LEGISLATIVE ASSEMBLY FOR THE AUSTRALIAN CAPITAL TERRITORY

STANDING COMMITTEE ON HEALTH AND DISABILITY

(Reference: Use of crystal methamphetamine "ice" in the ACT)

Members:

MS K MacDONALD (The Chair)
MS M PORTER (The Deputy Chair)
MRS J BURKE

TRANSCRIPT OF EVIDENCE

CANBERRA

WEDNESDAY, 16 MAY 2007

Secretary to the committee:
Ms G Concannon (Ph: 6205 0129)

By authority of the Legislative Assembly for the Australian Capital Territory

Submissions, answers to questions on notice and other documents relevant to this inquiry that have been authorised for publication by the committee may be obtained from the committee office of the Legislative Assembly (Ph: 6205 0127).

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The committee met at 9.33 am.

SOO, **DR TUCK MENG**, General Practitioner, Interchange General Practice

THE CHAIR: I will read this card to you. The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

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Dr Soo: I do, thank you.

THE CHAIR: Welcome, Dr Soo, and I thank you for your submission to the committee. Would you like to address that submission and then the committee can ask questions of you?

Dr Soo: I would. I would like to thank the ACT Legislative Assembly Standing Committee on Health and Disability for inviting me to appear before them today. I am a general practitioner working in a large general practice in Canberra city and, because my practice has always taken on a responsibility of looking after disadvantaged minorities in the Canberra community, we see a lot of patients with drug abuse problems. Reports from my patients indicate to me that crystal methamphetamine is now the most commonly used illicit drug in the ACT.

I am sure that members of this committee have been acquainted with the deleterious mental, physical and psychosocial effects of the use of methamphetamines, and if anyone would like further information I could direct them to sources of information.

I would like to use the time I have now to talk further about some proposed measures to reduce the harm that methamphetamines do in our community. A lot of people who use methamphetamines, probably the majority, only use methamphetamines sporadically. From the literature and from people I have spoken to, this is often associated with dance parties and other social occasions. Nevertheless, even occasional use can be associated with the development of psychosis and other deleterious health effects.

My first proposal is that the ACT government looks at an education campaign to inform users about the potential health effects of amphetamines. The purpose of the campaign would be to educate users and their friends so that users and their friends can identify early symptoms of disease and friends can be encouraged to seek assistance from the medical community.

Unfortunately, there is not good evidence of any form of pharmacotherapy that clearly helps methamphetamine users at the various stages of methamphetamine use, whether with withdrawal or with abstinence. this creates both challenges and opportunities. I think it could be useful for the ACT government to conduct a survey of methamphetamine users to see where they perceive their greatest needs are. The needs could be in several areas, for example in the provision of medications to help with withdrawals, a safe environment in which to withdraw, easy access to early identification of psychosis and/or the provision of services to aid with abstinence.

If this survey indicates that there is a clearly identified demand for pharmacotherapy I believe the ACT could institute trials of pharmacotherapy. As I have mentioned earlier, there is not any good evidence to say that any particular one drug is very useful in this area, but that does not mean that the evidence just is not there. So if there is a demand in the ACT for this we could run a pilot trial to see whether any particular drugs that are picked could be helpful.

On the other hand, most of the literature and treatment for methamphetamines has focused on behavioural interventions and it seems that there is a fair amount of evidence in overseas literature to support the use of something they call contingency management in methamphetamine dependency. I think it could be worth while for the ACT to offer a program of contingency management, with further access to other counselling services as required. That was all I was going to say.

THE CHAIR: Okay. Thank you very much for that. That is certainly very interesting and certainly it has been coming up that there is no pharmacotherapy treatment at the moment, although I understand from evidence received from the department last week that there are national trials looking at ways to deal with it.

Dr Soo: That is right, yes. I think Alex Wodak when he came up here mentioned some trials that they are running there, and I think the drugs that have been used have been dexamphetamine for chronic users and also modafinil. Modafinil is a drug that is currently on authority prescription in Australia for the treatment of narcolepsy, so it is very good at stopping people from falling asleep. But the hope is that it might be useful; I am not sure that there is great evidence yet to say that it has really been all that useful.

THE CHAIR: It is interesting that you have mentioned that you see it as being an opportunity as well, and you have suggested some ways that the ACT can proceed by looking at conducting a trial. You obviously have patients coming to you who are reporting to you that they are using this drug. Some of the evidence that we have heard has been that many people who are using crystal methamphetamine, or methamphetamines generally, do not see that they have a problem. Are you seeing patients who want to get off it and want to seek some alternative?

Dr Soo: I agree with that assessment. As I mentioned in my submission earlier, the impression I get is that the majority of people who use it use it recreationally, so at a weekend party they might use it for 24 hours or so. They then feel absolutely terrible for a day or two afterwards, but I would put to the committee that if you spend a weekend drinking alcohol you probably feel pretty bad for a day or two afterwards. So I suspect that a lot of social users perceive it in a fairly similar sort of way—they just get a good time on the weekend.

The majority of users do not develop an addiction. They probably hold down their jobs and perform reasonably well and would not develop any problems with their use. But recreational use can sometimes lead to the development of psychosis, which is where it is useful to have an education program, so that people are aware of the side effects and their friends are aware of the side effects and can look out for people who are using and maybe alert them, "Look, you know, you've got this symptom that is mentioned in this pamphlet I've got. You really should go and see a doctor." Early identification of psychosis, given that mental health is one of the major side effects of use of methamphetamines, is really very useful.

THE CHAIR: You mentioned the idea of being able to say, "Well, here's a pamphlet I've got." What is your experience of the ease of access to information on methamphetamines and the effects?

Dr Soo: I am afraid I have to say I do not know the answer to that one. Coming back to your earlier question about people who come to my practice: recreational users we really do not see all that much. As you say, and I agree, a lot of them do not perceive their methamphetamine use as a health problem. I occasionally get patients who come to see me to say, "I am probably going to be partying this weekend and after that party would like to get some sleep; can I get a script for some benzodiazepines to help me sleep?" That is not all that common. The commonest context in which I tend to come across it is with poly drug abusers, people who use methamphetamines as part of a range of drugs, and people like that often seek help for lots of different reasons.

THE CHAIR: We heard evidence last week from a representative of the police that a lot of the drugs that people think are ice are actually not necessarily ice. I think we might have heard that from Family and Friends for Drug Law Reform, not the police; I will have to go back and check the *Hansard*. The comment was that crystal methamphetamine is over 80 per cent pure, whereas a lot of the drugs that people are taking and which are being sold to them as ice have lower levels of purity—60 per cent or sometimes even less than that. Do you have a comment to make about that or are you hearing from patients about—

Dr Soo: No, I have not heard very much about that. If you are injecting a drug it is difficult to know what you are injecting. But one favoured use of methamphetamine is to vaporise it, and I guess if someone is sold something that is of a lower purity and actually not methamphetamine they probably could not vaporise it very successfully.

THE CHAIR: Okay. We might look into that further.

MS PORTER: I just want to go back to the education aspect. A lot of people have

recommended that that campaign be undertaken, but I want to understand what you believe would be the best method of imparting the information to people and the best method of educating, firstly, people who are already using and their friends and, secondly, people who are not. What should be the method of delivery, or are there a number of methods of delivery you would suggest, of that message?

Dr Soo: I have to admit I have not thought about exactly how we are going to do that. My thoughts about the matter would be that you could use peer networks, so with the poly drug abuse community you can probably reach some of them through CAHMA and other peer networks like that. With the recreational users I think you probably have to target clubs, party venues and things like that, with, say, a poster campaign; television campaigns are probably a bit expensive and probably a lot of these people do not spend a lot of time watching television.

MS PORTER: I have not asked anybody else but other people have mentioned the web as a source of education. Do you think putting something on the web might be a good idea or do you think—

Dr Soo: It would be. I suspect that a lot of party users are probably very new-media savvy, but I cannot say that I am very good with new media. I am not quite sure exactly how all this works, but one idea could be to SMS message people—"For information on ice, ring," et cetera—or something along those lines, because the impression I get is that younger people who go to lots of parties probably use mobiles, text messaging and things like that.

THE CHAIR: They do seem to text a lot.

MRS BURKE: Thank you, Dr Soo, for being with us this morning. I do not know if the chair has already captured this, but you did allude at the beginning of your presentation to information sources that you have—you said you could provide the committee with that—in relation to ice being the most commonly used drug in the ACT.

Dr Soo: I think that was about—

MRS BURKE: You said at the beginning—

Dr Soo: No, I do not have that information. I was going to say that I had information on the mental, physical and psychosocial effects of the use of ice.

MRS BURKE: Okay, if you could provide that to the committee, with the chair's indulgence.

THE CHAIR: Yes, although we do have that in some of the other submissions.

MRS BURKE: Do we? Okay, but if there is anything extra you think you could add.

Dr Soo: Yes, sure.

