

LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE
**Inquiry into the supply and use of methamphetamines, particularly ice,
in Victoria**

Wodonga — 24 February 2014

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Witnesses

Mr A. Fisher, Clinical Leader, Drug and Alcohol Community Treatment Services,
Albury Wodonga Health.

The CHAIR—Welcome, Mr Fisher, you are replacing Dr England, as I understand. You are the clinical leader for the Drug and Alcohol Mental Health, Emergency Department of Albury Wodonga Health.

Mr FISHER—Yes, and the Community Drug and Alcohol Treatment Services as well. I cover both the Community Drug and Alcohol Treatment setting, as well as the acute settings, like emergency, psychiatry and the medical and surgical wards.

The CHAIR—Excellent, thank you. Welcome to this public hearing of the Law Reform, Drugs and Crime Prevention Committee. As you will appreciate we are here in Wodonga today as part of an inquiry to the supply and use of crystal meth, particularly, as a reference from the Victorian Parliament. We have allocated time this morning to 11.45. Before you make some opening remarks I will read you the conditions under which you are providing evidence to this committee this morning.

Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention. 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 said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees.

Mr FISHER—Yes, I have.

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 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. I would now like to invite you to make a verbal submission, and obviously the committee then will take the opportunity to ask questions.

Mr FISHER—Thank you very much. For the last 14 years my role in health has been predominantly in the treatment of addiction and also mental health problems and disorders, along with obviously the medical problems that can be associated with drug addiction. I have worked in metropolitan and regional sectors, predominantly regional. I have been in Albury Wodonga for approximately seven years, working on a clinical level with the acute departments, along with the community treatment services. One does get a feel for what is happening in the area, and I have had a chance to note over time and measure different demographics around different drugs. That is pretty much my background and that is one of the reasons why it is good to have an opportunity to come along today and look at some of the questions.

Some of the questions are probably outside of my area in the sense that they are probably more relating to law and legal matters, mine is more concerned with health and wellbeing. We are—in mental health and drug and alcohol—in a position to evaluate and estimate the short-term costs and the risks of using methamphetamine in the long term but also in the short term as well. In the short term we do see the utilisation of acute services, such as ambulance, police and emergency department, and quite often acute psychiatry as well, that is to say people are transported into hospital for the purposes of a mental health assessment. That is conducted in the emergency department and the decision has been made whether people need treatment in an acute mental health unit.

With methamphetamine in the short term, and people are admitted into hospital, that does give us the chance to treat people's psychosis or mental disorder, but it also allows us a chance to detox the person safely off the drug. As you have probably heard, it is a drug that once people are dependent on is one of the more difficult drugs to come off, and people experience quite

significant psychological stressors, mood disorders, suicidal and homicidal ideation. Ideally it needs to be within a reasonably controlled and safe environment.

We see problems with the way that people are using methamphetamine, and they are on the increase, and that is the complications of using, for example, injecting. The drug is predominantly smoked or injected. We are seeing evidence pointing towards long-term respiratory problems of smoking the drug, and we are seeing an increase in complications of injecting the drug, that is to say when people breach the skin integrity, bacteria gets in and one can get very nasty abscesses, blood poisoning, heart valve infections, those types of things. They are not specific to amphetamines but if you are getting methamphetamine injected, there will be more injecting problems. That we will definitely see in a medical setting, and we may get called to assist with that person's withdrawal in that area.

In the long term we see people with crippling financial debt, breaking the law to obtain money to get methamphetamine. It is not a cheap drug. People seldom can survive on a pension or a low wage and maintain an amphetamine dependence. Unfortunately that means things like credit card fraud, theft, those types of things, stemming from family. In other words, as well as seeing the psychological and psychiatric problems, the physical health problems, we also see the extended family or carer problems, law problems, homelessness or risk of homelessness, increased offending and general global lifestyle problems. We do not just see a methamphetamine problem, we see a whole lot of problems radiating from that initial source.

