practice Mental Health Standards Collaboration.

Recommendation 17

The Commonwealth, state and territory governments should work with the specialist treatment sector to design and implement a national quality framework that sets the standards for:

- the delivery of evidence-based services for the population, with clear expectations of the quality standards for each service type
- workforce capabilities, which must be matched to the service-type and population need
- cross-agency partnerships and collaboration
- monitoring and evaluation of outcomes and effectiveness to inform continuous quality improvement.

Recommendation 18

The Commonwealth, state and territory governments should further invest in alcohol and other drug specialist treatment services. This investment must:

- target areas of need—this includes consideration of regional and remote areas and Indigenous communities
- be directed toward evidence-based treatment options and models of care for every stage of a patient journey
- involve consultation across the Commonwealth, states and territories and the alcohol and other drug sector
- be subject to a robust cost-benefit evaluation process
- ensure service linkages with social, educational and vocational long-term supports.

Recommendation 19

Commonwealth, state and territory governments should improve planning of alcohol and other drug specialist treatment to ensure the right mix of resources and services are provided to the areas of highest need.

This must determine the national distribution of funding and planning responsibilities, and ensure the implementation of a robust accountability and contestability framework that evaluates government investment against outcomes. Primary Health Networks could be a key focus for determining locally appropriate solutions that meet the needs of their populations and through which Commonwealth funded services can be directed.

Recommendation 20

Commonwealth, state and territory governments should improve existing commissioning and accountability processes for alcohol and other drug treatment by supporting longer funding periods to strengthen service planning and workforce development, and increasing the focus on evaluation to improve treatment outcomes.

Recommendation 21

The Commonwealth, state and territory governments should work in partnership to develop a national approach to strengthening the collaboration and intersection between the mental health and alcohol and other drug treatment sectors. This should also be reflected in the development of the Fifth National Mental Health Plan.

Recommendation 22

The Commonwealth, state and territory governments, in close consultation with Aboriginal Community Controlled Organisations and communities, should take steps to improve access to integrated, evidence-based, culturally appropriate services for Indigenous Australians.

This should be aimed at:

- ensuring services are targeted toward areas of need
- maximising efficiency
- supporting organisational and community development and capacity building
- ensuring good governance and Indigenous participation
- maximising linkages with broader health and support services.

Recommendation 23

Under the National Drug Strategy framework, state and territory governments should increase the focus on evidence-based approaches to treatment in correctional facilities and youth justice centres.

Strengthen law enforcement

Recommendation 24

The Commonwealth Government should continue to protect the aviation and maritime environments against organised crime by strengthening the eligibility criteria for holders of Aviation Security Identification Cards and Maritime Security Identification Cards; and establishing a legal mechanism to enable compelling criminal intelligence to be used in determining suitability of workers to hold such a card.

Recommendation 25

The Commonwealth Government should establish a new national platform for criminal intelligence to improve the existing information sharing infrastructure. This will enable greater national collaboration to proactively tackle organised crime in Australia, informed by the findings of the current programme by the Australian Crime Commission.

Recommendation 26

The Commonwealth Government should:

- in collaboration with states and territories, work through the Serious and Organised Crime Coordination Committee to operationalise joint national and jurisdictional responses to ice. This should include regional and remote areas (including Indigenous communities)
- exercise existing powers to identify organised crime groups that are operating in regional and remote areas. This information should be used to identify methods of regional ice distribution, sources of new demand, and to generate operational leads for local law enforcement representatives
- work with the states and territories through the Australian Federal Police-led National Anti-Gangs Squad to tackle the significant outlaw motorcycle gangs' involvement in ice production, importation and distribution, and through the Australian Federal Police's Rapid Lab capability to disrupt regional ice distribution through the mail and parcel post.

Recommendation 27

The Commonwealth Government should strengthen international advocacy and engagement on cooperation and information sharing between law enforcement agencies and, in particular:

- conduct a stocktake of existing international cooperative arrangements relevant to the supply of ice, identify gaps and make improvements
- establish a Commonwealth strategy to focus specifically on disrupting the supply of ice and precursors to Australia from major source and transit countries
- consider the development of a broader Commonwealth transnational engagement strategy in the Asia-Pacific to target international drug networks which focuses on defined objectives for the coming three to five years.

Recommendation 28

The Commonwealth, state and territory governments should prioritise finalising the necessary arrangements to allow a national cooperative scheme on unexplained wealth to start as soon as possible.

Recommendation 29

The Commonwealth Government should:

- continue to work with the states and territories to examine ways to achieve greater national consistency of controls on precursor chemicals and equipment, and an agile mechanism to amend existing legislation as illicit manufacturing methods evolve
- prioritise the development of a national electronic end-user declaration system to provide law enforcement agencies with access to information about precursor and equipment sales across Australia through an online, searchable database
- encourage states and territories to enact legislation to support compliance with the new end-user declaration regime
- engage with industry to facilitate the development of a more contemporary and comprehensive industry code to provide best-practice guidelines for supply diversion into illicit drug manufacture.

Recommendation 30

The Commonwealth Government should work with at least one state or territory government to pilot a Swift and Certain Sanctions programme for ice offenders on probation, drawing on lessons learned from implementing these models in the United States, including the Hawaii Opportunity Probation with Enforcement Project trial in Hawaii.

Recommendation 31

Under the National Drug Strategy Framework, state and territory governments should review diversionary programmes to determine best practice approaches, and consider options for improving and expanding existing arrangements.

Improve governance and build better evidence

Recommendation 32

The Commonwealth, state and territory governments should introduce a simplified governance model to support greater cohesion and coordination of law enforcement, health, education and other responses to drug misuse in Australia, with a direct line of authority to relevant Ministers responsible for contributing to a national approach.

Recommendation 33

Under the National Drug Strategy Framework, the Commonwealth, state and territory governments should jointly develop a new national performance framework to evaluate outcomes from the National Drug Strategy as part of the National Drug Strategy 2016-2025.

The framework should contemplate annual reporting on performance against objectives.

Recommendation 34

The Commonwealth Government, in collaboration with the states and territories, should establish an illicit drug monitoring clearinghouse for national data. This will be the central point of information for health, justice and law enforcement illicit drug data in Australia, and provide regular reporting on drug use and market trends.

Recommendation 35

Governments should work together to expand and improve the data sources available for the central analysis of illicit drug trends. This should include:

- establishing a national wastewater analysis capability, which should be drawn upon to provide a more accurate analysis of drug use in Australia
- extending the use of the existing Drug Use Monitoring in Australia programme to more sites in Australia as part of an expanded information base
- establishing a system to gather and share national ambulance data drawing on the Victorian 'Ambo Project'
- commissioning the Australian Institute of Health and Welfare to undertake the National Drug Strategy Household Survey on a more regular basis, and strengthen the methodology of the survey, including the use of online distribution methods.

Recommendation 36

The Commonwealth Government should establish and fund a new research programme to support law enforcement responses to illicit drugs, including ice.

The scope of the research programme should be confined to illicit drug and precursor markets, focusing on key gaps and priorities identified in the first instance by the National Ice Taskforce, and subsequently by the Intergovernmental Committee on Drugs.

Recommendation 37

The Commonwealth, state and territory governments should jointly review existing research into illicit drug testing to identify opportunities to advance the development and use of lower-cost drug testing.

Recommendation 38

The Commonwealth Government should fund research into evidence-based treatment options for methamphetamine treatment.

As a priority, research should examine the effectiveness of various treatments including:

- early intervention, including evaluation of training models
- low to high intensity models
- treatment settings (for example, residential and non-residential)
- cost effectiveness
- engagement and retention of methamphetamine users into treatment.

Research should also explore promising pharmacological options for the management of methamphetamine withdrawal and maintenance.

This work should be undertaken in consultation with the Australian National Advisory Council on Alcohol and Drugs.

CONTENTS

INTRODUCTION

The National Ice Taskforce was established on 8 April 2015 to advise the Government on the development of a National Ice Action Strategy.

Mr Ken Lay APM, the former Chief Commissioner of Victoria Police, was appointed to lead the Taskforce. Also appointed to the Taskforce were Associate Professor Sally McCarthy, Medical Director of the Emergency Care Institute NSW Agency for Clinical Innovation and a senior emergency physician at the Prince of Wales Hospital in Sydney, and Professor Richard Murray, Dean of the College of Medicine and Dentistry at James Cook University.

The Minister for Justice, the Hon Michael Keenan MP and the Minister for Rural Health, Senator the Hon Fiona Nash, oversaw the Taskforce.

Terms of Reference

The Terms of Reference set out the scope and direction of the Taskforce's work. The Taskforce was asked to work with the states and territories to:

- undertake a stocktake of existing efforts to address ice at all levels of government
- receive submissions from communities and experts
- identify gaps in knowledge specifically around treatment models, associated criminal activity and the impact of ice on vulnerable groups
- identify specific initiatives that are currently providing good outcomes for the community
- examine ways to ensure efforts to tackle ice are appropriately targeted, effective and efficient
- provide advice on appropriate primary prevention activities, informed by evidence and best practice
- consider options to improve collaboration and coordination across governments
- develop a broader package of recommendations for the National Ice Action Strategy.

The full Terms of Reference are at Appendix IV.

Consultations with experts and the community

The Taskforce engaged extensively with people around Australia to develop this report.

The Taskforce spoke to over 100 experts on research, education, prevention, treatment, law enforcement and support for users, families and Indigenous people.

The Taskforce also visited nine treatment and support services, and received around 100 submissions from organisations, clinics, research bodies and academics.

The Taskforce also received more than 1,200 submissions from the public. Around a quarter shared personal stories of how ice has affected them, their families and their communities. The Taskforce also held seven targeted community consultations in Mt Gambier, Broome, Darwin, Newcastle, Hobart, Townsville and Mildura.

Minister Keenan and Senator Nash, as well as other parliamentarians, held community consultations around the country. They provided the views of their constituents to the Taskforce.

The Taskforce received extensive input and advice from all state and territory governments, Commonwealth agencies and the Australian National Advisory Council on Drugs.

Scope of the report and recommended actions

This report focuses on the drug ice, and how Australia might best approach the problem of ice use within the context of the National Drug Strategy (NDS).

The NDS, and its forerunner the National Campaign Against Drug Abuse, have provided the framework for action to prevent the uptake of harmful drug use and reduce the harmful effect of both licit and illicit drugs in Australia since 1985. The NDS is a cooperative venture

between the Commonwealth, state and territory governments in partnership with service providers, local government and the community.

The National Drug Strategy 2016-2025 is being developed by the cross-jurisdictional Intergovernmental Committee on Drugs and is expected to be finalised by the beginning of 2016. This new National Drug Strategy will provide a nationally agreed approach to prevent, minimise and address the harm caused by alcohol, tobacco and other drug use, both licit and illicit.

Consistent with the NDS, governments around Australia are already acting to address ice use. Several state and territory governments have recently committed substantial additional funding to support this.

The recommendations in this report are intended to supplement current activity by all governments and the non-government sector under the NDS.

The report focuses on actions that the Taskforce thinks are particularly important to make an impact on ice use—actions that complement the investment already being made.

The Taskforce has also been guided by the NDS in identifying actions across the NDS's three pillars: demand reduction, supply reduction, and harm reduction.

It is clear that action is needed across all three pillars to effectively address the harmful effects of ice use in Australia. These actions, as the NDS notes, need to be 'applied together in a balanced way'.

During its research, the Taskforce has identified areas where it believes further action under the NDS is warranted, and included these areas for action in its recommendations.

Terminology and data

Methamphetamine is a synthetic drug that stimulates the body's central nervous system, and comes in several forms including powder, crystal, tablet and base.

Ice is a colloquial term for the crystalline form of methamphetamine, and this report uses the term 'ice' to refer to this form of the drug.

There is little data or research available specific to ice, either in Australia or internationally. Instead, most reports and research provide information on the underlying substance, methamphetamine, or on broader categories of drugs with similar effects and origins. As such, this report has used data and research on methamphetamine and broader categories of drugs where ice-specific data was unavailable.

The two most-used broader categories in this report are:

- Amphetamine-type stimulants: a group of psycho-stimulant substances that commonly includes drugs such as amphetamine, methamphetamine and MDMA (ecstasy). The term is used across health, law enforcement and international reporting (for example, United Nations reporting).
- Meth/amphetamines: a group of substances that includes drugs such as methamphetamine, some types of amphetamine, certain prescription medicines, and pseudoephedrine-based cold and flu tablets, but excludes MDMA (ecstasy). The term is most commonly used in health sector reporting.

This report draws extensively on the findings of the National Drug Strategy Household Survey (NDSHS), run by the Australian Institute of Health and Welfare. This remains one of the more comprehensive data sources on Australia's ice use. The NDSHS is conducted on a triennial basis, with the last survey completed in 2013, and its reliance on self-reporting to identify illicit drug use means it is likely to underestimate the actual practice of illicit drug use and related behaviours. The Taskforce's consultations and data derived from other sources uncovered a substantial array of evidence that Australia's ice problem has grown beyond that reported in the 2013 NDSHS.

Structure of the report

This report has three main parts.

Part A looks at ice use in Australia. Chapter 1 discusses who supplies ice in Australia. Chapter 2 examines the demand for the drug. Chapter 3 looks at the impact of ice on individuals, families and communities.

Part B provides a comprehensive stocktake of efforts to tackle ice use in Australia. Chapter 4 discusses law enforcement efforts to disrupt the supply of ice. Chapter 5 outlines what Australia is doing to prevent or delay people using ice. Chapter 6 looks at current activities to help people stop using the drug. Chapter 7 discusses other activities that underpin effective action in reducing supply and demand.

Part C examines the gaps in Australia's current response to ice and identifies where additional action is necessary. Chapter 8 identifies immediate actions that can be taken to help families, communities and frontline workers. Chapter 9 considers law enforcement. Chapter 10 looks at primary prevention. Chapter 11 examines strategies to help people stop using ice. Chapter 12 considers other factors which underpin effective action. These findings should inform the National Ice Action Strategy and ensure a comprehensive and coordinated approach to reducing the use of ice in Australia.

The Appendices provide more detail on particular elements of the Taskforce's work to inform this report and key findings. They include the outcomes of the Taskforce's public consultations with the community and sector experts, and a summary of findings on the social determinants of illicit drug use.

PART A
THE PICTURE OF ICE IN AUSTRALIA

ABOUT PART A

This part of the report examines ice in Australia—how it is supplied, why there is demand, and its resultant harms.

Ice, as the crystalline form of methamphetamine, has been observed as a drug of concern in Australia since the early 1990s. Since 2010, there has been a significant increase in the supply and demand for ice in Australia, with a corresponding increase in the harm it causes.

Chapter 1 examines the supply of ice. Although governments cannot directly measure the supply of the drug, many indicators that act as a proxy for the drug's availability are increasing: since 2010 there have been more arrests for possession and trafficking, more border detections, and more domestic seizures.

Australia is not the only country that has experienced a surge in the supply of ice over this period. However, ice has presented a particular challenge for Australia, in part because it is one of the only illicit drugs that is both imported and produced domestically in substantial quantities. There has also been a dramatic increase in the purity of the methamphetamine supplied in Australia, with a national median purity of 19 per cent in 2010-11 rising to a national median purity of 62 per cent in 2013-14.

Chapter 2 identifies the drivers of demand for ice. Reported use of ice has more than doubled since 2010. More than 200,000 Australians reported using ice in 2013, compared with fewer than 100,000 in 2007. Much of this increase has been a result of a shift in the form of methamphetamine being used, as Australians switch from powder to the crystalline from.

While some of this uptake can be attributed to the significant increase in availability of ice in Australia since 2010, there are other strong factors driving demand. These factors include increased dependence, the normalisation of ice use among some younger Australians, and the rise of smoking as a more socially acceptable method of administration. The stability of the street price, combined with the increase in purity, has translated to a significant reduction in the price per pure gram of ice.

Chapter 3 discusses the harms that ice causes. Ice is not the only drug problem in Australia, nor is ice the drug responsible for the most harms and economic costs to our country. Both alcohol and tobacco have a greater aggregate negative impact. The 2013 National Drug Strategy Household Survey found that only 1.1 per cent of the population reported using ice in the past 12 months. Yet ice is a disproportionately harmful drug.

In the majority of submissions and consultations, the Taskforce heard about the uniquely harmful nature of ice, that even irregular use has a high risk of serious harms, and that regular and dependent use can seriously damage the user as well as their friends, family and community. Since 2009, there has been a significant increase in the number of harms caused by methamphetamine: more dependent users, more deaths and more costs to the community.

These three factors—more supply, more demand and more harm—have created today's complex ice problem in Australia.

CHAPTER 1
SUPPLY OF ICE

Supply of ice has quickly outstripped that of other amphetamine-type stimulants.

Since 2009 the global market for ice has increased significantly.[1] Criminal groups are producing ice in more countries and in greater quantities than ever before. From 2009 to 2013, the weight of methamphetamine seized globally increased from 32 to 88 tonnes, with East and Southeast Asia accounting for the largest seizures.[2] Growth in the Australian market has outstripped this global trend. The weight of ice seized at the Australian border grew almost 60 times between 2010 and 2014.[3]

The supply of methamphetamine to Australian users is both generating and responding to increasing levels of demand. Use is increasing significantly, with some evidence to suggest that methamphetamine is now the second most commonly used illicit drug in Australia after cannabis,[4] and is now more common than ecstasy, cocaine and heroin (see Chapter 2).[5]

Supply of ice has quickly outstripped that of other amphetamine-type stimulants. In 2013-14, it made up 79 per cent of the weight of amphetamine-type stimulants seized at the Australian border, compared with 61 per cent in 2010-11.[6]

Ice and other forms of methamphetamine pose a unique set of challenges for law enforcement, because it is both imported and manufactured domestically, using diverted precursor chemicals and equipment. Strong demand and Australia's controls on precursor materials are contributing to a trend toward importation of finished product from places such as China, Mexico, the United States and Canada. High profit margins and growing demand make Australia an attractive market.[7]

Organised crime is heavily involved in the importation, domestic manufacture and distribution of ice, as well as other illicit drugs. They have access to extensive networks used to supply ice from overseas and distribute the drug within Australia. No single group

dominates. There are multiple entities involved in all levels of the market, from manufacture and importation to street-level dealing.[8]

The global rise of ice

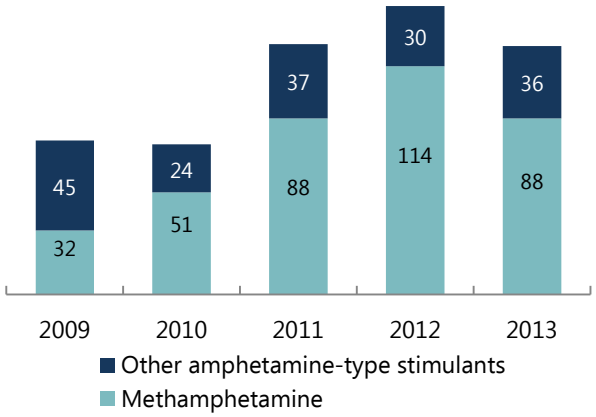
While it is difficult to measure the production of illegal substances like ice, it is clear that global supply is growing rapidly. Amphetamine-type stimulants are now the world's second most commonly used illicit substances after cannabis. In 2013, there were an estimated 14 to 54 million users of amphetamines worldwide.[9]

North and Southeast Asia contain the world's largest and most established markets for both production and use of amphetamine-type stimulants.[10] The amount of methamphetamine tablets and ice seized in China has tripled in the last five years, and was the highest in the world in 2014.[11] A large proportion of these drugs seized in China were sourced from Myanmar. However, there is also significant domestic production in China, including on an industrial-scale. Countries such as Thailand and Indonesia have large markets.[12]

Latin America, particularly Mexico, is another key source of methamphetamine. Mexican organised crime groups are expanding their global presence, including into Southeast Asia, Europe and Africa.[13] Iran was ranked fifth in volume of global methamphetamine seizures from 2010 to 2012 and is a primary source of methamphetamine to markets across the Middle East and Asia Pacific.[14] India's large chemical industry makes it an attractive possible ice production base for organised crime, with the potential to emerge as a major global source of diverted chemicals. West Africa, North America and South Asia are also key source regions for methamphetamine.[15]

A number of factors have driven the fast growth in the global trade of ice. As discussed further in Chapter 2, the nature of the drug has contributed to high demand. Ice can be combined or 'cut' with a range of adulterants and diluents to reduce purity and increase profit margins.

Figure 1.1: Weight of global seizures of methamphetamine and other amphetamine-type stimulants, in tonnes[16]



However, like other forms of methamphetamine, it is perceived by some users as less adulterated, and therefore more desirable. The large decline in global ecstasy supplies has contributed to demand for methamphetamine, as some users see it as a substitute despite its different physiological effects.

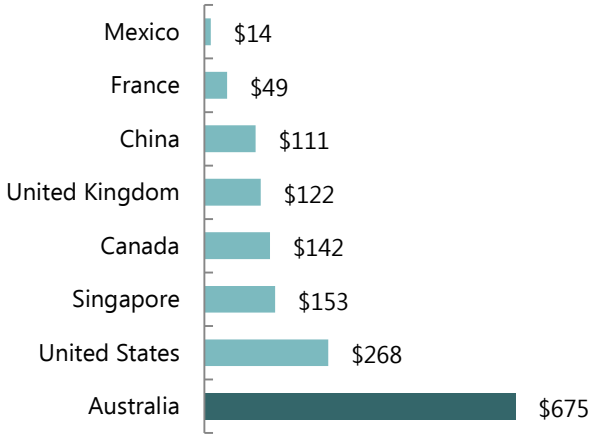
Ice is an attractive commodity for producers, given its high profit margin, particularly in Australia. As a purely synthetic drug, production is not dependent on plant-based material (unlike cannabis, cocaine or heroin). Nor is it dependent on any single chemical precursor or production methodology. It can be produced in relatively unsophisticated laboratories, including at small scale. These factors make production very mobile and flexible, and increase criminals' ability to avoid detection. Producers are also able to adapt readily to law enforcement efforts to control the supply of precursor materials, including finding alternative sources and changing production methodologies where alternative precursors are available.[17]

The high value of a small amount of ice makes it an attractive illicit commodity that can be easily concealed and transported, including across national or interstate borders. The internet currently plays a small part in the trade, but its role in facilitating imports of both ice and its precursors is growing.[18]

Imports to Australia

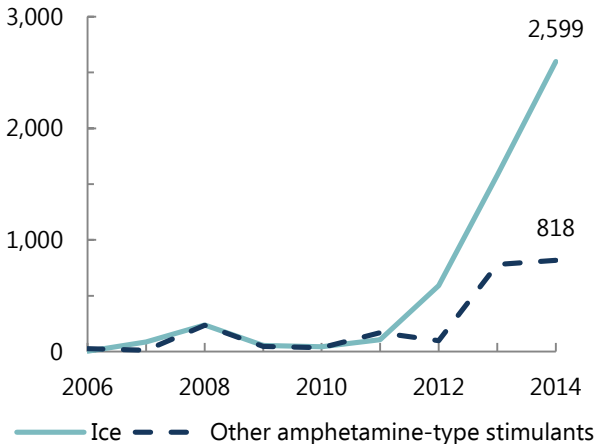
Australia is an attractive destination for imports of ice. Australia's wealth and rising demand underpin a large price differential between Australia and source countries. Nationally, in 2013-14, the Australian price for a kilogram of ice ranged between $160,000 and $265,000.[19] This was as much as 80 times higher than the price of a kilogram in some areas of mainland China. The median price paid per gram for ice in Australia is considerably higher than in many other countries.

Figure 1.2: Median street price of a gram of ice, in Australian dollars[20]



There has been a significant increase in ice imports to Australia in recent years, as indicated by rapid growth in seizures at the border.[21] Such imports are making up an increasing proportion of Australia's methamphetamine market.

Figure 1.3: Weight of Australian border seizures of ice and other amphetamine-type stimulants, in kilograms[22]



Over five tonnes of ice was seized at the Australian border from 2010 to 2015. The sharp increase in these detections is due to a rise in both high and low volume smuggling to Australia.[23] Additional screening of incoming cargo from July 2014 may have also contributed to increased seizures since then.

Concealment of large-scale shipments in sea cargo has increasingly become common. Sea cargo accounted for 58 per cent of the weight of ice detected at the border in 2014-15.[24]

Importation by international mail is also common. This includes the 'scatter-gun' method, which involves sending large volumes of postal items, each containing a small amount of drugs, to multiple addresses or post box numbers. Criminal groups and individuals using this method are prepared to lose a proportion of their items to get some shipments through.[25]

A significant amount of ice is also imported through air cargo and incoming passengers. Criminals use a variety of concealment methods at varying levels of sophistication.

Illegal imports have been found in goods ranging from food items and toys to electronic equipment and machinery and parts (see Figure 1.4). Some air passengers also conceal drugs on their person or in their luggage, often using concealed compartments or hiding substances in the lining of baggage.

Between 2010-11 and 2014-15, China (including Hong Kong), Thailand, Mexico, Canada and the United States were the main points of embarkation for ice shipments to Australia by weight—accounting for 91 per cent of weight of the drug detected entering Australia.[26]

Seventy per cent of the total weight of detections by weight was shipped from China (including Hong Kong) alone from 2010-11 to 2013-14 (see Figure 1.5).[27] This appears to reflect organised crime groups from mainland China and Hong Kong accessing large quantities of high-quality, low-cost methamphetamine manufactured in China. Such organised crime groups exploit pharmaceutical industries to access and divert amphetamine-type stimulants and precursors.

In many cases these diverted chemicals feed into industrial-scale laboratories that produce ice and other illicit drugs for export to other markets.[28]

The international ice trade consists of extensive international networks drawing on product from key manufacturing hubs. Established international organised crime groups are actively cooperating with organised crime in Australia.

Transnational criminal groups will continue to use Asia Pacific countries as key transit points. This is driven by permissive factors in the region such as poor border security,[29] strong regional precursor flows[30] and a high organised crime presence. Australia's comparatively stronger domestic precursor controls are an incentive for organised crime groups to import both precursors and finished product into Australia, instead of attempting to source precursors domestically

Figure 1.4: Detections of ice at Sydney Mail Gateway (marker pens) and in air cargo (portable petrol engine)[31]

The darknet and postal imports

While it has had limited impact to date, the darknet is increasing as a means of sourcing and importing drugs, including methamphetamine and precursors.

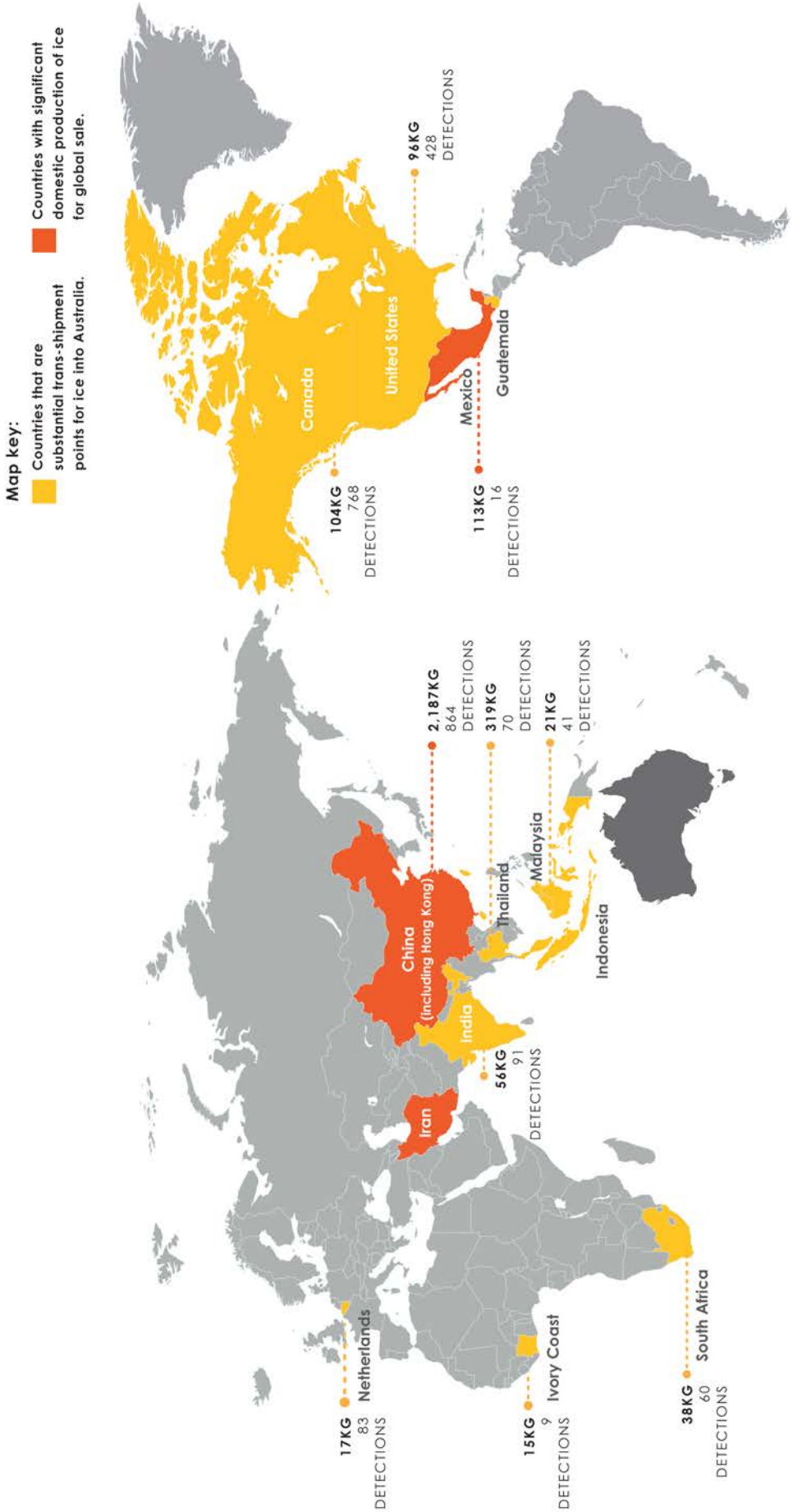
The darknet is the term given to private online networks not readily accessible through search engines such as Google. Access is anonymous, largely untraceable, and frequently associated with criminal activity.

While drug users who source their drugs through the darknet generally only purchase relatively small quantities (perhaps one or several grams), it is possible for users and suppliers to purchase multiple kilograms at a time online.

The generally lower prices charged and the anonymity measures used by these sites make them attractive to some low-level and mid-level users and suppliers. They may also attract new users who are reluctant to deal with criminal entities in person. Most methamphetamine buyers on these sites are users seeking the drug only for themselves or a small group of associates. There is only limited evidence of organised crime groups using this method to source commercial quantities.[32]

Delivery of items is most commonly through parcel post or mail streams to false delivery addresses or post boxes, and increasingly to parcel lockers that can be organised online using false identities. This allows some buyers to use the 'scatter-gun' approach by conducting multiple, relatively low cost importations that reach them through different routes.[33]

Figure 1.5: Major embarkation countries of ice imported to Australia, 2010-11 to 2014-15[34] [35]



Australian ice manufacture and distribution

Domestic seizures of amphetamine-type stimulants provide evidence of the fast growth of this drug market in Australia. The weight of these seizures increased more than five times between 2009-10 and 2013-14 to over four tonnes, with an estimated street value of more than $3 billion.[36] Ice use as a proportion of meth/amphetamines use in Australia has also increased dramatically over this period.[37] This is supported by anecdotal evidence from police, emergency services and community groups indicating an alarming rise in the use of ice and its impacts on society in recent years.

The role of organised crime

Organised crime groups are deeply entrenched in the importation, manufacture and distribution of methamphetamine in Australia. Two-thirds of the groups on the Australian Crime Commission's National Criminal Target List are involved in the market for methamphetamine or its precursors. This includes nearly three-quarters of the criminal organisations assessed as the highest threat to the community.[38]

Members of outlaw motorcycle gangs, transnational groups and other established criminal groups are prominent in the ice market. There is increasing cooperation between organised crime groups both nationally and internationally. Many groups involved in the market have evolved from working exclusively within their own group or network of contacts, to cooperating with non-traditional partners. Such collaboration is primarily based on mutual criminal and financial benefit, rather than ongoing loyalty.[39]

Outlaw motorcycle gangs are significant players in the importation, domestic manufacture and trafficking of illicit drugs in Australia, including ice. Their ongoing role is enabled by strong domestic and international serious and organised crime links and established drug distribution networks. Their use of violence and access to weapons and specialised money laundering services also facilitates their role.[40]

A number of criminal groups have expanded their activities into markets for different illicit drugs. This diversification has broadened methamphetamine sourcing and distribution channels, and strengthened resilience to disruption by law enforcement agencies and competitors. These relationships have also facilitated laundering of profits, including offshore.[41]

Precursors and ice manufacture

Domestic manufacture of methamphetamine, including ice, remains at significant and concerning levels, despite the substantial growth in imports. However, there are signs that the level of domestic manufacture may be starting to decline.

After doubling over the past decade, the number of clandestine methamphetamine laboratories detected by law enforcement agencies has plateaued in recent years. However, the laboratories detected have become larger and more sophisticated on average, so it is not clear whether the overall quantity of methamphetamine being produced in Australia has fallen.[42]

Border seizures of precursor materials used in methamphetamine manufacture (by weight) fell to around 2010 levels in 2014, following strong growth in the intervening years.[43] However, during the same period there were two very large domestic seizures of precursors, of 10 and 11 tonnes in 2013-14 and 2011-12 respectively, suggesting that large scale domestic manufacture of methamphetamine continues.[44]

Every gram of ice manufactured in Australia results from either the diversion of a precursor, pre-precursor,[45] reagent or solvent from a legitimate industry in this country, or the illegal importation of these products. These chemicals, which include pseudoephedrine, ephedrine and phenyl-2-propanone (P2P), generally have wide-ranging legitimate uses, such as in pharmaceuticals or products like pesticides.

A substantial quantity of chemicals is required to produce methamphetamine, including ice. For example, one common route for the manufacture of ice using P2P requires 10 to

20 kilograms of chemicals for each kilogram of methamphetamine produced.[46] This provides opportunities for law enforcement agencies and regulators to monitor potential diversion from legitimate industry, where recording systems permit.

Chemicals can be diverted from a range of sources, including from products sourced through legitimate industry in Australia or through imports. Other sources can include hospitals and other medical facilities, transport chains and through break and enters at pharmacies and chemical companies. Some core ingredients can also be produced using a wide range of pre-precursors, but the level of technical complexity in manufacturing increases with the number of steps required to produce the end product. While Australia's domestic controls over precursor chemicals are stronger than some other countries, they are not fully comprehensive, nor are they consistent across the country. This is a vulnerability that may be exploited by organised crime.

When it is manufactured domestically, ice is manufactured by 'cooks' working in clandestine drug laboratories, which can vary greatly in size and sophistication. These cooks are generally taught by other experienced cooks, but instructions are also available on the internet or darknet.

Cooks are often contracted by criminal networks and groups and can be employed to perform discreet tasks within the manufacturing process. There are a range of manufacturing methods, depending on available precursors and equipment, familiarity and technical understanding. Criminal groups, both in Australia and internationally, have adapted by changing supply and manufacturing methods to respond to the availability of inputs and associated regulatory controls and policing. This creates substantial challenges for law enforcement efforts.

> *"The well organised crooks do monitor the legislation … They've been through it. They understand what our methodology is like and putting restrictions on chemicals, so they start looking at different ways to manufacture.*[47]

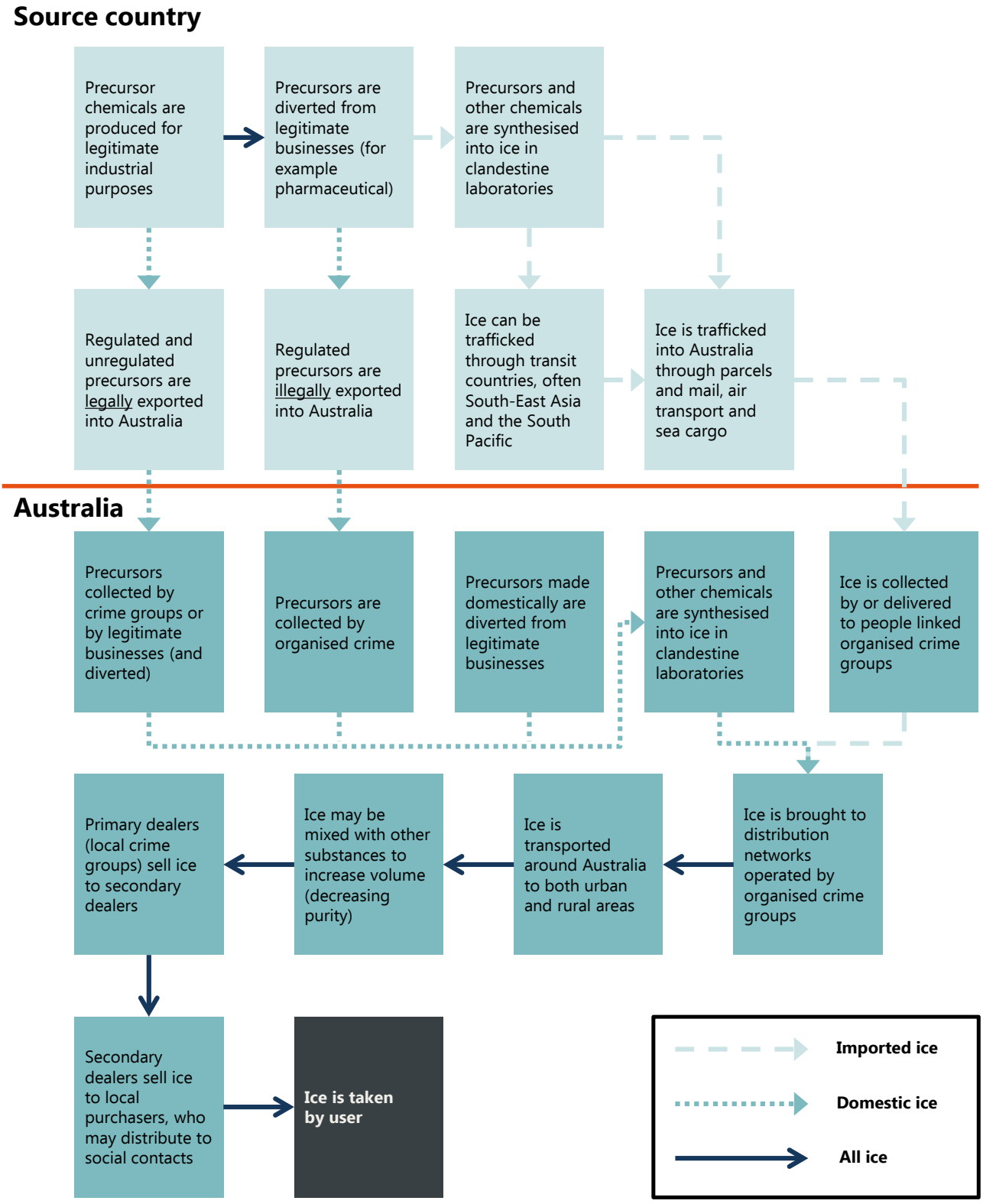
Domestic distribution

Ice is distributed throughout Australia via extensive criminal networks, drawing on both imported and domestically manufactured product. Evidence suggests that the majority of ice currently distributed within Australia is sourced through criminal groups in the eastern states. Most methamphetamine available in jurisdictions such as Western Australia, Tasmania and the Northern Territory is transported to these jurisdictions in large quantities, then cut with bulking agents and/or distributed by local criminal groups.[48]

As noted above, methamphetamine distribution accounts for a significant amount of the criminal activity of many outlaw motorcycle gangs. Some of these groups have expanded their distribution networks and customer bases by extending their activities into regional areas. This has also enabled them to establish new localised groups or chapters, take advantage of major transport routes and exploit vulnerable populations in regional and remote locations.[49]

Like many illicit drug markets, there is deliberate segmentation of ice supply between importers/producers, wholesalers and retailers. Organised criminal groups dominate ice importation, medium-scale to large-scale production and wholesale distribution. These groups often outsource functions such as street-level dealing to individuals operating largely through social networks and word of mouth. Lower-level dealers normally do not have knowledge of activities further up the supply chain. This provides higher-level dealers with a greater level of protection from identification and conviction, as well as enabling them to maintain greater control over their supply chains. Control of supply within given regions, or 'turf', plays a significant part in this system.[50]

Figure 1.6: Ice production, transit and use patterns



Innovative production methods

As access to pseudoephedrine and ephedrine has become more difficult, some illicit drug manufacturers are producing precursors such as ephedrine in clandestine laboratories. These chemicals are then used as an intermediate input to produce methamphetamine. This process requires a higher level of technical competence, but information regarding the chemicals and processing methods is readily accessible to motivated individuals. Sources include particular underground press publications and internet sites devoted to the dissemination of drug manufacturing techniques.

Recently uncovered clandestine laboratories have been found to be using a novel method to produce amphetamine-type stimulants. Helional, a non-controlled chemical, has been used as the starting point in the production of MDA (3,4-methylenedioxyamphetamine). Innovations in production methods expand opportunities for criminals to manufacture illicit drugs, including methamphetamine, from non-controlled or non-regulated chemicals, and increase control and response challenges for law enforcement.[51]

A large proportion of lower-level dealers are introduced to dealing through their own use of ice or other drugs. Incentives to sell ice include the money that can be made from dealing to other users and the access to drugs at wholesale prices. Some distribution also occurs through networks of friends, primarily to provide access to ice within a social group. While methods such as street dealing exist, most dealers operate out of their own houses, sometimes meeting clients at mutually convenient locations or events or delivering to clients' homes.[52]

The implied threat of violence at lower and middle levels of the supply chain plays a substantial regulatory role in the supply of ice. This serves to protect people involved in supplying the drug from theft or unwanted competition, and introduces the risk of retribution when people breach unwritten codes of conduct, do not pay debts or renege on other obligations.

At the same time, informal understandings and collaboration between some of the more sophisticated organised crime groups facilitates high-level supply to the market. This is particularly the case where each group is making substantial profits from the trade. It also contributes to a high degree of stability in street prices. A number of police services have noted that while street prices for ice remain high, the wholesale price for larger quantities of the drug has fallen, meaning that profits for the larger organised crime groups and importers, who purchase large quantities at wholesale prices, are likely increasing.[53]

Supply to regional, remote and Indigenous communities

In recent years, there has been an increase in the use of ice in regional and remote communities.[54]

Prices paid for illicit drugs in regional and remote areas are generally considerably higher than in larger urban centres and cities. Law enforcement agencies are concerned that serious and organised crime groups can easily use the existing networks that supply other drugs such as cannabis into Indigenous communities, to supply ice

Accessibility of ice in regional and some remote Indigenous communities appears to be increasing, albeit from a low base. It has become more prevalent in many regional hubs and there is significant concern that supply will expand to remote Indigenous communities.[55]

Police made the first seizures of commercial quantities of amphetamine-type stimulants destined for remote communities in Far North Queensland in early 2007. These seizures raised the concern that these drugs were being used by Indigenous community members in the region. In addition, cannabis producers and importers had expanded their dealings from

regional centres to remote communities, raising further concerns that an expansion of the cannabis trade could provide a potential vehicle for trafficking in amphetamine-type stimulants.[56]

While organised crime groups rarely operate directly in Indigenous communities, they often use local Indigenous residents and others as 'mules' and suppliers. Non-Indigenous contractors working on infrastructure projects, or in mining, in regional and remote towns are another source of supply.[57]

There is also often a strong correlation between the presence of outlaw motorcycle gang members or chapters in a regional location and increased distribution of ice in the area. In many cases, the outlaw motorcycle gang chapter is the only organised crime group represented in the area, giving them control of distribution over other organised crime groups. The gang leverages off its links to supply sources in major cities and recruits lower-level local distributors (who are often also illicit drug users) to engage in street-level supply.

The Taskforce heard anecdotal evidence that drug suppliers are targeting remote welfare-dependent Indigenous communities due to their vulnerability.[58] Reports that ice was being sold cheaply and, in some cases, supplied free contributed to concern that suppliers were trying to lure people into using the drug, with the aim of dependence and possibly eventual engagement with criminal drug activity to support their dependence.[59]

> *"This town is in the middle of nowhere and has been targeted by dealers as I suppose many regional towns are. It is no accident that ice has found its way here … There needs to be a far greater effort to stopping the dealers from manufacturing and spreading this drug.*[60]

CHAPTER 2
DEMAND FOR ICE

Demand for ice is driven by its unique characteristics. It is an extremely powerful stimulant and carries a high risk of dependence.

Recent increases in the supply and purity of ice have been mirrored by, and to an extent are likely to be a result of, an increase in demand for the drug. Around 200,000 Australians reported using ice in 2013—more than double that reported in 2010.[61] [62] These are conservative estimates that are already out of date. More recent data suggests there are now well in excess of 200,000 users. This is based on increasing ambulance callouts, emergency department attendance of ice-affected users, and the rise in the number of people testing positive for ice who have been apprehended by police.

Evidence indicates that those using ice are doing so with increased frequency, with dependence rates increasing. Frontline treatment services are feeling the impact, with many reporting significant increases in demand from clients experiencing problematic use.[63] [64] [65]

Social networks are playing a prominent part in the supply and distribution of ice, making it harder for users to distance themselves from the drug. Some evidence points to a 'normalisation' of ice—particularly among younger users—due to greater exposure and an emerging social acceptance of the drug. The more people that access and use the drug, and enjoy the experience, the more popular it becomes.

The unique characteristics of ice also contribute to the increase in demand. Ice is a powerful stimulant, and the people using the drug often experience euphoria, confidence and enhanced sexual pleasure. The popularity and attractiveness of the drug leads to more people wanting to try it and experience its effects.

Ice also carries a high risk of dependence. It is commonly smoked or injected, which has a more rapid effect on the central nervous system than snorting or swallowing other forms of methamphetamine. This increases the potential

for dependence.[66] Higher rates of dependence result in more people using the drug more often, which can increase demand for the drug, and, likewise, increase the harms resulting from its use.

Ice use is higher among some demographics, with evidence suggesting that young people, the unemployed and lesbian, gay, bisexual, transgender and intersex people have higher usage rates. There is also evidence that ice use is an emerging issue for some Indigenous, regional and remote communities, as well as among the inmate population.

Evidence of demand for ice

The ice market in Australia is growing exponentially. Ice is easily accessible, the price remains stable and the purity of the product being sold has risen sharply over the last five years.

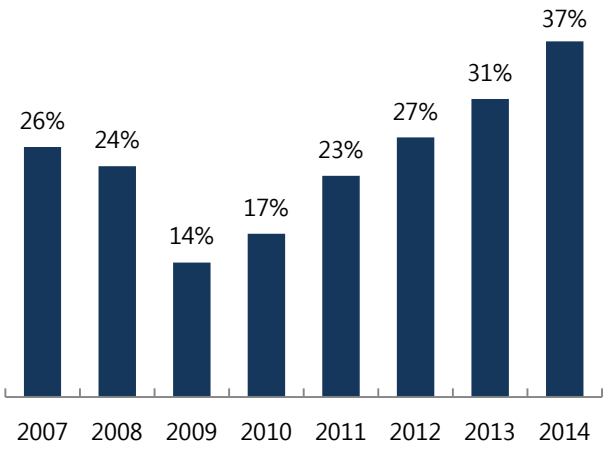
Ice first emerged as a drug of concern in the early to mid-1990s, with law enforcement agencies reporting it as a new and emerging threat.[67] In 1999, the availability of ice rapidly increased,[68] with its use through smoking appealing to new social subgroups, including young people.[69] By 2007, the reported use of methamphetamine had dropped,[70] and more than three times the number of users reported that they used powdered methamphetamine ('speed') rather than ice. Reported use of both powdered methamphetamine and ice further declined between 2007 and 2010.[71]

According to the National Drug Strategy Household Survey (NDSHS), the percentage of the population that reported using meth/amphetamines remained stable between 2010 and 2013 at 2.1 per cent of the population aged 14 years and older.[72] However, preliminary estimates by the National Drug and Alcohol Research Centre of the number of regular (monthly or more frequent) and dependent methamphetamine users indicate that use of the drug by these groups has increased each year from 2009-10 to 2013-14.[73]

Other measurements suggest that the actual amount of methamphetamine consumed (separate from the question of whether the number of people using has changed) has increased significantly year-on-year since 2009. Wastewater analysis of samples collected at two separate Queensland sites with a combined catchment population of almost 500,000 people indicates that methamphetamine use in those populations increased year-on-year from 2009 to 2015. Wastewater analysis in Adelaide also showed a steady increase in the level of methamphetamine consumption between December 2012 and the conclusion of the study in June 2014.[74]

Data collected by the Australian Institute of Criminology's Drug Use Monitoring in Australia programme (DUMA) also shows a steady increase in the use of methamphetamine from 2009 to 2014 by people detained by police at a number of sites in Australian capital cities. The Institute suggests that the rise in use among police detainees could be an early warning of a potential rise in use among the general population, which may be reflected in the next NDSHS.[75] [76]

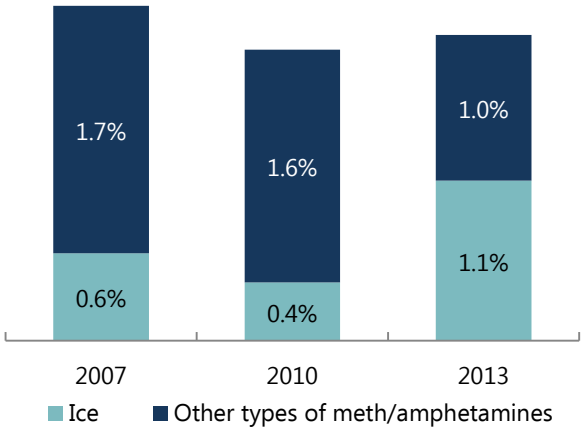
Figure 2.1: Percentage of Australian adult detainees who tested positive to methamphetamine at DUMA sites[77]



Ice has replaced powdered methamphetamine as the most frequently used form of methamphetamine. In fact, the proportion of recent methamphetamine users reporting ice as the main form used more than doubled, increasing from 22 per cent in 2010 to 50 per cent in 2013. As a proportion of the population, this was a rise from 0.6 per cent of those surveyed reporting using mainly ice in 2007 to 1.1 per cent of the population in 2013.

Those respondents using ice also reported that they were doing so more frequently, with daily or weekly use more than doubling from 12 per cent in 2010 to 25 per cent in 2013.[78]

Figure 2.2: Percentage of Australians aged 14 and over reporting meth/amphetamines use in the past 12 months[79]



Data from the Illicit Drug Reporting System, which captures drug use trends among those who inject illicit drugs, also reported an increase in recent use (use over the preceding six months) of ice, from 37 per cent in 2009 to 61 per cent in 2014. Interviewees reported a corresponding drop in powdered methamphetamine use, from 48 per cent in 2009 to 30 per cent in 2014.[80] [81] The median frequency of ice use among the national sample of people who inject drugs also increased from fortnightly to close to weekly.[82]

While most ice users use ice infrequently, in 2013 a quarter of ice users reported using the drug at least once a week (see Figure 2.3). Ice users reported to using the drug more frequently compared to other methamphetamine users.[83] [84]

Across all states and territories, Western Australia reported the highest proportion of people mainly using ice in 2013 (2.9 per cent). The second highest rate of use was in South Australia at 1.4 per cent. This is compared with the national average of 1.1 per cent (see Figure 2.4). New South Wales, Victoria and Queensland also reported increases in ice use since 2010.[85]

Broader illicit drug trends

The availability of, and preferences for, one illicit substance can affect demand for another. For example, in 2001, the methamphetamine market was given a boost by a shortage in the availability of heroin in Australia. With decreased access to their drug of choice, heroin users increased their use of methamphetamine,[86] which led to a small rise in methamphetamine use overall.[87]

Reports that the number of ice users has steadily increased coincides with the significant reduction of ecstasy imports to Australia.[88] The evidence suggests an initial shift from ecstasy to methamphetamine during 2008 to 2010, and then a shift within the methamphetamine market to ice after 2010.[89]

While ice use has been increasing, it is not the most used illicit drug in Australia. In 2013, 10.2 per cent of the Australian population aged over 14 years reported having used cannabis in the past 12 months. In addition, 2.5 per cent reported recently using ecstasy, while 2.1 per cent reported recent cocaine use (see Figure 2.5).[90] However, as previously discussed, alternative data sources, such as wastewater analysis and DUMA, indicate that use of methamphetamine, including ice, has increased beyond that reported in the 2013 NDSHS. These data sources also suggest that methamphetamine use has significantly exceeded the use of both ecstasy and cocaine in certain catchment populations since 2009.[91] The findings from the alternative data sources are more consistent with law enforcement data and intelligence holdings.

There are unique harms associated with the use of ice, including risk-taking behaviours, danger to frontline workers and trauma to families. The harms associated with ice use are explored in greater detail in Chapter 3.

Figure 2.3: Frequency of use by Australians aged 14 and over reporting meth/amphetamines use in the past 12 months in 2013, by main type used[92] [93]

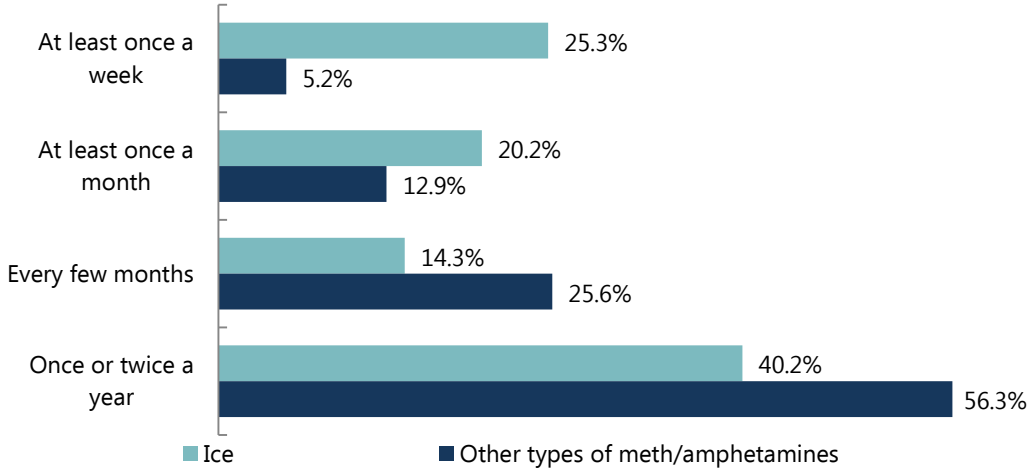
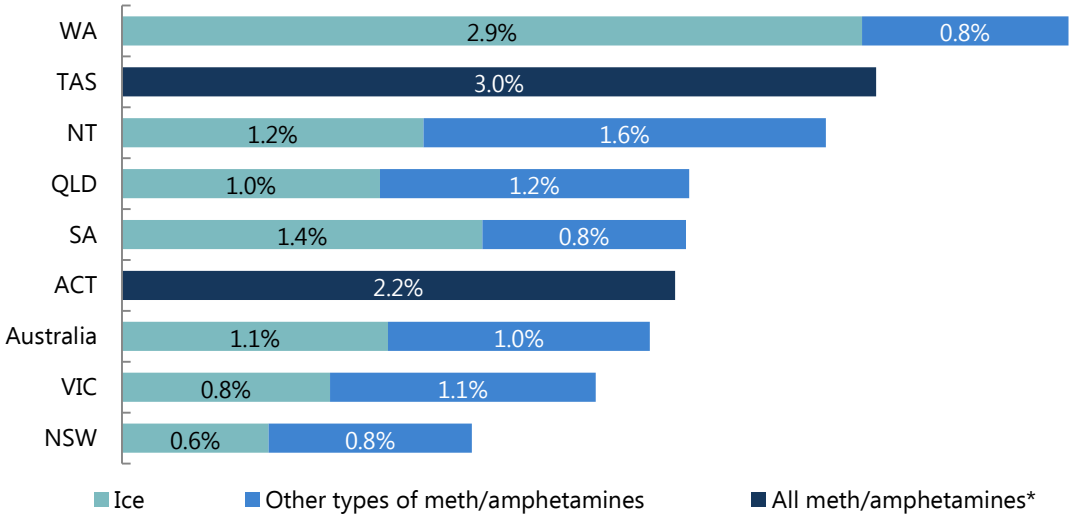
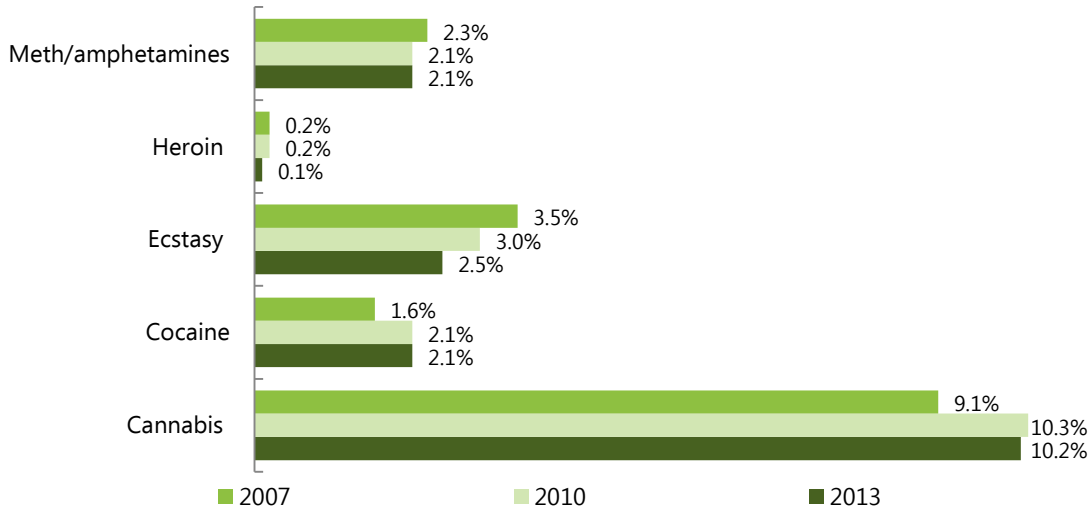


Figure 2.4: Percentage of Australians aged 14 and over reporting meth/amphetamines use in the past 12 months in 2013, by state and territory[94]



Breakdown of types of meth/amphetamines used not available for Tasmania or the Australian Capital Territory.

Figure 2.5: Percentage of Australians aged 14 and over reporting illicit drug use in the past 12 months, by type of drug[95]



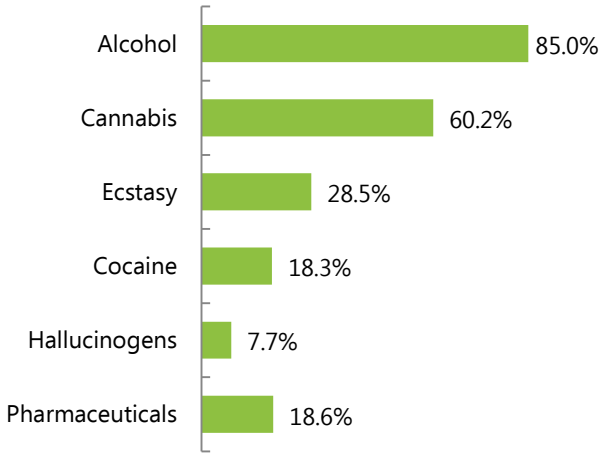
Polydrug use

The Taskforce heard repeatedly during consultations that ice is commonly being used in combination with alcohol and other illicit drugs,[96] [97] which is increasing the impact of harm on individuals, families and the community.[98] Evidence also suggests a high correlation between ice use and cigarette smoking.[99]

People often use ice in conjunction with depressants, such as alcohol and cannabis, to counter the stimulant effects. This may calm the nervous system to enable rest and sleep. Conversely, some use ice in combination with alcohol as it enables them to drink more for longer without feeling sleepy.[100] For injecting users, research has found that concurrent opioid and benzodiazepine use is a common strategy to 'come down' from methamphetamine.[101]

Ice is also taken in combination with other stimulants, such as ecstasy or other amphetamines. For some users, this enhances the excitement and alertness they experience.[102]

Figure 2.6: Percentage of Australians aged 14 and over reporting ice use[103] in the past 12 months in 2013 who also reported using other drugs at the same time[104]



According to the NDSHS, the most common substance used at the same time as ice is alcohol (85 per cent). This is consistent with what the Taskforce has been told throughout its consultation process. The second most commonly used substance used at the same time is cannabis (60.2 per cent).

The reasons behind polydrug use vary depending on the type of user (for example, experimental or dependent), the experience they are seeking, their knowledge of different substances, and the substances available at any given time.[105]

Why do people use drugs?

Factors influencing drug use are complex. While it is not intended that this report undertake a comprehensive analysis of all the factors leading to illicit drug use across the population, there is nonetheless value in considering how some of these factors contribute to the current situation of ice use in Australia as a way to better comprehend the full picture.

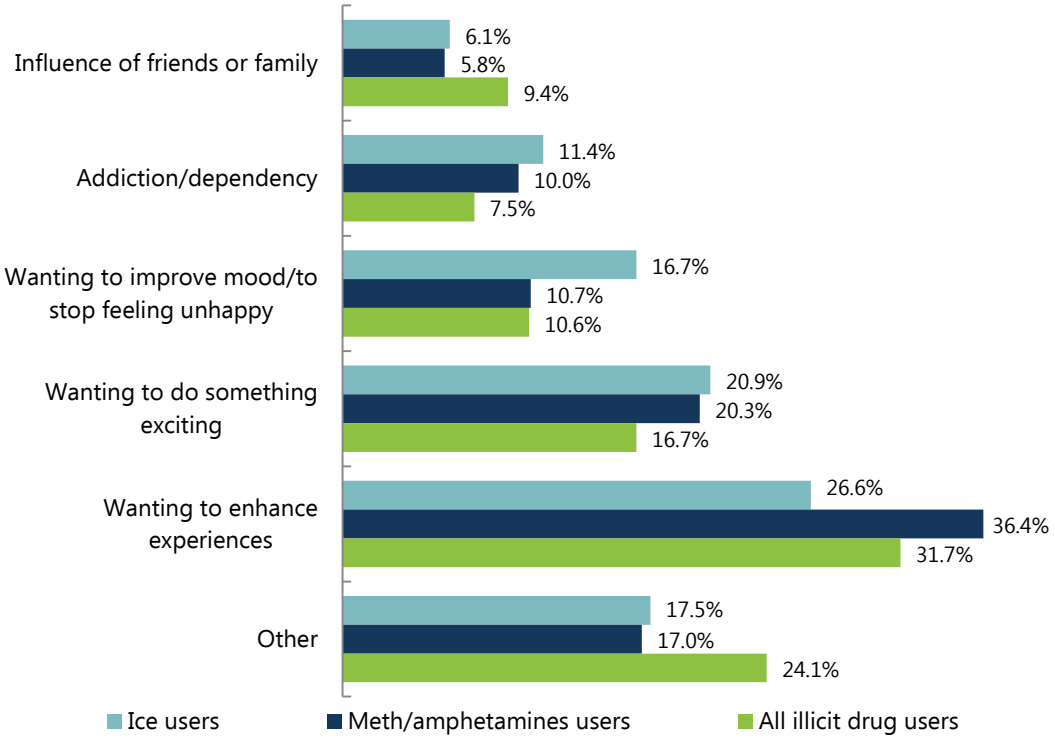
People who use illicit drugs are motivated by a range of factors, including: [106] [107]

- Experimentation: use to satisfy curiosity about a new experience or as a result of influence from peers.
- Desire to have a good time: use that generally occurs within a recreational or social setting.
- Situational/functional use: use as a coping mechanism or to improve functionality.
- Dependence: use that is frequent, habitual and often accompanied by a physical and/or psychological dependence.

A common reason why many people use illicit drugs is to have fun. Ice is no different—its known effects include increased energy, alertness and sexual desire and pleasure through its stimulant effects.[108]

In 2013, 27 per cent of people who reported ice use stated that they used the drug to enhance their experiences, while 21 per cent stated that they wanted to try something exciting.[109] Experimental users tend to be younger, while those who use for fun often do so in a social context.[110] A smaller but still significant proportion (11 per cent) of people reported that they use due to addiction/dependency (see Figure 2.7).[111] These people are likely to have used more frequently and over a longer period.

Figure 2.7: Reasons given for continued illicit drug use by Australians aged 14 and over reporting illicit drug use in the past 12 months in 2013[112]



Breaking the cycle of use is much more difficult for dependent users. Dependent and heavy users are less likely to be in full-time employment and more likely to be involved in criminal activity.[113] [114] While dependent, injecting users are generally older, the Taskforce has heard that the cohort of dependent users who smoke ice is becoming younger.

Use as a coping mechanism is more commonly associated with powdered methamphetamine. However, the Taskforce received feedback that some ice users are motivated by the perception that ice will improve their functioning by making them more alert and able to work harder for longer hours.[115]

Social determinants of drug use

Disadvantaged populations are at greater risk of harm from illicit drugs.[116] The Taskforce received a number of submissions that identified the need to consider the broader social determinants that contribute to drug use, including the complex issues of social and economic exclusion, poverty, marginalisation, racism and stigmatisation.[117] [118] [119]

A vulnerability to engage in drug use often depends on the presence of 'risk' and 'protective' factors.[120] While no single risk factor can be pinpointed as the cause of future issues, the more risk factors that persist over a longer period of time, the greater the cumulative impact.[121]

The emergence of risk factors is something that occurs across the lifespan from prenatal/perinatal through to adulthood. Exposure to risk factors earlier in life can have a 'snowball effect,' with subsequent risk factors accumulating as a consequence of earlier issues.[122] The relationship between drug use and social determinants is explored further in Appendix II.

Key demand drivers

The Australian methamphetamine market is robust and growing. New demand is being created in areas where the drug has not previously been observed.[123]

There are five prominent drivers boosting demand for ice in Australia:

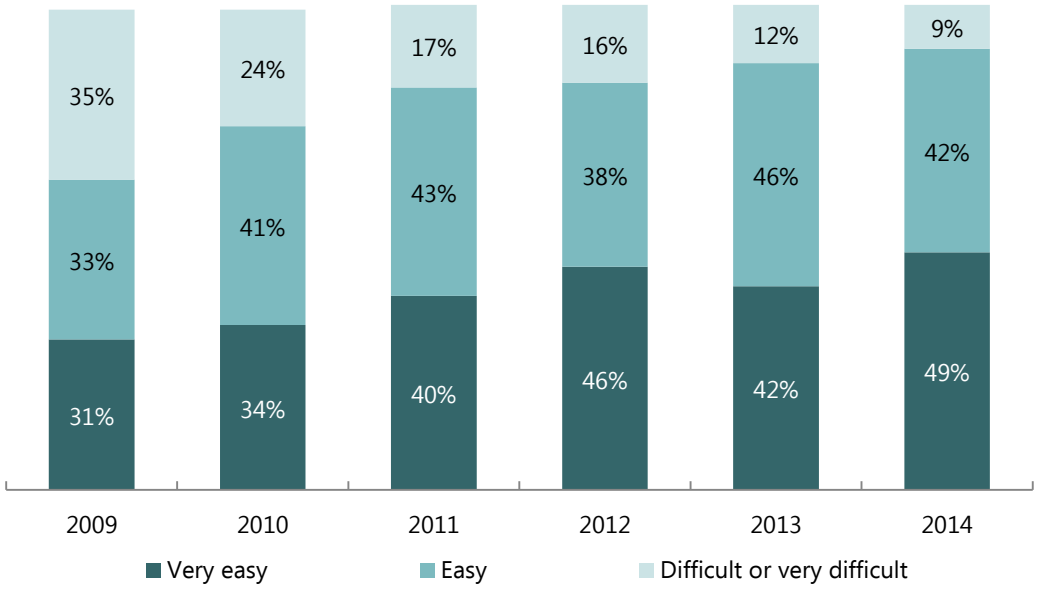
- Availability: there has been significant growth in the detected importation, manufacture and supply of methamphetamine, and users are reporting the drug as easier to obtain than five years ago.[124]
- Affordability: the price for ice has remained relatively static in recent years and has even dropped in some areas.[125] [126]
- Purity and potency: the purity of ice and other forms of methamphetamine is increasing,[127] and there is strong evidence that smoking and injecting increases the potential for dependence, compared with other forms of administration.[128] [129]
- Social factors: social networks are playing an increasingly pivotal part in reinforcing demand;[130] the more people using the drug, the more popular it becomes.
- Dependence: while not all users become dependent, ice has a high 'dependence liability'. This means that people who use ice are at greater risk of becoming dependent.[131] Higher rates of dependence lead to greater consumption, further increasing demand for the drug.

Availability

As discussed in Chapter 1, there has been significant growth in the detected importation, manufacture and supply of methamphetamine. Ice users are also reporting that the drug is easier to obtain than five years ago. In 2009, a total of 31 per cent of Illicit Drug Reporting System interviewees reported that ice was 'very easy' to obtain. This increased to almost half of respondents in 2014, with no interviewees identifying ice as very difficult to obtain.[132]

Users are also reporting that ice can be obtained very quickly. According to data obtained from April 2008 to March 2014 across Melbourne, the time taken to purchase ice was typically short—a median of 20 minutes. Fewer than 10 per cent of ice purchases took longer than 60 minutes.[133]

Figure 2.8: Reported difficulty of acquiring ice by Illicit Drug Reporting System interviewees [134]



Affordability

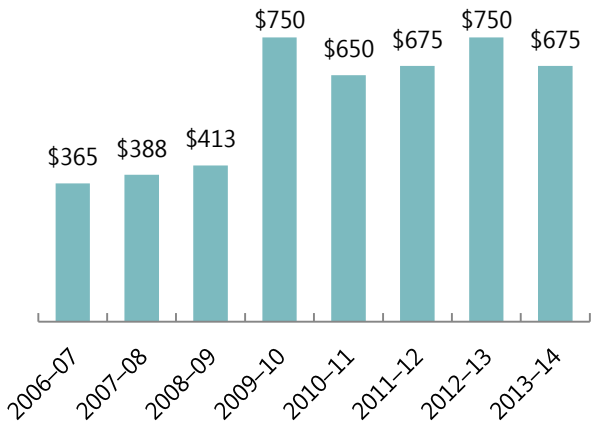
Affordability is an influential factor within the drug market. By international standards, Australians pay a higher price for ice,[135] with wholesale prices between $160,000 and $265,000 per kilogram.[136] As previously discussed, this makes Australia an attractive option for traffickers looking to make a profit.

The price for ice has remained relatively static in recent years.[137] [138] The Australian Crime Commission reports that, in 2013-14, the median price for a street deal of ice (0.1 gram) was $100. Data from the Illicit Drug Reporting System reports that, in 2014, users were typically paying between $50 per 'point'[139] in New South Wales to $150 in the Northern Territory.[140]

According to data from the Australian Crime Commission, in comparison with other illicit drugs, the cost of ice remains higher. For example, the median price for 0.1 gram of heroin is $75, while the median price for 0.1 gram of cocaine is $65. However, the Taskforce has heard anecdotal reports that ice is relatively cheaper and more accessible than other illicit drugs in many parts of Australia.

Although there was a significant rise in the national median price of a gram of ice in Australia from 2006-07 to 2009-10, since that time the price has remained constant.

Figure 2.9: National annual median price of a gram of ice[141]



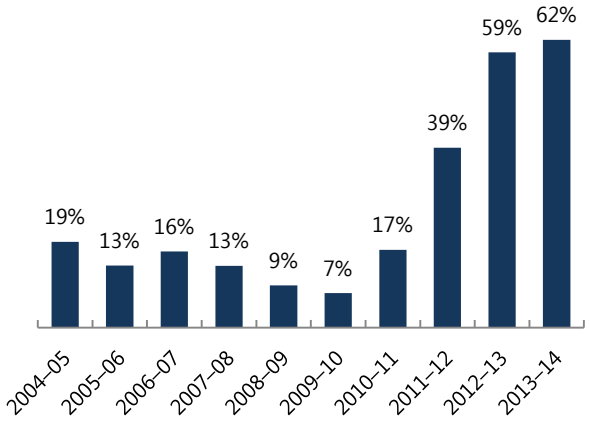
When taking into account recent increases in the purity of ice, users are receiving a more potent product for the price they are paying.[142]

For many users, however, ice is considered an affordable option, and even a cheaper option when compared with alcohol and other illicit drugs. Anecdotally, there are reports from young people that they can have a 'fairly cheap night out' using ice, as opposed to spending $8 to $10 per alcoholic drink.[143]

Purity and potency

The median purity of ice and other forms of methamphetamine is increasing. In 2013-14, every state in Australia reported an increase in the annual median purity of methamphetamine. The national median purity of domestically seized methamphetamine increased from 17 per cent in 2010-11 to 62 per cent in 2013-14.

Figure 2.10: National annual median purity of methamphetamine[144]



A comparison of purity of illicit drugs nationally for 2013-14 shows methamphetamine has the highest purity at 62 per cent followed by cocaine at just under 40 per cent and heroin at 17 per cent.[145]

Victoria reported the highest annual median purity of 80 per cent: the highest reported in the last decade. Several sources suggest that the increase in recent methamphetamine harms seen in Victoria may be linked to this increased purity.[146] [147]

The Melbourne Injecting Drug User Cohort Study also demonstrated a sharp rise in the purity of ice available to users between January 2009 and June 2013. The study also found that the average purity of ice seizures increased from 21 per cent to 64 per cent.[148]

The study found significant disparities in the purity of ice, with some batches of very high purity (more than 70 per cent) and others of very low purity (less than 20 per cent).[149] Such disparities between samples make it harder to judge risks associated with the 'doses' people take.[150]

The way ice is used also affects potency. The most common method of administration in Australia is smoking (78 per cent),[151] which is achieved by heating ice and inhaling the vapours. Ice can also be injected after being dissolved in water.[152] Both of these forms of administration are linked with a more rapid effect on the central nervous system (compared with snorting or swallowing)[153], which increases the potential for dependence.[154]

Purity, potency and user preferences

A 2005 study found that users had a strong preference for more pure forms of methamphetamine, including ice, because they believe it provides a longer lasting 'high.'

Users also preferred ice to other forms of methamphetamine as they perceived it to be uncut and 'professionally' produced.

Participants of this study stated that they would be willing to pay more money for ice than other forms of methamphetamine that they perceived to be less pure.[155]

Treatment services have traditionally seen higher numbers of clients that inject meth/amphetamine. However, the proportion of clients that smoke meth/amphetamine has increased significantly since 2003-04 (see Chapter 3).[156]

Social factors

Illicit drug markets in Australia are often regarded as fierce business enterprises dominated by criminal groups. While this may accurately describe some of the upper echelons of the market, the lower end of the market is more driven by social networks.

While the influence of social networks on illicit drug markets is not well understood, there is evidence that friendship-based networks are becoming a more powerful influence on drug markets, particularly with respect to ice and other psychostimulants. Social networks appear to make up at least half (and probably more) of methamphetamine transactions at the retail level. These dealers tend to acquire customers through little effort and largely through word of mouth.[157]

This phenomenon may be due to the perceived distance between suppliers (the criminal world) and users, as the intermediaries are friends or friends of friends. Furthermore, friends who supply drugs often do not consider themselves as drug dealers, and are often perceived as supplying drugs on a limited or nil-profit basis.[158]

Social circles can provide the channels through which a drug's reputation is reinforced, with initiation to drug use spread by light and moderate users.[159] This contributes to the 'network effect': more people accessing and using the drug leads to greater promotion and exposure, which in turn increases its popularity.

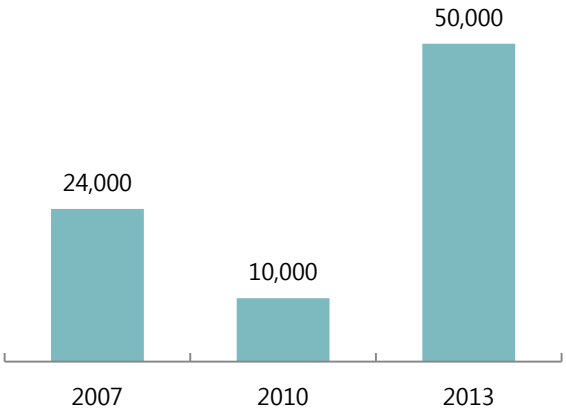
The following factors have been identified as potential drivers behind the emergence of social network and not-for-profit drug supply markets:[160]

- Changes in the profile of illicit drug use—a shift away from 'street market' drugs, such as heroin, and a shift toward psychostimulant drugs, which are more commonly dealt in closed markets where a higher level of trust is necessary between the purchaser and dealer.
- Demographic characteristics of 'Generation Y'—social networks are of central importance and this may influence friendship-based drug distribution patterns.
- Self-perception of illicit drug users and suppliers—many lower level drug suppliers and users do not consider their actions to be criminal, given the social context and not-for-profit nature of transactions.
- A law enforcement focus on 'open' illicit markets—law enforcement has historically concentrated on more open markets dominated by heroin and, to a lesser extent, cannabis.

Dependence

There is evidence that the number of dependent ice users has increased rapidly over the past few years.[161] [162] Extrapolating from the number of Australians aged 14 and over who report ice use, the estimated number of users in Australia reporting weekly methamphetamine use increased from around 10,000 in 2010 to around 50,000 in 2013.[163] This suggests an increase in the number of people using at problematic levels[164] and is likely to be a factor contributing to demand within the ice market.

Figure 2.11: Estimated number of Australians aged 14 and over using ice in the past 12 months and using at least once a week[165]



It is important to note that not all people who use ice become dependent. However, the increasing purity of ice means that users are at increasing risk of becoming dependent.[166] Problematic methamphetamine use is often associated with a shift toward more rapid routes of administration (such as smoking and injecting) and heavier polydrug use. The rise in the number of dependent users is likely to be linked with a trend toward smoking ice by newer, younger users.[167]

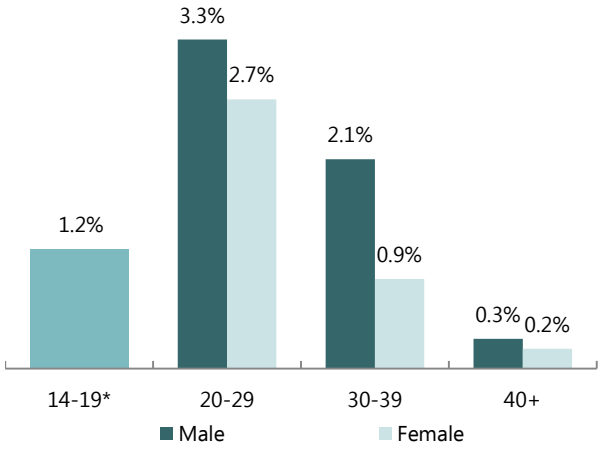
Use and demographics

Young people

There is strong evidence that ice is being increasingly used by young people, particularly on an experimental basis.[168] Initiation to the drug generally occurs between 18 years and 22 years.[169] [170] As noted previously, there is some evidence that ice use is becoming 'normalised' among young users due to an emerging social acceptance.[171] [172] [173] [174] Many young users define their use as 'social' and distance themselves from common representations of dependent users.[175]

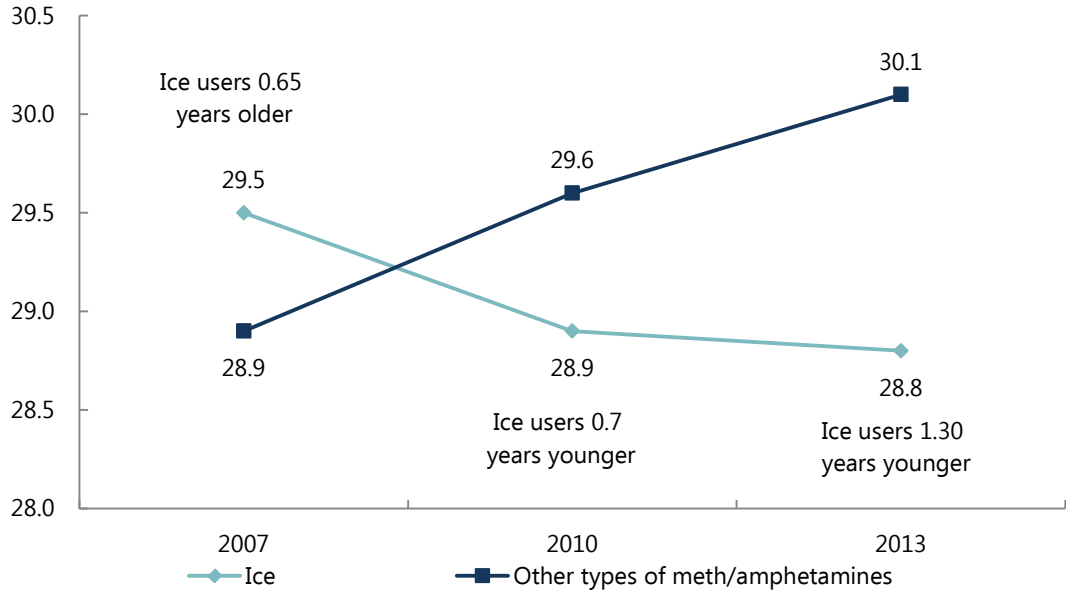
Younger people are more likely to use ice than other forms of methamphetamine and the average age of ice users is trending in the opposite direction of general methamphetamine users (28.8 years for ice users compared with 30.1 years for all methamphetamine users, see Figure 2.13). The 20 to 29 year age bracket has the highest proportion of people reporting to recent ice use (3.0 per cent). This is double the rate of the second highest age bracket, 30 to 39 years.[176]

Figure 2.12: Percentage of Australians aged 14 and over reporting ice use in the past 12 months in 2013, by age group and sex[177]



**Breakdown for the 14-19 age group is not available.*

Figure 2.13: Average age of Australians aged 14 and over reporting meth/amphetamines use in the past 12 months, by main type used[178]



The proportion of people aged between 14 and 19 years using ice has increased threefold from 0.4 per cent in 2007 to 1.2 per cent in 2013. By comparison, the proportion of people within the same age group who reported using other forms of methamphetamine dropped from 1.2 per cent in 2007 to 0.8 per cent in 2013.[179] Of particular concern is the increase in use among males aged 14 to 19 years (1.2 per cent in 2010 to 2.3 per cent in 2013).[180] There are reports that young people become more easily initiated into using ice due to smoking being the most common form of administration.[181]

A number of young people said their own use, or their friend's use, began because their friendship group was using the drug. They described using ice as a way to pass time, have fun and, for some, a way to earn an income through selling the drug.[182]

Most young people who might experiment with illicit drugs do not go on to experience long-term dependence and related problems. However, early use of drugs is associated with greater risk-taking behaviour, such as engagement in high-risk sexual activity or risk of driving while impaired.

Despite the fact that most young people who experiment with illicit drugs do not experience long-term dependence, even occasional use in small amounts can cause harm. Toxic reactions have been reported with small amounts and on the first occasion of use.[183] Young people—particularly those with pre-existing risk factors—can be particularly vulnerable.

