LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Melbourne — 3 February 2014

Members

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Mr J. King, Chief Executive Officer, Victorian Aboriginal Health Service.

Dr N. Quiery, Senior Clinician, Victorian Aboriginal Health Service.

The CHAIR — Thank you both for appearing before the Law Reform, Drugs and Crime Prevention Committee this morning. We have Mr Jason King, chief executive officer, Victorian Aboriginal Health Service, and also Dr Niall Quiery, senior clinician. Before I start, on behalf of the committee I would like to pay our respects to the traditional custodians of the land on which we are meeting today and pay our respects to their elders, past and present.

I need to read you the conditions under which you are presenting to this inquiry this morning, so bear with me while I go through that. Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention Committee. 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. I will perhaps ask you if you have received and read the guide for witnesses presenting to parliamentary committees.

Mr KING — Sorry, I did not quite — —

The CHAIR — There is a handbook, which you have in your original documentation, I think, and which you would have seen.

Mr KING — Yes.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness 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 will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. We have time allotted until 12.30 this afternoon. I understand there are to be some opening statements.

Mr KING — Yes, just general ones. I think we sent these through to Sandy.

The CHAIR — Okay. Then there will be some questions the committee would like to ask. Jason, are you going first?

Mr KING — Yes, either/or, that is fine.

The CHAIR — Thank you.

Mr KING — First, I would like to thank the parliamentary committee for inviting us, the Victorian Aboriginal Health Service. Ice has become a major issue in the Aboriginal community, not just in Melbourne but in the wider community. A case in point: on the weekend we lost a young fella, about the age of 16, down at Lakes Entrance who has passed away from ice use. It has become a problematic and chronic issue for us within our community and with our families, and there needs to be a family and community approach to this. We need to have access to a wider range of detox and rehabilitation services, residential support and in-home support for families to get through this epidemic that we currently have within our community. I will hand over to Niall.

Dr QUIERY — I have worked for about 20 years in the Indigenous community. I do a lot of drug and alcohol work. I am a methadone prescriber and Suboxone prescriber, and I facilitate people detoxifying from everything from alcohol through to heroin, speed and ice. I do ordinary general practitioner work as well, so I have strong links with extended families. I do not just see people who have addiction issues but support and work with family members of people with drug addiction issues.

Ice in particular is a growing problem, and it has been around for about three years that I have seen. It is really flooding our workplace at the moment. When I talk to people who have been long-term drug users, they are telling me that it is quite ubiquitous. It is cheap. It is easily available. It is remarkable how many young people have either used ice on occasions or are using it regularly. I think part of the issue with methamphetamine use is that it is a much more sociable drug than some of them — than heroin. Young people get together at parties where they usually

drink alcohol or smoke a bit of marijuana, and it is a very small step to then get together in a group and smoke a pipe that has ice in it. The movement from marijuana to heroin is a major shift because you are using a needle and a lot of young people just go, 'I'm not interested in that'. To get together in a group where you do not have to buy the drug — initially it is something that is shared between a group of friends — users do not see that as a major step up in their drug use.

Like many drugs, people use it socially, and not everyone but many young people then go on to develop a habit. It seems to be very destructive in the social family environment. They do not sleep, and they become aggressive and violent towards family members. There is the usual process, as there are with all drugs, of chasing money and trying to secure your ongoing habit, but I feel as though the family disruption is much greater than I have seen with other drugs — certainly than I have seen with speed, which is a comparable drug. As workers we really are not able to offer what families really need when young people come in and say, 'I want to get off this drug'.

Hearing suspended.

The CHAIR — I reconvene the public hearing. We were hearing some verbal evidence from Dr Niall Quiery, so I will ask him to continue.

Dr QUIERY — I was talking about service provision. Obviously we are a community-based organisation, and family and community members come to us readily. With most drug addiction issues it is usually the user — the person with the addiction problems — who presents. Methamphetamine use is different in that we tend to get more family members presenting with the issue than we get users presenting. Both present, but the proportion is significantly different. We have mothers and aunties and brothers and sisters coming in and saying, 'This person has been a problem, and the whole family has got a problem. Can you help?'.

