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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

(Roundtable)

Reference: Impact of illicit drug use on families

WEDNESDAY, 7 MARCH 2007

GOLD COAST

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Wednesday, 7 March 2007

Members: Mrs Bronwyn Bishop *(Chair)*, Mrs Irwin *(Deputy Chair)*, Mr Cadman, Ms Kate Ellis, Mrs Elson, Mr Fawcett, Ms George, Mrs Markus, Mr Quick and Mr Ticehurst

Members in attendance: Mrs Bronwyn Bishop, Mr Cadman, Mrs Elson and Mr Quick

Terms of reference for the inquiry:

To inquire into and report on:

how the Australian Government can better address the impact of the importation, production, sale, use and prevention of illicit drugs on families. The Committee is particularly interested in:

1. the financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders;

2. the impact of harm minimisation programs on families; and

3. ways to strengthen families who are coping with a member(s) using illicit drugs.

WITNESSES

ALCORN, Ms Mary, Executive Director, Gold Coast Drug Council Inc. 2

BLATCH, Mr Charles William, Chief Executive Officer, Goldbridge Rehabilitation Services 2

BURNETT, Mrs Joanna, Social Worker, Palm Beach Currumbin Clinic 2

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KONINGEN, Ms Sue, Family Support Worker, Gold Coast Drug Council Inc. 2

LUBACH, Mrs Maree, Chairperson, KinKare 2

LYNCH, Ms Laura Joyce, Manager, Logan House, Alcohol and Drug Foundation, Queensland 2

NEWMAN, Mrs Maree Joan, Chairperson, Grandparents Assisting Grandkids Support, Gold Coast Region 2

PEARSON, Dr Gregory Nicholas, Director of Psychiatry, Palm Beach Currumbin Clinic 2

Committee met at 10.11 am

CHAIR (Mrs Bronwyn Bishop)—I now declare open this public hearing of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drugs on families. Today's evidence is going to be taken by way of a roundtable, and we thank you all for coming. We will particularly focus on the following three things that are relevant to the damaging impact of illicit drug use on families: the cost to families who have a member using illicit drugs; the usefulness of current policy and programs; and ways to strengthen families who are struggling with a member or members who are using illicit drugs.

The public are welcome to observe the roundtable, and a transcript of the evidence gathered today will be available on the committee's website. I will invite you all to make a brief opening statement and we will then discuss topics on a theme that you wish to give us. Members of the committee will then have the opportunity to ask questions, and this will be followed by a general discussion from people who have just arrived and who will be able to make a three-minute statement.

[10.12 pm]

ALCORN, Ms Mary, Executive Director, Gold Coast Drug Council Inc.

BLATCH, Mr Charles William, Chief Executive Officer, Goldbridge Rehabilitation Services

BURNETT, Mrs Joanna, Social Worker, Palm Beach Currumbin Clinic

FEASEY, Ms Glenda, Community Liaison Officer, Youth Enterprise Trust

KONINGEN, Ms Sue, Family Support Worker, Gold Coast Drug Council Inc.

LUBACH, Mrs Maree, Chairperson, KinKare

LYNCH, Ms Laura Joyce, Manager, Logan House, Alcohol and Drug Foundation, Queensland

NEWMAN, Mrs Maree Joan, Chairperson, Grandparents Assisting Grandkids Support, Gold Coast Region

PEARSON, Dr Gregory Nicholas, Director of Psychiatry, Palm Beach Currumbin Clinic

Witnesses were then sworn or affirmed—

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mrs Newman—I also represent Mirikai, the Gold Coast Drug Council.

Ms Koningen—I am here to represent Mirikai, the Gold Coast Drug Council, and the families that they support.

Mrs Lubach—I am a cofounder of KinKare, a grandparents support group.

CHAIR—Thank you. Each of you has a different aspect to how you approach the problem and how you see the problem. I invite each of you to make a short opening statement.

Mrs Newman—There are two sides of the coin here, two major problems. There is the lack of money, the lack of funding—and that covers a very broad spectrum—and also the lack of rehabilitation centres and the value that they offer to this problem. That is not being addressed in the community.

Ms Koningen—I am basically here for the same reason: to make sure that funds are allocated to services which provide fabulous support and therapies to our children, services that are having to fight for funding—which is, to me, quite disgraceful.

Ms Alcorn—For me it is about fiscal resources as well. On the Gold Coast, with a growing population, it is also about integrated service delivery models.

Ms Lynch—I work in residential rehab and I notice that there is definitely a demand for such facilities.

Mr Blatch—I also work in a residential program. My biggest concern at the moment is—because we have an adult population—what happens to the children of clients.

Ms Feasey—The Youth Enterprise Trust have an essentially wilderness based experience for young people aged 16 to 24. Parents and workers from throughout Queensland refer young people to us. What we are noting is young people struggling with that transition, moving on from childhood and adolescence through to becoming productive and worthwhile young adults in the community. That is essentially our aim: to complement workers such as these in their role to help young people move forward. Many of those young people are struggling to move on from substance abuse. This is a key issue which is a serious concern for us.

Mrs Lubach—I am coming from perhaps a slightly different aspect. I was pleased to see Charlie mention the children of addicts, and of course that often leads to grandparents rearing their grandchildren. That is often a forgotten area, I feel, in the substance abuse thing, and it is an area that we feel needs awareness and a lot more assistance.

Dr Pearson—I am essentially representing a private acute adult in-patient psychiatric unit which has a subsection that deals with drug and alcohol problems. I would like to alert the committee to the issue of dual diagnosis—that is, the presence of both substance abuse and a major mental health disorder—as an area that requires particular emphasis because of the impact that substance abuse has on the prognosis in mental disease and the tremendous impact that this has on families.

Mrs Burnett—I would say the same as Dr Pearson. Probably what we see with families is a lack of knowledge and education around dual diagnosis. There is also a lack of treatment centres for families to get information from.

CHAIR—Thank you very much. Can I begin by asking all of you whether or not you see the problem that you are dealing with—in terms of numbers—increasing? Are you getting a bigger and bigger demand for your services?

Mrs Newman—Absolutely. I average, here on the coast, one or two calls a week from grandparents wanting support raising grandchildren or wanting directions for services that may be able to assist them. It is not decreasing; it is increasing. We cannot assist them to the point where we could last year because we are no longer incorporated. We do not have the time to fundraise for insurance policies. We do have meetings where the grandparents all get together and discuss their issues, but sadly we can no longer have our picnics in the park. We would have about 40 grandchildren turn up and they could identify with one another and say, ‘Hey, I am no different from that one because we have all got old parents.’ It was very, very beneficial. This has gone now. We can only sit back and do it in a different way because of the lack of funding to cover insurance. If you are not incorporated, you cannot ask for funding; it is a catch 22.

CHAIR—Are you saying you cannot afford the cost of public liability insurance and so therefore you cannot have a picnic?

Mrs Newman—Absolutely. Public liability insurance would cost over $2,000 a year. We are supported by the Gold Coast City Council. They give us enough to keep the chequebook open but not enough to pay for insurance. That is, they give us what we need to function and we can do the rest ourselves. We are going into our fifth year. We are still linked in with Canberra. They phoned me the other day to see if we were still functioning and I said, 'Yes, we are still going.' We are linked with all the facilities that refer people to us, including Centrelink. What we need to give back to these families that are struggling is the togetherness; we need to touch base with these families and say, 'Yes, I know what you are going through,' and let the children know that they are not alone.

CHAIR—So, if they are being brought up by their grandparents, if they can meet with others in the same situation they feel normal?

Mrs Newman—Yes, absolutely.

CHAIR—Would anyone like to comment upon the growth in the demand for their resources?

Ms Koningen—I think the difficulty for families is that substance abuse is promoted as bad and evil, and, whilst the number of rehabs that address these issues are minimal, families find it very difficult to put their hand up and say, 'We need help.' If it were the chicken pox or sugar diabetes, they would see the doctor in a flash—this is not. Current strategies claiming, 'You're a mug if you do drugs—just don't,' and things like that, have made families feel that they are lesser than others and that they are responsible. They are ashamed. So it becomes a courageous thing to put your hand up and say: 'I need help to do this. I need help to address my child's issues because I don't understand what they are.'

CHAIR—But are you seeing more people asking for services?

Ms Koningen—We are seeing more, but we should be seeing thousands.

Mr QUICK—Who is keeping the statistics? Does each organisation keep statistics separately or is there some link to the state government health department so we can actually quantify the numbers?

Ms Alcorn—It is very difficult because, if you take my organisation, for instance, there are eight different funding bodies and each of those funding bodies has small amounts of money. Each of them, from federal to state government, requires different statistics. So there is no overall picture that we would present to any one funding agency. I think that is a key issue that could be addressed by the National Illicit Drug Strategy in the future: to collect their data across the board and present that to state and federal governments. It is an issue. It is a nightmare to administer as well, as you can imagine.

Dr Pearson—I might just comment on that. For example, in regard to the coding that occurs with a patient separation from hospital, the only time that a substance abuse issue would be coded is if a diagnosis of abuse or dependence is made, although the much greater issue is the

issue of substance use, which very rarely gets coded as a problem at that point of separation. So a lot of the health department’s statistics are based on that separation data. The only other data that they have available to them is in relation to things like overdoses, completed suicide and those sorts of things which are not necessarily a reflection of the broader scope of the issue.

CHAIR—I do not quite understand what you said there. You said it only gets coded if it is abuse?

Dr Pearson—Yes.

CHAIR—If they are taking an illicit drug then the use is an abuse; it is illegal. So it is not recorded?

Dr Pearson—It is not recorded as a diagnosis, so it is not recorded as an issue that related to the person’s contact with the hospital. For example, in a psychiatric hospital you might code that the person entered the clinic and had the diagnosis of schizophrenia or depression. If they had a concurrent condition of amphetamine abuse or dependence, you would also code that. But, if the patient actually had amphetamine use, it would not be coded as a diagnosis because it does not reach a diagnostic threshold, even though that is a significant—

Mr CADMAN—What do you mean by ‘diagnostic threshold’? I do not understand that term.

Dr Pearson—It is not actually a diagnosis according to any classificatory criteria.

Ms Lynch—It is a symptom rather than a stand-alone condition. It does not get registered.

Ms Alcorn—For example, if they use it three times per week, it does not classify as dependence, or if they use marijuana, alcohol and amphetamines four times a week it is not classified, so you are not picking up the data. We are seeing the presentation, but you are not picking up the data and the effect on people’s mental health.

Mr QUICK—When you apply for funding, you have all these criteria, assessment and threshold levels, which sounds like a dog’s breakfast.

Ms Alcorn—And different state and federal departments require different lots of data, so it is very confusing. The real cost to the community is never really recorded; it is hearsay.

Mr QUICK—Mary, you mentioned the fact that you were funded from eight different sources. Can you give me some examples of those sources?

Ms Alcorn—The Department of Communities funds one arm of the Drug Court supported accommodation; Queensland Health funds diversion through Commonwealth grants and, on different reporting data, funds episodes of care without taking residential days into consideration; the Commonwealth department, the Department of Health and Ageing, through the National Drug Strategy, funds Oasis, some out-client programs and family support programs; the Department of Education, Training and the Arts in Queensland funds some of the education and vocational tools that we operate within our therapeutic community; it goes on.

Mr CADMAN—A point of clarification: is there a medical diagnosis of somebody who is addicted?

Dr Pearson—Yes. That is drug dependence.

Mr CADMAN—Drug dependence: is that the classification?

Dr Pearson—For addiction, yes.

Mr CADMAN—How do you diagnose that? What are the criteria? I need to understand how you make a diagnosis.

Dr Pearson—There are two commonly made diagnoses when it comes to drug abuse or drug use. One diagnosis is the situation of dependence, where there is a physiological reliance upon a compound, and it is usually characterised by two things: one is tolerance to the compound—that is, that someone requires more and more of the drug to gain some sort of experience from the compound—and the other is the presence of withdrawal if they do not have access to the compound. Those two things really demonstrate physiological dependence on a drug. The other diagnosis that we commonly make is the diagnosis of abuse. That is where an excessive amount of the compound is used.

CHAIR—If it is illegal, use is illegal; so why are we talking about abuse? If it is used, it is illegal.

Dr Pearson—We are not talking about legal things here as much as being able to make the diagnosis of a pattern of use. ‘Abuse’ means someone using an excessive quantity of the drug. Let us use a legal drug as an example. Alcohol, perhaps, is a very good example of this. You would make the diagnosis of abuse if someone drank excessively and there were social and professional consequences of that. They might embarrass themselves socially or they could carry on at a professional do in a manner that would impact adversely on them professionally. Where there is excessive use or use at inappropriate times, we would usually make the diagnosis of abuse.

What we do know is that there are many people in the population—and let us use alcohol, again, as an example—who drink excessively. The World Health Organisation criteria for the maximum recommended use of alcohol is roughly four standard drinks a day for a man and two to three days of not drinking a week. We know that in our population there is an extraordinary number of people who drink in excess of this amount, but that does not qualify for the diagnosis of either dependence or abuse, so that would not be a diagnosis that is coded on a hospital admission as either dependence or abuse.

CHAIR—So you make no distinction between legal and illegal substances in the records that you keep. Is that what you are telling me?

Dr Pearson—Yes, that is true.

CHAIR—Why?

Dr Pearson—I do not know that there is a necessity to do it.

CHAIR—One is legal and one is illegal. One is against the law.

Mrs Burnett—We are a health organisation.

CHAIR—That does not matter—you have to comply with the law too.

Dr Pearson—It is not that the people are using substances in the hospital. We are still bound by medical confidence. If this is a situation that is not immediately endangering the life of the patient or other people, then we are bound by confidentiality to not release that information.

CHAIR—When you get the access card, are you going to put it on the chip?

Dr Pearson—The coding of the diagnosis would be put on a chip. If we make a diagnosis of illegal drug use—amphetamine use, cannabis dependence or whatever—that diagnosis is coded. That information is readily accessible through all health statistics and health departments. It is collated at a state health level and is freely available for anyone who wants to use it. But my understanding is that it is treated as a medical confidence issue and therefore it cannot be used for legal prosecution or investigation.

CHAIR—I was not coming to the prosecution stage of things yet. I am just saying it is illegal and we need to make the distinction between what the law says is legal or illegal.

Dr Pearson—It is not a distinction that we spend a lot of time worrying about from a medical point of view. It is such a common and complicating factor in treatment.

CHAIR—The fact that you do treat it like that—that it is okay—could well be seen to be part of the problem of the soft language that makes it okay.

Dr Pearson—I do not think so. There are many things we hear in medical confidence that are not okay that we are not able to distribute.

CHAIR—I accept that.

Dr Pearson—It is an extremely common problem.

Mr CADMAN—Could I follow on from the chair’s question. It is important to understand this. Are you saying that the coding factor—the notification factor—is pitched so high in abuse or use of a substance that there are people under the radar who you would consider worthy of treatment and are causing problems with their families and their capacity to function normally—

Dr Pearson—Absolutely.

Mr CADMAN—and that there should be a way of identifying them?

Dr Pearson—I think there are two issues. Generally speaking, if the drug use is identified as a factor—I can only speak from my treatment perspective—during the course of hospitalisation, that would be addressed as part of the treatment program. There are many people who use medication or substances at a level where it does not seem to alert many health professionals to the fact that it could be a complicating factor in their treatment. What I am saying is that it is not a standard inquiry in many institutions to determine drug use. It is certainly a standard inquiry to determine abuse and dependence. Remember that this committee is looking at drug use, not just abuse and dependence. There are many more people out there who are using illicit compounds and are not necessarily abusing or dependent on them. The fact that they are using them is not being captured in health data.

Mr QUICK—How do we go about rectifying that matter? When you apply for funding, Commonwealth agencies want you to quantify the number of clients that you are going to see, times X number of dollars and that sort of thing, but if it is all below the radar how do we put a regime in place? No doubt people see Laura, Glenda, Charlie and Maree, and if there is not enough funding people will use whatever is available because there is not a one-stop shop. How do we put in place a template to remove the stigma, because you want to solve the problem rather than push it aside? Does anyone here have an idea about what sort of template we could put in place, especially for our young people who are experimenting? As a former school teacher, I know that if you experiment you are expelled, and then there is a black mark against you which could possibly affect your potential job future.

Mrs Newman—That comes under early intervention if you are talking about young ones. I am going to address that in the last segment today using proven statistics that were researched by the federal government. It is shocking. This problem is still out there today because the services for our youth—our children—are nonexistent. If parents today, like we did as parents, have a problem with an adolescent—I am talking about kids from 11 years of age who are out there on the streets—they go to the services. These are usually kick-started with the department of families or the Department of Child Safety. They are turned away. They were turned away when we were raising what are now addicts. They are still being turned away today.

The police cannot assist you. The schools cannot assist you; they can only suspend or expel a troubled student. Out of 85 per cent of grandparents raising grandchildren due to a drug problem, 55 per cent of them went as parents to the authorities with young ones from 11 to 15 only to be turned away. That covers state child protection. This research is right throughout Australia and this is what the figures are coming out as. Of the 55 per cent of them that were turned away that went for help, I believe that if they had been helped we might have 25 to 30 per cent that would not be addicts today because they were nonusers when the parents went for assistance. There are a range of things that cause our youth to go out onto the streets. It can be medical, emotional or straight-out rebellion, but there is nowhere that parents can go today for help. You are still encouraging the politicians who do not implement policies to protect our youth or to assist the parents. That is your answer to our youth today. It is out there and it is frightening.

CHAIR—But what sort of help do you want to see, Maree?

Mrs Newman—I can talk on a personal level here and a collective information level. This is general feedback to the support group. They did not know. They just knew they had a problem with a child. They might have no problems with the other children, but one in particular was not

coming home. To give you an example, in our case our daughter had a head injury at the age of 10. Gold Coast Hospital said she was fine and to take her home. At the age of 12, she won a scholarship to high school. She spent the first term as an A-grade student. The second term, she was sleeping in bushes and crying, ‘Mum, help me; I don’t know why I’m doing this.’ She was not yet 13. Her father is a pharmacist. I said, ‘This child has a medical problem.’

We tried to get help. She needed to see a neurologist, but by the time her appointment was due she was out on the streets and could not be found. I went to the Department of Child Safety, as they are known now—I used to be a foster carer years ago—and said, ‘I need an order for Malarka so that when I go up to Surfers looking for her, I can show it to the police.’ They could not help you. They were not allowed to. I needed an order to say to the police, ‘If you see this face, I need her home.’ They said, ‘Maree, we can’t help you. She has to break the law three times before we can do anything.’ I said, ‘If you leave a child out on the streets long enough, they will break the law.’ Luckily, in one way, she did break the law. She stayed out on those streets. She would come home and cry. She did not know what was wrong with her. We could not help her. We were not going to abandon her, but we could not understand. She went from wandering the streets to a learnt behaviour problem. By the time she was 14, she was in a juvenile detention centre.

