LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Melbourne — 3 February 2014

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Ms T. Lynch, Manager, Royal Women's Hospital Alcohol and Drug Service.

Dr Y. Bonomo, Addiction Specialist, Royal Women's Hospital Alcohol and Drug Service.

Dr E. Bowman, Paediatrician, Royal Women's Hospital Alcohol and Drug Service.

The CHAIR — This is a public hearing of the joint parliamentary committee of Law Reform, Drugs and Crime Prevention. We are presently conducting an inquiry into the supply and use of methamphetamines in Victoria, particularly ice. We welcome the three of you from the Royal Women's Hospital Alcohol and Drug Service. Here with us we have Theresa Lynch, manager, Women's Alcohol and Drug Service. We also have Yvonne — Bonomo, is it?

Dr BONOMO — Yes.

The CHAIR — All right. Addiction specialist, Women's Alcohol and Drug Service. Also Dr Ellen Bowman, who is a paediatrician.

Dr BOWMAN — Yes.

The CHAIR — Welcome to the three of you. We have allocated until 10 o'clock for this section of this public hearing. I know we are running a few minutes late so we will try and allow perhaps a little bit more time as required. I will have to read you the conditions under which you are presenting to this committee this morning, so just bear with me for a minute.

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 read and received the guide for witnesses presenting at parliamentary committees?

Dr BOWMAN — Yes.

Dr BONOMO — Yes.

Ms LYNCH — Yes.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness as to 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.

The format that we generally use is to allow you to make some brief statements or parts of a submission, a verbal submission, and then the committee would like to respond and ask you a range of questions. I think Sandy has provided you with some questions.

Ms LYNCH — No.

The CHAIR — No? Normally she does, but that is fine. We will get off script and perhaps just ask some questions that we have already arranged ourselves after the presentation.

Ms LYNCH — Okay. We have actually prepared a speech and within that I will do a brief introduction to the hospital and our service, and then we have five key messages that we would really like to put forward to you. So that is how we will organise our speech today.

The CHAIR — Good. Thank you.

Ms LYNCH — Just briefly, the Royal Women's Hospital is Australia's largest specialist hospital dedicated to improving the health of all women and newborn babies. The Women's is recognised nationally and internationally for its contribution to improving the health of women of all ages and newborns through research, innovation and the provision of specialist training and direct patient care. Established in 1856, a core remit back then was to care for the most vulnerable and disadvantaged women in Victoria, and that commitment to the most poor and disadvantaged women in Victoria is one of the key reasons why the Women's Alcohol and Drug Service remains part of the fabric of Victorian services to disadvantaged women. The Women's is a unique health

service and it has been shaped over the years by many women's voices. We provide over 200,000 occasions of service to women throughout the year. We care for all women through the life cycle — young women, pregnant women, middle-aged women and mature women.

Our hospital has a culture of innovation. The Women's Alcohol and Drug Service is one great example of our innovation in health and commitment to the wellbeing of the most poor and disadvantaged women in Victoria. Whilst it is the only funded statewide drug and alcohol service providing specialist clinical services and professional support in the care of pregnant women with complex substance use and alcohol dependence, my knowledge is that we are the only state or territory in Australia that actually provides this funding to a maternity hospital, so it is quite unique in that sense.

We are also unique in that we have the funding and resources to provide a multidisciplinary team approach to advance the health and wellbeing of women and the medical needs of their infants. In addition to clinical care, WADS provides assessments, training, clinical practice guidelines, support to other maternity hospitals caring for pregnant women with drug and alcohol use, mentoring and secondary consultations. A lot of what we do is about sector service development to other maternity acute health services to ensure that support is provided.

But our service also provides a 24-hour on-call obstetric service which has been quite a critical aspect of our care for both metropolitan and rural hospitals. Unique to our hospital is that we routinely care for women with highly complex medical, social and psychiatric conditions. Again that is a remit of our service — that we care for the most complex women in Victoria. The women who come to our service usually have horrendous experiences of childhood trauma, violence, sexual assault and neglect, and poor mental health.

