LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Melbourne — 30 September 2013

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The CHAIR — I welcome the three of you to the joint parliamentary Law Reform, Drugs and Crime Prevention Committee, which is conducting an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. Welcome to our first public hearing today. We do have media presence, as you will see, with us; it is a public hearing. We have the full complement of the committee. Before we commence, I will have to read you the rules of engagement in relation to you presenting to this inquiry.

Welcome, as I said, to this public hearing of the Law Reform, Drugs and Crime Prevention Committee. All evidence at this hearing is protected by parliamentary privilege, as provided by the Constitution Act 1975, and further subject to the provisions of the Parliamentary Committees Act 2003 and the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in the other Australian states and territories. Any comments you make outside the hearing will not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Assoc. Prof WALKER — Yes, we have.

The CHAIR — You are all nodding your heads. We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate.

We thank you again. We are running a bit behind time; I apologise for that. I will take responsibility for that as the chair; however, we are moving into lunch, so there is some flexibility. The important thing is to allow committee members to ask questions of you, obviously, in response to your presentation, and we will try to give you without interruption at least some time to present to us, and then allow us some time to ask questions of you. Are you happy with that format?

Assoc. Prof WALKER — Yes.

The CHAIR — Thank you. Over to you.

Overheads shown.

Assoc. Prof WALKER — Thank you, Chair. On behalf of Ambulance Victoria, thank you for the opportunity to present to you today on this very important issue. Just as a brief background, I am the general manager, regional services, responsible for statewide emergency operations. Allan is an intensive care paramedic and team manager operating in the metropolitan environment and has significant background working in the drug related space, and Dr Karen Smith is an epidemiologist and manager of research and evaluation. She has significant background in a lot of the data elements related to the provision of information around amphetamine and drug use within our organisation.

If you are happy, I will move straight into the presentation. We will just go through, probably, our areas of expertise. I will let Karen introduce this section.

Assoc. Prof SMITH — I saw Belinda Lloyd in the corridor, so I am probably just repeating everything she has said, to a certain degree.

The CHAIR — We tried to stop her going through all the steps; no need to go through them all again!

Assoc. Prof SMITH — I am sure she has highlighted the collaboration we have with Turning Point Alcohol and Drug Centre. That has been running for quite a number of years now. Now that we in Ambulance Victoria have moved to an electronic patient care record, our VACIS system, we provide them with a monthly extract of all of our cases where there is any mention of alcohol or drug involvement. Then they do quite a bit of data cleaning and processing and report quarterly to the Department of Health as part of a surveillance activity, and they also produce an annual report which is publicly available.

In terms of crystal methamphetamine, that was isolated as a type of presentation in the data from 2002 onwards. I am not sure whether Belinda talked about this as well, but also they have received funding from the federal Department of Health for the last 12 months to expand that data collection to include mental health presentations, with a particular focus on suicidal ideology. We actually provide them with all of our mental health presentations and the drug and alcohol presentations, so there is a lot of opportunity there in the future to look at the crossover between those two groups of patients and the synergies. It is still only 12 months old, so that data is preliminary at this stage. That is probably all I need to say about that.

Assoc. Prof WALKER — We looked at the use of crystal methamphetamine in Victoria. Certainly our organisation is experiencing an increase in the number of calls regarding the use of crystal methamphetamine, and that has risen from 69.16 cases per 1 million population in 2010–11 to 142 in 2011–12, with a mean increase in attendance per day from 0.77 to 1.62. We attend approximately 650 to 700 cases per annum for crystal methamphetamine. I think it is an important issue but fades in significance around the numbers of cases of alcohol we attend. Alcohol has a much bigger impact on our organisation with regard to volume; however, as we talk about throughout this presentation, some of the behavioural and violence issues that can be associated with crystal methamphetamine do have an impact on the organisation and our paramedics particularly. The demographic is increasing. The social impact is, in our view, broadening, and we see a disproportionate amount of violence anecdotally, violent behaviour, police co attendance and time it takes to manage cases where crystal methamphetamine is involved.

This slide provides an example of the use of crystal methamphetamine compared to other drugs. You can see there it has had a 109.9 per cent increase since 2010–11, but the numbers remain relatively low in comparison to areas such as alcohol, which I mentioned earlier.