Factors that may influence a young person's susceptibility to dependence include adverse childhood experiences, social disadvantage and a lack of bonding to family.[184] The Taskforce heard that ice use has become normal among some disadvantaged communities and in areas where young people have limited opportunities.[185]

Preliminary data from the Queensland Government indicates that approximately nine per cent of young people under a supervised youth justice order reported using ice either on its own or in combination with other drugs.[186] In 2014, Victoria's Youth Support and Advocacy Service reported that clients aged less than 18 years who classified their household income as 'lower' were more likely to have tried ice (26.2 per cent) than those who self-assessed their family as 'comfortable' to 'well-off' (17.8 per cent).[187]

There is also an association between methamphetamine use among young people and the nightclub or dance culture. A 2014 South Australian survey found that 21 per cent of the sample reported having used methamphetamine when attending Adelaide

nightclubs, with some respondents indicating that such use has become 'normalised' within their social circle. One 23 year old user reported:

> *"It's common these days for people to use meth in clubs—it's only a problem when you get home and you drop another 5 or 6 points, that's serious.*[188]

Use in regional and remote areas

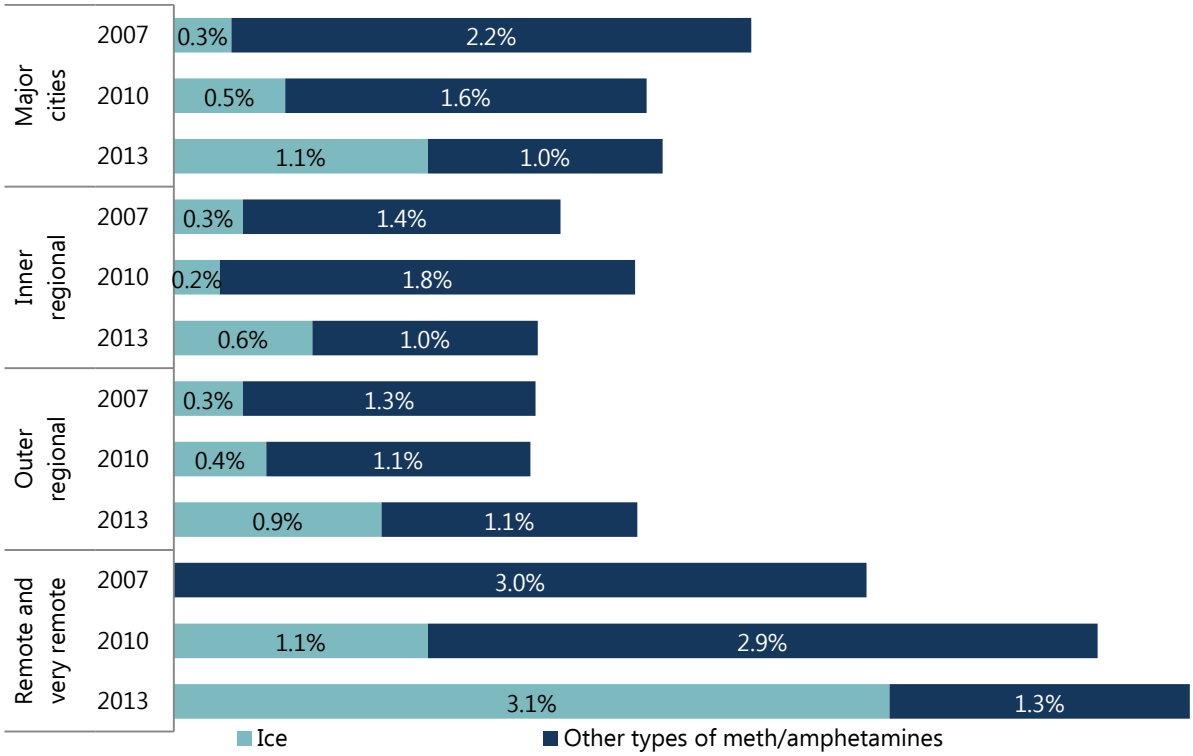
There is emerging evidence that ice is becoming an increasing problem in some regional towns and remote communities.[189] While data on the emergence of ice in these areas is limited, available information supports reports of increased and problematic use. The proportion of people using ice as their main form of methamphetamine in remote or very remote areas almost tripled between 2010 and 2013. The proportion of people using ice in outer regional areas more than doubled between 2010 and 2013.[190] [191]

There are anecdotal reports that ice is starting to emerge in remote communities where it previously has not been seen, including in the Northern Territory.[192] Further anecdotal information suggests that use is becoming prevalent in areas that have transient workforces or where there has been recent population growth due to mining and industry.[193]

The Taskforce has also heard through community consultations that a wide variety of social support services, including services in many regional areas, are reporting that ice is having a marked impact on service demand.[194] [195]

In general, people in remote areas are more likely to have higher rates of risky health behaviours. The Taskforce heard that higher rates of ice use in some regional areas are associated with generally lower incomes, lower levels of education, fewer employment prospects and high unemployment.[196]

Figure 2.14: Percentage of Australians aged 14 and over reporting meth/amphetamines use in the past 12 months, by main type used and by remoteness[197] [198]



Indigenous communities

There is some evidence indicating that the prevalence of methamphetamine use may be higher in some Indigenous communities, particularly in urban and regional settings.[199] [200] According to the NDSHS, Indigenous Australians are 1.6 times more likely to use methamphetamine than non-Indigenous Australians.[201] [202] Between 2007 and 2013, reported methamphetamine use among Indigenous Australians increased from 2.3 per cent to 3.1 per cent.[203] [204]

The New South Wales Government has identified methamphetamine use as a rapidly growing issue within Indigenous communities. Indigenous people accounted for 15.6 per cent of all patients with methamphetamine-related hospitalisations in 2013-14 in New South Wales, even though they represent just over two per cent of the total New South Wales population. This reflects a tripling of the rate of methamphetamine-related hospitalisations among New South Wales Indigenous people in the four years to 2013-14.[205] It is noted that, in general, Indigenous Australians are more likely to be hospitalised than non-Indigenous Australians. In 2013-14 nationally, Indigenous Australians were hospitalised at more than twice the rate of other Australians.[206]

The evidence suggests that Indigenous Australians seeking treatment for a principal drug of concern of meth/amphetamines are more likely to be injecting the drug, although use by smoking also appears to be increasing. Between 2009-10 and 2013-14, the number of specialist treatment episodes provided to Indigenous Australians who were injecting meth/amphetamines increased from 756 episodes to 2,069 episodes (an increase of 174 per cent, compared with an increase of 95 per cent for the non-Indigenous population). Over the same period, the number of specialist treatment episodes provided to Indigenous Australians smoking meth/amphetamines increased from 102 episodes to 879 episodes (an increase of 762 per cent, compared with an increase of 480 per cent for the non-Indigenous population).[207]

In some Indigenous communities, particularly high usage rates have been noted. Some services have reported more clients presenting with issues related to ice use, and even some clients moving from heroin or other drugs to ice.[208] [209] The proportion of Indigenous health organisations that reported amphetamines as an important issue in terms of staff time and organisational resources rose from 28 per cent in 2012-13 to 41 per cent in 2013-14.[210]

Further, a 2014 survey of Indigenous services found that 92 per cent of respondents reported that ice or powdered methamphetamine was a significant issue in their local community. The same survey asked whether respondents thought the use of ice or powdered methamphetamine among their clients had been increasing. Forty-three per cent stated it had increased significantly, while 33 per cent stated it had increased somewhat.[211]

Submissions received by the Taskforce also raised the concern that Indigenous people are using ice at a younger age. Information provided notes that methamphetamine use by Indigenous people commonly begins before the age of 19. Polydrug use is common and the use of methamphetamine is most often combined with alcohol consumption.[212]

Anecdotal information provided to the Taskforce indicates that ice use is becoming more widespread and that some remote communities have seen a marked increase in use recently.[213] While surveys conducted within three remote Indigenous communities in far north Queensland between 2011 and 2012 found that use of amphetamine-type stimulants in these communities was generally low (0.5 per cent of the sample), there was a disquiet that ice use in neighbouring communities meant it was only a matter of time before it was introduced locally.[214] Concerns have also been raised that some regional and remote Indigenous communities are becoming more exposed to ice through increased availability of the drug in areas where fly-in/fly-out workers are frequenting.[215]

Lesbian, gay, bisexual, transgender and intersex communities

A growing body of literature within Australia and internationally suggests that individuals identifying as lesbian, gay, bisexual, transgender, and intersex (LGBTI) are at higher risk of dependence compared with the heterosexual population.[216] [217]

In the most recent NDSHS, people who identified as homosexual or bisexual reported that they were 4.5 times more likely to use meth/amphetamines than heterosexual people.[218] The data from the survey also found that, while reported methamphetamine use had dropped since 2007, those reporting ice as the main form of methamphetamine they use increased from 4.4 per cent to 5.4 per cent.[219] [220] In addition, the results of the Global Drug Survey points to lesbian, gay and bisexual people showing greater concern about their friend's drug use. For gay men, ice was identified in the Global Drug Survey as the drug of most concern after alcohol.[221]

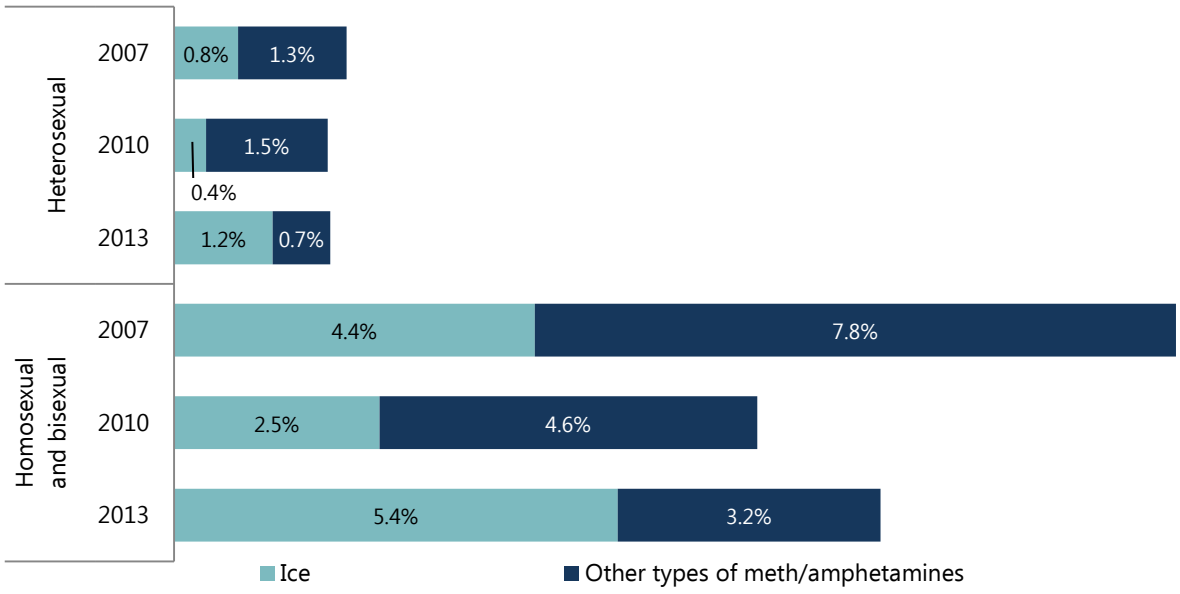
There are several reasons why members of the LGBTI community are more likely to use drugs. For example, LGBTI people are more likely to experience stress due to victimisation, stigma and uncertain self-identification. Some of these risk factors can apply equally to LGBTI and heterosexual groups. However, in many cases these factors are experienced to a greater extent by the LGBTI population.[222]

As with some other groups, an association with nightclub and party culture is a factor that can drive ice consumption within the LGBTI community. While this is not an issue that is exclusive to LGBTI culture, it is a concern raised by the LGBTI community, as well as health workers and educators.[223]

Use by inmates

There are significant gaps in knowledge regarding ice use by people in the corrections system. However, there is some evidence that methamphetamine, and ice in particular, is becoming an increasing drug of concern for the inmate population. For example, a Victorian magistrate reported to the *Inquiry into the Supply and Use of Methamphetamines, Particularly Ice, in Victoria,* that the number of people presenting before court with methamphetamine-related issues had increased from almost zero in 2008 to approximately 50 per cent in 2013.[224]

Figure 2.15: Percentage of Australians aged 14 and over reporting meth/amphetamines use in the past 12 months, by main type used and by sexual orientation[225] [226]



In 2012, a total of 37 per cent of correctional facility entrants reported using methamphetamine. This was the second highest drug reported behind cannabis (50 per cent). A higher proportion of females reported methamphetamine use (44 per cent, compared with 36 per cent for males). Young inmates aged between 18 and 24 years were more than twice as likely as older inmates (aged 45 years or over) to have used cannabis, methamphetamine, heroin and ecstasy prior to entering the correctional system.[227] Reported illicit drug use rates by inmates are significantly higher than rates of reported illicit drug use by the general population, with only 2.1 per cent and 10.2 per cent of the general population aged 14 years and over reporting recent methamphetamine or cannabis use respectively.[228]

A more recent study collected data from over 900 inmates participating in alcohol and other drug treatment programs within Victorian public correctional facilities. This study found that, since 2011, the percentage of inmates reporting amphetamine as their main problem doubled, from 20 per cent to 40 per cent. The study also found that 57 per cent of inmates who reported methamphetamine as their most serious drug used it daily before their imprisonment.[229]

Ex-inmates are also vulnerable to relapse and recidivism, with some evidence suggesting that poor socioeconomic status and a lack of stable housing and employment opportunities make relapse and further offending likely.[230] There is some evidence that the use of methamphetamine and other drugs are contributing to drug-related mortality and morbidity among ex-inmates due to their high vulnerability post-release.[231]

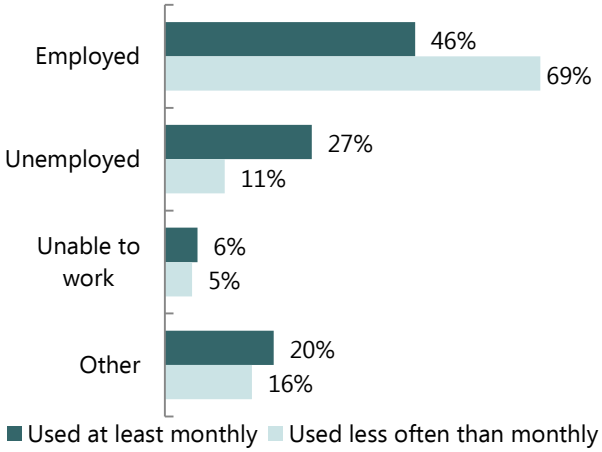
The unemployed

There is a strong association between drug use and social and economic factors, including unemployment.[232] Research suggests that the unemployed experience higher rates of substance misuse and are more likely to develop dependence on both alcohol and illicit drugs.[233] Unemployment can contribute to boredom, apathy and loss of self-esteem, which can influence drug use decisions and behaviour.[234]

In Australia, the link between unemployment and drug use is well-established. In 2013, 24.9 per cent of unemployed people reported that they had used illicit drugs in the past 12 months, compared with 16.8 per cent of employed people.[235]

The association between ice use and unemployment is particularly pronounced. In 2013, ice users were more likely than other drug users to report being unemployed. Furthermore, ice users were more likely to report being unemployed than other methamphetamine users (18.3 per cent compared with 13.8 per cent). Those that reported to using ice at least monthly were substantially more likely to be unemployed (27 per cent) than those that used less often than monthly (11 per cent).[236]

Figure 2.16: Employment status of Australians aged 14 and over reporting ice use in the past 12 months in 2013, by frequency of use[237]



The relationship between unemployment and problematic drug use is not linear. Marginalisation and exclusion can contribute to unemployment and disadvantage, which can then influence drug use. This can then further exacerbate problems due to the stigma often associated with drug use and the cycle of disadvantage.[238]

CHAPTER 3
IMPACTS OF ICE

The increasing use of ice is creating a distinct problem for Australia.

Ice can have a major impact on the individuals who use it. Users can experience a wide range of serious physical, psychological and behavioural effects. But the impacts extend beyond the individual. When a person uses ice, it can cause substantial stress for the family—for children in particular.

There are also broader costs to the community, including additional challenges for frontline workers and increased crime.

Impact on individuals

Ice use can result in immense damage to a user's physical health, occasionally resulting in death. It can have a range of psychological, cognitive and behavioural effects which researchers are only beginning to fully grasp. Darke and colleagues undertook a comprehensive review of the major health effects of methamphetamine use. They found that:

> *"...methamphetamine use is associated with a number of extremely serious negative health effects. While high profile consequences, such as psychosis, are given prominence in the public debate, the sequelae [health consequences] extend far beyond this. This is a drug class that causes serious heart disease, has serious dependence liability and high rates of suicidal behaviours. The current public image of methamphetamine does not adequately portray the extensive, and in many cases insidious, harm it causes.*[239]

Ice users can also experience less direct consequences, such as social exclusion, which further exacerbate the costs. A dependence on ice impedes the ability of a person to live a healthy and productive life.

Physical effects

Ice can have serious consequences for an individual's physical wellbeing. As the research continues to develop, a clearer picture of these effects is emerging.

Physical health

Ice use can damage a user's health and, in certain instances, also result in death.[240] Methamphetamine use places heavy demands on the cardiovascular system by increasing the heart rate and blood pressure.[241] [242]

Physical effects can include sweating, headache, hot and cold flushes, reduced appetite and teeth-grinding.[243] The physical indicators of a toxic dose include nausea and vomiting, chest pain, tremors, increased body temperature, increased heart rate, breathing irregularities and seizures.[244] Anyone can have a toxic reaction to ice. Darke and colleagues have pointed out that 'toxic reactions can occur irrespective of dose, frequency of use or route of administration, and have been reported with small amounts and on the first occasion of use'.[245]

The use of methamphetamine in combination with other drugs can increase the physical effect. For example, the use of both methamphetamine and alcohol together results in a higher heart rate and blood pressure than the use of methamphetamine alone.[246]

In Australia, in 2011 there were 101 accidental drug deaths identified as involving methamphetamine.[247] Deaths caused by psychostimulants such as ice are usually caused by seizures, heart failure or respiratory failure, but can also be caused by brain haemorrhage, strokes or kidney failure.[248]

Death from methamphetamine use typically occurs among men in their mid-30s who are experienced drug users.[249] One explanation for this is that repeated use of psychostimulants such as ice leads to a cumulative risk of cardiac and coronary artery disease.[250] Therefore the health risks increase in people who have used for longer periods of time and who use more regularly.[251]

The Australian Medical Association has said that some of these acute and chronic medical conditions related to methamphetamine use can be particularly difficult to manage due to poor compliance with medical advice, follow-up or treatment.[252]

The number of methamphetamine-related hospitalisations has increased rapidly, which provides some evidence of the escalating health impacts. In 2013-14, over 8,000 people left hospital after being treated for methamphetamine-related issues. This is an increase from around 1,600 in 2009-10 (see Figure 3.1).[253] There has similarly been a rapid rise in treatment for methamphetamine, which is outlined in Chapter 5.

How does ice work?

The properties of ice mean it can readily be smoked or injected. These methods allow the drug to be rapidly absorbed into the bloodstream and move quickly into the brain.

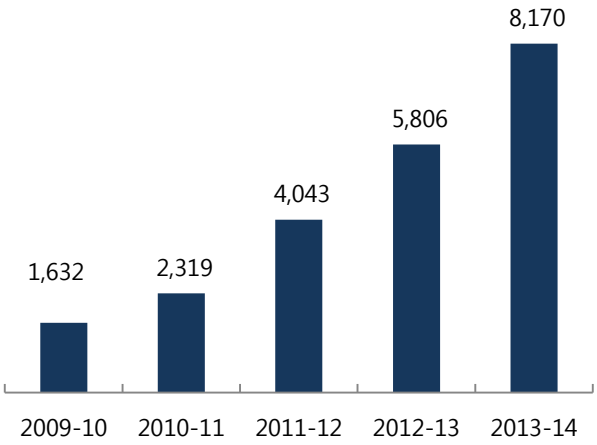
Ice increases chemicals in the brain called monoamines. Monoamines are the neurotransmitters dopamine, noradrenaline and serotonin. Their role is to transmit information. Dopamine, for example, is important for regulating movement and cognitive processes such as attention.

The observed effects of ice include euphoria, increased alertness and improved physical performance. However, the drug can also result in symptoms such as panic, extreme anxiety and agitation, extreme paranoia, hallucinations and excited delirium.

Methamphetamine use places heavy demands on the cardiovascular system by increasing the heart rate and blood pressure. A toxic dose of ice can cause seizures, heart failure or respiratory failure.

Once a dose of ice leaves the system, there is often a corresponding crash in mood and energy as the effects of the drug wear off. This typically manifests as a deep exhaustion and can last for a few days.

Figure 3.1: Annual number of hospital separations where the principal or additional diagnosis was methamphetamine related[254]



Dependence

Dependence is commonly described as a pattern of substance use that leads to clinically significant impairment or distress. It includes behaviours such as a tolerance to the drug, a withdrawal reaction in the absence of the drug, and an inability to regulate use of the drug or separate use from other aspects of social and work life.[255] Dependence on drugs is influenced by a range of factors, but is also strongly related to patterns of drug use such as route of administration (the way the drug is taken) and duration of use.[256]

People who are dependent on methamphetamine are more likely to be tolerant to the drug and show stronger withdrawal reactions than non-dependent users. Increased tolerance can result in a preference for a more potent effect from the drug. This can result in a user transitioning to injecting, using higher doses, using more frequently and preferring higher purity methamphetamine.[257] The research and knowledge on methamphetamine withdrawal is limited.[258] However, methamphetamine withdrawal syndrome appears to be different from the withdrawal syndromes associated with other drugs, such as opioids and alcohol.

The symptoms of withdrawal experienced by methamphetamine users can include fatigue, sleep disturbances, appetite disturbances, depressed mood, irritability, slowed-down or agitated movement and thoughts, and strong cravings for the drug.[259]

In comparison to other drugs, methamphetamine is understood to have a more protracted withdrawal period.[260] For the first one to three days, users generally experience a 'crash period', which is characterised by extreme fatigue and lethargy (a 'hang over' effect).

The 'acute' phase lasts for around seven to 10 days, with recovering users often experiencing depression, fatigue, vivid unpleasant dreams, insomnia or hypersomnia, increased appetite, psychomotor retardation or agitation.[261]

This is followed by the subacute recovery phase, which lasts for a longer period of time.[262] In some cases, complete recovery from ice dependence can take many months (see Figure 3.2).[263]

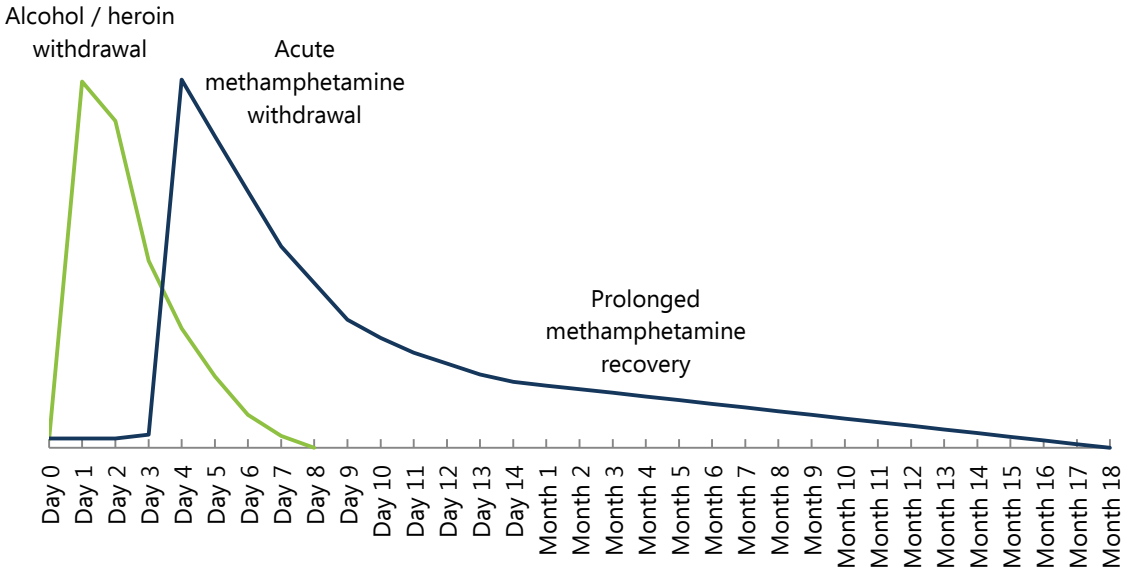
As outlined in Chapter 2, a large proportion of users—around 40 per cent—take methamphetamine once or twice a year. However, around 25 per cent take the drug at least once a week or more. Dependence is common among those who use twice or more per week.[264]

Psychological and cognitive effects

Methamphetamine use is associated with psychosis, mood and anxiety disorders and cognitive deficits.[265] The Taskforce received multiple submissions from treatment providers detailing the effects of ice on their clients' behaviour.[266] [267] [268]

Ice, of course, has some sought after effects. These include euphoria, elevated mood, a sense of wellbeing, increased alertness and concentration, reduced fatigue, increased talkativeness and improved physical performance.[269] However, a toxic dose can result in psychological symptoms such as panic, extreme anxiety and agitation, extreme paranoia, hallucinations and excited delirium.[270]

Figure 3.2: Estimated intensity of withdrawal periods for drug dependence[271]



The reported impacts are wide ranging:

> *"Many Mission Australia staff provided stories of the devastating impacts ice use was having on their clients. Problematic behaviours induced by ice include violence, aggression, paranoia and erratic and irrational behaviour. Clients also present as desperate, depressed and exhausted by sleep deprivation when they are coming down.*[272]

Mental health

There is a strong correlation between use of ice and mental health issues.[273] [274] The most common mental health issues experienced by methamphetamine users are psychosis, depression and anxiety. In addition, in 2013, fewer than 60 per cent of users reported moderate, high or very high levels of psychological distress, compared with around 40 per cent of all illicit drug users and 30 per cent of the general population.[275]

While there is a strong correlation between drug use and mental health issues, the research is not definitive on the causal relationship.[276] [277] In some cases, drugs are used subsequently to experiencing mental health symptoms and in other cases, drug use may lead to the development of mental health issues. There may also be biological or environmental factors that lead to both mental health problems and drug use.[278] [279]

Some individuals do experience mental health issues subsequent to methamphetamine use. Lee and colleagues surveyed dependent methamphetamine users with mental health issues. They found that around 20 per cent of users said they had mental health issues before using the drug, and around 70 per cent said mental health issues appeared after they began using the drug. The mental health problems experienced by the users tended to coincide with problematic methamphetamine use.[280]

However, this study was not able to determine causation and in some cases the arising mental health issues may have been coincidental. In addition, not all mental health issues experienced by methamphetamine users are enduring. Many of the mental health symptoms experienced by users are due to the direct effect of the drug—or occur during withdrawal—and may resolve rapidly.[281] The types of issues most commonly experienced by methamphetamine users are discussed below.

One of the key clinical differences between psychostimulants—such as ice—and other illicit drugs is that psychostimulants can induce psychosis.[282] People experiencing psychosis are unable to distinguish what is real—they lose contact with reality.[283] Psychosis induced by methamphetamine is primarily characterised by

persecutory delusions and hallucinations.[284] Users have reported that the persecutory delusions often take the form of a feeling that others wish to harm or threaten them.[285] Users have also said that the hallucinations often involve hearing voices that make insulting remarks or command them to do certain things.[286]

In a survey of people who use methamphetamine at least monthly, McKetin and colleagues found that around one in four had experienced psychosis in the past year. This prevalence of psychosis is 11 times higher than the general Australian population.[287] Methamphetamine-induced psychosis can last from a few hours to a few days and subsides when the drug is no longer in the body.[288] However, some people experience more chronic symptoms, especially those with a pre-existing psychotic disorder.[289]

Mood disorders and anxiety are also associated with methamphetamine use.[290] [291] [292] Darke and colleagues say that, compared with psychosis, depression and anxiety can be 'more common, more chronic and potentially more debilitating'.[293] There is also some evidence of high rates of attempted suicide. A United States study by Zweben and colleagues found that almost 30 per cent of a cohort of 1,016 dependent methamphetamine users reported a suicide attempt in their lifetime.[294] This compares with around five per cent in the general population.[295]

As with other effects of ice, the likelihood of experiencing mental health issues varies between users. However, the aforementioned mental health issues are more likely to be experienced by people who have used methamphetamine for long periods, use more frequently, are dependent and inject the drug.[296] For example, dependent users have been found to be three times more likely to experience psychotic symptoms than non-dependent users, even after adjusting for a history of psychotic disorders.[297]

Cognitive effects

There are links between chronic methamphetamine use and damage to the brain. In particular, chronic users of the drug have been found to have abnormalities in brain function, including depleted levels of the neurotransmitter dopamine.[298] Neurotransmitters are chemicals in the brain that transmit information. Dopamine is important in regulation of movement, cognitive processes such as attention, working memory and motivational behaviour.[299] However, it has not yet been established with certainty whether methamphetamine use specifically causes this damage. While studies of animals have shown that methamphetamine leads to the degeneration of nerves in the brain, this cannot be easily tested in humans.[300]

Nonetheless, there is evidence of cognitive deficits in regular users, such as impaired attention, memory and motor skills.[301] [302] However, as with other issues discussed, more research is required to establish whether methamphetamine is the direct cause of these conditions. As a chronic user recovers, attention problems can persist and reduce the effectiveness of treatment—such as cognitive-behavioural therapy—or opportunities for employment.[303]

Other consequences

The impact of ice on individuals is not limited to the health effects. Ice use has also been linked to a range of harmful behaviours and can affect a user's social wellbeing.

Violence and aggression

Many submissions to the Taskforce raised concerns about the violence of ice users. For example, the Townsville Community Ice Taskforce said in its submission:

> *"People are displaying extremely violent behaviour when they are coming down off ice. Domestic violence is rising due to ice. People are doing more break and enters due to ice. Ice doesn't discriminate, it affects everyone in the community.*[304]

There is an established correlation between methamphetamine use and violent or aggressive behaviour.[305] [306] However, there is not a substantial body of evidence that methamphetamine directly causes violence.[307] [308] The relationship between drug use and violence is complex. People who use ice may, for example, be predisposed to violence. Additionally, violence may arise in conjunction with a drug-using lifestyle, such as involvement in criminal drug networks or theft to fund drug use.[309]

That said, evidence of a causal link is emerging. A recent study by McKetin and colleagues found that people were around six times more likely to be violent when they were using methamphetamine than when the same people were not using the drug. The methamphetamine-related violence in this study was characterised by 'interpersonal violence, ranging from altercations that led to fights to seemingly unprovoked physical attacks'.[310]

Further, the study found violent behaviour was much more likely among people who used methamphetamine frequently. Psychotic symptoms and heavy alcohol consumption increased the risk of violent behaviour. However, the increase in violence also occurred independently of psychotic symptoms and alcohol consumption, which suggests a direct relationship between methamphetamine dose and violent behaviour.[311]

Risk-taking behaviours

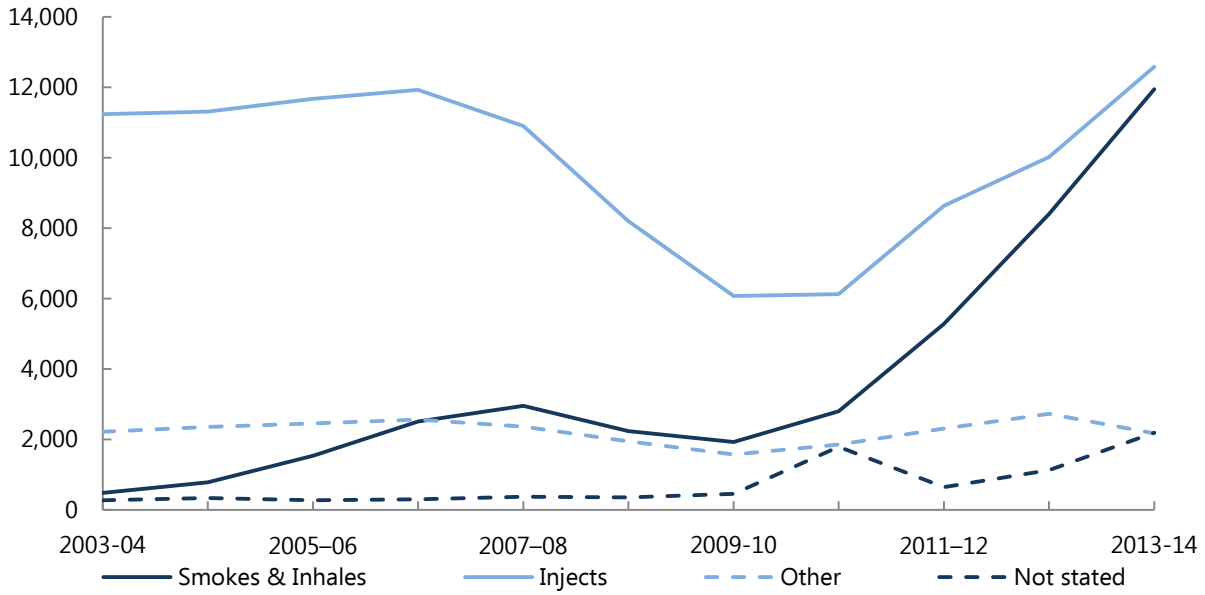
Methamphetamine use is also associated with a range of risk-taking behaviours, including unsafe injecting practices, sexual risk-taking and drug-driving.[312]

The two most common ways people use ice are smoking and injecting. In 2013, around 80 per cent of ice users reported smoking as the main method of use, and around nine per cent reported injecting.[313]

However, users of meth/amphetamines who attend treatment are more likely to inject than smoke. In 2013-14, around 44 per cent of this group reported injecting and 41 per cent reported smoking.[314]

Unsafe injecting—such as sharing contaminated needles—carries the risk of infection and the transmission of blood borne viruses such as hepatitis C and HIV. In Australia, unsafe drug injecting is the most common way of contracting hepatitis C. Around 90 per cent of newly acquired cases of hepatitis C infection and 80 per cent of existing cases are a result of unsafe injection of drugs.[315]

Figure 3.3: Number of completed treatment episodes where meth/amphetamines was the principal drug of concern, by main method of use[316]



'Other' includes ingesting and sniffing.

In addition to the risks of injecting methamphetamine, experts are concerned about the risks of smoking methamphetamine. The proportion of ice users who smoke the drug increased from around 50 per cent of users in 2007 to around 80 per cent in 2013.[317] McKetin and colleagues said:

> *"The smoking of ice among young recreational drug users is an important new trend that warrants urgent attention. Smoking is a highly accessible route of methamphetamine administration that provides an instant drug effect with very few immediate deterring side-effects; however, smoking ice has a high dependence liability and has been associated with a range of adverse consequences. The trend toward smoking ice also has the potential to introduce a younger, less drug involved population of people into a more risky pattern of drug use, and increase their risk of becoming dependent on methamphetamine.*[318]

In a separate study, McKetin and colleagues found that people who smoked methamphetamine were less dependent on the drug than injectors. However, smokers took the drug as often as injectors and had similarly high levels of psychological distress, poor physical and mental health, psychotic symptoms, sexual risk behaviour and criminal involvement.[319]

Further, not only injecting drug users are at risk of transmitting blood borne viruses—non-injecting drug users also have an increased risk of transmitting blood borne viruses compared with the general population. This increased risk is usually considered to be due to high levels of risky sexual behaviour among this group, such as unprotected sex or multiple sex partners.[320] [321] There is also some evidence that the molecular effects of methamphetamine increase susceptibility to infection with HIV-1.[322]

The reasons for the association between methamphetamine use and risky sexual behaviours are not well understood. However, there is some evidence it is because methamphetamine can reduce inhibitions and increase sexual desire.[323] In addition to increasing the risk of transmitting blood borne viruses, unsafe sexual practices increase the risk of spreading other sexually transmitted infections.

This link between methamphetamine use and risky sexual behaviour has been most strongly established in relation to men who have sex with men—most studies have focused on this cohort.[324] There is also evidence of a link between methamphetamine use and risky sexual behaviour among heterosexual methamphetamine users.[325]

Several submissions to the Taskforce reported that some people are supporting their ice use with sex work.[326] [327] This group is at particular risk of contracting blood borne viruses and other sexually transmitted infections, as well as other harms. In a 2005 survey of 72 female street-based sex workers in greater Sydney, 40 per cent reported using ice in the previous year.[328] However, the use of heroin and cannabis was far more common. The current data on sex workers using ice in Australia is limited, so it is unclear how the picture has changed since 2005.

There is also some evidence of drug-driving. A 2007 survey reported that over half of methamphetamine users had driven within three hours of taking the drug.[329] Methamphetamine causes a number of driving impairments including lapses of attention, disorientation, lack of coordination, aggressive driving and risk taking.[330] There have also been numerous road deaths involving methamphetamine.[331] Driving while using ice poses serious risks to other road users and the community.

Social consequences

Ice use can limit an individual's ability to fully participate in society. Some of the most common social challenges that methamphetamine users report are social isolation, relationship problems and financial difficulties.[332] In a submission to the Taskforce, the Weave Youth and Community Services identified lost opportunities in relation to education and employment as one of the main impacts of ice use.[333]

There is some research showing that the social stigma experienced by methamphetamine users deters people from seeking or completing treatment programs.[334] The Taskforce heard this message frequently in the consultation process. In its submission to the Taskforce, the Australian Injecting and Illicit Drug Users League said negative representations of ice users in the media—such as reports that imply 'they do not deserve help or that they are worthless'—can contribute to the stigma that users experience. The League told the Taskforce it believes 'discrimination is a key reason why we are seeing increases in problematic behaviour associated with an extended period of use, as many will only seek help or come in contact with health services when experiencing a crisis'.[335]

Some Indigenous people experience high barriers to accessing treatment and support services, in both remote and non-remote areas. In 2012-13, 30 per cent of Aboriginal and Torres Strait Islander peoples reported that they needed to, but didn't, go to a health care provider in the past 12 months.[336] Commonly reported reasons include the cost and long waiting times. For people in remote areas in particular, transport and distance were also reported as common reasons for not attending health care.[337]

Cultural factors can also deter a user from seeking help. Of the 30 per cent of Aboriginal and Torres Strait Islander people who reported not seeking treatment when needed, commonly cited reasons for not accessing care included: dislikes the service or professional/embarrassed/afraid (22 per cent); felt it would be inadequate (9 per cent); did not trust the service or provider (9 per cent); and discrimination/not culturally appropriate/language problems (4 per cent). These types of barriers were higher for counsellors than other health services.[338]

Submissions to the Taskforce from service providers supported these findings. For example, the Salvation Army told the Taskforce that some Indigenous people experience severe negative effects if they need to be separated from family, community and country to access treatment.[339] The Taskforce also heard reports of Indigenous youths avoiding treatment facilities because attending would be 'shame'.[340]

These reports are particularly concerning given that rates of methamphetamine use among Indigenous people are higher than for the general population (see Chapter 2).

Impact on families

The consequences of methamphetamine use extend beyond the individual. Ice use by a family member can have a severe impact on the immediate family and can also affect grandparents, extended relatives and friends.

The Taskforce heard from many family members about the devastating impact of ice use on family life. For example, one parent said:

> *"Our son is a recovering Ice addict, he is well now but we have been through 14 years of hell. There have been car accidents, suicide threats and attempts and, of course, as with the great majority of addicts theft from us and his siblings. Our other two children have been distressed by seeing the impact of our son's behaviour on us as his parents. The emotional toll of trying to keep him alive has been enormous for me and I suffered an emotional breakdown. I continue to struggle with depression and anxiety.*[341]

Family stress

A person's drug use can cause extreme stress for their family. Some feelings commonly experienced include confusion, fear, shame, guilt, anger and mistrust.[342] Orford and colleagues argue that the impact of addiction on close family members is a massive source of ill health which has enormous but often unrecognised implications for public health and economic development.[343]

The stress experienced by family members is multifaceted. Orford and colleagues identify worry as one of the defining features:

> *"Worry for the relative is often at the forefront; including worry about the relative's physical and mental health, self-care, educational, work or other performance, finances, the company the relative is keeping, and his/her future. But it usually also includes concern about the functioning of the whole family, the maintenance of good quality relationships both within the family and with others and concern about the ability of the family to function well now and in the future for the sake of all its members. The greatest weight of worry is often about possible effects on children: concern at the possibility of violence or neglect, more general worry about interference with good upbringing of the children, or concern that children might repeat the relative's behaviour.*[344]

The Taskforce also heard from family members who have been required to take on caring responsibilities for the children of ice-using family members. This can increase the financial and emotional burden on those family members.

For example, a person told the Taskforce that *'friends of ours now have custody of their grandchildren because their daughter is dependent on ice. Hard work for them taking on a 5 and 7 year old when they should be thinking about retiring'*.[345] Dawe and colleagues have noted that the potential impact on children raised by alternative carers—such as grandparents, extended family members or elder siblings—as a result of parental substance misuse has rarely been studied.[346]

The social stigma related to drug use can also affect a user's family. Corrigan and Miller found that the family stigma related to drug dependence is stronger than the family stigma related to other mental and physical health conditions. In particular, they found family members are likely to be blamed for the onset of their relative's condition and relapses.[347]

Corrigan and Miller also found that family members of drug users are more likely to be viewed as 'contaminated' by the drug dependence, more shameful, and more likely to be socially shunned. Of the different family members, children are most likely to be viewed as 'contaminated' by a parent's drug use. A users' parents and spouses were most likely to be viewed as responsible for the drug dependence.'[348] Orford and colleagues have also observed that family members are sometimes explicitly or implicitly blamed for a relative's dependency.[349] There was evidence of the stigma felt by families in some of the submissions to the Taskforce:

> *"As a mother of a daughter with an ice addiction I felt helpless and alone. You can't talk to anyone because you feel shame and there are not enough resources to help. The pressure being placed on families is immense. Do I throw my child out of her home thereby condemning her to a life of homelessness and crime? She has an addiction to a vile drug and they can't just stop no matter how many threats are made against them.*[350]

The importance of family and community relationships in Indigenous culture can add complexity to the relationship between a drug-user and their family. In an international cross-cultural study, Orford and colleagues found that Indigenous Australians in particular felt pressure to 'put up with' their relative's dependency problems and anticipated criticism if they 'responded to relatives in ways that broke traditional family responsibilities…or which ran contrary to general cultural norms for sharing and hospitality'.[351]

The Taskforce spoke to several people who said that because family and community is particularly important in Indigenous communities, the impact of a family member using ice can be strongly felt. For example, Weave Youth and Community Services told the Taskforce that 'the Aboriginal young people we spoke to said it was particularly difficult because those using [ice] are not just their friends but also their families so it was harder to get away from'.[352]

In 2012-13, 18 per cent of Indigenous Australians reported that alcohol or drug related problems had been a family stressor during past 12 months. Indigenous people reported these alcohol or drug related problems at

3.6 times the rate of non-Indigenous Australians.[353]

Family conflict

Orford and colleagues also identify the decline in the quality of family relationships as a factor in the stress experienced by families. This can take the form of open conflict, aggressiveness and sometimes physical violence.[354]

The Taskforce heard reports of violent family members in the public submissions:

> *"Ice use by our 29 year old son has had a devastating effect on our family. This is the worst thing to ever happen to anyone, it just destroys everything, and your whole life is just chaos. We have had lots of things we have worked hard for smashed or broken, with holes punched in walls and doors. There seems to be no end to it all and it's very frustrating when there is no help and no one to turn to for help.*[355]

The majority of research on the links between drug misuse and family conflict or violence has focused on alcohol. For example, it is well established that when alcohol is involved, the level of harm associated with family violence increases and results in more severe injuries.[356] However, there has been little research into the links between family conflict or violence and methamphetamine in particular. However, the research that does exist indicates a correlation.

One United States study found around 90 per cent of methamphetamine users reported conflict with a family member in the past year. The users reported that they were most likely to have conflict with parents and siblings about drug use, lifestyle issues, interpersonal and communication issues and concern for other family members.[357] In addition, another United States study of people arrested for domestic violence found around half were using methamphetamine at the time of their arrest.[358] Both these studies had relatively small sample sizes of approximately 100 respondents and so the results should be interpreted with caution. However, given the emerging strength of evidence of the links between methamphetamine use and aggression and violence, these results are not unexpected.

Impact on children

There is a large body of evidence that children can be severely affected by a parent's drug misuse. However, the research on parents who use methamphetamine specifically, rather than other substances, is limited. Nonetheless, insights can be drawn from the literature on parents who misuse drugs in general, as well as what is known about how methamphetamine affects users' behaviour and the evidence provided to the Taskforce in submissions.

The Foster Care Association of the ACT observed some of the effects on children in its submission to the Taskforce:

> *"Many of these children have parents who are heavily involved with illegal drugs, including ice/methamphetamines. Many of these children are directly exposed to drugs—in utero, through second hand smoke and been given illegal drugs directly or indirectly. Many of these children are exposed to the chaotic, neglectful and violent environment that so often goes hand in hand with their parents' drug use.*[359]

It is important to note that poor parenting is not an inevitable outcome of drug use or misuse. However, drug misuse can compromise a parent's ability to provide psychological and physical support to their children. There is evidence that children whose parents misuse drugs are more likely to develop emotional and behavioural issues.[360]

In addition, the direct effects of intoxication or withdrawal can—for example—impair a parent's ability to prepare meals and ensure a child regularly attends school. The use of illegal drugs can also mean parents spend time and money on criminal activities.[361] This further reduces their ability to provide a supportive environment for a child. Dawe and colleagues have also suggested that children of stimulant users may be more likely to be exposed to physical abuse, given the link between methamphetamine use and psychosis and violence.[362]

Children of illicit drug users can also be exposed to health hazards, such as the equipment used to manufacture, prepare or use drugs.[363] Children in the homes of methamphetamine users or manufacturers are particularly at risk of ingesting associated chemicals.[364] [365]

The use of amphetamine-type stimulants by mothers during pregnancy can have adverse effects on a newborn child. These can include cleft lip, cardiac defects, low birth weight, growth reduction and reduced head circumference.[366] There is also some evidence that prenatal exposure to amphetamines continues to hinder children's health outcomes into adulthood.[367] However, it is challenging for researchers to isolate the effects of the drug from the broader social context in which children are brought up.

Lack of support

The Taskforce heard that families can play a key role in helping an ice user manage their dependence. However, the stress and conflict experienced by families of methamphetamine and other drug users is exacerbated by the lack of available support services.

For example, Weave Youth and Community Services spoke to staff and clients to ask them about their thoughts on ice use, and reported the responses in its submission to the Taskforce. The importance of family support was a prevalent theme:

> *"Everyone stressed the importance of having family, friends, and community as a support: to educate young people about ice use, to be role models for living a positive healthy life, and to help those who are using [ice] to stop. But to do this, people felt there needed to be support services to help families/communities achieve these things and to manage their own stresses so they can in turn support members who are using.*[368]

The Salvation Army Australia reiterated the importance of family support services:

> *"Families are often left to deal with the impacts of methamphetamine use by a family member or members without the necessary information, support and respite services. They are the frontline in dealing with incidences of intoxication, overdose, withdrawal, psychosis and violence.*[369]

The Taskforce heard that services are particularly limited outside of major cities. Robert Waterman of Rural Health Tasmania has said:

> *"I have encountered as many distraught parents and family members as I have methamphetamine ice users. In almost all cases they want to know what they can do, who can help, where they can go and how to help their child, family member or friend. It is extremely difficult and disturbing having to explain that there is limited support available that specializes in support for family members of methamphetamine ice users.*[370]

Impact on communities and society

The National Ice Taskforce travelled around Australia to listen to communities discuss the impact of ice. The drug is having a major impact across Australia, particularly in a number of smaller towns where support services are often limited. In addition, some of the symptoms of ice, such as aggression and psychosis, mean the effects are particularly visible and impacts are felt right across the community.

Some of the ways the drug trade affects society include increased corruption, reduced worker productivity, diversion from employment or education, and a redirection of resources to drug production and money laundering.[371] Ice use also has a direct financial cost to Australia. While recent methamphetamine-specific data is not available, the cost of all illicit drugs to Australia was estimated to be around $8 billion in 2004-05.[372] This includes lost productivity at work and at home, the cost to healthcare services, direct costs to the justice system and the cost of associated crimes including road accidents and property damage.

There are myriad ways in which the trade and use of illicit drugs impact society, and there is not scope to discuss them all in this report. This report discusses two effects on communities that the Taskforce heard were of particular concern—workforce safety and community safety.

Workforce safety

There is evidence that the behaviour of some ice users affects frontline workers. This section focuses on the effects on police and emergency workers, as these groups often come into contact with methamphetamine users when they are intoxicated and exhibiting aggressive behaviour or psychosis. It is important to note that other frontline workers can also be affected—such as alcohol and drug service providers, general practitioners, nurses and mental health professionals.

McKetin and colleagues found users who were exhibiting psychosis or aggression could be unpredictable, impulsive, irrational and hostile. They also had a high level of sustained energy and were hyper-alert.[373] The combination of these factors increases the risks for frontline workers.

Police and law enforcement

Police have a high level of contact with methamphetamine users. In McKetin and colleagues' study, around 40 per cent of methamphetamine users had come into contact with police in the previous month. This included people who had been approached by police because of something they had done, but also included those who came into contact with police for other reasons such as witnessing a crime, being a victim of a crime, or being in the company of an offender.[374]

The Police Federation of Australia is concerned about 'direct contact on the street with the users themselves and managing their erratic and violent behaviour'.[375] McKetin and colleagues found police risked being assaulted while trying to restrain or search users exhibiting aggressive psychotic behaviour. They also risked contracting transmittable diseases from injecting equipment or the physical contact required when restraining or searching a user. The difficulty in being able to rationally communicate with a person using methamphetamine exacerbated some of these risks.[376]

The police in this study observed that the majority of cases involving severe uncontrollable aggressive behaviour occurred among injecting drug users following their use of ice. These concerns are not limited to police. In their submission to the Taskforce, Victoria Legal Aid told the Taskforce that assisting ice-affected clients presents 'potential risks to our staff's health and safety'.[377]

Ambulance and emergency workers

The risk posed to ambulance and emergency workers by methamphetamine users is also concerning. Bunting and colleagues studied the emergency department at St Vincent's Hospital, Sydney in late 2006. They found that, compared with other intoxicated patients, methamphetamine users were:

- significantly more agitated, violent and aggressive
- significantly less alert, communicative and cooperative
- more likely to arrive alone or accompanied by police
- more likely to have a history of intravenous drug use and mental health problems
- more likely to require scheduling under the *Mental Health Act 1990 (NSW)*
- more likely to have used the drug on the street than in bars, clubs or events.[378]

Ambulance and emergency workers face similar difficulties to police in managing users with psychosis or aggression. Particularly high risk situations for these groups include transporting patients in an ambulance, restraining patients prior to sedation and intravenous sedation. Similar to police, these situations increase the risk of assault or contracting transmittable diseases from injecting equipment.[379]

Numerous submissions to the Taskforce raised concerns about agitated or violent methamphetamine users in emergency departments. St Vincent's Health Australia said in its submission:

> *"In both our public hospitals, St Vincent's Hospital Sydney and St Vincent's Hospital Melbourne there have been increased volatile and aggressive interactions between patients who have used meth/amphetamine and our emergency and health-care professionals and co patients. Many of these assaults have been of a serious nature and have resulted in staff requiring medical attention and lost time to recover from their psychological and physical injuries.*[380]

The Australasian College for Emergency Medicine (ACEM) estimate that amphetamine-affected patients make up around one per cent of presentations at emergency departments.[381]

While this may be a relatively low proportion, managing these patients is resource intensive. Methamphetamine users often require several medical staff, one-on-one nursing and security supervision.[382] A 2005 study of the emergency department at Perth Royal Hospital found a third of amphetamine-affected patients required sedation, which correlates with a high load of pre-hospital, nursing, medical and security resources.[383]

This can divert resources away from other patients. The ACEM said its members have reported that the care of other seriously ill patients can often be delayed, due to the lengthier treatment times typically required for amphetamine-affected patients.

The ACEM also said that security issues for staff and other patients is a major concern. It reported that there is sometimes not enough staff to safely manage affected patients:

> *"Five trained staff is considered the minimum number required to hold an agitated patient appropriately. During sedation there are usually not enough security officers to perform a five-point hold down. This is a risk to staff safety, and staff are frequently injured when there is inadequate security cover.*[384]

The Taskforce was told during the community consultations that some frontline workers were reluctant to engage with ice users at all due to fear of violence. It was suggested that better information or training could give frontline workers the confidence to engage safely with ice users.[385] Some emergency departments are already implementing, or planning to implement, strategies to manage the risks to frontline workers and other patients. For example, St Vincent's is considering sectioning off areas of the emergency department and acute wards, and has increased training for staff on dependency, mental health and managing aggression.[386]

Clandestine laboratories

The clandestine manufacture of illicit drugs also presents a serious risk of harm to human health and the environment. Clandestine laboratories can be set up in a variety of locations, including residences, commercial premises, hotel rooms, watercraft, vehicles or underground.[387] Operators frequently ignore safe chemical manufacturing and handling practices, which can put those who come into contact with the laboratories at risk.

A range of people come into contact with clandestine laboratories. In the first instance, law enforcement officers are usually involved in locating the clandestine laboratory and collecting evidence. The Police Federation of Australia has said it is concerned about 'the risk of exposure to harmful chemicals within ice manufacturing/laboratory settings.'[388] Other professionals can also come into contact with the laboratories, such as fire crews or environmental authorities tasked with remediation. The laboratories can also pose a risk to residents, neighbours and the community.

The risks to these groups include the residual contaminants and the toxic waste produced by the drug manufacturing process. Depending on the manufacturing process, up to 10 kilograms of waste may be generated for each kilogram of the drug produced.[389]

The exact nature of hazardous chemicals produced depends on the method and precursor chemicals used, but they can be flammable, corrosive or otherwise dangerous. These chemicals can irritate the skin, eyes and respiratory system.[390] In addition, these

chemicals can be difficult to remove because they can be absorbed by floors, walls, drains, ducting and furnishings or fixtures in the vicinity of the laboratory. The chemicals can also cause environmental damage if disposed of through the plumbing system or in surrounding soil.[391]

Fires or explosions are another risk of the manufacturing process. In these instances, contamination issues are greatly compounded and can present both immediate and long-term hazards to neighbouring residents.[392]

While the total number of methamphetamine clandestine laboratories has remained roughly constant since 2010, there has been a trend towards larger laboratories with a corresponding increase in the risk they create for professionals, the community and the environment.[393]

Work health and safety

The 2013 National Drug Strategy Household Survey data indicates that around two per cent of the Australian workforce had used methamphetamine in the past 12 months.[394] The use of ice—or methamphetamine more broadly—is more common in some industries than others.

For example, use of methamphetamine is particularly prevalent in industries such as wholesale trade, construction, mining, hospitality and among tradespeople. Some of the factors that contribute to this are the demographic profile of the workforce, the ease of access to drugs, and workplace factors that cause fatigue such as long hours, fast-paced work, shift work or fly in-fly out work.[395]

This can pose a risk to health and safety in those industries. For example, the use of ice can impair concentration, the ability to gauge speed and distance, judgment and coordination. The risk to health and safety extends beyond the period in which someone is directly affected by the drug. For example, users can find it difficult to sleep for several days after using methamphetamine, which increases fatigue and related issues. The longer-term issues associated with regular ice use, discussed previously, can also affects health and safety and productivity.[396] This is particularly risky in industries where people are required to drive or operate machinery.

Crime and community safety

Numerous studies indicate that ice use is associated with criminal behaviour.[397] [398] [399] Two forms of ice-related crime can affect the community: crime related directly to the criminal networks that trade illegal drugs; and secondary crime related to drug use such as theft and violence.

The criminal networks that distribute ice in Australia are discussed in Chapter 1. In summary, organised crime groups, such as outlaw motorcycle gangs, are heavily involved in the importation, manufacture and distribution of methamphetamine. More than 60 per cent of nationally significant organised criminal groups are involved in the methamphetamine and precursor market.[400] There is some evidence that organised crime groups are expanding their activities into regional areas. Within these drug markets, the threat of violent retribution is used to deter competition or unpaid debt.[401] Organised crime groups often outsource street-level dealing to lower level dealers who do not have knowledge of activities further up the supply chain. These lower level dealers are often drug users who sell the drug to their friends.[402]

McKetin and colleagues found that criminal involvement is high among regular methamphetamine users, as it is for many illicit drug users. In their study of the Sydney methamphetamine market, the researchers found that around half the users had committed an offence in the past month, one quarter had been arrested in the past year and one-third had been to a correctional facility at one point in their lives.[403]

McKetin and colleagues found that the most common type of crimes committed by regular methamphetamine users were property crime—such as shoplifting, theft and break and enter—and drug dealing. Around 70 per cent of regular users had committed these types of crimes at one point in their life. In this study, violent crime was less common. Around 30 per cent of the users had ever committed this type of crime

and only eight per cent had done so in the past month.[404]

A more recent study by Torok and colleagues found that around 50 per cent of weekly methamphetamine users had committed a violent crime in the past year. The link to violent crime was higher than for other drugs. This study also found that 35 per cent of heroin users had committed a violent crime in the past year.[405] Both the McKetin and Torok studies focused on people who use methamphetamine frequently, and so the results should be interpreted with caution. Nonetheless these studies do indicate a link between regular methamphetamine use and property or violent crime.

McKetin and colleagues also found that two-thirds of methamphetamine users who had committed a violent crime in the past year were under the influence of drugs or alcohol at the time. However, the link between methamphetamine use and violent crime is not straightforward—many users said methamphetamine use was not directly related to the crime:

> *"People who were intoxicated with methamphetamine at the time of their most recent violent crime described how the drug gave them more energy and made them feel more confident and alert, but that methamphetamine intoxication could also make them feel aggressive or angry. In a couple of cases, anger associated with methamphetamine use was the antecedent to committing the act of violence e.g. resulted in assault. However, most people who had committed violent crimes pointed out that they had intended to commit the crime in any case, and their methamphetamine use was incidental to the crime.*[406]

Violence and crime related to ice use were some of the most prevalent concerns in the submissions to the Taskforce. Some people told the Taskforce about specific instances they had witnessed:

> *"The police attended a situation where a 17 year old and friends as young as 14 were breaking into cars at 6.00 am to purchase Ice. When confronted the boy attacked anyone coming close to him with a machete. I wrote to crime stoppers and the local council advising this house was a danger to the community. No response. I believe the young man living there could have been helped with his addiction, removing the supply from our area.*[407]

More general fear of ice use in the community was a common theme in submissions to the Taskforce:

> *"[It's] completely devastating. it makes crime rate go through the roof, making people do more irrational things, stealing, assaulting people, etc. it's caused entire areas to be avoided as people know a lot of ice addicts live there and for their own safety they do not wish to go there.*[408]

> *"Ice has had a major impact on young people as well as members of the community as it is such an addictive drug which often induces violent and psychotic episodes. When someone is under the influence of ice, they become a danger to themselves and to others. With an increased presence of ice in the community, I feel as though our streets are not as safe as they used to be.*[409]

PART B
THE EXISTING EFFORTS TO RESPOND

ABOUT PART B

This section of the report examines what Australia is currently doing to address the ice problem.

The Taskforce examined existing efforts to address ice at all levels of government, identifying specific initiatives that are currently providing good outcomes for the community.

Chapter 4 looks at current efforts that aim to reduce the supply of the drug at the local, national and international level. These efforts generally focus on seizures of ice and its precursors, arrests, and disruptions of criminal networks involved in producing, importing and distributing ice.

In practice, this is challenging. Ice can be produced through a range of methods, making it hard to control precursors and curb production. Ice is relatively easily to conceal, making it difficult to identify imports and combat distribution. And ice commands high prices in Australia, making it a very attractive commodity for organised crime. Production, importation and distribution methods also evolve over time in response to law enforcement efforts.

Chapter 5 outlines efforts to prevent people from taking up ice. A range of prevention activities—particularly primary prevention activities—are undertaken at the national, state and territory level to inform people of the risks associated with illicit drug use, including ice, and to prevent uptake of illicit substances wherever possible.

Chapter 6 discusses current efforts to help people to stop using the drug. Australia's alcohol and other drug support and treatment system is a complex web of services that span the public, private and non-government sectors, delivered across a range of settings, including primary care, hospitals, correctional facilities, community health services. Treatment and support is provided by a range of professionals, including addiction medicine specialists, nurses and alcohol and other drugs workers, as well as counsellors, psychologists, psychiatrists, pharmacists, social workers, general practitioners, emergency department workers, community workers and other generalist health professionals.

Chapter 7 outlines a range of efforts that are already underway at the Commonwealth, state, territory and community level to strengthen our responses across these key areas. The governance and advisory arrangements in place to inform and coordinate Australia's alcohol and other drug policy are also outlined.

CHAPTER 4
DISRUPTING SUPPLY

Law enforcement has responded strongly to disrupt supply of ice—with domestic ice seizures increasing more than eight-fold in the past five years.

In recent years there has been enhanced coordination and collaboration between the Commonwealth, state and territory governments across Australia. Australian governments devote considerable resources to control the supply of illegal drugs, including ice, spending an estimated $1.7 billion each year. Most of this goes to law enforcement and criminal justice.[410]

Australian law enforcement efforts at the local, national and international level aim to reduce the overall supply of ice within Australia. These efforts generally focus on seizures of ice and its precursors, arrests, and disruptions of criminal networks involved in producing, importing and distributing ice.

Law enforcement actions also seek to reduce the broader harms to society from the activities of organised crime groups involved in the ice trade. They encompass both border and domestic policing, including controlling the availability of precursor chemicals and equipment used in the manufacture of ice. Broader actions to disrupt the business model of organised crime, such as targeting criminal profits, are also an important aspect of this work.

In practice, this is challenging. Ice can be produced through a range of methods, making it hard to control precursors and curb production. Ice is relatively easily to conceal, making it difficult to identify imports and combat distribution. Ice commands high prices in Australia, making it a very attractive commodity for organised crime. Production, importation and distribution methods also evolve over time in response to law enforcement efforts.

Australia's legal framework

The Commonwealth, state and territory governments share responsibility for the control of illicit drugs. Legislation at the Commonwealth, state and territory level provides the framework for efforts to reduce ice manufacture, importation and distribution. The legislation reflects international practice and multilateral agreements that Australia has signed. Law enforcement agencies work within this framework to counter the availability of ice and the impact of the market on Australian society.

There is no single drug law pertaining to methamphetamine, but it is listed as a prohibited substance in Commonwealth and all state and territory drugs schedules. The Commonwealth Government is primarily responsible for controlling prohibited drugs at the border and for international cooperation efforts to address the illicit drugs trade. State and territory governments are responsible for other criminal laws and controls, such as those relating to the possession, trafficking or manufacture of illicit drugs. They are also responsible for determining the penalties for these offences, and for administering their criminal justice systems and the prosecution of offenders.

There is considerable cooperation between the Commonwealth and states and territories to coordinate efforts to combat illicit drugs, and organised crime more broadly. There are also similarities in the legislative provisions, offences and penalties of the Commonwealth and states and territories.

The Commonwealth Criminal Code

The Commonwealth has a range of legislative and regulatory frameworks to combat the threat posed by serious drugs, including ice. This includes the serious drug offences in the Commonwealth *Criminal Code*, and the *Customs (Prohibited Import) Regulations 1956* which regulates licensing and the importation of prohibited or controlled substances. The Commonwealth has broad power to control substances at the border, and has an obligation to ensure Australia complies with its obligations under international treaties. It has powers to investigate offences involving illicit drugs within Australia, provided they are listed in the *Criminal Code Regulations 2002*. These powers complement state and territory drug legislation and facilitate multi-agency investigations across jurisdictions.

Serious drug offences under the Criminal Code primarily fall into two broad groups: the import and export of drugs and their precursors; and domestic offences including the possession, manufacture and supply of controlled drugs and precursors. The more serious offences in Part 9.1 of the Criminal Code include:

- trafficking
- commercial manufacturing
- importing and exporting
- possessing
- drug offences involving or harming children (for example, supplying drugs to children, or using them in drug supply or trafficking).

Offences under the Criminal Code are tiered according to the quantity of the drug involved. Greater penalties generally apply to 'marketable' or 'commercial' quantities.[411] The maximum penalty for import or export or manufacturing of a commercial quantity of methamphetamine (0.75 kilograms or more) is life imprisonment and/or $1.275 million,[412] while the maximum penalty for a marketable quantity of methamphetamine (two grams or more) is 25 years imprisonment and/or $850,000. Offences relating to the possession of lesser amounts may attract a penalty of two years imprisonment and/or $68,000 (see Table 4.1).

State and territory legislation

Drug laws vary across Australian jurisdictions, but they have common central themes. Offences generally cover use, possession, manufacture and cultivation, and trafficking of illicit drugs.

Table 4.1: Summary of penalties for possession, trafficking and large-scale supply of methamphetamine

Jurisdiction	Possession	Trafficable / Supply		Marketable		Commercial		Large commercial	
	Penalty	*Qty (grams)*	*Penalty*	*Qty (grams)*	*Penalty*	*Qty (grams)*	*Penalty*	*Qty (grams)*	*Penalty*
Commonwealth (controlled drug)	2 years 400 penalty units	2*	10 years 2,000 penalty units	250*	25 years 5,000 penalty units	750*	Life 7,500 penalty units		
Commonwealth (border controlled drug)	2 years 400 penalty units			2*	25 years 5,000 penalty units	750*	Life 7,500 penalty units		
New South Wales	2 years 20 penalty units	3	15 years 2,000 penalty units			250	20 years 3,500 penalty units	500	Life 5,000 penalty units
Victoria	1 year 30 penalty units	3	15 years			500, 100*	25 years	1,000, 750*	Life 5,000 penalty units
Queensland	15 years	2^	20 years (possession by drug dependent person) 25 years (possession by other person) 25 years (trafficking—no threshold quantity) 20 years (supply—no threshold quantity)			200	25 years		
Western Australia	2 years $2,000	2	25 years $100,000						
South Australia	2 years $2,000	2	10 years $50,000			500, 100*	25 years $200,000	1,000, 750*	Life $500,000
Tasmania	2 years 50 penalty units	25	100 penalty units or 4 years (supply) 21 years (trafficking)						
Australian Capital Territory	2 years 50 penalty units	6	10 years 1,000 penalty units			3,000	25 years 2,500 penalty units	6,000	Life
Northern Territory	5 years, 85 penalty units (public place possession) 2 years, 40 penalty units (all other cases)	2^	14 years (supply) 14 years (possession in a public place) 7 years (possession in all other cases)			40	25 years		

Quantities listed are mixed quantities except for those marked with * which are pure quantities.

The value of a penalty unit varies between jurisdictions. Commonwealth penalty units currently each equal $170.

Jurisdictions marked with ^ do not have a presumption that a person in possession of a trafficable quantity of methamphetamine intends to supply or traffic it.

Unless otherwise indicated with a ^ symbol, possession of the trafficable quantity presumes the person possessed the drug with the intent to supply or traffic it.

If a person possesses over 28 grams of methamphetamine, they may be declared a drug trafficker and be liable to have all their property confiscated.

South Australia includes aggravated offences for committing a drug trafficking offence as part of a criminal group.

States and territories use different drug threshold quantities to measure the seriousness of drug offences. Thresholds vary by drug type and whether the drug is measured by the amount of pure chemical compound present, or the combined weight of the pure chemical and adulterants.[413]

Three different thresholds generally distinguish the seriousness of the offence and the related penalty ranges that apply (see Table 4.1). Terminology may differ, but these thresholds generally describe a:

- small quantity—the possession of which will usually constitute personal use
- trafficable quantity
- commercial quantity.

The latter two quantities form the basis of trafficking or supply offences. In most states and territories, drug trafficking thresholds reverse the traditional burden of proof. That is, the possession of a trafficable amount is prima facie evidence that the drug was in the accused's possession for the purposes of trafficking, with the onus on the accused to prove they had the drug for something other than supply.

Each threshold triggers increasingly severe penalties. The maximum penalty for possession varies across Australia, ranging from one year (Victoria) to 15 years (Queensland), but most states and territories have a two-year penalty.

There is greater variation in quantity thresholds and penalties for trafficking, supply and commercial quantity offences. Maximum penalties range between seven years and life imprisonment.

Penalties may also be influenced by other factors. For example, in the Northern Territory, possession in a public place is seen as an 'aggravating' factor, attracting a maximum penalty that is double the maximum for other cases involving the same quantity. In Queensland, the maximum penalty for possession of a trafficable quantity by a drug dependent person is five years less than the penalty for other people.

Current legislative initiatives

As at 1 October 2015 the *Crimes Legislation Amendment (Powers, Offences and Other Measures) Bill 2015* was before the Australian Parliament. The legislation, if enacted, will improve the operation of the serious drug and precursor offences in the Criminal Code. These amendments will make it easier to successfully prosecute individuals who are knowingly engaged in large-scale drug and precursor importations.

First, the laws will ensure that it is simpler to prosecute individuals who currently evade punishment by managing their involvement in a drug operation in such a way that the prosecution cannot prove they have the relevant level of knowledge about that operation.

The amendments will apply the same burden of proof ('recklessness') in cases involving an attempted drug offence that apply when an offence is actually committed. Under this change, the prosecution will only need to prove that the person knew there was a risk the substance involved was an illicit drug.

The second change will simplify offences for importing the chemicals used to make illicit drugs, such as ice. Under the amendments, the prosecution will no longer have to prove the importer intended for the chemical to be used to manufacture an illicit drug. It will be enough that they imported a chemical without the appropriate authorisations.

Stopping ice at the border

As noted in Chapter 1, there is a trend toward increasing importation of ice into Australia. As such, efforts to prevent and disrupt imports of ice and its precursors are an important aspect of strategies to reduce supply.

Law enforcement efforts at the border need to be balanced with enabling movement of people and goods for legitimate trade, travel and migration. It is impossible and ineffective—both financially and logistically—to inspect every passenger or consignment that crosses the border.

The large volume of people and goods passing through the border continues to increase rapidly. In this context, efforts need to focus on ensuring available resources are directed towards illicit imports and the criminal groups involved in the drug trade.

The Taskforce heard that those trying to import illicit drugs are becoming increasingly responsive and resilient to law enforcement interventions and tactics. Serious and organised crime is transnational, highly networked, professional, well-funded and operates with high-level specialist advice to evade detection or exploit gaps in legislative and regulatory regimes. It has capitalised on high demand in Australia for methamphetamine, particularly ice.[414]

Serious and organised crime has also been innovative in infiltrating legitimate industries to hide illegal activities, and making use of 'trusted insiders' who work throughout the supply chain,[415] including at entry points at ports and airports. These criminals are adept at identifying and exploiting new and emerging technologies to facilitate their criminal activities, expand their reach, and provide anonymity and distance from their crimes.[416] Within this context, it is hard to substantially reduce the supply of illicit drugs solely by interventions at the border.

Like other law enforcement initiatives, border protection activities need to happen in conjunction with broader policies to address all facets of illicit drugs. The direct impact of border protection efforts is a matter of some contention. There is some evidence that border seizures can have a significant impact on the supply of some types of illicit drugs.

Seizures of heroin have been followed by a fall in supply and purity levels.[417] A range of factors led to Australia's 'heroin drought' of 2000-01. These included adverse climatic conditions which reduced opium yields, decisions by members of transnational organised crime networks to reduce exports of heroin in favour of other drugs, and offshore activities by a foreign government against poppy growers. However, some consider that increased resources for the Australian Federal Police (AFP) and the Australian Customs and Border Protection Service in 1998-99 may have also led to significant increases in border seizures.[418] The additional resources enhanced the ability of these agencies to investigate the trafficking of illegal drugs and cooperate with international law enforcement agencies in the region. Although the Australian heroin market has since stabilised and is now smaller, the price for heroin has not returned to pre-2001 levels, and its purity has remained low.[419]

Most empirical evidence suggests that border seizures alone are ineffective in reducing the availability, or in raising the price, of illicit drugs as their impact may be moderated by other factors such as domestic production.[420]

The Taskforce heard that this is particularly the case for synthetic drugs such as ice, which do not depend on plant crops for their production like drugs such as heroin. Synthetic substances are more easily replaced when a batch is seized, including through domestic production. This greater flexibility has led some organised crime groups previously involved in heroin trafficking to divert their efforts away from heroin toward methamphetamine in recent years.[421]

Intelligence-led operational success

In August 2011, the AFP began investigating an international organised crime group following information received from the United States Drug Enforcement Administration (DEA). In January 2012, the Australian Customs and Border Protection Service identified several foreign nationals from Hong Kong arriving in Australia who were suspected to be preparing for a large-scale drug importation.

These people became targets of an intelligence operation. As a result, in July 2012 two suspect sea cargo containers arriving in Sydney from Thailand were targeted and sent to the Port Botany Container Examination Facility. X-ray images revealed anomalies consistent with possible illicit drug concealment within the shipment of terracotta pots. Further examination of the containers revealed a total of 306 kilograms of ice and 252 kilograms of heroin.

The AFP arrested seven men attempting to take possession of the drugs, including four foreign nationals and three Australia-based syndicate members. The investigation also continued overseas with the assistance of the DEA and the Royal Thai Police, with a number of additional people detained and questioned. At the time, this was the largest seizure of ice and the third largest seizure of heroin in Australia's history.

Intelligence-led targeting and technical capabilities

Intelligence-led targeting is the most effective way of achieving significant seizures of illegal drugs at the border. It is fundamental to identifying suspect shipments among the high volume of goods entering Australia every day. Knowing in advance which cargo consignments or passengers are most likely to contain or be concealing illicit substances greatly increases the ability to intercept such shipments.

In 2015 the Commonwealth Government established a National Border Targeting Centre to provide a nationally coordinated, whole-of-government approach to operational border risk assessment and targeting. The centre aims to provide a unified understanding of available intelligence through a central hub. It has the ability to provide real-time intelligence and targeting information to support border operations. The centre also works collaboratively with partners in the Asia-Pacific region and targeting centres in the United States, Canada, the United Kingdom and New Zealand.

Australian law enforcement agencies have had some success against the illicit drugs trade in recent years, through greater information and intelligence sharing. A number of collaborative taskforces targeting criminal exploitation of Australian ports and related supply chains have identified significant vulnerabilities, achieved major seizures of illicit drugs, and disrupted serious and organised crime groups.

Commonwealth, state and territory law enforcement agencies have also collaborated to develop a National Law Enforcement Methylamphetamine Strategy under the auspices of the Serious Organised Crime Coordination Committee (SOCCC).

The strategy provides a coordinated approach for national operations to disrupt methamphetamine manufacture and distribution, underpinned by a more detailed evidence base. It will encompass taskforces and joint Commonwealth, state and territory police operational activity targeted at outlaw motorcycle gangs, the waterfront, distribution by mail and parcel post, vulnerabilities at airports and infiltration of key sectors by 'trusted insiders'. The strategy will also focus on the highest-priority methamphetamine supply targets. The SOCCC will regularly monitor the progress of the various components of the strategy.

The Taskforce heard the Department of Immigration and Border Protection (DIBP) is preparing a strategy specifically in relation to its border management activities addressing

methamphetamine importation and international engagement.

In addition to increased intelligence sharing, the Australian Border Force in the DIBP is enhancing its detection capabilities at the border through advanced analytical techniques and tools to focus on high-risk people, goods and environments.

The Australian Border Force is collecting and analysing data from a wide range of sources to direct and shape operational, investment and resourcing decisions. Tools used include x-ray and trace detection technology, detector dogs and internal body scanners.

The AFP has developed strong partnerships with international law enforcement counterparts. It draws on these relationships to exchange intelligence, information and assistance through shared facilities, joint operations and advice. The AFP uses information gained to support investigations, disrupt transnational criminal syndicates and ensure methamphetamine and other illicit drugs are seized at the earliest opportunity in the supply chain.

The three key elements of the AFP's role internationally are:

- collaboration—brokering collaboration with international law enforcement agencies to drive investigations and support bilateral or multilateral cooperation
- intelligence gathering—collecting and exchanging criminal intelligence in support of international law enforcement efforts
- capacity building—enhancing the capacity and the capability of international law enforcement agencies to combat transnational crime and manage borders.

The AFP International Network comprises 98 members at 37 locations in 29 countries. It also has a number of Memoranda of Understanding with international law enforcement partners who assist to combat transnational organised crime and develop police-to-police cooperation. The AFP and other Commonwealth law enforcement agencies also cooperate with international agencies, such as the United Nations Office on Drugs and Crime.

Other Commonwealth departments and agencies are also involved in international collaboration against the drugs trade.

The International Crime Cooperation Central Authority (ICCCA) in the Commonwealth Attorney-General's Department facilitates evidence gathering from overseas to assist in the investigation and prosecution of criminal cases in Australia, including drug cases.

ICCCA makes a range of requests for assistance from other countries, including for witness statements, telecommunication records and search warrants, and works with foreign counterparts to ensure this evidence is admissible in Australian courts. In 2014 and 2015, ICCCA made over 100 mutual assistance requests to other countries in relation to drug offences—a large number of those requests related to methamphetamine.

The DIBP has a long history of international cooperation, including information and intelligence sharing with counterpart agencies in Canada, the United Kingdom, the United States, New Zealand, and the Asia-Pacific region. The Commonwealth has successfully pursued operations targeting illicit drug trafficking through its involvement in regional forums and the World Customs Organization.

Agencies such as the Commonwealth Attorney-General's Department (AGD) and the Department of Foreign Affairs and Trade cooperate closely with international partners to support the capacity of regional countries to combat crime and cooperate effectively with international partners, including Australia. This work focuses on areas such as strengthening policies and legal regimes, addressing illicit money flows, strengthening evidence collection, responding to mutual assistance and extradition requests, and drawing on international experience to inform approaches to drug control, prevention and treatment.

Australian–Chinese Cooperation: the rise and fall of ContacNT

From 2010 ContacNT—an over-the-counter cold and flu pharmaceutical manufactured in China for the Chinese domestic market—rose to prominence as a source of pseudoephedrine for the clandestine production of methamphetamine in Australia. Pseudoephedrine is one of the main methamphetamine precursors. ContacNT is manufactured at one production site (a factory in Tianjin) in capsule form, and contains a very high concentration of pseudoephedrine.

ContacNT trafficking to Australia started in 2010 and peaked in 2012, with ContacNT comprising nearly one-third of the total weight of all drug precursor chemicals detected at the Australian border. Between 2011 and 2014 approximately 1.6 tonnes of ContacNT was seized.

In 2012, Chinese authorities introduced point-of-sale restrictions in China for pharmaceuticals containing high concentrations of pseudoephedrine. The point-of-sale measures included a restriction of two packets of ContacNT sold to any one person, and a requirement that all purchasers must produce identification documents. The trafficking of ContacNT to Australia effectively collapsed in 2013-14, and it has ceased to be a factor in domestic manufacture.

Targeted strategic engagement with specific countries has successfully disrupted supplies of drugs and precursor chemicals. Cooperation with China is central to efforts to reduce the supply of ice, given that around 70 per cent of ice by weight detected at the border in the three years from 2010-11 to 2013-14 was shipped from China.[422]

Australia has developed its strategic engagement with China over several years. Australia and China entered into a Customs Strategic Partnership Programme in 2012, and signed a Memorandum of Understanding on precursor chemical control in 2013. This engagement has contributed to Chinese authorities making a significant number of detections and arrests which, together with Australian customs enforcement activities, have disrupted syndicates supplying pseudoephedrine to the illicit drug market in Australia.

International agreements and forums

Australia plays a broader role in international cooperation on illicit drugs. It is a signatory to three major international drug control treaties: the 1961 Single Convention on Narcotic Drugs; the 1971 Convention on Psychotropic Substances; and the 1988 Convention against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances. These treaties provide the basis for international cooperation to combat the use and supply of illicit drugs.

Australia is an active participant in international and regional forums to address drug trafficking. These include the United Nations Commission on Narcotic Drugs and relevant Association of Southeast Asian Nations and Pacific Islands Forum bodies. Australia works closely with countries throughout the Indo-Pacific region in particular, in support of legislative reform, law enforcement skills development, and health outcomes.

The United Nations General Assembly Special Session on the World Drug Problem, to be held in New York in April 2016, will provide an opportunity to take stock of achievements and assess challenges in countering global drug problems, including the links between drugs and organised crime, public health, human rights, economic development and social stability.

Combating the infiltration of air and sea ports

Airports and maritime ports are gateways for imports of illicit drugs. Serious and organised crime groups may target 'trusted insiders' working in these environments to help facilitate the movement of illicit drugs and avoid law enforcement intervention. Trusted insiders can include private contractors and public sector

employees providing a range of support services, including baggage handling, cargo processing, quarantine services and aircraft and vessel maintenance. Back-office staff with access to systems and sensitive information can also help facilitate illicit drug movements.

The Taskforce heard that serious and organised crime has been innovative in infiltrating legitimate industries to hide illegal activities and make use of trusted insiders working throughout the supply chain, including at entry points at sea ports and airports.

In 2013-14 alone, the work of multi-agency taskforces targeting criminal exploitation of Australian ports and related supply chain activity at the waterfront in Sydney, Melbourne and Brisbane resulted in 56 arrests and the seizure of 138 kilograms of illicit drugs and precursor chemicals, as well as the seizure of 177 tonnes of tobacco and seven firearms.[423]

Anyone who needs regular access to secure areas of Australia's air or sea ports is required to hold an Aviation Security Identification Card (ASIC) or a Maritime Security Identification Card (MSIC). The ASIC and MSIC schemes currently focus on minimising the risk of unlawful interference with aviation and maritime transport. The AGD conducts background checks on people applying for an ASIC or MSIC to identify individuals who should not be eligible to access these secure areas because they may pose a threat to aviation or maritime security.

Disrupting mail imports

The AFP has established an International Mail Processing and Disruption Strategy to respond to the substantial increase in the volume and frequency of illicit drug and precursor importations through international mail. As part of this strategy, the AFP partners with state and territory law enforcement agencies to enhance capabilities to pursue criminal syndicates that import illicit substances through the mail stream.

Within this context, the AFP's National Forensic Rapid Lab (Rapid Lab) has provided an important additional source of intelligence to increase border detections. Rapid Lab analyses information from AFP drug seizures to support targeting of priority criminal syndicates within Australia and internationally. It forensically examines international mail items containing illicit commodities to gather all available forensic intelligence.

Additional AFP forensic techniques include the chemical profiling of methamphetamine, which may help indicate precursor chemicals used in manufacture and possible links between drug seizures. Monitoring changes in the precursors used or manufacturing methods can also inform strategies to prevent methamphetamine manufacture.

Commonwealth law enforcement agencies have also partnered with state and territory law enforcement agencies to pursue criminal syndicates importing drugs through the post. They bring together available intelligence and provide leads to domestic and international law enforcement agencies to disrupt criminal networks.

Responding to domestic manufacture and trafficking

Despite the substantial increase in ice imports in recent years, domestic manufacture of methamphetamine continues. Since reporting on the size and production capacity of detected laboratories began in the *2011-12 Illicit Drug Data Report*, the majority of clandestine laboratories detected nationally have been small operations to support individual use. However, the average size and sophistication of detected laboratories has increased.

The proportion attributed to small-scale, medium-scale and industrial-scale laboratories has more than doubled in recent years, increasing from to 21 per cent in 2011-12 to 48 per cent in 2013-14.[424]

State and territory responses

As noted previously, the states and territories have general responsibility for enforcing criminal law in Australia, including in relation to domestic manufacture and distribution of drugs. State and territory law enforcement agencies are at the forefront of gathering criminal intelligence and information in their

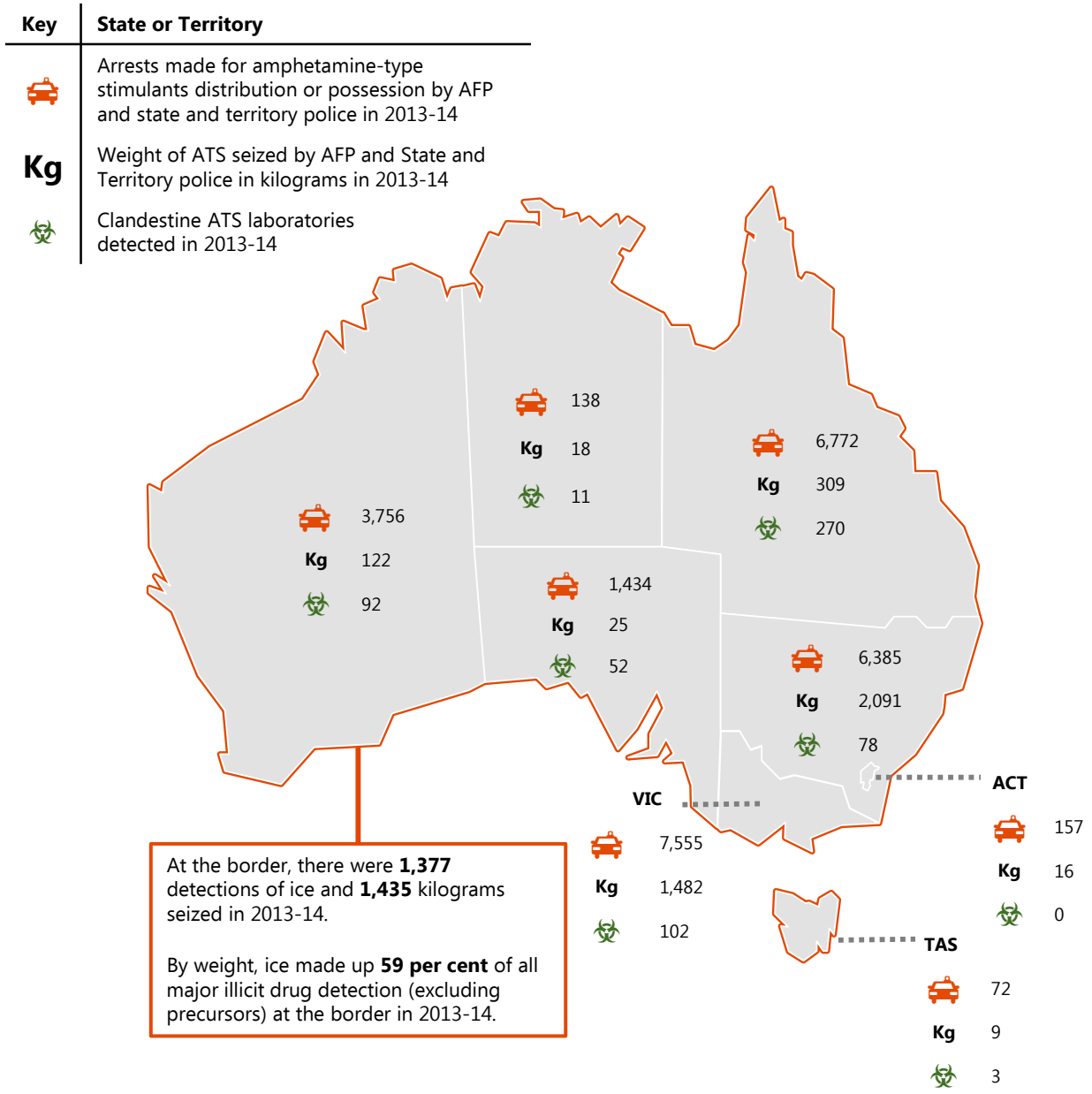
jurisdictions to conduct local operations and inform a national response to serious and organised crime.

Jurisdictional drug squads target groups responsible for trafficking, supply and manufacture of ice, either independently or in partnership with other agencies. They monitor suspicious transactions regarding precursor chemicals, detect and dismantle clandestine laboratories and protect the community from harms caused by methamphetamine manufacture and use.

Joint Management Groups in each jurisdiction facilitate identification and targeting of locally significant organised crime groups, such as outlaw motorcycle gangs.

Local police in each state and territory play an important role in efforts to tackle ice in their communities. Their local knowledge and links with the community are fundamental to responses on the ground and actions to ensure the safety of local populations. Many state and territory police forces also undertake roadside drug testing to reduce risks to the community from people driving under the influence of drugs such as ice.

Figure 4.1: Amphetamine-type stimulants-related arrests, seizures and clandestine laboratory detections, 2013-14



National responses

National law enforcement agencies are working together to tackle the methamphetamine market through intelligence-led operations to target methamphetamine manufacture and distribution including ice. Commonwealth, state and territory justice and law enforcement Ministers—through the Law, Crime and Community Safety Council of the Council of Australian Governments—identified the need to address the increasing presence of methamphetamine in the community as a priority under the National Organised Crime Response Plan 2015-18. The National Law Enforcement Methylamphetamine Strategy is one component of this broader plan.

Significant trafficking of methamphetamine occurs between jurisdictions, and multi-agency and multi-jurisdictional taskforces are also tackling components of the ice problem nationally.

This collaboration enables more sophisticated responses to serious and organised crime activities and harnesses the specialised skills of each agency, including national agencies, such as the Australian Crime Commission (ACC) and AFP. For example of multi-jurisdictional cooperation was the establishment of Task Force Morpheus to investigate, disrupt, disable and dismantle the criminal activity of Australia's highest-risk outlaw motorcycle gangs and their members. The AFP also leads a National Anti-Gangs Squad to coordinate and support operational activities against the wider gang environment. The ACC examines the means by which illicit drugs are transported between jurisdictions to develop operational leads and identify vulnerabilities.

The AFP coordinates the Enhanced National Intelligence Project on Illicit Drugs to support this capability. The Project enables the chemical profiling of state and territory illicit drug samples, including methamphetamine. It supports the AFP in identifying relationships between seizures made at the Australian border and those made by state and territory law enforcement agencies.

Drug-related arrests and sentencing

Nationally, arrests for offences related to amphetamine-type stimulants increased by 88 per cent between 2009-10 and 2013-14 from 13,982 to 26,269. The proportion of national illicit drug-related arrests associated with amphetamine-type stimulants also increased over this period from 16.4 per cent to 23.4 per cent over this period (see Table 4.2).[425]

It is more difficult to get a national picture of sentencing trends for methamphetamine-related offences. The average custodial sentence for illicit drug offences generally across Australia in 2013-14 was 26 months,[426] but data by drug type is not available at the national level.

Some data is available at the state level, however. For example, in Victoria, methamphetamine accounted for 42 per cent of drug trafficking offences between 2008-09 and 2012-13.[427] A sentence of imprisonment was imposed in 86 per cent of these cases. The median total effective term of imprisonment was four years and six months (see Table 4.3).

Annual reporting from New South Wales criminal courts shows that people found guilty of trafficking in a commercial quantity of amphetamine-type stimulants are predominately sentenced to imprisonment—between 84 and 94 per cent (as opposed to other penalties such as home detention, intensive corrections order, suspended sentence with supervision, community service or bond). Those found guilty of trafficking/dealing a non-commercial quantity are less likely to be sentenced to imprisonment (between 47 and 52 per cent).[428]

This data it is consistent with the reported trends in recent years that more people have been arrested for offences related to amphetamine-type stimulants. The snapshot of sentencing data from Victoria and New South Wales also indicates that people found guilty of trafficking in commercial quantities of methamphetamine and other amphetamine-type stimulants are more often than not sentenced to a correctional facility.

