LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Geelong — 28 October 2013

Members

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Ms B. McNair, Service Development Officer, Southern Territory Alcohol and Other Drugs Unit, Salvation Army, Kardinia.

The CHAIR — Belinda, thank you very much for making the time available to present to the committee this afternoon.

Ms McNAIR — My pleasure.

The CHAIR — This is a joint parliamentary committee of Law Reform, Drugs and Crime Prevention, and the inquiry we are currently working on is the supply and use of methamphetamines in Victoria, particularly ice. We have allotted some time this afternoon. My understanding is you have a small presentation and then the committee would like to ask questions of you. Before we commence I do have to read you the conditions under which you will be presenting to the committee this afternoon. 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. 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?

Ms McNAIR — Yes, I have.

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 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. I would now like to invite you to make a verbal submission and we will ask questions as appropriate. Thank you.

Ms McNAIR — Thank you. My position, I am a service development officer for the Salvation Army so I sit within the Territory Alcohol and Other Drugs Unit, the Geelong withdrawal unit. I am going to talk specifically today about the withdrawal unit in Geelong and what we have found there and then I can speak a bit more broadly when we get to question and answers. I am giving you a combination today of statistical data that we have drawn from our database and also anecdotal evidence drawn from experiences and observations made by staff and clients of the Salvation Army and that has been reported to the alcohol and drugs unit. We have seen an increasing trend of ice use not only in our AOD services but across other social programs, so mental health, domestic violence, primary health, housing and homelessness services are also reporting an increase.

The Salvation Army itself, you are probably well aware, has had a presence in Australia for over 130 years, is well known and respected as an international charitable organisation. We are well experienced and dedicated to provide support services to the most disadvantaged people in the community and those who would experience significant health, economic and social issues that result in significant deprivation and isolation from the broader community. We provide a range of social programs from homelessness and accommodation services, domestic violence, alcohol and drug, court and prison, aged care, out of home care, family support and so forth.

We have had a long history of being an AOD service provider. We are one of the first organisations funded back in the early 90s to provide alcohol and drug provision. We provide services from primary interventions, such as needle syringe programs and primary health, right through to individuals who are pre contemplating and still actively using, through to secondary and tertiary interventions for those who are motivated to seek treatment. We provide, in terms of AOD drug treatment, residential and home based withdrawal services, resi rehab, counselling, consultancy and continuing care, AOD supported accommodation, outreach services, drug diversion and forensic drug treatment, after-care and post-withdrawal linkages and support groups, and programs that are specifically designed to meet the needs of special populations—correctional clients, IV drug users, women, homeless people and particular ethnic groups in the community. Primarily our funding is through the Department of Health. We do have some programs funded through the Commonwealth Department of Health and Ageing and, in addition, the Salvation

Army itself invests generously through the provision of Mission Support Funding. I might add that Mission Support funds are only available to programs that are in receipt of government funding.

The evidence presented today primarily relates to ice and/or speed rather than other amphetamine type substances, such as cocaine or ecstasy. I have given a little breakdown there of the three main amphetamine drugs that we are seeing present. That is methamphetamine, methamphetamine base and amphetamines. As you would be aware we have those who present who are either ingesting, smoking, snorting or injecting. The effects last from eight to 24 hours but there is a half life of about 12 hours with amphetamines. The effects of amphetamines being wakefulness, increased mental alertness, ability to concentrate, hyperactivity, reduced appetite, euphoria can induce increased libido, feelings of bravado and invincibility and decreased inhibition.

Obviously the negative effects of that are overstimulation with restlessness, insomnia, anxiety, tremor, paranoia, erratic, sometimes violent and sexually inappropriate behaviour, can induce individuals to behave in ways and/or take risks they would not normally be accustomed to. The mental health consequences is it can induce a toxic psychosis characterised by paranoid delusions, hallucinations, thought disorders, mood swings, out of control rages, extremely violent behaviours and again sexually inappropriate behaviours. Withdrawal presents hypersomnia, depression, suicidal ideation, low moods, physical and mental cravings.