That slide just gives us an example of where we have seen a decrease in use of some other drugs over time. If we look there, there is obviously an increase in some drugs. As per the previous slide, we have seen a decrease in the use of some of these drugs compared to previous years. The prevalence of methamphetamine use remains a problem, predominantly around the central business district of Melbourne, but we are seeing it spread outside the CBD into inner suburbs and into rural communities. Based on our data, the top three ranking local government areas are Melbourne and the local government areas of Port Phillip and Greater Dandenong. Melbourne has retained its ranking as the LGA with the highest proportion of cases, whilst Greater Geelong and Latrobe had the highest number of related attendances in 2011–12.

The CHAIR — Can I just ask before I forget — and I apologise to the committee — what is the relevance between the police statistics in relation to attending an incident where obviously the drug has had some impact as against your attendance to that? I understand alcohol; alcohol is a legal drug. So to compare apples and apples, I am talking about illicit drugs.

Assoc. Prof WALKER — Yes, of course.

The CHAIR — In relation to police and your own statistics, do you actually compare notes in relation to your attendances and theirs?

Assoc. Prof WALKER — I might ask Karen to comment on that.

The CHAIR — Or you can keep it aside till the question period. I am happy to use that as my question to you later, if you like.

Assoc. Prof SMITH — We do not compare notes per se, but with the Turning Point data collection, one of the variables they record in their database is whether there was police attendance as documented on the ambulance patient care records. I know Turning Point do interrogate police data as a separate set of data. We would go to a high proportion of cases for health related matters that would not involve police attendance.

The CHAIR — That is the point I am getting at. The impact of the drug on the community might not be reflected in your statistics, because there have not been calls for response by ambulance or clinicians.

Assoc. Prof SMITH — Our data would be an underestimation of the total impact, but the vast majority that are being attended by police I would hazard a guess would probably have an ambulance attendance as well, if not the other way around.

The CHAIR — Thank you.

Assoc. Prof WALKER — This is a bit of a busy slide. It is obviously easier to see in the slide in front of you, but this just provides the prevalence of methamphetamine use in local government areas within the metropolitan area and where it has gone up and down over the period. This provides the same information with relation to its use in rural local government areas, which I mentioned earlier. We are seeing the highest predominant numbers within Greater Geelong and Latrobe, but we are talking about, in relative terms, small numbers compared to, say, the CBD — but it is an increasing issue for us.

This provides a breakdown of the age and gender of attendances. As you can see there, it provides the attendances that we attend per day, their median age and their gender, as well as police attendance. That does give you an overview of where we have attended and where police have attended as well. On those we transport to hospital, there is a reasonably high — close to 80 per cent — transport rate for patients we attend who have used crystal methamphetamine. We do not collect ethnicity data, but anecdotally the feedback from our staff who do is that there is a wide base of ethnic origins. There is nothing that stands out there from our perspective. The greatest increase in ambulance attendance was noted amongst people aged 15 to 29 years of age.

From a consequence point of view, I might hand over to Allan Eade, who can talk to this from personal experience. Allan is actually a practising intensive care paramedic in the CBD and has extensive background in drug related matters with regard to education and providing support in our organisation.

Mr EADE — No worries. Thank you. The reason for your inquiry is because of the socialised and sometimes social media presence of crystal methamphetamine. It is highly addictive. It gives a very intense high, and it is one of the reasons people go back to using it over and over again. It has different uses in different environments. The recreational use is prevalent at parties, festivals, nightclubs and the like. That is the largest cohort of people we see, from an ambulance point of view, whom we are attending for a methamphetamine related problem.

There is also another group — people who are using crystal methamphetamine because they have become dependent on or addicted to that substance. These are the daily or very frequent users. These are the people who are more likely to be socially isolated. Their dependence and their frequent use of ice have now impacted upon their capacity to earn money. Because they cannot work, they may actually be involved in offending, so therefore it is going to affect their socioeconomic status. We attend them primarily for methamphetamine related problems but, with the addition of those socioeconomic challenges, also for their general health decline. There is a combination of reasons that we might attend that second group.

There is an increase in ice related harms, which is noted around the mental health space, particularly around psychosis. But methamphetamine is also primarily associated with bleeding in the brain or haemorrhagic stroke and can cause cardiac like chest pains. You can actually have a heart attack at the age of 20 if you use methamphetamine.

The challenges for paramedics was one of the questions. The drug itself creates a change in behaviour. That change in behaviour is different for every single individual every time they use it. It is never predictable. It can cause agitation, hostility, unpredictability, paranoia or aggression, and ultimately it can result in some violence. I want to specify that agitation is not aggression and it is not violence; agitation is the inability to sit still or achieve a state of calm. So this can be somebody who is unable to sit still and looks quite scary, but if you ask them to do something they will do it. They will stay on the chair. They might not be able to stay still on the chair, but they will stay there. Not everybody who uses methamphetamine does become violent — that is a misnomer — but they are unpredictable and they could become violent, and that is where the scariness comes from.

