LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Ballarat — 18 November 2013

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Mr Peter Cranage, Alcohol and Other Drug Program Manager, UnitingCare Ballarat.

The CHAIR — Welcome, Mr Cranage, as the alcohol and other drug program manager of UnitingCare Ballarat, to this public inquiry by the Joint Parliamentary Committee of Law Reform, Drugs and Crime Prevention. You are here today to provide a verbal submission to the committee in relation to our inquiry into supply and use of methamphetamine, particularly ice, in Victoria. We thank you for your time.

Mr CRANAGE — Thank you.

The CHAIR — We have allotted till 3.45 for this session. I appreciate we are running a few minutes late, hence my apology to you. The normal course of events is that you provide a brief introductory verbal submission and then the committee will ask questions of you. Are you happy with that?

Mr CRANAGE — Yes, certainly.

The CHAIR — Thank you. I will have to read you the conditions under which you are providing evidence. Just bear with me for a minute. This is, I think, the seventh or eighth time I have done this today, so I will do it fairly quickly.

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 you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting to parliamentary committees?

Mr CRANAGE — 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 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 provide a verbal submission to the committee. Thank you.

Mr CRANAGE — Thank you. I was asked to basically answer 10 questions in a letter, so I have met with my team of drug and alcohol workers on a couple of occasions to talk about the issues so we are getting it firsthand from the people actually seeing the clients. From those meetings I took down some notes around the answers to those questions that were presented.

I will start with the first one: 'Is the issue of ice use becoming more serious amongst the clients you work with?' and 'How does this compare to the use and harms caused by other drugs, including alcohol?' The response from the workers certainly stated that, yes, it was definitely more serious and there has been an increase in our clients using ice because of the availability and cost. It has been a major issue around Ballarat for young people starting to use ice. It has become a widespread issue across all ages of clients who present at our service. Some of the clients are dealing and trafficking ice as a way of supporting their own habit and certainly the clients suggest that it is very addictive.

The CHAIR — Peter, I do not want to throw you off, but do you mind just telling the committee, when you say your organisation, UnitingCare, provides a service to 'your clients', is that clients that come to you with drug related problems, or at what part of the cycle do they come to UnitingCare for help?

Mr CRANAGE — We have got a range of drug and alcohol services. Our philosophy is based around harm minimisation, so we provide support to clients through intake assessment. We have got adult counselling services. We have got youth outreach services. We have got post-withdrawal linkages services, so that person refers clients into withdrawal units and rehabs. We have got drug and alcohol support accommodation programs for single men and single women,

drug and alcohol support accommodation for women and children, and we have also got Tabor House, which is a youth residential withdrawal unit. We provide services for clients at all different stages of their drug use, from young clients who are quite often in a pre contemplative state when they access the service, so it might be more around providing education, right through to people that are wanting to be abstinent.

The CHAIR — Thank you.

Mr CRANAGE — Does that answer your question?

The CHAIR — Yes.

Mr CRANAGE — Alcohol and cannabis are simply identified by stats as the drugs that are most used by our clients, but what I have found through our statistics is that ice is certainly on the increase. I have got statistics in the time frame of 2012 to 2013 that show that for primary drug use, for our clients No. 1 was cannabis, followed closely by alcohol, and the third drug of choice was amphetamines, obviously including ice. They are the three main drugs that the clients were saying were an issue. For the secondary drug of concern, once again it was very similar, but alcohol was the first, cannabis was the second and amphetamines was the third, and we have noticed over a period of a few years that it has certainly been increasing.

As the manager of the drug and alcohol team, one thing that I am continually concerned about in relation to ice is the levels of violence and aggression associated with providing a service to this client group, so quite often we have discussions around how we can provide a safe environment, particularly for our youth workers who are providing outreach services, so providing a service to clients not necessarily in our agency. That is certainly another concern with this group.

The second point is, 'What are the consequences of methamphetamine use, particularly ice, that your clients are experiencing?' Some of the consequences that we have noticed through the intake assessment or gathering information from our clients are the loss of family, the loss of meaningful relationships, increased stress on extended family and loved ones, homelessness, unemployment, mental health issues such as psychotic episodes and paranoia, physical and general health issues, self-harm, loss of appetite, and violent and aggressive behaviours are certainly more apparent.

