LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Melbourne — 3 February 2014

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Ms E. Foster, Drug and Alcohol Counsellor, Monash Health, South East Alcohol and Drug Service.

The CHAIR — Good morning. Sorry for keeping you waiting. Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention Committee. We are conducting an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. We thank you for your time this morning to present evidence to the committee. I will just read you the conditions under which you are presenting evidence in this hearing this morning.

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 any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting at parliamentary committees? 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 you can correct it as appropriate.

Now I would invite you to make a verbal submission. I am aware that we have allocated until 10.45 a.m. for this session, and I know we are running a little bit late. Part of the reason we are running a little bit late is that the presentations from the witnesses go for some time, and it does not really allow us to ask questions about the things we want to know about. I just flag that with you. If perhaps you could make your presentations brief, and that will allow the committee to perhaps raise some questions out of that or ask other questions they may have.

Dr JACKA — Roger can lead.

Dr VOLK — Yes, and I will start with a disclaimer — like any good salesman, I guess — which is that we are a treatment agency, we do not do demographic surveys, so we cannot talk about all ice users in Dandenong or the south-eastern suburbs. We can only talk meaningfully about people who walk through our door. On top of that, our statistical system that the Department of Health issues is so outdated that it does not differentiate any more between methamphetamine and normal stimulant use, so we cannot even tell you at that level the people walking through the door from a statistical point of view who are ice users as supposed to speed users. There is just not a way of gathering that information. So a lot of the things we are telling you will be anecdotal information, I think very meaningful, from the people we have conversations with about their ice use.

Having said that, with regard to the first question, 'Is use of methamphetamine escalating in Victoria?', we cannot tell you whether the population of drug users is increasing or simply whether those using certain drugs are moving around like the same pack of cards being reshuffled. I suspect that it is — that the people using ice are replacing people who would have used other drugs in the past. In terms of being an escalating problem, I would want to say that the press has done the most fabulous sales job for any ice dealer that you could ever expect. I will give you a very brief example. In the *Age* a month or so ago, in the Sunday supplement, there was a dealer boasting — and there was no counter narrative — of having turned on a whole town in Gippsland.

Eden and I were at a public meeting about two weeks after that and we were talking about that. It was a bunch of housing professionals. This woman puts up her hand and says, 'I am from that town and I can assure you the whole town is not turned on to ice'. The research point of that is that the perception that everyone is doing it makes it easy to cross a threshold of non-use into use. So I think a tremendous disservice is done by reports that do not have a counter narrative like that, because if you think everyone is doing it you are more likely to do it. But the fact is more people think others are doing it than are actually doing it, and that research is decades old. Would you want to talk about whether it is at crisis point?

Dr JACKA — I can do. I just wanted to point out as well that we come from three different perspectives. Although we are from the same service, I come from a very medical perspective in my current role, which is based across the service but a lot of it is hospital based. A lot of my work is about people who are admitted to hospital in emergency departments and the like. Roger's

expertise is largely about forensic counselling, so it is at the more severe end of the drug users who have ended up in the forensic system. Eden is much more about voluntary counselling — people who have self-referred for counselling. So we offer three different perspectives as to what is happening in our area.

Certainly the police in our area are concerned, but I do not think anybody would say that it is a crisis out there. I have asked a lot of my colleagues, particularly in the emergency departments and at the hospital, 'Is this appreciably worse this year than last year or the year before?', and there is no sense that it is. There are certainly services that are concerned about how much ice use there is and how many people come in disturbed to the emergency department, but that is not clearly worse this year than last year or the year before.

Alcohol remains the largest crisis in our area, rather than methamphetamines. What appears in hospital and what ends up in our emergency departments is still largely alcohol-related violence, alcohol-related mental illness or alcohol-related disturbance. So there are certainly people who end up in our emergency departments with amphetamine-related acute anxiety, acute psychosis, but as to a crisis, I would not have said so.

