

**Homelessness Sector ICE Forum Tuesday 14 April 2015**

**Notes: Ice**

**Presentation by: Crios O’Mahoney – Penington Institute**

**Background:** The Australian Bureau of Statistics identified that Australians spent $7B on certain types of drugs in 2010, namely cannabis, amphetamines, MDMA, heroin and cocaine. Australia is a high drug using country and 15 people die a day from alcohol related illnesses. Amphetamine Type Stimulants are the 2nd most used illicit drug in the world (UNODC). Australia has one of the highest levels of Methamphetamine use in the world. Methamphetamine comes in different forms: liquid (ox blood); speed (powder); base (paste); ice (crystal). The purity of methamphetamine has increased dramatically in recent years.

New psychoactive Substances (NPS) are turning up in Europe at 1-2 drugs a week. The European Monitoring Centre for Drugs AND Drug Addiction (EMCDDA) report the number of these types of drugs now available has increased from 40 to over 450 in the past few years.

Police in QLD have reported several deaths from synthetic drugs, the chemical structure of which can vary dramatically even among those sold as the same product. This is challenging for AOD workers as it is hard to give harm reduction advice when there is no information on these new drug.

**Usage:** Australia is not facing a new crisis in drug use – just changes in the use. Methamphetamine purity levels have caused increased harm. The National Drug Strategy Household Survey reports no real change in the number of methamphetamine users between 2010 – 2013, however there have been some important changes in use. Namely the number of people using the powder form of methamphetamine (speed) has halved while use of crystal methamphetamine (ice) has doubled. Worryingly, the number of people using ice daily or weekly has also increased.

**Price:** The price of ice has changed little in that time: the price for a gram of ice in 2013 was between $400 and $1600/gram across Australia. The Australian market is profitable for those importing the drug with prices in China the price for a gram is $80USD whereas on average in Australia a gram of ice will cost approx. $500. Ice is often sold in points (one tenth of a gram) with reported costs varying from $40 to $150.

**Production:** Some ice is imported from overseas. There are different methods of making ice: using pseudoephedrine, farm chemicals, solvents and other chemicals. Ice is a very dirty drug to make. For every kilo of ice made there is over 6 kilos of toxic waste are generated.

The Australian Crime Commission report that 70% of those clandestine laboratories found are in residential areas, with many working on a small scale, making 50 grams per production cycle. The Victorian Police submission in to the Parliamentary enquiry on reported an increase in the numbers of children working found at searches of labs. Some labs are very small, producing methamphetamine in a process known as the “one pot” or “shake and bake” method.

**Why do people use ice:** People have been using amphetamines since 1887 for a variety of reasons. Amphetamine-based medicines were used to treat a range of medical conditions including asthma, depression and fatigue. From early on these medicines as well as illicit amphetamines were used for a number of reasons including: drug effect, performance (ie work harder), coping strategy, get through the day, weight loss, self medication, wish to feel good/not bad. Many of the reasons remain the same although the purity of ice and the lack of quality control make the use of the drug much riskier than those early medicines.

**How is ice used:** Ice can be snorted, swallowed, smoked, shafted, injected. All forms of use have their own issues. These include the risk of burns and dental problems if smoking and blood-borne viruses if injecting.

**How ice works:** The chemicals in the brain allow us to think, act, feel. One of these chemicals, serotonin – is the ‘world is OK’ chemical. Ice has a strong effect on this chemical. Another chemical it works on is dopamine. Dopamine helps us to understand things, to move and, most importantly, gives us a reward. Dopamine encourages us to do things again and again – life affirming such as eating, sex. Every time we feel a pleasurable feeling, some dopamine has been released, latched on to receptors and then is switched off after pleasure – this feeling encourages us to repeat the action in order to achieve the feelings of pleasure again. The strong effect of ice on this system can cause feelings of euphoria and confidence although there can be very negative effects too. Repeated use of the drug can reinforce the use-reward system and lead to physical and psychological problems including dependence.

Ice use can cause increased levels of Noradrenaline (fight or flight response) - too much in the brain can make us jumpy, anxious and suspicious.

