



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Reference: Impact of illicit drug use on families

WEDNESDAY, 14 MARCH 2007

PERTH

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **<http://www.aph.gov.au/hansard>**

To search the parliamentary database, go to:
<http://parlinfoweb.aph.gov.au>

HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Wednesday, 14 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 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

ALCOCK, Mrs Judith Ann, Parent/Volunteer, Parent Drug Information Service.....	53
HAMILTON, Dr Dale Francis, King Edward Memorial Hospital.....	11
HARRIS, Ms Sandra, Parent/Volunteer, Parent Drug Information Service	53
HARRISON, Mrs Celine, Head of Department, Social Work Department, King Edward Memorial Hospital	11
HENDERSON, Mrs Claire Joanne, Chemical Dependency Service, King Edward Memorial Hospital	11
HERBERT, Mrs Wendy, Spokesperson, WA Coalition Against Drugs; Fellow, Drug Free Australia.....	24
HODSON, Ms Jo-Anne Lynn, Manager, Pregnancy, Early Parenting Illicit Substance Use Mums and Children Program, Women’s Health Services	65
KERRY, Private capacity.....	24
LENTON, Associate Professor Simon, Deputy Director, National Drug Research Institute.....	38
MULLINS, Mrs Geraldine Mary, Founding Member, Adviser and Spokesperson on Illicit Drugs, WA Coalition Against Drugs	24
MURPHY, Mr Terry, Executive Director, Drug and Alcohol Office, Government of Western Australia.....	1
RAESIDE, Mrs Lee-Anne, Coordinator, Parent Drug Information Service.....	53
REID, Ms Fiona Katrina, Outreach Counsellor, Pregnancy, Early Parenting Illicit Substance Use Mums and Children Program, Women’s Health Services	65
THELMA, Private capacity	24
WILKES, Professor Edward (Ted) Thomas, National Drug Research Institute	38

Committee met at 8.34 am**MURPHY, Mr Terry, Executive Director, Drug and Alcohol Office, Government of Western Australia**

Witness was sworn—

CHAIR (Mrs Bronwyn Bishop)—I declare open this meeting of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drug use on families. We have a full program ahead of us today. We will be taking evidence from the Western Australian government, the antenatal chemical dependency clinic at King Edward Memorial Hospital, the Coalition Against Drugs of Western Australia, the National Drug Research Institute, the Parent Drug Information Service and Perth Women's Centre. We look forward to hearing their professional and personal perspectives on the impact of illicit drugs on families. The public are welcome to observe this public hearing, and a transcript of the evidence gathered today will be available on the committee's website.

We have received submissions from the King Edward Memorial Hospital for Women and the Coalition Against Drugs of Western Australia, and we have received a further confidential submission from Mrs Herbert of the Coalition Against Drugs of Western Australia. Is it the wish of the committee that these submissions be accepted as evidence? There being no objection, it is so ordered.

I now welcome our witness from the Drug and Alcohol Office of Western Australia. Would you like to make an opening statement?

Mr Murphy—I will make a few points and touch on the terms of reference, and then obviously I am open to any questions. My first point is in relation to the first term of reference, the impact on families, particularly with reference to mental health. There is no question that illicit drugs have an enormous, destructive effect on families. We all know that and that is obviously why you have set up the inquiry. Our challenge in the drug and alcohol sector and as governments is to respond to that with appropriate policy balanced between the competing demands for safety, treatment and prevention and to ensure that our services are sensitive to the needs of families.

With regard to the mental health impact, it is worth noting that most mental health problems associated with illicit drugs are depression and anxiety, not psychosis. A fairly small minority of people who use illicit drugs become dependent on them, do suffer psychotic symptomology, much of which naturally resolves and some of which does not. It then becomes a diagnostic question as to whether it is the chicken or the egg—whether the illicit drugs have precipitated a latent mental illness or been the cause of that.

CHAIR—And some die.

Mr Murphy—Some die; however, not as many as did during the heroin epidemic when a very large number of people died from illicit drugs. I do not want to give any sense that I am minimising these problems. We put in an enormous effort to tackle them on that range of fronts.

