LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Traralgon — 28 January 2014

Members

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Ms Kerstin Bichel, Manager AOD Service, Gippsland Lakes Community Health Centre.

Mr Eion May, Alcohol and Drug Worker, Gippsland Lakes Community Health Centre.

The CHAIR—Eion and Kerstin, welcome to this parliamentary inquiry and hearing this afternoon in Traralgon. We are the Law Reform, Drugs and Crime Prevention Committee of the parliament, a joint parliamentary committee, and we have a full committee here today in attendance. You have given a written submission to the inquiry, which we appreciate. I had a chance to look at that last night in some detail and I might ask some questions out of that submission as well as on your additional remarks.

Before we start I need to read to you the conditions under which you are giving evidence to this committee this afternoon, so bear with me. 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, by both 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 from reciprocal legislation in other Australian states and territories. It is important that you note 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 in parliamentary committees?

Ms BICHEL—Yes.

Mr MAY—Yes.

The CHAIR—I think Sandy would have sent that to you.

Ms BICHEL—Yes.

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. We have allotted time from 1.45 this afternoon to 2.30. I do apologise, I have to be reasonably strict on the finishing time, although we have encroached on some of your starting time, but we do have I think two other witnesses to present and we have to be finished here at 4.30.

Ms BICHEL—Okay.

The CHAIR—I appreciate your time this afternoon, thank you, and who is leading off?

Ms BICHEL—I thought I would just give a little bit of a background.

The CHAIR—Thank you.

Ms BICHEL—Gippsland Lakes Community Health Alcohol and Drug Services provides services throughout the East Gippsland catchment, so just after Sale to the New South Wales border and up to Omeo and those areas. We have broken down some figures, and during the financial year of July 2012 to 30 June 2013 a total of 291 clients presented with alcohol or cannabis as their primary drug of concern; 43 of these identified secondary drug use as amphetamines. We have done the same for the first half of this financial year and so far a total of 151 clients have presented with alcohol and cannabis as their primary drug of concern, and 41 of these identified secondary drug use as amphetamines. So there has been an increase and 29 of these clients have identified using ice. Thirteen of these clients were referred by the courts or police, and alcohol use and violence were the reason they were involved in the criminal system.

Being such a large area, we provide services to rural and remote areas such as Orbost, Cann River, Mallacoota, up to Omeo and so forth. Often we offer secondary consultations to other professionals that work in those areas and also provide education sessions around the different substance use. There has been a call-out from Cann River in regards to ice use and the need for education. They seem to have a fairly decent issue there, but it is interesting that clients are not wanting to seek services. However, what we are doing is upskilling the staff that they have daily contact with, and police and schools and so forth, so that they have the necessary skills themselves.

The CHAIR—When you said that alcohol is the primary agent for court actions, would that be because methamphetamine is less likely to be detected or is it a combination? I am just wondering if that is slipping under the radar in relation to a court matter relating to the use of it.

Ms BICHEL—I think it is just what the police are presenting as evidence is that a person has been under the influence of alcohol when the offence was committed. It is not till they then have an assessment done by ASCO codes that they actually disclose that they also use ice.

The CHAIR—Okay.

Ms BICHEL—It is a bit like the chicken and the egg; which comes first?

The CHAIR—I raise it because the headlines at the moment are about alcohol-fuelled violence and the king hit or one-hit scenario, where alcohol has been attributed as being the agent that is fuelling the violence. I am just wondering if maybe it is a combination or a significant factor is the use of drugs, methamphetamine, to create the quite violent, aggressive behaviour that is still being seen as alcohol fuelled, whereas it might well be it is drug-fuelled with a further combination of use.

Mr MAY—As a community health organisation we have not just a drug and alcohol service. We have a family violence support service, we have a family support service, a housing service, and so on and so forth. If we were to look broadly, and of course it is difficult to not be speculative because statistics can be really hard to pick apart and get an accurate picture of what is going on, but I think if we were to talk to our family violence people we would find that alcohol is still our core business and it still does seem to be the substance that is most primarily linked to other forms of harm. That is family violence, child abuse et cetera.

So certainly we can see that methamphetamine—we can see statistically for us, and we have had to sort of tease those out, because our programs do not allow us to specify ice as a substance. It is amphetamine use and in our assessments we specify that it is ice. So we have to go in and tease those out.

