**LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE**

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

**Shepparton — 25 February 2014**

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Mr C. Oguntade, Clinical Manager, Adult MHS, Goulburn Valley Health.

**The CHAIR** — Welcome, gentlemen, to the public hearing of the Law Reform, Drugs and Crime Prevention Committee of the Parliament of Victoria. I understand you are all from Goulburn Valley Health.

**Mr McGREGOR** — That is correct.

**The CHAIR** — I understand also that you have been given a briefing in relation to the reference we are dealing with at the moment in relation to the supply and use of methamphetamines, particularly ice, in Victoria. This is one of many regional hearings that we have conducted over the last five months. We are always interested to hear from clinicians and those who are at the front face of emergency departments, particularly in hospitals and health services. We look forward to your contribution this morning. I will just read you the terms under which you are providing evidence this morning. I expect you will then make some introductory statement after which the committee will ask you some questions.

Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention Committee. 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 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important to 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 presenting evidence to parliamentary committees?

**Mr McGREGOR** — Yes.

**The CHAIR** — It is also important to note that any action that 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 you with a proof version of the transcript at the earliest opportunity so you can correct it as appropriate. They are the conditions under which you are providing evidence to the committee this morning. I thank the three of you very much for your time. Cameron, are you going to lead the batting?

**Mr McGREGOR** — I will lead the batting. In leading the batting, we are more open to questions than we are to opening statements, so I will give a quick overview of what we do and our involvement and then leave the floor open to you. I have had 14 years experience in the drug and alcohol area and 20 years experience as a nurse working at Goulburn Valley Health. That has been at the front line of detox, specifically assisting people in rural areas to come off drugs and alcohol. That is provided in the home predominantly 60 per cent of the time, in hospital settings around 20 per cent of the time and through referrals to Melbourne about 20 per cent of the time. We are certainly seeing an increase of secondary drug use of ice around this area, and it has become predominant within the health service system. I personally work closely with the mental health services, which Charles will give an overview of, and the emergency department, which Tyler will give an overview of, and then also within this segment, utilising the expertise of GPs, pharmacies and community health services within the drug and alcohol sector at regional, statewide and local levels.

**Mr OGUNTADE** — I am Charles Oguntade. I am the clinical manager at the Goulburn Valley Area Mental Health Service. I manage the adult community mental health services, which cover the whole of the Goulburn Valley area from here to Cobram. It goes out to Tatura. We have services in the lower Hume as well that cover the area up to Kinglake, Kilmore, Yea and Alexandra and all those areas.

I have been in this role as a clinical manager for a very short period, but before this time I worked as a senior clinician in the adult inpatient clinic for a period of five years and I have worked as a senior clinician in the adult community mental health service in Shepparton for a period of three and a half years. In my role in the community I work as a case manager, working as an acute response clinician in crisis care. I do a bit in the triage services as well, and this role involves seeing clients for the first time and includes visiting the emergency department, doing the

comprehensive assessment and determining what sort of assistance they are going to need from there on.

My experience over the years has been the same or very similar to Cam's. Like my colleagues, I have seen a large influx of drug and alcohol issues and illicit ice use, which is quite a troublesome and significant issue for us to manage as a service. We have mainly been set up as a service that looks after core mental health issues, and when you see someone who presents with drug and alcohol use, predominantly ice use, they present with this very aggressive nature. They are a high risk to themselves and to others, and you find yourself at a crossroad on how you manage this, most especially when it is 1.00 a.m. or 2.00 a.m. in the middle of the night and you struggle with how to deal with this. Do you have to do whatever you can do to minimise the risk and put them in an acute ward, or do you simply ask them to go away because this is not what you are managing here?

In these circumstances — being in a rural area with limited services where you cannot access areas of support — you just have to do what you have got to do. At the end of the day you see a much greater number coming into the adult ward and you keep them there for a certain period of time to wean them off, and then you start looking at where to go from there. It is one of the issues we have been tackling over the years. That is where we are still at, at this time.

**Mr TRICARICO** — My name is Tyler. I have been nursing for approximately 20 years in various departments within our organisation. One of those departments is the medical ward, where I have been able to start to see, probably over the last five to seven years, a change in admissions coming through where there is an age bracket of patients in their early 30s to mid-40s, and drugs and alcohol are grossly impacting on those people's health; whereas trends of maybe decades ago indicate it might have been an age group that was a little bit longer in the tooth, if you could call it that.