Short and long term effects of ice use:

• increased energy

• euphoria

• wakefulness

• confidence

• poor decision making

• anxiety

• irritability

• aggression

• dependence

• inability to feel pleasure

• depression

• paranoia

• psychosis. There can be a number of contributing factors to methamphetamine induced psychosis. Ice causes variations in the levels of chemical which help you understand and move through the world. Polydrug use and sleep deprivation increase the risk of an ice user experiencing a psychotic episode.

Polydrug use can increase the potential for negative effects of ice. Drugs like alcohol and cannabis can increase the risks of psychosis.

There is a need for more evidence of the effects of methamphetamine use on an unborn child. Reports of complications include premature birth, low birth weight and issues relating to high blood pressure.

**Dependence:** The purity of ice and the fact that it can be smoked or injected increase the risk of dependence. The journey from using first time to dependency can be much shorter than with other drugs such as alcohol. Over time impact of ice use reduces– dopamine levels are depleted each time you use. People use more and more to get the same effect – tolerance, and this and this may lead to dependence.

**Other problems associated with ice use:** money issues, family violence, relatives becoming permanent carers (ie of the children of drug users), risks to children (using and being around those using the drug), sexual health, sexual assault, increased reliance on support services, involvement with the legal system, intergenerational drug use.

**Testing:** Can test from a couple of hours to 48 hours but there are so many variables and impact reliability and lead to false positives and negatives.

**Reducing / stopping ice use:** Many people stop using ice. This can be a long and incremental process and is best done with the support of a professional service such as an alcohol and other drug team or doctor. If people can stop or control their ice use, the dopamine system should start repairing itself but this takes a long time. Some people stop using ice and can still seem depressed several months later. A good diet and exercise help the process of repair however you need to be realistic when speaking to clients about diet. Some food is better than no food in assisting the process of repair.

There is currently no formal pharmacotherapy for ice user. There are trials of medicines in Australia and overseas which are promising. Other medications are used to support clients based on consultation with a medical professional. These include anti-depressants and other medications can assist with symptoms.

**Overdose:**

Risks include stroke and heart attack. Symptoms of overdose can include: behavioural disturbance, overheating, seizures, headaches and chest pain.

If you suspect someone is overdosing on ice, call 000. Try to be reassuring, encourage slow breathing, try to cool them if overheating and reduce stimulation around the person.

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**Tips for supporting people who are Ice users**

The following tips are drawn from the material presented by Crios O’Mahoney (Penington Institute) and by Peter Matthews (Odyssey) and from questions submitted to the Panel:

* Carol Addicoat and Nathan Hall - Homelessness Youth Dual Diagnosis Initiative, a joint Housing/Mental Health Initiative providing support to young people in the homelessness service system with mental health and/or substance use issues (based at Hope Street and WRAP). Carol and Nathan provide primary, secondary and tertiary consults, group supervision, one on one and group training.
* Nicole Thomson and Alex Gianopoulos – Substance Treatment and Recovery Program (STAR) – a partnership between VincentCare and the Salvation Army, covering the Inner North and North West. (Alex previously worked for the Homelessness Drug Dependency Trial that lost funding through the AOD reform. STAR now outposts to Ozanam Community Centre and VincentCare Glenroy Hub one day a week. 9 – 12 clients can drop in for immediate screening and booking of assessments at the same time next week. The aim of STAR is to continue working in places where clients already feel comfortable. STAR can also undertake brief interventions with clients.

**Discussing problematic drug use**

* Try to help people identify the point between which pleasure stops and problematic issues start.
* Provide written materials because for people who may not take in verbal information. When giving health information to the community, aim to produce written material at the level of a 12 year old.
* Coming down from significant ICE use is very difficult. First someone will crash and then may experience behavioural issues. It is worth warning people about this and about the fact that it might take some time for a sense of pleasure in life to return.
* Try to encourage people to sleep and to take breaks from ICE use. Encourage eating and (non alcoholic) drinking during break times. Work with someone on the problems around them and assist them to work on those in order to reduce the stress they may be experiencing.
* Is the brief intervention focus going to be effective in assisting a poly use client? Yes, it is useful to talk with clients about why they are using, what is good about it, moving on to what is not good about it. Provide information that person can think about. Use brief intervention for engagement and check in. Someone may not want to change behaviour then and they may still take away messages. A lot of people would like to reduce their use but don’t have access to good information about strategies. Work on some harm minimisation during brief intervention. Ie provide information about risk of Hep C when sharing a pipe with another person who might have a cut lip. The most important thing is to be non judgemental and to provide information at level of comprehension. Much research is available on the effectiveness of brief intervention.
* One thing that often accompanies ICE use is sexual risk taking behaviours. Staff can talk with clients about strategies to help keep them safe. Discuss needle syringe programs where clients can access lots of free information, condoms etc.

