

energy etc.), and the lack of a strong physical withdrawal syndrome (cf. heroin use), means that help-seeking can be delayed relative to drugs like heroin.⁴⁸

Our identification of a group of younger regular/dependent crystalline methamphetamine users suggests the existence of a broader population of young people who are using crystalline methamphetamine at lower levels, and who may benefit from prevention initiatives. We were not able to capture this population in our survey because we only surveyed people who had already progressed to regular use, and also because we could not interview people under 18 years of age, who may have been in the early stages of use (e.g., 45% in this sample initiated methamphetamine use before they were 18 years old).

The use of crystalline methamphetamine amongst older people who injected heroin

The use of crystalline methamphetamine had also been taken up amongst an older group of people who had a long-standing history of injecting heroin or other opioids, including people enrolled in OST. This group mostly injected crystalline methamphetamine but also smoked the drug. The use of methamphetamine amongst people who inject heroin is well documented,⁵¹⁻⁵⁴ and reflects the high rates of polysubstance use seen with injecting drug use. People who inject heroin will switch between drugs (e.g., dependent on availability),^{55,56} while individuals enrolled in OST often continue to use other drugs, including methamphetamine.⁵⁷

The use of methamphetamine may introduce new harms to people who inject opioids, for which harm reduction tactics are not well developed. For example, harm reduction strategies for opioid overdose (e.g., naloxone) are well developed, as are services to reduce the risk of BBV infection within this group (e.g., provision of sterile injecting equipment via NSPs). However, there are no equivalent strategies to manage episodes of methamphetamine-related paranoia or other harms commonly associated with the use of the drug (e.g., elevated risk of stroke, “meth mouth”, sexual risk behaviour). Ongoing methamphetamine use may undermine the benefits of OST (e.g., BBV risk associated with ongoing drug injection). Around half of the participants enrolled in OST in our sample were dependent on methamphetamine, suggesting a possible need for additional treatment to manage levels of methamphetamine use.

Key points

Crystalline methamphetamine use will drive increasing treatment demand, even if the number of people who use methamphetamine remains stable

A new cohort of young crystalline methamphetamine smokers suggests an opportunity for early intervention

Strategies to reduce methamphetamine-related harms amongst heroin users/OST clients need to be considered

Strategies to address tobacco and cannabis related health effects are needed

Patterns of other substance use

The vast majority of participants also smoked tobacco, highlighting the potential for anti-smoking strategies (which may include tobacco control) to improve health in this population. Although tobacco is often perceived as a lesser concern than methamphetamine or other illicit drug use, tobacco smoking has well-documented health consequences including cardiovascular and cerebrovascular pathology, increased risk of chronic obstructive pulmonary disorders and various cancers, particularly lung

cancer.^{58,59} Tobacco smoking is likely to compound cardiovascular pathology seen in chronic methamphetamine users (e.g., cardiomyopathy) and exacerbate the risk of cardiovascular events associated with methamphetamine use (e.g., sudden cardiac death) by increasing atherosclerosis.⁶⁰

The health effects of daily cannabis smoking on lung health should also be considered (80% of participants in this sample smoked cannabis, and, amongst those who did, the majority smoked daily or almost daily). The adverse effects of cannabis use on lung function are less well documented than those for tobacco, but they include chronic bronchitis during periods of regular cannabis smoking,⁶¹ which may compound the ill-effects of tobacco smoking on lung function and also increase the risk of respiratory failure in opioid overdose.⁶²

Treatment coverage

Treatment coverage for methamphetamine dependence was low, with only 7% of participants dependent on methamphetamine having received specialist treatment within the past year for methamphetamine use (including detoxification, rehabilitation and drug counselling). Participants were more likely to get professional help other than from specialist drug treatment services: 45% of people dependent on methamphetamine had received some form of professional help related to their methamphetamine use in the past year, most commonly from their GP.

