LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Mildura — 5 December 2013

Members

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Ms N. Davey, General Manager, Health/Family/Community, Mallee District Aboriginal Services.

Mr I. Mansoor, Manager, Primary Health Care, Mallee District Aboriginal Services.

Mr B. McKinnon, Manager Mental Health Services, Tristar Medical Group.

The CHAIR — Welcome and thank you for your time. I appreciate that you are from Mallee District Aboriginal Services. On behalf of the committee, I acknowledge the Latje Latje tribe, the custodians of the land on which are meeting today, and the Paakantyi tribe, who I understand are from the other side of the river, and we pay our respects to elders past and present.

We have allotted until 12.30 for this session. I appreciate that you want to make a very short contribution. Committee members will then ask questions of you. I know that you are familiar with the reference and the inquiry into the supply and use of methamphetamines, particularly ice, that is being conducted by the committee, which is one of 12 joint party committees of the Parliament.

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 have said in evidence, may not be afforded such privilege. Have you received and read the guide to witnesses presenting evidence to parliamentary committees?

Mr KIRBY — Yes.

The CHAIR — It is also important to note that any action that 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 a proof version of the Hansard transcript at the earliest opportunity so that you can correct it as appropriate. You are aware that we also have media in the room. On that basis, who is presenting first?

Mr KIRBY — It will be a short presentation. Nahtanha will present and then we will answer any questions that the committee wishes to ask. On my behalf, thank you for the opportunity.

Ms DAVEY — It is a shared presentation by Imran and me.

Overheads shown.

Mr MANSOOR — My name is Imran Mansoor. I work at Mallee District Aboriginal Services. My background is in mental public health and currently I work as the primary health care manager. Having started over here in Mildura, I have noticed that the mental health issue is a growing problem among the Indigenous community. Alcohol and drugs are a problem and now we have encountered increased usage of the methamphetamine known as ice. It is no secret that drug use in Australia is increasing. Aboriginal communities are no exception, and we feel that Aboriginal communities are at greater risk of harm because of their history, the impact of the colonisation and the inequity that they have gone through.

Ms DAVEY — Can I just add to the presentation on the availability of the drugs and the marketing strategies at the moment as reported by our clients. Initially they are given free samples and given credit up-front for the drugs, obviously because they are vulnerable, as Imran has stated. When they are seeking more, if there are no finances, it is easier for them, isn't it? That is why our vulnerable clients, our Aboriginal community — these are our people — are being significantly impacted upon.

Mr KIRBY — I think when you look at the data here in Mildura, over 60 per cent of youth justice clientele are Koori, and 40 per cent of the correction clientele are Koori. If you look hard at those vulnerable individuals, from my point of view it is quite concerning.

Ms DAVEY — Obviously there is an increase in mental health issues, depression, paranoia and psychosis. There are other drugs that they use — alcohol and marijuana obviously. We see that on the ground every day. Obviously there are increased rates of family violence, and we see disengaged Aboriginal youth. These are the members of our community.

Mr SOUTHWICK — So just to clarify that, you are suggesting that Aboriginal people are being particularly targeted by being given free samples?

Ms DAVEY — They are more vulnerable, and they are definitely being targeted.

Mr SOUTHWICK — And given credit to get them onto the drug.

Ms DAVEY — They are provided with credit so they can have the drug.

Mr KIRBY — Once you are hooked, you then deal.

Mr McCURDY — Do we know whether this is targeted just at Aboriginal people, or is it other groups as well?

Mr KIRBY — I think it is broad as well. That is the feedback we are getting from our clientele, which is Koori-specific. But in general it is the feedback we are getting from our clientele.

Ms DAVEY — Obviously there is associated criminal activity that we see.

The CHAIR — Sorry. For the record, you are definitely not Ms Raelene Stephens, Imran — —

Mr MANSOOR — No.

The CHAIR — My apologies. Do you have a title with the MDAS?

Mr MANSOOR — Yes, it is called manager, primary health care.

The CHAIR — Manager, primary health care. My apologies, Imran. In the rush of everyone sitting down, I suddenly realised I was a female short.

