LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Melbourne — 3 February 2014

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The Hon. M. Gould, Director, Youth Projects.

The CHAIR — Welcome, ladies and gentlemen. The reason you are here is to provide evidence to the inquiry which we are presently running, looking at supply and use of methamphetamines here in Victoria, particularly ice. We appreciate your time this afternoon. Given that there are a fair number of you, I ask that you keep your opening statements fairly brief, which will then allow the committee to ask questions relevant to their interests.

Just before you make your opening statements I will read you the conditions under which you are providing evidence to this committee this afternoon. I welcome you to the public hearing of the Law Reform, Drugs and Crime Prevention Committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and is further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. However, it is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Ms RAYMOND — We have.

The CHAIR — It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence that they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence and will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. Before you start, thank you very much for your written submission, which the committee has read and no doubt will want to raise questions about as well.

The Hon GOULD — Chair, on behalf of Youth Projects I would just like to thank you and the committee for the opportunity to present to the hearing today. Our delegation will be led by Melanie Raymond, who is the chair, but she is also the acting CEO of our organisation at the moment. I, as deputy chair, am just here because I am familiar with the surroundings, so I thought I would come with them, but I will hand it over to Melanie, and once again thank you for giving us the opportunity to explain to you what we do in the CBD and in the north-western regions of Melbourne.

The CHAIR — Thank you.

Ms RAYMOND — Thank you very much for the opportunity, and I understand that our submission has been received and that you have had an opportunity to look at it. What is particularly important in relation to Youth Projects' evidence is its extremely front-line nature at the very grassroots of methamphetamine use in our community and the eyes and ears on the ground provided by an organisation that works in street outreach and mobile outreach throughout Melbourne and 50 suburbs in the north-west of Melbourne. We are not a research body but we are the people at the very front line and we have some views and perspectives and experiences that I am sure are of value to this committee. In particular, Youth Projects sought to make a submission based on the very alarming upsurge in methamphetamine use that we had witnessed in our service and the fact that it was among a much younger clientele. We have found that patterns of drug use and injecting drug use tended to be in an older age bracket but were very alarmed by the reports of much younger people starting on harder drugs.

We also wanted to talk about responses that are important both for the community, for consumers, for people affected, but also a reminder for the people who are working in this space that methamphetamine use changes the practice domains and the way we operate because it is different to cannabis, heroin and other forms that we had been more used to dealing with. Therefore the responses need to take into account workforce planning and issues around how the sector in alcohol and other drugs and mental health are able to respond and assist with recommendations that you might want to make, and our experience of how this is changing and how confronting and challenging this is to people who are absolutely at the ground level.

Bearing in mind that Youth Projects is the only street outreach and the longest standing needle syringe program in the state, I think that we would very much bring the expertise that will be needed to deliver an effective response. We are also wanting to bring to you at this stage some evidence that is anecdotal, that has also some research and evidence base to it but we think needs addressing and needs to be picked up in your work, and that would be around the association of motor vehicles and methamphetamine use.

We are also a registered and accredited Drink Drug Drive trainer and have been for a very long time. Therefore we regularly see people who have been within that system. We also work with young teens who may be at school, disengaged from school, out of school, or the long-term unemployed. We are picking up on perspectives through the relationship we have with clients, to hear things a little bit differently, with a bit more honesty, that perhaps are not being talked about, and I think these issues change the way we might want to respond about the messaging around youth culture and what we perceive as a gap between what the sector or the government or policy-makers understand as appropriate and how that is received by the very young audience that is, of its nature, very different from what we have seen before.

If I may refer to some different and new content to your submission, I would like to talk about methamphetamine use and driving and the idea that motor vehicles have an association with it that is both practical and desirable for methamphetamine users. In particular I think that the locational issues around areas with limited public transport provide particular impetus to base drug use around a motor vehicle, around people who are still in the parental home and need to be out of the gaze of parents in order to partake of drug-taking activity and a culture that normalises drug driving, where risk perception is dramatically different to what we think makes sense and what is logical.

We are seeing a high prevalence of drug driving amongst illicit drug users. We think that there is a perception that you might more likely be detected if you are using alcohol and driving but there is a much lower risk if you are using drugs. We think for some in emerging communities and different religious and ethnic groups there is a prohibition on alcohol where they perceive there is no such prohibition on illicit drug use. So that is a better way to get high. There is also the idea that you do not need ID and you do not need to be 18 to acquire methamphetamine and there are multiple sources of supply for this age group.