We do have treatment options, which you will be familiar with. We attempt to do home detox, but we have difficulty finding long-term placements, and we often wait for weeks, which is not really adequate. We need to be able to act on the day or certainly very soon afterwards if we are going to help families.

Our workers are snowed under with requests for work, and we do get a bit of frustration, if not anger, from the community about, 'Why can't you do more? Why can't you get my son or daughter into a placement today or tomorrow?'. Often by the time we come around to placement the situation has changed and shifted and the user is no longer either keen to use or the circumstances have changed. Because people do not sleep with methamphetamine, families are having to do 24-hour support and cover, which is really exhausting, and people often will not sleep for days on end, so our workers are inundated. I suppose we are at a loss for what we can offer to our community. We need more programs, and we need quicker access — and I suppose we need that sooner rather than later.

The CHAIR — I want to ask one question, and it will be up to you whether or not you want to answer it directly. It has been suggested to us in other hearings that the Indigenous communities are more at risk in relation to predators — dealers, organised crime, outlaw bikie clubs — where they see Aboriginal communities offering potentially a catchment where it is easier to manipulate people in accessing the drug or providing the drug and increasing the debt associated with the cost of that drug and where that then transitions into dealing and basically being then at the mercy of the criminal element. Is it a fair reflection on the communities you represent that not only are they perhaps more at risk for a range of social factors but also they are an easy catch to drag into the system and basically being used by organised crime to distribute?

I know some of your recommendations. Your first major recommendation in bold is 'Accessibility/supply'. Our evidence collected so far indicates a bit of a mix between domestic manufacturing and international importation of degrees of purity of the drug. Could you make some comment about that?

Dr QUIERY — As far as supply is concerned, what I am hearing is that some people are getting their drugs through well-established crime or distribution/dealing services, but I think there

is a significant amount of manufacturing of this drug on a small scale, and some people are getting the drug that way. Any relatively impoverished community with large families and extensive social networks is always going to be more vulnerable — vulnerable from a financial point of view, the supports people have before they start using the drug and other drugs that are used heavily in the community. I do not necessarily see that the Indigenous community would be more vulnerable than any other community that had those social and economic disadvantages, but I do think the sociability of the group means that I think the drug spreads faster through the group. I think that probably is true. I do not work in the mainstream, so it is hard for me to do a direct comparison, but looking at other drugs and usage, I see that that applies.

Mr KING — For younger members of the community socialisation is the major issue — 'If my mates are doing it, then I can do it'. It is because it is that cheap — it is cheaper the marijuana, or yahndi as we call it. It is that much cheaper and it is easy to get a hold of. The younger mob stick together, especially in Melbourne. They are frightened of being isolated out in the community for fear of the stuff like the coward punch and all that sort of stuff when they are out, so they stick together in big groups. They will go to one person's house one week if there is a payment due, and then they will go to another house if there is going to be drinking and then there is something else. If there is a big issue — if someone dies in the community — there are going to be several houses that are going to be full of same-aged individuals who will sit down and share a joint, and it could be mixed with ice. It is that sociability stuff. Aboriginal communities stick together; they find strength in numbers.

The CHAIR — I asked that question not really on a discriminatory basis, but because our terms of reference identify the Indigenous population particularly. As part of our inquiry we need to be confident that the recommendations identify if, say, the Indigenous population is more vulnerable than other parts, and we can tailor recommendations to programs or interventions that deal specifically with that demographic. The response I am getting is that it could be any sort of community or sector that faces the same socioeconomic circumstances as the Indigenous population. It might well be that we do not have tailored programs specifically for that group.

Dr QUIERY — And any group that has high rates of imprisonment has high rates of exposure to other criminal factors. People who are unemployed or not going through the education system are going to be more vulnerable.

The CHAIR — Yes, I understand that.

Dr QUIERY — That defines our group quite well.