Dr VOLK — I think it is mistaken for a crisis because it is such a dramatic drug. I see in forensics two populations: young men who are psychotic who use ice to calm down the voices in their heads, and others who are psychotic where the ice use triggers a violent outburst. It is the police at their houses and a divvy van down to the emergency room. It is a lot of drama. This man's likely fate is he is going to be so dramatic that the police will shoot him to subdue him at some point. So I think it feels like a crisis because each incident is way more dramatic than an alcoholic perhaps falling asleep and ending up in the emergency room.

Dr JACKA — I think in the Monash catchment we have changed our response to people coming into the emergency department, partly related to violence in the emergency department and partly related to nursing union action. So the response that arrives at the front door of the hospital when someone is brought in by police is a lot more aggressive on the hospital's part than it was a year or two ago. The security officers meet people in the emergency department. It is not a particularly friendly place at the best of times; it is certainly not the quiet, relaxing environment that you would like to put someone in who has got an ice or a methamphetamine overdose. You would like to have them in a calm, dark, cool, reassuring space, but they arrive in the hospital, in police custody very often, and are met by a similar aggressive response from the security services at the emergency department. Unfortunately I think we have accelerated the response and actually exacerbated some of the drama that is around the presentations.

Dr VOLK — We would also want to point out that a lot of our consumers talk about the functional uses of ice, and unless you understand that I do not think we as professionals can make a good response. I will give two brief examples. Tradies who come to us having not been convicted but on cautioning notices from the police will talk about using ice at the weekend to complete a job. It makes people tremendously focused and energetic. I have got a father who cleans his house before DHS visits on a bit of ice because it gets the whole thing done in about 2 hours. Currently I am seeing the wife of a couple. The ice made them so organised in financing their use that they went onto websites that had holiday lets.

Websites with holiday lets have the vacancies. 'Oh, I know when it is occupied; I know when to burgle the place'. Those websites have what is available for the pleasure of guests but for the stealing point of these people. They did this, and the woman's point of view was that the husband messed it up in the end because he did something too close to home. But they were able to do this string of burglaries for about a year without being caught because the ice actually focused them so much. There is a piece of it that is functional, for want of a better word, rather than simply disruptive and dramatic.

Dr JACKA — I think we can learn a lot from South-East Asia. This epidemic of methamphetamines into Australia was preceded probably 15 years ago in Thailand, Laos and Cambodia, and it is now moved into China and Vietnam. It was largely functional use there in the beginning and slowly the mental health services particularly started to see the ill effects of a small

cohort of that group who could not handle it or became dependent or used too much and ended up in psychiatric services or in hospitals or in prisons. But the vast majority of the people who are using methamphetamines in Asia — that is where I have been the last seven years: working in WHO in Vietnam — the bulk of people who use the drug do not get into trouble with it. It is largely a recreation or a relatively functional use, and I think that is what we see here. There are a large number of people who benefit from it recreationally or functionally.

Ms FOSTER — From a voluntary clinician's perspective, I am getting clients who might be using it to function academically — university students coming in stay up until the wee hours of the morning, cramming for an exam or an assignment. There is a functional aspect of it that as a voluntary clinician I am seeing a lot.

The CHAIR — How quickly does the transition from functional to habitual take? That is the area of concern. We understand it is not a party drug, it is a killer drug, but there is recreational use, and then there is habitual use. I guess, given that there is no come-off like methadone for heroin, that people take it up again. Once they come off, in three or four days they want to take that opportunity of being enlightened again, so they are back on the drug again. It is a vicious circle and that is when you get addicted. You talk about functional use, but we are hearing a lot more about habitual use.

Dr JACKA — The vast majority of people never go beyond functional use. They never go beyond recreational use. It is nowhere near as addictive as cigarettes, nicotine or amphetamines. Crack cocaine is a really good example of something that is much more addictive. Heroin is much more addictive. Methamphetamine, crack and ice are perhaps more addictive than ordinary amphetamines, but it is still of the order of 15 to 20 per cent of people who use the drug habitually will become dependent. It is not the majority by any means.

Mr SCHEFFER — I just want to follow up on that. We have sort of wrestled a bit with what we mean by addiction.

Dr JACKA — Absolutely.