It is clearly an emerging problem for us as a treatment service, but we can of course only comment on the people that are actually part of the treatment population, and it appears that statistically and anecdotally if you are talking to other clinicians, at least within our service in East Gippsland, cannabis and cannabis and alcohol are still the primary drugs of choice and those that cause the most harm—not that any form of harm and the things that we are talking about is acceptable but that methamphetamine still seems to play a lesser role than those other substances.

Ms BICHEL—I meet regularly with Latrobe Community Health, Southern Health and Bass Coast and they seem to have, from those discussions, more of an issue with ice than we actually do in our region. But I suppose when you have a look at the numbers, already we have nearly doubled the numbers of people who are identifying ice as their secondary drug. So obviously it is making its way up that way a bit.

Mr SOUTHWICK—From what base, when you say double the numbers?

Ms BICHEL—For the whole financial year we had 14.8 per cent of clients identifying amphetamines as their secondary drug of choice, and we are already up to 27.2 per cent, so it has nearly doubled, and that is only in a six-month period where the other one was 12 months.

Mr MAY—There are a number of reasons why that might be, and certainly, as I mentioned, people are perhaps starting to use it more. But also I think as clinicians we are starting to perhaps make a point of trying to assess a little more accurately and are actually starting to ask those questions, because quite often clients are actually presenting with, like I said, problematic alcohol use. Then when we do an assessment, we might find that there is in fact some methamphetamine use. To determine whether it is problematic or not can be very difficult. Perhaps one-off use is still problematic, because it is a very dangerous substance and it is illicit, so obviously any use is an issue.

Even with those statistics, are we finding there is an increase there? Is it because there is an increase in supply? I do not know. Is it because we are assessing more accurately? I do not know. But it does not necessarily mean it is their primary substance either; it is a secondary substance. A number of our clients are polydrug users, and what is available at the time and what they are doing and how they are trying to medicate themselves or enhance a situation may dictate what they use.

Ms BICHEL—We can say that referrals through drug diversion have increased around amphetamine use, and that is particularly people from our area being caught in Melbourne in possession of amphetamines and having the option to undergo a diversion program. Once again, I think that has happened more so in the last six months than in the previous—

Mr SCHEFFER—So who would they be? Would they be young people going to Melbourne for a good time?

Ms BICHEL—Yes.

Mr MAY—Yes, absolutely, and that is where we are talking about the treatment population. They would not normally be part of the treatment population, except that they are being caught early and sent through a diversional process, which is wonderful because we get an opportunity for early intervention and to be working with people for whom the substance is not necessarily problematic at this point in time. They are using it as a lifestyle drug. They are going to parties and festivals in the city and are using that substance to try and enhance their experience. They experience getting caught by the police and then being diverted to us to have some support and some information and some intervention.

That is certainly increasing, but again is that because the use is increasing or because the policing is targeting that substance? It can be really difficult, because then we are being speculative, but certainly we are seeing some more things happen there. The opening question that we were asked to comment on there is, can we say that it is becoming more of a serious problem? That could be quite an ambiguous thing to try and answer. 'How does it compare to the use and harms caused by other drugs and alcohol?' If we were to measure, like I said, the relationship to harm, it appears that alcohol is still top of the tree.

There are certainly some unique issues with methamphetamines as a substance and a challenge to us as clinicians in trying to support people, so I do not know if it is worth commenting and moving onto the next part there. A number of our clients are mandated to come and see us. So, being an illicit substance, it is causing criminal problems for people—legal issues—obviously being caught with it but also in the efforts that they have to go to to procure the substance if they have an expensive habit. Often they are involved in illegal activity.

We can see significant mental health issues as a result. Often people are self-medicating, so it is quite common that they actually have an existing mental health issue and are self-medicating with methamphetamines to try and cope, but certainly we can see that there is an exacerbation and/or some potential cause of mental health issues as a result.

If I am talking personally—and I have a broad role within the agency and so I often work with a withdrawal nurse supporting people to go through drug and alcohol withdrawal—the biggest challenge for me, I think, with methamphetamines is the protracted withdrawal process. What we do not see, like we might with alcohol or heroin, is an acute physical manifestation of withdrawal symptoms. Most users are able to actually stop from a physical perspective quite easily, but what we see is a really protracted withdrawal phase, where they are really incapable of feeling any type of pleasure or joy, which really then makes it very difficult to try and support people to maintain that abstinence and not relapse and go back to using, because often they are in a position where the only way for them to feel any kind of pleasure is to actually use that substance.

That is a real challenge for us, so we try and work very closely with GPs and with the hospital and with psychologists and mental health services to try and support people through that process, but I think that is an area that probably needs far more research into possible options for pharmacotherapy and other specialist supports to address that issue.

