LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Warrnambool — 3 March 2014

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Ms B. McIlroy, Manager, Glenelg Southern Grampians Drug Treatment Service (QUAMBY).

The CHAIR—Can I welcome the three of you to this public hearing of the Law Reform, Drugs and Crime Prevention Joint Parliamentary Committee of the Victorian Parliament. We have had a number of regional public hearings right across Victoria as part of an inquiry in relation to the supply and use of methamphetamines in Victoria, particularly ice. I know you are familiar with the background. I am sure you have read the references in relation to the inquiry, so I will not go into detail about that. I am sure Sandy, who is sitting next to me on my right, who you know as the executive officer of the committee, has provided you with background information. To set the record straight we have Mr Geoff Soma, chief executive officer, and Ms Cathy Bligh, youth worker and AOD counsellor, from the Western Region Alcohol and Drug Centre otherwise known as WRAD. We also have Ms Bev McIlroy, manager from the Glenelg Southern Grampians Drug Treatment Service, otherwise known as QUAMBY.

I will read you the conditions under which you are presenting to this public hearing and then perhaps invite verbal submissions from the three of you. 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. You have received and read the guide for witnesses presenting evidence to parliamentary committees. 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. I would now like to invite you to make a verbal submission to this committee.

Mr SOMA—Thank you for the opportunity to talk to you today. I will read my statement and then I will talk about the stats. I thought it was a good opportunity to give you an idea of how clients access our service and something about the impacts of drug use, and then I will talk about treatment.

My name is Geoffrey Soma and I am currently the director of the Western Region Alcohol and Drug Centre in Warrnambool and south-west Victoria. My comments draw on almost 30 years experience working in the alcohol and drug field. My organisation operates an outpatient service which is different to residential services or detoxification services. We provide counselling and support services, referral and secondary consultation. We also operate a fee for service medical practice. Clients access the service with varying levels of motivation, meaning that some people are in the early stages of change, and some people have reached the point where their drug use is such that they require treatment and they are ready to go, and our clients usually satisfy the criteria for drug dependence. They are self-referred in the majority of cases or are pressured through family, work or justice involvement.

Clients attending our service present a broad range of problematic drug issues, including alcohol, cannabis, methamphetamines opioid analgesics, and other prescription medication, heroin, hallucinogens and solvents. In a lot of cases clients are using multiple drugs, and the choice of drugs is influenced by price, availability and the variety of effects that different mind-altering drugs produce. The trends of drug use have varied over the years with alcohol, cannabis, methamphetamines, opioid analgesics and heroin consistently featuring in drug collection data recorded at our agency.

In regards to methamphetamines, clients only often seek treatment when their lifestyle becomes chaotic and there is a drug dependency that has resulted in increased use and the associated high costs that often result in crime. I thought it was important to differentiate between those that access treatment, and there are obviously those that are out in the community that have issues around methamphetamines that we do not see. The drug has a

significant effect, I am sure you have found so far, on their emotional, physical and psychological functioning. They can be difficult to treat in an outpatient setting and as a result they require a combination of behavioural therapies—normally cognitive behavioural therapy—family education, individual counselling, support networks, drug testing and medical interventions.

A critical treatment intervention may be required and this becomes difficult in a rural setting due to limited resources, time and the comprehensive management interventions required. There is a concern from counsellors who treat clients with chronic methamphetamine use as it can result in violent behaviour, psychotic behaviour, mood disturbances and suicidal thoughts, making it difficult to treat. Obviously that differs with individuals.

Residential treatment is the gold bar and certainly an option but referrals to residential treatments are problematic as there are considerable waiting lists for these services and they are mainly in the metro area. No current residential treatment service is available in the south-west and as well there is the issue of limited detox beds, and these beds are currently under review as part of the government's AOD reform process. Whilst I understand that the government is introducing the bed register and other initiatives, I believe there is a case to consider funding long-term specialist treatment services for clients with methamphetamine related issues and other drug problems in rural Victoria, as services are currently limited to address the growing complexity of drug problems in the region. It is no secret I have been outspoken on this issue for a number of years and will continue to do so, having worked in residential settings for 17 years of my career and seen the magic that can be worked with people with complex problems.

