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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Witnesses

Mr James Dale, Acquired Brain Injury and Alcohol and Other Drug Clinical Consultant, Latrobe Community Health Services.

Ms Debbie Stoneman, Alcohol and Other Drug Nurse Clinician, Latrobe Community Health Services.

The CHAIR—Can I welcome you both to this public inquiry into the supply and use of methamphetamines in Victoria. It is given to us by the parliament of Victoria, the Law Reform, Drugs and Crime Prevention Joint Parliamentary Committee. Debbie, you are an alcohol and other drug nurse clinician—is what I have on my notes here—as part of the Latrobe Community Health Service.

Ms STONEMAN—Correct.

The CHAIR—And James, you are the acquired brain injury and alcohol and other drug clinical consultant.

Mr DALE—That is correct.

The CHAIR—I have not yet worked out what the acronym would be for that.

Mr DALE—We do simplify it to ABI/AOD.

The CHAIR—Okay. Welcome, both. We have allotted some time till 3.15 this afternoon for your verbal submission. Before you start, I will read you the conditions under which you are presenting to this committee this afternoon. 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, 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 STONEMAN—Yes.

Mr DALE—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. Any questions?

Ms STONEMAN—No, not from me.

Mr DALE—No.

The CHAIR—Who am I inviting to make the first presentation? You are doing the PowerPoint, James, are you?

Ms STONEMAN—We are going to share.

The CHAIR—How long does this go for?

Ms STONEMAN—Not long, I think. Some parts we will be able to skip over. Others we will spend more time on.

The CHAIR—I am just aware that I would like the committee to be able to ask questions on issues that they want answers to.

Ms STONEMAN—Definitely.

The CHAIR—So, either through the presentation or after, we would like to allow some time for that to happen.

Ms STONEMAN—Yes.

The CHAIR—Have you got a preference? We can either stay silent as you do the PowerPoint or raise some questions as we go through.

Ms STONEMAN—Happy for both.

The CHAIR—We have got the ground rules. Thank you.

Overheads shown.

Ms STONEMAN—We will start by explaining a little bit about our service and where we come from. Latrobe Community Health Service is the major provider in this area of primary health and support, with a large staff base of 400 people. Our aim is to reduce disease and illness. We spent a lot of time in prevention, health promotion and looking at social, physical and cultural change. We have quite a multicultural cohort of people living in this area. We aim to deliver an integrated and coordinated approach to the delivery of our services at a local, subregional and at a regional level.

As a service, we offer an assessment, referral, counselling, after-care, information and education service to the people who are affected directly or indirectly by the abuse and the use of all substances, whether they're illicit or licit; also prescribed medication. We provide services to the LGAs of Baw Baw, Latrobe and Wellington, so we cover quite a large geographical area. We provide a telephone intake service which also incorporates being able to touch base with people who walk into the service. We have general and forensic alcohol and drug counselling for both adults and youth. We have a rural withdrawal program for adults and youth and that incorporates withdrawal nursing and support and linkages workers.

We have a Koori specific program, care and recovery programs. James is our acquired brain injury person and he holds a regional position, and we have a mobile drug safety worker who works at an early intervention level and with our needle and syringe exchange programs. There is a lot of education in that role. We have a family support program, which is obviously vital in our work, and a pharmacotherapy program in regard to opiate replacement therapies.

Mr DALE—I am not sure today how much actual information about ice you have been given. You have probably been given a fair bit of it, I am assuming, so a lot of this we can just maybe skip over.

The CHAIR—It is not just today. We have actually had five or six public hearings, regionally and in Melbourne.

Mr DALE—All right. A lot of the stuff on this slide is around ice specifically as a form of methamphetamine, the different levels of purity and also the different forms that it comes in. As you probably know, there are other forms, so there is speed in powder form, and the base. It is a central nervous system stimulant and it increases the body's responses, making people feel more alert and energetic, and it affects the neurotransmitters, which include dopamine, noradrenaline and serotonin, which you probably already know.

