LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Melbourne – 31 March 2014

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Mr M. Turnbull, Manager, Service System Development and Reform, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division, Department of Health.

Ms C. Williams, Manager, Service Performance, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division, Department of Health.

The CHAIR—From the Department of Health this afternoon we have Ms Judith Abbott, who is the acting director, Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division, and Mr Martin Turnbull, manager, Service System Development and Reform Community Programs and Prevention Branch, Mental Health, Drugs and Regions Division. Cath, sorry, we have nothing for you, but you could perhaps tell us—

Ms WILLIAMS—Manager of service performance in the same area.

The CHAIR—Thank you for coming. We have Dr Nicole Lee down the end, who is doing some outside consultancy work for us. She is doing some work in relation to some treatment program work, so that is why she is sitting in on this hearing this afternoon. In fact, this is our last hearing. We have conducted a number of public hearings right across Victoria in the regional areas and also metro. I think we are up to about 156 witnesses, with about sixty-five submissions. They are still coming in.

There has been about four months work, so quite a lot of effort has gone into this inquiry. The inquiry, as you know, is a reference given to us by the parliament in relation to the supply and use of methamphetamines, particularly ice, in Victoria. You are here today obviously to give us a perspective from the Department of Health in relation to the work that is currently being undertaken and also where you can provide additional evidence to the committee for the preparation of their report, which is due to be tabled in August. On that basis, I will read to you the conditions under which you are giving evidence to this committee this afternoon, if you would bear with me for a second.

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, 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? I note there are nods.

It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of parliament. We are recording the evidence and will provide a proof version of the *Hansard* transcript at the earliest opportunity so you can correct it as appropriate.

We do ask our witnesses to provide verbal submissions if they wish. We obviously have some questions we would like to ask of you and we have allotted time to 3.15 this afternoon. Thank you very much, again, for appearing before the committee this afternoon.

Ms ABBOTT—Thanks for the opportunity to come and speak today. We have put together a PowerPoint presentation as a start and what we have tried to do in that is address the range of questions that the committee have asked, so on the way through we will make those links back to the committee just so it is really clear. We thought we might start with the data questions to set the scene and then we will move to talk about the treatment system, the current investments the Department of Health is making, address some of the specific questions that the committee has asked around things like research and rural and regional issues, and then we will finish up with the set of questions that relate to the environmental health/remediation of clan lab type issues.

Slides shown.

Ms ABBOTT—One of the questions the committee asked is for current data to the last quarter where possible, to give a sense of methamphetamine use in the community.

Really, in terms of community-wide datasets it is the National Drug Strategy Household Survey that gives the best dataset for that and you may well be aware that the most recently available data at the moment is the 2010 data which identifies about two per cent of respondents as using methamphetamine. It is a survey of 26,000 people across Australia. Of the respondents, about 15 per cent said they had some illegal drug use, cannabis and ecstasy being the two most commonly used drugs there. It is a bit of a challenge in this space. Certainly our data people observe that one of the challenges about getting a measure of illegal drug use in the community is that the nature of it means that people will not necessarily always want to report it, so that is always a bit of a challenge there.

There are a few other datasets we did just want to highlight in relation to this question. The second is around the illegal drug reporting system. As part of that work there is a national survey of a sample of injecting drug users done each year. This is a group of about 900 people, on average, sample size. About 150 are Victorian. Because it is mainly injecting drug users, the cohort tends to be male, tending towards middle age, heroin as the drug of choice, but as the data there shows, 67 per cent in 2012 and 61 per cent in 2013 reported using some form of meth and one of the things that highlights is the polydrug use you see, particularly in the injecting drug use. It is rarely a single substance; it is often multiple substances.

Just to mix things up a bit I am going to step down to the Australian Secondary Students Alcohol and Drug Survey, which is another national survey done every three years. We raise this because it rounds out the picture a little bit by talking about the experiences that secondary students are reporting. The most recent data is 2011, the next survey to happen this year. I understand preparation is in place for that to occur.

The 2011 data suggests that most secondary students have never used amphetamines. Across that sample in 2011, there were about six per cent of the overall cohort that had tried amphetamines at some stage. There were two per cent of 17-year-olds in the sample that said they had used methamphetamines in the last month, but of the people who reported using methamphetamines, what they were reporting was that the majority of them had tried it once or twice. I just think it is a useful winding-out of the picture of who is using and what the patterns look like.

On top of that, there are a couple of Victorian datasets. Turning Point does some data collection analysis for the Department of Health. I know you have had Turning Point here, and others. The first is analysis of drug related ambulance attendance data from Ambulance Victoria, so this is the dataset that is looking at all ambulance attendance data where the attending staff members identified that they believed there were alcohol or drugs involved, and Turning Point does analysis to look at issues related to trends in groups of drugs and the like. It is one of the things that we use in the department as a bit of an indication of what is happening out in the field and what emerging trends are, because we can get it in a bit more timely a way than most of our national datasets. It is affectionately or otherwise known as the ambos' dataset

What we are seeing in that dataset is still a fairly small number of methamphetamine users identified there, but some growth. In 2010-11 there were about two per cent of almost 17,000 attendances. In 2011-12 it was up to three per cent with about 18,400, so we are seeing the number of drug related ambulance attendances rise, and the proportion, while still small, of ice associated attendances also increase.