In regards to clients presenting to our service with methamphetamine issues, I note there has been an increase in recent years where the drug has been identified as the primary problem. We ask the clients their primary drug problem and secondary drug problem. These figures have doubled since 2010. As mentioned earlier, clients use multiple drugs and there has been a significant percentage of our clients who identify methamphetamines as the secondary problematic drug. This figure has declined slightly in the first six month report up to the end of December but it has been higher than 15 per cent of the total alcohol and other drugs since 2010.

There are a number of things that I think are interesting. In 2010 with a primary drug there were 22 clients; in the 2013 year to date there were 45 clients recorded. The numbers peaked in 2012-13. If you look at the graph, this was when we collected data before pharmacotherapy clients, things like heroin were not recorded as part of our stats. At that time alcohol was the most problematic drug, followed by cannabis, followed by methamphetamines. In 2012-13, when we started collecting the pharmacotherapy data, alcohol still remained the most problematic drug, but heroin and opioid analgesics followed cannabis and alcohol, and methamphetamines were below that.

If you look at the secondary problematic drugs, it paints a more interesting picture in that you will note the percentages in green start rising from 23 per cent in 2010, it decreases slightly in 2010, it remains pretty much the same in 2012 and drops with the December figures 2013. The figures in 2013, up until December, were 69 methamphetamine clients, compared to, in 2010, 97. Again if you look at the figures, in 2010 cannabis was the secondary most problematic drug followed by alcohol, followed by amphetamines. The picture starts changing when you look at the secondary drug use. In 2012, again it is cannabis, followed by alcohol, followed by methamphetamines. In 2013, cannabis again, followed by alcohol, followed by methamphetamines. The opioid analgesics is there and obviously is of concern to us. If there is one message to take away from there I guess we are concerned about methamphetamine use obviously, partly because of the treatment implications, but we are also concerned about the other drugs, the opioid analgesics and alcohol, especially. Thank you very much.

Ms McILROY—As discussed, I am going to talk about anecdotal evidence, what I am presenting on today, and that is about families and community impact. What we have

noticed is a 63 per cent increase in the presentation and contacts with families, various components of families, whether it be parents, brothers, sisters, husbands, wives, and from the community point of view it is from welfare agencies and the workplace in particular. Due to the nature of the effect of amphetamines—I am quite sure you have heard of the effect. The effect on the families is so quick. They are naive drug users who we are talking about here, people who, for the most part, have not been long term or regular drug users. Those people have a sense of what harms are associated with drug use, and they are able to mitigate them or prepare for them et cetera. You cannot do that with methamphetamine, simply because it comes on so quickly. The fear that is associated with family members, not necessarily young people.

People keep saying 'young people' and I do a bit too, but it is not young people. We are noticing anything up to 50 years of age, from 10 years up to 50 years of age is what is coming through from us. It is quickly followed by all of the things that destroy families, whether it be financial support required because of the fear of retribution from dealers, whether it be the drug debts that people get into, and all the losses that come from the drug debts and the fear associated with not being able to pay those drug debts back. Parents and husbands and wives, of course, are going to do whatever they can. The dichotomy is they do not like this, they cannot understand this, and most importantly cannot understand it but they are not going to see their kids be chased by drug dealers either. In our community, Glenelg and Southern Grampians, particularly Hamilton, Portland and Heywood, that is a very real issue.

We have had drug deaths associated with drug debts. We have had deaths, I should say, murders, associated with drug debts. It is very real in our community. There is only a 10,000 population in both of our major centres, so it is very visible. Therefore families find it very difficult to seek help because of the lack of anonymity, the lack of confidentiality that is associated with seeking help. Many times we get phone calls from people in Hamilton asking can they come down here and talk to us about their children, or bring their son down because 'my sister works at the Hamilton hospital or the Casterton hospital', things like that.