The high-risk behaviours often result in increased conviction rates. A lot of the clients report that before using ice they would not necessarily have been involved in the legal system but that that has certainly become more of an issue for them—certainly a rise in legal issues generally. They are saying it is certainly highly addictive. It causes financial issues, isolation, prostitution, and our older clients talk about issues around child protection being involved, where their child might have been removed.

A lot of clients have stated that they feel they are at a loss about what to do. They state that there is such a high by using ice that when they are going through the withdrawal from ice, when they come down, there is no enjoyment in their life, because the impact on the dopamines when they are using ice is almost like this flood or a reservoir that sort of sends all the dopamines, and when they come down it is very hard to get any enjoyment in their life.

I think that one of the challenges for our workers is that there is such a high and such a low—such extremes. When we are looking at things like individual treatment plans for our clients and trying to look at things that they might be able to do to make changes around their drug use, it is really hard to find things that will excite clients, that they will get passionate about. Research shows it takes up to six to 12 months for there to start to be some repair around the brain for those sorts of issues, so for us it is about making sure that the clients are very aware of the impacts of these drugs and what is actually happening. We do not just say to them, 'Oh, look, you need to make new friends,' 'You need to go and join a sporting club.' We talk to them about the fact that, 'This is the impact it is actually going to have on you when you go through the withdrawal. You're going to have a long period of lows,' and we find that it is really important to be able to discuss that as an issue with our client to help with change. When you are looking at change, a big challenge for workers is trying to maintain a client over a longer period of time.

Also, the majority of our clients present with other underlying issues such as low self-esteem, mental health issues, homelessness, sexual abuse, physical abuse, trauma. Also, there is the impact on the community, on the health sector, the legal sector, mental health and the departments. And, yes, it is certainly used as a recreational drug. A lot of the youth workers I have spoken to said that a lot of their clients will go to a young person's house and use a lot of ice before going out and drinking alcohol. They will start at somebody's house and use ice. That certainly happens quite a lot.

The profile of clients in relation to ice is fairly broad, but we are certainly noticing that it is becoming younger people who are using ice. We have noticed a lot of 14- to 16 year olds are using ice now around the Ballarat area. There seem to be a lot of ice users in the age group between 25 and 35, and in the more mature age group as well, but the 25 to 35s are probably our biggest group. It is a mix of males and females. There is no significant difference between males and females in who is using the drug.

We have found a lot of our clients are in a relationship and both parties are using the drug, so they will use at home, just in the relationship. A lot of people are dealing and trafficking the drug as a way of supporting their own habits. There are also a lot of clients that have been identified through our intake assessment who have been diagnosed with ADHD and they are using ice as well as a way of controlling that condition. Also, some clients state that they actually use it as a way of losing weight, so that is another reason why they have used ice.

'Is polydrug use a problem in the context of methamphetamine use? If so, what other drugs, including alcohol, are being taken in association with it?' Yes, certainly there is more polydrug use while using ice. Clients state that they use drugs to come down off their high, so they are using the cannabis, heroin or benzos as a way of bringing themselves down. There certainly is a lot of polydrug use, as opposed to a few years ago when we would find that a lot of young people might be just using, say, cannabis and not necessarily using any other drugs, so this is certainly something that has increased, causing a high risk of overdose due to the extreme highs and the extreme lows when they are using different types of drugs. There is certainly more risk and we certainly look at how do we provide education around that very issue, around safety concerns.

I was listening before when you were talking to the people from Community Health. When we look at interventions, I think the education system is really important in relation to educating young people around drug use, but it is about the way we go about it. I think we need to use a range of interventions, starting at school around prevention. Currently in Ballarat we have programs in year 9 and year 10 which look at all drugs, but we probably need to start earlier than that. I have been working at UnitingCare in drug and alcohol for 15½ years and we used to actually provide education in primary schools around the use of cannabis. The schools identified that young children were coming to school under the influence of cannabis.

We are doing some things well, but I think it has to be a part of the curriculum in schools. I think we do it reasonably well, but we could do it a lot better in relation to prevention. I think we need a lot more information out there to everyone that experiences a ripple effect from the ice. We have a lot of fear driven parents that contact our services and say, 'Look, we're really concerned because of the aggression.' They need more education and our community needs more education. Our school system needs to look at how to create more resilient children so they actually do not use these drugs as a way of coping, but we need to attack it at a range of different levels.