There are a couple of caveats around that. It is related to the incident on the ground, so it does not give a sense of the number of people involved. There are people that could be multiples there. Also, in a number of instances one individual will have multiple drugs or will report multiple drugs. It really does help us, though, in terms of getting a sense of what is emerging there.

The CHAIR—Can I just get clarification?

Ms ABBOTT—Of course.

The CHAIR—This data is from the Australian survey? It is not collected by Victoria?

Ms ABBOTT—The ambulance attendance data is collected by Victoria.

The CHAIR—I understand that, but that data is not overly consistent with some of the work that we have been doing in relation to the prevalence of crystal meth, particularly in Victoria.

Ms ABBOTT—Sure.

The CHAIR—In fact, it is not even close.

Ms ABBOTT—Okay.

The CHAIR—The only dataset you are using is from the ambulance incident reports, is it, in relation to crystal meth?

Ms ABBOTT—No, we also look at things like drug treatment data, which is on the next slide. If I go to the Earlier Identification of Drug Harms information, that is a data collection that Turning Point runs for us, which it does every couple of months. It makes contact with 45 agencies and gets anecdotal advice from those agencies about what is happening in the field, what they are seeing, what is emerging, and a range of things. That gives qualitative information but very of-the-moment information about what agencies are observing out in the field and the kinds of things that are coming from that are high availability of ice in the rural and metro areas, the prevalence of mental health issues amongst ice users, increases in use amongst the party drug user group, and recognising that the information coming from that suggests the majority of users are polydrug users. We have the ambos' data, we have the Earlier Identification of Drug Harms information that gives us a forward look, and we have the broader kind of community surveys, as well as the treatment data, and we bring all of those things together to give us the picture.

The CHAIR—Okay. I only mentioned that because when we were in Canberra with the Australian Institute of Criminology data, which was similar to that, which is about four years ago, and the Australian Crimes Commission I think also presented data similarly, there did not seem to be an up-to-date collection of Victorian data in relation to prevalence and—

Ms ABBOTT—Broad community use?

The CHAIR—In trying to paint a picture, even hospitals were unable to give us the sort of data to try and paint a picture of what prevalence there was in the state, apart from responses front-line, which are always a bit higgledy-piggledy.

Ms ABBOTT—We are going to talk a little bit about health service—

The CHAIR—Okay.

Mr SCHEFFER—Can I just ask one question?

The CHAIR—Sure.

Mr SCHEFFER—I know we do not want to divert it all into this one issue. I am going to ask you the question I asked the woman from the Australian Institute of Health and Welfare, because the information that you talked about that you get from the agencies on the ground that are reporting exactly to us what you are picking up, I asked her whether that data in the lead-up to the 2010 data from the National Drug Strategy Household Survey could be like an advance indicator of what we might expect to see in 2014. Her response, if I remember

correctly, was that there was not a correlation, so you could still find that data on the ground but it might not necessarily show up in the 2014 data. Do you have the expertise to be able to comment on that?

Ms ABBOTT—I personally do not have the expertise to be able to comment on that.

Mr SCHEFFER—Okay.

Ms ABBOTT—Can I just clarify. Was that making the connection between what drug treatment statistics look like, versus broader measures of what might be happening in terms of prevalence of use?

Mr SCHEFFER—Yes, what agencies are coming in who are supporting people with a drug related issue relating to methamphetamines. The chair was saying there was an escalation and that they were seeing quite worrying trends on the ground that were not at this stage showing up in the macro data. My question was, can we expect to see that on-the-ground experience manifest itself in those datasets?

Ms ABBOTT—I guess that may in part reflect the lag between commencement of use and accessing treatment.

Mr SCHEFFER—True.

Ms ABBOTT—There is always going to be a bit of a lag between, one starts using a substance and one seeks treatment. As to specific data in terms of what the timing of that lag is, I am not able to answer that today.

Mr SCHEFFER—Okay, thank you.

Ms ABBOTT—If we go to some drug treatment data, this is data taken from our ADIS collection. Consistent with the committee's request, what we have done is used the most current data we have, which is quarters 1 and 2 of 2013-14. Let me just walk you through some of these.

A critical point to make about this is that ADIS currently does not collect information and details about types of amphetamine or methamphetamine such as ice, so this is data about all amphetamine use. One of the things you will be aware of is that we are in the process of reforming our treatment system, and that will include a new data collection where we will be addressing that, amongst a range of other issues. This is all amphetamines. It does not go down to methamphetamine specifically.

If we look at the most current data—so this is July to December of the current financial year—14.8 per cent of courses of treatment identify amphetamine as the primary drug of concern. We use courses of treatment as our measure of activity across the system. When we look at the demographics of who is in that group, it is around one-third female and two-thirds male, which is a fairly common picture across other drug groups. The figure around metro and rural there is looking at, of those courses of treatment, what proportion is delivered in metro places—72—and what proportion is delivered in rural places —28.

Another way of thinking about this is to ask the question, what proportion of all metropolitan courses of treatment are related to amphetamine types of substances? That is 15.4 per cent over the same period. Of all rural courses of treatment delivered, it is 13.8. The devil is in the detail with data, so I did just want to tease it out in a couple of ways for you.