There are few other estimates of treatment coverage within Australia to compare the ACT estimates. However, those that do exist for methamphetamine have also revealed low treatment coverage. Published estimates of treatment for methamphetamine use range from 25-38%^{13,19,15,63} although variation in the definitions of treatment and the time-frames used in different studies hinders any direct comparison with the current estimate of treatment coverage.

Low treatment coverage is not specific to methamphetamine dependence.⁶³ According to the 2007 National Survey of Mental Health and Wellbeing, the past year rate of professional help for substance use disorders in the Australian population was found to be 24%.⁶⁴ However, it does stand in contrast to the greater than 50% coverage seen for opioid use.^{65,63} where treatment coverage is bolstered by the availability of pharmacotherapy options (e.g., 57% of current heroin users in our sample were enrolled in OST).

Key points

Methamphetamine treatment coverage is very low

Low methamphetamine treatment coverage has also been found in previous studies in Australia

Treatment coverage for drugs other than heroin is typically low

High levels of help received from GPs could reflect that several primary health care services exist within the ACT that provide specialist AOD support. Episodes of AOD-related care provided via these services would not necessarily be captured within our definition of specialist drug treatment. High rates of AOD-related contact with GPs may also reflect OST prescribing, given the high rates of opioid use in this sample. Therefore, further investigation would be necessary to understand which types of GP services were being accessed and what type of help was being provided.

We also found that men would be more willing than women to seek help for methamphetamine use from their GP. We cannot be certain why this gender disparity existed, although it could plausibly be

related to concerns about *child custody*, as women were more likely to have dependent children (59% vs. 35% for men) and reside with dependent children (33 vs. 6%); participants with dependent children were significantly less willing to discuss their *methamphetamine* use with their GP. Other possibilities could include greater stigma for women using the drug, gender differences in prescribing of medications which may be affected by methamphetamine use (e.g., urine testing for OST, prescribing of antidepressants or sleep medication) or broader gender-related differences in GP–patient interactions.⁶⁶

Barriers to seeking treatment

One of the most disconcerting findings in our survey was that participants indicated that they would be unlikely to seek help from anyone if they were having problems from their methamphetamine use. Although this response could reflect the stigma attached to using an illicit drug, particularly methamphetamine, concern about stigma and discrimination did not feature strongly amongst the various reasons people cited for not seeking treatment. Examination of those reasons for which participants would not seek help from treatment services suggested a more complex range of factors were driving people's reluctance to seek help from treatment services.

Amongst these factors was a very strong desire to continue to use methamphetamine. People liked the effects of methamphetamine and did not go to treatment because they did not want to be told to stop using drugs. This phenomenon is not specific to methamphetamine use and reflects a conundrum in *managing all forms of substance dependence*, with competing motivations arising from the hedonic and desirable effects of intoxication against the adverse impacts that can occur with dependence. This strong motivation to continue methamphetamine use suggests that the perceived focus of drug treatment on *ceasing or reducing drug use* as a primary goal is likely to be a deterrent for many people.

The provision of low threshold services that provide support for methamphetamine-related issues, rather than focussing on the *reduction of methamphetamine use* as a goal, is one strategy to engage with people who have a low perceived need for treatment. Responding to this barrier to treatment has also been addressed using motivational enhancement strategies (e.g., through the online “Breaking the Ice” program⁶⁷), which can successfully increase help-seeking in people who use methamphetamine. Other strategies to reduce harm related to methamphetamine use for individuals who continue to use the drug are discussed in the subsequent sections on mental health needs and BBV/STI risk and prevention.

There were also a variety of reasons reported for not attending treatment that suggested a lack of awareness of what treatment options were available and what they might involve, and a lack of confidence in their effectiveness (e.g., participants reported that they were afraid of what might happen to them if they went to treatment, or that they did not think treatment would help them). This could explain why many people indicated that they would not seek help from anywhere if they had a problem with their use. Improving knowledge of the different treatment options available, what they involve, and establishing clearer expectations around the goals of different types of treatment, and likely post-treatment outcomes, may help alleviate these reservations.

