LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Wodonga — 24 February 2014

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The CHAIR—Good morning, Mr Wilson and Mr Currie. My name is Simon Ramsay and I chair the joint Victorian parliamentary committee of Law Reform, Drugs and Crime Prevention Committee. As you know we are currently undertaking an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. Thank you for your time this morning in giving evidence to this committee. I am aware you have been given the reference and background in relation to this inquiry. I will read you the conditions under which you are providing evidence to this committee this morning, and then perhaps ask you to make some brief introductory remarks and the committee will ask questions of you.

Welcome 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 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. It is important that you note that any comments you make outside the hearing, including effective repetition of what you said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting to parliamentary committees.

Mr WILSON—Yes.

The CHAIR—Thank you. It is also important to note that any action which seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of parliament. We are recording the evidence and will provide you with a proof version of the *Hansard* transcript at the earliest opportunity so you can correct it as appropriate. I would now like to invite you to make a verbal submission, and obviously the committee then will take the opportunity to ask questions.

Mr WILSON—I listened briefly but I did not hear all of what Alan Fisher had to say. Alan is on the other side of the border and we are on this side of the border and there has been a problem with cross border collaboration for a long time because of the different state requirements. Ice has been around for quite some time, as you probably are aware, in varying forms and in varying purities. It is much more potent than speed which used to be readily available and procurable in the old days for around about $50 a gram. Prices have skyrocketed in terms of the amount you would need to spend on a gram of ice. I would imagine $100 a point, and multiply that by 10 is $1,000. That is a lot of money. People are spending a significant amount of money on this drug. Its availability in this regional area is massive to be quite honest. I have heard the media use the term 'epidemic' and it is probably approaching those proportions. I have even heard from clients directly that it is easier to obtain than cannabis. It is a significant problem for us, also in terms of its tendency to rev people up so much—and Alan said it—that they get aggressive, they demonstrate psychotic type symptoms like delusional thinking, they can get quite paranoid, often do not sleep for days on end, do not eat well and when they are coming down, on the downside of the influence of the drug, they tend to get very cranky and can get aggressive again. Then they are seeking other types of drugs, like sedatives, to take the edge off.

We do not have any treatment facilities in this region, unfortunately, none. All our referrals are either to interstate—the closest facility for us in terms of detox is probably Wagga Wagga. Most of our referrals go to Melbourne for residential detox treatments. I have worked in a detox in Melbourne for an organisation known as ReGen, formerly Moreland Hall. When I was working there, ice was not that common. There was a lot of speed around and there was a little bit of ice. What has happened now is ReGen have extended their waiting lists, or extended their treatment time is what I am trying to say. It is from seven days to 10 days. Now that has blown out, the waiting lists, and it is much more difficult to get people way in, in a timely way.

I am sure you are aware that if we can get people into a treatment facility quickly then the outcomes would definitely be better. We do not have any residential post-detox treatment

facilities here either. We do in Benalla. Odyssey House run a program called the Circuit Breaker. I do not know whether you have heard of that one. It is a six-week program which is quite a good program. We often refer clients there. The other residential programs are in Melbourne and surrounds.

I work primarily with young people between the ages of 12 and 25 years old. I do work with adults as well but most of my work is with adolescents. Adolescents, being risk-taking and adventurous, like ice. They experiment with it quite readily. It is available, it is a party drug, it keeps them going. They drink alcohol with it. They do not really feel the effects of the alcohol so much because the stimulant is masking the effects of the alcohol. They could be thinking that it is okay to drive, for example, or do other things, and clearly their blood alcohol content might be five times the legal limit, that is off the top of my head as an example. It is causing us a few dramas.

I think there is an urgent need for a treatment facility in this area, and there has been for a very long time, and people have been asking for it. Our clients often do not want to go to Melbourne or Wagga Wagga or Sydney, they would rather have a treatment facility close to their home.

Mr McCURDY—For all drugs?

Mr WILSON—That is across the board, definitely.

Mr CURRIE—The echo which you have all heard while you have been doing this inquiry is resources. That is certainly the biggest barrier we have at the moment when supporting these individuals because we can certainly support them to come into us and support them to go to a detox and do a detox, but we then we cannot support them from there. This is the thing that occurs in all health and that is, there are no beds. Therefore we can support someone to go and do a detox and that will be totally unpleasant for them and they will come out at the other end they will feel that they have achieved enormous goals, but then being able to provide that constant support for them after that to ensure that they do not relapse and go back to using the ice is not easy because we do not have the clinicians on the ground, we do not have the bed availability in rehabilitation services, and those supports that these people really need are not there once they have finished their detox.

