LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Mildura — 5 December 2013

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Ms M. Lonsdale, Team Leader, Drug Treatment Services, Sunraysia Community Health Services.

The CHAIR — Welcome. As you know, we are conducting an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. We have had public hearings, both in Melbourne and a number of regional towns and cities across Victoria, and we are very pleased to be in Mildura today to have the opportunity to listen to witnesses from this region coming forward to present to this inquiry. Thank you for your part in that.

As you know, we encourage brief contributions from our witnesses, and then the committee would like to ask questions of both submissions, verbal and written. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Ms LONSDALE — Yes.

The CHAIR — I note that you have. 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. Thank you.

Ms BASSI — In response to a question that you requested we provide information on asking have we seen an increase in ice use through our drug treatment services at Sunraysia Community Health, two years ago we reported that around 3 per cent of our clients had been on ice. Our latest figures show that 24 per cent of clients are currently getting treatment for ice use. However, when we look at the specific progress, because we offer myriad different treatment options for our clients, there are approximately 47 per cent of our clients attending our services who are using ice.

Mr SCHEFFER — What is that in actual numbers of people?

Ms LONSDALE — I suppose, roughly, from our diversion programs we see around 300 or so clients, so we are looking at probably 147 or 145 roughly.

Ms BASSI — Do you know what diversion programs are through the criminal justice system? What we are seeing in clients who use ice or present to us with ice is the damage that ice does in a short period of time compared to other drug use we have experienced in the past — alcohol, heroin and even ecstasy or cannabis. We see loss or damage happening to clients in a much shorter space of time.

We also find that we get a lot more presentation from family and carers seeking advice on how to actually deal with a loved one who has experienced ice. There is limited support for them. We can give them support, we can give them education about the cycle of change, but the hardest message is for the family to accept the fact that if a user is not prepared to change, it is very limited what they can do. What we are seeing is a lot more dysfunctional families, family breakdowns, loss of income and loss of assets. Our main target group ranges from 15 to 42. Predominantly the bulk of our clients range from between 25 to 35 and are predominantly males from all different socioeconomic backgrounds. It is a different cohort of people we are seeing.

Ms LONSDALE — I think that when we start looking at some of the harms, as well as the long-term consequences, you have the physical and psychological effects of ice; however, it is getting into the financial issues, the relationship breakdowns and things like that. We have quite a significant number of clients who are coming in reporting ice and who have huge unmanageable debts. Trying to work with somebody around that who may want to be addressing their ice use, trying to work with them around their ice use and trying to look at all that when they have perhaps $10 000, $15 000 or higher worth of debt and are still having to have contact with dealers and people living that lifestyle is quite an implication for treatment as well. It is not a cheap drug, so

people do need the money or financial means to be able to use. Whether or not they change to criminal activity for that, we are actually seeing people who have been working, who have cars, houses, quite significant possessions and things like that and who have actually lost a lot of that wealth trying to pay back debts to people they have been buying off and things like that.

The CHAIR — Can I just ask a question? Quantifying a debt, that is not to financiers but to dealers who have a debt sheet?

Ms LONSDALE — Sometimes it is dealers. We are really happy when it actually might be with a real estate agent or a credit card company or something like that because you can actually deal with that. It is not ideal, but you can put measures in place to deal with that. If it is to dealers and things like that, your room for negotiation, I suppose, in paying that off is really diminished.

The CHAIR — Does that incite some debt collectors to lean very heavily on guys who have accrued the debt?

Ms LONSDALE — Yes.

The CHAIR — Are there any specific people who — —

Ms LONSDALE — I suppose from a treatment perspective we do not get into who is dealing what. We look at what the issue is with the client. Yes, we have had clients reporting to us that they have had people being a bit heavy with them if they are not paying up — heavy with the family members and things like that. Who that particular group is — I suppose from a treatment perspective it does not assist us in our treatment with the client.

Ms BASSI — Which leads to us having more clients than we have experienced in the past presenting with physical damage from dealers. It is not uncommon for a client to come in with perhaps a broken nose, black eyes or busted ribs looking for our support, and it is the dealer that has put the heavies on them.