The drug changes perception. We have a reduction in inhibition in the people using these drugs. In the setting of someone who is now paranoid, as a consequence they become quite perturbed by sudden changes in acceleration and deceleration in the ambulance, by noises and by any tactile stimulation or any stimulation at all really, so they become quite unpredictable. The drugs increase heart rate, they increase blood pressure and they increase body temperature. The combined effects of that in the agitated person result in someone who is incredibly physically strong and behaving in an unpredictable and irrational manner. From a paramedic point of view, they are scary. The effort required to subdue these people often results in injuries to paramedics, to the police and, disappointingly, to the patient.

There are some paramedic related injury data specifically isolated for drug related presentations. Overwhelmingly we believe this to be an underrepresentation of the actual problem in that this is just what is actually reported and documented by the paramedics. We believe that unfortunately this sort of behaviour that they are experiencing and tolerating is becoming normalised, and paramedics are now finding that it is normal to be physically confronted during their daily practice. So we think that is an underrepresentation of the actual problem.

Assoc. Prof WALKER — Looking at the link between methamphetamine and comorbid mental illness, we know acute presentation of methamphetamine can often have changes in behaviour and this can appear as a mental health issue. It is very difficult in a prehospital setting to be able to differentiate the two, so we treat symptomatically based on what we have in front of us and with a view to transporting them to hospital where they can get a full medical assessment, which includes drug screening as well. It is well documented that the longer term use of methamphetamine can lead to mental health disease, and our paramedics observe that in practice. We note that the amphetamine related episodes of care provided by drug and alcohol services have increased by 77 per cent since 2010–11. As I said, it is difficult for us to identify whether the mental health issues have resulted in substance abuse or the substance abuse issues have resulted in mental health issues, and there are probably others who can better speak to that. It is not in our area of expertise.

With regard to polydrugs or the use of drugs simultaneously, a significant number of the substance overdoses we attend are related to alcohol. Almost all other overdoses or substance presentations involve more than one substance. Alcohol involvement was noted in 27 per cent of the crystal methamphetamine related attendances; that has decreased since 2010–11, and 47 per cent of other amphetamine related attendances involve alcohol based on the data we have from Turning Point. We also note that methamphetamine users tend to use other stimulants as well, so they may use drugs such as ecstasy, cocaine and caffeine in a stimulant sense but also use agents to try to come off the stimulants, so combining alcohol, cannabis, benzodiazepines and GHB.

These can cause some significant challenges for us in a clinical setting and also for health services, such as hospitals, because the drugs we use to treat some of these issues can make their clinical condition worse. For example, the drugs we would use to treat someone who presents with chest pain may actually worsen their condition, so it can be a clinical challenge for our attending paramedics and within the hospital environment as well.

The other risk is that those seeking to add sedating medication to their stimulant use have a risk of oversedating, which can cause a loss of consciousness and depression of their breathing, which can have a life threatening impact. Also the mix of stimulants and sedating drugs, which have different levels of life within the body, can result in them wearing off at different rates, and that can cause the person to present completely differently during their phase of treatment. That can be a challenge for the clinicians in a prehospital setting and a hospital setting as well to provide optimal care, because the drugs are having different effects at different times on their body.

If we look at the question of the effectiveness of past and current strategies, we feel that others are probably best to provide information to the committee on what is best for the evaluation of strategies and policies. But we note that the plateau of methamphetamine presentations occurred during times when there have been campaigns operating, such as the ‘Ice — It’s a dirty drug’ campaign and also the development of the Victorian amphetamine type stimulant and related drugs

strategies in the Victorian alcohol action plan. There are others who are probably best to comment; that is just a note from our perspective.

With regard to strategies to address methamphetamine abuse in Victoria, we believe they should tackle all forms of amphetamine use and not just abuse. There is a sense that there are people who are using it and probably living normal lives, so it is the whole issue of the danger of this drug. As Allan said earlier, it can be a downward spiral for some people. We feel that focusing only on methamphetamine at the expense of all other stimulants, particularly in the climate of expanding levels of new stimulants that are coming on every day, is not likely to result in broad success. People will choose other stimulants as well, so this is an ongoing issue we are going to experience as a society. There is no magic solution, and ultimately for society to shift away from using these agents will require multiple approaches.