A recent audit of our service undertaken by our Mental Health Team for the period 2007-2009 indicated that 84 per cent of the women have had experience of a past psychiatric disorder, with 60 per cent having more than one psychiatric disorder. Women suffer as a result of homelessness, poverty, polydrug use and past experiences of infant removal from child protection, and their current experiences are also ones of trauma, sexual assault, neglect and often forensic involvement. Over 75 per cent of our women have involvement with the Department of Human Services at the time at which they deliver their babies.

Our specialties include addiction medicine, drug and alcohol counselling and assessment, obstetric care, paediatric care, assessment in caring for babies with neonatal abstinence syndrome, infant home-based withdrawal program, methadone stabilisation, mental health assessment, nutritional care, and pharmaceutical advice and assessment. Just to give you some statistics before we move to our key messages, in 2013 we delivered 67 babies, but that translated into care of over 129 women in our service. That number has escalated. I have been looking at our statistics recently and we have a 12 per cent increase in women who attend our services over the last three years.

That could reflect the fact that we are doing really well but I often think it reflects more the complexity of drug and alcohol use in the sector and the fact that we are the only multidisciplinary team that has the resources to care for this complex group of women. For example, in the last six months we cared for 83 women, which is quite a high number. So that is the background. I will now hand over to Dr Yvonne Bonomo, to talk about our experiences of ice use.

Dr BONOMO — By way of background, I am a physician in addiction medicine. I joined the WADS team last year because, as Theresa said, there was a need to have specialist input into the care of these women. The women who attend the WADS clinic largely reflect the patterns of drug use that we see in the community, and that is a spectrum. There are those women who use ice in a typically dependent pattern — they will use every day for a period of time, from a number of days at a time to a fortnight and they will typically crash, as it is called — or there are those women who will use sporadically. They might use ice once a week or every few weeks. Then there are the so-called party drug users. They are ladies who will use ice recreationally, from time to time, and they consider it a recreational use of the drug. So there is that spectrum of ice use that we see in the clinic just like you would see in the community.

Typically ice is used with other drugs. It is quite uncommon to see someone who is only using ice. They typically use it with alcohol, tobacco and then the other sedative drugs like cannabis, opiates, and prescription drugs, and they can be used to come down from the high they have been experiencing with ice, or it might be that they are using all of those concomitantly. If we look at the trends in the WADS clinic, in 2011 around 13 per cent of the women who were attending the clinic were using ice; in 2012 that had increased to 17 per cent; and last year 23 per cent of the women attending our clinic were using ice, so you can see that it is escalating. For each year approximately 50 per cent of those women are using ice in conjunction with many other drugs.

There is not a lot of literature around yet about the effects of ice on pregnancy, but we know it is associated with adverse effects. Typically these women will present late in the pregnancy and that makes their clinical care quite difficult. Instead of presenting in the first trimester of pregnancy they often come in much later than that. When they do come in they tend to be admitted to hospital more often than your non–ice-using pregnant woman. We know that of those women who cease their amphetamine use in the first trimester, they have better outcomes, and the kinds of adverse effects that we are seeing are both on baby and on mother. In terms of baby, I will hand over to Ellen shortly, but essentially there is poor growth and development of the baby and foetal distress; and the one we most worry about is premature birth because that delivers babies with immature lungs, immature organ systems, and then all the complications that occur with that, and also increased mortality. I will let Ellen expand on that.

The maternal complications of ice use are of course haemorrhage during pregnancy, stroke, heart attacks, and they are devastating consequences when you think that these women are still relatively young. So I will hand over to Ellen for more about the neonatal effects.

The CHAIR — Can I just quickly ask: how are they taking the ice? Injecting? Smoking?

Dr BONOMO — All of the above. But very often injecting.

Dr BOWMAN — I just have some comments about the infants. Yvonne has already mentioned that the literature is not well developed in this area, but we have some information. Impaired growth is particularly noted, and the area of growth that is concerning and most consistently reported is of a small circumference of the head. People worry about that because it does have correlations with later intellectual functioning.

