LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

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

Mildura — 5 December 2013

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Ms D. Sanders, Indigenous Engagement Officer, Mallee Family Care.

The CHAIR — Good afternoon. The Law Reform, Drugs and Crime Prevention Committee is undertaking an inquiry into the supply and use of methamphetamines, particularly ice, in Victoria. Welcome to this part of the hearing. We ask that you provide a very brief overview of what you want to present to the committee, and then the committee will ask questions of you. But before we do that, I ask you to bear with me while I read the conditions under which you are presenting to this hearing this afternoon. All evidence taken at this public 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 know 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 evidence to parliamentary committees?

Ms HARLEY — Yes.

The CHAIR — It is also important to know that any action that seeks to impede or hinder a witness or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence and will provide a proof version of the transcript at the earliest opportunity, so you can collect it as appropriate. I invite you to make a verbal submission to the committee. Thank you.

Ms HARLEY — Thank you. I would like to start by acknowledging the traditional owners of the land and pay our respects to elders, past and present. Thank you very much for giving Mallee Family Care the opportunity to present to this inquiry. I am Fiona Harley, the deputy executive director of Mallee Family Care. I will present on the vulnerabilities of the Mildura community and how this correlates with the concerning use of ice. The psychosocial impact of this drug will be outlined by Cath Murphy, the director of disability and mental health support services, and Darlene, a colleague, will tell her personal story and experience of how ice has impacted her and her family.

Mildura is a vulnerable community. The Mildura LGA is ranked the fifth most disadvantaged community out of the 80 LGAs in Victoria. In Mildura around a third of families have an income of less than $600 per week — significantly more than at the state level, which is 23.8 per cent, and the national level, which is 23.7 per cent. Similarly a third as many households in Mildura have a weekly income of more than $3000, compared to 10.8 per cent of the state and 11.2 at national levels.

While there are many indicators that point to the community's vulnerability — and I am sure much of this has already been or will be outlined in future presentations — I thought I would focus on those related to educational attainment, as the links between educational attainment and good life outcomes are well documented and really do correlate well with what is happening in our community. Research indicates that young people who have a history of low commitment to education and failure at school are more likely to engage in drug use. Our young people do not engage as well as their peers across the state with education. Our year 12 or equivalent attainment rates are among the lowest in the state at 69.7 per cent, compared with regional Victoria at 74.1 per cent and the state at 79.8 per cent. We have relatively high levels of disengagement among young people, with 24.9 per cent of 15 to 19-year-olds not engaged in education, training or employment, compared with 15.4 per cent in Victoria. That leaves a lot of young people with very little to do.

Of those young people who do complete year 12, only 37.1 per cent have gone on to university, compared with 49 per cent for all of Victoria. This of course directly relates to the low income levels previously mentioned. Conservatively it costs between $15 000 and $20 000 per year to support a young person to study in Melbourne at university, and Adelaide is a similar figure, and of course youth allowance and those sorts of things do not nearly go far enough to make up that cost. Needless to say this impacts on the number of people with a degree or above qualification living and working in Mildura, with only 8.2 per cent of the Mildura workforce having a degree or above qualification.

The Department of Education and Early Childhood Development reports that for the Mildura area the student families occupation data indicates that the share of students from families whose student family occupation category is D, which is unskilled or semi-skilled occupations, and N, which is unemployed, is now nearly 45 per cent. Mildura also has almost triple the rate of teenage parents compared with the rest of the state. Research tells us that this cohort usually disengages from their education once pregnant and is unlikely to re-engage once their child is born.

Our Indigenous young people and their families are well overrepresented in all of the above indicators of vulnerability. In every respect these statistics underpin our vulnerabilities and consequently expose our young people to being susceptible to high levels of risk-taking behaviour, including drug abuse.

One program being run by Mallee Family Care is a program that links mentors with young people at risk of disengagement from education. In preparation for this presentation I had the coordinator have some discussions with the young people about the availability and use of the drug ice. These young people are in years 8 and 9, and I guess while the information received can only be considered anecdotal the young people did indicate that ice is very easy to get, available at all Friday night parties and at Blue Light discos. It is considered cheaper than alcohol and the effect lasts longer, so for kids who have not got much money that becomes the preferred way to get high over alcohol.