I was very lucky because one of the child protection fellows that I knew—I had known him for years—knew that I was trying to get her diagnosed before she was 13, and she was then 14½, nearly 15.He sent her in handcuffs to a neurologist in Wickham Terrace. She was diagnosed with scarring lesions on the left temporal lobe which would have been causing a type of epilepsy and confusion and wavering better sense of judgement and she was put on tegretol to soothe the lesions. Had we been able to get help for her when we tried, she may not be where she is today, because it was too late. The lesions were solved, but the learnt behaviour from being out there on the streets is now in Mary’s hands. It is a Pandora’s box out there for these children, and it is sad.

CHAIR—Kids are always falling over, aren’t they? If we look at statistics—

Mrs Newman—She fell out of a tree, and I pass by that tree every day to get home.

CHAIR—I know myself from looking at separation statistics that kids aged seven to 12, particularly boys, are quite high users of hospitals. Do you think there are other children out there who literally have a physical brain injury of that nature, or is she a one-off?

Mrs Newman—No, she is not a one-off. Medical issues go unresolved because you cannot force, take or implement a 13-year-old to go see a doctor if they do not want to. At that age you have hormones kicking in and you have ‘I know everything’ kicking in. I remember writing to John Howard. I asked him to implement a boot camp for rebel teenagers and troubled ones before they break the law, and get them sorted out in there. Parents’ hands are tied. As a parent, you can only go for help. If parents knew the answers they would not have a problem. They need to be able to get resources through these services which are not available.

Mr QUICK—Someone mentioned the lack of rehab.

Ms Alcorn—We will all talk about that in our themes. I will just quickly comment on early intervention. There are many parents out there with young children and adolescents with

behavioural management problems—for instance, a mental health problem—that have not been diagnosed. They might suffer ADD, but none of those fall into the category because of the categorising of the mental health system. Under the child and mental health adolescent system, they are unable to access those services, so there is nowhere to go in the community. I sit on a complex needs panel, which is currently trying to address that issue, where we sit around, with several different departments and community agencies getting together. It is the first attempt to try to address all the gaps in services. But it is very difficult if you have a child suffering from ADD or learning difficulties who starts to act out. Who gives you those behavioural management strategies? Where do you go if you do not fit into the child and adolescent mental health services? You do not fit the criteria for a diagnosed mental illness, but most young people under the age of 18 they are fearful of diagnosing anywhere, so you are excluded. That is a common problem that I see every day with children aged 12 to 17.

Mr QUICK—Are we sending the wrong message to our kids because, as someone who comes from Tasmania, this neck of the woods seems to be the epicentre of schoolies. This area is seen as: ‘Come here and have a great time, the drugs are available, and we’ll have a laissez faire atmosphere for those couple of weeks and all the businesses and motels will make a fortune.’ No wonder the kids are all screwed up and mixed up.

Ms Alcorn—That is really only about the weather, dare I say, and we would be happy to give schoolies to you. But there is no way we can stop that. Most of those young people are well-behaved young people. There would be a small percentage of young people who are out of control in schoolies week. I think it is very difficult to stop celebrations, but it is an entirely different story to not be able to get help.

Most of the people we all treat for addiction had an early onset of drug misuse, and they have coexisting mental health or behavioural problems that needed addressing earlier. They also need clinical pathways so that their parents, who are really desperate, can get help. That is not available. Could you think about this: by 2020, on the northern corridor—we are talking about 10 kilometres up the road, in the Coomera area—there is going to be a city the size of Cairns, but we have no services. There is currently one position that addresses underage alcohol and drug use and provides specialist support for young people. So for the whole of the Gold Coast there is one position for the 12- to 18-year-olds. We are talking nothing—no integrated planning, federal or state—to support non-government agencies to develop services in that northern corridor. There is no funding available to do it, and yet 40 per cent of those people are going to be under 25. So we are in a pretty desperate position on the Gold Coast.

CHAIR—Dr Pearson, Ms Alcorn just mentioned people with ADD; do you see any correlation between children who start off having ADD or ADHD and those ending up in your hands? Is it a larger proportion? Is it a smaller proportion? Is there any correlation?

Dr Pearson—ADD is a complicated area. It is complicated for a number of reasons. Essentially, the psychiatric community is divided in terms of the diagnosis of adult attention deficit hyperactivity disorder. There are some concerns about the overdiagnosis of the condition and the early prescription of amphetamines, and the underdiagnosis of behavioural disorders which may have an environmental or social cause rather than a purely attentional cause.

CHAIR—So Ritalin is an amphetamine, is it?

Dr Pearson—Ritalin is a stimulant. The other treatment is Dexamphetamine, and there are some newer treatments on the market. What further complicates the situation is that amphetamines will generally improve concentration in the general population. So if we all took amphetamines today we would probably concentrate much better in the committee. There do seem to be benefits to the general population in terms of purely concentration related problems. So it is a complicated area.

There is a very high rate of comorbidity in children and adolescents diagnosed with attention deficit disorder. That rises considerably if the diagnosis is not made, because they are adventurous and getting into all sorts of trouble; the secondary problems that they can find themselves in are really quite great. But it is a very complex area.

CHAIR—Is the answer to my question that people who are identified as having ADHD are more likely to end up with a drug usage problem?

Dr Pearson—Than the general population?

CHAIR—Yes.

Dr Pearson—They are—but far less likely than those who have the condition and are not identified. That is quite common as well.

CHAIR—So it could be a preceding condition?

Dr Pearson—Yes.

CHAIR—There was a lot of denial about marijuana for a long time—

Dr Pearson—Yes.

CHAIR—but I think we have finally got that sorted out. Having sent the wrong message out for a long time, we have now started to send the right message out.

Dr Pearson—Yes, that is very true.

CHAIR—This has been a major problem in the growth of drug usage in these particular areas, whereas heroin is definitely declining, on all the statistics that we have seen.

Dr Pearson—Yes.

CHAIR—Maree, you said your daughter is now getting help from Mary?

Mrs Newman—Oh, yes—I feel like I have won the lottery, after all these years! We have been dealing with this problem with her since she was 13; she is now 25. Mary had a roundtable conference with us and her support team, and what she is offering our daughter—I am still in awe of it. I cannot wait to spread the news to the grandparents about what type of help is available with rehab centres like Mirikai. And that is something I will bring up later—the lack of information. But this is exciting; it really is.

CHAIR—Laura, would you like to comment on those issues we have been talking about?

Ms Lynch—I would like to make a comment to back up Dr Pearson. Having worked in health for 27 years, I think a change to the mode of diagnosis would be excellent—and not just in the mental health arena. I guess what I am thinking of is: in the general medical setting, you might have someone, for instance, who comes in with peripheral vascular disease; what is underlying that primary condition is the fact that they have smoked cigarettes all their life, or they have had a poor diet and clogged their arteries.

Again, to back up the doctor, having worked in mental health, people with mental health disorders are probably hugely at risk because they feel so terrible that they want to change the way they feel. So someone with depression is going to be more prone to consume more alcohol perhaps to change that mindset. Through the DSM4—are you familiar with the DSM4? That is the diagnostic and statistical manual, which is what the medical people use to diagnose different mental health conditions, and those conditions are diagnosed in the context of clusters of symptoms. There is so much going under the radar. We are not picking up that the depressed person is drinking to excess because the depression is what is in the limelight. The schizophrenic who may smoke a joint once a week, again, goes under the radar because it is their schizophrenia that is in the limelight.

CHAIR—Except we now know the causal relationship between marijuana and schizophrenia. We admit it now where it was in denial for years.

Ms Lynch—Definitely, but I would go out on a limb here to say that there are lots of people that have had a schizophrenic illness before they probably even smoked a joint, if that makes sense. Again, it is because they feel so uncomfortable and so terrible in themselves that they will venture into substance use to try to change the way they are feeling. We are missing so much.

Ms Alcorn—I think the statistics bear that out, in that 70 per cent of people with a primary mental health illness suffer with substance misuse, and I think in the substances misuse population it is 40 per cent of people with a primary substance misuse—

CHAIR—No: if we are talking about substance, we are talking about illicit drugs now, so it is substance use.

Ms Alcorn—Yes.

CHAIR—Alcohol you can misuse because it is legal, but if it is illegal it is use.

Ms Alcorn—Yes. In the illicit substance misuse population, there is around 40 per cent of secondary diagnosis of mental health illnesses. So we can see that by treating mental health at earlier stages, including young people, we are going to reduce the illicit drug use by treating them effectively. That is borne out by statistics. Equally so, if we treat both co-occurring disorders we are going to get far better outcomes than treating them singularly, and therein lies the issue that we will all talk about around integrated service systems.

Mr CADMAN—Does it start with the doctor? Does it start with a medical assessment first? Where does it start—the identification, the diagnosis if you like—maybe not a firm diagnosis but a cause for concern, which then trickles through and activates other agencies?

Ms Alcorn—It is difficult to act to get those. There aren't the doctors out there in the community who will bulk-bill this subset or this population of people. We are really struggling. The mental health system—and I think we go into that a little—treats the most acute of the most acute, and it is hard to get a diagnosis and good psychiatric treatment with specialist addiction people, so it is very difficult. I think that we cover some of that. When we throw that up to our themes, if we go across the table, you can perhaps ask us some questions around that or the doctor might be able to answer them.

Mr QUICK—You spoke about the stigma of use but you also mentioned the word 'psychiatric'. That immediately conjures up—

Ms Alcorn—It is huge.

Mr QUICK—out there amongst the great unwashed: you should not be part of society because you have got this huge problem. So you have got these two stigmas.

Ms Alcorn—It is terrible. They are isolated, and there are very few treatment services available and hence there is an increase in homelessness and a range of other problems—35 per cent. There is an increase of dual diagnosis in the prison population because there is nowhere else for them to be.

CHAIR—This is another problem: we had the cost-cutting policies of state governments that shut down all the facilities or homes that existed for people who had a mental illness, and they end up on the streets and in jail, to be honest—that is where they end up.

Ms Alcorn—The number of people disaffected by mental health and substance use who are in jail has increased steadily; you are right.

Ms Lynch—That would then compound their mental health conditions.

CHAIR—Of course; jail is not a nice place.

Ms Alcorn—And they are released without any continuity of service and long-term follow-up.

CHAIR—One person told me about their adult child who had been a long-time user of marijuana, finally became psychotic and was hospitalised under an order under New South Wales law. He was there for six weeks and was supposedly having treatment under the legal restrictions that were applied, because he was under the court's jurisdiction. He checked himself out and came to Queensland, where they do not acknowledge the orders of New South Wales. There was absolutely nothing the parents could do. This adult was living under a bridge in Queensland and his parents could do absolutely nothing about it because the validity of the orders under which he was supposed to be being treated was not recognised across the border. That is crazy stuff.

Dr Pearson—It is state-wide legislation; it does not apply across the border.

Ms Lynch—That is right. Melbourne used to be the place to go.

Mr QUICK—I want to raise the issue of social workers. If you live in a housing estate, there are social workers there. There are social workers in the health department, there are social workers in the juvenile justice department and there are social workers in the education department. There are not enough of them; they are spread widely. How do they get together? How do we ensure that we actually know the number of people we are talking about so that we can say that we need X million dollars to provide adequate services for this corridor that you are talking about? They are all flat-chat, they are all underresourced and they are spread very thinly. Yet we pour hundreds of millions of dollars from Commonwealth agencies into the National Drug Strategy. People out in the street would say, ‘We’ve given you $500 million. Why aren’t the resources out there?’

Ms Alcorn—That is difficult to answer but it is an interesting question. There needs to be holistic community responses where families and the people involved need to have some say in the planning of the services. Often the money that is directed through the Commonwealth to the state governments is not targeted or is utilised to support their own services. We in the community need more community based services. We are cost effective and we have lots of self-help programs. We help ourselves, as the grandmothers do. So I guess we need to be included in any sort of planning. Families affected by mental health problems and substance abuse, and the community based agencies, need to be part of the planning process.

Mr QUICK—Should we take it off the state government and give it to the local government agencies? You know where your local council chamber is. Should they be the coordinating body in the Southport region that says: ‘There are 150,000 people. We need X number of social workers. We need so many rehab beds and we need linkages between our education system, our juvenile justice system and our health system and the agencies that provide support to families.’ Is that is the best way to—

Ms Alcorn—That is called planning, and that means the federal government has to lead the way in directing that integrated planning process and the delivery of services through the states to the community I think. It is a tricky one.

CHAIR—Does that mean you have given up on the state government? Why do I keep hearing that the state government will not do it and you have to do it? We have a federal system. Maybe you all have to run for state parliament and get your own candidate up.

Mrs Newman—Yes.

Ms Alcorn—We have absolutely nothing.

Mrs Newman—They are too busy fighting this war.

Ms Alcorn—I think that you can influence policy. I think there has to be an integrated planning process—it cannot just be state governments putting out their own health plans.

CHAIR—But that is what they are elected to do.

Mrs Newman—Somebody should tell them that.

Mr Blatch—When it comes to the National Drug Strategy and the way the money is divided up, I do not know exactly how that is done but I think the police get an awful lot of money for detection, to stop importation and that sort of thing whereas down on the ground where we are working, in areas like Coomera, there is simply not enough money—there is enough money, but it is about the way it is divided up. I think it would be useful to look at just how effective it is giving the majority of the money to the police services for detection.

CHAIR—Can I answer that question. We had Commissioner Keelty appear before us a fortnight ago. The AFP have had costed the benefit to the nation of the work they do offshore to prevent drugs coming here, and that includes precursors for amphetamine making. I have to say that in Queensland the incidence of the hot boxes, where they cook their own, is huge. I will get the details of who did the costing, but according to this they have saved Australia in excess of $3 billion by not having those drugs get here in the first place in terms of doctors, nurses, hospitals and all the services that are needed once people get onto it. That brings us to the question of prevention. What prevention policies are any of you aware of?

Ms Alcorn—Early-use strategies are being implemented now to support families and parents. I think some of the prevention strategies we have in Queensland are quite good. They are growing.

CHAIR—But your usage here is growing. This is the honey pot here.

Ms Alcorn—So is our population. I do not know why we do not have the services, because we are a growth area. Maybe it is about political boundaries, I do not know. Traditionally the Gold Coast is underfunded. Its health services are underfunded in comparison to Brisbane. Its community based services are almost nonexistent. Quite frankly very few of us would have survived without the National Illicit Drug Strategy, so we say keep that going and give us more—and recognise what a growth area we are and how desperate are here.

CHAIR—The Institute of Health and Welfare told us that the greatest per cent, and I think the figure was 30 per cent—it might even have been higher—of people give the reason for taking a drug in the first place as curiosity. Where is the information that we put out as responsible governments that gives them the reason why not? There is none. Are you aware of any?

Ms Alcorn—I think school education programs are starting to tackle some of that. I saw a very innovative program presented a couple of weeks ago where they started in year 7 or year 8 and it went through to year 10. I would have to get the details of that. The young people themselves presented it and they looked at all of those issues: they looked at self-esteem, relationship to self-esteem, and where they could reach out for help. It was part of a health program. It was brilliant. It was presented to the Premier actually.

CHAIR—The other evidence they gave us was that the latest smoking program had been very successful, particularly the ad with that hideous face with the cancer around the mouth. It is about image. It does not scare kids to think that they are going to die; but it does if they think

they are going to look horrible. They all want to be Paris Hilton. So if we had a few photos of what she would look like if she was heavily into ice continually then that is something they could identify with and that would get the message through. To date we have not had anything like that. We have heard about party drugs and recreational drugs. We talk about harm, which is a nice benign word which does not mean much. What do you think?

Ms Lynch—I would like to see the longitudinal impact of those ads because we know well that a lot of that terror tactic sort of approach does not have an enduring impact on people. It will have that shock factor and will probably kerb the behaviour for X amount of time, but it does not tend to be enduring. So it will be interesting to see some longitudinal studies. I guess harm minimisation might be somewhere where we really need to improve our game, because total abstinence is not realistic—that is sort of aiming for pie in the sky.

CHAIR—No, but what we are talking about is preventing people getting onto it. When we are dealing with people who have started then they are in your hands. They need your treatment and your help. There are a whole lot of other kids who could be stopped from ever going on it.

Ms Koningen—We live in a society that has changed dramatically in the last 30 or 40 years, and the problems that our children are facing are different and far more complex than the ones that were faced back then. Their access to information and all sorts of things worldwide is at their fingertips. They are influenced by so many things. There are far more domestic violence situations. There are far more kids growing up in an environment that is totally unhealthy and being affected by it, but it is not being addressed.

CHAIR—Do we have more domestic violence or do we just recognise it more?

Ms Koningen—I also work at a domestic violence refuge and we never have enough beds.

CHAIR—But they are prepared to escape now because there is somewhere to go.

Ms Lynch—It was behind closed doors before.

Ms Koningen—Very few will actually escape. Most stay. A lot of families go back seven times before they make the decision to stay away. We are not addressing the impact on these children when they are raised in that environment. We are not addressing the plight of families or the needs of the kids.

CHAIR—I will tell you a horrible statistic. There were 94 children in New South Wales last year who were killed at the hands of a parent or loco parentis. That is horrendous.

Ms Koningen—It is not only children who are suffering. People are not getting the skills to cope with these changes. We do not have a community that is resilient. We do not have a community that can problem-solve. We do not have a community that gets the support it needs when these things happen to educate them and help them to cope more effectively. They are slipping through and what is left are all these beautiful people here from the services who pick up the pieces of the children. Why aren't we addressing the primary needs of the family as well as those of the children so that it is a joint partnership? I would like to help everybody. Let us create communities that are united, that can support their own.

Mr QUICK—That is exactly my point. The resources should be in your local community.

Ms Koningen—I agree.

Mr QUICK—Why not bypass Brisbane, Sydney, Melbourne, Adelaide, Perth and Hobart and put it out into the local community? We do it with home and community care. Some local government authorities look after the aged people tremendously well. We have heard evidence of people moving suburbs in Melbourne because local governments have got off their whatsits and provided the services. You talk about community investment, why not fund it for the community? If this community does it and Mount Isa doesn't, it is their bad luck and your good luck. Rather than just spreading the money out right across the state, we ought to be thanking, encouraging and rewarding communities that set up structures to protect their kids and support their families in an area like this.

Ms Alcorn—The problem with that is that it raises fear in me that the real need might be overlooked by the political gains to the community at different times or that, since the at-risk are in the minority, the majority might rule. There are those kinds of issues, so it would have to be policy driven to ensure that it addressed the needs of those who are most at risk.

