LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Geelong — 28 October 2013

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Ms M. Grady, Youth Worker, Barwon Youth.

Mr T. Robinson, Co-ordinator, Barwon Youth.

Mr D. Moyle, General Manager of Client Services, Barwon Youth.

The CHAIR — Welcome, Melinda, Terry and Daniel, all from Barwon Youth, all presenting at the Law Reform, Drugs and Crime Prevention joint parliamentary committee hearing this afternoon. As you would have seen by our reference we are doing an inquiry into the supply and use of methamphetamines in Victoria, particularly ice. The inquiry is quite broad so we are looking forward to visiting a number of regional cities across Victoria and, of course, Geelong is one that we are here today. Thank you for your time.

I am going to read you the conditions under which you are presenting today. You know the rules about the evidence that you are presenting. The 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. However, it is important that you note that any comments that you make outside of the hearing, including effective repetition of what you have said in evidence, may not be afforded such a privilege. Have you received and read the guide for witnesses presenting evidence at parliamentary committees? Yes?

Ms GRADY — Yes.

The CHAIR — Thank you. It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for evidence that they would give or have given may constitute and be punishable as a contempt of parliament. We are recording the evidence and we will provide a proof version of the Hansard transcript at the earliest opportunity so that you can correct it as appropriate. We have allocated a time from 1.15 to 2 pm. I appreciate we are running a few minutes late, my apologies for that. As is the custom we do like to ask questions of you in relation to this inquiry. I know there are three of you and I am sure there are equal parts of the presentation, but given the time allowed we do ask that you allow some time for us to raise questions, and we might do so through your presentation.

Mr MOYLE — I might start and provide a little bit of context of who we are and what we do. My name is Daniel, general manager of client services, Barwon Youth. Barwon Youth used to be BAYSA but has been Barwon Youth for a number of years and has been operating as a service provider for 32 years. It provided a range of programs for educational training, youth justice programs, mental health programs and obviously drug and alcohol programs. Those drug and alcohol programs we have provided for some time, and I, particularly with my two colleagues to my right, have a fair bit of experience in working at the coalface with young people, particularly around that presenting issue of methamphetamine. I might hand over to Terry who will speak to some of the stuff that we have regarding methamphetamine use.

Mr ROBINSON — My name is Terry Robinson. We have been asked to come and have a bit of a chat about crystal methamphetamine today. We have not had a lot of preparation time. The information I have here, I got this morning off our stat system. It is basically evidence of the increased use of crystal methamphetamine, certainly the region within Geelong. I have been living here for 20 years and I must say the last 18 months to two years there is a really noticeable increase in the use of crystal methamphetamine use. As we know they always end up starting off in the cities and they build up a base and they spread outwards. Around the clear link between crystal methamphetamine and crime, we have certainly noticed that is the case. We have taken on in the last 16 months or so a COATS program—Community Offenders Advice and Treatment Service. In that time we have certainly noted that 33 per cent of the people that are coming to that program are reporting methamphetamine as their primary drug of concern. That is a fairly high stat. For a whole lot of reasons we are talking about crime around financial aspects, burglaries, assaults with weapons—

Mr SCHEFFER — Sorry, Terry, to interrupt you, that 33 per cent was that representing actual numbers?

Mr ROBINSON — We have 128—is the numbers for that—and I can tell you that 81 per cent of that male.

Mr SCHEFFER — Thanks very much.

Mr ROBINSON — You can see it is quite high there. We had 104 males come through the program during that time, and 24 females. The age range varies. We had five between 10 and 14; 61 between 15 and 19; 56 between 20 and 24, and we had six that were 25. We service 12 to 25 as part of that actual program. If we keep moving along with that—and I will go back to my notes—the one thing that we have noticed, while there has been an increase over the last 18 months to two years, we have not noted it with violence any more than alcohol. There is nothing out there that has shown us there has been an increase compared to alcohol at this point in time, we talk about the different neurotransmitters and we talk about dopamine, serotonin and norepinephrine, the fight and flight response which is norepinephrine that we talk about as being really important—it will increase the potential for violence if you have a predisposition to that. It is a bit like alcohol where we say that some people are happy drunks and some people are not.