Coming to services for families, the position of the Drug and Alcohol Office, the position of the government of Western Australia, is that services for families are as important as services for the individuals affected by drugs. Western Australia has a long history of responding to the needs of families. Agencies such as Holyoake and Palmerston 20 years ago set up services orientated to families.

Ten or so years ago we developed a major program of increasing the sensitivity of agencies to the needs of families so that their needs were included as part of the management of individuals. That was a philosophical shift for some agencies—Holyoake and Palmerston were well across it, but others needed to shift to include families as part of the total picture and make them as much a priority as individuals. The current situation with general services for families is that our core network of services—the community drug service teams—provide family support programs along with a number of other specialist agencies. So if a family needs or wants support they can get it and that is with other families having the same sort of experience.

We also have a number of absolutely specialised services, a number of which you are hearing from today. I would just mention—and you have quite a long session of evidence with them—the Parent Drug Information Service, which is quite a unique and highly valued service by the Drug and Alcohol Office. It is part of the Drug and Alcohol Office. They have a specialist phone line for parents whereby they can speak to other parents who have been through the mill themselves. You will hear the evidence from the Parent Drug Information Service. The main point I would like to make is that that has the full support of the Drug and Alcohol Office and the government of Western Australia and is seen as a very important way to provide readily accessible support to parents.

Other specialist services you will hear from today are the King Edward Memorial Hospital Chemical Dependency Service and the Perth Women's Centre, which offers support for young mothers and their children. You will not be hearing from one of the other main family services we have, called Sarana, part of Cyrenian House, which is a residential program for mothers and children. Once again, this is a very important part of helping those people who are generally very socially isolated and socially disadvantaged. If they need a major intervention, that is there. It has only eight beds at the moment but we are hoping to expand that over the coming year or two.

One of the 10 priorities of the Drug and Alcohol Office at the moment is building systematic linkages with the Department for Community Development, which is about to become the Department for Child Protection. We see it as essential that our core services—the community drug service teams and the main agencies—have formal and robust linkages with the child protection services. Together with the King Edward maternity services, they form a whole for, once again, a very vulnerable group of women who are generally severely isolated and disadvantaged.

Turning to your second term of reference, the impact of harm minimisation on families, forgive a departure into semantics, but the National Drug Strategy has created a somewhat unique definition of harm minimisation. It is really designed to be a catch-all for strategies to reduce demand for drugs, supply of drugs and the harm created by drugs. Harm minimisation is often therefore confused with harm reduction and that set of strategies that accept that drug use occurs and seeks to reduce the harm accruing. It is very difficult therefore to say what the impact

of supply reduction strategies is on families. The less drugs there are, the less drugs are used and the better off families are.

Turning to harm reduction strategies, which tend to be the focus of political debate, I think everybody involved professionally in the drug and alcohol sector, in developing drug policy and drug strategy, knows that there are trade-offs in drug strategy. In this state, we provide 3½ million needles and syringes a year. There is no question that that has been a very successful strategy in preventing an HIV epidemic in this country. We are reasonably confident—but less so—that that is reducing the spread of hepatitis C. Equally, it would be naive to suggest that there is no impact on how drugs are used or on drug use culture, but that is a trade-off we knowingly make.

When assessing the impact of those sorts of strategies on families, once again that has to be balanced against the nature of drug use in the community—drug use is driven by supply far more than by ancillary programs and our response to families. Our view is that that is the most important point at which we can ameliorate the impact of drugs on families and provide direct support to them.

Your last term of reference—ways to strengthen families—is, frankly, far more difficult. I would have to say that beyond direct service support to families that are affected by drugs—which is important and does strengthen families through times of acute or prolonged crisis—the levers to strengthen families are not in the hands of the drug and alcohol sector. This goes to things like income support, family support payments, the availability of child care and the strength of our communities, which in turn depends on things like employment and our other efforts to support the connectedness of communities.

The drug and alcohol sector has a very important role in providing direct service support to families. I will finish by repeating what I said at the start, which is that the Drug and Alcohol Office sees services for families as being as important as services for individuals affected by drugs.