Mr SOUTHWICK—Bill, you mentioned the ReGen program is seven to 10 days. That is the detox program?

Mr WILSON—It is a detox. It is not a residential rehabilitation program per se. They do have day programs that they run down there but it is specifically for alcohol treatment. Ice has been around a while but there is a lack of long-term research done on the best treatment that is available. I mean, Alan alluded to a pharmacotherapy type treatment which has been successful, and we run a very successful pharmacotherapy program for opiate dependency. It has been around for a long time and it has reduced the impact of crime on the community, but we do not have anything of that equivalent that we can use to treat methamphetamine dependency.

Mr CARROLL—We have visited Odyssey House in Lower Plenty.

Mr WILSON—In Melbourne.

Mr CARROLL—Yes, in Lower Plenty in Melbourne. They do great work. A lot of the evidence we received from that visit was that with ice it is not like a 10-day detox. It could be six months; work out what is in the person's DNA; what psychological help do they need; how do they get routine back. They have about a six-month waiting list.

Mr WILSON—Yes. It is difficult for us because we have a lot of paperwork to do to try and get somebody into a facility like that. Then there is a waiting list. When you tell people

there is a three- to six-month wait, hello, what are they going to do?

Mr CARROLL—Yes, there is also a cost as well. I know they sometimes take people's disability support pension.

Mr WILSON—Yes, 80 per cent of it usually. That is a rough figure off the top of my head but, yes, that is right. Sometimes they put some money aside so if they stay in the facility for a lengthy stay, they might have a little bit of money at the end when they leave.

Mr CARROLL—Yes.

Mr CURRIE—All addictions are ongoing. Certainly post-withdrawal with methamphetamine is very unpleasant, and because of its addictive qualities it certainly does drag the user back to it, but the same can be said with alcohol, cannabis and heroin. There are certainly all those things there as well, but the dynamic of this drug is different because this drug is much more addictive and therefore the individuals do not have to develop a long-term habit before they become addicted, it is almost immediate addiction. Once you start using, if you are worried about the comedown from that and you continue to use then you will certainly become extremely addicted and coming off it will be very hard. Then you are forming those social connections, those social linkages. When you have done a detox, you have gone into detox which is 10 days, and that is when you withdraw, and then waiting for rehabilitation after that, that is when the wheels start to fall off.

We can certainly support some people, and some people do extremely well in the community remaining off the meth, but without that 24-hour, seven-day a week support program teaching these people and cognitively retraining them that, 'These are skills that you have and that you can do without relying on the drugs,' that cannot be done in an outpatient facility. That cannot be done meeting up with them once a week and reinforcing to them all the good work they have done, and it cannot be done once every three days either. These individuals really do need to go into a supported environment to be able to completely remove themselves not only from that culture but completely break the habit.

Mr WILSON—I think with ice too, people can become unwell very quickly because of the nature of the drug itself, because they are not eating and they are not sleeping. Speed was bad enough but ice, you can multiply that by X, you know, 10 times maybe. That sounds a little over-dramatic but people do get unwell and they are very unpredictable sometimes in their behaviour.

Mr CARROLL—Long-term rehabilitation, we have been right around regional Victoria, and Wodonga is not the only one unfortunately that in fact does not have the long-term rehabilitation beds.
The bigger regions seem to have the big hospitals where they have the emergency facilities and the beds, but some of the smaller regions do not. Alan's evidence was stronger linkages to Melbourne would go a long way to get someone from Wodonga into a facility but he acknowledges that you still have to manage them when they come home. Obviously it is a massive cost to set up the capital investment for long-term rehabilitation beds.

Mr WILSON—Yes, that is exactly right. I must say it is not something from a financial perspective and a political perspective that is sellable or marketable in a way.

Mr CARROLL—Although we have heard some evidence that long term the taxpayer gets paid back pretty well when the person is rehabilitated and is contributing to society.

Mr WILSON—Yes. There is no doubt—and the research evidence demonstrates this—that the longer a person stays in treatment, it does not matter what it is, the better the outcome.

