LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Melbourne — 30 September 2013

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The CHAIR — Welcome, Mr Laurence Alvis and Ms Donna Ribton Turner, from UnitingCare ReGen, to the first public hearing of the Law Reform, Drugs and Crime Prevention Committee into the inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. Thank you for your time. You understand that we have media present, and I will just have to read you the rules around the evidence you are providing to this committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of the reciprocal legislation of Australian states and territories. Any comments you make outside the hearing may not be afforded such privilege. Have you received and read the guidelines for witnesses presenting evidence to parliamentary committees?

Ms RIBTON TURNER — We have.

The CHAIR — Thank you. We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. Thank you for your time. We normally allow a brief presentation, then obviously the committee is keen to raise questions, as you have seen with the previous witness, in respect of this inquiry. Thank you, and I leave it to you to present.

Mr ALVIS — Thanks very much. I will start by just giving a little bit of background about what ReGen does and then move on to the issues around methamphetamines. ReGen is a UnitingCare drug and alcohol agency that has actually been running since 1970 in the northern suburbs of Melbourne. In relation to drug and alcohol treatment and education, we are also an RTO, so we do a lot of education around drug and alcohol in relation to running a number of diversion programs plus also training other staff in other drug and alcohol services around some of the competencies. Our major area, though, is the treatment side, and again, as far as drug and alcohol services go, we are one of the agencies that actually provide the whole breadth of services, from when somebody comes through the door right to the point of detox and then follow up day programs. The only program we really do not provide is long term rehab, but we obviously use services like Odyssey House and some of the others in relation to where people need to move on to that.

I am going to briefly talk about the methamphetamine history in relation to how it has been at ReGen. For people who might not know either, for 42 or those 43 years that we have operated, we operated as UnitingCare Moreland Hall, which is probably a much more familiar name to some people. We have only just changed to ReGen in the last 15 months. Donna is the director of clinical services, so she is going to talk more about some of the clinical issues that come up that are different about methamphetamine treatment.

It has been interesting to listen to what John was saying previously and some of the questions. When you talk about the ice crisis, I can remember five years ago the press ringing me and saying, 'There's this new drug ice that's around, and we've got this crisis. Are you seeing this in treatment?'. I was saying, 'No, our numbers have been consistent for probably a number of years, around that 5 per cent or under, for people who are seeking treatment for ice or methamphetamine'. At the same time I made the comment, 'Talk to me in five years, because it usually takes about five years for people to discover that they've got an issue or a problem with a drug and then start seeking treatment'.

Probably for the last two years methamphetamine has been certainly the fastest growing drug that we have been seeing people in treatment for. It was about 5 per cent five years ago. Up to two years ago it just maintained its level that about 6 per cent of people were seeking treatment for methamphetamine. Two years ago it jumped to 12 per cent, and in the last quarter of this year that we have just had — finishing 30 June 2013 — the numbers were up to about 14 per cent.

We did an interesting thing 12 months ago. It is traditional for drug and alcohol services to ask people what their primary drug of use is. Because we were seeing so many more people with poly drug use, we decided 12 months ago that we would start asking people about what was their second drug of use. We were picking up then that although 14 per cent in the last three months of

the year were saying methamphetamine was their primary drug of use, we were picking up another 11 per cent off people who were saying it was their secondary drug of use, which certainly brought up the fact that nearly 25 per cent, or a quarter, of the people who we were seeing were having some involvement with methamphetamine.

I might hand over to Donna now to talk about the clinical side, and especially about some of the trials we have undertaken specifically around methamphetamine use.

Ms RIBTON TURNER — John made a point earlier that a lot of people who are using amphetamines do not come into treatment, and that is absolutely true. We are concerned about the group that are now coming into treatment, and they are a very challenging group. They are challenging because of their behaviours not only while they are intoxicated but also during withdrawal. They are aggressive, and we have seen a real increase in the number of violent incidents that we are dealing with around methamphetamine withdrawal.

