LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Canberra — 11 February 2014

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Mr G. Vumbaca, Executive Director, Australian National Council on Drugs.

The CHAIR — Good morning. I welcome Mr Gino Vumbaca, executive director of the Australian National Council on Drugs, to this public hearing of the Law Reform, Drugs and Crime Prevention Committee, a joint committee of the Victorian Parliament. We are currently conducting an inquiry into the supply and use of methamphetamines in Victoria, particularly ice.

I thank you for your time this morning. I have to read you the conditions under which you are presenting. All evidence taken at this hearing is protected by parliamentary privilege in accordance with reciprocal provisions in defamation statutes in Australian jurisdictions as if you were giving evidence in Victoria and as provided by section 27 of the Victorian Defamation Act 2005, the Constitution Act 1975 and the Parliamentary Committees Act 2003. Any comments you make outside the hearing may not be afforded such privilege. Any reporting of these proceedings enjoys qualified privilege for fair and accurate reporting as if the proceedings were in Victoria. Have you read the guide for presenting evidence to parliamentary committees?

Mr VUMBACA — I have.

The CHAIR — Thank you. All evidence given today is being recorded, and the witness will be provided with a proof version of the transcript in the next few weeks. We have representatives from the Australian Institute of Criminology here, along with our executive officer for the committee, Sandy Cook, whom I am sure you have had correspondence with.

We have a lot of time — until 11.45 a.m. I understand you have probably been given a list of questions or information in relation to the inquiry so I do not need to go through that.

Mr VUMBACA — Terms of reference and the like, yes.

The CHAIR — The background to the inquiry. The normal process is that we invite you to make an introductory statement and then the committee asks questions of you. On that basis are you happy to commence?

Mr VUMBACA — Yes. Thank you for the opportunity to present today and to be a part of this inquiry, because I think it is quite important. I will make only a very short statement at the start because I think it is important if you have particular queries or questions that we focus on those. As I am sure you are aware, there is a lot of information available, and depending on what areas you think are more valuable to Victoria that is where we would like to assist the most.

The key statement I would like to make on behalf of the council is that one of the principles the council advocates is the need for a balanced approach to drug use. By that, we mean a focus not just on law enforcement, not just on demand but also on harm reduction. Those three strategies need to work in some sort of cooperative fashion to achieve the outcomes that the community desires.

What we tend to see sometimes is an overinvestment in law enforcement approaches to drug use and an overreliance on those to resolve the issues. It is important that you have a law enforcement response, but what we are hearing from the front line in particular and services around the country and also in Victoria is that their ability to deal with people with problematic ATS or ice methamphetamine use is being limited and the resources and options they have available are quite concerning for them about how they deal with the impact on the individual, the family and the broader community.

It has been said by a few people at times that you cannot arrest your way out of these problems. Karl O'Callaghan is the police commissioner in Western Australia and a member of the ANCD who has referred to alcohol problems and not being able to arrest your way out. We have to deal with the culture and the demand for alcohol. The same can be said of any drug, including ice. You are not going to be able to arrest your way out of it. We have to look at what we call a balanced approach, meaning restricting supply but also dealing with the demand, the treatment needs and the broader health needs of the community and how you address that.

In terms of some of the specific work the ANCD has done, it released a paper back in 2007 when there was a developing peak of ATS/ice use at the time over those few years. More recently we are

working with NACCHO, which is the National Aboriginal Community Controlled Health Organisation peak body, about getting some information about the level of ice use among young Indigenous people. Tellingly, at the last meeting they had in Victoria there was some information coming back from the Indigenous communities they met with about the high levels of use which appear to be affecting young Indigenous people in both urban and rural communities. That is where that sense I talked about of not really knowing what to do or how best to deal with this is coming through. They are struggling with coping with that, the existing services, about what best to do, and their options at times are limited in relation to what they can offer to people in dealing with these situations. That is the other area.