As for our treatment approaches for methamphetamine, it should be matched to the client's stage of readiness to change. Have you been shown the stages of change model?

The CHAIR—Yes.

Mr DALE—What we are finding is that we are getting a lot of clients who are in the pre-contemplation stage, and the contemplation stage as well, so they are aware that they have a problem but there is not really much of a commitment to taking any steps to change.

What LCHS has been seeing is a rise in clients presenting with amphetamine use in the last year. Our reporting data systems do not allow us to separate the different types of amphetamine and things like that, so all we can report on is that it is amphetamine use that is on the rise, and as ice users start moving into the different stages of change, we will find different levels, so going from abuse to dependence, into long-term use. Do you have any comments on that slide?

Ms STONEMAN—Yes. I am envisaging that over the next 12 months we are going to see quite a rise in that, based on what James just said, while people move from occasional use or abuse into dependence and potentially then seeking assistance and services.

Mr DALE—The most common age group that we are finding in our data is 20 to 30 years of age, predominantly male, but there is an increase in females as well amongst this age group. As we know, ice is indiscriminate and affects all ages and all socio-economic groups. We can expect an increase in presentation to drug treatment services as ice use moves from abuse to dependence, which we just spoke about.

While the media stereotypes the ice user as being of low socio-economic background, there is anecdotal evidence to suggest that there is an increase in occupational users, including those who work shifts and in industry. This is particularly relevant to Gippsland due to major industry in the area, so forestry, energy and the desalination plants.

The CHAIR—What about transport? I am just a bit worried about a lot of these drivers on very long shifts that are full of amphetamines.

Ms STONEMAN—The people that we are seeing that are truck drivers often are coming in having already recognised that they cannot continue to work under the influence of these drugs and they are wanting to get treatment to be able to return to driving. Most of them are reporting to me that the increased checking of blood alcohol levels and drug-testing is quite a deterrent, so it is quite different perhaps to what is actually happening there versus the people that are presenting to us. People come to us wanting assistance—voluntary clients who are acknowledging it—and the truck drivers themselves tend to not be driving. Other drivers of course are a different cohort.

Mr SOUTHWICK—The old problem of, say, speed is, you would say, on the decrease because of the testing?

Ms STONEMAN—It seems to be that the clients that I am working directly with are far more knowledgeable around the effects of amphetamines in general, and certainly of ice in particular, and they are acknowledging that they cannot be out there on the road risking themselves and other people—keeping in mind that they are the people seeking assistance.

Mr DALE—We provide a family support program which we feel is relevant to all drug treatment clients but, particularly for today, methamphetamine clients. Obviously we try and give coping strategies for parents, siblings and significant others, and assistance to develop family emergency plans, because what we are finding is that family members are contacting the service in crisis and there are no plans in place to address those; also to reduce the harmful impacts; and, obviously, relevant referrals to our other services.

We have received 95 per cent of our annual target for our family support program, so we feel quite happy with the work that we have done in supporting families, but there is a long way to go. Families tend to feel very frustrated with referral pathways and things like that—detox wait list times and wait list times for long-term rehabilitation—so we would benefit to have more education around how the drug treatment sector works.

Ms STONEMAN—Can I just comment on that annual target figure—that percentage—given that that is a financial year. The reason we wanted to highlight that was that here we are in January and we have reached that target, so it really highlights the need for families to have a really good, robust support program. They just desperately need—

Mr SCHEFFER—You talked about developing a family support program and then you said straight after that that families already are in the middle of a crisis. So how is the package used? Is it provided to them at that point, or are you looking at more a broadcast preparatory kind of awareness package to the community through websites or something?

Mr DALE—We do it with the crisis response. I cannot comment on whether or not we have had any advertising on the program itself—you know, blanket in the region.

Ms STONEMAN—The programs that are run that are often six-week programs are advertised, but we also respond on a crisis basis to families who are ringing our intake service in particular.

Mr SCHEFFER—What is this six-week program? You do that for the general public?

