



# WASUA

## WESTERN AUSTRALIAN

## SUBSTANCE USERS

## ASSOCIATION



# A user's guide to Ice.

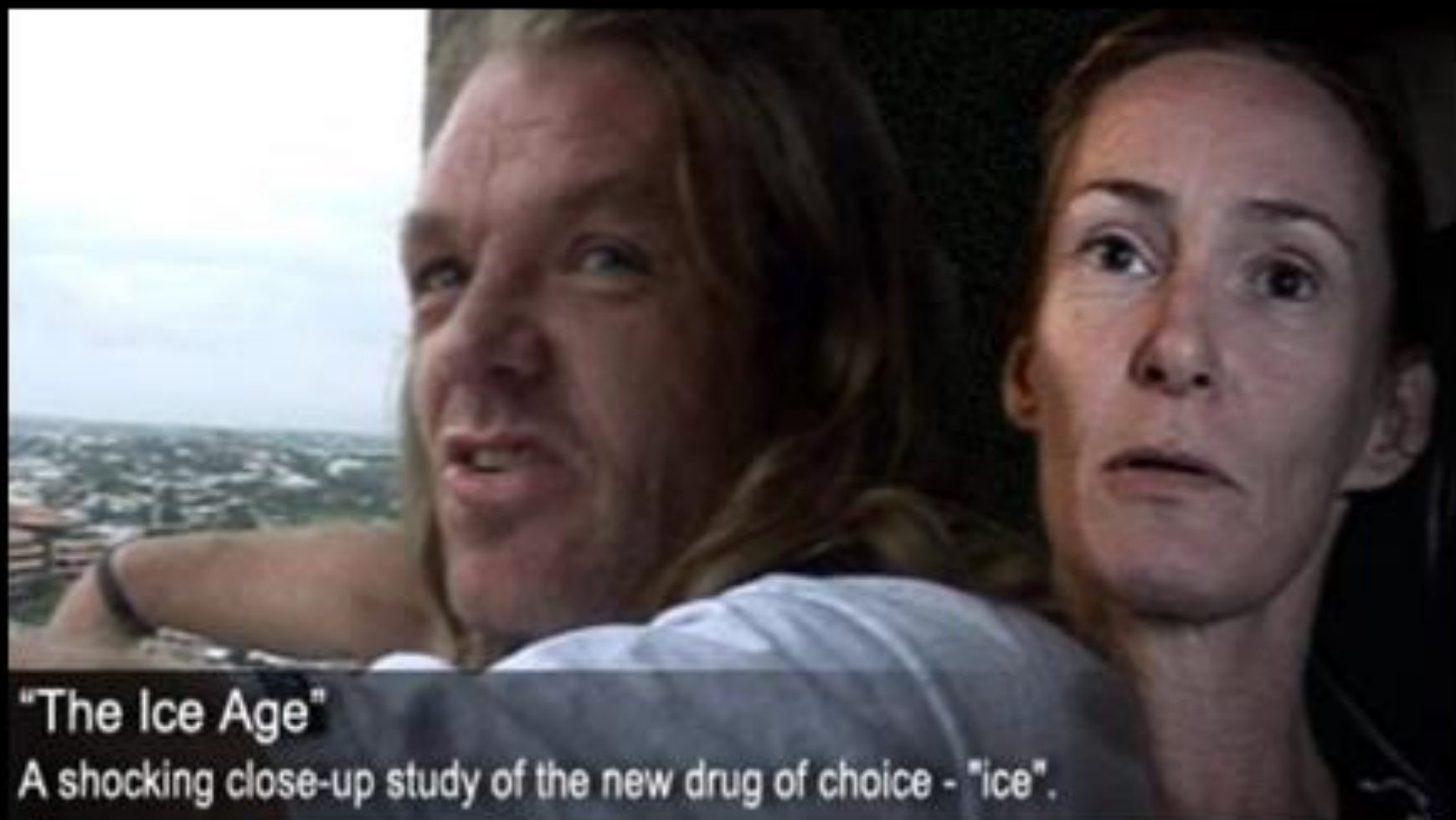
## The Western Australian Methamphetamine Forum, 2015.

Are we really experiencing a  
*“methamphetamine epidemic”*?

# ICE AGE

Produced by ABC Australia





## "The Ice Age"

A shocking close-up study of the new drug of choice - "ice".



**60**  
MINUTES



Australia - gripped by an ice age?



# ICE EPIDEMIC



**A CURRENT  
AFFAIR**

# Ice addict 'gouged out eyes and ate them'

This story was published: 17 DAYS AGO | MAY 23, 2015 10:26AM



Australia's ice epidemic

**AN ice addict in a hospital emergency department gouged out his own eyeballs and ate them, a Federal Liberal MP has revealed.**

The horrific story was revealed yesterday at an Ice Summit on the Central Coast organised by the Express Advocate to address the epidemic in the region.

Dobell Federal Liberal MP Karen McNamara relayed the story as she opened the

*Federal Liberal MP Karen McNamara relayed the story as she opened the summit before a packed auditorium this morning.*

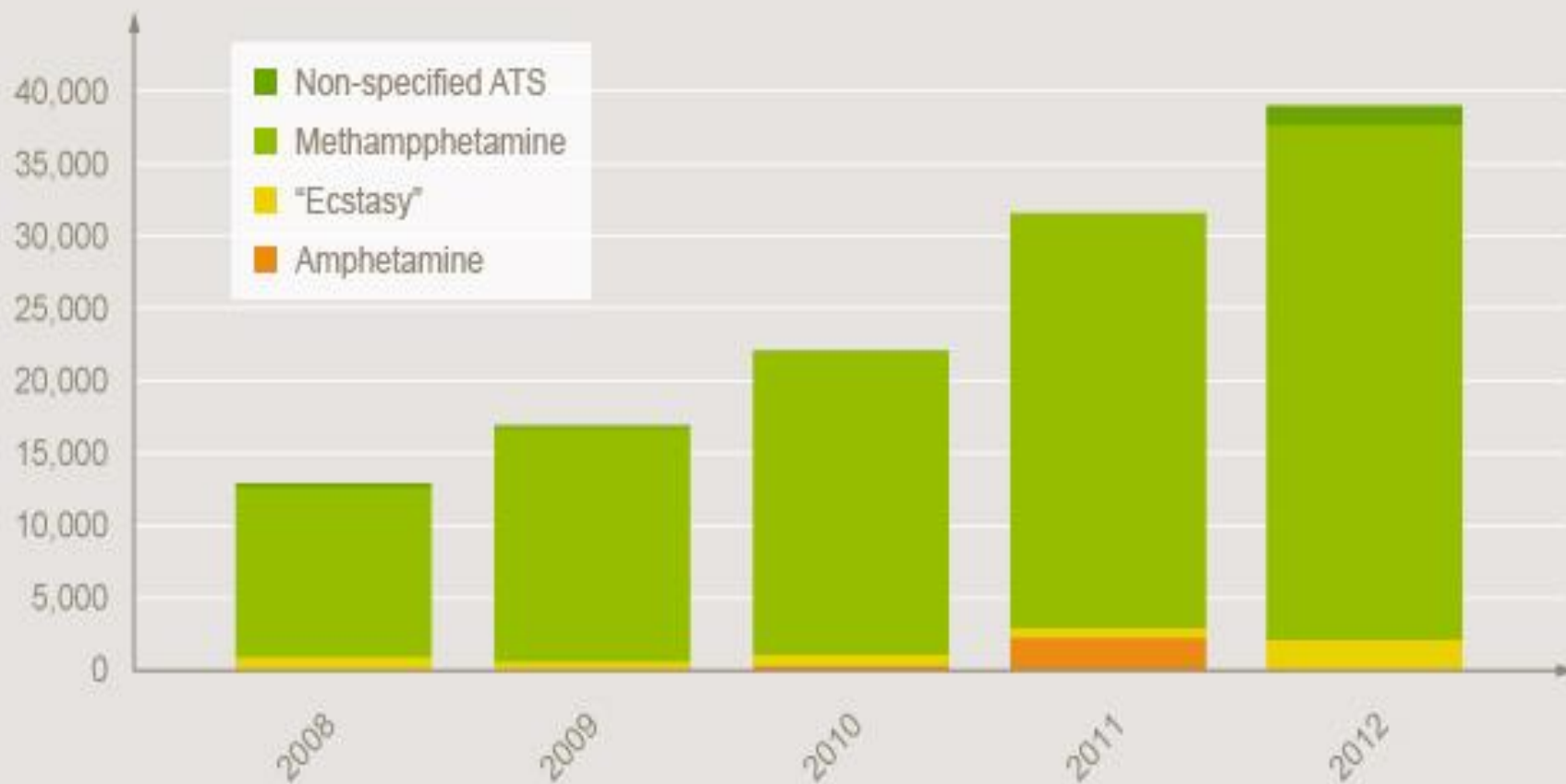
*"There is nothing at all recreational about this drug," Ms McNamara said.*