We see we have a role as an ambulance service to lend our weight and voice to any educational prevention strategies out there. Our paramedics by default are attending and can talk to the experiences they have, so we feel there is a role for the ambulance service to play in supporting any education and prevention campaigns that may occur.

One area where we feel there should be continuing investment in is the health aspects of mass gatherings and dance parties, which are often a location where there is use of these drugs. A code of practice was developed and published in 2004. A 2012 edition has been developed but it has not yet been published, and we recommend that occurs as soon as practicable. Our view is that any advice and guidance we can give to organisers of these events to help them in their planning is important. Unfortunately drug use does occur at these events from time to time, and Victoria Police and others do an excellent job in trying to minimise that, but it can occur. Ensuring that the people who organise these events understand the strategies to put in place to prevent it is fairly important from our perspective. That completes our presentation. We are happy to take any questions.

The CHAIR — Thank you very much. I invite committee members to ask questions.

Mr SCHEFFER — Thank you very much for your presentation. We are starting to get a variation of views from the people who are coming to talk to us. I noted that in your presentation you talked about methamphetamine as being highly addictive, you talked about it causing bleeding in the brain and heart attacks and you talked about it being a cause of aggression and so forth. When you make those observations, as you have presented them to the committee, do you derive them from briefings from medical people that is evidence based? What is the basis of your making those observations?

Mr EADE — The effects of methamphetamine are reported in the medical literature, and we use those to inform our strategies. I bring to you this information based around the published medical literature, which is also used and referenced in the national guidelines for the management of methamphetamine related harm, which were published by both Turning Point and the commonwealth. Those are the documents we use to support the assertions. Beyond that we have the patients in front of us. The experience we are able to determine out of our medical records is that we are having patients who are presenting with aggression, we are having patients who are presenting with cardiac chest pain and we are having patients who are presenting with stroke — and that is haemorrhaging or bleeding in the brain. Whilst there is published literature, our unfortunate experience is that our documented medical records support that those journals are correct.

Mr SCHEFFER — It was put to us previously that while there is an association with aggression in a number of instances, there is not actually a lot of evidence about a causative relationship, as distinct from a circumstantial one, and it has been put to us that one of the reasons why this association is constantly presented — and I am not saying you are wrong; you are the expert in this field — is because those sorts of incidents are more memorable and they tend to loom larger and become a narrative of their own.

Mr EADE — I should say that not everybody who uses methamphetamine becomes violent. I think I did say that.

Mr SCHEFFER — Yes, you did, indeed.

Mr EADE — I think some of the campaigns have presented methamphetamine in a way that if you take one ingestion of it, you are going to turn into the Incredible Hulk and destroy the emergency department you are taken to. That is clearly incorrect. There is no safe method to use methamphetamine, and there is no safe amount of methamphetamine to use. Everybody reacts to it differently, depending on the day, the week, the month, when they last ate and how much sleep they have had. It affects people differently each time they use it. Nobody can adequately predict whether or not they will have a pleasant experience or a negative experience when they use it. Not everybody gets violent; they all have the potential to get that way, and a lot of it has to do with the volume or the amount of the substance you have ingested. Again, that is something that most users are unable to determine in that they might buy the same amount, but whether it is the same amount they actually receive is completely unpredictable.

Assoc. Prof WALKER — I acknowledge as well that we get called to the ones who have a health overlay — that is, if someone has abnormal behaviour, if someone has a health issue; we are seeing those. I think this was mentioned by the Chair at the beginning — we do not see those in the community who do not require medical intervention. Other groups, like the police, may, but we do not see those patients.

Mr SCHEFFER — That is great. Thank you very much.

Mr McCURDY — Allan, I have a very basic question. Can you just explain: when it is on site treatment, are 99 per cent of them then taken back to a health service? I am trying to establish the pressure on the rest of the health system. Are they literally treated on site and away they go, or does anybody go back to hospital and stay there overnight or for two days or two weeks? I am just trying to get a bit of an understanding.

Mr EADE — With methamphetamine, we have a higher transportation rate, and the numbers presented on the slide are sitting at 79 point something per cent. Let us is call it 80 per cent, if that is all right. Of the patients that we come into contact with where methamphetamine is the primary reason for us being there, we take 80 per cent of those people on to an emergency department. How long those people stay I am unable to answer, I am sorry. That will vary depending on how unwell they are, but it has a very high transport to hospital rate. The nearest equivalent, I think, is prescription medication overdoses. It is certainly much higher than direct alcohol attendance, and it is much higher than heroin.