There is limited service access. There is limited access anyway for drug and alcohol services, but a number of services are not dealing with methamphetamines not only because of the behaviours but also because there is not real evidence based treatment for methamphetamine. Given that ReGen is one of the few services that are taking people into our residential services, we experience waiting lists — up to two weeks sometimes to have an assessment, and that is not a bed. We have got a six week wait for counselling, and we have got 14 people unallocated who have been referred to us through forensic services for counselling, so there is an additional demand created by this group.

The real concern is the lack of any evidence based treatment. We have got a service system that was really set up around heroin and then adapted around alcohol when we started doing a lot more work with alcohol. For example, the average length of stay in a withdrawal unit is seven days, which is around heroin withdrawal. Over the last six months when we have been doing some investigations into the group of methamphetamine users we have found that they were doing very poorly in treatment. They do not seem to be able to be retained in withdrawal services. For this group, at the end of a seven day admission they were demonstrating withdrawal symptoms sometimes as severe as at the beginning of their stay. People were being discharged at the end of treatment still experiencing withdrawal symptoms and therefore very likely to relapse. It seems that for methamphetamines the withdrawal period is longer, up to six weeks, with the intense period being the first two weeks, the first three days of which is a crash period.

One thing we noticed we were doing — and other services do it as well — is that we have got a fairly intensive program that happens when people come in. It is all about helping them plan what they are going to do afterwards, so groups and all sorts of education sessions. For this group that does not work at all, because all they want to do in those first three days is sleep. They are not really getting any benefit of being in a withdrawal service, except that there is somewhere they can sleep. Then they get up about day three really irritable, really depressed — often suicidal — and that is when a lot of people discharge and go home. Those who are staying the seven days are going home still experiencing withdrawal, and often not engaged in any further treatment. It seems like we have a service system that is not doing anything for this group of people, and that is the concern.

The other group we are concerned about is families. We run a whole range of family programs, and we are getting more and more families coming in really distressed about managing this group of people for a number of reasons. One is aggression, which is really hard for families to manage, followed by periods of severe depression and suicidality, which is equally difficult for parents to manage.

One of the things that families are telling us in our support programs is that more and more they are being involved in legal sanctions for their adult or adolescent children. In some situations people have to live at home. In one case a woman was telling us recently that her son is not allowed to catch public transport but he is going to school, so they have had to rearrange their family life around picking up and driving this 16 or 17 year old to school every day.

It seems like there are great expectations from the courts around families at the same time that the work we are doing with families is often encouraging them to put some boundaries around it, which sometimes involves people not living at home. It is very confusing for families; they are very concerned. They are finding this really difficult.

John or somebody mentioned the Aboriginal community. We have formed a partnership with VAHS, the Victorian Aboriginal Health Service, to try and work better with the Aboriginal people who are diverted out of court. An Aboriginal worker has been employed to work with us on trying to retain people in treatment. But there is only so much you can do with the treatment, which does not match the withdrawal or the presentation of the drug use.

Mr ALVIS — We are talking about voluntary treatment through all of this process, so at any stage anybody can choose to leave treatment. As Donna was saying, one of the things — and we have given you a copy of this — is the fact that it was so concerning to us that there was very little available for methamphetamine treatment, especially in detox. We did a six month study, from January to June this year, just in terms of looking at the specific issues that came up out of methamphetamine treatment. As Donna said, it certainly suggested that you needed a quite different preparation. Putting somebody into a withdrawal unit for four weeks was not necessarily going to work either, because they would not stay that long, but it needed a combination of areas or a combination of treatment that you could use using some of the non residential services as well as the residential services.

Ms RIBTON TURNER — We have changed the program so that people can crash for that first few days, and we have gone right back to basic nursing care — giving people fluids and food and keeping them in a low stimulus environment for the first three days, and then gradually introducing a much lower stimulus program. We are offering 10 day admissions, but even something like that has the capacity to reduce our throughput by about 200 episodes a year, and we are trialling a step up, step down approach, where someone can step down to non residential withdrawal support, which needs to be for at least four to six weeks after, because they are still experiencing withdrawal systems in that period.

The CHAIR — Are you happy if we ask some questions now?

Mr ALVIS — Absolutely.