Lack of anonymity in a small rural community is not to be overlooked in any circumstance when you are trying to get people to engage in drug treatment, particularly in this because it is such a fearful drug. It is such a dangerous drug. According to the ABC this morning they are calling it 'dangerous drugs' coming out of the inquiry. I suppose the anecdotal information I am getting from parents is fear. The family dynamic is destroyed within months. Brothers and sisters do not want anything to do with them because of the crime that is often associated with it, but because of the change in the personality of the person it destroys the family dynamic. Once the family dynamic is destroyed through drug use it is very difficult to get it back again, especially when oftentimes you have dual diagnosis, mental health issues going along with that as well.

Complete disconnection: anyone who is using or withdrawing from methamphetamine, we find, and the families find, that you cannot connect with that person. You cannot rationalise, you cannot have a discussion. There is no period of time when, 'We'll wait until he's sober.' There is no sober. There is use and then there is withdrawal, and then there is use and then there is withdrawal. That is what we are finding with chronic use where we are talking about this drug starts out as something that people might use irregularly, they might use at weekends, and very quickly they either like the way it makes them feel, and the body and the brain very quickly become dependent on having more of that drug and then everything else falls into place. One of the things we have had in the last 18 months, we have had employers ask us for help because good, valuable employees are starting to use this drug, and as a result their concentration at work is affected, their ability to pass drug tests et cetera. We do drug screening right across the western district and more and more employers are asking for random drug screens based on the fact that methamphetamine is in the workplace.

We work very closely with the Aboriginal families. We have a close relationship where the parents are often the client, not the user themselves. The parents are wanting to know how do they deal culturally with the issues when the young people have gone outside the culture. I am

sure you have heard that this morning and I will not go into that any further.

GPs are part of our anecdotal evidence. Their presentations are chaotic. They are, to a degree, more aggressive but there is zero tolerance in place there to deal with that but GPs are not prepared for this increase in this trend. They are not prepared for families asking for help, mothers et cetera. Often it is mothers, of course, but fathers as well are asking for help of GPs. GPs usually only have the usual tools that you use for alcohol which is, as you are already aware, the most common drug of most harm in our community. People say, 'It's a trend, what is the next trend going to be? Ecstasy was a trend.' This trend has been seen to be extremely harmful in our community for many of those reasons that I have mentioned.

We have been able to access a lot of our information probably a bit anonymously but we had a media campaign running last year, and again this year at the end of the year and it was in response to community requests. The community would write in or ring and ask us to do a media article on such and such. We were inundated for requests for information around ice. I speak to the service clubs, all they want to know is about ice, and all I want to talk about is alcohol. I am happy to talk to them about the current trend of ice, the same as we had when it was prescribed medications. We have a few tools in place for those things. It is impacting on our community, our needle syringe program is through the roof. We have one of the highest numbers of needle syringe pick-ups in Victoria—not the highest but it is in a very high range. That is a lot to do, as Geoff said earlier, with the poly drug use. They are often using other things to come down. Anecdotally we do not hear or see it but there is a lot of injecting drug use of methamphetamine, but the drugs they use to support the harms that they are experiencing is often injecting drug use.

As I say, naive drug users do not know about the harms, they do not know how to deal with them. The drug debts create a fear such that they have never known before, and the fear stops them from engaging. They will come along with mum and they will cry and they will sit there and say they want to stop this, but then they walk outside and they know that they are looking over their shoulders the whole time, and that is real. In a small community it is not something you can pass off as, well, drug debts. I suppose what I would probably like to mention in closing is the only supports we can offer people—because harm reduction or harm minimisation for methamphetamine is not easy. Most of it is in the way of family support, education. We have developed, with funds from Drug Action Week last year, a youth app for the smart phones and that gives them information where they can go locally, the harms associated with drug use et cetera. We also have a website.