Ms DAVEY — Raelene is very sick. Of course she wanted to be here.

The CHAIR — Welcome, Imran.

Mr MANSOOR — Thank you very much.

Ms DAVEY — Imran is our manager for our comprehensive primary health care service.

Mr MANSOOR — I think the increased use of methamphetamine is due to the increased availability of drugs. Now you have drugs that are very easily available in Mildura, Mainly they use methamphetamine and they do not know about the side effects. They are not from a medical or scientific backgrounds, so they just use drugs for recreation not knowing the harm that can be done.

When we are looking at ice there are three problems with it. One is that you can develop tolerance. Another is that you can develop dependence, and then there is the problem of the lethal dose. Initially young or vulnerable people might use the drug for recreation to get an initial high. We know that methamphetamine is a stimulant. It increases neurotransmitters, dopamines and serotonin and so people use it to experience an initial high. Then what happens is that they develop a tolerance to the drug and they have to use increased dosages of the drug to experience the same high. Now just to get the same high they need to increase the dosage.

The next stage is that they can become dependent on the drug — that is called dependency. They become dependent on the drug, and if they do not get it, they experience lethargy, exhaustion, tiredness and withdrawal symptoms. The third is the lethal dose, which can cause death or increased suicidal tendencies. People do not know what the lethal dose is, but they just keep increasing the dose and having more methamphetamine to get high. They do not know that they could be taking a drug overdose. These are some of the problems we face.

The CHAIR — How do they afford to do that at $100 a gram?

Ms DAVEY — They start using it recreationally. Our community members think it is okay to have the drug for recreation, but they do not understand the impact on their brains.

The CHAIR — But how do they afford it?

Ms DAVEY — I guess they turn to crime.

Mr KIRBY — Quite simply crime.

Ms DAVEY — Unfortunately.

Mr KIRBY — They turn to anything that lets them have it.

Ms DAVEY — Increased crime rates within our communities. It is evident.

The CHAIR — Are they part of the trafficking?

Ms DAVEY — There is evidence.

Mr MANSOOR — There is evidence. I think anybody could be a part of the trafficking and manufacturing; it does not have to be only the Indigenous community. If people come to Mildura looking for a drug, they might ask an Indigenous person if they know where the drug might be available. But it is not only the Indigenous community; the rest of the population I think is equally vulnerable.

The CHAIR — No, I was not suggesting it was specific to the Indigenous population.

Ms DAVEY — No.

The CHAIR — We have talked about the extremely high cost for a small amount of the drug whether it is for Indigenous people or others in the low socioeconomic demographic. How do people afford to buy it? You are talking about tolerances and increased use.

Mr KIRBY — Certainly dealing. I think if you are in that position, you will turn to any means to fill your supply whether it means dealing and trading it on or selling it on to other community members.

Ms DAVEY — There are other significant impacts, and we will talk about that later in the presentation. We see a significant rate of homelessness and people not coping with everyday basic living needs. The impact is that they are spending their money on their addiction. There are key drivers. I had a discussion with the Australian Bureau of Statistics. What did you say about all the wrong boxes been ticked for Mildura?

Mr KIRBY — Mildura ticks all the wrong boxes for all wrong reasons.

Ms DAVEY — And because they are paying for their ice use and not paying for their basic living needs.

Mr MANSOOR — What has happened is that ice has now replaced alcohol and marijuana as the recreational drug — —

Ms DAVEY — At the local level here.

Mr MANSOOR — At the local level. Previously they had been using alcohol and marijuana, now they prefer to use ice. That is from just looking at the statistics.

Ms DAVEY — Significant supplies, readily available.

Mr MANSOOR — But we do not think that a supply reduction and a demand reduction would have any effect. As we have already stated, there is a dependence, and if you cut down demand, that would mean they would not have the drug anymore and they would suffer from

withdrawal symptoms. The best way to manage it is to taper it off and you need people and facilities for that. You need a withdrawal support program.

Ms DAVEY — Which is part of our recommendations as well.