We see people in states of malnutrition. Methamphetamine is a very strong appetite suppressant. People tend to not eat for days and weeks on end, and not sleep. This causes a whole lot of other problems. If people are deprived of sleep for any length of time their chances of becoming psychotic or losing contact with reality are very high, as well as the psychoactive properties of the drug. We can end up having what we call substance induced psychiatric disorders, that is to say that they do not always go once the drug stops. People may cease the drug, get into treatment and stay clean, but they may have a mood disorder which has been induced by the drug which remains with them.

Most of the time, fortunately, people's psychiatric symptoms abate once the drug stops and treatment is instigated. Treatment does work. One of our main frustrations for us as a professional service, but also for families and carers, is getting entry into treatment settings that are appropriate for people that are dependent on methamphetamine. As I alluded to earlier it is a very difficult drug to come off, and there are times when, despite having good community based withdrawal services, we cannot meet the clinical demand, or the risk is too high. In other words, we need to get entry into a detoxification unit without delay or without huge delay, and consequently entry into residential treatment settings. We are finding that getting those things to happen simultaneously or in a parallel fashion is difficult, particularly for people over the border a little bit which will be covered by the new area mental health service. There can be barriers getting into Victorian services.

We have talked about some of the physiological and psychological harms. The other thing that I wanted to talk about today was that with the amalgamation of the border services it would be an opportune time to look at models of withdrawal, community based withdrawal, where people can withdraw with a responsible person or carer, whether it can be done in a country within the region which may have beds, or the possibility of utilising an existing withdrawal unit bed in Melbourne where we could get fairly direct entry. That is a thing that has been ringing with us for a long time now. Only 10 minutes ago I was talking with a mother of a child who has amphetamine dependence and they are struggling with looking after the person. The person is an adult, but their needs are such that they really do need the care of their parents. Their parents come into the end of that, it has become very difficult, and our service is waiting for a bed in Melbourne.

What seems to come through in this is that the treatment works and treatment saves a lot of money but we do have difficulty getting into treatment in a timely fashion. In this area I do think we need priority for detoxification beds in Melbourne. I know they exist already, we do

not need new ones, we need access to the existing ones. The reason I say Melbourne is it is reasonably easy to get to from Albury Wodonga and the border region, as opposed to Sydney or Canberra.

Methamphetamine is also sometimes difficult where some treatment services will not treat people with methamphetamine dependence, they will treat alcohol or cannabis. That narrows the field down even more. I have mentioned it a few times but we are quite passionate about looking at models of careful withdrawal and rehabilitation services, and better and easier access to benefit people. The consumer, the carer, the health community, and the community at large all benefit from treatment. When treatment happens, less harm happens to the person and less harm happens to the community.

I would like to briefly ballpoint some of the data that I have collected over the last seven years in the area. It is important to note, I feel that where you have methamphetamine dependence, three out of four people will also have abuse or dependence on another substance. Having amphetamine dependence on its own is relatively unusual without another drug. Typically they will be prescription drugs, such as alprazolam—Xanax—cannabis, alcohol or other central nervous system depressants; that is to say that often people will have a run on speed but then when they want to come down off the drug they will use a depressant to help ease that passage down, rather than struggling and hanging on with white knuckles. That introduces another set of complications because will become dependent on more than one drug. It is more usual to have another drug problem with amphetamine than not. That, once again, makes it difficult and challenging to treat and to get people into appropriate treatment services. It also complicates their presentation and their psychological and psychiatric conditions. As we know, people are playing a seesaw, stimulated and going up—a central nervous system stimulant—but then using a depressant to come down. People are drifting between two worlds a lot of the time.

New South Wales Health has very good treatment guidelines around amphetamine dependence. I believe that we probably need a bit more capacity to roll out training to people to be able to use them. We have good guidelines, we do need more people to be aware of these guidelines and treatment approaches; that is to say we do not need to reinvent things, they exist, we need people trained and have the capacity to train more people to be able to use them.

The last point I would like to make is that with amphetamine dependence we end up with massive biopsychosocial stressors. That means purely that there is not one or two problems, there are several problems. They will involve relationships, they will involve family breakdown, splintered and fractured families, child protection, maybe probation and parole, mental health services, drug and alcohol services. The person's life becomes incredibly complicated. Once again we need to try and use some of the guidelines and principles that exist already. For example the New South Wales guidelines on treatment of co-occurring disorders—co-occurring disorders meaning drug and alcohol, mental health, medical, financial and psychological problems. Often the treatment becomes a lot simpler with fewer people involved and we definitely get better outcomes. Once again it is not creating something, it is using something that already exists.