*"Let me tell you a story that demonstrates this ... about a young boy taken into an emergency department for treatment who gouged out his own eyeballs and ate them," she said.*

*"We have to get these kinds of stories out to young people — this is not a recreational drug."*

## Seizures of amphetamine-type stimulants (ATS)

Total ATS seizures reported in East and South-East Asia, Oceania and the Pacific, 2008-2012  
(Quantity seized, kg)



Source: United Nations Office on Drugs and Crime (UNODC)

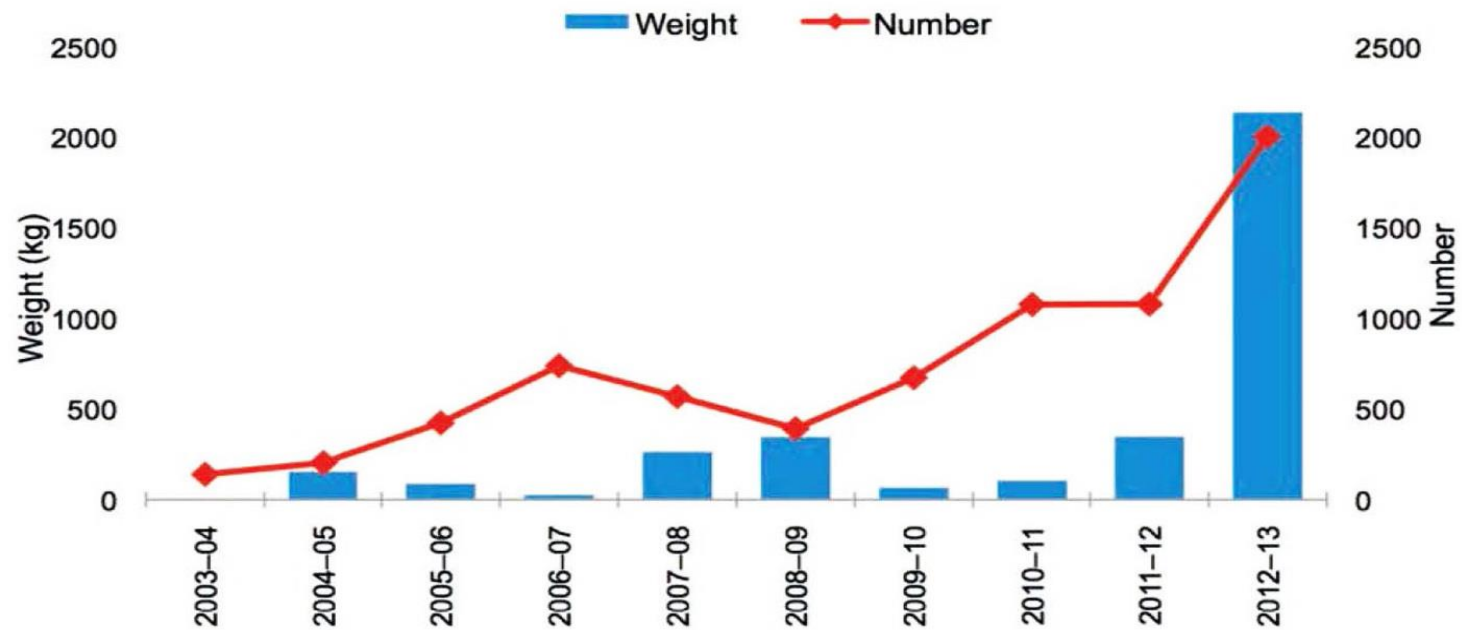








FIGURE 1: Number and weight of ATS (excluding MDMA) detections at the Australian border, 2003–04 to 2012–13 (Source: Australian Customs and Border Protection Service)





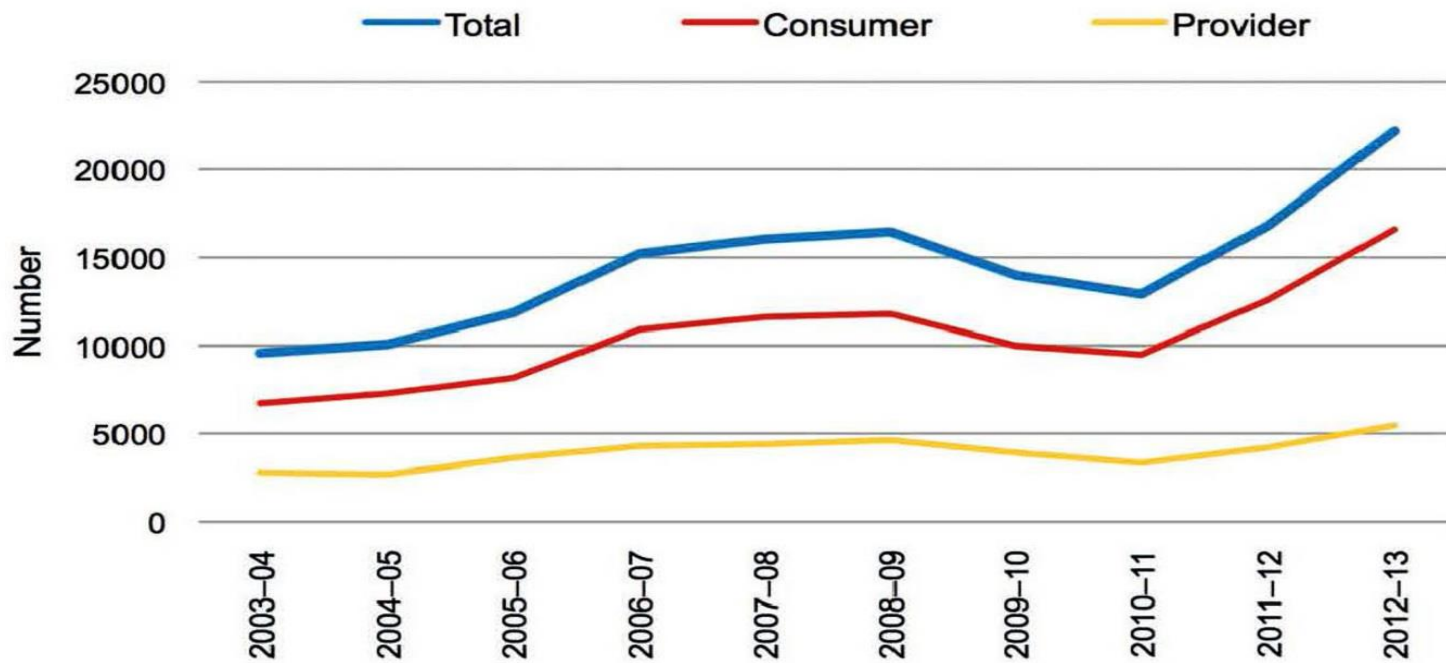
# Project “STOP” and domestic methamphetamine (ICE) manufacture in Western Australia.