CHAIR—In looking at families and the use of drugs, there are basically three problems. We have the young people in that vulnerable age group from 14 to 26 who are using drugs and therefore causing a problem for their families—their siblings and their parents. We have the appalling situation of parents who are totally drug dependent. Their children are abused or neglected, very often resulting in grandparents having to become the legal guardians of those children—and we have learnt, from evidence, about the impact on unborn children. Then there is the problem of a policy that seems to be very fashionable in government bureaucracies, which is that children must be returned to their parents no matter what—that biology is important. As a result of that policy, 94 children have been killed in New South Wales, and we have heard that 97 children were killed by that policy in Queensland. How many children in Western Australia have died because of this insistence on children going back to their biological parents?

Mr Murphy—I would make two points. One, I do not have the figures at hand. However, the number of deaths reviewed by our own child death review committee is a much smaller number than that, and it is not possible to isolate where that specific approach towards a bias towards reunification of biological families has resulted in a death. We in this state have just had a review of our child protection services. The Department for Community Development is being

redeveloped as the Department for Child Protection. I think we will find that there is a very robust attitude towards the protection of children being the first and singular priority of the department and that the long-term planning for those children seeks to achieve permanency at the earliest possible juncture.

It is my understanding that Victoria has an approach whereby within something like 90 days they are obliged to make an assessment as to whether a child needs to be permanently placed away from their family or there is potential for reunification. This is not my area of expertise. However, I think that that policy approach, while you may argue about the arbitrariness of the time, is being reflected in the redevelopment of our own child protection services.

CHAIR—Let me put it this way: in your experience, how many children are placed back with a drug dependent parent? How many instances of that would you have and what tests do you apply?

Mr Murphy—These are areas more for child protection than for drug and alcohol services. From the drug and alcohol services perspective, a statistic that we use, which I think gives the other side of the picture, is that of all those children in the care of the CEO of the child protection department, 57 per cent come from drug dependent families. That is a very high proportion and I think it would indicate that there is a readiness to bring those children into state care. Notwithstanding that, every piece of literature on child protection will tell you that state care is not a first resort and the challenge of state care for children is not to do more harm than the situation from which they are removed.

CHAIR—Mr Quick and I were both on the inquiry into overseas adoptions. In the course of that we became very aware of an anti-adoption attitude that exists in bureaucracies—that this biology-first policy seems to permeate all childcare services. Everybody says it is in the interests of the child, but there is very little evidence that that is really what is happening. You tell me that 57 per cent of children come from drug dependent parents and yet we insist on putting them back with them.

Mr Murphy—Once again, I cannot speak with authority on behalf of the child protection department, but I do think that that approach is not absolute. There is always a bias towards children being with their families, because, in fact, if families can be supported to become functional, then that is the best place for children. The dilemma of bureaucracies, child protection workers and their management and governments who support them is making the decision as to when the harms and the risks are too great to leave a child in those circumstances. With the recent review of our child protection services in Western Australia, I am confident that there will be greater clarity as to when children should be removed from their parents, when alternative placements should be sought and when those placements should become permanent.

Mr QUICK—You mentioned that there is strong and robust liaison between departments. As an ex-teacher I would be interested to know the linkages between the education system, the juvenile justice system, the health system and perhaps the housing system. Which one takes priority? If the manifestation is antisocial behaviour in the classroom, the normal thing nationwide is to suspend the child. The child is excluded from the school and there is a supposition that someone is looking after the child. Usually the police department end up picking up the child in the mall for being antisocial and the like. How does that sort of system

work? We have half a dozen case managers for one particular family because there are two or three people within a family structure that are known offenders or the usual suspects. How does that work? You say here that services for families are just as important as services for the clients so how do you drag all that together?

Mr Murphy—That is the endless challenge for government: to make the systems connect and to connect not for everyday work but for the most difficult cases. We have a number of key linkages. We have to have strong and robust linkages with the child protection system for the very reasons that the chair was outlining. Secondly, we need strong linkages with mental health services because of the overlap in our clientele. Thirdly—and this is the most developed area of our interaction—we need strong linkages with corrective services because of the overlap, once again, in our clientele.