Ms STONEMAN—Yes. It is an advertised program. Mainly it is for people who have been identified as family members of people using, but certainly others can come—

Mr SCHEFFER—Others can come?

Ms STONEMAN—Yes.

The CHAIR—There has reference made to the desal plant three times already today. I have heard of the desal plant being blamed for all sorts of things, but increase in ice use is not one of them. Is it because of the transient nature of the workforce, because my understanding is that they are well paid for the work they do around the desal plant. Is it because they now have cash to use for recreational use? What is the impetus for the greater drug use around that plant?

Mr DALE—I think it would be fair to say it is probably a good mixture of all of that: the type of work; the length of the hours that people are working; like you say, people being cashed up. Being in a remote area, it is difficult to find things to do with your downtime.

Ms STONEMAN—When we look at ice in particular and the serious issue that it is, we are finding that people are reporting that it is extremely easy to get their hands on. It is very available. The cost of ice has become affordable for a lot of people. In fact, when we speak to adolescents, they are reporting that it is often cheaper for them to get ice than it is to get alcohol and that it is easier for them to access.

The manufacturing at home, the ingredients and recipes—you can YouTube everything, obviously, and it is easy to get the information on how to manufacture ice. I heard you mention earlier the sexiness of ice in the media and the ideas in the community, and certainly programs such as *Breaking Bad*, while they also highlight the horrors involved, do somewhat romanticise the use of ice.

The associated harms we are seeing, not just in the initial use period and when people are abusing but the long-term, ongoing use, are quite phenomenal. The ongoing mental health issues, the criminal issues and the psychological issues that are involved—social, financial, legal, health—are quite incredible.

When we talk about how ice compares to other drugs, in our service we still see alcohol as being the most common drug that people are presenting with. However, the effect on families and on the community and on the individuals themselves is certainly comparable. The long-use use, as I said before, is really concerning.

The consequences of ice use that we are seeing—obviously when people are injecting and the associated blood-borne viruses; respiratory issues with smoking ice; gastro-intestinal problems with people swallowing the substance; and of course you see the quite standardised scabbing and sores that people are presenting with after long-term use; gum disease—and most of these people seem to be very malnourished once they are spending all of their lives trying to find ice and not worrying about feeding themselves. With poor nutrition, in particular, we are seeing a lot of that with the symptom of loss of appetite. People just are not eating.

The disruption to families and family breakdown is a grave concern; children being removed. Many of these families have Child Protection involved. Family violence is a huge issue, with the agitation and mood disregulation that comes with ice use. Extensive stays in treatment, if we can get people into long-term treatment, are concerning for people. If they have been able to maintain a job, that affects employment, and of course financial difficulties. The legal consequences: violence you would well and truly have heard about—family violence, drug possession, trafficking, manufacturing, theft and driving offences.

Mr SOUTHWICK—Do a lot of the drugs have the same versatility of use as ice? Obviously marijuana does not, but some of the other amphetamines—speed and ecstasy—you can swallow and smoke and all those sorts of things.

Ms STONEMAN—Yes. Speed certainly does have the same versatility. With ice what we are seeing a lot of now, which is adding to that, is that it is able to be sprinkled onto cannabis, so it is versatile in all areas.

Mr SOUTHWICK—Is that part of the appeal to young people—the fact that there are so many options of use?

Ms STONEMAN—I think so. I think it makes it a lot easier to use for people if you have all of those options, yes.

Mr DALE—With the disruption to families and family breakdown, it is not only things like increased rates of violence and things like that that occur, it is also exposure to the drug. So children being exposed to the drug at a very early age in a normal family setting is another concern where families are concerned as well.

Ms STONEMAN—If I can add to that, we talk about prenatal use and the effects on the foetus. There are some studies coming out that are showing such an impact on the unborn baby, not only prenatally but in early childhood as well, and some studies are showing an increase in attention deficit disorder for children who have been exposed to methamphetamines prenatally.