They are the main points I wanted to make. It is a huge area and you have heard a lot already. At this point I will finish and if you would like to ask any further questions.

The CHAIR—Thank you.

Mr CARROLL—Thank you, Alan, for your presentation. As you ended, there is a lot to it. What I am interested in, with the people that you are seeing, before they have taken up a methamphetamine addiction, have they been on any other type of substance or drug?

Mr FISHER—Cannabis is starting to show evidentially as—we were always a bit loath to say 'gateway drug', that is, if you smoked cannabis you will get another drug problem

and you will be on very hard stuff, and that. We always like to be a little bit cautious about that. However, there is a considerable coexistence of cannabis dependence or abuse, prior to people then venturing on usually a couple of roads, using stimulants or using depressants, such as opioid type drugs, heroin—not so much in the country but pharmaceutical type opioids. People seek a preference fairly early in the piece. Some people like being high, stimulated. But we would have to say that cannabis and alcohol are noted precursors.

Mr CARROLL—Okay. You mentioned about you think facilities in Melbourne would be adequate enough in terms of more beds, treatment facilities. Is part of that also taking the person out of their environment and putting them in Melbourne and getting access to the best treatment and facilities, and should that happen, what do you think does need to happen locally when they do come back to the environment that they have been used to for most of their life?

Mr FISHER—That is right. Those questions are questions that we have wrestled with and thought a lot about. We would like, in response to those questions, look at sensible and proactive statements and opinions, rather than reactive. We need to not get too worried away. If we had read the media we would—I would be very frightened as a parent. I think we need to stop and—and this is a brilliant opportunity to do that. It is a real advantage to get people, once they are dependent, out of the people, places and things associated with that. That is very difficult for people to come to terms with, where they are quite anxious and scared about leaving their home, leaving their family. However, by the time they are treating them or attempting to treat them, those relations have broken down, families and carers are completely worn out and they are becoming unwell.

One of the other reasons is to get people quarantined away from their environment, away from the triggers, away from the dealer that is only a phone call away or a street away, away from the other drugs they are using when they cannot get or cannot afford methamphetamine. The biggest advantage to that is also for people to get into treatment and learn to live their life and manage problems, such as anger problems or emotional problems, problems they have had in their childhood that they did not ask for or did not deserve. There is a very high correlation with that, much more so than cannabis. Time needs to be taken to unravel the pieces and to put them back together. There is no fast fix. It has to be slow and evidence based and methodical treatment which could take in the region of two to six months, or possibly even more, depending on the severity. For that to happen you need to get into detox.

I believe there are superb detoxes in Melbourne, medical detoxes. We need to maybe make some more arrangements with them and be talking to managers, and saying, 'Look, we need to prioritise.' If there is a priority case in the regional area they need to take priority. We would be happy with that if we could get an expedited entry into a detox, such as the Western Hospital or St Vincent's. He will go away and be treated, and part of the treatment will be, of course, 'What's going to happen when you return back to your area of origin?' We really do need people to formulate—and this is what will happen in rehab is a post-rehab support plan. That could be coming to us for counselling weekly, it could be going to an Narcotics Anonymous meeting, those things. It does not have to be too heavyweight but as long as it is consistent. There is a role for community service drug and alcohol staff, very much so, involved in the after-care of somebody, and helping them maintain their sobriety off that particular job.

Mr SOUTHWICK—You mentioned the success of treatment. I wonder if you could talk to us a little bit about the relapse rate of some that go through treatment, and what that rate might be.

Mr FISHER—Sure.

Mr SOUTHWICK—Then what other strategies there are.

Mr FISHER—Certainly. What we know is that the amount of treatment or the

intensity and length of treatment correlates with what we would call a long-time abstinence rate. Long term is not lifelong, you could be looking at two years, six months or five years. We tend to look at ones in the middle that are relatively realistic. Two years is pretty good. If people do not relapse for that long that would mean their treatment was very successful. We also need to acknowledge drug dependency or alcohol dependency does come with a high risk of relapse. In other words, lapse and relapse is normal with drug or alcohol dependence in any form.