- Every year since the commencement of Project STOP, WA Police report detecting significantly increasing numbers of clandestine labs producing methamphetamine.
- Restrictions on the availability of pseudo-ephedrine, in a state with a high per-capita demand, has simply “devolved” local production of methamphetamine to expedient “shake and bake” labs. **90% of these “addiction-based” labs produce  $\leq 1.5\text{g}$  of “Ice” per batch, ~50% produce  $\leq 1\text{g}$  per batch.**

<https://au.news.yahoo.com/thewest/a/9717825/clan-labs-addiction-based/>



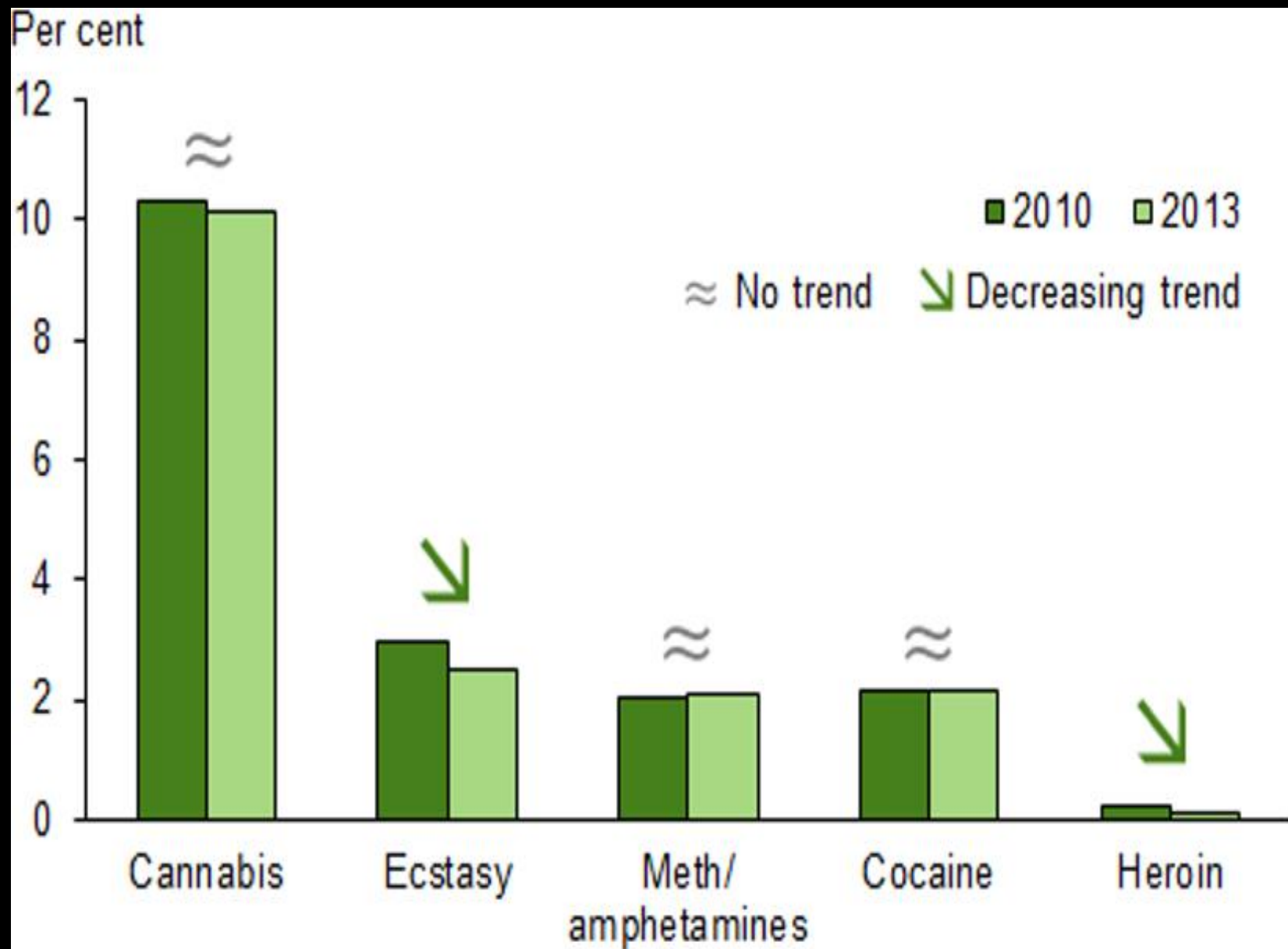
FIGURE 18: Number of national ATS arrests, 2003–04 to 2012–13



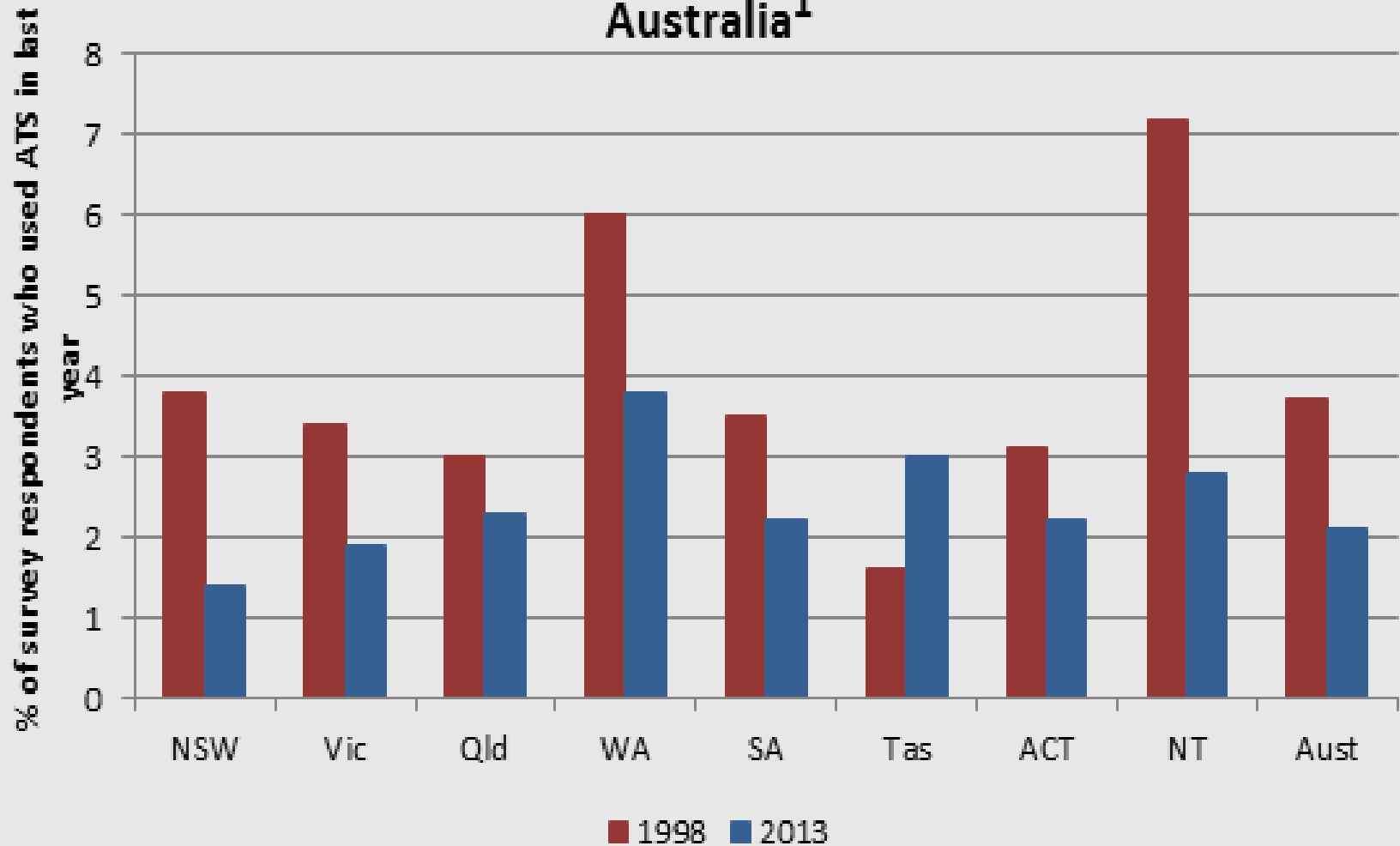
# 1998-2004 Household Survey (WA)

Drug	1998		2001	2004	
	Ever used?	Recent	Recent	Recent	Ever used?
	%	%	%	%	%
Alcohol	90	81	83	84	91
Tobacco	65	26	23	21	47
Cannabis	39	18	13	11	34
Hallucinogens	10	3	1	0.7	8
Amphetamines	9	6	4	3	9
Benzodiazepines	6	3	1	1	3
MDMA	5	2	3	3.5	8
Inhalants	4	1	0.4	0.4	3
Cocaine	4	1	1	1	5
Heroin	2	1	0.2	0.2	1.4





## Recent amphetamine-type stimulant use across Australia<sup>1</sup>



Per-capita use has dropped significantly in all states except Tas, but problems have increased. Why?