In 2014 this program has been extended to working with young people transitioning from year 6 to year 7, a particularly challenging time for some children. The coordinator learnt recently that some of these children, who are currently in year 5 in preparation for the transition to the program, were already sexually active. That is kids probably 11. These vulnerabilities outlined leave our young people open to engaging in risk-taking behaviours and becoming the target of drug dealers in our community.

Ms MURPHY — I will outline the psychosocial impact, but I will also be talking about collaborative efforts that we as a community sector engage in to tackle issues such as ice within the mental health service system. Mallee Family Care has for 20 years experienced managing people with severe mental illness to live and maintain a quality of life within their communities. Our mental health programs include a mixture of state and commonwealth-funded programs, including the newly formed commonwealth program Partners in Recovery, a major initiative. Mallee Family Care is one of three non-government organisations within Australia leading this program. All other programs are led by Medicare Locals within their given regions.

Partners in Recovery is about dealing with the complex care needs of individuals with a mental illness, ensuring that coordination and collaboration is achieved across the whole of the health, welfare and justice sector to fully support the person and their families in need. In the first three months of operation, Partners in Recovery has seen nine referrals to the program. Three of these referrals have been ice related, and engagement has been incredibly difficult to navigate, to say the least. As Leanne Dellar from the Mildura Base Hospital said this morning, the window of opportunity for treatment and to engage is very narrow, and that is certainly what we are finding.

In this presentation I will briefly describe the psychosocial impacts of ice on the individual families and carers of people with a mental illness. This is best described in a case scenario where the people's identity has been protected. I will also talk about the strategic and collaborative efforts this sector is engaging in to work with individuals, families and carers to support and facilitate recovery. I will also talk more broadly about the Mallee Family Care organisation and what is being seen in our family services and community services directorates. I will also highlight the need for alternative accommodation that supports the work of the sector.

The psychosocial impact — ice is not nice. It is devastating and it is tearing families apart. Neville and Rose, not their real names, are considered a middle-class family with a successful Mildura business. They have five adult children aged between 20 and 35. Their eldest son, Max, has succumbed to ice. Max came to our attention via an inquiry from his aunty. She wanted to know how to help her extended family and how to get her nephew engaged in services that would ensure his rehabilitation.

Max is someone who achieved academically. He had every opportunity to participate positively in his community, and he has held down a job in the family business for many years. Ice, however, has been the negative in Max's recent history. Max was married at 27. At the age of 31 he and his wife had their only child, and it was in this post-natal phase that Max started to mix other recreational drug use with ice. His now estranged wife, Anne, lives in a major capital city with their infant child.

The psychosocial consequences for Max as a result of ice include the following. Poor health and physical health outcomes and significant periods of disconnection from reality — severe highs and lows draw Max back to ice each time, as the alternative is not worth contemplating. Poor engagement into treatment services — myriad psychiatric appointments and drug and alcohol appointments have not led to any positive outcomes for Max. Max's capacity to manage his own life or to allow others to assist him to facilitate his recovery from this dreaded drug is intricately difficult.

Employment and loss of income — Max has now lost his stable form of income within the family business. He became unreliable and was using the income to support his habit. He has therefore lost sight of all the possibilities that were in front of him as a result of his once-held capacity to work. Housing — Max has had to sell the family home to repay debt owing to ice. He has no security in terms of housing and no security left for himself, his estranged wife or his child. Max is now homeless. He couch-surfs within the town he now lives in.

Relationships — Max is separated from his wife, child and immediate family members. The irrationality imposed by ice does not allow for Max to secure a sense of reality and acknowledge that, despite the hideousness of ice and all that it has done to ruin his life, his family still love and care for him. He sees them as the enemy, and this is breaking their hearts. Social connectedness and strained relationships — what were consider as genuine friends now equal significant isolation and lack of connectedness. What Max once identified as a part of who he was is now difficult for him to contemplate.

For the family, they have lost their dream of enjoying the next phase of their life within their once happy family environment. In their mid-50s they were looking forward to being active grandparents and supporting their son and daughter-in-law in their pursuits. Instead they live with the daily dread of wondering where their son is, what he is doing to support his habit or whether in fact there will be any form of rehabilitation for their son. Of course their most dreaded fear is losing their son altogether. They have tried and tried to engage and support, but because of the irrationality of their son whilst on ice and the paranoia whilst coming down, there is little hope of them making any positive impact. They have had to impose strict boundaries for their own safety, and this of course is construed by their son as them siding with his wife.