Ms LONSDALE — We could answer all the questions, but if you guys have got — —

Mr SOUTHWICK — Maybe you could talk us through some of the diversion program, what it might look like and where you are getting some successes from clientele that you are working with.

Ms LONSDALE — From the diversion programs they have had involvement with the criminal justice system. Unfortunately we are seeing some of the main successes with some of the clients who have had a period of incarceration for a time before being involved in the services. Part of that is giving the clients some involuntary — I mean, they did not wander in wanting that — but to have the opportunity to have some time out, to have some intervention or someone going and speaking to them, a bit more clarity in their thought processes and things like that, but then they are engaging with the service and you are able to work with the person.

Ms BASSI — Can I clarify that? It is really by default, because they were incarcerated they had a period of withdrawal and they were medicated.

Ms LONSDALE — Yes.

Ms BASSI — So that gave them the time to withdraw from the drug and have some clarity in their thinking before they engaged with us, whereas from a community base we do not have that luxury. We do not have appropriate withdrawal treatment options for these clients — very limiting.

Mr SOUTHWICK — So they are not really diversion programs if they are ending up incarcerated.

Ms LONSDALE — I suppose the diversion programs are designed to try and lessen the involvement with the criminal justice system. A lot of the time they may be incarcerated for different reasons and it is to try and link them still into treatment. A lot of the time if it is the drug

using or trying to do things to gain drugs that gets them into involvement with the criminal justice system, it is still trying to focus on treatment rather than a punitive model, I suppose, when it is the drug taking or drug usage that has caused them to be involved in that.

Mr McCURDY — So there is that gap, is there? Diversion programs need to be there prior to the criminal justice system.

Ms LONSDALE — Yes. The majority of the ones we have got are pre-sentence, so it is often when somebody has already, and it is the work that somebody would do. A lot of the time if they have been incarcerated, it is a period of time that they might be held in the local cells, even for five days, until they have got bail, and then they come out and are involved in that program. We are not talking post sentence after they have been charged and sentenced and things like that — coming into drug treatment; that is a bit of a different program. But yes, probably the drug diversion programs are where, if somebody is caught with a small amount of an illicit substance, they have the option of being charged with possession or coming into drug treatment services for an assessment and follow-up appointment. We will see spikes in that type of referral at different times; it is not a consistent referral process.

Mr SOUTHWICK — But the starting point is you need a period of time where the person is able to dry out?

Ms BASSI — For want of a better word, yes.

Ms LONSDALE — Yes.

Ms BASSI — And clarity and thought. We assess the situation.

Ms LONSDALE — Although I guess it goes against the principles of AAD services and things like that, voluntarily clients accessing these services is not high; it is usually that period of time is enforced upon them, and then it is voluntary after that. To try and sit down and plan a client to go to a withdrawal service is very difficult. If they are still using, they are quite chaotic and quite disorganised, with erratic thinking and things like that. It is in that period of time that is enforced upon them that we are finding we have a better engagement and better outcome with the clients in significantly reducing or abstaining from ice.

The CHAIR — So what about a person who wants to voluntarily come and seek help? Are you able to assist?

Ms LONSDALE — Definitely.

Ms BASSI — Yes.

The CHAIR — We have been told on a number of occasions through different hearings that there has been a call for help and no-one has been listening.

Ms LONSDALE — We hear that a lot, and I suppose it comes down to what the client is asking for. If they are ringing us up and saying, 'We need withdrawal and rehab', we say, 'Yes, you can come and see us, and we start doing the processes and the applications, and then maybe in two to three months you will be able to get a bed'.

The CHAIR — Two to three months before they can get a bed?

Ms LONSDALE — Yes. Sometimes you might get it in six weeks. At other times it could be up to four or five months for residential rehabilitation. It depends on what the client is asking for. We will see somebody. The day they called we would have an appointment for them within probably a week or two weeks for them to come in and speak to somebody at a minimum. We have a walk-in service, so someone can come in and talk to us about that. I suppose it comes down to what treatment they are wanting. If it has got anything to do with a residential treatment type, yes, they are going to be waiting for a long period of time.