The CHAIR—Kerstin, I realised I cut you off at the chase a bit just before the questioning, so please feel free if there are additional comments you want to make.

Ms BICHEL—No, that was it. Yes, Eion is coming in at the right time.

The CHAIR—Can I perhaps invite the committee to raise some questions with you, aside from the submission that you made.

Mr MAY—Absolutely.

The CHAIR—Mr Scheffer.

Mr SCHEFFER—I wanted to come back to I think something you said, Kerstin. I thought you said at one point that clients themselves are not calling for help but services are. Have I got that right?

Ms BICHEL—No. Actually, our data shows that, with regard to clients who identify amphetamines as their secondary drug, self-referrals are higher than even courts and police, but they are actually coming in because of problematic alcohol or cannabis use.

Mr SCHEFFER—I see. When they come there, they talk to you about the alcohol and then the rest of it comes out in the process.

Ms BICHEL—Yes, and then we sort of pull it apart and find out what else is going on and what else they are using.

Mr SCHEFFER—Okay, which brings me then to a comment that Eion made about the protracted withdrawal process. I think you said in the short term it is relatively easy to come off it but it is maintaining that in the long term—

Mr MAY—Yes.

Mr SCHEFFER—What are the reasons under that?

Mr MAY—The difficulty to maintain abstinence?

Mr SCHEFFER—Yes.

Mr MAY—When we talk about the short term, it is quite common for amphetamine users to maybe have, say, three days of using and then they come down, if you like, so they might have a day or two where they do not use. In the short term, to achieve a week's abstinence seems to be something that people are able to achieve, because it is often almost part of the pattern of their use anyway. But the long-term issue, other than the anhedonia that people report experiencing—if we were to look at a profile of some of the common users for whom it is actually problematic.

Again what is problematic? What is serious? We are not talking necessarily about young people for whom at the moment it is just a lifestyle choice, because they might use it once a month or once a year at New Year's Eve. We are talking about people for whom it is a really significant problem. If we were to assess them and we were to look back, we would see that there is often a history of learning difficulties at school, social problems, lack of connectedness, histories of family violence, mental health and those sorts of things. Often, if we can, we support them through the other issues that they are having. We are finding that these are people who are really struggling with life and so methamphetamines have been their way of self-medicating and trying to cope.

Another interesting thing is their profile. It is only anecdotal and it is probably something that needs a little bit of further research, but we certainly see it, and you were listening to the ambulance officers earlier, who were making mention that it appears to be a lot of young men; so we are talking about young men. We might be talking from 20 to 30, 35. There is quite often a history of those learning difficulties, often a diagnosis of attention deficit disorder and/or there is speculation that it may not have been diagnosed because they did not have access to a paediatrician, and often there has been, as adolescents, the prescription of dexamphetamines, or

Ritalin if you like, so then they find themselves self-medicating to try and navigate a life. That is something that I cannot say is a definitive issue, but certainly with a lot of young men—

The CHAIR—It is very complex because we are getting all different kinds of strings in it. One proposition that has been put to us is that the cohort that use this drug are much more cashed up, much more capable in the world than, for example, the cohort that might have been using heroin. So we are getting that and we are getting the kind of position that you are putting as well.

Mr MAY—Yes. Listening to the ambulance officers, I think that is in part because the person they are called to might be the young man at a party who has found himself in trouble. They are not necessarily people that are part of our treatment population, because they might have had an acute issue with it but they do not have a chronic problem. I think that is where there could be that difference. Certainly because of the diversion process, because we have things like alcohol accords where people will be referred to us with prompting and poking, we can find that there are young tradesmen—painters and builders and things—that are using it and using it quite regularly but they are managing to maintain, at this point in time at least, quite an appropriate existence. That is simply different from these daily users where it is a really, really chronic issue and we are seeing all of the comorbidities that come with it—that is, their mental health.

Mr SOUTHWICK—Thank you for your presentation. I was keen on hearing a little bit more in regard to the organised crime that you mention in your submission and particularly the suggestion that a number of people are flying to Sydney and stuff is coming in from Sydney. If you could just give us a little bit more on that—obviously not the specifics of it, but just generally. How organised is the nature of the drugs that are coming into the region?