The family unit unfortunately did not engage with our service due to the stigma that is often associated with services such as ours. They had never been service users before, so it was a totally foreign concept for them to be walking into an agency like Mallee Family Care's family care and mental health support service to ask for help. All we could do is provide many phone numbers for help lines and point the family in the right direction via their aunty's inquiry.

In regard to other parts of our organisation, what has been seen through family services and community services are the accounts of the impact of ice from workers within our organisation where they talk about the extreme domestic violence measures used, such as use of implements and dowsing partners with petrol. These actions of course lead straight to the justice system, and the families are left to live with post-traumatic stress, high levels of anxiety and constant fear.

Dealing with such issues within the family environment brings into question the occupational health and safety concerns of workers. The risk is too high for them to be attending as a single worker. The pressure therefore put on the system to attend with two workers then places pressure on the achievement of targets and ultimately the meeting of funding requirements. This needs to be considered. Workers within one of our program areas suggest that the treatments for people on ice are not understood and can lead to workers across sectors being at odds with one another simply because they do not understand how or why somebody is being treated.

There is still a lot of knowledge to be built out there. They do not understand why children are left in families where there is clear evidence that there is at least one adult in the home using ice. In talking to our community services manager, who manages the community legal service, financial counselling and family relationship centre, she made the following comments. The program areas have not identified presentations being linked to ice as such. Eighty per cent of the legal service case load addresses issues of family violence and family law. This may actually in itself back up what Superintendent Paul Naylor suggested this morning, with the link to family violence and the use of the drug ice. But within the service ice in itself is not being identified.

Within the financial counselling program there is a broad spectrum of issues presented, from aged people managing their ability to pay their utilities to young people presenting with overcommitment through things such as mobile phone contracts. It is suspected that many presentations for crimes associated with ice would present to the private law firms within the town.

The mental health service system at both a clinical and non-clinical level have a united front in strategically addressing the issues associated with the complexity of mental health and anything that comes with that, such as ice or other drug and alcohol issues. Mallee Family Care, together with other significant players, many of whom you have heard from today, actively address service gaps within the Northern Mallee and Lower Murray regions.

Partners in Recovery is representational of this partnership. The most pleasing feature of this particular program is that there are no geographical boundary issues, so we can design a local response despite the mighty Murray dividing our region. Collaboratively on the ground our workers work in partnership with clinical mental health, Sunraysia drug and alcohol services, in an initiative called optimal health collaborative therapy. This initiative has come out of the state-funded program, the dual-diagnosis program. Other collaborative efforts include greater efforts in coordinated case planning, so there is not a duplication of service, joint projects around media campaigns and health promotion and, as I said before, closing the gap on service inadequacies.

Another example of where we all work together within the Lower Murray mental health alliance is the recent expression of interest submitted to headspace for a headspace in Mildura, which we currently lack. In the Mildura Rural City Council precinct we have a 12-bed inpatient unit within clinical mental health services, and between this service and our non-clinical mental health support service, where 80 per cent of our workers are dual-diagnosis competent, we are stretched with serving the complexities of mental health, drugs and alcohol within our community. We have no PARC unit — prevention and recovery care — which many other regional and metro areas do have, and as you have heard today, we have no alcohol and drug detox residential facility.

As you know, we are 4 hours from Adelaide, 4 hours from Bendigo, 5 from Ballarat and 6½ from Melbourne, where we would have the opportunity to locate members of our community if in fact there were any beds available in such facilities in these regions. Further dislocation from families and familiar environments is not helpful to rehabilitation measures.

When we hear reports from the state government of the day and their plans to spend $250 million on the facade and maintenance of the iconic Victoria market, you can understand the despair of our community when we lack such basic facilities. As our dual-diagnosis consultant, Jill Gleeson, said today, the effort it takes to locate a rehabilitation service for someone seeking rehabilitation for drugs and alcohol, the impact on children, being separated from their parents while this is occurring, and the additional isolation as opposed to family support being close by felt by the person are horrendous.