Mr QUICK—But when you set up policy, you set up a bureaucracy and you people are battling the bureaucracy. You have to put submissions in, you have to use a huge amount of your funding to jump through all the hoops for the eight funding bodies. That money should be on the ground for when a family suddenly gets into a situation where their child is experimenting and needs rehab and support. If the money is not there it is no good a social worker saying, 'We can see you in two weeks' time.' That is too late. You need the resources to tackle the problem here and now, otherwise they will end up in some of these psychiatric clinics—

Ms Koningen—At $350 a day.

Mr QUICK—That is right.

Mrs Burnett—It is certainly my experience from working with families in the hospital that there is a lack of identification from parents with their children on drug use and also behavioural issues. Particularly if you are looking at education programs and intervention at an earlier stage, the parents do not seem to be able to identify some of the experimental behaviours versus the more dependency and abuse issues. The kids tend not to relate to the medical models, so they are less likely to go to GPs and they are less likely to put their hands up.

CHAIR—I have read so-called 'official' documentation that has been put out describing what fun you can have taking drugs. I find that appalling. It doesn't tell you what it can do to your brain or how you can end up; it tells you that you can have euphoria and have fun. I think that is immoral and we have to be held responsible because they end up with you—and with you. Dr Pearson, do you find that the pressures are greater for you? Are you seeing more and more?

Dr Pearson—The hospital is far busier than it has ever been. There's been an exponential rise in the rate of admissions in the last 12 months that I have been involved with the hospital. I cannot say that that is necessarily because of an escalation in drug use. I think there are a whole variety of factors that have acted on that.

CHAIR—Would you like to explain the different sorts of treatment that you use in dealing with the major problem of opiates and people who are addicted to those versus the problems that come from, say, crystal methamphetamine and the powder form, speed?

Dr Pearson—Our experience with crystal meth is not great. That is primarily because we do not have any gazetted beds and we cannot hold people against their will. A lot of the problems that arise from crystal meth are acute problems with florid disturbance of behaviour and psychosis. This is an issue that has complicated emergency-room treatment of acutely disturbed young men very gravely. I think all hospitals are a little wary and concerned about the nature of the presentation of those people.

The whole area of narcotic and amphetamine addiction is a really complex area. Once people are involved in intravenous drug abuse or drug dependence you are usually dealing with a whole plethora of difficulties. It is rarely just the drug dependence that is the issue. They are usually people with multiple problems, the most common of which are that they have experienced neglect and trauma in childhood and that their overall psychological development has been adversely affected. They are generally a disenfranchised group that have drifted into heavy drug use. So the treatment is really very complicated.

CHAIR—But you do get kids from perfectly normal families or advantaged families—people who do not fit your descriptor at all—who also fall into the trap.

Dr Pearson—Yes, we do. That is definitely true. It is not all about trauma and neglect, but when it comes to the complications of treatment I think it is important that we see drug abuse as not just an isolated event in someone’s life. It is usually related to other significant psychopathology and very commonly it is associated with other great difficulties—social, psychological, emotional.

CHAIR—But there are more and more places you can walk into that would scare the living daylights out of you. You can walk into a club or a bar where they will all be drinking water, and you know that there is big trouble in that place. It is fun—that is the way it is portrayed. That is the way the documentation portrays it. We get the ridiculous situation where a footballer can be found taking steroids and he is banned for life, but taking a little party drug or recreational drug is not considered that bad. What sort of messages are we sending out?

Dr Pearson—It think it is a really complicated situation. Drugs have played a role in humanity from the beginning of time. There have always been efforts to escape reality. I do not know what the right answer is and what the right message is to portray, but I share your concerns that if drugs are painted in a positive light then it is dangerous. However, if we try to educate the youth and say, ‘Look, drugs are horrible. They’re dangerous and if you take them it is going to be a disaster,’ and then they go out there and experiment with drugs and find that they really are great fun, they will not believe a word that we are saying. Then they would be able to completely write off any of the advice that they get from people in positions of authority. So somehow you need to give correct information, but it needs to come with a warning.

CHAIR—But we already did that—we did it with the AIDS campaign, and that was effective. There is now a need to revisit that sort of thing because AIDS is on the resurgence. But it did work.

Dr Pearson—But it needs to be consistent.

CHAIR—Yes.

Dr Pearson—I think one of the issues with drug abuse also is that, as Jo was saying, for the youth to identify with the campaign, it has to be a very clever campaign.

CHAIR—Paris Hilton!

Dr Pearson—Yes, well, something that they can identify with very strongly. I do not think there necessarily have to be huge amounts of advertising dollars spent on television. Most of the kids spend their time on the internet and I cannot help but think that there could be something done—

CHAIR—Done on the internet?

Dr Pearson—On the internet. They would have ready access to it. That could be a really powerfully boosted campaign that was useful enough for them to be able to identify with and where all the dangers are spelt out very clearly.

CHAIR—A combination of television and internet could be quite powerful.

Dr Pearson—But I think it is also important that it is an accessible thing too, that they can identify with it and that it is not a big scare campaign. Half the reason they take these drugs is that it is exciting. Youth are attracted to scary things.

CHAIR—But that is the point: there is nothing to counteract it. They are just told that it is exciting and you can dance all night. They have even invented terms like 'downer Tuesday' or something, having been up for three days—all those sorts of things. That is creeping into the language.

Dr Pearson—But this continues despite the fact that there are fatalities happening nationally.

CHAIR—None of them think they are going to die. But they do know they can be disfigured. They do know they can look ugly, and they do not like that at all. But they do not think they are going to die—somebody else will die.

Dr Pearson—Yes.

CHAIR—But they do know they could end up looking awful, and they do not want that at all.

Dr Pearson—Denial is a very powerful defence in a vast majority of the population.

Ms Lynch—It is part of adolescence. It is all about driving a car really fast because that will never happen to you—you will never crash.

Dr Pearson—Yes, adolescent bravado.

CHAIR—And also we now have evidence that the brain does not really finish developing and have balances put into it about risk, particularly with boys. Am I right or wrong?

Dr Pearson—Yes, that is right.

CHAIR—Which is why, when we did our inquiry into crime, we found the most vulnerable population is young boys, 17 to 25. They are the major perpetrators of crime, and also the major victims.

Dr Pearson—And the major perpetrators of drug abuse as well.

CHAIR—Hence that old expression that people would be off it or dead by 26.

Mr QUICK—How do we put a consistent message out through the police, through the education system that kids are going to try this stuff but if you are unlucky enough to get caught—

CHAIR—No, they are not all going to try it.

Mr QUICK—A lot of them are going to try. But the school has a policy of basically zero tolerance. The police have a policy of three strikes and you are out.

Ms Koningen—I am all for addressing the behaviour. I think that is really fabulous—three strikes and you are out or whatever, like that. But what we are not addressing are the complications of the child prior to using or whilst using. We are not addressing that. We are getting tough on behaviours, and very few services are able to address the needs of the child. We are not funding it. We are leaving parents out, without a clue what is happening; they are out in the cold and they are not actually able to help these kids.

Mr QUICK—What you are describing seems to indicate that every two parents need some sort of mentor. You are not really describing something where somebody comes down from Canberra, sprinkles a little money around and you have solved the problem. I do not think that is the way to fix it.

Ms Koningen—No, I am talking about the behaviours that develop when the child has ADHD from those early days.

Mr QUICK—Yes, but what number of people that finish up with the doctor have ADHD? It is a tiny percentage.

Mrs Newman—You do not have to have ADHD to end up an addict.

Ms Alcorn—I think we are all talking at cross-purposes, because we are talking about preventative messages, which is what you were talking about, then confusing it with the most at-risk population. You asked that question about preventative measures. I think that most of the money that comes for drug prevention and drug education comes through the Commonwealth anyway. So I think forums with both the state and those who are managing their policy in alcohol, tobacco and other drugs et cetera—illicit drugs—need to come onto some common

ground. It has to be that we all agree at some level. The harm reduction policy people are never going to agree that people will not experiment and say, 'Just say no to drugs.' They want to tell people what the effects of those drugs are and how to minimise the harm if they are taking them. That is the confusing message, of course, with saying no to drugs. People are being given such diverse messages.

CHAIR—You also have the people who talk about harm minimisation who really want to legalise all drugs. That is the real aim of the game.

Ms Alcorn—It is very confusing for young people, isn't it?

CHAIR—Precisely, which is why we are looking—

Ms Alcorn—There are three different messages out there.

CHAIR—There are some people in the world who think they could be a big drug dealer like some of the big arms dealers. There is a lot of money to be made, and there is evidence that drug dealers are moving away from agricultural crop drugs, because they are dependent on the weather, to the chemically based drugs. What are the treatments you use?

Mrs Newman—I would like to pick up on what Sue said about the child abuse and domestic violence that is going on here at the coast. We do not want another generation of what these children have just witnessed, and there is not enough support in the area of domestic violence. I think—correct me if I am wrong, Maree and KinKare—the statistics show that the South Port court had more child abuse going through than any other court in Australia a couple of years ago when we were doing that research. The Gold Coast area was running at the highest child abuse. Are the children that witness this violence—and drugs and alcohol do come into it—going to be without treatment? There is not enough treatment for what they have witnessed and been through. Are they going to be the next generation of users? We need to look at breaking the cycle that goes on—and it really does. That needs to be addressed. It all goes back to lack of facilities and services—education.

CHAIR—Does it meet up with unemployment at all?

Mrs Newman—Lack of finances in every area of the community will cause a system to not function right. You are talking about mum and dad not being able to pay the rent and organisations not being able to implement services. Finance plays a big part in our community.

CHAIR—How do you treat them? What do you do?

Ms Alcorn—It depends. I was going to give you this great big spiel through the themes, but for comorbidity or dual diagnosis, there are two areas. First of all is severity of symptoms. There is nowhere in Australia—as far as I know—where we have a dual diagnosis, other than the private units, that treats the severity of symptoms, so we need some specialist residential that has medical support.

CHAIR—What do you actually do? Do you dry them out? Do you give them a drug that allows them to dry out? What happens?

Ms Alcorn—Ours come through a residential setting. There are all sorts of settings: residential settings, outclient settings and supported accommodation settings. I will talk about the therapeutic community first because it is specially designed for dual diagnosis for young people between the ages of 18 and 29. First of all they have to have a medical assessment and a psychiatric assessment, and they have psychologists so they are labour intensive. From there they do social development depending on how unwell they are. That takes in itself a month to two months to see whether the major illnesses are going to resolve themselves. If they get to a stage where they are resolvable with medication, they have social rehabilitation and learning. They learn to get up early in the morning—they learn all the living skills they have missed out on through their mental health deterioration and substance misuse.

CHAIR—What drugs do you give them?

Ms Alcorn—About 80 per cent to 90 per cent of our clients are addicted to amphetamines or a combination of marijuana and alcohol. We probably admitted only two opioid addicts in the last quarter.

CHAIR—So that represents the trend—that opioids are out and amphetamines are in?

Ms Alcorn—There are also substitute opioid treatments available, such as suboxone et cetera.

Mr Blatch—Mary deals with a much younger age range. In my particular program, the average age is 30 years. Our statistics, compared to last year, show that we are seeing a small rise in the use of heroin amongst our population.

Ms Alcorn—It is the opposite for us.

CHAIR—What about cocaine? Or is that a kind of elitist—

Mr Blatch—There has been a very small rise. As primary problems, there has been a rise in amphetamine use and perhaps a drop in alcohol use.

Ms Alcorn—Isn't that interesting, because our average age is around 21 or 22. We are seeing an increase in alcohol combined with marijuana use, which presents with mental health problems, and certainly an increase in amphetamines of all descriptions, whether it is ice or speed. You asked what we do. We do similar things, but we do them differently because my particular age group needs different and varied tasks: physical education, health education, literacy, job skills, counselling, group therapy—a holistic approach—teaching them how to cook, clean—

CHAIR—Hygiene.

Ms Alcorn—Consequence of action is a big part of what we do: for every action there is a consequence. If one of those consequences is taking your medication every day then that is it.

CHAIR—When you give them medication, what do you give them?

Ms Alcorn—It depends on what the psychiatrist has ordered—it runs from antipsychotics to antidepressants.

Ms Lynch—Antidepressants are pretty popular.

Dr Pearson—If it involves alcohol, we use valium as the primary detoxification agent. It is usually only a matter of days—four or five days—of using valium to block any withdrawal syndrome, the worst of which is delirium tremors, which account for a very high mortality rate. For other conditions, such as use of opiates, it is a quite complicated detoxification regime, using a variety of compounds which essentially just give the patient symptomatic relief in the first several days.

CHAIR—Does that include naltrexone? Do you use that?

Dr Pearson—No. We use buprenorphine sometimes, although much more commonly we will use a rapid reduction in doloxene, which is a synthetic narcotic, in combination with things like antidiarrheals, antispasmodics, some valium for sedation and a drug called clonidine, which is a centrally acting noradrenaline antagonist to reduce high blood pressure, sweating and the sorts of things that occur in the setting of withdrawal. Quite commonly, people are on other medications—most commonly antidepressants—because there is a very strong association between substance abuse and depression and anxiety disorders. Other people have a primary psychiatric disorder, such as bipolar disorder or schizophrenia, where they will be maintained on antipsychotic medication and need stabilisers.

CHAIR—What about people who are on amphetamines? What do you do for them?

Dr Pearson—Very little. Amphetamine withdrawal is not a complicated process. Very rarely they need some sedation with a hypnotic or anxiolytic drug, like valium or stilnox. Occasionally, people present with psychotic symptoms and need an antipsychotic drug, usually for only a very short period in terms of the detoxification. It is a relatively benign detoxification compared to some of the other compounds—certainly much less complicated than alcohol detoxification.

Ms Lynch—At Logan House we take no-one younger than 18. The oldest resident in the short time there was 65. I would say that our breakdown is 60 per cent amphetamines, 30 per cent alcohol and 10 per cent narcotics.

CHAIR—Opiates?

Ms Lynch—Yes.

Mr CADMAN—I got an impression from earlier comments that the common combination is alcohol and marijuana.

Ms Alcorn—No—amphetamines, alcohol and marijuana. That is the common poly substance misuse. You have to understand that they will switch to anything if they do not have the money—for example, if they do not have the money for amphetamines, if that is their primary drug. There is an increasing number of very young people who are involved in just marijuana and alcohol as a combination, which is causing mental health problems.

Mr CADMAN—So there are three age groups: the under 18s, those aged 18 to 28—

Ms Alcorn—Eighteen to 29.

Mr CADMAN—and those aged 30 and over?

Mr Blatch—Twenty-five to—

Mr CADMAN—Is that basically the way it seems to work?

Ms Alcorn—Yes.

Mr CADMAN—In your opinion they should be treated in separate age groups because their problems tend to relate to their social and economic circumstances?

Ms Alcorn—No-one over 30 or 35 would cope with our residential program. Our young clients need activity and there are specific needs. We have a touch football team so they play in the community, sometimes against the police, and there are other activities. When you take away those drugs and their mental health, their maturation is such that, particularly with dual diagnosis clients, people at 35 and 40 who are reasonably mature do not cope with them.

Mr CADMAN—Charlie, what sort of programs do you have?

Mr Blatch—Our programs are very similar to Mary's. We provide a service for people who are seeking abstinence. They want to build a better life for themselves and their families. They have all had hazardous drug problems rather than recreational problems. Our demand is through the roof in terms of waiting lists. That is possibly the same all the way across the Gold Coast. Because of our age range, we have a lot of people whose key reason for seeking treatment is that they are responsible for children. About 70 per cent of our population would say that. This poses a big problem for us, firstly, because we cannot accommodate everyone who is looking for help and we cannot refer them because other programs are full. Secondly, our population is very often male dominated. It would be about 70-30 or worse than 80-20. We are quite concerned about the access to services by women in particular, especially those who are responsible for children.

For a long time we have thought it would be very useful to have a facility in Queensland that could manage family groups. By that I mean they could be a single parent with children or a partnered couple with children. I think there are only about two facilities in the whole of Australia that actually work with the whole family group. That is a very big concern to us because our clients are responsible for children. Of course they are also children of parents as well. We would certainly like to be able to work towards integrating family members far more into the program.

Mr CADMAN—Bring grandparents in as well?

Mr Blatch—Yes. Not to live in but to be involved with.

Mr QUICK—This committee previously in the substance abuse inquiry visited Odyssey House in Melbourne where they have the capacity for families to stay together. They work with

the local schools so that there is some sort of normality within this crazy drug induced system so that they can survive.

Mr Blatch—It is the same in Canberra but there is nothing in Queensland. We certainly would like to see resources allocated so that at least one program could provide that sort of service so that a parent and child do not have to be separated. Perhaps there are opportunities to mend the damage in those relationships. Of course it would be quite an expensive exercise because it would have to consider things like child care and the extra costs that children are going to bring, but those issues have been worked through in Victoria and in Canberra with the Karralika program through the Alcohol and Drug Foundation. I do not see any reason why that could not occur in Queensland.

Ms Lynch—As part of the ADFQ we run Holyoake. Unfortunately, my peer cannot be here today. Basically, with our service at Logan House we would refer the significant others to Holyoake so there is some sort of complementary therapy going on. Unfortunately, because Julie is not here I am not able to provide any statistics or information about that. I just wanted to pick up what Charlie was saying about a lot of people coming through because they are at risk of losing their children if they do not address their substance abuse problems. I am amazed at the number of male clients who have come from a partnership where there has been drug use and the females have had the legal prerogative of having the children. The men are coming in to clean up their acts to have a better case to argue with regard to getting custody of their children. Again, I am fairly new there. That is just what I have noticed anecdotally. It would be interesting to see the stats on that as well.

Mr QUICK—Who is keeping those stats?

Ms Lynch—Me, but it is day 50 for me in my new job today so I have not got anything profound for you. We will be measuring all sorts of things in the very near future.

Mr CADMAN—Maree, you have not had much to say.

Mrs Lubach—I wanted to come in particularly on this issue.

Mr QUICK—Just butt in! We are very informal.

Mrs Lubach—From a grandparent's point of view, it worries me. I was saying earlier that it has often been reported to me that the people abusing drugs are in their late 20s to early 30s and are coming to the stage where they are not able to cope with their children anymore. The grandparents are seeing this. The authorities cannot see it or do not want to see it or perhaps it is too expensive to see it, and it is almost hidden. The grandparents are worried and are finding they can do very little in that situation and nothing is happening for these people. It is being hidden under a rock. I would love to see such a facility because I feel that that way the parents would not have the need to hide their addictions and the grandparents could work with them in the way they want to. Instead of ending up physically holding the baby, they could work with them to get over the problem.