Mr SCHEFFER — It has been put to us that addiction to heroin is fundamentally different physiologically than — I am putting it in inverted commas — addiction to methamphetamines. Could you explain that to us in words with one syllable?

Dr JACKA — I do not believe they are fundamentally different, given that the two big agencies in the world, WHO being one of them, use a diagnostic criteria called the ICD-10, which is a bit like the DSM-IV or the most recent DSM-V of the American Psychiatric Association. They try to provide syndromes of drug use that describe an out-of-control drug use. It is not so much the physiology of the drug, although that is one part of it. It is about having to take more of the drug to get the same effect and when you stop you get some sort of withdrawal syndrome. But it is more about the social disruption, the psychological dependence on the behaviours, the narrowing of a focus of activity so you no longer enjoy other recreation or that you continue to use the drug despite problems. Even though you are getting problems, you are injecting and you have had an admission to hospital, you still continue to use the drugs.

Those definitions are really quite useful, and using those definitions we have still come to less than 20 per cent of people who will become dependent on methamphetamine. The majority of people may develop elements of that syndrome, but to make a diagnosis of dependence you need at least three of those elements together — the physiological and the behavioural elements together — to diagnose dependence. I do not think it is a very difficult diagnosis to make.

Mr SCHEFFER — The impact that methamphetamines has as a neurotransmitter, are you saying that the effect is the same as a person using heroin, or what?

Dr JACKA — No, they are quite different effects, but it is the dependence element. For example, alcohol dependence is diagnosed in a very similar context. It is a mix of physiological, so that is tolerance to alcohol, withdrawal — when you stop using alcohol — as well as the more behavioural elements: thinking of alcohol, craving alcohol, continuing to use alcohol despite the

problems and harms that it is causing you. Even though the physiology of methamphetamine is quite different to heroin, the behavioural aspects are what defines the dependence just as much as it is the physiology.

The physiology is quite different. It is such a stimulant, and it is a stimulant that most people use in an episodic fashion, but it is the behavioural stuff about losing control of your use stopping the other things that you used to like to do, thinking of it all the time and continuing to use it even though it is causing you real harm. That is what diagnoses the dependence just as much as the biochemistry in your brain. So yes, the biochemistry is quite different, but the dependence syndrome is really similar.

Mr SCHEFFER — You do not subscribe to the one hit and you are gone?

Dr JACKA — No. I do in a sense in that we do not know what makes people dependent. That is our frustration. You asked a really sensible question: how much do you have to use this drug before you become dependent? You hear people say alcohol does it for them: 'I knew when I had my first drink this was the drug for me'. Heroin is the same: 'After my first hit, I knew this was the drug'. And you hear people say it with methamphetamines. We do not know what makes that choice for them. It is the same as we do not know with rats. Why do only a third of rats become dependent on drugs and the other two thirds do not? We have no idea, and it differs from different drugs. It is not like there are dependent rats or there are non-dependent rats.

Dr VOLK — If someone comes in as a cautioning client who has not got in a whole heap of legal trouble, we say to them, 'We are going to talk about your ice use, but we cannot successfully predict whether you're going to go in this direction or that direction. All we can do is say, "That is what that route looks like and that is what that route looks like".'

Dr JACKA — And there is a risk with any drug.

The CHAIR — Do you want to move on to the set presentation? I still invite the committee to ask questions. We can have an interactive play perhaps for the next 10 minutes.

Dr VOLK — Before we get into treatment, I just want to say that an episode of ice use looks so different from an episode of heroin use or alcohol use, which can be self-limiting, self-defining. An ice episode use can go on for days. Someone will stay awake for days, and then they will crash and then they will sleep for three days, but the impact on them during that time makes the treatment look very different. You are replacing hours and hours and a lifestyle of use, which is different from an alcohol user or a marijuana user, which is how the Matrix program is probably going to be effective.

Ms FOSTER — It provides a structured format. At South East Alcohol and Drug Service this year we have started an intensive group treatment program for drug court clients who are using methamphetamines. It is intensive as it is 16 weeks where they attend three times a week. The idea is, as Roger said, to provide a structured lifestyle to replace the lifestyle of substance using.

