LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Mount Waverley – 5 June 2014

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Mr M. Sabin MP, Member for Northland, New Zealand Parliament.

The CHAIR — Welcome to this public hearing of the Law Reform, Drugs and Crime Prevention Committee of the Victorian Parliament. With us we have Mr Mike Sabin, who is a member for Northland in the New Zealand Parliament, but he is speaking to us in his capacity as founding director of MethCon Group.

Mr SABIN — I am here talking to you as someone with background and experience from a number of different areas. I am certainly not here as a government MP, but that is my current role.

The CHAIR — Thank you. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including effective repetition of what you said in evidence, may not be afforded such privilege. I understand 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, hinder or threaten a witness for the evidence they would give or have given may constitute and be punishable as a contempt of Parliament. We are recording the evidence, and we will provide a proof version of the transcript at the earliest opportunity so you can correct it as appropriate.

I note we provided you with some questions in relation to this hearing, and I thank you for the responses you provided to those. Would you be happy to table that question and answer paper to the committee, which will negate having to go back through some country that we have covered this morning and also in relation to your responses?

Mr SABIN — Yes, absolutely.

The CHAIR — Normally in a hearing such as this we invite you to make some opening statements, and then I will invite the committee to ask you some questions in relation to areas that we have not covered that are of interest to this committee. Welcome again, and I invite you to make some opening remarks.

Mr SABIN — Thank you for the opportunity to speak to this very important committee. I respect the opportunity, and while I am here participating in this summit it is indeed a privilege to be able to share some thoughts with the committee as well.

Firstly I should point out that while I am a member of Parliament, I come to you not in that role but as someone who has developed a field of experience since the mid-1990s. I am relatively unique probably, because I come from an enforcement background, but when I decided that enforcement was not the only solution, I got involved and did a significant amount of research and study looking at the problem from its various facets.

I looked at demand reduction, education, prevention and so forth. I looked quite closely at treatment and understanding addiction from the brain's perspective rather than from a human judgmental perspective. I looked at it in terms of the science of it and did a lot of work in terms of looking at what I am probably more comfortable talking about, which is the area of enforcement and supply reduction to addiction and that side of the equation. I had some unique opportunities in doing that, travelling through the United States, Europe and Asia, and I have seen the good, the bad and the ugly. It has enabled me to pull together a collection of information that I think has been helpful in the New Zealand context. I submitted to the then government in 2008 and then again in 2009 on a range of recommendations. The Tackling Methamphetamine action plan that was put in place in 2009 has made a substantial difference in terms of structural change and in terms of some of the key indicators that demonstrate we are getting on top of the problem.

I have worn a number of different hats, and I am happy to avail the committee in any way, shape or form. If I can provide any answers that may be of help to you, I am more than happy to do that. I commend the committee for the work that you have been doing and the importance of it. I am strongly of the belief that when you take the time to sit down and work out what is working and

what is not, why is it and what outcomes we want and look at this in a very holistic way, while it is highly complex, it does provide an opportunity to provide some leadership.

In my view, ultimately political leadership is vital in terms of a response to something that affects so many facets of society. I am happy to take the committee's lead on how you would like me to address things. I did try and answer some of those questions for you, and I am happy to speak to any elements. If members have not had a chance to read over it — if you are anything like me on select committees, you certainly do not read all the papers that you get in front of you to the nth degree — I am happy to speak to that or to address any other issues that you may want to put forward.

The CHAIR — Thank you. Initially I will ask about what has happened in New Zealand and perhaps invite other committee members to raise questions. As I said this morning, we had quite a detailed discussion within the forum that looked at supply, demand and treatment areas in relation to the supply, use and prevalence of methamphetamines, in your case in New Zealand, and of our interest here in Australia.

I was at an ice forum last night, and there seems to be a move within communities to put together action plans. Communities have decided to take ownership of issues of concern within their own small communities about developing action plans that have as their intent trying to deal with not only the current issue but also ongoing prevention. I would like some comments from you in relation to the sort of framework that you helped develop for the New Zealand government across departments to develop a framework to respond to the problem.

What is unique about New Zealand, which has a significant high prevalence of use of methamphetamine particularly per capita? How do you see addressing that problem in the long term? Why is New Zealand different to every other country in relation to its high drug use and the strategies that you see in the longer term that can reduce that position but also move towards prevention rather than treatment? It is a twofold question.

Mr SABIN — I will address the second question first, which may give some context to the second question that you raise around communities and an effective framework that helps bring community into your strategy. New Zealand and Australia are quite similar; we are cousins in many respects in terms of our place in the world, and with drugs it is no different than that. New Zealand is geographically isolated and has a relatively small population. If we look at New Zealanders, I think we are a very young country. We are kind of like the little brothers of the world. We want to be like the big brothers, but we are not quite mature enough yet in many regards if we are looking at it through a drug-focused lens. Typically our idea of having fun involves getting completely written off. It is not a social drink; it is drink till you drop. It is not, 'Try a drug'; it is, 'Try a handful of drugs'.

It is kind of like the little brother trying to be like the one who has already learnt the lessons, if you like.

In terms of our identity in the world, what I do know is that in terms of social norms in a population that is isolated like that, things very quickly become normalised, and drug-taking behaviour, alcoholism and so on have become quite normalised. That trundled along. Cannabis use has increased markedly over the years, and so has the potency of cannabis. But everything, the whole game, changed in the late 1990s, when we saw the first advent of pure methamphetamine, which we know in New Zealand as P.

We had a population that had become quite accustomed to so-called recreational drug use — it is not a phrase I like to use, but that is so often what it is called — and a high prevalence, 80 per cent, of those aged 25 had tried cannabis at least once in their lifetime. I am convinced that you do not go from mother's milk to a methamphetamine pipe; there is generally some pathway in terms of making that decision.

We were a country that, I guess, had a young and immature alcohol or substance abuse culture. We were a country that had, and still has, a high prevalence of cannabis use and I guess to some extent

a social acceptability of that. We were a country that had — how can I put it? We were in a position where methamphetamine took hold very quickly for a number of circumstances that all collided at once.

