LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Bendigo — 25 October 2013

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Ms C. Sobczyk, General Manager, Primary Health and Integrated Care, Bendigo Community Health Services.

The CHAIR — Welcome, Cheryl, to the joint parliamentary Law Reform, Drugs and Crime Prevention Committee and to this inquiry into the supply and use of methamphetamines in Victoria. Before you provide evidence to this committee, I have to read you some conditions under which you will provide that evidence. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable. the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Ms SOBCZYK — Yes, I have.

The CHAIR — It is also important to note that any action that seeks to impede, hinder or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence, and we will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. We have allotted time for your hearing from 10.00 until 10.45. I note that it is now 10.20, so I apologise for the late start to this session, but hopefully we can hear from you and have the committee members ask questions of your presentation in the time allotted. I will allow 10 minutes for your presentation to the committee, and then we will ask some questions of you.

Ms SOBCZYK — All right. Just to let you know what our organisation does and my involvement with that organisation, I manage an alcohol and drug service at Bendigo Community Health Services. Those alcohol and drug services have been in existence for approximately 20 years. Within that range of services we have harm reduction services — so needle syringe programs, pharmacotherapy, withdrawal, counselling and a range of other outreach and support services.

The number of clients we see for alcohol and drug related issues during a year period is in excess of 800 people. For the majority of the clients we currently see the primary drug of concern is alcohol, with cannabis being the second highest drug of concern. Over the past 18 months we have certainly seen an increase in ice being a primary drug of concern for people presenting, with a relative increase from about 4 per cent of presentations in the preceding 18 months to about 14 per cent of presentations.

Mr SOUTHWICK — How many? Fourteen, was it?

Ms SOBCZYK — Fourteen per cent of presentations for that 18 month period and certainly an increase in the last 6 months over the preceding 12 months. The range of people we see — we have youth service counselling in regard to alcohol and drugs. The predominant number of services we offer for alcohol and drug services are adult related services, and those services are open to clients, actual users as well as their family, so people can present as a family member to our services.

We operate a residential withdrawal service in Bendigo which has been in operation for approximately 10 years. That is a statewide service. Predominantly we service people from the Loddon Mallee and Grampians regions for that particular service, and the ice presentations at that service in the last 12 months have been certainly increased, in line with what I have said previously with the increase in presentations overall.

For the people presenting with issues where they have identified ice as being their main issue or problem, the majority of people presenting are from — given that this is an adult service — 21 to 30, with a high percentage of those being 25 and under. We have what appears to be two primary cohorts of people presenting particularly around the ice issues. One is the newer group of people who have been using ice for a lesser period of time. People in the older age group have been using a number of different drugs, and they have taken up ice use as a preference in the last 12 months or more. The older group are the people who would predominantly be injecting ice drug users. The newer cohort of people coming through predominantly are smoking.

The people actually presenting are a range of persons from various socioeconomic groups. We are seeing an increased number of younger professionals, or younger tradespeople, coming through our service whom we had not actually seen before — so people who have been initiated into this particular drug. These particular clients coming through our services are a new cohort of people we had not previously been seeing — not at the younger age. Quite often if people become longer term and dependent on drugs, they may access treatment when they are much older, but we are seeing people who have been initiated into using ice actually accessing treatment a little bit earlier. But they are also a different cohort of people, as I had just said before. Do you want me to go through the particular question areas or just an overview of our service?

The CHAIR — Give an overview, and if you want to touch on the questions, we would like also to ask questions of you.

Ms SOBCZYK — Yes, certainly. With the service, Bendigo Community Health Services also operates a range of other services and has strong links to those services. Child and family services are a significant link for us with alcohol and drug services. We have a child health invest service which is based on a paediatric service — a community paediatrician working with the children. We have a collaborative program where many of our program participants in the alcohol and drug service are linked in or also the children of the people seeing our drug and alcohol service. We work collaboratively with the paediatrician on case conferencing in relation to the children involved in their care and utilising the issues that are facing the family to deal with the problem in a much more generalised way. You cannot just deal with the issues of the children; you have to look at the bigger picture in relation to the family dynamics and the issues that are related to that child in that sort of setting.

The family services from our agency certainly have been dealing a lot more with people with more problematic alcohol and drug use, and those services are done primarily as outreach services. Apart from the direct alcohol and drug services and the opportunities for people to be referred from the family services into drug and alcohol, there is still a significant gap in what we can offer for family members of people with drug and alcohol problems, even though they can individually or as a family access alcohol and drug services. I do not think the actual opportunity or education or knowledge of even the workers and their ability to work with families who are struggling with the problems their loved one or the user in the family — I think that is a particular gap we currently have.