**Escalating situations**

* People using ice can be heightened but may still be coherent. If someone is coherent, it might be possible to calm them down. If they are not coherent, you may need to consider options such as calling the police.   
    
  If violence is escalating, ask the person whether there is anything you can do to support them. Find out whether the person is angry for a reason such as, worker hasn’t been available for the third time. Acknowledge the cause of their anger and ask ‘how can I help you. I do want to help you’.   
    
  Approach someone who is heightened with your hands out and open. Present as calm. Try not to have a quiver in your voice. Know your limits - if you don’t believe you can handle a situation, it is much better to get someone more experienced.
* You can name inappropriate behaviour. If someone is yelling and screaming, say “I would like to help you but I can’t help you when you are screaming”. You might have to say something three times before being heard. Conduct an appropriate risk assessment. Learn to identify the difference between violence and agitation.
* If police have been called to a situation, let the police know ahead of time what they will be confronted with. Some of the police respond incredibly well and people are comforted by their presence. Give police tips on what is likely to be a trigger for a particular client. Don’t tell people to ‘calm down’. Any help that we can give the police will assist them to respond better. Identify whether there are any other support people who have a good relationship with the client.   
    
  It is really important to let client know that you have called the police to help de-escalate the situation. Let client know that your major concern is to keep them safe – not to do any harm. Work with police – providing information. Many clients are using illicit substances and so may be fearful of the police – re-assure them that police are called for safety.

**Signs of ice use**

* What signs do I look for that a client is using ice, when on a home visit? Assess the situation – what can you see and hear. You might witness: alertness, rapid speech, sweating, shaking, jaw clenching, teeth grinding, someone may be unusually talkative.
* Signs of someone who has been on a binge and is coming down: Agitation, irritability, scabs forming on face and arms from lack of sleep, poor nutrition, self inflicted wounds, extreme loss of weight in a short space of time, pupils pinned. Different people are affected differently. A client who has ADHD might be relaxed on ice.
* Safety issues – workers have a duty of care if there are children involved. Make an assessment of safety for client, worker and other members of household. Some of the symptoms are also symptoms of mania so client may have mental health issues – or mental health issues combined with drugs. Some side effects of mental health drugs are debilitating. Some people use ice to counter act the impact of these drugs.

**Referral to AOD**

* Work through the AOD screening tool with clients – do it in as relaxed environment as possible. Try to make questioning as relaxed and informal as possible. Change the wording of the tool so you are as comfortable as possible. You can pull the tool up on an ipad or phone <http://www.health.vic.gov.au/aod/reform/screening-assessment-tool.htm>.
* Many clients don’t know about reform – it is terrific if workers are on the front foot in explaining reform to clients and letting them know their options.

**Detox and rehab services**

* If a client is wishes to access a rehab service, check that the client has chosen this goal. De tox will need to occur first and then someone can access rehab, which has a focus on abstinence. The longer someone can access support the better post detox. If someone has chosen rehab themself, they are more likely to have a positive experience. Rehab provides a great break from situational stresses and the environment in which they have used drugs. Having an after care plan is so important outlining what happens after rehab.
* Waiting lists for residential rehab are very long. In the meantime non residential services can provide counselling and care planning. Rehabs are abstinence based but will also consider pharmacotherapy.
* De tox generally takes three days to come off ice before detox. Generally someone can only access three days at a detox facility but each detox service has it’s own policies. There are some dedicated ICE beds in detox. One proposal was to have visiting nurses manage the three days of crash on an outreach basis prior to detox.
* Every de tox centre works differently. Different strategies and philosophies work for different people so the variety is useful. People can access de tox multiple times. Some people use de tox to reduce use.
* De tox services are not catchment based.
* If you are having trouble getting someone into any of the AOD de tox services, working with client on risk management plan. Help them identify their relapse signs/triggers and develop a plan for client and de tox facility about managing triggers and relapse. It is good for clients to learn what sets them off. Clients identify for themselves what they might be experiencing pre relapse. A support letter from a GP might help get someone into detox.