Lack of awareness of ACT specialist drug and alcohol services was apparent and necessarily would present a barrier to people not seeking help from these services. This was particularly true for people who did not use opioids, and even more apparent amongst crystalline methamphetamine smokers. Up to two-thirds did not recognise the name of specific ACT-based drug treatment services. Participants had better recognition of the not-for-profit service sector names, which could reflect their branding (e.g., naming of services as “Directions”, “Karralika” and “Arcadia House”) and/or related marketing of these services. Conversely, lower recognition of government services may reflect their more descriptive naming (e.g., the “withdrawal services” provided at the Canberra Hospital, dubbed by some consumers as “Building 7”). Although these descriptive names provide information on what these services do, such generic names have less traction in people's minds.

One of the more important barriers to receiving treatment was that treatment was not available when people sought help. There was also a perception that people would have to wait too long to get into treatment. When interpreting this finding, consideration needs to be given to people's expectations of how quickly they should be able to enter drug treatment (e.g., they may expect that they should be able to start treatment immediately) versus the practical constraints around enrolling in drug treatment (e.g., the need to go through an assessment process prior to entering treatment, the duration of waiting list once they have been accepted into drug treatment). Engaging people rapidly into treatment when they present for help is critical to improving treatment coverage. Therefore, additional processes may be needed to engage with people immediately, and/or provide support during waiting periods.

Many participants held a view that they could not afford treatment. To some readers, this may seem at odds with most services being government run or not-for-profit. However, considering most participants in this study were on very low income, the cost of treatment may nonetheless represent a significant proportion of their income and thus be perceived a barrier to attending. Treatment fees may also restrict the participants' capacity to cover the cost of other expenses while being in treatment (e.g., rent), particularly if being in treatment would involve a loss of income or incur additional expenses (e.g., child care). The perception of cost could also reflect the high cost of private treatment services that have been promoted in the media, suggesting a need to inform people about the costs of services that are available within the ACT, particularly lower cost (e.g., publicly funded) services.

Peer-based services are likely to play a pivotal role in communicating information about the nature of services available to support people who are using methamphetamine. Of all of the services we listed in our survey, participants rated peer-based services as the most likely place that they would seek help (followed closely by counsellors). There was also relatively good awareness of peer-based services amongst people who used methamphetamine, although (as with other services) awareness was lower amongst non-opioid users and especially amongst crystalline methamphetamine smokers. Additional efforts may be needed to provide peer-based outreach to this group.

Key points

Low threshold services that target harms from use, and increase help seeking, may be beneficial to engage with people who do not want to stop using methamphetamine

Education and marketing around the types of treatment services available, what they offer, their cost and wait times, may improve treatment coverage

Additional efforts are needed to engage with crystalline methamphetamine smokers

Mental health needs

The high rates of mental health disorders, and poor quality of life related to poor mental health, indicate a clear need to provide mental health support services for this population. Rates of depression and suicidality, particularly coupled with low rates of service contact, flag a critical need for suicide prevention information (e.g., suicide call-back services) to be provided via outreach (e.g., NSPs). High rates of depression among people dependent on methamphetamine are common.^{68,69} Although depression is often premorbid to methamphetamine use, and alleviated by intoxication with methamphetamine,⁷⁰ heavy use can worsen depression through a dysregulation of brain chemicals

involved in mood.^{71,72,73} These changes can last for up to several months, and are normalised by methamphetamine intoxication⁷², perpetuating a cycle of using the drug to alleviate depression.⁷²

