LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Warrnambool — 3 March 2014

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The CHAIR—Welcome to this public hearing of the Law Reform, Drugs and Crime Prevention Joint Parliamentary Committee of the Victorian Parliament. This committee—and we are only part of it today, is conducting an inquiry into the supply and use of methamphetamines in Victoria, particularly ice. This is our last regional public hearing, as far as I know at this stage. I suspect Sandy Cook has given you some background in relation to the inquiry.

I will read you the conditions under which you are presenting today. 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 have said in evidence, may not be afforded such privilege. You have received and read the guide for witnesses presenting evidence to parliamentary committees. 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 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 you are also going to make a PowerPoint submission. Is that right?

Mr BROECKMAN—That is right, Simon.

The CHAIR—If you are happy we will table that as part of the committee's report.

Mr BROECKMAN—That is fine, yes.

PowerPoint presentation.

Mr BROECKMAN—Thank you very much for the opportunity to come before you and talk to you about ice. We have tried to stick with the questions that you have, and some of those questions we have collated together for expediency. There is a range of services that Brophy Family and Youth Services provide. Without going into every single one of those, there are 35 different programs. There are some key areas: one is our Family Support Services which incorporates our Child First and Integrated Family Services; the second one is around Out of Home Care Services, which I think you will be familiar with, including foster care, adolescent care and kinship; our Youth Homelessness Services team, which Peter is the team leader of, provides quite a holistic number of services that relate to homelessness support for young people between the age of 16 and 24; our Youth Justice Support Services also provides a number of support to young people who are coming through Juvenile Justice System; our Youth Outreach Program called Youth Connections provides a south-west coverage for supporting young people that are at risk, and that is a critical program that is working out there from Casterton, all the way through to Camperdown, so it is a pretty significant one; our Men's Family Relationship Services involves working with men, particularly those that have significant relationship issues, and there is support provided to men who have violence issues; Community Outreach Services which support a number of adult homelessness services; our Education, Training and Employment arm and our Health and Support Services which also includes Headspace and a number of other mental health services.

What we wanted to concentrate on today were the ones in red here that we believe are the ones that are most affected by methamphetamines. The first one in yellow, Family Support Services, our Child First and Family Services, we are working with very vulnerable families there. We are starting to see the impact of ice in that particular area. Anecdotally it is one in five. Referrals are coming through at the moment that ice involvement. Out of Home Care Services, the one particular area that is quite significant for us is the Leaving Care Service and that is supporting young people from out of home care into independent living. The other key area that we are finding significant ice usage is in the Youth Homelessness Services area, our

Youth Justice area and our Youth Outreach programs. We have some figures to come.

The other area that is on standby or we have a watching brief on is our Men's Family Relationship Service. Again we have had, over the last two months, eight referrals for men's behaviour issues relating to ice. It is becoming more prevalent. Here are the clients we have put together for 2013. These clients are from 15 to 24 years of age. They are case managed by Brophy through the Youth Services Teams of Youth Connections, the Homelessness Services area, Youth Justice and Leaving Care. They are 15 to 24, but 80 per cent of those young people are aged between 16 and 21. We have broken it up into two categories. Ice tends to have a sense of secrecy around it. We have broken it down into those that have been disclosed, clients that have disclosed ice usage to the worker and also clients suspected of being on ice by the worker in which there are very significant indications that they are, particularly in terms of behaviour.

When we look at our Youth Connections Program, again that is covering a fair bit of the south-west, but this is in particular 150 clients that we are working with. This is the Warrnambool and Corangamite region. That is working with young people that are at risk of falling out of school. They are either still at school or they have fallen out of school and we are trying to support them into other education or training support service. Half of the work is done in schools and the other half is out of school. We are finding the program is working with young people out of school who are the ones that predominantly have some involvement with ice. We are looking at about 12 per cent of those young people being involved in some form of ice. The homelessness clients, there were 160 that we worked with in 2013 of which 20 disclosed ice and another 12 were suspected. We are looking at 20 per cent. The Youth Justice area, there were 35 young people referred to us of which nine disclosed and three were suspected. We are heading up to 34 per cent. The worst cohort is the Leaving Care clients, albeit the smallest group. Of 16 there is four that have disclosed ice and two suspected.