What we found is the age range of crystal methamphetamine users has generally been higher than lower. The increase of it in availability and ease of access has increased. Nobody, according to the later surveys that I have seen, found it very difficult to access crystal methamphetamine. The cost is fairly stable, around $100 a point, up to $500 a gram. Some people get it for less than that. These are all things you are probably well aware of. There are reports of around 23 per cent of offenders that are dealing with methamphetamine as well which then went into the crime indicators.

When we compare our COATS system, which is our mandated court system, to our voluntary services, we have the Department of Health and we have St John of God, and we work with voluntary 12- to 25 year olds in both those services. I have done a quick rundown of historically methamphetamine use versus the current methamphetamine use for those voluntary programs. What we found is our Department of Health program, between 2006 and 2010, the primary methamphetamine use was only 2.2 per cent. We are talking about 6.2 per cent as the primary methamphetamine use for 2011 to current but, more importantly, over our last quarter we are talking about a 14 per cent methamphetamine as primary for this last three-month period.

St John of God which services up to 25, which is slightly higher than the DOH which is up to 21, was reporting 6.1 per cent in 2006 to 2010, higher than DOH by about four per cent, and 11.28 per cent from 2011 to current. Dealing with the older ones it shows there was an increase, almost double in both of those scenarios that we are talking about.

Other things we are looking at is how we engage people, what is really important as far as treatment goes. We are talking about engagement as being a very important component, especially in AOD. We are talking about 30 per cent of a treatment engagement being a primary support. What a young person brings into a meeting that we have them is about 40 per cent. We are talking 30 per cent as far as engagement and trust and building up rapport and relationship, and then we are looking at treatment and other things aside to that. We are also looking at different models. We are talking about trauma informed care, we are talking motivational interviewing. These are some of the things we are looking at. Melinda would like to talk a bit around the trauma informed care and motivational interviewing.

Ms GRADY — Sure. I predominantly work with the COATS clients, those clients who are or have been through the court system and have an AOD treatment order on their youth justice order. It is usually (indistinct) order from 12 to 25, so it is quite a broad range. Amongst the younger cohort we see a lot of alcohol encounters, maybe 15, more 16½. I have not see much more methamphetamine use. They have gone to court for things like burglaries, dealing, assaults, and some weapon charges. COATS will refer them to us as maybe a violent offender et cetera, and really it is our job to work out an assessment plan and a treatment plan. We use a couple of tools. One is a first response tool which looks at the current situation where they are living, how they are finding where they are living. We do mental health scoring checks through that. We look at a K10 which looks at a variety of emotions. We look at suicide, a (indistinct) screen and a mania screen. They are all questions that look at how a young person is functioning within themselves, their internal dialogue and how they are expressing that externally. That would be our first port of call, and we can get a quite good picture. It does open up an engagement tool. Young people will talk through those things.

Remembering these are mandated clients, not necessarily voluntary at this point. Our aim is to engage and continue treatment. We find that a very good tool to do that. Young people find it quite interesting themselves to discover where they are at emotionally, how the drug is impacting on their health, lifestyle and their mental health. They have been all very good. What also comes out of that is the trauma informed care model. We look at past issues that may have brought a young person to substance use. It does not just necessarily happen, it is a stream of things that bring that about for them. We use strategies, such as motivational interviewing which is about working out where a person is at in regard to treatment, do they want to make change or not, and if not what we can provide for them. A lot of that is education and information. They are very interested in how the drug impacts on them and their friends. They are not generally alone in that. It is a peer group situation as well. We find that very interesting and necessary to develop treatment plans for young people.

As I said before with the younger people, let's say 12 to 15, more cannabis than alcohol; 16, certainly cannabis and alcohol and maybe prescription medications are big players, and ice is now a much bigger player. They can use ice or methamphetamine. We are not sure about the levels of purity, but their use of it, they can be up for many days in a row which has a big impact on their mental health and their ability to cope with their moods. They are very agitated and anxious. We work on plans to help them, work through that, and not stem the amount of time they stay up. Not all clients are like that but the majority certainly who are like that will have a lot of paranoia type experiences, family unable to deal with the behaviours that are coming out of that, and police are likely to be involved.