We found substantial comorbidity between PTSD and depression, which is often seen among people with substance use disorders,⁷⁴ and which is associated with a particularly high suicide risk.⁷⁵ Trauma leading to PTSD can arise from childhood abuse,^{76,77} and can be perpetuated by adverse life-events associated with an illicit drug-using lifestyle.⁷⁸ Drug treatment services need to be trauma-informed to avoid perpetuating stress responses (and consequent relapse risk) amongst drug treatment entrants who have PTSD.⁷⁹ PTSD symptoms do not necessarily resolve following drug treatment, and therefore additional treatment for PTSD is necessary.⁸⁰

Paranoia and hallucinations were more common among people dependent on methamphetamine, and is similar to rates seen in previous surveys of people who use methamphetamine.^{81,82} Heavy methamphetamine use can exacerbate and precipitate symptoms of psychosis, particularly in people with an underlying vulnerability to psychosis, or when coupled with other risk factors (e.g., stress, sleep deprivation).^{83,84,85} Most symptoms of psychosis seen in people who use methamphetamine are transient and do not warrant hospitalisation or antipsychotic medication, although they can have a negative effect on the person's social relationships and occupational functioning. Harm reduction strategies (e.g., educating consumers to cut-back on their use when they experience early signs of psychosis) can be a useful way of managing the risk of psychotic symptoms.

Participants also reported high rates of anxiety. The relationship between methamphetamine use and anxiety is not well understood. Methamphetamine has the potential to increase anxiety by increasing arousal, and, in doing this, produce panic-like symptoms (e.g., rapid heartbeat, sweating, shortness of breath). These symptoms of methamphetamine intoxication may have conflated ratings of anxiety. Paranoia, which can be associated with methamphetamine use, is also associated with high levels of anxiety.⁸⁶ Alternatively, people with pre-existing social anxiety may be drawn to the confidence-enhancing effects of methamphetamine.

Key points

Support for mental health is needed in AOD services

Suicide prevention information is critically needed in AOD outreach settings

AOD services need to be 'trauma-informed'

Harm reduction strategies (e.g., education) for paranoia and hallucinations are needed

HIV and other BBV/STI risk and prevention

Risk reduction strategies need to target both BBV and STI in this population. That is, they need to not only address injecting behaviour but also sexual health and the potential for infections to be spread through burns and other skin lesions from smoking crystalline methamphetamine.

NSP coverage was very high among the participants who injected drugs. Not being able to access sterile needles was a rarity. Having said this, awareness and use of NSP services was slightly lower amongst methamphetamine injectors who were not injecting heroin, suggesting additional efforts may be needed to engage with methamphetamine injectors through NSP and outreach services.

Even though the sharing of used needles was very low in this sample, 28% of participants who injected had shared other injecting equipment (e.g., tourniquets, swabs). Sharing of non-sterile drug preparation equipment can present a similar risk of hepatitis C transmission risk as sharing used syringes,⁸⁷ and therefore this presents a mechanism for the transmission of hepatitis C and possibly also other BBV⁸⁷. We did not assess which specific equipment was shared (e.g., spoons vs. tourniquets or swabs), so there remains some uncertainty about what level of risk this poses.

Methamphetamine use also presents a risk of HIV and other STI transmission through sexual risk behaviour.^{54,88-91} This was a sexually active population which included a minority of people who had multiple sex partners and unprotected sex with casual sex partners in the past month. We found that sexual activity was higher amongst younger participants who were not using opioids, suggesting that sexual health messages need to particularly target this group. This pattern of results is likely to be linked to the libido-enhancing effects of methamphetamine⁹² and/or the converse loss of libido that can occur with chronic opioid use.⁹³

The risk of sexual transmission also applies to hepatitis A and B, as these infections can be spread via both sexual contact and via exposure to blood, although this risk can be managed with vaccination. The risk of sexual transmission of hepatitis C, which is more prevalent among people who inject drugs, and for which there is no vaccine, is fortunately considered very low,^{94,95} and generally limited to individuals who engage in high risk sexual activity (e.g., men who have sex with men, sex workers).