**Recovery**

* Cognitive behavioural therapy has been promoted as a recovery tool. The US has a matrix model, incorporating a range of therapies, which is looking promising.
* Examples of wellness recovery and action plan are available on the internet
* What to do with a client who is presenting to a service angry and violent. Don’t kick them out or they will just turn up to another service. Be honest about behaviour. Suggest the client phones in for assistance. You can ask them to leave but find ways to continue to offer a service – put boundaries in place and say that behaviour is unacceptable but offer alternative such as phone support. Call the next day to check in.
* Reassure clients that it is normal not to feel motivated for some time after they stop using ICE.
* Normalise with people that change takes an average of 7 attempts. Take a strengths based approach - every period of not using is a period of reduced harm.
* Yoda website for young people. Counselling modules young people can use themselves.



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**Notes: Alcohol & Drug Sector Reforms**

**Presentation by: Peter Matthews, Catchment Manager, North West Melbourne**

**North & West Metro AOD Service, Odyssey House**

**Introduction:**

In 2014 the Department of Health commenced a ‘recommissioning’ of the AOD funded sector. The rationale was drawn from a 2011 Report that stated that Victoria has a fragmented AOD sector with limited outcomes for clients.

The recommissioning aims to reduce the number of AOD providers and to collapse 30+ service types into six services types. The process began with the Adult AOD community based services. Phase 2, due to have been implemented in June this year, was to have been the redevelopment of residential and youth AOD services. Phase 2 is now under question.

**What has changed?**

As of 1 September 2014 services are now funded according to the six activity based models and funding is allocated according to very complex formulas. Allocation of services is based on an assessment against set ‘Tiers’. Non resi withdrawal was also condensed through the reform. The focus seems to be on supporting GPs who are managing withdrawal. Historically adult services in AOD supported 18 + but adult services are now mandated to work with 16+. Adult services would encourage young people to continue to access the youth system as there are more services available.

The activities now funded are:

* Intake and Assessment
* Counselling (Standard 4 sessions or Complex 12 sessions)
* Care and recovery coordination - a small amount of funding allocated for clients rated as complex, is a completely new role to AOD. Funds are allocated for 15 hours of support with people pre, during and post rehab, withdrawal units. There is some capacity for extensions and variations to counselling and care and recovery coordination.
* Non resi withdrawal
* Area based Planning – the Department has handed over the local planning function to agencies by allocating a very small planning budget

The Reform has been chaos for the AOD sector. Two months notice was given from awarding of tender to commencements of service. The Sector experienced a period of enormous instability prior to the release of tenders. Short timelines have meant that the new Intake and Assessment services have experienced difficulty setting up IT systems and with recruitment and other establishment.

It is too early to tell whether the reform will work. People who are homeless may be one of the ‘victim’s’ of the reform because they can’t present directly to services any longer. Services are so busy trying to make system work for clients whilst meeting their new targets.

**Accessing the AOD system**

The new system centralises access through intake and assessment services, to the other service types. Intake and assessment requires an initial screening (generally over the phone) then an appointment for a longer assessment.

The assessment identifies whether someone is in one of five Tiers. Service allocation is based on the Tier.

Tiers 1 and 2 – if someone has been abstinent for six months they won’t rate on a tool.

If a person reaches substance dependence, they can access an AOD assessment.

The Tier most likely to be of greatest relevance for the homelessness service system is Tier 5: substance dependence with three additional complexities (i.e. homelessness, unemployment, mental health).

The services that Intake can refer to are:

* Counselling (Standard 4 sessions or Complex 12 sessions)
* Care and recovery coordination – small amount of funding allocation – only for clients rated as complex
* Non resi withdrawal

**Locations and contacting Intake and Assessment**

The North West has three sites:

* Hub – 77 Droop St, Footscray
* Co located with Lantara Uniting Car in Broadmeadows, 413 – 419 Camp Rd
* Craigieburne – 59 Craigieburn Rd,
* Contact the call centre: 1800 700 514 for all AOD in the North and West
* Contact Direct line: 1800 888 236 for after hours

Some drop in services have been established but generally they can only provide a screening interview and not an immediate assessment.