Assoc. Prof SMITH — Good.

Mr SOUTHWICK — I am just wondering how easy it is to diagnose those who are under the influence of meth. Is it something you can see through physical or behavioural characteristics pretty easily?

Mr EADE — It is not easy, and it tends to be a diagnosis you fall back on by exclusion. You exclude overt medical causes, and then you start trying to work down the different actions. Mostly they get grouped into stimulants as a whole, rather than just crystal methamphetamine. Users report their drug use differently. Some are exceedingly honest and helpful, and they will tell you everything they believe they have had. Others will not tell you anything, and say, 'Please don't ring my mum', and that can be some of the 40 year olds. So users' reports are unreliable and it comes down to the symptoms. With stimulant related presentations, we gather them all together and manage them in the same way. Management is essentially the same for all of them. Defining whether somebody has had crystal methamphetamine is almost impossible unless they report it. They just appear to have a faster heart rate, higher blood pressure and raised body temperature amongst other things that are physical symptoms.

Mr SOUTHWICK — And what about overdosing? Are you able to overdose on crystal meth as opposed to other drugs?

Mr EADE — You can overdose on any drug. Take enough of anything and it will be bad for you. Crystal methamphetamine is the purest form of methamphetamine. There are three broad types of methamphetamine. It is the purest form, and as such it is more potent, and so with crystalline methamphetamine there is a higher risk that you will overdose, but if you take enough of any of the amphetamines or any of the stimulants, then you can become very unwell. You just get there quicker with crystal.

Mr CARROLL — Allan, I was going to ask you, just on the violence, as you said before, how much of the violence can be attributed to basically being caught out? If you are a well functioning 40 year old, you have taken crystal meth and all of a sudden an ambulance and possibly police are in attendance, and basically your drug problem is out in the open, can that be a sign that, 'Well, I have been well functioning and now I'm angry at myself, if anything, that this is out in the open', and then there is sort of a force of resistance when the ambulance arrives?

Mr EADE — People who are upset at themselves do not tend to lash out at us. I cannot say that I have seen the example that you have presented. Mostly these people are not aware of their surroundings. They are paranoid, and they have an acute change in their behaviour. They tend to then be agitated and potentially aggressive as a result of that, rather than the fact that they have just been caught using illicit substances and have potentially damaged their career or impacted on their personal wellbeing. I am not sure how else to answer that, I am sorry.

Mr CARROLL — We are learning. So it is the properties of the drug. It is not just what the drug does to the people; it is also what the people bring to the drug — their own circumstances, their life, their upbringing, their career and all of those things.

Mr EADE — If they are angry at themselves, they do not tend to take it out on others.

Assoc. Prof SMITH — As much as possible, too, with our patient care records, paramedics will document if there is a pre existing mental illness. That is hard to elicit from these patients, but if there are family or friends at the scene, we have data as well to look at whether there is already an existing mental illness as well as the drug use. The collaboration we have with Turning Point, where we are moving into more of that mental illness space, will give us better data on that as well.

The CHAIR — We have not talked much about supply, and we have not talked much about another part of the reference, which is the use of ice in the Indigenous population in particular. I guess we might be heading outside the scope of Ambulance Victoria, but would you care to comment? I always find that generation Y has been quite a premeditated lot in demographic. They know where they want to get to, and if there is a cheap source of stimulant then they use that, perhaps instead of alcohol or maybe with a slight mix. I am not sure how many of those fall into this trap of addiction and then ongoing use, because it is not a demographic that is socially disadvantaged; it is a group that parties and is looking for a quick, cheap stimulant.

We talked about, and I am trying to understand, regional towns. They are coming to us saying they have got significant problems because of the demographic, the unemployment and other things that have social problems. Then you have got the Indigenous population, which seems to be also not only using the drug but also trafficking the drug, because it is a quick rich proposition in relation to making quick money, being able to turn over these drugs quite quickly, quite profitably. I know that is a bit of a mixed bag for you, but we seem to have a number of issues associated with this reference about supply, trade, use and then the addiction and impacts of that addiction.

Assoc. Prof WALKER — From our perspective, we can see the patterns of the cases that we attend. Our data can show us clusters of use where ambulance has been in attendance. As for the supply and use by various other groups, we probably do not have that level of detailed data within our system. I do not know. I do not think we can comment on that specifically; I imagine Turning Point or Victoria Police may be in a better position to. Unless Karen and Allan have something, I do not think we have got any data, and I am not aware of any anecdote that we would probably be able to say with any authoritative sense around that.