This is a program that, as far as I know, has not been used in Australia. It was developed in the United States about 20-odd years ago to address the cocaine epidemic over there, and they have adapted it to for methamphetamine users and other substance use. It has been researched and found that is actually quite effective with good attrition rates. Plus also in terms of substance use, compared to treatment as usual, they have found more negative urine samples amongst participants in the Matrix program compared to treatment as usual as well. So we thought it was about time we started something in our area, considering there is an increase in methamphetamine use but no methamphetamine-specific intervention, so it was well and truly needed.

Mr SOUTHWICK — In terms of the work that is done in the Dandenong drug court, which we have had a look at, it runs very much a carrot and stick approach. I understand putting a regimented structure in people's lives, but what is the stick element? In the court scenario it is to take days away, and effectively they end up in jail if they continually do not follow that system. In the Matrix program where is the carrot and stick?

Ms FOSTER — I guess they are being provided with more credits, so for the three sessions that they attend a week they will get three credits.

Dr VOLK — More carrots.

Ms FOSTER — More carrots. But in saying that though, we have had a few clients who — because some of them are still using, the motivation is quite different to a voluntary client. The motivation is to stay out of prison, whereas for a voluntary client it would be, I guess, the motivation to become abstinent. We are sort of ironing out all of those bumps there. But in our trial we are finding that the attendance rate is fairly good. We have had some that have gone into prison because of a lack of attendance, but like I said, more carrots with the credits. But if they continue to use, therefore the sanctions will outweigh the credits.

Dr JACKA — US evidence is very much stronger towards positive contingency management that towards negative contingency management. The stick is not as effective as the carrot, and this has been shown a lot, particularly with methamphetamines. It has not worked as well with the opiates. I think the contingency management programs, the counselling programs, the intensive group programs are nowhere near as good as methadone in the treatment of opiate dependence. But for methamphetamines, in the absence of methadone, these programs have been remarkably effective, particularly the positive contingency management. In the US they use a lot more than we are able to do here. They offer financial rewards; they offer food vouchers; they offer a whole variety of positive rewards. We just offer gold stars.

Mr SCHEFFER — In the US what kind of impact has it had on the — you said it was cocaine that it was used for originally?

Dr JACKA — This is largely coming from California, west coast US, and it is largely now methamphetamines. It is almost an identical population there: people either voluntarily admitting themselves for treatment or mandated by corrections services into treatment for their methamphetamine use. It has been remarkably effective.

Dr VOLK — I worked in the States in the 80s and the cocaine episodes were very similar to methamphetamine episodes — a little shorter, but quite long. It was a lifestyle drug — a whole lifestyle drug — and we saw people three times a week; urine testing and then three times a week for education, family counselling, individual counselling. It seemed to be effective in replacing — the people imprinted on cocaine became imprinted on getting better and recovering because we saw them so much. I think Matrix was developed for cocaine.

Dr JACKA — It was, yes.

Dr VOLK — So I am pretty optimistic about its chances of being effective with ice users — and other things that we think will be helpful, when we get to the recommendations bit.

Dr JACKA — We have not really chosen Matrix because it is better than anything else, other than it is an off-the-shelf product. It is very well described, and it is mandated by SAMHSA in the US as being an appropriate treatment for methamphetamine use.

Dr VOLK — It is more its structure than because it uses CBT or anything else. The research is crystal clear that the particular approach you use explains very little change and that it is engagement and relationship with people that explains most change. So you could use CBT, or you could use tarot cards — I am being a bit cynical — but it does not make a huge difference; it is the structure of Matrix that makes the difference.

Mr SOUTHWICK — Is most of it done one-on-one, or is there group counselling involved, and how effective — —

Dr JACKA — Mostly groups.

Ms FOSTER — It is skills-based training, and it is a group program. There are three individual sessions at the beginning, middle and end of the program, but predominantly all group-based skills

training. It is cognitive behavioural therapy training, family and client psycho-education, social support, skills training. We come from different perspectives, so it is a multimodal intervention incorporating research-based interventions.