Mr CURRIE—We have those linkages with Melbourne. We do have a great

relationship with Odyssey House.

Mr WILSON—We do, particularly with ReGen and Odyssey House.

Mr CURRIE—Yes. We have a good relationship with DePaul House. All these specialist substance abuse facilities, we do have a great relationship with, but if the bed is not there, the bed is not there. It does not matter how good a relationship it is, if the bed is not there, the bed is not there. There used to be a time where in certain areas, you would get priorities. If you were from this area you would have a certain amount of beds in that facility that you would be able to utilise. It is statewide now and we do not have those benefits either. The simple fact of the matter is the beds are not there. You can have great relationships, and we do do secondary consults, and we do get supported by these services while we are waiting but we cannot get the client in.

A client comes to us and they are motivated and they want to cease using the product, we put them into counselling, they see the counsellor, then they will go to withdrawal emergency support, then to get into a facility to detox and that is where often the buck stops because then that is actually trying to coordinate, 'Okay, how do we get them from here to rehab?' Usually what we will find is that this person will have to go in and do three or four detoxes before they get to the rehab, because all the time they have been waiting for the bed, they have lapsed again and they have started using again and we have had to do another detox and another detox until the bed becomes available.

Mr CARROLL—I understand, yes.

Mr SOUTHWICK—If you have the volumes of the problems that we are suggesting and we have heard that this could take up to six months for a rehab program to really kick in effectively, it seems to me as though no matter what we do in terms of resourcing issues we are not going to be able to provide the amount of beds and spaces available. Is there any other way we could look at this?

Mr WILSON—Prevention, education, peer support. As we know peer education is a very successful model. Peer self-help programs, like SHARP in Melbourne, I do not know whether you are aware of that. SHARP is a very good program, a supported accommodation type program for young people. It is young people educating other young people because they are the experts, they relate to them. They talk their language. I worked at SHARP for a while. I have been around in this field for about 18 years. I started work in Melbourne and I have only been in this area four years. As a clinical worker Alan is very good, very knowledgeable, he comes from Albury on the other side of the river. It would be nice if we could do more collaborative work together, considering we have a population base of around about 100,000 people. We still do not have a dedicated treatment facility available.

Mr CURRIE—But certainly that prevention is important in providing the education, but it is about providing the education way before the train has left the station. It is providing this education to children before they even get to high school so that they are aware of the dangers that are out there. It is also making sure that we are providing the education without creating hysteria, because one of the questions that was asked before was about security in emergency departments. Violence has been going on in emergency departments long before ice was around. We have alcohol fuelled violence on the street now. That does not necessarily have anything to do with methamphetamines. It is putting resources on the ground, and I am as confused as you are about what they are. What resources can we put on the ground to make sure we do combat this problem appropriately. It is working out what we can put on the ground to support these individuals and their families to be able to help them either change their substance use or completely stop using the drugs or getting them on to something else that is better for them in the long run for life.

The biggest problem is that crystal meth is very easy to make. Crystal meth can be made anywhere. You do not even need a roof over your head. You can make it in a paddock.

Mr WILSON—The shake and bake method. You have not heard of the shake and bake? That is using the precursor chemicals, shaking it up in a bottle and left overnight and then it crystallises and you have a very impure form of crystal meth, but it is pretty easy to make.

The CHAIR—On that issue—and I guess I want to bring you back to the political reality—we talked about a requirement for more resources, detox, rehab. Politically the argument would be put that you have so many dollars in the health and mental health arena, you have potentially people that are sick and need beds and need help that have contracted an illness through no fault of their own, and they are waiting for a bed too. Yet you also have the requirement for those that self-inflict using illegal drugs that are looking for government dollars for detox. That is the next question about how to accommodate both, appreciating there is a need for both.

The question I want to pose to you—because I am not sure whether we are going to answer that one because there is always going to be a need for both. Early intervention seems to be the most practical method of trying to satisfy at least one part of that, and we talked about that this morning. I was interested, given where we are and the timing, is the New South Wales government has introduced laws in relation to late-night drinking, and the lockouts at 1.30—and given you are across both alcohol and drugs—what is your response to that, living in Victoria, about whether that would curb some of the public violence outside those establishments by stopping the access of public drinking and drug-taking, presumably, at a time which the government must have had some thought about whether it would have some impact.