Table 4.2: National drug arrests: number and proportion by drug type, 2009-10 to 2013-14

Drug	2009-10		2010-11		2011-12		2012-13		2013-14	
	No.	%	No.	%	No.	%	No.	%	No.	%
Amphetamine-type stimulants	13,982	16.4	12,897	15.2	16,828	18.1	22,189	21.8	26,269	23.4
Cannabis	57,170	67.1	58,760	69.3	61,011	65.5	62,120	61.1	66,684	59.5
Heroin (other opioids)	2,767	3.2	2,551	3.0	2,714	2.9	2,463	2.4	2,771	2.5
Cocaine	1,244	1.5	839	1.0	995	1.1	1,282	1.3	1,466	1.3
Steroids	314	0.4	365	0.4	511	0.5	661	0.6	936	0.8
Hallucinogens	512	0.6	373	0.4	484	0.5	565	0.6	704	0.6
Other and unknown	9,263	10.9	8,972	10.6	10,605	11.4	12,469	12.3	13,219	11.8
Total all drugs	85,252	100	84,757	100	93,148	100	101,749	100	112,049	100

Table 4.3: Median total terms of imprisonment for offences of trafficking in commercial and large commercial quantities of methamphetamine in Victoria from 2008-09 to 2012-13

Offence	Total number of cases (charges)	Number of cases for drug type meth/ice (per cent of cases)	Total cases where sentence of imprisonment imposed (per cent)	The median total effective term of imprisonment
Trafficking in a drug of dependence in a commercial quantity (over 500 grams or 100 grams pure)	138 (152)	64 (42 per cent)	119 (86 per cent)	4 years and 6 months
Trafficking in a drug of dependence in a large commercial quantity (over 1 kilogram mixed or 750g pure)	72 (79)	23 (29 per cent)	70 (97 per cent)	7 years and 10 months

Access to intelligence

The ACC compiles and analyses criminal intelligence on organised crime and illegal activities, including the trade in illicit drugs. It cooperates closely with Commonwealth, state and territory law enforcement agencies to access information, and provides analysis to support criminal targeting and law enforcement operations. The ACC's specific technical and human resource capabilities facilitate this analysis and intelligence sharing.

The ACC-led National Criminal Intelligence Fusion Capability provides a particular means to exploit intelligence available nationally. It brings together subject matter experts, investigators, analysts and tools from across a range of national and state and territory agencies. It applies advanced computer technology to identify previously unknown targets, relationships between targets, and strategies used by serious and organised crime groups. It plays a central role in developing the National Criminal Target List and enables law enforcement to be proactive in tackling emerging threats before they become entrenched.

Proceeds of the drugs trade and unexplained wealth

Proceeds from the methamphetamine market will continue to drive much of the illicit economy. Approximately 90 per cent of the illicit drugs, precursor chemicals and cash seized over the past three years by the ACC-led Task Force Eligo—the cross-jurisdictional task force targeting the transnational laundering of criminal proceeds—can be linked to the methamphetamine market.

The National Ice Taskforce heard that around 70 per cent of the referrals to the AFP-led Criminal Assets Confiscation Taskforce involve money laundering activities associated with drug importation and trafficking. More than $70 million in estimated asset value has been seized or restrained this financial year as a result of this work.

There is significant potential for law enforcement to increase the disruption of criminal activity by targeting money and assets acquired through the drugs trade. Unexplained wealth laws are a tool used to achieve this. These laws allow a court to require suspected criminals to demonstrate how they acquired their assets, rather than law enforcement needing to prove the assets were linked to a particular crime. They complement other criminal asset confiscation options and are intended to deter criminals by reducing the profitability of illegal activities and diminishing their ability to finance other illegal acts.

Unexplained wealth laws are a means of disrupting criminal enterprises and targeting senior organised crime figures behind criminal activity who derive substantial profit from it but distance themselves from the actual commission of the offence to avoid prosecution.[429] They have been found to be effective in jurisdictions both overseas (for example, Ireland)[430] and domestically (for example, in the Northern Territory).[431]

Most Australian states and territories have introduced unexplained wealth laws. Recent legislative amendments to the *Commonwealth Proceeds of Crime Act 2002* aim to strengthen the Commonwealth regime for unexplained wealth investigations and litigation. The AFP is now assessing a number of investigations to take advantage of its ability to pursue unexplained wealth orders.

Countering supply to Indigenous communities

Addressing the supply of ice to regional and remote Indigenous communities is a challenge for both law enforcement and local communities. Contributions to the Taskforce highlighted the need to stop supply at an early stage before it becomes entrenched in these communities.[432] There are significant barriers to policing efforts in remote areas in particular. These include: difficulties in recruitment to remote localities; a lack of appropriate detention facilities; distances involved; and a lack of sentencing options available to courts.[433] The ACC is working with relevant jurisdictions to identify and disrupt sources of polydrug supply to those communities.

There are a number of existing policing initiatives designed to reduce the supply of illicit drugs to Indigenous communities. In the Northern Territory, police have enhanced search and seizure powers to intercept alcohol and kava destined for Indigenous communities. New laws have been proposed to expand these powers so police can also target suspected drug traffickers; these laws are aimed at stopping the distribution and use of methamphetamine, and will be modelled on existing South Australian legislation where specific roads can be declared as 'drug transit routes'.

The Commonwealth Government also provides funding to police forces in the Northern Territory, South Australia and West Australia to operate Substance Abuse Intelligence Desks and Dog Operations Units. These work to improve the collection of intelligence to interrupt the supply of drugs to remote communities.

Community Engagement Police Officers are also working in the Northern Territory to help build better relationships between communities and police. Community Engagement Police Officers are sworn police officers who support other general duties police, including in remote communities, to engage with community members in a culturally sensitive manner and highlight the importance of community safety and the role of police. They help to promote awareness of social issues around alcohol and substance misuse.

Participants in the Taskforce's Broome community consultation also highlighted the effectiveness of Western Australia's Police Community Relations Officers programme in communities where it is used. This programme uses local Indigenous residents to act as a link between local communities and Western

Australian Police. These residents support programmes to reduce crime in their communities, engage community members and assist crime reduction strategies that address the underlying causes of criminal activities in their communities, including in relation to illicit drugs.

Precursor controls

Effective controls over chemicals that can be used in drug production are essential to reduce the supply of ice. Australian governments work at state and territory level, nationally and internationally, including through the International Narcotics Control Board, to regulate access to these chemicals.

The global shortfall in the manufacture of MDMA (ecstasy) that occurred between 2007 and 2010,[434] including in Australia, is thought to have been the result of increased controls on key precursor chemicals.[435] Australia's precursor controls have also contributed to the significant fall in the number of clandestine methamphetamine labs detected in Australia during 2014—15. This is consistent with international experience. In the United States, for example, precursor controls were found to have reduced methamphetamine laboratories by 36 per cent in states that adopted them.[436]

Criminal groups, both in Australia and internationally, continually look for ways to circumvent existing controls, including by changing supply and manufacturing methods to respond to the availability of chemicals, and associated regulation and policing. This has created substantial challenges for law enforcement efforts.

As noted earlier, the Commonwealth Government is primarily responsible for controlling precursor chemicals at the Australian border. The Criminal Code includes criminal offences for importing, manufacturing or possessing precursor chemicals without appropriate licences. The penalty for the importation/exportation of commercial quantities is up to 25 years imprisonment and/or $850,000. The Customs (Prohibited Imports) Regulations 1956 also lists precursor chemicals that can only be imported into Australia with a permit or licence.

All states and territories have controls to restrict the possession and sale of precursor chemicals and equipment through either criminal offences, licensing or permit processes. However, these arrangements vary from jurisdiction to jurisdiction. In particular, the schedules of controlled chemicals differ between the Commonwealth, states and territories—meaning some chemicals controlled in the states and territories can be imported to Australia without restriction, and some chemicals controlled in one state or territory are not controlled in others.

A key aspect of these controls involves recording the sales of scheduled precursor chemicals and equipment through end user declarations (EUD). EUDs document the details of the supplier, purchaser and purpose for which the precursor chemicals or equipment are required. In most jurisdictions, suppliers must retain these documents for a certain period of time and make them available to law enforcement on request. However, in Western Australia and Queensland EUDs must be submitted to police automatically.

A cross-jurisdictional working party under the auspices of the Senior Officers Group on Organised Crime has recently finalised a discussion paper on the development and implementation of a national electronic EUD system. Under the proposal, an electronic EUD system would provide law enforcement agencies with immediate access to information about precursor sales through an online searchable database. The Commonwealth will progress the recommendations of the electronic EUD report through broader work Australian governments are undertaking to improve and harmonise controls on precursor chemicals and equipment.

The Commonwealth, states and territories endorsed a National Framework for the Control of Precursor Chemicals and Equipment in May 2010. The framework aims to reduce the diversion of precursor chemicals and related equipment for illicit use, while minimising the compliance burden for legitimate industry.

Government and industry representatives have worked under this framework to provide a risk-based assessment of precursor chemicals and have outlined recommendations for achieving greater national consistency in precursor controls.

At the Law, Crime and Community Safety Council meeting on 22 May 2015, Commonwealth, state and territory law enforcement and justice Ministers agreed to work toward more nationally consistent precursor controls and to arrange public consultations on a range of proposals. The AGD will analyse the benefits and regulatory costs of possible options, including the development of a national electronic EUD system. Law, Crime and Community Safety Council Ministers are scheduled to consider the outcomes of this study in the first half of 2016.

Industry regulation

Australia's chemical and scientific industries, in partnership with law enforcement agencies from around Australia, developed a Code of Practice for Supply Diversion into Illicit Drug Manufacture in 1994. This code is intended to provide a best practice guide for companies to prevent the diversion of legitimate industrial chemicals to illicit drug manufacture. It outlines procedures for secure storage, sales monitoring, record keeping and reporting, as well as education and training.

The code was most recently updated in 2008. While adherence to the code is voluntary, some of the procedures described in it are also set out in state and territory legislation.[437]

Effective responses to stem the supply of illicit drugs also rely on cooperation from the private sector. An example of an industry-led initiative is Project STOP. The Pharmacy Guild of Australia developed Project STOP to assist pharmacists to prevent the diversion of pseudoephedrine into illicit drug manufacture.

Project STOP is an online database that allows pharmacists to record customer details against pseudoephedrine sales. The programme was introduced in Queensland in 2005 and expanded nationally in 2007. It reduces the criminal diversion of pseudoephedrine from pharmacies to the manufacture of illicit drugs. Project STOP is currently mandated in Queensland, Western Australia and South Australia, and is used to varying degrees in other jurisdictions.

Diversion programmes, drug courts and mandatory treatment

Criminal justice diversion

State and territory governments run a range of diversion programmes to divert perpetrators of relatively minor drug-related crimes to treatment, rather than judicial sanctions. The type of diversion programmes vary across Australia, with different policies and legislation in each state and territory. They can be applied at any point in the law enforcement cycle, from before arrest, to post-sentencing.

Diversion programmes work to break the cycle of offending by diverting offenders away from the criminal justice system towards appropriate drug-based assessment, education and treatment services. These programmes were once seen as controversial,[438] but are increasingly seen as a pragmatic response, and have become one of the most used policy interventions in Australia.[439]

Most diversion programmes are targeted at people who are in possession of, or using, a small amount of illicit drugs, or those arrested for alcohol-related offences. They seek to direct offenders into activities that will benefit both the offenders and the community, and reduce the incidence of reoffending. Victoria's diversion programme, for example, has been successful in reducing re-offending, assisting participants with rehabilitation and providing magistrates with increased flexibility.[440] Western Australia Police recently introduced an early intervention strategy for low-level drug offences that provides officers with discretion when prosecuting for first minor offences, based on a requirement for offenders to attend drug treatment.[441]

Diverting offenders into treatment programmes can also save significant costs in the justice

system. These programmes can increase the efficiency of the criminal justice system by reducing costs incurred through police investigations, hospitalisation, criminal activity, correctional facilities and probation supervision.[442]

Drug courts are sometimes used as part of diversionary approaches. While there are considerable differences across jurisdictions, there are common elements to all Australian drug courts. They are specifically designed to consider drug cases and are overseen by a magistrate who monitors the conduct of individual drug offenders over an extended period of time. They are also supported by a multidisciplinary team, which assesses and monitors offenders.

Drug courts perform a dual role by punishing criminal behaviour through sentencing and arranging rehabilitation services for offenders to address their substance use. The use of drug courts has been found to have a substantial impact in reducing the rate of adult reoffending, relative to traditional criminal justice approaches.[443] A 2008 evaluation of the New South Wales Drug Court found that participants who successfully completed the Drug Court programme (relative to a comparison group) were:

- 37 per cent less likely to be reconvicted of any offence
- 58 per cent less likely to be reconvicted of a drug offence.[444]

However, completion rates are variable. A 2012 review of the South Australian Drug Court found that two-thirds of participants did not complete the programme,[445] whereas a 2008 study of the Victorian drug diversion programme found that 75 per cent of participants did complete the programme.[446] The effectiveness of these programmes is lower when offenders don't complete the programme.

Jurisdictions regularly review these programmes to evaluate their effectiveness and identify refinements. Continuation of diversion programmes remains a priority under various state and territory policies and the National Drug Strategy.

Mandatory treatment

Mandatory treatment programmes for severe substance dependence operate outside the criminal justice system in Australia.

Four jurisdictions have legislated for mandatory treatment of people with alcohol and other drug dependence: New South Wales; Victoria; the, Northern Territory; and Tasmania.[447] These schemes have evolved from 'Inebriates Acts', in place since the early 1900s. The legislation in New South Wales, Victoria and Tasmania provides for mandatory treatment for people dependent on alcohol and other drugs, while the Northern Territory's legislation applies only to alcohol and volatile substance misuse (such as solvents and petrol).

There are common features between the legislative regimes operating in Australia. Under the New South Wales, Victorian and Northern Territory regimes, mandatory treatment can only be authorised where a person is at risk of serious harm, and less restrictive means are not available. There is also a requirement for substance dependence to be severe, and for treatment to be beneficial for the person. The objectives of the schemes include stabilising health and enhancing capacity to make future decisions about substance use and personal welfare.

The regime in New South Wales provides for an initial detention period of up to 28 days, and Magistrates can extend the period for up to three months, on application by an accredited medical practitioner. In Victoria, detention is limited to 14 days. In Tasmania, a person can be detained for up to six months, with potential for a further six months if a responsible medical officer believes it is necessary. In the Northern Territory, the period of detention for volatile substances is 16 weeks, and three months for alcohol.

The regimes in New South Wales and Victoria authorise mandatory treatment only where people are incapable of making, or have lost the capacity to make, decisions about their substance use. In New South Wales the person must also have refused treatment.

A range of views and issues have been canvassed in relation to mandatory treatment, including in recent reviews of the New South Wales scheme in 2013,[448] and the Victorian scheme in 2014.[449] The high cost of mandatory treatment has raised questions about whether it is an appropriate treatment option, given limited resources and lack of a robust evidence base. Concerns have been raised that mandatory treatment may diminish the capacity for treatment to be delivered flexibly and in a manner that enables the individual to own their problem. Ethical and human rights concerns have also been raised about interfering with a person's civil liberties by imposing medical treatment without their consent.

Mandatory treatment is a complex area. Research suggests that, while there is some evidence mandatory treatment for short periods can be an effective way to reduce harm, there is little evidence to support its effectiveness in rehabilitating or achieving long-term behavioural change.[450]

CHAPTER 5
PREVENTING ICE USE

Across Australia, a range of prevention activities are being undertaken to stem the flow of new ice users.

Prevention activities encompass a broad range of interventions designed to prevent (or delay) the use of illicit drugs. Many alcohol and other drug (AOD) prevention activities—particularly primary prevention activities—are already being undertaken at the Commonwealth, state and territory level to educate and inform people of the risks associated with illicit drug use, including ice, and prevent uptake of illicit drugs wherever possible.

This Chapter provides a high-level overview of the areas where much of Australia's current AOD prevention efforts are focused—school-based drug education and media campaigns. Current AOD prevention efforts within workplaces are also discussed, particularly in the context of efforts that aim to improve workplace health and safety.

It is noted that broader AOD prevention efforts—particularly across the non-government and private sectors—span beyond the detail provided in this Chapter. Cataloguing the entirety of these efforts is outside the scope of this report.

Further, the Taskforce notes that a range of interventions across the Commonwealth, states and territories are aimed at addressing the broader social determinants of health, which may include activities targeting risk factors associated with drug use. The focus of this work is much broader than tackling one specific illicit substance and, as such, the Taskforce has not attempted to summarise these efforts in this report. Nonetheless, the Taskforce recognises the value of such efforts and has included a brief overview in Appendix II.

An overview of community-based prevention efforts is outlined in Chapter 7.

School-based activities

School-based prevention activities are an essential component of Australia's drug prevention efforts. It is pivotal that prevention activities occur before young people are likely to be exposed to drug use, which usually occurs in adolescence. The younger children are when drug use commences, the higher the likelihood that their drug use will be particularly harmful, especially for those with higher risk factors.[451]

All states and territories incorporate school-based AOD education in the public school curriculum. This involves both the delivery of drug-specific information to help students build awareness of the risks associated with AOD use and misuse, and activities aimed at developing the social skills necessary to increase their resilience. States and territories have also implemented policies and approaches to manage drug-related incidents in public schools.

Resilience activities in school-based programmes include building skills in communication, problem-solving, assertiveness, negotiation, help-seeking behaviours, and cooperation. These activities are aimed at helping students build social skills that may assist in managing situations where drugs may be offered and used.[452]

These activities are generally targeted at different age groups, with different objectives at each point of intellectual and social development. For younger children, school-based measures generally aim to enhance protective factors so children are less likely to engage in risk-taking behaviour as they grow older. For adolescents, the focus shifts to increasing awareness of the risks and potential consequences of AOD use and misuse.

Figure 5.1: Australian Curriculum: Health and Physical Education—relationship of curriculum elements[453]

The Australian Curriculum

AOD education is a discrete area of learning under the Australian Curriculum: Health and Physical Education (HPE). This area of learning explores a range of drugs, including prescription, bush medicines and alternative medicines, energy drinks, caffeine, tobacco, alcohol, illegal drugs, and performance enhancing drugs. The content supports students to explore the impact these different drugs can have on individuals, families and communities.

Students are expected to have regular opportunities to revisit these focus areas from the start of their schooling to Year 10. As they mature and their ability to understand more complex concepts increases, students are expected to explore the following areas:

- safe use of medicines
- alternatives to taking medicines
- how drugs affect the body (including energy drinks and caffeine)
- factors that influence the use of different types of drugs
- the impact of drug use on individuals and communities
- strategies to support making informed decisions about drugs (assertive behaviour, peer influence, harm minimisation)
- use of performance-enhancing drugs in sport.

The HPE curriculum was endorsed by all Education Ministers in September 2015. Implementation has commenced in several jurisdictions.

National Safe Schools Framework

In addition, all Australian governments have agreed to the National Safe Schools Framework, which provides guiding principles to develop and implement positive and practical student safety and wellbeing policies.

To assist schools in implementing the framework, the Australian Government Department of Education and Training is funding the Safe School Hub. The Hub, developed and maintained by Education Services Australia, provides information and resources on safe school and student wellbeing issues for teachers, students, parents, specialist professionals supporting students, and pre-service teachers. The resources are available to all members of the school community free of charge. The Hub includes a page for students on *Alcohol and drugs, and keeping healthy*, which links to various resources, such as Headspace and drug awareness information.

National Drug and Alcohol Research Centre educational resources

In November 2014, the National Drug and Alcohol Research Centre (NDARC) released free and evidence-based drug education resources aimed at empowering young people to make positive choices for their health and wellbeing. The resources—a series of drug information booklets and fact sheets targeted at students, parents and teachers—were distributed to over 3,000 secondary schools across Australia.

Each booklet includes additional information relevant to the target audience, including guidance for students on making informed choices and dealing with pressure from peers, advice to parents about what they can do to protect their children against drug use, and information for teachers about proven school-based prevention programmes.

The resources also include fact sheets for teachers (and parents) with definitions and descriptions of classes of illicit drugs, teacher notes, lesson plans and suggestions for in-class exercises or projects, and advice for teachers on sources of help for students with drug misuse and mental health problems (particularly mental disorders that might result from illicit drug use).

NDARC also developed the CLIMATE school drug prevention programme, which is an evidence-based online platform offered to schools, delivering a harm minimisation message. It strongly encourages abstinence; however, also provides information to lessen the negative consequences for those that do use illicit drugs.

The psychostimulants and cannabis module of this programme was evaluated using

randomised comparison trials in 21 New South Wales and Australian Capital Territory schools. It was found to be effective in increasing drug-related knowledge and decreasing pro-drug attitudes.[454]

Victoria's 'Get Ready' education programme

The Get Ready programme was made available to secondary schools across the state in 2014. The programme is based on sound theory and current research, and promotes a whole-of-school approach to health and wellbeing.

The program provides culturally appropriate, targeted and responsive drug education that addresses local needs, values and priorities. It aims to provide accurate information and meaningful learning activities that dispel myths about drug use and focus on real life contexts and challenges.

A recent trial of the programme showed a significantly greater increase in knowledge about alcohol and other drugs in the students who received the programme. They were more likely to communicate with their parents about alcohol, their alcohol consumption was much less and they experienced less harms associated with their drinking.[455]

Other school-based prevention efforts

Since 2004, the Australian Government's *Principles for school drug education* has provided guidance on the delivery of drug education in public schools.[456] The 12 principles are a framework of the core concepts and values that support effective drug education. They are intended as a guide for school executives, teachers and staff, as well as families, community agencies and other stakeholders for making decisions on drug education in schools. For example, the principles call for comprehensive and evidence-based practice, a focus on a positive school climate and relationships, programmes that are targeted to needs and context, and an emphasis on effective pedagogy.

The Commonwealth, state and territory governments also provide and/or contribute to other drug education resources. The Victorian Government supports the Get Ready programme and the Western Australian Government supports the School Drug Education and Road Aware programme. Other nationally available resources are also provided by Life Education Australia and the Australian Drug Foundation.

In New South Wales, students learn about AOD, protective strategies and the life skills required for them to make positive health decisions through the Personal Development, Health and Physical Education course. This learning is extended into the senior years through student participation in the mandatory 25-hour Crossroads course, which is designed to help students address issues of health, safety and wellbeing at a time when they are likely to face significant changes and challenges.

The Personal Development, Health and Physical Education course focuses on developing and reducing risks to self and others in a range of different situations. These skills include assertiveness, problem, solving, decision making, planning and communication.[457]

Media campaigns

Media campaigns are a common tool used to communicate drug education messages through print, television, radio, or other forms of advertising, such as billboards.[458] Media campaigns are often informed by different objectives, which can include:

- deterring use by increasing awareness of the negative effects and dangers associated with drug use
- clarifying social and legal norms associated with drug use to influence attitudes and decision making
- challenging or correcting misconceptions around the normalisation of drug use (for example, that many adolescents accept or tolerate drug use)
- positive role-modelling
- raising awareness of where to seek help and promoting the message that change is achievable.[459]

Media campaigns can be universal (target the broad population) or selective (target particular at-risk groups). Recent ice-related campaigns have generally targeted young people and followed a philosophy of deterring use by highlighting the dangers and negative effects.

Media campaigns have been a common fixture of prevention efforts in Australia to address problematic drug use, including risky drinking and smoking (for example, the *Every Cigarette is doing you damage* campaign).

In 2014, Victoria commenced the *What are you doing on ice?* campaign, as part of its $45.5 million package to tackle the use of illicit drugs, including ice. In 2015, Western Australia released the latest phase of its *Drug Aware Amphetamine Campaign,* which is targeted primarily at young people, but also aims to reach the family and friends of young people who may be using amphetamine.[460] An outline of these campaigns is provided below.

In 2015, the Commonwealth Government launched the *Ice Destroys Lives* campaign, which was developed as part of the National Drug Campaign. The campaign advertisement was widely televised and the Taskforce received a high number of submissions from members of the public commenting on its messaging.

Western Australia's School Drug Education and Road Aware programme

The School Drug Education and Road Aware programme (SDERA) works with schools and the wider community to provide prevention education. It runs professional learning workshops and provides support and resources to assist schools and communities develop effective drug and road safety education programmes.

The programme has a website and a social media presence to make it easy for people to access resilience, drug and road safety information, resources, interactive games and activities, and other reliable and relevant websites.

The SDERA also has ambassadors—such as sportspeople, journalists and researchers—who support the aim of improving the mental health, wellbeing and resilience of young people. All SDERA programmes adhere to and incorporate the principles for school drug education into product development and service delivery. The SDERA has received additional funding to further develop drug education resources and professional learning with a focus on methamphetamine.

The Government of Western Australia's Mental Health Commission and the Road Trauma Trust Fund Account funds the SDERA. It is governed by a committee with representation from funding bodies and the education sector.[461]

Victoria's *What are you doing on ice?* campaign

The Victorian Government launched the *What are you doing on ice?* campaign to educate young people about the addictive nature of ice and the damage it can cause to health and relationships. The campaign was developed by the Victorian Department of Health in partnership with the Penington Institute. The campaign aims to present a realistic picture of the progression from recreational use to dependence, and provides information on where to go for help.[462]

A survey of 150 young people found that, since seeing the campaign, 75 per cent of those who had taken drugs had given thought to their attitudes towards ice or had spoken to family and friends about the drug.[463]

Western Australia's *Drug Aware Amphetamine* campaign

In May 2015, the Western Australian Government released its next phase of the Drug Aware Amphetamine campaign, which is a joint initiative between the Western Australian Government and Curtin University. The campaign primarily targets young people, with a message that 'amphetamines turn you into something you can't see for yourself'.

The campaign has two main objectives:

- to prevent and delay use and reduce harms associated with amphetamine use among young people
- to increase awareness and knowledge of the potential health, social and legal consequences of amphetamine use and the salience of the information on the potential risks associated with amphetamine use.[464]

Online evaluation results from the May 2015 campaign indicate it was successful in engaging young people, their families and friends. In addition, during the campaign, online media achieved 44,675 visits where people accessed general information on methamphetamine, information on helping family and friends, and information on quitting.[465]

Commonwealth's *Ice Destroys Lives* campaign

In 2015, the Commonwealth Government launched the *Ice Destroys Lives* campaign aimed at raising general awareness of the problems associated with long-term and heavy ice use. *Ice Destroys Lives* was based heavily on the Commonwealth Government's previous anti-ice television advertisement, *Don't Let Ice Destroy You*, which originally aired in 2007.

An evaluation of the *Ice Destroys Lives* campaign in mid-2015 found it had been successful in delivering clear messages related to the harms of ice and/or discouraging use. The evaluation surveyed 3,805 people and found that the campaign was particularly successful in communicating the message that ice can lead to aggression and dependency, and that it destroys lives.[466] In submissions to the Taskforce, members of the public were generally supportive of the *Ice Destroys Lives* campaign or similar campaigns. In particular, it was suggested that these types of campaigns can assist with opening discussions between parents and children, raising awareness of the problem and confronting users.

However, only 35 per cent of young people and 37 per cent of parents evaluated found the campaign to be 'personally relevant' to their circumstances.[467] The evaluation was conducted only a few months after the initial phase of the campaign and therefore did not involve any longitudinal analysis on its effect on ice usage trends.

The Taskforce also received a lot of negative feedback—particularly from experts—regarding the *Ice Destroys Lives* campaign. Concerns were raised that inflammatory or sensationalised messaging can stigmatise users and families and deter them from seeking help.[468] The Taskforce also heard that no studies have reported the long-term effectiveness of such campaigns. Some studies also report increased drug use in some sub-populations after such campaigns.[469]

The Northern Territory has also undertaken a multimedia campaign to communicate police initiatives and activities targeting ice. The *Putting the heat on ice* campaign demonstrates to the Northern Territory community that activities are underway to reduce the supply, demand and harm of ice within that state.[470]

Prevention efforts in the workplace

The Commonwealth, Australian Capital Territory, New South Wales, Northern Territory, Queensland, South Australia and Tasmania have all implemented model Work Health and Safety (WHS) laws developed by Safe Work Australia, with some material variations in laws between different jurisdictions.

The model WHS laws provide for an employer's duty-of-care to ensure the health and safety of each of their employees. This duty places an obligation on employers to ensure a person is not in a position of personal risk and does not present a risk to the health and safety of others, where alcohol or other drugs impair their capacity.

Victoria and Western Australia have not implemented the model WHS laws. Victoria's Occupational Health and Safety laws have a similar obligation with employers legally obligated to address AOD issues in the workplace through the duty-of-care provisions in the *Occupational Health and Safety Act 2004*.

Western Australia's Occupational Safety and Health laws impose a general duty-of-care obligation on employers to ensure that, as far as practicable, workers are not exposed to hazards or risks that could arise from workers being impaired by AOD and, where it may arise, use is addressed through a systematic risk management process.

To assist employers in meeting these duties most regulators, including Safe Work Australia, provide guidance on addressing AOD use in workplaces.

Safe Work Australia resources

In 2015, Safe Work Australia published guidance material to assist workplaces in addressing AOD misuse. The guidance material provides advice on developing policies on AOD and potential workplace prevention programmes, such as:

- Employee Assistance Programmes used for initial treatment and assessment of people with alcohol or other drug problems
- health promotion to provide general information to improve or maintain health
- brief interventions to reduce or change problematic behaviour
- education and training to raise awareness of workplace policies
- AOD testing, such as breath testing, urine analysis and saliva tests.[471]

State and territory governments have also implemented other programmes to address AOD use in workplaces. For instance, the Queensland Government funds 'MATES in Construction' to run a programme aimed at raising awareness of issues relating to AOD in the Queensland construction industry. The organisation was established to improve mental health and wellbeing, but has expanded its programme to also address AOD issues.[472]

The construction industry in particular is a high-risk occupational group for alcohol misuse and illicit drug use. Consequently, some industry bodies are developing resources to reduce AOD use at work. In addition, the New South Wales Government funds the Building Trades Group Drug and Alcohol Programme aimed at reducing AOD use in the construction industry by teaching workers to take responsibility for their own safety and informing workers of available treatment options.[473]

Incolink—a joint initiative of the employer associations and unions in the building and construction industry in Victoria—also provides free AOD counselling, as well as education and information for people who think they may have an alcohol or drug issue.

Commonwealth drug testing

Several Commonwealth organisations, including the Australian Federal Police (AFP), the Australian Crime Commission (ACC), the Department of Immigration and Border Protection (DIBP), the Australian Defence Force and the Civil Aviation Safety Authority have implemented AOD testing as part of their professional and integrity standards framework.

The AFP, ACC and DIBP undertake random and targeted testing of their officers and staff for prohibited drug use and alcohol impairment. Authorised external service providers are engaged by agencies so that sample collection and testing is carried out by an independent qualified practitioner.

While urine is the primary sample collected, the DIBP can also take hair samples for prohibited drug testing. Suitably accredited laboratories are used to test for a range of prohibited drugs, including amphetamine-type stimulants, cocaine, opiates and cannabis. All agencies listed above work closely with the Australian Commission for Law Enforcement Integrity, including providing regular updates on the details of verified positive results.

Australian Drug Foundation resources

The Australian Drug Foundation produces education information and a toolkit to help workplaces undertake risk assessments, develop workplace policies, and to be a good 'corporate host'. The Foundation also provides online and other support through its *ADF Aware* programme.[474]

National Centre for Education and Training on Addiction workplace resources

The National Centre for Education and Training on Addiction (NCETA) has an ongoing programme of research to inform the development of practical resources and effective strategies to minimise AOD -related risk to workplace safety, productivity and worker wellbeing. To assist workplaces to respond to AOD -related harm in the workplace, NCETA provides a range of resources including:

- an information and resource package that provides a best-practice model for responding to AOD -related harm in the workplace, as well as a companion Training Kit
- additional guidance as issues arise, such as information on methamphetamine use and its implications for workplaces through the 'Ice and the Workplace' guidance material
- a consultancy service to assist workplaces to manage AOD -related risk and to develop workplace policies and responses.[475]

CHAPTER 6
HELPING PEOPLE TO STOP USING ICE

There are a range of activities at the national, state and territory level aimed at helping people to stop using ice.

Australia's alcohol and other drug (AOD) support and treatment system is a complex web of services that span the public, private and non-government sectors. These services are delivered across a range of settings, including primary care, hospitals, correctional facilities, and community health services.

While each person's treatment will have short-term and long-term goals specific to their circumstances, most AOD treatment and support programmes have four objectives:

- reducing alcohol and/or other drug misuse, including abstinence
- reducing harms from AOD use
- improving general health and psychosocial functioning
- preventing or reducing the frequency and severity of relapse.[476]

There are a range of current activities at the national, state and territory level to help people stop using ice. This includes efforts in the specialist AOD treatment sector, as well as those in the general health and support sector and in Australian correctional facilities.

Across Australia, more than 1,200 organisations deliver some form of AOD treatment and/or support.[477] This includes services that have a dual or broader health focus (for example, mental health). Treatment and support is provided by a range of professionals, including addiction medicine specialists, nurses and AOD workers, as well as counsellors, psychologists, psychiatrists, pharmacists, social workers, general practitioners (GPs), emergency department workers, community workers and other generalist health professionals.

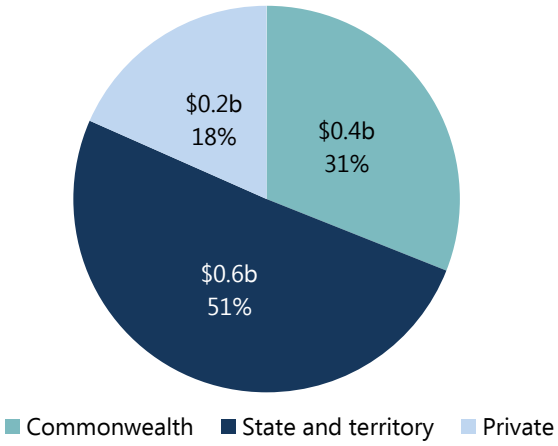
Current efforts to support the workforce and community-led strategies to help people stop using ice are outlined in further detail in Chapter 7.

Investment in AOD treatment

Australia's investment in AOD treatment is substantial, with an estimated $1.2 billion expended in 2012-13.[478] [479] This investment includes services provided through primary care and allied health, as well as through specialist AOD services.

Of this investment, the Commonwealth and states and territories contribute 31 per cent ($0.4 billion) and 51 per cent ($0.6 billion) respectively. Private sources (philanthropy and client co-payments) contribute the remaining 18 per cent ($0.2 billion). In 2012-13, spending on AOD treatment represented 0.8 per cent of total health-care spending.[480]

Figure 6.1: Sectoral contribution to expenditure on AOD treatment in Australia[481]



The highest proportion of expenditure is state and territory AOD treatment grant funding (41.2 per cent), followed by public hospitals (15 per cent), then private hospitals (10.8 per cent), and followed by the Commonwealth AOD treatment grants (10.7 per cent). When government-only expenditure is considered, the split between the Commonwealth and state and territories is 38 per cent and 62 per cent respectively.[482]

Types of interventions currently provided

Before discussing current efforts to help people stop using ice, it is useful to consider the types of interventions that are provided by treatment and support services. These are listed below.

Brief and early intervention

Brief and early intervention involves engaging people who are at risk of developing alcohol and/or other drug dependence or who are at risk of greater harms, with the aim of reducing or changing behaviour before it becomes problematic.

These interventions can consist of a single, time-limited session that aims to motivate patients to change their behaviour. Alternatively, they can comprise several counselling sessions, with evidence suggesting that two to four counselling sessions are effective in increasing abstinence among regular methamphetamine users.[483] This approach can be used across various settings, including primary care.

Detoxification (withdrawal management) programmes

Detoxification supports people to stop or reduce drug use, often after a period of long or frequent use. Detoxification services usually provide support for between four and 10 days (as outlined in Chapter 3, the 'crash' withdrawal phase for methamphetamine lasts for around one to three days, while the 'acute' withdrawal phase lasts for around seven to 10 days). Detoxification can be provided in a residential, home or outpatient setting. Detoxification is often seen as an important pre-requisite for entry into further treatment.

Recovery/rehabilitation programmes

'Recovery'/rehabilitation programmes support people through the longer 'cravings' and recovery phase. For some dependent methamphetamine users, this can last up to 18 months (see Figure 3.2 in Chapter 3). These programmes can include counselling and general support.

There are various programme models of differing intensity. These include:

- Residential programmes, including therapeutic communities—Individuals usually stay onsite for three to 12 months, and the programmes are usually abstinence-based. The programmes

generally provide psychological, legal, financial and physical care and support, and many require clients to undergo detoxification prior to starting.
- Day programmes—Individuals spend between four weeks and several months participating in daily programmes while continuing to live at home. Many of these services also provide psychological, legal, financial and physical support.
- Counselling and case management—Interventions can range from short-term engagement to longer-term counselling and support.

Follow-up support

This involves supporting people once they have completed a recovery or rehabilitation programme, which can include the provision of vocational, financial and social support.

For those recovering from methamphetamine dependence, follow-up support is often needed for the prolonged recovery phase, as few recovery or residential programmes provide this support for longer than 12 months.

Assessment

Most support and treatment programmes incorporate an assessment of an individual's history to understand the scope and severity of their AOD use. This assessment then informs the selection of interventions.

The treatment and support pathway

As outlined in Chapter 12, there is limited evidence regarding effective treatment pathways for ice and other methamphetamine users.

What we do know is that the treatment and support pathway should involve the user receiving interventions across a continuum of care (client-centred care delivered across multiple services over a period of time), depending on the needs of the individual.

For example, a user with severe dependence would often start in a detoxification programme, then progress into an intensive long-term 'recovery'/rehabilitation programme and, ideally, receive ongoing follow-up support.

Other users (those with less severe dependence) may start treatment through a moderately intensive 'recovery'/rehabilitation programme and maintain their abstinence with the assistance of follow-up support. Some programmes also offer a 'step up/step down' approach, where the intensity of the intervention can change depending on the needs of the recovering user.

Current efforts across the treatment and support system

Hotlines

Each state and territory operates AOD information and counselling hotlines. These hotlines generally offer information on drug-related harms, advice on treatment options, referral to treatment, and treatment assessments. Some hotlines also provide crisis counselling, support and advice to frontline workers. Several jurisdictions run additional support and information lines that are drug-specific or tailored to families.

Many hotlines have reported an increase in calls relating to ice. For example, New South Wales reported that ice became the second most common primary [484] drug (after alcohol) for which calls were received from January to June 2014.[485] And Western Australia reported that, between May 2014 and May 2015, there was a 38 per cent increase in calls related to amphetamine-type stimulants.[486]

An overview of the telephone counselling and information lines available in each jurisdiction is provided in Appendix III.

Online counselling

The Commonwealth Government funds Turning Point (based in Victoria) to deliver a free, Australia-wide AOD online counselling service: *Counselling Online* (www.counsellingonline.org.au). The 24/7 service includes interactive screening tools, self-help materials and other information.

Each year between 3,000 and 4,000 people use online counselling through this service, and more than 30,000 visit the site for information.

Since 2008-09, Turning Point has reported the online counselling service as experiencing a steady rise in those seeking help for methamphetamine use.[487]

The online counselling service model aims to improve community access to early intervention, treatment and referral. It provides an option for those who face barriers to treatment, including geographical remoteness, difficulties in accessing services during business hours and those concerned about anonymity and stigma. More than half of the counselling sessions occur outside business hours, with one-third occurring between 6 pm and midnight and a fifth between midnight and 8 am.[488]

Demographic factors associated with not seeking treatment include being female and being in full-time employment.[489] A 2009 evaluation of *Counselling Online* found that web-based services have the capacity to increase treatment accessibility—particularly for clients whose access to traditional treatment services is limited—and appeal to a client group who differ from 'conventional' treatment and telephone counselling clients. This includes a higher proportion of young, employed and female clients.[490]

Primary care

Primary care encompasses a large range of providers across public, private and non-government sectors, with services typically incorporating health promotion, prevention, early intervention, treatment of acute conditions and management of chronic conditions.[491] In 2012-13, a total of 84.7 per cent of Australians visited a GP at least once and 35.3 per cent visited a GP six or more times.[492]

In 2012-13, a total of $52.9 billion was spent on primary care in Australia.[493] During the same period, it is estimated that expenditure on primary care services providing some form of AOD treatment was $53.65 million. This equated to 4.3 per cent of total expenditure on AOD treatment.[494]

While primary care is predominantly the responsibility of the Commonwealth Government, funding is delivered from multiple sources, including:

- Commonwealth Government programmes, such as the Medicare Benefits Scheme, the Pharmaceutical Benefits Scheme and other programmes
- state and territory government programmes
- local government programmes
- fees charged directly to patients
- private health insurers and workers' compensation insurers
- other non-government funding sources, such as private charities.[495]

Primary care providers, including GPs, are well placed to deliver timely interventions that help address AOD issues,[496] especially as they are often the first point of contact in personal health care matters.[497] In particular, they are well-placed to facilitate early intervention through screening and assessment aimed at detecting alcohol and/or drug misuse before it becomes more severe.

Primary care providers may also provide brief interventions aimed at:

- reducing AOD misuse
- facilitating health behaviour change, particularly in individuals who engage in high-risk levels of consumption
- increasing an individual's understanding of the risks associated with use.[498] [499]

In Australia, an estimated 826,000 GP visits a year are for alcohol or other drug-related care and treatment.[500] Around a third of these (33 per cent) are estimated to be for illicit drug or non-medicinal drug use disorders and around 58 per cent for alcohol use disorders, with the residual encounters related to medicinal drug use disorders.[501] [502]

There is no specific data available that disaggregates the number of methamphetamine or ice-specific treatment episodes in the primary care sector. However, there is some evidence that primary care services are the most common source of service engagement for many users. For example, one study found that, during the follow-up phase of treatment, GPs were the

most common source of professional support for people recovering from problematic methamphetamine use.[503]

Hospitals

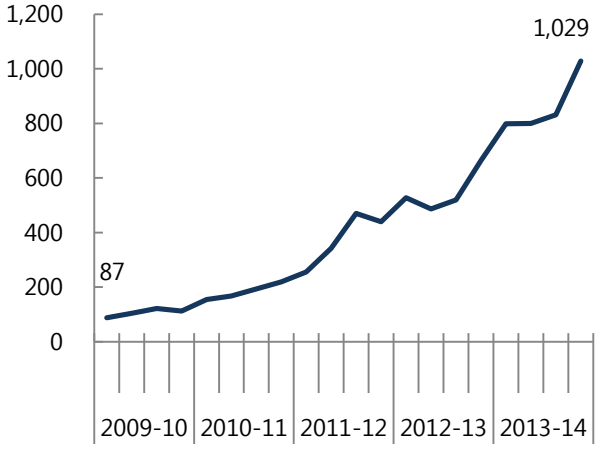
Public and private hospitals provide tertiary treatment for AOD misuse disorders and related harm. This includes:

- emergency care for patients presenting with the acute effects of AOD intoxication and overdose
- patients admitted for other medical and surgical problems who have a co-existing drug use problem
- patients admitted treatment for withdrawal, intoxication and other drug disorders.

In 2012-13, public hospital funding for AOD treatment admissions was estimated to be $189 million. Funding for AOD treatment in private hospitals was estimated to be $141 million.[504]

Since 2009-10, there has been a marked increase in public hospital separations where methamphetamine is the principal diagnosis—from 87 separations in the first quarter of 2009-10 to 1,029 in the fourth quarter of 2013-14.[505] [506]

Figure 6.2: Quarterly hospital separations with a methamphetamine-related principal diagnosis[507]



While the number of patients presenting to emergency departments for methamphetamine related problems is modest in terms of overall numbers (between one to three per cent of attendances), the higher acuity psychiatric and/or medical issues associated with these attendances are resource intensive.[508]

The specialist treatment sector

Australia's specialist AOD treatment sector provides support and treatment within a specialist setting. Specialist AOD treatment services are generally more suited to clients with more severe dependence and those with significant disadvantage and comorbidities.

Funding

In 2012-13, Australia's investment in specialist AOD treatment was estimated to be around $630 million. The funding split for the specialist AOD treatment sector is estimated at around 79 per cent and 21 per cent for states and territories and the Commonwealth respectively.[509] [510]

In 2013-14, there were 795 publicly-funded AOD specialist treatment service providers across Australia.[511] They ranged from 15 in the Australian Capital Territory to 292 in New South Wales (see Figure 6.3).[512] A high proportion of treatment services funded by the states and territories are also funded by the Commonwealth,[513] particularly non-government organisations.

Services that receive Commonwealth contributions are funded under the Non-Government Organisation Treatment Grants Programme and the Substance Misuse Service Delivery Grants Fund.

There are also private treatment services available in Australia, with user-pays treatment options available through private counsellors, psychologists and self-help groups. It is estimated that over 50 private specialist treatment services are available across Australia.

Figure 6.3: Distribution of specialist treatment services across each state and territory[514]

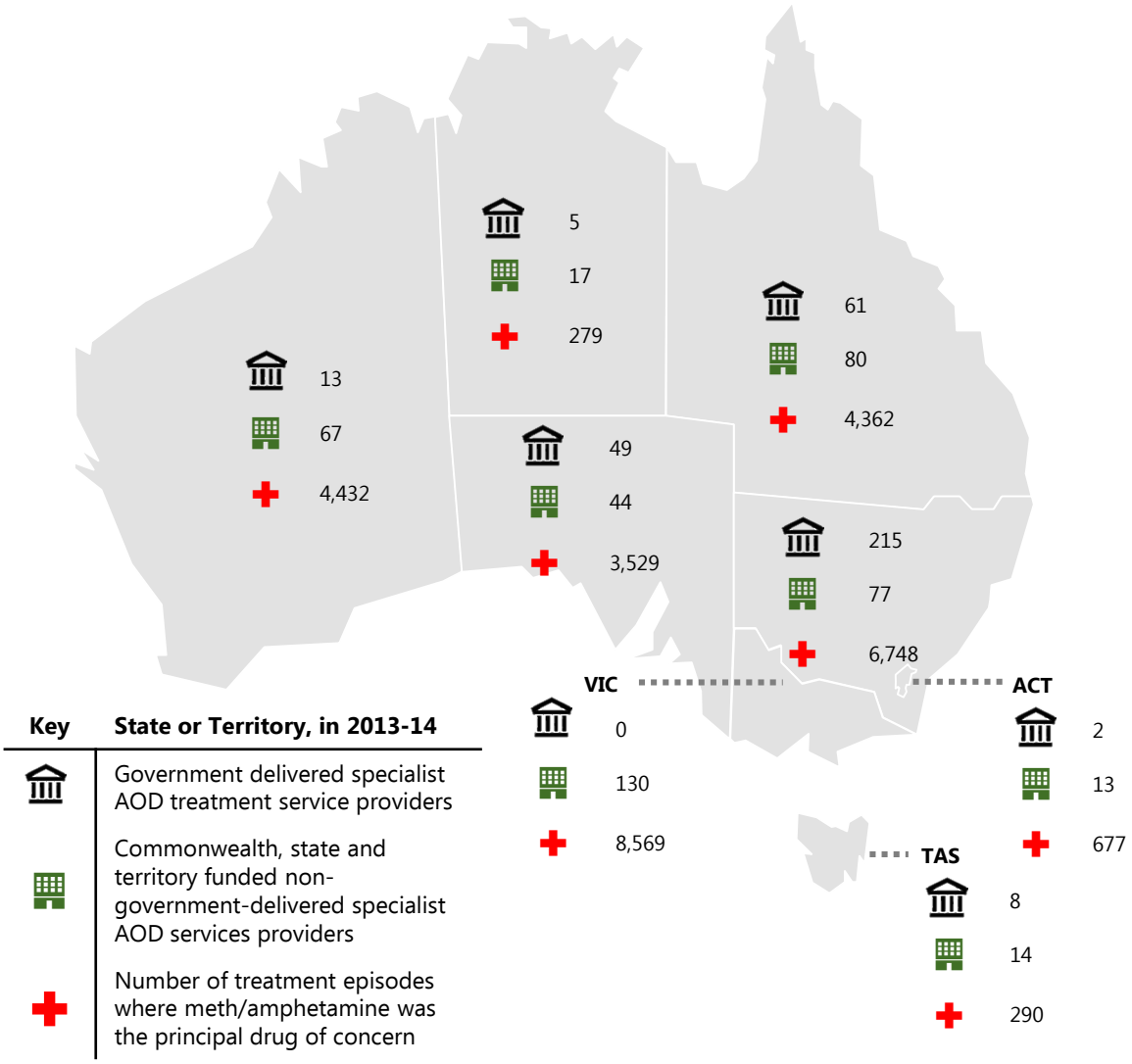


Figure 6.4: Number of completed treatment episodes where meth/amphetamines was the principal drug of concern in 2013-14, by location and remoteness[515]

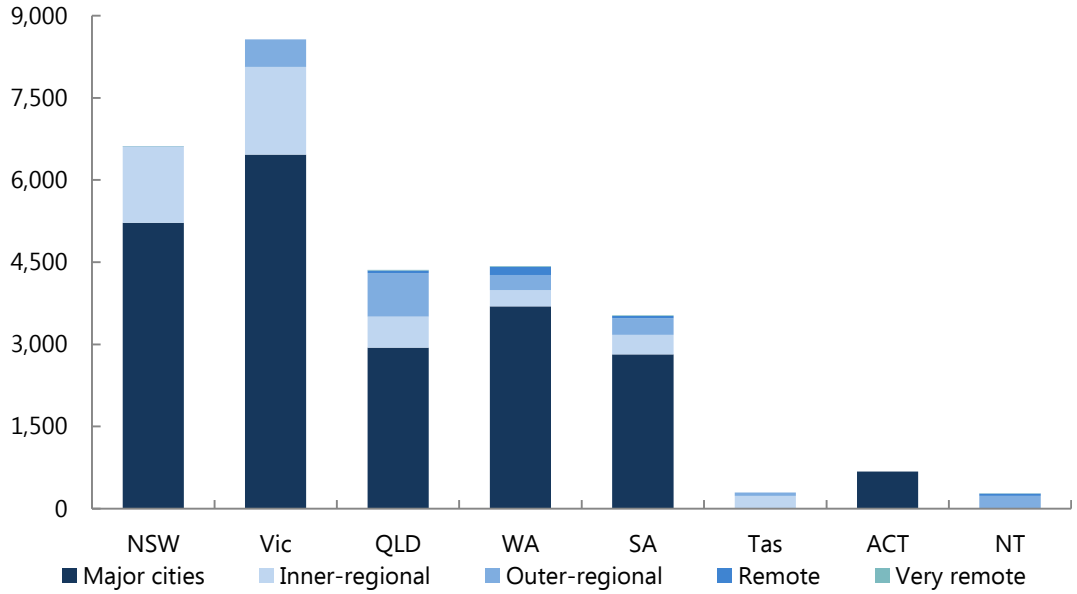


Figure 6.5: Completed treatment episodes where meth/amphetamines was the principal drug of concern in 2013-14, by location and treatment setting[516]

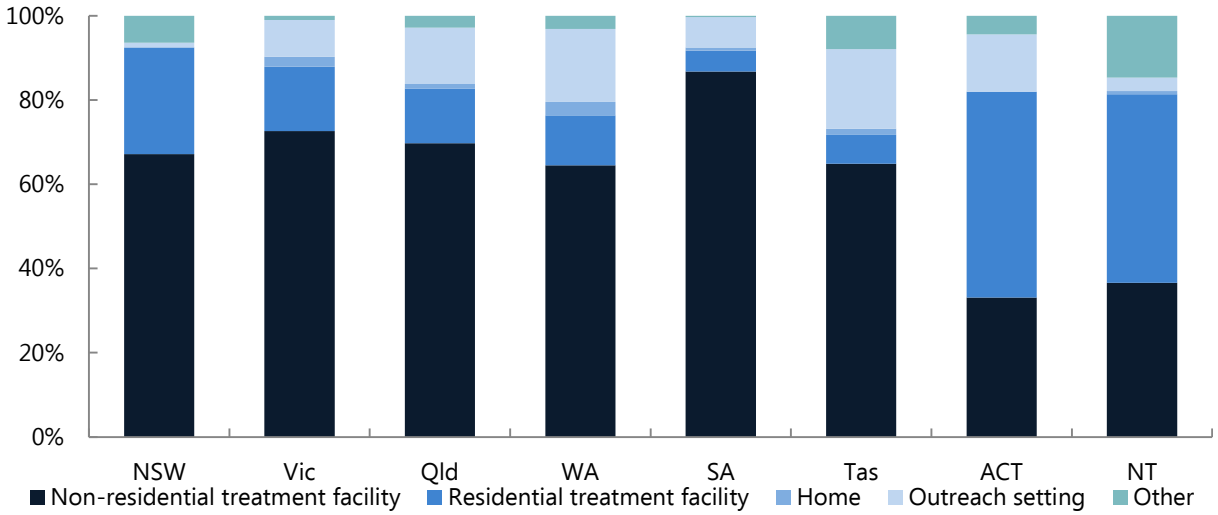


Figure 6.6: Number of completed treatment episodes where meth/amphetamines was the principal drug of concern in 2013-14, by main treatment type[517] [518]

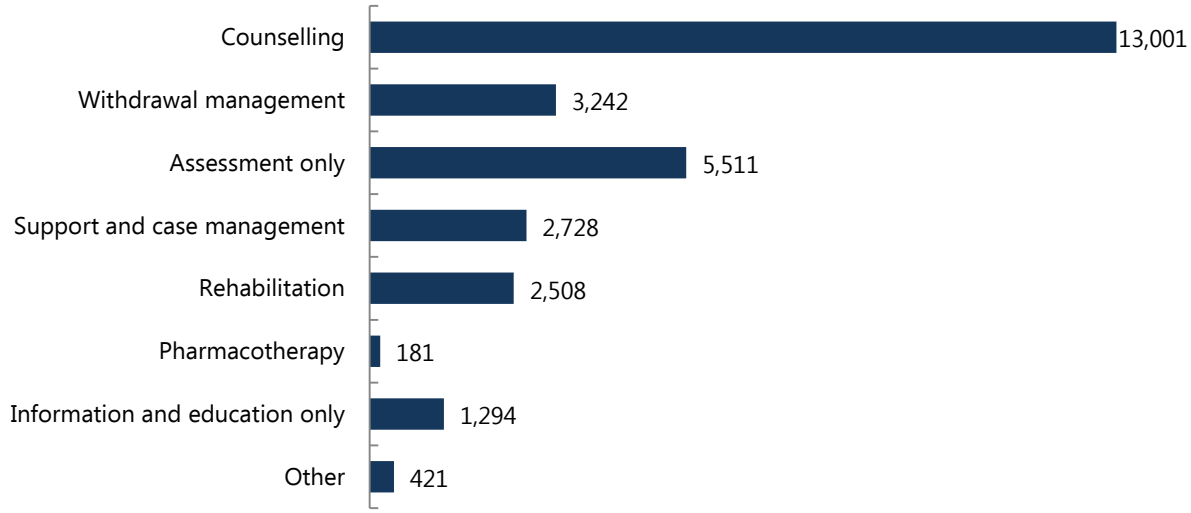
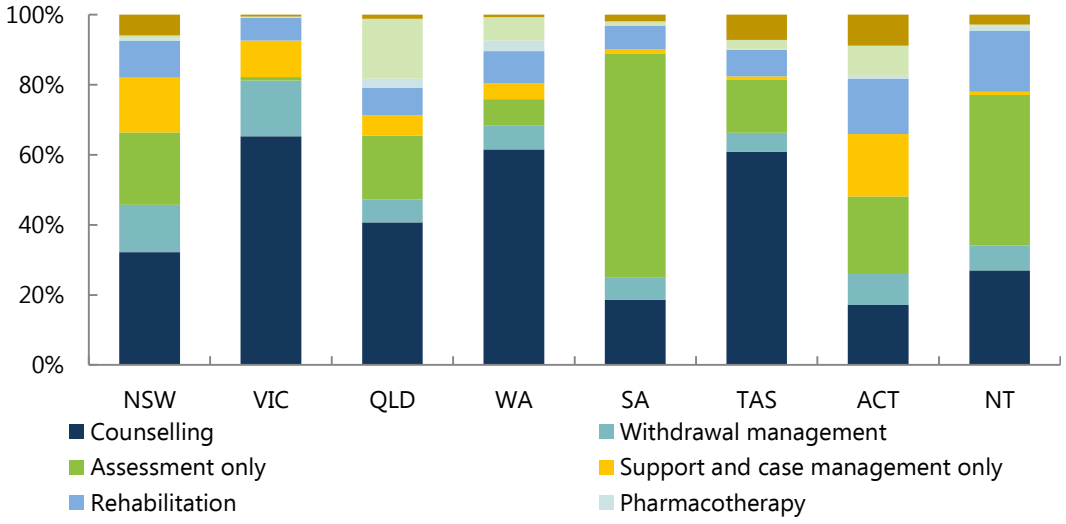


Figure 6.7: Completed treatment episodes where meth/amphetamines was the principal drug of concern in 2013-14, by location and treatment type[519]



Treatment locations

Most treatment agencies are located in metropolitan areas. New South Wales and Victoria also provide a large number of services in inner-regional areas, but Queensland provides more outer-regional services. Queensland, Western Australia, South Australia and the Northern Territory all provide services in remote areas (see Figure 6.4).[520]

Treatment setting

In 2013-14 across Australia, treatment episodes where meth/amphetamines was the principal drug of concern were most likely to take place in a non-residential treatment setting (70 per cent of episodes). The delivery of residential rehabilitation differed markedly from one jurisdiction to another (see Figure 6.5).

Treatment types

Overall in Australia, in 2013-14, counselling was the most common treatment type where meth/amphetamines was the principal drug of concern (45 per cent) (see Figure 6.6).[521]

In Victoria, Western Australia and Tasmania, counselling made up more than 60 per cent of the treatment episodes provided[522] where meth/amphetamines was the principal drug of concern. In South Australia, assessment only [523] was the most common treatment type of treatment (64.1 per cent). Conversely, in Victoria, assessment only made up only one per cent of treatment episodes provided.[524]

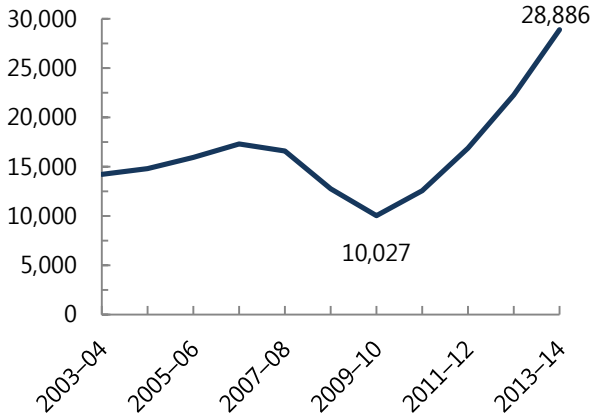
The proportion of rehabilitation services provided where meth/amphetamines was the principal drug of concern ranged between 17.4 per cent in the Northern Territory to 6.5 per cent in Victoria. Detoxification (withdrawal management) services ranged between 13.4 per cent in New South Wales to 5.4 per cent in Tasmania (see Figure 6.7).[525]

There are disparities in the breakdown of types of treatment provided by specialist AOD treatment services in each state and territory. Different jurisdictions have different data collection business rules, which affect reporting. This includes variations in data definitions and the mandatory collection of different types of treatment episodes. The difference in approaches to data collection in each state and territory is the most likely reason for such significant disparities. While the above data provides some overview of treatment practices across the states and territories, better standardisation of the data is necessary to enable a definitive comparison of treatment trends.

Specialist treatment demand for meth/amphetamines

The number of treatment episodes for meth/amphetamines use has increased substantially over the last five years, both in absolutely numbers and as a proportion of all treatments.

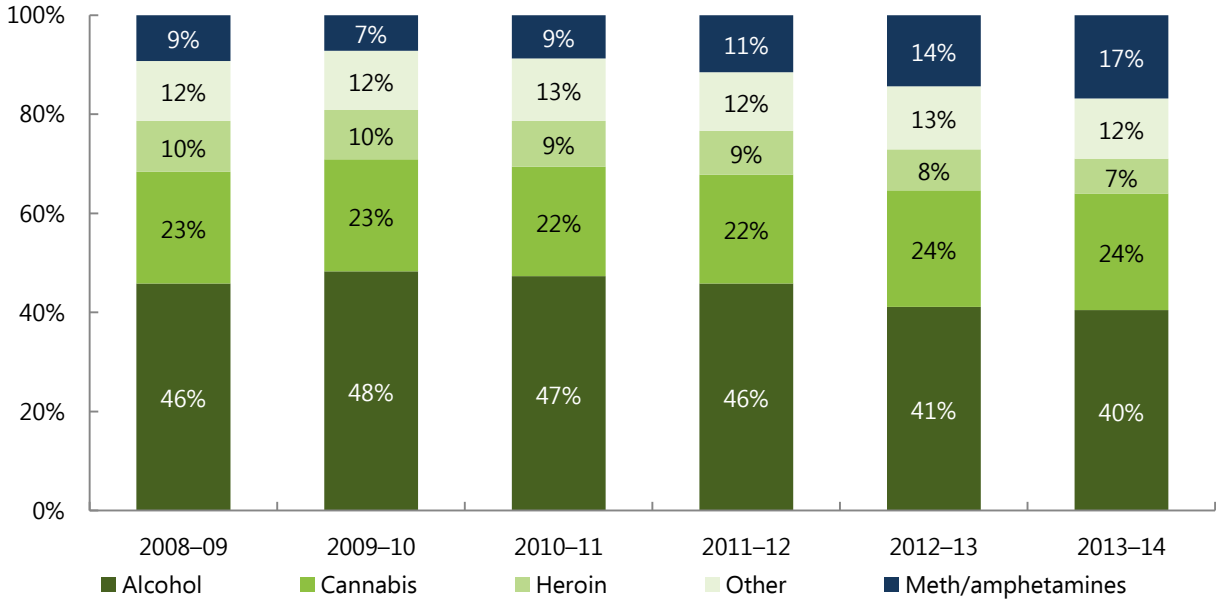
Figure 6.8: Number of completed treatment episodes where meth/amphetamines was the principal drug of concern[526]



The number of users seeking treatment where meth/amphetamines was the principal drug of concern increased from 10,027 episodes in 2009-10 to 28,886 episodes in 2013-14 (7 per cent to 17 per cent of all episodes).[527] Treatment episodes for meth/amphetamines are now the third most common, behind treatments for alcohol and cannabis (see Figure 6.9).

The proportion of treatment services where meth/amphetamines was recorded as an additional drug of concern (that is, a drug secondary to the most problematic drug used by the client) also increased by 31.6 per cent between 2010-11 and 2013-14.[528]

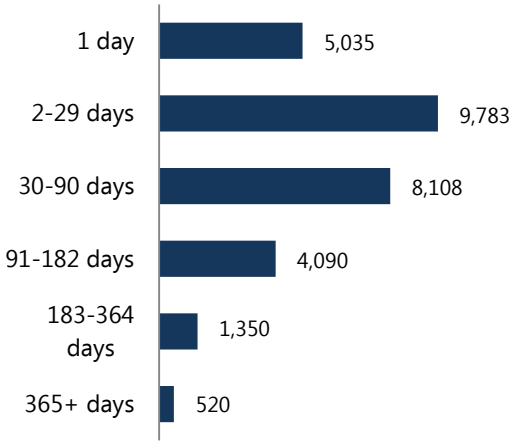
Figure 6.9: Completed treatment episodes provided in Australia by principal drug of concern[529]



Duration of treatment episodes

In 2013-14, the most common duration for treatment episodes where meth/amphetamines was the principal drug of concern was between two days to one month (around 34 per cent). A further 28 per cent lasted between one to three months. Only two per cent of episodes lasted for a period longer than 12 months.[530] As outlined in Chapter 3, the withdrawal and recovery period for methamphetamine dependence can last up to 18 months.

Figure 6.10: Number of completed treatment episodes where meth/amphetamines was the principal drug of concern in 2013-14, by duration of treatment[531]



Several states and territories have taken additional action to improve their treatment sector responses and ensure services are better placed to respond to the growing rate of ice use. Further detail regarding the current efforts in each state and territory is outlined in Appendix III.

Treatment services for Indigenous Australians

Indigenous-specific AOD services that aim to improve access to culturally appropriate substance use prevention, treatment and aftercare services for Indigenous Australians form part of the Safety and Wellbeing Programme under the Commonwealth Government's Indigenous Advancement Strategy.

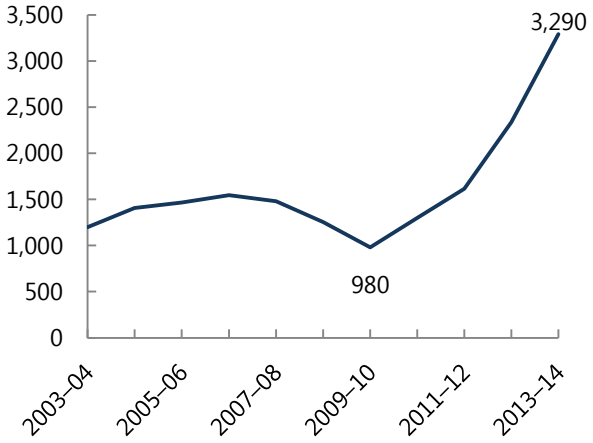
To date, the Commonwealth Government has allocated around $69 million in 2015-16 to over 80 Indigenous-specific AOD organisations, who provide a range of services across the country. This includes residential rehabilitation, counselling, referral, transitional aftercare and 'sobering up' shelters. State and territory governments also provide a range of funding for Indigenous-specific diversion and treatment programmes.

While the mix of services varies considerably by state, territory and region, they are generally delivered by:

- Aboriginal Community Controlled Health Organisations or Aboriginal Medical Services, which can provide a broad range of community and primary care services, as well as specialist AOD treatment services
- non-Aboriginal, not-for-profit organisations
- government agencies, which most commonly provide AOD treatment services targeted at the general population, but can be inclusive of Aboriginal clients.

Within the specialist AOD treatment sector, the proportion of Indigenous Australians receiving treatment for meth/amphetamines use has increased significantly. Since 2009-10, the number of episodes provided to Indigenous Australians where meth/amphetamines was the principal drug of concern more than tripled from 980 episodes to 3,290 episodes in 2013-14.[532]

Figure 6.10: Number of completed treatment episodes where meth/amphetamines was the principal drug of concern, for Indigenous[533]



Treatment in the correctional system

All states and territories deliver AOD treatment programmes within the correctional system. However, the focus and design of these programmes varies. Treatment programmes generally form part of a broader drug management strategy, which includes urinalysis, pharmacotherapy, efforts to reduce supply into correctional facilities, and broader health services (see Table 6.1).[534]

AOD treatment programmes in correctional facilities can be broadly divided into the following categories:

- harm reduction programmes that seek to enhance awareness of high-risk behaviours and the physiological effects of AOD misuse
- psycho-educational programmes that aim to improve understanding and awareness of the link between drug misuse and criminal activity, and increase motivation to enter more intensive programmes
- therapeutic programmes of moderate intensity that involve participation in groups and focus on understanding AOD misuse, developing mechanisms to cope with cravings and withdrawal, developing alternative behaviours, managing emotions, enhancing problem solving and communication and developing relapse prevention plans
- corrections-based therapeutic communities, which are programmes of higher intensity where participants are separated from prison culture and immersed in a dedicated therapeutic environment[535]
- detoxification programmes, which assists a drug dependent person to stop using the drug safely and with a minimum discomfort or danger to their health.

Entry into AOD treatment programmes within correctional facilities generally requires the inmate to undertake a risk or need assessment. Higher intensity programmes tend to have more rigorous assessment strategies, including the use of psychometric measures of change.[536]

Therapeutic community models of treatment have been demonstrated to be the most effective corrections-based programs.[537] A study of inmates who received treatment within a therapeutic community setting found that participants were over three times more likely to be drug-free than non-participants.[538] Evidence also indicates that participation in detoxification programmes should be linked with additional treatment interventions.[539]

Table 6.1: Correctional AOD treatment programmes in each state and territory

	Programme	Type	Target group	Duration
NSW	Remand Addiction	Psycho-educational	Remandees	40 hours
	EQUIPS Addiction	Therapeutic		40 hours
	Intensive Drug and Alcohol Therapeutic Program (includes Pathways)	Therapeutic		250+ hours
	Yallul Kaliarna (includes Pathways)	Therapeutic	Women	250+ hours
	Compulsory Drug Treatment Correctional Centre	Therapeutic	Drug court participants	Duration of sentence
	Ngara Nura	Therapeutic	Pre-release	150 hours
	Addiction Support Groups (including Narcotics Anonymous, SMART Recovery)	Maintenance		12+ hours
	The Connections Program	Maintenance	Post-release	Unspecified
VIC	Health Stream programmes	Harm reduction/ Psycho-educational		Up to 24 hours
	Criminogenic group programmes	Psycho-educational		40-130 hours
	Individual counselling	Therapeutic		Varied
	Identified Drug User Case Reviews	Psycho-educational/ Maintenance		Varied
	Peer Educator Program	Psycho-educational		Varied
	Exit Preparation programmes	Psycho-educational/ Maintenance		Varied
QLD	Positive Futures	Psycho- educational	Indigenous	36 hours
	Low Intensity Substance Intervention	Therapeutic		16-24 hours
	Substance Abuse Maintenance Intervention	Maintenance		16-24 hours
	Pathways	Therapeutic		126 hours
	Turning Point	Motivational/ Psycho-educational		15 hours
WA	Pathways	Therapeutic		100 hours
	Alcohol and Other Drugs (external agency)	Therapeutic	Young People	Varies
	Indigenous Men Managing Anger and Substance Use	Therapeutic	Indigenous males	55 hours
	Alcohol and Other Drugs Program	Therapeutic		16 hours
	Drug and Alcohol Throughcare Service	Therapeutic		As required

	Programme	Type	Target group	Duration
NT	Illicit Drug Use Assessment	Comprehensive bio-psychosocial assessment		1-2 hours
	Illicit Substance Use Treatment	Individual education and relapse prevention plans		2-6 sessions
	Alcohol Treatment Program	Psycho- educational and individual counselling		10 hours
	Group Program	Psycho-educational group work		16 hours
	Referrals to non-government organisations and other services	Liaison and assessment		Variable
TAS	Gottawanna	Therapeutic		12 weeks
	Getting SMART	Therapeutic		24 hours
	Pathways	Therapeutic		120 hours
ACT	Harm Minimisation	Psycho-educational: group program	Remand and Sentenced Men and Women	2 hours
	AOD Counselling	Therapeutic: individual	Remand and Sentenced Men and Women	Between 1-5 x 2 hour sessions
	SMART Recovery	Psycho-educational: group program	Remand and Sentenced Men and Women	10 x 2 hour sessions (with more access if required)
	AA and NA meetings	Psycho-educational: group program	Remand and Sentenced Men and Women	Multiple 1-2 hour sessions
	PathwaysSOLARIS Therapeutic Community	Therapeutic: group program	Sentenced Men	100 hours 4 months treatment phase fulltime.
	Referrals and Assessments for NGO's and other services	Liaison and Assessment	Remand and Sentenced Men and Women	Various
	Blood Borne Virus Awareness Workshops (Hepatitis ACT)	Psycho-educational: group program	Remand and Sentenced Men and Women	2 hours
SA	Making Changes Phase 2	Therapeutic		50 hours
	Drug and Alcohol Therapeutic Community program	Therapeutic		600 hours
	SMART recovery	Maintenance		50 hours
	Violence Prevention Program	Therapeutic		60 hours

These programmes can be further enhanced by transitional services, such as pre-release and post-release programmes, that reintegrate the former inmate back into the community.[540] The impact of treatment within a therapeutic community setting is maximised when inmates are transferred directly to community-based treatment on release. For example, one study found that, compared with the non-treatment group, the risk of recidivism halved for those who completed treatment programmes while incarcerated and post-release.[541]

Treatment in the mental health sector

Mental health and AOD treatment services commonly share a similar clientele. Some mental health services (and practitioners) accommodate this by also offering AOD treatment and support interventions. For example, the Commonwealth-funded Better Access Initiative and Access to Allied Psychological Services (ATAPS) can provide AOD treatment as a component of their broader mental health focus.[542] The capacity of mental health services to effectively treat AOD misuse disorders varies, depending on skill sets and service focus.

The Better Access Initiative is aimed at improving early detection, treatment and management of common mental disorders in the community through access to short-term psychological interventions through the Medicare Benefits Schedule. In 2012-13, a total of $635 million in benefits was paid for this programme.[543] Patients are eligible for a maximum of six sessions in any one referral. Following this initial course of treatment and on review, individuals can access a further four sessions, totalling a maximum of 10 sessions per calendar year.[544] [545]

The ATAPS programme provides short-term psychological services for people with a diagnosed mental disorder of mild to moderate severity.[546] The ATAPS programme was allocated $74.1 million in 2012-13.[547] Patients are eligible for a maximum of 12 sessions per calendar year, with an option for a further six sessions following a mental health review by the referring GP.[548]

Neither of these programmes specifically targets treatment of alcohol or drug misuse, with AOD treatment more likely to be provided alongside the treatment of co-existing mental health issues. However, in 2012-13 an estimated $26.4 million in benefits were paid for AOD treatment under the Better Access Initiative. During the same year, it is estimated that $5.8 million was provided for AOD treatment under the ATAPS. This collectively represents around 2.6 per cent of total expenditure on AOD treatment.[549] The data does not allow for further disaggregation to determine what portion of this was dedicated to treatment of ice and other methamphetamine-related issues.

A 2012 evaluation of the ATAPS reported that, between July 2003 and December 2011, a total of 14,505 clients with AOD use disorders were referred to ATAPS services, representing 7.4 per cent of all referrals for which diagnostic information is available (noting that multiple diagnosis could be made for each referral). In 2012, it was estimated that around eight per cent of clients seeing a clinical or registered psychologist under the Better Access Initiative were in treatment for alcohol or other drug misuse disorders.[550] [551]

Another Commonwealth-funded mental health service that can provide AOD treatment is Headspace. Headspace caters for young people aged between 12 and 25 years who need help in the areas of mental health, employment, AOD, relationships and school. In 2012-13, the Commonwealth's allocation to Headspace was $63.7 million.[552]

In addition to these activities, community and residential mental health services operated by state and territory governments are estimated to have provided over 131,000 drug treatment episodes in 2010-11. A vast majority of these treatment episodes occurred within a community setting. It is estimated that just 32 residential episodes were provided.[553]

As with primary care, there is insufficient data to provide a synopsis of treatment in the mental health sector that specifically relates to ice and other methamphetamine use. However, given high rates of mental health comorbidities experienced by dependent ice users, they are more likely to have interactions with mental health services. It is also likely that this interaction will be with acute mental health services rather than shorter-term early intervention services, such as that delivered through the Better Access Initiative or ATAPS. This reflects the small proportion of clients who are estimated to have received AOD treatment through these programmes.

CHAPTER 7
SUPPORTING ACTIVITIES

Families, communities and frontline workers all play an important role in tackling ice.

National coordination of policy and service delivery, and research to build the evidence base, underpin efforts to reduce supply and demand.

There are a range of activities that underpin action to reduce the supply, demand and harm of ice and other illicit drugs. These include efforts to:

- support the frontline workforce
- facilitate community action and engagement, and
- undertake research and analysis to improve the evidence base that informs our responses—particularly across health and law enforcement.

This Chapter outlines a range of efforts that are already underway at the Commonwealth, state, territory and community level to strengthen our responses across these key areas. The governance and advisory arrangements in place to inform and coordinate Australia's alcohol and other drug (AOD) policy are also outlined.

Supporting frontline workers

The overwhelming majority of frontline services that engaged with the Taskforce through submissions and consultations reported increased contact with ice users. Hospital emergency departments are reporting more presentations, local police forces are reporting more arrests, and AOD treatment and support services are reporting increased demand from people using ice.

In Australia, the development and implementation of strategies to create and sustain this workforce is the responsibility of the Commonwealth, state and territory governments. Activities to support workforce development include: ensuring sufficient recruitment and retention of frontline workers; providing frontline workers with ongoing professional development, support, education and training; and establishing structures and systems that link together frontline workers in divergent sectors.

Who are our frontline workers?

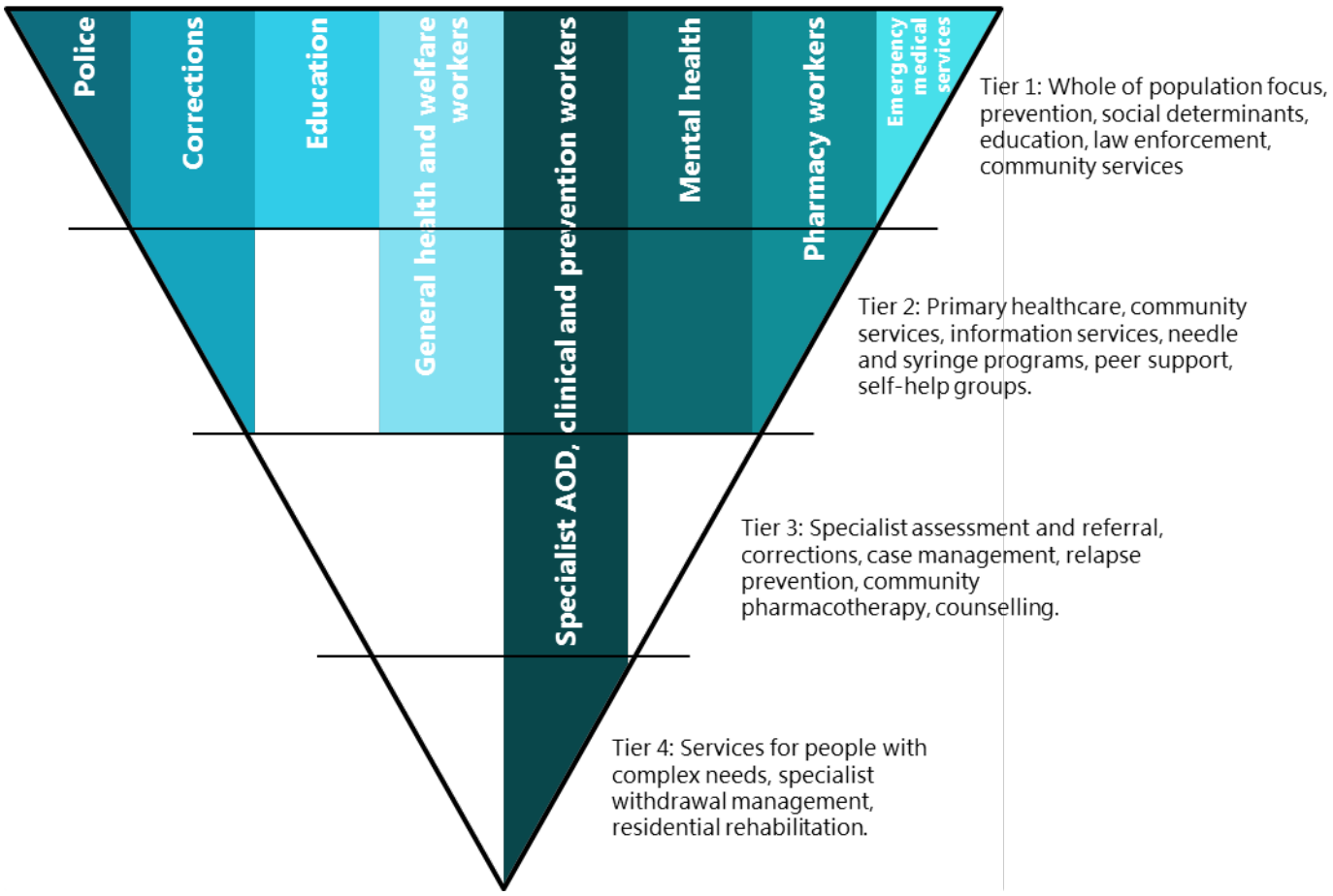
There are two broad groups of frontline workers: specialist frontline workers, who deal with AOD issues as their primary role; and general frontline workers, who deal with AOD issues incidentally or occasionally as part of their broader professional role.

Specialist frontline workers include addiction medicine specialists and other trained professionals that specialise in AOD treatment, such as psychologists, social workers and counsellors. They generally work in AOD specialist organisations or practices, or in dedicated AOD programmes operating out of broader health, community or correctional services.

General frontline workers are those that respond to AOD issues as part of their day-to-day professional duties. This includes those employed in the broader health sector, such as general practitioners (GPs), emergency department doctors and nurses, paramedics, and mental health specialists, in social services, such as housing and child protection, and in law enforcement, such as police officers and corrections officers. Frontline workers in other sectors, such as teachers and pharmacists, can also deal with the impacts of ice and other methamphetamine use.

Figure 7.1 identifies the four tiers across which frontline workers deliver services, and identifies how the major groups of specialist and generalist frontline workers span these tiers.

Figure 7.1: Tiers of activity in which different occupational groups make their contribution to reducing AOD-related harm.[554]



Specialist frontline workers

There is limited national data available in Australia on the size and composition of the specialist frontline workforce. A 2003 study estimated that the specialist frontline workforce had more than 10,000 workers, and that there was a generally even distribution between those employed directly by the government and those employed by non-government or private organisations. The study also found that:

- approximately two-thirds of the workforce were female
- almost half were aged 45 years or older
- almost one-third were employed part time
- the median length of service in AOD work was five years
- the most common occupations were generalist AOD workers and nurses.[555]

Education, training and qualifications

Every jurisdiction provides support for the education, training and qualification of specialist frontline workers. However, there are relatively few nationally consistent (and nationally recognised) professional accreditations for AOD specialist work. Currently, the only two specialist frontline professions with national standards are addiction medicine specialists (through the Royal Australasian College of Physicians), and AOD nurses (through the Drug and Alcohol Nurses of Australasia Pathways of Credentialing programme).[556] The Taskforce heard that the lack of nationally-consistent systems of accreditation has been a barrier to establishing formal minimum standards for AOD workers.[557]

Only Victoria and the Australian Capital Territory have minimum qualifications required of specialist frontline workers—both requiring at least a Certificate IV qualification in Alcohol and Other Drugs (Certificate IV qualification). Despite the lack of minimum qualifications in most other jurisdictions, the majority of specialist frontline roles requires at a minimum a Certificate IV qualification, or another equivalent tertiary qualification. Services often stipulate that minimum experience of one to two years is required for frontline staff.

Despite this, a proportion of frontline workers possess no AOD-specific qualifications, with a 2011 survey reporting that 11.3 per cent of the specialist frontline workforce lacked such qualifications.[558] Overall, there appears to be a strong preference for practice-based and skill-related training rather than for theoretical courses.[559]

A wide range of AOD training is available through the tertiary education sector, at both the higher education and vocational education and training level. A 2008 review identified 387 accredited AOD courses across 107 higher education and training institutions in Australia.[560] Courses frequently undertaken across the country include a Certificate IV in Community Services (Alcohol and Other Drugs Work) and a Diploma of Community Services (Alcohol and Other Drugs Work). These courses are delivered by various training organisations, including universities, other tertiary organisations, and non-government providers.[561]

In addition to formal training and accreditation, government-funded programmes provide specialist frontline workers with both ad hoc and structured information, guidelines and training for dealing with AOD use and misuse. However, many of these guidelines require updating. State and territory government-funded bodies also offer training seminars to specialist workers, including practical techniques like de-escalation procedures.[562]

Australian governments also support specialist frontline workers through funding for the National Centre for Education and Training on Addiction (NCETA), an internationally recognised research centre for AOD research.

Representation

In each state and territory, the treatment and support agencies that employ many specialist frontline workers are represented by peak bodies in their relevant jurisdiction, such as the Alcohol Tobacco and other Drugs Council of Tasmania and the South Australian Network of Drug and Alcohol Services. Most are partially funded by Commonwealth, state and territory governments.

NCETA guidelines for frontline workers

NCETA has previously developed national guidelines to assist a variety of frontline workers in dealing with people affected by methamphetamine and other psychostimulants. These guidelines are available for frontline workers to access from NCETA's website.

In May 2015, NCETA compiled a comprehensive list of methamphetamine publications and resources for policy-makers, researchers and frontline workers on its website. The list includes:

- *Responding to challenging situations related to the use of psychostimulants: A practical guide for frontline workers* (2008)
- *Treatment approaches for users of methamphetamine: A practical guide for frontline workers* (2008)
- *Management of patients with psychostimulant use problems: Guidelines for general practitioners* (2007)
- *Management of patients with psychostimulant toxicity: Guidelines for emergency departments* (2006)
- *Management of patients with psychostimulant toxicity: Guidelines for ambulance services* (2006)
- *Psychostimulants—Management of acute behavioural disturbances: Guidelines for police services* (2004)
- *A brief cognitive behavioural intervention for regular amphetamine users: A treatment guide* (2003).[563]

These organisations represent AOD services and their workers, and provide support, leadership, information and representation. The state and territory AOD peak bodies are also more broadly involved in the community sector, working to improve the quality of life of people and communities affected by alcohol or other drugs, as well as sharing information and education from specialist frontline workers with the general frontline workforce.

General frontline workers

Compared with specialist frontline workers, less is known about the needs of the general frontline workforce. A major challenge in implementing appropriate workforce development for these types of frontline workers is that the time they spend on AOD issues can vary significantly from day to day. The requirements for education, training, retention, professional development and systems and structures for police who deal with AOD-affected individuals differ depending on the needs of the population and the focus on their work.

The main support Australian governments provide to general frontline workers is through education, training and guidelines on how to respond to situations involving AOD issues. The emphasis on this training and support differs across each sector.

For the broader health workforce, the Commonwealth contributes up to $1.5 billion in funding each year for workforce development, with the goal of increasing the supply and capability of all health professions, supporting the Indigenous health workforce, and addressing workforce shortages in regional and remote areas. The states and territories manage the National Registration and Accreditation Scheme for the health workforce, which aims to establish national standards and qualifications for a number of health professions and allow better mobility of health professionals between jurisdictions.[564]

General Practitioners

As noted in Chapter 6, GPs are well-placed to provide care, support and referral pathways for patients experiencing problematic ice use. This includes screening to identify problematic use

of the drug, intervening early to encourage users to seek treatment and support and change their behaviour, and offering advice and referrals to patients in need of more intensive services to deal with their ice problems. The Commonwealth Government provides around $220 million a year to fund the vocational training of medical graduates wanting to specialise in general practice through Australian General Practice Training.[565]

GPs operating in regional and remote areas often provide services in the community, as well as in the emergency department and hospital setting. Regional and remote GPs therefore have a broader scope of responsibilities in managing patients with AOD issues.

The acute care workforce

In hospital and pre-hospital settings, frontline workers, including emergency department doctors, nurses and paramedics, respond to patients requiring emergency care for ice-related harms. Research has found that one to two per cent of patients present to Australian emergency departments with methamphetamine-related harms. These presentations generally take up extensive resources due the presence of high acuity psychiatric and medical issues.[566] [567]

St Vincent's Hospitals in Melbourne and Sydney have both reported significant increases in the number of aggressive and volatile interactions within their emergency departments. In their submission to the Taskforce, they noted that many of these assaults have been serious in nature, and have resulted in staff requiring medical attention and time off work to recover from their psychological and physical injuries.[568]

These hospitals have taken steps to mitigate the risk of such volatile incidents occurring in their emergency departments, including regular staff training on the management of aggression, professional development for nurses in managing users' AOD withdrawal, and changes to the physical environment of the emergency departments to better assist with the management of these patients.

The Indigenous health workforce

Across Australia there are a range of Indigenous-specific training courses. These courses acknowledge that Indigenous AOD workers face a combination of cultural and workforce issues when working in the sector. One example is the Certificate IV in Alcohol and Drugs run by the Western Australian Government,[569] which is considered to be a national standard in the delivery of culturally sensitive training of AOD workers. The Certificate qualification was designed for people who have completed the Certificate III in Community Services Work, which is also run through the Western Australian Government. The course builds on knowledge and skills in responding to AOD issues and related harms in Aboriginal communities, and provides information on mental health issues and co-occurring disorders.[570]

Other jurisdictions deliver similar courses or generalist AOD courses with an Indigenous-specific component of the curriculum. Some examples include the Alcohol and Other Drugs Work Certificate IV (Chisholm Institute, Victoria) and Certificate IV in Alcohol and Other Drugs delivered by Odyssey House in Victoria.[571]

Pharmacists

Pharmacists play an important role in helping reduce the supply of methamphetamine to communities. Some pseudoephedrine-based products that are available over the counter, for example certain types of cold and flu medication, can be used as a precursor for methamphetamine. Legislation in the states and territories regulate over the counter access to these products. These regulations, together with professional standards, education and training of pharmacists and their staff, largely ensure pharmacists can identify and manage attempts to procure pseudoephedrine for purposes other than therapeutic use.