Dr VOLK — Preparing people for using self-help groups, though sadly the ice-specific self-help group that is in Sydney is not around here. But we are helping people use AA and NA. You cannot just send people to meetings; you have to say, 'This is what you can expect. This is how you will get the most out of it'.

Mr SCHEFFER —-What about evaluation, both in the United States and also your program, particularly at Monash? How is that being evaluated?

Dr JACKA — This is the first run we have done.

Dr VOLK — We are in the second month.

Dr JACKA — But it has been evaluated many times in many countries, and I think the evaluation done in Thailand after it was introduced was really bad, and that was largely because it was poorly implemented, the doctors who were trained to do it were not actually interested in running the course, so the outcomes for the program were not great. That just shows you cannot roll it out to too big a population too quickly with disinterested staff. You have got to have a passionate group of professionals involved.

Ms FOSTER — But in the United States it has been thoroughly investigated. I think a recent multisite, randomised clinical trial in about 2004 was completed by Rawson, I think — the developer of the program.

Dr JACKA — Yes, Rick Rawson's team did it.

Ms FOSTER — And that found that there were more negative methamphetamine urine samples, longer periods of abstinence, and better retention rates compared to treatment as usual. So it has some promising results with the American population and hopefully likewise with the Australian population when we — —

Dr JACKA — I think there are more similarities here than there were in Asia.

Ms FOSTER — Yes.

Mr McCURDY — I am just trying to get this alcohol and ice use in perspective because up until today we have heard, probably a lot more, that ice is far worse than alcohol. We also understand that alcohol, in terms of numbers in our community, is far worse than ice too — don't get me wrong — but from what you are saying, 15 to 20 per cent of ice users might end up addicted or with an issue. So recreational use is alive and well and managed by many out there, as is alcohol. What are the numbers in alcohol that match up with it? Is it similar?

Dr JACKA — It is about 10 per cent. It is about half. Half the number of alcohol users will develop substantial problems. I think what is different — and it occurs with methamphetamines — is that binge use is problematic with alcohol. So not all binge users are alcohol dependent, but they still come to the attention of police and emergency departments, without necessarily being dependent. Methamphetamine users also do the same. They come to the attention of the emergency departments because of a binge. They actually lose control. That might be the first and last time they do it — this is an accident; they have used more than they intended to use. Who knows what they are using? This is a big problem we are giving you: what are these people using? We have no idea. And that is one of our big frustrations. We have no resources for testing people when they come into the emergency department to find out what drug they are intoxicated with. It is a great frustration that people come in, loopy as all hell, and we have no mechanism of testing to find out, because we do not have the resources to test — —

Dr VOLK — In other words there is not the analogue of testing machines in raves and discos like there is for ecstasy, where, certainly in Europe, people would come and put their stuff into the

machine and say, 'Oh, I'm good to go, I'll get high'. So, whatever you think about the use in the first place, the damage from it was much less. There is not an analogue of that for ice at this point.

Dr JACKA — No, and I think injecting is much more likely to produce an intoxication, a binge, where people end up in an emergency department. It is something they are less in control of than if they are smoking, and I am really surprised to discover in Australia how many people are injecting methamphetamine compared to smoking it. Although smoking is still probably the largest way of using it, I have now seen people in the emergency departments in hospitals who have not only got infections but have died from their infections from injecting amphetamines. So it is a real problem in our community that not only are they using it but they are injecting it. The techniques for injecting it are really bad. It is a dirty drug, and they are getting heart infections, spinal infections and the like, and dying as a consequence. So there is a problem with injecting, but that is another area again. That is the method of use rather than the amount of use.

Dr VOLK — I think, just finally, the drama per use is just way higher for ice than it is for alcohol, so it is apples and oranges. There is: how many people are doing it — addictively or very highly — and then there is how much drama is created by one episode, and those two things get mixed up. So people are saying, 'Oh, it's an epidemic.' But we do not know that.