Constantly we are being told we do not have the population base to support such facilities, and this is simply no longer acceptable. If I may borrow a phrase from our newly elected member for the seat of Mallee, Andrew Broad, who presented his maiden speech in Parliament yesterday, it is not too much to ask. I say on behalf of the sector's approach: it is not too much to ask the state government of the day to have a vision beyond their metro confines, to have a vision beyond more populated regional towns closer to Melbourne and to think more broadly about the impact of isolation felt by those in the northern and southern Mallee who have to travel so far from home, so

far from their families and support networks, to have the same standard of services that the capital cities and larger regional towns are afforded.

We will continue to fight for such services, we will continue to work collaboratively as a community to melt the ice and not let it take hold any further and we will continue to support families like Neville and Rose and individuals such as Max to ensure we are doing all we possibly can to respond. We do want to be listened to and taken seriously, and we require a timely response from this hearing of intended outcomes to support all that we are doing here in the northern Mallee.

The CHAIR — Thank you, Cath. That was very detailed and well researched, with a political statement flavour, but we appreciate the effort you have obviously gone to to provide that evidence to this hearing. Thank you. That did consume some time, so I will ask Ms Sanders if she would like to make a contribution and then we will go to questions.

Ms SANDERS — Yes. I am a member of the Indigenous community here. I am not originally from Mildura, I am originally from Perth, but I have lived here over 20 years. My son is actually a drug addict. I have had to live with the drugs. I have had to live with the behaviour that he presents when he comes home — the unpredictable behaviour, the threatening, the violence. I have had to put a restraining order on him. He is incarcerated at the moment, but I have had to put a restraining order on him for our safety because I have my daughter and my granddaughter living at my house also. Due to him she had to leave her place, her own house — my daughter — and move back home because he would go there and he would use her place, or other addicts would be there. It was hard for her to start her own life. The reason I had to put that on him was so that we could be safe in our own home and be okay.

There were things like you would wake up in the morning and he would be in the house and you would not know what behaviour would present, so it was quite frightening at the best of times. I have had to leave my own house and stay at another person's house for safety. I was forever ringing the police, and I mean the police can only do so much, so I built a good relationship with a lot of the police officers here because of him and his actions. I guess it was me thinking about the guilt of, 'What have I done wrong? Did I do too much for him? Did I do not enough for him? What can I do, because he is my only son?'. From going to court and getting him bailed out I could probably tell you every judge that I spoke to at the courthouse due to him attending court. I actually spoke to magistrates and said, 'He's in the witness stand now; he's agreeing to what you're saying. Before the sun goes down today he will be high. He's not the victim, we're the victims, because we are being held hostage to his drug addiction, and I'm not doing it anymore. If he wants to live that life, that's entirely up to him'.

So now on the restraining order he is not allowed to come near me, he is not allowed to approach my house. He is allowed to ring me, and the only reason I do that is that I want to know that he is alive. So I get phone calls now and again. He does ring me from jail just to let me know what he is up to and what he is doing. Unfortunately he is doing a lot more in there than he is on the outside. He gets out, he is good for maybe a week, and then we are back to square one again.

Mr SOUTHWICK — When you say he is doing a lot more there, what — —

Ms SANDERS — A lot more, like he is doing adult education, he is doing first aid.

Mr SOUTHWICK — Rehab?

Ms SANDERS — Yes, he is not doing the drugs, he is actually doing drug education.

Mr SOUTHWICK — I just wanted to be clear.

Ms SANDERS — No, he is doing a lot more for himself to better himself. He has also got a son who lives in this community. My grandson is 2, and I have not seen him for a year due to the fact of ice. It has played out that way because mum does not want dad to see him, so unfortunately we cannot see him. That saddens me, because my grandson is missing out on his Indigenous

heritage and his culture, and we are a very rich culture. But due to the ice we cannot see him. That hurts me the most, that my grandson is missing out and we are missing out on him as well.

Mr SOUTHWICK — How old is he?

Ms SANDERS — He is 2.

Mr SOUTHWICK — No, how old is your son?