The second is infant behaviour directly after birth, and there are two sorts of ways that that presents. One is with a baby who is very floppy and just will not eat, which is not good; and the other is a baby with variable motor tone who is irritable and tremulous and just never relaxes. These babies are very hard to care for. So those are the two sorts of things we see. In terms of the prevalence of that sort of behaviour, where it is only amphetamines that the baby has been exposed to, about 40 to 50 per cent of infants will see some sort of effect like that. Fortunately it is rare that that will come to require pharmacological management. Usually it can be contained with various supportive management. About 4 to 5 per cent get to actually need medication where it is sole amphetamine use, but, as Yvonne said, with the vast majority of the babies that come to our attention — over half — the mother has had polysubstance use, and in that case there is a much higher pharmacotherapy requirement for the babies.

Regarding longer term impacts, once again the literature needs more information, but the long-term issues are growth, particularly head circumference. At age 8 the sorts of things that are remarked upon are poor social adjustment and aggression and poor academic outcomes over the journey. They are the sorts of things noted. Whether this is all the effect of the substances themselves or whether it is compounded by the often reduced social circumstances and emotional and social deprivation these children may well be subject to is uncertain.

The issue is that when women have babies these days the mum and baby normally go home after two days in hospital if it is a vaginal delivery. If it is an operative delivery, it is four to five days. Where there are issues of substance exposure there is a prolonged initial hospital stay. For women where opiates are the case, the usual minimum hospital stay is seven days; where it is

polysubstance — usually opiates are involved — it is seven days; and where it is other single substances, it is a minimum stay of five days.

The reasons for that prolonged stay are multiple. One is the possibility of withdrawal of the infant. The second is the high risk of mental health disorders of the mother, assessing for their mental wellbeing, which can be upset by all the issues of actually having a baby. The third thing is that the social circumstances may not be well sorted out, the parent craft ability is not well understood, and necessary and vital referrals have not had an opportunity to be made because of the late presentation. It is complex.

I need to say a little bit about women who are dependent on opiates or on opiate replacement therapy — that is, methadone and buprenorphine. Two-thirds of those infants by contrast will show withdrawal symptoms, and about one-quarter of the babies will require medication to control their withdrawal symptoms. Once a baby is started on medication, that baby will not be going home until they are four weeks old at a minimum. If there is polysubstance use involved, it is usually a minimum of six weeks. It is a really long period of time.

We have recently reviewed our experience with infants who are medicated for management of their withdrawal for the years 2004 through to 2010. Fifty per cent of the women were polysubstance users. The average length of hospital admission for all the babies was 40 days. This was term babies; this is not premature babies or anything else that Yvonne was alluding to who can be born. Just over 50 per cent had involvement with protective services, and just over 20 per cent were discharged from the hospital into foster care. These are startling things.

At the women's hospital there is a special program where selected infants can be commenced on the medication and then conclude that detox of coming off the medication in a home-based situation. About one-third of our babies can be eligible for that — in other words, the social circumstances and parenting capacities are considered to be appropriate for that. That is really helpful because it helps with the bonding of the infant and the family if they can go home after two weeks instead of four or six weeks. It is helpful for the family because the visiting is expensive, disruptive and difficult. And of course it helps hospital resource utilisation as well.

Perhaps it is important to say that some of the outcomes can be even more troubling. There was one baby last year who was two months in hospital before that baby was eventually able to be discharged. That baby was on multiple medications — three different medicines — to try to control behaviours and withdrawal.

Mr McCURDY — Baby and mum for two months?

Dr BOWMAN — No, the mum went home after a week or a few days — maybe five days I think it was in that particular case — but the baby was in hospital. This baby was not able to suck its feeds and was eventually discharged to an experienced foster carer who was able to provide tube feeding for the baby. The last time I saw the baby, the baby was being transferred to the special home enteral nutrition program at the children's hospital because there was no prospect — the baby was coming up to four or five months of age — of there being anything but the tiniest bit of sucking of feeds. This was going to be very long term. This mother was a regular ice user and there were cannabis, cigarettes and prescribed methadone, but there was nothing else in this baby's extensive evaluation to indicate any other medical problem that might have been contributing to this.