With the community consequences, we are seeing this particular substance put such a strain on service provision. Certainly the agitated and chaotic nature of these people is quite a strain for us at our service. We can provide all of the assistance that a person could possibly require, but we are needing the local psychiatric services and the emergency department to stabilise a person first before we can even get to the starting line there. So there is a lot more strain on other services.

Mr SCHEFFER—You said before that what we are looking at is a move from use to dependence, and I was going to ask you a bit later but this is probably the opportunity. How are you as an organisation tooling up for that shift, and I guess there is broader question in that about how the local system networks that you are in are tooling up for that.

Ms STONEMAN—I guess as a service ourselves we are well equipped to deal with providing service to people are far as dependence goes of any of the substances. The problem that we have with ice in particular is the protracted withdrawal time compared to the other amphetamines and also the post-acute withdrawal syndromes that we are seeing. We are equipped to deal with a withdrawal period and then post-withdrawal support and ongoing counselling, but what we are seeing is that these people can suffer for weeks, months, years with a post-withdrawal syndrome.

Mr SCHEFFER—Yes, and that is what we are hearing a lot. When you go into your staff meetings, how are you thinking about that and planning for it?

Ms STONEMAN—I do not think that we have anything specifically around ice. It is still a part of the work that we do on a wider basis with all substances. Certainly the drug and alcohol reform that is occurring and the change that is happening and the greater emphasis on care and recovery will be looking at that post-withdrawal support and putting things in place for people longer term. Without a local residential rehabilitation facility or a patient withdrawal unit we are quite restricted in the kinds of rehabilitative work that we can do for people from a community basis.

Mr SCHEFFER—So are you putting together budget bids around that or working out what a model might look like?

Ms STONEMAN—For inpatient withdrawal?

Mr SCHEFFER—Yes, that sort of work, because people have said what you said to us before, and we understand the problem. But I guess what I am thinking about now is, if I were in your job I would be sitting there thinking, 'Hell, what's going to happen over the next year or two if we are seeing this trending-up?'

Ms STONEMAN—Yes.

Mr SCHEFFER—Doubling in some cases.

Ms STONEMAN—I do not know that there are budgeting bids specifically around inpatient withdrawal and resi rehab from our service. We have a restricted amount of funding available to us for the services we provide. But certainly for many years we have discussed and put forward the desperate need for an inpatient withdrawal unit and a residential rehabilitation facility for this area.

Mr SCHEFFER—Yes. Okay, thanks.

Mr DALE—I think with the availability of an inpatient withdrawal and rehab unit in the area we can provide a lot of therapy and counselling to our clients, and support and that kind of thing, but having to put them on a train and get them into a detox unit unsupervised and that sort of thing is very difficult, because—what we were saying before with the stage of change—you have to grab them at that right moment or they have to be in the right stage in order to do it. Because of the roller coaster effect of methamphetamine, it is very difficult to line things up. So it could maybe be more about service coordination rather than that sort of thing.

Ms STONEMAN—Yes. Polysubstance use we see often. I am finding, as a withdrawal nurse, typically people would be using more than one substance. More and more I am starting to see young people, in particular, using ice more in isolation than we used to see with speed. Certainly people are still using cannabis and alcohol. The big one that I come across is the use of benzodiazepine medication combined with ice use, and that is usually around people trying to normalise their moods. They are using ice to get the up; they are using benzodiazepines to get the down and therefore flatten out a little bit. The subsequent benzodiazepine dependence is on its own a huge problem, and you get this layering of an onion kind of effect around different substances used and different dependencies occurring.

When you look at ice withdrawal and, for example, benzodiazepine withdrawal, some of those symptoms are the same, so often you do not know what it is that you are looking at and what is what. It takes a long time and is quite difficult to untease what is what when you are looking at a person who is using more than one substance.

Mr DALE—Some of the challenges that we are finding, as we said before, are with clients not being ready to change and clients engaging in services when they are in crisis who, once the crisis has dissipated, believe that there is no issue, so they disengage completely from services. As we talked about, one of our biggest challenges is that there is no inpatient withdrawal unit or resi rehab facility in Gippsland. Again, the access to these facilities is problematic due to the distance and the wait lists associated with receiving this kind of treatment. Due to the delay in treatment, clients can disengage with services and often relapse. Did you want to talk about the period of time for a standard detox?