The statistical evidence collected by the withdrawal unit in Geelong appears to support the anecdotal evidence provided by clients and staff from other AOD services that the uptake and misuse of methamphetamines is occurring in the community and has increased. To put the statistical data in context a brief overview of the Geelong SalvoConnect Network is perhaps warranted. The withdrawal unit in Geelong is a 12-bed community based residential program, and a three-bed residential independent living program. The unit offers a recovery program that consists of three stages: stage 1 of the program is an average six night residential stay for adults seeking to withdraw from alcohol and other drugs in a safe and supportive environment; stage 2 of the program consists of up to a further 21 night residential stay to enable people to stabilise, commence planning and initiate action towards a return to their community post-withdrawal; and stage 3 offers a further 12 week stay in a residential house off site but located closely to the unit where people can come and participate in programs during the day.

We also provide post-withdrawal linkages support and that provides advocacy, support, outreach and referrals to appropriate services and supports for individuals during and following their withdrawal episode, and the program offers facilitated groups to people in the community, as well as support to individuals and their families. The aftercare program provides a range of support to clients following the withdrawal episode and the program has two full-time workers. We also have a COATS or a forensic counsellor based at the withdrawal unit who provides consultation, counselling and continuing care to individuals referred by the justice system. The program has one worker three days a week, and all referrals come through COATS, the forensic service provider broker.

Within the SalvoConnect network down here we also have a mental health service, a women's service that has an AOD support component, a community support service, crisis and financial counselling, and a network chaplain. In the mid-2000s, methamphetamine appeared in Melbourne's drug markets. Prior to this it was really only speed that had been available. Interestingly, meth or ice started to appear in Melbourne's drug markets about the same time as the so-called heroin drought in Melbourne. If we go back to 2002-2003 at the time I worked in needle syringe provision but that is when we started to see people coming in for equipment for ice. In actual fact it was not for needles, they would convert lighters to be like Bunsen burners that they were using the needles for initially. There was a bit of a spike in ice use in 2006 and 2007 that led to the state government doing quite a large advertising health promotion campaign and AOD funding was diverted to some specialist treatment services relating to ice use.

Prior to this not many people presented to residential units for amphetamine withdrawal. In fact, some units refused to take clients for amphetamine detox in those days. In 2006 or 2007 when people were starting to present with ice misuse problems, the Geelong withdrawal unit revised and altered clinical practice for methamphetamine withdrawal, and the change in practice was required

due to the different nature of withdrawal symptoms for amphetamine type substances compared to alcohol or opiates and to ensure risk factors were mitigated and that client comfort and outcomes were improved. The actual physical withdrawal symptoms of ATS whilst perhaps not as medically risky can take longer to subside, require different medical regimes to manage symptoms, and strategies need to be in place to manage difficult and/or challenging behaviour.

However, the volume of ice presentations has increased which does place pressure on the unit. Currently all clients—alcohol, cannabis, heroin or amphetamines—get about a six to seven day withdrawal episode. That is what most services are funded for. We have found that amphetamine users definitely need 10 days, sometimes longer. Primarily for the first few days in the program and in withdrawal we have found that clients need to sleep and eat basically. People are agitated. When they do go to sleep they want to be left to sleep. We were finding that if they were rousing people to get up for the program or get up for particular things that is often when the challenging behaviour emerged. All they felt capable of doing at that point was sleeping and starting to get some nourishment, so the program was changed a bit. Obviously if people were well enough to participate from day one, they could, but there was some leniency in the first few days to allow people that time to sleep and start to get some nourishment.

Mr SCHEFFER — Prior to that part of the treatment regime where they would go to sleep, what happens in that in-between bit? I am saying that in the context of—does the agitation subside of its own accord or do you need to take some intervention to calm people?

Ms McNAIR — Bear in mind I am not a clinician—

Mr SCHEFFER — No, I understand.