Research suggests that 16.9 per cent of the general public of Australia have driven a car while affected by drugs. That is very concerning. The anecdotal evidence from our various programs — our concern around methamphetamine in combination possibly with steroids and a cultural issue and recreational issue in highly disadvantaged communities with a locational disadvantage — is that these could be fuelling these very worrying patterns of methamphetamine use.

We worry that Broadmeadows and Glenroy, which has been our home area for 30 years, have become ground zero for methamphetamine use in our community, and our statistics are showing that in terms of its use via our outreach teams and our counselling services and through our mobile services. We feel that clients are becoming resistant to the risk of this sort of use. We are concerned about the progression into injecting drug use and other things, and the issue of polydrug use, where other forms of prescription drugs or cannabis are being used in order to combat the long-term problem with sleep. With being amped up, they will then use other forms of drugs to combat that — or in combination.

We are concerned that this is seen as positive behaviour and not dangerous behaviour — for example, performance enhancing behaviour — that they are better drivers because of their methamphetamine use. Therefore I think there is a gap between the perception of the problem and the sorts of responses that need to be very youth based. We need to understand party drugs and the rave culture. We need to understand the resistant nature to health promotion messaging and the extent to which multiple supports need to be put in place. It is challenging to work within such an ill-informed and illogical response to the rest of us, but what makes sense for this client group. We have raised that issue on the basis that there is not a lot of evidence around that, but we have seen some, and it is also emerging within our teams.

I would also like to talk about some new reports from our street outreach teams in the Melbourne CBD — the Foot Patrol, who work day and night, every day and night of the year with drug users. They are also talking about the fact that reports of it becoming far more prevalent among African youth, particularly in the North Melbourne area They are also talking about the increased consumption of tobacco and alcohol when people are using ice. They are talking about the use of heroin, barbiturates and other depressants as a means of coming down after ice use, and the very high risk of overdose, cardiac arrest and arrhythmia that they fear they will start to see again on streets as their mobile overdose response. They feel it is also popular amongst steroid users, particularly for those who are using it for aesthetic reasons rather than sports-based enhancing reasons.

We work in HIV/AIDS and sexual health obviously. The links are clear around needle syringe programs and harm reduction — the lapses in judgement, the failure to adhere to the safe sex message, promiscuity, the lowering of inhibitions and feelings of invincibility that increase risk-taking behaviour that can have very long-term consequences around assault and around blood-borne viruses and so on.

We are also hearing from our teams that people cannot recall offences and are doing things they would not normally do when they are under the influence. In our service there is an assumption around violent behaviour that causes us to act in ways that may or may not be necessary, but we will take that precautionary principle. We are worried about violent or deranged behaviour or the perception of it. That not only puts our staff at risk but puts the user at risk of interventions that might involve tasers or shootings.

We think there has been a shift in the preferred route of administration from smoking to injecting following the removal of the sale of ice pipes. We back the evidence that you heard just before, in that we know these can be sourced at many markets, tobacconists and sex shops anyway under the guise of glass tobacco pipes. An internet search will show you how to modify a household light bulb. Young people talk about the ease with which they are able to source it through friends and older siblings compared to alcohol. There are other points within our submission that refer to the problems of responding to methamphetamine that make it different. Would you like to now ask Richard about some of the differences between dealing with clients with cannabis, heroin and meth.

Mr MICHELL — Obviously the differences are — and you heard from the pharmacy guild earlier — around the fact that there are no proven forms of treatment or pharmacotherapy relating to methamphetamine. While there are a number of behavioural-type interventions — behavioural group programs have proven effective — quite often I think what we are seeing is that the withdrawal period for someone on methamphetamine starts about two or three days in and goes for a bit longer. We are not sure that withdrawal services are geared to deal with the longer withdrawal or even if the withdrawal should be done in a different way.

We are seeing a mixed cohort of individuals. Usually your drug of choice looks at your background as well. What we see is not one type of person coming through. We see carpenters, plumbers and people who work in all different trades coming through, and they are using it for different reasons. Obviously with the other substances we had before, you would not necessarily take lots of heroin and go to work, because it would be fairly obvious. If you took benzos it would be fairly obvious. With methamphetamine, particularly in those trades or industries where people need to perform, I think it is seen as a supplement to their workforce.