I have worked in medical for 10 years, I have worked in mental health for 5 years and I have also worked the last 2 years at a correctional facility which is close by to our local area called Dhurringile, so I am starting to see various facets in different life aspects of where drug and alcohol can affect people. My current position is that I am the emergency department liaison, specifically in the field of drug and alcohol, whereby I am attempting to set up systems to try to capture these people at the coalface, more or less from the entry point, and to either bring them to our service if they feel they are at that point of change and require help or to try to at least make these people aware that there are various services available. Part of my role as well is to try to upskill the emergency department staff and try to hopefully, as time progresses, get some accurate reporting of statistical data to more or less show how much this is influencing our health system at that entry point.

**The CHAIR** — All right, thank you. That is good news because previous evidence indicates, one, that hospitals do not get that data in relation to presentations of triage, and two, that hospitals do not have capacity to perhaps provide some holding area for those who are obviously affected by methamphetamine, which is creating a lot of angst within the ED. A dedicated person, perhaps, to look at the presentations of meth users in the EDs is probably something that has not been done, presumably, from what we are hearing. I am pleased to see that you are taking a proactive role in all of that.

Again, my question — and I will keep doing this all day — is to try to elicit from you what sorts of recommendations we might make to help in your particular area of expertise to make it easier to deal with the problem of meth users particularly, or those seeking assistance who have been using crystal meth, and obviously trying to provide some direction to them in the detox and rehab areas. Through the committee questions, you could perhaps get your mind around what we can do to assist in making recommendations to Parliament to put in place better procedures, better directions, better signposting or whatever in respect of your area. On that basis, without having to respond, you might want to do that through the questions as you go.

**Mr SCHEFFER** — Initially I just have a question to Tyler. You said that you have this approach to try to capture — I think your word was 'capture' — people using drugs at the entry

point and then to track them through, as it were, and then try to make interventions as you move along. How do you do that front-end bit?

**Mr TRICARICO** — Currently Cameron and I are waiting on some things to be approved. There is a triage document whereby we are going to utilise CAGE-AID questions. They are a set of four questions pertaining to drug and alcohol specifically whereby, if a person at the entry point of triage answers yes to one question, that would then lead to the second; therefore they would require further screening whereby we would use a self-assessment screening tool as part of the requirements with alcohol and other drug clinician guidelines. We are utilising it from that. Once that self-screening tool is completed and filled out it would then lead on to a process that the emergency department staff could refer to our addiction service and capture them that way. That is one area.

I have a book now whereby it sits with the nurse who is in charge for the shift. If any of the nurses on that shift feel that somebody has a drug and alcohol problem, that book can then have their name put forward in it, and then I go at 8.30 in the morning and 1.30 in the afternoon to check that book to see if there are any potential clients who require help. We also utilise — it sounds like a very basic format — a sticker whereby it defines that this service is engaged with that client at that point, therefore it can be coded and captured by health information. I am trying to think of what else we are trying to put into place.

**Mr McGREGOR** — There are also codings now of provisional diagnosis to their initial presenting problem. Many people who present to the emergency department do not present with a specific drug and alcohol issue, it is secondary to an emergency, so it is now identifying through screenings the secondary issues. It is also the provisional diagnosis, so that can be calculated and sent through the system on the notes, and also education then too of the doctors and the nurses about the new codings and about the assessment procedures and putting them in place. The other strategies Tyler spoke about then also are at the ground level, so we are getting information from the doctors, secondary through the triage nurses in the triage systems and then thirdly being able to access information straight into the addiction service.

**Mr SCHEFFER** — Is that capable of being broadened out to GPs in the community? Can they feed into that process when people present to them — as you were just saying, Cameron — maybe not initially to do with a drug and alcohol issue but to do with something where there might be an indicator or lead into the identification of that issue that a patient might have?

**Mr McGREGOR** — If you are looking at recommendations, that would be a great one. The current systems that GPs use are completely different to hospital data systems, so it is still a fax report that goes through to GPs on discharge of the clients, and that will only show a secondary diagnosis, not all the follow-ups therein. Having those systems in place could be a very valuable tool.