Law enforcement

Police have reported that responding to methamphetamine-related issues are the most demanding and time consuming types of incidents they deal with.[572] Major concerns are

the personal health and welfare impacts of dealing with ice and ice users: not only with handling the potentially erratic and violent behaviour of users, but also in dealing with the high-risk of exposure to toxic chemicals when dealing with clandestine drug laboratories.[573]

The Australian-New Zealand Policing Advisory Agency—a collaboration between state and territory police jurisdictions, the New Zealand Attorney-General's Department and the Australian Attorney-General's Department—works to develop guidelines, standards and training for law enforcement officers. As part of the National Organised Crime Response Plan 2015–18, the Agency is developing a range of tools to educate and train law enforcement officers to better respond to clandestine illicit drug laboratories.[574]

Protecting frontline workers

Queensland and Victoria have recently increased penalties for assaulting frontline workers to help protect them from harm. The Queensland legislation provides for a maximum penalty of 14 years for serious assault against a public officer, including health workers, nurses, doctors and ambulance officers, increased from seven years.[575]

Under Victorian legislation, the violent assault of an emergency worker, including police, ambulance officers and emergency department staff who are delivering care carries a penalty of five years imprisonment. Other assaults against emergency workers and health practitioners providing care or treatment in hospital or in private practice can attract a penalty of six months imprisonment.[576]

The National Alcohol and Other Drug Workforce Development Strategy

The need for a coordinated, national AOD workforce development strategy in Australia has long been recognised.[577] In August 2015, the Intergovernmental Committee on Drugs released the National Alcohol and Other Drug Workforce Development Strategy 2015-2018, a national framework that identifies key strategic action areas to enhance the capacity of Australia's AOD workforce.[578]

The new National Alcohol and Other Drug Workforce Development Strategy acknowledges that there have been societal changes and advances in knowledge that influence the workforce response. These include:

- shifting patterns of use, particularly polydrug use
- new psychoactive substances
- an expanded range of pharmacotherapies and other treatment options
- greater awareness of co-existing mental health disorders and multiple morbidities (especially in the context of an ageing population)
- greater awareness of foetal alcohol spectrum disorder, child protection and family sensitive practice issues
- problematic use across a widened age spectrum
- greater emphasis on cost efficiency, professional practice efficacy, improved outcomes and inter-sectoral collaboration
- a better understanding of effective preventive measures
- greater recognition of the wide variety of workers involved in reducing AOD-related harm.[579]

Victoria's Health Service Violence Prevention Fund

The Victorian Government has committed $20 million to the Health Service Violence Prevention Fund to make workplaces safer and more secure. To encourage a culture of workplace security, health and mental health services will be required to publicly report violent incidents and develop a consistent response to violent incidents.

The Government announced it will invest $600,000 in clinical supervision training to support professionals working in drug treatment and mental health services. Funding will also support further training of existing supervisors and make sure organisations have structures in place for supervision.

The new National Alcohol and Other Drug Workforce Development Strategy acknowledges that these factors increase the need for responsive and adaptive workforce development to effectively respond to current and emerging issues.[580]

Community engagement

Collaborative strategies that engage a range of stakeholders are critical to addressing challenging social problems including the prevalence of ice in Australian communities. This is particularly important when the solution requires sustained behavioural change.[581]

Australian communities struggling with the impact of ice intrinsically understand this point. Community consultations conducted by the Taskforce across the country all emphasised the importance of local approaches. Submissions to the Taskforce also highlighted this point. For example, the National Rural Health Alliance told the Taskforce:

> *"Design of interventions targeting illicit drug use among rural residents will require strong community consultation so as to engage and empower rural communities. It is important to recognise that rural communities have diverse characteristics and interventions will need to be localised rather than follow a one-size-fits-all approach.*[582]

There are a range of government-led community engagement initiatives across Australia in relation to ice. There are also examples of communities initiating such responses themselves.

Examples of government-led community initiatives

The New South Wales Government has established Community Drug Action Teams in 73 locations across the state, funded through the Australian Drug Foundation. These teams bring together volunteers with the goal of minimising and preventing the harmful use of AOD in their neighbourhoods.

The Community Drug Action Teams lead community activities to engage at-risk youth, and educate the wider community. They involve parents, schools, TAFEs, universities, health workers, law enforcement, businesses, community organisations and local residents coming together to plan and run educational programs and community forums, and develop resources.

The Victorian Government runs Regional Management Forums. These forums bring together chief executive officers of local government councils and senior representatives from state government departments to identify and address critical issues facing the region, which can include concerns such as social disadvantage and AOD misuse. Through this local cooperation, the forums seek to encourage collaboration between departments, councils, statutory authorities, businesses and local communities to set and deliver key priorities.

Similar collaborative programmes operate in Queensland, through the Regional Managers' Coordination Networks, and in Western Australia through Regional Development Commissions.

As part of its Ice Action Plan, the Victorian Government is providing $500,000 over four years to fund grass roots Community Ice Action Groups across regional and remote Victoria. Grants provided through the initiative will support a range of activities including forums, production and development of communication resources, promotion of education opportunities, and the evaluation of these initiatives and interventions.[583] To date, 13 community groups have received grants of up to $10,000 for 2015–16.[584]

The Commonwealth also provides funding to the Australian Drug Foundation to run the Good Sports Programme, which supports sporting clubs to reduce high risk drinking as well as providing education and advice on other drugs, including ice. During 2015, the programme is hosting 'ice forums' in Victoria with experts in drug prevention and treatment, to provide advice to local clubs on the development of policies to deal with ice.[585]

Examples of community-led initiatives

In addition to the initiatives established by governments, grass roots action on ice has also emerged in local communities.

For example, Project ICE Mildura is a co-operative campaign established by a consortium of community, health, welfare and enforcement organisations in Victoria.[586] The project focuses on education and awareness through community information sessions, posters, billboards and the media. An evaluation of Project ICE Mildura concluded that it had been successful in raising awareness and understanding of ice, and resulted in the community being 'called to action' in terms of seeking out information.

Also in Victoria, the Wimmera 'Ice' Action Plan has been developed to address ice use through a prevention framework at the local level. The Wimmera Drug Action Taskforce, which comprises partners across a range of non-government and government organisations, oversees the Action Plan. Primary prevention activities include a locally-developed Grade 6 drug education programme, Knowledge is Power, and regular information presentations to community groups.[587]

Likewise, in South Australia, the Limestone Coast Drug Action Team was formed by local police and community members. It provides a network across the region that works to identify specific problems concerning drug use and to implement strategies to deal with these problems. The team includes police, counselling services, government departments, correctional services, and the Aboriginal community-controlled health service, Pangula Manamurna. It runs question and answer sessions across the region with panels of local experts, and ran a series of community forums this year with support from organisations such as Rotary Club and local councils. The team also provides information resources for local sporting and other clubs to raise awareness throughout the community via a dedicated website.

In Queensland, the Mount Isa Community Yarning Circle is a grass roots campaign targeting the local Indigenous community. Gatherings focus on empowering people to develop the skills to be able to deal with the impact of drug use on the community. One of the key messages is making the community aware—both drug users and the family and friends of those affected—that help is available.[588]

Governance

Responding to ice is a shared challenge for governments across Australia.

Responsibility for policy and service delivery for problematic drug use is jointly managed across the Commonwealth, state and territory governments, as well as the non-government sector (Figure 7.2 refers).

Effective responses require coordination between health, law enforcement, education and other sectors to plan, fund and implement the types of activities described in this report.

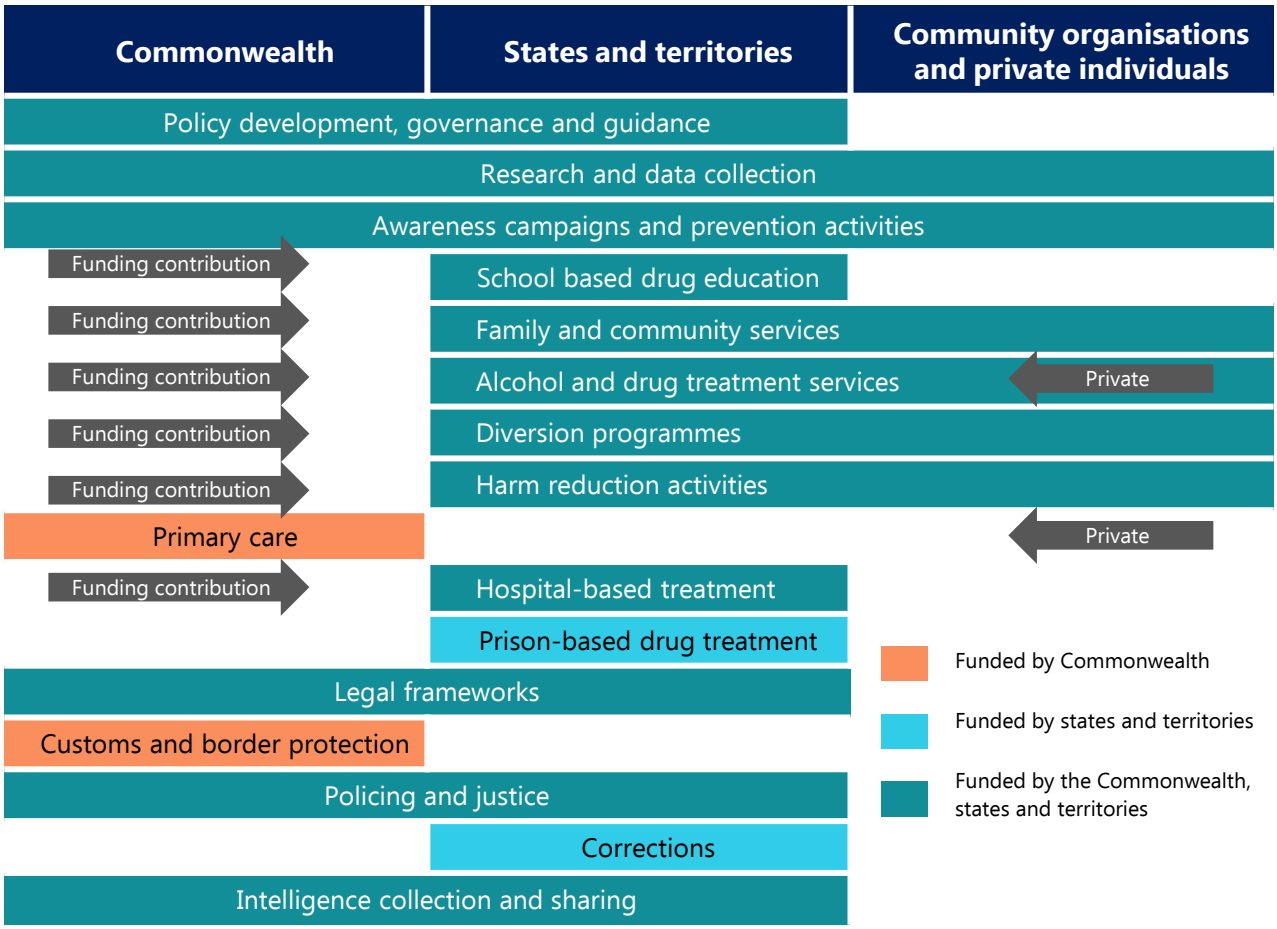
Coordination and oversight

The Council of Australian Governments (COAG) is the peak forum for cooperation between the Commonwealth, states and territories. It comprises the Prime Minister, state and territory Premiers and Chief Ministers, and the President of the Australian Local Government Association. COAG has a broad-ranging agenda focused on improving the wellbeing of Australians.[589]

Following changes to the COAG Ministerial Council structure in 2011, the former Ministerial Council on Drug Strategy was discontinued.

Today, two COAG Ministerial Councils have joint responsibility for overseeing cooperation on drug-related policy: the Health Council (Ministers from all jurisdictions representing the health portfolio); and the Law, Crime and Community Safety Council (Ministers and Attorneys-Generals from all jurisdictions representing the law and justice portfolios).

Figure 7.2: Responsibilities for responses to problematic drug use



A number of other senior health and law enforcement coordination committees—including the Australian Health Ministers' Advisory Council, the Mental Health, Drug and Alcohol Principal Committee, and the National Justice and Policing Senior Officials Group—also sit within this COAG framework (see Figure 7.3).

The Intergovernmental Committee on Drugs is the focal point for coordination of drug-related policy within this framework. The Committee includes representatives of health and law enforcement agencies from Commonwealth, state, and territory governments. As such, it has a key role in coordinating health and law enforcement responses. Decision-making and commitments to initiatives involving new funding decisions are primarily the role of the two Ministerial Councils and the COAG.

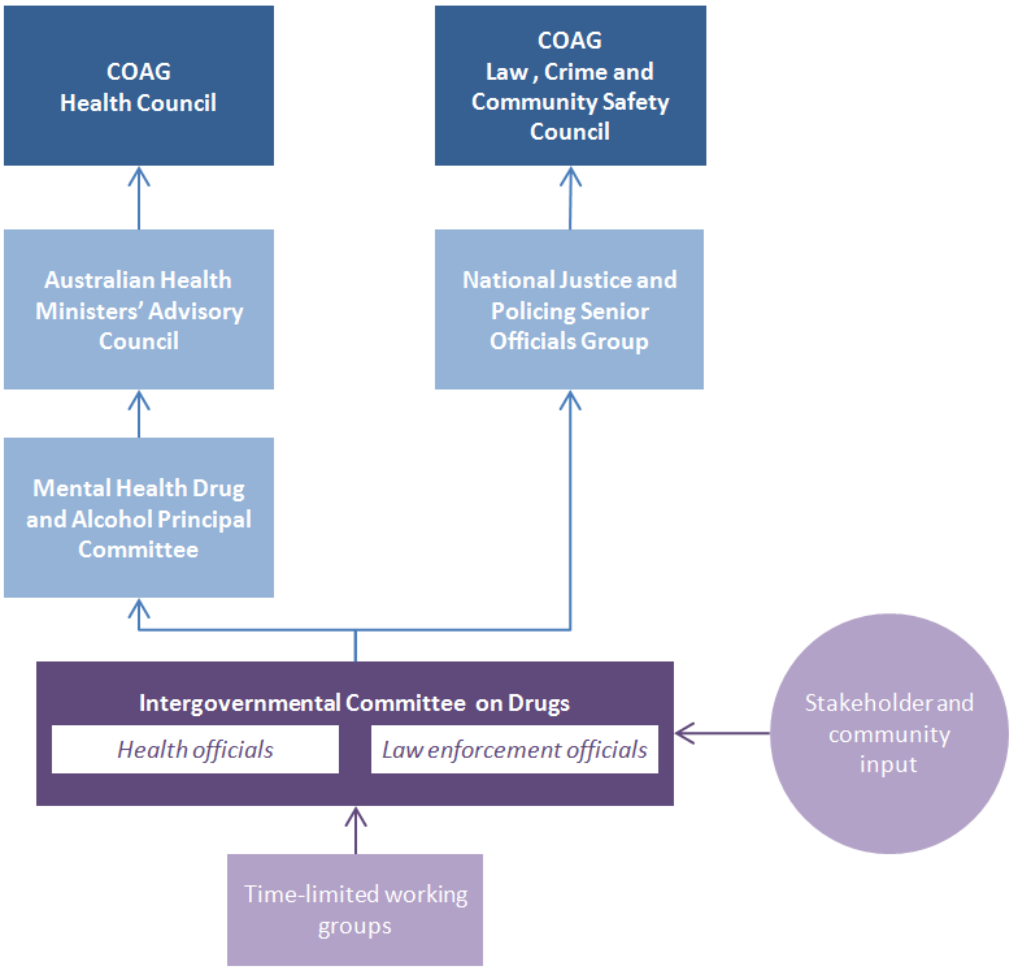
The Intergovernmental Committee on Drugs has identified methamphetamine as one of its key priorities in 2015–16, recognising the increasing prevalence of ice and harm associated with ice use across Australia.

The National Drug Strategy

The Commonwealth, state and territory governments and the non-government sector established a partnership approach to drug-related policy in 1985 through the National Campaign Against Drug Abuse. This was renamed the National Drug Strategy (NDS) in 1993. The Intergovernmental Committee on Drugs manages the development and implementation of the NDS and provides policy advice to relevant Ministers on drug-related matters. The current iteration of the NDS covers 2010-2015. With this period soon to expire, the Committee is developing a new NDS which will cover 2016-2025.

The NDS establishes a structure for coordinated action between the government and non-government sectors, and for cooperation between the health, law enforcement and education sectors in developing effective responses to drugs. The NDS builds on longstanding partnerships in these areas.

Figure 7.3: Governance bodies operating under the auspice of the COAG framework[590]



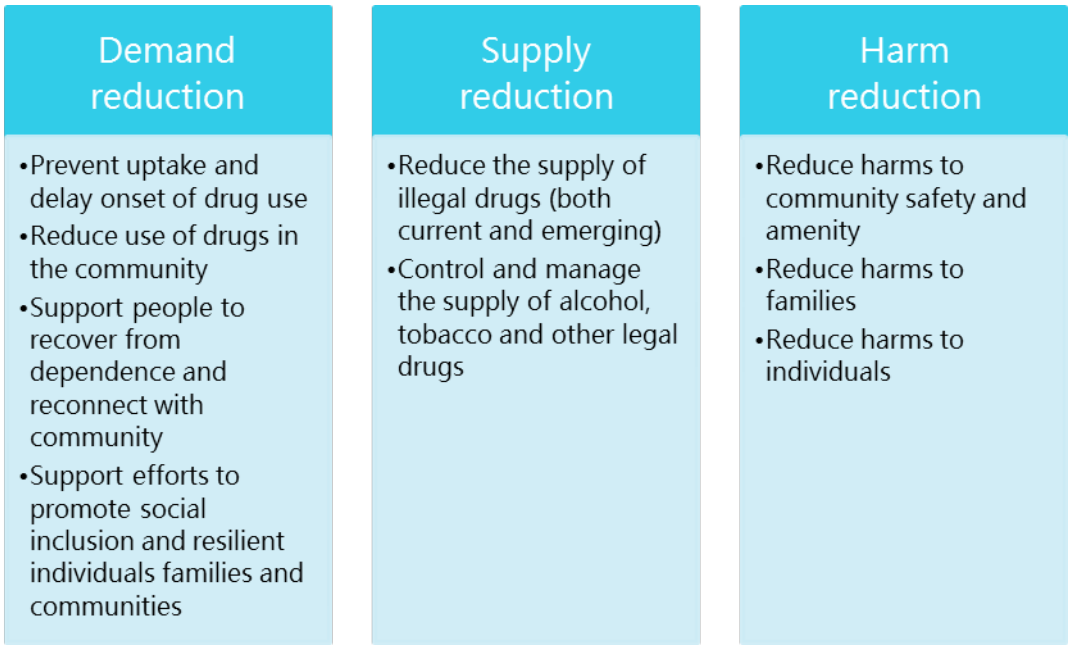
The aim of the NDS is to build safe and healthy communities by minimising drug-related health, social and economic harms among individuals, families and communities. It seeks to achieve this aim by applying a balance of three equally important pillars: demand reduction; supply reduction; and harm reduction. Prevention is an integral theme across all pillars (see Figure 7.4).[591]

Australia has had some significant successes in responding to illicit drugs since establishing this collaborative approach. Illegal drug seizures have increased substantially, harms associated with injecting drug use have been reduced, and governments have a better understanding about effective drug dependence treatment.[592]

The NDS has a number of sub-strategies that provide direction and context for specific issues of importance. The 2010-2015 NDS contains seven sub-strategies:

- National Aboriginal and Torres Strait Islander Peoples Drug Strategy
- National Alcohol Strategy
- National Tobacco Strategy
- National Illicit Drugs Strategy
- National Pharmaceutical Drug Misuse Strategy
- National Workforce Development Strategy
- National Drug Research and Data Strategy.

Figure 7.4: Pillars of the current National Drug Strategy[593]



Review of implementation and effectiveness

The current NDS includes three performance measures to help monitor progress and guide its implementation:

- prevalence of illegal drug use, smoking and alcohol consumption
- disruption of illegal drug supply, and
- harm associated with drug use.

A National Research and Data Working Group was established at the start of the current NDS to prepare annual reports against these measures and examine ways to improve the quality of the data sources that inform them. However, the last annual performance report published was for 2011–12 and the National Research and Data Working Group has since been discontinued.

Australian National Advisory Council on Alcohol and Drugs

In December 2014, the Commonwealth Government reshaped its advisory council on drugs to include alcohol within its remit. The Australian National Council on Drugs was renamed the Australian National Advisory Council on Alcohol and Drugs. The Council provides advice to the Commonwealth Government on a range of national AOD issues to ensure the Commonwealth is well placed to respond. This includes a focus on emerging issues and new substances. The Council has been tasked to examine issues facing Australia from the increasing use of ice as a priority.[594]

Some state and territory governments have similar advisory bodies, such as the Queensland Mental Health and Drug Advisory Council.

Research and data

Robust research and data is central to establishing a clear understanding of issues surrounding the ice market and its impacts.

Understanding the level of ice use, influences on supply and demand, and harms related to its use are important. This knowledge will enable government decision-makers to:

- determine the extent of the problem and the priority that should be given to responses
- identify strategies to respond and the level of resources which should be devoted to these
- evaluate the impact and level of success of various response strategies.

An evidence base around the ice market and associated issues has been building under the NDS. This is largely based on data from sources

such as the National Drug Strategy Household Survey (NDSHS) undertaken approximately every three years by the Australian Institute of Health and Welfare, national and international research, and police, customs and medical records.

Available research and data

Governments across Australia rely on research and data from diverse sources to understand illicit drug markets and their impacts.

Research, statistical and analytical bodies

The Commonwealth Department of Health currently funds three national drug research centres of excellence: the National Drug and Alcohol Research Centre; the National Drug Research Institute; and the NCETA. These centres collectively provide core research to inform drug policy development and assist in improving the effectiveness of treatment programmes.[595]

In addition, from 2009 to 2014–15 the Department of Health resourced the National Drug Law Enforcement Research Fund. The research funded through the Fund has contributed to the evidence base for drug law enforcement practices.[596] Other agencies that contribute data, analysis and research include the Australian Institute of Criminology, the Australian Crime Commission, the Australian Bureau of Statistics and the Australian Institute of Health and Welfare.

Law enforcement data

Law enforcement agencies collect data on drug-related arrests, seizures and clandestine laboratory detections, along with other information on known criminal activity. However, the illicit nature of drug markets means there will always some behaviour and activities of drug suppliers and users that cannot be captured in data on law enforcement or social trends. Law enforcement data can also be distorted by agency priorities and the focus of crime intervention activity.[597]

International data

Australia draws on international data from a range of sources to understand broader international trends in drug use, supply and policy responses.

These include information from partner countries' law enforcement and health agencies, and research and data from international organisations such as the United Nations Office of Drugs and Crime and the World Customs Organization.

User self-reporting

Several existing surveys are based significantly or exclusively on user self-reporting. These include the NDSHS, Illicit Drug Reporting System (IDRS), and Ecstasy and Related Drugs Reporting System (ERDRS). The NDSHS collects information about drug use among the general population in Australia and has been a valuable source of information on illicit drug use patterns and attitudes. The data derived from this survey has been central to understanding illicit drug use in Australia, including as a basis for developing law enforcement and health policies to respond to the problem.

Other surveys collect data from specific drug-using populations: injecting drug users in the case of the IDRS; and self-identified users of ecstasy and similar drugs in the case of the ERDRS. Surveys of particular groups are valuable in providing indications of drug use, drug markets and attitudes among these populations.

The Drug Use Monitoring in Australia programme surveys participating police detainees in certain locations around Australia. This survey is supported by urine sampling, which provides an opportunity to compare self-reported information with more objective data. The current programme is limited to four sites: Sydney (alternately Surry Hills and Bankstown), East Perth, Adelaide and Brisbane.

Emerging approaches

A number of emerging approaches seek to improve the breadth of data sources on illicit drugs. The use of diverse and indirect indicators is particularly important to understand illicit drug markets, due to their clandestine nature.[598] The Norwegian Fore Var system uses an approach that incorporates data from law enforcement, emergency and health services, drug user self-reporting and material from news media, the internet and street press.[599]

Victoria Police captures and reports on a broad range of indicators related to drugs through its operations. This information supports its Drug Harm Index, which aims to measure the harm resulting from drug-related crime and informs operational and other responses related to illicit drugs. The Drug Harm Index uses law enforcement data along with other sources including research by the National Drug and Alcohol Research Centre and data from the Drug Use Monitoring in Australia programme.[600]

Wastewater analysis is used in South Australia and Queensland, and internationally in Europe, North and South America and North Asia. Wastewater analysis is used to enhance understanding of the prevalence of illicit drug use in a population. This kind of analysis can estimate levels of illicit drug use by analysing population size, daily volumes of wastewater produced, and the excretion rate of particular substances.[601] This capability has been employed in Australia in large population centres,[602] a major annual music festival[603] and a correctional facility.[604] It can detect a variety of pharmaceuticals and other drugs, and has a range of public health, prevention and law enforcement applications.[605]

In Victoria, the Turning Point Drug and Alcohol Centre administers the 'Ambo Project'. This is a world-first surveillance system which reports Victorian ambulance attendances related to AOD consumption. The system records specific drug sub-types, including ice, with 90 per cent of the project data successfully linked to emergency department and hospitalisation datasets in Victoria.[606] The project has also been successfully piloted nationally in a mental health and suicide context.

PART C
HOW TO STRENGTHEN OUR RESPONSE

ABOUT PART C

This section of the report examines opportunities to strengthen efforts to tackle ice in Australia, and makes recommendations for consideration as part of a National Ice Action Strategy.

In confronting the growing market for ice in Australia, law enforcement agencies face complex challenges in containing supply, due to the unique nature of the drug. While supply side interventions can be improved, the major opportunity lies in curbing demand. The Taskforce heard many reports of the increasing normalisation of ice use, with use of the drug influenced by a host of social determinants and individual life circumstances.

Chapter 8 outlines the pressing need to provide help and support for the groups who are experiencing the impact of the upsurge in the use of ice in Australia. This includes families, communities and frontline workers. The Taskforce's view is that this should be the first priority for government efforts.

Chapter 9 outlines opportunities to improve Australia's prevention efforts, including through targeted campaigns and ensuring schools and high-risk workplaces are equipped to respond. There is also opportunity to enhance our work with disadvantaged communities by targeting the risk factors that often lead to alcohol and other drug misuse.

Chapter 10 examines how to help people to stop using ice. While the Taskforce noted during its consultations a belief that residential rehabilitation is the only effective option for treating dependent users, this position is not strongly supported by evidence. More accessible and cost-effective early intervention and counselling services need to be made available to ice users when they need it, and residential services should focus on those with significant social disadvantage or other comorbidities as a first priority.

Many services are not equipped to respond to the unique characteristics of ice withdrawal and recovery. The key challenge is to ensure the right mix of services is available for the population, and to ensure that services can adapt their treatment programmes to incorporate evidence-based interventions for treating ice and other methamphetamine dependence.

Chapter 11 outlines areas to improve Australia's law enforcement efforts to tackle ice. It focuses on targeting crucial links in the supply chain through better intelligence, international engagement and a stronger regulatory framework.

Chapter 12 considers how to improve the evidence base, and ensure good governance in the overall approach to tackling ice. Australia's efforts must be underpinned by better data, more research and regular reporting through a robust governance framework. A better understanding of emerging trends and demographics of use will help governments to direct resources at priority areas and monitor how well these efforts are working.

CHAPTER 8
SUPPORT FAMILIES, COMMUNITIES AND FRONTLINE WORKERS

People need to know where to go for help, and how to best engage with and support ice users. This should be the top priority for all governments.

As discussed in Chapter 3, an individual's ice use can have far reaching consequences for the people around them. The Taskforce heard from families, communities and frontline workers across Australia who had been profoundly affected by someone else's ice use.

During the Taskforce's consultations, families, communities and workers often said they needed more information, support or training. People were keen to know where to go for help, and how to best engage with and support ice users.

Family support

The impact of ice use on families was one of the most commonly raised concerns during the Taskforce's consultations. The Taskforce also received more than 500 submissions on this topic.

An individual's ice use can have severe impacts on their family. Family members often experience extreme stress about their relative's physical and mental health and wellbeing, and have broader concerns about the functioning of their whole family and possible effects on children.[607] In addition to these concerns, family members can often experience a social stigma related to a relative's drug dependence.[608] The impact of drug dependence on close family members can be a major source of ill health, leading to health and economic consequences.[609]

The Taskforce heard that families can play an important role in helping a user manage their ice use.[610] Families can provide a supportive environment that can reduce the risk of a family member using illicit drugs in the first place. Their ability to do this is increased if parents

receive information or education on encouraging healthy family development.[611]

Many families told the Taskforce they did not know where to go to find support and they were not sure how to best manage a family member's drug use. While there are a range of family support services available, there are service gaps—particularly in regional and remote areas.

The broader community is also looking for answers on how best to respond to ice. The submission from the Kimberley Regional Methamphetamine Forum encapsulated some common concerns raised by communities. For example, community members asked:

> *"What resources and services are available? Who's doing what?*
>
> *How do we know the services are out there?*
>
> *How do we support families in our regional and remote communities?*
>
> *How do we reach those who are falling through the gaps?* [612]

Families and communities need better access to information about the services that are available to support ice users, and more practical information about ice. This includes credible and accurate information about the drug and its effects, and how to best engage with relatives using ice to provide a supportive family environment.

The information should be easily accessible online, and should be selected and maintained appropriately to ensure the information is current and accurate. It should also draw on appropriate resources that are already available, providing families and communities with a 'one-stop-shop' to access the information and advice they need.

This information should draw on successful strategies and resources used by individual communities where this could be usefully passed on to other community groups looking to take steps of their own to address ice.

Noting that service supports and systems are slightly different in each state and territory, the Commonwealth should work closely with the states and territories to develop this resource.

Recommendation 1

The Commonwealth, state and territory governments should work together to develop an online curated toolkit of information and resources to support families and communities to better understand and respond to the problems caused by ice.

Community engagement

Local or 'place-based' approaches involve tailoring policies to local circumstances. These local approaches seek to address complex problems at a local level by strengthening the capacity of communities to take action themselves.[613]

Such approaches engage the community as active participants in policy development and service delivery, enabling personalised engagement between professionals and service users, and among members of the community.[614] [615]

The involvement of communities is vitally important in Australia's efforts to prevent people from using ice, and help people to stop using ice. As outlined in Appendix II, many factors influence drug use behaviour across the lifespan. These factors can include community disadvantage and disorganisation[616] and the availability and perceived use of drugs within the community.[617]

Evidence supporting the benefits of multi-level, community-based interventions is growing.[618] However, communities need information and advice to inform their responses. Many local prevention efforts focus predominantly on law enforcement. While this is an important part of targeting supply and preventing harm, such strategies alone may not be effective.[619]

Community prevention efforts—particularly in vulnerable communities—need to include comprehensive responses at the local level. Such approaches attempt not only to influence individual behaviour but also incorporate participation of the general community and its

institutions to address the environmental and social factors that contribute to alcohol and other drug (AOD) problems.[620]

For Indigenous communities, it is important that prevention efforts recognise the importance of culture, family, and community. Community-led diversionary activities, such as sports, recreation, and links to country, can help prevent substance misuse and build mental health resilience. Healing programmes that connect people to cultural traditions also address social and emotional wellbeing issues.

There are some key principles that should inform community action to prevent ice use and associated harms. Strategies should be multifaceted and incorporate a range of activities that mobilise community responses across law enforcement, health, media, education and community support.

Successful prevention efforts often benefit from involving coalitions of organisations and interested individuals that foster community participation and ownership of the issue. These collaborative efforts take advantage of local diversity and expertise to develop and promote more effective and sustainable solutions.[621]

Community-based models have been adopted in a range of social policy areas. For example, the Alice Springs Transformation Plan has been effective in improving social support services and reducing homelessness through flexible funding to address community priorities. In Broadmeadows in Victoria, the Communities for Children initiative is a successful place-based approach to early childhood education that delivers tailored solutions, such as the translation of children's stories into different languages.

In the Queensland community of Logan, a Shared Assessments model joins up the Commonwealth and state agency services provided to socially excluded people. This includes simple initiatives like sharing information between agencies to save clients from having to provide the same information more than once.[622]

Communities that Care operates in a number of communities, including Bunbury, Mornington Peninsula, and Ballarat to improve the health and wellbeing of children and young people. The program empowers and guides local communities to implement effective strategies to address issues of most concern, including substance use.[623]

Regional and remote Australia

A community-based approach is likely to have benefits for tackling ice in Australia, particularly given the emergence of ice as a problem in regional and remote locations. The socioeconomic pressures faced by many regional communities in Australia, combined with more limited choice of services and variable local circumstances, suggest community engagement will be especially important in these areas.

New South Wales crime statistics give an indication of the prevalence of ice use in regional New South Wales. For example, in the local government areas of Orange, Hay, Muswellbrook and Moree Plains, from April 2014 to March 2015, police recorded rates of amphetamine use or possession that were around three to four times the New South Wales state average.[624]

Many regional areas face economic challenges, such as high unemployment, that contribute to social problems like illicit drug use. As at April 2015, Cairns and outback Queensland faced youth unemployment of over 20 per cent, and youth unemployment in western New South Wales was over 22 per cent. This compares with an overall youth unemployment rate of around 14 per cent for Australia.

The challenges that ice poses for services across Australia are exacerbated in regional and remote communities. For example, there are often fewer treatment options available and less specialisation by treatment providers. This places pressure on general practice and hospitals to manage emerging public health issues, such as ice.

Resourcing constraints are acute in some communities, with services having to juggle competing priorities, including treatment for AOD-related issues. Connections between services are particularly important in smaller

communities with limited resources, sometimes spread over large geographic areas.

As outlined in Chapter 2, there is emerging evidence that ice is becoming an increasing problem in some regional towns and remote communities.[625] The Taskforce heard that people living in smaller communities face particular issues in dealing with ice, such as difficulties in remaining anonymous, or having their confidentiality protected, which may deter people from seeking help.[626]

A number of remote Indigenous communities have raised concerns about the potential emergence of ice, particularly where there is already a high prevalence of AOD-related problems. Community-based models play a central role in the delivery of many services in these communities.

Community based initiatives

Taskforce consultations suggested that Australian communities want to be involved in finding solutions to ice. However, many communities either don't know what to do or don't have sufficient resources to develop a response.[627]

There is an opportunity to use community-based initiatives to empower local residents to become active players in the process of community change. For example, an innovative model introduced in Birmingham in the United Kingdom called Reach Out Recovery recruits volunteers from across the community to offer brief interventions for people with drug dependence in their everyday lives. Newsagents, bakers, taxi drivers, pharmacists and others with Reach Out Recovery stickers on their windows are available to offer help, including referral to peer mentors, doctors and a telephone hotline.[628]

Investments in small grants programmes have been shown to provide an avenue for learning new approaches, encouraging joint action, and nurturing local talent and leadership.[629] Communities should also have access to information about successful local initiatives around the country, which they could use as models for their own community.

There is a range of existing Commonwealth-funded programmes that could potentially be expanded to deliver information and support to families and communities. This includes the Good Sports Programme, which has recently run a series of 'ice forums' across Victoria, with experts providing advice to local clubs on the development of policies to deal with ice.[630] Further, numerous existing locally-based programmes with strong community support and awareness could be harnessed to avoid duplicating effort.

The outcomes of these programmes should be evaluated to help build the evidence base for effective local solutions and initiatives.

Recommendation 2

The Commonwealth, state and territory government should provide additional funding to communities to empower them to develop locally-based solutions to ice and other illicit drug issues.

For example, this could be facilitated through existing community capacity building programmes such as the Commonwealth's Good Sports Programme, to avoid duplication of existing mechanisms.

Identification of appropriate, high-priority communities should be done collaboratively between governments, particularly where there are existing planning frameworks in place, to avoid inefficiencies or overlap of investment.

Community based policing

The Taskforce consistently heard about the importance of engagement between local police and the community in dealing with the problem of ice, particularly in regional and remote areas. A key theme that emerged in community consultations was the tension people face in engaging with local police about friends and family who are using ice. People are concerned that if they provide information to police on ice use in their communities, they may place their friends and families at risk of arrest.

Community-based policing is critically important for dealing with ice. Partnerships between the police and communities can help to ensure a safe environment, while trusted local police can also be a point of early intervention for ice users.

Australian police organisations engage in community policing in a number of ways, including community-based crime prevention initiatives such as Neighbourhood Watch, outreach programmes, such as Police Citizen Youth Clubs, and community consultative mechanisms where communities can provide feedback, such as police liaison officers.[631]

Local police need to ensure that their community engagement activities include a focus on ice, with clear messages for the community about the value and consequences of early engagement with police about illicit drug use.

Better local coordination of services

The Taskforce found that some communities are far better connected than others. At several Taskforce consultation roundtables, service providers were meeting for the first time. At others, such as in Mildura, strong relationships were already in place.

Mission Australia commented on the need for integrated services in its submission to the Taskforce:

> *"Government agencies and community service providers need to provide integrated services in order to effect sustained change. Treatment programs need to be provided through the health and justice systems in collaboration with community services, and housing needs to be addressed as a priority to provide a stable foundation for change. Care also needs to be continuous with entry and exits to and from services properly coordinated to provide a seamless experience for the client where possible.*[632]

In its submission, the National Centre for Education and Training on Addiction also identified a need for sector-wide systems and better organisation to ensure proper coordination and links between services dealing with ice users.[633]

The Taskforce heard that collaboration needs to go beyond health services, to also include coordination with housing and employment assistance to support the most vulnerable ice users. This is important because individuals who present with problematic drug use typically present with other issues, including unemployment, homelessness, criminal justice involvement and social exclusion.[634] Linking clients to these resources can be an important factor moving them toward self-sufficiency as they overcome dependence.[635]

One approach to improve coordination would be to introduce 'brokers' or 'coordinators' to bring together local health, law enforcement, employment and justice services with business and not-for-profit organisations to ensure activities are connected.

Area Health Networks could offer an existing regional network through which to deliver this function.

Recommendation 3

The Commonwealth, state and territory governments should work together to improve coordination between community-based alcohol and other drug services, and support referral pathways between local health, support, employment and other programmes.

This should build on existing coordination and governance mechanisms where possible, and involve Commonwealth, state and not-for-profit services to establish cross-service networks and provide better support for people seeking help for alcohol and other drug problems.

Frontline workforce

The frontline workforce that responds to AOD issues is extremely diverse, and ice is only one category of drug this workforce has to deal with. The Taskforce heard that both the specialist and general AOD workforces are facing major challenges from shifting patterns of drug use and increasing polydrug use, barriers to recruitment and retention, a general increase in the demand for health services, and an increasingly ageing workforce.[636]

In particular, frontline workers (including the medical workforce) have raised concerns about their capacity to respond to methamphetamine-induced psychosis, the symptoms of which can be exacerbated by polydrug use.[637] For example, research has found that, while the number of patients presenting to emergency departments with methamphetamine-related harms is not sizable (one to two per cent), the resource implications are significant due to these patients presenting with high acuity psychiatric and medical issues.[638]

The National Alcohol and Other Drug Workforce Development Strategy acknowledges the critical role of workforce development in preventing and responding to AOD-related harm. There is a need for these practices to continuously evolve in response to changes in societal needs and advances in knowledge.[639]

In the context of the broader work already underway, the Taskforce has identified some areas for improving the capacity of frontline workers to respond to ice and other forms of methamphetamine. This includes providing nationally consistent and up-to-date methamphetamine-specific guidelines and resources, improving professional development pathways, supporting recruitment and retention in the AOD specialist sector and improving the capacity of the Indigenous workforce.

Enhance workforce capabilities specific to methamphetamine

Many submissions to the Taskforce identified gaps and opportunities for improvement in the capacity of both the generalist health and the specialist AOD workforce to respond to ice and other methamphetamine use.

A 2009 study found that 'AOD service providers are not clear about the best way to respond to clients seeking methamphetamine withdrawal treatment'.[640] This assessment was reflected in many of the organisational submissions to the Taskforce that called for substantial workforce and service development efforts to ensure services meet the needs of ice users and their families.

The Taskforce heard that frontline workers often perceive ice and other methamphetamine users to be difficult to engage and reluctant to seek treatment and support.[641] Many felt that existing service offerings and training are designed to deal with alcohol and opioid problems, and are not adequate or suitable to deal with ice and other methamphetamine use, including the often aggressive and violent behaviour by users.[642]

Many services also rated themselves as either poorly or only reasonably equipped to respond to methamphetamine-using clients.[643] Some ice users claimed that they were discriminated against by frontline workers, leading them to avoid services until their issues become more chronic and costly to deal with.[644]

It is important not to discount the value of the current frontline workforce, or the skills and capabilities that the workforce does possess. There is a great deal of experience across the specialist and generalist frontline workforces, and many workers *do* possess the necessary skills and capabilities to respond effectively to ice and other methamphetamine use. However, the Taskforce has listened to those workers who have said that more guidance is needed to ensure that a majority of workers have the confidence and skills to deal effectively with ice use—particularly as demand for treatment increases.

> *"[C]ontinued investment in workforce and organisational development is indicated to improve confidence, capability and processes … and ensure competence in dealing with specific meth/amphetamine issues and challenges.*[645]

A key area of opportunity to better support frontline workers is the development of nationally consistent, easily accessible and up-to-date methamphetamine-specific resources. The need for nationally consistent resources was a common theme in both the Taskforce's consultations and submissions it received. The Taskforce heard that existing guidelines are either not nationally consistent or not up-to-date.

Further, a variety of workers told the Taskforce that, for their particular sector, there are no ice-specific guidelines, despite them increasingly coming in contact with ice users.

Another common theme was the importance of 'just-in-time' resources for workers who only occasionally come into contact with ice users. These resources should be available on an as-needed basis.

Royal Australian College of General Practitioners clinical guidelines

In its submission to the Taskforce, the Royal Australian College of General Practitioners (RACGP) suggested a need to expand its clinical guidelines on smoking, nutrition, alcohol, and physical activity to cover psychostimulant use and other drugs.

The RACGP indicated that this could improve general practitioners (GPs) engagement with psychostimulants and other drugs and embed the role of GPs in asking about drug use more firmly by placing it on equal footing with other lifestyle conditions that are seen as part of mainstream general practice.[646]

The existence of guidelines is particularly important for workforces that provide emergency response, such as paramedics and emergency department physicians and nurses. The Australian College for Emergency Medicine said that it is essential to 'train all staff members in how to manage aggressive and violent patients'. The College also argued that it is critical for other non-specialist AOD staff to be educated about the nature of methamphetamine, and the harms that may be displayed by the clients who use it.[647]

The Taskforce notes that some jurisdictions have led the way in developing resources for frontline workers, both AOD and generalist, to assist them to respond to ice and other methamphetamine use. Guidelines have been developed across multiple sectors. However, many are more than 10 years old and require updating. With appropriate review, there is potential for these to contribute to a national strategic approach in response to ice.

The Taskforce recommends action be taken to expand the availability of material specific to methamphetamine and other psychostimulants for key frontline worker roles and sectors.

These resources should be developed in consultation with sector experts, and—whilst nationally consistency should be an underpinning goal—there should be flexibility to ensure materials take account the specific service system and legislative frameworks of each jurisdiction.

Recommendation 4

The Commonwealth, state and territory governments should engage expert leadership to provide evidence-based information for frontline workers on how to deal with methamphetamine in a variety of sectors and settings.

This should be done by updating existing national guidelines for frontline workers or developing new guidelines for frontline worker sectors and settings where national guidelines do not already exist. The guidelines should have a nationally consistent basis, but be flexible enough to take account of relevant differences in each state and territory.

Provide better professional development pathways

The challenges associated with treating ice and other methamphetamine use is often exacerbated by polydrug use and/or comorbidities. For example, ice users may require treatment and support for mental health and a range of other issues, often along with other trauma issues, at the same time as they

receive treatment and support for their methamphetamine use.[648] A recent survey of frontline workers demonstrated that the most common reason why frontline staff needed new skills or training was to enable them to work effectively with clients with a dual diagnosis.[649] [650]

Ongoing education and training in relation to ice and other methamphetamine use is crucial.[651] Workers across multiple sectors are seeking more training on how to respond effectively to clients who are presenting with symptoms associated with ice use.[652]

There are opportunities for existing professional bodies to incorporate methamphetamine-specific training into their own professional development programmes. This includes frontline AOD workers, police, paramedics, GPs, emergency physicians and nurses, mental health workers.

As a first step, training under the General Practice Mental Health Standards Collaboration (GPMHSC) should be strengthened to include management of ice and other psychostimulant use. GPMHSC-accredited programmes are offered by both the RACGP and the Australian College of Rural and Remote Medicine (ACRRM). ACRRM inclusion is vital, as primary care in regional and remote areas is often provided in hospitals and emergency departments, as well as through GP practices. Health workers in regional and remote areas are also key in providing early intervention and counselling given a lack of immediate access to AOD treatment and support services.

Beyond strengthening GPMHSC training, future work should occur to develop and promote readily accessible continuing professional development programmes for GPs and other professionals that provide care specific to methamphetamine and other psychostimulant use. This includes programmes through the RACGP and the ACRRM. Continuing professional development programmes should also be developed and promoted for Indigenous health workers, nurses (including those working in regional and remote areas), psychologists, psychiatrists, paramedics and police. Police programmes should incorporate training on safely approaching and apprehending methamphetamine users who are experiencing psychosis.

Recommendation 5

The Commonwealth, state and territory governments should work with relevant accreditation associations and training organisations for various frontline workers (including general practitioners, regional and remote health workers, Indigenous health workers, nurses, psychologists, psychiatrists, paramedics and police) to ensure that education and training relevant to ice and other psychostimulant use is included in the medical curricula and foundation qualifications and in continuing professional development programmes.

As the first step, the Commonwealth Government should work through the General Practice Mental Health Standards Collaboration to strengthen stimulant-specific content in mental health skills training for general practitioners relevant to both the urban and the regional and remote context and in the continuing professional development of general practitioners.

The Taskforce also heard that professional development of frontline workers and other health professionals is hampered by a lack of available training places in Certificate IV AOD qualifications. This is particularly salient for regional and remote areas, where workforce development is a key issue.[653]

The availability of Certificate IV training places is not only vital for a skilled specialist treatment workforce, but also for ‘wrap-around’ services, such as primary care, mental health and community services. In areas of need, it is vital that these workers are appropriately skilled to deliver interventions effectively.

States and territories are best placed to monitor the demand versus availability of Certificate IV courses, particularly in the context of workforce and skill shortages within the specialist treatment sector. Training availability must be addressed as a matter of priority to promote

workforce development and strengthen the role of 'wrap-around' health and support services.

The Taskforce recommends that states and territories review availability of the Certificate IV AOD qualification for frontline workers and other health professionals and address shortages as a matter of priority.

Recommendation 6

Under the National Drug Strategy framework, the state and territory governments should review the availability of Certificate IV alcohol and other drug qualifications and take action to address placement shortages as a matter of priority.

Supporting the addiction medicine specialist workforce

Another key theme of the Taskforce's consultations was the importance of ensuring individuals with complex needs have access to addiction medicine specialists in the future. There was general concern during consultations of a diminishing addiction medicine specialist workforce, given the falling numbers of new recruits into this speciality.

The need to support the addiction medicine specialist workforce was also noted by the Royal Australian and New Zealand College of Psychiatrists. The College noted that limited investment in addiction psychiatry support and a growing level of need in the community for these services, as well as an increase in complex and challenging presentations, is putting a strain on already limited resources. This means that many users do not receive the treatment they require in a timely manner.[654]

The Medical Services Advisory Committee endorsed new Addiction Medicine items on the Medical Benefits Scheme in August 2013. These items were intended to help to address this workforce challenge and ensure complex, high quality care is available to those most in need. In addition, these items were intended to help improve access to treatment for those in Indigenous and regional and remote communities and improve integration of services. The Medical Benefits Scheme items recommended by the Medical Services Advisory Committee also provided remuneration for tele-health consults and case conferencing.

Implementation of the Medical Services Advisory Committee's decision to endorse the Addiction Medicine items has been delayed.

While the Taskforce supports the implementation of these items in a timely manner, there are also further enhancements that would support improved management of patients within the primary care setting and ensure resources are directed toward those at greatest need. These should be considered as part of ongoing improvements in future.

Recommendation 7

The Addiction Medicine Medical Benefits Scheme items approved by the Medical Services Advisory Committee in August 2013 should be implemented as a matter of priority.

Future consideration should also be given to the following enhancements to the Medical Benefits Scheme items:

- diagnoses must be consistent with Diagnostic and Statistical Manual of Mental Disorders, 5th Edition or International Classification of Diseases 11th Revision criteria
- source of referral should be narrowed to include general practitioners and nurse practitioners only
- items should include requirements for assessment and management of patients within the primary care setting, with communication exchange between the specialist and primary care provider.

Improve Indigenous-specific capabilities of the workforce

The continued development of a skilled, culturally-appropriate workforce to deliver services to Indigenous communities, families and individuals is integral to achieving positive outcomes. Maintaining an Indigenous workforce is a vital component of this.

However, many Indigenous AOD workers have reported that they do not consider themselves as having the necessary skills to address illicit drug use.[655] A 2013 survey of frontline workers in Indigenous services found that a high proportion reported that they needed more resources, knowledge/guidance and service linkages to respond effectively to amphetamine use.[656]

Workers in the Indigenous health sector must be supported and qualified to provide evidence-based care, treatment and support and targeted prevention programs.[657] An understanding of mental health, along with broad social and emotional wellbeing issues, is critical given the strong links between these issues and harmful use of AOD in Indigenous communities. Building the Indigenous health workforce enables culturally-appropriate treatment and support to be available and accessed in these communities.

AOD treatment and support for Indigenous people must be culturally safe, competently delivered, and respectful. The AOD workforce generally is characterised by high levels of stress due to complex client presentations and often difficult working conditions. Stress can lead to burnout and have a significant impact on the wellbeing of workers. Such issues are likely to be further exacerbated for Indigenous workers as they strive to assist community members in dealing with profound and complex AOD problems.[658]

Recommendation 8

The Commonwealth, state and territory governments should work together to develop workforce development pathways and career options for more Indigenous Australians in the alcohol and other drug sector, including strategies to ensure the workforce is appropriately supported and sustainable over the long term.

CHAPTER 9
TARGET PREVENTION

Stemming the demand for ice must focus on prevention. Complementary, evidence-based and appropriately targeted strategies are needed to do this effectively.

Alcohol and other drug (AOD) prevention activities are aimed at preventing the first use of drugs, particularly among children and young people. Prevention activities are carried out by all three levels of government (Commonwealth, state and local), along with non-government organisations, academia, the private sector and community groups.[659] Prevention strategies can include education to dissuade use and promote health, and structural policy changes to tackle disadvantage.

Prevention strategies can be segmented into the following categories:

- universal prevention: targeting whole populations
- selective prevention: targeting people with a greater than average risk
- indicated prevention: targeting those with emerging problems.[660]

Prevention approaches differ depending on the population group targeted. Drug prevention activities have historically focused on changing behaviour by addressing individual risk factors, such as knowledge, attitude and skills. These efforts have often targeted young people—the age at which most drug-use behaviour starts.[661] Approaches can be drug-specific or aimed at tackling AOD use and misuse more broadly.

Prevention strategies must take into account the reasons why people use drugs in the first place. This includes the social determinants of drug use and risk factors that contribute to the development of problems across the lifespan.

There is a well-established relationship between social determinants and problematic drug use. Drug use is strongly associated with several social and economic factors, including poverty, unemployment, culture, and community and family disadvantage.[662] Marginalised youth in disadvantaged communities with little or no family support and limited access to education are especially vulnerable.[663]

The Taskforce acknowledges the importance of tackling the risk factors that lead to drug use through long-term, whole-of-government action. Governments are already taking action to tackle the disadvantage that contributes to, among other things, poor social and health outcomes. However, additional work is required—particularly within Indigenous communities and regional and remote areas—to overcome social and economic disadvantage, and support the development of protective factors for at-risk children. The Taskforce supports the finding within the National Amphetamine Stimulant-Type Strategy 2008-2011 that:

> *"...efforts to tackle disadvantage should be expanded, including developing and trialling family-centred approaches to build resilience.*[664]

This work should be pursued under the broader Council of Australian Governments (COAG) framework.

To tackle ice specifically, there are a range of activities that Australian governments can implement to improve Australia's prevention efforts. This includes more action to support schools and workplaces, as well as ensuring communication activities are appropriately targeted. Prevention efforts should be complementary and ensure messages are credible, wide-reaching and effective.

What works?

There is no single, stand-alone mechanism, person or agency that can prevent drug use in the community.[665] Prevention strategies should be one component of a balanced response to drugs that includes law enforcement, supply reduction, support and treatment, and prevention of health and social harm.[666]

Universal, selective and indicative approaches have all been found to yield positive results for preventing AOD misuse, depending on the context in which they are delivered (see Table 9.1). However, the effectiveness of prevention activities relating to specifically to ice is less clear as there are few 'rigorously evaluated' prevention activities that relate to amphetamine-type stimulants.[667]

The evidence that is available points to the need for prevention approaches that incorporate a range of strategies—from universal approaches that aim to prevent uptake to more targeted interventions.[668] These should be complemented by broader activities that address the needs of disadvantaged and vulnerable communities, families and individuals,[669] as well as targeted family support strategies that are initiated early with the aim of reducing risk factors and enhancing resilience.[670]

Prevention in schools

Available evidence suggests that effective school-based prevention programmes focus on developing students' psychosocial skills and life skills[671] and building school connectedness through social and academic competence.[672] More effective school-based prevention programmes are connected to other initiatives across the school and the broader community, instead of occurring in isolation.[673]

School-based programmes are also more effective in targeting those at greater risk if they include a strong focus on school engagement or re-engagement, along with other risk factors.[674]

The Taskforce heard during consultations about the importance of engaging young people in targeted and relevant ways. For example, one roundtable participant said the focus should be on young people who exhibit risk factors.[675] Several experts also emphasised the importance of age-appropriate drug education.[676] [677] The provision of accurate information is pivotal.[678]

Table 9.1: Summary of interventions and policies that have been found to yield positive results in preventing AOD misuse[679]

Setting	Prenatal and infancy	Early childhood	Middle childhood	Early adolescence	Adolescence	Adulthood
Family	*Selective:* Prenatal and infancy visitation ☆☆					
	Selective: Interventions targeting pregnant women with substance use disorders ☆					
			Universal and Selective: Parenting skills ☆☆☆☆			
School		*Selective:* Early childhood education ☆☆☆☆				
			Universal: Personal and social skills and classroom management ☆☆☆			
			Selective: Policies to keep children in school ☆☆			
				Universal and selective: Prevention education based on personal and social skills and social influences ☆☆☆		
				Universal: School policies and culture ☆☆		
			Indicated: Addressing individual vulnerabilities ☆☆			
Community				*Universal:* Alcohol and tobacco policies ☆☆☆☆☆		
	Universal and selective: Community-based multi-component initiatives ☆☆☆					
				Universal and selective: Media campaigns ☆		
				Selective: Mentoring ☆		
					Universal: Entertainment venues ☆☆	
Workplace					*Universal, selective and indicated:* Workplace prevention ☆☆☆	

Key: ☆=limited efficacy; ☆☆=adequate efficacy; ☆☆☆=good efficacy; ☆☆☆☆=very good efficacy; ☆☆☆☆☆=excellent efficacy

The Taskforce also heard that teachers need to be supported to educate young people. At the Education Roundtable, attendees said that teachers need training and resources to run an effective prevention programme.[680] Further, the Taskforce heard that parents need access to information to help them understand the signs and symptoms of ice use.[681]

There is also some evidence that a 'social norms' approach to school-based prevention efforts may be effective. This approach is based on evidence that young people tend to overestimate how heavily and frequently their peer group engages in illicit drug use, which encourages their own use.[682] Messages that correct misconceptions are intended to reveal the actual, 'healthier' norm and influence people to either reduce their problematic behaviour or be encouraged to engage in protective, healthier behaviour.[683]

States and territories are best placed to ensure school-based drug education activities are robust and delivered according to the needs of each school and community. With the endorsement of the new Australian Curriculum, and as well as activities underway in individual states and territories (for example, the Get Ready programme in Victoria), efforts are already underway to enhance how schools are supporting the development of health, wellbeing and resilience, as well as improving the way that drug education is delivered.

Access to better information and resources will assist schools to appropriately adapt and target their prevention activities, depending on the needs of families and the community. Children and young people require ready access to the information they need to make informed decisions, while families need resources that will give them an accurate understanding of ice and help them respond appropriately.

The Commonwealth can contribute to this process by working with the states and territories to ensure a suite of information and resources is available for teachers, parents and students across various risk and age groups.

This includes making available information and resources that address ice across the following groups:

- Younger children (pre-high school), which includes prevention resources for teachers and parents in high-risk communities where exposure to ice and other illicit drugs is more likely to occur at an earlier age.
- Middle school age children (Year 7 to Year 9), with the aim of reaching this cohort before they are likely to have significant interaction with ice and other illicit drugs.
- Older adolescents, including resources to support teachers and parents responding to those who may already be using.

As described in Chapter 5, a number of resources already exist and may be appropriate for inclusion, which would streamline how such resources are disseminated and made available. The information suite should also link to broader community tools and resources, to assist communities and families in taking appropriate action.

Recommendation 9

Building on existing efforts, the Commonwealth, state and territory governments should work together to ensure that ice and other methamphetamine-specific resources are available to support and inform teachers, parents, families and students. The resources should:

- be endorsed by alcohol and other drug experts and the education sector
- incorporate a range of information and educational materials across risk and age groups
- include specific resources that are relevant for regional and remote and Indigenous communities
- be made readily available online and linked with the existing online school web resources and the online curated toolkit.

Communication activities

Mass media campaigns targeting illicit drug use have been criticised as expensive and lacking a strong evidence-base. Such campaigns are rarely subject to rigorous evaluation to establish whether or not they have been effective in reducing drug use or drug related harm.[684]

However, mass media campaigns that target health promotion have had some demonstrated success in Australia. These include the *Every cigarette is doing you damage* campaign, which began in 1997, as part of the National Tobacco Campaign to reduce smoking, and the *Grim Reaper* campaign, which began in 1987 to increase HIV/AIDS awareness.[685] But while there is a good evidence-base that media campaigns can prevent tobacco use, the findings are somewhat weaker in relation to illicit drug use.[686]

Concerns have been raised that mass media campaigns that focus only on negative messaging can contribute to stigmatisation and marginalisation of users and discourage them from seeking or being offered assistance.[687] [688] There is some evidence that exposure to drug-related behaviour through advertisements is associated with an increase in drug use by young people.[689]

A large-scale prevention campaign in the United States provides an example of how negative, exaggerated graphics may have mixed results. Some reviewers of 'The Montana Meth Project' have raised concerns regarding the lack of supporting evidence for the campaign, and found that such campaigns increase the acceptability of using methamphetamine and decrease the perceived danger of using drugs.

Mass media campaigns do have a place in Australia's efforts to prevent ice other drug misuse as they reach the widest audience. However, these activities need to be evidence-based and embedded as one component of a multifaceted response.[690] This should include more targeted prevention activities, law enforcement efforts (such as increased prevalence of drug-driver testing) and improvements in how the system supports those with problematic use.

The development of mass media campaigns requires close consultation with experts and stakeholders to ensure credibility and minimise the potential for any unintended consequences. Such campaigns are more likely to be effective when they:

- target a clearly defined audience
- have a basis in advanced marketing strategies that effectively target and communicate with the audience
- have credibility with the desired audience and provide a credible message
- include positive messaging that builds hope for recovery, including providing information about support and treatment for methamphetamine.[691] [692] [693]

There is an opportunity for Australia to strengthen its approach to drug prevention campaigns. The next phase of communication activities under the National Drug Campaign should take a multifaceted approach and include activities that target at-risk groups, based on analysis and exploration of the best approaches to raising awareness in a way that will be credible with target populations. The use of negative messaging should be handled carefully.

The Commonwealth's communication activities should engage target populations in new ways. There is some evidence to suggest that peer-to-peer communication strategies can be effective by disseminating prevention messages through people that are perceived to be credible sources of information. Engagement through peers can also enhance access to people who are otherwise difficult to reach.[694]

Social media is another mechanism through which communication can be more effectively targeted to particular audiences. This includes not only young people, but groups such as the lesbian, gay, bisexual, transgender and intersex communities and those in regional and remote areas.

While one-off activities may have some impact, the messaging is likely to be more effective if sustained over a long period of time. This ensures that the messaging not only reaches the target population, but also reaches younger people entering the at-risk demographic.[695]

The Montana Meth Project

The Montana Meth Project is a large-scale prevention programme aimed at reducing ice use through public service campaigns and community outreach. The Project was established in 2005.

The Montana Meth Project is aimed at reaching young people between 12 and 17 years of age. The key messaging of the Project's public service campaigns are that ice:

- is dangerous to try even once
- will make you look different
- will make you act differently to the way you normally act
- affects the lives of other people, as well as the user
- can cause problems in your community.

The Montana Meth Project campaigns communicate these messages predominantly through graphic and disturbing images. The campaign relies primarily on graphic print impressions, radio and television ads, and highway billboards.

In addition to the campaign, the Montana Meth Project organises community events and conducts school and community presentations across state. There is also a Facebook presence at https://www.facebook.com/coloradomethproject.

In October 2006, the Meth Project was cited by the White House as a model prevention programme for the nation. Due to the apparent success of Montana's campaign, seven additional states adopted their own Meth Projects: Arizona, Idaho, Illinois, Wyoming, Colorado, Hawaii and Georgia.

An evaluation by Seibel and Mange found that the Montana Meth Project substantially changed the attitudes and behaviours of the audience (noting that the Seibel Foundation original funded the Montana Meth Project). The evaluation found that:

- ice use among teens fell by 45 per cent
- positive drug tests for ice fell by 72 per cent
- ice-related crime dropped by 62 per cent in Montana by 2007.

However, subsequent studies have questioned the effectiveness of the Meth Projects. A 2008 study published in the journal *Prevention Science* found that the Montana Meth Project had selectively reported its research findings. The study found that exposure to the graphic ads was associated with an increase in the percentage of teenagers who believed that taking meth was socially acceptable and not dangerous.

In 2014, Anderson and Elsea analysed data from the national and state youth risk behaviour surveys for all eight Meth Project states and found no evidence of a relationship between the Meth Projects and ice prevalence (although there was some evidence that the Project may have reduced ice use by white high school students).

As with other prevention activities, there are still gaps in Australia's knowledge about the effectiveness of communication activities in relation to ice use. Robust evaluation of future communication activities is essential to ensure the effectiveness of their impact is assessed.

Recommendation 10

The Commonwealth should develop a comprehensive, evidence-based two-year prevention communication plan, in consultation with expert bodies (including the Australian National Advisory Council on Alcohol and Drugs), that focuses specifically on ice.

The communications activities should include:

- a follow-up national public awareness campaign that is informed by robust evidence and promotes the treatment and support options available for users and their families
- targeted communication activities for at-risk groups to be delivered through different mediums, including social media and (if appropriate) peer-to-peer methods. These activities should capture people living in regional and remote areas, Indigenous communities, young people and lesbian, gay, bisexual, transgender and intersex people.

The communications plan should be comprehensively evaluated after two years, including effectiveness in reaching target audiences and impact on ice use. This should then inform the development of future communication activities relevant to ice.

High-risk workplaces

Some industries are being adversely affected by employees taking illicit drugs, particularly ice. This can not only pose a risk to those within the workplace, but also the general public. As well as addressing employer safety and wellbeing, workplace prevention and intervention efforts can have benefits for the wider community.[696]

There are various factors that influence AOD consumption patterns among workforces. These include high levels of workplace stress, AOD availability and 'normalisation', whereby social networks and sub-cultures influence employees' beliefs. Workplaces that involve employees working long and irregular hours can also develop a culture where stimulants are used to combat fatigue.[697] [698]

During consultations, the use of ice in workplaces was raised as a significant issue. This is supported by evidence that 2.3 per cent of the Australian workforce used some form of meth/amphetamines in the past 12 months and that less frequent (yearly) users of ice tend to be employed (69 per cent).[699]

The impact of ice use on the work environment can include:

- irritability, agitation and mood swings
- difficulty concentrating and reduced performance
- mental health problems, such as paranoia, delusions, feeling despondent or depressed
- lack of concern about otherwise serious matters
- health problems, such as palpitations, infected injection sites or lesions.[700]

Higher methamphetamine prevalence has been identified among certain industries, including wholesale trades, the construction industry, the mining industry and the hospitality industry.[701] [702]

Ice use by fly in/fly out workers was also raised as a concern.[703] [704] This is not only impacting the workplace, but the surrounding communities, with some anecdotal evidence that Indigenous communities are being increasingly exposed to ice in the regions where fly in/fly out workers are travelling.

As with other prevention strategies, there is a lack of concrete evidence regarding the effectiveness of workplace prevention activities, including in response to ice. This lack of evidence is, in part, due to the challenges associated with conducting controlled outcome and effectiveness evaluations in the workplace.[705] This is also due to a lack of programmes targeting the use of ice and other drugs within the work environment.

Despite this lack of concrete evidence, opportunities for workforce prevention activities should not be overlooked.[706] Interventions in workplaces have the potential to be effective because:

- employees spend a substantial amount of their time at work
- employers are likely to support strategies, given the negative impact of drug use on workplace safety, productivity and worker health
- strategies can be incorporated into existing work health and safety frameworks
- prevention and harm reduction messages delivered in the workplace are likely to extend to the wider community.[707]

The workplace remains underused as a prevention and intervention setting. All workplaces that have high instances of AOD use need comprehensive policies that deal with all aspects of the problem and clearly define objectives, roles and responsibilities.[708]

For those workplaces that are being affected by ice specifically, more needs to be done to support preventative action. This involves working with high-risk industries to develop workplace prevention activities that are ice-specific and tailored to the unique needs of the workplace and surrounding community.

Given the lack of a strong evidence-base, this work should start with a pilot programme developed in consultation with industry and AOD experts. This programme should adopt an organisational approach to change, targeting both culture and behaviour within the workforce. The pilot should also include working with the organisations to enhance treatment pathways by linking the workforce with treatment and support service providers.

The programme should build on the evidence base for workplace prevention activities to inform the wider roll-out of future ice-specific programmes. A robust evaluation and assessment methodology is therefore necessary, with the results to be made public and shared across all jurisdictions.

Recommendation 11

The Commonwealth should partner with state and territory governments and industry groups to develop a pilot workplace prevention programme to roll-out across high-risk industries.

This pilot programme should:

- be developed in consultation with alcohol and other drug and industry expertise
- be rolled-out across multiple high-risk industries over an appropriate length of time to monitor outcomes
- incorporate a robust evaluation methodology to inform future workplace prevention activities.

AOD misuse prevention planning

As outlined in Appendix II, the probability of drug use can be assessed based on social determinants that exist before the emergence of drug use behaviour.[709]

Exposure to risk factors earlier in life can have a 'snowball effect,' with subsequent risk factors accumulating as a consequence of earlier issues.[710] Risk factors include: genetic influences, social disadvantage, family breakdown and dysfunction, childhood neglect and abuse, community disadvantage and disorganisation, and poor adolescent adjustment.

Risk factors can be countered by the development of resilience and protective factors, particularly in early childhood. The more protective factors that exist, the greater the likelihood is for someone to have resilience to a range of poor outcomes,[711] including problematic AOD use.

Australia's prevention efforts must work to address the social determinants and risk factors that lead to AOD use. To do this, collaborative partnerships need to be formed across jurisdictions and portfolios, including health, social services and education. This is particularly important for Indigenous communities, for whom social and economic disadvantage is interconnected with historical loss of land and culture, intergenerational trauma, child removals, and high incarceration rates.[712] Prevention activities need to target vulnerable populations across the life-course, including pregnant women, young children and adolescents.

Governments are already taking action to tackle the disadvantage that contributes to, among other things, poor social and health outcomes. However, additional work is required to effectively target vulnerable and high-risk populations. This includes governments adopting a collaborative, consistent approach and working in partnership with vulnerable communities, including Indigenous communities, to overcome social and economic disadvantage.

Under the COAG framework, the Commonwealth, state and territory governments should agree a national approach to AOD misuse prevention planning. This should outline the whole-of-government approach to tackling disadvantage among vulnerable populations and prioritise the roll-out of parenting and early childhood programmes aimed at building resilience.

Recommendation 12

The Commonwealth, state and territory governments should agree to take a whole-of-government approach to prevention, with a focus on vulnerable populations, including Indigenous Australians.

This should include two key elements:

- working in partnership with vulnerable groups and communities to address the risk factors that lead to drug misuse
- working in partnership to enhance the roll-out of parenting and early childhood programmes aimed at developing resilience in young children, particularly in disadvantaged communities.

CHAPTER 10
TAILOR SERVICES AND SUPPORT

There is a growing demand for treatment services to help people stop using ice. Better tailored services are needed to provide effective support to help people quit.

The growing demand for treatment services indicates that a significant number of users want help to stop using ice, or to reduce their use. Helping people to achieve these aims is an important step in efforts to reduce overall demand.

Many people reduce or stop using drugs without the benefit of formal treatment.[713] [714] In fact, recent studies have found that significant proportions of those who either reduced their methamphetamine use or achieved abstinence did so in the absence of treatment or professional support.[715] [716] Others, particularly those with more severe dependence, require long-term support and treatment to assist them to recover.

Many ice users are reluctant to seek treatment, likely due to the stigmatisation experienced by some ice users. Further, some find traditional treatment programmes too rigid, especially if the person seeking treatment is employed or has dependents to care for. Treatment dropout rates are relatively high for ice and other methamphetamine users. For treatment episodes where meth/amphetamines was the principal drug of concern, 25 per cent of treatment episodes (over 7,000) ceased unexpectedly in 2013-14.[717]

While some efforts have been made to improve how services respond to ice (for example, the Stimulant Treatment Program in New South Wales and Uniting Care ReGen in Victoria), the current alcohol and other drug (AOD) treatment system is not configured in a way that is well-suited to ice users. Many services are designed to treat use of other drug types, such as alcohol and heroin, and do not provide the extended support necessary to accommodate the withdrawal and recovery period associated with ice.[718] In addition, there is extra demand on the AOD specialist treatment sector, resulting from increased ice dependence rates.

These factors help explain why many users are not receiving the support they need.[719]

The Taskforce noted during its consultations a common belief that residential rehabilitation is the best way to achieve abstinence from ice. However, for ice and other methamphetamine users, even residential rehabilitation, as a single course of treatment, achieves low rates of sustained abstinence or reductions in use. A lack of extended follow-up is likely to be a factor behind these low success rates.

Further, relapse patterns across all drug types indicate that multiple courses of treatment may be required to succeed.[720] This may also account for the apparent low success rate of specialist AOD treatment.

It is important to ensure the right mix of service options is available to match need across the population—especially in light of the resource constraints currently facing the specialist AOD sector. Services need to be able to adapt their treatment programmes to incorporate interventions that are evidence-based for treating ice and other methamphetamine dependence. This includes moderately-intensive lower-cost interventions, such as cognitive behavioural therapy with contingency management[721] and follow-up support,[722] which can be delivered in both a residential and non-residential setting. Residential rehabilitation for ice and other methamphetamine users should be targeted towards those with more severe dependence and health needs, and those with more significant social disadvantage.

The funding and planning arrangements for the treatment sector also need improvement. Services are often funded in a manner that results in duplication, inefficiencies and a lack of long-term planning. Within an environment of fiscal constraint, services must be configured to maximise positive outcomes and cost-effectiveness. Duplication and inefficiencies simply mean that less people receive help when they need it.

Ice users need to be aware of the other treatment and support options that are available to them. This is particularly important for those seeking early intervention for their drug use, or for those in regional and remote areas where treatment options may be more limited. People need to know that they can talk to their general practitioner (GP) about the best options available to them, which can include interventions through existing allied health and counselling services. Online and telephone counselling should also be available to support both users and families in dealing with ice.

For Indigenous Australians, the Taskforce heard that significant barriers remain in accessing culturally-appropriate treatment services.[723] Access to these services is vital for the achievement of positive outcomes among vulnerable Indigenous communities.

Improving access to support and treatment

Treating ice use and dependence is challenging. The impacts on cognitive functioning can influence a user's capacity to engage and remain in treatment. For example, withdrawal symptoms can result in poor memory and planning ability, as well as anxiety, depression, craving and psychotic symptoms.[724] Ice users also commonly engage in polydrug use (see Chapter 2): this further complicates the treatment process.

Further, there is an average time-lag of around five years between early methamphetamine-related problems and when people seek help.[725] This means most users only seek help once their dependence becomes severe.

The Taskforce has identified the following gaps in Australia's treatment and support system:

- Users and the community are often unaware of the broader options beyond residential rehabilitation. These include cost-effective counselling services, which can also be delivered online or via telephone.
- There is a lack of effective early intervention. GPs and other frontline services could be playing a much greater role, which would help to address the extent of unmet demand for ice-related treatment and support in Australia.

- Most services are not well suited to those seeking help for ice-related problems. Services need to be able to adapt to changing drug trends effectively and provide evidence-based treatment for all drug types. The most intensive services should be reserved for those with the greatest need.
- Specialist treatment services are unable to keep up with demand and people seeking help are falling through the cracks.
- There is a lack of national planning across the treatment sector. This means that services are not necessarily being delivered in the most efficient manner or being directed to areas of highest need.
- There is a lack of collaboration between the AOD and mental health sectors. At times, clients with co-existing AOD and mental health issues are not accepted into either service due to the complexity of their issues.
- Indigenous Australians need to have access to services that are culturally appropriate and linked in with broader Indigenous health services.
- Corrections-based treatment programmes require some improvement to appropriately meet the needs of ice and other methamphetamine users.

Opportunities to address these gaps are outlined below.

Motivations and stages of change

There are a range of reasons why people who use drugs contemplate change and subsequently seek support and treatment, including environmental, physical and attitudinal factors.

Numerous studies have demonstrated that many people can modify drug taking behaviours without the benefit of formal treatment. This is sometimes described as 'natural remission' or 'spontaneous remission'. Factors that tend to support change include employment, positive social relationships, and physical and mental health.[726]

People can be driven to seek help because of social dysfunction, social pressure, inability to solve their own problems, job-related pressure, and religious/legal inducements.[727]

In order to provide effective support to an individual user, it is important to understand their willingness to change. The 'stages of change' model best describes the change process for both 'self-changers' and those that seek support or intervention.[728] The chronic, relapsing nature of drug dependence is characterised by cycles of treatment, recovery, relapse, and repeated treatments.[729] Many require various attempts to change their behaviour before they achieve their objectives.

The stages of change are:

- Pre-contemplation: Most individuals are unaware of their problems.[730] However, families, friends, neighbours, or employers are often well aware that there are problems.[731]
- Contemplation: Individuals are able to consider the possibility of quitting or reducing AOD use but feel ambivalent about taking the next step. They think that, on the one hand, use is enjoyable and exciting. On the other hand, they are starting to experience some adverse consequences (which may include personal, psychological, physical, legal, social or family problems).[732]
- Preparation: Individuals believe that change is necessary and that the time for change is imminent.[733]
- Action: Individuals are actively involved in taking steps to change their using behaviour and making great steps towards significant change. Ambivalence is still likely at this stage. Individuals may try several different techniques and are also at greatest risk of relapse.[734]
- Maintenance: Individuals are able to successfully avoid any temptations to return to using. They have learned to anticipate and handle temptations and are able to employ new ways of coping.[735]

Challenges with treating ice

Ice affects people in ways that are different from other drugs. It is associated with violent and aggressive behaviour,[736] [737] as well as psychosis, mood and anxiety disorders and cognitive deficits.[738] This has major implications for treatment, particularly with regard to the skills needed to respond effectively.

Another issue unique to ice is the time it takes to recover. Withdrawal and recovery from methamphetamine dependence is more protracted (up to 18 months) than from other drugs (such as alcohol and opioids).[739] Longer support periods are needed before significant improvement is achieved.[740] The withdrawal effects are also different, with users generally experiencing a 'crash period' of between one to three days, with an 'acute withdrawal' period occurring for around four to 10 days. Many services require clients to engage in activities during the initial days of withdrawal, which is not suited to those experiencing 'crash' symptoms.

The Taskforce heard from experts, individuals and frontline workers that there are many other factors that make the treatment of ice and other forms of methamphetamine complex.[741]

Retention (an individual remaining in treatment for a recommended period of time) is a key challenge because of the protracted withdrawal and recovery period.[742] Cognitive impairment, such as poor self-control, selective attention and slowed processing speed, is associated with methamphetamine dependence and is also likely to result in poorer treatment retention.[743] [744] Performance in psycho-educational programmes can particularly be affected by cognitive impairment.[745] Relapse is common for methamphetamine users and is as high as 80 to 90 per cent.

Other factors that complicate treatment include risky behaviours, which often require the need for additional support, increased mental health issues, and erratic and aggressive behaviour. Emergency presentations for ice-induced psychosis are particularly challenging to manage as these patients often present with violent and unpredictable behaviour.

Expanding treatment and support options for users and families

With the specialist AOD treatment sector under increasing pressure, it is vitally important that users have a range of available treatment and support options. Given the high cost of residential rehabilitation, alternative, cost-effective models of care must be available.

This includes ensuring that options are accessible to people from all walks of life, encompassing those living in regional and remote areas and those with employment commitments. Having a range of options available is particularly important for those in the early stages of problematic use and those who are less likely to seek out more 'conventional' treatment and support options.

Online interventions are showing promise by increasing engagement with early intervention and treatment, particularly for those who experience barriers or are less likely to seek help. Online interventions have been found to be effective for problematic alcohol use and smoking,[746] and there is emerging evidence that such interventions may be successful in targeting cannabis users and preventing the uptake of cannabis by young people.[747]

For ice and other methamphetamine users, there is evidence that online interventions are successful in engaging clients who are less likely to seek help through more 'conventional' treatment services. This includes young people, those with employment commitments and females.[748]

Given the recent rise in ice use, available online interventions should be enhanced to include modules that appropriately target ice and other methamphetamine users. This is consistent

with expert advice received by the Taskforce recommending the expansion of online interventions to maximise opportunities for user engagement with early intervention and treatment services.[749] [750] [751] Increasing access to new and accessible support options is particularly important given the increasing prevalence of ice use across Australia, increased rates of dependence and rising demand for traditional treatment services.

Recommendation 13

The Commonwealth Government should improve access to online interventions by funding the development and delivery of ice-specific counselling and self-help online options, and by commissioning an evaluation of uptake and outcomes resulting from these initiatives to help build the evidence base around these forms of support.

Telephone counselling is also proving to be a vital engagement mechanism, with evidence that an increasing number of people are using these services for ice-related matters. Most jurisdictions operate their hotlines on a 24-hour basis; however, waiting times can vary and some jurisdictions operate call back services to keep up with demand.

It is important that these hotlines have the capacity to effectively engage clients. Users contact these lines when they are ready for immediate help and may be in crisis. It is therefore important that hotlines provide 24-hour access to a service that is responsive to individual needs and complexities, particularly where problematic ice use is concerned.

Despite the availability of these services, the Taskforce heard repeatedly from the community and families that they did not know where to go for help and information about ice. The need for a clear source of information about how to help a family member affected by ice was a strong theme in the feedback received.

It is therefore important to ensure that users, families and communities are aware of what hotline number to call to receive support, especially given the different hotlines that operate across jurisdictions. This is an area where the Commonwealth, states and territories can work together to develop a national model to provide users and families with a single point of contact that has the capacity and expertise to respond effectively to ice.

Recommendation 14

The Commonwealth, state and territory governments should work together to ensure users and families affected by ice have ready access to a single, national hotline where they can receive information, counselling and other support services.

This hotline must be resourced with the appropriate expertise to respond effectively to ice across a broad range of issues—this includes ensuring support is available for families when they need it.

Improving early intervention responses across health and community services

Early intervention has the potential to connect users with the help they need before their dependence becomes a major concern. Evidence demonstrates that screening and brief interventions for AOD misuse issues are effective—particularly within a primary care setting.[752]

Brief interventions can consist of a single, time-limited session of information and advice that aims to motivate patients to change their behaviour or can continue for several counselling sessions. Evidence suggests that two to four counselling sessions can be effective in increasing abstinence among some methamphetamine users.[753]

These interventions should be delivered across primary care services, emergency departments, ambulances and the community sector, identifying problems and engaging users at a time when they are more likely to be responsive.

For example, an emergency department nurse treating a patient presenting with ice-related

harm has the opportunity to perform a brief intervention to link the patient with ongoing help and support. Likewise, a GP may screen a patient who is presenting with symptoms consistent with ice use and perform a brief intervention to help raise the patient's awareness about the impacts and severity of their use.

The involvement of GPs and other primary care workers in screening, detection and management of AOD misuse issues is pivotal. GPs are often the first point of contact for ice users seeking medical help, even though this initial contact may be in relation to issues other than the use of ice itself, such as mental health issues, sleep problems, nutritional deficiency or relationship breakdowns.[754] The ability of GPs to screen patients for potential problems and deliver appropriate interventions, or provide connections with community support services, has great potential to reduce harms not only to the individual, but also the family and broader community.[755]

GPs are also ideally placed to assist users with less severe problems, allowing specialist services to better target those with more severe and complex AOD dependence.[756] Research has found that increased interaction with primary care reduces the use of acute care services among those with problematic substance use issues.[757] [758]

However, opportunities for early intervention are being missed. For example, GPs are often reluctant to ask about drug use as it may adversely impact the doctor–patient relationship. Others may choose not to ask as they do not believe that they can effectively intervene.[759] As outlined in Chapter 8, GPs need access to better training on how to respond effectively to patients who are presenting with symptoms associated with ice use. It is important that this be complemented with immediate efforts to upskill GPs in the delivery of AOD screening and brief interventions, particularly for those working in regional and remote areas.

There is more scope to ensure the broader health and community workforce is better equipped to engage users in a timely and appropriate fashion and link them with other treatment and support services. It is particularly important that hospitals employ the necessary skills, particularly in high-risk areas. This includes regional and remote communities where hospitals and emergency departments are often key to providing early intervention due to a lack of immediate access to other services.

While some hospitals do incorporate specialist AOD expertise (for example, the Hospital Drug and Alcohol Consultation Liaison services in New South Wales), the Taskforce has heard that further work is necessary to ensure that emergency departments across the country are equipped to perform necessary screening and interventions for ice, as well as link people with appropriate services.

Training and support for the workforce is essential to enhance worker skills and ensure more effective delivery of early intervention responses. The workforce ultimately needs support to develop the skills and capabilities necessary to incorporate these vital early intervention responses into regular practice.

A workforce training programme should be rolled-out for a range of professional roles. The roll-out should be developed jointly with states and territories to target areas of need and ensure it accurately reflects the differences in jurisdictions and existing training already available.

Recommendation 15

The Commonwealth, state and territory governments should work with sector experts to roll out a national training programme to improve delivery of alcohol and other drug screening and brief interventions for:

- primary care workers, including general practitioners
- emergency department nurses and physicians and paramedics
- community workers.

The roll out of this programme should occur in consultation with professional bodies and the Australian National Advisory Council on Alcohol and Drugs.

Improving treatment pathways through primary care

Primary care can provide a pathway for users with more problematic issues to access more intensive interventions, including counselling and specialist treatment. This would ideally involve ongoing care and management of the patient within the primary care setting, with the GP or nurse practitioner providing a referral pathway to a trained psychologist, psychiatrist or addiction medicine specialist for treatment.

This has significant potential to reduce the burden on the specialist treatment sector—especially given that counselling was overwhelmingly the most common treatment type provided to all specialist treatment clients in 2013-14.[760] [761] For ice users specifically, psychosocial counselling interventions, such as cognitive behavioural therapy, are known to be effective when tailored to meet clients' needs.[762] Such interventions could be appropriately provided by trained professionals outside the specialist AOD treatment sector.

Appropriate treatment pathways already exist through which people with AOD misuse issues can receive counselling and treatment outside the treatment sector. The Better Access Initiative is an example, with both alcohol and substance misuse disorders included in the eligibility criteria for referral into the programme. With appropriate training and skill, this programme is likely to have particular benefit for ice and other methamphetamine users, especially given the higher levels of mental health comorbidities among users.

There is an ideal opportunity to review and enhance the Better Access Initiative to ensure all aspects of the programme are appropriate for those individuals with a diagnosed drug misuse disorder. This includes ensuring that care plans, monitoring and referral to allied health and counselling services meet the needs of this cohort. In particular, it is important to ensure the workforce is appropriately trained and skilled in AOD treatment (including methamphetamine treatment specifically) to deliver interventions effectively.

Recommendation 16

The Commonwealth Government should review and enhance the Better Access Initiative to ensure that individuals with a diagnosed alcohol and other drug misuse disorder have greater access to appropriate treatment and care through their general practitioner.

This should include improving referral pathways for alcohol and other drug-specific psychosocial intervention, and enhancing associated training through the General Practice Mental Health Standards Collaboration.

Improving the treatment sector response to ice

The Taskforce heard from specialist AOD treatment services that it is difficult keeping up with the demand of an increasing number of ice users seeking treatment. The Taskforce received consistent messages from experts, treatment services and users that waiting lists can be as long as several months, with some services closing their books to new clients.[763] [764] [765] [766]

Experts have stated that:

> *"We need to make sure treatment is available when people seek it—there is only a small window when people want treatment and if a spot is not available immediately we may miss that window.*[767]

> *"The core essential is that people can access services when they need it, we don't have that at the moment—how can we cater services so that they can still help when people turn up?*[768]

The Taskforce has also heard that many services do not have the skill-set to provide the type of structured psychological therapies that are more effective with ice users. This treatment type is often only available on an ad hoc basis, depending on the workforce available to the service.[769] Further, many

specialist treatment services—including residential services—are largely tailored for treatment of more traditional drug types, such as alcohol and heroin.[770] The evidence also demonstrates that detoxification, in isolation of other forms of treatment, is not effective in treating methamphetamine dependence.[771] These factors help explain why many treatment services are struggling to respond to ice.

The community is widely of the belief that residential rehabilitation is the only way to treat ice. The Taskforce does not consider this to be an accurate or helpful characterisation of the treatment options available. For example, these services may not be suitable for those with dependents or those that have to travel extensively to reach the service, which is particularly pertinent for Indigenous Australians.

Residential rehabilitation has an important role to play in the treatment of ice. However, for any given budget, fewer residential rehabilitation places can be funded in comparison to less intensive forms of treatment. The challenge for policy makers is to fund a mix of services that balances the availability of treatment with effectiveness and population need. In terms of effectiveness, residential rehabilitation on its own does not deliver particularly high rates of long-term abstinence or reductions in use, despite short-term positive results.[772]

The Methamphetamine Treatment Evaluation Study—the most rigorous evaluation of treatment outcomes for methamphetamine dependence in Australia—compared abstinence rates for people who had undertaken residential rehabilitation for methamphetamine dependence (248 participants) compared with a combined control group that received no treatment (101 participants) or received detoxification only (112 participants). It found that:

- three months after treatment, nearly half (47 per cent) of the treatment group were no longer abstinent compared with 82 per cent of the control group
- a year after treatment commenced, 80 per cent of people who had been through residential rehabilitation were no longer abstinent, compared with 93 per cent of the control group[773]
- by year three, 88 per cent of people who had been through residential rehabilitation were no longer abstinent compared with 93 per cent of the control group.[774]

It is noted that the absence of long-term follow-up support is likely to be a contributing factor to these findings, with research overwhelmingly pointing to the need for follow-up care if positive outcomes are to be realised in the longer term.[775] [776] Specialist treatment programmes are often provided for a maximum of 12 months, which does not account for the extended withdrawal and recovery period associated with ice.