**Process for referring into the AOD system:**

* Contact the intake and assessment service in the local catchment
* Complete an AOD initial screening – 20 mins over the phone (this captures demographics and scores on a AOD, MH and alcohol use score)
* Assessment scheduled
* Clinical review of assessment
* Treatment planning and referral

If worker rings with a client who is unlikely to be able to manage on a 20 minute phone call, let the AOD Intake Worker know so that they can try to book in a joint screening and assessment appointment.

80% of those people who have been screened turn up for assessment. The system can no longer necessarily offer the same person to undertake both the screening and assessment.

All the tools used by the AOD services can be found at: <http://www.health.vic.gov.au/aod/reform/screening-assessment-tool.htm>. Homelessness support workers are encouraged to use the screening tools with clients. If worker can print off tool and work through it with client and send it to Intake, then the client can bypass the screening process. Odyssey can pick up the assessment from there.

**Resources**

**Attached resources**

* See attached resources collected by Carol Addicoat, Homelessness Dual Diagnosis Initiative Worker (HYDDI):
  + Responding to challenging situations related to the use of psycholstimulants
  + Alcohol and Drug Treatment Services, Fact Sheet: Screening for complexity, July 2014
  + Referring to Services. Mental Health Triage: TIPS
  + ReGen training brochure
* See attached brochure about the Star program

**Links to useful resources, collected by Carol, HYDDI**

### Free downloadable texts on various subjects relating to Dual Diagnosis Issues. Including managing difficult behaviours with substance use.

### [Free dual diagnosis texts - Downloadable sites](http://www.google.com.au/url?sa=t&rct=j&q=&esrc=s&source=web&cd=8&ved=0CEIQFjAH&url=http%3A%2F%2Fwww.nmml.org.au%2Fcontent%2FDocument%2FDual%2520Diagnosis%2520Text%2520Resources.doc&ei=7j8sVfewKuaNmwXfsYHgDw&usg=AFQjCNEYJyGHCoa-Y8wtXAHwWJTdzM_s7Q&bvm=bv.90491159,d.dGY) [www.nmml.org.au/.../Dual%20Diagnosis%20Text%20Resources.doc](http://www.nmml.org.au/.../Dual%20Diagnosis%20Text%20Resources.doc)

### YoDAA is Victoria's Youth Drug and Alcohol Advice service.

### Ph: 9415 8881. Free 24hr line: 1800 458 685

### Website for young people. Counselling modules young people can use themselves.

### [www.yodaa.org.au](http://www.yodaa.org.au)

### Youth Support and Advocacy Service

### http://www.ysas.org.au

* **Orygen Youth Health**

[**http://oyh.org.au**](http://oyh.org.au)

* **Directline: Confidential Alcohol and Drug Counselling Line.**

**24 hours/7 days a week. Ph: 1800888236**

[www.**directline**.org.au](http://www.directline.org.au)

* **Hepatitis Victoria : Phone: 1800 703 003**

[**http://www.hepcvic.org.au**](http://www.hepcvic.org.au)

* **Odyssey House**

[**www.odyssey.org.au**](http://www.odyssey.org.au)

* **ReGen**

**www.regen.org.au**

ReGen offers

* training for clinicians, admin staff and clients
* Pamphlet on the Tiers
* Resource list – great printable resource

**Resources for parents and loved ones**

Funding has been allocated to SHARC and Family Drug Help – latter is running forums all through Victoria. Funded through reform to specifically work with families of people who use substances.

**Training**

Odyssey runs an accredited course on working with people with clients with amphetamine type stimulants.

**Other resources**

* Google ‘Ice powerpoint’.
* Join VADAA – they have newsletters, training opportunities. A lot of training for service users.
* Wellness recovery and action plan templates can be found on the internet
* Feel free to contact:
  + **Nicole Thompson**  
    Clinical Co-ordinator Team Leader

Star- Substance Treatment & Recovery Program

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