I have also been engaged in discussions with the federal government about the need to look at this rise in the use of ATS not just in Australia but, as I am sure you have heard from other witnesses, this is a worldwide trend we are talking about. Production is increasing across the board. Particularly in places like Myanmar and the like, where you have increased production and availability, the price decreases and use tends to increase. We also know that drug use is cyclical in nature and although ice use did peak a number of years ago and then levelled out and steadied, it is starting to increase again and there are a range of factors involved in that.

The ANCD is concerned about the impact of ice on communities and families and also about the need to increase the level of research and treatment opportunities for people with ice or methamphetamine-related problems.

Mr SOUTHWICK — Can I just interrupt? You mentioned that there is that increase again after the levelling out. On what basis are you suggesting that?

Mr VUMBACA — We look at a number of data sources. We are looking at household surveys generally, but we are also looking at treatment presentations. We have seen an increase in the number of people presenting at treatment services who are registering ice or methamphetamine as their primary drug of concern but also as their secondary concern. The number of arrests has increased as well. I am sure you have been given evidence by the Australian Crime Commission about the increase in the arrest rate, particularly in Victoria. We have seen an increase in Victoria.

The other dataset we look at, though I have not seen the latest one, is DUMA, which is run by the AIC. That is particularly important because it is based on urinalysis rather than self-reporting, so you are getting a much clearer indication of what people have been using. What we are seeing is that when you look at all the datasets that are out there, coupled with some anecdotal information about the consultations we conduct with front-line services, Indigenous groups and other community groups, this is coming up as a problem.

I also had a chat yesterday to double-check with the family help line that operates in Australia and covers Victoria as well that over the last year they have been seeing an increase in the number of parents and family members who are calling about amphetamine or methamphetamine use being an issue of concern in their family. Primarily they are kids, but sometimes it is the other way — kids calling about parents — but it is primarily about the children using. All of that paints a picture of increasing use for us and problematic use.

I will leave it there, and I am happy to take questions on specific areas I have raised.

The CHAIR — Would you be able to tell us a little bit about the national amphetamine-type stimulant strategy? Were you involved in that, and was crystal meth part of the discussion around that strategy?

Mr VUMBACA — It was. That was developed a few years ago now — it would probably be at least five years ago — and was done under the auspices of what was the Ministerial Council on Drug Strategy at that time. The problem with those national strategies, including our own national strategy, is that they tend to be fairly broad. They provide some guidelines and direction, but when it comes down to dealing at the front line with what is happening, it does not give a lot of direction to those services. It does not give a lot of advice or assistance to families. It can provide a broad

outline of how government should respond at a strategic level; what is needed is almost like an action plan or the next level down from there of what services should do.

One of the issues that keeps coming back to us — at the moment we have a draft report which we are trying to finalise, hopefully in the next few months, on treatment options — is that there are very few treatment options for ATS, amphetamine-type stimulants, and that is problematic for us. When people do present and want assistance, what can we offer them to deal with that? There is a lack of evidence; there is a lack of research being conducted into what those options may be. I think that is where you can talk about dealing with it, but from our point of view when people present you need to have something to do with people. Even if it is working with law enforcement about diversion — where you are diverting them to — there need to be services that are able to effectively deal with ATS problems, and that is problematic at the moment.

Mr SCHEFFER — Gino, other witnesses have cautioned the committee about the need to strike a balance, with harm minimisation on the one hand and law enforcement on the other. They have also reminded us about what you have said that maybe there is a bit too much of an emphasis on the law enforcement side. I think it is fair to say that in this committee's reference we have been looking at the law enforcement more than the supply end of it, but what I ask you to talk to us about is: what do you think the appropriate law enforcement response should be at the user end?

Mr VUMBACA — The principle we have worked on — and it goes back to the advice provided to John Howard back when he started the tough-on-drug strategy and there was a real focus on dealing with illicit drugs in Australia — is that you need to differentiate between the high-level dealers and people profiteering and the users. Both are in breach of the law; we understand that. The people who are using drugs are dependent or have problematic use and are in breach of the law, but the best way to deal with that is not a prison sentence or necessarily a custodial sentence. That is not the way to deal with it. What we try to argue for is diversion into treatment; you are better off dealing with the real cause.