There is a cohort of ice users with more severe issues that may benefit more from residential treatment, combined with mutual aid and follow-up support. This includes those users who are more likely to have a broad range of ongoing health and wellbeing problems, such as homelessness and chronic medical issues.[777]

For example, a study published in 2014 found that residential rehabilitation had higher rates of success for its participants who had chronic health and wellbeing issues and the majority of whom had a history of multiple engagement with specialist AOD treatment.[778] At the one-year follow-up mark, 61 per cent of those that nominated methamphetamine as their primary drug of concern reported abstinence in the past month, while 26 per cent reported abstinence throughout the previous year. However, it is noted that those participants that reported methamphetamine as their primary drug of concern had a significantly higher dropout rate from the study (41 per cent, compared to 27 per cent for alcohol, cannabis and opioids respectively).[779]

Uniting Care ReGen 'Step-Up Step-Down' model

In 2013 Uniting Care ReGen made a series of changes to its treatment services to provide a new 'Step-up, Step down' withdrawal model for methamphetamine users. The model provides a stepped care approach that includes a period of non-residential nursing support for clients prior to residential withdrawal admission. The non-residential period consists of home-based outreach withdrawal support, including:

- education and harm reduction strategies and self-care
- motivational interviewing and counselling support
- advice on expectations of the withdrawal experience and the residential service
- liaising with GPs and linking consumers with support services
- support for families of consumers during home-based withdrawal.

The programme provides admission into residential withdrawal for up to 10 days. This is followed by a step-down of around four weeks consisting of support from the same non-residential withdrawal nurse. The step-down period includes continued withdrawal information, counselling and case management support, including facilitating links with other services.[780]

New South Wales: Mental Health & Substance Use Co-Location Program

The ORS Group operates a Co-Location Program within the Newcastle Mental Health Service and Lake Macquarie Mental Health Service within the Hunter region. The programme operates under the Individual Placement and Support (IPS) model, originating from Dartmouth University, USA.[781]

There are eight core principles of IPS which apply to the Co-Location Program:

- Focus on competitive employment: IPS consultants are committed to finding competitive employment for clients within the community, rather than non-competitive jobs.
- Eligibility based on client choice: Clients are not excluded on the basis of readiness, diagnosis, symptoms, or substance use history. The only requirement is a desire and motivation to work.
- Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams. IPS consultants regularly participate in case conferences to review client progress.
- Attention to client preferences: Services are based on client choices, strengths and experiences, rather than the service or consultant's judgement.
- Personalised benefits counselling: Consultants assist clients in obtaining personalised, understandable and accurate information regarding their circumstances, including Centrelink and the potential impact of employment.
- Rapid job search: IPS programs use a rapid job search approach to help clients obtain jobs directly and quickly, rather than through lengthy pre-employment processes.
- Systematic job development: Consultants build an employer network based on clients' interests, and develop relationships with local employers through systematic contacts.
- Time-unlimited and individualised support: Follow-up support is individualised and continued for as long as the client wants and needs the support.

The IPS model is an evidence-based practice that focuses on each person's strengths. Services are individualised and long lasting, helping to promote recovery and wellness through work.

To respond to changing needs and drug trends, we need to ensure that a range of service types are available. This includes having the right mix of residential and non-residential services that cater for the needs of the populations they serve. Services also need to adopt more evidence-based and flexible treatment approaches to respond to ice.[782] [783] This includes incorporating psychological interventions, such as cognitive behavioural therapy and contingency management,[784] and providing care and support over longer periods to accommodate the withdrawal and recovery period for methamphetamine dependence.

Users with more severe dependence may need a treatment goal of reduced use or less risky patterns of use, rather than complete abstinence.

The Taskforce has also received advice that treatment and support services should consider improving withdrawal protocols and reconsidering entry criteria to better respond to ice and other methamphetamine users who have made the important first step into withdrawal treatment.[785]

Some efforts have already been made to better tailor services for ice and other methamphetamine users. For example, the Stimulant Treatment Program in New South Wales and Uniting Care ReGen have incorporated models of care that are more suited to methamphetamine withdrawal and recovery. However, more needs to be done to ensure that a majority of services are equipped to address a range of treatment needs, depending on what is appropriate for the client.

Stimulant Treatment Program

The Stimulant Treatment Program (STP) was established in New South Wales in 2006 to provide a specialised treatment option for stimulant users, including methamphetamine users. The service is delivered through two clinics: in Darlinghurst (St Vincent's Hospital) and in Newcastle (Hunter New England). The STP is funded by the New South Wales Ministry of Health.

The STP clinical model is based on a harm minimisation philosophy and involves a stepped-care approach that modifies the intensity and nature of the clinical intervention according to the severity of the problem and goals of the client. Paramount to the stepped-care approach is that treatments are individualised, evidence-based and the least-restrictive option. The treatment approach of the service incorporates a range of interventions, including comprehensive assessment, brief intervention, counselling (group and individual), and pharmacotherapy.

In 2012, an evaluation of the STP was conducted and the findings demonstrated that methamphetamine users entering the program showed significant reductions in stimulant use and related harm at both three and six month follow-up. Overall, the evaluation findings found that the model of care was successful in lowering amphetamine-type stimulant dependence and improving the health and social functioning of users. This included substantial decreases in psychotic symptoms, hostility, crime, injecting drug use and disability due to mental health.

The STP also provides dexamphetamine maintenance for patients who do not respond to pharmacological treatment alone. Approximately 44 patients have been treated with dexamphetamine maintenance since the clinics commenced operation, with two-thirds demonstrating significant reductions in drug use or cessation of methamphetamine use.

New South Wales recently announced $7 million to expand these clinics to the Illawarra Shoalhaven, Mid North Coast/Northern New South Wales and Western Sydney Local Health Districts.[786]

New models of care are emerging—such as the stepped care model. This model allows for flexibility in interventions and matches the treatment to clients' needs, while also accommodating differences between clients' severity of use and readiness to change.[787] Greater adoption of such models would improve the efficiency of treatment sector responses, creating greater capacity among services and improving access.[788]

Further, users who are employed and have social support are more likely to successfully recover from using methamphetamine. This suggests programmes that holistically address social and vocational needs are likely to have a beneficial impact on outcomes.[789] A range of external supports may also be required to ensure stable accommodation and to connect people with education and employment opportunities.[790] Services within the treatment sector should be incorporating linkages with these supports. Where appropriate, services should also be maintaining healthy connections to family and community, to strengthen the long-term support network.

While changes are necessary to ensure treatment services are more responsive to ice, these services still need to cater to more traditional drug types. This is especially the case for alcohol dependence, which remains a major cause of harm within Australia. What is needed is greater adaptability to respond to emerging and changing needs. While formal accreditation standards currently exist, there are also clear gaps in the provision of evidence-based practice and assessment of outcomes.

A national mechanism is needed to ensure capacity building and continuous quality improvement. This will help services build their capacity to respond to ice more effectively and ensure that the specialist sector is best-placed to respond effectively to emerging issues and trends. This mechanism should set the standards for the delivery of evidence-based services for the population, workforce development and monitoring of outcomes. This should also include minimum qualification standards for the specialist treatment sector.

A national framework should set standards for engaging in collaborative partnerships with other health and support services. This will support the delivery of client-focused services, maximising the opportunity for positive outcomes.

Recommendation 17

The Commonwealth, state and territory governments should work with the specialist treatment sector to design and implement a national quality framework that sets the standards for:

- the delivery of evidence-based services for the population, with clear expectations of the quality standards for each service type
- workforce capabilities, which must be matched to the service-type and population need
- cross-agency partnerships and collaboration
- monitoring and evaluation of outcomes and effectiveness to inform continuous quality improvement.

The Taskforce has heard from a range of experts and stakeholders about the strain on the AOD specialist treatment sector. This strain is evidenced by the significant increase in demand for AOD specialist treatment services for methamphetamine-related problems (see Chapter 6).

While recognising that unmet demand is a longstanding issue, the Taskforce supports further investment to strengthen the capacity of services to respond more effectively and ensure that more people are getting the help and support they need, when they need it.

However, directing this investment toward more costly and less-effective models of treatment is unlikely to have a significant impact on sector capacity. Any further investment to address current demand must consider the evidence regarding what treatment models are more likely to work and be cost-effective. This must also be targeted toward areas of need.

As previously mentioned, the Taskforce recognises that, in addition to ice, the problematic consumption of AODs (both illicit and prescription) continue to cause harm to many Australians. The distribution of any additional investment should be determined by those with an understanding of local population needs. In the interest of safety and wellbeing, services should continue to prioritise clients on the basis of need, regardless of their principal drug of concern.

Further investment in the AOD specialist treatment sector must also be delivered in a way that supports improved system planning (see Recommendation 19).

Recommendation 18

The Commonwealth, state and territory governments should further invest in alcohol and other drug specialist treatment services. This investment must:

- target areas of need—this includes consideration of regional and remote areas and Indigenous communities
- be directed toward evidence-based treatment options and models of care for every stage of a patient journey
- involve consultation across the Commonwealth, states and territories and the alcohol and other drug sector
- be subject to a robust cost-benefit evaluation process
- ensure service linkages with social, educational and vocational long-term supports.

Improving system planning

The Taskforce heard that there is a lack of clarity around the respective roles and responsibilities of the Commonwealth, state and territory governments, and that multiple funding streams often create inefficiencies and duplication.

While many services welcome multiple funding streams, the Taskforce heard that a lack of planning and duplicative administration processes has increased the burden on services.[791] [792] This is likely to be having an impact on their capacity to keep up with demand.

Funding arrangements also create difficulties in ascertaining a national picture of current services and identifying existing gaps. A lack of national planning impedes the development of targeted responses in areas of greatest need and hampers the Commonwealth's ability to provide high-level, strategic leadership.[793]

There were some reports that the AOD specialist treatment sector is currently funded according to historical decisions, rather than based on need, effectiveness and efficiency. Duplicative and inefficient planning means that services are not necessarily configured to meet client needs. As previously discussed, the sector should be supported to ensure services are configured to meet the emerging needs of clients, including the increasing number of ice users seeking treatment, and are able to adapt to cycles of drug use.

Some jurisdictions have adopted the Drug and Alcohol Service Planning Model for Australia, which was commissioned in 2010 to be developed as a national tool for transparent, consistent, needs-based planning. However, this tool has never been endorsed nationally and has therefore not been implemented consistently across all jurisdictions.

The Commonwealth, states and territories need to take a 'systems approach' to improve planning. Most importantly, and consistent with the findings from a recent review of AOD treatment services in Australia, Commonwealth, states and territories need to agree on roles and responsibilities into the future.[794] This should include considering whether the states and territories should assume full responsibility over treatment sector funding and planning, as they are best-placed to facilitate locally-relevant, needs-based planning. However, care must be taken to ensure that funding levels to the AOD specialist treatment sector are not adversely impacted.

Planning should take into consideration gaps in available service types and map the range of services required to best meet the needs of the population.

Recommendation 19

Commonwealth, state and territory governments should improve planning of alcohol and other drug specialist treatment to ensure the right mix of resources and services are provided to the areas of highest need.

This must determine the national distribution of funding and planning responsibilities, and ensure the implementation of a robust accountability and contestability framework that evaluates government investment against outcomes. Primary Health Networks could be a key focus for determining locally appropriate solutions that meet the needs of their populations and through which Commonwealth funded services can be directed.

Commissioning periods (funding cycles) need to be considered. The Taskforce heard that the current short-term funding cycles are not conducive to longer-term service planning and workforce retention.

Further, the Taskforce has heard that short-term funding cycles inhibit services from committing to the longer term treatment programmes that would benefit many ice users. These factors significantly affect the quality of services provided to the community.[795]

Services have reported that, during re-commissioning phases, they are treated by governments as 'fiscal enemies' in the lead up to tendering and contract renewal. This is in contrast to 'collaborative commissioning', in which the funder partners with service providers in a collaborative, learning relationship.[796]

These views are consistent with advice to the recent Parliamentary inquiry into the harmful use of alcohol in Indigenous communities:

> *"Short-term funding can undermine community commitment, weaken consistent implementation of quality treatment, and destabilise services through loss of experienced staff and continual diversion of resources into cycles of recruitment and training. Seven year funding blocks should be the standard requirement for effective implementation.*[797]

Longer funding cycles will support services to increase capacity to adapt and respond to changing drug trends. It will also improve the ability of services to evaluate outcomes at both the programme and project level, in order to contribute to the evidence base for effective AOD treatment models.

Recommendation 20

Commonwealth, state and territory governments should improve existing commissioning and accountability processes for alcohol and other drug treatment by supporting longer funding periods to strengthen service planning and workforce development, and increasing the focus on evaluation to improve treatment outcomes.

Improving collaboration across the mental health and AOD treatment sectors

Through its consultations, the Taskforce heard that integration between the AOD treatment and mental health sector is generally fractured, with clients often 'bouncing' between services.[798]

Many clients entering AOD treatment have co-existing mental health issues, such as depression and anxiety. Given the challenges of treating co-existing mental health and drug misuse, it is important to ensure collaboration among drug specialist and mental health services at the local level.

Jurisdictions have taken action to adopt a 'no wrong door' approach to improve treatment access for those with co-existing mental health and substance misuse issues. This includes

more training and development for the AOD treatment sector, as well as the enhancement of models of care and clinical practice within government and non-government AOD specialist services.

Despite these efforts, the Taskforce has heard that further work is required to better support integration and appropriate treatment pathways. AOD services are not always equipped to provide adequate support to manage co-morbid mental disorders or provide appropriate referral and linkages. Likewise, mental health services do not always incorporate or link with AOD expertise to manage patients with problematic substance misuse issues.

The Taskforce heard that, due to organisational philosophy, many residential treatment facilities do not allow any medications, including medications for severe mental illnesses, such as depression, bipolar and schizophrenia.[799] In many cases, this exacerbates the client's mental health issues, reducing their chances of successful recovery.

Users that present to services with methamphetamine induced psychosis often fall through the cracks. At times, these clients are not accepted into either AOD or mental health services due to the complexity of their issues. There has been a rise in the number of people admitted to hospital for psychosis due to stimulant drugs like methamphetamine,[800] with this lack of coordination a likely contributing factor.

Treatment responses for individuals with co-existing mental health and drug misuse need to be coordinated. The previous Amphetamine-Type Stimulant Strategy acknowledged this in recommending that partnerships be improved between the AOD treatment and mental health sectors.[801] It is also important to ensure a 'no wrong door' approach is fully implemented across both the AOD and mental health sectors, with client-focused, collaborative models of care strongly supported.

The Taskforce recommends that the Commonwealth, state and territory governments work together to develop a national approach to enhance AOD and mental health service collaboration. This should also be reflected in the development of the Fifth National Mental Health Plan.

Recommendation 21

The Commonwealth, state and territory governments should work in partnership to develop a national approach to strengthening the collaboration and intersection between the mental health and alcohol and other drug treatment sectors. This should also be reflected in the development of the Fifth National Mental Health Plan.

Improving the Indigenous-specific treatment sector

The Taskforce heard that there are currently significant barriers to treatment for Indigenous Australians in relation to the availability of services, the cultural appropriateness of services, the range of treatment options and the costs of services.[802] The Taskforce also heard that many services are struggling to respond to the emergence of ice within local communities.

Access to AOD treatment services by Indigenous Australians is often affected by:

- geography (for example, physical distance to health services, availability of transport and quality of roads)
- the cultural competency of services
- affordability (for example, the cost of services, pharmaceuticals, and travel)
- availability of services and health professionals
- cultural beliefs and attitudes concerning AOD misuse, such as shame associated with seeking treatment, concern about getting into trouble with the law and fear of losing their children.[803]

There is no 'one size fits all' approach to dealing with AOD issues; and flexibility is particularly important within the Indigenous context.[804] Access to culturally appropriate treatment is also important to maximise positive outcomes. This includes ensuring services adopt an approach that includes:

> *"…an understanding of historical factors including traditional life, the impact of colonisation and its ongoing effects. Support for traditional ways of learning, providing teachings on how to attain and maintain connection with creation, and use of elders and returning to country.*[805]

Treatment and support services for Indigenous communities are administered by a range of government, non-government and community-controlled health services. Linking services is important to ensure a holistic approach that takes into account the varying and often complex health and broader needs of Indigenous people and communities. Many Aboriginal community controlled health organisations have called for AOD treatment services to incorporate holistic, culturally sensitive practices to address the broader wellbeing of Indigenous participants.[806] Sharing knowledge and expertise about evidence-based practices is also important, with information suggesting that this is not occurring as often as it should be.[807]

As with the specialist treatment sector generally, previous reviews suggest that fragmented planning and a lack of coordination has impacted the efficient and effective delivery of Indigenous services. For example, a 2010 review of Indigenous-specific AOD treatment intervention projects found that:

- there were considerable gaps in terms of the range of services available at the regional level
- there was no relationship between the range of services provided at the regional level and the size of regional populations
- the amount of funding allocated for AOD treatment services at the regional level was not related to the size of regional populations
- the distribution of services provided evidence of limited planning of service delivery.[808]

The Commonwealth Government's Indigenous Advancement Strategy has recently been implemented, under which the Safety and Wellbeing Programme funds activity to improve drug, alcohol and substance misuse prevention and treatment for Indigenous Australians. The Indigenous Advancement Strategy Guidelines include provisions designed to improve efficiency and coordination of Indigenous services.

The new National Aboriginal and Torres Strait Islander Peoples' Drug Strategy has also been recently endorsed by all jurisdictions and provides guidance to governments, communities, service providers and individuals to identify key issues and priority areas for action relating to the harmful use of AOD. This new strategy sets four priority areas:

- build capacity and capability of the AOD service system, particularly Indigenous-controlled services and its workforce, as part of a cross-sectoral approach with the mainstream services to address harmful AOD use
- increase access to a full range of culturally responsive and appropriate programs, including prevention and interventions aimed at the local needs of individuals, families and communities to address harmful AOD use
- strengthen partnerships based on respect both within and between Indigenous peoples, government and mainstream service providers, including in law enforcement and health organisations, at all levels of planning, delivery and evaluation
- establish meaningful performance measures with effective data systems that support community-led monitoring and evaluation.[809]

Despite these efforts, Indigenous stakeholders continue to raise concerns that many Indigenous communities still do not have ready access to the services they need, and that there is often a misalignment between service priorities and what the community identifies as

their priorities. In particular, stakeholders reported that access to culturally appropriate services remains a key gap.[810]

Stakeholders also told the Taskforce that they were concerned that community-control in delivering some services is being reduced through the contracting of service provision to non-Indigenous organisations. Indigenous stakeholders believe that greater local participation is necessary.[811]

Governments need to work together to ensure better access to culturally appropriate services for the Indigenous population. This includes considering planning models that support local participation, organisational and community development and ensuring that resources are allocated on the basis of need.

Recommendation 22

The Commonwealth, state and territory governments, in close consultation with Aboriginal Community Controlled Organisations and communities, should take steps to improve access to integrated, evidence-based, culturally appropriate services for Indigenous Australians.

This should be aimed at:

- ensuring services are targeted toward areas of need
- maximising efficiency
- supporting organisational and community development and capacity building
- ensuring good governance and Indigenous participation
- maximising linkages with broader health and support services.

Treatment in correctional facilities and criminal detention centres

The link between drug use and crime is well established, with a high correlation between excessive illicit drug use and criminal activity and reoffending. Up to 70 per cent of correctional facility entrants have reported use of illicit drugs in the preceding 12 months, and many of these people enter a correctional facility without their problematic drug use being addressed.[812]

For many methamphetamine users, incarceration facilitates their first contact with treatment services. Forty eight per cent of methamphetamine users from the Victorian public correctional facilities study had not previously accessed treatment.[813]

A 2007 review of users of drug treatment in correctional facilities found that access to appropriate treatment options for psychostimulant and other non-opioid drugs was poor, both in the community and in correctional facilities.[814] The Taskforce heard that corrections-based treatment programmes require some improvement to appropriately meet the needs of ice and other methamphetamine users. For example, a submission to the Parliamentary Joint Committee on Law Enforcement stated that some inmates with problematic methamphetamine use had been offered or placed on opioid replacement therapy,[815] which is not an appropriate mode of treatment for methamphetamine users.

Inmates released into the community after having served their sentence often face many problems associated with readjusting. This is particularly the case if the offender has a history of drug dependence. Drug treatment programmes for inmates have been demonstrated to reduce rates of reoffending, have a positive impact on the rehabilitation of inmates, and improve inmates' health outcomes.

New Zealand provides an international example of efforts to improve treatment in correctional facilities specific to ice and other

methamphetamine use. New Zealand's *Tackling Methamphetamine: an Action Plan* includes a focus on improving the drug treatment and rehabilitation available to inmates, which aims to reduce their re-imprisonment rate. Successive progress reports on the New Zealand strategy have shown that Drug Treatment Units have been successful at reducing re-imprisonment rates by up to 20 per cent.[816]

The design of corrections-based treatment programmes should be more consistent with best-practice approaches. Given the higher rates of methamphetamine use among inmates, it is vital that correctional facilities are equipped to deliver and provide access to appropriate treatment. States and territories have a key role in ensuring that evidence-based treatment programmes are available to the corrections-based population, reducing the risk of relapse and reoffending by inmates when returning to the community.

The Taskforce recommends that Australian jurisdictions increase the focus on evidence-based approaches to treatment in correctional facilities and youth justice centres.

Recommendation 23

Under the National Drug Strategy framework, state and territory governments should increase the focus on evidence-based approaches to treatment in correctional facilities and youth justice centres.

CHAPTER 11
STRENGTHEN LAW ENFORCEMENT

The unique nature of ice has implications for how to combat the drug. Law enforcement efforts can be more targeted to disrupt supply.

Law enforcement agencies are putting considerable effort into disrupting the supply of ice, including prosecuting those who traffic the drug. Nonetheless, the supply of ice in Australia continues to grow.

From 2010-11 to 2013-14, arrests in relation to amphetamine-type stimulants (which includes ice) more than doubled, while there was an eight-fold increase in detections of ice at the border. At the same time the market for ice flourished, with availability and purity increasing and price remaining stable.

Supply reduction

As discussed in Chapter 1, the unique nature of ice impedes law enforcement efforts to curb supply.

Ice is a synthetic substance, which means production does not rely on plant-based material. It can be produced both in Australia and overseas, using a wide range of precursor chemicals. New production methods continue to emerge in response to efforts to restrict precursor chemicals. One disrupted source of supply is easily replaced by another.

Ice is a lucrative business for organised crime, both within Australia and overseas. The high price of the drug in Australia, relative to other countries, creates significant profit incentives for criminal groups. There is increasing cooperation between organised crime groups, and group leaders are adept at shielding themselves from detection and prosecution. Organised crime is using the internet and encrypted communications to coordinate activities.

The internet is also being used to facilitate imports through international mail. Ice imports are increasingly difficult to detect as a result of the high volume of traded goods within which they are concealed, and the increasingly sophisticated concealment methods.

Australian governments already dedicate substantial resources to addressing these challenges and the approaches taken by law enforcement and other agencies continue to lead to positive outcomes. However, there are a number of areas where refined efforts could strengthen the law enforcement response.

The effective use of criminal intelligence is central to good law enforcement outcomes. Improving the gathering, analysis and sharing of intelligence can strengthen law enforcement targeting and drive better results. Criminal intelligence can also be used in new ways to disrupt criminal networks. Controls over precursor chemicals can be strengthened through greater national consistency and responsiveness. Stronger and better coordinated international engagement can help stop ice imports at their source. New tools can help strengthen law enforcement efforts to target profits from the drugs trade.

Law enforcement efforts need to be flexible and responsive to the challenges presented by ice. They must be well-coordinated to minimise the opportunity for criminal groups to take advantage of loopholes in regulatory arrangements. They need to be comprehensive to counter all aspects of the supply chain, and well-targeted to make the best use of the finite resources of law enforcement agencies.

The agility and responsiveness of criminal groups means it is important to consider all possible implications of supply reduction strategies to ensure enforcement efforts are not easily circumvented or do not result in unforeseen negative outcomes and increased harm to the community.

The Taskforce found that drug diversion programmes offer a number of benefits over the traditional criminal justice responses for some of the less serious categories of offenders, including reducing the rate of reoffending and overall costs, and improving health and social outcomes. While there are general similarities between the different diversion programmes across Australia, there is room for broader application of best-practice approaches. Given these programs apply more broadly to drug offenders (than just those using ice), the Taskforce has recommended this be considered in the context of the National Drug Strategy.

Security at air and sea ports

The Taskforce noted the substantial increase in ice imports to Australia in recent years, and that airports and maritime ports are gateways for these imports. Law enforcement efforts targeting criminal exploitation of Australian ports and supply chains in the waterfront environment have successfully disrupted criminal activity (for example, the multi-agency Polaris, Trident and Jericho Task forces). However, the Taskforce found that there is a need to continue to harden the aviation and maritime environments against organised crime.

A number of independent reviews, including the 2011 Parliamentary Joint Committee on Law Enforcement *Inquiry into the adequacy of aviation and maritime security measures to combat serious and organised crime,* have noted that serious and organised criminals are exploiting secure maritime and aviation areas for criminal purposes. These reviews have recommended the Aviation Security Identification Card (ASIC) and Maritime Security Identification Card (MSIC) schemes be expanded to ensure those working at air and sea ports do not have links to serious and organised crime.

The ASIC and MSIC schemes are the primary means to confirm the identity and suitability of workers to operate within secure areas at air and sea ports. These schemes currently focus on minimising the risk of unlawful interference with aviation and maritime transport on the basis of a criminal history check and national security assessment. They do not currently consider criminal intelligence as part of the background checking process.

The Taskforce found that the use of criminal intelligence in the background checking process for ASIC and MSICs could help identify links to organised crime among workers at air and sea ports and enhance the effectiveness of this regime in mitigating the risk from trusted insiders. The Australian Crime Commission is a

valuable source of criminal intelligence to support such background checks.

The Commonwealth Attorney-General's Department and the Department of Infrastructure and Regional Development are already progressing reforms to the ASIC and MSIC schemes. These reforms seek to amend legislation (the *Aviation Transport Security Act 2004* and the *Maritime Transport and Offshore Facilities Security Act 2003*) to include serious and organised crime considerations in the ASIC and MSIC eligibility criteria and to introduce a tiered approach to eligibility criteria, based on the seriousness and risk associated with different criminal offences.

There is potential to also lay the foundation for the use of criminal intelligence to identify cases where individuals have links to organised crime, but have not been convicted of a relevant offence.

Options for benchmark legislation may be found in state and territory security schemes, such as the 'fit and proper person' and 'public interest' standards that exist in the governance of New South Wales security licences.

Recommendation 24

The Commonwealth Government should continue to protect the aviation and maritime environments against organised crime by strengthening the eligibility criteria for holders of Aviation Security Identification Cards and Maritime Security Identification Cards; and establishing a legal mechanism to enable compelling criminal intelligence to be used in determining suitability of workers to hold such a card.

Managing criminal intelligence

Imported and domestically manufactured ice is distributed throughout Australia via extensive criminal networks. Understanding the criminal groups and networks responsible for the supply of ice throughout Australia is difficult. Sharing criminal intelligence between law enforcement agencies is critical in developing a comprehensive national picture and ensuring the most effective use of law enforcement capability to disrupt supply.

Timely exploitation of intelligence is a core requirement of an effective law enforcement response to stem the supply of illicit drugs, including ice. Real-time sharing of criminal intelligence can drive effective responses to illicit drug markets and organised crime more broadly. Collaboration between Australian jurisdictions, and centralised consolidation and analysis of available intelligence, are also key to an effective approach.

Given its importance in disrupting the ice trade, there is potential for better coordination and application of intelligence to target priority criminal groups involved in the market, both at the border and within Australia.

The Australian Crime Commission is the primary means for sharing intelligence and information between law enforcement agencies nationally. The Australian Crime Commission is required by section 7A(c) of the *Australian Crime Commission Act 2002* to maintain a national criminal information and intelligence database to support this approach. The existing Australian Criminal Intelligence Database (ACID) was created in 1984 and a scoping study of this system found that it is no longer fit for purpose, because it has not kept pace with evolving technology and user requirements. This limits the effective utilisation of criminal intelligence nationally. As time goes by, the gap between the existing capability and user requirements will widen.

There is a need for a contemporary national criminal information and intelligence system to replace ACID and the Australian Law Enforcement Intelligence Network (ALEIN), which supports the sharing of information from ACID and a number of other criminal

intelligence databases. ACID and ALEIN are the sole current means by which classified criminal information and intelligence is shared nationally.

Given ACID in particular is not fit for purpose, there is little point in continuing to make minor enhancements to the existing systems. It would be more effective to develop a replacement National Criminal Intelligence System platform. This would provide a standalone capability requiring no ongoing investment post-implementation, apart from routine maintenance and upgrading.

The Taskforce notes that the Australian Crime Commission received some funding from the Confiscated Assets Account to improve the existing capability. However, significant additional investment is required to deliver a fully networked national capability.

Recommendation 25

The Commonwealth Government should establish a new national platform for criminal intelligence to improve the existing information sharing infrastructure. This will enable greater national collaboration to proactively tackle organised crime in Australia, informed by the findings of the current programme by the Australian Crime Commission.

Tackling ice in regional and remote communities

Regional demand for ice has increased significantly since 2010. Organised crime groups and less sophisticated criminal enterprises are satisfying this demand and, in some cases, generating further demand. Stakeholders consulted by the Taskforce have identified the supply of ice to regional and some remote communities as a particular problem. Law enforcement resources are more thinly spread in regional locations, so there is an increased need for collaboration to disrupt supply in these areas.

The supply of ice and other drugs to regional and remote Indigenous communities is increasing, but for many communities, there is still an opportunity to prevent ice from becoming a major problem. Work needs to be done to identify and disrupt organised crime groups and criminal entrepreneurs that are supplying illicit drugs to Indigenous communities, using both Indigenous and non-Indigenous drug couriers. Significant amounts of illicit drugs and precursors are also being distributed to regional and remote communities by the mail and parcel post.

The Taskforce found that outlaw motorcycle gangs play a key role in distributing ice and other illicit drugs to regional towns and communities where they are represented. These organisations have a competitive advantage over other organised crime groups in this context because of their geographic diversity.

Major infrastructure projects and mining sites also provide a market for illicit drug use in regional areas. These workers often have significant disposable income and access to the supply of illicit drugs from major population centres. There is a need to better understand the illicit drug threat posed by the fly in/fly out workforce nationally.

The Taskforce found that Commonwealth agencies have the capacity to use their special powers (for example, Australian Crime Commission coercive examinations) to identify organised crime groups operating in regional and remote areas, methods of regional ice distribution, sources of new demand, and operational leads for local law enforcement.

The Commonwealth is also well placed to ensure all relevant information and intelligence—including information obtained from international mail and parcel post drug seizures—is shared in a timely manner with jurisdictions and, where appropriate, is exploited for law enforcement operations.

The Australian Crime Commission has for a number of years had a standing determination focused on High Risk and Emerging Drugs, which includes looking at ice. This is valuable work that could also be more targeted at regional and remote communities. In addition, collaborative work by Commonwealth, state and territory agencies under the auspices of the

Serious and Organised Crime Coordination Committee will facilitate joint planning to operationalise activities against ice, including in regional and remote communities.

Any further efforts should complement the state-based multi-agency operations already underway, including on mail and parcel importations in several states under the National Organised Crime Response Plan.

Recommendation 26

The Commonwealth Government should:

- in collaboration with states and territories, work through the Serious and Organised Crime Coordination Committee to operationalise joint national and jurisdictional responses to ice. This should include regional and remote areas (including Indigenous communities)
- exercise existing powers to identify organised crime groups that are operating in regional and remote areas. This information should be used to identify methods of regional ice distribution, sources of new demand, and to generate operational leads for local law enforcement representatives
- work with the states and territories through the Australian Federal Police-led National Anti-Gangs Squad to tackle the significant outlaw motorcycle gangs' involvement in ice production, importation and distribution, and through the Australian Federal Police's Rapid Lab capability to disrupt regional ice distribution through the mail and parcel post.

International cooperation

The global ice trade is centred on extensive international networks drawing on product from key manufacturing hubs. The majority of Australia's ice and its precursor chemicals come from overseas, and this proportion has increased greatly in recent years.

Mainland China is a major source of ice production. In the three years from 2010-11 to 2013-14, 70 per cent of ice detections by weight was shipped from China.[817] Submissions to the Taskforce highlighted the importance of engaging China to stop ice and its precursor chemicals at their source. This includes cooperation on chemical regulation and the exchange of intelligence between police and border security agencies.[818]

Other countries in the East Asian region are commonly used as transhipment points. Stronger legal regimes, disruption capabilities and exploitation of intelligence all have the potential to improve action against methamphetamine production and trafficking in these countries. International cooperation is essential to achieving these outcomes and reducing the international trade in the drug.

Australia already works closely with regional countries and other partners to tackle the offshore supply of ice and its precursor chemicals. Engagement through agencies such as the Australian Federal Police, the Department of Immigration and Border Protection and the Department of Foreign Affairs and Trade seeks to secure international cooperation to address the range of challenges associated with illicit drugs. Australia's international engagement has resulted in successful law enforcement outcomes, such as disrupting the supply of particular precursor chemicals.

The Taskforce found there is scope for a more coordinated and targeted national approach aimed specifically at reducing the offshore supply of ice and precursors to Australia from the Asia Pacific region, with a particular emphasis on China. Such an approach should include collaboration and information sharing between the Commonwealth, states and territories, as well as other countries in the region.

Recommendation 27

The Commonwealth Government should strengthen international advocacy and engagement on cooperation and information sharing between law enforcement agencies and, in particular:

- conduct a stocktake of existing international cooperative arrangements relevant to the supply of ice, identify gaps and make improvements
- establish a Commonwealth strategy to focus specifically on disrupting the supply of ice and precursors to Australia from major source and transit countries
- consider the development of a broader Commonwealth transnational engagement strategy in the Asia-Pacific to target international drug networks which focuses on defined objectives for the coming three to five years.

Unexplained wealth

Unexplained wealth laws help to undermine serious and organised crime by targeting wealth and assets that are suspected to have been obtained via criminal activity. The high profits to be made from the ice trade are a major incentive for organised crime groups to be part of this illicit market. Over 60 per cent of Australia's highest risk criminal targets are involved in the methamphetamine market and these groups are adept at exploiting regulatory weaknesses in Australia.[819]

The Taskforce heard that while law enforcement is investing considerable efforts to target the organised crime profit machine, more needs to be done to target the billions of dollars organised crime generates each year, including through the methamphetamine market. The Taskforce also heard that greater information sharing could help support criminal asset confiscation action and organised crime investigations more broadly.

The Taskforce heard that current unexplained wealth arrangements are not working effectively to target criminal assets, particularly where these are spread across multiple jurisdictions. There are significant differences in the unexplained wealth arrangements of Australian states and territories, including whether a link to an offence is required, whether the court has discretion to make an order to seize assets, and the applicable time limits. The Taskforce heard that some organised crime networks are deliberately relocating their assets to jurisdictions with more favourable legislative frameworks to avoid having the assets seized.

The Commonwealth Parliamentary Joint Committee on Law Enforcement has argued for consistent approaches within Australia and recommended that states give a limited referral of powers to the Commonwealth to facilitate a comprehensive national response to unexplained wealth. It contends that a national response would overcome difficulties in identifying and confiscating assets that are held in several jurisdictions and mitigate the risk of criminals moving assets between jurisdictions to avoid confiscation.[820]

The Law Crime and Community Safety Council of the Council of Australian Governments (COAG) is currently considering a national cooperative scheme on unexplained wealth, which will provide authorities with an additional tool to target, disrupt and deter criminal syndicates and to prevent profits being reinvested to support further criminal activity.

Recommendation 28

The Commonwealth, state and territory governments should prioritise finalising the necessary arrangements to allow a national cooperative scheme on unexplained wealth to start as soon as possible.

Precursor controls

Domestic manufacture of ice remains at significant and concerning levels. Ice is manufactured in Australia using precursor chemicals and equipment diverted from legitimate domestic industry or illegally imported from overseas.

All states and territories have controls to restrict the possession and sale of precursor chemicals and equipment as part of efforts to address this challenge. However, these controls are neither comprehensive nor consistent across the country. In particular, the schedules of controlled chemicals differ between the Commonwealth, states and territories, meaning some chemicals controlled in the states and territories can be imported to Australia without restriction, and some chemicals controlled in one state or territory are not controlled in others.

This is problematic. Criminal groups, both in Australia and internationally, have been adept in changing supply and manufacturing methods to respond to the availability of chemicals and associated regulatory controls. Variation in controls is a vulnerability that organised crime may exploit to circumvent restrictions.

Further, there is evidence that these controls are not working as effectively as they could, particularly in the area of end-user declarations (EUDs).[821] While the majority of states and territories require the completion of EUDs, this is not mandatory in all jurisdictions. Record keeping systems vary across jurisdictions, are largely paper-based, and suppliers are not always required to actively submit EUD information to law enforcement agencies. These factors reduce the effectiveness of EUDs and hinder the efficient flow of information to law enforcement agencies and their analysis of that data. The net result is that there is no central repository for information about precursor sales and no uniform requirement across Australia to complete EUDs or provide them to police, even in relation to suspicious purchases.

The chemicals industry has also sought to require members to more consistently collect EUDs about chemicals and equipment listed in a voluntary industry code. Unfortunately, the code has not been updated since 2008 and these lists are now outdated. Until recently, industry awareness of and compliance with the code had been limited, particularly in the area of purchasers completing EUDs. As with the government regulations mentioned above, there is also a disconnect between the collection of EUD information and its disclosure to law enforcement agencies for assessment of potential diversion to drug manufacture.

The Taskforce found there was a need to improve controls over precursor chemicals, reagents, solvents and equipment through nationally consistent legislation and regulation, and ensure there is a framework in place to more quickly respond to emerging manufacturing methods. Developing an electronic EUD system will also support a nationally coordinated approach that is capable of managing the dynamic market for illicit precursors in Australia. Strong links between legitimate industry and law enforcement are also important to limit the diversion of precursor chemicals into illicit drug manufacture. An updated and more comprehensive industry code will strengthen this interaction.

Australian Governments are already moving toward nationally consistent regulation of precursor chemicals and equipment. In May 2015, Ministers at the COAG Law, Crime and Community Safety Council meeting agreed to progress recommendations on precursor controls to reduce the risk of diversion as well

as the regulatory burden on industry. The Commonwealth is currently examining options to achieve this.

Recommendation 29

The Commonwealth Government should:

- continue to work with the states and territories to examine ways to achieve greater national consistency of controls on precursor chemicals and equipment, and an agile mechanism to amend existing legislation as illicit manufacturing methods evolve
- prioritise the development of a national electronic end-user declaration system to provide law enforcement agencies with access to information about precursor and equipment sales across Australia through an online, searchable database
- encourage states and territories to enact legislation to support compliance with the new end-user declaration regime
- engage with industry to facilitate the development of a more contemporary and comprehensive industry code to provide best-practice guidelines for supply diversion into illicit drug manufacture.

Swift and certain sanctions

Courts in Australia, including drug courts, currently use diversion into drug treatment rather than a correctional facility as a sentencing option for those found guilty of using drugs such as ice. While diversion programmes are considered lower cost and more effective than correctional facilities, in some cases successful completion of programmes is low, and re-offending rates can be high. For example, a review of the South Australian Drug Court in 2012 found two-thirds of offenders did not complete the programme, and 55 per cent of those who completed the programme re-offended.[822] A 2014 evaluation of the Drug Court of Victoria found 51 per cent re-offended within 12 months.[823]

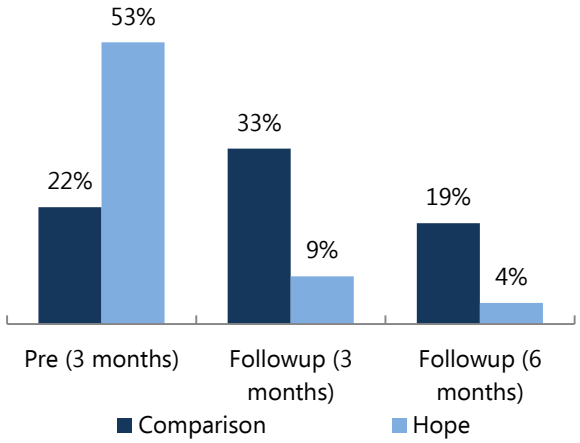
A new approach to probation being adopted in the United States focuses on swift and certain sanctions for probationers who fail random drug tests rather than mandatory treatment for all. The programme was originally trialled in Hawaii with very positive results for methamphetamine users.[824]

The approach was developed after it was recognised that people on probation for drug offences tended to face inconsistent consequences for re-offending, often with long delays before the consequences came into effect. The Hawaii Opportunity Probation with Enforcement (HOPE) trial introduced random drug testing for probationers, with swift punishment for non-compliance—usually short jail terms issued within 72 hours. The vast majority of participants in the trial were methamphetamine users (69 per cent).

Under the HOPE trial, probationers were sentenced to drug treatment only if they continued to test positive for drug use or if they requested a treatment referral. This economical use of treatment freed up treatment places for those proven to need them. This avoided a situation in which clients in mandated-treatment crowded out clients in voluntary-treatment.

The most dramatic outcome of the HOPE trial was the reduction in positive drug tests by trial participants compared with a control group undergoing mandatory treatment. Participants selected for the HOPE trial were more likely to test positive to a drug test in the three months prior to the trial than a control group who were sentenced to mandatory drug treatment. Six months after the trial, positive drug tests amongst the HOPE cohort had fallen to from 53 per cent to four per cent. Positive drug tests among the control group who had been through mandatory treatment dropped only marginally from 22 per cent to 19 per cent over the same period.[825]

Figure 11.1: Hawaii's HOPE trial—average number of positive drug tests, by period



There were initially concerns by the courts that the requirement for immediate sanctions would be unworkable. However, streamlined processes were introduced to help mitigate this such as simple, easy-to-complete forms for parole officers.

A survey of probationers participating in the HOPE trial showed strong support for the programme.

The model is now being run in 21 States in the United States. Similar arrangements are set to be trialled in the United Kingdom, after being announced in the lead up to the 2015 election (Fast Sanctions and Testing).

The Commonwealth should work with at least one state to trial and evaluate swift and certain sanctions in Australia.

Recommendation 30

The Commonwealth Government should work with at least one state or territory government to pilot a Swift and Certain Sanctions programme for ice offenders on probation, drawing on lessons learned from implementing these models in the United States, including the Hawaii Opportunity Probation with Enforcement Project trial in Hawaii.

Diversionary programmes

The Taskforce heard that drug diversion programmes offer a number of benefits over traditional criminal justice responses, including reducing the rate of reoffending and overall costs, and improving health and social outcomes.

While there are broad similarities between court-based drug diversion programmes across Australia, they differ greatly in governance structures and how they operate. Some of this variation is justified due to differences in geography, culture, the nature of drug-related problems and other interventions, but there is room for the broader application of best-practice approaches.

The Taskforce heard concerns over the equity of diversion, access to diversionary programmes, and consistency of programme implementation. A number of groups find it difficult to participate in drug-court programmes, including women, young offenders, Indigenous offenders and those in regional and remote areas. This largely occurs as a result of eligibility criteria, physical remoteness and the cultural appropriateness of programmes, particularly for Indigenous people.

The Taskforce recommends that jurisdictions review drug diversion approaches in Australia and consider ways to improve and expand existing arrangements, and increase options for diversion.

This could include:

- assessing how current designs are working and interacting with each other
- identifying the types of offenders who would be best served by court-based diversion
- identifying barriers to access and equity, particularly with respect to cohorts including young people
- examining different approaches and best programme design.

Recommendation 31

Under the National Drug Strategy Framework, state and territory governments should review diversionary programmes to determine best practice approaches, and consider options for improving and expanding existing arrangements.

CHAPTER 12
IMPROVE GOVERNANCE AND BUILD BETTER EVIDENCE

The unique complexities of the ice problem, and the current gaps in our understanding of the market, highlight the need for more effective government decision-making, better data, more research and regular, nationally-consistent reporting.

Responding to the challenges posed by ice requires close and effective collaboration between the Commonwealth, states and territories. All governments share responsibility for implementing the broad range of actions needed to tackle ice.

Good governance structures are needed to support timely collaboration between governments to ensure policy approaches respond to emerging challenges. Timely and coordinated decision-making is important to ensure policy responses are effective, particularly in the context of a federated system of government like Australia's. These structures also need to provide ongoing review of the effectiveness of these responses.

Illicit drug markets are dynamic and can change rapidly in response to global market shifts, emerging transnational organised crime trends and changing user demands. A more comprehensive understanding of the ice market is important to designing appropriate policy approaches and understanding their effectiveness. The opaque nature of this illicit market and the unique complexities of the ice problem mean there are substantial gaps in national understanding. Better data, more research and regular reporting, that is accessible to all stakeholders, is needed. This will enable identification of emerging trends and help governments to direct resources towards priority areas.

Australia also needs to invest more research in evidence-based treatment pathways. While some specific interventions are known to be effective, more evidence is needed on the most appropriate treatment and support pathways for ice users to fully recover from dependence.

Good governance

Tackling ice is a shared challenge for the Commonwealth, states and territories. Actions are spread across many sectors including law enforcement, health and education. Close cooperation and coordination between the various sectors and jurisdictions is important for successful national approaches.

Effective governance structures are the foundation for this cooperation. These structures need to provide a strong framework for coordinated and comprehensive national action. Good governance also provides an important accountability mechanism for the implementation of strategies, along with ongoing review and refinement.

Timely and effective decision-making

The Taskforce found the existing system of governance does not facilitate timely collaboration between Commonwealth, state and territory governments to implement effective responses to drug-related issues. The current structure under the Council of Australian Governments (COAG) requires the Intergovernmental Committee on Drugs (IGCD) to obtain endorsement of its work through numerous other intergovernmental committees. This can often undermine timely and coordinated policy-making on illicit drugs.

The separation of health and law enforcement issues in the IGCD's governance framework can result in delays in the endorsement of national policy responses. It can also lead to consideration of illicit drug policy issues being overtaken by other health and law enforcement matters.

The Taskforce recommends that governments consider simplified drug-related governance models under the COAG framework. This should ensure policy advice is provided to relevant Ministers more directly and with greater cohesion between law enforcement and health responses.

More senior representation on the IGCD may also better reflect the priority of drug policy both nationally and internationally, and improve the effectiveness of the IGCD as a prioritisation and decision-making body.

Recommendation 32

The Commonwealth, state and territory governments should introduce a simplified governance model to support greater cohesion and coordination of law enforcement, health, education and other responses to drug misuse in Australia, with a direct line of authority to relevant Ministers responsible for contributing to a national approach.

Oversight of implementation and effectiveness

The success of existing drug strategies is not currently measured under a performance framework. The National Drug Strategy 2010-2015 includes performance measures to help monitor progress and guide implementation and established a mechanism for preparing an annual report on data against these measures. However, the last report was published in 2012 and this process has since been discontinued.

A robust performance framework is needed to inform the adoption and ongoing operation of drug policies and practices. Consolidating and strengthening information gathering efforts across health and law enforcement, including providing an early warning system of drug use trends, would assist in evaluating current drug strategies.

A new national performance framework to evaluate outcomes of the National Drug Strategy and to oversee implementation of initiatives in the National Ice Action Strategy would make an important contribution to the ongoing assessment and refinement of existing responses.

Since the release in 2009 of its report *Tackling Methamphetamine: An Action Plan*, the New Zealand Government has published reports every six months that review progress against both action and outcomes. The New Zealand Department of the Prime Minister and Cabinet provides these reports to the Prime Minister

and relevant Ministers. The progress reports include quantitative assessments of a range of factors including price, purity, availability, demand and access to treatment, which provides an opportunity to assess the effectiveness of approaches under the Plan.

The approach taken under New Zealand's Tackling Methamphetamine Action Plan may inform some elements of such a framework. However, the Taskforce recognises that Australia has the added complexity of a federal system of government and would need to collate data across a range of jurisdictions.

The Taskforce recommends that the Commonwealth, state and territory governments develop a new national performance framework to evaluate outcomes from the National Drug Strategy. This performance framework should be part of the National Drug Strategy 2016-2025. The framework should also be used to review implementation of the National Ice Strategy.

The Taskforce also recommends that Australian jurisdictions consider establishing a dedicated body of subject matter experts to examine data quality and reporting issues, to identify where work needs to be done to best inform progress against the National Drug Strategy.

Recommendation 33

Under the National Drug Strategy Framework, the Commonwealth, state and territory governments should jointly develop a new national performance framework to evaluate outcomes from the National Drug Strategy as part of the National Drug Strategy 2016-2025.

The framework should contemplate annual reporting on performance against objectives.

Building the evidence base

The Taskforce found that existing data and research does not provide a sufficiently comprehensive evidence base to support optimal policy-making on ice and to measure the effectiveness of these responses. Major information gaps exist, including in relation to:

- harms attributable to methamphetamine and the extent of these harms
- the size and value of the methamphetamine drug market
- the nature and extent of links between methamphetamine and crime—including crimes involving property, violence and trafficking
- the impact of policy responses on the methamphetamine market
- the cost to governments and the community of policy responses to the methamphetamine market.

These gaps apply to illicit drugs more broadly and could usefully provide a basis for targeted research by major national institutions, which could in turn inform policy and operational responses.

The Taskforce's consultations also highlighted deficiencies in the available evidence.[826] Limited sample sizes, sample selection biases, and long periods of time between measurements all limit the accuracy and usefulness of existing information sources. There is also a lack of specific data on ice, with research focusing on broader drug categories,[827] and inconsistencies in the breakdown of types of alcohol and other drug (AOD) treatment in different states and territories. The latter is due to different jurisdictions having different data collection business rules, including variations in data definitions and the mandatory collection of different types of treatment episodes.

More balanced and regular data collection would improve decision-making and public understanding of the threat posed by illicit drugs. Better standardisation of the data is necessary to enable a definitive jurisdictional comparison of treatment trends.

Research derived from broad-based user surveys has been a very valuable source of information on drug use and attitudes. However, this information has some inherent shortcomings which could be addressed by additional, objective data sources such as waste water analysis and ambulance attendance data. Self-reported data is inherently at risk of under-reporting the prevalence of drug use in the population due to a number of factors including:

- responses being skewed because those surveyed are aware that possession of illicit drugs is a crime
- embarrassment and fear of punishment or social disapproval by those surveyed[828]
- unintentional misreporting due to a lack of understanding by those surveyed of the drugs they are actually consuming.[829]

In 2003, the Australian Institute of Criminology compared self-reporting data collected from police detainees in the Drug Use Monitoring in Australia project with results of their urinalysis to measure the extent of under-reporting of heroin, methamphetamine and cocaine use.

The survey found that:

- at least 20 per cent of detainees who recorded positive urinalysis results for heroin, methamphetamine and cocaine did not self-report use of the drug in the past 30 days
- only 20 per cent of detainees who self-reported MDMA (ecstasy) use in the past two to three days tested positive to MDMA (ecstasy), while 65 per cent of them tested positive to methamphetamine
- detainees aged over 30, who worked full time and lived in their own house, were more likely to under-report their drug use.[830]

Some existing surveys also suffer from poor reliability resulting from small sample sizes. With the exception of cannabis, the use of most illicit drugs is reported by fewer than five per cent of survey respondents, meaning very large samples are needed to estimate trends in their use.[831]

Illicit drug users are likely to be under-represented in many surveys. In its submission to the Taskforce, Turning Point noted that population-level AOD surveys are marred by poor response rates and data collection practices that limit participation by heavy users and hard-to-reach populations such as the homeless, institutionalised people and other disadvantaged groups.[832] For example, the National Drug Strategy Household Survey excludes people in accommodation such as hotels, boarding houses, hospitals, and AOD rehabilitation centres, and homeless people. The difficulty in reaching marginalised people is likely to have affected estimates in the survey.[833]

Other surveys reach particular cohorts, but miss much of the community.[834] The Illicit Drug Reporting System and the Ecstasy and Related Drugs Reporting System each survey less than 1,000 people nationally in specific drug-using populations.[835] The Drug Use Monitoring in Australia data set augments self-reporting data, but is drawn entirely from police detainees at a small number of locations around the country.[836]

Best practice in data collection on illicit drugs requires ongoing collection of a mix of population surveys and other objective data.[837] Benchmark data should provide a continuous capture of real world data from a wide variety of utilised services, including statistics on hospital admissions, drug dependence treatment, needle and syringe provision, arrests and police call-outs, drug seizures, emergency department admissions and ambulance attendances.[838]

Such sources should provide information on specific drug types wherever possible, rather than broad categories. Centralised analysis and reporting of diverse data would benefit all stakeholders, provide consistent messaging and improve early warning of new drug trends. This would greatly improve the credibility and utility of drug-related information.

Establish a central point for analysis of drug-related information

The Taskforce found that the diversity of data sources and reporting can lead to confusion and a lack of consistency in understanding and planning responses to drug-related problems. There is a need for clear, authoritative

assessments of available data on levels of demand for, and use and supply of, illicit drugs.[839]

Establishing a central 'point of truth' for all national illicit drug prevalence data could benefit health, law enforcement and other stakeholders and may provide early warning of changes in illicit drug markets. It would reduce the risk of contradictory interpretations of available information and improve governments' ability to make sense of this information.

Recommendation 34

The Commonwealth Government, in collaboration with the states and territories, should establish an illicit drug monitoring clearinghouse for national data. This will be the central point of information for health, justice and law enforcement illicit drug data in Australia, and provide regular reporting on drug use and market trends.

Improve and expand data sources to support the central analysis of drug-related information

There a range of data sources that could be expanded and made available for the centralised analysis of the prevalence of illicit drug use and trends.

Waste water analysis

As discussed in Chapter 7, waste water analysis (WWA) can estimate levels of illicit drug use by analysing population size, daily volumes of waste water produced, and the excretion rate of particular substances,[840] and has a range of public health, prevention and law enforcement applications.[841]

WWA results to date indicate a much higher use of methamphetamine within the community than previously identified in user surveys. A study in South Australia also found evidence of: higher levels of methamphetamine use than in comparable European studies; greater use in urban than regional areas; and higher rates of use on weekends.[842] The study also found that methamphetamine was the highest consumed stimulant in South Australia from December 2012 to June 2014, and that there had been a steady increase in the levels of methamphetamine consumption over that time.[843]

A similar study undertaken in Queensland attempted to quantify use, both in terms of consumption and associated financial cost. It found a considerable increase in the levels of methamphetamine detected between 2009 and 2010.[844] Studies such as these are unable to determine actual user numbers, or individual doses consumed. Rather, they provide an estimate of average use over a population, total amounts of the drug consumed and can inform estimates of the likely proceeds of the drug trade.

WWA offers a non-intrusive method of monitoring drug trends, identifying the emergence of new illicit drugs and evaluating the effectiveness of supply and demand reduction strategies. WWA also lends itself to international comparisons, given that a comparable collection methodology is used in multiple sites across the world. In a 2014 international methamphetamine comparison, Canberra and Toowoomba ranked third and fourth respectively against 52 collection sites around the world.[845]

WWA can efficiently provide reliable, objective data on drugs of major concern to the community in both small and very large population groups. Sampling may be conducted at short intervals, encompass people from all socioeconomic backgrounds, avoid potential misreporting, and is not subject to changes in the activities and policies of law enforcement agencies.[846]

Drug Use Monitoring in Australia and ambulance data

The Australian Institute of Criminology's Drug Use Monitoring in Australia (DUMA) programme marries a survey of detainees at police stations and watch-houses with analysis of urine samples supplied by survey participants. This enables comparison between drug users' self-reporting and the results of the urinalysis. Extension of the current programme to sites in

capital cities not currently covered by DUMA, and to several major regional cities, would enable wider comparison between reported and actual drug use and a broader perspective on national drug trends.

The 'Ambo Project', administered by Turning Point in Victoria, reliably records ambulance attendance data related to AOD consumption, including recording information on specific drug sub-types such as ice. The data can also be cross-referenced to hospital admissions and treatment data. Extension of this or a similar project nationally would fill significant gaps in knowledge around ice, and potentially improve information on the links between ice use and acts of violence.

National Drug Strategy Household Survey

The Australian Institute of Health and Welfare's National Drug Strategy Household Survey provides a three-yearly estimate of drug use nationally. The survey also captures information concerning drug-related attitudes and perceptions and the level of support for government policies.

The survey is widely regarded as the authoritative population-based drug use data report in Australia. Findings from the survey are used to inform policy planning and development, as well as research projects across several sectors including health, education and law enforcement. However, the three-yearly time cycle for the survey means it is only effective in highlighting long-term drug use trends. Although there are other more regular drug reporting mechanisms available (for example, the Illicit Drug Reporting System and the Ecstasy and Related Drugs Reporting System), these tend to survey limited groups and do not measure the prevalence of drug use nationally. The Pennington Institute has highlighted the need for data that captures shifts in drug use as they occur, enabling timely responses.[847]

The Taskforce found there would be significant advantages to conducting the survey more regularly, given its value in providing an estimate of the prevalence of drug use in the Australian population.

Recommendation 35

Governments should work together to expand and improve the data sources available for the central analysis of illicit drug trends. This should include:

- establishing a national wastewater analysis capability, which should be drawn upon to provide a more accurate analysis of drug use in Australia
- extending the use of the existing Drug Use Monitoring in Australia programme to more sites in Australia as part of an expanded information base
- establishing a system to gather and share national ambulance data drawing on the Victorian 'Ambo Project'
- commissioning the Australian Institute of Health and Welfare to undertake the National Drug Strategy Household Survey on a more regular basis, and strengthen the methodology of the survey, including the use of online distribution methods.

Support law enforcement drug research

The Commonwealth Department of Health, with support from the Australian Institute of Criminology, funded the National Drug Law Enforcement Research Fund (NDLERF) up until 30 June 2015. The Commonwealth contributed $765,000 per year to NDLERF from November 2009 to June 2014, and $500,000 in the 2014-15 financial year.

The purpose of the NDLERF was to prevent and reduce the harmful effects of drug use in Australian society. The NDLERF supported action to address illicit drugs by undertaking research to support evidence-based practice in drug law enforcement. This research contributed to innovation in responses and enhanced links between law enforcement personnel, human service providers and research agencies. However, a significant proportion of NDLERF research was dedicated to alcohol-related issues; the Taskforce found that there is an opportunity to better target

research to the illicit drug and precursor markets through a new research programme.

A new programme with a more specific focus on illicit drugs would help to strengthen knowledge around this less-understood policy area, and have a valuable ongoing role in enhancing national data and research efforts specific to illicit drugs.

The programme could be administered by an existing agency such as the Australian Institute of Criminology, with research priorities identified through the IGCD and the ANACAD. Such a model would have enduring benefit to law enforcement and health agencies.

Recommendation 36

The Commonwealth Government should establish and fund a new research programme to support law enforcement responses to illicit drugs, including ice.

The scope of the research programme should be confined to illicit drug and precursor markets, focusing on key gaps and priorities identified in the first instance by the National Ice Taskforce, and subsequently by the Intergovernmental Committee on Drugs.

Support development of lower-cost drug testing

A number of private sector and government organisations use testing to identify drug use within their organisations and the broader community (see Chapter 5).

This has important safety implications and can help employers meet their duty of care requirements. Drug testing in hazardous industries can help prevent workers putting themselves and others in danger by working while affected by drugs.

Some law enforcement agencies also use random drug testing to identify road users under the influence of drugs. A number of Government agencies, particularly those with a law enforcement role, also test workers as part of efforts to maintain the professional integrity of their workforce.

Tests can be undertaken in a number of ways, including through analysis of urine, saliva and hair follicle samples. Secondary tests, including blood tests, are sometimes used to verify positive test results. These tests can perform a useful role in eradicating dangerous and potentially compromising drug use, but the Taskforce found their cost can be prohibitive for some users. The Australian Crime Commission reports that initial testing can cost between $90 and $115 and the more robust testing used, for example, in secondary tests is more expensive.

The Taskforce heard that workplace drug testing is a sensitive and complex issue, which should be underpinned by a clearly defined and agreed rationale, developed in consultation with the workforce.[848] Identifying lower-cost drug testing options would enhance the usefulness of drug testing as a tool in a range of contexts, particularly for roadside drug testing.

Recommendation 37

The Commonwealth, state and territory governments should jointly review existing research into illicit drug testing to identify opportunities to advance the development and use of lower-cost drug testing.

More research on evidence-based treatment pathways

Pharmacotherapy

Pharmacotherapy medications aim to eliminate withdrawal, control or eliminate cravings or block the euphoric effect of further drug use. Pharmacotherapies, such as methadone, buprenorphine and buprenorphine-naloxone, have been available in Australia for opioid dependence for several decades. Opioid pharmacotherapies have been found to reduce heroin use and improve health and wellbeing on a range of indicators, including reducing injecting behaviour and associated risks, reducing crime, improving quality of life, retaining people in drug treatment, and preventing relapse.[849]

Given the significant benefits of opioid pharmacotherapies, many researchers are eager to find an equivalent pharmacotherapy for methamphetamine dependence. Despite a decade of trials, there is limited evidence regarding safe and effective pharmacotherapies for methamphetamine treatment. The most up-to-date review of pharmacotherapies for methamphetamine was undertaken in 2013 by Brensilver et al. This review noted promising signals for several pharmacotherapy options in reducing stimulant use in subgroups of patients,[850] which included methylphenidate (stimulant used to treat ADHD), the opioid antagonist naltrexone (oral), bupropion and mirtazapine. Some of these medications have the common ability to reverse neural deficits in individuals with methamphetamine dependence. However, none have demonstrated sufficient evidence of safety and effectiveness to be approved for use in either methamphetamine withdrawal or as a substitution therapy.[851]

There are also some small-scale trials currently underway in Australia. One example is a trial at St Vincent Hospital, Sydney where dexamphetamine is being offered as a treatment for a small number of ice users as a last resort measure. The researchers involved are encouraged by the results to date.

Many experts in this research field advised the Taskforce of the need for further research in Australia for promising pharmacotherapies.[852] [853]

> *"Pharmacotherapy options provide a potentially cost-effective and scalable treatment option, which is difficult to provide through other means, and which could significantly offset the cost of methamphetamine use in Australia…Although pharmacotherapy trials are expensive, they are the only way we can provide an evidence-based response to methamphetamine use, and the cost of these trials is minimal when compared to the cost of methamphetamine dependence in Australia.*[854]

This emphasises the need for further controlled clinical pharmacotherapy trials for methamphetamine dependences in Australia, focusing on drugs that are currently showing promising signs. The effectiveness of the drugs needs to be well-understood, including potential side effects.

Throughout the Taskforce consultation period there were various media articles regarding naltrexone implants as an effective pharmacotherapy for methamphetamine dependence. Only a small number of submissions received by the Taskforce discussed the use of naltrexone. According to the National Health and Medical Research Centre, naltrexone implants remain an experimental product and should only be used within a research setting.[855] Haile and Kosten also state that whether naltrexone benefits methamphetamine users or not remains to be determined by properly controlled clinical trials.[856] Until relevant findings are available and validated, the efficacy of the treatment, alone or in comparison with best-practice, cannot be determined.

The treatment pathway

There is limited evidence regarding effective treatment pathways for methamphetamine users. While the evidence to date supports the inclusion of psychosocial interventions and follow-up support for treating methamphetamine dependence,[857] relapse rates remain high. Research has also found significant limitations in the long-term effectiveness of residential rehabilitation programmes in treating methamphetamine use for a majority of users.[858]

The Taskforce heard from many experts that the treatment pathway for methamphetamine users is different to other drugs. Ice users are also calling for treatment options and recovery pathways that are flexible, that provide long-term support, and that are more suitable to their social context. Better and more cost-effective models of care need to be researched and implemented.

While there is emerging evidence that guides effective support and treatment for

methamphetamine users, there is more to be learned about what combination of interventions across a patient's treatment is associated with success. We need to understand more about how to best configure the treatment and support system to optimise and maintain positive treatment outcomes for ice and other methamphetamine users in the longer term.[859] [860]

Recommendation 38

The Commonwealth Government should fund research into evidence-based treatment options for methamphetamine treatment.

As a priority, research should examine the effectiveness of various treatments including:

- early intervention, including evaluation of training models
- low to high intensity models
- treatment settings (for example, residential and non-residential)
- cost effectiveness
- engagement and retention of methamphetamine users into treatment.

Research should also explore promising pharmacological options for the management of methamphetamine withdrawal and maintenance.

This work should be undertaken in consultation with the Australian National Advisory Council on Alcohol and Drugs.

APPENDICES

APPENDIX I CONSULTATIONS

The Taskforce consulted extensively with experts and the community. The Taskforce drew on the observations and advice they received to develop their recommendations in this report.

The Taskforce is grateful to those who gave their time and shared their knowledge. The feedback from people with first-hand experience of dealing with the drug was invaluable in developing this report.

This appendix includes an overview of the consultations conducted; summaries of the key themes raised; and lists of organisations represented in the consultations.

Overview of consultations

The Taskforce travelled around Australia to listen to communities and experts share their observations and advice on tackling ice. Australians were also invited to contribute written public submissions to the Taskforce. In addition, the Taskforce met with many other experts and people with knowledge of ice use and its impacts on society.

A summary of the places visited and submissions received is detailed below.

Community consultations

The Taskforce hosted seven targeted community consultations in regional Australia to speak to people experiencing the impacts of ice use in their communities.

The locations were selected in consultation with Commonwealth agencies and state and territory governments. There were a variety of reasons for selecting each location. Some of the communities had successful programs in place to reduce ice use, which the Taskforce wanted to learn about. Others were facing relatively high levels of ice use in their community. Others had particular demographic features that the Taskforce wanted to learn about, such as population groups at risk of developing high levels of use. The range of places visited meant the Taskforce was able to hear a cross section of views from Australians all around the country.

Table AI.1: Community consultations

Place	State or territory	Date	Taskforce attendees
Mount Gambier	South Australia	14 May 2015	A/Prof Sally McCarthy
Broome	Western Australia	19 May 2015	Professor Richard Murray
Darwin	Northern Territory	20 May 2015	Professor Richard Murray
Newcastle	New South Wales	26 May 2015	A/Prof Sally McCarthy
Hobart	Tasmania	27 May 2015	Mr Ken Lay
Townsville	Queensland	2 June 2015	Professor Richard Murray
Mildura	Victoria	3 June 2015	Mr Ken Lay

Federal, state and territory Parliamentarians also made submissions to the Taskforce on behalf of their electorates. A number of submissions also contained the outcomes of consultations held by local communities and councils.

Roundtable meetings

The Taskforce hosted nine roundtable meetings of experts from different sectors. Each roundtable meeting was focused on a particular theme and involved representatives of relevant organisations. The experts were identified in discussions with Commonwealth agencies and state and territory governments, as well as through the advice of others in the alcohol and other drug sector.

Table AI.2: Roundtable meetings

Organisation type	Place	Date	Taskforce attendees
Peak alcohol and drug bodies	Brisbane Queensland	5 May 2015	Professor Richard Murray
Health and medical associations	Melbourne Victoria	11 May 2015	A/Prof Sally McCarthy Professor Richard Murray
Educational organisations	Adelaide South Australia	13 May 2015	A/Prof Sally McCarthy
Deputy Police Commissioners	Melbourne Victoria	19 May 2015	Mr Ken Lay
Drug and alcohol research centres	Sydney New South Wales	22 May 2015	A/Prof Sally McCarthy
Organisations involved in prevention activities	Sydney New South Wales	22 May 2015	A/Prof Sally McCarthy
Treatment services	Sydney New South Wales	25 May 2015	A/Prof Sally McCarthy
Services that support users and families	Sydney New South Wales	25 May 2015	A/Prof Sally McCarthy
Indigenous health and legal organisations	Sydney New South Wales	4 June 2015	Professor Richard Murray
Police Commissioners	Sydney New South Wales	10 June 2015	Mr Ken Lay
Organisations that represent drug users	Melbourne Victoria	11 June 2015	Mr Ken Lay A/Prof Sally McCarthy

Site visits

The Taskforce also visited treatment and support services around Australia and spoke to service providers and users. This helped the Taskforce to understand some of the practical challenges of treating ice dependency.

Table AI.3: Site visits

Organisations	Place	Date	Taskforce attendees
Life Without Barriers	Mount Gambier South Australia	14 May 2015	A/Prof Sally McCarthy
Broome Hospital emergency department	Broome Western Australia	19 May 2015	Professor Richard Murray
Banyan House	Darwin Northern Territory	20 May 2015	Professor Richard Murray
Stimulant Treatment Centre	Newcastle New South Wales	26 May 2015	A/Prof Sally McCarthy
Salvation Army Bridge Program	Hobart Tasmania	27 May 2015	Mr Ken Lay
Link Youth Health Service	Hobart Tasmania	27 May 2015	Mr Ken Lay
Headspace Youth Centre	Mildura Victoria	3 June 2015	Mr Ken Lay
UnitingCare ReGen (Coburg)	Melbourne Victoria	11 June 2015	Mr Ken Lay A/Prof Sally McCarthy
UnitingCare Regen Curran Place (Heidelberg)	Melbourne Victoria	11 June 2015	Mr Ken Lay
Turning Point Alcohol and Drug Centre	Melbourne Victoria	3 July 2015	Mr Ken Lay A/Prof Sally McCarthy

Public submissions

All Australians were able to contribute their views in an online public submission between 22 April 2015 and 29 May 2015. The Taskforce received over 1,300 submissions in total. Around 90 per cent were from individuals including users, families and people with experience in alcohol and other drug services. The remainder were mainly from organisations in sectors such as such as health, not-for-profit, academia, business and Indigenous support.

Other Taskforce consultations

In addition to the formal consultations, the Taskforce met with many other experts and interested parties, including advisory councils, law enforcement officers, State and Federal members of parliament and academic researchers. They also worked in close collaboration with Commonwealth, state, territory and local governments to ensure the final strategy is nationally integrated and takes account of a range of views.

Parliamentarians' consultations

The Minister for Justice, the Hon Michael Keenan MP, and the Minister for Rural Health, Senator the Hon Fiona Nash, held a number of community consultations with members of the public right across the country. They provided comprehensive advice to inform the Taskforce's considerations.

A number of other Federal, state and territory Members of Parliament also held community consultations in electorates all around Australia. Parliamentarians fed the views of their constituents back so the Taskforce could hear a wide range of community views.

Key themes

The Taskforce heard similar themes from the consultations and submissions and these are summarised below.

The section begins with an overview of community and experts' experiences of ice use. It then summarises what the Taskforce heard on the key themes of community and family; treatment and support; law enforcement, policing and the justice system; and governance, research and data.

The footnotes indicate the source of the observations and advice.

Observations of ice use

Patterns of use

Communities and experts shared their observations about how ice is used. All the communities the Taskforce visited observed that—in recent years—more people appear to be using ice, people are using it more frequently, and the impact on society is greater than has previously been the case.[861][862]

In addition, many communities and experts observed that ice is becoming more prevalent among particular groups. In two communities, the Taskforce heard that the most common users appear to be young males.[863] However, some also said that use seems to be becoming more prevalent among very young people[864] and older people,[865] in some Indigenous communities[866] and in the lesbian, gay, bisexual, transgender and intersex (LGBTI) community.[867] Others told the Taskforce there is a high prevalence of ice use in mining communities and communities with a high population of 'fly-in-fly-out' workers.[868]

Some also said that because ice is frequently smoked, people are more willing to try it or use it more often than drugs that are typically injected.[869] At the same time, several people observed that—while people usually smoke ice—injecting is also a common method of administration.[870]

The impacts of ice use are felt particularly strongly in some regional and remote areas.[871] This can be a problem as people in these areas often experience challenges accessing local treatment and support services.[872] The Taskforce was told that ice use was a major issue in many regional towns and appeared to be increasing in regional hubs such as Broome and Darwin.[873] They were also told it is emerging as an issue in some more remote areas such as Cape York.[874] However, the Taskforce also heard that in particular remote

communities (for example, Fitzroy Crossing or Palm Island) ice was not considered to be a major problem.[875] Nonetheless there was concern among some people that ice use could leak into those remote communities. At the Broome community forum, participants said they were keen to learn more so they could be prepared should ice use become a greater problem in their community.[876]

Some people pointed out that drug use tends to be cyclical: that is, while recently they had observed an increase in people using ice, they had observed a decrease in the use of other forms of methamphetamine and other illicit drugs such as heroin.[877]

Another common observation the Taskforce heard was that ice users often use more than one drug.[878] At the roundtable of organisations representing users, one participant said that the concept of a 'drug of choice' is outdated and people are often 'polydrug' users.[879]

In addition, the Taskforce was told that drug users often present with multiple health issues or 'comorbidities'—in particular mental health issues.[880] One expert in Newcastle said they consider that ice use is usually a symptom of other problems and it is essential to address the social and mental welfare of a client in addition to their drug use.[881]

Some communities have observed an increase of drug-induced psychosis or violence.[882] One expert told the Taskforce that clients with drug-induced psychosis sometimes cannot be managed by alcohol and other drug services and they may not be eligible for mental health services. This means people with ice-induced psychosis may then be sent to emergency departments. In Townsville and at the treatment services roundtable, the Taskforce similarly heard that ice users in a drug-induced state are sometimes sent to mental health services when it would be preferable for them to be sent to drug treatment services.[883]

The Royal Australian and New Zealand College of Psychiatrists also told the Taskforce that the increase in complex and challenging presentations to acute inpatient psychiatric units has put a strain on what were already limited resources. They said it is important that acute inpatient psychiatric units, as well as emergency departments, have sufficient resources to be able to respond effectively to the mental health implications of acute methamphetamine use.[884]

The Taskforce heard from multiple experts that it is important to build partnerships between mental health and drug treatment services to develop clear 'care pathways' and avoid clients bouncing back and forth between the two sectors.[885] The need for collaboration is discussed further in the section, Coordinated services.

Impact of use

The Taskforce received around 1,200 submissions from individuals, and about one in four shared personal experiences of how ice had affected themselves, their family and their community.

The Taskforce received many submissions from people with an existing or former dependence on ice:

> *"I remember smoking my first pipe. Creating my first swirl. Telling my friends how awesome it was. Thinking about for the rest of the week. I loved how much fun it was. How cooked I got. How quick and energetic I felt. How skinny I got. How long I could stay awake for… And how much it brought people together.*
>
> *Until it tore people apart. Until it tore myself apart.*
>
> *You think you have the statistics for how many people are using ice. You guys have no idea!*[886]

There were also numerous submissions from people on how ice had affected their family:

> *"Ice use by our 29 year old son has had a devastating effect on our family. This is the worst thing to ever happen to anyone, it just destroys everything, your whole life is just chaos.*
>
> *We have had lots of things we have worked hard for smashed or broken, with holes punched in walls and doors. There seems to be no end to it all and it's very frustrating when there is no help and no one to turn to for help.*[887]

In addition, people shared their stories of the broader impact on communities:

> *"The impact of people using ice in [our regional town] is devastating!!! One ice user can affect so many people's lives!!! Families, businesses, sporting groups, safety on our roads, the safety of our homes and positions. Nothing and no one is safe anymore. I'm affected by this horrendous drugs aftermath. I found that there was not support for people who are affected by ice users.*[888]

Community and family

Community-based action

The most common advice the Taskforce received across all community consultations and expert roundtables was that locally-driven actions are essential to reduce ice use and the harm it causes. The importance of community-led action was raised at all the community consultations and many of the expert meetings.[889] It was also raised in public submissions:

> *"Have every state / territory design and implement their own campaigns which are suited to their own communities, showcase local role models and champions. Communities and people on the ground can then deliver these messages through innovative approaches.*[890]

The Taskforce heard that community-based approaches help to ensure responses are appropriate to the specific needs of a community. Several people advised this is particularly important in regional areas and remote Indigenous communities.[891] For example, one participant in the roundtable of peak alcohol and other drug bodies said he had observed that what works in metropolitan areas does not necessarily work in regional areas.[892] In their submission to the Taskforce, the NSW Young Nationals also raised the particular importance of community based responses in regional and remote areas.[893]

Participants felt that local people are best placed to know what works in their community and what services are needed. In addition, the Taskforce was told that local people have established relationships and are trusted by their communities.[894] The Taskforce visited several communities—such as Mildura and Mount Gambier—where community-driven programs to combat ice are already in place.[895]

At a forum led by Ann Sudmalis MP, it was suggested that the whole community needs to be involved in all aspects of reducing ice use. One suggestion was that there is a need to improve community facilities so that young people can have fun without the need for drugs or alcohol.[896]

Coordinated services

The Taskforce frequently heard that partnerships and coordination between services and sectors needed to be improved.[897] Mission Australia told the Taskforce:

> *"Government agencies and community service providers need to provide integrated services in order to effect sustained change. Treatment programs need to be provided through the health and justice systems in collaboration with community services and housing needs to be addressed as a priority to provide a stable foundation for change. Care also needs to be continuous with entry and exits to and from services properly coordinated to provide a seamless experience for the client where possible. Ice users should not be exited to homelessness and a housing model with wrap around supports is required to address the complex need of ice users.*[898]

The importance of a coordinated approach was also raised by Fiona Scott MP in her submission to the Taskforce. At a forum led by Fiona Scott, it was suggested the Taskforce consider 'breaking down the siloing of services and responsibilities; and providing a shared approach between health professionals, law enforcement, social workers and other community representatives to enable a whole of Government and community focus for tackling the issue'.[899]

A number of people told the Taskforce that service coordination should be managed at the local level.[900] Again, this was because local communities are in the best position to build links between organisations. However, in some communities, service providers did not have a lot of knowledge of the range and scope of other services in the area.

One expert warned against forming overly complex partnerships between sectors because they can become unwieldy and stuck in planning. At the Newcastle community forum, one participant said that in the past, an attempt to coordinate organisations at the local level (in response to youth crime issues) had been difficult because the burden of work had not been shared between all the organisations involved.[901]

Family support

The most commonly raised concern about ice in the public submissions was how the drug impacts families. The Taskforce received over 500 submissions on this topic. This was also a common concern in expert and community consultations. One parent of an ice user told the Taskforce:

> *"Ice breaks up families. All members of the family of an ice user are constantly stressed, angry, fearful and sad. Constantly on edge waiting for the knock on the door from the user or the police.*[902]

In the submissions, community consultations and expert roundtables, some of the specific impacts on families that people discussed included relationship breakdowns, domestic violence, homelessness, financial difficulties and legal difficulties.[903] Some people also said families experience stigma and fear related to a family member using ice.[904] The Taskforce was told that in Indigenous communities, the impact of an individual using ice can be especially widespread as family and community networks tend to be extensive.[905]

At the roundtable of educational organisations, a participant told the Taskforce that a major impact on families is the ability of parents using ice to support their children and the behaviour of children at school.[906] The risk to children was also one of the most prevalent themes in the public submissions.

At both the community consultations and expert roundtables, there was a lot of support for practical information or education for families on how to best engage with and find help for a family member who is using ice.[907] Suggested resources included information sheets[908] and education courses.[909]

Many people also said that more support services for families are needed—especially in regional and remote areas.[910] Suggestions included family counselling,[911] access to Family Drug Courts[912] or ongoing support after a user leaves treatment.[913] One issue raised in Broome and Mount Gambier was that families are not always well equipped to provide support to a drug user after they are released from treatment.[914]

The Salvation Army Australia told the Taskforce that, 'whilst there are some services that exist to support families, including those provided by the Salvation Army, the provision of a responsive, evidence based family education, intervention and counselling service is needed'. They also said this could be provided face to face or by telephone and web based platforms.[915]

Treatment and support

Primary prevention

Numerous people recommended to the Taskforce that there should be a strong focus on primary prevention and early intervention so individuals, communities and governments can stop ice use before it becomes a problem.[916] At

the roundtable of peak alcohol and other drug bodies, a participant said that given limited resources, the current focus is often on treating those with the most severe dependence.[917]

Numerous people said effective public messaging such as practical information campaigns is a useful form of primary prevention (discussed in the section on Public communication). Several participants also said school education has an important role to play in primary prevention.[918] At the forum led by Steve Irons MP, constituents supported school education programs being run in all schools including primary schools, high schools and including programs for parents.[919] At the education roundtable, attendees said that teachers need training and resources to run an effective prevention program.[920]

A number of people the Taskforce spoke to emphasised the importance of engaging young people in targeted and relevant ways. For example, one roundtable participant said the focus should be on young people who exhibit risk factors—rather than generalised school education campaigns.[921] Several people also emphasised the importance of age-appropriate drug education.[922] Some communities and experts also spoke about how education programs should focus on the determinants of drug use by building resilience in young people—rather than focusing on the drug itself.[923]

Experts and communities nominated role-model,[924] leadership[925] and peer-to-peer[926] programs as effective ways of targeting young people. They suggested young people respond well to people they can relate to and whose stories they find authentic. One participant at the roundtable of support organisations said that role-models can work well in Indigenous communities especially.[927]

In the public submissions, targeted education was the most commonly supported approach to reducing ice use. One community member resident told the Taskforce:

> *"Obviously detection and punishment of offenders is important, and the penalties should be draconian. However, education of the target market is likely to be more effective. Governments should consider drug use in all of its forms as important enough to make it an essential part of school curriculums.*
>
> *The education should not be handled by teachers or police, but by well-informed people who have or can gain credibility with students. If we are able to take the demand away we will move one step closer to minimizing the problem.*[928]

However, at a forum led by Senator Nash, it was also pointed out that education should not just be targeted at school aged children and that older people in the community were also trying the drug.[929]

Early intervention

Early intervention was identified an important way to address ice use before a person becomes dependent. The Taskforce heard that messaging can play a role in early intervention. One participant in the roundtable of peak alcohol and drug organisations said it is important that occasional users have access to information to let them know what support is available so that their drug use does not progress to become a problem.[930]

Several experts and communities said that early intervention is hampered when services are not available on demand when a person seeks help.[931] The Taskforce heard that due to a lack of resources or 'bureaucratic roadblocks',[932] some users are placed on lengthy waiting lists before receiving treatment and the window for early intervention is missed. This is a particular issue in regional and remote areas where there are fewer services.[933]

In a similar vein, a number of communities said that there should be support services available 24 hours a day so that users, families and frontline workers can access help when needed.[934] At the Townsville consultation, one participant said that once emergency departments have an ice user under control,

they find they have nowhere to send them as there is a lack of afterhours support.[935]

Frontline and primary health workers are in a position to assist with early intervention as they are often the first group to come into contact with people when their drug use starts to become a problem. An expert told the Taskforce that this form of early intervention is crucial as occasional ice users are more likely to go to their General Practitioner for help than to treatment or support services. This is discussed in more detail in the section on Workforce development.

In addition, the National Centre for Education and Training on Addiction at Flinders University identified the workplace as a pivotal setting for prevention and early intervention of methamphetamine use, but noted it is often overlooked.[936] Some communities indicated support for workplace testing for methamphetamine across all industries.[937]

Treatment and services: availability

The Taskforce was told by communities that we cannot 'arrest ourselves out of the problem' of ice.[938] A common sentiment from both the law enforcement and health sectors is that—while law enforcement is important—the best way to reduce drug use and its associated harm is through the health system.[939] The submission from the University of New South Wales' Drug Policy Modelling Program stated that 'general law enforcement activities have not been demonstrated to be cost effective whereas treatment and harm reduction have been'.[940] At the same time, there was a clear preference in some public submissions for strong action against drug traffickers. This is discussed further in the section on Law enforcement and policing.

One common message from treatment providers was that treatment programs can be effective for people dependent on ice.[941] For example, Odyssey House Victoria said that outcomes for people they treat for amphetamine problems are similar to those for people treated for other drug or alcohol problems.[942]

However, the Taskforce heard from numerous communities and experts that there was a need for more of certain types of treatment and support services. For example, the Taskforce heard from a number of people that—in both urban and non-urban areas—more services such as detox, crisis and respite care are needed to help manage the withdrawal phase.[943] For example, in Townsville, some in the community said they needed a local court-ordered detox centre.[944] At the roundtable of organisations representing users, one participant said that homeless, street based users need crisis accommodation so they can get fed and sleep safely for a day—and that some mainstream services will not take them in.[945] The Taskforce also heard that in some places, there is a real need for respite care for users and families so people do not need to turn to emergency departments or mental health services.[946]

Numerous people also told the Taskforce that all types of drug treatment and support services are lacking in regional and remote areas.[947] However, the Taskforce heard that some people in regional and remote areas may be reluctant to disclose their drug use to healthcare professionals who are more likely to be personally known to them.[948]

It was clear that the specific needs of each community differ across the country, and many people highlighted the importance of managing service needs at the local level (see Coordinated services). For example, while some towns said more detox facilities were needed, in Hobart the Taskforce heard that state-wide detox facilities are accessible, but there were delays getting into rehabilitation.[949]

At some of the roundtable meetings, people stressed the importance of counselling and therapy in treating ice users.[950] In the public submissions, counselling and therapy was one of the most commonly supported approaches—for both users and their families.

> *"I believe efforts should be rehabilitation and counselling support for those affected by the drug, especially families of those affected, this drug is sure to have long term effects on children of these families.*[951]

Some people also emphasised the importance of ongoing post-treatment support, such as support in finding adequate housing and employment.[952] Similarly, others also spoke about the necessity of 'wrap around' services.[953] This involves access to a full range of support services, such as family support, housing, employment and legal assistance, focused on the specific needs of the individual client and usually coordinated at a central point. This model would help to address the needs of users who have other issues beyond problematic ice use.

Treatment and services: tailoring support

Numerous experts also emphasised the importance of ensuring treatment is tailored to the specific needs of ice users.[954] For example, in Darwin, the Taskforce heard that a service provider was considering modifying their treatment program for ice users given they had observed volatile behaviour and long, intensive withdrawal periods among this group.[955] UnitingCare ReGen—a alcohol and other drug treatment and education agency in Victoria—has already implemented a new treatment model for people undertaking methamphetamine withdrawal. An external evaluation of the program found positive results.[956]

Other people told the Taskforce that treatment should be tailored to the individual. This was a key message at the ice forum held by Karen McNamara MP in the Central Coast of New South Wales. Constituents at that forum said that 'there are different rehabilitation methods that work and…we must identify an approach which is suited for the person seeking help'.[957] For example, the Taskforce heard from a number of experts that residential rehabilitation is not necessarily the best option for some ice users as it means people must be away from their family, community or employment.[958] Rehabilitation in the home environment may be preferable in many cases.