Mr CADMAN—How do you see that happening physically? What is the ideal situation? Is it the bureaucratic bar or legalistic bar that is the problem which does not allow that to occur?

Mrs Lubach—I imagine it is the lack of facilities and the lack of funding for such facilities. As we have just heard, there is not one in Queensland. Is that what you mean?

Mr CADMAN—You seemed to indicate that the authorities did not seem to want to see a grandparent's role as significant.

Mrs Lubach—The child safety, child protection role is very much towards reunification of children with their parents. I am cynical enough to think that this has a lot to do with the fact that then the state government no longer has to pay the fostering allowance to those other people who are rearing the children. It is often convenient to not notice the drug addiction of parents or to not recognise its implications. I think there is also a myth about drug addicts that they are the hobos in the gutters in the streets. Some drug addicts can present very well and hide their problems quite well.

Ms Lynch—And come from very well-to-do backgrounds.

Mrs Lubach—Yes, absolutely.

Mr QUICK—In your relationship with Centrelink about family payments, are they more understanding than the state department of health and welfare?

Mrs Lubach—To be honest, I have a lot of time for Centrelink and the way social workers advise our grandparents. We always advise grandparents to make an appointment to see a Centrelink social worker. We find that they look at the whole problem and refer grandparents to all sorts of places where they can get some sort of assistance and not just the financial assistance that Centrelink provides. They have also in recent years put out pamphlets specifically for grandparents to let them know what benefits they are entitled to.

CHAIR—They can get the family tax benefit part A and part B and they can get access to 50 hours a week of child care. Adding to the point you were making about the problem with the children being perpetually placed back with their parents, one of the things we discovered in doing our inquiry into overseas adoption was a sort of culture of biology first—I can only put it that way—to always strive to put the child with the biological parent no matter what. Some of the ramifications were dreadful. I cannot help wondering, quite frankly, because it is the same department, so it is the same culture we are dealing with, if the attitude to grandparents is not exactly the same as the attitude they have displayed with regard to adopting parents or to a range of things which they say they are doing in the interests of the children but which are clearly not. What you are saying is that many grandparents have had to fight to say, 'These children's best interests are served by us being in loco parentis, and if we're going to be in loco parentis then we're entitled to have whatever benefits flow so that we can do the job properly.'

Mrs Newman—I have a constant battle with state child protection. I have both sides of the coin. I have custody of our daughter's children's as a grandparent carer. The children of our home are Indigenous children, and our daughter is Indigenous. This is in reply to what you asked earlier, 'What do they do with the children?' Two and a half years ago, nearly three years ago, two children—a six-week-old and a 3½-year-old—came for one night. These are nonrelatives. I am involved with the Indigenous community, and I phoned them up over a problem that was going on with a baby and a mother in jail. They had asked me to take this baby for a month.

They said, 'I haven't had time to get to your problem; I'm looking for a bed tonight for two children and I can't find one anywhere.' I said, 'Give them to me for the night.' They are still at home.

We then became involved with state child protection on a very personal level. I was dealing with them on the grandparent loop and the issues Maree was describing about sending these kids back too soon to addicts and finding them floating in canals. I said: 'I can't do this. They're my enemy—I'm tackling them all the time over what they're doing to families and children. Make me a foster carer.' They said, 'If you want to keep these kids, Maree, you'd better do the course.' We are now foster parents and we are also dealing with the discrimination that grandparent carers deal with. We have these two beautiful grandchildren that we are raising on the family tax benefit—try doing it, guys, on an aged pension. And then we have the David Jones model of the foster kids—and we love them dearly—that get paid for—

CHAIR—You get the payment for the foster caring.

Mrs Newman—by state child protection. Now I am taking them to task because in their wisdom they are cutting costs on state child protection children—it is nothing to do with grandparents—and they just want to get these kids' names on a piece of paper. The kids do not eat, do not hurt, do not cry, do not breathe—they do not count for anything under our system. They are just names to be played with.

They are trying now to move children from our home to Brisbane. Their parents live down here. These children see their parents. I am not at liberty to talk too much about this case, but I will give you an idea. There are problems within state child protection not just pertaining to grandparents raising grandchildren and what they do there. We have kinship carers that are under state child protection with their grandchildren and they are just treated like foster carers. The children have been made at times to go to jail in the government car.

CHAIR—To see the parents?

Mrs Newman—There is a major problem with state child protection. In fact, I think they cause more damage to the children than some of the parents. I think it is a Pandora's box that needs to be looked into.

CHAIR—What you are saying is deja vu, because this is what we heard so often when we were taking evidence in our overseas adoption inquiry, which then unearthed all that was happening in these departments dealing with children for adoption and children at risk. Our report has actually been accepted by the federal government and the federal government is working with the state government, but I am hearing the same problems.

Mrs Newman—I can go back three years, to when Margaret May paid for a forum for Larry Anthony to attend here on the coast. This was prior to having these children under state child protection. I got up and I said, 'It's a fact: our children die waiting to be protected by state child protection.'

CHAIR—Do you have any numbers of those, Maree? I told you what the figures are for New South Wales last year.

Mrs Newman—Somebody mentioned a document pertaining to the neglect in state child protection.

CHAIR—Did you say that there were 96 last year?

Mrs Newman—Yes. I am fighting all the way, and not just for the grandparents.

CHAIR—Kids are at risk.

Mrs Newman—The kids are at risk. I will take the department to a tribunal. The parents do not want them moved. The department let their brothers and sisters leave the coast 11½ years ago. They made the mistake. I will take them to task, because it is not in the kids' best interests. It is not nice to be dealing with governments when you have to fight them.

Dr Pearson—Mr Cadman's original question was about why we do not have enough family involvement in the treatment. The bottom line is that our resources are stretched. Family involvement in treatment programs is labour intensive. I am fortunate to work in the private sector, where we certainly have better resources and less extensive family problems than some of the problems that have been encountered. But even in a private hospital there is no funding for individual contact with a social worker under their medical insurance. That is something that they would have to pay for in excess. In many ways, they are conspired against even in the private sector. The funding issue is still a major problem. There are some medical insurance companies that discriminate actively against substance abusers or substance dependants. They will fund a very brief admission for detoxification only and then cut the rate that they will pay the hospital for caring for the patient down to a day patient only rate very quickly—after a matter of seven to 10 days. That puts the hospital in this invidious position, where the person is not well enough to leave but the hospital is getting very little revenue for keeping them there.

CHAIR—You work in the private sector. How many public mental health beds are there in hospitals? In my own electorate we are short of them and they close them. How many are there?

Ms Lynch—I do not know about the number of beds, but I know that from the alcohol and drug perspective Queensland Health has wound down. We used to have quite a fine rehabilitation program running from the Royal Brisbane Hospital through the HADS unit, which is the hospital alcohol and drug service. Now it is a five-day detox and then goodbye. A lot of people may look at coming to a residential facility, such as the one that I am managing. But they may have to wait a few weeks and if they do then they have gone back to the substance so they need to go back and detox. There is a revolving door syndrome. I am not sure about mental health beds. I will take that back to the doctors. But I know that the A and D services have been pared right back in the public sector in Brisbane.

Dr Pearson—I do not know how many public beds there are on the Gold Coast.

Ms Alcorn—There are no detox medical beds.

Dr Pearson—We have leased—

Mrs ELSON—There are no detox beds in Queensland hospitals, are there?

Dr Pearson—Yes, there are.

Ms Alcorn—Royal Brisbane Hospital has some.

Mrs ELSON—The list that I was given said that there were none and that you had to go to these private companies, which I had a list of. They would detox you and then they would take you into the mental health system.

Ms Lynch—Once upon a time they did it through mental health. But there is such a demand for mental health beds that they cannot accommodate any detox. We used to detox people in medical units, but there is demand for medical beds. A lot of the medical staff are not trained to deal with detox, so quite often the detoxes go haywire and you have people facing violence that they are not able to deal with because they are not mental health workers. That whole concept of using medical beds for detox has shut down as well.

Mrs ELSON—There is a system in Queensland at the moment where parents are getting so fed up with not being able to get help for their children that they are getting a court order to have them mentally assessed and put into a mental hospital for 10 days. That is what is taking up all the beds at the moment. That is the only way that the parents can get help. There are no counsellors available. It is the same thing with grandparents, isn't it? If you go to Centrelink, you will get a social worker. But there is no-one that you can sit down with if you have massive problems. That is why the grandparents group is having those problems: there is no-one else to talk to and get assistance from.

Mrs Lubach—There is a major problem with that.

Mrs Newman—That side of it is long and lengthy. When you have a child come to you who has witnessed things or been involved in things, who has a learning problem and an emotional problem, you cannot get these facilities unless you go and pay for them.

Mrs ELSON—That is right.

Mrs Newman—They are very costly, but they are out there if you want to get in the queue.

Mrs Burnett—There does appear to be a lack of specialists in dual diagnosis. They tend to be either drug and alcohol or mental health. I know that the policy is about integrated services, but those do not seem to be appearing on the ground at the moment.

Mrs Lubach—Grandparents too have a lot of problems getting to talk to people who are trained as to their special issues. Grandparenting is often seen by some counsellors as similar to parenting but at an older age. Really it is a quite different thing altogether. Those of us who are a little older will understand why. There are special issues for the children involved too. The children, once they have come to the grandparents, are highly traumatised. They have this loss and grief. Their grandparents are feeling a similar loss and grief for their own children as the children are for their parents. These things are very difficult to get appropriate counselling for. Really we need somebody more qualified than—and I do not mean to put them down—for example, the St Vincent de Paul counsellors. We really need psychologists in this rather than counsellors because it is a more complicated issue.

Ms Alcorn—The new Medicare system with psychologists will help you enormously. It is getting to see GPs on the coast. It takes two to three weeks to get in to see a general practitioner.

Ms Lynch—And only if you can fix it in 12 sessions.

Ms Alcorn—There is one way of getting six to 12 sessions with a psychologist now. I take your point. There are no specialist counsellors on the ground in the Gold Coast. You really have to understand this. We have this huge growth. If you take under-18 services, they are all in Brisbane. We have one specialist counsellor. We just do not have the resources and counsellors on the ground to deal with this. The person who is seeking help is turned away versus their parents versus their grandparents. There are simply not the services to go around. As we said, we are expecting an explosion at Coomera. I treat one in 10. As far as I understand, Mirikai is the only dual-diagnosis therapeutic community in the country that is public. We are just saying no, no, no. There are two issues with that comorbidity or that dual diagnosis. We need two types of dual-diagnosis residential services: one for the severely mentally ill who need rehabilitating and vocational guidance at a slower rate and one for the people we can manage with behavioural psychotic bipolar that have to get well. You do not treat the symptom; you have to treat the whole person. If you treat the unit that presents to you within the family, then that is not great for the whole family. You need a whole family, whole person, holistic type treatment service.

Mrs Burnett—We are a hospital. We are not really geared for young people, so it actually falls mainly to Mirikai in the area even though young people do come to our service.

Ms Alcorn—We get called. The irony of all that is that we are about to start closing beds because of the Commonwealth benchmarks. We have a recognised psychiatrist working alongside us who bulk-bills. Fantastic! We have a GP there three or four days a week who bulk-bills. Fantastic! We have worked really hard to secure those kinds of services and do the research and stuff that we do to become accredited. But we are about to close beds because Queensland does not benchmark its residential beds.

CHAIR—What do you mean by that?

Ms Alcorn—It costs to deliver a service. It costs around $33,000 a year; that might be two or three episodes of care. Queensland does not have a policy that benchmarks the bed to that price.

CHAIR—When you say ‘benchmarks the bed,’ what do you mean?

Ms Alcorn—The Commonwealth costs out a diversion bed on the ones that they have funded through the National Illicit Drug Strategy at $33,000. Currently, I think I am getting about $13,000 for the same service. So to provide the quality, the services and the additional medical services that we offer is just impossible.

CHAIR—I might be obtuse this morning. I do not understand.

Ms Alcorn—When you look at 24-hour care, seven days a week, to run a residential facility such as Logan House, Goldbridge or Mirikai—

CHAIR—That is $33,000. So where is the problem?

Ms Alcorn—Then it costs a certain amount of money per bed to maintain them. The Commonwealth have benchmarked the beds they fund for diversion, not for dual diagnosis.

CHAIR—When you say it is 'benchmarked,' what do you mean?

Mr CADMAN—Is it capped or limited or what?

Ms Alcorn—They set a mark that they think is reasonable for the bed. For instance, if you are in prison, I think it averages at $60,000 a year. If you are in the public mental health system, I think it averages at $350,000 a year per bed. For two episodes of care we are costing that at around $33,000 to $35,000 a year. We are not getting that money, so we will have to close the doors.

CHAIR—How does it apply in other states, for instance?

Ms Alcorn—As far as I understand it, from talking to my counterparts last week at the Australasian Therapeutic Communities Association, if beds in Victoria are used they get even more money.

CHAIR—From whom?

Ms Alcorn—From the state government—and the federal government tops it up through the National Illicit Drug Strategy for a lot of beds.

CHAIR—Are you saying that the state government does not give you any money and all you get is top-up money from the Commonwealth?

Ms Alcorn—It is not their policy. I do not think, currently, residentials are a high priority in the alcohol and tobacco and other drugs list.

CHAIR—I just do not get it. You are getting Commonwealth money?

Ms Alcorn—I am getting Commonwealth money for outpatient services, and I am getting state money for Mirikai residential beds.

CHAIR—Why don't you get the same amount of money that they get in Victoria?

Ms Alcorn—Because it is not their policy. They give money to support—

CHAIR—The Commonwealth has one policy. It applies to all the states. It is against the law to have different policies for Victoria and Queensland. You cannot do that.

Ms Alcorn—We do not receive any Commonwealth money for our beds. Some states do; some residentials do. We applied at the time that the NIDS funding became available for outpatient services, such as parent support, and all the things we needed to prop up.

CHAIR—I do not understand that. If Victoria is getting Commonwealth money for the same service you are providing, you are entitled to the same money. So why aren't you getting it?

Ms Alcorn—Because it is just not the policy of the Queensland—

CHAIR—No, the policy is the same for every state and territory. You cannot have a Queensland federal policy and a Victorian federal policy.

Ms Alcorn—Currently, state funding is partially funding our beds. They give us a contribution towards it. We do not have any federal funding for our residentials.

CHAIR—But you said in Victoria they were getting some.

Ms Alcorn—Some Victorian, New South Wales and Western Australian programs have applied and received funding from the Commonwealth NIDS.

CHAIR—You had better find out what they are doing that you are not doing so you can apply and also get some.

Ms Alcorn—Next time around we will.

Mrs Newman—Mary also supplies nurseries to pregnant mums, and I think that is to be commended.

CHAIR—Seriously, you have to find out. You must have done the wrong—

Ms Alcorn—At the time the National Illicit Drug Strategy came around, we were prioritising outpatient services because we were simply overwhelmed by people wanting services. So we decided we would include family support. You can only get one or two bites of the cherry. Next time around we are hoping, but I do not think it will be in time.

Mr QUICK—Some of these might have been pilot programs where funding was available for three years and that was the end of the story. That could be one of the reasons why other states received it and, by the time you got around to applying for it, it was a pilot program that had ceased.

CHAIR—We will make inquiries.

Ms Alcorn—At the time, we also looked at our region and Charlie received some money for Goldbridge Residential Services, and I received some money for outclient services. The truth is we needed both, so it was a case of who wanted what. I was managing better with the residential money at the time, but now I can't because the cost of accreditation, the cost of providing our services has escalated enormously—

CHAIR—Hang on—we have just had a new factor in here. Now to get funding you have to be accredited—is that right?

Mr Blatch—Almost.

Ms Lynch—There are requirements you must meet.

Ms Alcorn—And you must be on your way to it. I am accredited and have been for years, so that is not the barrier. The barrier is this: if you want to provide residential services for dual diagnosis you need to pay people to do them. The state government, at this point, is giving us a contribution towards our beds that does not differentiate according to age, complexity or mental health. And it is only a contribution.

CHAIR—They give you a flat, per-bed grant?

Ms Alcorn—Every program gets a different amount, depending on how much they negotiate and who they know.

Mr Blatch—I think that is what it comes down to in Queensland with the state government: the best lobbyist gets the most money.

CHAIR—But you keep re-electing them!

Ms Lynch—And it depends what services you provide as well. We take the interim drug court order clients—

Ms Alcorn—They pay well for them.

Ms Lynch—We also run the QIDDI program, which is the court diversion program for people caught with under three grams of cannabis, to rehabilitate them and steer them out of the legal system rather than into the legal system.

CHAIR—How do you measure your success rate?

Ms Lynch—Outcome measures, basically, at this stage—looking at completion rates, and at qualitative stuff like feedback from residents.

CHAIR—Can you find out what happens to them when they leave you?

Ms Lynch—We do, and I was going to make that comment earlier. There are actually three parts to this: detox, rehab and aftercare. I talked about the revolving door; I can see that the lack of aftercare just feeds right back into the beginning of the cycle again.

CHAIR—Yes, absolutely.

Ms Lynch—We actually do do aftercare. We used to run some houses in the community, so people could move from the residential or rehab centre to the community, live in the community, find jobs, et cetera. But they did not work so well, I believe, so they shut down; that was before my time. At the moment we just do follow-up through phone contact, and through measuring whether they are working, whether they are using, whether they have had lapses—

CHAIR—And do you help them get into a job, for instance?

Ms Lynch—We do that before they leave rehab. I do not know if you are familiar with the Harvey Milkman program, which is something that the Queensland Magistrates Court seems to have incorporated in their drug court. The first phase of awareness is developing insight and ownership. Transformation is looking at how they can stop doing what they are doing and change their behaviours and the way they think about things. And the 'reconnect' is about reconnecting with the community, with society.

Mr QUICK—So is the drug court right across Queensland, or is it just in particular settings?

Ms Alcorn—No, it is in South East Queensland. It is also in northern Queensland, but it is spasmodic. In northern Queensland there is one in Cairns and one in Townsville, and then there is the south-east.

Mrs ELSON—I want to ask about your drug court and the diversion program. The feedback I get from the community—from parents and from users—is that they were using that system to divert away from being charged. They go in there and stay at Logan House for three months and then they are back out doing it again. They know that they can get that three months of sitting in there and not get a court case. Then on the other hand—and I would like to know what the figures have been for the last two years—there are some smarter ones who say, 'I am not going to go through that drug court system because I don't want to go into rehab; I don't want to get fixed up; I don't have a problem.' So then they go through the court system, knowing very well they are going to be given a $1,000-a-day barrister to sit in that courtroom and get them off the charge. And nine times out of 10 they are not charged. So they do not need to get help in that early stage; they have got a system going such that they know they can get away with it. So have your court diversion numbers decreased over that period of time?