Many of our intake calls — so people wanting to get information about drug and alcohol services — are actually from family members. Even though we can offer them individual counselling or refer them to family support services, it does not go far enough to address how they cope day to day with a using member of their family. At the forum last night we heard about a mother whose 24 year old daughter is a significantly dependent ice user. The daughter has a three year old child. I caught up with this woman after the event, and she is certainly hoping to access the service, but they are at a loss what to do day to day. They just do not know what to say to her or how to encourage her into treatment. They have to look at what they have to do to try to ensure that the child is safe. That puts a significant burden on them because that is not what they were expecting — to have to also look after the grandchild, the child of their daughter.

Intergenerationally we have seen this as a long term problem. For clients of the alcohol and drug service who have children it is often the grandparents — their mother and father — who become the primary carers during the periods that the dependent person is at their worst in relation to their drug use or at the point where they are in less control of their drug use. Having a child themself is not necessarily the motivator or the issue; if the person is quite significantly dependent, they find it difficult to find all the reasons to seek help or treatment.

It is certainly an area that we have to think about in going forward in targeting parents and education around looking at the ways we support families to support people who may not be at that point of actually accessing treatment themselves and looking at the ways you can motivate or get people to understand the significant impacts that that particular drug is having on not only themselves but their families. It is a really difficult one. Ice particularly seems to be having an increasingly devastating effect on the families, in that the families are finding it hard to cope with

the typical presentations of people who are very dependent. For example, in many of the stories we hear that the very dependent person will in an almost binging fashion be using for two or three days and then they will sleep for the next three or four days. On the availability or affordability of that drug for that person, they only have to afford it for a two, three or four day period at tops. They sleep for the next three or four days, and then they can afford the drug that is available to them.

The information that we have on accessibility is that it is freely available and accessible. As I said, it is not just what we have seen previously around the typical or expected use of users, especially in the days of the heroin injecting. That was usually more confined to the people who were using it. That is certainly not the case with this particular drug. It is freely available, and the number and types of people using are much broader than we have seen before.

The only benefit, I suppose, is that some people are actually seeking to access drug treatment at an earlier age, as compared to the days of heroin or people who were quite dependent on heroin. There seemed to be a lot longer lag time before those people accessed treatment.

Most of the people using ice are not using just ice. The highest concentration of the secondary drugs that people are reporting is cannabis That is the next highest drug of use, followed by alcohol. The majority of the people presenting are not necessarily just ice users. They are using a combination of different drugs. Part of that goes to how they manage their drug use, from their periods of feeling quite euphoric or high when they are using ice to how they manage the time when they are feeling quite low. Often that is by using the depressant type drugs to get them through that period.

With our withdrawal services, we notice that, as you would be well aware, when a person is coming off ice the first thing they want to do is sleep. People will sleep up to 18 hours or so a day. That has certainly changed the way that we have had to manage withdrawal, especially within the residential withdrawal service. We usually have a fairly structured program in looking at strategies for people, with coping mechanisms and the reduction of harms. There is an engaging education program for people when they come through the withdrawal unit. We have had to adjust that because people need the first two or three, even up to four, days just to rest to restore a little bit of a sleep cycle balance. Interestingly, though, people still do not tend to stay longer. The average stay in our withdrawal unit is around seven days. We fully expected that people need to stay longer given that in the first few days they basically just slept, but they still look to discharge after seven or eight days.

The significant issue for people going through withdrawal is that it is reasonably okay to have that initial stop where they actually cease using the drug, but the actual time it takes for them to recover is much more protracted than we have seen in relation to alcohol, cannabis, heroin or other drugs. We are talking about at least a six month period before people start to restore some of their physical health and some of their feelings of wellbeing in relation to their emotional health. The actual time it takes them to recover is much, much more protracted.

The benefits of the current alcohol and drug reform process in Victoria are that there is a concentration on care and recovery coordination, ‘recovery’ being an optimal word in relation to that aspect of the reform. With this particular drug, I think we will see a number of people with issues that we are referring to as of complex nature and who require a longer period of care after their initial withdrawal or their initial treatment. I think what we are going to be needing to concentrate on primarily in adjusting some of our current treatment or withdrawal regimes is looking at catering for people over a longer period of time. That obviously takes a particular workforce or resource strategy in relation to the current workforce or the way that people operate, so that they can engage with people for a longer period of time.