Key points

- There are multiple transmission mechanisms for HIV, hepatitis and other BBV
 - BBV risk reduction strategies are needed to reduce sharing of drug preparation and injection-related paraphernalia
 - Improved awareness of NSPs is needed for non-opioid injectors
 - Strategies are needed to reduce the risk of BBV transmission through pipe-sharing
 - Sexual health and risk-reduction around STI transmission is important for this population
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In addition, there was also the potential for transmission of BBV through smoking pipes. Sharing of ice pipes was an almost ubiquitous practice among people who smoked methamphetamine. Pipe-sharing can provide a mechanism for BBV transmission when people have burns or sores on their lips (which can occur from smoking ice through a glass pipe). Around one-quarter of crystalline methamphetamine smokers reported burns or sores on their lips. This suggests a need to educate crystalline methamphetamine users about the risks associated with sharing pipes (and not to share pipes if they have burns or sores), along with information on how to avoid and treat burns. Although one obvious possibility for imparting this knowledge would be to provide information (e.g., leaflets) to crystalline methamphetamine smokers via ice-pipe retailers, our impression was that these retailers were not immediately receptive to promoting information about methamphetamine use within their premises. Consultation with consumers and other relevant parties will be needed to determine the most effective means of communicating this information to crystalline methamphetamine smokers.

Reaching younger crystalline methamphetamine smokers will be challenging because of their lack of contact with NSPs or other injecting-related outreach services. GPs would be one possible way of accessing this younger group because most reported receiving sexual health testing through their GP, and they generally had high levels of GP contact. Mechanisms for how to do this would need to be considered in consultation with GP; for example, considering what relevance the issue of methamphetamine has to their practice (e.g., mandatory reporting issues, prescribing of psychoactive medications), what information may be useful to them and their patients (e.g., treatment options, STI and BBV risk, referral information for mental health issues), and what mechanisms would be most appropriate to facilitate communication between GPs and their patients (e.g., leaflets in waiting rooms, GP training on how to discuss illicit drug use).

4.2 Implications for providing treatment and other health services

It is clear that treatment coverage for methamphetamine dependence in the ACT is very low. Even if our figures were imprecise, and potentially biased by not having a perfectly representative sample, correcting for such biases would unlikely bring the treatment coverage to an optimal level. Understanding what implications this has for providing treatment is more complicated.

It is tempting to assume that low drug treatment coverage is an indication that more treatment places are needed. However, there are number of factors that require careful consideration in deciding whether more treatment is needed, and, if so, how much treatment and what this treatment should look like. These include how existing services are being used, barriers to services currently available, and what proportion of people are likely to seek treatment even should services be readily available. Specifically:

- If the desired outcome is to provide an optimal level of treatment coverage to reduce dependence on methamphetamine, then the number of treatment places that seek to address dependence deserves consideration.
- Low awareness of treatment services means that providing more treatment places without improving awareness of these services is unlikely to substantially improve treatment coverage.
- Low threshold services, including those that are not necessarily abstinence-based, are likely to be critical in engaging people who are dependent on this drug but for whom their desire to continue using is a deterrent to accessing treatment.

In providing treatment for methamphetamine use, consideration also needs to be given to the types of treatment services that are most effective for treating dependence on methamphetamine⁹⁶⁻⁹⁸ and the specific issues related to methamphetamine that need to be considered when designing an optimal treatment environment.

Consistent with broader research, high need for mental health support was clear from the current survey of people dependent on methamphetamine within the ACT, with particularly high levels of depression, anxiety, suicide risk, paranoia and hallucinations. Developing the capacity to manage mental health issues amongst people presenting to treatment for methamphetamine use is likely to benefit from collaboration and linkages with the mental health sector to share information (e.g., on best practices for managing substance use/mental health disorders) and to identify appropriate treatment strategies and pathways for individuals who have comorbid mental health and substance use disorders.