The Taskforce also heard that treatment should be appropriate to the level of dependency of the user. For example, in a forum led by Senator Nash, there was support for more clearly identifying and supporting the role of primary care in less complex cases.[959]

In addition, some experts told the Taskforce that responses should be targeted to specific communities of ice users. For example the Victorian AIDS Council advised that some mainstream alcohol and other drug services are not adequately resourced to respond to members of the LGBTI community, which can deter LGBTI people from seeking treatment.[960] Similarly, the Victorian Alcohol and Drug Association found that while culturally and linguistic diverse (CALD) communities are at increased risk of experiencing harms related to alcohol and other drug use, they are underrepresented in treatment. The Victorian Alcohol and Drug Association told the Taskforce that therefore, more needs to be done to improve the capacity of treatment providers to deliver culturally safe and responsive services.[961]

The age of users should also be taken into account. Mission Australia told the Taskforce that adult treatment facilities are not appropriate—and often not available—for young people:

> *"Most facilities are only available to those over 18 years of age and are not appropriate for young people. Adult facilities often do not provide the supports…young people need to recover, particularly young people with underlying experiences of trauma, and may in fact expose young people to more trauma through contact with older people going through withdrawal. Youth-specific facilities which deal with young people holistically in a safe, secure and encouraging environment are much more likely to succeed long-term.*[962]

The Ted Noffs Foundation similarly called for the establishment of more youth treatment services across Australia and pointed to

evidence that ice users tend to start in their teens and that treatment is more effective the earlier it begins.[963]

Treatment and services: resourcing

A number of experts and communities are concerned that there is not enough government funding for treatment and support services.[964] Similarly, some family members of ice users told the Taskforce about the extremely high cost of private treatment:

> *"There was an excellent program in South Australia which our son was fortunate to do…*
>
> *It was $22,500! But if I had to do it again for another family member, I would. It has changed our son, saved him and enabled him to use the skills taught and understandings of addiction, to lead an independent life.*[965]

However, the primary challenge raised by experts and communities was the short term nature of funding[966] and tendency for funding outcomes to be confirmed at the last minute.[967] Many people argued that lack of funding certainty means they cannot run long term programs[968] and it is difficult to retain good staff.[969] Several people said the lack of long-term programs is particularly an issue in relation to methamphetamine treatment given the withdrawal period is longer than for many other drugs.[970]

The competitive nature of government funding was also discussed. Some said this leads to rivalry between providers rather than collaboration.[971] People also said it means a lot of resources are spent applying for funding—or preparing for a funding cut—rather than helping people to get off drugs.[972]

Some communities and experts also told the Taskforce that changes to funding arrangements related to the Commonwealth Government's Indigenous Advancement Strategy have exacerbated some of these challenges for organisations in remote areas.[973]

Workforce development

Around 50 workers dealing with ice—including individual nurses, doctors, police, social workers and teachers—made public submissions to the Taskforce.

Numerous communities and experts said there is a need for more information or training for people who work with ice users, especially those on the 'frontline'.[974] The workers who people suggested need more training or resources include health workers such as general practitioners,[975] emergency doctors,[976] ambulance workers,[977] nurses,[978] mental health workers,[979] pharmacists[980] and alcohol and other drug service providers.[981] Other workers identified included legal officers,[982] magistrates[983] and police.[984]

Many people also said that certain workers need more training or resources on drug treatment and referral networks. This would help workers to identify ice users and provide advice on the most effective care pathways.[985] In Newcastle, the Taskforce was told that when users first engage with the health or justice system, they do not always get the assistance that they need.[986] In Townsville, a participant suggested a telephone support line would be useful for healthcare workers and police to assist users.[987] The organisation Turning Point Alcohol and Drug Centre run this type of helpline for General Practitioners:

> *"The role of addiction medicine and psychiatry specialists in providing support to frontline workers has already been demonstrated through the statewide Drug and Alcohol Clinical Advisory Service (DACAS), operated by Turning Point in Melbourne, a 24/7 model that enables general practitioners and other health professionals to seek timely and expert clinical advice via a telephone/paging system. The service has wide-reaching ability to assist practitioners in regional and remote locations with the current coverage across Victoria, Tasmanian and the Northern Territory.*[988]

In addition, the Taskforce heard that more guidance on treating users was required and that current guidelines need to be updated to

account for issues such as higher purity of ice, harms caused and new treatment evidence. The submission to the Taskforce from the National Centre for Education and Training on Addiction supported these views:

> *"Substantial workforce development efforts are required to reorient services to meet the needs of ice affected users and their families. The nature of methamphetamine-related problems means that services may need to: modify their appointment scheduling to allow for shorter but more frequent sessions; and engage in proactive follow-up to ensure treatment retention.*[989]

At the roundtable of Indigenous support organisations, the Taskforce heard that some workers—in fields such as policing, teaching and health—could be inexperienced and already struggling to cope in Indigenous communities. The addition of dealing with ice means there are greater challenges and workers without adequate support may not stay very long in the communities.[990]

In Darwin, the Taskforce heard that some workers are reluctant to engage with ice users as they are fearful of violence. It was suggested that providing people with information on ice and its effects would help give workers greater skills and confidence to engage safely with ice users.[991]

Harm reduction

There was some support for harm reduction approaches by experts, communities and in submissions, but it was not a strongly prevalent theme in the consultations.

One of the most widely supported harm reduction approaches is needle and syringe programs or education about safe injecting methods.[992] These programs can help to reduce the risk of transmitting blood borne viruses. One suggestion in Broome was to reintroduce a needle exchange program to avoid needles being discarded and creating a hazard for the community.[993] It was also suggested that the Taskforce consider expanding these programs to smoking implements (for example, ice pipes).[994] At the Indigenous roundtable, one participant said that access to existing needle and syringe programs was a challenge in remote Indigenous communities.[995]

There was also some discussion of the importance of ensuring safety in emergency departments—some of which report seeing an increase in psychotic presentations and violence against staff, families and police.[996] On the other hand, at the roundtable of health sector representatives, one participant said that most ice users are not violent and will not destroy the emergency room.[997]

In the submissions to the Taskforce, there were reports of ice-related violence in emergency departments. For example, St Vincent's Health Australia told the Taskforce that in their Sydney and Melbourne hospitals:

> *"...there have been increased volatile and aggressive interactions between patients who have used meth/amphetamine and our emergency and health-care professionals and co-patients. Many of these assaults have been of a serious nature and have resulted in staff requiring medical attention and lost time to recover from their psychological and physical injuries.*[998]

An emergency nurse from New South Wales reported a similar experience:

> *"I was involved with an aggressive Ice abuser in Darwin. She threatened us that she would shoot us and herself...*
>
> *Despite a 5 people 'Hold-down', the patient hit the Emergency registrar in the stomach and arm with her leg and hit me onto the arm...*
>
> *I am concerned that any aggressive patient on Ice can attack us and we can't legally protect ourselves.*[999]

UnitingCare ReGen in Victoria supported the view that ice users present particular issues for frontline workers:

> *"The emergence of methamphetamines has created challenges for frontline workers. This is mainly due to behaviours such as agitation and violence that can be associated with intoxication, particularly for those experiencing drug-induced psychotic symptoms such as paranoia.*[1000]

Safe injecting or 'ice consumption' rooms were not commonly raised in the submissions. However, the Sydney Medically Supervised Injecting Centre (MSIC) made a submission to the Taskforce in which they stated they had managed over 8,000 injections for methamphetamine in the past year.[1001] The MSIC reported that they managed this degree of methamphetamine use without any health and safety incidents specifically related to ice.

The submission from the MSIC noted that they believe this is because 'the staff treat all clients with dignity and respect and are highly skilled at early intervention and de-escalation techniques'. It says this 'shows that violence is not inevitable, is linked to the broader context of drug use, and to a significant degree can be minimised with an appropriately skilled workforce'.

Decriminalisation of drug possession was raised at some community meetings[1002] and in some submissions.[1003] However, it was not discussed at length in meetings and it was not a prevalent theme in the consultations.

Law enforcement, policing and the justice system

Law enforcement and policing

At the expert roundtables and community meetings, the Taskforce heard suggestions for improving law enforcement and policing. The Taskforce heard that it was important for law enforcement to have the resources necessary to effectively investigate and deter drug manufacture and distribution.[1004]

Several people suggested that it was important to deal harshly with traffickers and criminal organisations who supply drugs. This was a particularly prevalent theme in the public submissions. For example, one father of a former ice user told the told the Taskforce to consider:

> *"Making the sale of ice and other hard drugs…a federal crime with a minimum sentence of 5 years non-parole for dealers and up to 25 or life without parole for the people at the top but you need the judges to enforce the penalty not a slap on the wrist like they get.*[1005]

Another suggested approach was to focus on disrupting the market at the point of origin. The Taskforce heard, for example, that the Australian Government should enhance international engagement with governments on pharmaceutical and chemical regulation and police and border security intelligence exchange.[1006]

The Taskforce heard about the importance of programs that build strong links between police and the community, especially in remote Indigenous communities.[1007] For example, in Broome, the Taskforce heard that Community Engagement Police Officers who work in some remote areas have been successful in building more trusting relationships between police and the community.[1008] Similarly, in Mildura the Taskforce heard that—because local police were already part of an established community network—when ice emerged as an issue in the community, people knew where to go for assistance.[1009]

At a number of the community consultations, participants also wanted to know how they could anonymously 'dob in a dealer'.[1010] The Taskforce heard anonymity is important for 'dob in a dealer' programs because people said they fear retribution from the community.[1011]

Some experts and communities also suggested that—similarly to other frontline workers—some police would benefit from more information on how to engage with and where to refer ice users.[1012]

Diversionary programs

At several community forums, people said that police or court diversion programs are effective in assisting users.[1013] This can involve police or courts sending users to treatment rather than

arresting, charging or incarcerating them. Some people also said that there were not enough diversion programs or that magistrates need more options to send people to treatment, especially outside of cities.[1014]

Several experts and communities supported specialty drug courts and diversionary programmes.[1015] The Australasian Therapeutic Communities Association nominated the Alcohol and Other Drug Treatment Court in Auckland, New Zealand as a particularly successful model.[1016]

The New South Wales Aboriginal Land Council also told the Taskforce that governments should increase diversionary options. They said this is important because Indigenous people are overrepresented in the criminal justice system, and incarceration has major health and socioeconomic consequences, both for individuals and the community from which the offender comes.[1017]

However, one issue raised was that people who have committed violent offences are usually excluded from existing diversion programs—which means violent ice users cannot access diversion programs.[1018]

Correctional system

While it was not frequently discussed in the consultations, there was some support for improving drug treatment and support programs inside correctional facilities.[1019] There was also a concern that drug use often starts or escalates in correctional facilities.[1020] At the roundtable of peak alcohol and other drug bodies, one participant was concerned that Indigenous people were learning to inject drugs in correctional facilities and taking that back to their community.[1021]

In addition, at the roundtable of treatment organisations, the Taskforce was told that—when people with drug problems leave correctional facilities—they sometimes lose access to support programs available in correctional facilities and risk relapse.[1022] This need for ongoing support for people after they leave a correctional facility was also raised at some of the forums held by Senator Nash.[1023]

Governance, research and data

Integrated responses

The Taskforce was told that drug use is a complex issue that requires a multifaceted and integrated response. For example, the National Drug Research Institute said in their submission that the Taskforce should 'recognise the complex factors that contribute to drug use and related problems and the need for multifaceted responses'.[1024] Similarly, the South Australian Network of Drug and Alcohol Services told the Taskforce that the complexity of alcohol and other drug use in Australia means that 'no one institution is capable of solving it alone' and 'it is not a problem that can be 'fixed' but how we deal with it can be improved by increments'.[1025]

In particular, the Taskforce heard from numerous experts and communities that the National Ice Action Strategy should complement or be integrated with other drug strategies and work already done to reduce drug use. This would ensure the National Ice Action Strategy builds on—rather than duplicates—existing work. For example, the Taskforce heard the response to ice should be integrated with the National Drug Strategy,[1026] the National Amphetamine-Type Stimulant Strategy 2008-2011,[1027] the recent Victorian Ice Action Plan[1028] and the National Aboriginal and Torres Strait Islander People's Drug Strategy 2014-2019.[1029]

In addition, the Taskforce was told that the National Ice Action Strategy should focus not just on ice, but on drugs more broadly.[1030] They heard that any new services should be integrated with services for other drugs.[1031] An issue raised was that there was a risk that targeting ice in isolation could just shift the problem to another drug.[1032]

There was also some concern that an exclusive focus on ice could result in cost shifting away from other alcohol and other drug services.[1033]

Leadership and coordination

Numerous experts and communities said that the Commonwealth had a role to play in leading and coordinating a national response to ice.[1034] It was also suggested that responses should be

led by a central agency—such as the Department of the Prime Minister and Cabinet or the Departments of Premier and Cabinet in each state and territory—because coordination between government agencies is required.[1035]

A number of experts and communities were also concerned about the lack of coordination of funding for services between the Commonwealth and state and territory governments.[1036] For example, at the roundtable of peak alcohol and other drug bodies, the Taskforce was told that some organisations faced funding challenges and potential gaps because they relied on both state and Commonwealth funding to deliver services.[1037]

A number of people told the Taskforce that coordination of law enforcement activities between the Commonwealth and states could be improved on several fronts. For example, law enforcement agencies in different jurisdictions needed to improve the sharing of data and intelligence.[1038]

In Mildura, the Taskforce heard that nationally consistent unexplained wealth laws between jurisdictions would be useful in targeting ice suppliers.[1039] This would help in tracking money at a national level so that criminal activities can be more frequently interrupted.

In addition, the Taskforce was told that a national approach to reducing the availability of precursor chemicals (the chemicals used in manufacturing ice) would also assist.[1040] In their submission to the Taskforce, the Pharmacy Guild of Australia detailed their support for a consistent national approach to the control of precursors, such as pseudoephedrine. However, they also acknowledged this is a complex issue which requires a whole of industry approach and tighter controls of all parts of the supply chain.[1041]

Public communication

Many people commented on how ice is often represented in the media and public communication campaigns. The Taskforce heard—particularly at expert roundtable meetings—that messaging on ice should not be inflammatory or sensationalised.[1042] People expressed concern that these types of representations can stigmatise users and families and deter them from seeking help. Numerous experts and communities said that instead, messages should give people hope that there is assistance available and that recovery is possible.[1043] Some people also raised a concern that the use of the term 'ice' glamorises the drug.[1044]

Many people suggested that users and families be provided with information about ice that is informative and useful.[1045] For example, practical information about the effects of the drug and where to get help. Multiple experts mentioned the National Cannabis Prevention and Information Centre website as a good model of this type of information.[1046]

This need for practical information was shared by the National Drug Research Institute:

> *"It is important to disseminate credible information to the community about methamphetamine including the prevalence of use, long and short-term physical and mental health and social effects.*[1047]

Multiple people told the Taskforce that there should be one phone number or website for the whole country.[1048] One participant in Darwin suggested this single point of contact should provide access to all services including assessments and legal advice.[1049]

In addition, numerous people told the Taskforce these messages should be tailored to specific cohorts of users.[1050] For example, people said public messages should be age-appropriate,[1051] culturally-appropriate,[1052] and targeted to people most at risk.[1053]

There was also some support for using technology to communicate. For example, people suggested mobile phone apps to raise awareness of available services,[1054] telehealth for training in remote areas,[1055] online intervention programs, and social media campaigns for occasional users.[1056]

On the other hand, many Australians—particularly in the public submissions—expressed support for strong messages about

ice, which are clear about the damage it can cause. One father of an ice user told the Taskforce:

> *"I also think that there should be significantly more advertising and publicity within schools and in the media on what drugs do to people and families. I cannot remember the last time I saw an advert on TV about this.*[1057]

A number of public submissions also said that public messages should be appropriately targeted:

> *"I feel since ALL kids have a smart phone and know how to use them, if we were to target them through social media, say when they opened facebook or some such site that most kids use, there would be a menu with "drugs are not for me" or some such words.*
>
> *Kids being inquisitive would look at it. This site would explain how drugs affect the body, your life, your family, your future. With photos etc. to explain in detail.*[1058]

Data and research

A number of people raised the issue of the lack of comprehensive or timely data on patterns of ice use. There are evidence gaps on—for example—who is using ice, how they are using ice and when they are using.[1059] There is also a lack of data that is specific to ice or even methamphetamine use.[1060] The Taskforce were told that one of the barriers to obtaining drug-specific data is that people often use multiple drugs or have other issues such as mental illness—which means they may not be classified as an ice user.[1061]

The Penington Institute raised the issue of the lack of availability of timely data on ice use in their submission to the Taskforce. They pointed out that 'there is a need for systematic early warning data systems to provide frontline staff with information about drug trends and to assist in developing targeted strategies to address ice-related harm, particularly to at-risk populations'.[1062] The roundtable of peak alcohol and drug bodies also told the Taskforce that a clearer picture of ice use would help in determining the best treatment models.[1063]

Some people told the Taskforce that wastewater analysis is a useful way for police to find 'pockets' or 'hot spots' of ice use. It is also an accurate way to collect real time data on drug use in a community.[1064]

Several experts also told the Taskforce that we need to build better evidence of effective treatment through more research and evaluation of programs. Numerous people said that more research and evaluation is required to determine specifically what works when treating methamphetamine users.[1065] Some also spoke about the need to clearly evaluate programs, so that funding grants can be targeted to programs that we know work.[1066] Some roundtable participants also said there is preliminary research that indicates funding alcohol and other drug services can result in longer term cost savings for the community, but more research would be useful.[1067] At the roundtable on alcohol and other drug research, people asked for longer-term funding for research projects and said this would assist in getting better outcomes.[1068]

Another issue raised at the roundtable on alcohol and other drug research was the need to coordinate all the research, treatment and support activities that focus on methamphetamine in particular, and alcohol and other drug issues in general. The participants told the Taskforce that while there is a lot being done, there is a need to harness all the information that already exists in a systematic manner.[1069]

Several experts said that treating users with legally prescribed drugs (pharmacotherapy) had potential—but more research was needed to find an appropriate drug to treat ice users.[1070]

Organisations represented

The tables below list the organisations represented at the community consultations, roundtable meetings and in the public submissions.

Table AI.4: Organisations represented at community consultations

Mount Gambier
Mount Gambier
ac.care
Centacare Catholic Family Services
DeGaris Lawyers
Department of Education and Child Development, Government of South Australia
Families SA, Department of Education and Child Development, Government of South Australia
Karobran New Life Centre
Life Without Barriers
City of Mount Gambier Council
Mount Gambier Hospital
Mount Gambier Prison
Pangula Mannamurna
South Australia Ambulance Service
Local Health Networks, SA Health, Government of South Australia
South Australia Police
South East Community Legal Service
South East Regional Community Health Service
Uniting Communities
Broome
Broome Hospital
Aboriginal Medical Service
Cyrenian House Milliya Rumurra Outreach Service
Drug and Alcohol Office, Government of Western Australia
Headspace
Kimberley Mental Health and Drug Service, Department of Health, Government of Western Australia
Ngnowar Aerwah Aboriginal Corporation
Nindilingarri Cultural Health Services
Nirrumbuk Aboriginal Corporation
Ord Valley Aboriginal Health Service
Royal Flying Doctor Service
School Drug Education and Road Aware, Department of Education, Government of Western Australia
St John Ambulance
Western Australia Country Health Service, Government of Western Australia
Western Australia Police
Darwin
Alcohol and Other Drugs Services, Department of Health, Northern Territory Government
Amity Community Services
Banyan House
CatholicCare NT
Council for Aboriginal Alcohol Program Services
Danila Dilba Health Service
Darwin Aboriginal and Islander Women's Shelter

Darwin Region Indigenous Suicide Prevention Network
Drug and Alcohol Services Association of Alice Springs
Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties
Headspace
Larrakia Nation
Northern Territory AIDS and Hepatitis Council
Northern Territory Crisis Assessment Telephone Triage and Liaison Service
The Salvation Army
St John Ambulance
Tobacco Alcohol and Other Drugs Services
Top End Mental Health Services
Newcastle
Awabakal Ltd
Brian Dowd & Associates
Calvary Mater Hospital
Corrective Services New South Wales, Department of Justice, New South Wales Government
John Hunter Hospital
Magistrates Early Referral into Treatment, Newcastle
Mental Health and Drug and Alcohol Office, New South Wales Health, New South Wales Government
Muloobinba Aboriginal Corporation
New Horizons
Newcastle Community Drug Action Team
New South Wales Police
The Glen Centre
Wandiyali ATSI Inc
Warlga Ngurra Women and Children's Refuge
We Help Ourselves
Yerin Aboriginal Health Services
Hobart
Alcohol, Tobacco and Other Drugs Council Tasmania
Alcohol and Drugs Services, Department of Health and Human Services, Tasmanian Government
Advocacy Tasmania
Department of Education, Tasmanian Government
Royal Hobart Hospital
Ambulance Tasmania
The Salvation Army
Anglicare
Drug Education Network
The Link Youth Health Service
Holyoake
Tasmanian Aboriginal Centre
Tasmania Police
Tasmanian Prison Service, Department of Justice, Tasmanian Government
Corrective Services Tasmania, Department of Justice, Tasmanian Government
Tasmanian Users Health and Support League
Family Inclusion Network Tasmania
CatholicCare Tasmania
Hobart City Mission
Relationships Australia Tasmania

The Hobart Clinic
Colony 47
Teen Challenge Tasmania
Townsville
Department of Aboriginal and Torres Strait Islander Partnerships, Queensland Government
Department of Education, Queensland Government
Ingham Hospital
Ozcare Drug and Alcohol Services
Queensland Ambulance Service
Queensland Police Service
Queensland Youth Services
Stagpole Street Drug and Alcohol Rehabilitation Unit
Townsville Recovery Services, The Salvation Army
Townsville Alcohol, Tobacco and Other Drugs Service, Queensland Health, Queensland Government
Townsville and Mackay Medicare Local
Townsville Community Ice Taskforce
Townsville Hospital
Townsville Magistrates Court
Townsville Youth Justice Centre
Mildura
Anglican Church
Community Correctional Services, Department of Justice and Regulation, Victorian Government
Department of Health and Human Services, Victorian Government
Department of Justice, Victorian Government
Local Aboriginal Justice Action Committee, Swan Hill Area, Department of Justice and Regulation
Mallee Accommodation and Support Program
Mallee District Aboriginal Services
Mallee Family Care—Haselgrove House
Mallee Sexual Assault Unit
Mallee Sports Assembly
Mildura Base Hospital
Mildura Rural City Council
Northern Mallee Community Partnership
Northern Mallee Local Learning and Employment Network
Sunraysia Community Health Services
Victoria Police

Table AI.5: Organisations represented at roundtable meetings

Peak alcohol and drug bodies
Alcohol, Tobacco and Other Drugs Council Tasmania
Alcohol, Tobacco and Other Drug Association Australian Capital Territory
Association of Alcohol and Other Drug Agencies Northern Territory
Network of Alcohol and Other Drug Agencies New South Wales
Queensland Network of Alcohol and Other Drug Agencies
South Australian Network of Drug and Alcohol Services
Victorian Alcohol and Drug Association
Western Australian Network of Alcohol and Drug Agencies
Health and medical associations
Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians
Australasian College for Emergency Medicine
Australasian Professional Society on Alcohol and Other Drugs
Australian College of Rural and Remote Medicine
Australian Medical Association
Australian Psychological Society
Council of Ambulance Authorities
Drug and Alcohol Nurses Association of Australasia
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners
Educational organisations
Australian Council of State School Organisations
Australian Parents Council
Australian Research Alliance for Children and Youth
Life Education Australia
National Catholic Education Commission
School Drug Education and Road Aware, Department of Education, Government of Western Australia
Drug and alcohol research centres
Burnet Institute
Dalgarno Institute
National Centre for Education and Training on Addiction, Flinders University
National Drug and Alcohol Research Centre, University of New South Wales
National Drug Law Enforcement Research Fund
National Drug Research Institute, Curtin University
New South Wales Police
Penington Institute
Turning Point Alcohol and Drug Centre
Organisations involved in prevention activities
Australian Drug Foundation
Youth Projects
Headspace
Homelessness Australia
National LGBTI Health Alliance
National Rural Health Alliance
Pharmaceutical Society of Australia
Pharmacy Guild of Australia
Public Health Association
UnitingCare ReGen

Treatment services
Alcohol and Drug Service, St Vincent's Hospital Sydney
Association of Participating Service Users
Australasian Therapeutic Communities Association
Australian Injecting and Illicit Drug Users League
Ted Noffs Foundation
The Salvation Army Australia
UnitingCare ReGen
We Help Ourselves
Services that support users and families
Carers Australia
Drug ARM
Family Drug Support
Legal Aid NSW (representing National Legal Aid)
Odyssey House McGrath Foundation
Indigenous health and legal organisations
Australian Indigenous Doctors' Association
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Prime Minister's Indigenous Advisory Council
Indigenous Allied Health Australia
National Aboriginal and Torres Strait Islander Health Worker Association
National Aboriginal and Torres Strait Islander Legal Services
National Aboriginal Community Controlled Health Organisation
National Drug Research Institute, Curtin University
Organisations that represent drug users
Australian Injecting and Illicit Drug Users League
Canberra Alliance for Harm Minimisation and Advocacy
Harm Reduction Victoria
New South Wales Users and AIDS Association
Northern Territory AIDS and Hepatitis Council
Queensland Injectors Health Network
Tasmanian Users Health and Support League
Western Australia Substance Users Association

Table AI.6: Organisations and parliamentarians that made publicly available submissions

Organisations
Aboriginal Health & Medical Research Council of New South Wales
Aboriginal Health Council of Western Australia
AIDS Council of NSW
Alcohol, Tobacco and Other Drugs Council Tasmania
Australasian Professional Society on Alcohol & Other Drugs
Australasian Therapeutic Communities Association
Australian Drug Law Reform Foundation
Australian Drug Law Reform Initiative, The University of New South Wales
Australian Federation of AIDS Organisations
Australian Injecting & Illicit Drug Users League
Australian Institute of Tropical Health & Medicine, James Cook University
Australian Psychological Society
Australian Strategic Policy Institute
Bridges Incorporated
Burnet Institute
Cape York Partnership & Apunipima Cape York Health Council
Caraniche
Lisa Chesters MP, Federal Member for Bendigo, Victoria
George Christensen MP, Federal Member for Dawson, Queensland
cohealth
Community Access and Services South Australia
Corryong Neighbourhood Centre
Crime Stoppers Australia
Dorset Community Ice Breaker Forum Team
Dreamtime Training
Drug Policy Modelling Program, National Drug and Alcohol Research Centre, University of NSW
Family Council WA
Family Drug Support
Foster Care Association of the ACT
Foundation for a Drug-Free World
Health&
Steve Irons MP, Federal Member for Swan, Western Australia
Living Positive Victoria
Lyndon Community
Associate Professor Rebecca McKetin, The Australian National University
Karen McNamara MP, Federal Member for Dobell, New South Wales
Mission Australia
Senator the Hon Fiona Nash, Minister for Rural Health and Senator for New South Wales
National Association of People with HIV
National Cannabis Prevention and Information Centre
National Centre for Education and Training on Addiction, Flinders University
National Drug and Alcohol Research Centre, University of New South Wales
National Drug Research Institute, Curtin University
National Rural Health Alliance
Network of Alcohol and Other Drug Agencies New South Wales
New South Wales Aboriginal Land Council

Organisations
Andrew Nikolic AM, CSC, MP, Federal Member for Bass, Tasmania & Eric Hutchinson MP, Federal Member for Lyons, Tasmania
Nimbin HEMP Embassy
Northern Territory AIDS & Hepatitis Council
Young Nationals New South Wales
Odyssey House Victoria
Penington Institute
Hon Tanya Plibersek MP, Federal Member for Sydney, New South Wales
Royal Australian and New Zealand College of Psychiatrists
Royal Australian College of General Practitioners, Network in Addiction Medicine
The Salvation Army Australia
The Salvation Army, Townsville Recovery Services
Scarlet Alliance, Australian Sex Workers Association
Fiona Scott MP, Federal Member for Lindsay, New South Wales
SMART Recovery Australia
Social Research & Evaluation Pty Ltd
South Australian Network of Drug and Alcohol Services
South Pacific Private
Specialised Pharmacy Supplies
St Vincent's Health Australia
Ann Sudmalis MP, Federal Member for Gilmore, New South Wales
Sydney Medically Supervised Injecting Centre
Townsville Community Ice Taskforce
Turning Point Alcohol and Drug Centre
UnitingCare ReGen
Victorian AIDS Council
Victorian Alcohol and Drug Association
Victorian Dual Diagnosis Initiative
We Help Ourselves
Weave Youth and Community Services
Western Australian Network of Alcohol and Drug Agencies
Brett Whiteley MP, Federal Member for Braddon, Tasmania
Senator Nick Xenophon, Senator for South Australia
youth2knowledge

APPENDIX II
SOCIAL DETERMINANTS OF DRUG USE

The term 'social determinants of health' refers to the interrelationship between health outcomes and the environmental and individual characteristics that affect a person's life. While debate remains regarding the precise means through which social factors affect health outcomes, the link between disadvantage and ill-health is beyond dispute.[1071]

The environmental and individual characteristics that can influence health outcomes include:

- Macro-social factors—political economy, the cumulative effects of historical factors, social institutions, culture
- Distal-social factors—neighbourhood and community
- Proximal social factors—family and friends
- Individual characteristics—socioeconomic, psychosocial and behavioural
- Genetic characteristics—human biology and genetics
- Pathobiology—pathological biomarkers.[1072]

There is a well-established relationship between social determinants and problematic drug use. Marginalised youth in disadvantaged communities with little or no family support and limited access to education are especially at risk.[1073] The relationship between social determinants and drug use does not occur in a vacuum and there are strong associations with other health damaging behaviours, such as poor diet, inadequate exercise, cigarette smoking and excessive drinking.[1074]

Strong links have been established between drug use and social and economic factors, including poverty, unemployment, culture, community and family disadvantage.[1075] People with drug dependencies are particularly likely to be unemployed and experience marginalisation—both of which can exacerbate problems and inhibit a person from seeking or benefiting from support and treatment.[1076]

Evidence suggests that the relationship between socioeconomic status and drug use is bi-directional.[1077] Low socioeconomic status can contribute to the harm experienced from drug use,[1078] while drug use can serve to further lower a person's socioeconomic status.[1079] This in part explains how drug use and resulting harm can become embedded in more disadvantaged communities.

Social disconnection from community and family is also an increasing risk factor for drug related harm.[1080] For Indigenous Australians, higher levels of alcohol, tobacco and other drug use among some sections of the Indigenous population are understood to be both a consequence of, and to contribute to, the social determinants of health and social inequality.[1081]

Aspects of the physical environment have been demonstrated to affect health, including drug use behaviours. The quality of housing, urban planning and transport are likely to affect the environment in a manner that either fosters or averts drug use problems within a community.[1082]

Table AII.1: Aspects of the physical environment that affect health[1083]

Aspect	Issue	Effects
Housing	Housing quality	Self-identity
		Despondency
		Depression
	Overcrowding	Depression
		Noise, which affects children's academic attainment and stress
	Cost	Exacerbates poverty
	Availability	Homelessness
		Insecurity
		Mobility, which affects children's academic achievement and socialisation
Spatial patterns	Concentration of public housing	Concentration of disadvantage
		Crime rates
		Drug markets
		Identity and self-esteem
		Social norms of education, employment, crime and drug use
	Suburban sprawl	Social networks
		Civic networks
	Geographic isolation, including regional and remote communities	Access to resources and opportunities, which affect engagement and employment
Community physical disorder	Community perceived as unsafe and unappealing	People stay indoors
		Reduced social interactions and networks
Inadequate public transport	Increased car dependency and traffic flow	Area perceived as less safe and friendly, resulting in less outdoor activity
		Less public interaction
		Increased stress
		Constraints on child development due to less exploration of the environment and reduced social contacts
		Effect on drink-driving and drug-driving
	Exacerbation of impacts of low socio-economic status	Reduced access to jobs and employment opportunities, social networks (contributing to loneliness and depression) and recreation (contributing to boredom and a lack of motivation)
Public spaces	Lack of public spaces in which young people can socialise in the presence of adults	Increased exposure to drug markets and antisocial youth
		Decreased informal social controls from adults and adult role models

Risk factors

The probability of drug use behaviour can be assessed based on characteristics that exist before the behaviour emerges.[1084] While no single risk factor can be pinpointed as the cause of future drug use, the more individual risk factors persisting over a longer period of time, the greater the cumulative effect.[1085] Exposure to risk factors earlier in life can have a 'snowball effect,' with subsequent risk factors accumulating as a consequence of earlier issues.[1086]

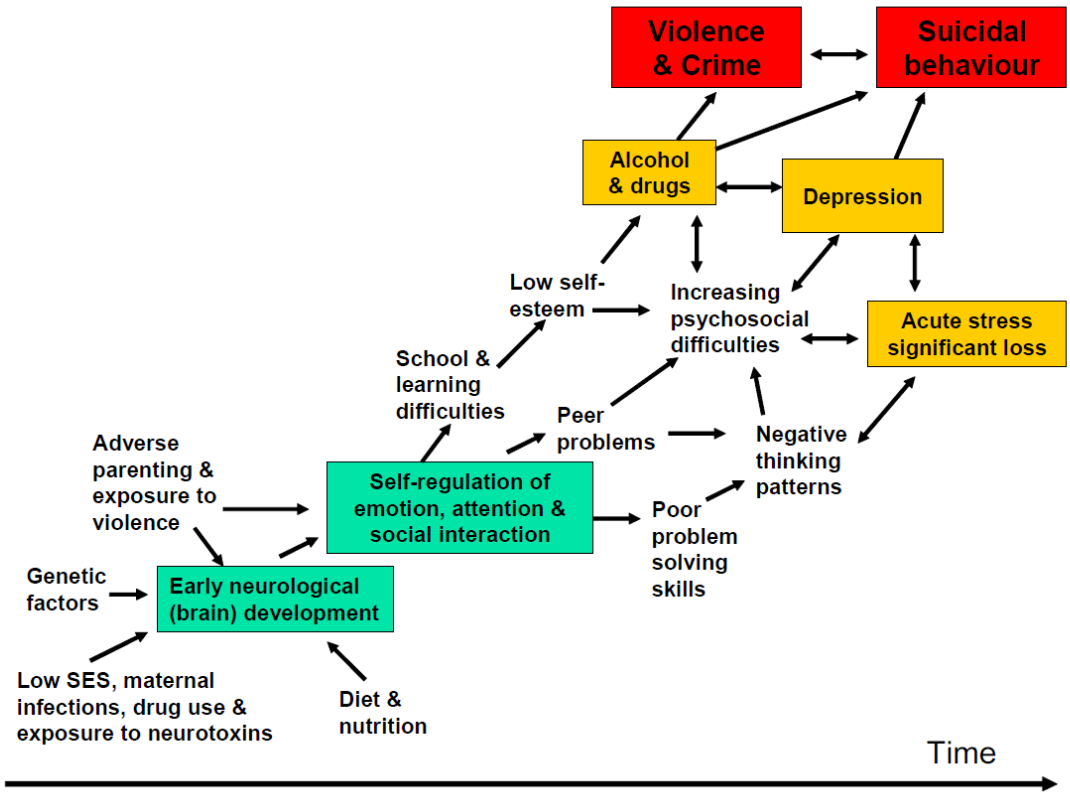
Risk factors emerge across the lifespan from prenatal/perinatal through to adulthood. The development of early risk factors can be a predictor of subsequent risk behaviour.[1087] Some of these factors are explored in greater detail below.

Genetic influences

Genetic predisposition is a risk factor for the development of substance misuse across the lifespan.[1088] There is a greater potential that more serious drug use disorders may be linked with a genetic susceptibility.[1089] [1090] It is unlikely that a single gene would predict drug use behaviour;[1091] [1092] it is more likely that a combination of genetic factors influences behaviour through their interaction with the environment.[1093] [1094]

Genetic risk for developing dependence can be shared across different categories of drugs or be specific to a particular drug. Evidence also suggests that genetic differences can make the use of psychoactive substances more or less pleasurable and can influence toxicity in terms of overdose and chronic health effects.[1095] This is likely to influence both the frequency of use and the harm experienced as a result of use.

Figure AII.1: Pathways to poor outcomes[1096]



Social disadvantage

The relationship between low socioeconomic status and harm is complex. While drug use problems are more prevalent among people with low socioeconomic status and who live in disadvantaged communities,[1097] drug use in general spans socioeconomic groups.

There is some evidence linking severe disadvantage with risks to healthy childhood development, which then has a cumulative 'snowball effect' that leads to serious social and behavioural problems throughout life. However, other studies have found that a high socioeconomic status can also be a predictor for entry to drug use, with patterns of drug use potentially introduced and made fashionable by those with a high socioeconomic status. Other research has found no direct relationship between illicit drug use and socioeconomic status.[1098]

Socioeconomic status does not necessarily predict harmful drug use behaviour; however, there is sufficient evidence to suggest that it does contribute to the level of harm experienced. This is consistent with a significant body of evidence that, for nearly all health conditions, the level of harm experienced as a result of that condition increases for lower socioeconomic groups.[1099] For instance, low socioeconomic status can create chronic stress that effects on the mental health and resilience of those who are less likely to have access to services and support.[1100]

Family breakdown and dysfunction

The influence family has on healthy childhood development is indisputable. Family factors associated with drug misuse are outlined in Table AII.2.

There is some evidence that family breakdown can be a risk factor to more frequent drug use during adolescence.[1101] However, the relationship between sole-parent families and drug use is more tenuous. One study found that sole-parent status appeared to increase risk of adolescent maladjustment independent of levels of family conflict.[1102] Other research has suggested that, while family breakdown can contribute to exposure to disadvantage, which can in turn contribute to drug use, sole-parent families are not inherently harmful.[1103]

The impact of maternal drug use during pregnancy is difficult to isolate from other factors, given that the children of women that use drugs during pregnancy tend to be exposed to a range of other risk factors.[1104] However, there is sufficient evidence that maternal intake of alcohol, nicotine and other drugs can have a negative impact on developing foetuses.[1105]

Childhood neglect and abuse

The key developmental goals for early childhood are the development of safe attachment to caregivers, age-appropriate language skills and other executive cognitive functions, such as self-regulation and pro-social attitudes and skills. A child in the early stages of life experiencing a lack of nurturing, ineffective parenting or a chaotic family setting is more likely to develop disruptive behaviours, temper tantrums and disobedient and destructive behaviours. If not properly addressed, these traits can become problematic later on in life.[1106]

Table AII.2: Family factors associated with drug misuse[1107]

Factor	Behaviour
Family history of behavioural problems	Parental or sibling role modelling of antisocial values and drug-taking behaviours Favourable attitudes about drug taking Parental criminality, psychopathology and antisocial personality disorder and drug use
Poor socialisation practices	Failure to promote positive moral development Neglect in teaching life, social and academic skills to the child or providing opportunities to learn these competencies Failure to transmit prosocial values and to disapprove of the use of drugs by young people
Ineffective supervision of the child	Failure to monitor the child's activities Neglect Latchkey conditions Sibling supervision Too few adults to care for the number of children
Ineffective discipline skills	Lax, inconsistent or excessively harsh discipline Parental behavioural under-control or psychological over-control of the child Expectations that are unrealistic for the developmental level of the child, creating a failure syndrome Excessive, unrealistic demands or harsh physical punishment
Poor parent/child relationships	Lack of parental bonding and early insecure attachment Repeated loss of caretakers Negativity and rejection of the child by the parents, including: • cold and unsupportive maternal behaviour • lack of involvement and time together, resulting in rejection of the parents by the child Maladaptive parent/child interactions
Excessive family conflict and marital discord	Often includes verbal, physical or sexual abuse
Family disorganisation, chaos and stress	Often due to poor family management skills, life skills or poverty
Poor parental mental health, including depression and irritability	Causes negative views of the child's behaviours, parental hostility to child, and harsh discipline
Family isolation	Lack of supportive extended family networks Family social insularity Lack of community support resources
Differential family acculturation	Role reversal Loss of parental control over adolescents by parents who are less acculturated than their children

Children who experience early neglect or abuse are particularly at risk of developing mental health issues, such as depression, antisocial behaviour, learning difficulties and problematic drug use.[1108] One study found a strong relationship between adverse childhood experiences and risk of drug initiation from early adolescence into adulthood, as well as problems with drug use and dependency.[1109] Another study found that sexual abuse in childhood or adolescence predicted higher rates of illicit drug use from 15 to 21 years.[1110]

Community disadvantage and disorganisation

Community disadvantage and disorganisation is linked with adolescent drug use.[1111] High rates of adolescent drug use behaviours have been associated with geographic localities that are characterised by low socioeconomic status, low income and poor quality housing.[1112] The availability of drugs within the community, as well as the perceived use of drugs within the community, has also been associated with adolescent drug use.[1113]

Poor adolescent adjustment

While the early years of a child's life are pivotal, the adolescent years are also important. Cognitive development is still occurring during adolescence. Furthermore, this is the period during which experimentation with drugs usually begins[1114] and psychosocial disorders, such as depression, suicidality and eating disorders, become apparent.[1115]

Other patterns of development during adolescence include:

- Major hormonal changes
- Physical changes
- Further development of cognitive competencies, including abstract reasoning and decision making ability
- Developments in social relationships
- Development of social and psychological autonomy
- Role transitions e.g. first job, first sexual relationship.[1116]

Behavioural and conduct problems during adolescence have been found to be a risk factor for alcohol and illicit drug misuse. A lack of appropriate fear during early adolescence has also been found to be a risk factor for drug use, particularly polydrug use. The relationship between anxiety and depression in adolescence and drug use is less clear.[1117]

Unemployment

As outlined in Chapter 2, there is a strong association between ice use and unemployment. Unemployed drug users can be difficult to reach, due to marginalisation, social exclusion and generally poor access to services and supports. Unemployment can also contribute to boredom, apathy and loss of self-esteem, which can influence drug use decisions and behaviour.[1118]

For dependent illicit drug users, unemployment has been found to increase the risk of relapse after treatment.[1119] There is a strong link between unemployment and low self-esteem, which can undermine a user's motivation and determination to stop.[1120] For dependent methamphetamine users specifically, maintaining or gaining employment over the follow-up period is associated with achieving abstinence in the year following treatment.[1121]

Resilience and protective factors

Resilience refers to the ability to avoid negative outcomes despite being exposed to risk factors. Resilient young people will use reasoning and behaviour regulation to inform their decisions about drugs, despite potentially being exposed to drugs and other risk factors. Resilience is not necessarily a permanent fixture or characteristic of a person: people may go through stages where they are more or less capable of being resilient.[1122]

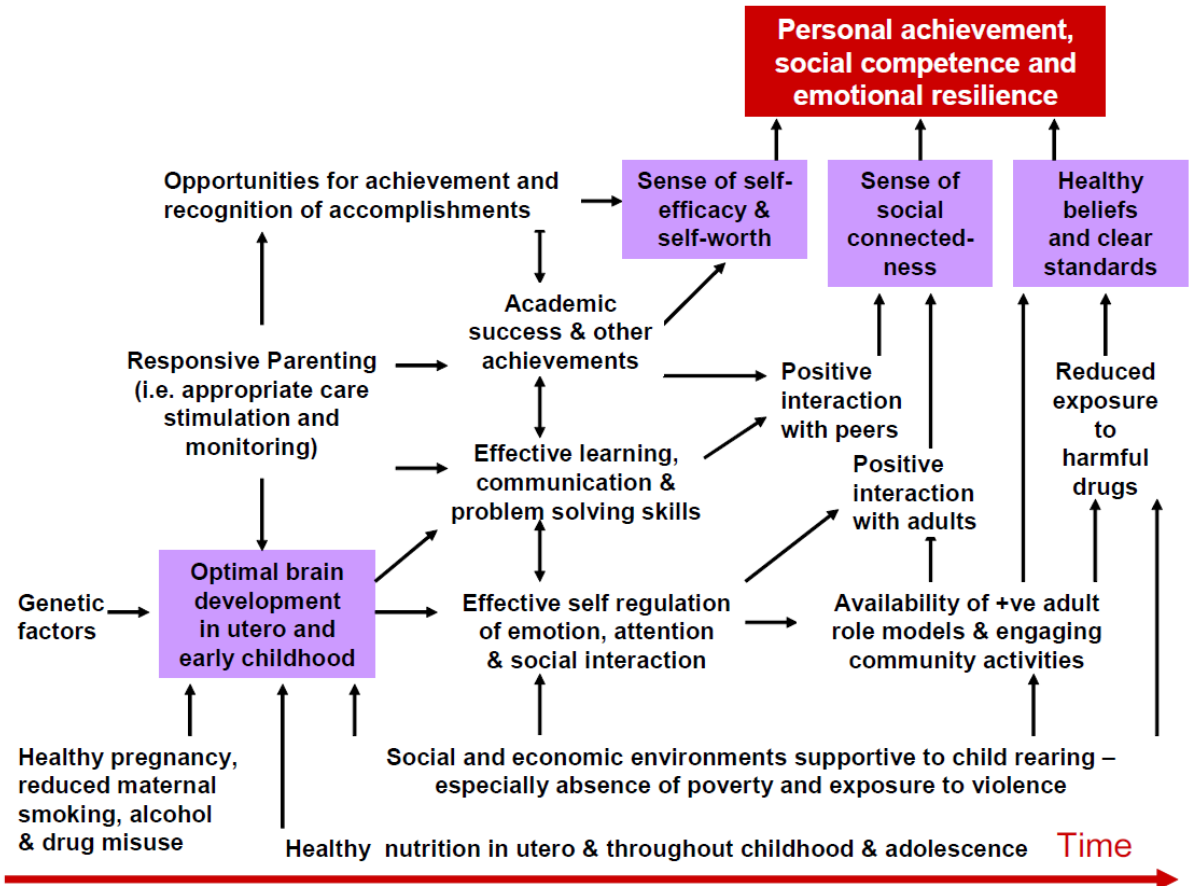
Protective factors that contribute to resilience are outlined below:

Table AII.3: Protective factors reducing risk for drug use[1123]

Domain	Protective Factors
Individual	Good coping skills
	Self-efficacy
	The ability to make judgements about the dangerousness of risks e.g. 'risk perception'
	Optimism
	Positive health-related behaviour
	Ability to resist peer pressure
Environmental	Economic situation
	Ability to control group situations e.g. 'situational control'
	Social support
	Social integration
	Positive life events

Programmes that target parental skills or aim to enhance children and young people's social skills have shown some effectiveness in building resilience.[1124] To maximise effectiveness, targeted family support strategies that aim to improve protective factors should be initiated early.[1125] Selective prevention activities during the prenatal and early childhood period present real opportunities to encourage healthy child development, thereby reducing the chance of the child progressing to heavy and harmful drug use.[1126] [1127] Programmes incorporating structured home visits have demonstrated effectiveness when targeted at vulnerable families.[1128] [1129]

Figure AII.2: Pathways to resilience[1130]



Recent efforts to tackle disadvantage and support vulnerable families

Some of the recent efforts being undertaken nationally and by states and territories to tackle disadvantage and support vulnerable families are outlined below.

Commonwealth

Families and Communities Programme

The Families and Communities Programme aims to support families, improve children's wellbeing and increase participation of vulnerable people in community life to enhance family and community functioning.

The Families and Children activity is one aspect of this programme, with the aim of supporting integrated services for families to achieve improved child, youth, adult and family wellbeing, increased economic engagement and more cohesive communities. To achieve this objective, services must work collaboratively to provide an integrated suite of local services. It consists of six sub-activities:

- Family Law Services
- Family and Relationship Services
- Communities for Children Facilitating Partners
- Children and Parenting
- Young People
- Adult Specialist Support.[1131]

Another stream of activity, the Strengthening Communities activity, aims to promote inclusion and participation of disadvantaged people in community life. It provides funding to organisations to develop solutions and deliver responsive and integrated services that meet local community needs and consists of three sub-activities:

- Community Development and Participation
- Volunteering
- Multicultural Affairs.

These sub-activities aim to build the capacity of communities and organisations to identify and address local community needs, facilitate partnerships that result in better services and service integration, assist volunteers and encourage volunteering, develop strategies to increase awareness of access to services, support organisations in the delivery of services to individuals and organisations and build social cohesion in culturally diverse communities.[1132]

New South Wales

Brighter Futures

Brighter Futures is a voluntary targeted early intervention programme for families with children aged under nine years or families who are expecting a child. It aims to prevent vulnerable children and families from entering the child protection system by providing intervention and support that will achieve long-term benefits for children.

Brighter Futures is delivered by 16 non-government agencies across New South Wales. These agencies provide a range of tailored services including case management, casework focused on parent vulnerabilities, structured home visiting, quality children's services, parenting programmes and brokerage funds. Eligible families will have at least one of the following vulnerabilities that adversely affect their capacity to parent and/or the child's safety and wellbeing:

- domestic violence
- drug or alcohol misuse
- parental mental health issues
- lack of parenting skills or inadequate supervision
- parent(s) with significant learning difficulties or intellectual disability.

The programme supports parents to address vulnerabilities and builds their capacity to meet their children's needs through case management, structured home visiting and parenting programmes to ensure the wellbeing and healthy development of vulnerable children and young people.[1133]

Getting It Together: Alcohol and Other Drugs

The New South Wales Department of Family and Community Services funds the Getting It

Together programme under the Alcohol and Other Drugs Program. This is an early intervention service model aimed at assisting vulnerable children and young people aged 12 to 25 years with alcohol and/or drug problems. Priority is given to children and young people under 18.

Getting It Together delivers case management including assessment, case planning (including referral), casework and brokerage to address the income, health, social support, educational, employment, training and accommodation needs of young people.

The programme provides services and support to enable vulnerable young people to establish or resume self-sufficient living, free of dependence on alcohol and/or drugs.

Individuals can access services that meet their needs for food/clothing, accommodation, therapeutic services and transport. They can also access specialist services in alcohol and other drugs, mental health, disability, family/relationship support, housing, health and legal support.

The Getting It Together programme initially commenced as a pilot in five sites in 1990, funded through the then Supported Accommodation and Assistance Program. There are currently 15 Getting It Together services funded across New South Wales: four in inner Sydney, four in suburban Sydney, and seven in non-metropolitan areas.[1134]

Substance Use in Pregnancy and Parenting

The Substance Use in Pregnancy and Parenting (SUPPS) service is operated through a collaborative model of care and is delivered by Barnardos South Coast. SUPPS is a coordinated multi-disciplinary early intervention service comprising Barnardos Family Support, Maternal and Paediatric workers, Drug and Alcohol services and the New South Wales Department of Family and Community Services. The project specifically targets pregnant substance abusing women at the earliest point of pregnancy.[1135]

Whole Family Teams

New South Wales Whole Family Teams provide specialist in-home and community-based interventions for children and families with complex mental health and alcohol and other drug issues where the children have been identified as at risk of significant harm. Referrals from Community Services are prioritised. Teams were established in 2010 and are located in Lismore, Newcastle, Nowra and Gosford.[1136]

Victoria

Best Start

Best Start is a Victorian government early years initiative that supports families, caregivers and communities to provide the best possible environment, experiences and care for young children from pregnancy through to school (0-8 years) with a strong emphasis on prevention and early intervention.[1137] The programme aims to improve the health, development, learning and wellbeing of all Victorian children, and supports communities, parents and service providers to improve universal early years services so they are responsive to local needs. These improvements are expected to result in:

- better access to child and family support, health services and early education
- improvements in parents' capacity, confidence and enjoyment of family life
- communities that are more child and family friendly.

Projects under the Best Start programme are designed to meet local needs and involve partnerships with key stakeholders in the community.

Child FIRST

Child FIRST (Child and Family Information, Referral and Support Teams) provide support and assistance to vulnerable children, young people and their families where there are concerns about the wellbeing of the child or young person. Child FIRST provides an entry point into family services or other support services to ensure families and communities

are linked with the services they need across Victoria.

Factors that affect a child's safety, stability or development which may warrant referral to Child FIRST include:

- significant parenting problems that may be affecting the child's development
- serious family conflict, including family breakdown
- families under pressure due to a family member's physical or mental illness, substance misuse, disability or bereavement
- young, isolated and/or unsupported families
- significant social or economic disadvantage that may adversely affect a child's care or development

Child FIRST is staffed by Family Service practitioners, with experience in assessing the needs of vulnerable children, young people and families. Child FIRST engages with the child, young person and family to plan how best to support the child's healthy development and improve parenting capacity. This may include facilitating connections with other appropriate services such as alcohol and other drug, mental health, housing or family violence services.[1138]

Queensland

Family and Child Connect

Family and Child Connect provides information and advice to people seeking assistance for children and families where there are concerns about their wellbeing.[1139] Family and Child Connect provides general advice and information to parents, family members, young people and community members and helps connect people with local services that can help:

- develop parenting skills and managing behaviour
- build better relationships between family members, including help with any violence at home
- manage alcohol, drug or gambling problems
- access housing, health care or other community or government services.

Family and Child Connect leads a local level alliance of government and non-government services within the community to ensure vulnerable children and families receive the right mix of services at the right time.

Youth at Risk Initiative

The Youth at Risk Initiative (YARI) is aimed at improving services to vulnerable young people between 10 and 25 years. YARI aims to support young people at risk to be active, safe and included in their communities, by ensuring:

- access to a simpler service system, which is easier for them to navigate and understand
- active referrals to suitable services
- engagement with workers who are better supported and have more opportunities for development, resulting in better quality services
- service responses through a coordinated approach between government and non-government organisations
- the right level and intensity of service response dependent on their circumstances
- encouragement and support to work towards self-determined goals that are sustainable.

A number of programmes are run as part of YARI that assist vulnerable young people to have positive futures.

South Australia

Family Services Program

The Family Services Program is a targeted service designed to support vulnerable families and strengthen and enhance family and community capacity to respond to children.[1140] Family Services Coordinators work alongside long day care, early childhood education and school staff, health workers and other services to help families develop and maintain safe, caring, connected and resilient relationships. Family Services Coordinators support parents to access the assistance they need within their own community, and work with families to increase their parenting capacity and early childhood development skills and knowledge.

This programme provides individual and family counselling to help with personal issues and connect families to the most appropriate services.

Western Australia

Strong Families

The Strong Families programme aims to support families experiencing difficulties with a range of issues including bringing up children, housing, family violence, children staying away from school, physical health, mental health, money, and alcohol or substance misuse.[1141] Strong Families is a whole of government approach to case management and brings a range of agencies together to share relevant information, identify goals and develop a plan to help meet the family's needs.

The programme aims to enhance the capacity of families and increase engagement with services. It also aims to see long term change in the underlying factors that contribute to social disadvantage by providing customised services for families whose difficulties require a tailored approach.

Tasmania

Child Health and Parenting Service

The Child Health and Parenting Service (CHAPS) aims to ensure families get as much help as they need, depending on their circumstances, to ensure their child gets the best start in life.[1142] CHAPS provides child-centred, family focused services from birth through to the preparatory period, including parent support and information, early intervention services, and child health assessments. Families requiring specialised services, such as alcohol and other drug services are given supported referral to receive additional assistance they need.

Child and Family Centres

There are Child and Family Centres (CFCs) in 12 locations across the State. CFCs are multi-service centres which offer a range of services based on community need. This includes health, education and care services for children from birth to school age and support for parents.

Northern Territory

Intensive Family Support Service

The Intensive Family Support Service (IFSS) is a parenting support service for families who have high and complex needs, which helps them to access specialist services, such as alcohol and other drug, domestic violence and mental health services.[1143] In the NT, IFSS works with children aged between 0 and 12 years.

IFSS workers work with families in local communities to provide the following support and services:

- plans and goals in partnership with families to meet their children's needs
- ongoing assessment and support of the caregiver's strengths and challenges
- ongoing assessment of the child's needs and case progress
- practical and structured in-home assistance
- referral and coordination of services.

Australian Capital Territory

Child, Youth and Family Services Program

The objective of the Child, Youth and Family Services Program (CYFSP) is to deliver a range of services that meet the needs of vulnerable children, young people and families in the Australian Capital Territory.[1144] The services and supports are delivered within an integrated and collaborative service model.

The services delivered as part of the programme include:

- providing a point of contact for information, initial support and engagement for children, young people and their families
- linking vulnerable and in-need children, young people and their families with a range of services throughout their local communities
- providing educational, interpersonal and skill development opportunities in areas such as parenting, intergenerational

conflict, cultural competence, youth diversion and mentoring/peer support
- intensive therapeutic or intervention services to achieve sustainable positive change for vulnerable children, young people and their families.

APPENDIX III
STATE AND TERRITORY EFFORTS

This section provides a more detailed overview of the efforts underway in each state and territory to address ice. This includes recent ice-specific investments, counselling and support hotlines, and a breakdown of activity data from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS), prepared by the Australian Institute of Health and Welfare.

As previously stated, the comparability of the AODTS NMDS data is under question due to different approaches to data collection in each state and territory. While the data provides some overview of treatment practices across the states and territories, better standardisation of the data is necessary to enable a definitive jurisdictional comparison of treatment activity trends.

New South Wales

Specialist treatment sector

In New South Wales, there are 215 Government-delivered specialist alcohol and other drug (AOD) treatment service providers and 77 publicly funded non-government specialist AOD treatment service providers.[1145] There are also 25 Commonwealth funded Indigenous Specific AOD Treatment Services.

Additional investment

The New South Wales Government has recently announced additional investment to address ice use. This includes:

- An additional $7 million in three new stimulant treatment services
- An additional $4 million in funding to the non-government sector to enhance local delivery of alcohol and other drug rehabilitation services, especially among regional and remote communities
- $14 million in total to commence the St Vincent's Hospital Psychiatric Alcohol and Non-Prescription Drug Assessment (PANDA) Unit and Emergency Department enhancements.

The New South Wales Government also provides funding to support over 1,000 treatment places in a range of non-government services located in regional and metropolitan areas. These range from short term to long term programmes of up to 12 months.

Drug and Alcohol Consultation Liaison services are also in place, which offer assistance in the management of alcohol and other drug concerns both in public hospital emergency departments and wards. This includes screening, brief interventions and referrals to treatment as well as building capacity of hospital staff to better identify and manage alcohol and other drug presentations.

Several hospitals in New South Wales provide drug use in pregnancy services to operate in tandem with ante-natal services. These services can assist pregnant women with amphetamine use problems during pregnancy and assist in ongoing care after delivery.

New South Wales also reports that some services are adapting their existing treatment approaches to better cater for ice and other methamphetamine treatment.

Treatment trends

In 2013-14, alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use (44 per cent of episodes). Cannabis was also relatively common as a principal drug, accounting for one-fifth of closed episodes (20 per cent), followed by meth/amphetamines (17 per cent) and heroin (8 per cent).[1146]

For treatment where meth/amphetamines was the principal drug of concern, counselling was the most common main and additional treatment type (32 per cent of closed treatment episodes) in 2013-14, followed by assessment only (21 per cent of episodes) and support and case management (16 per cent of episodes).[1147]

Hotlines

The New South Wales Alcohol and Drugs Information Service (ADIS) is a state-wide telephone service providing education, information, referral, crisis counselling and support for illicit drugs such as heroin, ice and cannabis, as well as licit drugs such as alcohol and prescription opioids. The hotline operates 24/7. It has separate metropolitan and regional hotlines.

Specialist medical consultants are on call to provide advice on diagnosis and management of patients. Qualified clinicians advise on drug effects and withdrawal symptoms, referral options, therapeutic and counselling techniques.

New South Wales also operates other drug-specific lines. The Opioid Treatment Line provides information, referrals, support and a forum for pharmacotherapy concerns (methadone and buprenorphine) and is available during standard office hours. The Stimulant Treatment Line provides brief

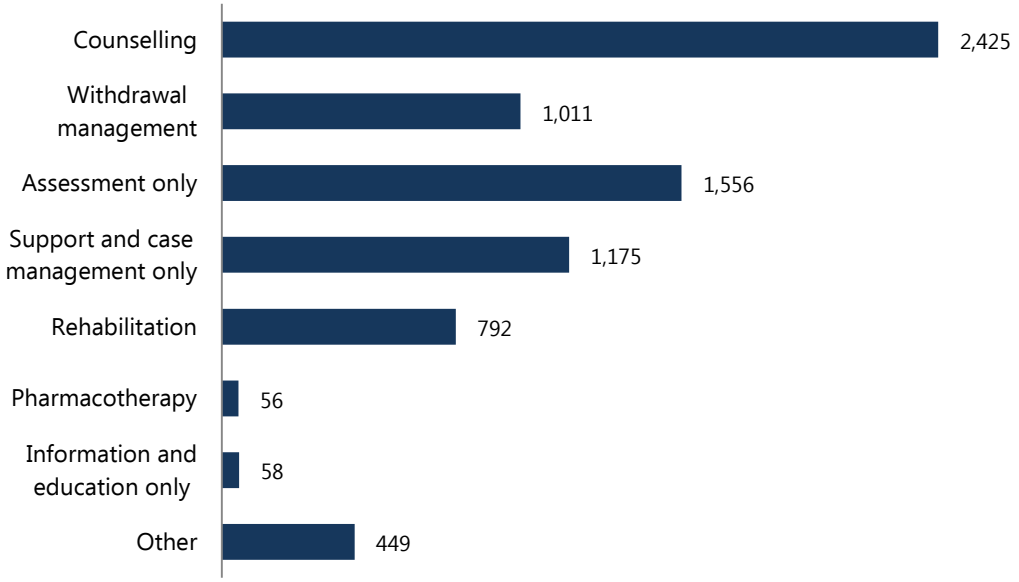
intervention to callers, referral to other non-specialist alcohol and other drug services (including the Stimulant Treatment Program) and intensive counselling and other interventions, including medication. This line operates 24/7.

New South Wales operates additional alcohol and other drug hotlines for users, families and professionals. For example, the Family Drug Support Line provides telephone support to families, support groups, public community drug awareness forums, and referral to alcohol and other drug treatment and rehabilitation centres. It can be accessed 24/7.

The 1300 DRIVER line is a 24/7 service for long-haul truck drivers and their families. It offers education, information, one-off and ongoing support for long-haul truck drivers, and referrals related to alcohol, tobacco, drugs and health and lifestyle issues. The service is offered via telephone, website and Twitter.

The Drug and Alcohol Specialist Advisory Service (DASAS) is a specific advisory line for health professionals only. The DASAS is a free telephone service for doctors, nurses, and other health professionals from any part of New South Wales and the Australian Capital Territory. The DASAS is especially designed to support regional areas where local support is unavailable, but is available to any health professional.

Figure AIII.1: Completed treatment episodes where meth/amphetamines was the principal drug of concern in New South Wales in 2013-14, by main and additional treatment types[1148]



Victoria

Specialist treatment sector

In Victoria there are 130 publicly funded non-government specialist AOD treatment service providers[1149] and five Commonwealth funded Indigenous Specific AOD Treatment Services.

Additional investment

As part of the Ice Action Plan, released in March 2015, Victoria invested an additional:

- $18 million to expand innovative models of community based, therapeutic day rehabilitation services in regional Victoria and outer metropolitan Melbourne
- $4.7 million to increase support for families, including $3.2 million to increase the availability of family support services across the state and $1.5 million for the development of an innovative Family Drug Education Program
- $1.8 million to enhance the capacity of Needle and Syringe Programs to deliver health information and harm reduction interventions for injecting drug users.

Treatment trends

In 2013-14 in Victoria, alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use (41 per cent of episodes). Cannabis was also relatively common as a principal drug, accounting for more than one-fifth of episodes (21 per cent), followed by meth/amphetamines (16 per cent) and heroin (10 per cent).[1150]

For treatment where meth/amphetamines was the principal drug of concern, counselling was the most common main and additional treatment type (65 per cent of episodes) in 2013-14, followed by withdrawal management (16 per cent) and support and case management only (10 per cent).[1151]

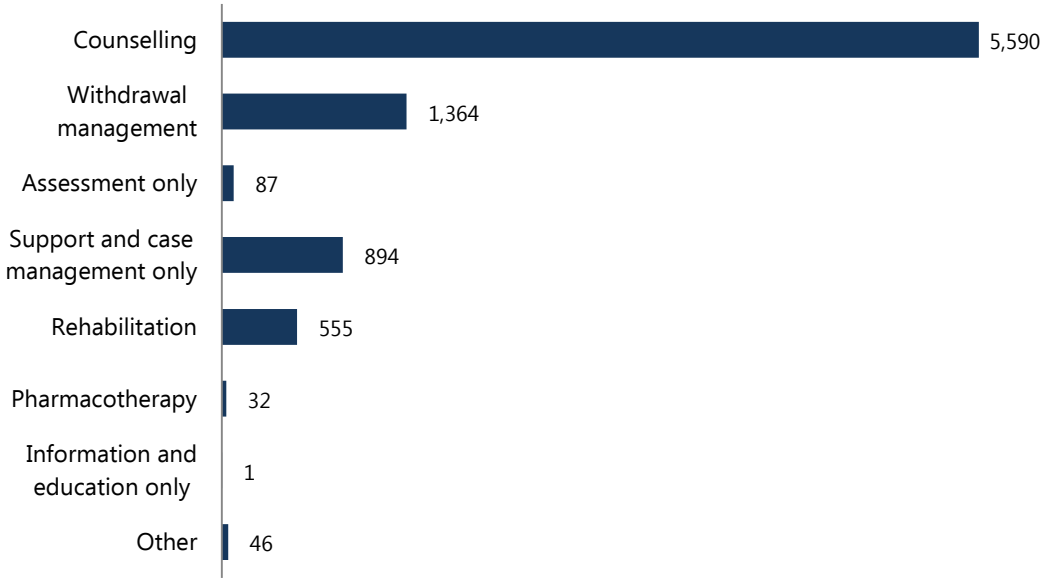
Hotlines

In April 2015, the Victorian Government launched the 24/7 1800 ICE ADVICE helpline. The helpline was identified as a priority in the Premier's $45.5 million Ice Action Plan, which addresses urgent issues to support families and provide treatment for ice users. The 1800 ICE ADVICE phone service provides a single gateway for users and families to access information and advice about support and treatment. It also provides clinical advice for health professionals working with ice users.

Turning Point, part of Eastern Health, operates the 1800 ICE ADVICE service, drawing on its experience in providing phone-based support. This service complements a range of existing information and support services.

The 1800 ICE ADVICE line is complemented by a range of existing information and support lines. The DirectLine provides counselling, information and referral for people with alcohol and other drug related issues and operates 24/7. Drug Info is a 24/7 telephone information service targeted at students, parents, friends, relatives and other people interested in obtaining relevant, up-to-date information about alcohol and other drugs. The Family Drug Helpline is a service for people concerned about a relative or friend using alcohol or other drugs. During standard office hours it is staffed by volunteers with experience of alcohol and other drug issues within their family. At all other times it is staffed by professional counsellors. The Youth Substance Abuse Service Line is dedicated to young people with substance issues and operates 24/7.

Figure AIII.2: Completed treatment episodes where meth/amphetamines was the principal drug of concern in Victoria in 2013-14, by main and additional treatment types [1152]



'Access Point': Turning Point Drug and Alcohol Centre

Access Point, a specialist methamphetamine service Turning Point Drug and Alcohol Centre, in collaboration with Access Health, run a specialist methamphetamine service aimed at providing information about stimulant drugs and effective treatment options.

The service also aims to increase community awareness about methamphetamine and related problems such as depression, anxiety and mental health issues.[1153]

A 2010 evaluation of the service found that Access Point helped attract and retain methamphetamine users in treatment programmes. Fifty per cent of clients had never accessed drug treatment and 85 per cent attended more than one session, compared with 25 per cent of regular AOD treatments over the same period. Access Point clients were also more likely to stay in treatment significantly longer.[1154]

Queensland

Specialist treatment sector

In Queensland there are 61 Government delivered specialist AOD treatment service providers and 80 publicly funded non-government specialist AOD treatment service providers.[1155] There are 15 Commonwealth funded Indigenous Specific AOD Treatment Services.

Treatment trends

In 2013-14, alcohol was the most common principal drug of concern in treatment episodes provided to clients for their own drug use in Queensland (38 per cent of episodes). Cannabis was the second most common principal drug of concern, accounting for just over one-third of closed treatment episodes (34 per cent), followed by meth/amphetamines (12 per cent).[1156]

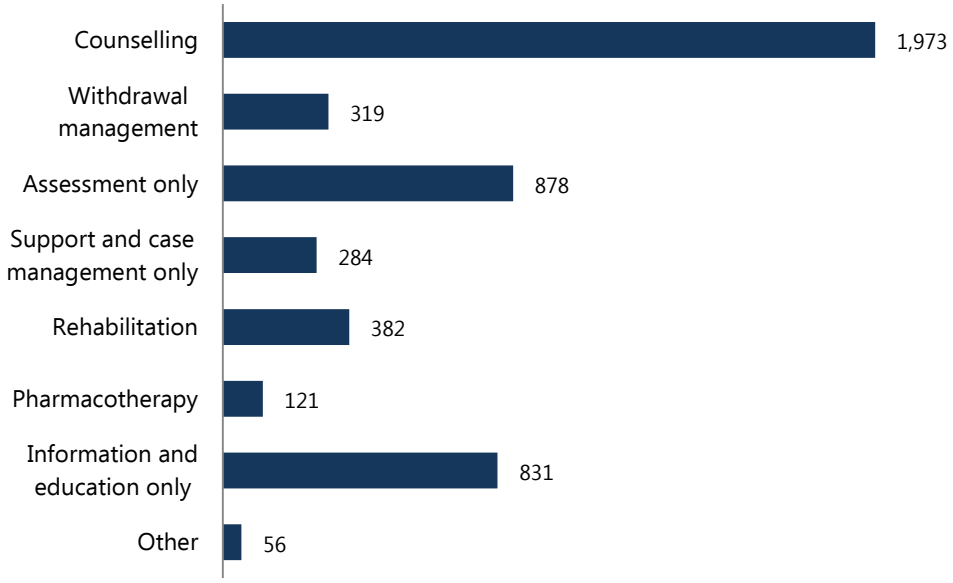
For treatment where meth/amphetamines was the principal drug of concern, counselling was the most common type of treatment (41 per cent of completed treatment episodes), followed by assessment only (18 per cent of episodes) and information and education only (17 per cent of episodes).[1157]

Hotlines

The Queensland Alcohol and Drugs Information Service is a confidential and anonymous telephone counselling service for individuals, parents and concerned others. The service provides telephone assessment, referral and advice about treatment options and information on the effects of specific drugs. It operates 24/7.

The Clean Needle Helpline and Community Services Information lines are also run by this service.

Figure AIII.3: Completed treatment episodes where meth/amphetamines was the principal drug of concern in Queensland in 2013-14, by main and additional treatment types [1158]



South Australia

Specialist treatment sector

In South Australia there are 49 Government delivered specialist AOD treatment service providers and 44 publicly funded non-government specialist AOD treatment service providers.[1159] There are also five Commonwealth funded Indigenous Specific AOD Treatment Services.

Treatment trends

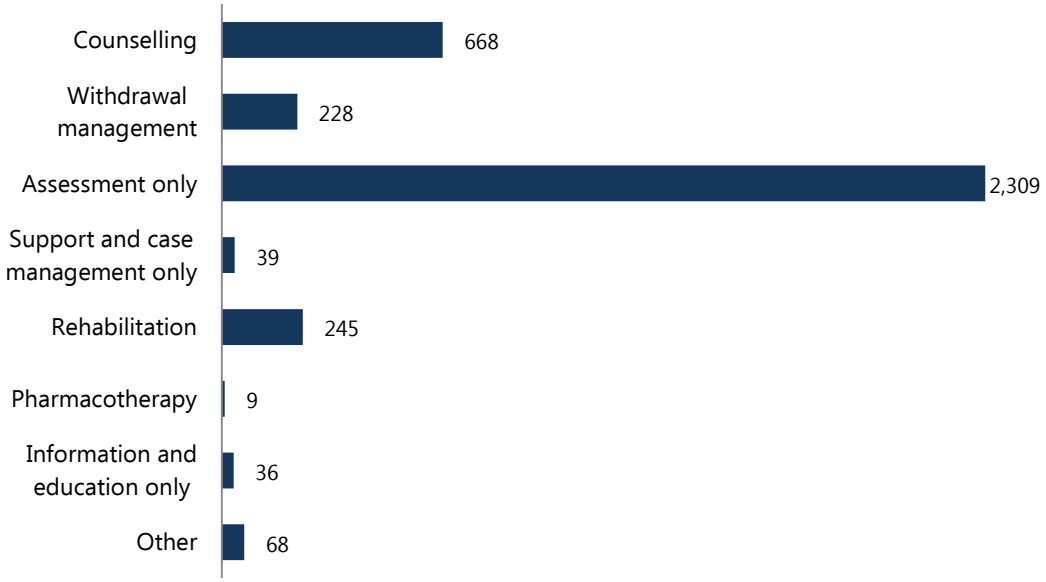
In South Australia, alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use in 2013-14 (36 per cent of episodes). Meth/amphetamine was also relatively common as a principal drug, accounting for over one-quarter of treatment episodes (27 per cent), followed by cannabis (17 per cent) and heroin (5 per cent).[1160]

For treatment where meth/amphetamines was the principal drug of concern, assessment only was the most common main and additional treatment type (64 per cent of episodes) in 2013-14, followed by counselling (19 per cent of episodes) and rehabilitation (7 per cent of episodes).[1161]

Hotlines

South Australia's Alcohol and Drugs Information Service is a confidential telephone counselling, information and referral service for the general public, concerned family and friends, students and health professionals. The hotline is available between 8.30 am and 10 pm every day.

Figure AIII.4: Completed treatment episodes where meth/amphetamines was the principal drug of concern in South Australia in 2013-14, by main and additional treatment types [1162]



Western Australia

Specialist treatment sector

In Western Australia there are 13 Government delivered specialist AOD treatment service providers and 67 publicly funded non-government specialist AOD treatment service providers.[1163] There are also 11 Commonwealth funded Indigenous Specific AOD Treatment Services.

Additional investment

The Western Australian Government has recently announced additional investment to address ice use, including an investment of $86.9 million for treatment and other services to reduce the adverse impacts of harmful alcohol and other drug use in the community.

Treatment trends

In Western Australia, alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use in 2013-14 (36 per cent of episodes). Cannabis was also relatively common as a principal drug, accounting for one-quarter of treatment episodes (25 per cent), followed by meth/amphetamines (23 per cent) and heroin (7 per cent).[1164]

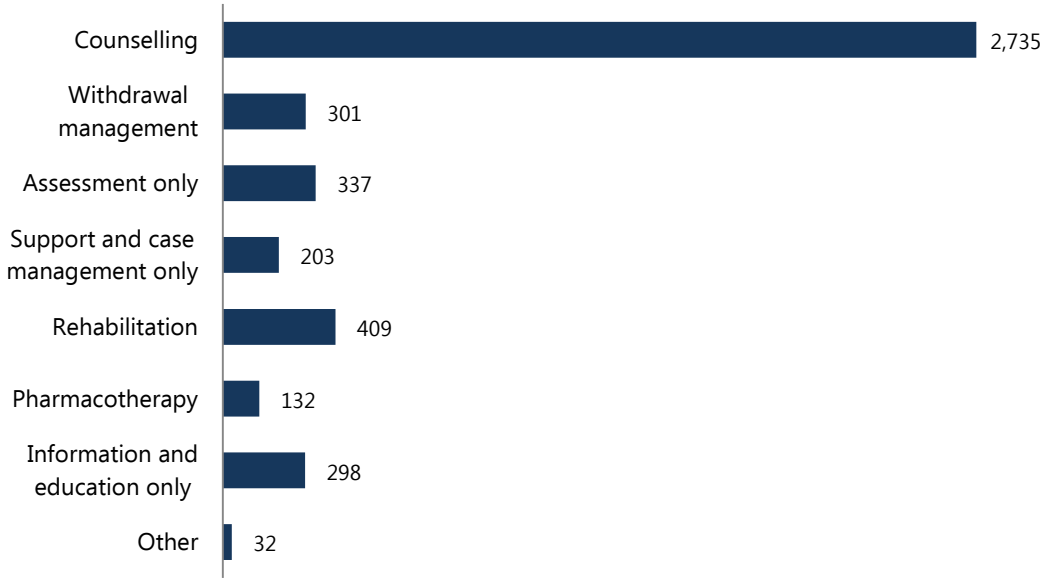
For treatment where meth/amphetamines was the principal drug of concern, counselling was the most common main and additional treatment type (62 per cent of episodes) in 2013-14, followed by rehabilitation (9 per cent).[1165]

Hotlines

The Western Australian Alcohol and Drug Support Line provides a state-wide telephone counselling, information and referral service for people concerned about their own or someone else's alcohol or other drug use. The service operates 24/7 and also includes web-based counselling.

This service also incorporates the Parent and Family Drug Support Line for families affected by the substance use of a significant other. It also incorporates a Working Away Alcohol and Drug Support service which provides a telephone information and referral service for those working away from home, their families and employers.

Figure AIII.5: Completed treatment episodes where meth/amphetamines was the principal drug of concern in Western Australia in 2013-14, by main and additional treatment types [1166]



Tasmania

Specialist treatment sector

In Tasmania there are eight Government delivered specialist AOD treatment service providers and 14 publicly funded non-government specialist AOD treatment service providers.[1167] There are also three Commonwealth funded Indigenous Specific AOD Treatment Services.

Additional investment

The Tasmanian Government has recently announced additional investment of $4.8 million to address alcohol and other drug use (including ice) in Tasmania, including 12 new residential rehabilitation beds in the North-West.

Treatment trends

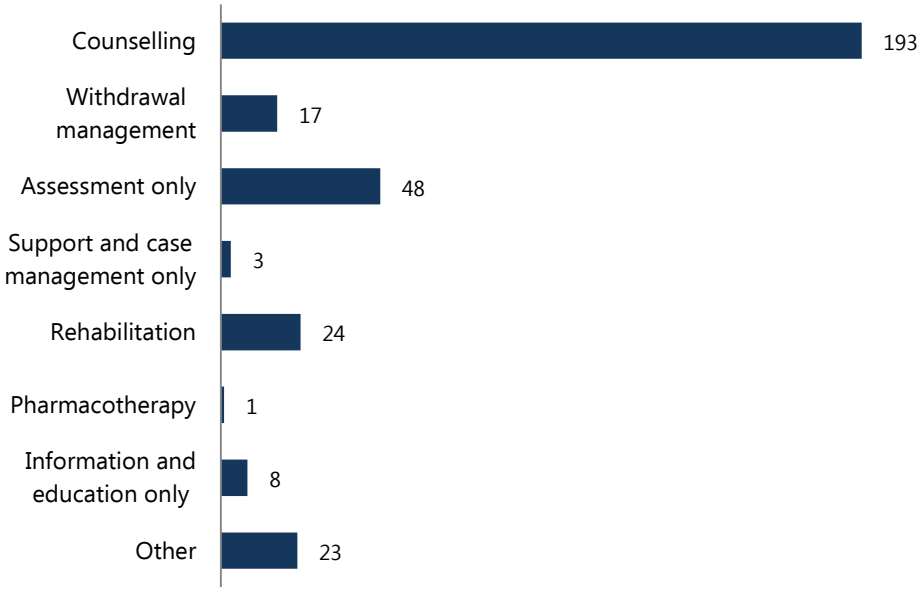
In Tasmania, alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use in 2013-14 (41 per cent of episodes). Cannabis was also relatively common as a principal drug, accounting for almost one-third of treatment episodes (30 per cent), followed by meth/amphetamines (11 per cent) and morphine (4 per cent).[1168]

In 2013-14 in Tasmania, for treatment where meth/amphetamines was the principal drug of concern, counselling was the most common main and additional treatment type (61 per cent of episodes), followed by assessment only (15 per cent of episodes) and rehabilitation (8 per cent of episodes).[1169]

Hotlines

The Tasmanian Alcohol and Drugs Information Service operates 24/7. This line provides information on alcohol and other drugs, advice and referral.

Figure AIII.6: Completed treatment episodes where meth/amphetamines was the principal drug of concern in Tasmania in 2013-14, by main and additional treatment types[1170]



Australian Capital Territory

Specialist treatment sector

In the Australian Capital Territory there are two Government delivered specialist AOD treatment service providers and 13 publicly funded non-government specialist AOD treatment service providers.[1171] There is also one Commonwealth funded Indigenous Specific AOD Treatment Service.

Additional investment

The Australian Capital Territory Government has recently announced additional investment to address ice use in Australian Capital Territory including $800,000 to improve service capacity and ensure interventions are made accessible and relevant for people experiencing problems with ice. A Consultation Liaison Service has been implemented for clients who have been admitted to Canberra Hospital who also have alcohol and/or drug issues.

Treatment trends

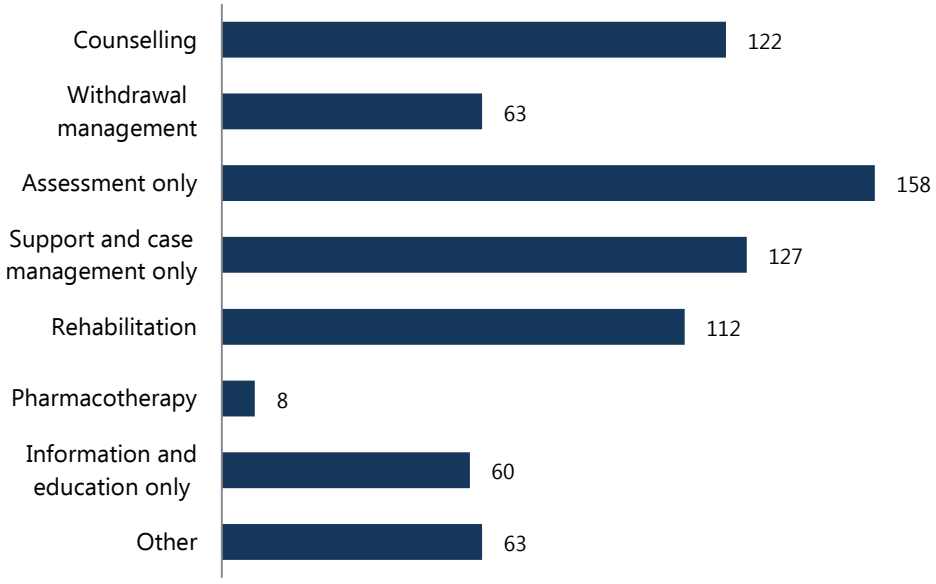
In the Australian Capital Territory, alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use in 2013-14 (47 per cent of episodes). Cannabis was also relatively common as a principal drug, (18 per cent of episodes), followed by meth/amphetamines (15 per cent of episodes) and heroin (11 per cent).[1172]

In 2013-14 in the Australian Capital Territory, for treatment where meth/amphetamines was the principal drug of concern, assessment only was the most common main and additional treatment type (22 per cent of episodes), followed by support and case management only (18 per cent of episodes) and counselling (17 per cent of episodes).[1173]

Hotlines

The Australian Capital Territory operates a 24/7 helpline that provides information on alcohol and other drug and associated issues, advice on assisting and managing people who may have alcohol and other drug issues, and support to people affected directly or indirectly by alcohol and other drug use.

Figure AIII.7: Completed treatment episodes where meth/amphetamines was the principal drug of concern in the Australian Capital Territory in 2013-14, by main and additional treatment types[1174]



Northern Territory

Specialist treatment sector

In the Northern Territory there are five Government delivered specialist AOD treatment service providers and 17 publicly funded non-government specialist AOD treatment service providers.[1175] There are also 16 Commonwealth funded Indigenous Specific AOD Treatment Services.

Additional investment

On 25 March 2015 the Legislative Assembly resolved to appoint a Select Committee on the prevalence, impacts and government responses to illicit use of the drug colloquially known as 'ice' in the Northern Territory. The committee is to report by 19 November 2015.

The Northern Territory Department of Health is developing territory specific resources for prevention, education and early intervention. These will be made available to frontline workers, young people and families in contact with methamphetamine and other drug users. They will also be developed to ensure cultural appropriateness for Indigenous people in urban and remote areas.[1176]

The Northern Territory Department of Health provides workforce development to frontline workers/volunteers in the health and community services sector. The program provides National Accredited Training to non-government and government services/staff across the Northern Territory, providing best practice AOD training and skills development in alcohol and other drug settings, including methamphetamine specialist training.

The Northern Territory is investigating options to enhance access and awareness of Certificate IV level study into Alcohol and Other Drugs, particularly across the regional and remote populations.[1177]

Treatment trends

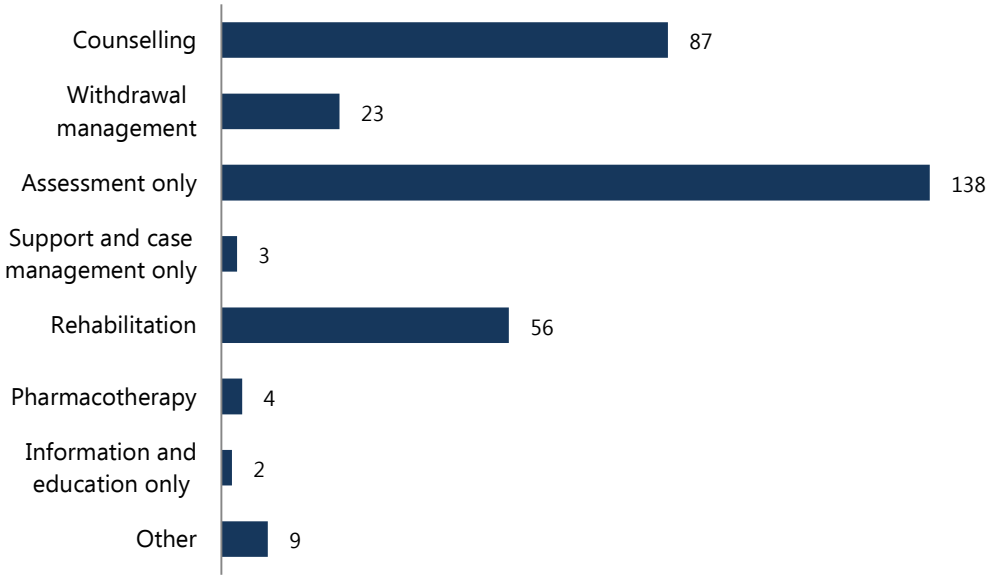
In the Northern Territory, alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use in 2013-14 (61 per cent of episodes). Cannabis was also relatively common as a principal drug, accounting for one in seven episodes (15 per cent), followed by volatile solvents (11 per cent of episodes), which was much higher than the national rate.[1178]

In 2013-14 in the Northern Territory, for treatment where meth/amphetamines was the principal drug of concern, assessment only was the most common main and additional treatment type (43 per cent of completed treatment episodes), followed by counselling (27 per cent of episodes) and rehabilitation (17 per cent of episodes).[1179]

Hotlines

The Northern Territory Alcohol and Other Drugs Information Service is available for anyone concerned about an alcohol or other drug issue. The service operates 24/7 and provides a service that is culturally appropriate for the local population.

Figure AIII.8: Completed treatment episodes, by main and additional treatment types (total) for own drug use, by Meth/Amphetamines as a principal drug of concern, Northern Territory, 2013-14[1180]



APPENDIX IV
TERMS OF REFERENCE

The ice epidemic in Australia cannot be ignored. The Australian Crime Commission reports that, despite increased investment in border protection, the past 5 years has seen significant growth in the detected importation, manufacture and supply of crystal methylamphetamine (ice). On the ground, reported use of ice by methylamphetamine users has more than doubled, increasing from 22 per cent in 2010 to 50 per cent in 2013 and those who do use, do so more frequently. The purity of ice has also increased making it even more dangerous.

Combatting ice is a priority for the Australian Government and all states and territories. Building on work being done in all jurisdictions, the Australian Government has established a National Ice Taskforce that will drive the development and implementation of the National Ice Action Strategy.

Role of the Taskforce

The Taskforce, working with the states and territories, will:

- Take a comprehensive stock-take of existing efforts to address ice at all levels of government;
- Receive submissions from community consultations and expert groups to ensure all Australians affected by ice have the opportunity to be heard;
- Identify potential gaps in knowledge specifically around treatment models, associated criminal activity and the impact of ice on vulnerable groups, including people living in regional Australia and Aboriginal and Torres Strait Islanders;
- Identify specific initiatives that are currently providing good outcomes for the community;
- Examine ways to ensure existing efforts to tackle ice are appropriately targeted, effective and efficient.
- Provide advice on appropriate primary prevention activities, informed by evidence and best practice;
- Consider options to improve levels of coordination and collaboration of existing efforts at the local, regional and state and territory level;
- Develop a package of recommendations to be actioned as part of developing a broader National Strategy for Action on Ice.