## Methamphetamine Presentations: Powder, Base, Crystal.

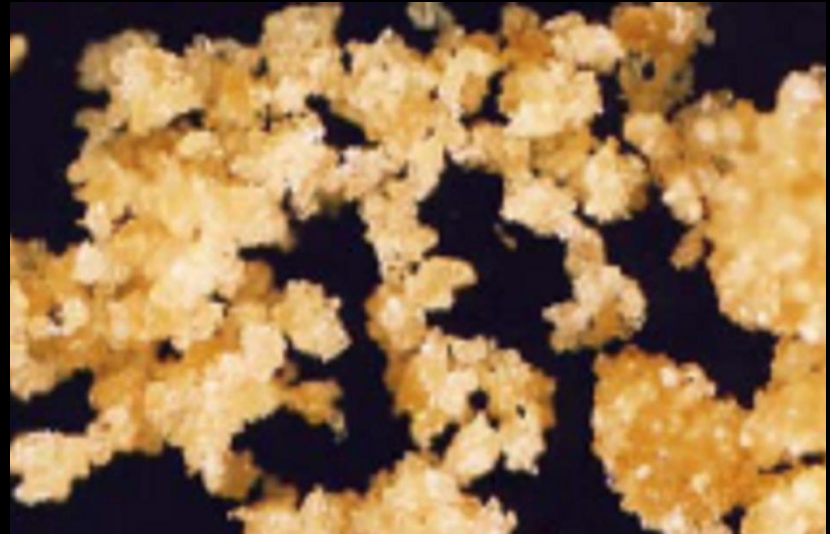
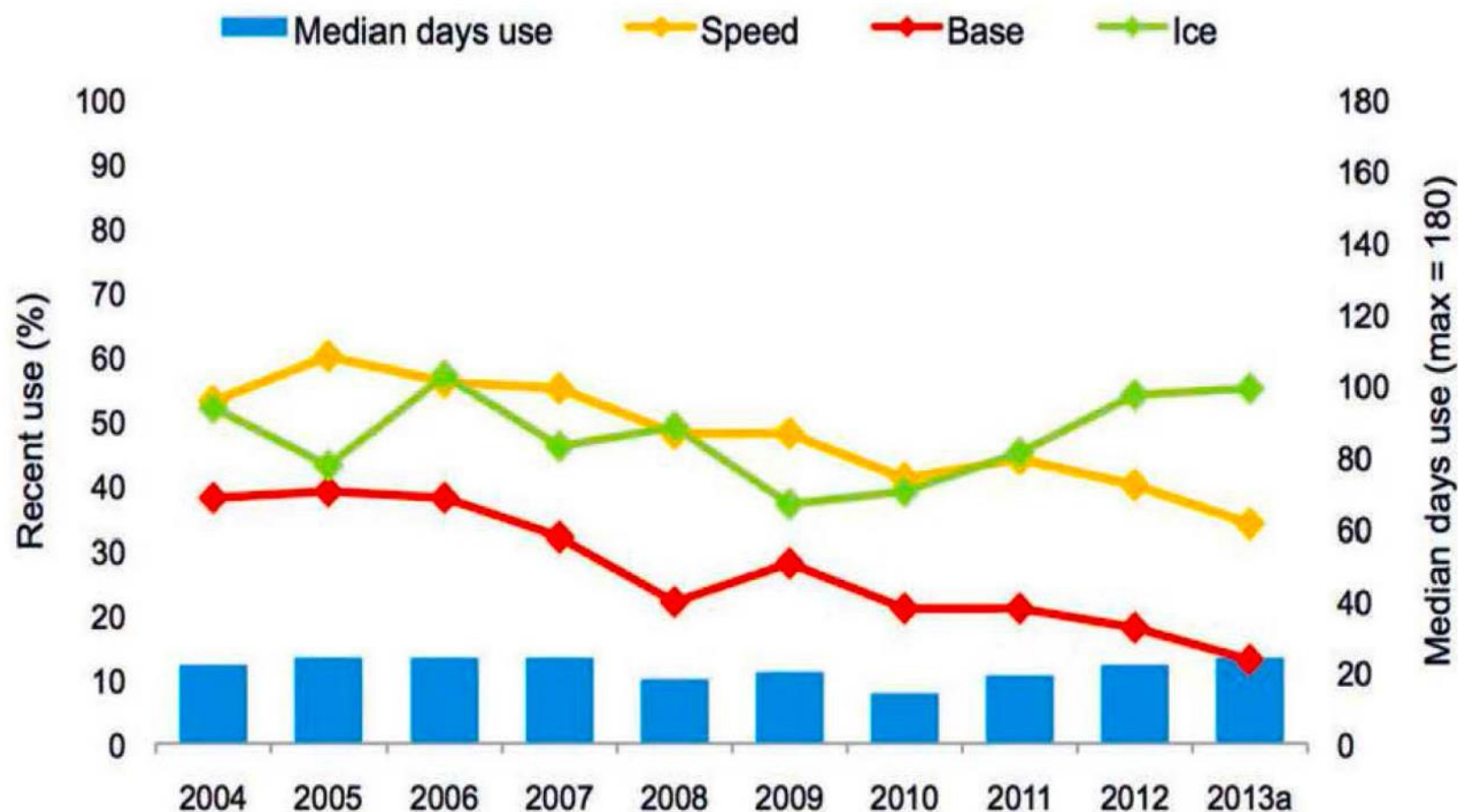