The poor quality of life and high level of social and welfare needs in this population suggest a need to link drug treatment with broader welfare and criminal justice services. Many participants were reliant on disability support and public housing. Parental support and child protection are likely to be important, as many people had children but were not currently residing with their children, suggesting custody issues. High rates of arrest and incarceration point to a potential for therapeutic jurisprudence and

diversionary approaches within the criminal justice system to reduce rates of recidivism in this population.

Finally, approaches are needed to reduce harms related to the use of methamphetamine and address many of the comorbid issues in this population among the vast majority of people who do not attend drug treatment. This need includes suicide prevention information, information on mental health services, and legal and social welfare support services, as well as services available for drug use (including accurate information about drug treatment services, what these services offer, their costs and waiting times). Peer support organisations (e.g., CAHMA), GPs and possibly emergency departments represent avenues through which this information could be provided to access people who are not engaged with treatment services.

Prevention strategies for HIV (and other BBV/STIs) may also need to be reconsidered for this population due to the multiple potential avenues for transmission of BBVs and STIs. HIV prevention strategies need to target not only injecting behaviour but also sexual health and the potential for infections to be spread through burns and other skin lesions, as these are a risk for blood-borne viruses and also infective endocarditis. Sexual health messages around STI prevention need to particularly target those who do not concurrently use opioids as a high risk group. Reaching this group is challenging because many do not inject drugs, hence do not have contact with NSPs or other injecting-related outreach services. GPs would be one possible way of accessing this group because most reported receiving sexual health testing through their GP, and generally they had high levels of GP contact.

Key points

Improving treatment coverage and providing health services for methamphetamine use in the ACT needs to consider:

How existing treatment services are being used

Overcoming existing barriers to treatment (knowledge of services, wait-times)

Ensuring a breadth of services, including 'low threshold' services, to engage with people who do not want to reduce their drug use

The capacity of treatment and other health services to support people who use methamphetamine (e.g., capacity to manage suicide risk, depression, paranoia)

The effectiveness of treatments being provided for methamphetamine dependence

Links between treatment and broader mental health, legal and social welfare services

Options for therapeutic jurisprudence to reduce incarceration rates

HIV, hepatitis and other BBV/STI prevention approaches to be modified to consider multiple potential routes of transmission (sexual risk, pipe smoking and injecting)

4.3 Limitations

How representative is the sample?

The key limitation of our research is that it was based on a snow-ball sample of people who used methamphetamine within the ACT. Being a hidden population, we are not able to verify the representativeness of the survey sample.

The likely representativeness of our sample was bolstered by having a reasonably large sample size for a small geographic area, and a variety of recruitment points from which we sampled through chain referral. However, the low socio-economic nature of the sample, and relatively higher recruitment rates via particular services (e.g., NSPs), and high rates of OST enrolment in the sample, suggests that our sample may have been biased toward this end of the population. This bias also reflects that fact that the survey was conducted *during* work hours (Monday to Friday) and participants were reimbursed for their participation, and therefore *would* have been more accessible and appealing to people who were not employed.

It also seemed that younger crystalline methamphetamine smokers were difficult to access via our recruitment methods, suggesting that this cohort may have been under-represented. It may have been that, because these people were more likely to be employed, they were less able to complete a survey during weekdays. This cohort may also have more to lose by disclosing their illicit methamphetamine use, or they may be more concerned about being recognised as someone who uses methamphetamine, with many not having had previous contact with specialist AOD services. Comparison of our survey data (20% smoked crystalline methamphetamine) with ACT drug treatment data (41% of methamphetamine treatment episodes involved smoking crystalline methamphetamine) suggests an under-representation of crystalline methamphetamine smokers.

