LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Bendigo — 25 October 2013

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The CHAIR — Welcome, Kerry and Diane. Diane, you are the acting senior manager of ICMS and residential care?

Ms BARKER — Yes.

The CHAIR — And Kerry, you are the manager of community programs from the Youth Support and Advocacy Service — YSAS — from Bendigo?

Ms DONALDSON — That is correct, in Bendigo.

The CHAIR — Welcome to this hearing of the Law Reform, Drugs and Crime Prevention Committee, an all party committee of the Parliament of Victoria. We are conducting an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. Thank you for this time this afternoon.

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 of other Australian states and territories. However, it is important that you note that any comments you make outside the hearing, including effective repetition of what you have said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting at parliamentary committees?

Ms BARKER — Yes.

The CHAIR — 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 will provide a proof version of the transcript at the earliest opportunity so you can correct it as appropriate. We have allocated time from 2.10 to 2.45 for this session. As you will appreciate, even though we do want to hear from you in relation to a verbal presentation, the committee does like to ask questions, so we will allow time for the committee to ask specific questions of you as part of that presentation.

Ms BARKER — First up, thank you for this opportunity. I am representing St Luke's in this instance and the out of home care sector and the impacts that we are experiencing at the moment with our young people who are using ice. To give you a bit of background, the client groups we work with are young people between the ages of 11 and 17, and we have had them down to 9. All these young people are on orders with the Department of Human Services. In the main they are custody orders, but there is a small filter of guardianship.

All of these young people have experienced severe and complex childhood traumas. The young people have been exposed to multiple traumatic events, including multiple abuses, neglect, family breakdown, developmental delays and poor mental health. They are low functioning in the main and not engaged in education. A number self harm and have been in the out of home care system for a long time. All of these young people display high risk and challenging behaviours, and some of the families of these young people have a culture of drug taking, including ice. They are socially marginalised within our community and often isolated from their families, therefore are vulnerable to older sexual predators and drug dealers.

A number of our young people are in the residential care area. We have four units across Bendigo — one for females, three for males — and with two of the units we are experiencing a few of the young people using drugs. At this time those ones who are using ice are presenting very unwell physically and emotionally. They are unpredictable in their behaviours and have become violent towards other young people and staff. Bullying is a regular behaviour displayed by these young people, which has created a very unsafe environment for the others.

Victims of ice are standing over others, threatening their lives physically and verbally abusing, stealing or simply taking others' belongings and selling them to purchase ice. One of our young victims has been intimidating another resident so badly that that resident is too frightened to return to the unit, leaving him — we would call — homeless on the street at the age of 14.

I want to focus a little bit on two siblings who we have with us and who are using ice on a regular basis — a young male, 14, and a young female, 13. Both of these young people were taken into the care by the department because of neglect and sexual abuse and other abuses they have experienced. Both are very traumatised and are delayed in their development, so they are very vulnerable. They live in different units. Over the last six weeks the young boy has presented pale, with sores and other signs and symptoms of drug use, such as not eating and not drinking. He is showing signs of paranoia and is very aggressive. He has terrorised kids and tries to do the same to staff, and in some instances — which I will get to down further — he is succeeding in doing that unfortunately.

It is known and proven that mum has been facilitating her two children with ice while they have been in care with us. We have been to the police, with whom we have a very good communication channel. I will focus first on the young boy. He steals from community cars, does standover stealing and we are not sure what else he is doing to finance his habit. We are aware that he was selling drugs for a mature man, a dealer. Something must have gone wrong because he was very high on his own supply, so to speak, and next minute he was in danger from this adult dealer. That is when we noticed that he started selling his belongings, pinching other people's belongings and generally pinching anything he could. We wonder about other things he may have been doing.

On the young girl, they all go to an address in Bendigo that is known to police. These people purchase the ice from another residence in Bendigo, at which we believe there is a meth lab and the police are looking into that very strongly at the moment. The ice that they are getting is quite strong. They are getting it cheap. They wheeled cash, might I say, into out of home care. Little do they know that they are being preyed upon by giving up that information.

Now he is in a heck of a position. We fear for his safety. However, he keeps going back there and we cannot stop him in our system, which I can talk to you about, too.