Mr SCHEFFER—What does Leaving Care mean?

Mr BROECKMAN—Leaving Care is a program that supports young people to transition from out of home care, from adolescent foster care or residential care, into independent living.

Mr SCHEFFER—They are still pretty young though?

Mr BROECKMAN—Yes, they are up to 18. The same with Youth Justice, up to 18 as well. The homeless clients are 15 to 24, and Youth Connections is from 13 through to 19 years of age. What we are finding overall is that when we are looking at those young people that have been case managed by Brophy in the Youth Services area, close to 20 per cent are using ice or have used ice. What we have found that it has been very incremental, it has been a curve, because 18 month ago we could have counted a handful of kids, and now 18 months further down the track and we are looking at 68 out of 361 kids using ice or having used ice.

Mr SCHEFFER—Is there a similar kind of a statistical pattern that other agencies are doing? There would be other people working with youth beyond Brophy.

Mr BROECKMAN—We are the predominant youth service across the south-west. There would be others that would be involved, in connection with the police, with WRAD as well, mental health.

Mr SCHEFFER—What I am getting at, that 19 per cent, that 68 total, is that kind of it, or would you say that is only—

Mr BROECKMAN—No, there would be more.

Mr SCHEFFER—But would it be double, do you think? Any sense of that?

Mr FLANAGAN—They are the young people who present at Brophy. There are all the people who do not present at Brophy too.

Mr SCHEFFER—I am trying to get the context of what that might represent.

Mr FLANAGAN—Yes, it is quite difficult to put into context. We can only read it in the context of who comes to us for service.

Mr BROECKMAN—You could safely say about another 25 per cent on top of that because WRAD will be working with us, and mental health will also be connected with us. Mental health would tend to be somewhat separate for a lot of those kids that are 18 and above. Headspace only deals with those that are in the early intervention end. I would give another 25 per cent and you are starting to look at the Warrnambool figures. Similar percentages in Portland and Hamilton but the numbers are smaller. That is what we are finding.

Which clients are most susceptible? What we are finding is that those young people with the least protective factors and that are highly at risk are the most vulnerable. We see this as a drug of disadvantage, not a drug of choice.

Mr SCHEFFER—What are the protective factors?

Mr BROECKMAN—The protective factors tend to be around three areas: one being family and how strong that relationship is, the strength of the relationship with your schools and key personnel, and then your connection/relationship with the community, that is Brophy. The stronger that those three are in tandem then the more likely it is that you will be able to address some of the risk factors. Obviously the risk factors you would know. What we try and do from a community perspective is link them up to key people to support them to build those protective factors and to support them through that process. That is mainly our job. If you wanted to paint a picture of which one of our clients use ice, they are early school leaving, they have had a history of trauma, family breakdown which may end up as homelessness, poor links to the community. They are the clients who we find that present with this drug use. Often there has been a gateway of drug use, I am sure you have heard—cannabis and then on to ice.

Mr SCHEFFER—There is a current that sometimes comes through some of our witnesses that it has as much rationality as a lightning strike—normal family, absolutely nothing wrong, suddenly the child goes off on ice.

Mr FLANAGAN—Yes, and I have seen that.

Mr SCHEFFER—You hear it and, of course, you cannot really open it up because it is not your business. Is that a plausible scenario or is it always to do with the lack of protective factors?

Mr FLANAGAN—The lack of protective factors is a huge thing. Even though those young people—and I know some in this community where the young person may have an underlying mental health issue or something has happened, the development of it, you could usually say that makes them susceptible, because the kids who are strong, who are linked to their schools, who do well, have a good circle of peers, you are very unlikely to see those kids. Anecdotally.

The CHAIR—If you are unlikely to see them, it does not mean they are not actively involved in using methamphetamines.