Ms BASSI — The system is not built up. When you have a client or a user who says, 'Right, I want to change, I want to stop this; I want to take control of my life', they expect to ring us up and say, 'I am ready now; you need to be ready to help me'. The system is not set up like that. We will take them in, assess them, give them what the options are, tell them what their responsibilities are and how we can assist, but there is a period before we can get them a bed. We have no beds locally, so they have to go down south, whether it is Bendigo, Ballarat or Melbourne. That is the reality of it.

Mr SOUTHWICK — Should the system be set up in a different way?

Ms BASSI — We would say yes.

Mr SCHEFFER — So how should it be set up?

Ms BASSI — In the ideal world — —

Mr SCHEFFER — If you could change it, what should we recommend?

Ms BASSI — Give them the bed straightaway, and get them into a treatment option straightaway, because the window of opportunity when a client acknowledges — —

If you look at the cycle of change, you can go around and around, and there is a small window of opportunity when a client admits that they have a problem and they want to change. Something has happened in their life. There is your moment; there is your window of opportunity. If you can engage them at that particular moment in time, give them the treatment that they need — the right treatment that they need — you will see that change. You still might have relapses — —

Mr SCHEFFER — So does that mean that you have got to have a bank of beds sitting idle because you might need them tomorrow, straightaway?

Ms BASSI — That is right.

Mr SCHEFFER — So that means you have to have a budget line that enables you to have standby.

Ms BASSI — Yes, exactly, but not even straightaway tomorrow, but even a week so we can organise things, but a much shorter time. If you tell a client who is hypothetically on ice — something has happened and his wife is leaving him, the mortgage is going to close on him and what have you — and he has had a moment of realisation, and you say, 'Yes, we can treat you, but you are going to have to wait four months', what do you think he is going to do? His life is hopeless.

Mr SCHEFFER — Have you done any modelling of what that might cost in your service?

Ms BASSI — No. Statewide we have, and we have always been told by our head office it is unrealistic dollars.

Mr SCHEFFER — I would be interested — —

Mr SOUTHWICK — Are you aware of any other models in other jurisdictions where there is a more flexible model around — in other parts of the world where they have got an at-call system?

Ms BASSI — In Sweden they have. They introduced an amazing model around 1998, and it was more like a community, for want of a better word. In the old days we used to have mental asylums, but it is for drug addiction and it was a community, and that works really well. But that is done on a voluntary and pay system, so that is more for your private clients, which we do not use here. But no, not in Australia. In comparison Victoria does okay in relation to rehab clients compared to the rest of the states.

Mr SOUTHWICK — What is your view on involuntary incarceration for those real troubled clients, let us call them?

Ms LONSDALE — In all honesty it is something that I have been thinking about and we have been discussing quite a lot. As I said, it goes against what AOD treatment should be about. You have got your severe dependence act, but a lot of these clients are not qualifying for that as well. You could possibly consider changes to that to be able to get people to stop the pattern of what is happening. They are not going to be happy with you or at all happy about doing it, but hopefully within a couple of days let them go through their crash period so you can be able to have a bit of a chat to them about what is going on. On a voluntary basis, yes, they might come through, but a lot of the time it is not based on voluntary. We are getting clients coming through either from the court system — their children are being removed or are at threat of being removed. There is often a threat or they are at high risk of losing something rather than the client at that stage coming to the realisation. They may, but how much damage will be done when they get to that period of time?

Ms BASSI — I suppose this is a positive. One of the biggest differences we have seen with clients presenting with ice is the number of families and carers who present to us really concerned, wanting to know how they can help. This is a real shift for us, because we do not really get that with people who abuse alcohol or cannabis. It is usually the client who comes through. We have just seen such an increase in families and carers presenting and saying, 'How can we help a loved one? What can we do?'. You have already got that support system in place, which is a huge bonus when you are trying to treat an individual with addictive behaviour, because 9 times out of 10 they are isolated, they are on their own — they are homeless or just disengaged from the family unit. But with the ice ones we tend to have a lot of family support and a lot of family concern, so you have already captured an audience for the support systems in place that helps clinicians in the drug field work. It just helps them so much to have that unit base.