Prior to this job I worked in the prison system in New South Wales and around Australia, and I also still do some work in prisons internationally. My argument and my advice to ministers at various levels has been: make it the last resort. If you spend time in a prison, it is the least effective venue to deal with someone's problems related to drug use.

Mr SCHEFFER — Can I just stop you there. What is the evidence for that?

Mr VUMBACA — The evidence for that is the rate of reoffending. Part of it is personal opinion; when you go into a prison the nature of prison life is not constructed in a way that is conducive to a therapeutic environment dealing with people's problems. A lot of drug use is related to people's problems, either traumatic incidents within their life or a response to mental health problems. In some cases it can be a factor of all those things. Prison is not the place you are going to deal with it, and the best thing we can do to reduce reoffending is to divert people into treatment and deal with their drug use problems. It does not mean everybody will benefit, but you have much more of a chance of dealing with that problem in a therapeutic environment like a residential or rehab facility than you have in a prison.

Mr SCHEFFER — Is the cost equivalent, because it is very expensive keeping people in prisons?

Mr VUMBACA — Far more expensive.

Mr SCHEFFER — Than going into residential rehab?

Mr VUMBACA — Yes, far more expensive, and that is because by the time you factor into security concerns — all those sorts of factors — —

Mr SCHEFFER — If, for argument's sake, a state decided that virtually all people who are in the corrections system because of a drug-related offence were to be placed in customised residential care rehab centres, could that be a cost-neutral option?

Mr VUMBACA — It would be a cost saving. Deloitte Access Economics did some economic modelling for our Indigenous committee. They focused on Indigenous non-violent drug and alcohol offenders because I think that makes it more difficult for lots of reasons you will understand about people who have violent offences as well. They costed it out, and there was over a $100 000 saving based on the actual cost and also the reduced reoffending rate and the ongoing cost to the state.

Mr SCHEFFER — Could you provide us with that?

Mr VUMBACA — Yes. The full report from Deloitte Access is available on the website. It measures out all the different costs. We deliberately got one of the big accounting firms to do this analysis for us because we wanted a strict economic analysis to compare the two pathways. If a non-violent drug offender goes to prison and a non-violent drug offender goes to residential rehab, both Indigenous, what are the cost implications? What are the cost-benefit ratios of these and the long-term outcomes? They clearly came down on the side that you get much better outcomes from residential rehab than you do from prison. The reoffending rates for drug use offenders are over 50 per cent within one or two years, so you will find a lot of people coming back into that system. The reality is that if you put people in prison, sure they are not on the streets offending or using at the time, but they are going to come out. You have to release those people after an average of six to nine months, depending on what jurisdiction you are in. You are not improving the lot of the community of that individual or their family if you do not deal with the drug use problem and they are released from prison.

The other issue that comes up is the long-term penalties associated with a prison sentence. As hard as it is — and in the last day or so we have heard about employment issues in Victoria at the moment — if you are an employer and you have someone with a prison record and you have someone without a prison record of equal merit, it is a no-brainer to guess who will get the job. It is a real hindrance for people to have served a prison sentence, and that is why it should be a last resort. The penalties associated with that, particularly for young people, who can make silly mistakes and get caught up in things they do not understand, can be long term. That is why I caution against prison.

I also argue it should not be mandatory. People should be offered that option, and more often than not they will choose the treatment option because there are not many people you meet who when they use drugs think, ‘I want to be addicted to this. I want to be dependent on this. I want to have problems with my life when I start using drugs’. No-one sets out to do that; it is a pathway they lose control of and end up down there.

Mr SOUTHWICK — I want to ask you about advertising and public campaigns that may have been run and supported by the Australian National Council on Drugs in the past. How effective do you think they might be in the future?

Mr VUMBACA — They are always difficult to evaluate. The evaluations the commonwealth does on the national campaigns are about recall, about whether people saw the ad. That is generally how it seems to be measured. And there is a debate within the drug and alcohol community about the value of public education campaigns. It is a difficult area, but we know that with tobacco, public education campaigns have shown quite a level of success and helped as part of the broader strategy about reducing tobacco use.