MRS BURKE: Secondly, talking about the educational campaign, I must put on the

record that obviously alcohol is considered to be, and we talk about it as being, social. The words "social use" or "recreational use" almost glamorise what is happening, and I am very concerned about some of those labels giving the idea of acceptance, as though it is okay for young people. I should probably declare a conflict of interest, having watched, or continuing to watch, a family member come off the awful trip that he has been on. What I want to ask you—and it is probably a silly question—is in terms of the mental health issues, psychosis and self-medicating: how many people presenting to you say, or don't they, that they are self-medicating to make them feel better?

Dr Soo: With ice you mean?

MRS BURKE: Yes. There has got to be an underlying problem.

Dr Soo: With the patients I see who report using ice they are using it as part of a poly drug abuse pattern. So they often have quite dysfunctional lifestyles and a lot of them have mental health co-morbidity. What they are self-medicating with and what the self-medication is doing is unclear because they are often using so many different things.

MRS BURKE: Yes. Again it is like alcohol: you take alcohol to hopefully make the problem go away. But isn't the real crux of it that we should be addressing mental health issues and depression at a higher level amongst young people, because what we are seeing is a masking of perhaps a deeper problem?

Dr Soo: I see, so you are saying that maybe people start using ice because they have mental health issues or are alienated from society?

MRS BURKE: And/or that they are told, "You'll feel better if you take ice; have this."

Dr Soo: I came across an article in a newspaper a few months ago which had looked at people who, I think, were on methadone or were opiate abusers. They looked for indicators of social dysfunction and the reports said that if you look at their history a lot of these people had indicators of social dysfunction before they ever used drugs, suggesting that in fact they might have a pre-existing mental health problem or a personality disorder and that that often then leads them on to using drugs. Anyway, this article was arguing that therefore methadone does not really help, but I do not think that is the conclusion that one could draw from that. But, yes, I think it is true that it is probably the people who have poorer personal resources that often end up using drugs in a dysfunctional manner.

I go back to the fact that the impression I get is that the majority of people who use methamphetamines are probably not using them in "a dysfunctional manner"; they are not using in such a way that it is impacting on their normal daily function. They might just use it on Saturday night when they go out to a party. They feel a bit off on Sunday, but then they go back to work and they manage to hold down their jobs and hold down their relationships. I think then it is a bit of a moral and ethical issue. If you are using it in that context and it is not impacting on your life, is it a bad thing or is it a good thing? I think that is a separate moral and ethical issue.

MRS BURKE: You say in your submission about the after-effects. I have seen this again first hand. If you are every weekend hitting on ice, is there a build-up of this drug in your system or does it completely deplete and flush away after a time? Do you know?

Dr Soo: It probably depletes quite quickly, and obviously not everyone that uses ice gets psychosis. The way I conceptualise it is that everybody has a different genetic susceptibility.

MRS BURKE: Disposition, yes.

Dr Soo: Some people get it really easily; some people do not. And some people get it really easily, just using ice once or twice: the drug precipitates it, causes it to happen.

MRS BURKE: Thank you.

MS PORTER: I have just one question. I know we are running out of time.

THE CHAIR: We are.

MS PORTER: You mentioned behavioural contingency. I wonder if you could just explain that to us briefly in layman's language.

Dr Soo: Yes; I know that is a jargon term. I had to read the article to find out what it meant as well. Contingency management means this: there is a theory that people use ice because they get a reward out of it so, if you give them an alternative reward, that might persuade them not to use ice.

MS PORTER: Right.

Dr Soo: There are quite a few papers about it in the literature, principally from the United States. There was one particular program. In the United States they are really worried about using ice, increasing unsafe sexual behaviour and therefore increasing the spread of HIV. There are hundreds of papers about it. There was one project in San Francisco, for example, where they set up several distribution points. They just advertised and said, "If you want to come off ice, come and join this program." On this program, you turn up three times a week and you do a urine test. They have a kit which can test urine right away to see whether there are any traces of methamphetamine metabolites. If you do not have any methamphetamine metabolites, you get given a financial reward. And each time you come in and have a clean urine, your financial reward increases—to a maximum of, I think, $10 per episode. They start off with a really low amount—I think $2.50. The first time you get a clean urine you get $2.50; the second time you get $4; the next time you get $5.50—and so on, to a maximum of $10. For the duration of the program, if you continue to have a clean urine you get $10 each time you turn up. If you have a dirty urine, you go right back to the start; the next time you come in and have a clean urine you get $2.50, and you start off again that way.

In order to exclude the effects of any counselling that you might be getting from

interaction with providers, the staff were trained to say, "You have a clean urine today. Here is your reward. We'll see you again in two days time." Or "You have a dirty urine today. You don't get any money. Come back in two days time." You do not get any reinforcing positive or negative messages.

You would think that something like that would not really work, because the monetary rewards are so small. Yet this program did. I think it recruited a reasonable number of people—I cannot remember off the top of my head, but it was not just a few people; it was a reasonable number—and it reported about a 30 to 40 per cent success rate. I find that really surprising. But there are several other papers in the literature about contingency management. In terms of behavioural interventions, that seems to be one that is the most reported on in the literature from the United States.

MS BURKE: It does not really get to the underlying problem of why they are doing it in the first place though.

Dr Soo: No, but—

MS BURKE: But we could have a whole debate on that.

Dr Soo: No, it does not, but you can argue that, if you can actually achieve a period of abstinence, that gives you a window to instigate further intervention.

MS BURKE: I agree.

Dr Soo: In this program, the workers were not allowed to actually give any counselling themselves, but if people indicated an interest they were allowed to refer them to another agency for counselling.

MS PORTER: Thank you very much. That was interesting.

MS BURKE: Thank you very much.

THE CHAIR: Thank you for your submission and for appearing today. We do appreciate it. You will receive a copy of the *Hansard* from today in the next week and I ask you to check that you have not been misquoted.

Dr Soo: Okay.

THE CHAIR: Check for accuracy. If we have any further questions, we will get back in contact with you.

Dr Soo: Thank you very much.

WRIGHT, MR DOUG, Clinical Co-ordinator, ACT Ambulance Service

THE CHAIR: I will read the card. The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

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Do you understand that?

Mr Wright: Yes, thank you.

THE CHAIR: Could you state the capacity in which you appear.

Mr Wright: I am employed with the ACT Ambulance Service, currently as a clinical educator. My background is that I have been in the ambulance industry for over 20 years, working in three states of Australia—Victoria, Tasmania and the ACT—in both metropolitan and rural areas. I will touch lightly on my background. After finishing my degree, I started postgraduate studies in public health promotion—men's health. So I have a little bit of knowledge of the public health area as well.

THE CHAIR: Thank you for appearing today, Mr Wright. We do appreciate it. Would you like to make a statement? Then we can ask some questions.

Mr Wright: The ACT Ambulance Service attends around 580 overdoses a year. We categorise these into categories such as prescription medications, poly pharmacy, alcohol, amphetamine type substances—or ATSs, as I will refer to them throughout this presentation—heroin, chemical gas, paracetamol, benzodiazepines, marijuana and others. The amphetamine type substances include crystal methamphetamine, ice, which is the purest form of amphetamine type substance; crystal meth is about 80 per cent pure methamphetamine.

The ACT Ambulance Service's data over the last four years has shown us that ATSs account for 5.5 per cent of all of the overdoses that we attend. Crystal meth, which is

ice, accounts for an even smaller proportion, which is only 25 per cent of that 5.5 per cent. To put this into perspective, alcohol on its own accounts for 30 per cent of our overdoses, year after year. You can see that crystal meth or amphetamine type substances are quite a small amount. Also, looking at our data on this, we discovered that over the last four years we have had a downward trend in the use of amphetamine type substances in overdoses—from a 6.2 per cent average down to now, in the first quarter of this year, only four per cent of the cases that we attend.

I would like to stress to you that this data relating to amphetamine type substances is subjective data. It is reported to us by either the users or bystanders; it is not based on toxicology results, which are very hard to get with amphetamine type substances. It is even hard to try and determine whether it is crystal meth. All you are looking for is trace elements of amphetamines in the system, so you can never really determine it. So this data is usually only subjective.

And often these cases revolve around a poly pharmaceutical overdose or a mix with alcohol, or both. It is not often just one drug on its own. The patients are generally in their late 20s and 30s, which is a little bit older than what we have seen with other drugs and what is normally portrayed in the media—who the users of amphetamine type substances are.

What faces a paramedic crew at one of these scenes? It can be a patient who is suffering with an acute psychotic event which has the patient hallucinating and with a high degree of suspicion about the people around them. Then along comes the ambulance. There is an increased suspicion about us and why we are there. Patients are agitated; they are often showing overreacting behaviour; they have a rapid speech pattern; they are shifting in conversations; they cannot hold a conversation straight. The patients become aggressive towards everyone and may need to be sedated.