The relapse rate is methamphetamines is higher because it is a fast-acting and potent drug and alters things dramatically neurochemically and neurobiologically. People with methamphetamine dependence are at a higher risk of relapse, there is no doubt about that. Where we get into problems is people measuring detoxification versus relapse, because detoxification on its own is not treatment. Detoxification is merely getting off that drug safely over a one to two or three-week period of time. During that time people are not really up to doing the cognitive work that is required because they are still coming to terms with coming down and often on medication to help them stabilise their mood and sleep. Therein lies the very prominent point for our service that we see is then going, progressing from detox into a treatment setting. Whether that be a very high intensity outpatient treatment setting—in other words, people attend every day of the working week—or whether that is a residential setting where they go and live.

The latter two have lower relapse rates simply because the intensity of treatment is higher. People are able to cope and recognise their triggers and stresses better. That is what rehab is about. It is about teaching people how to live and what their problems were, what led them to use drugs in the first place. Occasionally there is no story behind drug dependence, it just seems to come out, but predominantly it is about early adult trauma, childhood trauma, undiagnosed and untreated mental health problems, depression and anxiety, post-traumatic stress disorder, or drifting into bad relationships and getting trapped in that, getting trapped in a very vicious cycle.

That is why we emphasis that detox and rehab are a great combination, or detox and intensive outpatient therapy are very valuable. Detox on its own, we have to question whether that is worthwhile doing if there is no plan for afterwards. We definitely do not recommend it.

Mr SOUTHWICK—Your views on compulsory orders for detox and rehab? We have heard people say, 'Regardless, just get them in.'

Mr FISHER—That is right, and we would do. Now, under the New South Wales Involuntary Drug and Alcohol Treatment Act 2007, but only recently implemented in September of last year, we do not hesitate. That would be in cases—if we are talking about amphetamines—of malnutrition where the person was literally starving to death but did not recognise it; where cognitively they are not able to estimate their risk or have the capacity to understand their position. To clarify, we do not believe the person can make a decision about the treatment for themselves and we will ask to have them assessed under that act by an authorised medical officer. Yes, we can do that if it comes to extremes, but it is preferable to get people into treatment under their own volition though. If we cannot then we would use that act, absolutely.

Mr SCHEFFER—You mentioned as you went through that it is difficult drug to come off—I think your words were. We have heard that part of the problem is, for example, there is no remedy, such as methadone, as there is for heroin. There are different things going on, that there is a longer time needed for detox, as compared to heroin. That is one set. The other that you raised in response to Mr Carroll's question about whether it is better to remove a person out of their context into another setting, we have heard, for example, from the indigenous communities where—to be fair, we have heard both sides—the preponderance of advice would be that you would keep people in their settings. This morning we heard about the difficulty of people who have responsibility for children, and I appreciate what you say about the breakdown is already fragmented which is a new angle that I had not considered. In

that context when you talk about 'it's a difficult drug to come off', can you comment on some of those things we have heard—the methadone, the removal of people, the longer time and the lack of regional facilities.

Mr FISHER—Sure. With opioid dependence, heroin dependence or narcotic dependence—and in our region it is certainly prescribed pharmaceuticals, it is not heroin—we do have a legal drug that can be prescribed for the treatment of opioid dependence, and every state has their own way of running it. We call that a pharmacotherapy program, that people can go from an illicit opioid to a prescribed, monitored and controlled opioid and thus not have to suffer the withdrawal. That means that people can get on and either get into rehabilitation or get into a more meaningful role in life, whether it be parenting, studenting or working. That drug is tremendous in the sense that it is not a cure but it does reduce the rate of people injecting, overdosing. People tend to do much better on it than not on it. People live twice as long on the drug than off the drug. The community benefits because there is much less crime associated. Methamphetamine is a lot trickier in the sense that it is a potent psychostimulant. Methamphetamine has come a long way from the speed that people used to use in the 60s and 70s in trucking and hospitality, and compared to methamphetamine relatively weak and certainly did not create this problem.