Mr WILSON—Newcastle has demonstrated that. They have done a great job with that. I cannot see why you could not duplicate that in an area like ours, for example, or even in larger cities.

The CHAIR—Would that have the impact though that the New South Wales government is indicating to curb some of the street violence, some of the drug trafficking that is going on in those establishments at that time of night, getting people home and—

Mr WILSON—I do not think you are ever going to eliminate it. I think you are going to have some sort of impact on it, yes, if you do restrict the opening hours of establishments that are serving alcohol because, let's face it, once somebody is inebriated their ability to think rationally is rather impaired. They might think it is a great idea to use another substance like ice.

Mr CURRIE—I can certainly see the logic behind that but a lot of alcohol fuelled violence that is occurring, is occurring on the street. If you have people locked out of facilities we are still going to have people on the street as well. If we do not have enough public transport to get these people away from the streets then that is where the violence starts to come out. Certainly by locking them out it creates a barrier where they may not be able to get access to other drugs because they are not inside those facilities but once again you cannot guarantee that that is not going to be out on the street anyway. We can put these things into place to try to deal with the problems but this is cultural, this is something that is an issue in Australia forever because it is a cultural thing.

Although we are sitting here now and having a conversation about an issue that we have with drugs, Australians as a whole are fairly complacent about substance issues and they do not recognise that if you are drinking a whole lot of alcohol every night and you are going out and you are being violent towards each other that that is a little bit similar to the same problem as these people with crystal meth have, where they are using crystal meth, and that is creating mental health problems for them and they are being violent as well. It is a cultural thing. What we need to do to be able to curb all these problems that are going on in our communities is that we need to start at an early stage changing cultures of families, of parents and of children.

We need to be saying to mum and dad that it is not okay to sit at home in front of your kids and drink six stubbies every night and be abusive and swear. It not okay to smoke and drink and use drugs in front of your kids, because for them that is normal. 'If mum and dad are doing it, then why should I stop doing it?' It is cultural.

Mr SCHEFFER—I wanted to take a slightly different direction to the Chair's preamble on resourcing. You mentioned there was a lack of resourcing, Mr Wilson, in your presentation, and you said quite clearly, without contradiction, 'If you don't have the beds, you don't have the beds.'

Mr WILSON—Yes.

Mr SCHEFFER—You would both be aware probably that if you look at the 2013-2014 Victorian State Budget, that the allocations to the space that we are working with, of drugs, has basically flat-lined. VCOSS and VADA in their media releases at the time of the budget drew attention to the fact that there was a collapsing resource, flat-lining, given it is particularly urgent in the context of the growing need that you have both alluded to. How do you work in that space, given that you have both said it, how do you work with VCOSS, how do you work with VADA, to start ramping up arguments about resourcing?

Mr CURRIE—Well, VADA are in the process of doing that now. VADA are in the process of doing that. I am a member of the VADA board. We are in the process of looking at trying to engage the government in some serious talk about what is the future direction of drug and alcohol. We are looking at having a state election this year so what are the parties' individual attitudes towards drug and alcohol? Where do we stand with that? Are we looking at combating it? You are right, we are in the process now and so is every other drug and alcohol service in Victoria, we are going through alcohol reforms. Right now we are in the process of waiting to see whether our service will be the next drug and alcohol service providers in this region. As of the 2014-2015 financial year there could be new services set up in the region doing exactly the same jobs with exactly the same amount of money but we are in the process recommissioning ourselves.

Once again if it is not seen as a priority by governments to be investing money into this issue and investing at preventative levels as well and maybe investing some more money back into providing beds in rehab, then I put my hands up in the air. I am not sure what we can do to get the government to really start pouring some serious resources into this problem in our communities.

Mr SCHEFFER—Absolutely. Thanks.

Mr McCURDY—In terms of post-treatment programs, you are talking the equivalent of the Circuit Breaker at Benalla?

Mr CURRIE—Yes.

Mr McCURDY—Can you paint that picture—

Mr CURRIE—You would go further than that. People on crystal meth you would want more than eight weeks.

Mr McCURDY—Okay.

Mr WILSON—Longer than six weeks would be better. If we could get a six-week program we would take it, no doubt.

Mr McCURDY—I suppose that is why I am asking, can you paint that picture. It is only six weeks at Benalla?

Mr WILSON—At Benalla, yes, but they often refer clients who need lengthier treatment times to their main program.