Mr MANSOOR — Which is a recommendation as well. The problem with the demand reduction and the supply reduction is that if you cut down the supply, there will be increased criminal activity. People will not know where to seek help, and they might just go somewhere else and try to get the drug by other means.

Ms DAVEY — And that is what we are seeing here in this community. Moving on to the next slide — —

Mr SOUTHWICK — Just a question: in terms of the people who are being caught up in drug use, are you seeing it is a broader clientele than you may have seen before and that would normally have had an alcohol or drug problem?

Ms DAVEY — Alcohol or drug.

Mr SOUTHWICK — So not necessarily the really vulnerable group that has always, if you like, had issues but a broader — —

Ms DAVEY — Absolutely, you are right. That is exactly what we are seeing.

Mr SOUTHWICK — Within the Indigenous community specifically?

Ms DAVEY — Yes, absolutely. These are your typical vulnerable clients that we see that would normally have significant alcohol issues. But now they have something better to stimulate them.

Mr SOUTHWICK — But I am saying in addition to that other people who are being caught up are not the traditional type of person you would support but maybe just a middle-class working person who is being caught up with the drug as well?

Ms DAVEY — Absolutely. I think we talk about that on the next slide.

Mr MANSOOR — This is what we call the environmental risk factors and behavioural risk factors in primary health care. The environmental risk factors are the company of your friends, peers and what they are doing. We did some case studies. Some people come to us for help and support, and they are at risk of relapse. Even if they stop the drug and alcohol use, there is a high risk that after six months they will start using again. Sometimes the best treatment is to send them far from their circle of friends. If they go somewhere else, there might be a chance that they can stop using the drug. There are definitely environmental risk factors, and there are behavioural risk factors — these people have been using alcohol and other drugs before and now they just want some other drugs to repeat that. There are socioeconomic factors. Because it is taken as a recreational drug and people use it for parties, it is mostly the young people or young couples who use this drug.

Ms DAVEY — We also talk in our presentation about people who are suffering depression and have low self-esteem, and that is what we are talking about — the ones who are not just regular users of alcohol and marijuana but might just have other types of symptoms in terms of depression or may not even be part of that category; they could be disengaged youth. But these are the people that we are seeing presenting in our health service within our AOD team. Like I said, they are persons with existing mental health problems, those with low literacy and numeracy with very little prospect of gaining employment, our vulnerable children of course, and our vulnerable young people. Often we see our victims of family violence taking up the use of this drug or single mums who are having financial difficulty. These are the types of clients that we have seen come through our service within the past 12 months affected by ice. Obviously these are our Aboriginal community clients.

Mr MANSOOR — If we move to the next slide and the one after that, I think we have discussed that subject.

Ms DAVEY — Yes. We have discussed that.

Mr MANSOOR — This slide tells us about some of the side effects of the drug. If a person is detected and continues using the drug, what happens is that their mental health, their mental state of mind is affected so there is more chance of paranoia, attracting negative thought, suicidal ideation — —

Ms DAVEY — Psychosis.

Mr MANSOOR — Psychosis and increased chance of the person committing suicide. It is also seen as a stimulant that has an effect on other systems of the body. The cardiovascular system is affected and there is the chance of a person going into a heart attack because of increased dosage or because of withdrawal. There is also a stigma attached to the use of this drug. People feel a bit ashamed when they want to access alcohol and other drug services to seek help to sort out this problem.

Ms DAVEY — We have seen this as a significant issue within our Aboriginal youth, particularly our Aboriginal men. They feel ashamed because they are so addicted to ice and they are trying to come off and do better for themselves. They are very ashamed of where they are at. They are ashamed because they have a debt that they have accrued and they are ashamed because perhaps in some cases they have been contacted by the dealer and the dealer is threatening them and their family. We have seen this more than once within our community, and tragically we have lost our members.

Mr KIRBY — Five suicides in four months, all aged between 17 and 19 — and male.

Ms DAVEY — It has hit us really hard that we have had to see the significant impact this has on families and on our youth, on our men, on our women and everybody in our community. But given that it is so close and still so raw for us, five is a significant number.