Because of this presentation, the ACT Ambulance Service—and the Victorian ambulance service—developed guidelines to deal with combative patients who may also be prone to having temperature rises which require cooling. I want to share with you what we came up with in our guidelines and where we went with that. We have a clinical management guideline for dealing with combative and agitated patients. It says:

> Use in situations where the patient cannot be managed due to agitation or combativeness.
>
> If concerned about safety call the police for assistance.
>
> Consider/exclude: hypoxia—

which is decreased oxygen supply—

> hypoglycaemia—

low blood sugars—

> head injury; post-ictal state—

which is post-seizure activity. The guideline continues:

> Treat as appropriate.
>
> Speak quietly—do not shout. Do not leave the patient alone. Attempt quiet reassurance in an attempt to persuade the patient to accept treatment.
>
> If reassurance and persuasion are ineffective or impractical, move to pharmacological management.

This is our last resort. It involves the use of midazolam at 0.1 milligrams per kilogram, usually intramuscular. If necessary the dose may be repeated after 10 minutes, to try and subdue the patient. The guideline also says to "Ensure adequate control of the limb and patient when injecting". That is an occupational health and safety issue. If the patient is agitated through psycho-stimulant use, we may increase the dose up to 0.2 milligrams per kilo; I will give some examples of that in a moment. The guideline says:

> Limb restraints are to be utilised in conjunction with pharmacological restraint.

So we use chemical and physical restraint with these patients. The doses of midazolam that we use are based on our experiences with these patients—and any patient in a combative agitated state.

Guidelines have been produced by the federal Department of Health and Ageing for paramedics in the care of patients for psycho-stimulant drug overdoses. These guidelines came out late last year. They suggest that you use up to a maximum dose of 15 milligrams of midazolam regardless of the weight of the patient. The ACT Ambulance Service's guidelines have been tailored to 0.1 milligrams per kilo—which, for example, would be eight milligrams for an 80-kilogram patient—or, intramuscularly, 0.2 milligrams per kilo, which is 16 milligrams IMI, or intramuscular injection.

You can see that our doses are slightly higher than what has already been recommended. This is a trend Australia wide. All ambulance services found that the guidelines that were put out by the federal Department of Health and Ageing are inadequate: we have all needed to have higher doses. And then we repeat the dose again 10 minutes afterwards.

Physical restraints have been introduced as well; this is to deal with the combative patients, to protect themselves from harm and also to protect the paramedics treating the patients from harm.

The patient with the methamphetamine overdose may also experience hyperthermia—high temperature—which can cause the patient to have seizures. For this reason, the ACT Ambulance Service introduced a provision into the guidelines to ensure that we monitor the patients' temperatures from overdoses—to ensure that they do not get too hot and to cool the patients if necessary. That is with active cooling or with fluids as well. The ACT Ambulance Service and MICA Victoria ambulance service are the only ambulance services in Australia who actually recognise this part of the process of an overdose with psycho-stimulants and have put it in our guidelines.

I would like to share some case examples with you, if I may—some real cases that we have attended in the ACT. The first case was in January this year; it was a call to a 27-year-old male. We were called to a male fitting. The crew were taken to the patient by the father. They found the patient in the bathroom. He was conversing with the family. He had a seizure and stated that he had overdosed on ice. The notes say, "The patient took ice this evening." Another note says, "The patient stated that he injected ice and that he injected approximately 70 to 90 milligrams of ice." He also stated that he had been drinking heavily all day—drinking bourbon and coke all day as well.

The crew attended to this patient, who was quite cooperative but quite agitated. He ambulated out to the ambulance. En route the patient was conscious and alert; then he suddenly developed seizures. In their observations on the patient, the crew noted that whilst he was seizuring he had an increase in his pulse rate, an increase in his blood pressure and a decrease in his respiratory rate. They were uncontrollable type seizures that required the intervention of drug therapy; midazolam was used to control his seizures. He was given three milligrams of midazolam with minimal effect, and then had a further two and five. So he had a total of 10 milligrams of midazolam to control his seizuring activity. According to the notes, the patient had no history of seizures or anything else relevant to that, so we would conclude that that was brought about by injecting with the ice.

The next patient I want to refer to was a 24-year-old male. According to the notes, we were called to a patient who was semiconscious and had taken an overdose of drugs. The patient was lying in a lateral position unconscious; friends present stated that the patient had taken ecstasy, which is an amphetamine type substance—post ingestion of ecstasy. The patient had also been drinking since midday; he had had 18 beers. He had also taken ecstasy and was unconscious. This case was not really anything of significance with the patient in the treatment. He was initially unconscious; then he roused and became combative and agitated. During that time—I want to stress this—the patient spat and sprayed officers with his own saliva, which resulted in an occ health and safety issue for the crew. The patient was cannulated and was given drugs to sedate him—midazolam. The AFP assisted in restraining this patient en route to hospital.

The next case I want to refer to is a little bit outside the general age group that I mentioned. It is a 15-year-old male who smoked ice during the evening. The crew have added a footnote: "a report from the patient and a report from friends that he had smoked ice and he'd also consumed a large amount of alcohol". This patient presented unconscious, with an overdose of alcohol and amphetamines. The crew have noted that his temperature was not warm—it was good that we looked at that. Once the patient became conscious when he was aroused, he became extremely violent, lashing out and thrashing out at everyone around. He was given 15 milligrams of midazolam intramuscular. The patient complied shortly after that took effect; he was transported to hospital not restrained and not with police assistance or anything. The crew were able to handle the patient once they had subdued him.

The next case involved a 21-year-old male who had ingested alcohol and amphetamine substances. According to the notes, "Friends stated that he was at a party last night and that he had ingested the drugs and gone off this morning." That is

a little bit odd; it is some time after the event. He was uncoordinated, he was violent and he was irrational in his behaviour. When the crew arrived at this case they were called to a psychiatric episode. When they arrived, the patient was coherent and aggressive. He was sat upon by two of his friends to hold him down until the ambulance arrived. He was tachycardic—increased heart rate—irrational, physically restrained and non-compliant. The crew have written that the patient required repeated doses of midazolam in order to put him into a compliant state. This patient had a 15-milligram injection initially; then he had two 2.5 intravenous injections post that. So they used 20 milligrams of midazolam to subdue the patient. You can see that the levels are getting a lot higher than what we had written in the guidelines from the Department of Health and Ageing.

I will read one last one which is, I have documented here, a case that I was aware of. It was a 38-year-old male that our crew went to. The patient was quite confused; he presented with "overdose or a psychiatric history". We did not know. In talking with the patient, he said he had taken ice. The patient was very, very agitated; he was not cooperative, but he would allow himself to go in the ambulance. He would not lie on the bed; he sat in the seat in the ambulance. He was not able to hold a structured conversation. En route, he continually complained about the driving—not that there was anything wrong with the driving. He sat there. He allowed the one paramedic in the back treating him to take a blood pressure on him; that was the only obs we could get on him. He had a blood pressure of 140 palpated, so his systolic blood pressure was quite high. We really needed to know what his diastolic pressure was as well, but he would not allow anything more than just palpating it.

The reason I bring this case up is that, just on arrival at the hospital, the patient began to seizure in the back of the ambulance. The crew quickly moved him to the stretcher and noted that he had nil respirations and nil pulse. CPR was performed; the monitor was put on. He was in a VT arrest. The patient was then—because we were just at the hospital—wheeled into the hospital with the CPR in progress and handed over to the hospital staff. The patient died.

THE CHAIR: Thanks for that. We are going to have to be fairly quick because we are running over time already.

MS PORTER: I just have two quick questions.

THE CHAIR: I just want to ask you if the committee would be able to obtain a copy of the ACT guidelines—and possibly the Victorian guidelines as well.

Mr Wright: Yes.

THE CHAIR: That would be great.

Mr Wright: Yes.

MS PORTER: I just have two very quick questions. One is this. Even though they are a small percentage of the number of overdoses that you are working with, as you demonstrated or as you told us, would you say that they are the most difficult for you to manage?

Mr Wright: Yes, they are.

MS PORTER: Thank you. The second question is: the drug that you were talking about that you are using to—

Mr Wright: Midazolam?

MS PORTER: That is the one. You were saying you are using more than the national guidelines recommend. Are there any serious side effects from that drug?

Mr Wright: Every drug has a side effect. The side effects from midazolam are that you get a decreased respiratory rate, a decreased blood pressure and a decreased conscious state. However, those are things that intensive care paramedics can quite easily deal with. We often sedate patients to look after their airways anyway—with head trauma and things like that.

Ms Porter: Thanks.

MRS BURKE: I was going to quickly ask for recommendations on the back of that.

THE CHAIR: Yes, please.

MRS BURKE: If you have got any recommendations you can give this committee, that would be very helpful.

THE CHAIR: What do you think should be done? I think that is what we are asking.

MRS BURKE: You can put this in writing to us as well, Mr Wright.

Mr Wright: I have it all in writing here.

MRS BURKE: That would be great if you want to give it to our secretariat.

Mr Wright: If it is taped, I can continue for five minutes.

THE CHAIR: Yes. We would be happy to receive that afterwards.