In terms of age cohorts, we do see some 35 per cent of people in the 15 to 24 age group in treatment for these services over this period of time—an additional 36 per cent in the 25 to 34 age group. That is fairly consistent with the picture that we see for other illicit drug groups such as cannabis, although that is a little bit higher in the 15 to 24 age group than what we see

for amphetamines. It is quite different to alcohol, where you tend to see older age groups in the treatment system. We have some differences there.

Thirty-three per cent of clients in that space were recorded as having psychiatric issues. One of the questions the committee had asked about was the prevalence of co-occurring mental health disorders among methamphetamine users. Once again we wanted to put that in the context of what happens for other drug types and how that compares. It is broadly consistent across all drug types. About 36 per cent of clients are identified as having psychiatric issues, so it looks broadly consistent with trends we are seeing in others (drug types). When we look, for example, at cannabis, it is 34 per cent and 36 per cent for alcohol, so it is fairly consistent with other drug types there.

Mr SCHEFFER—Can I just ask you about the second-last one, age groups. Can one conclude from that that the balance of 30 per cent is in a cohort older than 34 and then do they bunch in a particular age group, or is it evenly spread up to, say, 65?

Ms ABBOTT—I can ask Cath to advise on that now.

Mr SCHEFFER—Because we have heard from other witnesses that there is a significant number—maybe not a majority—of older users.

Ms ABBOTT—Cath, are you able to answer that or shall we take it on notice?

Ms WILLIAMS—A large proportion—probably about half again, so about 15 per cent—are in the 35 to 44 age group and then around 6 per cent in the 45 to 54 age group and 3 per cent who are 55 plus.

Mr SCHEFFER—Yes, okay. It tapers off to that, but you still get that—

Ms ABBOTT—Yes.

The CHAIR—Have you got the numbers for those percentages?

Ms WILLIAMS—The actual numbers for courses of treatment?

The CHAIR—Yes, the number of people engaged in the treatment.

Ms WILLIAMS—We have the courses of treatment.

Ms ABBOTT—This data has been presented as courses of treatment. If you would like the number of clients, we can provide that in writing after the—

The CHAIR—The data that is given to us talks in percentages—30 to 40 per cent—yet they might only be talking about an increase of six to eight.

Ms ABBOTT—Yes.

The CHAIR—We get a proper understanding of the magnitude of people impacted by ice. We shy away from percentages sometimes, because it is not a true reflection on how many people—

Ms ABBOTT—I can give you some figures. In the first half of 2014 there have been 4,641 courses of amphetamine treatment against a total of 31,328 of all courses of drug treatment over the same period, just to give you some actual numbers around that. Would the committee like some information cited in terms of clients as opposed to courses of treatment?

The CHAIR—Can we have that? Thank you.

Ms ABBOTT—On average, about two courses of treatment per client.

The CHAIR—Right.

Mr TURNBULL—We have around 29,000 clients going through the system each year.

The CHAIR—Of all drugs?

Mr TURNBULL—Yes.

Ms ABBOTT—We will get back to you. That is quite a nice segue into the data around Aboriginal clients and treatment, because it is a good example of the numbers starting to get quite small. There are a few ways you can describe this. We said previously that almost 15 per cent of all drug treatment in the first two quarters of this financial year has been related to amphetamine. Of that, six per cent relates to Aboriginal people. Another way of looking at that is, for all drug treatment services delivered to Aboriginal people some 15 per cent is amphetamine related. We are seeing similar proportions between the general community and the Aboriginal community in the current treatment data.

That gets slightly higher. In our drug treatment service we have a wide range of mainstream services and we also have some Aboriginal-specific services. We will speak to you about those a little bit later. In the Aboriginal-specific part of the service system it is marginally higher, with about 18 per cent courses of treatment. It is 15 per cent in the general space and then it goes up to 18 per cent in the Aboriginal-specific space.

Mr SCHEFFER—Sorry, I do not understand the difference there. What is happening?

Ms ABBOTT—We have basically three bits of information in those first two points, the first being that, of all courses of treatment related to amphetamines, six per cent are for Aboriginal people.

Mr SCHEFFER—Yes.

Ms ABBOTT—The second is that, of all drug treatment services delivered to Aboriginal people, 15 per cent are amphetamine related. The third is specific to only the Aboriginal-specific services. We have a number of Aboriginal-specific services, and that is just giving a measure of, in those specific services, what percentage of drug treatment services relate to amphetamines, just to kind of tease it out a bit.

When we start to go into the numbers, the numbers are quite small—286 courses of treatment for the period. When we go to age groups, we brought them down to numbers of courses of treatment, because the numbers were starting to get quite small. You can see the numbers up there—117 courses for the 15 to 24 age group and 88 for the 25 to 34 age group. Once again just to provide some comparison, for Aboriginal drug treatment we looked at how this compared to what we saw in other kinds of drug groups, and we saw a similar pattern for things like cannabis, where there is almost a higher percentage of courses of treatment in that 15 to 24 age group. There are quite similar patterns in both the Aboriginal community and the general community. Just to be very clear, the general community system-wide data does include Aboriginal people as well. We have just lifted the data out onto this slide to give you some specifics but they are very similar kinds of pictures.

In terms of regional Victoria, one of the things that is quite interesting is that we see more courses of treatment that are amphetamine related being delivered in rural than metro areas. In the two quarters for 2013-2014 there are some 183 courses of treatment have been delivered in rural areas, compared to 96 in the metro areas.