We have what we call the 'number 8 wire mentality' in New Zealand — I am not sure if it is referred to in Australia — where you can basically turn your hand to anything. You can make something out of nothing and just fend for yourself and do things. Methamphetamine is the only hard drug in the world that you can cook on your kitchen bench from retail chemicals. We are a very innovative population, and it very quickly became the case that as soon as people worked out they could make the stuff themselves, they did.

A high prevalence of cannabis use translated very quickly into a lot of people trying methamphetamine, and pure methamphetamine, because it stimulates such a significant neurotransmitter response of dopamine — you know, 12 times normal life pleasure. Typically the user is very quickly reinforced, and so on and so forth. So we had a population where an epidemic was waiting to happen.

I have seen a very similar situation in the Australian population. It is slightly different because Australia has a more diverse community spread across a larger land mass and it has state and federal differentiation, I guess. When you look at the United States, which is a bigger example of that again, you see other complexities around that. If you look at Victoria, or if you look at Sydney or Brisbane, you see the same sorts of pockets of problems that occur once it takes hold and reaches a critical mass. New Zealand is no different from that.

We went from having virtually no problem in the late 1990s to having among the highest recorded prevalence in the world by the mid-2000s. Having said that, New Zealand and Australia keep very good data on this; a lot of other jurisdictions, particularly those in Asia, do not. I do not think it would have been the highest prevalence, but in terms of our traditional measuring models, it certainly was. We had large-scale use of methamphetamine. Maybe anything from 5 to 10 per cent of the population had used or were using. It was the no. 1 drug of choice. We had never really had another hard drug problem, other than Terry Clark and the sort of Mr Asia flirtation with heroin, which was only ever consigned to a very small demographic.

What methamphetamine did was it transcended the social boundaries and found the New Zealand blind spot. The New Zealand blind spot is the middle New Zealander population — the families that have brought their kids up to understand and obey the law, do well at school and plod along. Just the Mr and Mrs Average Kiwi, or it could be the average Aussie. I believe that population was highly exposed because some of them had been exposed to drug-taking through cannabis and it is so easy to translate that into a methamphetamine pipe. Never before in the history of my country had we seen middle New Zealand captured by a hard drug problem. So it came out of the blind spot, whereas we have seen populations that have been hit by, for example, heroin — another hard drug problem.

Overlaying that was the problem that we saw once the media started getting captivated by this. We saw hysterical stories of celebrities who had fallen from grace or high-profile homicides where absolutely insane sorts of crimes had been committed by people high on methamphetamine. That emphasised furthermore the isolation that that blind spot was experiencing, in the sense that middle New Zealand thought, 'Well, that's a high-profile celebrity. It's not like real men. Let's face it: my children do not hang out with that sort of crowd', or, 'That's just these scary gangsters involved in horrible, murderous behaviour, and that is just something that is alien to me'. What it did was it reinforced the false sense of security that I think middle New Zealand experienced, while all the time what was going on was that middle New Zealanders were becoming the base users of the stuff.

If you look at a bell curve, we saw the margins flatten right out, so suddenly you had this transcending of the problem. From what I have seen in Australia, I do not see anything different. In fact if we look on through the United States, which is another similar jurisdiction, we see the same thing there. But it is not prevalent just in the middle New Zealand population, because obviously if you are affluent you are in a position to be able to afford to pay for the habit for a long time before

you start committing crimes or before people start noticing and wondering why you have sold your car, mortgaged your house and so on.

Typically we saw a population that would be more inclined to use ecstasy or cocaine — so a higher society drug, if you like — starting to dabble with pure methamphetamine as something far more exciting and more in vogue than cocaine, and they got caught as well. There are two populations there which probably never would have stuck a heroin needle in their arms but which were and to some extent still are consumed by the most pernicious and pervasive drug problem that I think the world has seen.

In the late 1990s to the early 2000s it was a case of thinking, 'Yep, the state's got a problem. Australia's starting to have one. Yes, of course we have seen the Czech Republic get into issues, but that won't happen here. We're kind of isolated from that sort of stuff'. We went from that to a situation where we said, 'Yes, we've got it here, but it's all under control. We're going to ramp up and spend a bit more money on treatment, and we're going to do this and do that. Those stories in the media are just exaggerating the reality of the situation'. So there was that denial — pretty much as you would see in the user, actually — but it was political denial.

When we got to the mid-2000s the call was, 'Some of the problem's plateaued. Drug problems are cyclical, and they go away. This one's already plateaued, and we're on the downhill slope. It's all game over'. By the late 2000s clearly there was an understanding that the problem had not plateaued. It had continued to increase substantially through the mid and late 2000s, to the point where we introduced the cross-government tackling youth methamphetamine action plan. That was the first time — step back 11 years — that there was conscious political and leadership recognition, and this is my personal perspective on it: this was a problem of a depth and scale the likes of which we had not seen before, and it needed a serious and substantial response. When you get that level of political leadership and engagement, it makes people sit up and take notice — not just the bureaucracy and other government organisations and so on but the community itself.

Ultimately what is required here is a top-down, bottom-up approach. That was the first time in that 11-year history that someone at that level had said, 'Hold on a minute. There is something quite substantial happening here'. Critical to that, which we can talk to during the course of this conversation, were the structures and accountability measures that were put in place by that. We should not underestimate the importance of a very strong political message and a very strong political leadership position in terms of a starting point that says, 'You know what? This is a very high priority, and it is something we are going to elevate. We just do not accept it is going to go away'.

Interestingly enough, that resonates very well with middle New Zealand, as it will or potentially could do with middle Australia, because most of the people in that population have children and the two things they care about are their kids getting a decent education and making something of their lives and their kids not getting wasted on drugs and becoming absolute lost causes.

Any politician knows that if you successfully engage with parents and support them in the area of education and supporting their children in reaching their potential, they love that. It is exactly the same with drugs. As I have seen — we have gone through it recently with the problem of so-called legal highs, or psychoactive substances, in New Zealand when we moved towards a regulated model to put the onus of health back onto the producers to not be able to sell what have been legal highs unless they are proved to be safe — the public started marching. The public came out in absolute abhorrence. They wanted the stuff gone, and they mobilised very quickly.