Mr McCURDY—They have done their rehab in Melbourne.

Mr CURRIE—They will do a detox in Melbourne and then they will come to Mollyulah to do a rehab.

Mr WILSON—Then maybe go back to Melbourne to do longer—

Mr CURRIE—Rehab is teaching people those life skills again.

Mr WILSON—Relapse prevention, self-esteem building.

Mr CURRIE—But also how to budget, how to do a job application, how to cook a meal, how to separate your colours when you are washing your laundry. They do all of that sort of thing so they are teaching these people life skills again. A lot of them have lost the ability to operate under that level.

Mr McCURDY—Okay, thanks.

Mr SOUTHWICK—Given that this particular drug we have heard that there is a very strong social element of people smoking in groups together, what are your views about people again leaving the region and returning back into an environment in which they have their mates et cetera.

Mr WILSON—It is a huge problem for us. If you send somebody into a treatment facility and they spend 12 months in a treatment facility and then they come back to all the same kind of pressures you can imagine that the risk factors then are exactly the same as they were before they left, if not worse. It is a huge problem for us. Housing is another issue because there is only a limited amount of public housing stock available. In terms of supported accommodation programs, really we would love to have a supported accommodation program. We do not have the resources to be able to run something like that. Once a person came back from a treatment facility in Melbourne, we could support them in, say, a two-bedroom unit or a house where we would go into the house.

Mr SOUTHWICK—Is there any active element counselling—I suppose the next element of this—to advise clients to relocate, to get out of the environment—

Mr WILSON—Often I have said that to clients.

Mr CURRIE—You can certainly encourage people to do that but that is not an easy thing for anyone to do.

Mr WILSON—They are leaving their families here often.

Mr CURRIE—We also have had people who have gone through the process and they have done their detox and then they have gone to rehab and they have had a really successful rehab, then they have come back to the area and they are determined they are going to stay off it, but they are also socially isolated because the friends they used to hang out with were users, and they have to disconnect from them. There is a grief process in that. They do grieve for loss of that social connectivity. Sometimes there is that barrier with their mum and dad or their family where they have already burnt some serious bridges with mum and dad. They want to reconnect with their family as well but their parents might be either extremely mistrusting, or the other end of the scale and be over-protective and will not let their children make their own decisions. It is very hard for them to come back here but no less hard than it would be—I mean, I could say, 'Look, why don't you relocate to Wangaratta or Benalla, let's get you into that region, move you away from your friends here and we'll get you started and help you get

back on your feet.' They will be sought out by drug users in that area. People will come and knock on their door and offer them drugs simply because that is how easy it is to get crystal meth in the area. People knock on your door and offer it to you.

Mr SOUTHWICK—One unrelated question. You mentioned about the cross-border issues earlier in your opening statement. Our previous witness was talking about the very good programs and systems that health have in relation to the processes that are set up. Is there anything we do not have in Victoria that New South Wales does have that we could learn from?

Mr CURRIE—No, I think we would be on a level playing field with New South Wales. What Bill was referring to probably was that with Albury-Wodonga Health it is merging to become one service which has been a long process over a long time and has not gone exactly smoothly, from a Victorian perspective and from a New South Wales perspective. We are not really sure of the processes, and therefore sometimes that communication is not had because we are not sure who is responsible for what.

Mr WILSON—Two separate towns.

Mr CURRIE—The Victorian Drug and Alcohol Service, nearly every clinician that works in the drug and alcohol service in Victoria is dual-diagnosis capable. Therefore, they are able to support people with their mental health issues, as well as supporting them with substance misuse. Nearly all drug and alcohol workers, certainly within my team, have the training and motivational interviewing, have the training and cognitive behavioural therapy, have the training and acceptance commitment therapy. They do all this work and they do a very therapeutic based approach to all of our clients.

The service that we provide on both sides of the state I would say is great, it is just at the moment we have this drug that is rewriting the book. It is not the usual drug that we have had in the past where there is evidence to say that if someone comes into us and they are on heroin we can offer them a pharmacotherapy or we can send them to Melbourne to do a detox and we can send them then to rehab for a detox, and hopefully that will be fluid. It may not be but it is a lot easier to support them between those two barriers than it is to support someone with crystal meth.

Mr SOUTHWICK—Lastly, your relationship with Victoria Police in terms of referral.