The media campaign—there are a couple of apps NDARC have put out on ice. 3D Me is one of them. We use that for families. They find that extremely helpful, because a lot of their stuff is they have no idea what they are dealing with. How is this affecting, why is it affecting et cetera. Those are the resources we have but you cannot reduce the harm of using the drug so much as you can with other harm reduction strategies because by the time they get there, the harm is done or it is well on the way.

I would like to mention two things: a wish list to deal with this trend and other such trends—and there will be. We are trying to determine what is the next trend going to be, and is it going to be more harmful than this one. People have always used methamphetamine but it has not been in the naive drug-using category. It has been in your hardened, chronic, experienced drug user, so what is the next trend going to be. Our wish list is for sufficient resources, both professional and otherwise, to support families because in our current—well, ours anyway, I am not quite sure about Geoff's but in ours we do not have funding or resources available for family support. They want to come to us because other people do not have that level of understanding either. It is a bit of a catch-22.

The CHAIR—I want to clear up two points and ask Cathy if she wanted to make some remarks. You indicated a 63 per cent increase of families presenting to your—

Ms McILROY—And community contact, yes.

The CHAIR—Is that drug-related? Is that specifically related?

Ms McILROY—Yes, specifically related. We did not differentiate between ice and other drugs but definitely the increase is due to drugs.

The CHAIR—Were they coming more from the Portland area than any other area?

Ms McILROY—No, Hamilton, Casterton and Portland are most definitely no different to each other. Hamilton—I suppose if I had to say where are we getting requests from or clients presenting from the Hamilton area, the southern Grampians area is probably a bit ahead of Glenelg. Then, of course, they are coming over from the border.

The CHAIR—That is why I asked because previous evidence suggested that may be Portland was more of a hotspot because of the border issues.

Ms McILROY—No. Anecdotally, once again we believe the manufacturing is happening around in the southern Grampians area, the manufacturing also is naive.

The CHAIR—Yes. Thank you, Cathy.

Ms BLIGH—I am going to report on the Youth Outreach Program which is funded for 12- to 25-year-olds that attend or present to WRAD. I have dated back the last 18 months. Out of the 55 contacts within the Youth Outreach Program, nine presented with the primary substance being amphetamines, however, 15 out of the 55 presented with amphetamines. We have combined amphetamine-like substances into that stat. That was quite high in comparison to the past six months. Up until the reporting period of December 2013—

The CHAIR—Sorry, you said nine originally.

Ms BLIGH—That was the primary presentation for service with 15 the secondary. That takes into account amphetamine and ecstasy as well.

The CHAIR—Nearly 50 per cent.

Ms BLIGH—Yes.

The CHAIR—Sandy has reminded me the question I should ask is can you differentiate between amphetamine or methamphetamine in the data?

Ms BLIGH—No, not currently. Included in that data is ecstasy as well, so it is amphetamine-like substance.

The CHAIR—Which is a problem we have consistently through the data collection is trying to differentiate between methamphetamine and other drugs.

Mr SOMA—Can I make a comment there?

The CHAIR—Yes.

Mr SOMA—It is often the issue with the clients, the clients do not know the difference which makes it incredibly difficult. The older ones do, the younger ones do not seem to really know the difference. They come in and present with, was it ecstasy or methamphetamine.

Ms BLIGH—Then the reporting period from July 2013 to 31 December, presentations for primary substance within that age group was five out of the 25 presentations. That sat at 20 per cent, and three identifying that as the secondary substance within that

period. Again for the first two months of this year we have had 13 episodes of care for service. Two young people identifying it as the primary substance and one identifying it as the secondary substance. It is probably mindful that this is the Youth Outreach Program only as well that these stats have come from.