Ms BICHEL—That was one example we had because it was a client that was engaged with our service. After the event it was discovered that, yes, a group of them would fly out every week from Melbourne, go up to Sydney, collect the amphetamines and bring them down by truck, and that was a frequent thing, and certainly when the drug bust happened—and it was quite significant; I think it was about $45 million worth—the comments from clients that were accessing our services was that there was not any ice and speed around, so obviously they had quite an influence on the amount of amphetamines and ice that were available. Once again, if there is a group of them going up, it is a fairly organised thing, but whether that is related to bikies or whatever, we have no idea. But it was something quite significant for our little area up there.

Mr MAY—I think it is fair to presume that a $45 million drug bust is going to be organised and related to somebody who has the means to fund that as opposed to one of our local people that are just casual users.

Mr SOUTHWICK—It would appear that most of your clients would be very much small-time in terms of where they are getting it from—local as opposed to potentially more stuff that is coming in.

Ms BICHEL—Generally we have a number of people who will come down to the valley or down to Melbourne and use it themselves and then bring it up and supply it to others up there, so generally users funding their—

Mr SOUTHWICK—Habit.

Ms BICHEL—Yes.

Mr CARROLL—At the moment there is no pharmacotherapy substitute available for methamphetamines. Given your experience, if one was developed, how beneficial would it be?

Mr MAY—I think it would be wonderful. That is not to suggest that pharmacotherapy is ever a silver bullet for an issue, but it is certainly always a very effective tool. There are a lot of positives and negatives if we were to look at pharmacotherapy for opiates—for example, if we look at buprenorphine and methadone—but it is still an effective tool and, for some people, quite an important part of their treatment and their recovery, so certainly further research could be done, looking perhaps at dexamphetamines as a form of pharmacotherapy. What we say is the reason

that withdrawal is quite protracted is the lack of dopamine available to people to improve mood, so if there were able to be medication to support people to feel something in relation to brain chemicals—serotonin, dopamine, noradrenaline et cetera—to balance those things out, it would be great. It would be a very effective tool. Of course, we would still be needing to address the social and emotional issues that are there as well, but pharmacotherapy is certainly an important tool for us.

Mr CARROLL—Have you found ice users calling for that in any consultations you have had and in therapy?

Mr MAY—Again it is not every client, but I have had a number of, again, young men particularly that report receiving a diagnosis as a young person of attention deficit disorder and being prescribed dexamphetamines and then often finding that, upon turning 18, they no longer saw the paediatrician and went and saw their local GP and were no longer prescribed Ritalin. They found their way onto ice, and so they are saying, 'If only there was some sort of support for me to more slowly make changes in my medication regime,' or, 'If only there was something else that I could take.' I have never taken ice and I do not know if anybody here or on the panel has, but I would imagine things speed up quite significantly. A lot of these young people are talking about things slowing down and they are actually able to focus. So, yes, I have heard people call for it.

Ms BICHEL—I also wonder is that why people are not accessing services, because they do not think that there is something there that can assist them? With alcohol there is pharmacotherapy. With the opiates there is. It is quite common in the press and whatever that it is saying there is nothing, there is no substitute for ice and whatever, so does that stop people actually accessing services, because they do not believe there is anything we can offer?

Mr MAY—And certainly not to oversimplify the withdrawal process of alcohol, but it is something that we have been doing for a long time, so we have got lots of tools and withdrawal regimes available; we know what we are dealing with and what we might expect even though there can be some complications. I think that there needs to be a lot more research done so that we have got some evidence based practice, so we are not just trying to do what we have always done; we are not having someone in an inpatient environment and we are using an alcohol withdrawal regime on someone who is withdrawing from amphetamines. To me it does not make a huge amount of sense, but I do not know what the answer is and I think that resources invested into addiction specialists to investigate this sort of stuff would be very good.

Mr CARROLL—I did read in your submission about the 18-year-old threshold. So if you are a young person and you are on Ritalin to deal with some behaviour issues, when you turn 18 is the onus then on you to get the script from the GP? Is that where the falling-down is?

Ms BICHEL—Yes, that is my understanding from mental health services when I have had discussions with them because when they turn 18 they are generally not picked up by the adult mental health services, and certainly my discussions with our local mental health services are that they are seeing the correlation as well between previous Ritalin use and—

Mr CARROLL—And turning to something else.

Ms BICHEL—Yes.

Mr MAY—Yes. There is quite a reluctance for psychiatrists and general practitioners to prescribe the substance, and that may be because there are some downsides. It is not at all clear-cut that it is a wonderful thing. Possibly young people need to be managed differently. I do not know, but still there is a gap there somewhere.