Mr CURRIE—Yes, we get support with—

Mr WILSON—Yes, diversion—we get a lot of diversion clients or clients that have been arrested or charged and given a warning. They come to us for treatment. We do have a reasonably good working relationship.

Mr CURRIE—Victoria Police are trying to combat it from a health perspective. The message I get from the police certainly is they do not see every single person that is a drug user as no benefit to society. Like, they are wanting to help them just as much as we do.

Mr SOUTHWICK—Yes, thank you.

The CHAIR—The evidence we have had this morning—and I am not saying this is for everyone—is there is a different demographic of users. We get the bored housewife who wants a bit of a pick-me-up during the day to get her through what is normally a mundane housekeeping role, and that is no disrespect to anyone involved in that. There is the tradie who, some would suggest here, are overpaid and underworked in certain circumstances on certain projects. They are using ice as a recreational filler for the day. Then you have the habitual user who, if they are not using crystal meth would certainly be using something else. But $2,000 to $3,000 a day, as was suggested to us this morning, for a typical long-term user,

how is it possibly financed? Even I cannot understand if I had to pay $2,000 or $3,000 a week for a recreational drug, financially I would not have the means.

Mr WILSON—It is unsustainable, that is true, yes.

The CHAIR—Your clients, I suspect, are not those people.

Mr WILSON—No, they are not recreational users. We do see the odd recreational users, no doubt, but most of the people we see are dependent drug users, and they are poly drug users. They are not only users of ice, or they may have graduated to ice because ice was all they could get. We have even seen people swapping from heroin, for example, to ice because there is no heroin available. Heroin availability in this region goes up and down, it fluctuates, like most drugs do, but definitely ice would be more available than something like heroin.

The CHAIR—So how do they get the means—

Mr CURRIE—It is also that pyramid system where the supplier provides the user with the drugs, and the user takes this much drugs and puts that much aside for personal use and then sells the rest.

Mr WILSON—Yes, and dealing.

Mr CURRIE—That is how they fund their use.

The CHAIR—I did not know if the associated increase in crime in this area with the Victoria Police—I will have to check the record again but to my mind if that is the case then the crime activity must increase substantially to be able to support the expense of running a habit like that.

Mr WILSON—Yes, you would think so, wouldn't you? We have not talked at all today about synthetics, and I am sure you are aware of the synthetics. There is synthetic speed, there is synthetic marijuana which is a different ballgame again. Recently the Border Mail did a good story, it was a good outcome type story. We had two clients who had purchased synthetic—I think it was marketed as synthetic cocaine. It was not cocaine, it was another type of substance that we had never really encountered before. That caused all sorts of nasty, psychotic symptoms in a male and female, and they came to us, did detox, did a withdrawal. One of them went to Circuit Breaker for a while and then came back. Unfortunately they lived a little bit out of town, and they had a rental house that was owned by a builder, and the builder had given them fairly low rent and said, 'If you fix the house up I'll pay for the material.' They had a project to work on as well. We supported them through that process and now they are doing really well.

Mr CURRIE—I do not know what the crime stats would be at the moment. I could not even tell you but usually a lot of the users that we have that come through the door, the way they pay for their habit is they distribute. They then sell on. They will take some and they will sell on the rest. That means they will pay $20 to get their supply and then they will sell that supply for $30 and that allows them to pay off their debt and also have some for themselves usually.

Mr WILSON—The other answer to that question might be that perhaps law enforcement is not that effective really.

Mr CURRIE—Here they have made a few raids and all that type of thing.

Mr WILSON—Yes, they make raids but how much of an impact do they make? How much of an impact do they make on the organised crime gangs in the region?

Mr SOUTHWICK—In terms of the educational messaging, is the thing that we really need to get out about this drug is the addiction component of it. We are grappling in terms of what is the messaging for our young people to ensure that particularly first-time users do not have that first experience.

Mr WILSON—That is true, and there is nothing specifically designed from an educational perspective about crystal meth, specifically. We know some of the basics about it but do not have a package that we can put together and take into schools, for example, where it could be well used.

Mr CURRIE—It is like the Quit program. You do not need to reinvent the wheel. Have a look at the reduction in smoking over the last 20 years just because people were there with the facts. The facts are about crystal meth is that it will shorten their lives; that it does have shocking effects on you physically, and it does have shocking effects on mental health. As a government they can provide an education portfolio that focuses on that and saturates the media with that, that kids are made aware that this is the outcome of it. If you participate in this drug use then the outcome—

Mr WILSON—Yes, expect the consequences.