The other thing we are seeing through our interventions at Youth Projects is a different cohort of people from different backgrounds who do not usually use alcohol, so that they are choosing methamphetamine as their drug of choice. One of the other things that we see is that people are in the early stage, often in pre-contemplative stages, of accessible treatment, so they are not really seeing any problems.

The other thing that we see is that people are accessing treatment earlier. If we looked at heroin, traditionally over a period — somewhere between 12 months and 2 years — people might start to access it for the first time because of associated issues. What we are seeing with methamphetamine

is that people are contacting our services either because of justice or criminality — based on whether it is driving or assaults et cetera — so they are coming in a lot of earlier. Quite often when they come in, they are coming in as fairly complex as well — usually with a range of medical issues, mental health issues et cetera. I guess the question then is: how do we work with people with methamphetamine? Some of the things might be some ideas around diversion programs that are a bit longer than, say, police diversions — which is normally two contacts often within a period of a week, which does not give you any longitudinal contact with that person — information, education and support for parents and family members in particular.

The CHAIR — Are you happy if we now ask some questions?

Ms RAYMOND — Yes.

The CHAIR — As you were speaking, Richard, I was thinking, yes, you are probably telling us what we have heard before at another hearings, but what we are going to do about it?

Mr MICHELL — What are we going to do about it?

The CHAIR — I am just giving you some guidance. We have talked about early intervention, particularly in schools. We have heard evidence that suggests much of the old programs have not worked. In fact the moment you get a drug education bus into a school, there is a greater awareness of drugs and there is a greater uptake of drugs, so it is almost self-defeating. While visually the Grim Reaper campaigns appear to have worked well, the data suggests that they did not. I guess we are trying to work out the best messaging we can do in relation to early intervention and trying to restrict the supply. My question really is: is price really the determinant on the transition to methamphetamine only, or is it a mix of price, availability, general acceptance et cetera?

Mr MICHELL — I think all of those. I think it is about availability and I think the fact that probably because markets and our dollar are traditionally high, it increases the possibility of overseas markets looking out for more bang for their dollar in getting something like methamphetamine in, which is fairly small in volume. In so far as the use through smoking goes, that is obviously something which is an easier way and is seen as more socially acceptable than probably injecting, but it is something we need to think longitudinally about because if it does turn to injecting in big ways, then there will be a whole lot of other more complex issues that will come with that as well.

I think it is about education and some of the education may also be about having very clear defining information around methamphetamine as compared to the other sets of amphetamines, because if they are all put on the same level of choice between MDMA, speed et cetera, people will go, 'Well, what's the one I get the most bang out of?'. If you have legislation and laws which probably reflect more that methamphetamine will not be tolerated, that may sway some people to a lower risk.

If we are talking about answers, that is a big question you are asking, around treatment, but I think it is about the more deterrents that we have but at the same time supporting truthful, honest information. Quite often things like the Grim Reaper ads work for something like HIV, but whether it will work for a substance like methamphetamine is still unknown. I think the treatment programs — and there has been some work around looking at withdrawal for people on methamphetamine and looking at the longitudinal issues that are associated with that — I think the new systems will be set up more about care and recovery planning, which is about follow-up of people on methamphetamine.

Within our justice system I think, once again, that may be through new systems of people who are charged with methamphetamine-related stuff, who are part of accessing services that are mandatory, maybe for a few sessions to make sure they have that contact, and support for family members and better information. Colin actually has some information, and there are some treatment types in America they are looking at as far as pharmacotherapy goes. It is quite limited at the moment, in early research, but hopefully research in Australia will be put into dealing with that situation as well.

Ms HUNT — Just to butt in, we recently did a forum, and we continue to talk to people, in the north-western area and we found that most of the people we spoke to would like to see education in the schools — no. 1 — and it is actually about saying, 'Yes, that is what's going to happen. There is a consequence of this particular drug' and as harsh as it might be I think personally, from a public health perspective, you really do have to hit the actual consequence home. What we are seeing is that in our field, particularly the first experience of use of methamphetamine, to the point where your life is completely broken down and your family around it, is between 3 and 12 months. There is not a very long time when people go from good to bad. The difference with cocaine, for example, is you have a bit on the weekend and then five years later you are still doing it and it is fine. Kids are smart. They know. They will go and find out what it is going to do and they will get on the internet and they will find out what the consequences are.