Mr McCURDY — Just on that same vein, I am trying to work it out. Do you think there is any evidence in the Indigenous communities — we have alcohol, a legal drug, and then we have the illicit drugs, like marijuana or whatever else — that people are going from basically being alcohol users to ice? Because in other parts of community there are people who have already been on illicit drugs and they are changing from ecstasy or something else to ice. Do you think that in your communities they are going from not using illicit drugs to ice, or have they been using marijuana and this is just the next phase up, for example?

Mr KING — The community does not see marijuana as being an illicit drug; it is just something you do. It is part of everyday life for those who are stuck in it from day one. I have seen it with my family members — extended family. It is just one of those things you do, similar to how most blokes sitting at the table played footy at one stage — you have a beer at the footy club. It is the same with marijuana use, and ice is cheaper now. It is cheaper than marijuana. You get it, you use it — simple as that.

Mr McCURDY — Okay.

Mr SCHEFFER — Just looking at the big picture, I would like to know whether you have data. I remember that years ago we did an inquiry into alcohol. The evidence showed that, in general, Aboriginal people drink less alcohol than the non-Aboriginal community, but where they drink they often drink more publicly. So it is different. Big-picture stuff like that — are you able to

give us a sense of that? I know you said that you did not adopt a query — that you did not know about the mainstream the way you know about the communities you are working with — but do you have a sense of what the use levels are in Indigenous communities and the sedentation in Indigenous communities?

Dr QUIERY — All I can really say is that when I talk to family members and community members, people say that it is everywhere — that ice use is everywhere. It is almost ubiquitous. People say, 'Everybody is using it', which obviously is an exaggeration, but what I am hearing them say is that it is not little pockets. When young people go out and party or when they socialise, there is a lot of ice usage. You are probably aware that I think Indigenous communities are more — possibly because of large family groups and possibly because of overcrowding, but any of their drug usage is more visible to the community because they do not go back into their house and use the drug. They often use it in the park or on the beach or somewhere in the open on the streets, so people see a lot more of it. It is very hard to say whether that reflects greater usage or whether it is just that it is more exposed and more visible to police and other community members.

Mr SCHEFFER — Do you know if there is any research being done on answering this sort of question?

Dr QUIERY — No, I am not familiar with any research being done.

Mr SCHEFFER — I guess what I am reacting to is that what I pick up from the evidence we have been hearing so far is that, yes, there is an increase from a small base, which certainly needs to be watched, and that, yes, the substance is causing a lot of disruption where it is being used in some instances, but we are not hearing generally, I think it is fair to say, that it is becoming massively widespread in the community. What you are saying to us is something a bit different to that — that your sense is that it is being used really widely across the Indigenous community.

Dr QUIERY — I suppose, thinking about what I consider comparable drugs in the sense of the effects of the damage that they have, amphetamines have been in community circulation for many years, and there are groups of people who use amphetamines. I split a lot of my patients into the ones who use heroin-type drugs and the ones who want 'uppers', for want of a better term.

Those two populations have been relatively stable, but I see ice as different. A lot of people are smoking ice who, really, previously drank alcohol and smoked marijuana. Maybe they have taken the odd pill from time to time on Saturday night if they wanted to dance all night, but those people are starting to use ice a lot more regularly. The word 'epidemic' has been used, and I think there has been a very significant increase in ice usage, which is a serious cause for concern.

Mr SCHEFFER — Thank you.

Mr CARROLL — Thanks, Jason and Niall, for your presentation. As has been in the media, there has been a big focus on Mildura recently, and the committee has travelled to Mildura. There has been a lot of attention. There was a spate of suicides in Mildura — young men on ice — and there has been speculation that the suicides were related to debts owed. My question is, and we have spoken about a range of initiatives to help: how much should the committee also be looking at targeting suicide prevention and mental health assessments toward the Indigenous community as part of any recommendations we might make to government? Do you have anything apart from the rehabilitation services, which in some ways encapsulate everything I am talking about, but for suicide prevention in particular and mental health assessments? Do you have a comment on — —