The government did have a specific methamphetamine advertisement. I recall it was one about someone going into a hospital waiting room and causing trouble, and there were different images that were part of that national campaign. What we saw — and it may have been coincidence; this was hard to work out — was a levelling off of ice use. Those campaigns are good. Someone who is already using and has problematic use is not going to see that ad and think, ‘I should stop using ice’. But if you are someone who has not used it and you may have some fears already about what the implications are, that can reinforce that in someone as a preventive measure. If they do get in a situation where they are offered it or can access it and that image is there, it may well have preventive influence on them choosing whether to use that drug. They might be a bit more scared of the drug.

I was talking about prisons. I note that some people do worry about going to prison, and that would obviously be a deterrent to them. They might not behave in a certain way because they think they are going to end up in prison. There is a deterrent level there. How widespread that is or which groups it affects is always difficult to know, and that is the same with public education campaigns. I do not think you could argue that this will somehow resolve it. I like looking at tobacco because I think we have seen significant reductions in tobacco use, but it was not just because of the campaigns. There were restrictions on use, and plain packaging is the latest move that has been made. It is a whole package of reforms and programs that are put together. I think informing the public of the danger has a preventive value as well.

Mr SOUTHWICK — Could you maybe talk a little bit about the tobacco-type campaigns and the overall strategy and potentially other similar sorts of areas in health? Could you talk about ways you think we could potentially tackle the ice problem we have, in conjunction with other measures as well?

Mr VUMBACA — As I said, the lesson we learn from tobacco is that the campaign is part of a broader package. They had smoking in public places. If we go back 20 or 30 years, when I worked in St Vincent's hospital in Sydney, people used to smoke in the workplace, even in hospitals. I remember sitting there and people used to smoke at their desk and things like that.

The CHAIR — They still do outside Peter MacCallum, which is a cancer centre.

Mr VUMBACA — Even on planes you used to be able to smoke. If you think back 20 or 30 years ago and how pervasive smoking was, it was not the graphic advertisements and the like that changed that. That was part of it, but there were also legislative reforms put in place which restricted access or restricted where you could smoke. A public education campaign about the dangers of smoking was inherent in that. Cost was also a factor — tax rises caused people to make economic decisions to stop smoking. All of those things together led to this quite dramatic decrease in the smoking rates in Australia. When you look at the figures there, it is quite staggering how quickly it has dropped.

Mr SOUTHWICK — We had evidence from the UK saying that ice is seen as a very dirty drug, that it is not trendy like cocaine, and that that has played a large role in regressing the amount of use over there. Is there anything we can do to right that balance in terms of how ice is being portrayed, particularly to young people?

Mr VUMBACA — That is what we talked about in the original campaign that the federal government undertook. We have to break this image. Even the name, ice, refers to something clean and sharp. People who manufacture and market these drugs understand how to market them. At the same time there was a whole range of beer products that came out with the term 'ice', promoting that clean, crisp image. There was an argument that they were tapping into that sort of view. You do have to undermine that view within the broader community that ice is somehow okay or clean. That is why a lot of the campaign was based on the message that ice is not a good drug, it causes ugly scenes, it is not manufactured in a way that is at all clean, that people should not associate it with being in some way clean or therapeutic and that they should not think there is some standard applied to the way it is manufactured. There is no such standard applied. You need to get that in, but it will only reinforce people who have a fear of using it anyway. It provides them with a bit more strength to refuse to engage in that behaviour. For people who are already using you need a different strategy that is going to be right for them.

Mr SOUTHWICK — One last thing: ice is in prisons. Could you comment on that?