The CHAIR—Can I ask what the arrow 10 might well be in the presentations of the 13. You have two primary and one secondary.

Ms BLIGH—Yes, the breakdown of that was that cannabis was highest primary substance being six; alcohol secondary at five, and amphetamines two.

The CHAIR—Do we take it from that the kids are smoking cannabis more than they would crystal meth as the primary drug use?

Ms BLIGH—My stats identify cannabis as the primary substance for the last 18 months, yes.

The CHAIR—Thank you.

Ms McILROY—Can I add something, and I am quite sure it probably came through from the Aboriginal presentation this morning of which I was part, that they would like to see an improved use of the diversion programs that currently exist, improved use of the diversion programs and that people can access early intervention and education rather than go through to once they are hooked sort of thing. That came through loud and clear from the survey we did, which I know you have the presentation for. The other thing that came through really loud and clear from our families, as well as from the Aboriginal surveys was that it is all very well to have reporting centres like Crime Stoppers but parents continuously will report. They report to Crime Stoppers who is cooking, who is using, who is dealing, where the harms are, and they do not see any action coming from that, despite the fact that we can now say with the increasing drug use that was reported in *The Warrnambool Standard*, the police system believes that that is in part due to better monitoring of policing information et cetera. It is not so much an increase in the drug use necessarily but it is also a response to not better policing but more policing around the drug stuff.

But the community needs to see a response from them reporting or what is going on. This is all visible, it is out there in the public domain, what is happening about it. I suppose, coming from that, it goes from every aspect of harm reduction. I meant to say that before.

The CHAIR—Yes.

Mr SCHEFFER—A question of Geoff in relation to the submission that you put in, what you took us through. You talk a number of times about limited resources. We did have evidence earlier on of only four detox beds, I think, here. What I would be interested in knowing, given that that need is pretty well established, how do you go about getting it? What do you do? Is it effective? Is anyone listening?

Mr SOMA—I think people are starting to listen. There are some changes afoot. In my 13 years here—and previously I worked in New Zealand, and obviously it is different. We were told by the Secretary of Health at the time that we were not lobbying effectively within the department. There has been a lot of work with VAADA, the Victorian Alcohol and Other Drug Association.

Mr SCHEFFER—Can I ask you does that mean that resources are distributed on the basis of someone's lobbying capacity rather that needs? Is that where you are taking us?

Mr SOMA—I think so. I really believe that. I sat in a room year after year where there were announcements about the budget and there were probably 400 in the room all representing worthwhile organisations. I am well aware of the limitations of Treasury. There is

only so much money to go around, and I am convinced that effective lobbying, as well as an effective media campaign, as well as approaching the appropriate MPs is the way to go. I do not think that is the only thing that is obviously effective. Public outcry—you know, if we had the Victorian community up in arms about alcohol and opioid analgesics and amphetamines, I think that would apply some pressure. But apart from that, Johan, I do not know what else to do, except to say drugs cost Australia something in the vicinity of $42 billion. In Victoria it is around $6 billion to $7 billion. It is by far causing the most harm to Victorians and their families. There were 77,000 admissions to the ED across Victoria. More people die of alcohol than die on the roads. Yet here we are with the government—and it is not about the current government.

Governments are investing around $165 million currently to fight a problem that is costing $6 billion to $8 billion. It is like putting out a fire with a water pistol. That is when I say that increased resources, research and the appropriate attention to a continuum of services to address the problem could not hurt, there is no doubt about that. I do not think it is only resources, I think it is getting smarter. What the current government are doing with the reform process and saying, 'We had too many treatment types, we didn't have a bed register, we didn't invest in amphetamines,' they are all really good things. Building on that is required to make some impact.

Mr SCHEFFER—The policy—and we were hearing this before—the new policy that is in place is a good one.

Mr SOMA—I think it is a good one.

Mr SCHEFFER—Yes, it generally gets ticks, but the budget is not there to support it. Is that a fair summary?