Mr Wright: Okay. Let me mention other problems that crystal meth present to us. Occupational health and safety issues are obviously things we need to deal with. Clandestine labs are another issue completely, and one which has not been considered. Often when there is an explosion you discover a clandestine lab. With that we are presented with patients who have explosion injuries and burns, but there are chemical burns and noxious fumes present. It is a completely different situation but it is related to this particular subject.

Turning to long-term health problems of patients that take amphetamine type substances, you would think about things like diminished brain functions or cognitive brain functions but I also want to raise another issue. When you take the drugs, it increases your blood pressure and your pulse rates and causes hypoxia. Younger

people are starting to suffer cerebral vascular accidents as a result of their recreational drug use—and also constrictive airways diseases, or what is known as crack lung syndrome, which is what started with cocaine users years ago. These are problems that present long term for their health.

As to solutions, I want to say that abstinence has never worked with any drug, and this is no different.

THE CHAIR: Can I interrupt before you go to that. At the ice forum you mentioned the crack lung syndrome; you also mentioned that there was an issue with emphysema.

Mr Wright: That is an effect from that.

THE CHAIR: Yes, and it is not reversible. That is the thing that I wanted to get on the record.

Mr Wright: Yes. I mentioned emphysema to you as a layman's term for what we—

THE CHAIR: Okay.

Mr Wright:—call constructive airways diseases, CAL or COAD—an easier way to explain it to you. You are right; it is not reversible. When you do that sort of damage to your lungs, it is not reversible.

THE CHAIR: Sorry. Please go on.

Mr Wright: Abstinence has never worked with any drugs. We found that through prohibition in America. I found it really odd that the people who are addicted to a depressant like heroin, when it has dried up out there, switch to an amphetamine, which is an upper. I find that really interesting—that somebody has gone from a drug that gives them a depressed feeling to something that gives them a stimulated feeling.

If humans have an addiction to something, it is this addiction that drives the people to look for a drug. Whether it is ice, heroin or gambling, it has to be fed. That addiction is what has to be fed. In New Zealand they have a drug called BZP, which is a herbal party drug. It is legal; it is purchased. In preparing for this statement today, I rang some colleagues in New Zealand and had a talk about BZP. I said, "Is it the great answer for us? Can we introduce that here and have a legal drug which is non-addictive?" But, speaking to them, it was no better. Unfortunately, when it is mixed with alcohol it creates aggression, hallucinations and all sorts of things—problems similar to what we get when we have patients with crystal methamphetamine or other amphetamine type substances.

However, what is really interesting from New Zealand is that ice—or P, as they call it over there—is considered by kids to be a nutter's drug. There is real peer pressure not to take it and not get involved in it. That is something that needs to be investigated. How did they get around to that?

Let me turn to marketing. How do we prevent this? We should not make amphetamine type substances another cane toad in Australia. We should not forget about it, ignore it

and assume that it will go away; it will just continue to spread. Last year, Michael Blackwell—I do not know where he is from—spoke on the topic of marketing at the Australasian conference on amphetamine type substances in Sydney, which I attended. He said, "You do not use rotten teeth to sell toothpaste." If you think about that for a second, you will realise that it is quite true. There is a need to focus on research on the target audience. To advertise showing someone with a needle in their arm or living rough does not really get the message across to the target audience; it turns them off. There needs to be careful research into what will be the best approach to this target audience. But I do not have the answers.

THE CHAIR: Okay.

MRS BURKE: Thank you very much.

THE CHAIR: We will have to leave it there. Thank you very much for your time.

CRESSWELL, MS ARA, Director, ACT Council of Social Service
FOWLIE, MS CARRIE ANN, Deputy Director, Youth Coalition of the ACT
REYNDERS, MR LLEWELLYN, Manager, Policy and Communications, ACT Council of Social Service

THE CHAIR: I will read the card. The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

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Do you all understand that? Yes, I am getting nods. Thank you very much for your submission and welcome. Did the youth coalition have input into this submission or not?

Mr Reynders: We were working with the youth coalition. They have developed some additional material, which is not quite finalised I understand.

THE CHAIR: Okay. We look forward to seeing that. I understand that with an organisation like the youth coalition it does take time for a voluntary organisation to get the stuff together. Would you like to start by addressing your submission?

Ms Cresswell: I will make a few comments to you and I will pass it over. Llewellyn did the bulk of the research on this particular paper, and together Llewellyn and Carrie have consulted the sector quite broadly around these issues. We apologise for the lateness of our submission; we just could not manage to get it all in at one time.

THE CHAIR: No, that is okay.

MRS BURKE: It wouldn’t be that you are under-resourced, would it?

Ms Cresswell: Heavens, no.

We have said in there, but I will reiterate, that social disadvantage and social

inequality have substantial impact on differential health outcomes for people across the entire social spectrum. There is no question that the social determinants of health are implicated in drug use, and any meaningful strategies that we put in place to address problematic drug use must seek to address social inequality and lack of opportunity.

I am sure you have heard about some very serious problems associated with the use of crystal methamphetamine but we would reiterate that it is only with some people; that the issues around drug and alcohol use in the ACT are very broad; that methamphetamine is used by a smaller population of drug users than the other drugs; and certainly the burden of health impact upon the ACT population is far greater with alcohol and tobacco.

I am sure you have looked at our submission and we really are stressing that we need to develop the entire drug and alcohol system to have much greater capacity. We have services in place; we need to develop those services. We need to ensure that the system can meet the need. The solutions are across the board. We are not looking at something particularly different with this drug; we are looking at what we have now and how we address it with the services that we have in place. We have to continue to develop the system. We could have predicted that we would have this problem now. This will not be the last one. We would like to know that we can be ready to respond next time before a problem is in place, but we need to get ready to respond to it.

I will hand over to Llewellyn to talk to you about some of the issues that are in our submission and then we will hand it over to Carrie.

Mr Reynders: As a way of introduction I want to bring up a couple of points from the submission. Firstly, with this issue of poly drug use, it is reasonably rare for someone to be addicted just to ice or just use ice. Ice is frequently used with a combination of other drugs and it may well be that it is the interaction of that poly drug use that produces many of the effects that we are seeing. I notice that you just heard from the ambulance service. Even in the case studies that he was mentioning there was poly drug use involved. In fact, what we are seeing, at least in the research that I looked at, is a tendency to try and contain the research to a single substance, whereas what is happening on the ground is that people are taking quite a number of substances at once. Indeed, in one of the consultations I did there was a perception that there was a group of recreational drug users who would go out and use whatever was available in whatever combinations. Trying to tie particularly government policy to a single substance really is not going to be effective because people are not using just a single substance.

The other issue I want to address, particularly in the context of methamphetamine, is the diversity of its use. Unlike perhaps drugs like heroin or even cocaine, we are seeing a much broader spectrum of user groups with the various forms of methamphetamine, as well as ice itself, including a number of youth subcultures, gay and lesbian people as well as the more severe injecting drug users.

From the submission the things I want to focus on briefly are some of the ideas about how the community sector in particular can respond and how it can be developed and resourced to address some of the issues that we are seeing with methamphetamine. I

want to introduce that by looking at a study that was commissioned by ACT Health which looked at where the ACT government expended its funds on drug and alcohol issues and found that 77 per cent of the ACT's spending was in fact on law enforcement, which left only 23 per cent to put into the health sector to support harm minimisation and treatment options. We are of the view that we need to really look at rebalancing that. By concentrating so heavily on law enforcement options to deal with the problem, we are really not able to get a balanced approach. We are really not able to hit all of the different ways of tackling the issue across the board. We seem to be focusing very heavily on one methodology.

From our perspective, certainly something we have seen from looking particularly at some of those heavy users and the high-end problems that are occurring is that the agencies we consulted very much point to a lack of availability of treatment options. The treatment facilities we have tend to be very full, difficult to get into or have either cost barriers or a lack of flexibility to entry. So, for example, when a person has a crisis or it gets to a point where something has to happen and they go, "Look, I have to deal with this; I have to get in," they ring up a detox facility or a rehab facility and say, "Look, I need to get in. I need to get off this stuff now" and they are told that there is a two or three-week or even a month-long waiting list and "You'll just need to stay out there and cope until you can get in." After that time has elapsed they are often using again; they are no longer in a head space to be able to cope with the idea of treatment and they do not enter the facility. So by building the capacity of the treatment system we can certainly get people into treatment faster and deal with those issues when people are ready to deal with them, rather than creating an artificial timetable which they need to fit into.

The other issue I want to reiterate is having a diversity of treatment options. Unfortunately, for virtually all types of drug and alcohol treatment none of the treatments that we have are failsafe. There is a high recidivism rate, there is a high drop-out rate, in virtually all types of treatment, and having a diversity of options, allowing people to find the treatment program and the treatment philosophy that suits them best, is at the moment the best predictor of success that we have, as well as assisting people who wish to use the treatment system to negotiate that system and find the option that is most likely to work for them.