Mr VUMBACA — It occurs. I am not aware of it being a big problem. I talk to people still working in the system, including colleagues that might stand with the corrective services system. It is not a great environment to be speeding in, basically. There are a lot of restrictions in your movement, and if you are stuck in your cell potentially for a 23-hour lockdown, you are more after a depressant such as cannabis or heroin so you can create a different atmosphere and provide yourself with a different way of dealing with that time. Prisoners have a lot of time on their hands. One of the issues within prisons is how you manage prisoners' time, how they manage their time

in there and how they deal with the long hours — in some cases quite long hours of lockdown — and restricted time. Speeding is more about being out and potentially drinking as well. We have seen it linked a lot with alcohol because it increases your ability to drink and to drink more without feeling intoxicated or drowsy drunk. It keeps you alert while you get drunk. That is not really a prison environment.

The CHAIR — What effect do you think restrictions on smoking in prisons would have on the psychological behaviour of inmates? That is a little bit away from this inquiry but it is something which, between us, we were looking at.

Mr VUMBACA — I am nervous about it. I can understand why. I think if possible they should be given the option of smoking wings and non-smoking wings. I think it is a pretty hard sell sometimes, if someone is doing a long stretch, to say, 'Don't smoke. It's bad for your health', when they are thinking, 'I've got 10 years in here'. I am not across all of that research, to be honest. I am talking more from a personal point of view based on my visits to prisons. I still occasionally go into prisons and have a look. I sometimes talk to prisoner action groups to get their views. I know they are concerned about what the impact will be on prisoners' behaviour when they are forced. If you are a smoker in the community, they can say, 'Don't smoke here, don't smoke there', but there are places you can smoke. In prison, however, you cannot smoke anywhere. I think that could be problematic.

The CHAIR — It is sort of related to David's question: if they have clear access to smoking, obviously smoking methamphetamine or crystal meth is probably an easier choice than injecting.

Mr VUMBACA — That is true, but prisoners tend to inject drugs if they can— powdered drugs and those sorts of drugs — only because there is more bang for their buck as far as they are concerned. It is more dangerous for lots of reasons, but if you are only dealing in small quantities or limited availability, you try to get the most you can out of it, given the reality of what goes on in there.

Mr CARROLL — Gino, I noticed in your background that you were responsible for the coordination and establishment of the New South Wales network of needle and syringe exchange programs on behalf of the New South Wales health department. I am not sure if you are aware, but the government in Victoria, in partnership with inner city councils, has announced it is going to roll out some 24-hour syringe vending machines, which has been jumped on by the News Ltd press. It has been brought up before; 'Taking a jab in the dark' was the title of a *Herald Sun* editorial. People get a bang for their buck by injecting ice. Can you tell us a little bit about the work you have done with that syringe exchange program? We are looking at best practice initiatives and solutions in dealing with users. If you could express your views on needle exchange programs, vending machines and supervised injecting rooms so we could have your views on record and analyse them.

Mr VUMBACA — I have a long history with needle and syringe programs. I was involved in the very first one that started in Darlinghurst many years ago — 1986 I think it was. I then worked with the New South Wales health department in setting up a whole network across the state and doing a lot of work in this area. The council also recently released an updated position paper on NSPs. They are clearly an effective way to reduce and minimise HIV and other blood-borne viruses.

They also provide a unique opportunity to engage with people who generally do not engage with the health system. I can go back to the very first day we opened up. I was working at a drug and alcohol service at St Vincent's hospital in Darlinghurst, right in the heart of Kings Cross. When we opened up the needle and syringe program we were seeing people we had never seen in the drug and alcohol service. They were coming to our service, and it provided an opportunity for us to engage with them. You did not badger people, but you went up to them and said, 'Listen, if you ever want to talk about this, there are people here you can talk about it with'. For the first time they were engaging one-on-one with myself and colleagues — counsellors — working at that service. That is the unique opportunity it provides: engaging with this hidden population, in a way.

The evidence is quite clear that it does not promote drug use. People do not inject drugs because there is a needle exchange program in their suburb. That is not the reason people inject; they are going there because they have already injected drugs. My understanding is, without a reference to any particular research, that most people who start injecting are introduced to it by another injector. They do not actually go to a needle exchange to start because they are thinking, 'I want to start injecting a drug'. They have actually already engaged in that behaviour before they go to a needle exchange. It would be rare that they start at a needle exchange. What you are doing is accessing people already injecting.