Ms McNAIR — Anything specific I can follow up for you. My understanding is it very much depends on the person, the level of use and how long they have been using as well on how the symptoms can impact on people. Some people may feel okay to participate in the program on the first day but others will not, so they monitor each client individually. They are obviously clinically monitored very closely in those first few days. If the client is expressing a desire to sleep or that is what they need to do then they are given time out of program to do that, and then they can join in.

Mr SCHEFFER — When they arrive, they are already pretty calm?

Ms McNAIR — Again that is a case-by-case situation. If someone has come in because of a drug treatment order and does not want to be there, there might be more agitation than someone who has already been thinking about it quite possibly or even started to cut down their use. That would vary but I am happy to take a question on that and then come back to you.

Mr SCHEFFER — Thank you.

Ms McNAIR — Really what would you like to know is when they present at withdrawal, how long before they are comfortable enough to start participating in the program.

Mr SCHEFFER — And whether the people working with them need to do something in particular for them to calm them.

Ms McNAIR — Yes, and that would come into the medical regime.

Mr SCHEFFER — I understand, yes.

Ms McNAIR — We have found these clients often need extensive support, monitoring and management as clients often experience odd thoughts, and they can be suspiciousness, paranoia, anger, delusions, jealousy, misperceptions, auditory hallucinations, magical thinking—I am not entirely sure what magical thinking is but I will follow that up—and aggression. The withdrawal phase for amphetamine type substances generally occurs as follows: day 1 to 3 is called the crash or coming down characterised by hypersomnia, increased appetite, feeling flat, exhaustion, forgetfulness, not coping with routine activities, need frequent reminders, warnings

and behavioural contracts. I have had some clinicians tell me there is a similarity when dealing with people with an ABI where you have to constantly remind people, give them support to come along.

Day 3 to 5: after the crash the body begins to recover but it manifests extreme mood swings, irritability, angry outbursts, sleep disturbances, headaches, aches and pains, poor concentration and, of course, cravings. Mood swings and irritability impacts on relationship conflicts and some clients may experience rebound depression, some psychotic, contemplating and suicidal ideation.

The CHAIR — Belinda—this is no disrespect—we have heard a lot of this.

Ms McNAIR — Okay, I can skip through it, yes.

The CHAIR — It is not so much about the symptoms, it is more what the Salvation Army has seen out on the frontline and how you think we might be able to help in relation to any recommendations we might make.

Ms McNAIR — Yes. I will skip the next bit which talks about sedation and symptomatic relief and so forth.

The CHAIR — Having said that, we have the documentation, but the committee may well want to ask questions of you on it, but rather than you go through it word by word.

Ms McNAIR — I appreciate that. The trends we have seen—I will get to the nitty-gritty—there has been considerable dialogue, particularly over the last 12 to 18 months between all our services but I have only pulled data on the withdrawal unit at this point. Over the past three to four years, in 2009 and 2010, 2.5 per cent of clients presenting to the withdrawal unit named ice as their primary substance and at that point it was the fifth highest reported primary substance at 15.3 per cent. In 2010-11, the number of people presenting increased from 2.5 per cent to 3.4 per cent and it was still the fifth highest recorded primary substance. By 2011-12, 7.6 per cent of presentations was for ice and it has gone up at this point to the third highest substance at 18.63 per cent, and in 2012-13 it has gone up again. It was 8.9 per cent of people reporting for amphetamine withdrawal, and again is now reported as the third highest substance. You can see there has been an escalation since 2009 by 6.4 per cent in terms of the primary substance on presentations.

The CHAIR — Is that methamphetamine or amphetamine?