**Mr McCURDY** — Charles, you spoke about some of the challenges that you have. Is there any specific training or area that we could look at for recommendations that would assist you in your endeavours?

**Mr OGUNTADE** — Yes. Very important training would be like specific training in managing a drug and alcohol issue. I know some years back the department was recommending that drug and alcohol training be put in a mental health setting. I believe that was the time that the drug and alcohol section was trying to combine it with the mental health care section. I remember a significant number of us then went into specific training in drug and alcohol management. We did a certificate IV diploma and all that in there. When you look at the turnover of the staff over the years, many have left into something different, and we have new trained office staff. I would probably say maybe, if my calculations were right, out of any officers who did that training, then probably in the whole staff in their profile maybe we just admitted three or four. The new incoming ones did a training day and not an ongoing thing, and the new incoming ones did not really have any specific experience in this area, and they pretty much struggle in dealing with issues like this when they present. I think that having that training, which I think somebody like me benefited from, as an ongoing thing would be very important.

**Mr McCURDY** — Thank you.

**Mr CARROLL** — Wherever we have gone, particularly in the regional areas, the biggest issue that has come up is the lack of beds compared to Melbourne. It came up yesterday in Wodonga. I notice in your information that you have a 280-bed acute facility, but in terms of recommendations for the committee to consider, how much of an impact would it made to have a residential bed facility on top of and in addition to what you have in the heart of Shepparton? Is there a demand for that?

**Mr McGREGOR** — The demand for beds in rehabs has been well documented in Shepparton for many years. I think you can go back to 12 years ago through the *Sun* newspapers and *Age* newspapers to see the lack of accessibility to rehab beds. If we are looking at overall drug and alcohol teams, it would definitely be a viable option to look forward to as a rehabilitation process and also to add expertise in your own area. As Charles said, it is not often available in rural areas. We do not have the same staff coming through the areas, so when they do leave for Melbourne there are huge gaps and huge holes and we have to rebuild. Having specific services also creates viable staffing options that help recruit and retain the information we have in the local rural areas.

The current process to accessing beds is a real issue for rural clients. Requiring them to have face-to-face interviews in Melbourne is completely inappropriate when they have to get onto trains teeming with drug users. They use more drugs, make new networks. It is just horrible for some of these clients. The six-week to eight-week waiting lists we can understand. I think beds overall across the state are probably lacking in that area.

If we are talking specifically ice, then I think we need to understand the drug a little bit better. When they withdraw off alcohol or heroin or something like that, the insight of these clients comes fairly quickly, within 5 to 6 days. We cognitively can work with them well and we cognitively can help them with foresights and future options and to see a life outside of drugs. With ice, it burns the dopamine and serotonin receptors so much that it down-regulates them into a depression for so long; 6 to 12 months is the minimal required time. When these clients come out of a detox unit and a mental health facility after all the good work from health professionals, they are feeling depressed within 7 to 10 days. What is the easiest way to get rid of your depression? Let us take another drug. We are really pushing some serious barrels uphill. I am not going to swear; I have got to be very conscious of that.

**Mr CARROLL** — How does it work with Goulburn Valley Health? Would you support inter-agency agreements with, say, Odyssey House in Melbourne or trying to get priority access to beds in Melbourne for some regional areas? Sadly, there is a waiting list, but then again there is demand in regional towns that arguably means these people should somehow have priority access to beds in Melbourne.

**Mr McGREGOR** — The statewide system does not really work that way. It would be great if it did, but there are not enough beds for it to work that way, in my opinion, to start off with. I can remember that 10 or 12 years ago I had a very good relationship with the Salvation Army, so I would ring up their intake worker and I was able to assist due to the expertise and the trust we had. It was about a trusting relationship, not about a process, and their trust that I could actually identify the clients, assess them appropriately, look at their needs, make sure the client was safe in relation to clients and other clients within the facility. That is the hold-up with a lot of the processing of getting these clients through the doors. It is: are they safe? Are they going to hurt our staff? Are they going to upset the system? That process takes such a long time with the bed rates that the clients are falling off before they have even had a chance to get in there. A system like that would be great.