The CHAIR — I might pose the first question, and then I will invite committee members to ask a question. You are tackling the treatment area. I would like to go back to the first phase, if I may, and discuss it somewhat broadly. My understanding is that methamphetamine is quite a lucrative trade for the manufacturer, the supplier and the trader. There are big dollars in manufacturing and selling as compared to perhaps some of the other drugs. The people who use it have quite a high stimulus initially; it creates all sorts of things whether it is greater awareness, sexual stimulus or a whole lot of other things, and then coming off the drugs there are a whole lot of complications around, as you said, depression, suicidal activity, family violence and also armed robbery. This is what we have been told by other stakeholders. We have talked about the impact on regional Victoria, and I think you were sitting here just before. You have a lucrative trade, you have the drug creating a number of physical stimuli and then coming off the drug creates a lot of antisocial harm in the community.

Our inquiry goes back into organised crime and outlaw bikie clubs, which we have been told are particularly engaged in the manufacturing process and trading. Then you have the policing of the use of the drug by the general populous and then the treatment and education programs at the other end to try to tell the story of how addictive and how harmful this drug is potentially to people themselves but also to the wider community. Where do you see the best impact being for the committee to do a lot of its investigative work in relation to trying to get the community to understand that this might be like eating chocolate — a stimulus — but at the end of the day it is particularly destructive.

Mr ALVIS — I think all the points that have been mentioned in the inquiry are really important in relation to Australia's drug policy around harm minimisation. It is about supply and

reduction and harm minimisation. It has been proved over time that the more you can take this off the streets, the less that is available. That is an area that needs to be supported strongly. But I think it is a multifaceted point. John talked about the fact that what we have seen with methamphetamine is that because of its availability and its cheapness to manufacture it is a much more affordable drug to so many groups of people. People do experience it. We have certainly had a number of people who have said, 'I don't have a problem with it because it's just a party drug'. It is still perceived that you only use it every so often and it is not going to be a problem, whereas as time goes on it can be more of an issue.

I think supply is really important — it is important to reduce the supply — but at the same time it is also really important to look at the hundreds and thousands of people who are affected by this drug, and the current treatment processes. As you said, one of the great things around heroin and some of the other drugs has been the availability of alternatives like methadone to assist people to break their habit. One of the biggest issues we have at the moment with methamphetamine is that there does not seem to be an effective drug so that you can tell somebody how they can get off it when they are in the position of being totally addicted. As a treatment agency, and certainly Donna can talk about that, we are currently using drugs like Valium to calm people down, which is not an ideal situation, and it is a short term situation as well. There is the whole issue of whether you want to move somebody from one drug to another. I think there are key issues around the whole horizon in relation to how you actually deal with this.

As we have talked about, from our point of view one of the critical issues is that we currently have a drug treatment system where because of the effects of methamphetamine — that is, the violence, the disruption that these people can cause — it is very different to the laid back sort of situation that people were found to be in under heroin or cannabis. They were probably more relaxed in those situations. A lot of treatment services do not know how to deal with them, and in the end they actually do not deal with them. They just say, 'We can't deal with these people because we are not suitably staffed or qualified to manage the aggression that goes with this'. There is also the time period. As we said, one of the most disturbing parts that came out of the trial that we did was the fact that after seven days, which is seen as traditional detox time, people were nowhere near at the point where they were not still craving the drug.

Ms RIBTON TURNER — It is probably worth saying, though, that with a little bit of adjustment to our program we have been able to change the retention rate for this group from 48 per cent to 60 per cent, so there are things that can be done. That was really mainly around giving people time to sleep and then relaxing or lowering the stimulus for the time they were in the unit. I think there are lots of things that can be done, but we need AOD services working with researchers to come up with models that work.

The other thing I think is worth noting is that most of the people who identify ice as their primary drug with us are in the 20 to 40 plus age group. What is really alarming is that it is one of the drugs young people use. We have a withdrawal unit for 12 to 21 year olds, and in that unit most of those kids are saying that they use ice sometimes, occasionally, when they go out. We know it takes about five years plus for people to move from recreational use into the problematic group — for those who do — so I think we have to be really careful about young people both for the progression but also for the depression and suicidality for that group.