I hear the term 'the war on drugs'. I just do not believe it. I think if there was a war on drugs we would be throwing all our resources at it; we would be going as hard as we could. I think we do not do enough in relation to drugs. It is such a huge issue in our society and we could be doing a lot more. As services, it is about how do we—whether it be the education system, the legal system, the welfare system—work more effectively together to be able to create change for young people? I do not think we do that well. We have had a lot of tries at it over the years, but I just do not believe that we are doing as good a job as we should.

What treatment options do we provide? As I mentioned before, we have got adult counselling. We have got forensic workers, family support workers. We have got the person who does see parents

and family members of drug users. We have youth outreach workers, we have had postwithdrawal linkages and, as I mentioned, the support accommodation roles. We have an intensive case management role, which is really important in relation to issues like ice. One of the main concerns is clients being able to access services. Our intensive case management has a very small case load. They are able to see their clients for four, five or six hours a week. That is fantastic because to create change, if you are seeing a person once a week, once a fortnight, once a month, it is a real battle, particularly when this drug has such a hold on people. Intensive case management is a great approach, being able to have the time to work with a person around these very significant issues.

We also have the youth withdrawal unit. Withdrawal is a really important component but it could also be extended in relation to the amount of time. I have coordinated a youth withdrawal unit in the past and we would have young people in there for from 10 to 14 days. Yes, you get the drug out of their system but you are just starting to get the education in. Maybe we could look at the current structure around making it two or three stages at the withdrawal level and then have the further option of rehab as a way of supporting young people. With research showing that ice can affect a person after they are clean for six to 12 months, we need to have a look at our interventions around those time frames as well, to make sure we can support them.

In these services we provide thorough intake assessment and it is really important to look at all the underlying issues around a person's drug use and to gain a greater understanding of what really needs to change. Is it generational drug use? Is it just a way of socialising? We do very thorough intake assessments to be able to then work out strategies around how to move forward.

As I have mentioned, we use brief interventions. Some of the youth workers have reported that a lot of our clients who might be using ice might only come for one session and then we might not see them again. So for us around that brief intervention, what can we get in in that one session that is going to be meaningful for that person to take away? It might be some education, it might be making them fully aware of what services are available to young people. A lot of young people do not know what is out there, so for us it is about how we use that brief intervention effectively to provide some good information or education for that person. We are finding that a lot of young people do not come back a second time, so it is really important. Obviously counselling and case management is really important. A lot of clients sort of flow through the service system. They might be with UnitingCare one day and Community Health the next week, and somewhere else the week after.

'How do we have a more integrated approach to service delivery for these clients so they feel like they are getting what they need at the one organisation?' Certainly we use referrals really well in relation to our withdrawal rehab. It is a really important part where a client comes into a service system. They might start here where they are saying, 'Look, I really just want to reduce. I am not really interested in giving up my drugs.' We would be working with that client all along that continuum to hopefully move them towards abstinence. If we were just to say, 'Look, you've got to be abstinent or that's it,' we would not have any clients at all accessing the service. It is about using the skills of the workers to engage a person who is contemplative, to be able to then move them through to hopefully significant change.

Sometimes it might be just about referring the client back to their local GP because they are just not ready to make those changes, but to look at health issues. We have good relationships with mental health services and we are continuing to broaden those relationships as well. A lot of our workers have been trained in how to assess a person around mental health issues. We have a coordinator from the mental health services who comes to our agency once a fortnight to provide education for our team members in relation to anything to do with mental health but also to provide secondary consults for a number of our clients. We try to provide to our clients as much information or resources as possible.

We have limited after-hours services, which is always a bit of a problem. We provide after-hours services for adult counselling but we always have to have two workers stay back so we can provide service up to seven o'clock at night a couple of times a week. That is really important for people who are working. It is about being able to provide a range of treatment options. Our service provides easy-to-access advice and support via drop-in or by phone or by referrals.

In the past with Tabor House, our youth withdrawal unit, we made a DVD which went through what it was like to go to a withdrawal unit. We provided that to services all around Victoria so they can show their clients that it is not that scary thing of 'I'm going to go into a withdrawal unit where they are going to be wearing white lab coats and they're going to lock me in my room.' We try to take away some of those myths about accessing services, providing good clear information to our client group about what they can expect from the services and what we expect from them as clients in relation to achieving goals. We try to be very inclusive in relation to the clients.