His sister is 13. Over that same period, she has been using ice continually, not looking very well and very abusive. She has assaulted younger girls in the community. Last weekend she was physically abusing someone so badly the young girl from the community went to hospital with a broken cheekbone and had to be hospitalised. This young girl has also been offering up favours to this mature aged male dealer and some of his associates, so she is being abused sexually constantly. When we talk with her, she looks at it as getting her needs met by being given the drug. She cannot see that she is being abused and is a victim. It is very hard to deal with a young girl in that position. Her behaviour was out of control. She could not regulate herself at all. She was very high on ice at the same address when she smashed a bottle and stabbed it straight through her wrist, right to the bottom. She was taken to the Bendigo hospital, where she had to have emergency surgery, endeavouring to save her life because of the blood loss. Because she wanted the ice so much, the day following the operation she pulled the IV from her arm and ran off to get to the dealer's again. They are just a couple of instances, but I think it is essential that you know what some of our little ones go through.

It is very difficult for us. I am sure you will be talking more about this. If we look at the work we try to do to help our young people to empower themselves, not involving drugs but turning their lives around by engaging in education and things like that, the drugs and dealers will win every time. I was fortunate enough to be at the forum last night. I was so impressed to see the community and professionals work together, because that is the key to it all. If we must look at a win lose situation, we are not going to win over dealers and help these young people.

On some of the problems for us to be able to keep young people safe, on a number of occasions we have applied and put the rationale to have our young people who are physically unwell, refusing to go to doctors, who will not stay at home, are continually absconding and are being abused in many ways to go to a place in Melbourne called secure welfare. I am unsure whether you have actually heard of that. It is not a jail like Parkville. It is an area in which to keep our young people safe. It must be done through the courts and the longest time that the young person can stay is 21 days.

Most kids are there for only four days or maybe a week, depending on how well they are. In this instance, with ice, we have put a number of rationales in requesting a placement for our children.

Unfortunately in that time none of those have been granted. Therefore we see our children getting sicker and sicker and at times, without being dramatic, they fear for their lives in many areas, not just in the use of ice but in other high risk behaviours they are engaging in.

Mr CARROLL — Is that because of capacity, Diane?

Ms BARKER — It is a capacity issue. There are nine beds available in the women's secure welfare and nine available in the male's. That covers the whole of Victoria and they are both in Melbourne. You know the psychotic behaviour with ice use down in Melbourne and everywhere and we understand that those beds are full. But what happens to our young people here in our community? We are powerless to keep them safe. So I guess it is very important that we look at what type of facilities there are and what could be used to assist young people, not just because of ice but because of poly drug use and for various other reasons. The secure welfare people are inundated. I know that they have some reviews going on through DHS to see what they can do, but there certainly will be no immediate solution to this.

On another thing where education comes in, a lot of people in our community view our children as menaces in society. They are marginalised, they are not accepted by the community in a welcoming manner, and we understand why. But it is so easy for them to fall into the clutches of dealers and to use drugs. It soothes their previous traumas and gives them feelings of wellbeing. All the stuff that I know you people heard last night, it helps them in their mind but not in the long term.

A lot of people in the community do not understand young people in residential care. We work under policies, procedures and the Children, Youth and Families Act. There is no locked door policy. We can keep predators, dangerous people or others out of the units, but inside our young people can come and go as they like. We cannot stop them. We use a lot of frameworks and strategies to keep children from leaving, but it is as ugly as a 9, 10 or 11 year old child and older being able to open a door at 2 o'clock in the morning and walk out and there is not a jolly thing we can do about it. We are not to be manhandling children. We can notify the police but the young people have gone — drug affected, with mental health issues and unwell. It is extremely concerning. I am not complaining about the no locked door policy. What I am trying to put is that we have a lot of challenges to confront.

Another thing is that we are finding a lot of drugs in the units. Our staff are allowed to do and they do random checks on a daily basis. We have to justify it; if we believe there are drugs or drug paraphernalia, we are allowed to do this. There have been syringes, bongs and other utensils found — ice packaged up. That is how we knew they were selling things like that. It is quite nasty even to stop the use within the unit. When the kids return, we can ask them to turn out their pockets and open their bags. If they refuse to, there is probably not a lot we can do about it, and we certainly cannot be manhandling and patting people down.