Ms STONEMAN—Yes. Because we are still in the early days of understanding ice and people tend to fall back on their understanding of speed withdrawal, what we are finding is that the withdrawal for ice versus speed is just so much more intense and much longer. The current withdrawal stays are set up usually at five to 10 days, and often we do not see people completing the difficult stage of their ice withdrawal for a couple of weeks. So the current withdrawal programs do not quite meet that need of these people.

When we look at hospital admissions for withdrawal, we are limited in this region to be able to admit a person to a local hospital primarily for a withdrawal, and of course beds are at such a premium that often we cannot keep people in hospital long enough anyway to get through a withdrawal.

Mr DALE—One of the challenges we face is that clients sometimes do not always disclose their drug use, particularly youth clients, for fear of parental backlash and that sort of thing, and whether it is culturally appropriate as well for Indigenous people.

The CHAIR—But not that it is illegal. You mentioned parents and that it is culturally not acceptable, but where does the law sit in that sense of not wanting to fess up?

Mr DALE—It is a challenge that we face. We may suspect that one of our youth clients is using the drug and, yes, they are afraid to disclose and they may not be receiving the right treatment.

The CHAIR—That is a really big dilemma, isn't it, because clearly the drug is so dangerous it would be extremely courageous to sort of deregulate it any way. On the other hand, the downside of it is that people feel prevented from seeking treatment. Do you share that dilemma, or do you think the setting is right?

Ms STONEMAN—I find that people who are using ice are so much more chaotic and it is sometimes more difficult to build a rapport with them. If we are in a situation where we can spend the time to build that rapport, then we can explain that, 'Our job is not to then ring the police to let them know that you're using.' Then we can elicit all of that information and run with the treatment.

The CHAIR—Yes.

Ms STONEMAN—It is in those initial stages when you first see a person, they have no idea how the treatment runs or how services run and we sometimes have the tiniest window of opportunity to build that rapport to get that information across. Certainly many people are very fearful of the law and, 'What's going to happen to me? If I tell you that I'm using ice, am I going to end up in prison?'

The CHAIR—Or in a psychiatric unit.

Mr DALE—We know that heightened levels of chaos and paranoia and things like that are a hurdle as well for people who are worried about reporting. Mr McCurdy, you mentioned earlier the term 'party drug'. We spoke about that briefly, tailoring education to the specific group, so making it youth-friendly, and also with Indigenous clients, making it culturally inclusive so that services are more approachable; provision for parents and sporting groups and the wider community; early intervention strategies for all community groups, and services to liaise with each other, so local councils, the criminal justice system and health providers to have more of a team based approach rather than siloing different services.

Ms STONEMAN—Can I just pop in there? Sandy, you asked us on the telephone about the local football clubs and my initial response to you was, no, we are not seeing a lot, and I think that is because it is usually an abuse situation, not a dependence situation, but I went on then to ask some questions of some young people and the outcome from that was, no, it is rife. It is everywhere—Traralgon Football Club, Cowwarr Football Club, Rosedale Football Club. The young people are reporting that it is becoming more common to see people off their heads on drugs than it is to see somebody with alcohol in their hand and that it is a huge problem in the local football and netball clubs. We are not seeing it because it is not yet having a full impact on their lives. However, my guess is that we will soon.

Mr McCURDY—Is there 'ice in moderation'? There are obviously plenty of people out there who drink alcohol and there are a few with an alcohol problem. There are plenty of people that gamble and they have a gambling problem. Do we know how many ice users there are so that we know what percentage of people we are talking about when we talk about those that have got problems with ice? Are they the same numbers as alcohol and gambling or is it a number that just grows very quickly because of the addiction?

Ms STONEMAN—I think that statistically at the moment it is showing a lower number of people using ice than alcohol and cannabis, but if we were sitting here in 12 months time or two

years, I think that our response to that would be different. Once again, I think as people move from abusing ice to being dependent, that percentage is going to probably go through the roof. It is because we are still in the early stages.