Regarding key messages, there is an important issue about education of other health providers. In 2012 WADS did a survey of all the maternity services providers. There were 66 hospitals that surveys were sent out to, and 62 responses were received, which was great. However, one of the key results was that 25 per cent of the hospitals do not routinely screen pregnant women for substance use, despite all the usual education stuff that says you have to screen every woman who becomes pregnant. People were asked what they really needed, and they all said what they really need is more education about how to manage these sorts of patients.

We do provide outreach education through WADS. It is done largely on a face-to-face basis, and the requests have now changed from being about wanting more about women who are on opiates to being about wanting more about women who have polydrug exposure or have ice exposure. It has really changed around.

The other thing is that we need to provide help and resources to all levels of maternity care. Because of the late presentation, the usual triaging that some of the smaller and less resourced hospitals would do is not able to be done because they just do not have the time, so these women just lob. They need to have management plans in place because of things they are not really resourced for and are not expecting to have to deal with. There is that too, so we need to give ongoing training and education.

Theresa mentioned that we have a secondary consultation service, which is provided within the resources that the WADS service has. Regarding educational tools, we participate in face-to-face education. We have been involved with other service providers such as the Australian Drug Foundation, which we helped in the recent update of their web service and web information, but we also need to have a better internet education information stream for health-care providers because our focus is on other health-care providers. We are aiming to provide them with the resources so that they can manage their issues. We are trying to progress this, but time and cost restraints make it slower than what we would love.

Theresa also mentioned multidisciplinary care. I want to highlight two things. There are a lot of allied services that we have to get involved with just within the women's hospital. We have to talk to the Aboriginal health and the intellectually challenged units because some of these women will fall within those groups. I am a paediatrician, but I will talk about the Choices Clinic. What is the Choices Clinic? It is the reproductive contraception clinic. We try to get these girls in touch with this clinic, and I think we have less than 1 per cent of women who actually turn up to it. It seems a sad thing. We are trying to have a better way of dealing with their contraceptive needs at the time when they are still in hospital before they go home. We have links to a fabulous psychologist who has infant family behavioural issue skills. They are informal links, but that is really fabulous and needs to be supported. We know that pregnancy is a time when women are often motivated to make change for the better in their lives. This is a window of opportunity to do this, but we need to support and get these services on board. I would personally make a plea from the baby's perspective that a well mum helps to have a better baby. We know that there are risks of women falling back into their old behaviours. Stats are high that this has a tendency to occur at six to eight months post-partum, and we just need to make sure that the services do not withdraw too soon. That is the other thing.

The last thing I need to highlight is data collection and research issues. There is really an urgent need to have more known about what are precisely the best therapeutic approaches and what are really the long-term impacts. We need better data tracking and better research. I would like to say that there is a lot of interest out there in the research community about epigenetics and MRI changes, but I will not go down that rabbit burrow unless you ask a question. WADS actively works with the Perinatal Society of Australia and New Zealand, which has recently set up a special interest group about substance use issues. I think we need to support things like that. There is also a collaboration of the maternity services across Victoria which have groups that do work in this area. Really the biggest difficulty there is the lack of data — good data, robust data; that is really pertinent. We really desperately need a minimum dataset for this.

Dr BONOMO — The bottom line is that engagement in treatment earlier rather than later improves outcomes. Unlike with heroin and other opiates, where we have methadone and buprenorphine to offer people, there is not a specific pharmacotherapy for ice use yet. I think that might be why a lot of people think it is not worth referring to a treatment service, and I think a lot of women do not engage in services because they think, 'Well, there's nothing in it for me, and if anything there is a risk because of potentially disclosing the substances being used'.

However, we know that if you are engaged in treatment your outcomes are better, whatever the drug. If you are engaged in a treatment service, not only will your alcohol and drug use be addressed but also your mental health will be addressed. Very often these women have a history of

mental illness right through their family and themselves. The social circumstances can be addressed, and they can be quite horrendous. Unstable accommodation, poor nutrition and a history of sexual and other physical assault is not uncommon in these women. Very often there is a history of forensic issues. All of that can be addressed. Then, of course, there is the antenatal care, which all women need, but I think these women sometimes forget that all women need antenatal care — for medical needs, childbirth education, parenting education. These women need that; everyone does.