Ms Lynch—Yes. We normally run 70-30; 30 per cent would be court ordered. At the moment, we have a 60-40 mix. And because we are trying to generate therapeutic community, we need to watch the dynamics of having too many court-ordered people. As far as their integrity goes, with regard to whether they really want to rehabilitate or it is an easy out: we assess everyone who applies, consider all options, and ask, 'Okay, is this ducking and weaving, or is this someone who is genuine?' It is not foolproof, obviously. And there are some very good actors as well!

Mrs ELSON—They can tell a good story. If you know they are not genuine—I know one who has been to your house four times and thinks it is a bit of a joke; a very good pretender who you were actually helping at the time—and they come back four times, is there something else that Logan House can do to move them on to get more serious help?

Ms Lynch—I have been there for 50 days as the new manager.

Mrs ELSON—I thought you were. I had not seen you there before.

Ms Lynch—Yes—I am the new manager. I would not have someone back four times, because to me that would actually speak volumes. They obviously need something else. I would not be wasting everyone's time and money if they were coming back for a fourth go. We certainly would direct people. Drug court people are a little limited. Does Moonyah take drug court people?

Ms Alcorn—We take it because of the money.

Ms Lynch—Moonyah, which is a rather large residential rehab in Brisbane, at Red Hill, has an eight-month rehab program for those who do not get it after three months.

Mrs ELSON—One of the philosophies, especially of Logan House, is that you have to want to rehabilitate in order to rehabilitate. If they are using the court system just to not be charged or put in jail, it would not be successful. Your main aim is: 'You come here as long as you admit to it and want to do it.' As a parent I cannot force my child into your house to get rehabilitation. That is why I wonder whether the court system would actually work, because you are putting them there as a place to go so that they do not get charged, rather than having them say, 'I want to rehabilitate.'

Mrs Newman—I would like to answer that. I have a daughter who has run the system. She would know how to get through every barrier. They acquire cunning. I would like to defend drug court because she did run and do exactly what you are saying, but it catches up with them. At the end of the day, she would now be facing two years in jail if she were not in rehabilitation. She had run the gauntlet with drug court a couple of times. I got the feedback recently: 'Oh Mum, if drug court won't have me back, then I've got to stay in here.' I said, 'You've had your chance.' Because she is very pregnant, I felt that, in jail, she was seeing daylight: 'My life can't go on like this.' And so I wrote to Mary. I was desperate, as her family, as a part of this system of having an addict for a daughter—you do not stop loving them and you cannot keep trying to help them when doors are not there.

But recently, after 10 years of trying to deal with jails, drug addiction and lack of services, I have found the most enlightening lady at Mirikai, with programs built in to cover every need for the addict and the family. I had a round table meeting with them. She allowed our daughter back again when other rehabilitation centres refused. I have to be totally honest: out of 10 years, between juvie and Brisbane Women's, she would have served six years. She has done the time for the crime, but has never been treated for the problem that put her behind bars, until now. I firmly believe that if an addict is going to be rehabilitated they must go through this centre. I do not care how good they are at scamming. Of course there are wise people who know what they are up to, but eventually they will have to face the consequences. I think it should be mandatory for anybody who is doing crime in jail today to support their habit—and my daughter did—to be rehabilitated before they are released.

Mrs ELSON—I honestly believe what you said. Jail is not the place—

Mrs Newman—It is not the answer.

Mrs ELSON—because they get more connections in there as to how to get the drugs when they get out again. So I do not think they should be in jail.

Ms Lynch—I would like to respond to what you are saying about the magistrates having a role in this as well. They need to be clear about having some responsibility and gauging whether a person is genuine or not. At best, you can only make a call on that. Having said that, though, we are actually working quite closely with them. We have had the magistrates come to Logan House, look at the facility, talk about the program and get an understanding of what we offer and

what we do there. Hopefully those sorts of examples—like someone saying, ‘It’s a laugh, it’s a breeze. We’ll just go to Logan House’—will, with time, be dampened down and we can head that off.

CHAIR—What percentage of people who become addicts can be rehabilitated?

Ms Lynch—That is the six million dollar question. I will call on my peers for a bit of support on that one.

Ms Alcorn—That is a very difficult one. The earlier they are, I think the easier it is.

Ms Lynch—It is hard to measure, because if someone has not used a substance for five years but they have had a glitch and they have used for a week, they would be potentially not considered a success. Whereas, from where I see it, that is an incredible success.

CHAIR—But you would take that person back, wouldn’t you, and help them?

Ms Lynch—Absolutely.

Ms Alcorn—But we don’t have the resources to.

Ms Lynch—Are you talking about repeat offenders—

CHAIR—Or people who simply—

Ms Lynch—Just don’t want to.

CHAIR—don’t want to.

Ms Lynch—That usually seeps out through therapy. I guess you would see it in the therapeutic community, because they are not compliant with everything that is expected of them as a member of that community.

Ms Alcorn—It is a very strenuous exercise, even for someone with a co-existing mental health issue. I think I prefer to treat one not the other and mix them up, and that is the difficulty. About 80 per cent of our population is dual, and we are known for that. So it is very difficult to mix it up with the eight drug court clients that we have. I think there are horses for courses and different types of programs for antisocial personalities versus people with bipolar and schizoid and those sorts of disorders.

CHAIR—The people who go on to become totally dysfunctional because their brains are destroyed—all you can do is—

Ms Alcorn—You would be surprised how they can come back.

Dr Pearson—Long-term follow-up studies are very difficult to conduct. This is a difficult patient population. The 20- or 30-year outcome data just is not available. From what I

understand, the natural history of addiction is that a majority of people are addicted for about 10 years and that, over that time, most people will give up an addiction. I think we all get coloured by a view—we see the people who are still being admitted to hospital—

CHAIR—As I said before, the old expression was that people are either off it or dead by 26. But that was basically applying to opiates.

Dr Pearson—Yes.

Ms Alcorn—I think that applies to amphetamines too, because they fry their brains if they don't—and marijuana and alcohol. I think that is pretty real. It is up to the age of 30, mostly. Have faith: two young women clients who were quite ill three or four years ago—they had a dual diagnosis—are now studying medicine. So you must have faith. It is from the worst to the best.

CHAIR—We will now take a short break.

Proceedings suspended from 12.13 pm to 12.37 pm

CHAIR—Welcome back. We have not isolated our themes; we have been dealing with them as we go, and that has been going quite well and we have been getting quite a good interaction, so we will continue to do that if everyone is happy to do so. Before we stopped, we were hearing from Dr Pearson.

Dr Pearson—I know that there was something that I wanted to say.

CHAIR—Go right ahead and say it.

Dr Pearson—Someone mentioned better access to health care, and I am a little concerned that the government might say, 'We're pouring all this money in and we're giving you all these resources,' because I think that that is a little misleading. Substance abuse or use is not something general practitioners are familiar with and necessarily want to know about. It is one of those questions that they probably do not routinely ask. If they do get a positive answer, they are not equipped to deal with it as an issue and so there is reluctance on their part to do so. What is disappointing with that is that there is a fair amount of research that shows that advice from a doctor at a very early stage of use of substances is effective in both harm minimisation and improving long-term outcomes. If they can capture that issue early enough, they will be effective in having some impact on the patient's use of the substance.

The other tragedy is that if they detect an issue of abuse or dependence I do not think that many of them are going to feel competent in dealing with that. We have seen a number of educational programs rolled out to GPs over the last several years. All of them have been privately funded by the pharmaceutical industry. There have been a number of educational programs on depression, the most famous of which is the SPHERE program that Ian Hickey rolled out through beyondblue. There is a whole variety of those programs. There has been one on psychosis, which was not very effective, and a couple on bipolar disorder, which were quite good. There is one program just starting that may educate GPs a little more about this. It is about developing a care plan and incorporating people into treatment where they have identified either

a dual diagnosis or a substance abuse issue. But at this stage they are not equipped to deal with the issue.

CHAIR—I want to ask about terminology. One of the things in this area that I have found difficult is the way we like to mix things up. We mix up legal and illegal drugs. We mix up alcohol with drugs—you talk about alcohol as being the same as drugs, yet, for instance, it comes in many forms: it is created to accompany fine meals; it is designed to do a whole lot of things. If people misuse it they can become ill, but the only reason somebody takes an illicit drug is to get off their face, and the two are totally dissimilar.

Ms Lynch—A lot of people drink to get off their face.

CHAIR—I said that is misuse, but that is not the reason it is created. There is no valid use for illicit drugs.

Ms Lynch—There is: if you look at cocaine, it is a powerful anaesthetic agent; if you look at opiates, we would treat people with pain disorders—

CHAIR—Actually, we do not.

Ms Lynch—post-operative or what have you—

CHAIR—It is still illegal. When you talk about dual diagnosis, I think that comes in two categories and, chatting around the room at the break to people who have got families involved, I found that they want the difference to be acknowledged too. You have people who have a mental disease problem and take an illicit drug to try and assist them in that way. You also have people who have taken a drug and become mentally ill as a result of it. They are two entirely separate problems.

Dr Pearson—The dual diagnosis does not necessarily imply causality; it just means we have got two problems. We have got a mental health issue—

CHAIR—You have got three, haven't you?

Dr Pearson—and a drug issue.

CHAIR—You have put them together, whereas you have really got two lots of people and two separate problems to deal with—two groups.

Ms Alcorn—In some ways we do.

Dr Pearson—If you look at patients from drug and alcohol services, most of them present with a primary drug dependence issue and there is quite a high rate of depression, anxiety disorders and personality disorders.

CHAIR—If you are dealing in a scientific method then you need to distinguish between the two. It becomes very confusing in this whole area lumping things in together.

Ms Koningen—That has been the problem: we have had the attitude they are all separate, but current findings are that they are not; they are all integrated. We need to move past right and wrong to understand that they are all integrated, and that is what these resourceful people are trying to overcome.

CHAIR—That is a different question. You cannot take morality out of it.

Mr QUICK—It is like saying domestic violence is caused by one particular stream of activities. It might be related to—

Ms Koningen—But we know it is not.

Mr QUICK—I know—mortgage pressures, inability to keep a job, substance abuse and a whole range of things.

Ms Koningen—And there is a whole range of reasons why people take a substance. It can be an antidepressant. It can be medication provided by a doctor.

CHAIR—There is nothing illegal about an antidepressant.

Ms Alcorn—Can I help out here? I think what the honourable member is trying to do is distinguish between substance misuse people who develop a mental illness, and people with a diagnosed primary mental illness that they have suffered all their lives who have not been treated in a way that supports them and includes them in the community, therefore making them feel isolated, and who take substances to make themselves feel better.

CHAIR—That is right.

Ms Alcorn—That was the issue, I think.

CHAIR—That is the distinction.

Dr Pearson—It is a very difficult distinction to make, to be fair, and it is a very important one with respect to treatment. If you are looking at the diagnostic category then it is important to acknowledge, and most people do not, that there are two—

CHAIR—A mother is not going to look at her child according to the diagnostic codename; she is going to be concerned about how she is going to cope with someone she loves who is in very dire straits.

Mr QUICK—It is a bit like the situation with Maria's daughter. Depending on when you intervened, you could have had the original accident or had it in another five years down the track—

CHAIR—Too late.

Mr QUICK—when she was in the juvenile justice system. It depends on when you intervene—

Mrs Newman—When we went for help; that is when the intervention should have happened.

Mr QUICK—I know.

Mrs Newman—I should have been able to get that child to a neurologist.

Mr QUICK—That is right. But because you couldn't—

Mrs Newman—But because I couldn't and she was left out there—

Mr QUICK—All these other things happened, yes.

Mrs Newman—Yes. It is very sad. But that case is not unique, if you do the research.

Mr CADMAN—Maybe that was right, maybe not.

Ms Alcorn—What you are saying, though, essentially, is that having the right diagnosis, the right intervention, including medical intervention, when it is needed would be part of the solution, and that is what we do not have access to.

Mr QUICK—That would be ideal, because with manifestation of aggression, for example, at a high school, they have a simple solution: exclude the child from the classroom, or if necessary the school. They are not concerned about referring that child to a GP or getting the parent in. Because there is pressure in large classes, it is a case of excluding the child.

Mrs Newman—You are right. But that is all they can do.

CHAIR—Can I ask another medical question. There seems to be an increase in the number of children who are diagnosed as being within the spectrum of autism. Is this because we have greater knowledge of autism and are picking them up more? Is there any interaction between the diagnosed condition of autism and drug usage, or is that completely irrelevant?

Dr Pearson—The epidemiological data on autism shows undoubtedly that there is no change in the frequency of the disease, but what has happened is that it is increasingly recognised. The current research on autism, or Asperger's syndrome, which is the most commonly made diagnosis, is that this is a feature that occurs throughout the population in a fairly standard manner. People have either more of it or less of it—and it occurs in a bell-shaped curve, like many other features of personality. So it is really the cut-off thresholds that have changed, and the fact that we are much more willing to accept the diagnosis these days than we were several years ago. That is really what it is. It is just more fashionable and more easily recognised.

Mrs Newman—Doctor, would you say that foetal damage through the abuse of illicit drugs and/or alcohol has anything to do with Asperger's and autism? Is there any medical documentation saying that in this area?

Dr Pearson—Not that I am aware of. There are certainly syndromes that are directly attributable to alcohol and drug usage during pregnancy. Foetal alcohol syndrome has been well recognised for a long time. But, as far as I am aware, the epidemiology on autism—and I read

about this recently—is that it is a very stable condition. We used to say, 'This is an abnormality that occurs in a very small percentage of the population,' but it is an abnormality that occurs in a small percentage of the population in extreme form. But in milder forms it is throughout the population to a greater or lesser degree.

Mrs Newman—You say it is a small percentage, and I agree with you because from a support group angle I would not say we were a large support group. I know of two children diagnosed with Asperger's in our group, and that is why I was wondering whether it has ever been tracked back to foetal damage, because other than in the support group I do not run into this situation. It is rather interesting.

Dr Pearson—I am not aware that there has been. They have tried to establish all sorts of causes of the condition. For a long time there was a lobby that believed it was related to immunisation, and in fact there is no data to support that. So they have examined it very carefully and they have not been able to find the environmental triggers for it. At this stage, I am led to believe that they think it has a strong genetic component. There are certainly family studies that demonstrate it runs strongly in families.

Mrs Newman—Thank you.

Mr CADMAN—Could I bring us back to the doctor's opening remarks about the billion-dollar program and the fact that some of it may be misdirected if the traditional lines of education for doctors are used. You said doctors are too busy and that the best courses you have seen have been run by pharmaceutical companies because they are relevant to doctors' needs. Is that right?

Dr Pearson—That is correct, yes. They are of a very high calibre. They are usually established independently and then rolled out. They are sort of sponsored by the pharmaceutical industry.

Mr CADMAN—So it is not a process for flogging drugs?

Dr Pearson—No, in fact the drugs hardly feature in the program. It is certainly aimed at recruiting the doctor's support for that company and probably the medication that the company supplies but the educational package itself is not related to a company as such; it is an independent educational package simply sponsored by the company. That is the manner in which it is rolled out.

Mr CADMAN—If we had Tony Abbott sitting here or you could write a passage in our report, what would you want to say about the education of doctors and people dealing with people who present with a drug and mental health problem?

Dr Pearson—I would say that, to coincide with the Better Outcomes in Mental Health Care initiative, we need an educational campaign targeted to GPs to alert them to early intervention and appropriate strategies that they may be able to implement. Then we need the appropriate use of healthcare professionals and other non-government organisations and residential facilities to cope with the problem.

Mr QUICK—Would you see a way of doing that? When I first went to Tasmania, I went to a little local GP. It is now a big conglomerate. It is like a sausage factory. If you present with any abnormal sort of behaviour, it just does not happen. You are the sort of freak of the sideshow. If we encourage this to happen—which I think is wonderful—then in your normal waiting room, you are going to have some different people there who will not be a threat but who will create a bit of tension within the waiting room. We all present to the doctor for a variety of reasons but if we suddenly encourage this, which as I said is wonderful, how do we remove the stigma?

Dr Pearson—It is a difficult question. I think having those people in the waiting room is a really important thing for the general socialisation of the public.

Ms Lynch—Destigmatising.

Dr Pearson—Also I am not saying that primary care is the only place where we need to put money and intervene, it is just I am worried that the government is going to say, ‘Look, we’ve put all this money in and this is what we’ve done.’ In actual fact it may not end up that the end user benefits greatly from it. I think the other impression that GPs have is that the funding really is for individuals. They may identify an individual with a substance use disorder and refer them on appropriately but they might not be aware of the fact that families could benefit from this as well and that part of that therapy could involve the family. I do not think that has been peddled out to them very well at all.

Mr CADMAN—Who would be best to deliver that sort of education program for families? I have been involved on a number of occasions with the program Rotary runs. They have an evening and they will have somebody like yourself, they will have a carer and they will have a sufferer—I am talking about mental illness now. Would this work for drug abuse as well? The professional talks about what schizophrenia is, what bipolar is, what depression is and will run through how people feel and the symptoms they exhibit. Then the carer will talk about all the problems they have managing somebody who wants to bash up their house one day or fly to the moon the next.

Dr Pearson—I think it is best rolled out through the divisions of general practice. There are local divisions of general practice. What is different about it is that it is voluntary, so generally speaking you get GPs who are interested in the area who will come along to the talk.

Mr CADMAN—Is that a good method though: an open forum where people can just come and listen and take it in? How do you educate parents or other people?

Ms Alcorn—Public campaigns do well. Federal government campaigns do well. The grim reaper campaign did well. I think they emanate up there and they can flow down for more question and answer time. Money can be dispersed in relevant community based organisations to do the support, education and advocacy but it starts with the federal government. If we are to destigmatise mental health, we have to have some really good programs—education programs at a federal level.

Mr CADMAN—We are on drugs though.

Ms Alcorn—By doing the mental health we can include the drugs.

CHAIR—We have vastly increased our cost of mental health because of the prevalence of drug use. It is our responsibility. We have not had programs out there that have been telling people what they can do to themselves. We have to take responsibility for that. We have to provide those programs for those people and we are not doing it, are we?

Ms Alcorn—No, you are not.

Mrs Lubach—As one of many parents who has had problems with a child on drugs, I had no idea that my son was taking drugs. I did not know what the funny smell was. When I finally realised what was happening, there was nowhere for me to turn. As I was saying to you earlier, I tried the police, I tried our local department—I think it was childrens services way back then—but there was no help. There was no-one who could see what was happening. There was no place I could get him to. I am talking about a 14-year-old. He had to volunteer to go to these places.

CHAIR—That is crazy, isn't it?