Also we see young people who are in residential care. That comes with COATS and on the voluntary programs. A lot of those young people are being introduced to methamphetamine and they are finding it quite difficult to manage those drugs and being home as well, and the behaviours that come from that. It is the carers, the families and the young people themselves. After we have done our first response and have a broad picture we then need to go on and do an assessment tool which goes much further into their lifestyle; where they have grown up;, if they are still in their family; their education; if they are still at school; if not; if they have any kind of learning disabilities; medical issues that may impact on their life and lifestyle, and who they are connected to; their family or not a family; kids et cetera.

Mr CARROLL — How long is the program, like, length, because we have heard a lot of evidence that it cannot be in and out, it really has to be—for rehabilitation, for people that have been on ice, it is the holistic approach—

Ms GRADY — It is.

Mr CARROLL — What has gone on in their background. It has to be months, it cannot be in and out in a matter of straight detox.

Ms GRADY — No. In fact, it can take quite a long time. On COATS and on the voluntary programs we can keep people a year or more. In that time their use may not necessarily be all the time, it may fluctuate. We would be facilitating moving them into residential units for detox and collaborating with other programs to connect people to general practitioners, psychologists who may be available as well to further assess their mental health. It is not a short-term issue, that is why engagement so vital. It is to keep the young person engaged as long as possible, regardless of the ups and downs that their substance use and lifestyle will bring about. Sometimes they can back off and they know they can come back, and sometimes we will facilitate phone calls as an outreach. We do the outreach to the young people, street based outreach, the bus is an outreach as well. We run education in schools as well.

Mr ROBINSON — Really what you are talking about around treatment is that holistic approach. It is really formulating a plan individually for a young person and how long is a piece of string as far as how long we may work with somebody. It is whatever their needs are. You are looking at their history because it is not just the substance issues, it is looking much further (indistinct) the cause and effects of those, the reasons why they (indistinct) getting them to make sense of that, it can start to work, and making some change (indistinct)

Ms GRADY — Often young people will medicate their trauma, the triggers of their trauma. We often will do that in a care plan, look at that trauma and help them identify what a trigger is and how they then medicate that with their substance.

Mr McCURDY — Do you feel like you are winning the battle? Obviously in amongst the group that comes through there will be repeat people that come back again.

Ms GRADY — Yes.

Mr McCURDY — We always put a lot of emphasis on those who are coming around and around. Are you comfortable with where you are going or are there more tools or resources that you would change to try and get better rates out the other end?

Mr ROBINSON — I think you always need more resources. We are resource poor. Also the key (indistinct) can be an issue. There can be a high turnover (indistinct) we will not go into all of those details at the moment but I think with the resources we have, if you have a good team it works well. We can get some positive results. There will be young people that get some positive results out of that. They need to be a part of that, they need to work with you. They need to be on board, especially voluntary. You cannot go out and bring them in. You need to build up that relationship and get that right and then you can really start getting to the bottom of the issues. We are talking about meth today but it might be other substances (indistinct)

Ms GRADY — On the COATS program the young people get orders that will last from eight months to maybe 18 months. The AOD treatment component, you can have several episodes in that 12 months, not just the one episode. That is really important. I have found in COATS that once we engage, when the young person is engaged, I find that there is an amount of success. They have got to the point where things are pretty tricky in their lives and a lot of young people will be open to the support that you can give them.

Mr ROBINSON — There will be those that (indistinct) and try a program and not leave that program. What we find is when they really get in dire straits, if they build up a bad relationship they will be back. We find that happens—

Ms GRADY — Yes.

Mr ROBINSON — That is the other drawback, we cannot contact them, they are uncontactable, they have dropped off a program and then lo and behold, two or three months down the track or whenever it might be they have presented back at the door. It is often when they are in somewhat of a major crisis that they need your support, so you reformulate another plan and start that process with them again. We have that really open door policy if we can. We only have so many workers so therefore you are sort of hamstrung a little bit that way. There can be a wait list at times. It is always best to strike while the iron is hot when people are ready to make changes, but we do our best to accommodate everyone if we can at some point in time.

Ms GRADY — We do introduce young people to models. I am not sure if any has seen the process of change model?