Mr SCHEFFER—Is the number of delivered courses of treatment a function of how many are available? For argument's sake, if there were infinite numbers of treatments available and infinite resources, would it be conceivable that the percentages would be higher than what we have there?

Ms ABBOTT—It would be speculation.

Mr SCHEFFER—Is that the upper limit, that in fact the money has run out and so that is where we have ended up but there is more need there?

Ms ABBOTT—I do not believe so, but to look at that we would need to look at activity measures, so we can take that on notice and provide you with some advice on that.

Mr SCHEFFER—That would be useful because groups do tell us that there is a shortage of access to what is available.

Ms ABBOTT—There were a couple of other questions that the committee had asked. The first was about coroners' data on overdose rates and contributing factors. We draw on coroners' data as we need it in relation to building the picture, so it kind of goes back to your question about what are the inputs that help shape our picture of what is happening. It is quite complex because of the poly drug use. There are often multiple substances involved. The Coroners Prevention Unit presented a conference last year and they identified medication being the most commonly present drug type, with illicit drugs identified in between 35 and 44 per cent of deaths, and that is all illicit drugs. They presented some numbers at that particular seminar that suggested 14 deaths in 2010, 29 deaths in 2011, 34 deaths in 2012 in which methamphetamine was present. In terms of further analysis of that, given the coroners hold the data, that would be the best place to get further information if that is something would wish to explore further.

The committee had also asked for some advice about current data on the estimated rate of diversion of pharmaceutical amphetamines to the illicit market. The pharmaceutical substance at most risk of diversion is pseudoephedrine, which is a schedule 3 or schedule 4 substance, which means all pharmacists are authorised to hold it. We run a drugs and poisons permit system so, in addition to pharmacists, manufacturers and wholesalers are required to have the permit to maintain and do things in relation to those substances. They are required to advise us if there is loss or theft, but in the case of diversion it is usually a large-scale criminal activity, so they are actions that the police will lead on rather than ourselves. There is no substantive data that we can provide to the committee.

The CHAIR—There are statistics relating to vehicular deaths connected to drugs. Is that included in part of that coroners' data? Were drugs not involved in a lot of those accidents?

Ms ABBOTT—I am not certain.

The CHAIR—I just note that there were three drug-related deaths in the last month connected to methamphetamine abuse, so I am just wondering where those stats end up.

Ms ABBOTT—Can we take that on notice also?

The CHAIR—Yes.

Ms ABBOTT—We have a list for you, haven't we?

The CHAIR—It is important for us because the submissions from the police indicate that there is some difficulty for them to drug test appropriately. There is plenty of alcohol testing done but not much drug testing. I guess if there is an increase in vehicle accidents and deaths related to methamphetamines, part of our recommendations might well be that the

police need more opportunity to drug test drivers.

Ms ABBOTT—We are going to move away from data for now and on to framing up a broader discussion which is a bit about government's approach and how it thinks about it, and the department's approach in thinking through this issue. In the past we did quite a few substance specific strategies, and you flagged the ATS strategy as one that has now lapsed. Over recent years there has been a move, both at a national and a state level, towards a broader approach to illegal drugs that recognises that intervention is the kind of response required across all illegal drug types for reduction of supply, reduction of demand and harm reduction. We have seen a shift away from substance specific approaches to those broader approaches that give the framework and then move on all the actions that go underneath that. That is the approach adopted in the National Drug Strategy and it is also the approach adopted in the current government's Whole of Government Victorian Alcohol and Drug Strategy that was released in January last, *Reducing the alcohol and drug toll: Victoria's plan 2013-2017*.

In thinking about what the department, and indeed government, is doing in response to ice, it is very much using the alcohol and drug toll document as a framework and focusing on those three areas of activity with a range of underpinning actions that you need to make those things work, which are everything from research and analysis, workforce development activities, things like communication and engagement, leadership and a range of other things. Before Martin speaks about the treatment system, I just want to give the committee a very broad, quick overview of what that means for methamphetamine in Victoria, how the department is approaching it and how it is working with others.

The first thing is it is trying to work very closely with other parts of government, with other parts of the sector, with the community more generally. You will have seen during your inquiry a lot of activity and a lot of people involved at a lot of different levels. One of the things for the Department of Health is what role it plays and how it fits with other parts of the system. In the supply reduction space, I understand VicPol has been here a number of times and spoken about the kinds of things it does, both in disrupting supply of the precursor chemicals and dismantling clan labs and the like.

A lot of the activity from the Department of Health focuses on both demand reduction and harm reduction. In the demand reduction space there are a few broad spheres of activity, so there are things like the department funds the Australian Drug Foundation to deliver a range of community information and education around drug issues, including ice. It also funds agencies like Turning Point and SHARC to run information lines that have information available not just for people who may have substance abuse issues, but also their families and other concerned individuals.

We also see a range of our funded agencies doing a lot of community education type work. A number of those have been before this committee and spoken about things that they are doing in that space, including organisations like Anex, YSAS and Turning Point.

Mr SCHEFFER—This is targeted information dissemination?

Ms ABBOTT—A combination of broad and targeted. The ADF has ice specific information, Better Health Channel has ice specific information. Anex and others have been out speaking at any number of community forums and providing information about ice, its impacts and the like.