Further, I want to draw the committee's attention to the idea that we need to develop the capacity of drug and alcohol treatment organisations. Community sector organisations across the board have concerns with their workforce at the moment. The term "skills shortage" comes up again and again, and not necessarily being able to compete with private businesses and the federal government, in particular, community organisations are often at the very pointy end of the skills shortage because we are often the least able to compete with other employers.

In addition to that, we need to give people the training opportunities that they need across the board, particularly in terms of dealing with people with crisis when we are looking at ice. There are a number of points in the system, including the emergency services system, the hospital system and community organisations, where people addicted to ice will often present for the first time. For example, we have seen it in homelessness organisations as well, but their staff are not necessarily trained or have the capacity to deal with people, particularly those who are highly agitated.

One issue I want to raise very briefly is the interaction of the public housing system. Quite often people have very long stays in rehabilitation services, yet, when they exit, their only housing opportunity is usually public housing and quite often they are then placed in residential complexes which have a high drug use environment, and in that environment quite often they are re-exposed to the drug and they develop their dependency again. We will take questions on the submission, but those are the issues I wanted to raise.

THE CHAIR: Ms Fowlie, did you want to make a comment?

Ms Fowlie: We would support very much the position of ACTCOSS on these issues. I just want to highlight a couple of other issues. First, I apologise that we have not yet submitted our submission.

THE CHAIR: Please do not worry about that; that is fine. We are glad that you are here today to talk to us.

Ms Fowlie: Thank you. It is also opportunistic because we recently completed a research project with the National Drug and Alcohol Research Centre and the ACT was one of the four venues across Australia and the Netherlands to look at ecstasy and related drug users. So it is actually a good chance to talk about some of the preliminary findings of that and how they relate to the ACT. We would very much support and reiterate the position that it is not just crystal methamphetamine that we are talking about. We are talking about amphetamine-type substances within the community and also the huge rates of poly drug use. Of the over 300 young people that we spoke to, poly drug use was the norm across the board. I think that is an integral issue.

But what I would like to talk about is the lack of drug education for 18 to 25-year-olds. As we know and as has been said, drug-related risk and harm are a common causal pathway for health and social outcomes such as youth suicide, dislocation and homelessness. Usually, the formal drug education in the ACT occurs within the school system. What tends to happen in there is that the drug education focuses on alcohol, tobacco and cannabis and it is often before young people have begun some type of illicit drug use. The type of education that they're getting in that system is appropriate for the age and experience that they are at, but what happens is that we know that 19 is approximately the age when illicit drug use is initiated, and there is no drug education happening for that group.

Through our conversations with young people we found that the way that they were sourcing their drug information was through their friends, through their family, through the media and through any type of personal research that they might do. That is a bit of a challenge in terms of public policy about how we might be able to guide what some of those health messages might be, because ironically there is no drug education going on for that age group, but that is the age group that tends to begin to use drugs and alcohol, and also where mental health issues start to emerge as well. So we really have an excellent opportunity for early intervention and prevention, and also, I guess, to empower young people with appropriate information for them to make decisions about their own health and wellbeing.

In the ACT there are approximately 29,000 students in tertiary institutions, and that is quite a large percentage of the population. With them being in those institutions, it might be quite a good opportunity to make use of that group to provide information about drugs and alcohol. I think it is important to note that the reduction in funding for student associations will significantly impact on the capacity of the universities to deliver that information and it will therefore possibly fall down on the ACT government and community services to step up and fill that gap, and currently there aren't the resources to be able to do that. There are, however, really good examples of how that has worked in the past. An example would be some of the work that sexual health and family planning has done looking at chlamydia and the high rates of that within that age group.

Another thing that I would like to highlight is the importance of the youth sector within all of this. The youth sector delivers quite a bit of drug education in schools and also through youth services delivers drug education, but that is only for a minority of young people in the community. Finally, I would just like to say that the misinformation and myths amongst the young people that we spoke to were really quite high and of concern for us. There were things like people saying that ecstasy is a drug that is safe, that a standard drink of alcohol can be consumed at a rate of one per hour all night, and that one in three people are allergic to cocaine. Those are some examples of the types of misinformation that are going on. This was a really effective project that managed to go in and talk to young people. But I guess the critical thing is that the harm minimisation messages, firstly, need to be harm minimisation messages and, secondly, need to be relevant and meaningful to them. They need to be messages that aren't just "don't mix drugs", but they need to have an explanation behind them. They really responded to that. So things like: don't mix drugs; for example, don't mix heroin and alcohol because they're both depressants, and then you go through and explain what happens, and suddenly you've empowered them with the information then to make an informed choice. I think that it is really important that interventions are targeted, specific and realistic to their circumstances.

THE CHAIR: Thank you. That certainly has been very useful from both organisations. We do appreciate it. There is no need to feel concerned, but we do look forward to receiving your submission as well. That will certainly be useful to us in deliberating on the final report.

MS PORTER: I have a quick question.

THE CHAIR: Yes, that's fine. We are running over time and the next witness is aware of that.

MS PORTER: You talked about skill shortages. Obviously, we are aware of that. You also talked about the training of staff. I presume you meant—you may have said so and I missed it—in the community sector and in the public sector as well. Should there be provided in some way training programs for the community sector in how to respond to the different behaviours and also how to recognise the signs of different drug use? Is that needed across the sector and is it needed across the public sector too, such as in housing, which you particularly focused on? Would you suggest that such training is necessary or lacking?

Mr Reynders: I guess there are two training issues. The first is that, yes, there is a wide variety of, I guess, frontline workers, albeit in the public sector or in the community sector, who quite often will face clients or people turning up on their doorstep who are in crisis or, indeed, in a psychotic episode or highly aggressive or under the effects of a number of drugs. Our understanding is that quite often they are afraid, they don't feel that they have been trained, they don't feel that they have the skills to cope with this situation, and that it is something that has been reported is becoming more common. It is not just one type of organisation. It is not just drug and alcohol organisations, which often aren't the first point of contact for people. It is things like youth organisations, homelessness organisations, mental health organisations, and even on occasion GPs. I am sure a similar story occurs in the public sector. So I certainly do think there is the potential for, particularly dealing with people in that crisis state, training very broadly delivered to a wide range of workers.

I guess the second training issue is developing the capacity of the drug and alcohol sector itself to ensure that it has the knowledge and the skills to provide treatment, counselling and rehabilitation services, particularly with what is a very diverse group. And also the increasing presentation of dual diagnosis which we are seeing in both the mental health and the drug and alcohol sectors, and the organisations we talk to generally say that they don't necessarily have the skills to deal with that group.

Ms Cresswell: Can I add to that?

MS PORTER: Yes.

Ms Cresswell: The ACT had a group convene the ACT community sector task force, which looked at the sector, its wages and conditions, and certainly in there are recommendations about training within the sector. There is no question that the community sector is the poor relation when it comes to training. We know that the community sector deals often with people who can be quite aggressive without any support available, and the services are telling us it is getting much harder. The needs are far more complex. They are struggling to deal with them and they are struggling to have a staff member off being trained because they can't leave the place unstaffed or they can't leave the place with one staff member.

So what we need to do is to have a comprehensive training strategy that is not simply about crystal methamphetamine. It needs to be about drug and alcohol issues, but all the areas that intersect; the issues that Llewellyn was talking about concerning co-morbidity where two conditions present at the same time and what the impact is on homelessness services, what it is on the services providing free food. So we actually need to develop a fairly comprehensive training strategy for the services that simply don't have the money to provide the kind of training that is needed. Those recommendations are in the community sector task force report.

MS PORTER: Thank you. I have a quick question about education for you. You made fairly clear what we need to educate about. I have asked a number of people about this. It is really the tool by which you deliver that. The message is fairly clear, but how do you get it out?

Ms Fowlie: I think the important thing is that if we were to look at, for example, 18 to 25-year-olds, they are not a homogenous group. All they have in common is that they are between 18 and 25. So there would need to be specific strategies for different subcultures and different groups within those. There might be a subculture where, say, injecting drug use is common. There might be another subculture where ecstasy and alcohol are common and they're into dance music. There might be another group that is coming through. There are lots of opportunities that exist through things like O week. I would really recommend identifying existing structures and how we can support those things that are already happening and utilise the resources that we have in the community, perhaps just reinforce them with additional funding.

MRS BURKE: You mentioned O week. For *Hansard*, can you say what you mean.

Ms Fowlie: I'm sorry, that is Orientation Week for the universities.

Mr Reynders: One strategy that we understand is promising and has, as Carrie mentioned, been used in the sexual health context is peer education, which is the idea that you recruit young people who are interested in providing their peers with information, train them in information provision, and then they can go out to where young people meet, to the environments where drugs might be used, and actually get people at the point of the experimentation, as well as from a person who they perceive as far more trustworthy than a health professional or a government advertisement, as well as being able to deliver individualised and specific information that the young people are interested in receiving in a context that they can understand.