The CHAIR — No. Would you tell us about that because if I could preface it by getting to the bottom of the issues. My mind reels with the levels and levels of what that might mean, and also in the sense that you might do something—and we have spoken to others who are doing some more things—but returning them back to the situation that a young person does not have control over, how does that work? That might be the vehicle for talking about that.

Ms GRADY — We use the process of change model. It is well known in the AOD sector. When you go through change there is a process attached to that. From the outside it is a circle and you can see you are a pre contemplator on the outside of that circle, so there is no problem. A young person would identify there is no problem, their drug use is good, they are into it, there is no problem. There may be a problem but if the young person does not identify it, there is no problem. Often with court that gets them to be a contemplator. Something happens here that gets them into the process of change, they become a contemplator and do consider that in fact, 'Oh, my drug use

might be a problem, actually. I did a burg, I got caught, I've got an order, could be a problem. My family won't have me at home, my friends won't speak to me,' a variety of things. They come into that. Whilst there needs to be sections we are limited—well, in a pre contemplator you must provide educational information about the substance and the impact and get them to identify how that works for them and does not work for them. Then they become a pre contemplator and then you can do a lot more work around the pre contemplation.

They now consider there is a problem, there is no going back to being a pre contemplator. Once you are there, you are there. We help them identify that they have come into that process of change and what do they want to do about that. Sometimes it is nothing or sometimes with the provision of information and education it could be, 'I should go and do a detox,' then we will facilitate an inpatient stay. That can take but whilst we do that, we will continue to see the person. It is engaging them in coming into treatment, continuing to see you, identifying triggers, when they use, how they use, who they are using with, and their behaviours whilst they are on the drug. They then get to consider all of that. Then they have to get into a stage where they determine to do something about that. They have to make decisions about what they want to do about that. It could be nothing or it could be going to an inpatient with detox or seeing their GP or seeing a psychologist or just continuing with us. Then there is an action stage so that action would be to get into the withdrawal unit and start a withdrawal, clean themselves up and get as straight as they can in that period of time. Often they will be returning to an environment that substance use is still the factor, so we can look at maybe non return rehabs for them. It is quite difficult, it takes time. It just takes time to get that done. There is an action stage, they have to move around that.

Once they identify that and know that there is something that they are moving through, I find that is a cycle for them, for young people. A lot of young people have issues with their education and comprehension. We have different kinds for young people, it would not just be the circle, you would do the little men, the little man who talks to himself as he goes through the cycle, what he is thinking as he goes through that. We look at their internal dialogue. What are they thinking as they go through that. There are often dips, things are going to be difficult at points but they can come up through that dip. There are structural things and tools that we teach them, that are colourful, that are different, that are towards the person's level of comprehension and they are quite structured. The first sections of this, often we will see COATS pre contemplators to contemplators, education, information, options are real tools there.

Mr CARROLL — Is pre contemplator where they do not really own up to having a problem.

Ms GRADY — Yes.

Mr CARROLL — But they have been through the court or something like that, 'Now, I'm contemplating, I've got a problem here that needs addressing.'

Ms GRADY — Yes.

Mr CARROLL — That is critical, and owning up to and wanting to take action.

Ms GRADY — Yes. That is a critical move right there from a 'No problem at all, it's all good' to, 'Actually there is a bit of a problem.' It can sit there for quite a while but that is about the engagement that drug and alcohol workers deal with, with young people through that time, and education. We have a variety of educational tools. We use little models of the brain and we help them understand what is going on in the brain. Education, visual things for young people—we do quizzes. What else do we do? Their concentration can be quite limited. We do find that with methamphetamine that concentration is an issue. With cannabis, it would be more around the motivation. Different drugs there would be different sensitivities. Educating young people about the rollercoaster of the change of process does not go easily all the time, and we all know that. We use different tools, and visual ones to show them that. Young people are clever and once they comprehend that it is part of—

Mr SCHEFFER — Most of the people you are seeing are the ones that have already shifted from the—

Ms GRADY — Pre contemplator.

Mr SCHEFFER — Pre contemplative stage.

Ms GRADY — Pre contemplator.

Mr SCHEFFER — You are not seeing the ones that have not hit that point yet?

Mr ROBINSON — Not usually. Certainly the voluntary program does not—

Ms GRADY — They would become a contemplator.