Mrs Lubach—A 14-year-old boy is not going to do that. There needs to be some sort of education out there. I suffered from the community's thoughts that of course I must have done something in order for this to happen. I think our first step should be to get rid of those sorts of stigmas so that people will go for help, and then we need to have somewhere for them to go to.

Mrs ELSON—As a mother who has done all the hard yards here, what would you have expected to get as a service when you made that first contact? What did you expect?

Mrs Lubach—When I first went to the state department, I expected that there would be some sort of rehabilitation that I as a parent could put a 14-year-old into to get him off the drugs and to detox and that sort of thing. There was no way that he was going to be able to make those decisions (a) at that age and (b) under the influence. That was my first thought. At that time I was probably thinking of the sort of rehabilitation programs I have heard the others describe here today.

Mrs ELSON—Unfortunately they give the rights back to the user. They say, 'You've got to want rehabilitation. So we cannot take you unless you say you want to come.'

Mrs Lubach—That is right.

Mrs ELSON—That is the circle that we have. I agree with you that having a first place to take them to is more important than anything else.

Mrs Lubach—I can see the point that unless they want to give up drugs they are not going to give up drugs. But until they are off the drugs they do not have the ability to make the choice.

Mrs ELSON—Do you think there should also be an education program for parents to look for the signs?

Mrs Lubach—Now that I have lived with a drug addict—

Mrs ELSON—You know what they are. Do you think it is important, too, that parents be educated as to what signs to look for?

Mrs Lubach—Yes. Even now when I speak to grandparents and I say to them, ‘So you’ve been down to cashies lately to get your vacuum cleaner back, have you?,’ they say, ‘How did you know about that?’ They are just amazed that they are not the only ones going through this. Even now they feel that stigma of having a child on drugs.

CHAIR—To recap, that was the first time you specifically asked for something that you wanted that would have helped you. There should be something where you can say, ‘My child is taking illegal drugs. He’s breaking the law. He’s destroying himself. I want him to go into this unit,’ so that you get him off it.

Mrs Lubach—Yes.

CHAIR—And it is something, to give you a chance to try to get him rehabilitated. But what happened to you in reality was that there was nothing?

Mrs Lubach—That is right.

CHAIR—And there was nothing you could do without his consent?

Mrs Lubach—Correct.

CHAIR—That is nuts, isn’t it?

Mrs Lubach—I feel that at 14, because it is a time of rebellion and—as Maree said before—hormones and everything are kicking in, it is very important for there to be a place with third party people available so that we can get that relationship going between the generations, between parents and children, as part of the rehabilitation thing.

Mr QUICK—So when it comes to strengthening families you do not want to be made more resilient. Some people think that is the way to strengthen families: to make them more resilient to all the things that are happening. That should not be the case. By strengthening them you should be able to provide a whole range of options for them to choose whichever one they want to—for example, Maree’s option might be different from somebody else’s option. What Charlie does by way of services might be different from what Laura is doing. You should be able to see those options out there?

Mrs Lubach—Yes.

Mr QUICK—Rather than making you more resilient.

Mrs Newman—Even if the options were out there, when you are dealing with a juvenile you have to look at what we touched on briefly earlier: does the child want to accept it? Since when does the child—

CHAIR—That is the point Maree is making. There is no option for the kid; it is ‘In you go!’

Mrs Newman—But who took the rights of the child away? It was the government that—

CHAIR—Took the rights of parents away.

Mrs Newman—gave children far too many rights.

Mr CADMAN—No, government took the rights of parents away.

Mrs Newman—Yes, they did; my word, you did. You try and raise a child of 13 or 14. They say, ‘I might go to Johnny’s tonight, Dad and Mum, and I might not go to school tomorrow.’ As I said to Larry Anthony years ago: ‘If that happened to you, where would you go and what would you do? There is not a thing you can do about it and there is nowhere you can go.’ You have given children the right to make bad choices and you have left parents and families without governmental support systems and the mechanisms to do what Maree needed. This is still happening out there and governments will not look at it; they will not look at what they have done with our families.

CHAIR—It was brought in as legislation after the United Nations Convention on the Rights of the Child; that is where it came from.

Mrs Newman—Every child needs to have a parent and guardian. If you are going to go by the United Nations guidelines for children up to the age of 18, it is not happening in Australia.

CHAIR—There was a lot of controversy about that at the time; you may remember.

Mrs ELSON—If we are going to educate, it is equally important to educate the child that, if they are caught using drugs, there is going to be some form of rehabilitation that they will have to go to. They should know that before they touch drugs; you cannot teach them later.

Mrs Newman—Our child was educated in a pharmacy; she grew up in a pharmacy. She knew; she had this incredible—

Mrs ELSON—I am just saying that they should learn before they become users of drugs that there is a course they will have to do.

Ms Alcorn—The marijuana diversion programs are funded. They are pulled up by the police for having three grams. An appointment is made and they come in; they could be stoned. They sit through an assessment and a video and they choose to have no further treatment.

Mrs ELSON—That is right—and no-one follows it up.

CHAIR—And they have just broken the law; that is ridiculous.

Ms Alcorn—I am funded to do that but I have not got any counsellors to deal with people who are begging for treatment.

Mr QUICK—How much funding do you get per person?

Ms Alcorn—I do not know. It comes through the federal government and the state government. The state government just allocates workers.

Mr QUICK—Irrespective of the number of people who come in the door?

Ms Alcorn—No, you are allocated cases through a central agency that deals them out to everybody. You only send four a day. It takes 1½ to two hours to do it.

Mr QUICK—What is the recidivism rate?

Ms Alcorn—They get charged the next time, because it is supposedly their first offence.

Mrs ELSON—But no-one follows them through to see if they are using again.

CHAIR—That is if they do it and you do not give them a caution.

Ms Alcorn—The very first time you are picked up with marijuana you come in and have an education assessment and then you say, 'See you later.' You could be stoned, but off you ago.

Mr CADMAN—That is a diversion program?

Ms Alcorn—That is a diversion program.

Mr CADMAN—Did you ever think a diversion program worked like that? Not in my way!

Ms Alcorn—I just wanted you to be aware of that.

Mr QUICK—What happens in schools?

Ms Alcorn—What do you mean?

Mr QUICK—What happens if they are caught with marijuana at school?

Ms Alcorn—I do not know. I think the police are always called. I think we give them warnings and maybe they are suspended. I am not sure of the education policy.

CHAIR—Give them a course.

Mrs Burnett—I would like to make a comment. You spoke about the range of options.

Mr CADMAN—Could you include in your comments some of the things you said to me? You were talking about the large number of young males you are starting to see now?

Mrs Burnett—Yes. In terms of the range of options, different families have different support systems. In terms of their children's usage, they may pick them up at different stages. What we have seen is that some families are really good at supporting their young people when it comes to their drug use. Other families are very limited, because they may have lots of dysfunction

anyway, in which case some kind of treatment or rehab would be better for them, whereas some families can actually support their own young people with some outreach care. So I think that range of options is probably quite important.

CHAIR—But the first point Maree was making was that you have to get them off it, and there was absolutely nowhere she could go to get him off it—a 14-year-old boy.

Mrs Burnett—Yes, but that is what I am saying: there are some people, particularly young people, who obviously are not very good at making good decisions for themselves, particularly when it comes to drugs. We also know that there is a very strong peer influence at that age, and if they have very much a drug-using peer group then they are best off relocating or being removed from that particular group.

CHAIR—But first of all Maree wants somewhere she can take the kid and say—

Mrs Lubach—Get the child removed.

CHAIR—'Stay there till you're off it.'

Mrs Burnett—Yes, that is right—

CHAIR—But there isn't anywhere.

Mrs Burnett—but there are also some families and some young people who voluntarily want to get off or are okay about getting off, and then the families do not have to go to the extreme level of having them put away somewhere. It is access—

CHAIR—No, it is not a question of putting away, fingerprinting and doing all that stuff.

Mrs Burnett—No.

CHAIR—It is saying: 'Here is a centre where, if you have this problem, you can bring your child and they will stay there till they're off it.'

Mrs Burnett—Yes, I agree—but also the whole range.

CHAIR—There is clapping for that one!

Ms Alcorn—We are talking about the under-18s. There is no hope for the over-18s, because they know their rights and there are too many people to show them.

CHAIR—And then Charlie is going to tell us about the ones in their 30s who are really destroying their families. There are different sets of problems and outcomes. What do you want for your people, Charlie?

Mr Blatch—First of all, we are being asked all the time to do more with less, so that is a big problem. We would like to be able to provide more opportunities to the people who are seeking help.

CHAIR—No, don't tell me about opportunities; don't tell me about funding. Tell me: if you had the funding and could have any opportunity you wanted, what would you deliver?

Mr Blatch—We would be looking at setting up a family program. We would be looking at the parents' needs and the children's needs. We would be looking at parenting programs. We would be looking at the relationship between children and parent and trying to mend the damage that is done. In a nutshell, that is what we would like to be able to do. If we had the resources, that is what we would do, and we feel that that would also meet what the people who come to us are looking for.

CHAIR—The first thing you want to do is get them off, though, don't you? That is rule No. 1?

Mr Blatch—Yes.

CHAIR—Okay.

Ms Alcorn—They are free when they arrive.

Mr Blatch—That is relatively straightforward for us, because we are talking about adults and we are talking about people who can probably negotiate their way through a detox program. When they come to us, they are already drug free. They are asking us to help them remain drug free.

CHAIR—So you are kind of another version of a drug AA, in a way?

Mr Blatch—Drug AA?

CHAIR—You give them the backup to keep them free?

Mr Blatch—Yes, that is the idea. Also, because people are older, perhaps they are nearer to the end of their drug-using career anyway. That is not to say that everybody who comes to us is 100 per cent motivated because they realise that drugs are destroying their lives and they want to do something about it; there is also all sorts of pressure. But, for about 70 per cent of them, the reason is that they want to get their children back or they want to put their family back together.

Mrs ELSON—Can I ask Glenda a question, Madam Chair?

CHAIR—Yes.

Mrs ELSON—I know about Glenda's program. By the time they get to your program, they are from the courts and they have to go in there, but you remove them from their peer pressure, don't you, and take them out bush? I would like you to record a little bit more about that program, because I have seen the success. I have seen them before they left, and I have seen

them in the program, finished. The attitude, the look, everything, was totally different. I do not know the period of time for which you take them away; that is what I am trying to get on record, because I think that is where the biggest success rate is.

Mr CADMAN—It is a very good program.

Mrs ELSON—They are not around, being tempted constantly every day, and they are being taught a different lot of principles and a focus on how good they really are without the drugs. Could you just tell us a bit more about it?

Ms Feasey—First of all, we are not a rehab camp, so we are not a drug program as such. We work with young people from 16 to 24 who come from all over Queensland and sometimes from out of state. They are not all disadvantaged—but then we have come to see that 'disadvantaged' covers a pretty broad category, not just the obvious, and just about any family out there can be affected by this program, as everybody around this table would know better than I would.

We have been going for over 10 years. I have been there seven years. I am pretty passionate about what we do because I have seen that, by the time many of these young people reach us, they have been through the system. I was talking about that before and about how they know all the systems and, frankly, are not very fond of them. I know that these young people can be very manipulative but, by the time most of them reach us, they are feeling what we commonly describe as 'stuck' and are pretty desperate. Their families are also feeling desperate. The opening statement from many parents by the time they reach me is: 'Glenda, thank God I've reached you. You're my last hope.' That sounds very dramatic but it is literally what is said to me, sometimes at 10 o'clock at night. These people have been through all the systems—the health system, rehab et cetera. I am seeing parents who are not just seeking information about drugs but also crying out for strategies.

It is a very goose-bumpy morning for me because at the moment a group of young blokes will be sitting in the middle of our farm at Mount Tamborine, under a kurrajong tree, and going through a graduation ceremony. My heart is with them at the moment. These young blokes came to us from all over Queensland, from government and community organisations, and from some very heartbroken parents who finally reached us and who are very thankful for it. These young people have been through the toughest process that they can imagine in their life. It is a positive experience but it is also very structured and challenging and blooming scary. They have to leave their comfort zone. They have to step out and join a bunch of strangers and head out to the bush in the middle of the outback of Central Queensland. It is a pretty unique process. Most of these kids know all the other systems and, all of sudden, they reach this lady, Glenda, who says to them on the phone, 'I want to take you out to the bush with a bunch of strangers and put you through the toughest thing you have ever been through.'

I would like to reinforce that we are not running a boot camp. It is not what this is about. We really love these kids. We are there alongside them. They go on a massive hike and do a lot of darned hard work. They live just like the old bushies did years ago and they have to do everything the hard way. There is no tap, there is no light switch and there are no distractions. They cannot ring their best mate or their mum and say: 'I hate this. Get me out of here.' There is one way out, so it is just move forward.

What they experience when they are out there is really a bit like a mirror. Their life, their history, the good but particularly the bad—all the stuff that they are ashamed of, feel guilty about, feel heartbroken about and feel sad and lonely about—comes back to them a bit like looking into a mirror. It hits them in the face; they cannot get away from it. Several people here have talked about consequences. I think in a very short intensive period, in the middle of the Carnarvon Range, these kids realise what they have been through. Often they have experienced a lot of neglect and abuse, but that is not necessarily always the case. As everyone here has said, many of them come from really good, caring and loving homes. They have just got a bit lost and sidetracked along the way—but that comes back to bite them and they cannot get away from it. So it all gets flushed out.

We do not play counsellor or social worker. There are better people around this table than us who can do that. It is about the bush itself—that connection with the land. It is about taking these young people away from the stresses of modern-day life, getting them out there to stand on their own two feet, living simply like the old bushies did years ago and, importantly, not just dwelling on their problems but recognising some of the magnificent things about themselves as well. It might be leadership strengths. It could be all sorts of things: ‘I matter in this world. I have a place. I have a name.’

I think that is where we are really stuffing up as a society. One thing that we have seen, which I was sharing with Alan before, is that our young people are not being supported in moving through their adolescence to their adulthood in a useful way. There is no rite of passage for young people through that. There is no structured process to say: ‘This is what a healthy adult looks like. You’re here but there is hope to get there and you’re going to have to go the hard road to get there. There is no magic pill. There is no magic program. You’re going to have to go through a bit of a process to get there.’ We have actually come to see along the way that this experience for young people—leaving their little comfort zones and entering this experience—has evolved as a rite of passage. This is now probably a unique experience in Australia for any young person.

My seven years there have been a very humbling experience. I have seen that there is no magic answer. We cannot say why this seems to work—we cannot pigeonhole it—but it is something that is really critical for young people. We have at the moment a group of young blokes who are graduating through this, and they have really earned that bit of paper that they will get at the end of it. But right now they will be terrified. I have asked kids how they feel about heading back home and they will say: ‘See that hill? Over that hill, the pushers are waiting for me.’ They know they are still vulnerable, and the parents know they are vulnerable.

I have had three parents of these blokes ring me in the last week saying: ‘Glenda, how’s he going? I miss him but I’m terrified about him coming back. I really need you guys to give us some pointers about how the heck we’re going to approach him to keep him on the straight and narrow as he is now,’ because they have done the hard roads. Two of those parents actually admitted to me that they lied to me on the phone through the screening process. They were so desperate to get their young bloke on the program. They had tried all sorts of other experiences and programs to try to help these young blokes, and they knew darn well that Glenda gives them the third degree to find out whether they are ready for this experience. As much as I love these kids, I am a bit of a tough cookie to get past. They have learnt from the system that, if they do not lie, their young person may not be considered for something like this.

Consequently, we had two of our young blokes on the program who, the night before they left, took ice and ecstasy and then came out on the program and had episodes. That was largely because parents were absolutely fearful and felt that they needed to cover it up. They thought that this might be the last thing that would help their son. This was in the middle of the Carnarvon Range; you can only imagine the trauma and stuff. Those young blokes have now come through. They have made serious decisions and they have been clean for a week and a half, which is mammoth. For at least three of them, that is the first time for many years that they can remember. I have sat over the last two days with each of these boys one on one for a couple of hours, eyeballing them, sitting in my room and hearing what this has meant for them and hearing how vulnerable they still feel in returning home. Many of them know that they are going back to unhealthy communities. We provide follow-up for up to 12 months, depending on the needs of each individual young person. We have found that, just like the canaries that they used to send down in the mines to test how healthy the air was and whether it was safe to carry on, our young people are an indicator of the health of not just individual families but also our communities as a whole.

Mrs ELSON—I know your program is all community funded. You would not take any government funding because you did not want to—

Ms Feasey—That is correct: we do not seek government funding.

Mrs ELSON—You still do not receive it. The philosophy was that if the kids said, ‘You’re only doing this because you’re being paid to do it,’ you could say, ‘No; the community is doing it to help you.’ So you are still not receiving any.

Ms Feasey—We can look them in the eye. We are about not just a nice warm, fuzzy experience. We are pretty serious about this. We want to say: ‘Get up off your bum and get going. You’re capable of this; you’re capable of magnificent things when you really do this.’ We think taking government funding might compromise that a bit, and I think they really respect us. They come out to our headquarters at our farm at Tamborine, which is only 20 minutes from here but it seems in the middle of Woop Woop to them. But after Carnarvon Range it probably seems a little bit easier.

Mr QUICK—What do you do for the girls?

Ms Feasey—The girls go through exactly the same process. The boys have one extra day, for two reasons. One is usually communication. The boys arrive and all look at the ground and won’t talk to each other for a while, whereas the girls are chatterboxes and are instantly communicating everything. The boys need that extra day to really feel they can trust these people to talk to them. But also we find the boys need that extra day hiking up real tough hills to burn out a bit of energy and to flush them out until they are at a point of dropping their shoulders and saying, ‘I have really got to stop and think about where I am at and where I am going.’ But the girls otherwise do exactly the same thing.

Mr QUICK—So this is one option Maree could have had—

Ms Feasy—Not at 14, unfortunately. Every day I probably get half a dozen calls from people out there like Maree who are saying, ‘Please, my son would really love this; he needs a boot

camp,' or whatever, but our process is that they need to be old enough to say, 'I really do not know what I need to do next, but I have got to make some change.' If they are at that point, they are ready for this experience. But at 14 they have not had enough life experience to process it. There is a program similar to ours in Victoria—we call it our sister program—that works with kids of this age group.

Mr CADMAN—What is the name of the program?

Ms Feasy—Typo Station.

Mr CADMAN—Could you give the details to our secretariat later, please?

Ms Feasy—Yes, sure. That takes specifically school-age kids, and it is a longer program. It has the same philosophy as ours: get them out making that simple connection with the bush—nothing fancy. Get them away to really see what their strengths are and be accountable and move forward, which is very much what we are about.

Mr QUICK—Mary, is one of the problems the fact that the Commonwealth and state governments fund all these programs and they never give you enough money; they just give you enough to keep your head above water and you are always struggling? With something like what Glenda is involved with, the community decides to go and do it and it gets done and it is not reliant.