Mr KING — A and D services now do dual diagnosis — so, mental health and drug use assessments at ground level. The alleged stuff from Mildura is not; it actually happened. We have spoken to family members up there. I am the chairperson of the Victorian Aboriginal Community Controlled Health Organisation, the peak body for health. I speak to CEOs nearly on a daily basis. These families did have debts that were transferred from the young ones who committed suicide, so it is actually happening. Because it is so cheap, it is like if you go and knock off 20 cents out of your mum's purse every week for 10 or 11 weeks; you are going to build up a debt. That is what

these young fellas were doing — 'Yes, I will pay you back next week, when I get paid'. This is the stuff that is going on.

Some of these young fellas did have mental health issues. They were already in the system under the health care — —

Mr CARROLL — Were they?

Dr QUIERY — Yes.

Mr KING — Yes, and they might have been little things around depression and family, not knowing where they fit in as men within families and being a father of these young ones, and then you have the debts. As soon as they have committed suicide, all of a sudden the debt was transferred to their family. Niall spoke before about families having stress on them. It is aunties and uncles who take responsibility for those children. Niall could probably speak a bit more on the mental health side of stuff.

Dr QUIERY — I think Jason is right; it is very hard to take the mental health and addiction issues and pry them apart, because they do overlap. I believe that when young people commit suicide or die under dubious circumstances that people will give reasons. I would suspect that a lot of the reason is in the nature of the drug. When people are coming down from ice, they get to a very depressed state, and often people have been taking a lot of other drugs with that. They take drugs to help with that process of coming down. I know that that is going to lead to depression and a detrimental mental state, so whatever your circumstances are, they are going to look a lot worse when you are coming off an amphetamine-type drug. The debts themselves are not necessary leading to suicides; it is the general sense of hopelessness and a depressed mental state. So I believe that supporting the withdrawal process is certainly going to reduce the frequency of suicide.

It is hard. In other financial areas we offer financial counselling for people. I see a lot of patients who are very anxious and worried and sleepless over financial issues. We can address that when these are mainstream financial issues, like parking fines, speeding fines and other fines. We can come to an agreement with the authorities and work out a plan. You see people with mental health issues rapidly improve when they see that there is light at the end of the tunnel. If your debts are to a bicycle gang or someone else, then we cannot really negotiate and we cannot give any assistance in those circumstances.

The CHAIR — Jason, just following on from my question, if we had an unlimited bucket of money — and there is no suggestion that we have — —

Mr KING — No, I understand that.

The CHAIR — To identify the most appropriate treatment programs that will help to indicate your recommendations, there has to be a family-based approach. What sort of programs, other than what are already in the system, would you be advocating, specifically for the people you represent?

Mr KING — Part of the recommendations in the paper that was sent through to the committee was about access to accommodation for family members and the individual coming off ice to go through the program, to actually show them what they can do at home and having home visiting support for the ice user and the family in non-violent behaviour so they can engage and be educated about the psychotic features of the drug and what happens when they do come down. A lot of family members do not know what to do, because they are violent. The respite and crisis service for families is probably one of the big ones. Families need to get away. When I was working in Bairnsdale, we had two properties. We could send families out into the bush so that they could sit down and talk with family members — take them out of the situations they were in. There are not a lot of drugs around in that situation. But when they go home, similarly to those who come out of prison, if they go back to where they came from, they are going to hang out with the same people again. It is to help educate the family as well, so taking the aunties, uncles, brothers and sisters in order to get the word out that this is not good.

It has to work at a community, family and individual level, but it is the detox and residential home support stuff that is probably the most important. We propose also in the northern and western suburbs to have purely A and D services for ice users, so a GP, nurse, A and D counsellors and receptionists — and security for those who might be coming down off the drugs. So to have just a one-stop shopfront for those individual users to come in with their families.

Mr McCURDY — From a percentage perspective — I have also read the recommendations you have submitted to us — if you look at detox for individuals and families and supporting families and individuals, as opposed to broader education, we are not saying 50-50. You would not say that if you had $100, you would put $50 into education and $50 into the other. It appears that there is a higher need at the moment to go into that individual, one-on-one stuff.