Vending machines provide an opportunity. On their own I think they are of limited value if you do not have the ability to actually interact with people as well, but there is a cost consideration here. Ice users in particular may be injecting a number of times and cocaine users a number of times. People engaged in the sex work industry as well, over the course of a day and night, come to our 24-hour needle exchanges with staff operating there. Vending machines can provide that access at a low cost.

Mr CARROLL — It is almost like — when I read the commentary I thought that if you going to cop the heat over a vending machine, you might as well go the next step and have a supervised needle exchange program because at least it has the staff there to treat people and put them into — —

Mr VUMBACA — Refer them on if they need to be referred.

Mr CARROLL — Yes.

Mr VUMBACA — Yes, I agree.

Mr CARROLL — This may be a step to that. No-one really knows at the moment.

Mr VUMBACA — Victoria has a network of needle and syringe programs operating now. I would think that vending machines just provide that opportunity sometimes in rural locations where you just cannot afford to have a staffed needle/syringe program, but I would be worried about only having that, because then I think you lose the value of that interaction and ability, as you say, to refer people on and deal with other issues that they may present with, such as health problems. Again, it is part of how you address HIV and blood-borne viruses. It is an option that I think should be utilised in various areas.

With injecting rooms, there are particular areas where it makes sense. Kings Cross — it makes sense. There may be an area in St Kilda that makes sense, but you need community support. That exists in Kings Cross. There is not an injecting scene in Kings Cross because the injecting room is there; it was there well before supervised injecting facilities started up. It is not something you put in every suburb or around the state or the country, but there are particular hot spots where we know people go to engage in injecting drug use. If you live in that area, you know that public amenity is an issue; people injecting in stairwells and needles and syringes being found everywhere is not a great environment for those people. In the last survey I saw of Kings Cross residents, there was something like 78 per cent support for the injecting room because it has had a positive impact on their community. If you live in that area, you are not then confronted with people injecting. You are walking your kids to school or whatever and there is someone in the stairwell injecting — you are not confronted with that as much, and that is positive for them.

Mr SOUTHWICK — I want to draw back to one of the questions we had earlier about harm reduction principles and whether they can be used to reduce methamphetamine use, particularly smoking and injecting, and, if so, how and in what sort of ways.

Mr VUMBACA — There are probably two ways. The first way is education. I think that with harm reduction, a lot of people are at the pointy end of it, which is the direct delivery of needles and syringes and maybe injecting rooms and that, but it is also about education and providing advice and information to people that is realistic and credible. By that, sometimes you have to accept that people are going to use the drug. There is no point giving out information that only says, 'Don't use the drug'. What you need advice about is, if you are going to use this drug, how to

do it safely and how to avoid situations that will cause harm to yourself and others. That is what harm minimisation also encompasses.

With injecting, for instance, you can say, 'Don't inject because of the problems, but if you're going to inject, make sure it is a clean needle. Make sure it is this. Make sure there is someone else there with you. Make sure you are aware of what you are using. Make sure you are in an environment that is safe. Don't use alcohol or other drugs with it'. It is about getting that advice to people. If you present advice to people that is useful to them in a non-judgemental way, then they are more likely to think, 'Okay'. That at least gets them thinking about what they are doing. If the only advice they are getting is, 'Don't do it. Don't use drugs; it's bad. Don't use — —

Mr SOUTHWICK — Who should be giving that messaging?

Mr VUMBACA — I think you need peer networks. In Victoria I think they have changed the name of the users association. They are often the most credible — other users who work in the health sector. People who work in drug and alcohol services can do this as well. There are needle and syringe programs that operate. They generally work on a harm-reduction, non-judgemental principle, and, again, I am of the view that if you engage with people, once get them talking to you, you can actually start to explore what those issues are that may be behind their use.