Mr FLANAGAN—That is right. They may well be, but if we do not see them maybe they are doing it more recreationally on the weekends and that type of thing. But that is exactly right, it does not mean they are not there.

Mr BROECKMAN—One example that would support our position is that we are not seeing anywhere near as many young people going through Headspace, which is our early intervention support program for depression, anxiety and stress. We are looking at about 500 kids going through that. Where there are other factors like homelessness, youth justice issues, where they have had a traumatic background, those kids are tending to use. Those other kids that have anxiety and depression that do not have those other factors are tending to work through our Headspace program and they are supported. There are so many families were things are going okay in the family, and it does go off the rails, they pick it up a lot earlier and they are able to get access and support. That is not to say that this drug is not highly addictive and it is very difficult to get off and very difficult to treat, as you would know.

Mr FLANAGAN—We know it is not only ice. Those protective factors we are talking about make them susceptible to all types of risk-taking behaviour and other drugs—cannabis, alcohol. This seems to have a short-term, harder impact and quicker.

Mr BROECKMAN—Why is it used? You have heard this all the way through. It is easily obtainable, it is reasonably cheap, it has a very intense high, and pushers—as in people who are trying to push the drug—offer first tries for free, and it becomes highly addictive. Peter can tell you about the number of kids who are very vulnerable who then get into the wrong crowd and start the use.

Mr FLANAGAN—They will end up being the runners, delivering it, right at the bottom of the scale in a delivery chain, just to keep themselves in the drug and keep themselves supplied. We have had a lot of young people who have used cannabis and they have spoken about ice users in a derogatory way, like, 'I'd never touch that. No way. I don't want to become that.' But once they do try it, it seems to be very rapid and they get into a life of strife, a lot of trouble. While people try and protect themselves, with the strong peer groups that use it, I think it is very difficult for them to say no.

The CHAIR—Out of interest, when you say it is cheap—and I have heard that all along, and I have heard too that it is expensive—if you are a user or using alcohol or cannabis, point 1 of a gram, $80 or $90 depending on purity, three or four grams a week, I am not sure what typical usage is, but quick maths would tell me that suddenly you are running up to a couple of grand a week in using crystal meth. Even myself I would be struggling to drink that much alcohol in a week, you would have some serious health issues. Even cannabis, I am not sure what the normal—you are saying 'cheap' as against traditional legal and illicit drugs that have been used before, or cheap because the dealers get them onto it as a freebie and then they suddenly become dealers themselves. How do you define 'cheap'?

Mr FLANAGAN—Yes, that is a very good question. If you use the example of $80 for point 1 of a gram, I do not really understand how far that goes either. To work out 'cheap' you need to work out how much they use. I think what happens is when they do start using, everything else goes out the window. It becomes the most important thing in their life. Their whole day is focused on getting it. Crime rates, I am sure, you have heard have gone through the roof around that type of thing, and a lot of young people are becoming dealers to keep themselves in it. Addiction is a very powerful thing, as you know, and people will do whatever they can to get what they need.

The CHAIR—That is the point I was trying to make because we have often compared alcohol as probably the primary problem drug, be it legal.

Mr FLANAGAN—Yes.

The CHAIR—The fact is we do not have people out there stealing, committing armed robberies or violent robberies or crimes, or family violence to get alcohol. It is much more accessible in a legal sense, but we do find that with crystal meth. There is a more social problem associated with criminal activity with crystal meth than there is with alcohol in its legal use.

Mr FLANAGAN—Yes, that may be correct, but if you look at the cost of alcohol in regard to family violence, it has a huge impact. They have different outcomes in the community, I think.

The CHAIR—Yes.

Mr FLANAGAN—It is a good question.

Mr BROECKMAN—It might become more obvious as we go through the impacts on some of the clients.

The CHAIR—I will keep silent for as long as I can and I will try to keep Mr Scheffer silent as well.