Mr SCHEFFER—And the broad?

Ms ABBOTT—The ADF also provides broad information. Most parts of our service system are broad for all drugs and then will have methamphetamine information as well, so it is always a bit of a balance between those two things. The other thing to say about demand reduction is the Department of Health staff, in particular regional officers, are often involved in a wide range of community activities, talking about ice and what is happening, talking

through some of the issues about what it is and what it is not. There is a lot of concern out there and there is also a range of myths about what it is that are quite disturbing and generate a lot of anxiety.

Harm reduction does span broader things like investment in treatment, as well as things like harm reduction activities including the Needle and Syringe Program. If you are injecting ice you have the same kind of risks of any other injecting drug use and so that becomes an important part of the response, and bodies like Anex, Harm Reduction Victoria who provide things like the DanceWize kind of support at parties and the like, all have a role to play in this space as well. Once again, those are not methamphetamine specific, but they encompass methamphetamine users.

Just picking up the other pieces that fit under that, we have talked a bit about research and evidence. Workforce development: we have things like funded training for AOD workers and others in the sector and ongoing interfaces through any number of intergovernmental committees, through assisting forums we have with communities, and in a range of other things to try and round up and get consistent messages out there to the community.

I am going to hand over to Martin to talk about drug services in Victoria, to give a sense of the treatment system, and address a number of your questions.

Mr TURNBULL—You have obviously spoken to a great many drug treatment services in Victoria and a quite high proportion of those will be the ones funded through the state government alcohol and drug treatment program. As I mentioned before, that is a program which sees about 29,000 clients each year, so it is a reasonably large system. The state government, through the Department of Health, invests just over $125 million a year in treatment services. That is in addition to another just over $25 million in some of the more educational/information prevention programs to which Judith was referring a moment ago.

It is important to note, however, that those services are delivered in a context and need to be seen in terms of how they relate to the community health service system, the hospital system, in Victoria. A small but not unimportant group are private drug treatment rehab services, and of course the Commonwealth government has a role in this area as well, particularly, as we will see in a moment, in terms of the Aboriginal drug treatment capacity.

These services that are funded through the department are delivered by just over 100 different agencies. They are a mixture of specialist drug treatment non-government organisations and community health services. About 30 per cent are community health services and around 20 per cent of the services are delivered by public health services or under hospital management. The distribution of those: they exist right across the state in the eight Department of Health regions. A large part of that is, by this time, a fairly historic funding distribution. It has also been influenced over the years through incremental funding increases, sometimes subject to insurance based processes.

You can see there some of the particular categories of service provision. The department over the years has developed what is now a fairly complex and long list of specific funding streams. That is just a summary. There are some 60 specific types of programs that are delivered at the moment and, as we will see in a moment, part of the system reform that we are undertaking is trying to bring that back into a more manageable and more flexible arrangement.

It is important to note that by and large services are not funded to address specific substances or largely specific population groups. There are a few very specific and fairly small exceptions. There are probably three main reasons why that is the case, and it is pretty consistent with what is seen as international best practice in managing and funding a network of alcohol and drug services.

The first reason is fairly simple. It is just because the system needs to be agile and responsive to changing patterns of drug availability and use in the community. As you have no doubt

heard, these things go in cycles. It is also a matter of clinical advice that the basic pattern of treatment and the elements of treatment that a client might need for amphetamine type substance misuse is in broad terms pretty much the same sort of function as for other drugs in terms of going through a pathway of good assessment, detoxification, withdrawal, rehabilitation, follow-up care and so forth. In a moment we will get to some of the important variations that might apply, but by and large that is the case.

The third reason is that we want to make sure that we do not artificially stigmatise or marginalise any one particular drug user group in terms of their use of a substance such as ice. That can occur very easily. The one exception that we do have in our system is the opioid replacement therapy, the methadone and similar drug program. That is essentially different because we have pharmacotherapy or a particular drug replacement regime, but even that is delivered in a mainstream community setting for the most part, to avoid that marginalisation and stigmatisation.

Before we get to the big picture, I wanted just to give you a sense of the system reform that we are doing at the moment. Over the last several years there have been a number of what we think are quite important enhancements to a system that we have some evidence are particularly relevant and of benefit to methamphetamine users. The first is the introduction of a new level of more intensive, what we often call therapeutic counselling and continuing care services, so specific new expansion of services has been put in place in a number of areas: Casey, Maroondah, Knox, Yarra Ranges and Barwon. This really allows for a more comprehensive, higher level of clinical input to the basic counselling and care that the system provides, and given what we know about the needs of many users of methamphetamine, this is particularly relevant to them.

Early data from the implementation of those services does highlight that a higher proportion of methamphetamine users—or I should say amphetamine users because, as we said before, we do not have the distinction, but certainly a higher proportion of amphetamine users in those more intensive therapeutic counselling than in the mainstream services.

The second thing that the system has put quite a bit of effort into is the trialling and the gradual introduction of more flexible, non-residential options for the rehabilitation phase. This has been spearheaded particularly by the Catalyst program which the management of ReGen UnitingCare service has led. Essentially, this is about providing a non-residential, structured program of around six weeks for people to go through. It has been trialled more particularly in the first instance with people with alcohol related problems, but also there is a specific forensic version of this program that has extended to all drugs, so there are very positive signs that this is a useful complement perhaps for people for whom direct entry into a residential program, with the commitment that that involves, may not be an attractive option.