Mr SOUTHWICK — Just going back to your comment, David, in terms of your surprise about those injecting, is that different to other jurisdictions? So in the US are more people — —

Dr JACKA — It has slowly moved into an injecting population. Gay men on the west coast are injecting quite a lot of methamphetamine. In Vietnam and a lot of South-East Asia it is still smoked or taken as pills, because a lot of methamphetamine is not crystal meth but is tablet methamphetamine, so they actually take it orally or smoke it. Here I think there is a culture of injecting that comes from the culture of injecting opiates; that has influenced the methamphetamine. But also I think there are these other drugs that are used with methamphetamine. You have got oxycodone and MS Contin that are used in conjunction with the methamphetamines to come down — probably the benzodiazepines: alprazolam, diazepam, oxazepam. All of those drugs are used to calm people down after a binge. A lot of those opiates people are injecting. It is really surprising to see. They are crushing up the OxyContin and injecting it, because that is the culture.

I think it would be really nice to influence that culture somehow to stop people injecting, because I think the injecting has all these other harms associated with it, other than just the high of the amphetamine. It really makes you very, very agitated if you inject it compared to smoking it. Smoking has a much lower morbidity and is a much nicer way of taking methamphetamine than injecting it. We used to notice this 20 years ago — not quite; 15 years ago — when the heroine drought came to Melbourne and people started to use methamphetamine. We noticed that the people who injected the methamphetamine at that time were the ones who got craziest, and the people who were smoking it at that time were much more likely to be mellow and using it in a more sustainable way. I think Roger is right.

Mr SCHEFFER — Given your experience in South-East Asia, and you mentioned the United States, California, and I think Europe as well in relation to the ecstasy, in a few words what is your sense about the public policy implications in relation to regulation and law around illicit drugs?

Dr VOLK — You tell us what your electorate will bear, and we will tell you what to do.

Mr SCHEFFER — That is a good answer.

Dr VOLK — Because in Germany what got the people through our treatment door was the equivalent of the Crown Prosecution Service being told, 'You will not prosecute people for X amounts of certain drugs, and you will divert them'. Some of that is happening here. It was not legalising any of those drugs; it was simply a policy around how the police approached those people. I would say that that would be particularly effective with ice users. In terms of recommendation, the DDL, the police cautioning program, needs to be researched and needs to be

restructured, because I think it is a way of getting people through a door to have a conversation about ice use way early in the picture rather than the emergency room or the courts end of things.

Dr JACKA — But I think we should also be selling crack pipes and having needle and syringe programs rather than having banned them. If you ban a product, then people will find another way of taking that product, until we have taken one of the safest ways of using methamphetamine off the market, in a sense — well, they are still readily available through the black market — and are encouraging people to go another route, which is often injecting. I would much rather people were smoking rather injecting. It is really dangerous. We are doing a number of things to try to make injecting safer, including the use of filters and things like that and changing people's perception that injecting this stuff is safe. It is dreadful; we do not even know what it is. I think one of the public policy things — I would like to know more about what is out there. I would like everybody who is using the drug to know what is out there. They are using this stuff and have no idea what it is, and I think it is really dangerous.

The CHAIR — It is not the question I was going to ask, and we will have to finish up, but given that you have gone on that tangent, are you in favour or safe injecting rooms for heroin users or needle exchange programs by local councils?

Dr JACKA — Yes. I think the evidence is so strong that it is a really good way of engaging people who are otherwise not engaged with health services. We know that particularly methamphetamine users are not well engaged. They do not talk to their GPs, they do not talk to needle and syringe programs and they do not talk to their pharmacies. They go out and buy syringes, but they do not talk to anybody about it, so they do not know the risks, they do not know what they are buying and they do not know how to reduce the harm of what they are doing.

Dr VOLK — They see themselves as aspirational. They see themselves as in a phase — the men especially — that they are going to grow out of. I will say to them, my clients, 'Wind the movie forward 10 years'. 'Oh, I'll have a wife and kids'. 'Will you be using ice?' 'Oh, no', and they look at me like I had suggested something pretty indecent. They have to be engaged in a different way.

Dr JACKA — They have to look after themselves while they are using.