Ms Cresswell: And this is particularly true for our indigenous communities. Our indigenous communities, we know, respond to indigenous workers when it comes to these kinds of issues.

Ms Fowlie: Just one final comment on that: the types of questions that people have about drugs are also really complex. They are things like, "Does cannabis affect my fertility?" or "What happens with sniffer dogs and my rights?" It is a fairly large understanding that you need to have, so any peer education initiative needs to be well supported and people need to be adequately trained and they need to have the support of an organisation that is able to feed through that information and support to the young people or whatever peers you are looking at working with.

MRS BURKE: I will be quick as I know that we are pushed for time, as always. On page 28 of your submission—I guess this is the macro to what we have just been saying—you talk about the development of a service system that has the capacity firstly to understand, secondly to analyse and thirdly to respond to changes in the drug use environment as they occur. What is that going to look like in reality? It is good on paper, but what is it going to look like in reality? How do you perceive that actually working on the ground?

Mr Reynders: I think there are a number of elements to that. One of those elements is having the capacity for academic as well as reality-based research, which is an environment in which organisations can feed the information that they are seeing on the ground back to a coordinating body, for example, as well as the dissemination of up-to-date information and research to people who are working on the ground.

Secondly, having an understanding or a capacity for organisations to develop the way that they deliver services; so being able to see what is happening and respond individually, or actually respond at an organisational level, to changes in the drug use environment, rather than what we have seen happen in the past, which has been that the service models have been rolled out by government funding certain models and then the drug use environment has changed but the models have not because they are attached to a funding contract that specifies so many counselling sessions using something or other. Then, the government seeing what is happening and its all going up through the bureaucracy, the models being reinterpreted, changed and then rolled out some years later. I guess what I am trying to advocate is a dynamic community sector and a dynamic public sector where there is some agency within organisations to respond at an organisational level, as well as in a collaborative manner, by interacting with other organisations, rather than, I guess, essentially controlled in a top-down approach, because quite often it takes a very long time for the information to flow around to that particular way of doing things.

Ms Fowlie: Also, to follow up on that, a way to look at that is to enable workers to respond to people who present in a holistic way. So, whatever issue they are presenting with, they might have a drug and alcohol issue, but they actually might need to deal with their housing or they might want to look at a different issue first and, as workers, you need to be able to respond to the issue that the person is presenting with and would like support with.

MRS BURKE: A multistrategic approach.

Ms Fowlie: Yes.

THE CHAIR: Before we finish up, do you want to make comment on the fact that the ACT is one of the few places in Australia which have not banned ice pipes? Do you have a comment to make about that?

Mr Reynders: We do touch on that at the end of the submission. From what I have seen and the research that I have looked at, there isn't a particularly compelling case that this is going to work. That is certainly the concern that I have. I guess the theory underlying it is that there is a particular group of ice smokers and smoking ice facilitates dependence and that banning ice pipes will somehow break that nexus and reduce the smoking and therefore the dependence on ice. There are a number of things that we have mentioned there. Will banning ice pipes necessarily mean that people won't smoke ice, or will they just find another way to smoke it? You can simply heat it on aluminium foil, as you can with cocaine

MRS BURKE: As you could with marijuana. That's exactly right.

Mr Reynders: Yes. You can smoke it in a bong. There is a whole lot of other ways to smoke it without necessarily using an ice pipe. I guess the other issue raised by that is that the other method of getting that very intense high from ice is by injecting. I guess it is uncertain, but will banning ice pipes lead people to inject more, which is an even greater risk from a health perspective? Do you want to comment as well, Carrie?

Ms Fowlie: Just that the ACT has a really strong track record on support for harm

minimisation initiatives like the needle and syringe program. That has been a really successful initiative. Australia has led the world in preventing and reducing disease because of things like that. I think it is really important to support clever, effective, evidence-based harm minimisation initiatives, and for that to be the position from which we act, not to respond to things in the media. This issue has been so media heavy and people have been getting worried about it all over the place and we just need to stay focused, I think, on what we know works.

THE CHAIR: Thank you very much for appearing today and for your very extensive submission. We do appreciate that. We look forward to the one from the Youth Coalition as well. It is good to see that you've worked together. As you know, you will be receiving the proof copy of the *Hansard* in the next few days to check for accuracy. If we have further questions, we will be in touch. Thank you very much.

MEAD, MS CAROL, Executive Director, Directions ACT

THE CHAIR: I will read the card. The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings. Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

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Do you understand that?

Ms Mead: I do.

THE CHAIR: Thank you, Carol, for appearing today. We do appreciate it, and we also appreciate that Directions ACT has put in a submission—signed by your predecessor, of course, but I am sure you had input into it as well. Would you like to start by addressing the submission?

Ms Mead: Sure. Thank you for the opportunity to speak to this inquiry. Directions ACT is a major drug and alcohol agency in the ACT that offers varying services such as counselling, education, life skills, outreach, detox and withdrawal, needle and syringe and pharmacy programs, treatment support services, and information and referral. We have approximately 35 staff, so we are very large.

Over the past five years the increase in use of crystal methamphetamine or ice by existing drug users, as well as many young people taking it up for the first time, has changed the nature of our services markedly. Ice use has increased, since the supply of heroin and cocaine dropped, from 15 per cent of injecting drug users in 2000 to 85 per cent in 2006; heroin in this time frame reduced from 90 per cent of ID use to 70 per cent in 2006 and cocaine has also seen a reduction.

There are many challenging behaviours that ice brings to our service; anger, frustration, euphoria tend to be the major ones. But heavy and prolonged users, as most of our clients are, have sleep disturbances, depression, anxiety, aggressiveness and psychosis. Not all ice users become aggressive; some are more prone to violence than others and we see that throughout our service. Many families find it problematic to live with an ice user. Parents and spouses are faced with moving away from the ice user or having the user forcibly evicted from their homes. Young people in many

ways are most at risk, as they lounge surf at friends' places or at their dealer's place, often as the hidden homeless population and open to abuse, violence and assault. Our counselling department is seeing a large increase in families coming in to access continuing counselling due to a family member on ice. We are now seeing more families than we ever have before.

We recognise that those in the front line dealing with behaviours are the police. Many clients who have never encountered police before are now being charged for their aggressive and violent behaviour.

Arcadia House is our detox unit. We do a seven -day detox for 10 clients at a time. We do not attract too many ice users, as we generally would, and this is largely because heavy ice users are not usually highly motivated to deal with their addiction and a knowledge that withdrawal will be extremely demanding; in fact, it is probably the worst withdrawal that we are at the moment attending to. Unlike with cannabis, alcohol or opioids, the craving for ice is extreme and ongoing, sometimes for many months after the last hit. Depression is also an issue.

Unlike with many other illicit drugs, withdrawal from amphetamines is highly problematic and requires medical responses to assist with the process. Many ice users try to self-medicate and take cannabis to come down. This also increases the psychosis. Doctors have been prescribing other amphetamines to help with the detox, plus sedatives and antidepressants to cope with the depression. We desperately need a pharmacotherapy to help these people detox and to set them through rehabilitation. At the moment there is none.

Our staff are often put at risk. People on ice are often aggressive and we have experienced an increase in antisocial and violent behaviour in detox. Staff have undergone training to deal with this, and we are now putting in a supervision model for our counsellors and our staff at Arcadia to deal with the issues that ice has brought to our services. There is a real danger of burnout of staff when dealing with ice, and we are finding that more and more.

It is irrelevant to our clients whether or not they had a pre-existing mental health condition. It is the chicken and the egg: did they have a mental health condition prior or was it after the start of use of ice? However, the effect is the same and recently Directions ACT signed an MOU with Mental Health ACT to work more collaboratively with them, as we realise that there are more problems to ice. One thing is for certain: all of the agencies and the government need to work together to provide a Canberra-wide response to this in a methodical and strategic way.

The other thing I would like to point out is that ice has been around for about seven years. We are starting to get a feel of it only now, but we do not know what the future brings. Once we are starting to deal with ice there will be something else. We need to get things in place for the next drug that comes through.

THE CHAIR: Okay. Thank you very much for that.

MS PORTER: I am a little bit confused about some of the things that we have heard this morning in relation to what you have just said. We heard from a GP earlier who I

think said—I might be wrong; I need to go back to the *Hansard* and also look at his submission again—that he did not think it was highly addictive, that it was only certain genetic—

THE CHAIR: No, what he said was that not everybody becomes addicted to it.

MS PORTER: Yes, genetically predisposed—

THE CHAIR: Yes, not everybody became addicted; everybody's genetic makeup is different, which is—

MS PORTER: Yes. The other thing he said was that numbers of people he sees—and they may be poly drug users as well—use for a weekend, like a party, and then they recover on Sunday and they go back to work on Monday and they function quite well; they hold down their jobs and they hold down their relationships and stuff. His practice is in the city so he is seeing the numbers of people in the city area here. I just wonder about the age groups. He talked about his patients being in the 30s mark, late 20s and their 30s. Do you have any responses to any of that?