'How effective are these treatment options?' This is a really difficult one to answer. We have the ability to provide a range of interventions for our clients. This gives us the best opportunity to create change but of course there are always going to be some clients who really struggle with those options that are presented. We have had a range of clients who have accessed our youth withdrawal unit over the years who might have been into withdrawal four, five or six times. Some people would say that is a failure if they have to keep coming back, whereas we look at it as at least that person is still trying. What we do when they access the service, we look at, 'Okay, this is what we talked about last time you were in our service. What do we need to change? What are your triggers?' so looking at providing those different types of interventions that will make meaningful change for people, but also having that open door.

When people want to leave our service we try and reduce the likelihood of them trying to burn their bridges. That is really important with this client group. They do not want to fail either. They do not want to be seen as being a failure in a withdrawal unit or when they are getting service provided. We always try to make sure they are fully aware. They can leave. If they want to leave, they can, but we will try and do that in the safest way possible. We try to provide as much support as we can but also make it that they can come back. That is really important with this client group because a lot of their life is around conflict, whether it is with their families or friends, with authority figures. We need to be really smart about making sure we have this open door policy for this client group. We need to have good strong boundaries as well and be very aware. I have spoken to my workers in the past about basically kicking clients out of programs because they are not abiding by the conditions they agreed to to start with. It is about providing good clear guidelines around the design of the program but also providing referral options.

In relation to effective treatment options, I suppose clients have a range of motivation levels when accessing services. For instance, some clients come in who are ready for change. They are ready to work. They are ready to sit down with a worker and look at strategies—short, medium, long term—have some plans in place, have something that is measurable so they can move on. Yet we have other clients who have come into our service because they are under a lot of pressure from their family and friends. They are not really motivated around making any change but they have turned up because it takes the heat off them for a little while. They can say to their parents, 'I went to the drug and alcohol worker. I've done what you told me to do.' That does not mean they want to change their drug use at all. They are just trying to appease the parents.

The other type of referral we get is what has been directed through the court system. That is very challenging. If you are forced to come into our service because if you do not you are going to get locked up, people more often will choose to come to the service. I had a great example of a young man who was not an ice user but certainly a full-on cannabis user. He was a forensic client when he came to our service.

Back in June 2012 I took a group of people to do the Kokoda Track. I took three clients from our service. One was a current user, this young man; one was a parent of a drug user who had drug and alcohol and mental health issues; one was a past user. There were also a police officer, a paramedic, myself, two other drug and alcohol workers and a film crew. We took a group over just to talk about the ripple effects of drugs on our community.

This young man who was a forensic client took up the challenge to come with us and we did screenings all the way through. When I first met with him he had no intention of changing his drug use but what we presented to him was a really big challenge around being able to complete Kokoda. He was able to make all these significant changes in his life by completing something that is one of the hardest walks in the world. He now sees other issues in his life as not so difficult

because he can say, 'Well, I've done that. I've trained. I've committed for six months. I could do anything.' When he first started he did not see his life beyond 23 years of age. For him it has been a massive change. Since being back he has been involved in courses, he has been clean, and that was someone who came through the forensic system, who just did not consider making any change at all.

With our interventions maybe we just need to get a bit more creative. I had to raise all the money for that trip from outside of my agency but I think we need to look at what we can do differently to engage this client group. It is such a challenge to try to get them to stop using the drugs. They report that they love it. They love the euphoric feeling they get from it. If you have someone who has been a victim of sexual abuse, trauma or just having a really crappy life, if they get a drug that makes them feel really good continually, it is hard to challenge that. As I was saying before, we need to be really honest with our clients and be crystal clear on 'This is going to take a long time to get over.' Talk about all the consequences of the drug use and the impact on relationships and family, a whole range of things, but also know it is going to be a real struggle.

Some workers get a bit scared about being too honest about it but we need to tell it how it is with these young people. We need to do more prevention stuff in the school system and show that if you—I was talking to a drug and alcohol worker today and he said to me, 'I had some great education in year 8 about heroin, and from that moment on I thought no, I'm never going to touch it.' Of course you would be able to find plenty of stories from the other side where they say, 'Look, I really wanted to try heroin.' We need to look at lots of different interventions. We need to better inform our families and communities around these issues and how they can actually pick up on those early warning signs, like what they can do to assist that person from getting too deeply into drug use.

The CHAIR — When you mention that I am reminded of the fact that I am one of those terrible reformed smokers. It was a great drug for me at the time and I felt fantastic too until I started feeling ill and then realised smoking was going to kill me. That is a pretty good awakener, whereas the people we have been hearing about who use ice—it offers all these wonderful things to them like the alertness, the euphoria, the sex stimulant, the feeling of nothing can harm.