Mr CARROLL — Are you then almost rehabilitating the family member as much as anyone else? This is an issue, the family is torn apart, the son or daughter is on the drug — —

Ms BASSI — Husband, wife.

Mr CARROLL — But if that person has not yet made the mental leap, 'I want to get better', because they are still happy on the drug, what do you tell the family members to keep supporting them and encouraging them?

Ms LONSDALE — I suppose a lot of it is that you focus a fair bit on self-care as well, provide the factual information and education to the family members about what is happening. I suppose you still need to instil hope in families. Without hope there is not much — you work with family dynamics: communication, looking at how they may be able to open the channels of communication with the person so they can discuss concerns. Not jumping onto the ice, but just looking at the concerns that they have, which is fine for a period of time. But for the families, when they are still dealing with it constantly, it can be — —

Ms BASSI — We do encourage them if the loved one is at home and the behaviour is erratic and you feel unsafe, to ring the police, ring the ambulance. You need to get some sort of help. You need that first point of contact, because there is no way that they would be able to bring the user in and say, 'We are going to take you to a drug and alcohol centre'. Ring the ambulance, get that first point of contact.

Mr CARROLL — The lack of rehabilitation beds in the Sunraysia region has been a theme that has come up several times today. If a rehabilitation facility were to be built in Mildura tomorrow, how many beds do you think it would need?

Ms BASSI — We have always based it very much on the Bendigo model. Bendigo got a detox-rehab centre in 1997 and it has four beds.

Ms LONSDALE — Yes, their withdrawal unit does. Their rehab through the Salvos has more beds.

The CHAIR — I assume that is for all drugs, like alcohol?

Ms LONSDALE — Yes. I know this is about ice, but I suppose if you are looking, there is concern about ice but there are also concerns about alcohol, cannabis and things like that. To actually look at just a place for ice users, then you are going to be wondering what is happening for alcohol abuse.

Mr CARROLL — The thing about ice though is that whereas with some of the drugs a person can detox in seven days, with ice it needs to be a minimum of three months for the individual to get the best care. Therefore they are in a facility for a very long time to get that whole-of-health approach where all the services look at what has led them to the drug and how they can get off it. I think that has had an impact that we have seen with this drug in particular. You can have the beds, but you have to be prepared to invest for the long term. This is not a seven-day detox, this is a minimum of three months for them to have any real chance of getting on a path to a better life.

Ms LONSDALE — When you are looking at families as well as the clients, it is important for them to know as well. With other drugs, when you are working with families, seven or eight days down the track the person is actually starting to feel some positive benefit from ceasing that drug. With this one, they are not; it is a long period of time before they will start to actually feel any better and so their chances of lapses or relapses are quite high. Yes, you are right. Looking at that longer term rehabilitation type.

Mr CARROLL — Thank you.

Mr SOUTHWICK — You mentioned a lot about family support. Do you think that if there were an opportunity to do so, families would contribute financially — if there were the facilities for rehab?

Ms LONSDALE — They already do. We love it if a client or their family, depending on the age of the client, has access to private health insurance, because if you have private health insurance, you can get into a 28-day program probably within a week. It opens up a lot more doors. We have had some family members who have paid quite significant amounts — several thousands of dollars — to have the young person go into a private rehabilitation program because they can get in a lot easier and quicker. They are also quite focused on the mental health side of things as well, so that is additional support for clients that is beneficial as well. There would be a proportion of clients though whose families would not be able to support them. However, in the public system, if they are on Centrelink benefits, the client contributes to their place in rehab anyway at the moment.

Mr SOUTHWICK — It seems to me any rehab would be quite cheap. We are hearing about supporting habits of somewhere between $5000 and $7000 a week.