Ms SANDERS — My son? He is 23, just turned 23. He has actually been on it for four years now. Every year around his birthday he is incarcerated. His 21st birthday present was being locked up. He got locked up that day because he was at home, I had to leave my house for the threatening behaviour, go to someone else's place, ring the police and then go back to my house to pretend nothing had happened. The police came, and then he was saying, 'Don't tell them I'm here', and I said, 'Well, you need to talk to them'. So he ended up getting locked up that night, and then he realised that I had rung the police on him.

When he is high and he is coming down, his behaviour is always directed at me. I get verbally abused. I have been pushed. I have been threatened. My house has been threatened, along with the people in my house. That scares me, because when they blink and they go into this blank state anything can happen. I have a 2-year-old granddaughter in my house. Unfortunately she sees photos of her uncle and says, 'Where's my uncle?'. Now she knows, and when she goes past the police station she says, 'There's my uncle in there'. She will ask, 'Where's uncle? Have the police got him?', because she has already witnessed all of this, and for me that is not on. It should not be happening, but unfortunately that is the best I can do to stay alive and keep my family safe, which is not to be a part of it anymore. It is hard, but these are the steps I have to take.

Mr SOUTHWICK — For what periods of time was he incarcerated on those three occasions?

Ms SANDERS — It is usually for four or five months, and then he comes out and looks to do drug and alcohol counselling and all of that. He does not turn up for appointments. He says, 'Yes, yes', and he does not do it. You see him — he turns up anywhere, pops up anywhere in the street — and then you know straightaway that he is high.

Mr SOUTHWICK — He has had fair amounts of time, blocks of time to dry out, so to speak, and that has not worked?

Ms SANDERS — No.

Mr SOUTHWICK — What strategies do you think need to be in play for somebody like him?

Ms SANDERS — I would like to see the law changed that makes it up to them if they go to rehab. I have said to a magistrate, 'That should not be their choice', because it is not our choice to put up with their drug addict behaviour. For me, that law needs to be changed. If they have said, 'You're going to rehab', you need to go to rehab and that is it. You do not get a say in it. We are losing them to the jail system, so they are going into jail and then coming out sometimes worse. That behaviour is harder. The elders are doing great work, but we need the males to be more readily available for them. My son says that he does not have a male role model, and everyone he gets close to either dies or leaves the area, so he cannot cope with what he is dealing with, and for him to speak to a female about it, he does not like that. That is not for him. He does not feel like a strong man. He goes and has ice, and for him that caps everything, so he does not have to think about anything; he is okay, he is high and that is it. That is what we are dealing with.

Mr McCURDY — When all this began for your son, was it a circle of friends or was it outsiders?

Ms SANDERS — A circle of friends. He left the area for a holiday, so to speak, and the friends he was with were all doing it. Because he refused to there was that peer group pressure.

When he came back I instantly recognised that something was going on and something was not right. He did not look the same as he did when he left. My son was pretty well built, and to see him change in a matter of three or four weeks and the weight he lost was unbelievable. My mind was telling me one thing, but my heart was telling me something else. The realisation was devastating because he is my only son, and I thought that maybe I had spoilt him too much. So hence going to court with him and getting him bailed out, and then I had to separate the heart from the head, and then that was it. It was not going to help me, and it was not going to help him. That is what it is down to now — just that phone call.

Mr CARROLL — Cath, one of our terms of reference is reviewing the adequacy of past and existing state and federal government strategies in dealing with methamphetamine use. I notice that you talked about Partners in Recovery. I think you are the first person to raise that with the committee. I do not think it has been raised before. I was doing a bit of research, as you were speaking on it, and I see it is a federal government initiative. Is Mallee Family Care one of the agencies — —

Ms MURPHY — We are the lead agency.

Mr CARROLL — So you are the lead agency in this region?

Ms MURPHY — Correct.

Mr CARROLL — You roll it out and bring all the agencies together?

Ms MURPHY — Correct, yes. We started that process 12 months ago.

Mr CARROLL — How long has it been going?

Ms MURPHY — We started on 8 October. That was when our team leader came on board. We received funding in July, and that was the implementation and set-up phase — the very early days.

Mr CARROLL — Feel free, Fiona and Darlene, if you want to jump in, but is it a successful model? It is driven by the federal government, but sometimes a lot of this stuff is better when it is grassroots up.