Mr CURRIE—It is really important as well—and it is something that has not been said much throughout this inquiry—that we need to make sure that people that are using are not seen as the problem. You said before where you were talking about beds that this is seen as a self-inflicted thing and why should you provide beds for people that are doing something self-inflicting when there are people out there waiting for beds that are not self-inflicting.

The CHAIR—They are not my words, mind you, they are words that—

Mr CURRIE—No, that is fine, but what I am saying—

The CHAIR—It is about sharing the health dollars.

Mr CURRIE—Yes. What I am saying is if the community had that attitude of, 'They're drug users, it's their fault so why should we do anything to help them because it's their own fault.' That is where that would build barriers and people that are on crystal meth, whether they are the housewife or the tradie, will all be categorised as the one thing and we cannot help them because it is their fault, their responsibility for that. We need to be really careful of that and make sure we do not stigmatise people into a silo of no benefit to society.

Mr WILSON—Stigmatism is a huge thing for our clients. They are stigmatised.

The CHAIR—We heard in evidence where there was a refusal of care of a user. We see there is some stigma attached.

Mr CURRIE—You are a social pariah if you are a drug addict.

The CHAIR—Whereas alcohol was kind of different in a way. It is socially sanctioned.

Mr WILSON—Absolutely. Look at what illegal drugs have done, the damage they have done. It is massive.

Mr CARROLL—Do you remember the 'Ice is a dirty drug' campaign?

Mr WILSON—Yes, I do actually. There has been some work done. Some of that stuff is useful.

Mr CARROLL—That was initiated under the previous government. It was quite

graphic.

Mr WILSON—That is right.

Mr CARROLL—Do you support that type of campaign—like, TV, social media—as getting the message through?

Mr CURRIE—I would support that campaign, absolutely.

Mr WILSON—Yes.

The CHAIR—Any other questions?

Mr SCHEFFER—More recently, the idea has been introduced to us through witnesses about the relationship between the use of methamphetamines and alcohol. We know about the poly drug user, and there is a kind of an interrelation there where it can facilitate greater drinking.

Mr WILSON—Yes, true.

Mr SCHEFFER—There is the possibility that the increased violence that we are seeing is maybe more related to the increase in alcohol that is facilitated by the ice.

Mr WILSON—It could well be.

Mr SCHEFFER—But that is a speculation.

Mr WILSON—It is a speculation, yes.

Mr SCHEFFER—It is a speculation but it has been put to us. On the other hand, we heard a witness this morning that said, no, the venue operators are saying because of the price disparity—the investment in buying the ice—that then to go into a venue and spend a whole lot more money on alcohol is not really what people do, they tend to drink more water. They go in there and lower their alcohol consumption because they have already used some ice. There are two different views. Do you have a take on that?

Mr WILSON—It really depends on the user and how much money they have. I have heard guys come and say they have spent $3,000 in a day, and that is not uncommon, but that is amongst a few people. If they are doing it in a group, somebody has some spare money somewhere along the line. Drinking is part of the deal. It is not only one drug we are talking about here, it is a number of different drugs and often cocktails to a varying degree.

Mr SCHEFFER—On social media—another interest of ours, of course, is a business model and how it is marketed and retail. Do you have views on how social media is used?

Mr WILSON—What about Silk Road, for example?

Mr SCHEFFER—What about Silk Road, for example?

Mr WILSON—Yes. It has been taken down now but there is certainly any number of different individuals ready, willing and able to take its place very quickly. Facebook causes a huge problem.

Mr CURRIE—It is massive.

Mr WILSON—Young people think they are invincible. All of us when we were 16 and 17 thought we were going to live forever and do whatever we want. It is all that sort of stuff. I have had this conversation with VADA board in Melbourne and that is that even films

like Breaking Bad glorifies the production and the use of drugs. That is probably the worst thing that could have ever happened because it did certainly glorify it and make it look like it was not that bad a thing that even a schoolteacher can get rich from doing it.

Mr WILSON—A chemistry teacher.

The CHAIR—Thank you. We might draw this session to a close. Can I thank you both very much for your time this morning.

Witnesses withdrew.

The CHAIR—We will suspend the hearing until 1.30. Thank you.

Hearing suspended.