Mr EADE — We are almost wholly a response organisation, so we deal with acute problems — sometimes in chronic illness, but delivery of problems. Addiction is something which is insidious and evolves over time. People do not ring because they have become addicted; they ring because they have had an overdose. We see the acute problem, but we are not the best organisation to answer that comment around addiction either, I am sorry.

The CHAIR — I will hold that thought for another stakeholder.

Mr McCURDY — With aggressive behaviour — I am not calling it violent behaviour — towards paramedics, has Ambulance Victoria had to take any extra steps over the last few years because of the changing culture? Do you see that associated with ice, for example, or is it a cultural change that people are more aggressive than they were in the past?

Assoc. Prof WALKER — It is an unfortunate indictment on society that the level of respect afforded to our paramedics who are out there helping has deteriorated over time. We have seen an increasing propensity to violence and aggression and verbal abuse to our paramedics over time. We have provided training to our paramedics on how to de escalate those situations and to protect themselves. That training occurs for all new staff. We have previously provided it to all our existing paramedics. Yes, it is an increasing issue in society. I know it is experienced by other ambulance services and by the health services as well. Allan is probably a bit closer to it than I am, but whilst we see it associated with some of the stimulant drugs, I think it is fair to say alcohol — acknowledging it is a legal drug — is an issue that probably has the biggest impact on violence towards paramedics. Would that be — —

Mr EADE — Absolutely correct.

Mr CARROLL — You highlighted that possibly government should be targeting the dance party scene and the success of the previous government's 'Ice — It's a dirty drug' campaign. Do you think basically the committee should be looking at best practice examples of how to influence the message in improved social media to target that under 40 cohort, 18 to 30 to 35? If you are going to target your message, you can do it at the rave party, but also through social media, radio, tram stops — —

Assoc. Prof SMITH — Yes. I would have thought it would be multifaceted. I think there are also opportunities with the paramedics for some sort of prospective intervention as well, where they might be leaving information or referrals at the scene and things like that. It could be explored further as well. On the demographic, obviously with the people they are targeting — Allan can talk to this too — I would have thought it would have to be a multifaceted approach.

Mr EADE — It needs to be contemporary for them, otherwise they are not going to see it. It needs to be honest, not necessarily a scare campaign. Be factual. You mentioned before that they are usually highly functioning. They start off their drug use gainfully employed, self funding and with a reasonable socioeconomic status. Let us use that in our method of communicating with them. They will know if we are telling them something that is just not true, so it needs to be a broad approach that covers all the aspects. Dance parties are one area where we know that we are going to have mass gatherings and we know that we are going to have a health impact. It would be really nice if we could go broader than that, but that is just one area where we know we can see some benefits.

Assoc. Prof SMITH — There have been some great programs, like the PARTY program, where they have taken high school students to see people in wheelchairs and the effects of drink driving and all sorts of things. There is a whole lot of opportunity for maybe getting the demographic before they experience the drug and showing what the impact of the drug could be.

Mr SOUTHWICK — You mentioned earlier the fact that there is the interchangeable problem in terms of the commodity that might be used — ice this time, something else the next. Would you consider that there are some unique elements to this particular drug, leading on from what Ben has just asked in terms of that coolness of the drug itself and the fact that there is a high clientele of young people in the party scene? We have also heard that a lot of people are using it for

productivity in the workforce. There are a number of elements to this that might necessarily need some specific targeting and messaging that is quite different to some of the other drugs that we have seen.

Mr EADE — Crystalline methamphetamine is not readily utilised in the workforce trying to improve functionality; it is a little bit too intense. Methamphetamine in general is less hallucinogenic than some of the other stimulants that are on the market. The enormous number of stimulant related substances and the fact that the number of them that are available for people to use increases almost daily is the fundamental core of the problem. If you were to wave a magic wand and crystal methamphetamine went away, then we would be sitting here next week talking about another stimulant that had become super popular. I think that is the reality of where we are at the moment. Can we do something specifically for crystalline methamphetamine? It is injected and smoked, whereas the other drugs tend not to be, so there is a point of difference. Yes, it is more potent than the two other methamphetamine groups, but the jury is out on these and newer stimulants as to how you measure potency. You can have a messaging campaign for parts of it, but you will probably need a broader one as well.

The CHAIR — Thank you, Mr Walker, Mr Eade and Dr Smith, very much for your time this morning.

Witnesses withdrew.