We do have local networks with Odyssey House; with the Benalla, which is a six-week program. But as we know, specifically with ice, after six weeks they are still depressed, they are still in a low mood, they are still coming back into the same environments and the drug is rampant in and around these areas.

**Mr SOUTHWICK** — My question, firstly, is in regard to involuntary treatment, particularly for a young person. We had evidence yesterday from the mother of a 16-year-old daughter who was not admitting that she had a problem but everybody around her could see the problem she was having. At what point is involuntary treatment suitable? When should we be doing this? And what are your views on having involuntary treatment for patients and the likely success rate? We have had other evidence to say it does not matter what we do, just get them in. We need to treat these people, particularly the young people who are spiralling down because of their use of ice and methamphetamine.

**Mr McGREGOR** — I will speak to the drug and alcohol. The drug and alcohol act does have a substance abuse provision, which is fairly hard to enforce. It still needs evidence from a medical practitioner and it needs to show that we have tried every other available service for the child. There are criteria to be met and many of those kids do not actually meet that criteria, so they are quite hard to treat. It is one of the emerging issues we see around here: we can really assist the parents but we cannot assist the child. There is not a lot that we can do in a legal framework to assist a 16-year-old female who does not wish to be helped. There is then the situation where they swap from falling under the drug and alcohol legislation to the Mental Health Act.

**Mr OGUNTADE** — Yes, this is very, very difficult, I would say. When you look at the mental health act, before you can commit someone for involuntary treatment you have to consider all the criteria that go with the mental health act. In the end you discover that this person does not meet the whole of the criteria, and to put an involuntary hat on such a person becomes a very difficult thing. It will even be much harder when the new mental health act comes into place. With what we have now, it is nearly impossible because the person has to meet all the criteria that would determine that they are suitable for involuntary treatment. Even going into the drug and alcohol one, if a court compels a young person to undergo treatment, saying, 'Yes, this has become a problem that we have identified, and you need to go for treatment at all costs', it is just an exercise in futility. Even an adult would become rebellious. They go in there and say, 'Yes, the court wants me to do it', they finish, and they go back to their old life. That is all.

When you look at the drug user in court, they must want to seek help; it has to be that they want to do it willingly. They have identified that this is a problem and they want to get help for it. That is when you are able to work with them. You have that window of opportunity to work with them. But when the person does not see it as a problem and a government agency is compelling them to do it, they are only going in there for fun, and when they come back they get even worse. They see it as a challenge, and it gets worse when they come back. It just makes a mess of your — —

**Mr SOUTHWICK** — Would you like to see reform of the Mental Health Act so that you are able to deal with adolescents in particular?

**Mr McGREGOR** — It is a difficult question. Charles mentioned there that the research does not back it up, in that the successful results at the end of it do not foresee — and again it is about understanding this drug. If they are depressed for 6 months or 12 months, how long do you allow them their autonomy? It is really difficult in the sense of gauging the clients who want to give up this drug. There may be outside-the-square ideas to that area. Let us look at their current resources. In the case of the 16-year-old girl, was the mother cooking for her, was there free rent, was she getting social security, was she on disability pensions — where was this child getting the money and resources from? Finding outside-the-square and innovative ways of addressing their ability to source the drug and to live a life happily using the drug may be a better strategy.

**Mr SOUTHWICK** — On the flipside of that, if somebody wants help and has finally recognised that they need the help and there is a six to eight-week waiting list, given that there are limited resources in terms of how many beds one can provide, is there other treatment that you could recommend that we could be providing in the interim to support that person so that they are not just flipping backwards to the drug until such time as they get proper rehab?

**Mr McGREGOR** — I think a lot of research in that area, considering it is such a new and increasing drug area — the drug is different to the other drugs — indicates that providing supportive environments and certainly starting to address the depression needs, the underlying

issues, environmental issues is helpful. A lot of these programs may not need beds. Six to 12 months of intensive outpatient programs, if they can be validated and researched upon, could be enough.