Mr SCHEFFER — But wouldn't that still be a function, something would have jolted them to come and knock at your door?

Ms GRADY — Yes.

Mr ROBINSON — Absolutely.

Mr SCHEFFER — What I am getting at is, do you have any sense of how many young people are out and about before that stage?

Ms GRADY — Are pre contemplators?

Mr SCHEFFER — Yes.

Mr ROBINSON — We could say lots. Putting a definitive number on that would be hard. It is certainly at all walks of life. We are hearing that tradespeople are using it, apprentices that are using methamphetamine to get through the day, university students, TAFE students at lunchtime.

Mr SCHEFFER — Sports people.

Mr ROBINSON — Yes, from all walks of life.

Mr SCHEFFER — White collars.

Mr ROBINSON — It is out there so it is obviously—

The CHAIR — I am mindful of the time, sorry to interrupt. Terry, did you have something else you wanted to add or we will throw it open to the committee.

Mr ROBINSON — Probably the importance of using other substances. I have not really touched on polydrug use, and what we are finding is that most of them are using other substances, and often too to come down—they will be using depressant drugs, the benzodiazepines, cannabis to come down, and alcohol. That is pretty important to know they are using those substances. It is also going to have a negative impact. With lots of drugs in general, some of them will try to reduce or stop one particular type of drug and then transfer to another one. It is trying to get them to change their whole behaviour. When you talk about some of the underlying issues, there is a plethora of what is out there, that is part of that engagement, trying to work out—are there any underlying issues; are there any light bulb moments; are there any particular places or time in history that have contributed to the behaviour, that risk-taking behaviour you are taking now.

Often if you can get them to see that then they can start making sense of it. It might be something like a family separation, mum and dad. It does not sound like it has a big impact on people but it has a much larger impact on people—male role models. It has been huge, I have been in this for 20 years and this has been one of the biggest deficits I have seen is a lack of male role models. We need more males in the field as well. Recently we had a young man with very high risk-taking behaviour, was in line for an accidental overdose there, and we got him to a point where we found

out that his father was not on the scene and he was really needing to be there for him and we managed to facilitate that to happen through his father and himself and then (indistinct) in rehab and doing it with the father. That is what I mean by getting to the bottom of an issue is to try and find out what it is with the young person, ask them as well, 'What's going on with you? What's the situation? Why are you where you're at? What do you want to do?' Work with them at the level that they are at. It is pretty basic stuff but it is really important for them to know why, and to have good people working with them.

Mr McCURDY — Is there a better success rate with family support rather than without family support?

Mr ROBINSON — I would say so, without a shadow of a doubt, if you can get everyone on board. Not every family is able to get on board or is prepared to get on board, but family inclusive practice has probably been underrated for a long time in this field and it needs to be acknowledged. It is extremely important to have care-givers and those around you. They are going to play a big part in any recovery for any person for that matter.

Ms GRADY — In the voluntary programs intake, a lot of mums are referring their young folk into a treatment service to try and facilitate that for them. I do think that is important. We have a parent program that we have put together, so we will have long discussions with the parent. Those programs are voluntary so we do need to speak to the young person themselves and we will provide information and support to parents.

Mr ROBINSON — Sometimes that needs to be external supports and other times it can be internal as part of the treatment program. You need to have the young person on board for that because they do not always want their parents around their current issues at that point in time but it is trying to have a conversation with them to say that it is really important for them to be involved at some level.

The CHAIR — Any other questions?

Mr CARROLL — I was going to ask two quick ones. You mentioned outreach programs about the bus, just a bit more about that, and your view generally on drug education in schools.

Mr MOYLE — Barwon Youth has a Streetsurfer bus. The Streetsurfer bus started off in Sunshine many years ago. We have had that since around 2009 and we utilise the bus at a number of places, community events but also used in outreach, going out on a Friday night. It used to be in the mall here in Geelong but there are other places that we are taking that to now, skate parks, community centres, schools. On the bus we have drug and alcohol workers, we have youth workers and we have some educational material, so we can get out and about where young people are. It is a fantastic bus, it is very youth-friendly, it has flames down the side, it has computers, it has TVs and PlayStations, all that sort of stuff. It is a fantastic opportunity to get out to where young people are and then provide them with some educational material and let them know that Barwon Youth exists and will provide these services.