The Taskforce will present an interim report to the Prime Minister for consideration by the Council of Australian Governments. Following consideration by COAG, the Taskforce will then:

- Consolidate the Commonwealth's leadership role in national prevention efforts;
- Work collaboratively with states and territories to draft a strategy which outlines priority actions and jurisdictional roles to ensure a collaborative approach to tackling 'ice' by all governments;
- Provide a final report outlining options for a National Action Strategy on Ice to COAG for consideration and action.

Membership

Members of the Taskforce will appointed by the Prime Minister. The Chair of the Taskforce is Mr Ken Lay APM.

Secretariat

A Secretariat for the Taskforce will be established and supported by the Department of the Prime Minster and Cabinet and will comprise representatives from relevant Departments.

Reporting

The Taskforce will report to the Prime Minister.

Timeframes

The interim report will be provided to the Prime Minister in June 2015 for subsequent consideration by COAG.

A final report will be provided to the Prime Minister with a final strategy to be considered by COAG before the end of 2015.

ENDNOTES

Chapter 1: Supply of ice

[1] United Nations Office on Drugs and Crime (UNODC) (2015) *World Drug Report.* Vienna: United Nations.
[2] *Ibid.*
[3] Department of Immigration and Border Protection (DIBP) (unpublished), Statistical Tables 2010-14.
[4] The term 'illicit drug' is used here to distinguish drugs that are not produced legally and have no recognised licit medical purpose. Reported non-medical use of pharmaceuticals (licit substances) exceeds recent use of all illicit substances except cannabis.
[5] Measured usage levels in 2015 of catchment populations from all states and territories except South Australia and representing 39 per cent of the Australian population, together with sentinel user data obtained under the Drug Use Monitoring in Australia program. The National Drug Strategy Household Survey 2013 found that the proportion of survey participants that reported recent use of methamphetamine (2.1 per cent) was less than those who reported recent use of cannabis (10.2 per cent) and ecstasy (2.5 per cent), and at the same level as cocaine use. However, more recent reporting from Entox (The Queensland Department of Health—University of Queensland) and Drug and Alcohol Services South Australia/the University of South Australia indicates that the level of use of methamphetamine has been increasing since 2010, and during that period significantly exceeded the use of ecstasy and cocaine. See also (2015) Submission by the Attorney-General's Department et al to the Parliamentary Joint Committee on Law Enforcement Inquiry into Crystal Methamphetamine (ice) (www.aph.gov.au), SCORE monitoring 2014 (www.score-cost.eu/monitoring2014) and Tscharke BJ et al (2015) Trends in stimulant use in Australia: A comparison of wastewater analysis and population surveys. *Science of the Total Environment,* 536. pp.331-337.
[6] DIBP (unpublished), Statistical Tables 2010-14.
[7] Australian Crime Commission (ACC) (2015) *The Australian Methylamphetamine Market—The National Picture*. Canberra: ACC.
[8] *Ibid*.
[9] UNODC (2015) *World Drug Report*.
[10] *Ibid.* See also UNODC (2015) *Global SMART Update,* vol 9. Vienna: United Nations.
[11] *Ibid.*
[12] *Ibid.*
[13] United States Bureau of International Narcotics and Law Enforcement Affairs (2014) *International Narcotics Control Strategy Report*. Washington DC: US Department of State.
[14] UNODC (2015) *World Drug Report*.
[15] UNODC (2015) *The Challenge of Synthetic Drugs in East and South-East Asia and Oceania, Trends and Patterns of Amphetamine-type Stimulants and New Psychoactive Substances.* Vienna: United Nations.
[16] UNODC (2014 & 2015) *World Drug Report.*
[17] ACC (2015) *The Australian Methylamphetamine Market—The National Picture.*
[18] *Ibid.*
[19] ACC (2015) *2013-14 Illicit Drug Data Report*. Canberra: ACC.
[20] *Ibid.* See also UNODC (2014) *Global Synthetic Drugs Assessment*. Vienna: United Nations.
[21] As an illegal drug, data on imports is not available. However, data on border seizures and chemical analysis indicating the sources of drugs seized in Australia provide an indication of importation trends.
[22] *Ibid.*
[23] DIBP (unpublished), Statistical Tables 2006-14
[24] DIBP (unpublished), Statistical Tables 2014-15.
[25] Law Reform, Drugs and Crime Prevention Committee (2014) *Inquiry into the Supply and use of Methamphetamines, Particularly Ice, in Victoria: Final Report*. Victoria: Parliament of Victoria.
[26] DIBP (unpublished), Statistical Tables 2010-14.
[27] ACC, *2010-11 Illicit Drug Data Report,* and *2013-14 Illicit Drug Data Report.* Canberra: ACC.
[28] Including in countries like Mexico. See West, B. (2012) *Meth in Mexico: A Turning Point in the Drug War?* United States: Stratfor Global Intelligence.
[29] UNODC (2013) *Patterns and Trends of Amphetamine Type Stimulants and other Drugs: Challenges for Asia and the Pacific.* Vienna: United Nations.
[30] United States Bureau of International Narcotics and Law Enforcement Affairs (2014).
[31] DIBP (unpublished), Information holdings.
[32] Law Reform, Drugs and Crime Prevention Committee (2014) Inquiry into the Supply and use of Methamphetamines, Particularly Ice, in Victoria: Final Report. Victoria: Parliament of Victoria.
[33] *Ibid.*
[34] DIBP (unpublished), Statistical Tables 2010 14.
[35] Data for 2014-15 only included up to 30 April 2015.China includes the Hong Kong Special Administrative Region.
[36] ACC (2015) *2013-14 Illicit Drug Data Report*. Canberra: ACC; and Penington Institute (2015) Submission to the National Ice Taskforce.
[37] AIHW (2014) National Drug Strategy Household Survey 2013.
[38] ACC (2015) *The Australian Methylamphetamine Market—The National Picture.*
[39] Ibid.
[40] ACC (2013) *Crime Profile Series: Outlaw Motorcycle Gangs, Canberra*. Canberra: ACC
[41] ACC (2015) *The Australian Methylamphetamine Market—The National Picture.*

[42] Information provided to the Taskforce from national law enforcement chemical diversion desks 2015.
[43] DIBP (unpublished), Statistical Tables 2010-14.
[44] ACC, *2010-11 Illicit Drug Data Report,* and *2013-14 Illicit Drug Data Report.* Canberra: ACC.
[45] The term pre-precursor refers to a chemical substance which cannot directly be converted to methamphetamine, but can be used to create a direct precursor chemical.
[46] Information provided to the Taskforce from the ACC's Project Alberta file holdings.
[47] Ritter, A., Bright, D & Gong, W. (2012) *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia, Monograph Series No. 44.* Canberra: National Drug Law Enforcement Research Fund.
[48] Law Reform, Drugs and Crime Prevention Committee (2014).
[49] ACC (2015) *The Australian Methylamphetamine Market—The National Picture*
[50] Law Reform, Drugs and Crime Prevention Committee (2014).
[51] ACC (2014) *Annual Report 2013-14*. Canberra: ACC.
[52] ACC (2015) *The Australian Methylamphetamine Market—The National Picture.*
[53] Information provided to the Taskforce from state and territory governments.
[54] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[55] National Ice Taskforce Community Consultation in Broome (19 May 2015), Darwin (20 May 2015) and Townsville (2 June 2015).
[56] James Cook University (2015) Submission to the National Ice Taskforce.
[53] National Ice Taskforce Community Consultations in Broome (19 May 2015), Darwin (20 May 2015) and Townsville (2 June 2015).
[58] While only 20 per cent of indigenous Australians live in remote locations, this is highlighted here due to particular conditions in these communities, including lack of access to services and the low presence of law enforcement.
[59] Cape York Partnership & Apunipima Cape York Health Council (2015) Submission to the National Ice Taskforce.
[60] Natalie (no last name provided) (2015) Submission to the National Ice Taskforce.

Chapter 2: Demand for ice

[61] All population estimates are calculated by multiplying prevalence and the relevant population count. The population estimates were based on the latest available age/sex profile using the relevant published Australian Bureau of Statistics estimated resident population data as at 30 June for the relevant year. Population estimates are shown to the nearest 100 or 1,000 depending on the size of the estimate.
[62] Australian Institute of Health and Welfare (AIHW) (2015), *National Drug Strategy Household Survey* (NDSHS) (2007-2013). Unpublished data.
[63] National Ice Taskforce Roundtable Meeting with Treatment services in Sydney (25 May 2015).
[64] National Ice Taskforce Community Consultation in Darwin (20 May 2015).
[65] National Ice Taskforce Community Consultation in Townsville (2 June 2015).
[66] Darke S., Kaye S., McKetin R., Duflou J. (2008) Major physical and psychological harms of methamphetamine use. *Drug and Alcohol Review*, 27(3). pp.253-262.
[67] Australian Broadcasting Corporation (ABC) (2006). *Chronology: The Emergence of Methamphetamines in* Australia. Accessed 16/09/2015 at http://www.abc.net.au/4corners/content/2006/20060320_ice/chronology.htm.
[68] National Drug Research Institute & the Australian Institute of Criminology (2007) cited in Ransley, J., Mazerolle, L., Manning, M., McGuffog., Webster, J. (2011) *Reducing the Methamphetamine Problem in Australia: Evaluating Innovative Partnerships between Police, Pharmacies and Other Third Parties, Monograph no. 39.* Canberra: National Drug Law Enforcement Research Fund (NDLERF).
[69] Goves, A., Marmo, M. (2009) cited in Ransley et al (2011).
[70] Austrailan Institute of Health and Welfare (AIHW) (1993-2013), *National Drug Strategy Household Survey Supplementary Tables*: *Illicit Drug Tables.* Table 5.3: Summary of recent illicit use of drugs, people aged 14 years or older (per cent).
[71] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[72] *Ibid.*
[73] National Drug and Alcohol Research Centre (NDARC) (2015) Submission to the National Ice Taskforce.
[74] Sewage Analysis CORe group Europe (SCORE) 2014 monitoring, COST ES1307 and associated partners, www.score-cost.eu/monitoring2014 . National Research Centre for Environmental Toxicology (2015) (unpublished), *Median Estimated Consumption Levels of Methamphetamine in two Queensland catchment populations*. Australian Institute of Criminology (AIC) (2015) *Drug Use Monitoring in Australia Annual Reports 2011-12 and 2013-14.* Canberra: AIC*; and* Tscharke BJ et al (2015) Trends in stimulant use in Australia: A comparison of wastewater analysis and population surveys. *Science of the Total Environment 536.*
[75] Australian Institute of Criminology (AIC) (2015) *Drug Use Monitoring in Australia (DUMA) Annual Report 2011-12 & DUMA Annual Report 2013-14*.
[76] More than 70 per cent of detained persons who complete a DUMA survey also submit a urine sample which is analysed to test the accuracy of their survey responses. The DUMA survey was completed by 3,456 adult detainees in 2013-14.
[77] AIC (2015) *Drug Use Monitoring in Australia (DUMA) Annual Report 2011-12 & DUMA Annual Report 2013-14*.
[78] Australian Institute of Health and Welfare (AIHW) (2014) *National Drug Strategy Household Survey Detailed Report 2013*. Drug Statistics Series no. 28, Cat no. PHE 183, Canberra.
[79] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[80] Stafford, J & Burns, L. (2010) Australian Drug Trends 2009. Findings from the Illicit Drug Reporting System. *Australian Drug Trend Series, No. 37*. Sydney: National Drug and Alcohol Research Centre (NDARC).
[81] Stafford, J & Burns, L. (2015) Australian Drug Trends 2014. Findings from the Illicit Drug Reporting System. *Australian Drug Trend Series, No. 127*. Sydney: NDARC.

[82] National Drug and Alcohol Research Centre (2015) *Media Release: Methamphetamine deaths increase across Australia and ice use jumps by 52 per cent among people who inject drug*s. Release date: 5 June 2015.
[83] Austrailan Institute of Health and Welfare (AIHW) (2007-2013), *National Drug Strategy Household Survey Supplementary Table*s: *Illicit Drug Tables.* Table 5.20.
[84] Taskforce analysis of data.
[85] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[86] Degenhardt, L., Day, C., Dietze, P., Pointer, S., et al. (2005) cited in McKetin, R., McLaren, J., Riddell, S., Robins, L. (2006) The relationship between methamphetamine use and violent behaviour. *The Crime and Justice Bulletin*, *New South Wales Bureau of Crime Statistics and Research,* 97.
[87] McKetin, R. & McLaren, J. (2004) cited in McKetin, R., McLaren., J., Riddell, S., Robins, L. (2006).
[88] ACC (2015) *Illicit Drug Data Report 2013-14*. Canberra: ACC.
[89] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[90] Australian Institute of Health and Welfare (AIHW) (1993-2013), *National Drug Strategy Household Survey Supplementary Table*s: *Illicit Drug Tables.* Table 5.3.
[91] SCORE 2014 (www.score-cost.eu/monitoring2014); National Research Centre for Environmental Toxicology (2015) (unpublished); AIC. *Drug Use Monitoring in Australia (DUMA) Annual Report 2011-12 & DUMA Annual Report 2013-14*; and Tscharke, BJ et al (2015).
[92] Australian Institute of Health and Welfare (AIHW) (2007-2013), *National Drug Strategy Household Survey Supplementary Table*s: *Illicit Drug Tables.* Table 5.20.
[93] Taskforce analysis of data. Estimate has a relative standard error of 25 per cent to 50 per cent and should be used with caution.
[94] AIHW (2015), NDSHS (2013). Unpublished data.
[95] AIHW (1993-2013), *National Drug Strategy Household Survey Supplementary Table*s: *Illicit Drug Tables.* Table 5.3.
[96] Victorian Alcohol and Drug Association (2015) Submission to the National Ice Taskforce.
[97] National Ice Taskforce Roundtable Meeting with Peak alcohol and drug bodies in Brisbane (5 May 2015).
[98] National Ice Taskforce Community Consultation in Mildura (3 June 2015).
[99] Australian Institute of Health and Welfare (2013) cited in Roche, A. (2015) *The National Methamphetamine Symposium: Methamphetamine Use in Australia: What the data tells us about patterns of use*, National Centre for Education and Training on Addiction, Flinders University.
[100] Law Reform, Drugs and Crime Prevention Committee (2014).
[101] Cogger, S., Dietze, P., Lloyd, B. (2013) cited in Law Reform, Drugs and Crime Prevention Committee (2014).
[102] Law Reform, Drugs and Crime Prevention Committee (2014).
[103] This data refers to those respondents to the NDSHS who indicated that they had used meth/amphetamines in the past 12 months, and that the main form of meth/amphetamines used was ice.
[104] AIHW (2015), NDSHS (2013). Unpublished data.
[105] Law Reform, Drugs and Crime Prevention Committee (2014) *Inquiry into the Supply and use of Methamphetamines, Particularly Ice, in Victoria: Final Report*. Victoria: Parliament of Victoria.
[106] Adapted from: Lee, N., Johns, L., Jenkinson, R., Johnston, J., Connolly, K., Hall, K., Cash, R. (2007) *Methamphetamine Dependence and Treatment: Clinical Treatment Guidelines for Alcohol and Drug Clinician*s. Victoria: Turning Point Alcohol and Drug Centre.
[107] Adapted from: Blue Moon Research and Planning Pty Ltd. (2008) *Patterns of Use and Harms Associated with Specific Populations of Methamphetamine Users in Australia—Exploratory Research*. Canberra: Prepared for the Department of Health and Ageing.
[108] Schilder A.J. et al (2005) cited in Schifano, F., Corkery, J., Cuffolo, G. (2007), Smokable ("ice", "crystal meth") and non smokable amphetamine-type stimulants: clinical pharmacological and epidemiological issues, with special reference to the UK. *Ann Ist Super Sanità*, 43(1). pp. 110-115.
[109] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[110] Blue Moon Research and Planning Pty Ltd. (2008).
[111] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[112] AIHW (2015), NDSHS (2013). Unpublished data.
[113] Blue Moon Research and Planning Pty Ltd. (2008).
[114] McKetin. R., McLaren, J., Kelly, E., Hall, W., Hickman, M. (2005) *Estimating the Number of Regular and Dependent Methamphetamine Users in Australia, Technical Report No. 230*. New South Wales: NDARC.
[115] UnitingCare ReGen (2015) Submission to the National Ice Taskforce.
[116] Australian Institute of Health and Welfare (2014) *National Drug Strategy Household Survey detailed report 2013*.
[117] National Drug Research Institute (2015) submission to the National Ice Taskforce.
[118] Anglicare Tasmania Inc. (2015) Submission to the National Ice Taskforce.
[119] Penington Institute (2015) Submission to the National Ice Taskforce.
[120] Spooner, C & Hetherington, K (2004) *Social Determinants of Drug Use, Technical Report Number 228*. New South Wales: NDARC.
[121] Newcomb, MD et al (1986); Glantz, M.D. & Leshner, A.I. (2000) in Loxley, W., Toumbourou, J.W., Stockwell, T., Haines, B. Scott, K., Godfrey, C., Waters, E., Patton, G., Fordham, R., Gray, D., Marshall, J., Ryder, D., Saggers, S., Sanci, L., Williams, J. (2004) *The Prevention Substance Use, Risk and Harm in Australia: A Review of the Evidence*. Canberra: The National Drug Research Institute and the Centre for Adolescent Health.
[122] Mitchell, P et al (2001) in Loxley, W et al (2004).
[123] Australian Crime Commission (ACC) (2015) *The Australian Methylamphetamine Market—The National Picture*. Canberra: ACC.
[124] Stafford, J., Burns, L. (2015).
[125] Scott N., Caulkins J.P., Ritter, A., Quinn, C., Dietze P. (2014) High-frequency drug purity and price series as tools for explaining drug trends and harms in Victoria, Australia. Addiction, 2015 Jan; 110(1):120-8.
[126] Scott, N., Caulkins J.P., Ritter, A., Dietze P. (2015) Understanding and Describing Australian Illicit Drug

Markets: Drug Price Variations and Associated Changes in a Cohort of People Who Inject Drugs, Monograph Series No.58, National Drug Law Enforcement Fund, Canberra

[127] ACC (2015).

[128] Darke et al (2008).

[129] McKetin. R., McLaren, J., Kelly, E., Hall, W., Hickman, M. (2005).

[130] Nicholas, R (2008) *The impact of social networks and not-for-profit illicit drug dealing on illicit drug markets in Australia: A discussion paper*. Canberra: NDLERF. pp. 4-6.

[131] McKetin, R., Kelly, E & McLaren J (2006) The relationship between crystalline methamphetamine use and dependence. *Drug Alcohol Depend*, 85(3). pp. 189-195.

[132] Stafford, J & Burns, L. (2015).

[133] Scott N., Caulkins JP., Ritter A & Dietze, P (2015). *Understanding and describing Australian illicit drug markets: Drug price variations and associated changes in a cohort of people who inject drugs, Monograph Series No. 58*. Canberra: NDLERF

[134] *Ibid.*

[135] ACC (2014) Submission to the Victorian Parliamentary Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria. p.10. (www.parliament.vic.gov.au)

[136] ACC (2015) *2013-14 Illicit Drugs Data Report*.

[137] Scott N., Caulkins JP., Ritter A & Dietze, P (2015).

[138] Stafford, J & Burns, L. (2015).

[139] 'Point' refers to a street deal or single 'dose' of ice.

[140] Stafford, J & Burns, L. (2015).

[141] ACC (2015) Illicit Drugs Data Reports 2006-07 to 2013-14.

[142] Scott N., Caulkins JP., Ritter A & Dietze, P (2015).

[143] Law Reform, Drugs and Crime Prevention Committee (2014) *Inquiry into the Supply and use of Methamphetamines, Particularly Ice, in Victoria: Final Report*. Victoria: Parliament of Victoria. p. 50.

[144] ACC (2015) Illicit Drugs Data Reports 2004-05 to 2013-14.

[145] ACC, *Illicit Drug Data Report* 2004-05 to 2013-14, unpublished data.

[146] Scott N., Caulkins J.P., Ritter, A., Quinn, C., Dietze P. (2014).

[147] Burnet Institute (2014) Submission to the Victorian Parliamentary Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria (www.parliament.vic.gov.au)

[148] Scott N., Caulkins J.P., Ritter, A., Quinn, C., Dietze P. (2014).

[149] Scott N., Caulkins JP., Ritter A & Dietze, P (2015).

[150] National Drug Research Institute (2015) Submission to the National Ice Taskforce.

[151] AIHW (2015), NDSHS (2013). Unpublished data.

[152] ACC (2014) Submission to the Victorian Parliamentary Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria. p. 4. (www.parliament.vic.gov.au)

[153] McKetin, R., Kelly, E & McLaren, J (2006). pp. 198-204.

[154] Darke S., Kaye S., McKetin R & Duflou, J. (2008). pp. 253-262.

[155] McKetin, R., McLauren, J & Kelly, E (2005) *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences*. New South Wales: NDARC. p. 70.

[156] Australian Institute of Health and Welfare (AIHW): (2003-04 to 2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[157] Nicholas, R (2008). pp. 2 –3.

[158] *Ibid*. p. 3

[159] Caulkins, J. P., Gragnani, A., Feichtinger, G., Tragler, G. (2005) High and low frequency oscillations in drug epidemics, Heinz College Research Showcase, Carnegie Mellon University.

[160] Nicholas, R (2008). pp. 4-6.

[161] NDARC (2015) Submission to the National Ice Taskforce.

[162] McKetin, R (2015) Submission to the National Ice Taskforce.

[163] AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*.

[164] McKetin, R (2015) Submission to the National Ice Taskforce.

[165] AIHW (2015), NDSHS (2007-2013). Unpublished data.

[166] McKetin, R., Kelly, E & McLaren J (2006). pp. 189-195.

[167] NDARC (2015) Submission to the National Ice Taskforce.

[168] Law Reform, Drugs and Crime Prevention Committee (2014) p. 271.

[169] National Cannabis Prevention and Information Centre, Medicine NSW, (2015) Submission to the National Ice Taskforce.

[170] AIHW 2013 NDSHS, unpublished data 2015.

[171] Young people defined as people aged 18 to 25 in Groves, A (2014) Rethinking the Methamphetamine Situation: Perceptions of Risk and Current Policy Dialogue. *Current Issues in Criminal Justice* 21. p26(2)

[172] Green, R & Moore, D (2013) "Meth Circles" and "Pipe Pirates": Crystal Methamphetamine Smoking and Identity Management Among a Social Network of Young Adults. *Substance and Misuse*, 48. pp. 691-701.

[173] Groves, A (2014) Rethinking the Methamphetamine Situation: Perceptions of Risk and Current Policy Dialogue. *Current Issues in Criminal Justice*, 21. p 26(2).

[174] Penington Institute (2014) *Community assessment of the impacts of methamphetamine use.* Victoria: Penington Institute. p. 35.

[175] Green, R & Moore, D (2013).

[176] AIHW (2015), NDSHS (2007-2013). Unpublished data.

[177] AIHW (2015), NDSHS (2013). Unpublished data.

[178] AIHW (2015), NDSHS (2007-2013). Unpublished data.

[179] AIHW (2015), NDSHS (2007-2013). Unpublished data.

[180] AIHW (2013) NDSHS (2013) cited in National Cannabis Prevention and Information Centre, Medicine NSW, (2015) Submission to the National Ice Taskforce.

[181] Youth Support and Advocacy Service (YSAS) (2013) Submission to the Victorian Parliamentary Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria. p. 271

[182] Weave Youth and Community Service (2015) Submission to the National Ice Taskforce.

[183] Darke, S., Kaye, S., McKetin, R & Duflou, J, (2008) p. 255.
[184] Australian Drug Foundation (2013) Submission to the Victorian Parliamentary Inquiry into the supply and use of methamphetamines, particularly 'ice', in Victoria. p. 4.
[185] Weave Youth Community Services (2015).
[186] Queensland Government (2015) *Ways to combat ice addiction in Queensland: Discussion paper*. Queensland: Queensland Government.
[187] YSAS (2013) p. 273.
[188] Groves, A (2014)
[189] National Ice Taskforce Roundtable Meeting with Peak alcohol and drug bodies in Brisbane (5 May 2015).
[190] Estimate has a relative standard error of 25 per cent to 50 per cent and should be used with caution.
[191] AIHW 2013 NDSHS, AIHW unpublished data 2015.
[192] National Ice Taskforce Roundtable Meeting with Peak alcohol and drug bodies in Brisbane (5 May 2015).
[193] National Ice Taskforce Community Consultation in Townsville (2 June 2015)
[194] National Ice Taskforce Community Consultation in Townsville (2 June 2015).
[195] National Ice Taskforce Community Consultation in Darwin (20 May 2015).
[196] National Rural Health Alliance (2015) Submission to the National Ice Taskforce.
[197] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[198] Estimate has a relative standard error of 25 per cent to 50 per cent and should be used with caution.
[199] MacLean, S et al (2015) Primary health-care responses to methamphetamine use in Australian Indigenous communities. *Australian Journal of Primary Health,* 15(1).
[200] Ward, J., Bryant, J et al (2014) *The Goanna Survey*. Northern Territory: Baker IDI Heart & Diabetes Institute.
[201] AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*.
[202] Note that due to the small sample sizes of Aboriginal and/or Torres Strait Islander people, estimates should be interpreted with caution.
[203] AIHW 2013 NDSHS, AIHW unpublished data 2015.
[204] Estimate has a relative standard error of 25 per cent to 50 per cent and should be used with caution.
[205] New South Wales Government (2015) *Crystalline Methamphetamine Background Paper—NSW data*. Sydney: NSW Health.
[206] AIHW (2015) *Admitted patient care 2013-14: Australian hospital statistics*. Canberra: AIHW. p. 50.
[207] AIHW, Alcohol and Other Drug Treatment Services National Minimum Data Set collection 2009-10 to 2013-14, Advice to the National Ice Taskforce.
[208] Waminda South Coast Women's Health and Welfare Aboriginal Corporation (2015) Submission to the National Ice Taskforce.
[209] MacLean, S et al (2015).
[210] Australian Institute of Health and Welfare (2015) Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2013-14, *Australian Institute of Health and Welfare website*. Accessed 07/08/15 at http://www.aihw.gov.au/publication-detail/?id=60129550843
[211] National Indigenous Drug and Alcohol Committee (NIDAC) & National Aboriginal Community Controlled Health Organisation (NACCHO) (2014) *Online consultation: Amphetamine-Type Stimulants use.* Canberra: NIDAC & NACCHO. p. 8.
[212] New South Wales Aboriginal Land Council (2015) Submission to the National Ice Taskforce.
[213] Western Australian Network of Alcohol and Other Drug Agencies (2015) Submission to the National Ice Taskforce.
[214] James Cook University (2015)
[215] National Ice Taskforce Community Consultation in Townsville (2 June 2015)
[216] Ritter, A., Matthew-Simmons, F & Carragher, N (2012) *Prevalence of and Interventions for Mental Health and Alcohol and Other Drug Problems Amongst the Gay, Lesbian, Bisexual, and Transgender Community: A Review of the Literature' Drug Policy Modelling Program Series No. 23.* Sydney: NDARC.
[217] AIHW (2014) *National Drug Strategy Household Survey detailed report 2013, Drug Statistics Series no.28, Cat no. PHE 183*. Canberra: AIHW.
[218] *Ibid.*
[219] Estimate has a relative standard error of 25 per cent to 50 per cent and should be used with caution.
[220] AIHW 2013 NDSHS, AIHW unpublished data 2015.
[221] ACON (2015) Submission to the National Ice Taskforce. p.3.
[222] Ritter, A., Matthew-Simmons, F & Carragher, N (2012).
[223] Fraland et al (2009); Dwyer et al (2012); Matheson et al (2010), in Law Reform, Drugs and Crime Prevention Committee (2014) p. 301.
[224] Law Reform, Drugs and Crime Prevention Committee (2014) p. 306.
[225] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[226] Estimate has a relative standard error of 25 per cent to 50 per cent and should be used with caution.
[227] AIHW (2013) *The health of Australia's prisoners 2012, Cat. no. PHE 170*. Canberra: AIHW. p.76-77.
[228] AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*.
[229] Caraniche (2015) Submission to the National Ice Taskforce.
[230] Gateley et al (2011); Anex (2013) in Law Reform, Drugs and Crime Prevention Committee (2014) p. 306.
[231] Kinner et al (2011); Victorian Alcohol & Drug Association (2013) in Law Reform, Drugs and Crime Prevention Committee (2014).
[232] Loxley, W. et al (2004).
[233] Henkel, D (2011) Unemployment and Substance Use: A Review of the Literature (1990-2010). *Current Drug Abuse Reviews*, 4. pp. 4-27.
[234] Spooner, C & Hetherington, K (2004).
[235] AIHW, *National Drug Strategy Household Survey*, Table S5.26: Illicit use of drugs, people aged 14 years or older, by social characteristics, 2007 to 2013 (per cent).
[236] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[237] AIHW (2015), NDSHS (2007-2013). Unpublished data.
[238] Spooner, C & Hetherington, K (2004).

Chapter 3: Impact of ice

[239] Darke, S., Kaye, S., McKetin, R. & Duflou, J. (2008) Major physical and psychological harms of methamphetamine use. *Drug and Alcohol Review,* 27. p.253

[240] Darke et al (2008), p. 255

[241] Kaye, S., McKetin, R., Duflou, J. & Darke, S. (2007) Methamphetamine and cardiovascular pathology: a review of the evidence. *Addiction*, 102. pp.1204-1211

[242] Darke et al (2008) p. 255

[243] Lee, N., Johns, L., Jenkinson, R., Johnston, J. et al (2007) *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methylamphetamine dependence and treatment.* Fitzroy, Victoria: Turning Point Alcohol and Drug Centre

[244] Darke et al (2008) p.255

[245] *Ibid* p.255

[246] *Ibid* p.254

[247] Roxburgh, A. & Burns, L. (2015) *Cocaine and Methamphetamine related drug-induced deaths in Australia, 2011*. Sydney: National Drug and Alcohol Research Centre

[248] Darke et al (2008) p.255

[249] *Ibid*

[250] *Ibid* p.255

[251] Kaye et al (2007)

[252] Australian Medical Association (2015) AMA position statement on methamphetamine 2015, *Australian Medical Association website*. Accessed 07/09/15 at https://ama.com.au/sites/default/files/documents/030915%20-%20AMA%20Position%20Statement%20on%20Methamphetamine%20%282015%29.docx

[253] Australian Institute of Health and Welfare (AIHW) (2015): (2009-10 to 2013-14) *National hospital morbidity database:* Advice to the National Ice Taskforce.

[254] Australian Institute of Health and Welfare (AIHW) (2015): (2009-10 to 2013-14) *National hospital morbidity database:* Advice to the National Ice Taskforce.

[255] Lee et al (2007)

[256] McKetin, R., Kelly, E. & McLaren, J. (2006) The relationship between crystalline methamphetamine use and methamphetamine dependence. *Drug and Alcohol Dependence*, 85. pp.198-204

[257] Darke et al (2008) p.256

[258] Pennay, A. & Lee, N. (2011) Putting the call out for more research: The poor evidence base for treating methamphetamine withdrawal. *Drug and Alcohol Review*, 30. pp.216-222

[259] *Ibid* p.256

[260] Lee et al (2007)

[261] American Psychiatric Association. 2013 Diagnostic and Statistical Manual of Mental Disorders. 5th Ed.

[262] McGregor, C., Srisurapanont, M., Jittiwutikarn, J., Laobhripatr, S. et al. (2005) The nature, time course and severity of methamphetamine withdrawal. *Addiction*, 100. pp.1320-1329.

[263] Lee, N (2015) Build it and they will come: what works in treatment and how to apply it in everyday practice. *Presentation to the National Methamphetamine Symposium*. On 12 May 2015, Arts Centre, Melbourne, Accessed 31/07/15 at http://nceta.flinders.edu.au/files/5314/3208/1280/Nicole_Leev3.pdf.

[264] McKetin, R., McLaren, J. & Kelly, E. (2005) The Sydney methylamphetamine market: patterns of supply, personal harms and social consequences, Monograph Series No. 13. Canberra: National Drug Law Enforcement Research Fund. p.xvi.

[265] Darke et al (2008) p.256

[266] Weave Youth and Community Services (2015) Submission to the National Ice Taskforce

[267] Mission Australia (2015) Submission to the National Ice Taskforce

[268] UnitingCare ReGen (2015) Submission to the National Ice Taskforce

[269] Lee et al (2007)

[270] Darke et al (2008) p.255

[271] Lee, N (2015) Build it and they will come: what works in treatment and how to apply it in everyday practice. Presentation to the National Methamphetamine Symposium. On 12 May 2015, Arts Centre, Melbourne, Accessed 31/07/15 at http://nceta.flinders.edu.au/files/5314/3208/1280/Nicole_Leev3.pdf

[272] Mission Australia (2015)

[273] Zweben, J., Cohen, J., Christian, D., Galloway, G. et al. (2004) Psychiatric symptoms in methamphetamine users. *American Journal of Addiction Psychiatry*, 13. pp.181-190

[274] Baker, A. & Dawe, S. (2005) Amphetamine use and co-occurring psychological problems: review of the literature and implications for treatment. *Australian Psychologist,* 40(2). pp. 88-95.

[275] AIHW (2014) *National Drug Strategy Household Survey detailed report 2013*, Canberra: AIHW. p. 97

[276] Baker et al (2005)

[277] Lee, N., Harney, A. & Pennay, A. (2012) Examining the temporal relationship between methamphetamine use and mental health comorbidity. *Advances in Dual Diagnosis*, 5(1). pp. 23-31.

[278] Baker et al (2005)

[279] Lee, N., Harney, A. & Pennay, A. (2012) Examining the temporal relationship between methamphetamine use and mental health comorbidity. *Advances in Dual Diagnosis*, 5(1). pp.23-31

[280] Lee et al. (2012)

[281] Baker et al (2005)

[282] Darke et al (2008) p. 257

[283] SANE Australia (2014) Psychosis. *SANE Australia website*. Accessed 30/07/15 at https://www.sane.org/snapshots/evan/185-psychosis

[284] McKetin, R., Lubman, D., Baker, A., Dawe, S. et al (2013) Dose-related psychotic symptoms in chronic methamphetamine users: evidence from a prospective longitudinal study. *JAMA Psychiatry*, 70(3). pp.319-324

[285] Sommers, I., Baskin, D. & Baskin-Sommers, A. (2006) Methamphetamine use among young adults: health and social consequences. *Addictive Behaviours*, 31(8). p.1474

[286] *Ibid* p.1474

[287] McKetin, R., McLaren, J., Lubman, D. & Hides, L. (2006) The prevalence of psychotic symptoms among methamphetamine users. *Addiction*, 101(10). pp.1473-1478

[288] McKetin et al (2013)

[289] Darke et al (2008) p.257

[290] *Ibid* p.257

[291] Jenner, L. (2012) Ups and downs: physical and mental health consequences of amphetamine-type stimulant use. In Allsop, S. & Lee, N. (Eds.) *Perspectives on Amphetamine-Type Stimulant*s. East Hawthorn, Victoria: IP Communications. p.88

[292] Zweben et al (2004)

[293] Darke et al (2008) p.257

[294] Zweben et al (2004)

[295] Darke et al (2008) p.257

[296] *Ibid* p.258

[297] McKetin et al. (2006)

[298] Volkow, N., Chang, L., Wang, G., Fowler, J. et al (2001) Association of dopamine transporter reduction with psychomotor impairment in methamphetamine abusers. *American Journal of Psychiatry,* 158. pp.377-382

[299] Baker, A., Lee, N. & Jenner, L. (2004) *Models of intervention and care for psychostimulant users, 2nd Edition, Monograph Series No.51.* Canberra: Department of Health and Ageing, Australian Government. p.35

[300] Darke et al (2008) p.259

[301] Mehrjerdi, Z., Kiakojouri, A., & Dolan, K. (2014) Attention problems and cognitive-behavioural therapy for methamphetamine users: implications for treatment. *Journal of Addiction Medicine and Therapy*, 2(1). p.1006

[302] Scott, J., Woods, S. Matt, G., Meyer, R. et al (2007) Neurocognitive effects of methamphetamine: a critical review and meta-analysis. *Neuropsychology Review* 17(3). pp.275-297

[303] Mehrjerdi et al (2014)

[304] Townsville Community Ice Forum (2015) Submission to the National Ice Taskforce

[305] Zweben et al (2004)

[306] Sommers et al (2006)

[307] McKetin, R., Lubman, D., Najman, J., Dawe, S. et al (2014) Does methamphetamine use increase violent behaviour? Evidence from a prospective longitudinal study. *Addiction*, 109(5). pp.798-806

[308] Topp, L. (2012) Amphetamine-type stimulants and risk-taking behaviours' In Allsop, S. & Lee, N. (Eds.) *Perspectives on Amphetamine-Type Stimulants*. East Hawthorn, Victoria: IP Communications. p.79

[309] Topp (2012) p.79

[310] McKetin et al (2014) p.803

[311] *Ibid*

[312] Topp (2012) p.69

[313] Australian Institute of Health and Welfare (2013) National Drug Strategy Household Survey. Unpublished data.

[314] Australian Institute of Health and Welfare (AIHW) (2015): (2003-04 to 2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[315] Department of Health (2015) Fourth National Hepatitis C Strategy 2014-2017. *Australian Government Department of Health website.* Accessed 31/07/15 at http://www.health.gov.au/internet/main/publishing.nsf/Content/ohp-bbvs-hepc

[316] Australian Institute of Health and Welfare (AIHW) (2015): (2003-04 to 2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[317] Australian Institute of Health and Welfare (2013) National Drug Strategy Household Survey. Unpublished data.

[318] McKetin et al (2005) p.xvi

[319] McKetin, R., Ross, J., Kelly, E. et al (2008) Characteristics and harms associated with injecting versus smoking methamphetamine among methamphetamine treatment entrants. *Drug and Alcohol Review*, 27. pp.277-285

[320] Molitor, F., Truax, S., Ruiz, J. & Sun, R. (1998) Methamphetamine use and risky sexual behaviours. *West J Med*, 168. pp.93-97

[321] Edlin, B., Irwin, K., Faruque, S., McCoy, C. et al (1994) Intersecting epidemics—crack cocaine use and HIV infection among inner-city young adults. *New England Journal of Medicine*, 331. pp.1422-1427

[322] Nair, M., Saiyed, Z., Nair, N., Gandhi, N. et al. (2009) Methamphetamine enhances HIV-1 infectivity in monocyte derived dendritic cells. *Journal of neuroimmune pharmacology*, 4(1). pp.129-39

[323] Volkow, N., Wang, G., Fowler, J., Teland, F. et al (2007) Stimulant-induced enhanced sexual desire as a potential contributing factor in HIV transmission. *The American Journal of Psychiatry*, 164(1). pp.157-160

[324] Colfax, G., Santos, G-M., Chu, P., Vittinghoff, E. et al (2010) Amphetamine-group substances and HIV. *The Lancet*, 376 pp.458-474

[325] Semple, S., Patterson, T. & Grant, I. (2004) The context of sexual risk behaviour among heterosexual methamphetamine users. *Addictive Behaviors*, 29. pp.807-810

[326] Holyoake (2015) Submission to the National Ice Taskforce

[327] Senator the Hon Fiona Nash (2015) Submission to the National Ice Taskforce

[328] Roxburgh, A., Degenhardt, L., Larance, B. & Copeland, J. (2005) *Mental health, drug use and risk among female street-based sex workers in greater Sydney, NDARC Technical Report Number 237*. Sydney: National Drug and Alcohol Research Centre

[329] Mallick, J., Johnston, J., Goren, N. & Kennedy, V. (2007) Drugs and driving in Australia: a survey of community attitudes, experience and understanding. West Melbourne, VIC: Australian Drug Foundation

[330] Goldsmid, S., Coghlan, S. & Patterson, E. (2015) Research in practice: Findings from the DUMA program: drink and drug driving among police detainees. Canberra: Australian Institute of Criminology (unpublished)

[331] Parliament of Victoria—Law Reform, Drugs and Crime Prevention Committee (2014) *Inquiry into the supply and use of methamphetamine in Victoria, Volume 1.* Melbourne: Parliament of Victoria. p.171

[332] McKetin et al (2005)

[333] Weave Youth and Community Services (2015)
[334] Patterson, T. (2005) Utilization of drug treatment programs by methamphetamine users: the role of social stigma. *American Journal on Addictions*, 14. pp.367-380
[335] Australian Injecting and Illicit Drug Users League (2015) Submission to the National Ice Taskforce
[336] Australian Health Ministers' Advisory Council (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*. Canberra: Commonwealth of Australia
[337] *Ibid*
[338] *Ibid*
[339] The Salvation Army Australia (2015) Submission to the National Ice Taskforce
[340] Weave Youth and Community Services (2015)
[341] Marjorie of Queensland (2015) Submission to the National Ice Taskforce
[342] Family Drug Support (2007) *A guide to coping: Support for families faced with problematic drug use*. Leura, New South Wales: Family Drug Support
[343] Orford, J., Velleman, R., Natera, G., Templeton, L. et al (2013) Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. *Social Science and Medicine*, 78. pp.70-77
[344] Orford et al (2013) p.72
[345] Gayle of South Australia (2015) Submission to the National Ice Taskforce
[346] Dawe, S., Frye, S., Best, D., Moss, D. et al (2006) *Drug use in the family: impacts and implications for children, research paper 13.* Canberra: Australian National Council on Drugs. p.41
[347] Corrigan, P. & Miller, F. (2006) Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, 20(2). pp.239-246
[348] *Ibid*
[349] Orford et al (2013) p.72
[350] Kate (location not provided) (2015) Submission to the National Ice Taskforce
[351] Orford et al (2013) p.74
[352] Weave Youth and Community Services (2015)
[353] Australian Health Ministers' Advisory Council (2015)
[354] Orford et al (2013)
[355] Leanne of Victoria (2015) Submission to the National Ice Taskforce
[356] Braaf, R. (2012) *Elephant in the room: responding to alcohol misuse and domestic violence, Issues Paper 24.* Sydney: Australian Domestic & Family Violence Clearinghouse
[357] Semple, S., Strathdee, S., Zians, J., Patterson, T. (2009) Family conflict and depression in HIV-negative heterosexuals: the role of methamphetamine use. *Psychology of Addictive Behaviour*, 23(2). pp.341-347
[358] Busch, A., & Rosenberg, M. (2004) Comparing women and men arrested for domestic violence: a preliminary report. *Journal of Family Violence,* 19(1)
[359] Foster Care Association of the ACT (2015) Submission to the National Ice Taskforce
[360] Dawe et al (2006) p. 43
[361] Dawe et al (2006)
[362] *Ibid* p. 40
[363] *Ibid*
[364] Australian Crime Commission (ACC) (2015) *The Australian Methylamphetamine Market: The National Picture.* Canberra: ACC, Australian Government
[365] Watanabe-Galloway, S., Ryan, S., Hansen, K., Hullsiek, B. et al (2009) Effects of methamphetamine abuse beyond individual users. *Journal of Psychoactive Drugs*, 41(3). p.243
[366] *Ibid*
[367] *Ibid*
[368] Weave Youth and Community Services (2015)
[369] The Salvation Army Australia (2015)
[370] Robert Waterman of Rural Health Tasmania (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (ice)
[371] Singer, M. (2006) Drugs and development: the global impact of drug use and trafficking on social and economic development. *International Journal of Drug Policy*, 19(6). pp.467-478
[372] Collins, D. & Lapsley, H. (2008) *The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05, Monograph Series No.66*. Canberra: Department of Health and Ageing, Australian Government
[373] McKetin et al (2005)
[374] *Ibid*
[375] Police Federation of Australia (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (ice)
[376] McKetin et al (2005) p.144
[377] Victoria Legal Aid (2015), submission) Submission to the National Ice Taskforce
[378] Bunting, P., Fulde, G. & Forster, S. (2007) Comparison of crystalline methamphetamine ('ice') users and other patients with toxicology-related problems presenting to a hospital emergency department. *Medical Journal Australia*, 187. pp.564-566
[379] McKetin et al (2005) p.144
[380] St Vincent's Health Australia (2015) Submission to the National Ice Taskforce
[381] Australasian College for Emergency Medicine (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (ice)
[382] McKetin et al (2005) p. 144.
[383] Gray, S., Fatovich, D., McCoubrie, D. & Daly, F. (2007) Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation. *Medical Journal Australia*, 186. pp.336-339
[384] Australasian College for Emergency Medicine (2015)
[385] National Ice Taskforce Community Consultation in Darwin (20 May 2015)
[386] St Vincent's Health Australia (2015)
[387] Australian Government (2011) *Clandestine Drug Laboratory Remediation Guidelines*. Canberra: Commonwealth Government.
[388] Police Federation of Australia (2015)
[389] Australian Government (2011) *Clandestine Drug Laboratory Remediation Guidelines*. Canberra: Commonwealth Government

[390] United States Environmental Protection Agency (2005) RCRA hazardous waste identification of methamphetamine production process by-products. *Environmental Protection Agency website.* Accessed 30/07/15 at http://www.epa.gov/osw/hazard/wastetypes/wasteid/downloads/rtc-meth.pdf

[391] *Ibid*

[392] Australian Government (2011) *Clandestine Drug Laboratory Remediation Guidelines*.

[393] Australian Crime Commission (2014) Illicit Drug Data Report 2013-14, *Australian Crime Commission website.* Accessed 03/08/15 at https://crimecommission.gov.au/illicit-drug-data-report-2013-14

[394] National Centre for Education and Training on Addiction, Flinders University (2015) Submission to the National Ice Taskforce

[395] *Ibid*

[396] Pitt, K. & Roche, A. (2015) Ice and the workplace. *National Centre for Education and Training on Addiction, Flinders University website*. Accessed 21/08/15 at http://nceta.flinders.edu.au/files/3014/3130/6035/EN593.pdf

[397] Torok, M., Darke, S., Kaye, S., Ross. J et al (2008) Comparative rates of violent crime amongst methamphetamine and opioid users: Victimisation and offending, Monograph Series No. 32. Canberra: National Drug Law Enforcement Research Fund

[398] McKetin et al (2005)

[399] Gizzi, M. & Gerkin, P. (2010) Methamphetamine use and criminal behaviour. *International Journal of Offender Therapy and Comparative Criminology*, 54(6). pp.915-936

[400] Australian Crime Commission (2015)

[401] McKetin et al (2005) p.51

[402] *Ibid*

[403] *Ibid*

[404] *Ibid* p.93

[405] Torok et al (2008) p.v

[406] McKetin et al (2005) p.96

[407] Kelsey from Western Australia (2015) Submission to the National Ice Taskforce

[408] Anonymous of Victoria (2015) Submission to the Taskforce

[409] Georgia of Victoria (2015) Submission to the Taskforce

Chapter 4: Disrupting the supply

[410] University of New South Wales (2015) Submission to the National Ice Taskforce

[411] Commercial and marketable quantities of border controlled drugs are listed in Schedule 4 of the *Commonwealth Criminal Code Regulations 2002*.

[412] This is 7,500 Commonwealth penalty units, each equal to $170.

[413] Adulterants are substances that criminals add to illicit drugs to 'cut' the drugs in order to reduce their purity and increase the number of individual street deals. The aim is to maximise profit for the criminal enterprise.

[414] ACC (2015) *Organised Crime in Australia.* Canberra: ACC, Australian Government.

[415] Trusted insiders are people who assist organised crime while they are employed in key positions that enable them to facilitate drug importations and trafficking, money laundering and other criminal activity.

[416] ACC (2015) *Organised Crime in Australia*

[417] Smithson, M., McFadden, M., and Mwesigye, S (2005) Impact of federal drug law enforcement on the supply of heroin in Australia. *Addiction,* 100(8).

[418] Ritter, A., Bright, D & Gong, W. (2012) *Evaluating drug law enforcement interventions directed towards methamphetamine in Australia*. Canberra: National Drug Law Enforcement Research Fund (NDLERF).

[419] *Ibid.*

[420] *Ibid*.

[421] ACC (2015) *The Australian Methylamphetamine Market—The National Picture*.

[422] Australian Institute of Criminology (AIC) (2001) *Australian heroin drought affects heroin market, Crime Facts Info Number 12.* Canberra: AIC. China includes Hong Kong.

[423] Australian Federal Police (2015) Submission to the Parliamentary Joint Committee on the Australian Commission of Law Enforcement Integrity, Inquiry into the integrity of Australia's border arrangements (www.aph.gov.au).

[424] ACC, (2013) *Illicit Drug Data Report 2011-12,* and (2015) *Illicit Drug Data Report 2013-14.*

[425] ACC (2015) *Illicit Drug Data Report 2013-14.*

[426] Australian Bureau of Statistics (ABS) (2015) *Criminal Courts, Australia, 2013-14*. Canberra: ABS.

[427] Victorian Sentencing Advisory Council (2015) *Major Drug Offences: Current Sentencing Practices*. Victoria: Sentencing Advisory Council.

[428] New South Wales Bureau of Crime Statistics and Research (2015) *New South Wales Criminal Courts Statistics 2014*. New South Wales: NSW Bureau of Crime Statistics and Research.

[429] Parliamentary Joint Committee on the Australian Crime Commission (2009) *Inquiry into the legislative arrangements to outlaw serious and organised crime groups*. Canberra: Parliament of Australia.

[430] Parliamentary Joint Committee on Law Enforcement (2012) *Inquiry into Commonwealth unexplained wealth legislation and arrangements*. Canberra: Parliament of Australia.

[431] Australian Institute of Criminology (AIC) (2010) Unexplained wealth laws in Australia. *Trends and Issues in Crime and Criminal Justice Paper No. 395.* Canberra: AIC.

[432] James Cook University (2015) Submission to the National Ice Taskforce.

[433] Gray, D., et al (2006) *Policing, volatile substance misuse, and Indigenous Australians, Monograph No. 16.* Canberra: NDLERF

[434] UNODC (2014) *World Drug Report.* pp. xiv, 79, 91.

[435] *Ibid.*

[436] Dobkin, C., Nicosia N., & Weinberg M (2014) Are Supply-Side Drug Control Efforts Effective? Evaluating OTC regulations targeting methamphetamine precursors. *Journal of Public Economics,* 120.

[437] The code is available at: http://pacia.org.au/Content/drugs.aspx .
[438] Hughes, C et al (2013) *Evaluation of the Australian Capital Territory Drug Diversion Programs*. New South Wales: National Drug and Alcohol Research Centre.
[439] Hughes, C., Ritter, A., Cowdery N & Phillips, B (2014) Australian threshold quantities for 'drug trafficking': Are they placing drug users at risk of unjustified sanction? *Trends and Issues in Crime and Criminal Justice,* no. 467.
[440] Law Reform, Drugs and Crime Prevention Committee. *Inquiry into the Supply and Use of Methamphetamines, Particularly Ice, in Victoria.* Victoria: Parliament of Victoria.
[441] Dobkin, C., Nicosia, N., and Weinberg, M (2013).
[442] Baker, J & Goh, D (2004) *The Cannabis Cautioning Scheme three years on: An implementation and outcome evaluation.* New South Wales: New South Wales Bureau of Crime Statistics and Research.
[443] Mitchell, O et al. (2012) *Drug Courts' Effects on Criminal Offending for Juveniles and Adults*. United States: The Campbell Collaboration.
[444] New South Wales Bureau of Crime Statistics and Research (2008) *Crime and Justice Bulletin Number 121*. New South Wales: Bureau of Crime Statistics and Research.
[445] Office of Crime Statistics and Research (2012) *The South Australian Drug Court: A Recidivism Study.* South Australia: Office of Crime Statistics and Research.
[446] Payne, J., Kwlatkowski & Wundersitz, J (2008) *Police drug diversion: a study of criminal offending outcomes, Research and Public Policy Series 97*. Canberra: Australian Institute of Criminology.
[447] *Drug and Alcohol Treatment Act 2007* (NSW), *Severe Substance Dependence Treatment Act 2010* (Vic), *Volatile Substance Abuse Prevention Act 2005* (NT) and *Alcohol Mandatory Treatment Act 2013* (NT), and *Alcohol and Drug Dependency Act 1968* (Tas).
[448] Legislative Council General Purpose Standing Committee No. 2 (2013) *Review of drug and alcohol treatment*. New South Wales: Parliament of New South Wales.
[449] DLA Piper (2015) *Review of the Severe Substance Dependence Treatment Act*. Victoria: DLA Piper.
[450] Pritchard, E., Mugavin, J., & Swan, A (2008) *Compulsory treatment in Australia: a discussion paper on the compulsory treatment of individuals dependent on alcohol and/or other drugs.* Canberra: Australian National Council on Drugs.

Chapter 5: Preventing people from using ice

[451] Loxley, W., Toumbourou, J.W., Stockwell, T., Haines, B. Scott, K., Godfrey, C., Waters, E., Patton, G., Fordham, R., Gray, D., Marshall, J., Ryder, D., Saggers, S., Sanci, L., Williams, J. (2004) *The Prevention Substance Use, Risk and Harm in Australia: A Review of the Evidence*. Canberra: The National Drug Research Institute and the Centre for Adolescent Health.
[452] Ritter, A., McLeod, R & Shanahan, M (2013) *Government Drug Policy Expenditure in Australia: 2009/10*. New South Wales: National Drug and Alcohol Research Centre (NDARC).
[453] Australian Curriculum (2015) *Health and Physical Education*. Accessed 4/07/2015 at http://www.australiancurriculum.edu.au/health-and-physical-education/curriculum/f-10?layout=1.
[454] Vogl, L., Newton, N., Teesson, M et al (2012) *Climate Schools: Universal computer-based programs to prevent alcohol and other drug use in adolescence, Technical Report No. 321.* New South Wales: NDARC.
[455] Midford, R., Mitchell, J., Lester, L., Cahill, H., Foxcroft, D., Ramsden, R., Venning, L, Pose, M, (2014) Preventing alcohol harm: early results from a cluster randomised controlled trial in Victoria Australia of comprehensive harm minimisation school drug education. *International Journal of Drug Policy,* 25(1). pp. 142-150.
[456] Meyer, L & Cahill, H (2004) *Principles for school drug education*. Canberra: Department of Education, Science and Training.
[457] Board of Studies Teaching and Educational Standards (BOSTES) New South Wales (2015) Personal Development, Health and Physical Education. *BOSTES website.* Accessed 17/09/15 at http://www.boardofstudies.nsw.edu.au/syllabus_hsc/pdhpe.html
[458] Soole, D., Mazerolle, L., Rombouts, S (2005) *School Based Drug Prevention: A Systematic Review of the Effectiveness on Illicit Drug Use, Drug Policy Modelling Project Monograph 07*. Queensland: Key Centre for Ethics, Law, Justice and Governance, Griffith University.
[459] Adapted from European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2013) *Perspectives on Drugs: Mass media campaigns for the prevention of drug use in young people.* Lisbon: EMCDDA.
[460] Drug Aware (2015) *Drug Aware Amphetamine Campaign.* Accessed 26/08/2015 at http://drugaware.com.au/About-Us/Campaigns/Drug-Aware-Amphetamine-Campaign.aspx
[461] The Government of Western Australia Department of Eucation (2015) *School Drug Education and Road Aware*. Accessed 25/08/15 at http://www.sdera.org.au
[462] Victorian Government Department of Health (2015) *What are you doing on ice?* Accessed 26/08/2015 at http://www.health.vic.gov.au/news/ice-campaign.htm.
[463] Penington Institute (2014) *Ice campaign hits home with those most at risk*. Accessed 26/08/2015 at http://www.penington.org.au/ice-campaign-hits-home-with-those-most-at-risk/
[464] Drug Aware (2015)
[465] Government of Western Australia (2015) *Media Statements*. Accessed 27/08/2015 at https://www.mediastatements.wa.gov.au/Pages/Barnett/2015/08/$1-1-million-for-WA-meth-prevention-campaign.aspx.
[466] Stancombe Research and Planning (2015) *National Drugs Campaign 2015 Evaluation Research*. New South Wales: Stancombe Research and Planning.
[467] *Ibid.*
[468] National Ice Taskforce Community Consultation in Mt Gambier (14 May 2015); Darwin (20 May 2015), Hobart (27 May 2015); Newcastle (26 May 2015); Roundtable Meeting with Peak alcohol and drug bodies in Brisbane (5 May 2015); Treatment services in Sydney (25 May 2015); Services that support users and families in Sydney (25 May 2015); Indigenous health and legal organisations in

Sydney (4 June 2015); and Organisations that represent drug users in Melbourne (11 June 2015).

469 Erceg-Hurn, D M (2008) Drugs, Money, and Graphic Ads: A Critical Review of the Montana Meth Project. *Prevention Science,* 9(4). pp. 256-263. See also Richards, AS (2014) Predicting attitude toward methamphetamine use: the role of antidrug campaign exposure and conversations about meth in Montana. *Health Communication*, 29(2). pp. 124-136.

470 Giles, A (2015) Putting the heat on ice. *Adam Giles Chief Minister of the Northern Territory website.* Accessed 17/09/15 at http://www.chiefminister.nt.gov.au/news/putting-heat-ice

471 Safe Work Australia (2015) *Work-Related Alcohol and Drug Use: A Fit for Work Issue.* Accessed 10/08/2015 at http://www.safeworkaustralia.gov.au/sites/swa/about/publications/pages/rr200703workrelatedalcoholanddruguse .

472 Work Cover Queensland (2015) *Mates tackles alcohol and drugs at work*. Accessed 10/08/2015 at https://www.worksafe.qld.gov.au/news/newsletter/esafe-newsletters/esafe-construction/march-2014/breaking-news/mates-tackles-alcohol-and-drugs-at-work.

473 The Building Trades Group Drug & Alcohol Program (2015) *About us*. Accessed 10/08/2015 at http://btgda.org.au/?page_id=157.

474 Australian Drug Foundation (2015) ADF Aware. *Australian Drug Foundation website.* Accessed 17/09/15 at http://www.adf.org.au/workplace-services-microsite/online-education

475 National Centre for Education and Training on Addiction (2015) *Alcohol and Drugs in the Workplace*. Accessed 10/08/2015 at http://nceta.flinders.edu.au/workplace.

Chapter 6: Helping people to stop using ice

476 Adapted from Schuckit, M (1994) in Centre for Substance Abuse Treatment (1997) *A Guide to Substance Abuse Services for Primary Care Clinicians, Treatment Improvement Protocols Series No.24*. United States: Substance Abuse and Mental Health Services Administration.

477 Adapted from Australian Drug Information Network (2015) *Australian Drug Information Network.* Accessed 13 May 2015 at http://www.adin.com.au/.

478 Includes: Commonwealth AOD treatment grants (Non-Government Organisation Treatment Grants Program and Substance Misuse Service Delivery Grants Fund); state and territory health department AOD treatment funding; public hospital admitted patients; private hospital admitted patients; primary care services (GP, Medicare); Pharmaceutical Benefit Scheme; allied health services (Access to Allied Psychological Services and Better Access); Australian Government Department of Veteran's Affairs; client contributions (excluding those covered under private hospitals); and philanthropy.

479 Ritter, A., Chalmers, J & Berends, L (2015) Health expenditure on alcohol and other drug treatment in Australia (2012/2013). *Drug & Alcohol Review*, 34(4). pp. 397-403.

480 *Ibid.*

481 *Ibid.*

482 *Ibid.*

483 Baker, A., Lee, NK & Jenner, L (2004) *Models of intervention and care for psychostimulant users, 2nd Edition, Monograph Series No 51*. Canberra: Australian Government Department of Health and Ageing.

484 The drug of the greatest concern to the caller.

485 New South Wales Government (2015) *Crystalline Methamphetamine Background Paper—NSW data*. Sydney: NSW Health.

486 Western Australian Government information to the National Ice Taskforce (2015) *Summary issues and trends in meth/amphetamines*. Western Australia: WA Government.

487 Turning Point (2015) Submission to the National Ice Taskforce.

488 *Ibid*.

489 McKetin, R (2015) Submission to the National Ice Taskforce.

490 Swan, AJ & Tyssen, EG (2009) Enhancing treatment access: evaluation of an Australian web-based alcohol and drug counselling initiative. *Drug and Alcohol Review*, 28(1). pp. 48-53.

491 Australian Institute of Health and Welfare (AIHW): (2014) *Australia's Health 2014, series no. 14*. Canberra: AIHW. p. 357.

492 National Health Performance Authority (NHPA): (2015) *Healthy Communities: Frequent GP attenders and their use of health services in 2012-13*. New South Wales: NHPA. p. iv.

493 Australian Institute of Health and Welfare (AIHW): (2014) *Health Expenditure in Australia 2012-13: Analysis by Sector, Health and welfare expenditure series no. 53*. Canberra: AIHW.

494 Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K & Gomez, M (2014) *New Horizons: The review of alcohol and other drug treatment services in Australia*. New South Wales: NDARC (unpublished).

495 AIHW (2014). pp. 357-358.

496 Samet, JH., Friedmann, P & Saltz, R (2001) in Lubman, D (2013) Obstacles to alcohol and drug care: Are Medicare Locals the answer? *Australian Family Physician,* 42(5). pp. 339-342.

497 AIHW (2014). p. 357.

498 Swan, A., Sciacchitano, L & Berends, L (2008) *Alcohol and Other Drug Brief Interventions in Primary Care: Final Report*. Victoria: Turning Point.

499 Roche, A & Freeman, T (2004) in Swan, A., Sciacchitano, L & Berends, L (2008).

500 Excludes encounters where an opioid substitute was prescribed or provided.

501 Based on Bettering the Evaluation and Care of Health (BEACH) data between 2008 and 2013, which captures data from a sample of general practitioners (1,000 GPs, 100 consecutive encounters). This figure excludes encounters where an opioid substitute was prescribed or provided.

502 Ritter et al (2014).

503 Quinn, B., Stoove, M & Dietze, P (2013) Factors associated with professional support access among a

prospective cohort of methamphetamine users. *Journal of Substance Abuse Treatment,* 45(2). pp. 235-41

[504] Ritter et al (2014).

[505] A completed episode of care for an admitted patient.

[506] Australian Institute of Health and Welfare (AIHW): (2009-10 to 2013-14) *National Hospital Morbidity Database.* Advice to the National Ice Taskforce.

[507] Australian Institute of Health and Welfare (AIHW): (2009-10 to 2013-14) *National Hospital Morbidity Database.* Advice to the National Ice Taskforce.

[508] Gray, S.D., Fatovich, D.M., McCoubrie D.L., Daly, F. (2007). Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation. *Medical Journal of Australia*, 186(7). pp. 336-339.

[509] Commonwealth investment for 2012-13 captures funding allocated under the Non Government Organisation Treatment Grants Programme and the Substance Misuse Service Delivery Grants Fund (including funding for Indigenous-specific services).

[510] Ritter et al (2014)

[511] This number is likely an underestimation of all publicly funded treatment services, as it is based on those AOD treatment services that provide data to the Alcohol and Other Drug Treatment Services National Minimum Data Set collection (AODTS-NMDS).

[512] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.

[513] Ritter et al (2014).

[514] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.

[515] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.8.

[516] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[517] Pharmacotherapy treatment captured within the AODTS-NMDS is for opioid pharmacotherapy only and reflects treatment where an opioid was recorded as an *additional* drug of concern.

[518] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SD.59.

[519] Australian Institute of Health and Welfare (AIHW): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[520] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.2.

[521] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SD.59.

[522] Including main and additional treatment types.

[523] Assessment only is when only an assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types.

[524] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[525] *Ibid.*

[526] Australian Institute of Health and Welfare (AIHW): (2003-04 to 2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.2.

[527] Australian Institute of Health and Welfare (AIHW): (2003-04 to 2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.2.

[528] Australian Institute of Health and Welfare (AIHW) (2015): (2009-10 to 2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[529] *Ibid*

[530] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[531] *Ibid.*

[532] Australian Institute of Health and Welfare (AIHW): (2003-04 to 2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.5.

[533] Australian Institute of Health and Welfare (AIHW): (2003-04 to 2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.5.

[534] Heseltine, K., Day, A & Sarre, R (2011) *Prison-Based Correctional Offender Rehabilitation Programs: The 2009 National Picture in Australia, AIC Reports 112*. Canberra: Australian Institute of Criminology. pp. 28-29.

[535] *Ibid.*

[536] Heseltine, K, Day, A & Sarre, R (2011). pp. 29-30.

[537] Hiller, ML., Knight, K & Simpson, DD (1999); Martin, C., Player, E & Liriano, S (2003); Pelissier, B et al (2003); Prendergast, ML et al (2004); Welsh, WN (2007); Wexler, HK et al (1999) in Heseltine, K., Day, A & Sarre, R (2011). pp. 26-27.

[538] Inciardi, J., Martin, S & Butzin, C (2004) in Larney, S., Mathers, B & Dolan, K (2007) *Illicit drug treatment in prison: Detoxification, drug-free units, therapeutic communities and opioid substitution treatment*, *Technical Report No. 266*. New South Wales: NDARC. p.16.

[539] Larney, S et al (2007). pp. 10-12.

[540] Hiller, MN., Knight, K & Simpson, DD (1999) in Heseltine, K., Day, A & Sarre, R (2011). p. 27.

[541] Hiller, MN., Knight, K & Simpson, DD (1999) in Larney, S., Mathers, B & Dolan, K (2007). p. 17.

[542] Ritter et al (2014).

[543] National Mental Health Commission (NMHC) (2014) *Report of the National Review of Mental Health Programmes and Services: Attachment B: Programme Overview.* Sydney: NMHC. p. 4.

[544] Australian Government Department of Health (2015) *Better access to mental health care: fact sheet for patients*. Accessed 17/07/2015 at

http://www.health.gov.au/internet/main/publishing.nsf/content/mental-ba-fact-pat.

[545] Australian Government Department of Health (2015) *Fact sheet: Transition arrangements for the allied mental health services available under the Better Access initiative.* Accessed 17/07/2015 at http://www.health.gov.au/internet/main/publishing.nsf/+content/mental-ba-fact-transfac.

[546] NMHC (2014) *Report of the National Review of Mental Health Programmes and Services: Attachment A: Current Commonwealth investment in mental health*. Sydney: NMHC. p. 4.

[547] *Ibid.*

[548] Australian Government Department of Health (2015) *Access to Allied Psychological Services.* Accessed 17/07/2015 at http://www.health.gov.au/internet/main/publishing.nsf/Content/mental-boimhc-ataps.

[549] Ritter et al (2014).

[550] This included alcohol and drug use disorders alone; alcohol and drug use disorders with depression and anxiety; alcohol and drug use disorders, with depression without anxiety, and alcohol and drug use disorders with anxiety without depression.

[551] Fletcher et al (2012) cited in Ritter et al (2014).

[552] NMHC (2014) *Report of the National Review of Mental Health Programmes and Services: Attachment B: Programme Overview*.

[553] Ritter et al (2014). Unpublished.

[554] *Ibid.*

Chapter 7: Supporting activities

[555] Roche, A & Pidd, K (2010) *Alcohol and Other Drugs Workforce Development Issues and Imperatives: Setting the Scene.* South Australia: National Centre for Education and Training on Addiction (NCETA).

[556] Nicholas, R., Adams, V., Roche, A, White, M. et al (2013) *A Literature Review to Support the Development of Australia's Alcohol and Other Drug Workforce Development Strategy*. South Australia: NCETA.

[557] *Ibid.*

[558] Pidd, K., Roche, A., Duraisingam, V & Carne, A. (2011) *Minimum qualifications in the alcohol and other drugs field: Employers' views*. South Australia: NCETA.

[559] Deakin, E & Gethin, A. (2007) *Training Needs Assessment of NGO Alcohol and Other Drugs Agencies in NSW.* New South Wales: Network of Alcohol and other Drug Agencies.

[560] Roche, A., Duraisingam, V., Wang, P., & Tovell, A. (2008) *Alcohol & Other Drugs, Mental Health & Comorbidity: A Training Review*. South Australia: NCETA.

[561] See for example, Odyssey House Victoria (http://www.workskillsweb.net/index.html) and TAFE South Australia (http://www.tafesa.edu.au/xml/course/aw/aw_TP00325.aspx).

[562] Roche, A & Pidd, K. (2010).

[563] NCETA (2015) *Methamphetamine Publications and Resources.* Accessed 03/08/15 at http://nceta.flinders.edu.au/nceta/resource-kits/methamphetamine-publications-resources/

[564] Mason, J (2013) *Review of Australian Government Health Workforce Programs*. Canberra: Australian Government Department of Health.

[565] General Practice Education and Training Limited (GPETL) (2014) *Annual Report, 2013–14*. Canberra: GPETL.

[566] Gray, S.D., Fatovich, D.M., McCoubrie D.L., Daly, F.F. (2007) Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation. *Medical Journal of Australia*, 186(7). pp. 336-339.

[567] Australasian College of Emergency Medicine (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (www.aph.gov.au).

[568] St Vincent's Health Australia (2015) Submission to the National Ice Taskforce.

[569] Government of Western Australia Drug and Alcohol Office (2015) *Training for Aboriginal workers.* Accessed 30/07/2015 at http://www.dao.health.wa.gov.au/Educationandtraining/TrainingforAboriginalworkers.aspx

[570] *Ibid.*

[571] Odyssey House Victoria (2015) *Certificate IV in Alcohol and Other Drugs.* Accessed 30/07/15 at http://www.workskillsweb.net/certiv_info.html.

[572] Roche, A., Duraisingam, V., Trifonoff, A & Nicholas, R. (2009) *In Pursuit of Excellence: Alcohol and Drug Related Workforce Development Issues for Australian Police into the 21st Century.* South Australia: NCETA.

[573] Police Federation of Australia (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (www.aph.gov.au).

[574] Australian Government National Organised Crime Response Plan 2015–18 (http://www.ag.gov.au/CrimeAndCorruption/OrganisedCrime/Documents/NationalOrganisedCrimeResponsePlan2015-18.pdf)

[575] *Criminal Code 1899 (Queensland)* section 340.

[576] *Sentencing Amendment (Emergency Workers) Act 2014, and Justice Legislation Amendment (Confiscation and Others Matters) Act 2014.*

[577] Siggins Miller (2009) *Evaluations and Monitoring of the National Drug Strategy 2004--2009 Final Report Volume 1: Findings and recommendations*. Queensland: Siggins Miller.

[578] National Drug Strategy (2015) *National Alcohol and other Drug Workforce Development Strategy 2015-2018*. Accessed 25 August 2015 at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/naodwds2015-18

[579] National Drug Strategy (2015) *National Alcohol and other Drug Workforce Development Strategy 2015-2018*. Accessed 25 August 2015 at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/naodwds2015-18

[580] *Ibid.*

[581] Australian Public Service Commission (APSC) (2007) *Tackling Wicked Problems: A Public Policy Perspective*. Canberra: APSC.

[582] National Rural Health Alliance (2015) Submission to the National Ice Taskforce.

583 Victorian Government Taking Action Stopping Ice (2015) *Fund to help communities tackle ice in their local area.* Accessed on 29/05/2015 at http://ice.vic.gov.au/fund-to-help-communities
584 *Ibid.*
585 Good Sports (2015) *Events in Victoria.* Accessed 29/05/2015 at http://goodsports.com.au/around-the-ground/events/vic/forums/.
586 Vinson Centre for Applied Social Research (2014)
587 Wimmera Drug Action Taskforce (2015) Submission to the Inquiry into the supply and use of methamphetamine, particularly ice, in Victoria (www.parliament.vic.gov.au)
588 The North West Star (2015) *Enough is enough.* Accessed 30/05/2015 at http://www.northweststar.com.au/story/2986468/enough-is-enough
589 Council of Australian Governments (2015)
590 Adapted from draft National Drug Strategy 2016–2025.
591 National Drug Strategy 2010–2015.
592 *Ibid.*
593 National Drug Strategy 2010–2015.
594 Senator the Hon Fiona Nash, Assistant Minister for Health (2014) *'Ice' the First Priority for Government's Reshaped Drugs and Alcohol Council Media Release*. Accessed on 29/05/2015 at https://www.health.gov.au/internet/ministers/publishing.nsf/Content/6C2AD951BC5C3D51CA257DAE0000275C/$File/FN074.pdf
595 *Ibid.*
596 National Drug Law Enforcement Research Fund (NDLERF) (2015) Submission to the National Ice Taskforce.
597 Willis, K., Anderson, J & Homel, P (2011) Measuring the effectiveness of drug law enforcement. *Trends & issues in crime and criminal justice, no. 406*; and Hall, W., Prichard, J., Kirkbride, P., Bruno, R, et al (2012) An analysis of ethical issues in using wastewater analysis to monitor illicit drug use. *Addiction*, 107 (10). pp. 1767–1773.
598 Willis, K., Anderson, J & Homel, P (2011)
599 Turning Point (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into Crystal Methamphetamine (ice) (www.aph.gov.au). p. 2.
600 Victoria Police (2009) *Illicit Drug Strategy Practice Guide: Reducing Re-offending through illicit drug diversion.* Victoria: Victoria Police.
601 Irvine, RJ et al. (2011) Population drug use in Australia: a wastewater analysis. *Forensic Science International*, 210.
602 *Ibid.*
603 Lai, FY et al (2013) Using quantitative wastewater analysis to measure daily usage of conventional and emerging illicit drugs at an annual music festival. *Drug and Alcohol Review,* 32(6). pp. 594-602.
604 Van Dyken, E et al (2014) Challenges and opportunities in using wastewater analysis to measure drug use in a small prison facility. *Drug and Alcohol Review,* and Van Dyken, E et al (2014) Monitoring substance use in prisons: Assessing the potential value of wastewater analysis. *Science and Justice*, 54(5). pp. 338-345.
605 Lai, FY et al. (2013). See also Lai, FY et al. (2013) Estimating daily and diurnal variations of illicit drug use in Hong Kong: A pilot study of using wastewater analysis in an Asian metropolitan city. *Forensic Science International*, 233 and JW, O'Brien et al. (2014) A model to Estimate the Population Contributing to the Wastewater Using Samples Collected on Census Day. *Environmental Science & Technology*, 48.
605 Van Dyken, E et al (2014)
606 Turning Point (2015) Submission to the National Ice Taskforce.

Chapter 8: Support families, communities and frontline workers

607 Orford, J., Velleman, R., Natera, G., Templeton, L et al. (2013) Addiction in the family is a major but neglected contributor to the global burden of adult ill-health. *Social Science and Medicine*, 78. pp. 70-77.
608 Corrigan, P & Miller, F (2006) Blame, shame, and contamination: the impact of mental illness and drug dependence stigma on family members. *Journal of Family Psychology*, 20(2). pp. 239-246.
609 Orford et al. (2013) p. 72.
610 Weave Youth and Community Services (2015) Submission to the National Ice Taskforce.
611 Loxley, W., Toumbourou, J., Stockwell, T., Haines, B et al. (2004) *The prevention of substance use, risk and harm in Australia: a review of the evidence.* Canberra: National Drug Research Institute and the Centre for Adolescent Health.
612 Kimberley Aboriginal Medical Services Ltd (2015) Submission to the National Ice Taskforce.
613 Murdoch Children's Research Institute (2011) *Review of the evidence base in relation to early childhood approaches to support children in highly disadvantaged communities for the Children's Ground Project.* Victoria: Royal Children's Hospital. pp. 8-9.
614 Castle, EN & Weber, BA (2006) *Policy and Place: Requirements of a successful place-based policy*. Oregon: Oregon State University.
615 Muir, R & Parker, I (2014) *Many to many: how the relational state will transform public services*. United Kingdom: UK Institute for Public Policy Research. p. 29.
616 Hawkins, DJ et al (1992) in Loxley, W et al (2004). p. 81.
617 Smart, R (1994); Bobashev, GV et al. (1998); Petronis, KR & Anthony, JC (1999); in Loxley, W et al (2004). p. 81.
618 Loxley, W et al. (2004). p. 133.
619 Caulkins et al. (2005), in Birckmayer, J et al. (2008) 'Prevention of Methamphetamine Abuse: Can Existing Evidence Inform Community Prevention? *Journal of Drug Education*, 38(2). pp. 147-165.
620 Kaftarian, SJ & Hansen, WB (1994); Lorion, RP (1991); National Cancer Institute (1991); Stokols, D (1992); Wagenaar, AC et al. (1994); Wallack, L (1994), in Aguirre-Molina, M & Gorman, DM (1996) Community-Based Approaches for the Prevention of Alcohol, Tobacco, and Other Drug Use. *Annual Review of Public Health*, 17:337-58.
621 Birckmayer, J et al. (2008) 147-165.

[622] Hall, G., Boddy, J., Chenowith L & Davie K (2012) *Mutual benefits: Developing relational service approaches within Centrelink*. Queensland: Griffith University.
[623] Communities That Care (2015). *Communities That Care.* Accessed 10/08/2015 at www.communitiesthatcare.org.au
[624] New South Wales Bureau of Crime Statistics and Research (2015) *New South Wales Recorded Crime Statistics*. New South Wales: NSW Bureau of Crime Statistics and Research.
[625] National Ice Taskforce Roundtable Meeting with Peak alcohol and drug bodies in Brisbane (5 May 2015).
[626] National Rural Health Alliance (2015) Submission to the National Ice Taskforce.
[627] National Ice Taskforce Community Consultations in Mt Gambier (14 May 2015); Broome (19 May 2015); Darwin (20 May 2015), Newcastle (26 May 2015); Hobart (27 May 2015); Townsville (2 June 2015); Mildura (3 June 2015); Roundtable Meeting with Educational organisations in Adelaide (13 May 2015), Drug and alcohol research centres in Sydney (22 May 2015); Indigenous health and legal organisations in Sydney (4 June 2015); Organisations that represent drug users in Melbourne (11 June 2015).
[628] Crime Reduction Activities (2015) *Refly-ach Out Recovery Birmingham*. Accessed 16/08/2015 at http://www.cri.org.uk/content/reach-out-recovery-birmingham
[629] Burns, T & Brown, P (2012) *Lessons from a National Scan of Comprehensive Place-Based Philanthropic Initiatives*. United States: Urban Ventures Group Inc.
[630] Good Sports (2015) *Events in Victoria.* Accessed at http://goodsports.com.au/around-the-ground/events/vic/forums/.
[631] Putt, J (2011) *Community policing in Australia, Research and policy series no, 111.* Canberra: Australian Institute of Criminology.
[632] Mission Australia (2015) Submission to the National Ice Taskforce.
[633] National Centre for Education and Training on Addiction (2015) Submission to the National Ice Taskforce.
[634] Lubman, D., Manning, V., Best, D., Berends, L et al (2014) A Study of Patient Pathways in Alcohol and Other Drug Treatment. Victoria: Turning Point. p.2.
[635] *Ibid* p.3.
[636] National Ice Taskforce Roundtable Meeting with Peak alcohol and drug bodies in Brisbane (5 May 2015), Services that support users and their families in Sydney (25 May 2015) and Treatment services in Sydney (25 May 2015).
[637] Australian Medical Association (2015) *Methamphetamine Position Statement*. Accessed 31/08/2015 at https://ama.com.au/position-statement/methamphetamine-2015
[638] Gray, S.D., Fatovich, D.M., McCoubrie D.L., Daly, F.F. (2007) Amphetamine-related presentations to an inner-city tertiary emergency department: a prospective evaluation. *Medical Journal of Australia*, 186(7). pp. 336-339.
[639] National Drug Strategy (2015) *National Alcohol and other Drug Workforce Development Strategy 2015-2018*. Accessed 25 August 2015 at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/naodwds2015-18
[640] Pennay, A., Lee, N. K., Ferris, J., Hester, R., & Dunlop, A. (2009) Treatment for Methamphetamine Withdrawal. *Drug and Alcohol Review*, 28(1). p.78
[641] Network of Alcohol and Other Drugs Agencies (2015) Submission to the National Ice Taskforce.
[642] St Vincent's Health Australia (2015) Submissions to the National Ice Taskforce.
[643] South Australian Network of Drug and Alcohol Services (2015) Submission to the National Ice Taskforce
[644] Australian Injecting & Illicit Drug Users League (2015) Submission to the National Ice Taskforce.
[645] NDRI (2015).
[646] Royal Australian College of General Practitioners (2015) Submission to the National Ice Taskforce.
[647] Australian College of Emergency Medicine (2015) Submission to National Ice Taskforce.
[648] South Australian Network of Drug and Alcohol Services (2015) Submission to the National Ice Taskforce.
[649] NDRI (2015).
[650] Dual diagnosis is commonly referred to as comorbidity, or in some instances multi morbidity. It often refers to situations involving simultaneous substance misuse and mental health issues.
[651] Tasmanian Health Organisation – South (2014) *Final Report of the Review of Drug Use and Services Responses in North West Tasmania:* Government of Tasmania.
[652] Alcohol, Tobacco & Other Drugs Council Tasmania Inc. (2015) Submission to the National Ice Taskforce.
[653] National Ice Taskforce Roundtable Meeting with Peak alcohol and other drug bodies in Brisbane (5 May 2015).
[654] Royal Australian and New Zealand College of Psychiatrists (2015) Submission to the National Ice Taskforce.
[655] NDRI (2015).
[656] *Ibid.*
[657] National Drug Strategy (2015) *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019.* Accessed on 6/08/2015 at http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/natsipds2014-19
[658] Gleadle, F et al. (2010) *Indigenous Alcohol and Drug Workforce Challenges: A literature review of issues related to Indigenous AOD workers' wellbeing, stress and burnout.* South Australia: NCETA.

Chapter 9: Target prevention

[659] Australian Institute of Health and Welfare (AIHW) (2014) *Australia's Health 2014, Australia's health series No. 14*. Canberra: AIHW. p.344
[660] Allsop, S. (2012) Prevention and public health approaches to amphetamine-type stimulant use and related harm. In Allsop, S. & Lee, N. (Eds.) *Perspectives on Amphetamine-Type Stimulants*. East Hawthorn, Victoria: IP Communications
[661] Spooner, C. & Hetherington, K. (2004) *Social Determinants of Drug Use*. Sydney: National Drug and Alcohol Research Centre. p.21

[662] Loxley, W., Toumbourou, J., Stockwell, T., Haines, B. et al (2004) *The Prevention of substance use, risk and harm in Australia: A review of the evidence*. Canberra: The National Drug Research Institute and the Centre for Adolescent Health, Commonwealth of Australia. p. 66

[663] United Nations Office on Drugs and Crime (2015) *International Standards on Drug Use and Prevention*. Vienna: United Nations. p.2

[664] Ministerial Council on Drug Strategy (2008) *National Amphetamine-Type Stimulant Strategy 2008-2011*. Canberra: Ministerial Council on Drug Strategy, Commonwealth Government. p. 24

[665] Spooner & Hetherington (2004) p.xiii

[666] United Nations Office on Drugs and Crime (2015) p. 2

[667] Colfax et al (2010) cited in Allsop (2012)

[668] Allsop (2012)

[669] Ministerial Council on Drug Strategy (2008) p.22

[670] Loxley et al (2004) p.244

[671] Foxcroft, D. & Tsertsvadze A. (2011) Universal school-based prevention programs for alcohol misuse in young people. *The Cochrane Database of Systematic Reviews*, 5

[672] Botvin, G. & Griffin, K. (2003) & Midford & Munro (2006) cited in Allsop (2012) p.177

[673] Stubbs et al (2004) cited in Allsop (2012) p.177

[674] Allsop (2012)

[675] National Ice Taskforce Roundtable Meeting with treatment services in Sydney (25 May 2015)

[676] National Ice Taskforce Community Consultation in Newcastle (26 May 2015)

[677] National Ice Taskforce Roundtable Meeting with Educational organisations in Adelaide (13 May 2015)

[678] Roche, A., Lee, N. & Cameron, J. (undated) Alcohol education: What really works in schools? Adelaide: National Centre for Education and Training on Addiction, Flinders University

[679] Adapted from United Nations Office on Drugs and Crime (2015) pp. 8-10

[680] National Ice Taskforce Roundtable Meeting with Educational organisations in Adelaide (13 May 2015)

[681] National Ice Taskforce Community Consultation in Darwin (20 May 2015).

[682] Birckmayer et al (2008) cited in Allsop (2012) p. 177.

[683] Berkowitz, A. (2005) An Overview of the Social Norms Approach. In Lederman, L., Stewart, L., Goodhart, F. & Laitman, L. (Eds.) *Changing the culture of college drinking: a socially situated prevention campaign*. Cresskill, USA: Hampton Press

[684] Allsop (2012)

[685] Australian Institute of Health and Welfare (AIHW) (2014) *Australia's Health 2014, Australia's health series No. 14*. Canberra: AIHW. p.346

[686] United Nations Office on Drugs and Crime (2015) p. 27

[687] Allsop (2012)

[688] National Drug Research Institute (2015) Submission to the National Ice Taskforce

[689] Terry-McElrath et al (2011) cited in National Drug Research Institute (2015) Submission to the National Ice Taskforce

[690] Allsop (2012)

[691] *Ibid*

[692] Miller et al (2013) cited in Penington Institute (2015) Submission to the National Ice Taskforce

[693] University of New South Wales (2015) Submission to the National Ice Taskforce

[694] Allsop (2012) p.178

[695] National Cannabis Prevention and Information Centre (2015) Submission to the National Ice Taskforce

[696] Pidd, K. (2015) Methamphetamine use in the workplace: Options for prevention and treatment. *Presentation to the National Methamphetamine Symposium*. On 12 May 2015, Arts Centre, Melbourne. Accessed 17/09/15 at http://nceta.flinders.edu.au/files/2214/3191/6685/Ken_Piddv2.pdf

[697] National Centre for Education and Training on Addiction (2015) Submission to the National Ice Taskforce

[698] Pidd, K. & Roche, A. (2013) *Workplace alcohol and other drug programs: What is good practice?* The Australian Drug Foundation. p.3

[699] Australian Institute of Health and Welfare (2013) National Drug Strategy Household Survey. Unpublished data.

[700] National Centre for Education and Training on Addiction (2006) cited in Allsop (2012) p.178

[701] National Centre for Education and Training on Addiction (2015) Submission to the National Ice Taskforce

[702] Ai Group (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (ice)

[703] National Centre for Education and Training on Addiction (2015) Submission to the National Ice Taskforce

[704] National Ice Taskforce Community Consultation in Townsville (2 June 2015)

[705] Allsop (2012)

[706] National Centre for Education and Training on Addiction (2015) Submission to the National Ice Taskforce

[707] Pidd, K. & Roche, A. (2015) cited in National Centre for Education and Training on Addiction (2015) Submission to the National Ice Taskforce

[708] Pidd, K. & Roche, A. (2013) *Workplace alcohol and other drug programs: What is good practice?* The Australian Drug Foundation. pp.2-5

[709] Loxley, W et al (2004) *The Prevention Substance Use, Risk and Harm in Australia: A Review of the Evidence*. Canberra: National Drug Research Institute and the Centre for Adolescent Health. p. 72.

[710] Mitchell, P et al (2001), in Loxley W et al. (2004). p. 73.

[711] Spooner, C & Hetherington, K (2004) *Social Determinants of Drug Use.* New South Wales: National Drug and Alcohol Research Centre. p. 55.

[712] Australian Health Ministers' Advisory Council (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*. Canberra: Australian Health Ministers' Advisory Council. p 58.

Chapter 10: Tailor services and support

[713] Prochaska, J., DiClemente, C. & Norcross, J. (1992) In search of how people change: applications to addictive behaviours, *American Psychologist*, 47(9)

[714] Quinn, B., Stoove, M. & Dietze, P. (2015) One-year changes in methamphetamine use, dependence and remission in a community-recruited cohort. *Journal of Substance Use*. pp. 1-8

[715] McKetin, R. (2012) Methamphetamines, rehab and recovery: research report. *Of Substance,* 10(3). pp.19-21

[716] Quinn et al (2015) pp. 1-8.

[717] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.