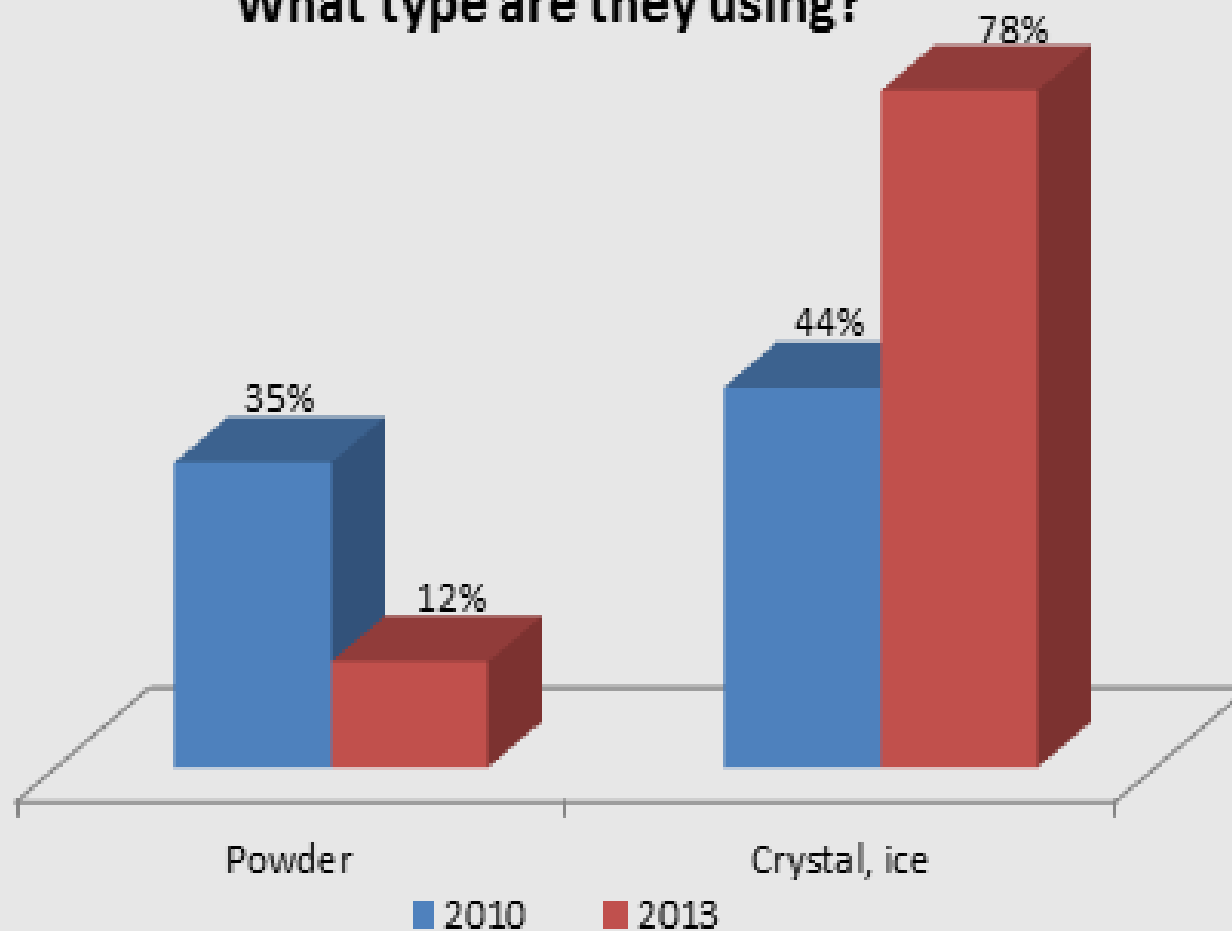


FIGURE 7: Proportion of a regular injecting drug user population reporting recent use of speed, base and crystal/ice compared to median days of use of any form of methylamphetamine, 2004 to 2013 (Source: National Drug and Alcohol Research Centre)

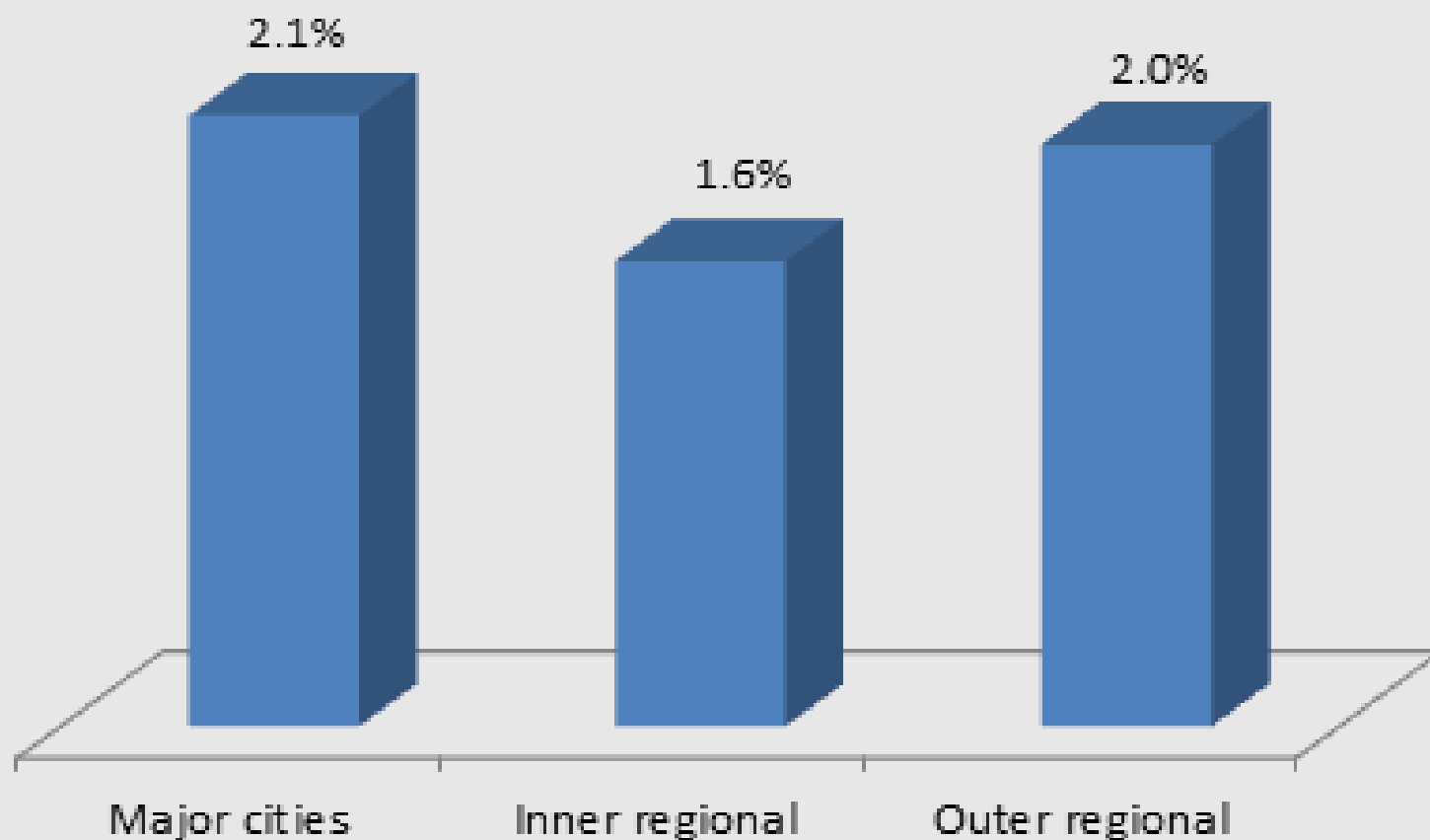


a. Note: Reported figures for 2013 are preliminary.

**Recent amphetamine-type stimulant users, WA<sup>3</sup>**  
**What type are they using?**



## Recent amphetamine-type stimulant use by location, Australia 2013<sup>6</sup>





- In 1970 10 billion amphetamine tablets were being produced (globally) every year by pharmaceutical companies.
- 50 to 90% of these pills were diverted into the black market.
- World Health Organization statistics make it clear that Australia was already a world leader in non-medical consumption of amphetamines (1978 survey: 4% reporting non-medical use in prev 12 months).



### why is this woman tired?

She may be tired for either of two reasons:

- because she is physically overworked. If this is the case, you prescribe rest, because rest is the only cure for this kind of physical tiredness.
- because she is mentally "done in". Many of your patients—particularly housewives—are crushed under a load of dull, routine duties that leave them in a state of mental and emotional fatigue. For these patients, you may find 'Dexedrine' an ideal prescription. 'Dexedrine' will give them a feeling of energy and well-being, renewing their interest in life and living. Dexedrine\* (dextro-amphetamine sulfate, S.K.F.) is available as tablets, elixir, and Spansule\* capsules (sustained release capsules, S.K.F.) and is manufactured by Smith, Kline & French Laboratories, Philadelphia.

\*U.S. Reg. U.S. Pat. Off.      Patent Applied For.

## W.H.O. Prevalence of Illicit Amphetamine Use in English-Speaking Industrialized Nations. 1983

- United Kingdom (surveyed 1977) 1/1000
- United States (surveyed 1980) 9/1000
- Canada (surveyed 1975) 30/1000
- Australia (surveyed 1978) 40/1000

Throughout the 1970's the Australian black market in amphetamine was amply supplied by pharmaceutical companies' overproduction.

As regulation became more effective, black market chemists began illegally producing dexamphetamine sulphate to meet the demand, using legally available precursors.

During the late 1980s, a combination of factors (increased regulation of legal dexamphetamine, restricted access to precursors, + black-market dynamics) led to methamphetamine dominating the illicit stimulant market in Australia.



# Prescribed amphetamine



## New life for the living

When the patient resigns himself to mere existence during the middle period of life, depression can so easily get the upper hand. The seemingly endless, daily routine of living is approached with apathy, inertia and lack of interest; and the patient's own outlook on life drags him down the path to eventual break-up—physical as well as mental.

For such a patient 'Dexedrine' Sulfate is of unequalled value. Its uniquely "smooth" antidepressant effect restores mental alertness and optimism, induces a feeling of energy and well-being. By helping to revive the patient's interest in daily affairs, 'Dexedrine' has the happy effect of bringing back life for the living. Smith, Kline & French Laboratories, Philadelphia

## Dexedrine\* Sulfate

the antidepressant of choice • tablets • elixir

\*E.M. Roy, U.S. Pat. Off. For Dexedrine-sulfate tablets, S.K.F.

**'Amphedroxyn Hydrochloride'**  
(Methamphetamine Hydrochloride, *Lilly*)

One Fl. Oz. (473 cc.) No. 248  
**ELIXIR AMPHEDROXYN HYDROCHLORIDE**  
(Methamphetamine Hydrochloride, *Lilly*)  
2.5 mg. per 4 cc.