What that says to me is that politically what you have got here is a large group of citizens who have not typically been involved in a nasty hard drug problem — a large population that you can actually mobilise to become part of a substantial culture shift or policy shift. I think politicians have probably underestimated that over time. I have seen that in other jurisdictions, similar jurisdictions, as well.

Mr McCURDY — Can I just jump in on that? I refer to the action plan that you first started talking about. Like Simon, I am in regional Victoria. We have been to at least half a dozen forums

with 500 or 600 people — nearly half the size of the population. They are now saying, 'What's the next step?'. Excuse me if it is already in here, because I only got the notes today, but what is the next action plan from these forums coming together? Have you gone down that path to say, 'Okay, we've had the forum. We all agree that we want to do something about it. We have educated our community about what is ice'. A lot of the people who were coming were mums and dads just saying, 'What do I look for? I just don't know anything about it'. We are in the really early stage. Have you got that step process that we can make an action plan out of?

Mr SABIN — Obviously we are going through a mini process of that in the summit; it is not part of this committee hearing itself. That process is one of, I guess, holding up a mirror and understanding: 'Have we got a problem? And if we've got a problem, are we actually addressing it successfully, and if not, what should we be doing?'. I think what you are doing by virtue of this process is actually the first steps of building an action plan. It has really been a case of trying to separate the wheat from the chaff in terms of what is just simply describing the problem versus what is something where there is obviously an intervention or a strategy change than can be given effect to.

I have provided — and it is in your papers — the papers that I basically presented to government over 2008–2009. While the company no longer exists, there are certainly some relevancies in there in terms of the critical factors to consider across the three main pillars of the issue, which are: demand reduction, obviously, treatment and supply reduction. We went through an exercise today. We see that there is a lot of intervention around treatment. There is a lot of stuff going on in that space. It is questionable whether or not it is actually achieving sound outcomes. When you ask your treatment providers — if you actually ask a lot of people who are paying for the treatment, i.e. the government and taxpayers — they do not even know what the outcomes are. You would think, naturally, that the outcome is: you get off drugs and stay off drugs.

One of the challenges is to identify: do we know what we are trying to achieve here, and are we actually achieving it in that process? What you typically find, if you look across countries like ours, is some tried and true supply reduction initiatives. You see — well, not tried and true but — a number of treatment initiatives, and then you see a smattering of demand reduction initiatives. What we tend to find, in my view, is that the vast amount of resources tends to be put into reactive stuff around supply reduction and reactive stuff around treatment because obviously treatment is occurring because people have gone on to use. There is very, very little emphasis on and effort in the prevention of drug use in the first place. It is a highly preventable problem.

One of the first things you need to thread through is to actually understand: what are you doing in those three critical areas now? What does it actually look like? Then I think the next step is to ask yourself, 'Knowing now what we do as a committee with the information we have gathered, what sort of outcomes are we getting? What bang for buck are we getting? What results are we getting out of those interventions?'. You will quickly start to identify that there are some areas where, and I use this analogy quite often, it is like a balloon full of water — you think you are squeezing in one direction and it is bulging out in another. What your strategies have to be able to achieve is that you pop the balloon and the water starts to drain. There are critical interventions that I think can achieve that. I happy to discuss them in detail, but essentially they are all in the correspondence that has been provided.

I think you have to work through a process of understanding and analysing your own problem. I think, Mr Chair, you pointed out today that one of the critical facets of this is that most people do not even understand the problem from the get-go. They do not understand how ice works, how the brain works and the interaction between the two. So you are actually designing policy when at the very basic level you have no idea what it is that the stuff is doing and why. That is a critical factor. If you are actually looking at helping sway populations — whether it be within the bureaucracy, within the community or across government, government agencies and what have you — if they do not have that understanding, you are kind of in the dark.

The CHAIR — Mike, do you mind if I cut you off there? I might invite another question.

Mr SABIN — Yes, sure; cut me off whenever you like. Otherwise I will just keep talking.

The CHAIR — We might have to, because we are time limited. I suppose the issue that I was heading towards, apart from that, is that we are struggling to find out what departments are doing, so your across-government approach is probably our first step. Every department — whether it is health, the Department of Justice or police — is doing different things in relation to responding to drug use. Perhaps down the track this might be teased out a bit more.

Mr SCHEFFER — I would like to come to the first question that we put to you, that you provided a written response to, about the extent of the methamphetamine abuse problem in New Zealand. You say there, as you reiterated in the comments you made just now, that the drug appeared in the late 1990s and then 10 years later it had the highest population prevalence. Then later on you refer to, around about the same time — I think, looking at the document — between 6 and 10 per cent of the population over the age of 18. I think according to our Australian national drug survey of 2010 it was about 3 or 4 per cent. So in New Zealand, if you take 10 per cent, it is dramatically higher. If you even take 6 per cent, it is nearly double or a third higher. It is pretty big. My question is: on the narrative that you have drawn for us, what are the datasets that you referred to? You talked about traditional models of data collection. What are those datasets that New Zealand relies on and that you rely on in making these observations and that tell you that it is a problem? And what do they actually say?

Mr SABIN — There are a number of illicit drug monitoring surveys and so on that are carried out.

Mr SCHEFFER — Are these state authorities that do this?

Mr SABIN — National authorities; we do not have any states as such.

Mr SCHEFFER — Sorry; I meant the state, generically.

Mr SABIN — Now that we have the Tackling Methamphetamine action plan, they are specifically engaged in those agencies for that specific purpose. There is a range of different illicit drug monitoring surveys. One of the areas that was looked at was post-arrest drug testing, held randomly at various police stations around the country. What they would do is ask people, post-arrest, if they would participate and provide a drug sample simply for research purposes. It was basically to work out how many people of those arrested actually had substances in their system.

Mr SCHEFFER — Arrested for any crime?

Mr SABIN — For any crime, yes. That figure was substantially higher with that population, for example. Yes, there is a range of different — —

Mr SCHEFFER — My understanding is that the national drug survey is a household survey that is done periodically. It is the most reliable and broadbased dataset we have. Do you have something like that that you have drawn on?

Mr SABIN — Yes, we have exactly the same thing.