The CHAIR — And your demographic starts from 12 years to — what did you say?

Ms RIBTON TURNER — We have a withdrawal service for 12 to 21 year olds. It is very unlikely that we would see 12 year olds, and the lower group, which is about 14, usually practically — —

Mr SCHEFFER — Have you seen a 12 year old?

Ms RIBTON TURNER — We have seen a 12 year old, but most — —

Mr SCHEFFER — How many? One?

Ms RIBTON TURNER — No, probably more than one. Most of the kids we see at that younger age are kids in out of home care. That is the group of young ones we would see. The average age is probably more like 17 or 18 in that unit if you exclude the out of home care group.

Mr SCHEFFER — We have only just started this inquiry, and we have had a couple of briefings and we have had this morning. I am hearing things that are not squaring for me. What I think I want you to do, Donna, having clinical responsibility, is to talk to us about what amphetamines do to the brain and what the effects of that are on the body. I am saying that in the context of hearing that the drug causes aggression on the one hand and then, no, it only does in some circumstances and it is contextual, so it is not a direct consequence of taking ice. Everyone who takes it does not become aggressive and that kind of thing. In talking about the detox time lines, if it is different to heroin, how is it different — the levels of addictiveness and how that works? What happens physiologically during a crash? Could you just step us through what it actually does?

We are told that this drug has been around since 1897, and yet you are saying that we have no idea, or not a good idea, about how we should treat it and we are still working that through. How is this drug different to that long history, which would have told us something at a pharmacological level?

Ms RIBTON TURNER — I think it is the fact that people are only really now just coming into treatment. We have not had much experience with methamphetamine users in treatment, which is why I think nothing has happened in terms of working out what is the best treatment.

Like any drug that has a capacity to be addictive, over time people build up tolerance and can use more. For some people that never happens; they are quite satisfied to use it on a Saturday night and whatever. But the group we see that have quite strong addictions are the same sorts of people who we are seeing with alcohol addiction and other sorts — that is, unemployment, problematic families, offending histories. The group of adults who are coming into treatment are a really complex group with a whole range of social problems, and I think that is part of it. This week they might be taking amphetamines, but they would have taken something else when that was not the fashion.

In terms of what we see when they come into the withdrawal unit, I think the crash is no more than absolute — —

Mr SCHEFFER — Before you go on, can you talk about what it does? You take it; what does it do in the brain?

Ms RIBTON TURNER — It is disinhibiting and it feels really good, according to everybody who uses it. They can feel anything — —

Mr SCHEFFER — How does a disinhibitor work neurologically?

Ms RIBTON TURNER — I am probably not the best person to describe that. That is a doctor one.

Mr SCHEFFER — That is okay. I thought that might be your expertise.

Ms RIBTON TURNER — To me it is as simple as it shuts down the normal things in your brain that tell you not to do things. In terms of what we see with the crash, I think it is just exhaustion. When people come in, they have usually been using for some time. They do not sleep. People will go days and days without sleeping and they do not eat very much and they do not drink, so they are dehydrated, exhausted and malnourished.

Mr SCHEFFER — They are the secondary consequences of bingeing out, having a wild weekend or a few days or weeks?

Ms RIBTON TURNER — It goes on for years.

Mr SCHEFFER — But it is not a direct cause of the drug?

Ms RIBTON TURNER — I do not know the answer to that. It is described as part of the withdrawal. When you look at the evidence of withdrawal, it is described as a crash phase, but why that occurs, I do not know.

Mr SCHEFFER — Right. So they could just be tired?

Ms RIBTON TURNER — Yes. They are not just tired though, they are absolutely exhausted.

Mr SCHEFFER — Yes; okay.

Mr SOUTHWICK — Would it be fair to say of a lot of the clientele you are seeing who are presenting with the use of ice that it would be the first drug they have used? How would it line up in terms of the profile of the user in a broader sense? Could it be seen as the drug for the middle class, in that you are finding a lot of workers who are using it as a party drug? Where does it sit as opposed to some of the other drugs that have been out there for some time?