A third element that I think is particularly relevant here is the focus on what the sector likes to refer to as dual diagnosis, which is really the competency of the services to deal with mental health and mental illness issues in combination with the substance abuse. We think that this is particularly relevant to ice users, not only because of the induced psychoses that accompany that drug use but more generally the level of general mental health disorders.

Mr SCHEFFER—Sorry, can I just interrupt. When you say 'focus on increasing dual diagnosis' comments, does that mean that they are not focused on that at the moment, or they have not been? How do you increase the focus on it?

Mr TURNBULL—Traditionally the way these systems—the mental health system and the drug and alcohol system—have developed has been fairly separate and there has been a gradual recognition, obviously backed up by the research and clinical evidence, of the importance of addressing both—

Mr SCHEFFER—It is making it more into one treatment package rather than two separate approaches?

Mr TURNBULL—It is sometimes doing that. It is making sure that, if you come to be assessed by a service, you do not have to go to two different clinicians, or two different services even, to get those two aspects of your condition properly looked at. It is certainly about making sure that, if you have a more extended individual package of care, that takes into account the various supports. A lot of that is about training, it is about secondary consultation, it is about getting that interaction between the services.

The fourth point I just wanted to mention briefly was the growth and enhancement of the capacity to provide forensic and diversionary programs. This is being assisted both in our funded system and also with the contribution from the Department of Justice—funding from that department. That is partly about providing more community rehabilitation options. It is also about recognising the particular needs of some of those clients to address acquired brain injury and the cognitive impairment that often accompanies those conditions.

The final element of recent enhancements that we wanted to mention was a very important investment in hospital emergency departments. This is over and above the investment in the specialist alcohol and drug services. It is money going directly to hospitals—in the first instance, 21 hospitals around Victoria—which obviously see a very large number of people affected by amphetamine use in their emergency departments. This is support that will assist those emergency departments to take a more focused and more organised approach to identifying, to supporting, to referring, to providing brief interventions to those people.

Mr SCHEFFER—How would that be different, because, as you would understand, we have spoken to a number of hospitals—people from their emergency departments—and it seems to me that they are doing all things possible, and as an outsider that sounds terrific. It gets 10 out of 10 from me for what they do. They talk I think not so much about having a lot of people under the influence of ice—methamphetamines—but that, when they do arrive, they can be a handful. How would a hospital emergency department be any different under point 5?

Mr TURNBULL—Each of the 21 hospitals is dealing with it a bit differently, so it is important that it is tailored to what the experience of that hospital is and their particular capacity—

Mr SCHEFFER—Isn't that what they are doing now?

Mr TURNBULL—This is an enhancement. It is certainly not starting from a blank page, you are right. Some of it is about having more capacity to employ addiction medical specialist expertise and make sure that that is accessible when it is needed in that context.

Mr SCHEFFER—Okay.

Mr TURNBULL—Some of it is about relationship building outside the hospital, seeking to get better referral patterns to our contract services.

Mr SCHEFFER—Is this in response to what they have asked for?

Mr TURNBULL—Very much. It is not a one-model-fits-all. It has been a process of asking those hospitals to develop plans—

Mr SCHEFFER—How did you find out what they wanted?

Mr TURNBULL—Pretty much it was an invitation to them to submit plans.

Mr SCHEFFER—Okay, and this is a response to what they have asked you for?

Mr TURNBULL—Yes.

The CHAIR—Has that been targeted for specific data on methamphetamine presentations, because hospitals are telling us that they do not differentiate between drug related admissions or presentations at triage. One of the issues we are facing is that we cannot differentiate between one drug and another in relation to presentations, so we cannot then collect the data in relation to what are methamphetamine presentations and what are something else—cocaine or whatever.

Mr TURNBULL—Yes, that is one of the limitations of emergency department data. I think it is a first step in this program. Just by having that more explicit focus ought to give us some better intelligence about that. It is early stages of the implementation of this initiative, but we would certainly be keen to look at it in terms of the differences between substances which I suppose are causing the most—

Mr SCHEFFER—Given the chair's comment, when you have there 'enhancements relevant to methamphetamine use', that is not necessarily specifically methamphetamine use but it is in the basket of issues in which that sits?

Mr TURNBULL—Yes. We are looking at activities and initiatives that we think can play a role here and, as they are progressively implemented, we will be looking at sharpening up that focus.

Mr SOUTHWICK—Can I just pick up on one of the points made earlier about the comorbidity issues, with people coming in with a number of different problems. What work is being done to reduce the amount of duplication and individuals having multiple case managers when it comes to these sorts of things? Does some of that fit within this body of work, or is that being done in another area?

Mr TURNBULL—It is. More so it will come in a moment when I talk about the broader system reforms, but certainly even, for example, within the more intensive therapeutic counselling continuing care, part of that is about the capacity to have a case manager who has a bit more time to reach out and talk to other professionals in the health services networks that might also be dealing with that individual or his or her family. There is a very strong focus on that putting together of the case management, or care coordination as it is sometimes called, with the relationship we have with Services Connect, is obviously very much in that direction as well.

Mr SOUTHWICK—The examples that we have had in the past of at-risk communities, for instance, having up to a dozen different caseworkers, that is being tackled in #(indistinct) instance?