Mr McCURDY—I would be interested in a comment. Education has to come in so many different forms and I would be interested in how this 'coward punch' versus the 'king hit' pans out over a period of years. I still have this real problem with party drugs and the fact that they are called 'party drugs'. Is it our responsibility and the media's responsibility to call them 'killer drugs' or 'life-ruining drugs'? Would that change the perspective at all? That is what we are trying to do

with this 'coward punch'. I know it is not as simple as that but I just wonder because while we continue to call them 'party drugs' it seems like a really sexy thing to be involved with.

Mr MAY—Absolutely. Fortunately, and unfortunately, the media plays a big role in the way we perceive all sorts of things. Education programs that change the perception of substances would be very valuable, but if we are talking about the people who access our services, these are the sorts of people that, even understanding the risks, are in a position where they almost see no choice. So if we are talking about education, if we are talking about early interventions, we are identifying young people with learning difficulties who are socially disconnected, are from a low socio-economic area et cetera. The risks are there and we see that they are struggling and floundering. While we are able to engage with them and support them there, I think we could expect that the likelihood of them using substances like this, even at parties, perhaps might be far less because we have helped them develop resilience and resources and social connectedness.

The CHAIR—Any other statement you would like to make?

Ms BICHEL—No. Sandy, when I spoke to you, you had queries about football clubs.

Mr MAY—I can answer. I think Kerstin is looking at me because I am a president of one of the local football clubs in Bairnsdale and a footballer myself, and a drug and alcohol practitioner. So I guess that gives me a little bit of insight there. I heard some discussion with the paramedics about the prevalence of amphetamine use in football clubs. If I can speak freely, if you like, about what I see and what I know as a member of a club, substance use happens quite commonly in most sporting clubs and social environments. Usually alcohol is the most common lubricant and therefore tends to be the one that is also the most problematic. The AFL and most football clubs are working really hard to try and change the culture around alcohol use in football clubs, which is difficult because of the culture of alcohol use in the broader community. Sporting clubs are just made up of members of the broader community.

I think it follows on from there with methamphetamine use. Members of the East Gippsland community use methamphetamines, so therefore you will find there are members of sporting clubs, including football clubs, in East Gippsland that use amphetamines. Unless the guys I am playing with are not telling me something and through what I have learned as a drug and alcohol clinician I am completely missing what I am seeing in them, it is certainly not an issue with the clubs. It is not an epidemic. It is not an issue that we as a club are having to work at addressing. We are still working really hard at striking a balance between being dependent on alcohol as a primary source of income, and the responsible service of it.

In the club that I was president of there were some young men who did use it and it did in fact become problematic for them. From the seniors right through to the juniors, if we are talking about 150 to 200 footballers then we are talking about two for whom it is problematic. Perhaps it is an unacceptable number of people but it is still not the majority that are using it.

Mr SOUTHWICK—In the past we have seen sport being used to curb drug addiction. In my electorate down St Kilda way we have had clubs that have been established on the basis of encouraging people to get into routine and all that sort of thing. Is ice an exception in terms of what it can do or seem to do to the individual?

Mr MAY—Do you mean in terms of whether being involved in sport is actually helpful to some people?

Mr SOUTHWICK—Yes, so getting involved in sport and being fit and healthy; you are not going to pump negative stuff into your body.

Mr MAY—I still think engagement in meaningful activity and connectedness is really key for all of us. If we are going to be healthy in all senses of the word, we are going to find that things in sport and sporting clubs can support us to be both physically healthy and healthy in terms of our social wellbeing. I still think it is a really valuable thing to have young people involved in sport, healthy pursuits and meaningful activity to try and create that community connection and that strength and resilience, to try and prevent them from using. Having worked on the streets of St

Kilda and played football with Sacred Heart Mission, and cricket with those guys, I may not have seen really profound change in those people that were involved in the football but certainly they were far less likely to turn up intoxicated. They still valued their ability to perform and to be able to do so.

We have seen some really high-profile people like Ben Cousins, and it is arguable that you would find a physically fitter man, but clearly he had some fitness issues in relation to his mental health. That was the thing that led him into that. Physical fitness is not the be all and the end all. I think it is more around the connectiveness and trying to encourage young people to be involved. I hope that answers your question.

The CHAIR—We might leave it there. Thank you very much for your time this afternoon and your contribution to this inquiry. We appreciate both written and verbal submissions. Thank you.

Ms BICHEL—Thank you.

Mr MAY—Thank you.

Witnesses withdrew.