Mr CARROLL — Was that this year?

Mr KIRBY — Just recently. We just set up that suicide task force in partnership with Northern Mallee Community Partnership, which I sit on — they just presented beforehand — and in partnership with the commonwealth. StandBy is the national response team. They are currently working here for the next 10 weeks on the bereavement, trauma and loss in the Sunraysia area, across the border over at [inaudible]. The suicide rate is just phenomenal. We are trying to work out what the driving factors are. Anecdotal evidence is that it is ice, but we want to make sure we know what the issues are before we say it is ice. Look, it is a contributing factor, but before we say that is the only issue we want to make sure that we deal with all the contributing factors around why young men in particular are committing suicide here in Mildura.

Mr CARROLL — Did they know each other?

Mr KIRBY — Yes. It is a very tight community in Mildura. Certainly there is no clear indicator as to why five young men within four months decided to commit suicide in Mildura. There have been a lot more of course; there has been a whole cluster, one after the other, so that is a significant concern for us in Mildura. We are trying to deal with why young men — we know that one or two of the men were certainly using, but with the others, as I said before, we want to make sure we know what the facts are first. That is why we have partnered with StandBy, the national response team.

Also, the other issues here have been for us, in our early years — the reports that I have gotten back — and I do not want to jump on board with your report, guys. When I spoke to my midwife, the report she gave to me is that when you see a newborn bub born to an ice addict, there is nothing you can do. You have this crying baby who cannot receive any medication, any support, because the child is born addicted to ice.

Mr SOUTHWICK — The child is what, sorry?

Mr KIRBY — Born addicted to ice; yet the mother does not acknowledge it because of the shame factor and the stigma associated. It is great to do the publicity and the promotion, but on the flip side is the shame factor of community members trying to hide their use. So you have to try to find a happy balance, a happy medium, whereby then you have got this mother, whom we know is an ice user but is not acknowledging it and seeking the appropriate help. Then we have got this issue of a young mum and our midwives and our early team trying to support and seeing the effects of this little bub who is really struggling. That is not just a one-off.

Mr CARROLL — So that is the shame factor in dealing with ice. Is there a shame factor with alcohol?

Mr KIRBY — Not necessarily, no; not what we are seeing with ice, no.

Mr MANSOOR — No. It is the drug that — —

Mr CARROLL — Ice is a dirty drug.

Ms DAVEY — It brings that bad to you. It is threatening your family.

Mr KIRBY — With alcohol, we have been able to deal with it; people come out and deal with it. Then we can provide support, and they acknowledge that they have got a drinking problem, but with ice — —

Mr CARROLL — It is the shame factor.

Mr KIRBY — A lot of alcoholics within the community have tried to bury it and hide it. But it is there.

Mr CARROLL — That is something for the committee to consider, breaking down that barrier and that perception. You have got to acknowledge the issue. It is not about being ashamed about being on it; it is about what you deal with, what has led you to the drug and how we can help.

Ms DAVEY — Yes, that is right.

Mr SOUTHWICK — Just on that, when are they seeking help, and how are you accessing help for your clients?

Mr MANSOOR — It is different strategies that would drive the pick-up plans we have been using for those who need help. Some of them might come and access our services because they need support; they are out of money, they do not have a job, so that is one way to deal with them. We have got comprehensive health services combined with community and family services. That is one way. The other way is that they come to our mental health counselling team. They have psychosis, paranoia, they are in severe depression — —

Ms DAVEY — Most times they do not tell us that they are using ice. You find that out along the way, and that is what Raelene has some concerns with within the AOD team. They come in presenting with these issues and talking about the fact that they are using marijuana, they are drinking a lot, but then she finds that they are using ice as well as the alcohol and marijuana. But alcohol and marijuana are their primary choices of drug, and then the using ice to obviously complement and stimulate those effects.

Mr SCHEFFER — When you opened, Imran, you spoke about the traumatic impacts of colonisation, and clearly we have heard that; we know that in the culture, and we know that from other Aboriginal groups that have come to talk to us. Could you just expand on that, given that is kind of the underlay, in a sense, of these other — the homelessness, drug dependencies and mental health issues that you have mentioned?