In sum, it seems quite likely that our sample was biased toward people who used heroin or other opioids, particularly those with lower socio-economic status, and away from the younger cohort of crystalline methamphetamine smokers, which we found evidence of, including those who would be higher functioning consumers and employed. On the other hand, polysubstance use is a well-documented phenomenon amongst people who use methamphetamine, as is the overlap with the opioid-using population^{51-54,55,56,57} and both tend to coalesce with disadvantage. Constraining the sample to participants who did not use opioids would merely provide a biased view of the population who use methamphetamine. The view provided by our sample, in contrast, reflects an actuality of methamphetamine use among people who inject opioids, including those who are enrolled in OST.

Do the findings apply to people who use methamphetamine only occasionally?

Our results apply to individuals who use methamphetamine at least monthly, and not less often. People who use methamphetamine at least monthly represent a small proportion of all consumers of methamphetamine. For example, around 6-7% of Australians have ever tried methamphetamine, but only 1-2% have used in the past year. Of past year users, only around one-third have used at least monthly.²⁰

We targeted individuals who were using methamphetamine at least monthly for pragmatic reasons. While the vast majority of people who have tried methamphetamine have not used the drug regularly, it is difficult to examine patterns of use and related health service needs amongst people who have not used the drug recently. Past month use provides a window within which we could obtain reliable self-report about current use levels, dependence and related harms.

Amongst this group of more regular methamphetamine users, we found half were dependent on the drug. This is similar to previous community-based samples of people using methamphetamine at least monthly. For example, a similar survey in Sydney found 56% of people using methamphetamine at

least monthly were dependent (using the same criteria as in this study).^{5,99} Our results are also consistent with the NDSHS, where around half to two-thirds of individuals who used methamphetamine monthly reported using the drug weekly or more often²⁰ (a proxy for heavy or dependent methamphetamine use). The results are also generally consistent with high levels of dependence seen among people who have used the drug more often (e.g., Sara and colleagues⁹⁹ found that nearly half of those individuals who had used stimulants on five or more occasions met the criteria for a stimulant use disorder).

Is self-reported drug use valid?

The validity of self-reported illicit drug use is often questioned, although it has been shown to be reliable when confidentiality was assured as it was in this study.¹⁰⁰ Naturally, there is a possibility that participants who had not used methamphetamine may have enrolled in the study to obtain remuneration. To offset this risk, we assured participants that they would be free to participate regardless of their past month drug use (with past month drug use forming the basis for most of our analyses). However, there remains a question about how accurately participants could recall events, *although* most of the questions related to the past month and have been validated for use in survey research with people who use illicit drugs. Where participants were intoxicated or unable to concentrate sufficiently to complete the survey, the interview was terminated and the data not included in the analysis.

Key points

The survey sample was biased toward older opioid injectors of low socio-economic status and away from younger crystal methamphetamine smokers

The results should *not* be generalised to people who use methamphetamine less than monthly

Despite the limitations of self-report, it is sufficiently reliable when surveys are confidential, and validated measures are used, as was the case in this study

4.4 Conclusion

This was the first in-depth study of methamphetamine use to be conducted in the ACT. It has revealed that, although levels of use are not elevated relative to other parts of Australia, there are a substantial number of people in the ACT who use crystalline methamphetamine on a regular basis, around half of whom are dependent on the drug. We found evidence of two relatively distinct populations of people who used methamphetamine: older people who injected heroin, who were also using crystalline methamphetamine as a pattern of polysubstance use, and a younger cohort of relatively recent initiates to methamphetamine use who primarily smoked the drug. Although these populations have different policy implications, they shared in common high rates of dependence; many had poor mental health, and multiple other social and welfare needs. Most of these people were not engaged with existing specialist alcohol and other drug services to get help for their methamphetamine use, relying instead on primary health care or other generic services.

In sum, the findings from this research suggest that there is a significant opportunity to optimise services to engage with, and respond to the needs of, people who use methamphetamine. Providing more treatment places is likely to be a necessary part of the solution to this situation, but it will be more important to engage with consumers to inform them of the services available, and to make sure that those services meet their needs.