Mr SOMA—That is very fair.

Mr SCHEFFER—Okay.

Mr SOMA—In fairness to the government, whatever happens with the current submission process it is going to be reviewed in 12 months and I would hope that that would be considered as part of that particular process. The other thing that we need to get better at is the data collection of stuff. The data collection, ADIS, at the moment is not a good one. All we really get is a set of numbers. No-one really looks behind the numbers. No-one breaks them down. It is a little bit like years and years ago the police never collected statistics but everyone knew the majority of people coming through the cells had drug issues. Getting smarter in collection of data and then putting the data out there so we can say, 'Okay, this is what's really going on,' we are doing something but we are not as effective as we could be.

Mr SCHEFFER—My other question is related to something that you said, Bev, but maybe the others can respond to it, and it links in with what Geoff has said about campaigning. What we have seen—and you would be aware of this as well as we are—is an absolute avalanche of media stories right across Victoria, all the regional papers, stacks and stacks of them, and you would be very hard pressed to think that there was not some motivation or organisation or campaign that was driving that. That is one thing.

The second thing the Department of Justice have been running—and I think they will do it here shortly—a rolling series of community meetings that are suitably addressed and gets lots of people in that have been, in my view, primed by the newspaper material. It is like an orchestrated campaign. This committee is arguably part of that process, going around as we are. Do you think that is enough to change the landscape—that is one thing—around the ice problem? But on the other hand we are getting information that is saying that this is not a big issue, not in terms of the individual involved but in terms of the stats that you have been putting to us around alcohol. I am getting kind of an imbalance here. What is going on?

Ms McILROY—My response to that is, very clearly, this a very small percentage of our work in rural Victoria. It is a dramatic part of our work and it is a very onerous and labour-intensive part of our work. Burnout in the drug treatment service is going to raise its ugly head in 12 months time, there is no doubt about that, simply because dealing with families is very different to dealing with someone who puts up their hand and says, 'I want some help.' There is that component of it. You put on your TV, as I will probably tonight, and watch the cricket and there is alcohol sitting in your face, advertising for alcohol sitting in your face. Everywhere else you go there is advertising for alcohol. Nobody is worrying about a campaign—well, there is a little bit of stuff starting to happen. But that is the biggest harm, and the biggest amount of money of the figures that Geoff put on the table would be to do with alcohol and cigarettes. We had a really good look at cigarettes and followed through with what we said we were going to do.

Amphetamines—the effect and the harm associated with amphetamines is very different, and that is for sure, it is very different. Therefore it is just as significant in the short term. However, when you are talking about campaigns, campaigns have to be structured, they have to be ongoing and sustainable. I do not know—in answer to your question, I do not know.

Mr SOMA—The hard thing for me is there have been lots of parliamentary investigations into a number of drugs and there have been some very good information and recommendations that have come out of that. It is actioning the recommendations. The thing that changed with the current reform process was because of mainly the Auditor-General's report that made recommendations and that was actioned and that was fantastic. It would be good to see whatever comes out of this—I agree with you, and I have been in the media quite a lot over the past six weeks saying it is not an epidemic, it is something that is an issue out there in the community, but certainly promoted that there are other drugs and it is a drug problem. Instead of being a war on drugs, it is a war on drug addicts, because they are the poor buggers that end up being left without treatment options. I think that is really important.

The media really only want to report what is wrong. I have had a lot of discussions with Sharc, who are participating users, around some more positive stories about what is working, and if it is working therefore it justifies a further investment. There is a lot of work to be done around that.