Mr KING — Yes.

Mr McCURDY — Obviously we still need to do that broader education as well, but you could be talking an 80-20, for example, rather than a 50-50 split?

Mr KING — I would seek that one. I am sure Niall — —

Dr QUIERY — That is very hard to answer. I have been in preventive health all my working life, so I am always keen to try to address the problem from a prevention point of view, and education is really important in the area and it is usually underfunded. I do believe that there is a bit of a crisis at the moment and I think we do need the opportunity to take the individual and if possible several family members out of the situation and give them six weeks where they can get care, get well and get educated and the family can rebuild their trust. Several of the family members can recover in that time scale, rather than a few days in rehabilitation.

The CHAIR — Has that worked with other drugs, though? There is a perennial alcohol problem, not with Indigenous people but with the wider community, with detoxing and putting them back in the same environment. Has there been a measure of success with detox, rehab and then going back into the same environment?

Dr QUIERY — I believe there has been a measure of success with marijuana use and young people, pulling them out of that environment and getting them clean from the drug and giving them time to really think about it. There is a relapse rate — there always is a high relapse rate — but certainly many times they have turned around and said, 'No. I'm leaving that alone'. People say usually they need to change their friendship groups, the people they mix with, to say, 'I'm not going back to those people again'. I think it is harder for people who are entrenched — in and out of prison, involved in dealing, where it has been a much larger part of their life — to actually get clear of that, because the people they have been associated with will hunt them down afterwards and get them involved again. Ice is more sociable I think than that, so I think it would be more comparable to marijuana. I think it would work to a degree, but you are right, there is going to be a lot of relapse.

There is the respite factor involved in that as well. Giving families a break for a while just helps them to recharge their batteries and then to talk about it and plan what their strategy as a family is going to be towards the person who is using ice, which I think makes them much more robust and improves their capacity to succeed and help the individual with the addiction.

Mr SCHEFFER — Dr Quiery, I want to come back to the matter that you both raised, about debt to dealers and the impediment that that involves for people getting out of their dependence on ice or whatever drugs they are on. You were saying that it is difficult to know where to go with that. I am sure there are a lot of difficulties with that and I am not trying to minimise the problems, but one of the issues is going to the police, of course, about something like that. How is that met?

Dr QUIERY — I do not know of any of my patients who have gone to the police in relation to drug-related debt. You more often see people going into prostitution and dealing as a way of trying to get out of their debt.

Mr SCHEFFER — From what you are saying, it does not seem that the law is a realistic option for people in those circumstances?

Dr QUIERY — I suppose some of that is historical — that our community do not have a lot of trust in the law and do not anticipate that that will give them a realistic solution, so that is just not an avenue they tend to take.

Mr SCHEFFER — Do they tend to keep the particular problem about their debt to themselves or to a small group or is that shared amongst the family and the people who assist them in that?

Mr KING — Usually they keep it to themselves. There might be one or two others that they share with, but normally they keep it to themselves.

Mr SCHEFFER — So that places an additional stress on them?

Mr KING — That is correct.

The CHAIR — Are they accruing debt to the dealers?

Mr KING — Yes, to dealers.

The CHAIR — Rather than organised crime?

Mr KING — Most of the stuff will go to the dealer. The dealer will then put pressure on and then the dealer has to find the money, so it goes back to organised crime. So it is all downhill. It does not matter who they owe the money to, all of a sudden the dealer is circumvented and it comes from organised crime.

The CHAIR — Do you have any closing statements, Jason or Dr Quiery, that you would like to make?

Mr KING — No. Just to thank you for giving us the opportunity to participate.

Dr QUIERY — And good luck.

The CHAIR — Thank you. We have your recommendations. Thank you for those. They will go in as part of the discussion around the report. If down the track you feel inclined to make us aware of something or provide a verbal or written submission, please let Sandy Cook know. We do have a couple of months before we start editing the report. Thank you.

Witnesses withdrew.