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6 Appendix 1

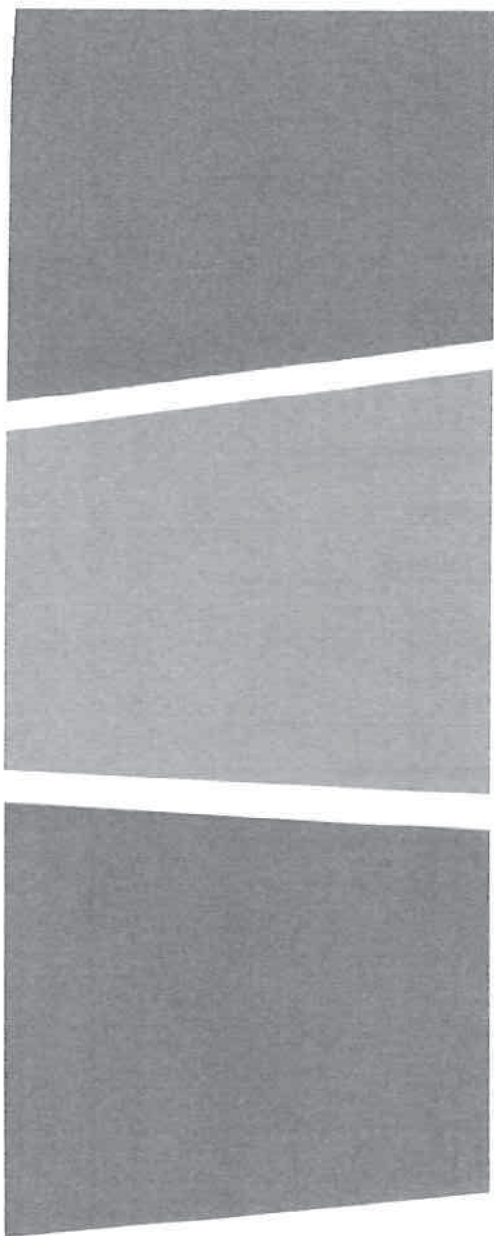


Source: Australian Bureau of Statistics, Australian Standard Geographical Classification 1260.0

7 Appendix 2

Offence Categories

Offences against the person:	Murder Conspiracies and attempts to murder Manslaughter and driving causing death Assault Other acts intended to cause injury Sexual assault Non-assaultive sexual offences
Dangerous or negligent acts endangering persons:	Dangerous or negligent operation of a vehicle Other dangerous or negligent acts endangering persons
Robbery and extortion:	Robbery (aggravated or non-aggravated) Blackmail and extortion
Theft and related offences:	Break and enter Motor vehicle theft and related offences Theft (except motor vehicles) Receiving or handling proceeds of crime Illegal use of property (except motor vehicles)
Deception and related offences:	Fraud, forgery or false financial instruments Counterfeiting currency and related offences Dishonest conversion Bribery Other deception offences (e.g., misrepresentation of profession)
Property damage and environmental pollution:	Property damage (e.g., graffiti) Environmental pollution (e.g., noise pollution)
Public order offences:	Disorderly conduct (e.g., conspiracy) Regulated public order offences (e.g., prostitution)
Illicit drug offences:	Import or export illicit drugs Deal or traffic in illicit drugs Manufacture or cultivate illicit drugs Possess and/or use illicit drugs Other illicit drug offences
Road traffic and motor vehicle regulatory offences:	Driving licence offences Road vehicle registration and roadworthiness offences Regulatory driving offences (e.g., DUI, speeding) Pedestrian offences
Offences against justice procedures:	Breach of justice order (e.g., breach of bail) Other offences against justice procedures (e.g., resist arrest) Offences against Government security Offences against Government operations
Other:	e.g., Weapons and explosive offences Abduction and related offences Harassment and related offences Public health and safety offences Commercial/industry/financial regulation Immigration regulation offences



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