Contains Alcohol 3 Percent  
Contains 100 cc.

**Indications:**  
Contraindicated in combination with other stimulants, especially when associated with hypertension, hyperthyroidism, and other conditions in which stimulation is contraindicated.  
**CAUTION:**—To be dispensed only to patients on the prescription of a physician.

100 cc. No. 1712  
**Tablets AMPHEDROXYN HYDROCHLORIDE**  
(Methamphetamine Hydrochloride, *Lilly*)  
5 mg.

100 cc. No. 1712  
**Tablets AMPHEDROXYN HYDROCHLORIDE**  
(Methamphetamine Hydrochloride, *Lilly*)  
5 mg.

**CAUTION:**—To be dispensed only to patients on the prescription of a physician.

**ELI LILLY AND COMPANY INDIANAPOLIS, U.S.A.**

IS OFTEN PREFERABLE TO OTHER FORMS OF AMPHETAMINE—  
because—  
smaller doses produce longer cerebral stimulation, with a minimum of undesirable excitement and other side-effects.

When patients with depression, narcolepsy, alcoholism, or obesity are selected as suitable cases for stimulant therapy, 'Amphedroxyn Hydrochloride' is a prudent choice of drug.

Detailed information and literature on 'Amphedroxyn Hydrochloride' are personally supplied by your Lilly medical service representative or may be obtained by writing to  
Eli Lilly and Company, Indianapolis 6, Indiana, U.S.A.

*Lilly*  
SINCE 1876



# Illicitly produced dexamphetamine





# Illicitly-produced methamphetamine



**One “point”= 0.1g = 100mg = \$100.00**





## Current trends;

**Approximately 2.1% of Australians have used methamphetamine in the last 12 months.**

**In WA about 3.7% of people have used meth in the last 12 months.**

**Approximately 25% of those Australians who have used meth in the last year have done so once a week or more frequently.**

**75% of meth users in Australia use less often than once a week.**

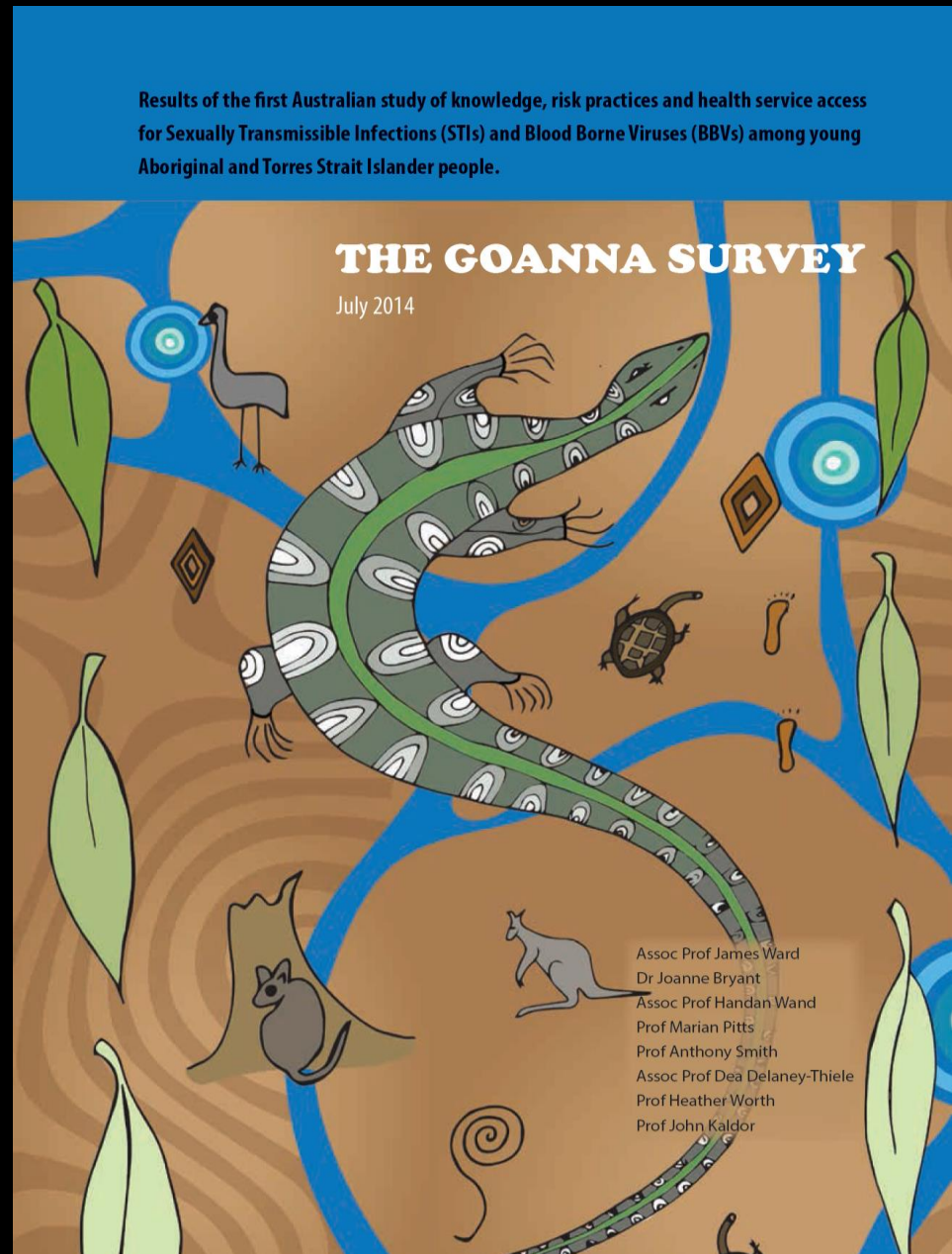
**70% of meth users in Australia use less often than once a month.**

Aboriginal Australians have significantly higher rates of HCV infection than non-Aboriginal people.

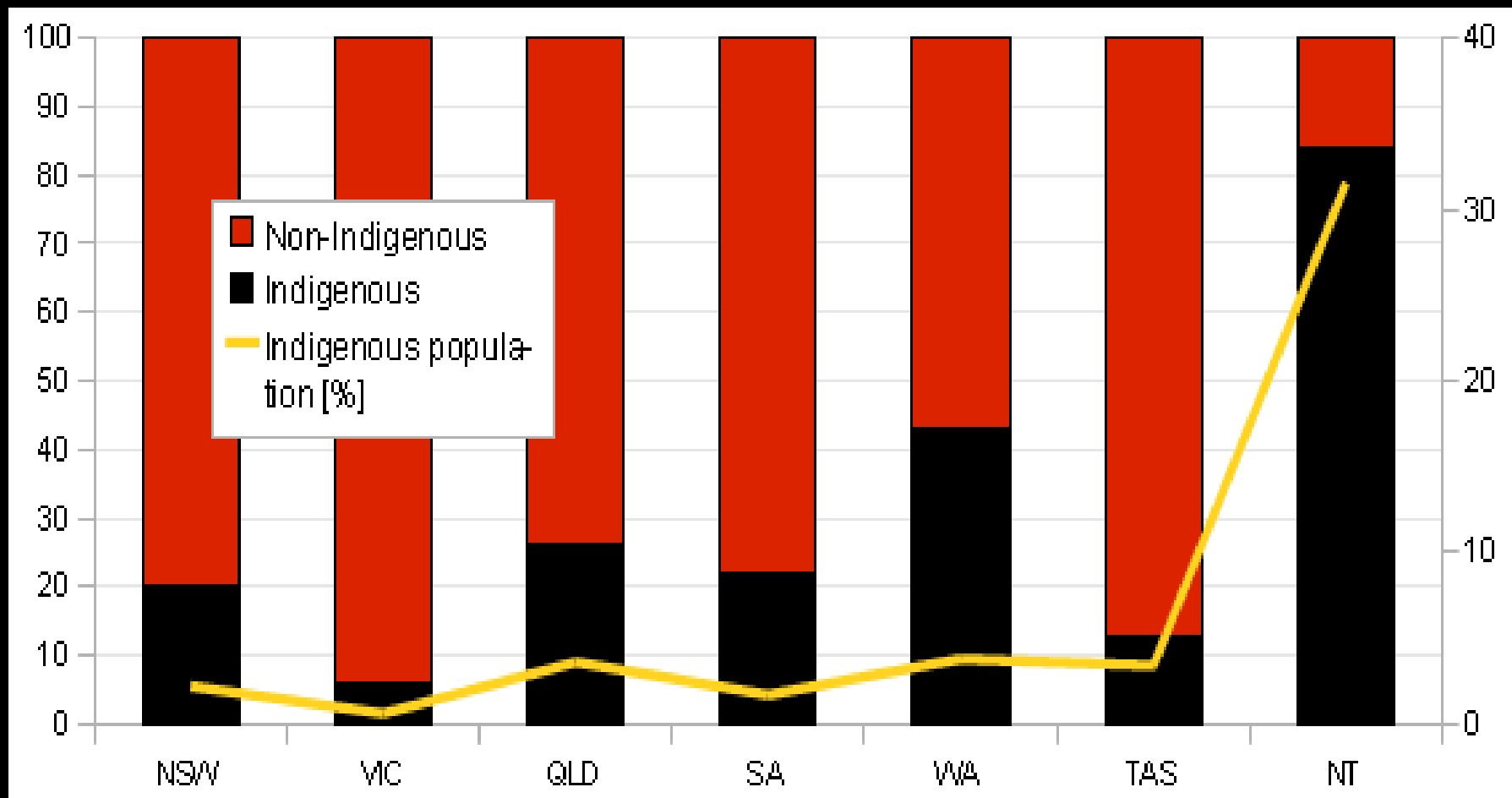
In WA the “new-notification” rate amongst Aboriginal people is 7 x that for non-Aboriginal people.