The CHAIR—Having said that, if I may, I have an alternate view with Mr Scheffer in that I do not believe the media are totally fuelling the interest and inquisitiveness of a society that wants to learn more about crystal meth, particularly the forums being held by DHE have been well attended by 200 or 300 people, and there is genuine concern within those 200 or 300 people the impact that that drug is having to families that live within their own communities. We have a responsibility as a government to provide those forums, regardless of the fact of whether the media is running the agenda or not, in that there has to be some substance to the story. If there was not, people would call them out. In that respect I have a slightly different view. I also have a view that early intervention is by far a better use of taxpayers money than post intervention which we talk a lot about. If there is an opportunity, regardless of the fact of its prevalence or not, or its priority in relation to drugs and alcohol—and, Bev, you are a classic, if I might say so, you have identified the problem but you did not put on record what you think should be the solution. I encourage you, if you are watching TV and saw cricket and VB, you might well want to put on record that you firmly believe the government should take steps to remove all alcohol advertising in the sporting arenas.

Ms McILROY—Can you tell me where I should send that to?

The CHAIR—Put it on the record here. I mean, that is it, we can talk a lot about it, and talk in circles, but until we get some public sentiment to do things—and getting back to Geoff's point—and we have spent a lot of time on this, nearly six months, 162 witnesses, 40-odd submissions, our time, six, seven months, that the recommendations we do put will be carried through. The onus will be on us to make sure government responds appropriately. I am of the view to take some action, and if action is required we need people to take it.

Mr SOMA—I agree with Bev. There are things like volumetric taxing is incredibly important and the government needs to look at that. The issue for me, Simon, is I have learnt over many years not to make the drug group homogenous. They are different in a whole lot of ways. Some people will respond to the early intervention and health promotion, brief intervention. There is a group that unfortunately because of the complexities—and they are to do with an individual's personality, their family, the environment, their education. There is a whole raft of things that affect individuals. Because of that, people turn to drugs to cope. I can go on record as saying a continuum of services is incredibly important when looking at treatment options. We cannot look at one and say that is going to treat everybody. My point about the residential treatment, we only have a fairly small amount of residential beds in total. It has been addressed on a number of occasions. The bed register is fantastic but there has not been any real increase in residential beds for quite some time.

Ms McILROY—I wanted to ask a question before and I forgot. I imagine this inquiry, like similar inquiries I have been part of before, are differentiating between rural and metro environment, rural and metro clients, rural and metro drug users?

The CHAIR—We are referenced to look at the impact of regional areas, as distinct from other areas, as we have indigenous populations, as with metro.

Ms McILROY—I wanted to clearly make the point that in our endeavours of the last six to eight months it is very clear that we need to be taken seriously as rural drug treatment services, rural issues and rural responses and rural impacts. I cannot say that strongly enough. What we see here, there is little relationship to what people see in the city. I understand figures, I understand numbers and I understand dollars, however, each person deserves the right to have their issues addressed no matter where they are.

The CHAIR—Could you tease that out a bit more so we have it on the record.

Ms McILROY—Yes.

The CHAIR—How do you appraise the differences?

Ms McILROY—Jump in Geoff as well, but how we appraise the differences, first of all I have already mentioned the lack of confidentiality and the lack of anonymity. That stops people from doing so much. It stops people from going to casualty because someone that they know will be working there. It stops people from going to the police. It stops people from going to their doctor's. It is as simple as that. It has taken 13 years for us to establish a trusting relationship with our communities in Glenelg and southern Grampians, piggybacking onto the work that WRAD did, because we all work in our community, we all live in our community, we are all part of service clubs, we are all part of—everything else. We are part of schools. Our kids go to school with the kids from drug-using parents. I do not think that is ever given enough importance. Then we have the obvious things like distance, lack of transport. WRAD has fantastic family work over here. We do not. We do not have funding and we do not have resources. How do we get our clients over here? The bus leaves Portland at 3 o'clock in the morning and gets back at 6 o'clock at night. That is a typical thing. For us to provide workplace professional development—all that type of thing. The rural aspect of looking after drug and alcohol work, and in particular the significant things that are different about methamphetamines is very much—

The CHAIR—Are you able to capitalise on technological developments as easily as you would like to?