Mr BROECKMAN—It is highly addictive and when the kids are hooked they go downhill very quickly. There health is impacted very quickly. We find they exhibit a lot of anxiety, aggression and violent behaviour. Then they use cannabis to mellow that out, and then they can become quite unmotivated, listless and apathetic. It is that type of cycle that tends to develop. There is a susceptibility to further sexual and physical violence once they get into this cycle, due to the accumulation of drug debt and then the use of violence to enforce repayments. It could be cheap at the start but obviously once they have you hooked then you are really open to whatever the demand is.

They disengage and withdraw from services very quickly. 'Yes, we're quite happy to come today or tomorrow and make an appointment,' they will not keep it. We find it is really difficult to try and re-engage these kids. They are unable to maintain routine and fail to keep appointments; unable to maintain accommodation. Everything really goes to rack and ruin for many of these kids. They get into it deeply. Relations quickly become more conflictual. When coming down off ice they present as anxious, paranoid and with suicidal ideation. It is clearly a high risk time for our involvement. It is an extreme effect very quickly in just about all walks of life.

In relation to the impacts on services, we find it very difficult to engage and maintain their connection. Violence threatened towards workers, especially if the client perceives their needs are not being met. We have had a number of incidences where workers have been really concerned about what might happen in terms of the aggression that is being threatened. To date we have not had any workers being abused physically but it is a real time bomb that we sit on with these particular kids. Client incidences experienced by workers are now predominantly due to clients using ice. It is more difficult to pick up, whereas with alcohol it is really quite easy. We need to become more adapt at picking that up.

Some of the differences in the rural and regional setting are around isolation, boredom, unemployment, lack of opportunities. Difficulty to change peer groups I think is one of the key areas. They get locked into a peer group and then wherever they go, they are found. Peter can talk to you more about this but if kids do want to get off it, the only place that we can really take them is down to YSAS down in Geelong to undertake withdrawal and detox. Again that at least affords us the opportunity to try and get the young person off it. It is quite a long way away and it is difficult to coordinate services because whilst you are doing that work inside, you also need to be working with the reunification or the transition back into the community—that is a positive—and strong enough to be able to then meet the demands of that existing cohort that will be trying to draw you back in. There can be a couple of months waiting period to access those services. That is a long time if someone wants to seek a service to try and hold them in that 'still want to change' phase before that is lost. I am sure you have heard in the WRAD submission about lack of services. When people are willing to change that you have the ability to work quickly and as seamlessly as you can to get those services is really important, when the time is right.

One way forward: there are a number of ways to look at it, and I am sure that you will have 454 different approaches by the end of this process. I am looking at it from a systems approach because that is what we are good at. For us the key messages are that this is a bigger issue than one response by one agency. It needs to be a collective of organisations coming together from across a number of sectors. Ice use is the effect of disadvantage and generally not the cause. I know there are a lot of issues. Once the young person is on ice then things will go south very quickly, we know that, but what were the precipitating factors that brought them to that point of using ice. It impacts users very quickly and it is really difficult to treat. They are quite resilient to treatment. It is only when they really want to change that you can link in YSAS and WRAD and then try and support them.

Our key direction are one of addressing disadvantage in our community and in our young people. There are a couple of models that are involved at the moment across the south-west. There is a collective impact model that is looking at education attainment, trying to improve education attainment. If you were to transpose that to link into ice and drug use, we know that the more educated people are, the less likely that they are going to use drugs and alcohol in an abusive way. Communities that Care, John Toumbourou, the work that he does in terms of working to improve the protective factors across the community whilst minimising the risk factors is again another really good example. In the neighbourhood renewal models we had a program called Wave about five years ago that was working and supporting Warrnambool East and Warrnambool West, and we had an intersectorial approach to it, including local government, Juvenile Justice, police, health, welfare, youth. It was a great way to start to talk to those people about them taking control over the issues that were happening in Warrnambool East. That then started to change the game to some extent. It does take a collective approach. It does not help us dealing with the next kid that comes through but certainly if we are going to be looking at strengthening our communities over a 10-year period then that is going to have a significant impact.