Ms BASSI — That is your high end. It is huge. In the space of 6 to 12 months, somebody who might have had a home and a mortgage or a car and assets could lose it just in that period of time. We have had clients who have had that experience.

The CHAIR — After the withdrawal period, who documents what sorts of options are best provided for someone in a treatment program for meth users specifically?

Ms BASSI — Who documents it?

The CHAIR — Yes. Has there been work done in relation to post-withdrawal about what options are available for that sort of ongoing treatment? We have visited a couple of drug agencies in Melbourne. I am just wondering whether there is a tailor-made approach in relation to programs or options that are available for meth users in the post-withdrawal phase.

Ms LONSDALE — There are guidelines. Turning Point has put out guidelines. There are other guidelines that people have put out. CBT has been known to be very useful for this client group post-withdrawal. There is CBT, things like that. Sorry, can you ask the question again?

The CHAIR — I will go round in reverse. What has been told to us in other hearings is that the reasons for people using the drug, and they are varied, are that they are at a point in their life where they want to have a kick-start, a quick high because of a whole range of circumstances. Coming off the drug, in the withdrawal phase, you are going into a longer term phase. How do you change the environment in which they initially took the drug, because there are a whole lot of associated issues or reasons for doing it, as against them going back into that environment? The strategy is to change the way they think about life and themselves — —

Ms BASSI — We call it the maintenance phase.

Ms LONSDALE — I suppose it is the holistic approach. If they are disengaged from all meaningful activities and things like that, what is it that they used to enjoy doing? What is it that they can still do? Just looking at the drug and talking to them about saying no and managing cravings and things like that is not that productive. You need to be looking at all the other aspects of the client's life and seeing what is actually going on and what is happening.

The CHAIR — It is low self-esteem, job satisfaction, self-improvement, all those sorts of things.

Ms BASSI — Relationships. Yes.

Ms LONSDALE — If you have had somebody who has lost a lot of stuff through using, it is really hard to try to focus on that. They have had it and lost it, so trying to regain it and things like that. Yes, it is a holistic approach. It cannot just be focused on the drug — and that is not just with ice, that is with all drugs and alcohol.

Ms BASSI — Some clients who have lost a considerable amount find it really hard to dig themselves out the hole. Suicidal ideations and those sorts of things present, so you have to deal with that concept as well for the clients. It is all the psychosocial and psychological aspects of the drug, so there is so lot of cognitive behaviour therapy that you have to engage in with the client to get that shifting. It is about self-confidence, it is about self-esteem and it is about self-worth.

The CHAIR — Yes. I guess if you know the root of the problem, and you get through the withdrawal phase, you can tailor a program to get them back into the life cycle again, where they are actually productive and searching for yet another fulfilment, enrichment or something, whatever that might be.

Ms BASSI — And 9 times out of 10, the withdrawal is the easiest part. It is the maintenance, so they do not relapse.

The CHAIR — I guess that is the area I was looking at, yes.

Mr CARROLL — What about pharmacotherapy? What if, as part of that holistic approach, an investment was made in trying to develop something for ice addicts?

Ms LONSDALE — I think that would be very beneficial. We see that with opiates — heroin and things like that — that methadone and suboxone have been very successful in maintenance. Unfortunately for this, there is not anything. Even through withdrawal there is not a lot you can give someone to make it a smoother process. You cannot actually assist the client. It is time that builds up the ability to produce dopamine and all your good chemicals again. It is very difficult. If there were a pharmacotherapy that could assist with elevating clients' moods while they were going through that stage, it would be a lot easier to get them to focus, plan and look at the future side of things.

Mr CARROLL — Have you dealt with heroin?

Ms BASSI — Not for many years.

Ms LONSDALE — No, ours is more prescription medications.

Ms BASSI — Heroin still occurs but very rarely.

Mr CARROLL — I just wondered, with some of your clients, if they are ice addicts, what would I do to have a prescription that could help manage my addiction at the chemist? Is that something that has been raised with you as something they would see as being very beneficial to them?