Although we cannot offer specific pharmacotherapies in the AOD sector, detox early is beneficial; the idea being that you come in, you do an alcohol and drug withdrawal, get the substances out of your system, and then move forward from there. You can think more clearly, unmask any mental health problems or any other issues, and with multidisciplinary intervention move forwards in a constructive way. Of course the difficulty can be getting into a detox bed quickly. Some individuals will need rehabilitation after undergoing a detox, because detox is usually 7 to 10 days. I would advocate that priority access for these women to detox beds would be a positive way forward. But getting back to education, the community needs to understand that there is still a lot that can be done, even though we do not have a magic potion that we can provide to these women.

Ms LYNCH — I am just going to finish up by saying that we cannot help but remember the important role of the Department of Human Services. I started my speech saying that over 75 per cent of our women have involvement with the Department of Human Services, so I think it is really critical that they be resourced and supported to better understand the needs of infants and women who are affected by drug and alcohol use. In our service we do a lot of education and give support to their staff to better understand. But it is critical that they do, because it can be quite challenging for us in terms of our discharge planning and care.

It is important to say, as the manager of the service, that the women who present using ice are most difficult to engauge. They require many more additional resources within our service. It is very challenging for us, and there is a high risk of their children being neglected and removed from their care. Again, that relationship with DHS is quite critical in the provision of care to these women, and it needs to be done correctly. I want to lastly say that pregnancy for all these women really presents as an opportunity to provide women who have limited health and social care with a good chance of better health care and a good chance of a better life. I think there is hope and there is motivation to change for all women who are affected by substance use. I am really quite moved by the passion, the dedication and the skills of our staff. We often turn around what I would imagine would be horrendous circumstances. By ongoing engagement and support we do see change in our women. Although it is presenting as a challenging issue, I am really confident that services like ours will prevail in the long term to bring about positive change in the lives of these vulnerable women and their children. I want to really thank you for the opportunity to discuss some of the key messages. We hope, or we are pretty convinced, they are the messages that you need to have. You might think otherwise, but anyway, thank you very much.

The CHAIR — Thank you. Are you happy to provide us with your written text as a submission?

Ms LYNCH — We have had a little bit of a move around. We all have different variations, but I am sure we will put together something for you.

The CHAIR — Maybe if you provide the notes to us?

Ms LYNCH — We can definitely do that. Do you need that today or during the week?

The CHAIR — During the week to Sandy would be good. Thank you. Just before I throw to the committee, can I ask: Dr Bowman, has there been an increase in unwanted pregnancies due to the stimulant increase of, I think you were saying, from 13 to 17 to 23 per cent of those women who are presenting? Part of what we see out of this drug is that it is a sort of sexual stimulant. I am just wondering, because of this drug particularly, has there been an increase in unplanned pregnancies that have presented to your hospital?

Dr BOWMAN — Our service is largely based on continuing pregnancies. The service that deals with women who are not necessarily wanting to continue their pregnancy is a different service. Because of the late presentation of most of the women we see, some of them are quite ambivalent about their pregnancies because they have fallen pregnant in the most horrific situations, from working as sex workers and becoming pregnant, where there has been violence — all sorts of horrible things. They have ambivalence as to whether they want to continue their pregnancy. But in our particular service the frequency of a woman choosing not to continue her pregnancy is very small. Maybe Yvonne — —

The CHAIR — I was actually starting at the other end.

Dr BOWMAN — She would be better able to answer it. Most of our clients are women who are in their twenties. We would rarely see girls in their teens who may elect quickly to not continue a pregnancy. I think that would be — —

Dr BONOMO — I do not think you can make a direct link. Certainly the women are not reporting a direct link between their use and becoming pregnant, but as an observer you can see more chaos in their lives because when they are using ice they are more chaotic generally, so therefore they are not taking the steps, or, as Ellen says, they are finding themselves in social circumstances that are just very difficult to manage.

Mr SCHEFFER — Thank you very much for the presentation. I just want to go back to, I think, Theresa Lynch's stats or data that you spoke about at the beginning. Could you just go over that for me? Did you say that there were 67 births you deal with and 120 women?