In respect of drug and alcohol services, I think we have very strong relationships with corrections. We are developing formal relationships at a local level with all mental health services and we will be doing the same with child protection services. With education, in this state the Drug and Alcohol Office funds school drug education. Part of school drug education is what we call the In Touch program, which is an early intervention program for kids in strife as identified by teachers, referred to student services, and then linked with drug services.

Mr QUICK—Is there a mandatory reporting system? With all of the telecommunications networks that we have available to us, if someone at a particular high school is suddenly brought to the attention of the worker at the high school, are they then linked in automatically through computers to social workers? What is the waiting list? Supposing there is a new client at the high school whose behaviour is totally out of character but obviously he has taken something over the weekend: how does it work?

Mr Murphy—Services are neither mandatory nor highly technological. But the way the In Touch program, in conjunction with student services at schools and treatment services, should work is that the teacher is usually the person who would identify somebody who is vulnerable and who is obviously taking drugs to some extent. They would work with the student services group, and all high schools have student services that variously comprise youth worker, social worker, psychologist, nurse and school chaplain. A number of those professionals cover multiple schools but each school has an identifiable student services team. They would look to effect referral to drug treatment services, if that was warranted and if they could not manage the issue themselves.

Mr QUICK—Is that prior to the thought of exclusion?

Mr Murphy—Absolutely. The rationale for the In Touch program is that suspension really has got to be the last option. Schools need the lever of suspension from school. Some behaviour is so outrageous and so destructive to other members of the school community that it warrants exclusion. But we know that people who are excluded from schools get worse. They do not get better—not everyone, but the majority. For some it is wake-up call and they will get better, but a lot of people—perhaps the majority—get worse.

Mr QUICK—Is the In Touch program right across all of the high schools?

Mr Murphy—It is right across all of our high schools and has been adopted nationally as well, but I am not as familiar with the roll-out nationally.

Mr QUICK—On a different tack, you mentioned that there is an eight-bed specialist centre and that is not enough beds. Are there any centres that allow parents to remain as a unit with their children here in Western Australia? It would be great to keep the family together rather than mum or dad being removed, going through a treatment process and then the rest of the family having to cope as best they can. Do you have many centres throughout WA that cater solely for families?

Mr Murphy—Not for whole families. The Sarana program at Cyrenian House caters for mothers and their children. Those mothers tend to be single mothers or they choose to go there just with the child. Unfortunately, single parenthood characterises a lot of women with drug problems and with children. We have one rehabilitation centre that takes whole families. That is Miaaya Rumara, an Aboriginal service in Broome in the north-west.

Mr QUICK—As to the number of families seeking assistance, what sort of percentage increase over the last five years has been seen in WA?

Mr Murphy—I would have to refer to the figures but, that said, I am very confident that it is stable. Our client treatment numbers have been stable over that period, certainly over the last three years. The latest research or survey evidence on illicit drugs—the National Drug Strategy Household Survey from 2004 and the Australian school students survey from 2005, which has been more recently released—show illicit drug use diminishing. It does come in waves—we know that. But we are very pleased to see the level of cannabis use going down. The level of amphetamine use we are even more pleased to see going down in both of those surveys.

CHAIR—That seems to be at odds with other evidence, I think.

Mr Murphy—I am sure it will be.

CHAIR—Like that of the Federal Police.

Mr Murphy—In this state the amphetamine statistics show use going down, police seizures going up and the proportion of treatment services, where the problem of people is amphetamines, at a very high proportion. In this state it is 22 per cent, which is double the national average. Each of those statistics for Western Australia is going in the right direction. Police seizures going up—

CHAIR—That usually means that use goes down.

Mr Murphy—Unfortunately, no. It usually means that use is going up. You can see that during a heroine time. Police seizures usually reflect the amount of supply. They get a proportion of the supply. The higher the amount of supply, if the proportion remains constant, the higher the level of police seizures.