Mr SCHEFFER — Does that say 6 to 10 per cent?

Mr SABIN — No. Those averages were basically from pulling out some of the lowest or some of the ends of the range, if you like. At its worst, a lot of our prevalence data was sort of 3 to 4 per cent initially, in the early years. Then we saw it as high as 5 and 6, and then we saw some that were as high as 10.

Mr SCHEFFER — What I am trying to get at is: is that from the national survey that was done or are these subsets? What I cannot answer in that is why New Zealand would have more of a problem than Australia does.

Mr SABIN — I guess it depends on the survey that you look at, because depending on the population that you are asking and the questions that you are asking, you are getting different

answers. It is one of the challenges that I think we have had: there is actually a lack of good data to rely on in terms of what actual drug use is going on versus those — —

We had some phone surveys, for example. That is just giving you some rough estimation in terms of population prevalence.

Mr SCHEFFER — That is pretty critical, because if we do not actually know what the situation is, then we are dealing with wildly varying statistics. And if people are building policy on data that they cannot rely on, that is odd, is it not?

Mr SABIN — I am not really sure where you are going with that.

Mr SCHEFFER — What I am hearing you say is that there are different datasets. You can believe any kind of data, depending on what questions you ask. I am saying: what is the baseline of data in New Zealand? I have said that in Australia it is the national drug surveys. Of course there is other, qualitative, data as well, but it is basically that dataset that we would be relying on to assess the degree of the problem.

Mr SABIN — I am not a great believer in relying on that dataset because it is always hugely understated, in my view from an enforcement background. For example, we had phone surveys where we would ring up and say, 'Okay, I just want to talk to you about your drug habit. Can you tell me?'. Methamphetamine users are notoriously paranoid, and the researchers will tell you this. It does not matter what you say to them and what inducements you provide, they are not going to provide that information. If they do, they are certainly going to understate it. Typically with those addicted users you also see a situation where they are actually not aware of their own level of use, if you like. I think you can get into trouble if you are sort of saying, 'Well, we'll only do something if we reach 5 per cent', for example, or what have you.

Mr SCHEFFER — I understand that. You have sort of answered what I wanted.

The other thing is in relation to your response to question 2, where you talk about Maori and Islander populations. There again I had the same kind of trouble reading it, because I was wondering what studies or surveys or reliable data the narrative that you paint there was really based on. You repeated it in your response to an earlier question. You start off saying it is low socioeconomic spectrum, then you talk about celebrities picking it up, but in your comments just before you said that was really largely media. Then you say there is a kind of a loop that goes back to working-class, for want of a better term, populations or lower socioeconomic populations. I could not quite understand where the data that you relied on to say that actually comes from.

Mr SABIN — You can look across any of the prison stats or any of the arrest stats. If the committee wants it, I am happy to give you screeds and screeds of data that shows that Maori New Zealanders, for example, are disproportionately represented in the criminal stats, drug-using stats, methamphetamine-using stats and so on and so forth — the same as we see with American Indians. I suspect you probably see the same with Aboriginal populations here.

Mr SCHEFFER — Well, we are not sure.

Mr SABIN — I can speak anecdotally and that is what I am doing there, but if the committee wants me to point to specific data, I can send it over by the truckload.

Mr SCHEFFER — I am just saying that, in the context of our alcohol study, when we did our alcohol review we found that actually Aboriginal Australians drink less but they do it more visibly. A lot of white Australians would think that Aboriginal communities had a higher consumption of alcohol, but it is not true. That is why that is important for us.

Mr SABIN — What we see in New Zealand is that unfortunately Maori are disproportionately represented in low socioeconomic stats and typically are higher drug users, typically cannabis. They latched onto this stuff very, very quickly. It became their drug of choice, so it took over. The cannabis trade did not extinguish itself, but it certainly dropped away when people realised the money that could be made from methamphetamines. So it translated very, very quickly into that. I

am giving you some sort of anecdotal responses. I did not take the time to sort of point to any specific research, but there is plenty of it there if the committee wants to get their teeth into it.

The CHAIR — If it is any comfort to you, Mr Scheffer consistently through public hearings questions witnesses in relation to data collection, whether they be from Ambulance Victoria or VicPol.

Mr SABIN — I think they are valid points, but I guess I do not feel I need to come here and prove the data exists. I am happy to provide it if it is wanted, but I wanted to come at it from a slightly different level, I guess.

Mr SCHEFFER — Thank you.

The CHAIR — I suppose the point is that it is important to get the validity of the data to demonstrate prevalence to have government respond in a policy sense. We do question the data — not just with you but also with Ambulance Victoria in relation to responses or to paramedics and with VicPol on offences et cetera.

Mr SABIN — I think that is a very wise thing to do. The only comment that I would make on that is to be very, very wary of the understated nature of data, one, when you are talking about stuff that is criminal, and two, where you are dealing with individuals who are incredibly paranoid and typically do not feel that comfortable about sharing information. In my experience it is really well understated but it does give you baselines, and ultimately that is what you can look at — you can measure baselines. There are actually many other critical areas that you can measure, around volume of crime, around particular types of crime and around how much of the precursors — pseudoephedrine — your country will actually consume if people had colds.

There are plenty of ways you can actually measure: 'Hold on a minute. We've got 16 000 more tonnes worth of pseudoephedrine being utilised in this year than if the population all had colds at the same time'. That tells you that there has been some diversion and pseudoephedrine is being used — and it is not being used by koalas and kangaroos. What I typically see is that when you look at these other areas, these other indicators of the problem, and then you look at illicit drug monitoring surveys and the sort of honesty test, if you like, they never line up, but it is one form of baseline that you can use as a measurement tool.

Mr SOUTHWICK — Thanks, Mike, for your presentation and for coming out to present. I have two lots of questions. The first ones are around demand reduction. I am wondering whether you would comment specifically around policing and some of the early intervention-type activities that may assist in demand reduction. The second component of demand reduction is around education. I know that earlier today you discussed the Montana Meth Project as an example of advertising that may be used. What are your comments around that sort of messaging being able to reduce demand of methamphetamine?