In relation to young people at home, parents have a lot more, I guess, luxury in being able to keep their kids safe in some instances. We do not have much at all. Through our youth resource team and the ICMS case managers and, I am sure, other areas in our sector, we track our young people through Facebook — it is not on the ICMS case managers' personal sites. We know the young people put lots of things on there, like 'One for 50 bucks. Ring me now'. Phone numbers, photos, young girls with older predators — we streamline that information through to the police. They will work us out one day, I think, and that will be the end of that strategy!

I really commend the police. I understand through working all this time very closely with them and through our mandatory reporting that they do not have the resources they need. However, we are lucky enough to have two youth liaison officers who are working very closely with us in relation to the ice problem in our area.

The CHAIR — Diane, we are nearly out of time, and we have not asked a question. We have Kerry to speak as well.

Ms BARKER — Sorry. Okay, I might leave it at that.

The CHAIR — If you do not mind, perhaps — —

Ms DONALDSON — I am a dot point sort of person, so I will be quick.

The CHAIR — Thank you. Sorry Diane.

Ms BARKER — That is fine. I was not sure what we could do.

The CHAIR — I want to make sure we get a balance of representation that will allow the committee to ask some questions.

Ms DONALDSON — I am aware that a submission has been given for the Youth Support and Advocacy Service by my executive officer, Paul Bird, and Andrew Bruun — this one. Pretty much that summarises the perspective of the work I do up here, but I just thought I would give you a colour of the regional perspective rather than — it does not really change that much from there.

I am just responding to term of reference 3, 'examine the nature, prevalence and culture'. In Bendigo we have seen a two and a half fold increase in young people where that is their primary drug of concern over the last 12 months. That is a significant increase. We had not seen that jump in a particular drug before. We have increased presentation for help from young people and families who are not familiar with the AOD sector or the legal systems. These people are coming from, as Richard Marchingo was saying, the more middle class families. They are tradies, apprentices et cetera. Even though those young people are presenting in crisis, they are still not able to accept that ice is a contributing factor to their situation. What we would call them is 'precontemplative', even though their life is starting to deteriorate, along with their relationships. They are in trouble with the police, their health is starting to deteriorate with their paranoid thinking and physical health, and they are becoming financially burdened. They still cannot make that connection that the ice is contributing, because of the rewards the ice is giving them.

Cannabis is no. 1 as a primary drug of concern for us, and alcohol is the secondary concern. Amphetamines, or ice, sit well under that. It is important to keep that in context — that ice is an emerging problem, but it is still not the most significant problem for young people in Bendigo. Most young people, even though they have a primary drug of cannabis or alcohol or benzodiazepines, there will use ice on occasions but not in a problematic way. So that comes into the polydrug mix of their use patterns. That is term of reference 3.

On term of reference 4, the links between meth use and crime, we have seen increased presentation of ice involved with crime — either people being referred to our service because they have committed crime whilst on ice or they have committed crime to fund their drug use habits. We are seeing people we have not seen before coming in, and young people we have worked with before picking up ice as a habit and getting linked into the criminal justice system, whereas before they may have been able to avoid it. As we said last night, there has been a bit of an increase in armed robberies. Young people are using armed robbery as a mechanism to get their needs met, which is a significant change. Normally they would do shop theft or home theft.

It is interesting that young people who are not using ice as their primary drug of concern would have been hanging around with a group of young people who are polydrug users, but what I am finding is that those groups are splitting and ice users are congregating together, because people who do not use ice in a problematic way cannot stand the behaviours of the ice addicts. The young people are saying, 'I am not going to hang out with them anymore, because they are irrational, they are schizzing all over the place, they are unpredictable and they are violent'. So the ice users are isolated again even within the drug using culture, which is interesting. They are hard to manage.

No. 5 — the short and long term consequences. Up here, as you would have heard, there has been an increase in sexual health problems. People become sexually aroused and heightened, so there is a lot of unprotected sex. We have a big problem with our STIs up here and unplanned pregnancies, and babies are being born to mothers who have used amphetamines. There is so much research that needs to be done in those areas. There was the lady who talked about people who are exposed to secondary ice smoke. What are the implications for young people? We do not know. All she could

do was say to those people, 'If you are going to use, use out the back or in the laundry away from the children, like you do with cigarettes or cannabis'.