Mr TURNBULL—Yes.

Ms ABBOTT—Drug treatment services—so these services—as well as some of the mental health community support services and are part of Services Connect.

Mr SOUTHWICK—As in—

Ms ABBOTT—They are in scope for that kind of integration and some of the treatment reforms are specifically looking at those issues—how do you support coordination works, the more complex client, and how do you at a local level bring together a range of services that have a common interest in their clients, so how do you start to think about them differently. There are a range of ways of tackling it, both in system architecture, in individual client response and in simple things like new screening tools that explicitly identify those issues and give everyone who is dealing with someone who may have a substance issue—whether it is through a Services Connect approach or whether it is through drug treatment, using the same tool for this kind of stuff helps make those connections. You have to hit it at some levels to start making it work.

The CHAIR—Martin, the problem is, before you get into the broader reforms, that you have to narrow it down to about two minutes.

Mr TURNBULL—Yes, good.

The CHAIR—Then we might be able to ask some questions as well. We are time poor.

Mr TURNBULL—We might just skip over the next slide. I think we have already mentioned some of the Aboriginal-specific services.

The CHAIR—Are you happy to table the PowerPoint presentations as well?

Mr TURNBULL—Yes, certainly.

The CHAIR—We can incorporate them in the reports.

Mr TURNBULL—Given that we only have a few minutes, would you like to nominate an aspect you are particularly keen to—

The CHAIR—I am just aware we do have another witness coming at 3.30 but if there is information you would like to present to us, feel free. You have a few minutes.

Mr TURNBULL—What might be most useful is just to mention a few things about how our broader systems reforms at the moment are being targeted and should benefit ice related needs in particular.

Ms ABBOTT—#(indistinct)

Mr TURNBULL—I think we will just stick directly to this one, so you might go back—

Mr SOUTHWICK—This home based care that you keep returning to, we have not had a lot of evidence about that. What are you suggesting or what are you proposing? Can you give us some more information? Maybe not now, but can you provide us some more information about that?

Ms ABBOTT—Sure.

Mr TURNBULL—A quick answer to that would be some of our major services have been trialing and proposing that what is needed is more of a stepped, staged process of rehabilitation because of the longer period of care and treatment that is often required; having some of that happening in the home and even perhaps having a centre based, bed based episode at the end and a more supported home based care period after that, combining that in a sort of step-up step-down manner. That is certainly one of the amendments being seriously looked at in other places. That just requires a bit more flexibility in how some of the services are organised to follow that client through.

Mr SOUTHWICK—You said family support is suggested as part of this?

Mr TURNBULL—That would be very much integrated into that sequence, from the home into that service and then back to the home. In fact the second-last dot point on that slide really goes to that a little bit. One of the features of the reforms that we are pushing forward at the moment is a new stream of funding which we would call Care and Recovery Coordination. This is targeted at an estimated 20 to 30 per cent of clients who have more complex care needs. That will really allow care to be carried through and structured in a more flexible way over a period of up to six months, or even longer than that if it is warranted. That is very much where some of those interactions with services that connect with other parts of the community

services systems can be followed through in more detail.

We are introducing an emphasis on earlier intervention, more timely response to emerging problems through some of the reforms to the front end of the system. That includes initiatives such as a new centralised intake assessment function in each of the catchment areas. That will be, on one hand, a sort of 'no wrong door' situation so that people will not just become ineligible for drug treatment. People will be supported possibly to use some self-management tools, possibly to have a more generous health response, or in some cases to be matched exactly to the right sort of drug treatment. I think the second point we have probably covered: a more tailored approach to individual client needs to try to piece together different parts of a long-term recovery period, be it in the home or in a centre based situation.

The idea of giving priority to clients with the most urgent needs is obviously pretty critical to assist in reform. Some of the things that are going to help that include a bed vacancy register. It is well advanced in development and application, so that will really identify where there are suitable beds for a particular individual, and help make sure there is rapid access.

Mr SCHEFFER—What we have been told from regional and rural communities in general and Aboriginal groups specifically, and from the agencies, is that there are not enough beds and also the beds are not in the places where people need them. In the case of rural communities they would like them closer, rather than having to go to Melbourne. We have been told that more than once and that is also true of Aboriginal communities where they would like to see the beds being provided close to where they are so that people can have treatment without having to be separated from their families and communities, which they think is harmful. That is a resourcing issue, I guess. Very few of them have raised problems around the questions you are answering in your presentation, which is fine but this is the thing that is galvanising them.

Mr TURNBULL—Yes, certainly the capacity to provide and even access treatment close to home and family is key to the reorganisation of the system into 16 local catchment areas, each with its own intake assessment, service networks, service planning and capability is seen as an important way to enhance that local availability and responsiveness.

Mr SCHEFFER—Is that the same level of resourcing spread over the 16 areas or will there be additions?

Mr TURNBULL—At this point the system is working with the resources it has, but I think—

Mr SCHEFFER—We live in hope after May but you will have to answer that—

Mr TURNBULL—Yes. I am aware that what we are forming is a basis for future development.