Mr SABIN — Obviously I come from a law enforcement background myself. Looking at this growth of volume crime particularly, we saw that methamphetamine use is an expensive habit and it causes a lot of other crime issues. Typically police responses tend to be to that statistical blow-out, if you like. There are obviously drivers of that. It has been my contention as a police officer that one of the most effective tools in the toolbox, if you like, is swiftness and certainty in terms of deterring people from criminal behaviour. One of the things that we have seen less of over time as the criminal justice system has struggled with an increase in crime is a tendency to sort of warn people for what you would call lower level drug use. So if someone is standing out the back of a pub having a joint or maybe they have only just a tiny amount of ice on them or something like that, there is a warning or turning a blind eye, if you like.

That is because of the constraints, or there are bigger fish to fry, if you like. So enforcement very quickly gets tangled up in this area where the bar actually has to keep being raised, when in actual fact what we know is that the most effective intervention in terms of those who decide that they are not going to obey the laws — because there will always be those who do that — is going to be the

intervention that you applied very, very early in the equation. Who is dealing with those people most often? It is the police who are out there.

One of the approaches that I looked at was to some extent being utilised in the United States. They have 18 000 different police forces over there, so they have a range of different approaches. What I thought was quite innovative and certainly something I suggested in the New Zealand context was basically that if street police officers were targeting drug use itself in the sense that we do drink driving or we do minor infringement-type offences — drug and disorderly behaviour, something like that — and if they identify that use, then there is an opportunity to actually halt that behaviour and identify: is this addictive behaviour or is this experimental behaviour that we can actually deal with?

The model that I would suggest just as one example of an innovative demand reduction tool — delivered, actually, ironically by your police force — is that the government departments or votes within government that ultimately have a vested interest in seeing reduced costs through reducing people being addicted and causing criminal issues and what have you provide a budget pot, if you like, from which police can allocate drug-prevention hours to go out and look for people or, when they are out there policing, look for people who are committing drug-using offences. Those people are then brought back to the station and are simply given a drug-screening profile. They are basically analysed — 'Are you an addicted user or are you actually just someone who is smoking a joint?'. Are they just 17-year-olds having a bit of fun experimenting or what have you?

They would be charged at that point, and they would be identified as an addicted user or someone who is a non-addicted user. The non-addicted user could be screened off through the district court in a district court system. That essentially provides 90 days for the jurisdiction of the court to prove sobriety — that they are actually not an addicted user and they are just experimenting. Over that time, like the drug court model, they have to come in for random drug tests on given occasions, and at the end of that 90-day period the judge or the magistrate dealing with the matter can say, 'Clearly you were obviously experimenting', and they would receive a slap on the hand — 'Naughty man. Don't do that again' — or, 'Clearly you are not a recreational user. You have a problem, and we are going to divert you off to a drug court'. If that is not appropriate, then obviously that charge will become live again and it will be dealt with in that way.

What that does is it provides a mechanism for police to quickly identify, screen and intervene and to work out who needs the most intervention and who needs just a little bit of intervention. What it says to the 17, 18 or 19-year-old who is going through this process is, 'There is a swift and certain outcome to my drug-using behaviour that might actually involve me having to explain to my boss why I am going off to provide a urine-screening sample or what have you', and it actually gives them a bit of a wake-up call. We know that for many that is all they need. It also means that the treatment dollar you need to spend on the most affected and most addicted is going to those who most need it. You are sorting it and screening it right from the get-go.

The police need to be funded to deliver those hours, and you can pay for it from the proceeds of crime from the get-go. It soon pays for itself, because every time you stop and intervene, that is someone who is not going to commit further crimes with ice within six months. They will not be ripping people off and will not be out of control. It changes the continuum entirely in terms of the idea that you can just smoke drugs and be a recreational user, that there are few or no consequences and that police do not pay any attention to it. The police become a tool.

The most effective deterrent will always be swiftness and certainty. It is not the consequences that are important; it is the fact that there will be a swift and certain outcome. So it is swift and certain. It is screening to identify where you need to most spend your resources, and it is an effective deterrent socially and culturally, I guess, to the individual because they receive a short, sharp shock that may stay with them for the rest of their lives and that may just stop a lifetime of drug problems. We know that if people in their adolescence are using drugs, there is a high likelihood they will have an addicted profile and it will be much harder to intervene in their later life. That is one area that police have typically become quite slack on — not just in my country but probably in yours, in the United States, in the UK and so forth, where the police are just almost turning a blind

eye to that low-level stuff. We should be doing quite the opposite. We should be absolutely focused on that because, like everything, it is the little things that get you.

If you let the little things go by, it just provides a platform for the big things to grow. I use the analogy of socks at school. If you look at a school where all the socks are up, you will see high achievement. I know it sounds obscure, but you will see high achievers, you will see tidy uniforms and you will see polite, courteous students — bang, bang, bang. It is not because their socks are up. It is because attention to detail is paid to the small things. Conversely, if you go to a school where all the socks are down — well, not all of them, but a lot of them — and the uniforms are a bit shabby, I can guarantee that you will see less respect for the teachers and you will see less academic achievement. Bang, bang, bang.

It is no different in society, and where we are missing the boat is we are chasing our own tails so much in terms of our law enforcement responses that we are forgetting the little stuff. Actually the little stuff is critical. The parents out there actually get this stuff. The idea is not to lock them up or put them in front of the court and say, 'That is using methamphetamine. That is a $150 fine and court costs. Bang — you're out of here'. That is not what this is about. It is actually about saying, 'Is this problem large or small? Prove it to me', and, 'You are off with a warning', or, 'We are providing an intervention that is required'. And the police are motivated financially to actually ensure that those hours are delivered.

Mr SOUTHWICK — And the education side of things? How do we get the education message across utilising things like the Montana Meth Project?

Mr SABIN — The challenge with some of the education is that youngsters will always be ignorant because they do not have life experience, and they will always be curious. Ignorance and curiosity are really dangerous when you have a drug like ice, which is quite available. Also — how can I put this? — they have pretty good bullshit meters, for want of a better phrase. They can work stuff out when someone is try to pull the wool.