There is psychological health and securing or maintaining employment. We have a lot of young people who have been to ABC, which is our psychiatric facility. We have had an increase in ABC admissions from young people presenting with a significant psychosis, but it is not being resolved after the drugs have left their system. So whether that is causing psychiatric illness or whether it is emerging more quickly is an area that needs more research too. Certainly we have had a significant number of young people who did not have a prior psychosis, who had used the drug, had a psychosis and have not recovered from it. That is an interesting thing to watch — but not very interesting for the families and the people involved. Again, there is longer withdrawal and recovery.

The impact on brain development is interesting, because alcohol has such a significant impact on the development of a young person's brain. You can imagine what impact this drug must be having on the development of a young person's brain. Also, the low mood that was discussed last night. It is really hard to maintain people in abstinence or controlled use when there is no joy in their lives. The things they used to find pleasure in they cannot find pleasure in, and it is really a very difficult state to hold young people in because they are so motivated and rewarded by joy, as they should be. Kids are joyful. It is a very sad thing to see children without joy.

No. 6 is state and federal strategies. It is similar to what Richard Marchingo was saying about cross sector training, AOD workers get a bit of a handle on the emerging drug trends of synthetics and ice and that sort of thing, but people who are using ice come across a whole range of sectors, like the industry sector for training and apprentices, welfare housing, mental health, Centrelink, education and maternal and child health. How do we get information around ice out to those people and some strategies so there is that cross sector education, and it is not just targeted at AOD. The strategies around demonising the drug have not helped, and they do not help. They do not help affected families. The shame, the isolation, the guilt and the stigma stops them from accessing help until a crisis arises, particularly in regional and rural areas. The stigma and the social surveillance are quite high, and people are reticent about coming forward for assistance because of the demonisation. It is a blame thing — the idea that people choose to be addicted, but they do not.

And that is me.

The CHAIR — Thank you. I invite committee members to raise questions as they see fit.

Mr McCURDY — In terms of the tools we need in regional Victoria, you spoke about the facility in Melbourne. Are the tools specific to ice, or would they be used for all sorts of issues for young people? Ice is the growing market, or the easiest to access, but obviously there are other issues.

Ms BARKER — Certainly, there is mental health. There could be trauma.

Ms DONALDSON — Secure welfare is for the pointy end of kids who are so at risk of harm to themselves that they need to be detained, and it is only for a short period of time. But drug and alcohol services are quite different. We do not see ice as a different drug. Drug use has its own function, and has its own meaning for people, and the drug does not really matter. The implication for us is in recovery and withdrawal because it takes longer. It is a bit different, the way we manage that, but when we are working with the drug user, it is the same issue as to why that young person uses drugs. It is not the same for everybody, but whether it is cannabis, alcohol, benzos or heroin, it does not matter.

Mr McCURDY — Same reason.

Ms DONALDSON — Yes.

Mr CARROLL — Thank you for your presentations; they were both very insightful. In a lot of the evidence the committee has received in terms of dealing with and trying to give people

treatment, it seems you need to basically take people away for five to six months and put them in some sort of treatment facility — a bit like a YSAS or an Odyssey House. For people with ice addiction, to try to give them the best treatment, you cannot have them in for five days and then out. Would you see that it needs a protracted, hands on, cancelling approach? Would it be several months to give them the best care available?

Ms BARKER — Yes. With our young people, most of us are not D and A workers, especially in the sector I spoke about. We rely on YSAS, psychologists and things like that. There is detox in the facilities, which young people are offered continually and encouraged to go to and make a connection with YSAS. But remember, they are adolescents too, so they want to be out there, experimenting and doing what they do, and a lot of our young children just absolutely refuse to engage.

Ms DONALDSON — They do not see it as a problem.

Ms BARKER — No.

Ms DONALDSON — If you take somebody out of their community and forcibly enter them into a treatment, the outcomes are not going to be favourable. Putting people in jail does not stop them using drugs. It is a similar sort of model. If you want to force them into treatment, they have to want to participate in the process of recovery.

Ms BARKER — You were talking about a period of time away. I guess that is looking at the rehabilitation part of it — there is detox and then rehabilitation. Young people have to want to do it, don't they?

The CHAIR — Yes.