Ms Mead: Sure. Directions ACT tends to see the people who are addicted; that is our clientele. We would possibly give injecting equipment through our NSPs to the clients of his. However, they are more likely to get most of their equipment from a pharmacy. So we are dealing with a different clientele. There are weekend users, but our clientele tend to be the ones that have been really affected and are now addicted to the drug. Ice is addictive, but there are definitely people who can take ice at the weekend and through the week function normally. We would not tend to see those clients unless we were giving them injecting equipment or we were dealing with some of the family issues and they were seeking counselling to come off ice and possibly detox. But, yes, our client group is a bit different from that GP's. As to ages, we have got people injecting ice from 16 and possibly before. So the ages that we are dealing with are not the 30-year-olds; they are teenagers and up.

MS PORTER: You talked about the fact that many of these families of people who are ice users come back continually for more and more counselling. Apart from the counselling, are there some other ways that you have found that you can help these families deal with the behaviour of the person they are living with and build resilience?

Ms Mead: We have five counsellors who are kept pretty busy most of the time, so counselling is a big part of what we do. Those counsellors have drug and alcohol certificates, so they are dealing with not just the work out of the family but dealing with how to cope with those behaviours, and they are quite well trained in that. We also refer into community organisations and other organisations for support, and we are just about to form a support group for parents and families of people with drug and alcohol issues, due to the fact that our services have been inundated by that.

THE CHAIR: A number of witnesses, both today and last week when we had another hearing, have commented on the issue of poly drug use. Do you wish to comment on that and your experiences at Directions ACT?

Ms Mead: Yes. Several years ago there was a heroin drought and with the heroin drought the ice became more and more prevalent. It was very interesting that the heroin users, which is a downer, actually started taking ice, which is an upper, and they have not reverted. So most people who have gone for ice instead of heroin have kept on that, which is really quite interesting to note. Our experience is that there is a lot of poly drug use. With ice they tend to take cannabis to bring them down, so that they can function, but they may also be doing alcohol and they also may be doing other drugs. Poly drug use is very common in the ACT.

THE CHAIR: There was a comment from somebody from the youth coalition just before you—you would have been here when the comment was made—about the impact of taking heroin and alcohol.

Ms Mead: Two downers.

THE CHAIR: Two depressants, two downers, so you should be aware of that, so that you are making informed choices when you do it. I take on board the comments about cannabis use and that contributing to the psychosis as well. We have heard quite a lot that a lot of people are drinking alcohol as well as taking ice. What is the impact of that combination?

Ms Mead: I guess everyone reacts to alcohol slightly differently and everyone reacts to ice slightly differently, so it is very hard for me to say what actually happens. If they come in we might see them getting more injecting equipment, through the NSP perhaps in Civic. They might be more aggressive. With heroin injecting, we used to encourage them to come and nod off, go to sleep, have a nap, in our NSP lounge area. We cannot do that with ice because they tend to be very aggressive with each other, so we are moving them on faster than we would have normally moved them on. I am not sure that I can really answer that question fully, though.

THE CHAIR: That is okay; it was just a curiosity on my part in terms of what the implications were. Do you want to comment on the amount of information that is out there at the moment on the impact of amphetamines and methamphetamines and ways to get that information out to those who choose to use?

Ms Mead: Yes, sure. We use an ice booklet, which is very useful and very succinct and which I can make available to you if you like.

THE CHAIR: That would be great. We would really appreciate that.

MS PORTER: Yes, that would be fantastic.

Ms Mead: I am not sure who it is done by—I think it could be ADP—but I will get that for you. We use that booklet particularly for ice users and for family members who are dealing with ice type use. Our staff are well trained and understand what is in that booklet to help people think about their options and the behaviour that they are exhibiting. We have a website. We go and do information into schools and colleges. We do information into shopping centres. Through other community groups we do promotion activities, and we always have those sorts of resources at those things. So I do not think there is a resource shortage, and there are some good ones available.

THE CHAIR: Okay. That is certainly interesting because that has been information that we sought from others.

MS PORTER: You say you are encouraging people to move through quickly. Does that mean you have less opportunity to intervene, steer them in a treatment direction or something like that or—

Ms Mead: We do as much as we can with people who are on ice when they are getting their equipment. There are always things around for them to read or look at—booklets or whatever. We do try and do that intervention stuff. But people on ice are not often very interested in that—they just want to go and get their hit—and it is easier to manage their behaviour to just move them on. If they are not interested in getting the information they are not going to get the information.

MS PORTER: No. So it does make it difficult.

Ms Mead: It does. You can get some people at a place where they are much more accepting of that information, that help and that intervention and perhaps getting into detox; then other days you know that it is not going to go through. You just help them with what they need to get and out they go.

THE CHAIR: Thank you very much for that. I think we might leave it there.

Ms Mead: Sure.

THE CHAIR: We do appreciate you making the time and also for, as I said earlier, the extensive submission. It is very useful.

Ms Mead: Could I comment on education just very briefly?

THE CHAIR: Yes, please.

Ms Mead: We have been thinking about our education model lately and we believe that we need to build resilience in young people in upper primary or lower high school to help them deal with some life issues and so that perhaps we can stop them experimenting with illicit drugs. That resilience stuff and building those skills is really important, we believe, to kids. Often by the time we get into high school they are quite resistant; certainly talking to a bunch of 16-year-olds with all their peers around is a problem. They often do not listen because the peers are far more important and what they think about how you are listening is much more important.

I wanted to broach the fact that it is not something that people have thought about but, if we do not get them young enough and build resistance and their skills to go against the peer pressure and feel okay about themselves, they are going to go and use illicit drugs. So we are really looking at that model at the moment, and I think it is a worthwhile thing to look at.

THE CHAIR: That is certainly very interesting to hear and we would like it if you could keep the committee appraised of your progress with that; that would be much

appreciated.

Ms Mead: Sure.

THE CHAIR: You will receive the transcript in the next week. If you can just check against that for accuracy that would be appreciated. Thank you very much for coming along today.

Ms Mead: Thank you for your time.

The committee adjourned at 11.19 am.

Evidence was then taken in camera, a portion of which was subsequently authorised for publication.

WATSON, MS MARION

THE CHAIR: The committee has authorised the recording, broadcasting and rebroadcasting of these proceedings in accordance with the rules contained in the resolution agreed by the Assembly on 7 March 2002 concerning the broadcasting of Assembly and committee proceedings.

Before the committee commences taking evidence, let me place on record that all witnesses are protected by parliamentary privilege with respect to submissions made to the committee in evidence given before it. Parliamentary privilege means special rights and immunities attach to parliament, its members and others, necessary to the discharge of functions of the Assembly without obstruction and without fear of prosecution.

While the committee prefers to hear all evidence in public, if the committee accedes to such a request—which we have done for you today, Ms Watson—the committee will take evidence in camera and record that evidence. Should the committee take evidence in this manner, I remind the committee and those present that it is within the power of the committee at a later date to publish or present all or part of that evidence to the Assembly. I should add that any decision regarding publication of in camera evidence or confidential submissions will not be taken by the committee without prior reference to the person whose evidence the committee may consider publishing. Do you understand that?

Ms Watson: Yes.

THE CHAIR: Can you state the capacity in which you appear today.

Ms Watson: I appear as a community member.

THE CHAIR: We appreciate you making your time available today. Would you like to make a statement? We can then ask a few brief questions.

Ms Watson: To make it as brief as possible, I think that we are going quite literally arseways around in looking at this problem. I heard recently that the government once again has chucked $150 million at the police, as they invariably do.

MS PORTER: The federal government?

Ms Watson: Yes, the federal government—absolutely. From my perspective, that is largely because John Howard really does not want to have anything to do with drugs. He does not want to hear about drugs; he does not want to know about drugs. His advisory committee is chaired by somebody who is no longer a member of the Salvation Army, despite the fact that he still wears his uniform. In fact, he was disowned by the Salvation Army because he believes that needle and syringe exchange programs are genocide, effectively.

That is a very old-fashioned way of looking at them, and in fact was the way that I think Mayor Giuliani used to look at them. That was his excuse for not making needle and syringe exchange programs available in New York, where they had a saturation

rate of HIV infection. We now have a saturation rate of hepatitis C infection in the ACT. Saturation rate effectively means over 60 per cent—it does not mean 100 per cent—of all injectors are hepatitis C infected. It does mean that, where we thought we were "winning" the war against HIV and against transmissible blood-borne diseases, we are not. It is even worse when it comes to the use of things like ice, which is fundamentally meant to be smoked but is not—it is being injected.

This is not for the record, but simply to give you some idea of my credentials these days—Mary knows what I used to do in the old days, which was work in the drug and alcohol sector. I have tried ice twice, and on both occasions it has made it very clear to me that it does not like me. I am not very fond of amphetamine-like compounds anyway, but it made me ill and gave me a really violent headache on both occasions. I simply decided it did not like me, and I was not particularly keen on it anyway. Believe it or not, drug users generally have a drug of choice; they do not just take whatever is available.