Ms RIBTON TURNER — We see two very distinct groups of people. We see the party drug users coming in through our diversion program. People will get picked up and they have to come into treatment for an assessment and a counselling episode, and they do not see they have a problem. They do not see it as a problem, and most of them probably have not got a problem at that point. They are quite different from the older group — the 20 pluses — who are coming in themselves looking and asking for treatment. Maybe it is because of the sort of service we provide. You do not pay for our service; we are not a private organisation. We are seeing a much more complex group with quite severe mental health problems.

Mr SOUTHWICK — In those two categories, would ice be the first drug that many of them have used or will they have experimented with other things?

Ms RIBTON TURNER — For the young group coming in to diversion, yes, often it is the first drug they have used and may be the only drug. But for the other group at the other end, no; it is one of many. In fact many people seem to use ice for a while and then they use something to come down — it could be heroin, it could be cannabis, it could be benzodiazepines. They go in that cycle: use for a while, come down for a while, use for a while.

Mr SOUTHWICK — Finally, in terms of treatment, are you saying that there is no evidential treatment at the moment that can be used? What about in other jurisdictions, say, the US? Has there been any investigation into what other agencies might be doing in other countries?

Ms RIBTON TURNER — There seems to be no good evidence of what is working. What I did bring in the other folder is the lit. review that we have just done, trying to look for what is happening in other places. There does not seem to be a treatment. I think that is because everyone is looking for the gold star, the methadone for amphetamines, and there is not one at this point.

Mr SOUTHWICK — Do we have as big a problem with meth, say, in Victoria as other states and other countries have?

Ms RIBTON TURNER — I would not think so. I do not see why we would.

Mr CARROLL — Thanks, Laurence and Donna. With that cohort of 12 to 21 year olds, the government is restructuring school education drug officers throughout the education system. If you could get the committee to make one recommendation on how to deal with drug education in schools, particularly with ice, what would it be?

Mr ALVIS — Not basic, mixed sessions. With drug education, what we have found all the way through is that a single session around drug and alcohol just does not work. It goes in one

ear and out the other. It has to be integrated into the syllabus, and as a real issue that is brought up all the time because it is something that is coming up all the time.

Ms RIBTON TURNER — The only thing I would add is to start really young and involve families.

Mr CARROLL — Can I ask you one more question, Donna, about clinical services? Victoria Police presented to us a little while ago, and they said that when you take the drug ice, they believe a little bit of it is secreted in the brain and that is when you get an episode some six, seven or eight weeks later. Is that your understanding as well? Can a little bit of it be secreted in the brain and cause issues one to two months later for people who have taken it? Have you heard of that before?

Ms RIBTON TURNER — I have not heard that before, no. Clients tell us everything we know. I have not heard any talk about that.

Mr ALVIS — Generally, across the board, one of the things we have not said or made a strong connection to but I am sure you are aware of is the strong connection between drugs and alcohol and mental health, and people self medicating with different substances to resolve some of their mental health issues. That is something we find very strongly, and over the years we work more and more strongly with mental health services to try to look at some of those issues.

Mr McCURDY — You spoke about 14 per cent or so of those seeking assistance having it as their first preference for a drug of dependence and another 11 per cent, so we are talking about 25 per cent. Is this similar or dissimilar to what we have seen in the past, whether it was with ecstasy or heroin? Mr Ryan said before that we do not need to be alarmist about this, but I am interested to know from your perspective whether this is a greater number that we have seen with other drugs or with alcohol, for example?

Mr ALVIS — I think alcohol has always been high. Certainly one of the most common discussions I have with people when I talk about it as the CEO of a drug and alcohol service is how terrible all those illicit drugs are. We keep saying, 'No, actually alcohol is the biggest issue that we see'. Over the eight years I have been at ReGen we have seen a steady decline in things like heroin, and we have talked a fair bit about ice being one of the drugs that is on the rise at the present time. One of our concerns is the lack of treatment options and that people are still fumbling in the dark in relation to what is the best method of treating people. I think we are going to have the same issue when the synthetic drugs come up as well, and I think John said something about that too.