In relation to the actual presentations and the population, I have said that young professionals are in that group that are currently coming to our service. We do not have enough data to say whether that is the trend overall. I am able to give you what we are seeing currently, but it does not go to whether that is the statewide trend or anything like that. It is only what is through our service.

Mr SOUTHWICK — On that point, the young professionals, the trades type, the party type, the middle class user, would you say that that is unusual compared to other drug users who have been requesting treatment in the past? Is this a particular issue with ice, compared to other drug use?

Ms SOBCZYK — It is a little bit difficult to know. I do not know whether it is that they are presenting earlier, that that cohort was also using other drugs but that was not as problematic or that they did not lose their jobs sooner — that is, that they were able to maintain their employment and lifestyle for a longer period if they were using other drugs. It is a little bit difficult for me to say whether it is a whole new group or whether those people have just shifted from using other drugs per se. It is just because the people who are presenting are presenting earlier that we know that this is the group. I am not sure whether they would have presented down the track. They may have not needed drug treatment. It may have stayed more recreational and not become problematic. It is a little bit difficult to explore that.

Mr SOUTHWICK — So you are not sure whether for this group this is the first lot that they have actually used, in the process or as part of the work that you have done?

Ms SOBCZYK — When a person is assessed, we usually ask them when they started using. Sometimes it actually is the first drug. I think that is about the perception of the drug, that it is still viewed as a relatively clean drug. Whether that is because it is not injected, that it can be smoked or that it even looks clean, it is interesting.

We need to understand why particular groups of people choose a certain drug over another drug. Sometimes it is about the effects of that drug more than anything else. Is it about staying awake? Is it about all of the other reasons why they might use that drug compared to other drugs? The other thing is that ice is a stimulant, whereas some of those other drugs are depressants, and maybe that is not the preferred option for people who are young professionals, tradespeople or whatever. I think that is actually a significant point — why it is that certain groups of people choose a particular type of drug over another one. Many of the drugs we were seen to treat were all depressant drugs, whereas this is a stimulant. I think that is potentially the critical difference.

The CHAIR — Just while we have that opportunity, perhaps with the time we have left we could invite questions from the committee.

Ms SOBCZYK — Certainly.

The CHAIR — We can tease out the information we are seeking.

Ms SOBCZYK — Absolutely.

Mr SCHEFFER — Following on from Mr Southwick's question, what I was going to ask was: when people present to you, are you picking up the stories of what the path was that has led them to the situation of coming to see you, because you have talked more about what you do once they arrive?

Ms SOBCZYK — The major reason people actually seek treatment when they do is that it is starting to affect their work and it is starting to affect their relationships. Their friends and family are responding to them about their behaviour. So people might still be in employment, but they are having more sick days and they are starting to not have as much money as they used to have. So it is starting to have an impact.

Mr SCHEFFER — Sorry to cut across you, but I am conscious of the time.

Ms SOBCZYK — That is fine.

Mr SCHEFFER — You said that some people are using it as a stable recreational drug and it is not problematic. From what you have just said, there has been a shift from people who are using it and managing it, and then things happen where they start not managing it, and then it gets worse.

Ms SOBCZYK — We certainly see that particular trend where it does start out recreationally. It might just be a weekend. Depending on what is happening in their lives, they then might start to use it a little bit more regularly. We do see the people who will use it all weekend and then end up having one or two days off during the week. So if they do not have those days off, they might then start to use during the week, which they may not have originally planned to do.

Mr SCHEFFER — But do you think it is at least feasible that there would be a cohort of people who would be using the drug in a manageable way all the time, or do you think that inevitably they have to come to face the damaging effects of the drug and seek help?

Ms SOBCZYK — With the use of ice, I can only really speak about the people who have ended up in treatment.

Mr SCHEFFER — Of course.

Ms SOBCZYK — It does appear, however, that recreational use does move into more dependent use sooner and quicker than with some of the other drugs people could use recreationally for a lot longer. Even with heroin use, I have known people who have used heroin recreationally for years and years. We are not seeing that same trend with ice.

Mr SCHEFFER — The last tail on that is that in the evidence we have received there have been two streams, and I am a bit puzzled in the middle, and that is why I keep going at it. On the one hand there is more of it available and more people are using it, and so it is becoming, in inverted commas, an 'epidemic', but on the other hand we are getting very reliable evidence that is saying to us that it is a cohort that is pretty stable, but the purity of the drug that is coming onto the market and its availability are meaning that the harms are increasing. Do you have a comment on that?