Mr SOUTHWICK—Just unpacking that comment before about the football, do you think the comments that were made were generated as a result of young people that have ice as part of what they are doing outside of football or is it part of being in a club? Where is it coming from? Where is it sitting in terms of our discussion?

Ms STONEMAN—My understanding with the responses I was getting from the questions was that it is a part of what they are doing in the wider community. It is not specifically around necessarily the football club itself. It is—

Mr SOUTHWICK—What is happening outside being brought—

Ms STONEMAN—what the young people are doing at parties, coming in. It is just that you have got a congregation of people—

Mr SOUTHWICK—Young people or—

Ms STONEMAN—in one group in the football clubs. Also, it is perfectly suited, if it is an occasional use, to driving up the central nervous system, so you are getting that real rush of heart rate and blood pressure and everything, and in the very short term people are able to perform at a higher level. Of course, they do not understand that very quickly they crash. Perhaps for the young people in the sporting arena, that is quite attractive, and without the hangover of alcohol, for occasional use versus the crash for dependent use.

Mr SOUTHWICK—Okay. Thank you.

Mr DALE—We looked at past and current policies and strategies and had a bit of a discussion about their effectiveness. We looked at lack of education and understanding of harm minimisation principles in the broader community and this comes back to our work with families and other groups, that there is just this fear about methamphetamine and I think that there needs to be more solid factual evidence that we can encourage families to find. Current and past strategies are not necessarily ice specific. Historically the focus has been on amphetamines, and the effects of ice, as Deb said earlier, clinically can differ in each presentation. You might have a client who presents with acute or subacute psychosis and then the same client may present in quite a depressed state, depending on where they are in the cycle.

For Indigenous people, as we said, and their reluctance to seek treatment due to the difference in cultural needs, we discussed that there need to be more opportunities to provide services and education in an outreach capacity rather than waiting for the clients, particularly in that cohort, to come to us. We need to be out there actively in the community, and there also needs to be genuine collaboration with community elders, similar to the Koori Court system. Do you want to do the next one?

Ms STONEMAN—Yes. This was built around the questions that you provided us with. One of the questions was, 'Where to from here?' and what we saw as being required for improvements from here. Obviously, at the top of the list for us regionally, here, is that we so desperately need a local inpatient withdrawal unit and one that is well resourced and understanding that withdrawal from methamphetamine lasts longer than a withdrawal from most other drugs other than benzodiazepine medication. We also need a local residential rehabilitation facility so that that ongoing, really hard work can be done for people and with people and by people, to learn to live without these drugs.

We need improved support and education to be given to all stakeholders involved. That includes health professionals, law enforcement, the courts, local councils and schools and, in particular, greater education provided at an undergraduate level to health professionals—certainly nurses, doctors and paramedics. We need ice specific, 24-hour online and anonymous counselling, which I guess leads into that fear of the legal ramifications—telephone counselling, with the ability to refer

to local service providers. The community is becoming so much more technologically savvy and counselling at that level is showing itself to be very effective.

We need an increased presence of the drug bus in Gippsland as a deterrent, to drag things out of the dark into the light so that they are seen and it acts as an education and a deterrent. We need increased drug-testing in industry, again supported by referral to drug treatment services. When you talk to people in the major industry in this area, they all know about the drug-testing, they all know that they are likely to be tested, but they will quite clearly say, 'Yeah, but they don't often do it,' so it is a game of Russian roulette. They are happy often to use and to go to work, in the hope that they are not going to be tested, so increasing that testing, we think, would help.

We need an improved ability to admit our people to local hospitals for withdrawal, particularly when you have got people who have other comorbidities, whether they are psychiatric or physical. Often with these people it is not simple, so a medical hospital admission is required. And, of course, we need improved funding to services to facilitate greater support to families and carers. If these people do not have the support around them to move forward in their recovery then it is much more difficult for them, so to support the families and the carers to deal with this is vital. We also need ongoing funding to secure the provision of drug treatment service programs both at an inpatient and a community level.