Education always has to be very careful in terms of understanding. My belief is that what you need to be able to say is, 'Understand how this works. Understand the science of your brain, and understand why it is no different to his, hers or yours for that matter'. Then understand what this drug actually does to interact with that brain and why it does. Those who were there this morning would have a sense of what I am talking about. It is education that comes not from a judgemental standpoint or a 'just say no' standpoint; it comes from a 'just understand the science' standpoint.

For modern youngsters it needs to be something empowering that gives them the ability to understand that drug use causes loss of control and loss of freedom of choice and that if people use, there are consequences and it all gets ugly. They need to understand why they are no different. It needs to be in that mechanism. There needs to be a place for the sort of stop-and-think messages — absolutely — as long as they are interwoven with stuff that is very much about understanding the inevitabilities of the science in this.

We understand far more about the brain now than we did 10 years ago. When I started studying this stuff as a policeman, I thought, 'Light bulbs are going off all over the place'. Now I understand why these people are doing this stuff. Now I understand what drives the behaviour. You have to get to that point where a generation of youngsters understand that, and they will drive that culture change for you because they understand it at that level. In terms of the Montana Meth Project, absolutely things there have a place. In my view one of the most effective tools you can have in education is having it led by the very generation you want to influence. You have to get alongside those people and understand the messages they resonate with and the media they resonate with.

One thing to consider in terms of a social marketing strategy is what I have seen in some places, which is called a roadblock campaign, where basically on a given day for a given hour across every media spectrum there is one message delivered. Town halls will run it and set up big screens, it will be on the television and it will be on the radio — it will be live cast everywhere. It is a roadblock across every medium that is well advertised and well promoted and basically provides

that in-depth scientific knowledge and understanding so that en masse you can educate your population to understand that this is what it is about.

Then you have captured them, and you can actually roll through your other messages. It sounds like a pretty unusual thing to do, but it is actually perfectly achievable with modern technologies. At some point you have to capture a critical mass of people through some prevention mechanism, but it is really important what that message looks like. You cannot just scare people off the stuff, because everyone thinks they are different.

Mr SOUTHWICK — The final question was around your cross-government action plan. You mentioned earlier today that this has been Prime Minister led in the actual plan. We currently have about five or six ministers involved in this area in one way, shape or form — health, committee services, police, Attorney-General and crime prevention. How would you direct a top-down type of approach? Would you suggest a ministerial council? Would you suggest something that would actually deliver a very coordinated approach to deal with the problems?

Mr SABIN — Certainly understanding the New Zealand context, which is slightly different to the Australian one, one thing I do know is that bureaucracies listen to a single stream of accountability far more effectively than they do a multiple one. A ministerial council absolutely make sense if you look at, say, police, justice, education, labour, health and customs, just off the top of my mind. There are about a dozen government departments actually dealing with that, and they all have to be on the same page on this. That is a lot of ministers around the table.

In my view, an ideal model would be a situation where you have one minister who is ultimately accountable for all policy decisions. Whether those decisions be in education, whether they be in workplace employment drug testing and so forth or whether they be in justice or corrections or what have you, ultimately anything that has an implication in terms of drug policy is going to be running through that one point of accountability. In terms of your strategy and report back, it can be done at another layer down in terms of other ministers who might sit around the table, but ultimately the buck has to stop with someone.

It just so happens that in the New Zealand model across six government agencies all roads lead back to the Prime Minister, and that adds some significant clout to it. I am not saying that it necessarily needs to be the Prime Minister, but you are all politicians. You all understand how bureaucracies work and how accountabilities work. They have to be very clear accountabilities, and the structure has to be absolutely top to bottom. It needs to go from the top and resonate right to the bottom, but there needs to be cross cut across the various stakeholders as well.

If you have someone from health who happens to be dealing with drug policy and then you have justice, which does their own thing, and then you have your workforce that says, 'We have a "Not at work, mate" policy — in other words, we don't care what you do in your own time as long as you are not using drugs at work', how does that fit with the prevention model if you are condoning drug use outside of work hours and the idea that drug use does not affect you all the time indirectly anyway? It is just a nonsense. You can see the trouble you get into when you have a whole lot of different silos and bureaucrats within them who are actually dealing with it. You need to cut through that, in my view, and the methamphetamine strategy in New Zealand certainly to a large extent covers it off. The CEs of those government departments are responsible for reporting back every six months on what those outcomes are.

Not only do you have to have the structure right, you have to have very clear goals, very clear outcomes and very clear accountabilities on achieving those outcomes. The more people it gets spread across in terms of where the buck finally stops, the weaker it ultimately gets. If you had a situation where someone had overarching responsibility of drug policy and then underneath them they had a ministerial council with the CEs all speaking to that, something like that could ultimately ensure that everything is actually going to go through the right filter. That is not to say that you cannot actually do it in your current structures, where ministers just go about the same thing, as long as everyone is following the same policy, but I guess there is a lot of institutionalised thinking. While you can have a change in policy, it does not necessarily translate itself into a change of outcome on the street.

The CHAIR — Mike, I just might have to put some riding instructions on this. We only have about 10 minutes in this session. Do you mind if we pepper questions — quick answers?

Mr SABIN — Sure.

Mr CARROLL — Thanks, Mike, for your presentation. I just want to draw on your history as a police detective. I am not familiar with the policing model in New Zealand, but you are probably aware that our chief commissioner this week has released a blue paper on the future of police 2015–2025. He gave a speech this week where he said that by putting more police in police stations we are actually losing the fight against ice domestic violence and that there is not enough money to go around but that if we are going to be smart and strategic with our budgets, we need to look at more police resources at the divisional and regional level and that it is about more chemists, more lawyers and more targeted police interventions. In your experience of tackling something like methamphetamine use in New Zealand and its widespread use in Victoria, do you think that that is probably the way policing is going in the future in terms of tackling an issue like methamphetamine use?

Mr SABIN — Sorry, I am not quite clear. How are you saying that — —

Mr CARROLL — With your history and what New Zealand has been able to do with policing and trying to — —

Mr SABIN — But what are you suggesting that the policing strategy is doing here? I am not quite clear on that.