Ms BASSI — They would, but there is nothing on the market.

Mr CARROLL — There is nothing there. It has not been developed.

Ms BASSI — With heroin you can get synthetic pharmacotherapy drugs, and that is what we do. Give us a heroin user any day, compared to an ice user.

Mr CARROLL — Yes, because there is just so much more out there.

The CHAIR — Are there any closing remarks you would like to make?

Ms BASSI — No.

Ms LONSDALE — I suppose the recommission.

Ms BASSI — I suppose when you look at the drug and alcohol sector at the moment, the whole sector has been recommissioned.

Mr SCHEFFER — It has been what?

Ms BASSI — Recommissioned. So you have to re-tender. So how we actually deliver services is changing, and that is a bit concerning for us when we look at continuity of treatment and how we provide treatment for clients. We are struggling at the moment to meet these demand.

Mr SCHEFFER — What are the concerns?

Ms BASSI — The concerns are about the continuity of care for clients through the system. They are changing our activities or our course of treatment. They are more segregated and more centralised, so we have concerns about how the drug and alcohol model would look in the future. That is something that has to be considered.

Mr CARROLL — Is that the Department of Health in Melbourne that is driving the process?

Ms BASSI — Yes.

Mr CARROLL — So this is basically the tendering out of services?

Ms BASSI — Yes.

Mr CARROLL — So would it be every five years that you have to re-tender, or is this a whole new thing?

Ms BASSI — This is a whole new thing.

Ms LONSDALE — And it is reforming the AOD system. I suppose it is the nature of the clients. There needs to be the opportunity of a brief intervention. If somebody wanders in, you might do a little bit — half an hour. They might then disappear for two or three weeks and then come back in. This is while the person is still using and you are trying to lead them into more engagement with the service. A lot of brief interventions and things like that are done with the clients before their ceasing the drug or reducing, and it is just looking at our targets, how that is going to work and the flexibility in services. Still being able to provide that to clients under a new body is concerning.

Mr SCHEFFER — You say it is concerning, but what is the rationale for doing that? Is it about cost cutting? You used the term ‘reform’, which suggests that it is a development that might

have beneficial outcomes. You are saying that it is concerning. Could you just tell us what you think it is about?

Ms LONSDALE — The reform came from the Attorney-General's report in 2011 that — —

Mr SCHEFFER — The Auditor-General, not the Attorney-General.

Ms LONSDALE — Yes, sorry. The Auditor-General. The report indicated that there needed to be a reform of the AOD sector, and it had been mentioned many times, but not a lot had been done. Does the reform need to take place? Probably yes when you look at the inconsistencies around the state on how services are delivered and all of those sorts of things. Yes, you would agree with it up to that point, but when you start to look at treatment models with particular client groups and how that is going to fit in to a new model is probably a concern for me.

Ms BASSI — An example of that that we are mainly concerned about is that our withdrawal targets have been decreased severely. We are 5 or 6 hours away from Melbourne, so we do a lot of our own home-based withdrawals here. We have access to two hospital beds where we can do alcohol withdrawals. We use Wentworth across the border to do withdrawals. So if we have our — for want of a better word — EFT staff reduced in withdrawals, when we are looking at the issues that are presenting and increasing all the time it is a big concern for us.

The CHAIR — We will take that on notice. It is probably more the unknown that is the concern, rather than what might eventuate out of the revamp of drug and alcohol. Thank you for putting us on notice. We will perhaps refer that back to the Department of Health.

Ms LONSDALE — We have answered all of the questions?

The CHAIR — Yes, we have, so I am going to ask you, if you would not mind, if you are happy to provide that for the committee as a written submission.

Ms BASSI — Can we send it to you electronically?

The CHAIR — Sandy will look after that. Thank you for going to the trouble of providing a written response to the questions, and thank you again for your verbal submission this afternoon.

Ms BASSI — You're welcome.

Ms LONSDALE — No problem.

Witnesses withdrew.