Also, with females we are finding they are using it for weight loss, so they are looking particularly to find a way — for whatever reason weight loss is popular in this particular cohort — so they know what the good consequences are, but they really need to know what the bad ones are too and they can then weigh up their own benefits or risks. Definitely within schools is the place to start. I do not mean just a one-off like, 'Okay kids, here's what we have to say'. I think it needs to be a constant part of the curriculum, to tell the kids truthfully where they are at that level and what the consequences are. Absolutely.

Mr SOUTHWICK — Just on that point, at what age should we be doing education? And also, where does it become the difference between education and awareness raising, as our Chair said earlier?

Ms HUNT — Good point. From a public health promotion perspective, I think you would start not at a young age, but particularly where it is appropriate. I have children myself and I will tell them about alcohol —-because again that is cultural — but it is giving them what they need at particular ages, definitely high school but even before then. It is one of those tough ones. Like you said, it is that fine line between, 'We are giving you the information so you know how great it will be and the highs you are going to get', but with methamphetamine, I think that when you compare it with, say, alcohol, for example, you could say, 'There is a social acceptability of alcohol, but there is no social acceptability with this particular drug. In fact it will destroy your life'.

So that truthful message depends on the educators as to how well or what they can actually take in at that age. But there is a consequence to this, and it is definitely worth hitting home.

Mr MICHELL — I think one of the things to pick up, too, around drug education in schools is that there are very clear plans around drug education and there have been certain changes in the last 12 months around the ages of when harm minimisation should be brought into the younger cohort. The other issue is about the quality of drug education in schools. It seems to vary between different schools because it depends on how they take up their drug education plan and who is actually running the drug education plan. So maybe there is more room for drug and alcohol agencies and drug and alcohol education agencies to be involved in the implementation of drug education in schools. If you go to different parts of the state, I am not sure it would be the same.

Ms HUNT — I do education programs mostly for year 8 and year 9. We do them in some colleges such as Xavier, so the very high-end schools, and a lot of them have absolutely no idea about the consequences of not just the drug itself but the social consequences. So when you tell them, 'Look, have you ever been broken into? Has your house ever been broken into?'. 'Yes'. 'Have your mum and dad got house insurance?'. 'Yep'. 'Great. Stolen laptops, bikes, all that sort of stuff that get stolen around the home?'. And they are like, 'Yes, that has happened to us, we have had our house broken into'. 'Well, why do you think that is?'. Here you go, 'These people need money to fuel their drug habit et cetera', and they then say, 'Okay. Right.' So it starts to all gel that it is not just the consequence to themselves but to the other people in society too. They start to realise that not only it is your own health but everyone around you.

Ms RAYMOND — We would say it is a segmented view, because some in this group seem completely immune to any sort of messaging. Some will receive that message quite well, but I think in terms of the party drug culture, the rave culture, the performance-enhancing culture, they

are not listening so it needs to be broken down much more specifically. It might be that locationally based that would make sense in those areas where there is a locational disadvantage, problems with transport, low school attainment and disengagement from school, where they might have a different profile from regions where they do not have those problems in quite such a pronounced effect.

We do not work in terms of the supply side, we are dealing with the demand side in terms of people who are buying and using, and we would like to have levers that actually make that less attractive, where there is something else to do. There are people with traumatic backgrounds who have no other sense of fun in their lives. They have had only trauma since they were small, so it is not a big step when you do not know and have never learned how to have fun, how to enjoy yourselves properly, where you have parents who are drug users, where you have intergenerational unemployment, where you have such entrenched pockets of disadvantage in public housing estates that this, we feel, fuels a culture of, 'Well, what does it matter? Let's do it. This will do it for me', and we think we cannot overlook some of the overlap between low socioeconomic status and the prevalence of illicit drug use.

So recognising the broader picture and the capacity to integrate supports that provide for keeping kids in school and giving them the motivation to do well at school, to finish school, that they might find a job and how to find a job, vocational preparation and training, the idea that you can change that trajectory and your family's background does not have to be your own, we think that is, as I put in the submission, our integrated responses around education, training, health, wellbeing and mental health that are seeing results in relation to other things. It has to be part of the response because it is proven successful. Youth Projects is the leading provider of getting youth at risk into employment in the country by the government's own rating system. So we are the number one providers of employment services for at-risk youth in Australia, there in the national hot spots.