We did not put research on there, and I think research is also one of the really important areas. I think it was you that was talking earlier around medication used during withdrawal and substitute pharmacotherapy.

The CHAIR—Pharmacotherapy, yes.

Ms STONEMAN—There is not a huge amount of research into that area, although what exists is fantastic. Certainly there is a centre in Melbourne really leading the way in that. I would love to see greater ability for research in the area of methamphetamine use.

Mr DALE—That is all we have in the way of PowerPoint.

The CHAIR—Thank you very much for your detailed presentation. We have a bit of a moral dilemma, in that a reformed smoker—I will use myself as the example. I went through hell to give up cigarette smoking and I was pushed by the fact that my children said, 'You're going to die of it,' every day, which actually got me to the point where through sheer willpower I got off that drug, as it was.

Ms STONEMAN—Well done.

The CHAIR—It was 20 years ago.

Mr DALE—Well done.

The CHAIR—I am in remission almost, well and truly. There is an issue about the young, which is the demographic which has been described to us as recreational users in the main, as distinct from the mental health cohorts. They have a choice to make. They have made a choice to self-gratify using ice for a recreational drug to make them feel invincible and they get some side benefits, whether it is a sexual stimulant or weight loss. Is it at that point that we have to make sure that we intervene to say, 'You have a choice to make. You stand alone in relation to making that choice but we will give you as much information as we can, so when you make that choice you know the eventual side effects and impacts down the track.' Against that, there was always an expectation that, 'If I make that choice there'll be someone to pick me up and feed me back into society.'

I am only raising this in relation to hospitals. Beds was an issue that was raised this morning by the hospital. Is it fair that someone legitimately gets sick through no fault of their own and requires medical attention but they in fact might be compromised by us trying to prioritise beds for immediate rehab of a drug user who has made a choice to use that drug and know the possible impacts down the track? I would support a drawn-out sort of moral discussion around how do we

prioritise funding, particularly for those that are legitimately sick and need help from the taxpayer and society, rather than those that make a very bad choice, knowing it is going to have some impacts on their life. They can get the same sorts of stimulants by eating good food and exercising and enjoying life but some have made a choice of self-gratification at that particular point in time.

Mr DALE—I think that is a Catch-22. When the clients have taken the drug and are presenting at emergency departments, they have made the choice to take the drug and they are taking treatment away from people who have no control over their illnesses. Our treatment approach is most effective when we find the client has not used in that period, where they are a bit more stable. So many people report that when they use the drug they feel invincible. You could say that they need help until you are blue in the face but because of the drug they are not going to admit that they need to seek help, because it does give them those feelings of euphoria and those sorts of reactions to the drug. That is when they are presenting, so we need to maybe look at how do we get them in during that interim period. For a lot of our recreational users it is Friday and Saturday nights and they will present at hospitals those nights. Then during the week we need to get them in when they have not got the drug in their system, so that we can start to facilitate the kind of change and the motivation that is needed to stop using such an addictive chemical.

The CHAIR—I guess that was my point. The best use of a taxpayer dollar would be in early intervention. In fact, banking up in a post-rehab stage would require significant investment in rehab centres and staff resource.

Mr DALE—The thing is, too, with the pattern of use that we are finding, with the recreational use in particular, at the moment the standard detox stay is, like Deb said, five to 10 days. Some methamphet or ice users can go that period of time and be fine and report being fine but, as soon as we get to that Friday night or whatever day of the week their pattern is and they are let out of detox, they are going to use again.

Mr SOUTHWICK—Is one of the big issues what Deb mentioned earlier; the ones that are not hooked now but down the track are looking like they are going to be the ones with the real issues? Let's take the recreational user. Should we be looking at more tougher processes, more visible things like drug testing of people at work to bring the issue more to the forefront? We have all the counselling and rehab stuff for when people are well and truly there but I am talking more of the early stages where people are just using on weekends or using it as a recreational, social drug. Where is the balance? Where do you think that line should be drawn?