Mr CRANAGE — Power.

The CHAIR — Yes, it is, from probably a low base, I suspect, in most cases. Why would you want to turn that tap off when all you have to do is have a hit and you are suddenly feeling on top of the world again?

Mr CRANAGE — Exactly.

The CHAIR — Going from there, though, to talking about educating in this long term protracted sort of rebound off this drug through either your agency or a like agency is almost hard to get into the minds of those people who are taking it on a recreational basis.

Mr CRANAGE — Absolutely, and I think we have to use history in relation to those discussions with a client. Where they might be at in the drug use might be a place they do not want to change from, so we talk about our history of working with clients and what we have seen. The clients have been at that point and they have really enjoyed the drug use but in the next year or years to come, these are the sorts of things that will happen to those clients. It is to show that there has got to be some sort of—

The CHAIR — Does that work?

Mr CRANAGE — With some it does, with some it does not. Sometimes people have to hit rock bottom. The danger with ice is that what we have seen as rock bottom, more often than not, is through assault or through the legal system. That is the concern. Clients continually state that they went from this point to assaulting someone really quickly without even realising what was going on. That is a major concern. When I mentioned before about being very crystal clear with the impact of this drug and saying, 'What's going on in your life that you need to continually use ice as a way of feeling good about yourself?' I suppose it is to normalise things too. I do not

know about you, but I do not feel fantastic and euphoric every day of my life. I suppose it is just normalising what it is like to live life.

Yes, it is good to have those real highs but what we want to do is get more of a balance with people. I often talk to clients about having the low and the highs, and low and highs. What we want to do is try and bring it down a little bit like that so you are still getting highs in life and you are getting enjoyment but your lows are not too low either. With peaks and troughs there is too much distance between them. What we try and encourage is to find other ways for people to have those highs in life but where they do not cause all those issues related to the drug use.

Look, it is really challenging. We just have to be creative. As part of our team meetings we have these discussions all the time. We talk about case studies. We have lots of workers come in and have input into what you can try in a situation. It is not about ownership of clients; it is about getting many professionals together to work on this issue and come up with some solutions. Some of the solutions are really good and some are average. Once again it comes back to the individual client, too, and what their needs are. For me it is about creating an environment in the workplace where our workers are really eager to try and find answers and be able to help the client group.

The CHAIR — Sorry to interrupt you but I have created a precedent. I will invite the committee members to interrupt as they have a question because we are getting to the end.

Mr CRANAGE — I am sorry.

The CHAIR — No, you keep going but perhaps if the committee members would like to ask questions on something you have raised in your presentation, I am happy for them to do so because I have just done it.

Mr CRANAGE — No worries.

Mr SCHEFFER — I do have a quick one. Earlier on, when you started talking about the treatment programs and the importance of demystifying the withdrawal process, you talked about explaining to people who are going through the depression that follows the withdrawal that there is a trajectory that could take 12 months or a long period of time. What is the response to that? In order to respond constructively to a scenario like that, you need to be able to disengage with the almost physiological experience and depression, for want of a better word, that you are caught in, and then have a kind of double vision that, over and above what it is you are experiencing, there is something else going on. This is just physical but there is another 'you' that can get through to the end of that year.

My point is that is a reasonably sophisticated disposition to put yourself in and able to be responsive to long term treatment. In some of the other presentations we have had, talking about treatment, it seems to me that they make a demand on people that is pretty sophisticated, yet we are dealing often with quite young people who I would say are not even cognitively developed enough to conceptualise properly and have self reflection. So I am asking you to step us through that a bit. Am I right or are there ways of presenting this that are very simple?

Mr CRANAGE — I certainly agree. I think our young people live in the here and now, not interested in six months down the track a lot of the time. The way we would look at it is in relation to the individual treatment plans for our clients, and it might be that we look at the short, medium and long term goals of change. It is about looking at what sorts of problems the drug use is causing and trying to minimise them, so if I think about someone who is making a change in relation to their drug use, quite often it is about trialling a range of strategies to see how they work, but also to simplify it for your client so they actually can look at achieving something. We would always test out with the client. For instance, we say, 'Well, instead of going out seven nights a week,' or whatever it might be, 'can you try going out five nights a week?' or, 'Can you go out later in the evening?' We just try really practical strategies.

Mr SCHEFFER — Can I just 'yes but' you on that?

Mr CRANAGE — Yes, sure.