I think we are at least partially entitled to say, therefore, that we see results through integrated responses that draw together all of the things that are at play in someone's life rather than focusing on one area when there are so many multiple and complex needs at work behind drug use. So in terms of responses, there has to be more capacity to deliver intensive support in communities where there is not much else and to recognise and be honest about it and be able to open avenues of opportunity for a better future within those communities.

The CHAIR — Thank you, Melanie. I invite other committee members to ask questions.

Mr CARROLL — Thank you, Chair. My question is to Melanie and to anyone else who might like to comment. Melanie, you just spoke about the strength of Youth Projects with the integrated services approach. I wanted to ask: do you receive referrals through the court integrated services program.

Ms RAYMOND — Yes, we do.

Mr CARROLL — That operates in the Sunshine, Latrobe Valley and Melbourne magistrates courts, so you are in some northern suburbs and disadvantaged areas of Broadmeadows, Glenroy, Coolaroo and so on.

Ms RAYMOND — Yes.

Mr CARROLL — If the court integrated services program was running from the Broadmeadows Magistrates Court, how big a difference would that make for your work and helping the accused get into the suite of services that are available?

Ms RAYMOND — I think if we can shorten and make a more place-based local response with on-site service provision, and that has been dealt with locally, that could only be enhanced for us. We push right out into Whittlesea and Craigieburn where these issues are very pronounced in young age groups.

Mr MICHELL — Sunbury too, yes. Those programs and all the other programs associated with justice and forensic services have been great because they have been about pushing people

into treatment but with very clear plans and follow-up around their treatment progression. I think the Broadmeadows court and the Melbourne Magistrates Court we have referrals from, and obviously things like the drug courts would be great for expanding services in having, I guess, appropriate service delivery and appropriate intervention for people who are using methamphetamine, definitely.

Mr McCURDY — You spoke about outreach teams and foot patrols. Who decides in terms of their role — has that role changed in terms of educational support when they are out? Can you tell us what they look like?

Ms RAYMOND — Foot patrol is street-based drug safety workers who work in a harm reduction health promotion model and also provide a unique point of engagement and referral. At the very hard-core end are people who are sleeping rough and who are homeless, with drug and alcohol issues but usually also a mental health issue and a variety of other significant problems in their lives, and they are often the first place and the first point of connection that a drug user will have. They have the training and experience around what they are looking at in spotting overdose and in reporting emerging drug trends. The pattern of referral is back to our primary health clinic in the CBD — the only one — and then we leverage also the night nursing team who are AOD-enabled, who are also out on the streets, so there are multiple layers working together in the collaborative model around what is best for those clients and how to do that critical first step of people who do not want to come in for any sort of assessment or treatment, to get them into that pathway, because what they are doing is illegal, they are fearful and the relationship of trust enables a hidden group to be able to have an impact.

Mr MICHELL — Some of the outreach capability, too, is that we try to adapt when we hear of emerging trends. Because we are fairly flexible in our outreach teams, we can look at deploying somebody to Sunbury, deploying somebody to Broadmeadows, so trying to be responsive, and that is part of the answer to the question, especially if you have large pockets of methamphetamine or other types of drug use.

Mr SCHEFFER — Thank you for your presentation. I am just looking at the paragraph that you have there on the breakdown from the 438 clients who assessed your organisation, and you say there that around about 40 per cent of the clients reported using methamphetamines. I do not have all the figures because we have had a lot of submissions and I have not got them all in my head, but my sense is that that is at the very high end of the figures that we have been receiving. My sense is, and perhaps my colleagues can correct me if I am not right — that what we are having reported to us overall is a low but significant incremental increase in use, and earlier on in our submissions we had organisations like Burnet, for example, saying to us on the macro data that they would be surprised if there was much increase, that what is happening is that people are shifting the drug they are using, which may well be corroborated in your words earlier on when you said that it is the preferred drug of choice. How did you do that figure? Can you help us understand it?

Ms RAYMOND — That was from presentations and 'drug of choice'. We are not an academic think tank, but we expect that for us it has not been anything gradual, it has been quite a dramatic upsurge over a couple of years, so much so that it has changed the way that we work. That might be specific to the suburbs that we work in rather than a national trend but we can only report what we see, and it is very pronounced and has happened over what we would say is a short space of time. Given the incidence of polydrug use, that is the first drug — it is not the only dug. The question might be what was the drug of choice or what were they using at the time, so it does make it difficult because we suspect there is a lot of polydrug use going on, but the fact that people are nominating methamphetamine as number one is the shift because it was always cannabis and alcohol until about three years ago.