CHAIR—We have taken evidence from the Federal Police who look at not only seizures here but also the action that they take overseas that prevent them getting here in the first place,

particularly precursors for amphetamines. Indeed, they have produced the Australian Federal Police Drug Harm Index. They say that between the years 1998-99 and 2002-03 it is estimated that Australia has been saved \$3.1 billion in expenditure by keeping these drugs off the streets, out of Australia and not in people's bodies, causing them to need hospital services or the sorts of services that you give. By prevention we have saved an estimated \$3.1 billion. That is a pretty significant indicator of the work they are doing.

Mr Murphy—Absolutely.

CHAIR—I want to ask you two questions. In all you have talked about, I did not hear much about prevention of use—stopping kids from getting addicted in the first place. In 2004 the Australian Institute of Health and Welfare said, for children 12 to 20, that the major reason people take drugs in the first place is curiosity—an average of about 80 per cent; peer pressure is around 50 per cent, to do something exciting, enhance experience, take a risk, feel better, family, relationship, work or school problems or traumatic experience is right down low at between four and eight per cent and to lose weight is 1.6 per cent. In other words, most kids start because they want to see what it is like and because we use words like 'party drugs' 'recreational drugs' and we talk about 'harm', we do not talk about destruction or things that really happen to people.

I asked the Australian Institute of Health and Welfare and Mr Keelty whether there was a need for a full-on advertising campaign to tell people exactly what can happen to them. The influences that stop people from taking drugs are top of the list 'just not interested'. Others are that they do not want to become addicted, they do not want to be out of control and they do not want to break the law. Right down the bottom of the list is because they had some education—2.7 per cent. If curiosity is the biggest factor where is the countervailing information that they become really aware of? They told us that the smoking campaign has been very effective, particularly the one with the disfigurement of the face, because they do not think they are going to die but they do not want to be ugly. Also the AIDS campaign was very effective because it scared the living daylight out of people. It is a long time since that campaign and AIDS is now on the rise again. Would you welcome such a campaign—would you see its effectiveness?

Mr Murphy—Absolutely. If I can pick up on three points: prevention, party drugs and supply, where you started.

CHAIR—Do not forget recreational drugs, which is the foulest thought.

Mr Murphy—Quite. Firstly, on curtailing supply, there is no question that that is essential. With respect to amphetamines in Western Australia, the increase in police seizures is absolutely going in the right direction when it is coupled by decrease in use. That is how we want to see it. Cutting supply is the first arm of prevention. Words such as 'party' and 'recreational' drugs, I agree entirely should not be used. Both the Drug and Alcohol Office and the WA Police at the end of last year adopted a policy to avoid the use of words such as 'party', 'recreational' and 'dance' in order to not afford illicit drugs a positive connotation.

I do believe—and it is the approach taken by the Drug and Alcohol Office—that we need to tackle a pro-drug culture that can grow up amongst young people. In terms of prevention overall, I am very proud of the coherent prevention approach we have here in Western Australia, but I want it to grow. There are three main prongs to our prevention. The first is public health

campaigns—the Drug Aware campaign was begun 10 years ago and is still active, but there was a period when it was not prominent in the media and we are seeking to address that. We begin a new amphetamines public health campaign on 18 March and that will run for six weeks.

CHAIR—What form will it take?

Mr Murphy—It will be through the youth press—the sort of free, music oriented and culture oriented youth press that has a very wide readership. In this state it is called *Express* magazine and there is another one called *Drumbeat*, I think. We will also use youth radio; we will go through the most popular radio station, Nova radio. We will also use convenience advertising—so, in the washrooms of nightclubs, hotels and so on.

CHAIR—And what is the message you are putting out?

Mr Murphy—We are emphasising the legal, mental health and social harms of amphetamines.

CHAIR—Can we use another word rather than harm? It rhymes with ‘calm’, doesn’t it?

Mr Murphy—‘Damage’?

CHAIR—‘Damage’ is a good one.

Mr Murphy—‘Damage’ is a good one, and we are just as comfortable with that.

CHAIR—‘Harm’ is almost onomatopoeic, isn’t it? It sounds—

Mr QUICK—Soft.

CHAIR—soft. It is really quite nice. It is calm; it is all very pleasant.