One of the biggest issues is that we do not know what is in them. We do not know what people are getting addicted to, so it is very hard to say, 'Let's treat it with this'. We know they have particular substances in them, but all the other things that go with it, we are just not clear about what is providing the strongest addiction.

'Crisis' is an interesting word, because I think it means something that has been building up for a while. The biggest issue and probably one of the criticisms sometimes of the treatment sector is that they just see one size fits all — 'Let's continue doing what we're doing because this has worked in the past'. When we are dealing with different substances we have to change our practice. I think that is one of the strongest messages that is coming out. What we are finding with the amphetamine trials is that seven day practices are not going to work for this drug, so do not bring people in or do not expect them to work in a particular area.

One of the other issues we have looked at is that because there is that drastic change, is it appropriate to treat people who are going through cannabis withdrawal or heroin withdrawal or alcohol withdrawal or methamphetamine withdrawal in the same environment? If you have someone who might need four weeks and they do have some of these issues that are coming up around aggression or violence, is that going to be detrimental to the other people you are trying to treat at the same time? Some of those things have always just been a case of, 'Let's just throw all these people in together and they'll go through detox together'. I think that is one of the critical issues.

Mr ALVIS — Do you want to add anything else?

Ms RIBTON TURNER — No.

The CHAIR — I will just pose perhaps another question. My own personal concern is for the most vulnerable. I know that 12 year olds are an exception, but we will talk about the demographic from, say, 15 to 21. You can go back to the Grim Reaper ads in relation to sexual education and you can go back to cigarette smoking and alcohol, which we have perhaps been less successful on, and also the other traditional drugs, but what meaningful role can we play in relation to this committee's work in trying to have that demographic understand the harmful effects of this drug?

We know it is a high for them initially. It is obviously cheaper. If they cannot get access to alcohol in a nightclub, they tend to take a substitute, which seems to be ice as the most fashionable drug at the moment. Treatment programs for those who are addicted to the use of other drugs are fine, but I guess it is that very vulnerable demographic that somehow we have to home into, and it is not just here in Melbourne nightclubs and King Street; it is outside Mildura and Gippsland and Geelong and Ballarat and other places. Do you have any thoughts about that? Is it an education program? Is it greater law enforcement? Is it a supply issue, which is going back to my questions beforehand? Where do we actually home into to get the greatest impact on that vulnerable demographic of children? They are children. Can you respond to that?

Ms RIBTON TURNER — I think it is a combination of all of those things. I think education is really important, but often the way that young people would normally mature and change their drug using behaviour is through relationships, education and work. I think they are really important things. I think the group that is most vulnerable is the one where those things are in jeopardy, so they are disconnected from their families and communities and do not have good education or work prospects. To me, they are the group most likely to progress to have problems. So it is alarming for us to have a withdrawal service for 12 to 21 year olds. The majority of young people we see have left school at about grade 8 or 9, and when we see them at that age they are usually disconnected from families and have really no job prospects.

Mr McCURDY — Which makes it harder for us to target that particular group as well.

Mr ALVIS — Yes. And I think that question that you raise is a really important one, but it is one we as parents go through too in relation to when teenage kids grow up and everything. I suppose we were the same when we were growing up in that you cannot tell them anything. They think they are immortal, and they go through these processes. But I think that is where it is really important. I think it is really important to have the multifaceted stress on these areas about reducing supply. I think one of the things the treatment sector probably thinks strongly has happened is that there is more of an emphasis on supply.

One of the constant things we get from people who first come up — and as Donna talked about in relation to families — is that when they are starting to notice some of these things happening with their children or whatever there is just no contact or information that they can actually access to know what to do in this situation. It is not easy, because we have so many situations all the time where people come in and say, 'You have a seven day withdrawal program. After seven days, will this mean that this person is completely okay and will be back to the normal person I used to know?'. I think it is around that education and around some of those things that are trying to combat some of these issues, because it is a hard one. It is the story of drugs, I think, through the ages in relation to why people become addicted.