Mr CARROLL — What the police commissioner said is that police in police stations are not fixing some of the epidemics we have in society at the moment. We need to be a lot better and more targeted with our resources and a lot more smart at detention and deterrence and finding out where the labs are, and that will require perhaps less focus on police in police stations and more focus at the regional level to work out how we best address this issue.

Mr SABIN — I think, in short, that traditional policing models are not sufficient for methamphetamine. You just cannot keep up with it, and it really does not provide the level of early and effective intervention that I think policing needs to deliver to actually keep up with it. We do not keep up with it. I have not seen a police force that has been able to keep up with that, so with traditional policing models, if you think, 'We'll throw a few more resources into it or just keep doing what we are doing, but let's try to do it harder and hope for a different outcome', that is not going to happen — not in my view.

Mr CARROLL — Just quickly, for the past eight months we have been all over Victoria — a lot of regional towns — and every session we have had we have always had paramedics at the table. They are under enormous pressure, from what they are telling us, with ice addiction. They get the call-outs. The person is off their face. They are aggro. There is domestic violence. They want to fight with the paramedics. They then draw on the police resources to come out to the family home or to the nightclub or wherever the offender is. At the moment we do not have a solution to assisting the paramedics on that sort of issue. Has it been a big issue in New Zealand for the paramedics and the ambos, and has anything been done in terms of best practice strategies for them in dealing with ice?

Mr SABIN — Absolutely that reflects exactly what we see in New Zealand. There were memorandums of understanding developed in terms of how paramedics go to jobs. They would not go unless police were there with them in this kind of carry-on. They have kind of just boxed on and got on with it. Dealing with clan labs, there have been practices that they have had to alter to allow for the issues you see, and we have actually seen the same in emergency wards in hospitals and so forth. Whenever first responders are typically involved there has had to be a step back — 'Hold on a minute. We're dealing with a whole different beast here'. The reality is that to some extent you are dealing with a problem with, no pun intended, the ambulance at the bottom of the cliff. You can put in place some interventions that might make things a little bit safer, but that is

actually in itself not going to respond to the problem or reduce the problem at all. It is probably just about safety in practice at the time.

I guess that is the overarching message I have come to the conclusion with after 15 or 18 years working in this area — that the big gains come in a policy focus when you look at total harm and the fact that it is a preventable problem, take a prevention-centred approach and run everything through a prevention lens. That even involves treatment. The police have a very important role in terms of prevention; they certainly will not if it is the old telescope to the blind eye with drug-taking behaviour going on all around them because they are too busy with other stuff and so forth, for example.

That is not to say that harm reduction or harm minimisation is not a valid and important treatment response, because it is. It is used as a treatment intervention, but if you start off with the premise that the guiding policy focus is about reducing harm, you are accepting that harm is going to happen in the first place. That is not the message, as I was saying today. We do not accept that obesity is going to happen in the first place; we try to teach people to eat well, exercise and have good nutrition. We do not just say, 'Right, let's just make sure there is lots of bariatric surgery and dialysis available'. It is exactly the same situation we are talking about there.

Mr SOUTHWICK — Going back to the action plan, you mention specifically around education that there is the Community Action Youth and Drugs program that works in 29 sites across New Zealand to build community resilience against drugs. Could you comment on how effective that is from a demand reduction perspective?

Mr SABIN — You are talking about CAYAD. When I looked at the evaluations of that up to about 2008 or 2009, it was not very effective. It was not very effective because its outreach was quite poor. Like anything, you have got to reach a critical mass. Politicians understand that when it comes time for elections; you have got to get a critical mass of support. It is exactly the same with culture change in terms of education. You have to reach a critical mass of population, and it has to be specific to the population that you most need to influence. We have to accept that a lot of us in our appearance are kind of old dogs-new tricks sort of material. You can spend a lot of money and a lot of time trying to influence change in people who are probably never going to change. The big ones come in terms of influencing that younger generation and getting a critical mass of them and getting alongside them to support it. For example, if that model in New Zealand was on steroids and it provided in every community a mechanism for everyone to access the information they need at a time when they need it and did so in a way that was mainstream in its outreach, absolutely.

Typically in schools we see some schools that do not like to have drug education, because they say, 'This encourages drug use', just like they do not like to talk about suicide, because that will encourage people to hang themselves. I am a great believer that kids get the science. Take the judgment out of it and give them the science and so forth. You have got to control the controllables.

In my view you have got two populations that governments have a lot of influence over. Firstly there is the population that is at work, because every day its members go to work. There is a very good opportunity for you to influence that population, because drug-free workplaces and workplaces that have policies that support that, education that supports that, is a big percentage of the population. Some 70 per cent of all drug users are in full-time employment. There is a captive audience you have got right there. If you provide the right tax incentives and the right encouragement and structures so that businesses are actively engaged in getting the message through to their population, where does that go? It also goes home to their kids, because the first thing they are thinking about is, 'Hold on a minute! This is happening to my kids'. I know that; that is why I spent a number of years doing what I am doing in my business.

The second captive audience you have is schools. There is a great opportunity there to educate and screen to intervene as well to identify early use as soon as possible and provide not a punitive response but a treatment response or an intervention. It is not about kicking kids out of school because they might be experimenting with dope; it is about ensuring that, if they are, they get stopped, and if we identify problems at home, we try and break that, because often they are

certainly repeating what is happening. Those are two big captive audiences that in my view are completely missed opportunities. Those are the areas where you can put some settings in place and control all of that. Sorry, I cannot remember what your question was. I went off target there.

The CHAIR — We are nearly there.

Mr SABIN — We have got it solved! We can move on.

The CHAIR — No. The only problem we have solved is that we have reached the time at which we have to close.

You have talked about demand reduction and supply reduction, and you have indicated today that you have had quite a lot of inquiry from our local press. Certainly the media has been running very strongly in relation to articles on methamphetamine. I note this because the local community forums have indicated that communities want action. They want the traffickers in particular to be prosecuted and incarcerated. Our election platform was very strong on crime, and communities generally respond well to strong-on-crime policies and government response. Yesterday I heard John Silvester, who is well known in our criminal circles — —

Mr SCHEFFER — Not as a criminal.