However Aboriginal people (per-capita) are not 7 x more likely to inject drugs than non-Aboriginal people.

While Aboriginal people in regional areas have even lower rates of injecting use, those who do inject are far more likely to share syringes and other injecting equipment.

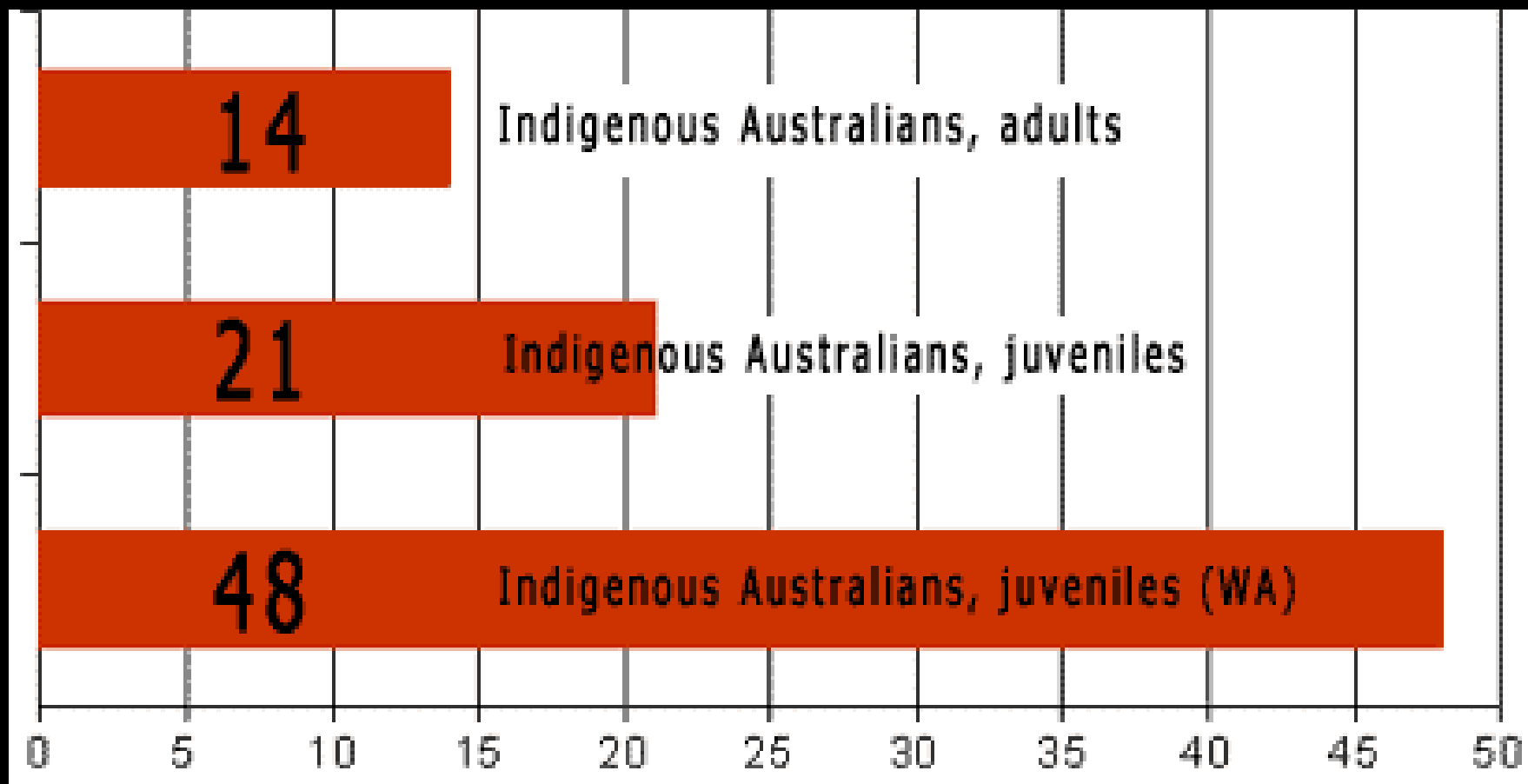






**The bar graphs show the percentage of Aboriginal and non-Aboriginal prisoners in each state or territory, (*read from left vertical axis*).**

**The yellow line indicates the percentage of Aboriginal people in the population of each state or territory, (*read from right vertical axis*).**



**In Australia, an Aboriginal adult is 14 x more likely to be incarcerated than a non-aboriginal person convicted of the same offence(s).**

**In WA they are 20 x more likely to be incarcerated.  
Juveniles in WA are 48 x more likely to be imprisoned than their non-aboriginal peers.**





“...so, yeah, I could tell it was the same fit he’d given me when I was on my last lag.  
That’s, like, more than a year before, like 15 months or more...”

J.D. Recent inmate, 2012

14/02/2012



# Understanding Methamphetamine-related harm.



## Four broad categories that influence outcomes.

- Dose, and Frequency of use/pattern of use.
- Route of administration.
- Physical Health;
  - Nutrition
  - Hydration
  - Sleep
- Individual vulnerabilities.
- Environmental factors, (both physical and social).



## Dose, and frequency or pattern of use;

The most significant factors in terms of physical health are the dose and pattern of use. Research shows users who use once per week or more often, and in larger doses, are significantly more likely to experience problems. Users who use less than ~50mg, less often than once per week, are typically much less likely to experience any serious adverse effects.



❖ Because Meth can remain active in the body for 12-24 hours, dosing more than once per day greatly increases the risk of toxicity.



# ATS may cause Acute or Chronic problems;

## ❖ Chronic Problems;

- Dependence, tolerance, withdrawal.
- Poor general health-  
↓immunity, skin infections, dental problems.
- Problems with mood, concentration, memory.

## ❖ Acute Problems (toxicity);

- Induced Psychotic Break.
- Cardiac infarction.
- Stroke.
- Hyperthermia.
- Seizure (fitting).