Developing a collective response across schools, services, police et cetera. I think that can be done. There are a number of avenues to be able to do that across the south-west, including the great south-west coast platform areas, in terms of health and welfare. We need to build in a rapid response capacity. What I mean by that is that when young people are ready to make that change, we need to be able to respond rapidly that we can support them and move them as quickly as possible. As much as there is a rapid impact by this drug, if we can provide a rapid response—especially early intervention or the earlier end of this happening—we think that we can match or treat those kids more quickly.

Obviously this particular issue has jumped us, and 18 months ago we were talking about a handful of kids that were involved in this, and now we are talking about 20 per cent over an 18-month period. That is pretty big news and a very important issue for us as an organisation to grapple with and develop interventions for, and start assisting families of these young people to get through it. I think too we need to get back to the basic reason why people use drugs. People use drugs to block out whatever they do not want to think about. They will use whatever they can get their hands on. There will be something after ice, there will be something after that. Trying to make people more linked to the community, more resilient, try and reduce that impact of social disadvantage is the long-term way to go. There within lies our presentation.

The CHAIR—Quite a challenge.

Mr SCHEFFER—Earlier on—and we have had other witnesses say this as well—you talked about the importance of working with families rather than individual young people, and we have heard in the case of probably all people who have a drug issue that it is better that they deal with their family and community. The thing that interests me that I would really like to get something on the record about is what are the nuts and bolts of doing that, because often it ends with us where people rhetorically gesture at it, 'We work with communities, of course, tick the box.' What does that really mean? Are the families coming together to sit around the table? Do you go away together? Do you visit the home? What are your tools? How do you do

that?

Mr BROECKMAN—There are a number of programs that link schools with youth services and we have one with Warrnambool Secondary College called Families and Schools Together in which we had a number of families whose young people in years 7 and 8 were very much at risk of leaving school early. They were identified as that. The school was able to involve those families and young people, and together with Family Services from Brophy, WRAD Drug and Alcohol, we were able to work with those parents to develop their parenting skills, to support them in being able to manage the issues of their young people, and we were also able to work with the young people themselves, collectively, and then you would have ties that they would come together. We found that was a really successful way in which we could interconnect both community services and the schools dealing with those kids that had been identified at risk. It was a really simple process and it had huge effects because the kids saw that the parents were wanting to do something, and the parents saw that the kids were also interested in doing something. There was a sense of commitment and it had really good outcomes. That type of relationship where you are able to involve the families in a sense of supporting their kids through school and providing them with some structure around their parenting is a great way because most parents really want to do that but they just do not know how.

Mr SCHEFFER—Most do but I guess that it is overlaid with all kinds of feelings of failure and responsibility and guilt and defensiveness. How do you dismantle that?

Mr FLANAGAN—There are some models around. I run the Youth Justice Conferencing Program, that is the process of restorative justice. There is also a family decision-making component that Brophy uses as well. You cannot throw people in a room and expect it to happen. A lot of work needs to happen to the lead-up. You need to work with all the parties and we need to talk about the things like guilt around having kids who have not done well. We need to talk about how that makes people feel, what it is like when your kids are in the community and not doing so well because everyone knows, and then get that support back in place, because most of the time their behaviours make it that hard that people find it very difficult to deal with. They are standing over people for money, they are having anger attacks and punching holes in walls, and people have had enough. It is trying to get those natural supports back in place with some boundaries on both sides and trying to reintegrate that, making people accountable—the young person and the family, I think.

Mr SCHEFFER—The men's programs that you talked about, presumably some of those men are fathers.

Mr FLANAGAN—Yes.

Mr SCHEFFER—Is that a component of this as well, because they would then be having issues with their children, as well as their partners. How do you do that?

Mr FLANAGAN—Yes, there are two programs in the Men's Family Relationship Service. One is around men's behaviour change, where you receive referrals from the police for those men who have exhibited violence. They have made a referral to us. We follow them up as voluntary as to whether they would like to go through a 10-week program for men's behaviour change.

Mr SCHEFFER—Does that include their families?