Ms Alcorn—Often the funding is too categorical and it does not fit the needs of the client. When you have got funding that was implemented three years ago but there is a change in the community, you still can't use the funding for that to manage that change. Funding and resources are so few and far between for this particular issue—for the early intervention and for young people generally and for dual diagnosis. There is very little money out there. Glenda is lucky. It is easier to sell for kids, let me tell you, and to raise money for young people in early intervention and to get the banks on board than it is for us with, say, mental health or drug addiction. Nobody wants to fund that. It is really hard to raise money for those issues.

Mrs ELSON—Would you say it would be a better alternative, if you had a lump sum of money at the beginning of a year, to run it into the programs that are necessary rather than the other way around?

Ms Alcorn—Yes, and to negotiate with funding bodies on the outcomes for each year—if we had to sit down with them—to be responsive to community needs. I think that is really important to have some flexible funds for kids who don't fit my program but might fit elsewhere. So I think there are two things. You need to top up the existing funds, because we are all bleeding. Secondly, you need to have some flexible funds that can be delivered if you put a good case to follow the client where they go, and that might well be what Maree is saying as well. The flexible funds might be for counselling for Maree or counselling for Maree's child, but if Maree's child did not want that counselling then Maree may well need it to cope with the situation, so the funding is available for that.

CHAIR—What about if there were a component of the funding which was results connected—in other words, you got paid for successful results as well?

Ms Alcorn—But what are you going to judge success on?

CHAIR—That is why I was asking you.

Ms Alcorn—In mental health, have a look at some of my clients with schizoid effective disorder or bipolar disorder. If I keep them out of prison and I keep them out of hospital, at $365 a day, and if I involve their parents in that case management—yes, I could do that.

CHAIR—Yes, I call that success.

Ms Alcorn—But they are going to be different again from Charlie's clients. You have got to be realistic and take the worst antisocial client that has got a 10 per cent chance—like the drug courts—or a 20 per cent chance of rehabilitation or you can use some existing resources. It is very difficult. Outcomes need to be negotiated according to the severity of the disorder they are suffering.

CHAIR—But you can have people who have got bipolar, for instance, who are back in the workforce.

Ms Alcorn—We get some fantastic outcomes: back in the workforce, yes; volunteer work—if you make it realistic and it is not about having one drink or one drug; mental health—not returning to hospital. One of the things we all aim to do as residentials is to give them work skills, vocational skills, life skills—all those independent living skills that they need—and skills to be able to take responsibility for their lives and their medication and all the things that go with that so they are not a burden on the community

CHAIR—We will take a short break, after which we will invite all the folk who are sitting behind you to come and join us at the roundtable to hear their stories.

Proceedings suspended from 1.27 pm to 1.40 pm

Community statements

Christopher, Private capacity

Danielle, Private capacity

Helene, Private capacity

Colin, Private capacity

CHAIR—We will now hear from our community statement people; everybody else will stay at the table. We might start with Danni.

Danielle—I have a daughter who is 36, who is currently enrolled in the Goldbridge program. When I first found out that my daughter Penny was on drugs, I did not believe the person who was telling me and I said, 'There's no way; how dare you say that about my daughter.' That was about nine years ago and I have since been led to believe that it was going on a long time before that. But, as parents, we completely trusted her and had seen no evidence to believe anything else.

When my eldest grandchild, who is now 11 years of age, was born, we had paid off our house, had closed off part of it for my youngest daughter who had got married and my husband said, 'Now we'll help Penny.' So we bought her, her partner and the little one a house. We said, 'If you pay $150 a week, once it accrues to a deposit, then the house will be yours; you can just take it over.' Two years into this, I started hearing that my daughter was on drugs. She rang me to tell me that her partner had been selling drugs, and I said, 'I hope he goes to jail.' I believe that all people who sell drugs should go to jail. Anyway, I was starting to get a gut feeling that what I was being told was true. I went around there a couple of times to find that there were people everywhere, bottles of alcohol and children running riot, and I was very concerned.

My little granddaughter was two at that time. I rang the then department of family services and voiced by concerns. They went out there and, on the day they went, my daughter was playing with cups of tea with her little girl, and she said, 'That mother of mine—she's just an idiot; don't take any notice of her.' This occurred a few more times and, by the time the little one was four and in preschool, I was very concerned. I was going to the police, I was ringing different places and I was being told, 'There's nothing you can do.'

Anyway, I worked in early childhood and someone told me about a gentleman who was in juvenile aid, so I went to see him. He said, 'Danni, I'm sorry; there's nothing we can do until your little grandchild starts school. But, once she starts school, they will notice that she's not coming a lot and then we can get involved.' This was in her preschool year. I went and saw her preschool teacher. My granddaughter attended very spasmodically and the teacher had noticed that she was quite a withdrawn little girl, but she said, 'I can't prove anything other than to say she's quite withdrawn.'

So my granddaughter started school. I phoned the school a month into her school year and said, 'I'm a grandparent and I would really like to come and see you; I have concerns about my granddaughter.' The deputy principal said, 'What's your granddaughter's name?' and I told her. She said, 'Very interesting. We also have very deep concerns about your granddaughter. Please come over.' So I went over to the school, and I said that I was very concerned that my little granddaughter was not being adequately cared for, and she said, 'Yes, I would agree with that.'

Later that day, I had not long been home when my husband said, 'The school is on the phone.' So I went to the phone and she said: 'I didn't think I would be speaking to you this soon, but I've just had a phone call from a hotel nearby. A gentleman has informed me that he knows your daughter and that she's at the hotel boasting of being on drugs and is very, very drunk. Would you like to come and get your granddaughter from school?' So I went and got my granddaughter from school and I said, 'Would you please ring the department of family services'—that is what it was called then—'and let them know that this has happening, because they're not listening to me.' So she phoned them—and there were a couple of other occasions when my daughter was turning up to the school drunk and they were not happy about the child going. Eventually, I went over to the department and said, 'You really need to do something.'

We had had an occasion where the child had been left at home on her own, even though her mother denied it. There was another occasion where my daughter rang me through the night and said that someone had written in blood on her wall. She was ringing me from the phone box down the street. I said, 'Where is Janae?' and she said, 'She's home in bed.' So you can imagine how I am feeling as a grandparent knowing that this little girl has been left home while her mother is off her head riding down on a pushbike to ring from a phone box to say that someone had written in blood on her wall. Quite a few other things happened too and the school was very supportive. The department stepped in and the child was given to me for a period of three days while they assessed things.

So Janae came to live with us. Three months into this, there was a meeting at the department. So I went to the department. My daughter was sitting there and saying, 'I don't want that m-m-m having my daughter.' I said, 'You know your daughter is safe with me; you know that she is happy with me and all we want is for you to get better.' She said: 'I don't have an effing problem. You're my only problem.' She was in total denial that she was on drugs and she said, 'I'm just a social drinker.'

Anyway, one thing led to another. About three weeks later, I was called over for a meeting at the department. My little granddaughter was sitting there with tears coursing down her cheeks. When they phoned me, the girl said to me, 'You're to come over to the department to say goodbye to your granddaughter.' I said, 'I beg your pardon, what do you mean?' She said, 'This is closure.' I said, 'What are the charges?' She said, 'Your undermining of the department and your daughter does not want her daughter to reside with you.'

That little girl had tears coursing down her cheeks. I took in her blanket. She hid under her blanket. My younger daughter had said that she would take her. My younger daughter at the time had two little girls who were not well and she was taking her out of Christian duty, because she knew that her time was very taken up with the two little girls. She was waiting to hear if the youngest one had cystic fibrosis. She did not; she had coeliac disease. But she still had a lot on

her plate. But my daughter in this meeting was just out—'I just don't want her having anything to do with my child.'

This little girl would not even have known my other daughter, had I not taken her to see her little cousins; she would not have even known them, because my other two children had nothing to do with Penny because of her behaviour—and their lifestyles are very different. So this poor little girl was removed from the only comfort zone that she knew. That was her safe retreat, our home, and she was removed.

We have been assessed by two psychologists, one with the department and one independent of the department, and both had come out and said what a wonderful environment the little girl was in and they saw no reason to change the status quo. But my daughter was listened to. Within a few months the little girl was returned to her mother and I said to the department, 'You are making a big mistake. Things are still not good there,' and I was not listened to again. In the meantime, my little granddaughter, at six years of age, wrote this note: 'My life is so hard to handle. I just can't take it any more. Things have to change.' I took that note to the department and said, 'Act on it today or I'm going to the newspapers.'

The consensus of the people at the department was that a six-year-old would not write that note but, thank God, a new manager had come. I took him other writings of hers and he said, 'Blind Freddy can see that this is the child's writing.' That little girl was so distressed and so frightened—and so frightened of her mother, who kept telling her that her grandmother was this evil witch—that that is how she was feeling. This new manager, thank God, took a different stance and he said, 'I'm going to have you assessed again.' So we were assessed again and once again we came up trumps. So the little girl was returned to me.

Within a few months, once again, my daughter was in another relationship with another fellow and pregnant with the youngest one, who now resides with me as well, and I knew that things were not good there. There was violence and there was drug taking. I was not listened to. Anyway, it came to the attention—I think I rang town, and several things happened and I got the older girl again. So this was twice within a short period of time. Then she was returned to her mother. I did have a good worker from that office at that time who said to me, 'Danni, I really know what you're saying, but I've been told to back off; the case is closed.'

So this little girl has been through absolute hell and no-one was listening. It was all about the mother. I really hope things are changing now. We put in a submission to the CMC and spoke there and I would like to think that things are changing. But the horror that some of these children go through, and not only my own grandchildren, because of their parents is just so unfair and so unnecessary. This little girl should not have gone through what she has been through—no way.

Mrs Newman—Danni, you could have got help from the commission for children. You could have taken the department to a tribunal.

Danielle—I rang the children's commission and they were told by the department that things were fine, Maree. They found out later, and the office that I am now dealing with also found out later, that everything I said was nothing but the truth. But my daughter was 10 times smarter than

those workers she was dealing with. She is a very smart cookie and they really believed her. Of course, it is much easier to give the child back, isn't it—much easier?

Mrs Newman—They do this.

Danielle—That is right.

Mrs Newman—We lose children.

Danielle—And I would love to say that she should have been returned, but I knew in my heart that she should not have been returned. I knew that my daughter was not well.

Mrs Newman—You have to fight them.

Danielle—Exactly, but I did. I went everywhere.

Mrs Newman—You could have gone to the tribunal.

CHAIR—Let it go, Maree.

Danielle—We went everywhere. I was able to see the minister through Margaret Wenham of the *Courier-Mail*, because she knew the work that KinKare were doing. I rang her and said, 'I need you to fast-track me to the minister.' Within an hour his office was on the phone; within two hours my husband and I were in there meeting with him, and things rolled from there. But this is why KinKare is there—because what about the people who are too frightened to do anything? I said to the minister, 'Be it on your head if anything happens to my grandchildren, knowing what I am telling you now, because I will shout it from every rooftop.' I said, 'If you weren't going to see me, my next move'—and, believe me, I was ready for it—'was to wear a placard on my front and on my back and walk up and down George Street.'

Then another little one came, a baby was born, so I was ringing the department yet again. I documented everything. I have documentation this high. I rang and this girl one day said, 'Oh, so what's your latest worry, Danielle?' I said: 'Where would you like me to start? But, before you do, give me your name because I am going to ring up and put in a complaint about you.' At under two years of age, the little one, following her sister, had crossed a main road because her mother was spaced out on a bed. Then things started to move and two years ago on Christmas Eve I got both of the children and they have been residing with me ever since.

My daughter is now in Goldbridge. I would love to say that she is there for the right reasons, but I am afraid that I have not seen any sign of any remorse and I was asking Charlie earlier if that is normal or not. I would love to think she is there for the right reasons. The 11-year-old has decided that she does not want to go and live with her mother again, because she has been through too much and I just hope my daughter is able to see that. With the little girl who is five in April, if I think my daughter is ready down the track for that, of course, I would be very happy—but, my God, she would have to prove it over and over again. But there are so many do-gooders out there and so many of those social workers who say, 'Oh, but it's so important for the child to be reunited with the parent.' Garbage—garbage, garbage. If that parent is not doing the right thing, why should these children be reunited with them?

I used to work three mornings a week. The other two mornings I would drive down and walk my little granddaughter to school. One day she was walking along kicking the road and I said, ‘What’s wrong, darling?’ and she said, ‘Nanna, take me to the department.’ This is from that little girl. I said: ‘I’m sorry, I can’t. I can’t put you in my car. I would be breaking the law. I will take you to school and the school can ring the department.’ I took her to the school and the school rang me at one and asked whether the department had been in touch and I said, ‘Of course not.’ The teacher was absolutely blown away. She said, ‘But I have said what’s wrong.’ I said, ‘No, I don’t expect to hear from them for some time.’

Maree will say that we are hearing stories like this all the time from people—from children who are being reunited with parents before the parents are ready. I am sorry, but I do not know whether I will ever trust my daughter again. It is not what she has done to me; it is what she has done to these children. My daughter said to me recently, ‘I know I have a disease,’ and I said: ‘Of course you have a disease, but you have a disease of your own choice. It is very different from having a disease that has been visited upon you through no choice of your own.’ I am sorry, but I don’t have a lot of sympathy for these drug addicts and these alcoholics. Maybe I am wrong, but we tried when we first heard it and I said to her, ‘All we want to do is help you,’ and all we copped was abuse.

CHAIR—Thank you, Danni. Perhaps we can now hear from Helene.

Helene—Thank you for listening to me. I am here today because I think what we are dealing with is a very complex issue. I do not think there are any simple answers. I think there are some simple things that we can do which would help us all deal with the matter better. I think we need, certainly, changes in the policies that we have at the moment. I think some of our programs need changing radically and I certainly think there is a need for a lot more resources for this issue, which is growing in both demand and complexity for the organisations and the health departments that are trying to deal with it on a daily basis.

I know we need—and this is from personal experience; I have a child who is affected by many of these issues—a lot more early intervention and assessment programs. I think there is a tendency, probably through frustration through the demand of the client throughput, of medicos et cetera to diagnose in a very sloppy way and to do it very quickly as a means of both pacifying the patient and the parents and to get everyone out of the door and on their way. I do not think we can continue to do that.

I think some of these issues that, say, children—and I am talking about adult children—can be presenting with can take sometimes up to six months or more to actually diagnose properly. My experience has been that there will be an initial diagnosis. Then, as in the case of my child, who is at Mirikai, as the organisation gets to know the child more, as he presents more to the clinicians there, diagnosis actually changes over time along with the medication and then ultimately, hopefully, you get some stability.

I think there is a need for more integrated services. There are some really good organisations on the coast doing different types of work, but I do not think the government systems allow for proper integration of those services. I think we need, for example, acute provision services and we need long-term services. Then, because of the complexity of these kids that tend to come and

go through the system, we need a capacity for them to go out and to come back and be topped up, and they will do that many times.

I think we need step-up, step-down facilities, where they can perhaps go through an acute service, come back; they feel better and so they will go to a step-down facility before they then proceed to whatever part of life they are up to. I think we also need to allow for multi-entries into these facilities. Three, four or even five times might not be enough. As a parent I know my child would have needed hundreds of entries, but it is an iterative process. It is two steps forward, one step back. Sometimes it is one step forward and three steps back, but you learn to go with it.

We need transitional facilities where they can continually build on the skills that they develop. Many of these skills that we recognise that these children need—they do not see the value of for themselves. It is only as they look back that they will say, 'I really did need that there.' We need halfway houses. In the case of Mirikai, they have good halfway houses where you will get more stable clients, for want of a better word, working with the not so stable, so there is that good peer support. It is a cheap way of providing services to these kids and it means they are supported by people who really understand them, and I think that is important. I do not think all of the programs we put in place need to be high dollar value programs; I think we can do it in many simple ways.

We need multifaceted programs. Some of the things that people spoke about here today are living skills, financial skills, social skills. These children are lacking very much in many of those skills. Financially, as an example, it is a nightmare. As they reach adulthood, you sort of breathe a sigh of relief and think, 'Oh God, they won't get caught wherever they should not be now because they are an adult.' What that unfortunately allows them to do is to start taking out things like financial contracts. There are predators out there, particularly mobile telephone companies, if I could identify that group, and also computer companies, who target these kids.

In my case, I have a very bright child. He loves that type of thing. He is just a sitting duck for these financial companies who do not do the right checking as to whether they are employed or not. Suddenly you will find they have a three-year contract for about $4,000 or $5,000. Your choice as a parent is that you either pay it out or you leave them to accrue a very bad credit rating. I guess everyone makes the choice that they need to at the time.

I think on the coast and perhaps through the state, there is a need for greater collaboration and communication between the service providers to share the resources. Also, for sure, we need more research. The US, I know, has done a lot of good research. I do not think we take the research from other countries and apply it to our own situation. There are many things that we could learn.

There are a couple of other things I want to raise. One of the issues I have had a problem with is the Privacy Act. Again, as the child becomes an adult, they go into the system and I as a parent cannot get any information out of the system. So I am really cut off and isolated. I do not think that helps either the child or the parent address the issue.

Ongoing love is very hard with many of these kids. You really do love them but at times it really breaks your heart to stick with them. It also breaks the hearts of many members of your

family but you have to keep on going. So I think therefore the families need support, education and also advocacy. I guess they are the main things that I wanted to address.

To sum up, some of the things I have addressed here are mental health, the drug issue, the suicide issue, homelessness—and I am sure many people here would have experienced that—Cash Converters—if I could name them; I think they really need serious looking at—and the hire-purchase contracts. Hopefully they are some practical things that can be considered. Again, thank you for listening to me today.

CHAIR—Thank you very much. Now we will hear from Colin.

Colin—I would like to elaborate on what the last speaker said. My story, which started 20 years ago, up to the present day is basically the same—the same starting and the same ending. It was just the lack of somewhere to go for help. I will go back.

My daughter is 34. My eldest grandson, who lives with me, is just on 16. His brother is 14. I have had one for 11 years and one for nine years, so they have basically lived with me all their lives. My daughter started taking drugs—we were unaware of it—20-odd years ago in Sydney. Being squareheads—that is what they call us, squareheads—we had no idea of what she was doing until there was a knock on the door from the police one day, when she was only about 14½. They brought her home from a blue-light disco. We had a talk to the policeman on that day. As I said, she was 14½. He said, 'I think your daughter is on drugs; can you do something about it?' I did not believe him—not a 14-year-old kid. He said: 'Yes, there's a few of them. We're taking a few of these kids home.'