Ms McILROY—We are starting to now. We have a consortium. We are very proud to be part of the consortium that has tendered for our new drug treatment services. To be able to put the services on the ground with the resources available we are going to have to get tech savvy, and that is about telehealth. We are starting to look at all those things. Yes, we have

had to jump on board with that, probably quicker than other people have needed to do, and quite happy to do that. The other part, in answer to you saying, 'Ask the question', I am definitely asking the question, can someone please address the issue of the most harmful drug that we have in relation to community health, community harms in Australia is alcohol. Can someone please look at the campaigns that are working against that, and I am talking about the very strong campaigns that the breweries and the like are using to encourage people, and particularly young people, to use their drug. If that happened with methamphetamine, what would happen? I know one is legal and one is not legal but the harms are the same. You are asking me to put it out there? I am putting it out there really strongly that something is addressed. The campaign is not necessarily related to the community and personal harms that are being done.

Mr SOMA—I would endorse Bev's comments. Certainly our clients that live in Camperdown and are on our pharmacotherapy program that have to wait for two trains and then they have to navigate their way around the pharmacies who will provide pharmacotherapy for them is an issue. The other big issue for me—and I have said it in previous inquiries—is the funding inequity. There is a real difference. We are told that rural services get a loading, and I am very good at finances and I cannot see it myself and never have. There is the economy of scale. If everyone is funded right across Victoria with the same widgets, the same formula pretty much, and in a rural environment when you are funded, because of population for the most part you are funded for, say, five EFTs, you still have to provide management, you still have to provide the administration, whereas in metro you may 30 EFTs and the bit that you take out for admin and for management becomes much larger.

We are leading the submission and we have had to capitalise on the various networks, the same database, all of those things. We have worked smart but it still becomes difficult when you have a lump of money that you are supposed to provide a service from Portland to Hamilton to Casterton to Camperdown to Warrnambool. It does not compute. That is my one issue that I hope is considered seriously in the future, some loading for rural agencies, and that is having worked in two metro type services in my 30 years in New Zealand and in Victoria. It is different.

Ms McILROY—Johan, the best example I can use is if we try to get people to come out they are funded statewide to provide professional development, train the trainer, all of the things we need to improve our skills and experience. We ask them to come out and talk to us. We can get the numbers that they need. They will come as far as Warrnambool and they will start panting, you know, 'God, how much further have I got to go to get to Portland? Hamilton, how much further have I got to go?' It is just the sense of distance that people cannot get their head around. People who are providing the services or funded to provide the services do not get that the people outside Frankston still need to have the same type of access to professional development but also the clients need the access to services in our areas.

To do all of this work—and I am sure Cathy will say that with the youth stuff as well—you need project workers, and whilst WRAD might have one that is not enough to do all the projects that they are required to do with their population, we have none. The hospitals do not have project workers. You are putting the onus back onto me or onto the very busy clinicians that are already under the pump to try and deliver services. Today for the first time, for the very first time in my drug and alcohol career, we have a waiting list of three weeks. That is putting pressure on the clinicians, on the staff, on administration. It is not something that our rural people are used to.

The CHAIR—All right. We might have to leave it there. Time is against us. I do invite any closing statements you would like to make.

Mr SOMA—I will, on record. It is my only opportunity, I have been gagged by probity for the last 12 months. There has been probity with the reform process and we have not been able to say anything to anyone. We have had four people die in the last three months, all over 45, all with significant drug histories. We have to do better at providing the treatments

and providing the response to address some of those issues. It is one of those things that is affecting people's lives. I talk to people every day in the waiting room around how devastating drugs are on their lives and on their families, and in some cases involve children. I really commend the work that is being done and I hope this results in some changes to the system because it certainly needs it.

The CHAIR—Thank you. On that note I will close this session and thank the three of you very much for your time this afternoon. I appreciate it.

Witnesses withdrew.

Hearing suspended.