There have been trialled as substitution drugs, dexamphetamine, in an attempt to replace the methamphetamine. It is a bit of a David and Goliath because dexamphetamine has problems in the sense that there is very stringent prescribing requirements. They did get some dispensation but the outcomes were not good and there were trials in England some years ago and they were not that favourable, simply because you need so much amphetamine to replace the equivalent of methamphetamine. At this stage with the current drugs that are available it is not, from what I have seen, looking very promising. That is not to say that down the road there will be a long-acting pharmaceutical amphetamine that can carry people through 12 hours or 24 hours between their points of getting dispensed the drug. A little bit of dexamphetamine does not really make up for lot of methamphetamine. People are using \$300 or \$400 a day injecting it. It is pretty hard to compete with that with an oral tablet which is relatively low strength.

What did work well with the trial was that it demonstrated it was not just dispensing medicine for amphetamine dependence, it was an integrated program with counselling, with social work, psychology, to deal with the rest of the person's life, or whether it needed somebody to help to reconstruct the family or have family meetings, meeting with DOCS, those types of departments—Community Services with child protection. Those things were successful even with the drug not being particularly successful. The good part about the drug was that people were attracted to the program and thus were involved with the rehabilitative and therapeutic aspects of the program. For me it was a good thing. Even though the pharmaceutical aspect did not work particularly well, it still had people engaged and that worked. They did get an outcome and in terms of the amphetamine dependence they were quite strong, some were 40 to 45 per cent which is what we get with residential treatment, which are terrible odds if you are having an operation—45 per cent—but as an addiction medicine that is a really good outcome. It sounds terrible but it is very good.

Mr SCHEFFER—I think you are the only witness that said that you do not need new facilities or new methods.

Mr FISHER—No, we have the methods, we have the evidence and we have guidelines—clinical guidelines and protocols. The problem is we probably would benefit from more staff being trained in those, being more au fait with what already exists.

Mr SCHEFFER—What about facilities?

Mr FISHER—I worked in Melbourne for two years in a very similar role and there are some very good medical detoxes. When I say 'medical', that is where you have provision for psychiatric—psychiatrists and a medical team that could come to that unit. They have staff

experienced clinically in the role of medications to help ease that, rather than perhaps a less medical detox facility where people, really, it is just time they need, who do not get the massive behavioural disturbances. People coming off amphetamines can go between zero and 100 on the anger scale in two minutes. They are fine one minute, the next minute they are punching holes in the walls. We need a facility that environmentally can help people and get them safe and also appropriately supervised, to medicate, observe and treat psychiatric symptoms. They do exist. To repeat, we need a fast entry into them, and whether that means purchasing a bed or time, whether it was inter-agency agreements, managerial agreements that we could all agree, that if a unit exists and a bed is there, then if we are saying that somebody needs to be in there urgently—we manage it in many ways and we do not panic at the drop of a hat, we manage very well, but there are occasions where we do need fast entry into such a unit.

In terms of taking people away, I do not mean for one minute—we can recommend things. That does not ever undermine people's values culturally. If people want to be with their family in their area of origin, that is absolutely fine. My point was that we do have a statute of limitations. The terminal velocity in what you can do in terms of community treatment, we will do our absolute best. We have very skilled and dedicated workers. With severity of dependence sometimes though that is simply not enough. They need to go into treatment. Each case is on its own merits. Most of the services we work very well in partnership—Albury-Wodonga Aboriginal Health Service, our service, the ambulance and police—we all meet and we all talk. It is not often we cannot sort things out. As I say there is no point recreating things that already exist. We should use the policies, procedures, protocols and guidelines, and expediting them into detoxification if that is going to be an advantage and importantly into treatment. It is both detoxification services and residential treatment services. I do believe it is time to look at those models of care.

Mr SCHEFFER—Excellent, thank you.

Mr McCURDY—In terms of staff training right throughout our whole community, do you see any significant changes that we need to make because of the presence of ice? Are those skills already there and need more training for individuals or are there different things we need to be looking into?