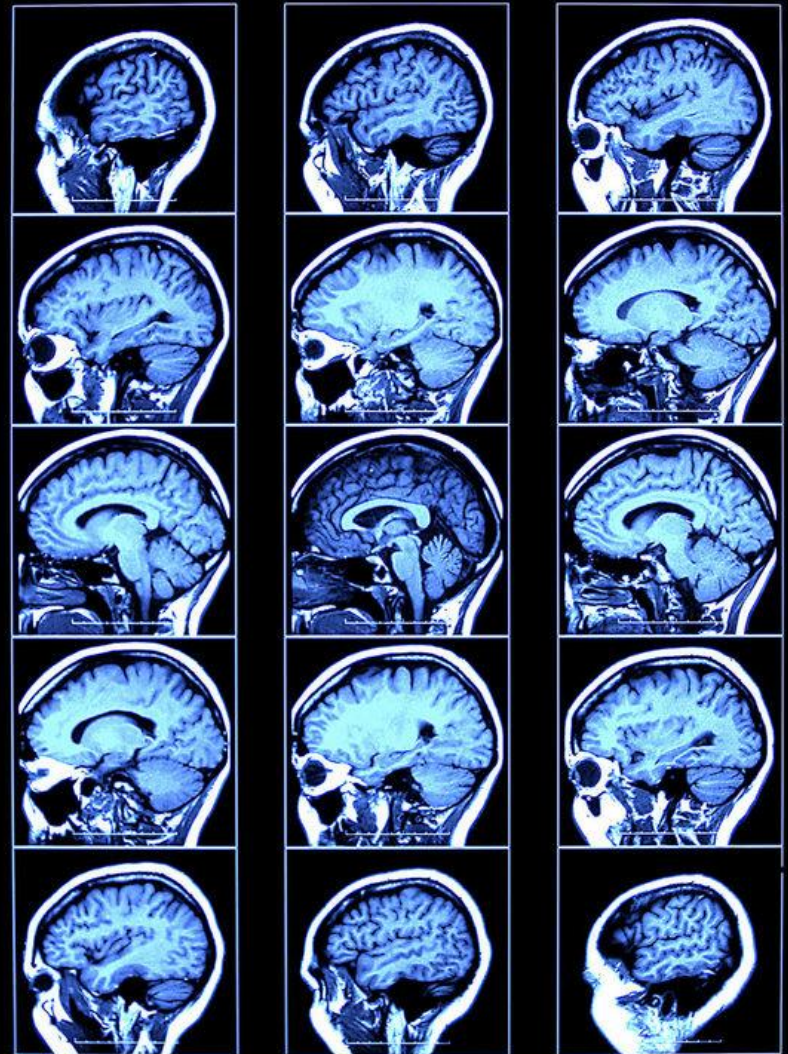
## **Mental Health problems associated with Meth dependence and withdrawal;**

- While media attention is focussed on psychosis, this is not the most prevalent problem amongst chronic users.
- Problems with mood control, depression and anxiety, concentration and memory, dysthymia (lack of energy/enthusiasm) and anhedonia (inability to enjoy simple pleasures) are far more typical, and may last for some months after ceasing use.
- These factors make relapse rates very high.



# Mental Health problems associated with Meth dependence and withdrawal;

- Chronic use down-regulates dopamine, serotonin, and (nor)-adrenaline. This is “neuroadaption”.
- Long-term use also can cause axonal pruning. This is damage to the connections between brain cells.
- Withdrawal symptoms relating to neuroadaption can last for two to three months.
- Urges to relapse relating to conditioned cues can re-occur for many months.
- Withdrawal symptoms relating to axonal pruning can persist for 3 to 9 months.





## Acute problems;

- Acute problems are caused by toxicity (i.e. “amphetamine overdose”).
- Responding to toxicity-induced cardiac problems, stroke, hyperthermia, or seizure as a first-aider is largely the same as responding to these problems when they are *not* induced by Methamphetamine.
- Responding to meth-induced psychosis as a first aider is identical to responding to an episode caused by mental illness.



## Harm Reduction messages specific to Physical and Mental Health can be organized into four broad categories.

- Dose, and Frequency of use/pattern of use.
- Route of administration.
- Physical Health;
  - Nutrition
  - Hydration
  - Sleep
- Environmental factors, (both physical and social).



## Harm-Reduction messages should include;

- Pay attention to your general health. Try to eat healthy food every day. Make sure you drink enough water. Get some rest regularly.

Not sleeping enough, being dehydrated, or being malnourished all make problems much more likely.

- Be aware of yourself and be aware of your level of drug use. Use with friends you trust. Listen to what they tell you. Pay attention to any changes you are experiencing. If you need to, ask for help.



*“you wouldn’t try to run a marathon if you hadn’t slept or eaten for three days, would you?”*



## **Use peer education to access “difficult to reach” populations, and to effect behavioural change.**

**Methamphetamine users represent a very diverse cross section of the community.**

Recruiting peer-workers from specific target populations is the most effective way to engage people and then to convey education in a way that is appropriate and credible. Peer-to-peer education can be highly effective and is cheap to implement.

**Pragmatic harm reduction education should focus on;**

- **Attention to physical health,**
- **Understanding what factors increase risk of harm,**
- **Timely recognition of warning signs that something is going wrong,**
- **First aid responses to acute physical health emergencies**
- **De-escalation and “verbal judo” skills**
- **Knowledge of available supports**
- **Encourage willingness to call an ambulance**
- **Encourage willingness to seek treatment**

# Treatment Options

**Counselling, CBT and some other “talking” treatments can help meth users to abstain. However, many meth users seeking assistance do not wish to abstain from use altogether or forever. Younger users often want help to take a break, and/or to reduce their level of dependence. They still enjoy the positive aspects of meth use. They simply wish to get things back under control.**

**The fact that many users don’t want total abstinence highlights the importance of harm reduction strategies, and the difficulties with engagement point to the importance of consulting users, and/or employing peer workers who are from meth-using backgrounds themselves.**

**If we want to engage dependent meth users in treatment, we need to offer treatment that actually improves the person's quality of life.**

**For many meth users, the desire for treatment may not always mean a desire to abstain totally, or forever.**

**It is very common for amphetamine dependence to spontaneously remit as the person enters their early to mid thirties.**



**Withdrawal from highly dependent use of methamphetamine can be very protracted, with symptoms persisting for several months.**

**Lack of energy, dysthemia and anhedonia, loss of sex drive, and problems with concentration, memory and mood are powerful drivers to relapse.**

**After someone has de-toxed, the availability of occasional counseling or other psycho-social supports in the community can be very useful.**

**The severity of the withdrawal syndrome varies greatly from person to person, but generally the dose, frequency of use, and duration of use are good predictors of what will happen when the person abstains.**

**Gradually reducing the dose and frequency of use for several weeks before attempting complete abstinence greatly reduces the severity and duration of withdrawals.**

**However, it is typically very difficult for someone using street drugs of varying potency, without supervision, to maintain a consistent reduction regime.**

# Pharmaceutical Treatment Options

Currently, there is no available “replacement pharmacotherapy” for treating severe cases of methamphetamine dependence.

Benzodiazepines and/or antidepressants (typically an SSRI or SNRI) are sometimes prescribed to people withdrawing from methamphetamines, recent trials of buprenorphine treatment.





## Agonist Replacement Therapy

- ❖ Oral doses of Methamphetamine, (Desoxyn).
- ❖ Oral doses of Dexamphetamine.
- ❖ Oral doses of sustained-release Dexamphetamine, or Lisdexamfetamine.
- ❖ Methylphenidate, (Ritalin).
- ❖ Non-amphetamine type stimulants, (Modafinal, Zyban).

A.R.T. would lead to a much higher level of engagement in treatment. Trials conducted to date with Dex consistently show improvements on all of the the same indicators as with Methadone in opiate dependence.



## What doesn't work?

**Arresting or imprisoning people whose primary issue is a drug problem or mental health problem.**

**Poorly designed or implemented prevention campaigns;** *Mass media “scare” campaigns*

*“Drug-proofing” your children, “Shock & Awe” School drug ed.*

**Short term detoxification**

**Residential programs that lack capacity to effectively engage and treat ATS users, or that lack follow-up and support post treatment**

**Naltrexone implants, “rapid detox”**

# What does (or might) work?

**Diversion to treatment, Drug Court**

**Well designed and implemented prevention campaigns;** *Evidence-based school drug education*

*Evidence-based campaigns targeted at specific at-risk communities or individuals*

*Evidence-based campaigns targeted at occasional/recreational users*

**Harm reduction services and education targeted to current users**

**Treatment in the community**

**Long term residential rehab with appropriate follow-up and support**

**Agonist replacement therapy**



What do we want  
**EVIDENCE-BASED  
DECISION-MAKING!**

When do we want it?  
**AFTER PEER REVIEW!**



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CAN hurt you..."*

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