Mr Murphy—So that is one arm. There will be a new Commonwealth government amphetamines public health media campaign in the near future. It is a bit of a moving target as to when to start, which makes the state campaign timing very difficult. The difficulty, I think, with both of our approaches—state and Commonwealth—is that, as our media company tells us, we need to be in the market constantly. You really have to do enough of it to make a difference. So it is certainly a priority of mine and of my office that we lift that profile substantially.

The second arm is school drug education, and we have a very comprehensive and coherent approach to school drug education in this state, funded substantially by the state but supplemented very substantially now by the Commonwealth.

CHAIR—But, when you go into a school, as I have done, and you go to talk to them about drug issues, you can pick the ones on drugs by a country mile. They are very easy to spot from the way in which they speak about drug use. Really, they would like it legalised. They are into it and they would like to spread it among their peers. How do you get rid of that influence in a school, if you say you cannot expel them?

Mr Murphy—I have to say, and I hope it does not sound defeatist, that I do not think we can eradicate this problem and I do not think we can change—

CHAIR—We cannot eradicate any crime. We have laws against murder, we have laws against burglary and we have laws against speeding, but we still have murders, thefts and speeding.

Mr Murphy—That is right.

CHAIR—That is the nature of society. But we are always trying to have laws that are for the betterment of society and individuals as a whole.

Mr Murphy—Exactly, and to squeeze down the extent of the problem.

CHAIR—But you do not get rid of it by saying, ‘We won’t call it a crime anymore.’

Mr Murphy—No, absolutely not, which is why the National Drug Strategy, and our approach here, has just as much emphasis on supply reduction and demand reduction as it has on what is called harm reduction. In schools, you are always trying to move the percentages and work against the development of a pro-drug culture. As I say, it is a comprehensive approach—teacher training, identified teachers, curriculum support, school drug policies and, as I outlined before, the In Touch program to identify vulnerable kids and provide the right sort of intervention.

The third prong to our prevention approach is local community action. We set up 10 years ago, and it is still running strong, a network of community action groups called Local Drug Action Groups, which involves members of the community doing things in their communities to spread the anti-drug message and provide support to young people or families who are experiencing difficulties. So prevention is just as important. The challenge for governments always—and this is absolutely the case for governments as much as for their bureaucracies—is to maintain the priority and expenditure on prevention when the results are not as clear, as immediate—

CHAIR—That is why the Federal Police have started to put a value on it.

Mr Murphy—Well, I do not think we will ever have any problems as to the political priority on supply reduction. But the more public health oriented prevention programs to change attitudes and behaviour are more difficult to support because their results are longer term. If you look at smoking, for example, around 17 per cent of people in this state still smoke.

CHAIR—You take a lot of tax for it, too.

Mr Murphy—They are the other parts of the strategy. We have banned advertising, we have increased the price enormously and we have had big public health campaigns.

CHAIR—But we are talking about illegals today, not legals.

Mr Murphy—That is right, but this is just to point out that when you draw those comparisons there are a number of strands to the story.

CHAIR—We are going to have to move on to our next witness, but could I ask you to take on notice to find those figures about the deaths of children that have been returned to their biological parents.

Mr Murphy—The figures I will be able to access are those published by the child death review committee and the categories they use. I will certainly undertake to provide those to the committee.

CHAIR—Thank you very much, and thank you for coming today.

Mr Murphy—That is my pleasure.

[9.16 am]

HAMILTON, Dr Dale Francis, King Edward Memorial Hospital

HARRISON, Mrs Celine, Head of Department, Social Work Department, King Edward Memorial Hospital

HENDERSON, Mrs Claire Joanne, Chemical Dependency Service, King Edward Memorial Hospital

Witnesses were then sworn or affirmed—

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

Mrs Henderson—I am a clinical midwife consultant and I coordinate the Chemical Dependency Service at King Edward Memorial Hospital.

Dr Hamilton—I am a consultant obstetrician at King Edward Memorial Hospital and I have primary responsibility for the obstetric care of the women who attend the chemical dependency clinic.

CHAIR—I now invite you to make an opening statement.