Ms DONALDSON — We are a bit sneaky with people's drug use. It is functional; we respect that. It is the young person's life, and they are choosing to do it, so we try to beef up the other parts of their lives. We try to improve their health, get them linked into a mental health plan and get them to work on their mental health, get them into stable housing, maybe try and link them back into education or a meaningful activity that makes them feel good about themselves so they are not using all the time. In that way we try to beef up their capacity for resilience so the drug might not take on that much of a meaning for them, and they might be able to look a little bit further than where they are and see the drug as a barrier to getting where they might want to go. Then they might want to look at their drug use. Certainly young people are reluctant to give up their drugs, because it is working for them. It does not work for us, looking at them, so we work across the spectrum of a young person's life, and often they are the systems that have collapsed. A lot of young people we work with have not been at school since grade 5 or year 7, and their systems have collapsed — 80 per cent of them have mental health issues that have not been diagnosed. It is significant to try to beef up those things.

Ms BARKER — It is similar with us. A lot of our young people have not been to school. They might have the equivalent of grade 3 or 4 education. We work on a strength based aspect where we find things they like and try to build and offer, but, you know, like I said before, the dealers — they are more important.

Ms DONALDSON — With the tradies and this new crew, they are wide eyed and the parents are so distressed, and rightly so because the child they have borne and protected and encouraged and nurtured is not the same person sitting next to them on the couch when we talk to them. But those young people have a lot of resilience and capacity for recovery, so their prognosis for recovery is much better, say, than a lot of the young people who Di works with, who have a lot more trauma based function to their drug use, who have not had education and do not have supportive families or a general level of wellbeing and health; so their capacity for recovery is good.

Mr CARROLL — With your organisation, Diane, you talked about how you cannot lock the doors and keep them inside.

Ms BARKER — Yes.

Mr CARROLL — Are there any positives that come out of it? What is your goal with the 13 and 14 year olds who have had severe trauma and are still going through severe trauma and have the addiction?

Ms BARKER — It is a really good question. We have these young people for a short window of time in order to be able to help them, but a lot of their behaviours are so entrenched that although we get in support and do a lot of work to assist them and help them feel valued and things like that, that short window of time we get with them is not enough time to assist them through retraining their attitude and all the cognitive areas.

The young people we get in are young people who cannot even stay in a home based care home, meaning foster care, because of their behaviours and everything else. It is very hard. I say to my staff a lot, 'Enjoy the little steps. If a child draws a picture or if a child laughs during the day, embrace and enjoy'. That might sound very punitive, but it is true. There is not much for these kids and they understand they are with us until they are 18. They are fearful of what is going to happen then. They try to break things down in the units and they will assault staff because they think they can then go home, and things like that. I say to my staff, 'If we see one success story in a whole year that we can talk about, be happy'. We usually see the changes and the kids will come back a lot. They will bring their baby at 19, 20, 22, and that is when you see the benefit of the work you have done.

Mr CARROLL — So they are with you until they are 18, and then they are legal adults and then they are sort of — —

Ms DONALDSON — Bye bye. They are gone.

Mr CARROLL — 'Off you go'?

Ms BARKER — Yes. It is very sad. I do not know if you are aware of a farm that Father Riley has in New South Wales. I worked in the at home care sector, and they have a lot of these young people with polydrug use problems. They cannot break away from their peers because they have no other peers to go to.

Ms DONALDSON — No family.

Ms BARKER — It is so sad. It is very difficult for young people. They go out to the farm, and the success rate in that is phenomenal. I would like to see Victoria have something like that for our young people. We have a therapeutic unit and there would need to be a therapeutic approach in that type of facility — like Hurstbridge in Melbourne. But what I am talking about is a bigger concept. I did meet with the child safety commissioner, I think it was early this year. Just to reinforce my thoughts, you know what you hope for these young kids. I would like to see the young people at 11, 12 or even 9 being able to go to these facilities so they are not subject to the elements that are out there and needing drugs and ice at this time.

The CHAIR — We did visit Odyssey House, which was a refuge for a slightly older demographic, but it was a bit away from the mainstream influences.

Ms BARKER — They are for adults though.

Ms DONALDSON — You went to Birribi out at Eltham? The residential withdrawal rehab?

The CHAIR — Yes, we went to your facility as well as Odyssey House. Can I just ask Kerry about the home based program, and I am reminded of the question from the lady last night who had a teenage daughter.

Ms DONALDSON — The 17 year old? What was the question?