Mr SOUTHWICK — Just breaking down those alarming numbers — from a 6 to 14 per cent increase — you mentioned earlier the two categories. Do you think that that increase is largely from that first time user, party type user, productivity type user, as opposed to somebody who has been using a number of different drugs and has presented to your organisation before? Where do you see the big increase coming from?

Ms RIBTON TURNER — The second group — the problematic group.

Mr SOUTHWICK — Right. So that increase has not come from the party drug user as opposed to — —

Ms RIBTON TURNER — There may be an increase there as well, but the big increase we notice is in the longer term problematic user with mental health issues.

Mr ALVIS — And that certainly has to do with the availability and also the price. John was saying earlier in relation to this that this is a cheap alternative to some of the other substances you may use, and if you are in that situation, you are not usually flush with money such that you can make a choice.

Ms RIBTON TURNER — But interestingly, despite the growth of that group, I was talking to staff and just asking questions. Most of our clients seem to be not injecting, which is interesting.

The CHAIR — Just on that, what is the normal means of taking ice? I know that there are a variety of options, but what is the most popular means?

Ms RIBTON TURNER — Most of what we are seeing is smoking. And the amount can be anything from a point, which is like a tenth of a gram, to people who are reporting that they are using over a gram.

Mr CARROLL — Just on that point, Donna, most people are smoking it, but the people who are injecting it with syringes — how are they presenting? Are they coming with other issues? Is there a bigger problem for the people who are using syringes versus smoking?

Ms RIBTON TURNER — The bigger problem is the likelihood of other harms around blood borne viruses and that sort of thing.

Mr CARROLL — Do you run a needle exchange program?

Ms RIBTON TURNER — Yes.

Mr McCURDY — You have obviously developed your own program as time has gone by, and, as you have said, there is nothing out there that we can say, 'This is what is going to work', so you are obviously developing it as time goes by. Have you made significant changes from when you started in where you see assistance, or do you think that that is still to come? You have spoken about seven days being clearly not long enough for those programs.

Ms RIBTON TURNER — Yes, we have made some changes — lengthening the length of stay. We are trying to step people down into non residential support. We have a team of three nurses who can support people in the community, so we are trialling that as an option. We have just changed the withdrawal environment, reducing the stimulus. We are trying to support people who can crash at home so they get better value from the time they are in the unit. We have formed a partnership with the Aboriginal community to try to retain Aboriginal people in withdrawal, and we are doing a lot of work with families. For example, if a family member rings us, we can offer them a single session with a counsellor as a family group within a couple of days, and we see that as really important. We have a range. We have single sessions, we have family counselling and we have partnerships with Family Drug Help, so we do a six week education program for family members, and that is booked out months ahead. Then we have a family and friends support group. So we are doing a lot of work with families to try to support them.

Mr ALVIS — One of the questions I think is worthwhile commenting on is in relation to when you were talking to John about the rural issues and enthusiasm in the rural areas to actually deal with some of these issues around methamphetamine. One of the notes of caution around this — certainly we have found — is that this is probably the most complex withdrawal process we currently have. As Donna said, we are using a combination of nurses and other professionals in dealing with those issues. I think one of the issues you may well have in the country is that you do not have that level of resource to actually do some of these withdrawals, and I think you have to be really careful because they are a different group. It is not, as we have said, the more passive drug

user who comes through and takes part in the process. It is quite complex, and there are issues that come up in it.

I think one of things we need to be really careful of is that we have the appropriate professionals in the right places to deal with the issues that actually come through methamphetamine; otherwise, as Donna said, one of the things we found is that they just leave treatment after a couple of days. Then a lot of agencies, if they have a difficulty with a particular person, will put so many restrictions on the availability of that person actually coming back that it just becomes unworkable.

Mr SOUTHWICK — You just mentioned that 11 per cent of people or thereabouts present with secondary drug abuse. What would the primary drug be that they present with?

Ms RIBTON TURNER — It could be alcohol. It could be cannabis.

Mr ALVIS — It is more likely to be those two.

Ms RIBTON TURNER — Yes, or even a benzodiazepine like Xanax.

The CHAIR — All right. Thank you both very much for your time this morning. The committee appreciates you presenting to it this morning. Thank you.

Witnesses withdrew.