Ms SOBCZYK — I think your second point is certainly what we have seen in regard to the purity. The other thing is about availability. Putting the young professionals and the tradespeople aside, the way this drug is marketed among the dealers and the using population is quite insidious. If you have not scored, they have your contact number, they know where you live and they will be on your doorstep. Even if people want to make a break or not use, it is really difficult for them to not use when they have someone dangling it in their face. The other thing we see — and we have seen this with other drugs in the markets within Bendigo or in the rural and regional areas — is that this particular dealing network takes credit; if people cannot pay, they take credit. We have heard of people paying for drugs not with cash but with goods and services, which is a range of things. The way that the dealers look to make people dependent is something we have seen here for quite a long period of time, and I think that is the way this drug appears to be more addictive in the sense that people want to feel good and have the drug, but if they are using it more and more their tolerance is increasing and the effects start to decrease.

Mr SCHEFFER — Thank you.

Mr McCURDY — My questions were around the trigger points for seeking treatment, so they have been handled.

Mr CARROLL — Thanks, Cheryl, for your presentation. You have just answered one of my questions about how addictive the drug is. Obviously you believe it is quite an addictive drug. You saw that we had the police present before you. I am interested in the link between the law enforcement agencies that seem to be at the front line, where the drug is present in crime, and the link to getting into treatment services that people like yourself provide. You seem to do a lot of good work. You spoke about how treatment for this sort of drug needs to be protracted, and you said that six months is ideal. The police spoke about wanting a stronger link to health professionals. Is that something you would also support and identify as a missing link for people on the drug, committing crimes, becoming repeat offenders and then getting into a health organisation like yours?

Ms SOBCZYK — I think that is the significant gap. When people are in that space when they have committed a crime, they end up in ED or end up in psychiatric services, and there is that

period where people need to come down, so their ability to receive useful information or to actually be responsive to information and/or treatment at that period of time is not good.

We have to look at how in that two or three day period — or 24 hour period — you can then make the link so that people are getting the information when they can hear it and are able to be responsive it. There could be a two or three day lag. When people begin their withdrawal, they sleep for the first two or three days. People who are agitated, who are in a space where they cannot hear or who have just been involved in a crime will not identify that it is the drug that is causing the problem, so there is a sort of messaging that we might need to think about in regard to how those messages keep getting repeated. Many people cycle through treatment on a number of occasions. Each time you build on the piece of information you gave before to a point where they keep building that information and education so that they start to make good decisions for themselves.

This is about them making a decision to change, being receptive to change and being in a position in their own life that they are able to change. That in itself is difficult, depending on their living circumstances and depending on those dealer relationships that I mentioned before. Often people say, 'Yes, I want treatment', and maybe even identify that they think they need treatment; they go back home and they are back to a situation that is not conducive to them actually making a change or even some of the decisions they thought they could make themselves are taken away from them.

We have to think about how we address that lag period. With other drugs people could just stop and they would be receptive to messaging and change straightaway, even with alcohol or heroin or cannabis. From day one or when they are in that period where they are not listening or hearing, ice just seems to be much more difficult. It is that notion of what it has done to them, why they are using and why they think that is okay, and how they see the actual harms and damage that it is causing. I think we have to build on the key messages in education to support family and community for people to see the potential damage that it is causing — because it does not always cause damage, unless people get into this space where they become dependent or are using more than what they thought was just recreational use.

Mr CARROLL — With your messaging, Cheryl, the drug is one thing, but is it also what the person using the drug has going on in their private life that has led them to the drug?

Ms SOBCZYK — Yes.

Mr CARROLL — You would find a lot of that — that you have to focus on the person?

Ms SOBCZYK — The combination of their psychosocial situation is critical. We cannot just do a withdrawal or provide counselling without looking at the whole person and all of their psychosocial aspects — you know, their living environment, their education, their employment, what is happening in the family. That is the most difficult thing, and all of the reforms that we are trying to push through are trying to encourage linked up services, but there still has to be acknowledgment or a want or desire for people to go down that track. Having said that, though, if you keep messaging, people keep hearing about the options for themselves and their families. I feel that is one of the critical things. It is just not enough to say, as we always hear, 'You can't do anything until the person is ready'. I think there are things that you can do, because it is around continual messaging and looking at the sorts of things that start to support people making a decision.

The CHAIR — We will have to break, I am sorry, because we are way out of time. Cheryl, thank you very much for presenting to the committee this morning.

Witness withdrew.