Mr SCHEFFER — The 'yes but' is that we heard today from a previous witness who said that the thing about ice compared to alcohol or cannabis is that it is very difficult to find those kinds of step downs.

Mr CRANAGE — Yes.

Mr SCHEFFER — It seems to be like an all-or-nothing.

Mr CRANAGE — Yes.

Mr SCHEFFER — If someone is on cannabis, you can say, 'Well, could you smoke two joints a day or just on the weekend?' but they say it is hard to do that with ice, and now you are coming back and saying you have actually got a bit of an angle on how to do that. Is that right?

Mr CRANAGE — I suppose we have got an angle because clients are accessing our service. It does not matter whether they are there because they want to be or not, they still come to our service, and it is about the skills a worker would use to be able to engage that person. If you have got somebody who is there because their parents have said, 'If you don't turn up at this drug and alcohol appointment then I'm going to kick you out,' there is still that bit of motivation around, 'Well, I'd better go and do that, otherwise I'm going to get kicked out,' so we would engage that person and the stages-of-change model would be the one we would use. I could talk to that a little bit, which might help to answer the question.

There are several different stages of change. It is a model we use in drug and alcohol which is quite useful. There is a pre-contemplative stage. One of the characteristics is that the client is not currently considering change at all, so it might be someone who has been through the legal system or whose parents have encouraged them to come long, and the work we would use would include to validate their lack of readiness, to actually talk about that issue of them not really wanting to be here, rather than have it as the elephant in the room; to encourage re evaluation of the current behaviour and explain the personalised risks associated with their drug use. It is to validate that, 'Yeah, I can see you really don't want to be here, but how can we use this time while you are here? Can we talk about some of those things that might be causing you some problems with your parents?' Quite often, when clients hear that, you are getting through a bit of the garbage with them as well, because they can say, 'Oh, well, they can see that I am not really that interested in change, but they might still be helpful.'

We then have the contemplative stage where the client is a bit ambivalent, sitting on the fence around the drug use. It has not been that much of a problem for them yet, but it is starting to get to that stage. One of the techniques that a worker would use is to encourage evaluation of the pros and cons, so decisional balance: 'How much effect is this having on your day to day living?' When you talk about ice, because the effects can be six to 24 hours, yes, it is about trying to find those moments in time to actually have those interventions, but what we are finding is that, because the clients are coming to us more often, there is room for the intervention; but it might be about how we go about it. It does not necessarily answer your question really well.

Mr SCHEFFER — No, it does. Fair enough.

Mr CRANAGE — Because they are coming to our service, then we have to assess where they are at in relation to the stages-of-change model and then provide intervention around that.

What supports do we provide for families of methamphetamine users? We have got an alcohol and other drug family support worker, and we have had for a number of years, but it is fairly limited. Her client load is always full in relation to providing education for families. Our other workers certainly have contact with family members but, of course, do not break confidentiality. Certainly more funding could be put into this area in relation to supporting families, because I think they are a great untapped resource. They are seeing what is going on with the person. A client can come to our service and tell us a whole lot of stories about what is going on, and you can actually hear the other side from a parent and it can be very different, so they are certainly an untapped resource that we really need to improve on in the future.

Some of the challenges of this work: I am sure everyone has said lack of funding, lack of resources. We are just going through recommissioning at the moment with adult services, trying to design some programs that will fit moving forward. It is an area that costs the community so much in money, time and resources. As I said earlier, I think we need to get really creative in our service delivery. We need to start looking at these issues in a different way. We need to look at how we can have a very free-flowing system, from our detox to rehab. That currently does not work that well. You can have somebody go into a withdrawal but there is not a bed available in rehab, so they have to come back later—even weeks or months later. With ice, there are not those options. Someone on ice needs a longer term engagement with services and they might not be able to get into a rehab for quite a few months. They then might drop out of that service system as well. It is about being able to have more services like rehabs available to our clients so they can actually be out of their current environment to be able to make changes.

Aggression from clients has certainly increased. As I mentioned earlier, as a manager of outreach workers, what they are going to come across is always a concern, so we do a lot of education and training for our team members around the different types of drugs we are dealing with and the different types of behaviours, and we try and put in place strategies to be able to inform our clients.

I have been in the welfare industry for 28 years and I think it has only really become more professional in about the last 10 to 15 years. The expectation on workers these days is a lot higher, as it should be, because we are messing with people's lives. We should have training. They should be well skilled in drug and alcohol, they should be well skilled in conflict management, they should be well skilled in mental health, because there is a lot at stake. They have a client group who are at risk continually, so I think there needs to be a lot more support put into the development of workers in this industry to make sure that we have got the best people out there to provide the best service for our client group.