Ms MURPHY — The program integrity and intent, obviously, is a very good model in terms of really emphasising that collaborative and coordinated approach. It is not a case management model. It is to ensure that services are where they need to be. If there is a communication issue or something is falling through the gaps for some reason, the responsibility of Partners in Recovery is to bring all the players together and to get everybody back on track. That is the very basic explanation.

Mr CARROLL — How long do you have a contract for?

Ms MURPHY — Everybody has been funded for three years, so until 2016.

Mr CARROLL — All right. We might look a bit further into that.

Ms HARLEY — I guess it is early days in that area as to how the model will pan out and what successes there will be with the model.

Mr CARROLL — Okay. Thanks for highlighting it to the committee.

Mr SCHEFFER — All of you spoke about youth disengagement, and you touched on areas like education and employment, but could you just paint a picture for us about what that disengagement might mean? If a young person or a person starting a family does not hold themselves in schooling or education and does not have a job, they might be more engaged in family or they might be engaged in some other community activity. How are you picturing disengagement? Can you just expand that out a bit? The reason I am asking that is because so much of what we hear is that people in that situation turn to the drug because they feel a deficit in

themselves in the way that you talked about your son not feeling like a man. There is an issue there. That is why I am asking how you are understanding this disengagement.

Ms HARLEY — My experience is that these young people who are disengaged from education are not involved in education, training or employment. I think it is good to outline the three, because keeping kids engaged with education is fantastic, and it is proven to lead to good life outcomes; however, for some people that is not the answer. But if they can move into training or if they can move into employment, that can lead to other things for them. There are a significant number of young people in Mildura who are not involved in any of those things, who do wander the streets, who are down at the skate park and who are not connected with family.

Most families, when they have a young person who is disengaged from school, are looking for alternatives for those young people to keep them involved or get them into training. A lot of these young people are not connected to their families and the families are not actually doing that. So a lot of them are not even living at home. They are couch surfing. I guess there is a large enough cohort of them that they have quite a good support network and peer group, so that that becomes their lifestyle and their activity. That does involve drug taking and crime. It does involve a number of different things.

There are, there have been and there will continue to be measures and attempts to engage these people, particularly back in education, and hopefully in the new year there will be a new alternative education setting established that will focus on these young people who have disengaged from school and who are not in the system anywhere. We will start to engage with them, and it will be a multidisciplinary approach. So it is educators as well as social workers as well as — —

Mr SCHEFFER — That is right. The interesting thing is that a number of witnesses have told us that the cohort that is using methamphetamines can be more highly educated, have a different age profile and can be employed, so we are seeing something else going on here. Can you, in your experience, throw any light on that in relation to disengagement? It is a different kind of disengagement.

Ms HARLEY — I guess that is probably more a disengagement potentially with family and community. Maybe for some people it is recreational use. It is used in the same way that other people would use alcohol. I think that the consequences could be far greater for those people in becoming involved in that, but I do not have any direct knowledge of that, no.

Mr SCHEFFER — Thanks.

The CHAIR — A couple of views were expressed about education in schools. Do you have a firm view of the appropriateness of early intervention — we have heard about at years 11 and 12, but perhaps earlier?

Ms HARLEY — In respect of education around — —

The CHAIR — Around drug use and the impact of that.

Ms HARLEY — It is interesting. I have been having this discussion with some people over the last week or so, and I would need to look at more research on this, but if I think about smoking as an example, over the years there has been a lot of focus on very early education — by 'very early' I mean preschool and kindergarten and primary school children — around how bad smoking is. As a consequence of that, lots of kids are going home and saying to mum and dad, 'Smoking's going to kill you'. In their minds smoking is really bad and something their parents should not be doing and they should not be doing because in fact it could kill you. It has been in their psyche from a very early age, and I know adults who give up smoking because of that — their preschool children coming home and doing that. They saw it on TV and ads, and there was certainly education in their schools.

I wonder whether we should not be looking at education around drug use in the same way — that it is not okay and that they learn from the time they are really little that it is not okay to do that. We teach kids that it is not okay to punch people or to be violent or to rob houses or to do those sorts of

things, and that is taught from a very early age, so I think this may be something that perhaps we need to be looking at in that way. I am not sure whether that has been done in other countries, and it could be worth exploring. Younger children are little sponges, and if you get it in their psyche that it is not okay to do something, then in fact — not for all, but for many — that will stay with them through life.