Mr CARROLL — That is all DHS funded, the bus?

Mr MOYLE — No, we pretty much fund that from philanthropy funding.

Mr ROBINSON — It probably is under-utilised, we could certainly do with more funding.

Mr CARROLL — It is a different angle to get at youth, isn't it?

Mr ROBINSON — Yes, to get it in there, to get the presence of it. You are looking at a number of hubs in Geelong and around Geelong. You are looking at Bellarine, you are looking at Drysdale and around that area, Ocean Grove, the Surf Coast, the northern suburbs, all those areas that really need some sort of service. There are a lot of young people that slip through the gaps. We need to get out there and try and service them as well.

The CHAIR — From the outset you said that the increasing use of methamphetamines by those youths seeking support has not increased. Is that what you said at the start?

Mr ROBINSON — No.

The CHAIR — I have here, 'Hardly noticed any more than alcohol.' Do I assume then the alcohol has gone up in line with the crystal meth use?

Mr ROBINSON — No, that was around the violence.

The CHAIR — The people you see through your system using crystal meth has increased dramatically or—

Mr ROBINSON — It has certainly increased if you go from the 2006 to 2010 which from the Department of Health was 2.2 per cent and this last quarter it was 14 per cent. If we look from 2011 to current, that is roughly to 6.2 per cent. It has gone from 2.2 to 6.2, but the last quarter in particular would be 14 per cent. We are looking, with St John of God, of that doubling from 6.1 almost doubling to 11.28 per cent over that same period of time. There is definitely an increase. The comment was more around the prevalence between ice and violence.

The CHAIR — Which is unusual because all the evidence that we are hearing is because crystal meth does create, in some, quite violent behaviour, that the frontline services—police and paramedics—are seeing.

Ms GRADY — The police and hospitals—

The CHAIR — It is more of an issue in relation to violent activity.

Ms GRADY — Police and hospitals would see the violence, the agitation.

The CHAIR — But not so much through the youth system?

Mr ROBINSON — Not through us. Our workers are—none of the team have been under any major threat from any of the young people they work with that have crystal methamphetamine issues at this point in time.

The CHAIR — Is there a stereotype use that you see in relation to drug and alcohol? Geelong obviously has more employment issues, particularly in the manufacturing base, which we are well aware of. Is unemployment attached or is it generational family unemployment that—

Mr ROBINSON — I personally think it is probably a combination of all of the above. In my view is if you look at society now there seems to be a lot more disenfranchised, dysfunctional type of—there is a high divorce rate. Financially people are not as well off as they used to be. I would suggest there is an increase for a whole variety of reasons. I do not think there is an easy quick fix.

The CHAIR — There is a generation of youth that it is 'all about me', isn't it? 'I need and I want now,' that is, 'I want wellbeing now.'

Ms GRADY — I think there is also instant gratification from substance use compared to the hard yards are not learnt first, that in fact the accessibility of drugs to young people is probably higher than it has ever been. They are disenfranchised and traumatised, there is generational family use, and it is easily accessible and it is an instant gratification issue. Does that make sense?

The CHAIR — Yes.

Ms GRADY — Substance use can to some degree help settle them down in some cases and can inflame them in other cases, yes.

The CHAIR — I think they are very complex propositions though.

Ms GRADY — They are.

The CHAIR — Looked at historically, I am not doing the interview with them, but I think it would be very problematic to draw some of those conclusions historically.

Ms GRADY — Yes, okay.

The CHAIR — You can go back to Socrates and young people want instant gratification. It seems to go with the turf.

Mr ROBINSON — Absolutely.

Mr MOYLE — Nothing new under the sun.

The CHAIR — In that sense they are very complex.

Ms GRADY — Sure, but there is accessibility, isn't there, and they are highly accessible.

The CHAIR — Of course. There has been alcohol that has been highly accessible.

Ms GRADY — Yes, absolutely.

The CHAIR — It is complex. That is all we are saying.

Ms GRADY — The treatment is complex, very complex.

The CHAIR — Of course. Thank you, the three of you, very much for your time this afternoon. We appreciate it.

Witnesses withdrew.

Hearing suspended.