As I mentioned, it is that challenge of trying to deal with the euphoric feeling that the clients get. If you have got somebody who has been a victim of trauma, they are looking for reasons to be feeling a lot better, and I think it is about once again making sure through your intake assessment that you are very aware of those issues that the client presents with. Are there childhood traumas that need to be dealt with? At what point do we get those services in to make sure that we are meeting the needs of the client to reduce the likelihood of them having to find other measures to be able to feel better about themselves? It is about being able to be very strong in taking an assessment.

We have had lots of clients say, 'Life's boring without the drug.' That is why it is a real challenge. Youth unemployment is really high. It is harder to get into courses these days. There are not necessarily as many opportunities around for young people, and when you have got someone who is just seeing life as boring without drugs, it is a real challenge for the workers.

The long-term challenge is to maintain abstinence, due to the changes in dopamine levels—the flow-on effect—and to be able to keep clients integrated in a range of different services. It might be mental health, and drug and alcohol, and housing. If you get a client who has burnt their bridges at home, and also with their friends, and they have not got a roof over their head, doing work with drug and alcohol workers and mental health is just not important to them. If they cannot even have a roof over their head, they are not going to be bothered about accessing services, so things like drug and alcohol support accommodation programs are really important.

We have got eight houses here in Ballarat for people with drug and alcohol issues so that they can actually get a bit of a credit history again. They might have done damage to properties in the past, they might not have paid their rent, whereas if they come into the support accommodation they have got a drug and alcohol worker there, we can give them a reference at the end of the day and we can actually help them engage in housing down the track as well. If we did not have those support accommodation houses, those clients would be out on the street, out in the gutter for real, and then on the TICA register, and that is a nationwide register where they will not be offered any accommodation. So we have to try and find ways of making sure that the person has got a stable environment so we can provide these services. That is a real challenge, because a lot of people have burnt a lot of bridges in relation to their housing. There are also the underlying mental health issues. Mental health can be quite an issue as well.

'Can interventions, including education programs, aimed at methamphetamine use (including treatment options) be better tailored for specific groups such as young people and Indigenous people living in rural areas?' One of my major concerns in relation to providing a service particularly with Indigenous services is our poor relationship with those providers. I am involved in interagency meetings for our region. We discuss issues in relation to our clients all the time and yet workers from our Indigenous services do not turn up. We continually invite people to come and talk about these issues and there is just this split in service. It is a bit of the ownership around clients. It is a real concern. We have tried a range of ways of trying to be inclusive and, for whatever reason, it has been a real challenge.

We had the same issue with mental health services a number of years ago. There seemed to be some issues around, I think, the mental health services not respecting drug and alcohol workers. I think what has changed that is the increase in education for drug and alcohol workers to have a higher standard of knowledge. It is a concern. We have had workers provide supervision to Indigenous services for their workers in the past, but it continually seems to fall over. I have not got a good answer for that. It is something that we have really struggled with in Ballarat for a number of years. We have certainly tried to be very inclusive but it has been very difficult.

I think we need to look at a lot more research in relation to ice. It is still a relatively new drug compared to a lot of the other drugs around. I think we need to get more education out there.

Mr SCHEFFER — What sort of research?

Mr CRANAGE — I suppose to look at the long-term effects as well.

Mr SCHEFFER — Physiological?

Mr CRANAGE — Yes, definitely. Absolutely. And to be able to disseminate that information to the broader community as well, to make sure that people are very aware of the long-term effects of this drug. I still think it is a really scary drug for a lot of people in the community, because the way it has been advertised through the media is that you see this person being dragged into the hospital and they are bashing up police. I think there is so much fear associated with this drug generally. That is why I think we need to educate. Yes, there are clients out there that are really aggressive, but there are a hell of a lot of clients that are not as well. We are seeing both, but I think the perception through the media is that all people who use ice are aggressive and that is not the case.

Mr SCHEFFER — How do you think that might be tackled?

Mr CRANAGE — We are making a documentary at the moment which is not about ice but about drug use. It is talking about these issues of the ripple effect on the community and getting people's perspective, getting statistics from the police and the ambulance, getting drug and alcohol workers to talk about the types of issues that we're addressing with drug and alcohol clients, getting parents to talk about their issue with their child. It is about looking at a range of ways, like using the media in a better way. Let's not just make it all about the big drama of the drugs, let's talk about why are people using drugs.