Ms DAVEY — Literacy, numeracy, homelessness.

Mr SCHEFFER — Literacy, numeracy — the range of things. They sit on this existential issue of colonisation. Can you talk about that a bit more so that we have got some sense of that on the record?

Ms DAVEY — Yes, we could all talk a little bit about that.

Mr MANSOOR — Yes. If you look at the history, what has happened is that the Indigenous communities have suffered from inequity. That has caused a low socioeconomic status and mental health problems and depression. To get out of these problems of depression they have moved on to alcohol and drugs as a way of picking themselves up and feeling a bit better, without knowing much about the harms of the drug. There is still a lot of unemployment, the education levels are really low, and just before the last decade there were a lot of inequities. They did not have equal opportunity or equal access to all of the health services, which I believe have led them to using more alcohol and drugs.

Mr KIRBY — I think a lot of it also, ever since colonisation, is dealing with the long period of trauma and dealing with grief and loss in the sense of colonisation. When you look at the fact that we are talking about the 1970s — —

Ms DAVEY — Yes, the stolen generation.

Mr KIRBY — Yes. The Koori people have, in a sense, only been able to have an equal footing in Australia since after the 1967 referendum and other things that took place. When you look at it like that, it has really only been a generation since Aboriginal people in Australia have been able to participate as equal citizens. If you look at the commonwealth Racial Discrimination Act, that came in in 1975, and all of those sorts of factors really only kicked in in the 1970s, and I think you are seeing a lot of grief, trauma and loss particularly with regard to the stolen generations, the return home, and dealing with their grief, loss and trauma.

For many years it has not been acknowledged that the stolen generation happened, which caused the grief, loss and trauma. There was the use of missions and previous acts that were moved by the Victorian and commonwealth parliaments too. I am not pointing the finger at anyone in any way, shape or form, but when you look at those past practices, at a time when Parliament moved laws that they thought were in the best interests of Aboriginal people, in hindsight they were not. In reality Aboriginal people in Victoria have really only been participants since the late 1970s. When you take into consideration that I was born in 1972, I am hoping that the next generation and the one after that — my children's children — will far exceed what I have been able to achieve in my life.

I think there is a lot of grief, loss and trauma that my family and friends at my age are still struggling to come to terms with because of what happened in the past, and dealing with that grief, loss and trauma. It sits underneath the anger — the pain of knowing what happened to my aunties, uncles, grandparents and great-grandparents. That loss still sits in there. I have sat within cross-cultural leaders training sessions with the Department of Justice in Melbourne and other places, and an individual person will ask: 'When are the Aboriginal people ever going to get over this?'. The response of one of the elders was, 'How do you think the Jewish people would feel if you asked them, "When are you going to get over the Holocaust?"?'.

So for us, you need to put those things into perspective, and when you take those things into consideration it has only been, realistically, in the last 20 or 30 years that Aboriginal people are trying to position themselves, whether it be with social indicators or about economic participation. It is going to take time, and that is the issue. It will not be an election response in the sense of dealing with that trauma and loss that has happened over 150-plus years. It will take time to deal with that, and the whole social infrastructure of the role of Aboriginal people.

We have a lot of strong men and women in our community, but the men lost their positions in society as being protectors and warriors and looking after the families and children — not being involved in issues around family violence. Family violence in the community is off the Richter scale, and I for one, as an Aboriginal man, am appalled by that, and I have talked for ages about it.

I know this is not necessarily the time to talk about it, but when you look at those underlying factors, those who are most vulnerable turn to the things that stimulate them, and ice is one of them. It takes away the pain, the grief and the loss of not understanding why.

Ms DAVEY — I think it is also important to mention that within our community I drive past massacre sites of Aboriginals who have been massacred, and that is still alive in our community. It is there on view for us, and we can talk to our families about it and it is still raw for a number of our community members.