Mr SCHEFFER — So this increase — I am not asking you to answer if you do not have the stuff in front of you of course; just your sense of it — over three years it has gone from what to 40 per cent?

Ms RAYMOND — It would have been — it came in third on a 'drug of choice' survey, where traditionally our outreach teams were looking at cannabis and alcohol as the predominant presenting drug problems in this group, to where — —

Mr MICHELL — I worked at Bendigo and then Sunbury and I have only been at Youth Projects recently, but across the board from all three areas, in the last two years, the change is from amphetamines being somewhere around 10 to 15 per cent of presenting issues up to around the same level as cannabis or actually more presentations than cannabis. In my short term at Youth Projects I have taken on a number of forensic referrals. Nineteen out of those 20 are for methamphetamine. So that is currently what is happening. Across the team it is a fairly high percentage.

Mr SCHEFFER — And do you think that is the same — I am being blunt here — but the same cohort that is switching the drug they are using? You might have seen these same people using cannabis in a way that was worrying them? Or are these new recruits?

Mr MICHELL — Possibly. It is probably about protection. A lot of our clients are forensic, so it is about protection. So people, because of the nature of methamphetamine, are being picked up either through their behaviour, through their driving, through some circumstances, through their polydrug use, but methamphetamine is being nominated as the primary drug whereas something like MDMA or cannabis they might not be as visual because they would be less likely to be engaged in activities which were related to violence.

Mr HUDSON — I think one of the important things is that methamphetamine lasts longer in the body system so when you are doing an analysis you will pick that up, whereas the other drugs will go within a couple of days, and now we are testing more for methamphetamine so we are picking it up. It stays in the body much longer than the other amphetamines.

Mr MICHELL — You are more likely to have some fairly severe health reactions too. If you have not slept or eaten even, your behaviour will become quite bizarre fairly quickly and fairly obviously.

Ms HUNT — I put together that data actually and this is self-reported data which actually goes back to the target of their health and it is what the client comes in with when they are assessed and what they actually tell us and that goes back obviously into the system. But also, like Melanie mentioned before, because the north-western area is very culturally diverse but particularly concentrated with Lebanese, Muslim and religious cultures, that maybe breaks us down into a smaller sector where they could say again that 'alcohol is not within our religious beliefs yet drugs are.' So if you imagine that you are a teenager — and this has come from the clinicians at Youth Project — they often hear stories where the client will come in and say, 'Look, Mum and Dad will not accept it. Alcohol is just not right. I cannot do it. But I can do drugs'. That is not in the Koran, literally. So for some reason it is more culturally acceptable to do that.

Ms RAYMOND — But also in terms of drug switching, what is of significance is the age, because the progression into hard-core injecting drugs like heroin, this was always a pattern that was a mid-20s pattern, whereas now you are looking at a very young age group, predominantly young people at an earlier age. That is what is significant — that this switch is from cannabis to methamphetamine at 17 years old. We think that that is significant because of the riskier long-term effects.

Mr MICHELL — We have also seen a decrease. Since regulations around safrole and other precursors for MDMA, the reduction in MDMA may also be part of the spike in methamphetamine. Same as GHB. We saw it with the heroin drought in 2000. Once there was a shortage of heroin, people moved sideways to different substances, whether that was benzodiazepine or whether it was OxyContin, which all kind of relate to the issues we have today. It is interesting to see that the tightening of some things, such as precursors, seems to have changed it, although on the other hand you could say that the tightening of precursors across our pharmacies has not stopped the introduction of methamphetamine.

Mr SOUTHWICK — I just want to challenge an earlier comment about the banning of the pipe as leading to more injecting and I want to know what research underpins that, particularly when you have the intrusive nature of a first-time user going from, say, smoking marijuana to then injecting. We have been told that there are so many other ways of being able to use the drug — there is snorting it, swallowing it and all those sorts of things. How can we necessarily make the correlation?

Mr HUDSON — There is a rapid high. Can I suggest that one of the most important things for people going through a behavioural change — you get the pleasure from the drug blah, blah, blah. You get a rapid high from injection.