Unfortunately, because there has been a monumental marijuana drought over the last three or four months, those same avenues that have been used to deliver marijuana are now being used to deliver ice. That always happens. Whenever we create a gap in one illicit drug market, we create an opening for yet another one. The police are not ever going to solve it, because it is not a police problem. It is a policing problem, because inevitably they get called in to manage the unmanageable people who have psyched out on ice because they have been injecting it.

As I say, the majority of people that I spoke to that smoke ice seem to have never had much in the way of physical problems—and certainly not psychological problems. But the people who are injecting it tend to inject more frequently than—it is meant to be a long acting amphetamine. As a rule, amphetamine has a seven to 14-hour half-life in your bloodstream, which means that its effectiveness after, say, 3½ hours is depleted monumentally. It is still detectable in your urine 14 hours after you have used it, but in the meantime it is reducing and reducing—the quantity in your body and in your bloodstream—basically to undetectability after about a day.

No matter how you look at it, it is one of those drugs that is used in penal institutions—and is easier to use—because of the speed at which it is excreted from the system. If you manage to buy any pot in one of the institutions or get hold of any pot in one of the institutions, the odds are that it is going to stay in your system for seven days. Generally it does. If you are a chronic dope smoker, it will stay in your system even longer than that after one more joint, because it is stored in the fatty tissues.

I have drivelled on for longer than I meant to. What I am saying is that at the moment we do not have a plan; if we did have a plan it would be police up here and rehab down here, and in the middle we would be ignoring the people who do not want to have to deal with anybody like police or rehab. That means that we are not touching 90 per cent of the people who are using ice. The only way that we can detect them is when they go vertically up a wall.

One of my friends down the road came down and was hearing things through the wall. He had been injecting ice. That had been mixed with heroin, I understand. He was not

expecting to be using ice; he was expecting to be given heroin and was getting ice and heroin mixed instead. He ended up really very paranoid. I answered the door one day, and three minutes later he had his hands around my throat. It was really very frightening. My son, who is 28 and occasionally lives with me, did not know what to do—whether to run out and get a knife or whether to manage it.

In effect, with psych affected people, when they are in a psychotic state, if you can bring down the emotional temperature of the environment—and women are usually very good at that: men tend to wind it up; and, even if they do not do it intentionally, the man that they are confronted with feels threatened by the presence of another man. Women tend to be able to talk men down and away from the violence and erratic behaviour that the psychosis goes with—that the ice psychosis goes with anyway.

THE CHAIR: You said that we are missing a very large percentage of those people who are using this drug and that they are only being picked them up when things go pear-shaped, basically. There have been comments made, sometimes disputed, that people who are taking crystal methamphetamine and sometimes methamphetamines generally do not see that they have a problem, that the use is just recreational and they are able to control it.

Ms Watson: They don't see themselves as junkies; heroin users are junkies.

THE CHAIR: That's right, "I am not a junkie; I just use it on weekends when I am out partying."

Ms Watson: Can I bring this up to you?

THE CHAIR: The secretary will get it from you. How do we get that information out to those people to ensure that they are making informed choices so that we can operate harm minimisation policies?

Ms Watson: We did have a system for doing that but, right at the moment, the national organisation, the Australian Injecting and Illicit Drug Users League, has been gagged by the federal government. They used to put out a magazine called *Junk Mail.* It used to be put out every three months, sometimes every six months, depending on how things were going. The federal government, the federal department of health, used to look at it, go through it, and pick out things that they thought were perhaps a little bit dodgy and maybe should not be included in it. These days, it is taking two years before they are getting the draft copies of their magazines back.

This woman died of a heart attack from ice. She was not an ice user but had injected it. She used to be a heroin user in the old days but got over that. If she did anything, she would smoke a little bit of pot but not very much. She didn't use ice. Her partner is the one that was going to wear the tie for the funeral. I have got that stuck on the wall at home. She was a really beautiful woman. Every time I forget what ice is like, I look at that and it reminds me of just how damaging it can be.

She may well have been an anomaly, not a common case, but that is exactly what she looked like before she died. She hadn't been using anything on a regular basis. She didn't look like a junkie. She didn't look like an ice user. Often you can tell people

have been using regularly, because they spend a lot of time in front of a mirror picking non-existent blackheads. I do that, too, but I am not an ice user and I have got blackheads. That is exactly what she looked like before she died.

Her partner rang the person that scored for her to say, "What am I going to do?" That is the big question for users and their partners—what are we going to do?—because they do not think the ambulance people know how to manage it either, whereas you can ring the ambulance people to get them to come and do a narcane without the involvement of the police. They have narcane and are happy to use narcane. I was talking to my doctor about that this morning. One of the reasons that I wanted to go and see him before I came here was to ask him whether minor tranquilisers would be a reasonable thing to equip ambulance drivers with for people who are unmanageable on ice.

MRS BURKE: They do use a drug already.

Ms Watson: They do?

THE CHAIR: No, it is a sedative.

MRS BURKE: Isn't that what you are referring to?

Ms Watson: It is an anti anxiety agent.

THE CHAIR: Yes. You are talking about where there is the risk of a heart attack or something like that.

Ms Watson: No, I am actually talking about people who were in a quite distressed, anxious and sometimes quite aggressive state. It renders people unmanageable and it scares the life out of the ambulance drivers.

THE CHAIR: We did hear today from the ambulance service that they do use midazolam.

Ms Watson: Is that a benzodiazepam of some sort, a minor tranquiliser?

THE CHAIR: I am not sure. I would have to have a look. But the comment was made by the representatives of the ambulance service that they use it in a much greater amount than the dose recommended by the Department of Health and Ageing.

Ms Watson: The only thing I would say in response to that is that recommended doses are optimum doses for people of optimum size, weight and shape. You are talking about people who are in an extreme state of distress, a high rate of fear, a high heart rate. Effectively, you could see them as being almost status epilepticus. The same kind of tension is building up in them and will continue to build up in them as would be if somebody was an epileptic and they were undergoing an epileptic seizure. They are prepared to use valium or some kind of benzodiazepam at that stage. I am sorry, do you want to ask me more questions? I know that I have dragged you very late.

THE CHAIR: That is all right. We will have to wind up.

MS PORTER: I have one question as to the method of getting the message out. You said that *Junk Mail* was a good way of getting the message out. Do you have any other way that we can get the message out?

Ms Watson: In the old days the needle and syringe exchange program used to be, not a one for one exchange program, but an opportunity to exchange drug using resources, the things that people needed, like clean needles and syringes, for the opportunity to educate. It is a very sensible way of looking at exchange. A lot of the stuff that you don't hear is the gossip on the street, and NSP programs are a good way of getting the gossip. The best way to do that is through peer needle and syringe programs.

I know our peer organisation has been less than effective and has been problematic over the last few years, particularly in terms of financial management. But, when you think about it, it is a bit like putting a bag of cookies down and saying, "Don't touch them." The reason that, when I was working at AddInc, the management of the ACT, I believe, was successful was that their financial management was taken out of their hands. It was managed by our financial manager. I am sorry to say so, but not only do we need to recruit new and intelligent people, but we need even people in the hepatitis C councils to acknowledge that they are or have been drug users and the majority of people in the hep C councils did get their hepatitis C from needle sharing. It may have been 20 years ago, but the stigma sticks.

THE CHAIR: I will have to stop you there. I am sorry that we have to wind up.

Ms Watson: I was late, which was my fault, but even in 20 minutes I would not have been able to tell you what I know.

THE CHAIR: I appreciate that.

Ms Watson: Can I just say that the one thing that really seems to be important is that there be, and we have usually been very good at this, a way of working where there is a team of people, of representatives, and the people that develop the information strategies from the team implement them through the organisations that they come from. The whole drugs issue is too big an issue. The coppers have created a marihuana drought and ice has filled that hole. They literally cut off the ACT.

THE CHAIR: Sorry, I am going to stop you. Before you go, we agreed to its being an in camera hearing. My understanding of that is that it was because of issues that have gone on beforehand and the publicity that there has been around you. We would like to use the information that you have provided to us today. How do you feel about us doing that?

Ms Watson: Using the information is fine.

MS PORTER: Just the information without attributing it to you.

Ms Watson: That's fine. I haven't even given you half of what I have written down in point form.

THE CHAIR: We would be happy for you to leave with us the things you have written down in point form.

Ms Watson: You would not be able to read it. Sorry, I do not have a computer and my handwriting is atrocious.

THE CHAIR: Thank you very much for your appearance today.

Ms Watson: If there is anything else that you think that I can do, and if at some stage somebody wants to sit down and pick my brains or something like that, I would be really happy to do that. As I say, I live in the middle of all of that stuff and the majority of the people that are accommodated in housing out my way are actually psych affected people in the first place. But I am perfectly happy to be made use of. You don’t lose interest in that stuff just because you cease to be paid to work with it.

THE CHAIR: Absolutely. Thank you.

The committee adjourned at 12.45 pm.