**Mr TRICARICO** — I was going to say as well, David, to validate those two things, I recently had a client that had three episodes at MJC whereby, I suppose, withdrawal had been forced upon him — it was not of his own choice. He then came to our service and I assessed him and went through the whole gamut of things. I said to him, 'One of the benefits of you presenting here today is that you've come of your own volition; it's your choice, and it isn't something that has been forced upon you'. He had more or less transcended back into that pattern of his habit, and I have successfully withdrawn him. I think that was one of the pivotal things: it was of his own volition and his own choice. You are almost halfway there to getting him to be successful.

**Mr McCURDY** — I think we heard that yesterday too. Somebody said something like: if it is mandated, it is never going to work or it is a lot harder for it to work, or something like that. Can I ask about the effectiveness of home withdrawal versus withdrawal in specific units? Are the options that we can look at to give people support in the home?

**Mr McGREGOR** — Yes. I will talk about other drugs and then ice. For other drugs, home withdrawal is a great option. Having clients learn to give up in their own environment, when it is supportive, is great. We can put them into a detox unit for 7 to 10 days, but where do they go afterwards? There are pros and cons for the home, hospital and residential units. The cons for the home are: the neighbour has the drug, it is across the road or it is easily accessible. The phone numbers are in their phone. They are the cons. But the pluses are that they learn to put up with those interruptions, they learn to put up with their missus walking out or their partner walking out, and learn to feel the distress and put up with the distress, with the support of a nurse on a daily basis who is able to problem solve to assist them through some of the emotional consequences of just living. In my 14 years experience, my clients seem to do better with the home detox, notwithstanding the ice ones.

Hospital detox is a great option; it is in-between. Families can visit the hospital. Users are away from their environment and they looked after, so it is a great in-between. But nurses are not traditionally trained in drug and alcohol, so they are not getting the same knowledge, although users still get the withdrawal nurse's knowledge once a day. It is also boring. They are stuck in a room not much bigger than this table. There is a TV on the wall, and they are bored. They cannot go out and pat the dog, do the gardening, even ride a bike or have a little bit of exercise — do the things that help during the withdrawal period. It is good to get them out of their environment for that shorter period of time, but the weakness is that it becomes very isolating and they have a lot of time to think about themselves.

Detox units down in Melbourne are a wonderful option. There are medical staff, and we use it for the complex clients. They have medical staff, they have other clients, they have social workers, psychologists and 24-hour care and can ask questions any time. So it is great, and they come out of there feeling absolutely excellent, but they jump back into the same couch chair, the same TV, the same load and the same arguments from the neighbours, and those environmental things pull against them very quickly. There are pros and cons for all of them. We sort of weigh that up beforehand.

Again ice is different. We can get people off ice for seven days. Physically the withdrawal is not huge. It is psychological, emotional and depressive, and those depressive, emotional symptoms last for such a long time. It is like living in *Groundhog Day*. It is getting up, going through the motions — cannot be bothered getting out of bed, cannot be bothered having a shower. Do I have to do lunch? I have to get the kids to school. It is the same boring routine, day after day after day. They know there is a solution there. The doctors will not give them speed, so they will go and get it themselves. It is a different drug when we are looking at treatment.

**The CHAIR** — We might leave it there. Thank you very much, the three of you, for your contributions this morning to this inquiry. We appreciate it.

**Mr McGREGOR** — I just want to make one quick comment, if I can, because I have done one little bit of research on it. It is so rampant in the rural areas that it is now home-grown. It is not coming from overseas through border security or from interstate anymore, it is home-grown. If you just type into the internet: 'How do I make ice methamphetamine at home', there are 55 800 000 hits that descriptively show you very simple methods of how to do this stuff. That is the problem we are facing.

I am happy for you to have any of the notes that we have taken, if you wish.

**The CHAIR** — I was going to ask if you would be happy to table the notes. I got a reminder from the executive officer, who is very vigilant in that manner. Thank you for that.

**Mr McCURDY** — Was that 55 million hits?

**Mr McGREGOR** — It was 55 800 000 hits. Don't try this at home, kids.

**The CHAIR** — That is the sad fact that the messages from the internet are not only about how easy it is to make it but also the high that you get from it. We are struggling to provide a message in response that these are killer ingredients in a killer drug that is going to make your life a misery. I guess at the end of the day our role is to come up with how best we can do that: inform the public and the demographic that is using that drug, which is a very wide demographic, I might add. Anyway, thank you very much.

**Witnesses withdrew.**