The stolen generation and the colonisation disconnected us from our community, our culture and our traditions, and our community has suffered from that disconnect and from not knowing where they belong or their real cultural traditions. There are a number of missing pieces to that history, to where they belong, and it is that trauma that they are still dealing with. We have housing that is a significant issue, where our community members are separated from the township and still disconnected.

Transport is an issue, employment is an issue, engaging our kids, our youth, schooling is an issue — this is Victoria. In this day and age that should not be happening, but it is, and it is very raw for us still, for all of us. Connection to culture is what, as an Aboriginal-controlled organisation, we are trying to bring back and enrich.

Mr McCURDY — In terms of your community, which age groups are you targeting?

Mr KIRBY — I think for an organisation and a community in the sense of the ice, it is affecting everyone. But I think in our organisation, our priority at the moment is that we are investing upstream. Our biggest priorities are from conception to four years of age, and to eight years of age. This is where the least investment is made by government. We know that, if we can invest there, we can change the next generation.

Ms DAVEY — Key ages and stages.

Mr KIRBY — Key ages and stages, and it is a model that we have just won a number of awards on. We know that, if we get the attachment theory right with mum and dad, the protective factors kick in where mum and dad want to protect the child. We know that the brain develops from nought to four. We know that, if you get it right there, all those other things downstream we can deal with. We cannot say it is not going to happen — we know all these sorts of things — but as an organisation we believe that we need to invest in the next generation to close the gap.

Mr SOUTHWICK — How do you do that with the situation when a child is brought up in an environment that is surrounded by, say, alcohol — if you compare that with alcohol, which we have struggled for generations to deal with in Indigenous communities? We now have yet another problem, which is more intense, in ice. How do you fix that from a generational perspective?

Mr KIRBY — I have a good answer for you: we have this model called bumps to babes and beyond. It is an intense case management model, and it works on a wraparound service. At MDAS we have a one-stop shop. We provide everything from housing to health to family services, child protection — you name it, we do it. What we provide in that bumps to babes and beyond, is intense support. We were working with 10 families in particular. Only the high-risk ones, and if you take into consideration all the other vulnerable factors in the Koori community, we work with 10 of the most high-risk mums and dads. Not one child was removed under this program in the two years it has been running.

Ms DAVEY — These are extremely vulnerable clients.

Mr KIRBY — Extremely vulnerable first-time young mums, 17-year-old homeless people — there is a whole presentation we have done with secretaries across the state. This model provides a wraparound, so it is about what is in the best interests of the child. So they support mum and dad and link them into all the support services. The reason we set this program up is because when I first became CEO at MDAS I had the case of a 17 or 18-year-old pregnant girl with her

first child who committed suicide four days away from giving birth, and there was a whole myriad of support services supporting this young mum, and ice could have been a contributing factor — I do not want to say what was driving her — but no-one was communicating.

So this is what we have set up. What we thought about doing is providing an intensive case management model. Yes, it is cost-intensive, but it actually works. It provides all the support services around housing, health, providing intense support for mum, understanding how to support the child and the key milestones for the child. That is the support service that we have put up as a model to the department. If you get it right here, we are not turning our back on the rest of the community by any means — that is why we have our vulnerable family support services, our drug and alcohol programs, our housing programs, youth justice programs, our support programs for men on community corrections orders and all of those sorts of things — but for us if you really want to turn things around in the Koori community around closing the gap, the area to do it in is nought to four. I do not think this is the right forum for it and I do not want to hijack it, but for us that is the age group. That is where our community is going. Everything else is bandaid solutions and bandaid responses.

The CHAIR — Can you just stop there, because I am mindful of the time and of the fact that we have not heard from Mr McKinnon. We have got about 6 minutes left. We will come back, because I would like to canvass the recommendations in your submission. Brett, I invite you to make some comments.

Mr McKINNON — I am here in support of the MDAS sub-team. Tristar Medical Group is the largest supplier of general practice services throughout the district. We have about 40 000-odd registered clients. We hold the ATAPS funding for the Indigenous community. We see lots of clients coming through who are having problems attached to ice in particular. We provide support to some of the families and extended families of people who have been the victims or who have had experience of family members or significant others committing suicide.