I have worked a long time as a counsellor as well, working with clients and that. No-one I ever met wanted to be in that situation where they were injecting a lot, on the street, working as a sex worker. Whatever it may be with their particular problem, they wanted a way out if they could. That was not always easy, and people relapsed and there could be other problems, but it was rare — I cannot remember anyone coming to me and saying, 'I'm actually really happy with my life working as a street prostitute and injecting drugs every day. I just want to continue that'. That was not what they were saying. They did not know how to get out of there sometimes, and even when they knew the way out, they could not get it together to actually do it. But we would work our best with them, and sometimes that meant getting them into a residential place to get out of that situation. They might be clean for a few years and do well, and then you find that they relapse. That is life.

We wish we could guard against that, but most people want out of that situation. People with a drinking problem or people who smoke, even people who smoke a pack a day — if you talk to them, do they really want to smoke a pack a day? They just find it really hard to stop. But if you said, 'I could click my fingers and make it stop. Would that be happy?', most of them would say, 'Yes please'. It is how they get there. So if you can engage with people who are using ice and other drugs and injecting them, that is a big step to getting them into treatment and helping them.

Mr SOUTHWICK — At what point do they recognise they have a problem?

Mr VUMBACA — That can be different. There is always an interesting argument about what you do. We have this theory about drinking where people — most often if you are talking about what is problematic in alcohol consumption, forget the NHMRC guidelines; most people use their own benchmark. 'What I am using is okay. Anyone who uses more than me has a problem'.

With drug use, sometimes it can be that something hits them. They lose their kids; DOCS, or the equivalent of it, take their kids away. They lose their house. They lose their job. It can be a fact like that that says, 'I have a problem'. That does not mean they can just stop, though, without assistance, and even with assistance it can be a long journey for some people and a never-ending journey, unfortunately, for others. But that is still a better approach, because it actually is better. If you look at community safety, it is better to try to deal with that person and sort their problems out. It is actually better for the community as a whole, as well as when you look at the impact that their drug use may be having on the immediate family.

Mr SOUTHWICK — Thank you.

The CHAIR — We might have to leave it there. I am sorry; we have a scheduled teleconference for 5 minutes ago.

Mr VUMBACA — That is all right.

The CHAIR — I just want to ask one final question for the record. We have not asked the number of questions we wanted to pose to you. I am just wondering if we could give you those questions we have not covered off in this discussion and if you would be happy to table responses as part of the report, because we have not talked about the outlaw bikie gangs, and we have not talked about a whole lot of other elements we wanted to. Time is against us, but would you mind if we gave you the questions we have not covered and if you could respond, and then we could table that?

Mr VUMBACA — No problem. I am happy to.

The CHAIR — Thank you. I do need to ask you one question. Given much of the discussion from you, do you think that at any time the use of methamphetamines should be decriminalised?

Mr VUMBACA — Decriminalised? Look, I have an issue with criminalising, as the impact is a criminal charge and then conviction against someone. As I have said, I think for young people, it causes problems they just do not understand, and I talk to judges who say they are really concerned about how some kids plead guilty because legal aid said, 'Just plead guilty', without understanding that that means they will not be able to work as a teacher or join the army. A whole range of occupations are out of bounds, as well as travel.

Decriminalisation is an option that needs to be considered, I suppose, yes. But when you are talking about personal use for someone who is not engaged in any profit-making activity, trafficking or dealing of it — if we treat it as a health issue, then we have to look at not having a criminal charge. That does not mean you can do it without any offence, but diversion or treatment options as a way of them not having a criminal conviction or charge, I think, should be explored.

Mr SOUTHWICK — Extending that to legalised?

Mr VUMBACA — Legalised, no. I think there are problems with — I think we have to be careful about legalising methamphetamine. I think we need to understand a lot more about it and its patterns of use and the problems it can create. I think we also need to be clear about how we would do that. There are a lot of options to explore. The first step is about removing the criminal sanctions, because I think there is strong evidence to suggest that the penalties are far too harsh, particularly for young people, and too long term. We need a way of addressing that, and the criminal justice system can see that and the community can see it as well, whereas legalisation is a big step. We have to be clear about how we would do something like that. It would have to have community support as well.

The CHAIR — Thank you very much, Mr Vumbaca, for your presentation this morning.

Mr VUMBACA — Thank you.

Witness withdrew.