Ms McNAIR — It is ice. We have seen very few people come in for just speed, it seems to be all methamphetamine. There are debates on that on whether people are buying ice or whether they are buying speed that has had an additive into it that makes it burn, so they think they are buying ice but according to the client it is ice. I have given you a couple of case studies there. Generally we are seeing a lot of clients with polydrug use. Often it is used alongside alcohol and cannabis as well. Where it has had an impact for us, I guess, on program is that we have needed to skill our staff in terms of difficult and challenging behaviour and managing that in a residential withdrawal unit because obviously when someone erupts that has an impact on the 11 other clients in the unit at the time, and because we have had to alter clinical practice in that these clients need a little bit longer, it is a matter of us being flexible around our episodes of care and so forth to manage that. In saying that, all alcohol and drug providers should be able to respond to people with meth use issues.

We all need to have the ability to respond in terms of what these service providers do. Service providers do need to review clinical practice service models to ensure that appropriate treatment models are available to meet the needs of clients, enhance positive outcomes and ensure duty of care for those who are dependent on amphetamine type substances is addressed. Ensure that staff have robust knowledge around these types of drugs and an understanding of the relevant and most appropriate treatment interventions. Build capacity in staff to effectively manage and respond to clients displaying challenging and difficult behaviour. Be aware of and respond to the health, social and economic harms associated with amphetamine type substances, including those harms not directly related to the drug itself but are a consequence of using the drug, and that allows staff to identify brief interventions and health promotion activities.

Often we find people have financial issues because of their using. They may well have sexual health issues if they have been using a lot, and there has been a lot of unsafe sex because of the nature of the drug and the bravado, and people often don not think about safe sex practices. There is a risk there in terms of spread of virus and also sexually transmitted infections. That is also an issue with the injecting equipment too. People can have bravado if they have run out of clean syringes. Those type of things happen, and workers need to have health promotion messages to remind clients about that. It might be they have not thought of a HIV test for many years but it might be a good time to have one.

Reduced nourishment is an issue because some people, if it has been long-term use, they have been impoverished as well. It could be borderline malnutrition, and I have already spoke to the safe injecting practices. Where we are finding real pressure is in our service types, like homelessness, domestic violence because there is staff that is not necessarily trained up around alcohol and drug use as such but they are experiencing it first-hand and they are also experiencing the behaviours first-hand. That happens quite a lot in our crisis services, particularly when people are living on the streets still actively using, needing accommodation. There needs to be, not only across the AOD sector but other social programs, education.

We are also of the view that there needs to be further research into withdrawal. There are some in the sector that would argue there is no clinical evidence to demonstrate a withdrawal syndrome for amphetamines. There perhaps needs to be some research there. Up until very recently there was still a couple of detox services not taking clients for amphetamine withdrawal because their view was there is no clinical evidence to demonstrate there is a withdrawal syndrome. We would certainly argue—and most people that I would speak to in the sector would argue—that there is definitely a withdrawal syndrome but it has not been clinically identified or researched.

The other perhaps disadvantage for people with dependencies to amphetamine type substances is there is no substitution or maintenance therapy for methamphetamine. There was a little bit of research done, again early 2000s, into possible substitution therapies like dexamphetamine but that never went any further. Given the success of opiate based substitution or maintenance therapies we would encourage perhaps some further research around that element. The knowledge base needs to be built in general around amphetamine type substances, and I would say alcohol and drugs, per se, in other health and welfare related disciplines—medicine, nursing, social work or other—and to ensure that information and health promotion campaigns provided to the community are accurate, rational and do not inadvertently create further stigmatisation for users.

One thing I have personally found significant is the price of amphetamines is increasing, particularly over the last five years or more. Traditionally, heroin was probably the most expensive illicit drug on the market, and now ice is. What people would pay for a point of heroin, which is about $50, they are paying about $80 to $100 for ice. The ramifications of that on the broader community, with it becoming more expensive, obviously people start to commit more crime to support their habits and that would be a concern that it is probably a result of increasing demand. If people can get that kind of dollar for it they will try and get it. It would appear to be slightly cheaper in regional areas than in the CBD, but we are only talking about a $20 difference, but it has skyrocketed. A gram of ice on the street is about $650. A gram of heroin on the street is about $500. That has only changed in the last few years. The other thing we have seen is not a newer cohort but often people are quite well-educated, are working. They could be tradesmen, they could be students, they could be shift workers, that they are starting to use the drug to help study or help with long shifts. We are seeing a slightly different cohort in that respect.