In our experience, some of those deaths have been the result of ice use and getting caught up in that vicious cycle of being drawn into dealing and then having the dealers, so to speak, or the suppliers knocking on their door and making threats to them, their families and significant others et cetera. We are aware that is a real hazard, especially in vulnerable communities as such. Certainly the people the suppliers have been targeting were vulnerable. From the outset they have had a lot of adversity stacked up against them in the first place, and they potentially saw dealing as a way forward or a quick way forward. There is a lot of complexity and hazard in and around that, as we have seen from the outcomes of some of those cases.

We are certainly very aware and very supportive of what MDAS is trying to do in some of its programs. We are supplying a mental health nurse to MDAS to do some work with the community, to see some of the Indigenous community and provide some support. That is starting up as of next week. We are trying to partner, where possible, to assist all and sundry.

We have a model — and I am touching upon the comments of the previous presenters, where they talked about getting into schools and so forth. We have a school model that we started in the last 12 weeks, where we have supplied a mental health nurse and a GP to one of the local senior colleges. Part of that process is supplying generalist health but also mental health input as well as education and training for the education staff and for the student cohort in and around mental health issues but also drug and alcohol issues. I certainly support the previous presenters in saying that is where it needs to start; getting in early and educating people as adequately as possible as a preventive measure, rather than playing catch-up at the back end where you have people who are already affected by the substances.

Mr SOUTHWICK — What age of kids are you targeting?

Mr McKINNON — We are in senior college — that is, the years 11 and 12 cohort. That is often the time we are seeing the first onset of illness, and it is often the time when people are first starting to dabble in some of these recreational substances as well. We are hoping to have a huge impact. We already have a similar model up and running in Bendigo Senior Secondary College,

and it has been getting rave reviews from the college community. That service in itself is actually expanding. Other secondary colleges within the district have also approached us to see if they can have a mirror service operating out of their schools and so forth.

Mr SOUTHWICK — And what message are you delivering to the kids?

Mr McKINNON — We are doing a mixed bag. We are obviously providing consults for people who are at risk. We are providing generalist services, but the education and training is in and around mental health conditions but also the negatives of drug and alcohol use and abuse in the longer term. Immediately we are effectively saying you are playing Russian roulette with your brain by partaking in some of these recreational drug-taking habits.

The CHAIR — Is that too late? We have been told there are 12 to 14-year-olds actively taking ice at the moment. Should you be intervening at an earlier age?

Mr McKINNON — Locally we targeted the senior secondary college mainly because it has the largest cohort of students, and that is where we thought we would start the process. We have plans to go out to the younger students. Chaffey Secondary College is an example which has the year 7 to 10 demographic, so there is no reason why we would not extend some of those education and training options to that cohort as well.

The CHAIR — Any other questions?

Mr McKINNON — Just before that, I will touch on the comment that Rudy made before about the alcohol and so forth, and I think the panel made a comment about the alcohol being problematic. Ice in itself is readily available, certainly in the Indigenous community. Often we see that the Indigenous community is hypersensitive to substances in the first place. Ice has such a profound effect, and it is magnified in that type of population. There are certain demographics — having worked in metropolitan Melbourne, in the Dandenong neck of the woods, where there is a large population of Asian people, who are hypersensitive to drugs and also medications. It is no different in the Aboriginal community, where they do seem to be hypersensitive to some of these substances. Adding ice into the mix probably has a more profound effect than what we would see in a generalist population anyway. That certainly comes through with the people we are seeing within the clinic. The Westerners, so to speak, are certainly able to tolerate the drug more readily, whereas the Indigenous people are hypersensitive to it — it has a more profound impact, and that is happening in an environment where they are already playing catch-up. That can be really problematic.

Mr McCURDY — Part of our inquiry is to do with outlaw motorcycle gangs and their role in ice. Is there any evidence that outlaw motorcycle gangs are playing a role in terms of trafficking to your communities?