The CHAIR — Not as a criminal; as a journalist and commentator. I will just make you aware that 3AW are trying to create a methamphetamine summit, so the likes of Tom Elliott, who does the Drive program, and Neil Mitchell, who does the Mornings program, have been running programs consistently in the last month around methamphetamine and creating some interest. I note that our laws at the moment are that you are a user if you are found to be using anything under 3 grams, but the moment you go over 3 grams you become a trafficker. You are deemed to be, unless you can prove otherwise.

The suggestion of John Silvester was that if you are convicted twice, or if you receive a second conviction for trafficking, you should be incarcerated for life. That is the strong crime message. To my mind if we took that very strong approach — and I am not suggesting we do — we would incarcerate some people who are just traditional users, because 3 grams is a small amount. If you use your analogy, today you were talking about $2000 or $3000 — —

Mr SABIN — Yes, 2 grams to 3 grams a day is not uncommon for a user.

The CHAIR — So a week would probably almost put you in a trafficking scenario. I suppose from your perspective that is over the top and would not create the sort of supply reduction, in that such a heavy penalty in relation to trafficking would actually deter people from being placed in that mode. We hear that many users are actually trafficking to pay for their habit; they become users then traffickers.

Mr SABIN — Absolutely, yes.

The CHAIR — Is it appropriate in order to achieve a reduction in supply to put such a heavy penalty on the offence so that people know if they are trafficking they will go to jail for life?

Mr SABIN — No, it is not; that is the short answer to your question. Typically over the years governments have been captured by populist responses to criminal activity of varying sorts. 'Lock them up and throw away the key' sort of stuff does resonate with people. That is really a sign of frustration that they believe there should be harsh consequences for the harm these people are causing. Will it solve the problem is the question you have to ask. The answer is: most likely no, because I have not seen any jurisdiction that has actually managed to arrest its way out of the problem.

My strongly held view in terms of where you need to spend your resources in the criminal justice system is getting to the real kingpins and the traffickers and ensuring that you have proceeds of crime legislation and the ability to absolutely strip them of their assets and their finances. Those are the ones who should be doing some serious time because ultimately they are the ones who are

profiting the most. Usually they are many steps removed from the average trafficker, who is simply a mule trying to sustain his own habit and doing the dirty work for the big guys.

The big guys definitely need to be taken down at every level. Going to prison is one thing, but I am telling you that taking all their assets — everything they own; everything they have earnt — hurts them equally as much, probably more in many respects. This is in addition to having effective proceeds of crime legislation that actually says to organised crime, 'We will do everything we can to target you financially as well as criminally and, if you are in that net, it's gone. Everything that you have worked for, everything that you actually care about — the proceeds of crime and money — goes back into your prevention, your education, your treatment and so forth'. There is a great ironic synergy in doing that. That is certainly something that New Zealand has picked up on, and I think it is a very effective tool because essentially what you get is a situation that is almost parasitical, where the drug user uses the proceeds of their own crime and diminishes their own ability to make more money.

You do not get soft on the idea of use or what have you, but what you have to identify in use is whether it is experimental use or addictive use and then apply the appropriate response. What you have to do when people are in a position of having committed a crime by virtue of their use is ask, 'How do we prevent you from recommitting that crime?'. The damage is done. The use has occurred; the crime has occurred. The question you must ask yourselves in terms of your policies and approaches and whether you have got it right is, 'Are we actually stopping them from reoffending?', because when you look at the reoffending stats I bet you anything you like they are pretty ugly. That is the key.

One thing is for sure: you can chuck them in prison for a while, but there are as many drugs in there as there are on the outside anyway. It is a university for drug manufacture, and it helps increase the networks. That is not to say that some people should not end up there; they should. But the reality is when you are getting to that point you have missed the boat — you have missed the opportunities that are actually there far sooner in this equation.

In terms of the population and their great concern about, 'We need stronger, tougher sentences', you can come out politically and make some very bold statements on the proceeds of crime and on the most serious, hardened drug dealings, the harm that they commit and what you are going to do about them; that appeases it to some extent. My next message to the community would be that the greatest achievement will come in terms of the misery that is out there when you deny these drug dealers their client base — the public — because the reason they exist is because you, your children, your neighbours and your workmates are buying their products. You the community are the greatest asset we have in terms of dealing with extinguishing organised crime, the money they make and the misery they cause.

We are going through this in New Zealand at the moment; we are looking at organised crime strategies and how we tackle gangs. I see one of the fundamental pillars of that as reducing their client base. Suddenly the public think, 'What does that mean?'. That is when you actually have to say, 'What that means is that this is the role you have to play in this', because no-one is forcing people to take drugs — they are taking them of their own free will — so there are a whole lot of people letting the side down here. You have a responsibility to say, 'Okay, we'll do our bit, but there is a role for you to play in this as well, because you are their client base, remember'.

The CHAIR — Do you have any closing remarks?

Mr SABIN — Thank you for the opportunity. Sorry for my verbose responses. Hopefully there is some other information in these documents. I will certainly share details and what have you with you. I am happy to assist you in any way, shape or form. I think the committee has an exciting opportunity here. When problems hurt, great solutions are often found.

The only thing I would say is that we spent a whole lot of time talking about it but it took us a long time to start walking. The public tire of talkfests very quickly. I think the opportunity that exists here is for the sort of political leadership that ultimately the public gets when you give the shape and form that they can participate in and become a part of.

I very much commend the work you are doing. I think there is a real opportunity to show some real leadership not only here in the state of Victoria but also across the country, because you are dealing with very similar things to us and it is an entirely winnable and achievable situation. Rather than responding to a crisis, it should be looked on as an opportunity to do things better.

The CHAIR — On behalf of the committee, thank you for your availability to attend the public hearing and also for giving us the opportunity to participate in the conference this morning. We appreciate that. We got a lot of valuable information out of that conference and also on record tonight, which was very valuable for Pete, who will have to transcribe eight months work and write a report that will probably run to over 1000 pages. I can assure you, Mike, that it will not be a dustcover. Committee members and staff have done a lot of work. There is an expectation that our work will provide significant benefit to the Victorian community and, we hope, nationally. Thank you for your part in that. We appreciate it. I formally close the public hearing.

Mr SABIN — Thank you.

Committee adjourned.