Ms LYNCH — Yes, 67 births last year.

Mr SCHEFFER — So that is in one year?

Ms LYNCH — That is in one year.

Mr SCHEFFER — Okay. And you see women who come to you who are using ice-polydrugs but also alcohol?

Ms LYNCH — Yes.

Mr SCHEFFER — Could you just separate out for us the relative figures there?

Ms LYNCH — It is actually a very difficult thing to say. I would have to go back. As you say, most of our women are polydrug users, so to presume that women are only using alcohol would be incorrect.

Mr SCHEFFER — Yes, I understand.

Ms LYNCH — So that would be the first thing I would say. I actually do not have the statistics available to me here which would say to you how many women are only just directly using alcohol.

Mr SCHEFFER — I guess where I was coming from is that a lot of the witnesses who have come to the committee have talked about the profoundly serious impacts of ice and amphetamines and drugs of that type, but they have also said that the impact of that is much smaller than the impact of alcohol across the cohort. I was just inviting you to reflect on that.

Ms LYNCH — Okay. All right.

Dr BOWMAN — I guess in our service there is rare identification of alcohol-only as the main problem of our clientele. Diagnosis of foetal alcohol syndrome, say — I am a paediatrician so am going to get back to the baby — we would see that only occasionally in our service. However, the less full-blown alcohol-effect disorders might be much more prevalent because they are harder to specifically diagnose as well. I think alcohol has a major effect and most of the women we see would have alcohol use involved in their antenatal exposures — I will put it that way. The big

change has been that the majority of our clients have largely been opiate or opiate-replacement therapy dependent, with some polysubstance use in a minority. Now we are seeing polysubstance use in a majority and basically a quarter of those where amphetamines are part of it, whereas five years ago you almost never saw any amphetamines in this group. That is the change from my perspective.

Mr SCHEFFER — The other question related to the longer term, so the adverse effects. You talked about babies tending to be more premature, you talked about the stress, you talked about the size and you talked about head circumference — all those sorts of things. Then I think one of you jumped ahead and talked about the children at the age of 8. I think you said there were poor social interactions and lower intellectual capacity — one thing or another. What I am curious about in that is that with the drug is the impact at the antenatal stage so severe that it could have those effects at such a longitudinal time? What we understand with a lot of drugs is that if an adult goes through rehab they could come out the other side. Anyway, what is the story there?

Dr BOWMAN — Sure. I guess my comment is that it is true that these pregnancies can be complicated, as Yvonne said, and prematurity can occur, and foetal loss can occur, but the majority of these infants are born at term. That is the first thing I should say.

The next thing to say is that whether it is the substances themselves or the later childhood experiences of social and emotional deprivation and poverty that are resulting in some of these adverse outcomes at age 8 is not entirely clear. However, as far as the issue of exposure to drugs in the antenatal period goes, certainly from the point of view of alcohol, we know that you can have quite significant effects on the brain of a child that are lifelong; you can see them on MRI scans and what have you from alcohol. In the United States, where cocaine has a prevalence, there is increasing information coming up with MRIs suggesting that there are some changes in the brains of babies. Increasingly there is a little bit of work coming out about other substances, like amphetamines, but the amount of published data is small — so more money for more research!

This whole issue of epigenetics is the big, intriguing question mark. This is this issue where you have your chromosomes, and they are there, but how they are expressed can be affected by chemicals that the cells are exposed to. Antenatally you can have this foetus. It is exposed to some substance, and the genes themselves are still there on the chromosome, but how they express in the animal — the human — can be changed, and that effect can be lifelong. There is a thing called Barker's hypothesis, which has to do with hypertension and what have you, that relates to this. I can show you these wonderful slides of little mice where, because they are exposed to a certain thing, they come out with wiggly tails instead of straight tails — stuff like that — which I know is not to do with amphetamines, but it makes a great slide in a presentation. There is increasing question that some of these substances, like amphetamines, may have in genetically predisposed persons some effects like that. This is really cutting-edge research stuff that needs to be funded.