Mr MANSOOR — One thing with drug trafficking is that the research evidence has shown that it is mostly done by people who move from one place to another. When we think about outlaw bikie gangs, they live in one place and tend to move quickly to another populated region of Victoria. This reduces the chances of their being caught. We do sometimes see bikie gangs travelling to Mildura and regional Victoria, so they could be involved in trafficking. They may not be. It is something to look at, I guess.

Mr McKINNON — Certainly in our experience we have had a number of clients come through who have actually said point-blank that it has been the outlaw motorcycle gangs who were behind the supply, threats and so forth. People are being taken away with shovels. They are told, 'If you don't toe the line, you're going to end up in the ground'. We have had a few people of that ilk come through.

The CHAIR — I suppose the reason we have asked these questions is that we are trying to have an understanding of how much is manufactured domestically, how much comes from Melbourne and how much comes internationally. We keep hearing it is so easily accessible, so we figure that there must be a supply coming from somewhere. If it is not local, it must be coming from Melbourne or must be coming internationally.

Ms DAVEY — I have had some talks with some of our AOD team members who have said that it is quite raw, very pure here in Mildura. The likelihood that it is manufactured here as well, obviously, is high.

Mr CARROLL — Rudy, you mentioned the success of the zero to four-year-old program. What about Indigenous youth, like males, in the Sunraysia region?

Mr KIRBY — There are a couple of things we have been running. We run a drug and alcohol program targeting grade 6 kids called the Go Program, and that is in partnership with Odyssey House and others. In Mildura there is a fantastic program my son is involved in — he is 16 — called the Clontarf program. I cannot speak highly enough of that program; it is absolutely brilliant. They have now set up a girls academy in Mildura. The Clontarf program has had measurable results for the boys, and the girls are doing this. So they set up a girls academy here at Chaffey Secondary College and Mildura Senior College. The Clontarf program now has 30-something young Koori men and girls enrolled — —

Ms DAVEY — Thirty-five.

Mr KIRBY — Thirty-five. Whereas four or five years ago there were none. The response there is great. We have some young men and women — future leaders — coming through, which is fantastic. The Department of Justice runs the emerging leaders program here in Mildura. So there are some things happening in the youth space here in Mildura, in developing a capacity for youth to be future leaders. There are some great signs coming through. We just need time.

Ms DAVEY — There are also some indicators that a lot are still disengaged.

Mr CARROLL — Previous presenters have highlighted a lack of rehabilitation beds in Mildura.

Mr KIRBY — That is a classic example; there is nothing.

Mr CARROLL — On that point, you mentioned Odyssey House. Would you send, if you could, an Indigenous male to Odyssey House? Has that worked in the past in Melbourne, or are they more — —

Mr KIRBY — It is difficult. We run Warrakoo station, which is a 10 000-acre property along the Murray, for men. Before they go up, they need to be detoxed. You cannot detox them, because there are no beds. We have the facility and the resources. We have men out there all the time. We have a 10 or 12-bed facility out at Warrakoo. Men's rehabilitation is a 12-week program, but before we can take them we need to be sure for the men's own health and safety that they have been detoxed. If not alcohol — —

Ms DAVEY — Most of the time, in sending people away to be detoxed, there is a time frame or a waiting list, and you cannot get in there straightaway. I know that our team has tried to do that, and we have had to wait weeks with somebody who was suffering with suicide ideation.

Mr KIRBY — I can give you a clear example, and I will not refer to the group. This young individual was willing to go away. He was an Irish user, and he was severely beaten blue, purple and whatever other colour he was because of a debt he owed to this group. We tried to get him off to a facility in Melbourne to help him out. It was a week or month too late. We sent him to Warrakoo for his own safety. The young individual came back, and he committed suicide within a week of leaving Warrakoo, because of the threats towards his family by these individuals.

Ms DAVEY — The lack of availability as well.

Mr KIRBY — He had moved to Mildura.

Ms DAVEY — And we did not have a facility to send this person to immediately, when there was a significant need.

The CHAIR — I am mindful of time. Thank you all very much for your contributions.

Witnesses withdrew.