Anyway, we let that go for a time. I said, 'It couldn't be.' About three months later, there was further trouble with her. So we decided to book into a counsellor, and there were some people in Maroubra in Sydney. By the way, the police had made a report on her at the police club regarding this blue-light disco situation. They took her name and everything. It was known, and they did say in the report that they felt she was taking drugs. At that stage, she was getting in trouble at school all the time and, when we went to the counsellor, the counsellor said, 'What do you want to do about it?' I said, 'What do we do for help?' This was 20 years ago. He said, 'Unless she really wants to participate in something'—and at that stage he had interviewed her himself and, of course, she denied everything. I said, 'But she's only 14; she has to do what we say. Surely we can put a plan in place to go to somebody and talk about her problems,' which, at the time were quite apparent from the school and also the police, and he said, 'No, there is not. There is nothing in place.'

So we started to put something in place with private psychologists—I think they were at the time; I am going back 20 years—or a psychiatrist. Prior to this she had heard about it and so she took off. She was not quite 15; she was about 14 and nine months. She left home. So away she went and we could not find her for weeks. She had joined the street gangs, and they were all on drugs and everything. Apparently, at that stage, at that age, she had applied for and obtained a living away from home allowance or something from, I think, the federal government.

CHAIR—Yes, it was.

Colin—I said, 'This is unbelievable.' I ended up going around with the police and finding her. He said, 'She's living at so-and-so; you can't bring her home.' I said, 'What's going on?' I had to go and see a solicitor. Things went on and on. Things led to other things and we just could not get any help.

At the time Bob Carr was my member of parliament, and I went and saw him about it. He said, 'Unless she wants to do something, Col, we can't do anything.' I was up against a brick wall. All through that stage I was right up against a brick wall. Then she got tied up with other people. At the age of 15 and about nine months she got arrested and was taken to the Children's Court. I think the magistrate was Margaret Holgate—is it Margaret?

CHAIR—Barbara.

Colin—Barbara Holgate. She was there and I had a good talk with her after she had sentenced her to, I think, a couple of months in Yasmar in Sydney. I said, 'We've got a problem here, but it's a drug problem. She's drugged up all the time.' By that time her hair was bright purple and she used to wear these pants. But we could not get any help.

She went to Yasmar, and that surely should have been a sign to someone that this girl needed rehabilitating, or some help, somewhere along the line, because at that stage she was not even 16. She did a few months in there and came out worse. Then she ran off with a fellow who was in there and received this allowance again. Things went on. She lived with this fellow in a commune for two years. At that stage, my wife and I did not know what to do. I got a transfer in my business to Brisbane and lived on the Gold Coast.

A couple of years later my daughter, at the age of 17½, landed on my doorstep heavily pregnant. By the time she had the baby she was 18, and I tried to get her and the baby into places like Mirikai and other places, but she was unwilling to go. They said, 'If she is not willing to go, we cannot take her,' which was fair enough. This led then to her leaving my place. As soon as the babies were born, she left there and off she went with these de factos and that. Violence erupted down the track. The first chap killed himself at the age of 21, one committed suicide, then she had a couple of other de factos. They both got sentenced for attempted murder. She drove the car and he tried to kill the other chap, so she is still in jail.

I will get to the point of where the frustration is. She was sentenced to eight years, 6.7 of them non-parole. The de facto who was with her got 12 years and he has to do 10 years. This was seven years ago, by the way. She is over the 6.7 years and is due to come out. She needed to be assessed. She was assessed prior to going in—prior to this court case, actually, so it was brought up in the court case—as severely drug dependent and bipolar. She was sentenced and went to jail. I had a good meeting with the department and I asked them what could be done for her. They said: 'For the bipolar, nothing. We are not treating that. For the other, she has to do a certificate in substance use.' I said, 'What does that do?' He said, 'Well, she gets a certificate.' I said, 'Oh, that's nice.' That was the assistance I got from the Department of Corrective Services. She went and did the course and got a certificate of substance abuse but no treatment for the bipolar.

We will speed time up. Last year she got sent to Numinbah and she is nearly due to come out. Of course, there are no drugs in the jail! Two months prior to coming out she was caught with

heroin—taking heroin, that is; they call it 'dirty urine' in jail. She was then sent back to Brisbane Women's Correctional Centre. In between times I asked the parole service: 'Why isn't this girl being sent to rehab? Why isn't she being sent to something? What are you going to do with her? What is the plan here? What is your plan of attack? In November she will get out. She will walk out the gate.' He said, 'Basically, yes.' I said: 'She has applied for parole again but she has only until this November before she's done the full eight years. What is in place?' He said: 'Nothing. She comes out.' I said, 'Where are you going to place her?' He said, 'Can you look after her?' I said: 'Well, you had better see the department of families. I have her two grandsons with me.' He said, 'All right, we will.' They asked the Department of Child Safety, which said: 'What? You're kidding! She's not going back to them.' So that ended that. I said, 'What will she do now?' He said: 'I don't know. You'd better make application through the Salvation Army or someone.' They refused her. The Salvation Army apparently said that anyone on a charge of attempted murder—a sexual case or murder—is not allowed into—what is it called?

CHAIR—A halfway house?

Colin—Fairhaven, at Southport. They will not allow them in there. So I said: 'What are we going to do? What is in place for people like my daughter?' She is, by the way, typical of the majority of cases in the prison system.

Mrs Newman—Yes, nearly 85 per cent of them.

Colin—I said, 'What's in place for these people?' They said: 'Nothing. They get out the door. We'll open the door.'

Ms Alcorn—It is a real problem.

Colin—'We'll let her out in November.' I said, 'Okay.' In between times the application for parole went in and she made application for the three children—there is another one in foster care. The eldest one is smart enough. He is just on 16 now. He said he wants nothing to do with her. He has barred her because of all the bashings from the de factos which happened years ago. He remembers. He has a good memory. So she dropped him out of it, but she wants the other two. At the moment we are proceeding through the court. We go to a hearing next week and she goes to court in early to mid-April for access to these children from November. She probably will not get it, but what I am getting at is: what is being offered? What happens to these people once they walk out of the prison? That gate is going to open in November and she is going to walk out of Numinbah and get a bus—unless I pick her up. What is next? She will go back again. Of course she will. There is just nothing in place.

Ms Alcorn—That is a universal problem. It costs $80,000 when they go back. They have no friends, so they go and find the ones they got in prison, they get together and go back in, and that is another $80,000 a year. If they could go to therapeutic communities on the way out—if there were special ones set up for them—and residentials, and we could do some work with them, it would cost $30,000 a year. At least they might have a chance.

Mrs Newman—Are you saying it should be mandatory?

Ms Alcorn—If they are drug affected.

Mrs Newman—It should be mandatory that they go to residential—

Ms Alcorn—When you are in prison, you cannot cook and you are not taught anything. Prison up here is about buying some Nikes, with the money that you put in to help them, and watching telly. It is not about work or rehabilitation.

Colin—There is no rehabilitation.

Ms Alcorn—They need life skills when they have been in—

CHAIR—The way they treat women up here is pretty dreadful—having taken evidence from sisters inside. Colin, has your daughter shown any indication that she wants to change?

Colin—My daughter is very good at improvising answers to questions. She could go to any counsellor and talk them around that she is sane, because she is so clever. Knowing her back in the early days, I am certain that she was bipolar before she had the drugs. I will guarantee it, because I knew her as a 12-year-old. There was something different about her. One day she was so happy and the next day she was so down on life. She used to make signs: 'life sucks' and drawing the devil. She was doing that from 12 years of age. We were just a normal family. We have a younger daughter who is terrific; she never showed any signs of this stuff. This was just completely contrary to what we brought her up to be and what the thinking was. That was happening from years 11, 12 and 13—those drawings that you see with arrows, skulls and the devil. Every number was 666 and all that sort of stuff at that time. Then she started drawing eight-balls. She used to go to a Catholic school and the nuns would not know, of course. She would draw eight-balls, which is heroin.

CHAIR—Is it?

Colin—They draw eight-balls—that is, amongst the druggies. She was doing that in those days.

CHAIR—She must have known that—learnt it somewhere.

Colin—She was showing these things beforehand. The next day she would want to play sport. She would go to tennis. I took her to tennis lessons. Also, she was in Terry Buck's class—he has since died. He was one of the leading swimming coaches and she was in his squad. He had the Australian squad and she was in the squad under him at that stage. She was doing terrifically at Heffron Park. The next minute—

CHAIR—So what you are saying is that, perhaps if you had been able to detect that at that stage and had the right medication, it might have been a different story.

Colin—Of course.

Ms Alcorn—For all of us.

Mrs ELSON—There is another group around now, too, which preys on children from the age of 12 up. It is called 'Emos', which is short for emotionals. They do exactly the same thing as

you just described. On the internet you can see the rubbish that they put on there, telling the young kids at the most impressionable age how bad this world is, how life is not worth living and that drugs are the only way out. That is being fed to all children.

Colin—I would like to sum up, if you do not mind. My eldest grandson is almost 16. He has been under pressure. We were talking before about what we should do—what sort of a program there should be for these children. I disagree in a way. To my grandson, the Grim Reaper has been his mother. He has been lucky in that way. His mother has been the Grim Reaper, in effect. He does not have anything to do with her and he calls her stupid after he has had a conversation with her. I said, ‘That’s what it does to you, Mate. She’s been on good drugs for 20-odd years.’ He understands all that.

But, in saying that, two years ago he went to Palm Beach Currumbin, which is an area up here full of one-parent families. He went to the school there and all his friends are in that area. It is well known here what sort of an area it is. Taxis will not go there and the police are having all sorts of trouble there. I said to him, ‘Mate, what are they doing with the drugs there? You’re at the age where they’re up to—’, and he said, ‘Everyone’s got pot; everyone.’ I said, ‘What are you doing?’ He said, ‘Well, have a look at my mother. What do you want me to do? What do you think I’m going to do?’ I said, ‘Someone—one of your friends, one of your good mates, one of the better footballers in the side—is going to offer it to you and you’re going to think it’s the thing to do, because he’s the top footballer in the side or whatever.’ And he said, ‘Oh, no. Nah.’ I said, ‘But you’re going to be offered it and it’s going to be very difficult for you to knock back getting into it.’ And I said, ‘With your genetics, from your mother, probably you’re going to have a hard time getting off it if you get on it, because she is addicted. She is addicted and I have had addiction go through the family.’ And he said, ‘I’ve got a problem, then, because they’re all on it.’ When he sees his mates when he goes there, a lot of them are in trouble.

The year before, I took him out of there and sent him to a Catholic college in Yeppoon called St Brendan’s College. Now he is completely different. He had come down and he was going to start an apprenticeship. But he came to me the other night and said, ‘Is there any chance of going back to St Brendan’s?’ I said, ‘Why is that, mate?’ And he said, ‘Well, they’re much better people up there.’ He said, ‘The pressure from going and seeing my mates down in Palm Beach—I’d rather have two years away. Can I finish my schooling up there?’

Mr QUICK—Very good.

CHAIR—You have said yes?

Colin—Oh, did I what! I didn’t disagree with that! But I think that if there’s going to be a program for these children—I have spoken to him about it and he is at the age where I can talk about it with him: 15, 16; that is the time to start with them and I would have liked to have started then with my daughter—instead of putting the fear into them, there should be a good sports star or a music star—someone like a Darren Lockyer or a Webcke or a Michael Voss; someone like that—who can say, ‘Listen, this is the message.’ And they will listen to people like that because they are their heroes.

CHAIR—But they had one of those hero type females on television the other day—

Colin—I know—

CHAIR—saying, ‘Drugs are great.’

Colin—And the biggest footballer, Wendell Sailor, got caught—look at that. So what do you do? But I think you can counteract it by having role models like them talking to young kids of 16. Well, it may not work. I don’t know.

CHAIR—First you have to find one!

Colin—You have to find one, yes. Thanks very much for listening.

CHAIR—Colin, thank you very much. It was a very human story. But it sounds like your grandsons are doing all right?

Colin—They are going to be okay.

CHAIR—They are doing all right?

Colin—Yes, so far. The worst of it will come, though, in the next few months. When she gets out, we are going to have to fight everyone again, although the Department of Child Safety are sticking with us and not bending one way with her.

Mr CADMAN—There is a bit of a story there, though. It is very hard when parents hit the wall. There is not much choice about what you can do, is there?

Mrs Newman—I like what Bronwyn suggested—a recognised place that you can take the problem child to. We need that. And we do not need it to be a small organisation; we need the government to stand up and say, ‘Hey, we’re going to help the kids of Australia.’

Ms Alcorn—The families of Australia need it.

Mrs Newman—But it is the child that needs the treatment. You have to have somewhere to take that child to. What you said earlier I really agree with. We must have a recognised body to take the children to. The families need the help to take the kids, but it is a two-for-one deal.

CHAIR—Is there anyone else who wants to make a statement?

Ms Lynch—We spoke quite a bit about people going into rehab wanting it, and, sure, that is a big part of it. But I just want to say that I have seen a lot of people coming to rehab not so willingly who have had quite a significant turnaround during their time in rehab. So just so we are not too concrete about that: not everyone wants to be there, but even those who do not want to be there can get some positive benefit from it.

CHAIR—We have one other person who wants to come and make a statement, so we will invite him up. When we have done that, we will go on our inspection. Welcome.

Christopher—I heard over the radio this morning that this was taking place, so out of curiosity I came here. I am doing a seminar series down at Mirikai. From personal experience—do you want any of my history or shall I just go into what I was going to say?

CHAIR—Say what you would like to say and then you can tell us that.

Christopher—I used heroin for five years but never became physically addicted to it. I saw people go under and they did all their stuff. I thought I was really head-smart and never used more than two days in a row—this is just to give you some background as to where I am at. And then I became addicted to it because I used it for seven days once, against all my policies. I became addicted and it took seven years for me to realise that I had to stop. In those seven years—this is where it is important to this forum—I would get windows of opportunity to get out. I would feel like I could go to rehab or detox and everything like that but, when I would get on the phone to get in contact with HADS up in Brisbane, there would not be a place available. The feeling of 'okay, I've had enough, I can get out' would disappear. I would go back into it. It was a subjective view, feeling like I was back in the run of things—that was my employment—and that was what would happen. I have not used for 2½ years and I am running my own business and things like that. Life could not be better. It has been a hard journey. It really is hard.

CHAIR—Well done, Chris.

Christopher—There is so much more to it. I can empathise with a person who is in drug addiction. There are opportunities to get out and they are very fleeting. There needs to be a bit more money at the coalface or for support for someone to get away. As I said before, it is very important that, if someone goes into rehab and are not really willing, they get time away from it. It is not like you might detox in a week; it takes a long time, a couple of years in my case, before feeling normal.

CHAIR—Well done.

Ms Alcorn—You are to be commended. So you are doing a drug awareness course, are you?

Christopher—I am down at Mirikai.

CHAIR—We are going down there next.

Ms Alcorn—What are you doing down there?

Christopher—I am just doing it for curiosity's sake.

Ms Alcorn—The drug awareness course on Monday nights?

Christopher—Yes.

Ms Alcorn—We run a drug awareness course.

Mr QUICK—What message would you give, for example, Colin's daughter? If he went to a high school and said, 'This is me; I'm Colin', what should he say to kids in years 10, 11 or 12?

Ms Alcorn—It is too late in years 11 and 12.

Christopher—In a sense it is. The culture at present is to partake in drugs. But it is about giving them information even if, 'Okay, it's probably going to happen.' I knew all that—I did. There was enough drug education out there. That is why I did not use for more than two days in a row. For me it was a depression issue and I can relate to that. I have got dyslexia and I feel a bit inferior to others. It was beautiful and I used because it was great to feel good. Where other people naturally have resilience or self-esteem, it was so much easier for me to buy it in a packet in a sense. I knew that, but it was all balanced out.

What would I say? I would give them the facts straight up: if you do it too much there are consequences. The addiction thing is the phenomenal aspect to it. As soon as you go over that threshold, it is like you are in the back seat; you are on a treadmill.

Ms Alcorn—Not in the driver's seat.

Christopher—You can have all the agency you want and you can be saying, 'I don't want to do this,' but you will just end up doing it. It is a really disturbing period of someone's existence. That is all I can really say. I would give them some awareness. 'Don't do it in the first place' is definitely the go. I would say: 'Look for some other way of getting a high.' There are natural highs and everything like that. 'If you do step into that realm, there are counsellors and everything. This is what to expect. Here is a great motivator.'

Mrs ELSON—Can I ask a question of you, because you did say something that was very interesting before. I read a report recently where they were warning parents that, if you have a child that has dyslexia or has difficulty in learning at school, that is when you should be getting help for your child—

Christopher—Yes.

Mrs ELSON—because studies have shown that there is a very high percentage of those children who end up using drugs. Were you very vivacious at school and hiding that? Were you a popular person at school? They were saying that, in the majority of cases, the kids show a facade. They become popular, but underneath they are hurting because they have not had help for their learning problem and that leads to taking drugs, just like you said, to make them feel better. Have you got friends who had problems learning at school have and took drugs?

Christopher—Yes, it is quite common.

Mrs ELSON—That may be where we have to start looking—in the classroom, at the very early ages, at children with learning problems.

Christopher—Yes, definitely.

CHAIR—We are very grateful that you were listening to the radio this morning and came along. Is that where you heard about it?

Christopher—Yes.

CHAIR—I am so pleased you did. Congratulations on running your own business and making it in your life.

Christopher—Thank you. It is a great pleasure to be somewhere where I want to be. I had all these goals and ambitions and you cannot do that while you are a drug addict. You can do some things, but in the end you are just wasting your life.

Mrs ELSON—Have you been tempted since and said no?

Christopher—I have been in situations where I could say that the opportunity has arisen where I could have. But I have really changed.

CHAIR—You are over it.

Christopher—That is it; it is over. It took so long—seven years of bashing myself and saying why can't I just go back to being like, say, an alcoholic having a social drink, until I got to the realisation: no, it is all over. It has to change, period.

CHAIR—So you were your own motivator.

Christopher—Yes. I have had a lot of help. I talked to a lot of people and everything like that, but it really came down to me.

CHAIR—Once you had made the decision, people helped you. But the point you were making to us was that you felt there was a moment while you were using where, if you could have connected with someone straight away, you could have got on that path earlier.

Christopher—Yes, definitely. There are windows of opportunity.

CHAIR—I would like to thank everyone very much for taking part in the roundtable today. It has been so illuminating. We have heard so many different ways of expressing what has happened to you and to those you love. Different solutions have emerged, and everybody said that what we need is more resources, which is pretty self-evident, but we have to make sure they are applicable for outcomes, don't we? I declare this meeting closed. Thank you very much, everybody.

Resolved (on motion by **Mr Quick**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 2.33 pm