I think we are trying to get that into adolescents' minds when adolescence is a period of risk-taking behaviour, and drug use is one of the risks they will take. While the majority of adolescents might do some risk-taking behaviour around alcohol and drugs, not many of them are going to go and beat up little old ladies walking down the street, so I think some of those things have obviously stuck with those children through their lives.

The CHAIR — Any other questions? If not, are there any closing statements you would like to make?

Mr SCHEFFER — I have one more — just a quick one, because it is an important one. Where do issues around ice sit within the other drug space, like alcohol and cannabis?

Ms HARLEY — I think they all impact people, and they all impact people in a negative way. Clearly at the moment we are seeing some significant impacts from the use of ice, but we also see them from alcohol and cannabis and other drug use. I do not see it as being any worse than those, I guess. I think it is around the quantity and quality and the impact it has on people.

Mr SCHEFFER — Okay. Thank you.

The CHAIR — Can I just redirect back to Ms Sanders? Given your personal experience, is there anything you would like to recommend to the committee about where there might have been a failure or a gap in the system that has not been able to totally assist in your personal experience? It might be an opportunity to — —

Ms SANDERS — I kind of suffered in silence because I did not know who to go to. I did not know who I could trust to go to, but through my work and where I work, everybody there has walked alongside me with my own personal life. They have helped me out. They have supported me. I get a lot of comfort in my work and my studies. Now I am just starting to understand and learn that there are agencies out there that can support me, but I have built myself up again to be able to go on, so I feel I do not need it, and I can always go to one of my coworkers and talk to them about it, and they will know my life story anyway because I share it with them. That is where I am so lucky to have the people I work with, because they are understanding of what is going on, and they do see it in our community.

To bring it to the table and openly talk about it, that is also where I find comfort, but for other people, I do suggest they go here or go there and speak to this one. Some of them too, they feel that it is not so much the shame factor, it is more, 'I don't know if I can bring myself to talk about it. Because it is so big to deal with, I don't know where to start'. For me personally, I suffered in silence for a long time and tried to deal with it on my own, but now I want to talk about it because it is here and people need to know about it. People need to think and talk about it, so talking about it for me also, that is where I find comfort, because I am not alone.

Other people are out there. We have grandparents who are rearing their grandchildren because their child is an addict or we have lost them to the jail system or the mental health system or we have buried them. That sort of level of talking to people in the community too, I find comfort there. We share our own sorts of stories and try to help each other, but to openly go and talk to an agency or something, there is a little bit of, 'I don't know if I want to or if I can'. But that is where I find my comfort.

The CHAIR — I was just thinking that where you have had the luxury, I guess, of being in a supportive group, someone else might not have had that opportunity.

Ms SANDERS — Exactly.

The CHAIR — I am just thinking: is there an opportunity for us to maybe look at — particularly in the Indigenous population, where there is a real requirement to mentor where you do not have people like yourself suffering in silence for so long and who are actively engaged in the community — talking about the problem and encouraging people to seek pathways, be it through Mallee Family Care or somewhere else?

Ms SANDERS — Yes, we do, because our elders are doing great work in our community, but we are so busy, so we do not make ourselves readily available. I say to people that it is all about just looking at someone and saying, 'Hey, are you okay?' or 'What's going on?'. The elders are understanding, more so now, that they need to be readily available for our young ones so they are able to approach them and say, 'Hey, I have a problem, and I need to talk to somebody about it', because we do not do that, because our lives are so busy, or we are so wrapped up in our own things and thoughts that we do not do it.

The shame factor, for me, has to be dropped in my own community, because realistically what is there to be ashamed of? I always say to people, 'I'm not ashamed to say that my son is a drug addict. What's there to be ashamed about?'. It is happening. It is here; we know it is here. Let us drop the shame and talk about it. If it is the fear of the unknown, take that next step and find that fear of the unknown and deal with it, and walk alongside each other as we are doing it. That is where you build your supports, and then you know, 'Yes, I'm just like you. I have the same things going on in my family as you have'. So we share that knowledge. That is how it is for me.

The CHAIR — Thank you. There are some important messages there. Thank you very much for your time this afternoon.

Ms HARLEY — Thank you for the opportunity.

Witnesses withdrew.