Dr Hamilton—On behalf of our patients, their children and the health professionals who work in this field, we would like to thank you for the opportunity to present our submission to you today. The written submission that we have sent to you was prepared by a multidisciplinary team of health care professionals from King Edward Memorial Hospital for women. The submission was drawn from the data collected as part of our clinical work and from the experiences of the staff who work at the hospital. King Edward Memorial Hospital is a tertiary teaching hospital and forms part of the statewide obstetric and newborn services.

King Edward Memorial Hospital delivers about 5,000 babies a year. It is estimated that women using illicit drugs during pregnancy constitute about seven per cent of the number who deliver at the hospital. These are a complex group of women who, by the nature of their drug use and other lifestyle comorbidities, have high-risk pregnancies. The hospital has a multidisciplinary specialist clinic that caters for the antenatal care of those women who are referred for obstetric care and who are identified as using illicit drugs or who are in drug treatment programs for past illicit drug use. Additionally, the neonatal clinical care unit and the paediatricians provide care for the newborns born to these women.

There is another cohort of women who do not disclose drug use or deliver their babies without antenatal care and are subsequently identified as having used drugs during the pregnancy. The aim of the service is to provide healthier pregnancies and outcomes. It is acknowledged that the terms of reference for this inquiry have as their focus the impact on families. Our patients about whom this submission is concerned are drug-using pregnant women and their families. It is our

position that the unborn baby, the father and the brothers and sisters of that infant and his or her grandparents will also be affected by the lifestyle and needs of the pregnant woman.

Providing services that care for these women will take care of the health, wellbeing and quality of life for her family for the whole of their lifespan. To this end, it is our view that we are dealing with a public health problem and the policies, strategies and practices need to mirror any other public health issue, with resources and services that focus on public education and prevention, early intervention and well-trained universal services with another layer targeting highly specialised services for support and treatment and also to back this by well-funded research to base informed practice on.

Our hospital has seen a threefold increase in the past three years in women who are using illicit drugs delivering babies there. It is estimated that about 350 such women attended the hospital for delivery of their infant in the last year. These women have complex medical needs such as hepatitis and are at risk of other life-threatening infections. They also have poor dental health and their pregnancies are at increased risk of complications such as placental abruption, particularly for babies who are born with a low birth weight and prematurely. Their infants therefore need to have extended in-patient stays and some have neonatal abstinence syndrome associated with drug withdrawal.

In 2005 and 2006 combined we had 102 babies admitted to the neonatal special care nursery for the management of their neonatal drug withdrawal. I think it is important to point out that some of the babies are of mothers who are actually in programs, particularly the methadone program. It does often cause withdrawal but it is shown to be best practice for getting the best outcome for that pregnancy.

CHAIR—So is the baby born with methadone addiction?

Dr Hamilton—The baby withdraws from methadone, yes. Their ongoing care in the community is currently fragmented and there is no committed follow-up on these children over the long term to assess their developmental needs. There are a number of mental health and child protection sequelae as a result of this.

We recommend therefore that substance use is not treated as an isolated problem. Services need to be provided as a package that includes treatment and counselling, support services, medical and dental care and legal support for the drug-using women. These same services should have the training and mandate to provide child-focused assessment and undertake case management with the child as the focus. The service should be at a single location, preferably, and the model should have an assertive outreach focus. Mother, child and family services need to be interconnected. Adult services, be they for mental health problems or domestic violence, should have pathways that include the care of the child in the family. Services must be child friendly and family focused.

When the statutory response dictates the removal of children from their parents, all effort should be made to continue the care of both parties, with adequate support for the children and their alternative care givers. We request an investment in research that studies the prevalence of drug use amongst pregnant women, the relationship between drug use and pregnancy, the long-

term developmental outcomes and needs of the children and an evaluation of drug treatment and early intervention programs.

A national system of governance is required to ensure that the programs are meeting nationally set guidelines of best practice. We recommend public education programs aimed at preadolescent boys and girls about the impact of illicit drug use. We recommend strong support for mainstream universal service providers such as child health nurses so that they are able to undertake home visiting and that the general practitioner be able to take the primary role of case management of the many needs of these women and their children.