Because I am only talking about the withdrawal unit, the other thing that has come to our attention is when people hit rehab, which is post-withdrawal, if they are eligible for rehab and go into rehab, some people are experiencing psychotic episodes three or four weeks after their withdrawal episode. The impacts of withdrawal are still prevalent a month or six weeks down the track. Again if they are in a resi rehab program that requires careful management of the staff. Again in a rehab program there are other people to consider as well. That probably brings me to the end of what I have collated in the paper for you. I thought you might have questions around postcode data or where the clients are coming from and roughly just over 60 per cent of the clients coming to the withdrawal unit—or it is more—over 60 per cent are from Geelong or surrounding suburbs, and

then the rest from further up the coast—7.8 per cent from Queenscliff; 3.2 per cent from the Surf Coast; 1.3 per cent from the Otways, and four per cent do come up from Melbourne and that is because withdrawal services are statewide services, so a client can elect to go to whichever withdrawal service they like. That is why we still see clients from Melbourne. Some might have been through other detoxes and they want to try a different one. I am open to any questions.

The CHAIR — Are you able to trace back where they get the drug from?

Ms McNAIR — We do not generally ask those questions. Obviously NSP people will be asked what drug they might be equipment for. There are concerns, particularly in a frontline situation, (a) in an NSP it is confidential, so you are not taking people's names or addresses or identification. People would need to be well and truly engaged with a worker before they would be telling a worker how they score and where they are scoring from. They will see whether it is easy or it is available or what they will pay but they often will not identify the final details or nuances. Like our heroin market, is not so much a street market any more, it is all mobile phone connections, meet and greet people. In saying that, that can be a problem because people often report that they are trying not to use but their dealer rings them when they have not heard from them for a week or so. 'Hi, mate, what are you doing? I've got good gear. I haven't heard from you.' That can make it extremely difficult for people and that has been a side effect of moving away from street based drug markets where it is all anonymous to dealers that are holding people's phone numbers where they can contact them back. If they are having a slow week they will start ringing around old clients.

Mr SCHEFFER — That was really interesting what you have told us. Reviewing the day, I think I have two messages: on the one hand you can have a profile or a person who has run into serious trouble through using ice and we have a picture there of someone who has deep personal psychological or cultural trauma that leads to a sense of low self-worth and this context reinforces that and so progressively reckless behaviour and they end up in a situation where they get picked up or they turn themselves in to do something about it. Then there is a kind of another modelling of professional tradespeople that use it on the weekends and the sense is they are in control of themselves and their lives are okay, they are having a bit of fun with it, but then the thing takes over and they end up in trouble. Is that how you see it?

Ms McNAIR — Yes.

Mr SCHEFFER — My question is, if they are the type of trends we are seeing, how do you deal with, on the one hand, that deeper side where you are plumbing the real depths of almost a spiritual, existential type experience that someone is having, how do you deal with that?

Ms McNAIR — Particularly with the long-term users and someone with a background that there is perhaps trauma and other issues, and certainly if they have mental health issues, you would be wanting to connect them into a mental health service initially for a proper mental health assessment and support through a mental health service because if you are talking long-term trauma like that, often it takes a lot longer than an alcohol and drug episode, and also not all clinicians are psychologists or psychiatrists, in terms of duty of care to the client you would be referring them to mental health professionals. Interestingly, I happened to speak to a gentleman the other day who confided that he had been on dexamphetamine for 10 years, there is a GP that prescribes it, and it can be done for prior speed use. For him it turned out he was self-medicating. He was not diagnosed with ADHD until his 40s. For many years he had been self-medicating with speed around his ADHD but was not aware of that.