A number of years ago I did a study on the reasons why young women started using drugs. We looked at a study over 12 months in our withdrawal unit. The reason they identified for their drug use: 85 per cent of the young women said they were victims of sexual assault and that is why they started using drugs. It was not because of peer relationships, it was not because of accessibility. They used drugs because they were victims of sexual assault. Dispelling all these myths around why people are doing it, there are a lot of good people out there who can manage drugs really well and hold down a job and you never get to hear about it. We only ever hear about the people who have been breaking into houses or assaulting people. They are still a very small percentage of the people we see on a day to day basis.

Even with things like detox and rehabilitation we need to look at age appropriateness of those services. Our youth withdrawal unit caters for people from 12 to 21. We could have a residential unit that would cater for those younger clients around 12 to 16 and just focus on that group as

opposed to having clients up to age 21. In our four-bed unit there might be one 13- or 14-year-old and the other clients might be 18, 19, 20. It would be great to have some withdrawal units that are really specific to that age group.

Support for families, accommodation, education, employment—in all those areas we need to be able to support our clients with moving forward. A lot of times the clients will have burnt their bridges, so we might have a client who is going into a withdrawal unit on rehab and they do not have an exit point because they are being kicked out of home. Being able to have those step-out programs as well, where they can still be accommodated rather than back on the street or couch-surfing again, would make it easier to maintain those clients.

The CHAIR — I am mindful of the time. Was that worded in a submission that you have?

Mr CRANAGE — I can print off copies for you but it is just my notes.

The CHAIR — I am thinking it might be useful for the staff to have access to the notes, if you do not mind.

Mr CRANAGE — No, that is fine. No worries at all.

Mr CARROLL — Just going back to what you were saying about programs in schools, Peter, I concur with what you said about the Kokoda projects. My electorate covers the City of Moonee Valley and many youths with some issues have been sent on the Kokoda project and have come back changed individuals, but it is quite an expensive option to send everyone over to Kokoda. You have experience of 28 years in the welfare sector. Has there been one particular program that you have seen in schools that appears to cut through in terms of drug education?

Mr CRANAGE — I do not think we do it well enough in schools. It has to be part of the curriculum. It is about creating resilient young people.

Mr CARROLL — What I am getting at is you cannot really have teachers tacking on as well as being the drug educators. There needs to be a more holistic approach, working with the welfare sector—

Mr CRANAGE — Absolutely.

Mr CARROLL — and having people who are directly related, perhaps even previously experienced with being on the drug ice, talking to the students.

Mr CRANAGE — Yes. We had a past user who came to our withdrawal unit and talked to the clients. This guy, out of 28 years, had spent 24 years in gaol. He came and talked about his experience from the point of view of, 'This isn't a great life, you know.' I have lots of friends who are teachers and they would hate to hear me talking about the fact that they would need to do more work. It is about using our services better. As I mentioned before, we work with schools at year 9 and year 10 levels. They are good programs but we need to get in earlier. I think primary age is what we really need to target. It is all about the type of intervention you use for those kids.

We have run programs in schools where it is about reunifying families. We used to run an eight-week program where we worked with the whole family. After school hours we would get the family in. We would do special play with a parent and one of the children having troubles. All the parents had drug issues and some of those kids were certainly using as well. We would have meals with the families, so we would have up to 80 or 90 people in the halls and one family would have to cook for everybody and they were supported. It was actually connecting them to the community. A lot of those programs continued on for two years after the initial eight weeks and they were supported. What the school noticed was that those parents who had normally been really negative around the school, or very abusive, became far more 'user friendly'. They were connected to the school and to that environment, and they noticed significant changes for those kids as well.

We need to be looking at creating a really resilient society of young people coming through and being able to understand the issues. That is not necessarily a role for the teachers and I think welfare agencies could certainly be doing a lot more work in schools; absolutely.

Mr CARROLL — Thanks, Peter.

The CHAIR — All right, Peter, I think we might have to leave it there and, if we could have a copy of your notes, that would be useful for some of the writings that will happen. Staff will take the opportunity of getting back to you if we require certain clarifications in the notes. Thank you very much for your time this afternoon. We appreciate it. It has been a very elaborate and intensive verbal submission. We appreciate that.

Mr CRANAGE — Thank you.

Witness withdrew.

Committee adjourned.