Dr BONOMO — It is important to realise, though, that child development is not just about the effect of drugs on the brain. Neglect, we know, affects child brain development. Trauma affects child brain development, and if you have someone who is using ice, who is not around, who is not parenting and who may be violent, then those are going to affect childhood development in the longer term. That is quite important to realise; it is not just drug effects.

Dr BOWMAN — Similarly we know that the mental health of these women is vulnerable; these women are much more likely to develop postnatal depression. We know that postnatal depression has impacts on the mental health of the infant very long term, and these women are, as we have been saying, not necessarily the ones who will proactively seek out health-care services.

The CHAIR — Thank you. I am going to have to ask you to keep the responses fairly brief because we are well out of time.

Mr McCURDY — Just very quickly, I just want to clarify. You spoke about 25 per cent of the hospitals not screening women.

Dr BOWMAN — Not routinely.

Mr McCURDY — Not routinely. Does every one of your clients come from another hospital or get referred, or are many direct?

Ms LYNCH — Do they come from another hospital? No, the women either self-refer, or are referred from a GP or from a drug and alcohol service or a community agency, or a friend or a family member will refer them. That 25 per cent we are talking about are other hospitals; it is not women who necessarily come to us. This was an opportunity for us to scope what was actually happening in the Victorian setting for drug and alcohol women, and pretty much we got what we expected, which is that there is some good work being done, but the hospitals are not resourced well enough to know how best to care for women, and some of them are actually not ever screening. That was the point.

Dr BONOMO — It is a tertiary service. It is like the too-hard basket come to the WADS, whereas others will be managed in the community.

Mr SOUTHWICK — I am just wondering if in any of your research you have looked at all into the care of children afterwards, particularly having been exposed to methamphetamine in a home and what that might do as part of the growth. So we have heard previously, particularly around smoking methamphetamine, that that causes severe harm to the child. Has there been research to indicate any of that?

Dr BONOMO — Not yet.

Dr BOWMAN — I think this is the sort of data that needs collecting. We need to have good databases so that we can actually get good information to present to people like you.

Mr SOUTHWICK — And as a follow-up, just in terms of the women who are presenting to you, is the intention of many of those to actually go on some form of detox while they are going through their pregnancy? Have you assisted with that? How many have been successful through that process?

Ms LYNCH — That is a very good question: how many are actually defined as successful? Detox does not happen regularly, but it happens when the opportunity presents and women are motivated to do so. But, as I said, the women who are presenting with the use of ice are usually quite chaotic, presenting late and detox may not be an opportunity.

Mr SOUTHWICK — When you say late, how late? How many months?

Ms LYNCH — Often women will present after 30 weeks, sometimes 32 or 38 weeks, so you really have very small window of opportunity to really do substantiative regular antenatal care. But that is not always the case.

Dr BONOMO — When you have earlier presentations then, yes, you are successful in getting them to undergo withdrawal and then continue, remaining engaged with them. But it gets back to presenting early. If we can get women to present early and engage and understand all the benefits that they can get, then you are likely to be more successful. With the ones who present later, you are really chasing your tail trying to help them.

Ms LYNCH — Our role, really, is not just educating? It is supporting other service providers and people in the sector to actually get women into us as early as possible. It is quite surprising sometimes how community agencies might be aware of a woman who is using alcohol and drugs and they do not bring her into pregnancy care. It is just that lack of knowledge and understanding of how critical it is to get a woman in these particular circumstances. They have a much better chance if they get into pregnancy care early. It is all about getting them in early, and then we do have success.

The CHAIR — All right, we might have to leave it there. Thank you, Yvonne, Theresa and Ellen for your time this morning. I appreciate it. We have got your five key messages, I think it was, or perhaps a bit more. And your notes, as I understand it will be provided to Sandy Cook.

Ms LYNCH — It is a really important inquiry.

The CHAIR — Yes, it is. We appreciate your time. We hope to table a report, I think, in late July. If there is any additional information you think would be useful for the committee, please feel free to have a chat to Sandy or provide another submission. As you said, it is a very important inquiry, and we want to make sure we cover all the bases. Thank you.

Ms LYNCH — Okay, fantastic. Thank you so much.

Witnesses withdrew.