[718] UnitingCare ReGen (2014) Methamphetamine treatment: building on successful strategies to enhance outcomes. *ReGen website.* Accessed 17/09/15 at file:///C:/Users/pmc5247/Downloads/Meth_Treatment_-_Building_on_successful_strategies_to_enhance_outcomes_v1.0.pdf

[719] National Ice Taskforce Roundtable Meeting with peak alcohol and drug bodies in Brisbane (5 May 2015)

[720] Lubman, D., Manning, V., Best, D., Berends, L. et al (2014) *A study of patient pathways in alcohol and other drug treatment*. Fitzroy, VIC: Turning Point

[721] Contingency management is an evidence-based treatment intervention based on principles of behaviour modification and aims to incentivise and then reinforce changes in behaviour.

[722] McKetin, R., The Australian National University (2015) Submission to the National Ice Taskforce

[723] National Ice Taskforce Roundtable Meeting with Indigenous health and legal organisations in Sydney (4 June 2015)

[724] UnitingCare ReGen (2014)

[725] Lee, N., Harney, A. & Pennay, A. (2012) Examining the temporal relationship between methamphetamine use and mental health comorbidity. Advances in Dual Diagnosis, 5(1). pp. 23-31

[726] Walters, G. (2000) Spontaneous remission from alcohol, tobacco, and other drug abuse: seeking quantitative answers to qualitative questions. *The American Journal of Drug and Alcohol Abuse*, 26(3)

[727] Rapp, R., Xu, J., Carr, C., Lane, D. et al (2006) Treatment barriers identified by substance abusers assessed at a centralized intake unit. *Journal of Substance Abuse Treatment*, *30*(3), pp. 227-235

[728] Prochaska, J., Norcross, J. & DiClemente, C (2013) Applying the stages of change. *Psychotherapy in Australia*, 19(2)

[729] Dennis, M., & Scott, C. (2007) Managing addiction as a chronic condition. *Addict Sci Clin Pract,* 4(1). pp.45-55

[730] Prochaska et al (1992)

[731] Prochaska et al (2013)

[732] Department of Health (2004) The stages-of-change model, Working with young people on AOD issues: learner's workbook. *The Department of Health website*. Accessed 17/09/15 at http://www.health.gov.au/internet/publications/publishing.nsf/Content/drugtreat-pubs-front9-wk-toc~drugtreat-pubs-front9-wk-secb~drugtreat-pubs-front9-wk-secb-3~drugtreat-pubs-front9-wk-secb-3-3

[733] *Ibid*

[734] *Ibid*

[735] *Ibid*

[736] Zweben, J., Cohen, J., Christian, D., Galloway, G. et al. (2004) Psychiatric symptoms in methamphetamine users. American Journal of Addiction Psychiatry, 13. pp.181-190

[737] Sommers, I., Baskin, D. & Baskin-Sommers, A. (2006) Methamphetamine use among young adults: health and social consequences. Addictive Behaviours, 31(8)

[738] Darke, S., Kaye, S., McKetin, R. & Duflou, J. (2008) Major physical and psychological harms of methamphetamine use. Drug and Alcohol Review, 27

[739] Lee, N., Johns, L., Jenkinson, R., Johnston, J. et al (2007) *Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No 14: Methylamphetamine dependence and treatment.* Fitzroy, Victoria: Turning Point Alcohol and Drug Centre

[740] Lee, N. cited in National Centre for Training on Addiction (2015) Submission to the National Ice Taskforce

[741] UnitingCare ReGen (2014)

[742] Jenner, L. & Lee, N. (2008) *Treatment approaches for users of methylamphetamine: a practical guide for frontline workers.* Canberra: Department of Health and Ageing, Commonwealth Government

[743] Meredith et al (2005) cited in Hester, R. (2015) *Presentation to the National Methamphetamine Symposium.* On 12 May 2015, Arts Centre, Melbourne. Accessed 17/09/15 at http://nceta.flinders.edu.au/files/9314/3191/7228/Rob_Hesterv2.pdf

[744] UnitingCare ReGen (2014)

[745] *Ibid*

[746] Rooke, T. et al (2010) cited in National Drug Research Institute (2015) Submission to the National Ice Taskforce

[747] Tait, S. et al (2013) cited in National Drug Research Institute (2015) Submission to the National Ice Taskforce

[748] Swan, A. & Tyssen, E. (2009) Enhancing treatment access: evaluation of an Australian web-based alcohol and drug counselling initiative. *Drug and Alcohol Review,*28(1). pp.48-53

[749] National Drug Research Institute (2015) Submission to the National Ice Taskforce

[750] McKetin (2015)

[751] Turning Point Alcohol and Drug Centre (2015) Submission to the National Ice Taskforce

[752] Kaner et al (2009) cited in Royal Australian College of General Practitioners Addiction Medicine Network (2015) Submission to the National Ice Taskforce

[753] Baker, A., Lee, N. & Jenner, L. (2004) Models of intervention and care for psychostimulant users, 2nd Edition, Monograph Series No.51. Canberra: Department of Health and Ageing, Australian Government

[754] National Drug Research Institute (NDRI) (2015) Submission to the National Ice Taskforce.

[755] National Ice Taskforce Community Consultation in Newcastle (26 May 2015) and Mildura (3 June 2015). See also Vinson Centre for Applied Social Research (2014) *Project Ice Mildura: Evaluation of the community campaign measuring reach and impact.* Victoria: Vinson Centre.

[756] Royal Australian College of General Practitioners Addiction Medicine Network (2015)
[757] Weisner cited in Lubman et al (2014)
[758] Parthasarathy et al cited in Lubman et al (2014)
[759] Royal Australian College of General Practitioners Addiction Medicine Network (2015)
[760] Includes cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing.
[761] Australian Institute of Health and Welfare (AIHW) (2015): *Alcohol and other drug treatment services in Australia 2013-14*, *Drug treatment series no. 25*. Canberra: AIHW. p.38
[762] McKetin (2015)
[763] National Ice Taskforce Roundtable Meeting with treatment services in Sydney (25 May 2015)
[764] McKetin (2015)
[765] Alcohol, Tobacco & Other Drug Association (ATODA) Australian Capital Territory (ACT) (2015) Priorities for Action by the Australian Government to Respond to Methamphetamine ("Ice") Related-Harms in the ACT. *ATODA ACT website.* Accessed 17/09/15 at http://www.atoda.org.au/2015/08/priorities-for-action-by-the-australian-government-to-respond-to-methamphetamine-ice-related-harms-in-the-act/
[766] Lubman et al (2014)
[767] National Ice Taskforce Roundtable Meeting with treatment services in Sydney (25 May 2015)
[768] National Ice Taskforce Roundtable Meeting with peak alcohol and drug bodies in Brisbane (5 May 2015)
[769] McKetin (2015)
[770] UnitingCare ReGen (2014)
[771] McKetin, R., Sutherland, R., Ross, J., Najman, J. et al (2010) *Methamphetamine treatment evaluation study (MATES): Three-year outcomes from the Sydney site.* National Drug and Alcohol Research Centre, University of New South Wales.
[772] McKetin (2012)
[773] Figures based on adjusted rate that account for differences in the characteristics of the sample groups at the start of the study which might impact on their subsequent levels of drug use (e.g. severity of methamphetamine dependence, psychiatric comorbidity).
[774] Figures based on adjusted rate that account for differences in the characteristics of the sample groups at the start of the study which might impact on their subsequent levels of drug use (e.g. severity of methamphetamine dependence, psychiatric comorbidity).
[775] Lubman et al (2014)
[776] McKetin (2012)
[777] Lubman et al (2014)
[778] This study captured 157 participants that nominated methamphetamine as their primary drug of concern, a majority of whom participated in residential rehabilitation.
[779] Lubman et al (2014)
[780] LeeJenn Health Consultants (2014) *Methamphetamine step-up step-down withdrawal model evaluation: Final Report*. Prepared for UnitingCare ReGen.
[781] Dartmouth College (2015) IPS Dartmouth Supported Employment Centre. *IPS Dartmouth* website. Accessed 17/09/15 at http://www.dartmouthips.org/about-ips/
[782] National Ice Taskforce Roundtable Meeting with treatment services in Sydney (25 May 2015)
[783] National Ice Taskforce Roundtable Meeting with peak alcohol and drug bodies in Brisbane (5 May 2015)
[784] McKetin (2015)
[785] Australian College of Emergency Medicine (2015) Submission to National Ice Taskforce.
[786] McKetin, R., Dunlop, A et al (2012) Treatment options for methamphetamine users receiving outpatient counselling from the Stimulant Treatment Program in Australia. *Drug and Alcohol Review,* 32(1).
[787] Lee et al (2007)
[788] National Drug and Alcohol Research Centre (2015) Submission to the National Ice Taskforce
[789] Quinn et al (2015) p. 1-8
[790] Ministerial Council on Drug Strategy (2011) *National Drug Strategy 2010-2015*. Perth: Ministerial Council on Drug Strategy, Commonwealth Government. pp. 10-11.
[791] National Ice Taskforce Roundtable Meeting with treatment services in Sydney (25 May 2015)
[792] Ritter, A. et al (2014): *New Horizons: The Review of alcohol and other drug treatment services in Australia*. Australia Drug Policy Modelling Program, National Drug and Alcohol Research Centre. Unpublished review.
[793] Ritter, A. et al (2014)
[794] Ritter, A. et al (2014)
[795] National Ice Taskforce Roundtable Meeting with peak alcohol and drug bodies in Brisbane (5 May 2015)
[796] National Ice Taskforce Roundtable Meeting with peak alcohol and drug bodies in Brisbane (5 May 2015)
[797] People's Alcohol Action Coalition (2015) Submission to the House of Representatives Standing Committee on Indigenous Affairs, Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities. p.66
[798] National Ice Taskforce Roundtable Meeting with Peak alcohol and drug bodies in Brisbane (5 May 2015).
[799] National Ice Taskforce Roundtable Meeting with Treatment services in Sydney (25 May 2015).
[800] McKetin, R (2015) Submission to the National Ice Taskforce.
[801] National Amphetamine-Type Stimulant Strategy 2008-11 (http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/ats-strategy-08). p. 35.
[802] Cape York Partnership & Apunipima Cape York Health Council (2015) Submission to the National Ice Taskforce
[803] Australian Health Ministers' Advisory Council (2015) *Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report*. Canberra: Australian Health Ministers' Advisory Council. p.150
[804] Central Australia Aboriginal Alcohol Programmes Unit & The Foundation for Alcohol Research and Education cited in House of Representatives Standing Committee on Indigenous Affairs (2015) *Alcohol, hurting people and harming communities: Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities*. Canberra: Commonwealth of Australia. pp. 70-71.
[805] Aboriginal Drug and Alcohol Council (SA) (2015) cited in House of Representatives Standing Committee on Indigenous Affairs (2015) *Alcohol, hurting people and*

harming communities: Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities. Canberra: Commonwealth of Australia. p.70

[806] Garvey, D. (2008) Review of the social and emotional wellbeing of Indigenous Australian peoples. *Australian Indigenous HealthInfoNet website.* Accessed 17/09/15 at http://www.healthinfonet.ecu.edu.au/other-health-conditions/mental-health/reviews/our-review

[807] House of Representatives Standing Committee on Indigenous Affairs (2015) *Alcohol, hurting people and harming communities: Inquiry into the harmful use of alcohol in Aboriginal and Torres Strait Islander communities*. Canberra: Commonwealth of Australia. p.67

[808] Gray, D., Stearne, A., Wilson, M. & Dowle, M. (2010) Indigenous-specific alcohol and other drug interventions: continuities, changes and areas of greatest need, research. National Drug Research Institute, Curtain University, Australian National Council on Drugs.

[809] Intergovernmental Committee on Drugs (2015) *National Aboriginal and Torres Strait Islander Peoples' Drug Strategy 2014-2019.*

[810] National Ice Taskforce Roundtable Meeting with Indigenous health and legal organisations in Sydney (4 June 2015)

[811] National Ice Taskforce Roundtable Meeting with Indigenous health and legal organisations in Sydney (4 June 2015)

[812] Australian Institute of Health and Welfare 2013, *The health of Australia's prisoners 2012*., Cat. no. PHE 170. Canberra: AIHW, p.76–77.

[813] Caraniche (2015) Submission to the National Ice Taskforce.

[814] Larney, S., Mathers, B & Dolan, K (2007) *Illicit drug treatment in prison: Detoxification, drug-free units, therapeutic communities and opioid substitution treatment*. New South Wales: National Drug and Alcohol Research Centre. p. 25.

[815] Rural Health Tasmania Incorporated (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (ice) (www.aph.gov.au)

[816] New Zealand Department of the Prime Minister and Cabinet (2012) *Tackling Methamphetamine: Indicators and Progress Report October 2012.* New Zealand: Department of the Prime Minister and Cabinet.

Chapter 11: Strengthen law enforcement

[817] Including Hong Kong.

[818] Australian Strategic Policy Institute (2015) Submission to the National Ice Taskforce.

[819] ACC (2015) *The Australian Methylamphetamine Market—The National Picture*.

[820] Parliamentary Joint Committee on Law Enforcement (2012) *Inquiry into Commonwealth unexplained wealth legislation and arrangements.* Canberra: Parliament of Australia.

[821] EUDs include the details of the supplier, purchaser and purpose for which the chemicals or equipment are required.

[822] Government of South Australia Office of Crime Statistics and Research (2012) *The South Australian Drug Court: A Recidivism Study.* South Australia: Office of Crime Statistics and Research.

[823] KPMG (2014) *Evaluation of the Drug Court of Victoria, Final Report*. Victoria: KPMG.

[824] Hawken H, & Kleiman M (2009) *Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii's HOPE*. United States: US Department of Justice.

[825] *Ibid.*

Chapter 12: Improve governance and build better evidence

[826] National Ice Taskforce Community Consultation in Newcastle (26 May 2015) and Hobart (27 May 2015), and Roundtable Meetings with Peak alcohol and drug bodies in Brisbane (5 May 2015), Drug and alcohol research centres in Sydney (22 May 2015) and Indigenous health and legal organisations in Sydney (4 June 2015).

[827] National Ice Taskforce Community Consultation in Broome (19 May 2015) and Hobart (27 May 2015).

[828] Swadi, H (1990) Validating and improving the validity of self-reports in adolescent substance misuse surveys. *Journal of Drug Issues*, 20(3). pp. 473-486.

[829] Harris, KM., Griffin, BA., McCaffrey, DF & Morral, AR (2009) Inconsistencies in Self-Reported Drug Use by Adolescents in Substance Abuse Treatment: Implications for Outcomes and Performance Measurement. *Journal of Substance Abuse Treatment*, 34(3). pp. 347-355.

[830] McGregor, K & Makkai, T (2003) *Self-reported Drug Use: How Prevalent is Under-reporting? Trends and issues in crime and criminal justice, No. 260.* Canberra: Australian Institute of Criminology.

[831] Hall W et al (2012) An analysis of ethical issues in using wastewater analysis to monitor illicit drug use. *Addiction*, 107, pp. 1767-1773.

[832] Turning Point (2015) Submission to the National Ice Taskforce.

[833] *Ibid.*

[834] Prichard J et al. (2012), *Measuring drug use patterns in Queensland through wastewater analysis. Trends and issues in crime and criminal justice, No. 442*. Canberra: Australian Institute of Criminology.

[835] National Drug and Alcohol Research Centre (NDARC) (2015) Submission to the National Ice Taskforce.

[836] ACC (2015) *2013-14 Illicit Drug Data Report*.

[837] Tscharke, BJ et al (2015) Trends in stimulant use in Australia: A comparison of wastewater analysis and population surveys. *Science of the Total Environment 536.* p. 331-337.

[838] NDARC (2015).

[839] National Ice Taskforce Roundtable Meeting with Drug and alcohol research centres in Sydney (22 May 2015).

[840] Irvine, RJ et al (2011) Population drug use in Australia: a wastewater analysis. *Forensic Science International*, 210.

[841] See Lai, FY et al (2013) Using quantitative wastewater analysis to measure daily usage of conventional and emerging illicit drugs at an annual music festival. *Drug and Alcohol Review,* 32(6); Lai, FY et al (2013) Estimating daily and diurnal variations of illicit drug use in Hong Kong: A

pilot study of using wastewater analysis in an Asian metropolitan city. *Forensic Science International*, vol 233; and O'Brien, JW et al (2014) A model to Estimate the Population Contributing to the Wastewater Using Samples Collected on Census Day. *Environmental Science & Technology*, 48.

[841] Van Dyken, E et al (2014) Challenges and opportunities in using wastewater analysis to measure drug use in a small prison facility. *Drug and Alcohol Review, 1;* and Van Dyken, E et al (2014) Monitoring substance use in prisons: Assessing the potential value of wastewater analysis. *Science and Justice*, 54(5). pp. 338-345.

[842] *Ibid*

[843] Commonwealth Attorney-General's Department et al (2015) Submission to the Parliamentary Joint Committee on Law Enforcement Inquiry into crystal methamphetamine (ice) (www.aph.gov.au)

[844] Pritchard, J et al (2012).

[845] Sewage Analysis CORe group Europe (SCORE) (2015) *Monitoring 2014*. Accessed 3/06/2015 at www.score-cost.eu/monitoring2014.

[846] Prichard, J et al (2012)

[847] Pennington Institute (2015) Submission to the National Ice Taskforce.

[848] Australian Safety and Compensation Council (2007) *Work-Related Alcohol and Drug Use: A Fit for Work Issue.* Canberra: Australian Safety and Compensation Council.

[849] Kimber, J., Copeland, L., Hickman, M., Macleod, J. et al (2010) Survival and cessation in injecting drug users: prospective observational study of outcomes and effect of opiate substitution treatment. *BMJ*

[850] McKetin 2015

[851] Brensilver, M., Johnson, V., Grotheer, A. Heinzerling, K. et al (2012) Pharmacotherapy of amphetamine-type stimulants. . In Allsop, S. & Lee, N. (Eds.) *Perspectives on Amphetamine-Type Stimulants*. East Hawthorn, Victoria: IP Communications

[852] National Drug Research Institute (2015) Submission to the National Ice Taskforce

[853] McKetin 2015

[854] McKetin 2015

[855] National Health and Medical Research Council (2011) *Naltrexone implant treatment for opioid dependence: Literature Review,* Commonwealth of Australia.

[856] Haile, C., & Kosten, T. (2013) Pharmacotherapy for Stimulant-Related Disorders. *Current Psychiatry Reports*, 15(11)

[857] Baker, A. & Lee, N. (2003). A review of psychosocial interventions for methamphetamine use. *Drug and Alcohol Review* 22(3). pp.323-335

[858] McKetin (2012)

[859] National Ice Taskforce Roundtable Meeting with peak alcohol and drug bodies in Brisbane (5 May 2015)

[860] National Ice Taskforce Roundtable Meeting with drug and alcohol research centres in Sydney (22 May 2015)

Appendix I: Consultations

[861] Note: This section abbreviates National Ice Taskforce Community Consultations and Roundtable Meetings as outlined below.

National Ice Taskforce Community Consultations in:

- Mount Gambier (14 May 2015): Mount Gambier c/c
- Broome (19 May 2015): Broome c/c
- Darwin (20 May 2015): Darwin c/c
- Newcastle (26 May 2015): Newcastle c/c
- Hobart (27 May 2015): Hobart c/c
- Townsville (2 June 2015): Townsville c/c
- Mildura (3 June 2015): Mildura c/c

National Ice Taskforce Roundtable Meetings of:

- Peak alcohol and drug bodies (5 May 2015): Peak r/t
- Health and medical associations (11 May 2015): Health r/t
- Educational organisations (13 May 2015): Education r/t
- Drug and alcohol research centres (22 May 2015): Research r/t
- Organisations involved in prevention activities (22 May 2015): Prevention r/t
- Treatment services (25 May 2015): Treatment r/t
- Services that support users and families (25 May 2015): Support r/t
- Indigenous health and legal organisations (4 June 2015): Indigenous r/t
- Organisations that represent drug users (11 June 2015): Representatives r/t

[862] Broome c/c; Darwin c/c; Mildura c/c; Mount Gambier c/c; Newcastle c/c; Townsville c/c; Education r/t; Health r/t; Peak r/t; Support r/t; Treatment r/t

[863] Broome c/c; Townsville c/c

[864] Broome c/c; Darwin c/c; Newcastle c/c; Townsville c/c; Education r/t; User r/t

[865] Newcastle c/c

[866] Newcastle c/c; Townsville c/c

[867] Darwin c/c; Treatment r/t

[868] Townsville c/c

[869] Townsville c/c; Treatment r/t

[870] Broome c/c; Newcastle c/c; Peak r/t; Treatment r/t

[871] Mount Gambier c/c; Education r/t; Peak r/t; Support r/t; Representatives r/t

[872] Mildura c/c; Newcastle c/c; Peak r/t; Support r/t; Treatment r/t

[873] Broome c/c; Darwin c/c;
[874] Peak r/t; Representatives r/t
[875] Broome c/c; Townsville c/c
[876] Broome c/c
[877] Representatives r/t
[878] Broome c/c; Darwin c/c; Mildura c/c; Townsville c/c; Health r/t; Peak r/t; Treatment r/t
[879] Representatives r/t
[880] Broome c/c; Darwin c/c; Mount Gambier c/c; Health r/t; Peak r/t
[881] Newcastle c/c
[882] Broome c/c; Darwin c/c; Hobart c/c; Education r/t
[883] Townsville c/c; Treatment r/t
[884] Royal Australian and New Zealand College of Psychiatrists (2015) *Submission to the National Ice Taskforce*
[885] Health r/t; Peak r/t; Network of Alcohol and other Drug Agencies NSW (2015) Submission to the National Ice Taskforce
[886] Robbie from South Australia (2015) Submission to the National Ice Taskforce
[887] Leanne from Victoria (2015) Submission to the National Ice Taskforce
[888] Carly from Victoria (2015) Submission to the National Ice Taskforce
[889] Broome c/c; Darwin c/c; Hobart c/c; Mildura c/c; Mount Gambier c/c; Newcastle c/c; Townsville c/c; Education r/t; Research r/t; Indigenous r/t; Representatives r/t
[890] Stephanie from Queensland (2015) Submission to the National Ice Taskforce
[891] Darwin c/c
[892] Peak r/t
[893] NSW Young Nationals (2015) Submission to the National Ice Taskforce
[894] Broome c/c
[895] Mildura c/c; Mount Gambier c/c
[896] Mrs Ann Sudmalis MP (2015) Submission to the National Ice Taskforce
[897] Newcastle c/c; Peak r/t; Treatment r/t
[898] Mission Australia (2015) Submission to the National Ice Taskforce
[899] Ms Fiona Scott MP (2015) Submission to the National Ice Taskforce
[900] Darwin c/c; Townsville c/c
[901] Newcastle c/c
[902] Anonymous (2015) Submission to the National Ice Taskforce
[903] Mount Gambier c/c; Support r/t
[904] Mount Gambier c/c; Treatment r/t
[905] Mount Gambier c/c; Indigenous r/t
[906] Education r/t
[907] Broome c/c; Darwin c/c; Mount Gambier c/c; Support r/t
[908] Darwin c/c; Support r/t
[909] Broome c/c; Mount Gambier c/c
[910] Mildura c/c; Newcastle c/c; Indigenous r/t
[911] Mount Gambier c/c; Support r/t
[912] Treatment r/t
[913] Mount Gambier c/c
[914] Broome c/c; Mount Gambier c/c
[915] Salvation Army Australia (2015) Submission to the National Ice Taskforce
[916] Hobart c/c; Mildura c/c; Mount Gambier c/c; Newcastle c/c; Education r/t; Peak r/t; Treatment r/t; Representatives r/t
[917] Peak r/t
[918] Broome c/c; Darwin c/c; Hobart c/c; Newcastle c/c; Education r/t
[919] Mr Steve Irons MP (2015) Submission to the National Ice Taskforce
[920] Education r/t
[921] Treatment r/t
[922] Newcastle c/c; Education r/t
[923] Broome c/c; Hobart c/c; Newcastle c/c; Education r/t
[924] Darwin c/c; Education r/t
[925] Broome c/c
[926] Darwin r/t; Education r/t; Research r/t
[927] Support r/t
[928] William from Victoria (2015) Submission to the National Ice Taskforce
[929] Senator the Hon Fiona Nash (2015) Submission to the National Ice Taskforce
[930] Peak r/t
[931] Hobart c/c; Newcastle c/c; Peak r/t; Treatment r/t
[932] Newcastle c/c
[933] Newcastle c/c
[934] Darwin c/c; Townsville c/c
[935] Townsville c/c
[936] National Centre for Education and Training on Addiction, Flinders University (2015) Submission to the National Ice Taskforce
[937] Senator the Hon Fiona Nash (2015) Submission to the National Ice Taskforce
[938] Senator the Hon Fiona Nash (2015) Submission to the National Ice Taskforce
[939] Peak r/t; Support r/t; Treatment r/t; Victoria Legal Aid (2015) Submission to the National Ice Taskforce
[940] Drug Policy Modelling Program, the University of New South Wales (2015) Submission to the National Ice Taskforce
[941] Treatment r/t; Odyssey House Victoria (2015) Submission to the National Ice Taskforce; South Australian Network of Drug and Alcohol Services (2015) Submission to the National Ice Taskforce
[942] Odyssey House Victoria (2015) Submission to the National Ice Taskforce
[943] Townsville c/c; Treatment r/t; Representatives r/t
[944] Townsville c/c
[945] Representatives r/t
[946] Treatment r/t
[947] Mildura c/c; Mount Gambier; Newcastle c/c; Peak r/t
[948] National Rural Health Alliance (2015) Submission to the National Ice Taskforce
[949] Hobart c/c
[950] Health r/t; Treatment r/t

[951] Kelly from New South Wales (2015) Submission to the National Ice Taskforce
[952] Newcastle c/c; Treatment r/t
[953] Darwin c/c; Newcastle c/c; Peak r/t
[954] Darwin c/c; Peak r/t; Treatment r/t
[955] Darwin c/c
[956] UnitingCare ReGen (2015) Submission to the National Ice Taskforce
[957] Mrs Karen McNamara MP (2015) Submission to the National Ice Taskforce
[958] User r/t;
[959] Senator the Hon Fiona Nash (2015) Submission to the National Ice Taskforce
[960] Victorian AIDS Council (2015) Submission to the National Ice Taskforce
[961] Victorian Alcohol and Drug Association (2015) Submission to the National Ice Taskforce
[962] Mission Australia (2015) Submission to the National Ice Taskforce
[963] Ted Noffs Foundation (2015) Submission to the National Ice Taskforce
[964] Broome c/c; Darwin c/c; Mount Gambier c/c; Health r/t; Peak r/t
[965] Amanda from Victoria (2015) Submission to the National Ice Taskforce
[966] Broome c/c; Darwin c/c; Hobart c/c; Mount Gambier c/c; Health r/t; Peak r/t; Treatment r/t
[967] Peak r/t
[968] Health r/t; Peak r/t; Prevention r/t
[969] Darwin c/c; Hobart r/t; Mount Gambier c/c; Treatment r/t
[970] Health r/t; Peak r/t
[971] Broome c/c; Hobart c/c; Peak r/t; Prevention r/t; Support r/t
[972] Support r/t
[973] Darwin c/c, Broome c/c; Cape York Partnership & Apunipima Cape York Health Council (2015) Submission to the National Ice Taskforce
[974] Health r/t
[975] Research r/t; Support r/t; Treatment r/t; Royal Australian College of General Practitioners (2015) Submission to the National Ice Taskforce
[976] Treatment r/t
[977] Broome c/c
[978] Broome c/c; Darwin c/c
[979] Support r/t; Darwin c/c; Treatment r/t
[980] Pharmacy Guild of Australia (2015) Submission to the National Ice Taskforce
[981] Network of Alcohol and other Drug Agencies NSW (2015) Submission to the National Ice Taskforce
[982] Darwin c/c
[983] Townsville c/c
[984] Darwin c/c; Support r/t
[985] Broome c/c; Darwin c/c; Research r/t; Treatment r/t
[986] Newcastle c/c
[987] Townsville c/c
[988] Turning Point Alcohol and Drug Centre (2015) Submission to the National Ice Taskforce
[989] National Centre for Education and Training on Addiction (2015) Submission to the National Ice Taskforce
[990] Indigenous r/t
[991] Darwin c/c
[992] Broome c/c; Darwin c/c; Indigenous r/t; Peak r/t
[993] Broome c/c
[994] Darwin r/t
[995] Indigenous r/t
[996] Broome c/c; Darwin c/c; Newcastle c/c; Townsville c/c
[997] Health r/t
[998] St Vincent's Health Australia (2015) Submission to the National Ice Taskforce
[999] Sabine from New South Wales (2015) Submission to the National Ice Taskforce
[1000] UnitingCare Regen (2015) Submission to the National Ice Taskforce
[1001] Sydney Medically Supervised Injecting Centre (2015) Submission to the National Ice Taskforce
[1002] Townsville c/c; Support r/t
[1003] Australian Drug Law Reform Initiative (2015) Submission to the National Ice Taskforce
[1004] Mr Andrew Nikolic AM, CSC, MP and Mr Eric Hutchinson MP (2015) Submission to the National Ice Taskforce; Mr George Christensen MP (2015) Submission to the National Ice Taskforce
[1005] Leigh from South Australia (2015) Submission to the National Ice Taskforce
[1006] Dr John Coyne, Australian Strategic Policy Institute (2015) Submission to the National Ice Taskforce
[1007] Darwin c/c
[1008] Broome c/c
[1009] Mildura c/c
[1010] Broome c/c; Mr Andrew Nikolic AM, CSC, MP and Mr Eric Hutchinson MP (2015) Submission to the National Ice Taskforce; Senator the Hon Fiona Nash (2015) Submission to the National Ice Taskforce
[1011] Broome c/c
[1012] Darwin c/c; Newcastle c/c; Townsville c/c; Support r/t
[1013] Broome c/c; Darwin c/c; Newcastle c/c; Townsville c/c
[1014] Mount Gambier c/c; Townsville c/c; Treatment r/t; Support r/t
[1015] Darwin c/c; Townsville c/c; Support r/t; Treatment r/t; Victoria Legal Aid (2015) Submission to the National Ice Taskforce
[1016] Australasian Therapeutic Communities Association (2015) Submission to the National Ice Taskforce
[1017] New South Wales Aboriginal Land Council (2015) Submission to the National Ice Taskforce
[1018] Treatment r/t
[1019] Broome c/c; Hobart c/c; Support r/t
[1020] Hobart c/c; Peak r/t
[1021] Peak r/t
[1022] Treatment r/t
[1023] Senator the Hon Fiona Nash (2015) Submission to the National Ice Taskforce
[1024] National Drug Research Institute, Curtin University (2015) Submission to the National Ice Taskforce

[1025] South Australian Network of Drug and Alcohol Services (2015) Submission to the National Ice Taskforce
[1026] Darwin c/c
[1027] National Drug Research Institute, Curtin University (2015) Submission to the National Ice Taskforce
[1028] Prevention r/t
[1029] Indigenous r/t
[1030] Darwin c/c; Mildura c/c; Newcastle c/c; Treatment r/t
[1031] Darwin c/c
[1032] Treatment r/t
[1033] Darwin c/c
[1034] Hobart c/c; Mildura c/c; Townsville c/c; Peak r/t
[1035] ACON (2015) Submission to the National Ice Taskforce
[1036] Peak r/t; Support r/t
[1037] Peak r/t
[1038] Mount Gambier c/c
[1039] Mildura c/c
[1040] Mount Gambier c/c
[1041] Pharmacy Guild of Australia (2015) Submission to the National Ice Taskforce
[1042] Darwin c/c; Hobart c/c; Mount Gambier c/c; Newcastle c/c; Health r/t; Indigenous r/t; Peak r/t; Support r/t; Treatment r/t; Representatives r/t
[1043] Hobart c/c; Newcastle c/c; Education r/t; Research r/t; Support r/t; Treatment r/t; Peak r/t
[1044] Darwin c/c; Hobart c/c
[1045] Broome c/c; Darwin c/c; Hobart c/c; Mount Gambier c/c; Newcastle c/c; Health r/t; Peak r/t; Support r/t; Treatment r/t
[1046] Health r/t; Support r/t; Pharmacy Guild of Australia (2015) Submission to the National Ice Taskforce
[1047] National Drug Research Institute, Curtin University (2015) Submission to the National Ice Taskforce
[1048] Darwin c/c; Treatment r/t
[1049] Darwin c/c
[1050] Mildura c/c; Representatives r/t;
[1051] Newcastle c/c; Education r/t;
[1052] Broome r/t
[1053] Treatment r/t
[1054] Newcastle c/c
[1055] Townsville c/c
[1056] Prevention r/t
[1057] Rod from South Australia (2015) Submission to the National Ice Taskforce
[1058] Ron from Victoria (2015) Submission to the National Ice Taskforce
[1059] Hobart c/c; Newcastle r/t; Indigenous r/t; Peak r/t; Research r/t
[1060] Broome c/c; Hobart c/c
[1061] Broome c/c; Hobart c/c
[1062] Penington Institute (2015) Submission to the National Ice Taskforce
[1063] Peak r/t
[1064] Hobart c/c;
[1065] Peak r/t; Research r/t
[1066] Peak r/t; Prevention r/t; Support r/t
[1067] Newcastle r/t; Support r/t
[1068] Research r/t
[1069] Research r/t
[1070] Support r/t; Treatment r/t

Appendix II: Social determinants of health

[1071] Loxley, W., Toumbourou, J.W., Stockwell, T., Haines, B. Scott, K., Godfrey, C., Waters, E., Patton, G., Fordham, R., Gray, D., Marshall, J., Ryder, D., Saggers, S., Sanci, L., Williams, J. (2004) *The Prevention Substance Use, Risk and Harm in Australia: A Review of the Evidence*. Western Australia: National Drug Research Institute and the Centre for Adolescent Health.
[1072] *Ibid.*
[1073] United Nations Office on Drugs and Crime (2015) *International Standards on Drug Use and Prevention*. Vienna: United Nations.
[1074] Loxley, W. et al (2004).
[1075] National Crime Prevention (1999) cited in Loxley, W. et al (2004).
[1076] Spooner, C & Hetherington, K. (2004) *Social Determinants of Drug Use*. New South Wales: National Drug and Alcohol Research Centre (NDARC).
[1077] *Ibid.*
[1078] Loxley, W. et al (2004).
[1079] Spooner, C & Hetherington, K. (2004).
[1080] Loxley, W. et al (2004).
[1081] Marmot, M (2011) Social determinants and the health of Indigenous Australians. *Medical Journal of Australia,* 194 (10). pp. 512-513.
[1082] Spooner, C & Hetherington, K. (2004).
[1083] *Ibid.*
[1084] Loxley, W. et al (2004).
[1085] Newcomb M.D. et al (1986); Glantz M.D., Leshner, A.I. (2000) cited in Loxley, W. et al (2004).
[1086] Mitchell, P. et al (2001) cited in Loxley, W. et al (2004).
[1087] Loxley, W. et al (2004).
[1088] Spooner, C & Hetherington, K. (2004).
[1089] Loxley, W. et al (2004).
[1090] World Health Organisation (WHO) (2004) *Neuroscience of psychoactive substance use and dependence*. Geneva: WHO.
[1091] Kumpfer, K.I. et al (1998) and Weinberg, NZ (1998), in Loxley, W. et al (2004). p.76.
[1092] World Health Organisation (2004).
[1093] Loxley, W. et al (2004).
[1094] World Health Organisation (2004).
[1095] *Ibid.*
[1096] Spooner, C. & Hetherington, K. (2004).
[1097] Boardman, J.D. et al. (2001) cited in Spooner, C., Hetherington, K. (2004).
[1098] Loxley, W. et al (2004).
[1099] Daniels, N. et al. (1999) cited in Loxley, W. et al (2004).
[1100] Spooner, C., Hetherington, K. (2004).
[1101] Loxley, W. et al (2004).

[1102] Silburn, SR (1996) cited in Loxley, W. et al (2004).
[1103] Spooner, C & Hetherington, K. (2004).
[1104] Maughan et al. (2001) cited in Spooner, C & Hetherington, K. (2004).
[1105] United Nations Office on Drugs and Crime (2015).
[1106] *Ibid.*
[1107] Kumpfer K.L. (1998) cited in Spooner, C & Hetherington, K. (2004).
[1108] Spooner, C & Hetherington, K (2004).
[1109] Dube SR et al (2003) Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Paediatrics*, 111(3). pp.564-572.
[1110] Fergusson, DM & Horwood, LJ (2000) cited in Loxley, W. et al (2004).
[1111] Hawkins, DJ et al (1992) cited in Loxley, W. et al (2004).
[1112] Smart, R (1994); Bobashev, GV et al (1998); Petronis, KR & Anthony, JC (1999) cited in Loxley, W. et al (2004).
[1113] *Ibid.*
[1114] ACT for Youth Upstate Centre of Excellence (2002); National Institute of Mental Health (2001); Strauch, B. (2003); Chambers, RA et al (2003); in Spooner, C. & Hetherington, K (2004). p.42.
[1115] Spooner, C & Hetherington, K. (2004).
[1116] Leffert, N., Peterson, A. (1995) cited in Spooner, C & Hetherington, K. (2004).
[1117] Loxley, W. et al (2004).
[1118] Spooner, C & Hetherington, K. (2004).
[1119] Henkel, D (2011) Unemployment and Substance Use: A Review of the Literature (1990-2010). *Current Drug Abuse Review,* 4(1). pp. 4-27.
[1120] McIntosh, J., Bloor, M & Robertson, M (2008) Drug treatment and the achievement of paid employment. *Addiction Research and Theory*, 16(1). pp 37-45.
[1121] Quinn, B et al (2015) One-year changes in methamphetamine use, dependence and remission in a community-recruited cohort. *Journal of Substance Use* (online).
[1122] Home Office Development and Practice Report (2007) *Identifying and exploring young people's experiences of risk, protective factors and resilience to drug use.* United Kingdom: Home Office. p. 4.
[1123] Adapted from World Health Organisation Alcohol and Public Policy Group (2004) cited in Spooner, C & Hetherington, K (2004).
[1124] Home Office Development and Practice Report (2007).
[1125] Loxley, W et al (2004).
[1126] *Ibid.*
[1127] Kitzman (2010) and Olds (2010) in United Nations Office on Drugs and Crime (2015).
[1128] Loxley, W. et al (2004).
[1129] United Nations Office on Drugs and Crime (2015).
[1130] Spooner, C &Hetherington, K. (2004).
[1131] Australian Government Department of Social Services (2015) *Families and Communities Programme.* Accessed 3/07/2015 at https://www.dss.gov.au/sites/default/files/documents/05_2015/fact_sheet_-_families_and_children.pdf
[1132] *Ibid.*
[1133] NSW Government (2015) *Brighter Futures program.* Accessed 3/07/2015 at http://www.community.nsw.gov.au/docs_menu/for_agencies_that_work_with_us/our_funding_programs/brighter_futures_program.html
[1134] NSW Government (2015) *Getting It Together.* Accessed 3/07/2015 at http://www.community.nsw.gov.au/docs_menu/for_agencies_that_work_with_us/our_funding_programs/getting_it_together.html
[1135] NSW Government (2015) *Substance Abuse in Pregnancy and Parenting Service*. Accessed 3/07/2015 at http://www.community,nsw.gov.au
[1136] NSW Government (2015) *Keep Them Safe Whole-Family Teams*. Accessed 3/07/2015 at http://www.keepthemsafe.nsw.gov.au/initiatives/acute_services/keep_them_safe_whole-family_teams
[1137] Victorian Government (2015) *Best Start.* Accessed 3/07/2015 at http://www.education.vic.gov.au/Documents/about/programs/health/beststartoverview.pdf
[1138] Victorian Government (2015) *Child FIRST.* Accessed 3/07/2015 at http://www.dhs.vic.gov.au/__data/assets/pdf_file/0016/590110/child_FIRST_fact_sheet_PRINT.pdf
[1139] Queensland Government (2015) *Stronger Families—Family and Child Connect.* Accessed 3/07/2015 at https://www.communities.qld.gov.au/resources/gateway/stronger-families/family-child-connect.pdf
[1140] South Australian Government (2015) *Family Services Program.* Accessed 3/07/2015 at http://www.sa.gov.au/__data/assets/pdf_file/0016/153610/decd-childrens-centres-family-services-program.pdf
[1141] Western Australian Government (2015) *Strong Families.* Accessed 3/07/2015 at http://www.strongfamilies.wa.gov.au/UserDir/Documents/Public/Strong%20Families%20-%20Information%20for%20Families%20Brochure.pdf
[1142] Tasmanian Government (2015) *Child Health and Parenting Service.* Accessed 3/07/2015 at http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0005/62861/CHAPS_DL_web_ready.pdf
[1143] Northern Territory Government (2015) *Intensive Family Support Service.* Accessed 3/07/2015 at http://www.ifss.net.au/about-ifss/what-is-ifss.html
[1144] ACT Government (2015) *Child, Youth and Family Services Program.* Accessed 3/07/2015 at http://www.communityservices.act.gov.au/ocyfs/child,_youth_and_family_services_program/cyfsp-services-and-programs-fact-sheet

Appendix III: State and territory efforts

[1145] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1146] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.

[1147] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1148] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1149] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1150] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.
[1151] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1152] *Ibid.*
[1153] Turning Point (2015) *Methamphetamine clinics provide new hope.* Accessed 3/07/2015 at http://www.turningpoint.org.au/Media-Centre/Latest_News/-Methamphetamine-clinics-provide-new-hope-.aspx
[1154] Pennay, A., Ferris, J., Reed, M., & Devaney, M. (2010) *Evaluation of 'Access Point' specialist methamphetamine clinic*. Victoria: Turning Point Alcohol and Drug Centre.
[1155] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1156] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.
[1157] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1158] *Ibid.*
[1159] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1160] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.
[1161] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1162] *Ibid.*
[1163] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1164] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.
[1165] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1166] *Ibid.*
[1167] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1168] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.
[1169] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1170] *Ibid.*
[1171] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1172] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.
[1173] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1174] *Ibid.*
[1175] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Agency (episodes)* Table SA.1.
[1176] Northern Territory Department of Health (2015) Submission to the Northern Territory Legislative Assembly 'Ice' Select Committee.
[1177] *Ibid.*
[1178] Australian Institute of Health and Welfare (AIHW): (2013-14), *Alcohol and Other Drug Treatment Services in Australia: Supplementary Tables*: *Drugs (episodes)* Table SD.1.
[1179] Australian Institute of Health and Welfare (AIHW) (2015): (2013-14) *Alcohol and Other Drug Treatment Services in Australia:* Advice to the National Ice Taskforce.
[1180] *Ibid.*

FINAL REPORT OF THE NATIONAL ICE TASKFORCE

2015

Rural & Regional Affairs and Transport Legislation Committee

ANSWERS TO QUESTIONS ON NOTICE

Hearing into Transport Security Amendment (Serious or Organised Crime) Bill 2016

Infrastructure and Regional Development

Question no./reference: Parliamentary Joint Committee on Law Enforcement

Program: NA
Division/Agency: Office of Transport Security
Topic: Transport Security Amendment (Serious or Organised Crime) Bill 2016 [Provisions]
Proof Hansard Page: 23

Question raised by Senator Edwards, Sean

1. **Senator Edwards,** when referring to the 2011 Parliamentary Joint Committee on Law Enforcement inquiry, asked:
   a. what were the submissions from the previous Maritime Union of Australia (MUA) and Australian Maritime Officers Union (AMOU) with regard to the maritime security identification card (MSIC) scheme and serious and organised crime; and
   b. what were the recommendations from the MUA and AMOU, specifically with regard to the scope of the MSIC scheme in relation to organised crime and terrorist activity.

Answer:

1. The 2011 Parliamentary Joint Committee on Law Enforcement (PJCLE) *Inquiry into the adequacy of aviation and maritime security measures to combat serious and organised crime* received a combined submission from the Maritime Union Australia, the Australian Workers Union, the Rail Tram & Bus Union, the Australian Maritime Officers Union and the International Transport Workers Federation (**Attachments A and B**).

2. The combined submission did not state any explicit recommendations. However, it broadly presented the unions' position that the MSIC scheme should remain focussed on countering terrorism in the maritime environment.

Attachments
Attachment A – Australian Unions submission to PJCLE 2011
Attachment B – Attachment to the Australian Unions submission to PJCLE 2011

AUSTRALIAN UNIONS SUBMISSION TO THE -

PARLIAMENTARY JOINT COMMITTEE ON THE AUSTRALIAN CRIME COMMISSION

INQUIRY INTO THE ADEQUACY OF AVIATION AND MARITIME SECURITY MEASURES TO COMBAT SERIOUS AND ORGANISED CRIME

The unions making this joint submission represent workers involved in both mainland and Offshore Oil and Gas industries impacted by the MTOFSA 2003 and associated regulations which include the application of the MSIC provisions.

"Unions" include the Maritime Union of Australia, Australian Workers Union, Rail Tram & Bus Union and Australian Maritime Officers Union, along with the International Transport Workers Federation.

In discharging our responsibilities to our members, unions seek to protect the health and safety of employees in the workplace. The issue of transport security is one of the most serious issues of workplace safety and is always afforded the highest priority.

Counter terrorism measures must however be balanced with a need to protect the privacy, job security, community values and human rights of the workforce, while ensuring that adequate protection is in place to minimise any potential terrorist threat to the broader community.

Australian Unions have been an active participant in the consultation process in relation to the development of the original legislation Maritime Transport Security Act 2003 which was extended and renamed the *Maritime Transport and Offshore Facilities Security Act 2003 (MTOFSA).*

"Unions" maintain a vigorous participation in the further development of all related regulations and participate in a number of key industry working groups including the Maritime Security Consultative Forum and the Maritime Security Identification Card working group.

Terms of Reference

The terms of reference ask that ***"the committee will examine the effectiveness of current administrative and law enforcement arrangements to protect Australia's borders from serious and organised criminal activity."***

Of particular interest to the Unions is (c) –

"the effectiveness of the Aviation Security Identification Card (ASIC) and Maritime Security Identification Card (MSIC) schemes; including the

process of issuing ASICs and MSICs, the monitoring of cards issued and the storage of, and sharing of, ASIC and MSIC information between appropriate law enforcement agencies;"

We have accepted and supported the introduction and ongoing commitment to the MTOFSA Act 2003 and associated regulations which include the introduction of the MSIC card as a counter terrorism measure.

In the process of applying for an MISC our members have been required to, among other measures, complete and sign a consent form for a police records check by the Australian Federal Police (AFP), again demonstrating each worker's personal commitment to Australia's counter terrorism efforts and border protection.

Background

In almost every terrorist attack in recent history there is one front line group who have been killed or injured, they are transport workers. Whether they are train drivers, pilots, flight attendants or seafarers the simple act of going to work each day can expose them to risk in this context.

Transport unions around the world understand support and actively engage in the formation of national and international legislation designed to protect workers from the violent manifestation of extremism in all its forms.

In many ways Australian Maritime Transport Security policy has led the way in the formation of transport security provisions where transport unions have worked with governments from all political churches in order to reach the best possible outcomes in a constantly changing environment.

In any context the Unions' views must never be conveniently misconstrued as being protectionist. Our record for supporting counter terrorist measures stands on its own merit as does our six year involvement in the maritime security legislative processes.

The terms of reference of this inquiry have focussed on the adequacy of the security cards to combat serious and organised crime.

There are two key elements to this debate which needs to be articulated so that the committee can put the Unions position into clear perspective.

Distinction between ASIC and MSIC

The Aviation Security Identification Card ASIC was introduced significantly earlier than its Maritime equivalent and had little initial involvement or consultation with the relevant unions. It was a process which appears to have been brokered essentially between the then Department of Transport and Regional Services (DOTARS) and Qantas.

The Maritime Security Identity Card (MSIC) by comparison was included in the development of MTOFSA and the subject of broad Industry, Union and Government collaboration over the entire legislative processes and amendments under the former government. This was done in an environment of a sometimes hysterical public debate in the press but a quality outcome was delivered nonetheless.

MSIC – Counter Terrorism or Policing

The Unions remain convinced that we can contribute to Australia's counter terrorism regime through our support of the MSIC card and MTOFSA.
It is critical however that the MSIC remain focussed on countering potential exposure to a terrorist threat in the maritime environment.

MSIC was developed in the spirit of industry cooperation to facilitate the specific objectives identified in the International Ship Port Facility Security Code dealing with controlled access.

MSIC Eligibility Criteria

Eligibility criteria has been the subject of much discussion at the industry forums and working groups as it sets the bar at which subjected workers can successfully apply for the card. In effect it has become ***"AUSTRALIA'S RIGHT TO WORK CARD"*** in the maritime industries.

Outrageous media reports quoting low rejection rates of MSIC applications use that statistic as the only basis to pronounce the card a failure.

In fact there is no other comparable industry requirement from which to draw an evaluation. Nor can there be any way to calculate how many workers simply do not apply after reading the criteria thinking they might not meet the standard.

In his critique of the GHD report referred to later in this submission Dr Mark Nolan compares the scope of the MSIC Eligibility Criteria to background checks for child care workers

It may be useful to refer to other occupational security screening legislative schemes (e.g. for child care workers etc under the *Commission for Children and Young People Act 1998* (NSW)). In doing so, we can obtain a sense of proportion about how to select offences which are most relevant to the occupational context being regulated for security reasons. Section 33B of the *Commission for Children and Young People Act 1998* (NSW) lists excludable prohibited persons whose prior offending closely relates to threat of child sex-offending. Notably, there is no lengthy speculative list of offences thought to be "gateway offences" leading to a future likelihood of child sex offending.

Decisions over listing MSROs as part of the MSIC scheme could benefit from such a narrow focus on offences related clearly to the feared (terrorist) behaviour. Below, the suggestion is to match MSROs as closely as possible to elements of the terrorist act definition in s 100.1 of the *Criminal Code Act 1995* (Cth). We should be mindful that the Commonwealth Attorney-General has just received community consultation on an exposure draft of proposed reforms to that definition. Tailoring the list of MSROs more closely to offending clearly related to the definition of terrorist acts is superior to using more speculative lists. More speculative lists result when guided by the type of criminological theorising present in *The Report* (see criticisms below) aimed at identifying antecedent crimes leading down a pathway to terrorist offending. The weaker approach used in *The Report* leads to inconsistent results including the recommended list of MSROs being *both* under-inclusive as well as over-inclusive.
Dr Mark Nolan

Key to the debate has been the relationship between the maritime security relevant offenses (MSROs) and the threat of terrorism from within the maritime industry.

The Office of Transport Security's arguments to expand the list of MSROs to include a criminal focus rely solely on their one commissioned report from GHD consultants. The Unions with broad support from industry agree that the GHD report is fundamentally flawed and of insufficient quality to draw any reliable conclusions.

Unions consulted Dr Mark Nolan (BSc (Hons), LLB, PhD), a senior lecturer at the ANU College of Law to analysis the GHD report and his findings are included in this submission. (Attachment 1)

Based on Dr Nolan's recommendations unions believe that the eligibility criteria discussion would be best served by commissioning a more appropriate study into the subject which could better analyse both the issues surrounding MSIC Scheme and any proposed changes to it.

Dr Nolan finds that the current setting can be improved and are current both under inclusive and over inclusive.

Table 6.07C – Maritime Security Relevant Offences (MSRO)

	Item	Kind of offence
Disqualifying offences a person convicted of an offence mentioned in item 1, 2, or 3, is disqualified from holding an MSIC, but, under	1	An offence mentioned in Chapter 5 of the Criminal Code. Note Offences for this item include treason, espionage and harming Australians.

regulation 6.08X, is entitled to seek reconsideration of the disqualification decision.	2	An offence involving the supply of goods (such as weapons or missiles) for a Weapons of Mass Destruction program as mentioned in the Weapons of Mass Destruction (Prevention of Proliferation) Act 1995
	3	An offence involving the hijacking or destruction of an aircraft or vessel
An issuing body must not issue an MSIC to a person who has been convicted of an offence mentioned in item 4, 5, 6, 7, 8, or 9, unless the Secretary, acting under regulation 6.08F, decides that the person is unlikely to constitute a threat to security and approves the issue of an MSIC to the person. If a person is refused approval by the Secretary under Regulation 6.08F, he or she may seek reconsideration of the decision under Regulation 6.08X.	4	An offence involving treachery, sabotage, sedition, inciting mutiny, unlawful drilling, or destroying or damaging Commonwealth property, mentioned in Part II of the Crimes Act 1914
	5	An offence involving interference with aviation, maritime transport infrastructure or an offshore facility, including carriage of dangerous goods on board an aircraft or ship, or endangering the security of an aerodrome, a port or an offshore facility
	6	An identity offence involving counterfeiting or falsification of identity documents, or assuming another individuals identity
	7	Trans-national crime involving money laundering, or another crime associated with organised crime or racketeering
	8	People smuggling and related offences mentioned in Chapter 4, Division 73 of the Criminal Code
	9	An offence involving the importing, exporting, supply or production of weapons, explosives or a trafficable quantity of drugs.

Nexus between Criminality and Terrorism

The Australian Crime Commission raises this fundamental issue which has been at the centre of recent debates about expanding the application of the MSIC.

It is an area which calls for enormous intellectual research and a few paragraphs does the issue no justice nor does it address the impact of accepting that conclusion without further analysis.

The MSIC working group continues to press the Federal Government to further explore the subject based on Australian empirical evidence and contemporary Australian legal case history.

The Australian National University has already completed a body of work in this field however there is no doubt that both national security interests and policy makers would be greatly assisted by a clearer understanding of the relationship between criminality and terrorism and the likelihood of petty criminals to become a terrorist threat.

Human Rights & Natural Justice

MSIC provisions stem from the MTOFSA 2003 which satisfies Australia's obligations to the International Ship & Port Facility Security Code and Safety of Life at Sea (SOLAS) Amendments 2002, ISPS Code.

Throughout the preamble of the ISPS Code are references to a balance between security and the recognition of human rights.

This fundamental guiding principal is amplified in the associated annex MSC/ Cir.1112 which specifically addresses rights to shore leave:

3. The 2002 SOLAS Conference incorporated the protection of the fundamental human rights of seafarers into the SOLAS chapter XI-2 and the ISPS Code. The preamble to the ISPS Code clearly states that the code shall not be interpreted in a manner that is inconsistent with existing international Instruments protecting the rights and freedoms of maritime and port workers.

As well as this international obligation to human rights Australian workers requiring unescorted access to security regulated zones and thus MSICs must be afforded natural justice and expect to be treated in line with community values.

Crime on the waterfront

Unions are unaware that the incidence of criminal activity is more prevalent on the Australian waterfront than in other domestic workplaces. We have seen and read divisive and scurrilous reports including newspaper headlines about organised crime being rampant on our waterfront but the articles lack substance while the social commentators' arguments are hardly compelling.

Both Australian Crime Commission maritime case studies included in their submission rely on allegations and suspicions. They suggest there is evidence

of gangs of organised criminals operating and infiltrating the transport industries but the evidence is not included in that submission.

If that is the case however, the criminal justice system is already armed with a suite of agencies and powers that must act immediately to address this reported surge of unlawful activity.

The ACC submission into this inquiry lists 10 major agencies with jurisdiction within the defined maritime sectors charged with law enforcement and regulatory compliance.

Gaps in Security

Unions do concede however that there may be some gaps in Australia's Maritime Security regime and have identified them in previous submissions in the lead up to MTOFSA 2003 in a senate hearing into MSIC in 2004.

These include-

- The absence of any requirement for background checks for those who have effective responsibly for the allocation of labour, the scheduling of ships, awarding of transport logistics contracts and recruitment of employees.
- The use of contracted security staff in most terminals with no continuity or commitment to the workplace.
- Lack of attention to waterside and airbounre restricted zones.
- The inconsistent and low level of background checks required for Maritime Crew Visas for Foreign Seafarers to work in the Australian coastal trade.
- The inability for the MSIC to be applied consistently in real terms to foreign nationals granted unescorted access through maritime security regulated zones such as ships, ports and facilities.
- The unavailability of Australian regulated and crewed ships to accommodate our coastal trade leaving us reliant on foreign flagged substitutes.
- The carriage of high consequence and dangerous goods such as explosive grade ammonium nitrate into and around our port cities on substandard ships.
- The very low reserve of the Australian maritime skills base to fill core jobs in our ports, terminals, regulators and associated industries.

- The low level of container inspections and the nonexistent level of inspection of "reportedly" empty containers transhipped into and around the Australian coast.

- The "Trojan Horse" concerns around the stuffing and un-stuffing of containers by "unchecked" staff outside of the security regulated zones.

Criminal Intelligence

Any suggestion of the use of criminal intelligence in the sense described in the GHD report is rejected by the unions as divisive, unreliable and counter productive.

This kind of evidence has been responsible for targeting union officials as described in the TWU submission and is notoriously unreliable.

Unions agree that the enormously unjust treatment and violation human rights in Mohammed Haneef case stands as a warning against the reliance on unsubstantiated criminal intelligence. In this case the victim (Haneef) was continually denied the presumption of innocence based unproven allegations of terror related activities.

Again the field of criminal intelligence is generally unclear to all of industry and the potential impact cannot be measured.

Conclusion

While transport unions in Australia remain committed to counter terrorism measures on the waterfront there is no justification for broadening the focus of maritime security settings to suit crime fighters.

To lift the MSIC provisions out of MTOFSA for use as yet another anti-crime tool will not help fight crime it will merely punish workers who may have offended in their past , in essence initiating double jeopardy.

Unfortunately in 2010 terrorism is a force to be dealt with and requires dedicated measures along with compromises from workers in some industries. For any other agencies to capitalise on these compromises blurs the objectives of counter terrorism and could risk support for it.

Transport Unions abhor organised crime in all of its guises and understands its impact on Australian society. MSIC however is not the tool for the job, better policing and a more coordinated approach to beating organised crime may well be.

Attachment 1

Comments on Department of Infrastructure, Transport, Regional Development and Local Government Office of Transport Security, *Assessment of Maritime Security Identification Card (MSIC) Eligibility Criteria* Report August 2009.

Dr Mark Nolan (BSc (hons), LLB, PhD)
Senior Lecturer
ANU College of Law
The Australian National University
Canberra ACT 0200
(02) 6125 8354
mark.nolan@anu.edu.au
http://law.anu.edu.au/scripts/StaffDetails.asp?StaffID=262

The opinions included here are my own personal views and not that of the ANU College of Law or of any other person or institution. This report has been authored solely by me.

Background to Comments

I received a copy of the August 2009 Report ('*The Report*') from the Maritime Union of Australia (the 'MUA') and was asked to report back on the merits of the recommendations contained in that report and the merits of the research upon which it is based. I was engaged by the MUA on a fee for services basis to prepare my comments that I understand will be used to guide some of the further discussions with the Department during a decision-making process relating to the reform of the MSIC scheme. In particular, I was asked to consider:

(i) if *The Report* should be the seminal body of work from which to base any rationale for change to the MSIC scheme, and,

(ii) if there needs to be a more appropriate study into the subject which could better analyse both the issues surrounding the MSIC scheme and any proposed changes to it.

In the short period of time that I have had available to produce my views, I believe that:

- *The Report* is an inadequate basis from which to consider evidence-based reforms to the MSIC scheme, and,

- that further systematic and comparative criminological study into the MSIC scheme is required.

I offer these views as an academic who teaches and researches in the fields of criminal law and procedure, criminal justice, legal psychology and social psychology. I have academic qualifications in law (LLB) and have been employed at the ANU College of Law, The Australian National University since 2002. I also have academic qualifications in social psychology (to honours (1994) and PhD level (2004)). I have been a co-investigator on an Australian Research Council project investigating domestic and international legal responses to counter-terrorism law. I led an empirical study under that project to measure social perceptions of Australia's response to the perceived terrorist threat. A list of my publications, as well as a list of the submissions I have made to various inquiries conducted by Australian governments relating to counter-terrorism law reform are listed at the following website: http://law.anu.edu.au/scripts/StaffDetails.asp?StaffID=262.

Central to my views on questions (i) and (ii) above are the following concerns I have with *The Report*:

(1) **Purpose of the MSIC**.

a. Is the purpose of the card to prevent terrorism or to regulate *any* criminal behaviour within maritime industry?

b. If the primary objective of the MSIC scheme is counter-terrorism, then *The Report* does not cite a range of relevant contemporary Australian sources.

(2) **Scope of the MSIC Eligibility Criteria**.

a. *The Report*'s listing of recommended maritime-security-relevant-offences (MSROs) sometimes appears to be under-inclusive.

b. This recommended MSRO listing sometimes appears to be over-inclusive.

(3) **Quality of the Criminological Research in *The Report***.

a. Many of the criminological comments from pp 35-41 are based on one work on criminal careers, a form of broken windows theory, by Blumstein, Cohen, Roth and Visher (1986), (not actually referenced in full in the reference section of *The Report*).

b. More relevant work is available on the causes of radicalisation and pathways to terrorism offending.

These points of concern give rise to *Recommendations 1-11* explained below and to suggestions of additional relevant research not included in *The Report*.

Summary of Recommendations

(1) Purpose of the MSIC.

Recommendation 1: **Clarify the purpose of the MSIC scheme before criminological arguments are used to support its expansion.**

***Recommendation 2*: Some existing and recommended MSRO listing may reflect exceptionalist views about how to respond to any threat of terrorism.**

***Recommendation 3*: Refer to completed Australian terrorism prosecutions to guide analysis.**

***Recommendation 4*: Clarify whether the risk assessment motivating *The Report*'s listing of MSROs is in fact the risk assessment test existing under maritime security legislation, and, refer to risk assessment tests required under other existing Australian counter-terrorism law for further context.**

***Recommendation 5*: Do not underestimate the human rights and natural justice concerns over the non-disclosure of intelligence relevant to MSIC eligibility decisions.**

(2) Scope of the MSIC Eligibility Criteria

***Recommendation 6*: Refer to other employment security screening schemes to consider if the existing MSIC scheme or *The Report's* recommended list of MSROs is over-broad in terms of employment-relevant fear of offending.**

***Recommendation 7*: Use the definition of a terrorist act in s 100.1 of the *Criminal Code Act 1995* (Cth) to assist in ensuring that the listed MSROs are neither under-inclusive nor over-inclusive.**

(3) Quality of the Criminological Research in the *The Report*

***Recommendation 8:* Critically question the utility of criminal careers theories of pathways to terrorist offending.**

***Recommendation 9:* Consider the discriminatory impact and human rights violations caused by the MSIC scheme if ethnic or other profiling based on individual, social or demographic characteristics is to be used.**

Recommendation 10: **Avoid unjustifiable causal analyses, especially those identifying unconscious behaviour as blameworthy.**

Recommendation 11: **Refer to contemporary legal, psychological and criminological research, especially research conducted in Australia or by Australian researchers.**

Comments

(1) Purpose of the MSIC

Preventing a Terrorist Attack or Any Type of Crime?

Many post-9/11 security-related national security initiatives, like the MSIC scheme, appear to have confused aims. When expansion of such regimes is mooted, articulating a clear purpose for the regime is critically important. I remain confused by *The Report*'s description of the purpose of the MSIC scheme, especially when the recommended list of MSROs is discussed. *The Report* claims that the Office of Transport Security (OTS) describes the policy objective of the MSIC scheme as being to "help mitigate the threats of terrorism *and of unlawful interference with maritime transport and offshore facilities* (p. 9). Does this mean the MSIC scheme is aimed at regulating the risk of all crime in the maritime industry, or aimed *solely* at preventing terrorism? If the purpose is to prevent terrorism, then the list of MSROs should have a clear link to planning or perpetrating terrorism from within the maritime industry. However, judging that link is not always easy to do in the abstract.

***Recommendation 1*: Clarify the purpose of the MSIC scheme before criminological arguments are used to support its expansion.**

Should the Terrorist Threat be Regulated with the Standard Criminal Law?

An ongoing concern about the proliferation of special counter-terrorism measures such as the MSIC, is that the existing utility and scope of the ordinary criminal law is often ignored. Ignoring that utility and scope often occurs amidst the rush to legislate many new "terrorism" law and procedures (Lynch, 2006). Often there is no time for adequate community and/or industry consultation. The view that new and exceptional criminal laws, procedures and security measures are justified following terrorist attacks has not always been supported in Australia. After the Hilton bombing in Australia in 1978, it was decided to counter terrorism with the ordinary criminal law (Hope, 1979; Nolan, 2005). Almost a decade later, no new offences or procedural law was discussed seriously following the attacks on the Turkish Consulate in Melbourne (resulting in prosecution under standard conspiracy to murder law: *R* v *Demirian* [1989] VR 97).

Following the Hilton bombing, Justice Hope recommended to the Australian Government in 1979 that no special terrorism offences should be added to the

standard criminal offences available at the time. Most of Hope's recommendations related to co-ordination between the police, the military (eg. use of call-out powers), and intelligence agencies rather than the suggestion that we need new terrorism offences.

Extracts from the Hope Report help to illustrate the choice between support for using the standard criminal law rather than the view that "exceptional" law and procedure is required to prevent the threat of terrorism in "exceptional" times. Having noted that some believe that terrorism is different to other examples of motivated violence because "every [terrorist] act is intended to have an intimidating global visibility", Hope maintained that:

> The existence of this distinction does not mean that the same means [i.e. the standard criminal justice process] should not be used to present, control or terminate violence, whatever the motive of the perpetrator.[1]

An orientation towards perceiving the risk to national security as a new threat from a different type of terrorism post-9/11 can be described as exceptionalism (Lynch, 2008b). This attitude has been described further by social psychologists as "siege mentality" (Bar-Tal and Antebi, 1992; Nolan, 2008) and has at least two consequences.

The first consequence is to duplicate substantive and procedural criminal law as well as policing resources. In the resulting systems, unintended consequences observed include co-ordination problems and weakening the prospects of successful prosecution (eg. as in *R v ul-Haque* [2007] NSWSC 1251: Nolan, 2009). The second consequence is to relabel existing criminal threats, deserving of regulation via the standard criminal law, as "national security threats". In turn, there is demand to create new regimes of prevention and control that are subject to critique from the perspective of international human rights law, administrative law, and constitutional law (eg. the challenge to the control order regime in *Thomas v Mowbray* [2007] HCA 33).

> ***Recommendation 2*: Some existing and recommended MSRO listing may reflect exceptionalist views about how to respond to any threat of terrorism.**

Need for Analysis of Recent Australian Terrorism Prosecutions

If one of the main aims of the MISC scheme is to enhance national security and to reduce the risk of terrorist attack, a systematic and thorough analysis of Australian terrorism prosecutions to date should be done and the implications of that analysis for transport and maritime industry systems should be considered.

Analysing Australian terrorism prosecutions gives insight into potential radicalisation of those who fall foul of discretionary, licensing-style decisions. A good example is the case of *R v Mallah* [2005] NSWSC 317. Mallah was refused an Australian

[1] Hope, 1979, 10.

passport on grounds that he was likely to engage in and be convicted and sentenced for firearm registration offences (see Gani, 2008, 285). In response to this passport refusal alongside the challenge of being prosecuted for firearms offences, Mallah subsequently made threats to bomb ASIO offices and DFAT offices to an undercover agent posing as a journalist. For making those threats, Mallah was convicted by a jury of threatening a Commonwealth official, though, was not convicted of two other preparation for terrorism offences with which he had also been charged. The escalation of Mallah's discontent with his treatment resulted in colourful media appearances prior to making the threats. This radicalisation is caused by an arguably less provocative event than being denied a chance to work as is possible under the MSIC scheme. Being refused a travel document that would have otherwise enabled Mallah to attend a family wedding overseas seems relatively minor when compared to being unable to work in your chosen or trained maritime profession following a MSIC refusal decision.

The Report claims that to refer to Australian terrorism prosecutions finalised to date, and to use these cases in any law reform analysis, is invalid due to the fact that:

> "Statistical analysis of offences committed by those who have been found to have been engaged in terrorist activity is not possible . . . [as] there have been insufficient convictions in relation to offences under 'Offences Against National Security' or "Terrorism' provisions to form a dataset of sufficient scale for meaningful statistical analysis." (p 6)

Presumably this is a comment about terrorism offence prosecutions under the *Criminal Code Act 1995* (Cth). I do not understand why the validity of such case analysis needs to be judged only on statistically grounds. What is the inferential statistical procedure contemplated in the analysis that would require possible consideration of the impact of sample size? As an empirical researcher who understands the need for such considerations in many quantitative analyses, I fail to see the relevance of such statistical comments here. Each completed Australian terrorism prosecution to date, with either single or multiple defendants, tells a valuable story for law reformers. These stories should be told and used to complement any quantitatively-derived, evidence base. This reference to statistical analysis, and the requirements of any supposed quantitative analysis, remains vague in *The Report*.

> ***Recommendation 3*: Refer to completed Australian terrorism prosecutions to guide analysis.**

Need for Clarification of the Required Risk Analysis

If one of the main aims of the MISC scheme is to enhance national security and to reduce the risk of terrorist attack, the nature of risk judgment recommended by *The Report* needs to be contextualised by understandings of other risk assessment tests legislated to date as part of Australia's response to 9/11. There is some confusion in *The Report* about the test required for risk assessment under the MSIC scheme. The relevant risk assessment is described in *The Report* as the "tangible risk of being associated with terroristic behaviour" (pp. 16; 21).

If this is the risk assessment used to shape recommendations in *The Report*, it must be identical to the actual risk assessment test contained in relevant maritime security legislation. Further insight into the appropriateness of *The Report's* recommendations related to the "tangible risk" test will be gained by referring to Australian research on the challenges of counter-terrorism risk assessment including the application of (catastrophic) precautionary principles (Goldsmith, 2007). Risk assessment tests are also prescribed and used as part of the Federal preventative detention and control order scheme in Divisions 104 and105 of the *Criminal Code Act 1995* (Cth).

> ***Recommendation 4*: Clarify whether the risk assessment motivating *The Report*'s listing of MSROs is in fact the risk assessment test existing under maritime security legislation, and, refer to risk assessment tests required under other existing Australian counter-terrorism law for further context.**

Human Rights, Administrative, and Criminal Law Principles Affected by the Secrecy and Non-Disclosure of Relevant Evidence

No doubt there could be, and perhaps have already been, strong concerns raised by some workers who are, even only initially, refused a MSIC. In such a context, *The Report*'s anticipation of concerns over natural justice following non-disclosure of intelligence sources (p. 34) is important. This concern deserves greater emphasis in *The Report* and in any expanded scheme. These natural justice concerns have psychological resonance in expectations of procedural justice which help to legitimate the status of the decision-maker (Tyler, 1997). They are also similar to expectations of fair trial and full disclosure of the prosecution case to the defence.

The fair trial expectations and the desire to avoid trial by ambush by prosecutors as supposed model litigants are major concerns with the restricted information aspects of the MSIC and other security-related (legal) processes. The person empowered to make discretionary decisions as to MSIC eligibility based on confidential information, does so risking the Government's reputation and legitimacy. There are trends in the post-9/11 era within Australian and other jurisdictions to deny disclosure under new secrecy laws such as the *National Security Information (Criminal and Civil Proceedings) Act 2004* (Cth). This Federal legislation has received much adverse comment from Australian human rights groups and NGOs reporting to the International Commission of Jurists' (ICJ) Eminent Jurists Panel on Terrorism, Counter-Terrorism and Human Rights. On the 4 May 2009, the ICJ published the results of their international report into such issues (International Commission of Jurists, 2009). Similar non-disclosure of "criminal intelligence" used for control order decision-making is now possible under newer legislation aimed at the regulation of organised crime in Australia (eg. *Serious and Organized Crime (Control) Act 2008* (SA)). International attention and local reaction from affected Australians will remain focused on any departures from administrative law, criminal law and human rights norms.

The impact of such mismatch between expectations and treatment could be exacerbated by possible privacy rights and labour rights (eg. right to work as provided

for in Article 6, *International Covenant on Economic Social and Cultural Rights*) concerns flowing from adverse MSIC eligibility decisions.

> ***Recommendation 5*: Do not underestimate the human rights and natural justice concerns over the non-disclosure of intelligence relevant to MSIC eligibility decisions.**

(2) Scope of the MSIC Eligibility Criteria

It may be useful to refer to other occupational security screening legislative schemes (eg. for child care workers etc under the *Commission for Children and Young People Act 1998* (NSW)). In doing so, we can obtain a sense of proportion about how to select offences which are most relevant to the occupational context being regulated for security reasons. Section 33B of the *Commission for Children and Young People Act 1998* (NSW) lists excludable prohibited persons whose prior offending closely relates to threat of child sex-offending. Notably, there is no lengthy speculative list of offences thought to be "gateway offences" leading to a future likelihood of child sex offending.

Decisions over listing MSROs as part of the MSIC scheme could benefit from such a narrow focus on offences related clearly to the feared (terrorist) behaviour. Below, the suggestion is to match MSROs as closely as possible to elements of the terrorist act definition in s 100.1 of the *Criminal Code Act 1995* (Cth). We should be mindful that the Commonwealth Attorney-General has just received community consultation on an exposure draft of proposed reforms to that definition. Tailoring the list of MSROs more closely to offending clearly related to the definition of terrorist acts is superior to using more speculative lists. More speculative lists result when guided by the type of criminological theorising present in *The Report* (see criticisms below) aimed at identifying antecedent crimes leading down a pathway to terrorist offending. The weaker approach used in *The Report* leads to inconsistent results including the recommended list of MSROs being *both* an under-inclusive as well as an over-inclusive.

> ***Recommendation 6*: Refer to other employment security screening schemes to consider if the existing MSIC scheme or The Report's recommended list of MSROs is over-broad in terms of employment-relevant fear of offending.**

Under-inclusive

Systematic analysis of Australian terrorism prosecutions again assists to identify where the recommended list of MSROs is problematic. For example, in the successful prosecution of Faheem Lodhi (*R v Lodhi* [2006] NSWSC 691) it was found that Lodhi impersonated an electrician in order to obtain official maps of the electricity grid (Gani, 2008, p. 292). However, *The Report* suggests that a range of impersonation and dishonest representation offences should be removed from a revised list MSROs, including removal of the offence of "impersonating a particular profession, trade, rank or status (09911)" (p. 21). This is despite the fact that *The Report* itself suggests (p.

13) that supply of false identity documentation can be related to terrorist activity (Smith et al., 2008).

Another curious omission is that federal cybercrime offences contained in the *Criminal Code Act 1995* (Cth) do not appear in the recommended list of MSROs. This is despite the fact that the definition of terrorist act in s 100.1 of the *Criminal Code Act 1995* (Cth) includes "seriously interferes with, seriously disrupts, or destroys an electronic system" including "a system used for, or by, a transport system". *The Report* itself also lists Damage to Property in Table 11, Appendix B, and defines it as damage to virtual environments, hacking and cyber-terrorism. There is the accompanying suggestion (p. 13) that Clutterbuck (1994) and Greenberg et al. (2006) have demonstrated links between cybercrime and terrorist offending.

Over-inclusive

Over-inclusive recommendations for MSROs derive from the reliance on "criminal careers" and pathways to crime theories (see criticisms below). The assumption promoted in *The Report* is that a range of offending behaviour (from graffiti to organised criminal activity) can all be possibly linked to eventual participation in terrorist offending.

> ***Recommendation 7:*** **Use the definition of a terrorist act in s 100.1 of the *Criminal Code Act 1995* (Cth) to assist in ensuring that the listed MSROs are neither under-inclusive nor over-inclusive.**

(3) Quality of the Criminological Research.

Antecedent Conduct and Criminal Careers

The Report cites a range of references relating to "antecedent conduct" which purportedly predicts terrorist offending (pp 12-13). It is a relief that the work on non-criminal behaviours (eg. telephone conversations and meetings etc; p. 12) as antecedents to terrorist offending is not developed in *The Report* as being of relevance for MSIC eligibility decision-making.

Furthermore, one reference to research into criminal careers by Blumstein, Cohen, Roth and Visher (1986) was the basis for much discussion in *The Report*. The full reference is not included in the reference section of *The Report*. However, this citation is probably a reference to Blumstein, Cohen, Roth, and Visher, *Criminal Careers and "Career Criminals"*. Notable is the lack of citation of more recent scholarship, either critical or supportive, of those 1986 ideas. It would be valuable to know what the more contemporary criminological scholarship now says of the concept of criminal careers generally in criminology or in the study of terrorist offending in particular. Missing from *The Report*, for example, is reference to the Special Issue on the longitudinal patterning of criminal activity edited by Piquero (2004) for the *Journal of Contemporary Criminal Justice* where reference to research on criminal careers, including work by Blumstein et al. (1986), was made.

The Report relies on Blumstein et al. (1986) and the research cited at pp 12-14 to suggest which type of offending is a clear antecedent to tangible risks of developing a criminal career as a terrorist offender. Such criminal careers theorising used in *The Report* is a form of "broken windows theory" (Wilson and Kelling, 1982), namely that neglecting the policing of minor crime (such as "broken windows" in a housing project or community) encourages even more serious crime. This theory is used to recommend increased policing of minor crime in order to deter serious offending. It is questionable that this is an appropriate basis for the MISC scheme and the exclusion of some workers from their workplaces.

Many commentators are critical of such causal links being drawn, especially when they are used to justify zero-tolerance policing of, say, public order offending. The critique of broken windows theory by Harcourt (2001) is discussed by Bronitt & McSherry (2005, p 745-748), especially in terms of the unreliability of empirical evaluations of the success of zero-tolerance policing (which uses tough on crime policies, non-discretionary enforcement, and ensures policing of minor offences: Marshall, (1999), p. 2). This critique is a useful guide as to why much of the criminal careers research cited in *The Report* should be questioned. The research is questionable in so far as it suggests that even minor MSROs on an applicant's criminal record should exclude them from maritime industry work out of fear that prior minor offending indicates a propensity to develop a criminal career in terrorism. The criminal careers research cited in *The Report* is at odds with the more appropriate body of contemporary research into why and how extremism develops and results in terrorist offending. The criminal careers work is of limited use in understanding the pathway to terrorist offending in the Australian maritime industry. Broken windows logic in *The Report* should also be questioned to prevent the MSIC scheme becoming merely one strategic choice by the Government to reassure the electorate that they are tough on crime on the waterfront, in the interests of national security, at almost all cost to the livelihood of a maritime worker.

> ***Recommendation 8:*** **Critically question the utility of criminal careers theories of pathways to terrorist offending.**

Ethnic Profiling

Despite the fact that *The Report* rejects ethnic profiling, and rejects the use of ethnicity as a predictor of criminal careers (p. 41), *The Report* still supports the view that "a range of demographic and individual characteristics . . . may affect the likelihood that an individual may be engaging in an active criminal career – and thus be considered a risk to maritime security" (p. 39). This suggests that some level of ethnic or other profiling is supported by *The Report*. Human rights concerns such as freedom from racial, ethnic or religious prejudice (in domestic legislation or in UN treaties) are relevant for tempering profiling being done and eligibility decisions being made on the basis of individual characteristics.

> ***Recommendation 9:*** **Consider the discriminatory impact and human rights violations caused by the MSIC scheme if ethnic or other profiling based on individual, social or demographic characteristics is to be used.**

Unconscious Involvement

Of additional concern is the use of the unexplained concept of "unconscious involvement". Whatever this concept is understood to be by the authors of *The Report*, it is, at times, given inappropriate weight in some worrying examples of speculative causal analysis:

> "For example, offences involving fraud *may* predispose towards involvement in organised criminal activity or trafficking in illicit products in the maritime context, which *could* in turn predispose towards conscious or *unconscious* involvement in activities directly or *indirectly* in support of terrorism *or* unlawful interference with maritime transport and offshore facilities." (*The Report*, p. 12, *emphasis added*)

> ***Recommendation 10:*** **Avoid unjustifiable causal analyses, especially those identifying unconscious behaviour as blameworthy.**

Research Omitted

Some important Australian legal and social-scientific scholarship which has emerged post- 9/11 is missing from *The Report*. A considerable amount of this research expands the more simple criminal careers, profiling and pathways to crime understandings cited in *The Report*.

Legal Research

Much of the post-9/11 Australian research is focused on the fate of human rights norms as the result of a range of legislative reforms with a national security rationale (eg. Bronitt (2008); Byrnes (2008); Mathew (2008); Lynch and Williams (2006), Lynch, Williams, and MacDonald (2007)). This work is shaped by both comparative and historical analysis which guards against undue exceptionalism in the analysis (Gani and Mathew, 2008).

Psychological Research on Radicalisation

Specifically, psychological theorising and research on the radicalisation and socialisation of terrorist offenders (via the "stairway to terrorism": Moghaddam, 2005; Louis, 2009) is omitted from the work. This work highlights the social dimensions, and the intergroup relationship between suspected offenders and the State (legislators, police, etc). This work asks what role societal treatment of groups perceived to be at risk of radicalisation has on their movement towards extremist behaviour. This work takes us beyond more simple notions of predicting risk based on prior offending and individual characteristics alone. It examines the dynamic social forces at play when law reform and institutional decision-making is perceived to be fair, or not, by those already at some stage in the radicalisation process. Further reviews of the (social) psychological causes of radicalization are detailed by Victoroff (2005).

Also missing from *The Report* is reference to more recent Australian research on pathways to crime for younger offenders (France and Homel, 2007). Further Australian critiques of simplistic, probabilistic and inductive approaches to profiling terror suspects would also add to the literature referenced in *The Report* (Petherick, 2008; Wilson, 2008).

Recommendation 11: **Refer to contemporary legal, psychological and criminological research, especially research conducted in Australia or by Australian researchers.**

References

D Bar-Tal and D Antebi, 'Beliefs About Negative Intentions of the World: A Study of the Israeli Siege Mentality' (1992) 13(4) *Political Psychology* 633.

A Blumstein, J Cohen, JA Roth, and CA Visher, Criminal Careers and "Career Criminals." (Washington, DC: National Academy Press, 1986).

S Bronitt, 'Balancing Security and Liberty: Critical Perspectives on Terrorism Law Reform' in M Gani & P Mathew (eds), *Fresh Perspectives on the 'War on Terror'* (Canberra: ANU ePress, 2008), 65.

S Bronitt and B McSherry, *Principles of Criminal Law* (2nd Edition, Pyrmont: Lawbook Co, 2005).

A Byrnes, 'More or Less Law? The Resilience of Human Rights Law and Institutions in the 'War on Terror'' in M Gani & P Mathew (eds), *Fresh Perspectives on the 'War on Terror'* (Canberra: ANU ePress, 2008) 127.

R Clutterbuck, *Terrorism in an Unstable World* (London: Routledge, 1994).

A France and R Homel (eds) (2007). *Pathways and Crime Prevention: Theory, Policy and Practice* (Cullumpton, Devon, UK: Willan Publishing, 2007).

M Gani, 'How Does it End? Reflections on Completed Prosecutions Under Australia's Counter-Terrorism Legislation' in M Gani & P Mathew (eds), *Fresh Perspectives on the 'War on Terror'* (Canberra: ANU ePress, 2008) 269.

M Gani & P Mathew (eds), *Fresh Perspectives on the 'War on Terror'* (Canberra: ANU ePress, 2008).

A Goldsmith, 'Preparation for Terrorism: Catastrophic Risk and Precautionary Criminal Law' in A Lynch, G Williams, and E MacDonald (eds), *Law & Liberty in the War on Terror* (Leichardt: Federation Press, 2007) 59.

MD Greenberg, P Chalk, HH Willis, I Khilko and DS Oritz, *Maritime Terrorism: Risk and Liability* (Santa Monica: RAND Corporation, 2006)

B Harcourt, *Illusion of Order: The False Promise of Broken Windows Policing* (Cambridge: Harvard University Press, 2001).

International Commission of Jurists, *Assessing Damage, Urging Action* (available at http://ejp.icj.org/hearing2.php3?id_article=172&lang=en, accessed 23 October 2009).

WR Louis, 'If They're Not Crazy, Then What? The Implications of Social Psychological Approaches to Terrorism for Conflict Management' in W Stritzke, S Lewandowsky, D Denemark, F Morgan, and J. Clare (eds), *Terrorism and Torture: An Interdisciplinary Perspective* (Cambridge: Cambridge University Press, 2009) 125.

A Lynch, 'Exceptionalism, Politics and Liberty: A Response to Professor Tushnet from the Antipodes' (2008b) 3 *International Journal of Law in Context* 31.

A Lynch, 'Legislating with Urgency: The Enactment of the Anti-Terrorism Act [No 1] 2005' (2006) 31 *Melbourne University Law Review* 747.

A Lynch, G Williams, and E MacDonald (eds), *Law & Liberty in the War on Terror* (Leichardt: Federation Press, 2007).

A Lynch and Williams, *What Price Security: Taking Stock of Australia's Anti-Terror Laws* (Sydney, UNSW Press, 2006).

J Marshall, 'Zero-Tolerance Policing' (1999) 9 Information Bulletin (South Australian Office of Crime Statistics).

P Mathew, 'Black Holes, White Holes and Worm Holes: Pre-Emptive Detention in the 'War on Terror' in M Gani & P Mathew (eds), *Fresh Perspectives on the 'War on Terror'* (Canberra: ANU ePress, 2008) 159.

F Moghaddam, 'The Staircase to Terrorism: A Psychological Explanation' (2005) 60(2) *American Psychologist* 161-169.

MA Nolan, 'Comparative Legal History of Counter-Terrorism Law in Australia and Japan: From the Hope Report to the Counter-Terrorism Committee' (Paper presented at the Gilbert+Tobin Centre of Public Law, University of NSW, Terrorism and Law Research Workshop, Crown Plaza Hotel, Coogee Beach, 20 June 2005).

MA Nolan, 'Counter-terrorism, Interviewing, and Investigative Interoperability: *R v ul-Haque* [2007] NSWSC 1251' (2009) 16(2) *Psychiatry, Psychology, and Law* 175-190.

M Nolan, 'Lay Perceptions of Terrorist Acts and Counter-terrorism Responses: Role of Motive, Offence Construal, Siege Mentality and Human Rights' in M Gani and P Mathew (eds) *Fresh Perspectives on the 'War on Terror'* (Canberra: ANU ePress, 2008) 85.

W Petherick, 'Offender Profiling in Australia' in K Fritzon and P Wilson (eds), *Forensic Psychology and Criminology: An Australian Perspective* (North Ryde: McGraw Hill, 2008) 237-250.

AR Piquero (ed), (2004) 20(2) *Journal of Contemporary Criminal Justice* (Special Issue) 100.

BL Smith, J Cothren, P Roberts, & KR Damphousse, Geospatial Analysis of Terrorist Activities: The Identification of Spatial and Temporal Patterns of Preparatory Behavior of International and Environmental Terrorists (Washington DC: National Institute of Justice, 2008).

TR Tyler, 'The Psychology of Legitimacy' (1997) 1 *Personality and Social Psychology Review* 323.

J Victoroff, 'The Mind of the Terrorist: A Review and Critique of Psychological Approaches' (2005) 49(3) *Journal of Conflict Resolution* 3-42.

P Wilson, 'Terrorism in Australia' in K Fritzon and P Wilson (eds), *Forensic Psychology and Criminology: An Australian Perspective* (North Ryde: McGraw Hill, 2008) 219-226.

JQ Wilson and GL Kelling, 'Broken Windows: The Police and Neighbourhood Safety' (1982) 249(3) *The Atlantic Monthly* 29.

Case Law

R v Demirian [1989] VR 97.

R v Lodhi [2006] NSWSC 691.

R v Mallah [2005] NSWSC 317.

R v ul-Haque [2007] NSWSC 1251.

Thomas v Mowbray [2007] HCA 33.

Statutes

Serious and Organized Crime (Control) Act 2008 (SA).

Commission for Children and Young People Act 1998 (NSW).

Criminal Code Act 1995 (Cth).

National Security Information (Criminal and Civil Proceedings) Act 2004 (Cth).

Reports

RM Hope, *Protective Security Review* (Canberra, Com