Mr FISHER—It is both. We do currently roll out training to the hospital staff, community based staff, mental health clinicians on drug and alcohol influence on mental health and wellbeing. It is gathered over the years, and the acceptance that mental health and drug and alcohol problems are pretty much normal. It is abnormal to see somebody with one problem. It is very normal to see people with multiple and complex problems. I do believe we need to upskill more. If we are treating people in the community because they want to stay within their area of origin then we do need to have the resources to deploy to those people. Probably steering away from that, you know, looking at a detox in the area, is utilising detoxes that exist already and, secondly, having more intensive type of workers available in the community to follow up people once they have come from detox or treatment. Sometimes counselling once a week is not enough. They do need more input. When people are reconstructing their life after collapsing in every possible way, they do need a lot of help to walk through all of the carnage and to do that well. If there were going to be suggestions it would be to increasing the support for people coming out of detox and rehab back into the community, reintegrating back into the community.

The CHAIR—May I ask a question, in lieu of Mr Enright not being here but associated with the emergency department. We have heard evidence from other hospitals in triage where they do not differentiate between the self-assessment process about what drugs are affecting them to be presented to triage. I am wondering does Albury-Wodonga have a system where there is a better assessment if a patient is coming that is obviously affected by methamphetamines, as opposed to another drug. Also if Mr Enright was here would he raise an issue around security in emergency wards of hospitals? Given we already have that in relation to Victoria, but in New South Wales is there a requirement for extra security to be

placed in emergency wards because of the presentations of methamphetamine and its quite aggressive, violent response?

Mr FISHER—Certainly. I cannot speak for Wodonga emergency department but I do go to the Albury emergency department to provide consultation or guidance and support to the staff and the patients entering that area. I would agree that when somebody is under the influence or withdrawing from or having significant signs of psychosis or mood disorder, emergency departments can be quite confronting and over-stimulating for people that are suffering those symptoms. There is lots of noise, there is busyness, there are machines. It is not the most brilliant setting to have somebody who is highly disturbed, irritable and agitated. We do have a small area where we can assist people in but it is pretty constricted, and often we would use a family room if it is appropriate, it is bigger. It is not as confronting, it does not look as clinical and it is not as threatening. Those things are really hit and miss, whether you can use those or not, whether they are already engaged. I would suggest that he would be very keen to see a more secure—when we say 'secure', I think 'safer' is probably the word, in the sense that it is an environment where there is soft furniture, there are no sharps—scissors—around vulnerable people who have intravenous lines, are very sick, and having somebody next door to them who is rocking the bed and yelling, hostile and having paranoid delusions. An area away from that would be advantageous.

That is probably what most metropolitan hospitals are able to utilise now. I remember when that was being talked about. There are probably not any metropolitan emergency departments that do not have an area we would consider safe, secure and have access to people who can help out when people do unfortunately become violent sometimes. I would like to say in terms of the triage, the triage are really quite good at detecting those things in Albury. They get on the phone and they call the emergency psychiatric clinicians. They have different acronyms in different states but basically the emergency psychiatric staff who come down promptly and perform an assessment and advise on the course of treatment that needs to happen at that juncture. I think that is a good relationship and works relatively well.

The environment as it stands in Albury is not hugely conducive if you have somebody with these problems. Having said that, once people are aware and move in, situations can be de-escalated. We can use medication to help people feel better and to listen to those symptoms of aggression. It is not common for us to have somebody running rampant and assaulting people. We do need to be careful—incidents when they happen, you certainly remember them but we also need to remember that a lot of the time we de-escalate things well, and I think the hospital staff need to be recognised for their ability. Yes, occasionally things do get out of hand, but that is not an everyday occurrence because I believe the appropriate treatments happen when people come in.

Commonly that might be from the police. The police might bring somebody in who is appearing to be unwell and the history may dictate that they have used amphetamines, or we examine them and they have signs or symptoms that we can see of amphetamine use or intoxication. Those things are managed fairly well overall but there will be times when it does get out of control.

The CHAIR—Thank you very much, Mr Fisher, for your time this morning. We appreciate it.

Mr FISHER—Thank you.

Witness withdrew.