Of course, he consequently ended up with problems, he has been right through the treatment cycle and has now been in recovery for about five or six years but he is still on dexamphetamine. That keeps him safe, it keeps the cravings at bay. That is where you have a diagnosis of an actual mental health issue where he has been self-medicating. There will be elements of that out there as well. People abused heroin over the years to self-medicate the depression. I daresay people are using ice also to self medicate for depression. Initially they feel great but the depression comes crashing down once they stop using.

Mr SCHEFFER — Do you think from your experience there could be—given the two cohorts I mentioned—a third cohort that is able to keep it to weekends and keep it to a level—like, not everyone who drinks alcohol becomes an alcoholic or has an alcohol problem. Eighty per cent of people are fine for most of their lives.

Ms McNAIR — Yes.

Mr SCHEFFER — Is there a cohort of that, do you think?

Ms McNAIR — I would agree that there is and we have seen that with opium users over the years as well, that there are some heroin users that are functional, continue to work, do not use every day, might use recreationally a couple of times a month and have always managed to maintain that; just like there is an element that started to use it because it felt good and it was part of what their peer group did at the time but then ended up running into trouble with it, or those that are attracted to it because of past trauma. I would say it is the same. You would have those three cohorts with ice, as you would with heroin. Even alcohol is another drug. Statistically it is one in four that drinks that goes on to have an alcohol problem. It is about the same with opiates.

Mr SCHEFFER — It could be there is a very large cohort of good citizens that buy into this market and it is part of their recreation and it is really not a big deal for them ever.

Ms McNAIR — Yes. In personal experience I have seen that. I come from a well to do private school background in Melbourne's bayside suburbs but I was interested to see in the year 2000 people in their late 40s, 50s that perhaps used cocaine every now and then, to start using ice every now and then and still continue to do so. But I have also had a friend coming seeking advice, a gay man recently moved back to Melbourne, ice has hit the gay scene very much and what started as what his peer group was doing has turned out to be a problem 12 months later.

Mr SCHEFFER — Thank you.

Mr CARROLL — One of our terms of reference is to consider best practice strategies to deal with methamphetamine use. I want to get back to your point about substitution therapies. With heroin, the methadone program is obviously getting recognised as achieving some good results, tailored with intervention. I am no medical expert but you may be able to answer this, with crystal meth ice where are we at the moment in developing a tailored substitution for it?

Ms McNAIR — Nowhere at the moment. Some years ago there was some talk, and I do not know whether the clinical trials ever took off. I can find out about it, or whether they stopped before it went to clinical trial, but the two drugs being flagged were dexamphetamine and modafinil for the treatment of amphetamine type substances. But I do not think the trials ever got off the ground. I do not know whether it was to do with—there has always been sensitivities about substitution programs anyway. Whether it was that and some bucking the system, but I can make some inquiries and find out. I thought it was Turning Point. I would have thought you would have spoken to Turning Point at some point. I think it was Turning Point that were going to do the trials but they could perhaps speak to that more on why it did not go ahead, or whether they started some preliminary work and found early in the piece that there were some issues and that is why it was not taken forward.

Mr CARROLL — You cannot adopt a methadone program for an ice user, can you?

Ms McNAIR — No. The drugs do not work. In fact, I heard disturbing reports of young people presenting to GPs with amphetamine problems that are then put on buprenorphine or Suboxone which is for the treatment of opiates not for amphetamines, and it makes you wonder why a GP is doing this and whether it is perhaps not understanding well enough, I do not know. You would certainly hope that anyone that is presented to go on a methadone or buprenorphine program would be given a urine drug screen to have a look at the drugs they are taking. Whether those young people also had opiates in their system, that might well be the case, I do not know, because it really does vary client to client.

Mr CARROLL — Thanks very much.

The CHAIR — Thank you, Belinda, we appreciate your time this afternoon. It was very enlightening.

Ms McNAIR — I will email, what I find out, to Sandy.

The CHAIR — Thank you.

Witness withdrew.

The CHAIR — In lieu of last of the witnesses and no other business, I will close this public hearing. Thank you.

Committee adjourned.