Mr FLANAGAN—No. The only part it includes, the men do a group work program and someone else has the partner contact to monitor the behaviours of the man because the men's behaviour change program is there to protect the safety of women and children. Someone will be ringing the partner and saying, 'What's going on? Is everything okay?'

Mr SCHEFFER—For example, we know quite often a drug is involved, and let's say

in this case it is methamphetamines and alcohol or whatever cocktail they are using, then you have a familial problem where the man in question may well be the perpetrator, you know, if you have got to start somewhere in the discussion, but that then has flow-on effects. We have talked about family dysfunction. The children then become part of that vulnerable cohort you mentioned before. How do you transact that given the perpetrator needs to be separated off to protect the family from immediate aggression, but then the child is witnessing that.

Mr BROECKMAN—The way that we do it, first of all we take it from an early intervention approach. You are absolutely right. How do you market a program to parents to come to the school to be part of a stigmatised program? What we try and do is work with the families from a positive strength base to say, 'We would like you to be involved in this particular program because we would like to get little Johnny through to year 10 because we think he has some fantastic talents and some great capacity to be able to get through.' All of a sudden you are starting to work on the strengths of the family that obviously he has not got to where he is here without the strengths of the family coming behind him. The idea then is not look at all the deficits but to look at what strengths we can build, what structures can we put in place with this family. One is as simple as having meals together and having discussions around the table, and how can that happen. It really looks at things from a very practical way.

When you are starting to get to family violence where actual family violence has been perpetrated then there are issues around power that are very significant that need to be dealt with and addressed separately. That is why we have the men's behaviour program together because we are there to break that cycle of power and say, 'That's not on.' The relationship usually with the victim means that you need to be able to get the change with the men first to agree to make that change. Once they have made that change then other family type of activities can begin but you really need to deal with that chestnut of the power issues first, the gender issues.

The CHAIR—Are they willing participants, the fathers?

Mr BROECKMAN—Yes, we are inundated. We have 14 men that are part of the program at the moment, and we could be running that if we had the resources.

Mr SCHEFFER—Which brings us to—you might have heard one of our previous witnesses talking about for the first time in her long career there is a three-week waiting list. Are you finding that?

Mr BROECKMAN—We have a waiting list as well, yes, for that particular program.

Mr FLANAGAN—It is how you frame things too. You would say with a man that you are surprised that they go but it is how you put things. 'Is it that sort of person you want to be? Is that the type of father you want to be? Is that the type of partner you want to be?' People are going to say no, most of them, then straightaway you have a platform to work on and it is around the strength to improve.

The CHAIR—Can I ask a quick question in relation to education programs. We had a witness who in fact was a user and he was certainly keen to be involved. In fact he is reformed, he is not using any more, but they have taken an ambassadorial role in the schools and kids can identify with their like kind, if you like. Do you see that as being instrumental in the education programs? We are struggling to—as part of our recommendations obviously there may well be something about early intervention and education. What sort of intervention? Do we go through the grim reaper stage again in relation to advertising? You are shaking your heads, and that is the view we got, that it did not work.

Mr FLANAGAN—I did not realise I was doing that, sorry.

The CHAIR—With smoking, Butt Out, No Butts, that was working quite well. Obviously the smoking message has penetrated through the mental barrier in relation to health

impacts. Can you perhaps advise us as a committee what type of early intervention education programs would best work and how they would be delivered.

Mr BROECKMAN—I think there needs to be a number of different interventions. Not one will fit all. Users that have come through the other end are very powerful testimonies that can be used. There are not that many people that could come to that position, but we have used that type of model very effectively within the homelessness services area, those that have gone through and come out the other side. That support and coaching is a really great way to do it. There also needs to be mentoring for those kids. The Standing Tall Program that Warrnambool schools are involved in and providing mentoring is a fantastic example of preventing young people who are at risk from necessarily falling into further drug and alcohol abuse.

The CHAIR—It is a sort of 'Say no' or standing up for yourself?