The CHAIR—Okay, fair enough. Perhaps if you can finish up and then I might invite the committee—I do want to explore—our next witness has not arrived yet. The information you are giving us in relation to your reforms is fine, but it is not addressing the evidence that we have been given in relation to the need for detox, beds and rehab. Rehab is nine months. You talk about the in-home sort of therapy, which is not consistent with what we are hearing in relation to the needs of people. They all need a home but they have been disengaged by family in a number of cases, so they are in for some external support. That is the cheap option and that is the most desirable option for in-home therapy, but if the world says that, it is probably not the commonplace.

I am a bit concerned that what you are telling us is a bit of patter around what is not dealing with the core issue, and the core issue is that in regional areas there are not the support services. There are not the detox beds available. There are not the long-term rehabilitation resources that are needed. That goes, as the deputy chair said, particularly to the Indigenous

populations where there is high prevalence of this drug and where they are not getting the support they are looking for. I am just putting on the table that what you are telling us in relation to your broader reforms is not going to meet the needs of regional areas particularly, and particularly Indigenous populations because there is no capacity.

Ms ABBOTT—Shall I start?

The CHAIR—We are probably out of time but they are the things that we need to hear from you about those issues, rather than a sort of—I do not know what you call that. I am not being derogatory. I am just saying that is probably not—well, I am speaking for myself. The other committee members can speak on their behalf.

Ms ABBOTT—Right.

The CHAIR—Not meeting what we are hearing are the needs out there in relation to the treatment and resources.

Ms ABBOTT—There is an issue about how we make the best use of the beds that are currently available, and the bed vacancy register is a way of doing that. With the existing bed based stock you have got, how do you make sure that the people that most need it get it, and where are they at any point in time? One of the options is how do you make best use of what you have in terms of bed based stock? There is the bigger issue of—is the bed based model the only model and what are the other options, and what do they look like and when can you use them, and how do you fit that to clients and what their needs are.

Probably the other thing to say is that there is a second stage of drug treatment reform, which is about reforming residential services and looking at where they might go. That is the next stage of reform. When we talk about this reform here, we are talking about the non-residential services at the moment. All of those issues feed into that second stage of reform and what it means for resi services and where they are and what they do. But, you are right, there is a set of fixed stock across the state and there are dilemmas around that and where people want to be and where they want to get their services.

Mr McCURDY—We are told there is a nine-month wait to get into a rehab centre, whether it is Odyssey House or some other facility.

Ms ABBOTT—Would the committee like some data on the waiting times, because that is not the data that we are aware of.

Mr McCURDY—It is not data, it is personal experience, in that they are on a waiting list.

THE CHAIR—In answer to the question, yes, we would like some—

Ms ABBOTT—Thank you. I am just mindful of time being short. I am not wanting to—

The CHAIR—If you have data in relation to waiting list times that is not consistent with what we are hearing, we would like to have that.

Ms ABBOTT—Sure, okay.

The CHAIR—Thank you. Any closing remarks? Cath, did you want to say anything?

Ms WILLIAMS—I was not supposed to say anything!

The CHAIR—No? Just support?

Mr SCHEFFER—If I can get a quick reaction. Part of our job is to in a sense reflect back through our questioning what communities are telling us as members of parliament and non-experts. Part of what I guess I have been hearing—and this is the last hearing we are having, so we have been through nearly a year of this—is that people seem to be doing a lot of things really well in various places that we have been to. There is a sense or an understanding that part of the bureaucracy's role is to think how we can stretch the dollar further—absolutely—how we can reform what we do in a better way and to shift change.

But there is a point where the accumulated experience of these agencies is sufficient to do a really good job, and it seems to me that there needs to be some rest—that they can on with it, and they need more resources to do it rather than being told, 'Well, you can't have resources, so let's see if we can make the dollar stretch further, let's see if we can reform the sector,' and then another round of resources are diverted into rethinking what they are already doing.

I do not know whether that makes sense to you, but that is part of what I think it is my duty to convey to you from what we have been hearing, or my sense of what we have been hearing, from the agencies. I think there needs to be a period of consolidation, where people can just get on with things that they seem to be doing really well and are able to prove the outcomes. I do not know if you want to comment on that just quickly.

Ms ABBOTT—We will take it as feedback from the committee. That is a comment—

Mr SCHEFFER—Take that as a comment.

Ms ABBOTT—An observation.

Mr SCHEFFER—Okay.

The CHAIR—Tim, did you have anything else?

Mr McCURDY—No, I am fine, thanks.

Ms ABBOTT—I think the other questions that you asked are explained in the presentation, but if there is anything else that we did not get to you will let us know afterwards and we will provide you advice in writing.

The CHAIR—The interaction between the Department of Community Services—because obviously there is a lot of crossover in relation to—

Ms ABBOTT—Yes. We spend a lot of time with our DHS colleagues talking about a range of issues.

The CHAIR—Is there a cross-department strategy in relation to dealing with methamphetamines with the work you are doing and the work Community Services is doing in relation to some of the discussion—

Ms ABBOTT—There is an interdepartmental committee on alcohol and drugs that has been established, so that has the Department of Human Services, several parts of the Department of Justice, including Victoria Police, the Department of Health and a couple of other departments involved. It meets regularly, and issues related to ice and methamphetamine are a standing item on that. It is part of trying to get that big picture and make sure we are all working together.

The CHAIR—Good. Thank you very much for your time, Judith, Martin and Cath.

Witnesses withdrew.

Hearing suspended.