Ms STONEMAN—I think it starts way before there, even before occasional use. Certainly it does start prior to dependence at occasional use. As a nurse I have been in this role for nine years and before that in emergency and before that in psychiatric nursing. Never have I nursed a person who ends up dependent on a drug who started with just occasional use. Always there are underlying issues and those issues are sexual assault, family violence, abuse, sometimes even the generational issue of people not having been able to learn how to be resilient. The illnesses and the injuries and the diseases that are occurring for people who end up using ice or end up dependent start way before there. These illnesses unfortunately are unseen. They exist the same as diabetes or a broken leg or epilepsy but they are unseen. If we can go back and provide education to parents and grandparents and children and teachers to help our children be resilient, then we can be most effective in preventing that from occurring.

Mr DALE—Do we look even further and say look at venue operators? How do we educate them about what to look for and that sort of thing? Where does the responsibility lie? Maybe more education needs to be given to the sporting clubs and the night club venues and things like that where the party drugs are initially taken. That is their choice.

Mr SOUTHWICK—But because of the addictive nature of the drug, not necessarily the person that you are talking about that may have underlying issues from way back but that social drug user or the tradie, or whoever that may be, are getting hooked on this drug. I suppose I am looking for two streams of treatment, the harsh up-front 'let's try and stamp out the social occasional side', the 'this is a real problem and this is what it ends up at', and the counselling support side for those who have the underlying longer term issues.

Ms STONEMAN—I think you mentioned earlier consequences and really coming forward and making sure that people are aware of those consequences if they do make that choice to use, 'This is perhaps what the picture is going to look like down the track,' so that education is really strong. You are right, there are two streams. There is the education, the prevention and the health promotion part of it. Then there is dealing and treating the people who are dependent. Also I think you mentioned earlier the changing of the words from 'party drugs' to 'killer drugs'. It is not about propaganda and scare tactics. It is about reality and showing really and truly what this picture will look like if you make this choice now—'You make this choice, you accept these consequences and this is what the consequences look like'—and really educating people on that picture.

Mr DALE—And will we see a burden on the health system like we have with tobacco in however many years time? With forward thinking will we see it like that?

The CHAIR—I am sorry to cut you off but I have been told that time is against us. We have started a bit of an interesting discussion which we unfortunately do not have time to flesh out this afternoon.

Mr CARROLL—Just one question to James. Your work with clients with acquired brain injury—we always think of a brain injury as basically physical trauma to the head. Have you seen any clients that have had a methamphetamine injury to the brain?

Mr DALE—Not specifically, no. With the level of sleep deprivation and lack of nutrition, any research done in the future will probably find some sort of cognitive deficit or injury to the brain, but what we are actually finding is that a lot of ice users are coming through to my service with a traumatic brain injury. They have been involved in a motor vehicle accident or they have been assaulted by a drug dealer. They now have a permanent brain injury.

Mr CARROLL—So using ice to almost numb themselves?

Mr DALE—Yes, and a lot of them are reporting that it makes them feel normal again. So whatever changes they have had to make to their life because of the brain injury and their cognitive deficits, taking ice makes them feel better.

Mr CARROLL—I understand.

Ms STONEMAN—Can I add to that from a nursing perspective because that is a really interesting point and certainly I am seeing people with cognitive impairment in regards to ice. I looked after a man in his late forties who had been using ice for a long time. Because of the effect of the dopamine and the serotonin and the long-term effects on the grey matter in the brain, these people present as though they have Parkinson's disease. Memory, movement, mood regulation, mental health—definitely nursing people with cognitive impairments from ice. They are few and far between but they exist.

Mr DALE—Research does seem to be suggesting that methamphetamine use can have long-term effects on the neurons.

Ms STONEMAN—Definitely, yes. No doubt about that from what we are seeing.

The CHAIR—All right, thank you very much. The committee is just breaking this hearing until 20 to four.

Witnesses withdrew.

Hearing suspended.