Mr BROECKMAN—It is a mentoring program that is relationship based to support kids between year 7 and year 9 that develop a relationship with them. There are outside people coming in who become mentors and support those kids to find the career they would like. That is the carrot. The idea is to try to build that relationship while they are searching for what they would like to do. The idea is to try and find their talents and build on those talents. Yes, it is not one size fits all but there are a number of different early intervention programs that you can utilise through that.

Mr FLANAGAN—I think sometimes when you tell young people—especially the cohorts who are vulnerable, it is not useful telling them not to do something. Do you know what I mean? They have been told that all their life. The key areas, you find that year 7 is a period of transition and they are finding their feet. I think year 8 is the time when kids can turn the corner either way. If you do some individual work—like Francis was saying, assess those individual needs and what they want. It does not necessarily have to be about 'Say no to ice,' because it will be something else that will be around. 'What can we do with you to make you stronger, more resilient and more linked to your community?'

Mr SCHEFFER—Just following up, the chair is right, we have really been wrestling with this issue around education and the kind of modelling or lessons, for want of a better word, we can place around young people, and there have been some quite divided views, as the chair said, about this. One view is it is much better to have teachers and people who are regularly in young people's lives to talk to them about some of these issues, and to bring external experts is not such a good thing, it was put to us, and to bring reformed drug users can maybe work at one level but on another level it turns them into heroes a bit.

Mr FLANAGAN—It can be problematic too.

Mr SCHEFFER—For people that are feeling a bit vulnerable it becomes something a bit exciting and tantalising. Do we have to suck it and see and tread carefully, or do you think there are some rules emerging around what we might do?

Mr BROECKMAN—I think you can do all of those. Some people who have come through it—and they need to be professionally assessed to ensure that they are not inadvertently saying how wonderful it was, and how great they are in terms of having got through it, because that might be giving the messaging, 'You can have a crack at it but you've got to be strong to get out the other end,' and that could be the challenge that they want. Those people need to be carefully screened to ensure that they are giving the right messages. Within schools the teachers are very useful, however, they do not feel as though they have the expertise. Joint co-teaching is really useful where you have people of your Rodger Brough type of person who has an extraordinary knowledge around this type of stuff, and you have the teaching profession coming together with them being able to get the messages across and make sure they are clear, you can establish that curriculum. That is how the original drug and alcohol taskforce back in Jeff Kennett's era undertook—in the Education Department they had

a drug and alcohol person that was quite specialised who would then teach the staff and the teachers, working in tandem.

What we are finding is that that is not going to work for us to some extent as an organisation because mostly the kids we are working with are not at school. What we did that was really successful was dealing with sexual health issues. We were able to get a group of young people to come together to work on sexual health messages, and together we had a designer that was able to take their ideas and we were able to draw them up and the young people were able to give their views. We had projects that enabled young people to become part of being able to get that message out, and through that process we were able to teach them to be able to get that message then further out to the schools around sexual health. That was a very effective way of getting across a number of schools involved with very little resources. I think it was about $10,000 to do that particular project. There are some good ways to do that but you need to do that regularly, every year, if you do something of that nature and therefore you keep working with the young people at that particular point in time to know what the messages need to be, to be able to get them out.

The cigarette banned stuff, we started with the grim reaper and then we found, 'No, that's too scary, we need to go to positive strengths,' and now we are looking at, 'Well, it's okay to try once. You can try as many times as long as you get off the smokes.' There are different ways, and I think it will progress, Johan, over the years.

The CHAIR—All right. We had better leave it there. We are out of time for this session. Are there any closing statements you would like to make?

Mr BROECKMAN—No, I think we are done.

The CHAIR—Okay. Thank you both very much for your time this afternoon. We appreciate it.

Mr BROECKMAN—Thank you.

The CHAIR—Are you funded federally at all through Youth Connections?

Mr BROECKMAN—Yes.

The CHAIR—Do you have a contract coming up shortly?

Mr BROECKMAN—At the end of 2014, December. We are waiting with bated breath.

The CHAIR—All right. I will close the public hearing.

Witnesses withdrew.