Mr SOUTHWICK — So is that not the issue — the fact that you get more of a high from injecting rather than the pipe being a reason?

Mr HUDSON — If the pipe is not available, syringes are available. I get a more rapid high, and because I have the rapid high, what am I going to do next time? I am going to do it again and again. The pipe will become obsolete. You are better off with the pipe — but we banned the pipe.

The CHAIR — And the bong.

Mr HUDSON — I have some good news at the end.

Ms HUNT — It depends; you have to look at individual samples. If you look at women and younger teenagers in particular, they will much prefer to smoke it because it is socially acceptable. Then you look at — —

The CHAIR — Where do they smoke it, just out of interest? We have had nightclub owners who have presented here and who say, 'There has been no trafficking of methamphetamines in my establishment'.

Ms HUNT — See, this is where they go back to the car.

The CHAIR — They go outside every time to — —

Ms HUNT — No, the car. This was in our research, and, again — because we do the drug driving — the car is a space for a teenager. You have your licence. You are 18. It is a rite of passage. 'I now have a car. I can take my friends away. We can go to the car parks, and we can sit and do up the windows' — I am sorry! It is like I know what I am doing! But they do. There has been some recent research, which we have quoted and referenced, that shows that teenagers will take their car to a car park. It is a social place to go. It is safe. It is away from the parents' eyes. Then, because they are using methamphetamines, there is a perception that they are like God. They can drive home, and that perception of being picked up by the random drug test is a lot less than that of the alcohol random breath test. The car is something that needs to be explored as well, particularly at Broadmeadows, where we are. For rave parties even as far as, say, Cobram, teenagers will travel in groups as far as they need to go to access these parties, and they will take the methamphetamines while they are there, and they will drive home. In fact I read research that noted that there had been a random drug test in Cobram and — I cannot remember how many they tested — for every teenage driver they tested, do not quote me, there was a very high percentage of drug use.

The CHAIR — You are quoting on the transcript.

Ms HUNT — Yes, sorry!

Mr SCHEFFER — Sorry Kate. We have to keep moving and wrapping up. Just a very quick answer — one of the threads we have been getting through from the witnesses has been that there is a sizeable cohort, if not a majority, that can use ice in a managed way over a long period. Could you just reflect on that quickly just before we wrap up?

Ms HUNT — It is not what we are seeing.

Mr MICHELL — I think with any substance that is probably the reality. The number of people who use is always quite large, and the number who have problems is usually quite small. What we are talking about, and what I think you are interested in, is the trends, and the worrying trend for us is the quickness with which people are accessing the service now and their multiple issues to do with mental health, health issues et cetera. Part of it is around the harm minimisation aspect, as I said before. The other thing we worry about is the removal of the pipe. If you use tinfoil and you smoke, it is quite bad for your health. Looking at harm minimisation strategies relating to its use, I think, is still really important.

Ms HUNT — Some of our clinicians are reporting, like I stated before, that from the first try of methamphetamine to the point where your life is in chaos is around 12 months. They could see a client who might just be experimenting, but when things are really bad — it is within about a year. That is just what we are seeing, so we can only report where — —

Mr MICHELL — That is not everyone who is using methamphetamine; those are the ones who are coming through forensics systems et cetera.

Ms HUNT — And when it goes bad, it goes bad. It is not like other drugs.

Mr HUDSON — If I could just answer the other question for you too, if I may: some people have enough insight to think as they take the drug, 'Hang on, it's harming me' and they will go off and seek their own treatment and are actually successful. So there is a cohort who can manage it and move on, get treatment and go back into society, but there are always going to be some people who unfortunately will become addicted and will have issues.

The last thing, if I may: I have some good news. There is some preliminary research overseas in America and Europe where they are trialling — unfortunately it is on rats at the moment, and I will leave this with you — —

The CHAIR — I was going to ask you if you could table that for us — perhaps some of that research.

Mr HUDSON — Certainly. It is looking fairly promising, so, hopefully, as with all the drugs we have always managed, from alcohol and opium and all the way along — we have always found something. I believe we will find something here. I will leave that with you.

The CHAIR — Thank you very much, all of you, for your time this afternoon. We appreciate the input you have into this inquiry. Thank you, and thank you to Honourable Monica Gould for returning to the halls of power.

Witnesses withdrew.