The CHAIR — That was not the question. I was going to try to have a question that hopefully would allow you to give us some guidance on the best way you see to deal with this problem. It is an emerging problem in regional areas in particular. We have done a number of forums and hearings in regional areas. It is quite cheap to procure. We know organised crime is active in the space of trafficking because it is profitable, so on that basis it has become a problem in itself in relation to law and order. We have talked and heard about early intervention, particularly at primary school level, or even at year 7 level. We know that 12 to 13-year-olds, even though they are not a large demographic, are active in that space and using methamphetamines.

We know and I was told that back in the 1970s and 1980s, I believe it was, when they had that drug education program running through the schools, that the statistics indicated there was a significant increase in the use of drugs after that education program. We were told regarding the Grim Reaper programs, while they seemed visually quite frightening and presumably would deter people engaging in sexual activity that will create HIV or something else, that in fact people turned off because they were so aggressive.

We are in a bit of a dilemma. We know we have a problem out there, and we have been charged with trying to provide Parliament with some recommendations to deal with it. Very briefly how would you best summarise the recommendations from your agency to help us make recommendations to Parliament in this report?

Dr VOLK — I would be pouring money into some equivalent of naltrexone for alcohol and methadone for heroin, some antagonists that do not make people sick when they use them but reduce the pleasure from it. Naltrexone — and this is from my clients — has a terrific reputation for, 'I do not have to give something up but I can use it like a normal person'.

Dr JACKA — It is for alcohol. Naltrexone for alcohol is fantastic. Methadone for heroin is great. There is a little bit of research around dexamphetamine for methamphetamine use. It is not strong, but maybe that is the direction to go: to look at what you can do with that really problematic user.

Most people, though, will respond to a decently structured program. I think a decently structured treatment program is what most people need. This is not terribly severe addiction for most people. There are a number of people who get to the hard end who end up with forensic problems and they need mandated engagement. But the majority of people need a voluntary program. We do not have one. We need one.

We need some decent data about what is going on. I agree with your comments about drug education. That is just what I have seen everywhere in Asia. All you end up doing is promoting drugs. You need to develop the school programs that engage kids in school and stop the early disengagement. The peer support program is a great program in Chiang Mai in Thailand for methamphetamine users, which is about friend helping friend. It is about groups of young people looking after the one who is a bit madder than the others and making sure he does not get into trouble. It has been shown to work with alcohol in the same way. When groups of young people go out drinking they look after the one who has a bit more of an alcohol problem. It is that sort of peer group support.

It is the same with peer support in schools: looking after the one who looks as though he is about to disengage — not expelling them into the community, but somehow drawing them back in. Some good studies have been done by the Centre for Adolescent Health here in Melbourne.

Dr VOLK — The ones that worked on military bases where the ones that engaged the whole adolescent in terms of life skills, including experimentation and risk-taking, so they were holistic rather than just, 'Don't, don't, don't', or putting ideas into people's heads, as you were suggesting that some programs do.

I would like to see more research and more engagement with the police cautioning program. I think it is a tremendous teachable moment for people for whom ice has not yet become a problem. They have had one encounter with the police by definition. If they have had convictions they do not get cautioned; they get whatever else is coming to them. It is such a teachable moment, because these are mostly employed young men and women who have a lot to lose.

Dr JACKA — We need a bit more data. You have hospitals, and police who are arresting people.

The CHAIR — We are hearing that pretty loud and clear from a whole range of agencies.

Dr JACKA — We just do not know what people are doing, what they are using. We need to know about it.

Ms FOSTER — I guess intensive interventions like the Matrix for voluntary clients before they get to the stage where they see someone like Roger in a forensic setting, so I guess funding for something that is intensive — a program like the Matrix, which has worked overseas. But right now we are only able to use it with drug court clients because that is an intensive program. I guess putting that in place for voluntary clients before they get to that stage is important.

The CHAIR — Roger, I appreciate that you have quite a swag of notes there. Is there anything in there that you would like to present to the committee?

Dr VOLK — No, we are done. It is just a security blanket.

The CHAIR — I thank you all very much for your time this morning. I appreciate that.

Witnesses withdrew.