The CHAIR — Yes. So we are at one extreme with Diane and some of her cases but there are, I suspect, a lot of recreational drug users where parents are quite concerned about the activity of their children. How successful are home based withdrawal programs as against moving them out — —

Ms DONALDSON — It depends on their environment. If their environment is a stable and non drug using environment and they have a commitment to change, they are reasonably successful. If their environment is a drug using environment, it is really very difficult. A lot of the young people are living in environments where the drugs are still there, so culturally it is very hard to move away from that. So you might take home based withdrawal to them and reduce them, then you might put them in a residential withdrawal and they are drug free, and then they go back and the drugs are in their environment so it is a lot harder.

That is what I was saying before — the people with the recovery capacity or with family, if they go back into that environment and there is no drug use, they have a lot better chance, unless there is an underlying problem. A psychological addiction is a big driving force for people. The no joy, the mental health, the anxiety, the depression keeps driving people back into use. So the shorter time you have been using, and the more supports you have the less trauma you have, the more positive recovery you will have.

Mr SCHEFFER — Just a quick one, I hope. First of all thank you, Kerry and Diane, for your presentations and especially the very moving account you gave of the two young people in your care at the moment. That was very affecting. But in the context of Kerry mentioning the notion about how dangerous it is to demonise the drug while being very mindful of the seriousness of it, and also the view that you put, Kerry, about understanding drug issues as drug issues, not specific drugs that are the problem — it is a global issue about the person — linking those two concepts to the forum last evening which I was not able to attend, and I have not have an opportunity to talk to my colleagues about what was there, you did say in your opening remarks how good it was, therefore I ask to you place on the record why you said that, what you thought about that forum, given the observations I made before, quoting Kerry.

The CHAIR — Bearing in mind that that forum went for two and a half hours.

Mr SCHEFFER — Yes, but we have not had any reflection of it, and it would be good, on the record, for our deliberations later — —

The CHAIR — Not all on the record, though.

Mr SCHEFFER — No, not the whole thing, but — —

Ms BARKER — The chap that presented, Chris from Anex, I was so impressed with him. When we work with communities we learn very quickly that the language we use is essential so people understand what they are saying. We cannot expect everybody to be good at English literature, have a BA and things like that, and people do not get it. What he did though, he spoke on a very respectful community level.

Ms DONALDSON — Yes. He condensed a whole lot of information into 45 minutes, and he got the key messages across in a way that people could understand.

Ms BARKER — Yes.

Ms DONALDSON — I think the panel was fabulously represented with people showing a commitment to own the problem, that it did not meet the needs of the community asking questions because it was not grassroots enough. So there was probably a bit of incongruence about the expectations of the community asking questions and the panel being able to answer some of those questions. Some of the members on the panel were closer to the grassroots but others were a bit higher up.

Ms BARKER — I was also very impressed with how many people attended. It was really warming, wasn't it?

Ms DONALDSON — It goes to show what a big problem it is.

Ms BARKER — Yes, communities want to be involved. I did ask a question there last night which was quite valid about how we empower communities to be not fearful when reporting drug activity close to their homes and families. There was a reason I asked that: because with the families we deal with a lot of times we will say, 'You don't have to put up with being bashed because you haven't paid your drug bill. You have rights as a person. You can report this anonymously'. They are so frightened, and our children too — our little ones — will not go through those channels to report, through fear.

Mr SCHEFFER — Okay. I am going to be really cheeky; just a real quick one. Do you think as many people would have turned up if it had been on alcohol?

Ms DONALDSON — No.

Mr SCHEFFER — Why not?

Ms DONALDSON — Because people have to look at their own behaviour too much with alcohol. I think people see alcohol as socially acceptable in our culture. It is only the people — they are the problem — who use alcohol, whereas the community sees ice as the problem. So it is a bit different.

The CHAIR — I would have thought ice would have been seen to be far more menacing in relation to linking back to the community and alcohol, even though the stats tell us that alcohol is — —

Ms DONALDSON — It is interesting because alcohol causes much more damage.

The CHAIR — We are creating another discussion which, honestly and sadly, we do not have time for. I thank you both, Diane and Kerry, for presenting to the committee this afternoon.

Ms BARKER — Thank you.

Ms DONALDSON — Thank you.

Witnesses withdrew.