Finally, we would like to see a focus on developing a consensus that frames women who use illicit drugs as having health needs and validates their potential as caring parents to their children. This would require a non-judgemental attitude and policies that focus on compassionate, high-quality treatment and support on a wide scale.

CHAIR—I just go back to what you said about the 102 babies. They were all basically born methadone dependent, you said.

Dr Hamilton—There was a variety. There are babies who have neonatal abstinence syndrome to a degree which requires some sort of medical intervention. There are babies of mothers who are using illicit drugs and, more commonly through the clinic, there are babies of mothers who are on identified treatment programs, particularly methadone programs which can cause withdrawal in babies.

CHAIR—So there would be mothers who are pregnant who are taking methadone presumably to get them off heroin but the baby still ends up with the problem, and in doing that they know the baby will go through withdrawal. So the only way you could take them off was with methadone. What would be the impact of naltrexone to take them off it altogether and give the baby a better start?

Dr Hamilton—There is certainly not a lot of good evidence about naltrexone at the moment. We do not have long-term studies that look at that.

CHAIR—I am going to the clinic to have a look at it today.

Dr Hamilton—We have women who are using naltrexone throughout as well. We see the broad spectrum. There are other drugs as well. Buprenorphine is another drug that is used. Internationally and nationally methadone is still the treatment for opiate dependent women. It has the best track record in terms of the outcome for the child and the child's development in utero.

CHAIR—You said there is no long-term follow-up of these children so how the hell do we know that?

Dr Hamilton—Looking at their birth weights—

CHAIR—But you do not know what happens to them afterwards. If a child is born not dependent on methadone it has got to have a better chance in life, hasn't it?

Dr Hamilton—What you are looking at is how we manage the woman who is using illicit narcotics—opiates.

CHAIR—I hope you try to get her off them.

Dr Hamilton—The evidence is—and this is, I guess, where you need to go back to the level of what the practice is about—that if you try to take women off them, firstly, in the first trimester there is an increased incidence of miscarriage. If you do it in the third trimester there is an increased incidence of abruption and prematurity if the mother withdraws. There is also a very high incidence of mothers going back to using drugs, and craving and all the things that go with that. So in terms of keeping women stable, giving them constant levels of opiate in their blood and of rationalising their lifestyle so that it becomes less chaotic and their nutrition improves so that they are not engaging in criminal behaviour to support the drug habit and all the things that go with it, then you actually produce at the end of that a healthier mother and therefore a healthier baby at delivery even though a percentage of those babies will actually withdraw. Not all of them will, but a percentage of them will withdraw, but the drug withdrawal is manageable.

CHAIR—If it is an addictive drug, that kid could be addicted forever.

Dr Hamilton—That is true, but if the alternative is the mother being on heroin or any of the other opiates that are around, whether it be home-baked or whatever it is they are using, we are only saying that as an alternative to the mother continuing with heroin—

CHAIR—What is the average age of the mother?

Dr Hamilton—In our clinic the average age of the mother is getting older. We are seeing a bigger problem and you have already mentioned it. There are different groups of drug-taking women. There are young women who try drugs and with early intervention they often can improve. But the problem here is that, without some sort of input, with each subsequent pregnancy the problems become more and more complicated for these women. I think we have the figures for the average age of women that we are seeing through the clinic. I think the average age is 30.

Mrs Harrison—What I have is the average age of women who present with complex social problems and they are represented more in the 25- to 35 age range. It is in that group that there is the highest representation of complexity—

CHAIR—I want to go with the average age of the mothers of the 102 babies who were born addicted.

Dr Hamilton—I cannot give you that number, but I could find out for you—

CHAIR—And also the average age of the 350 mothers—that would be very helpful, thank you.

Mr QUICK—And can we have the number of mothers who continue to come to your clinic. They have had one child and one would assume or like to think that, after you have gone through the trauma of having one child that is drug addicted, there would be a message to say, 'Look, I

brought this child into the world—hopefully I am not going to present at your clinic ever again.’ Is there a recidivism rate? Do they have their second and third? Are they caught in a web and we cannot get them out of it?

Dr Hamilton—I think that often is true. We certainly have a study that Trevor might like to comment on. The HIT study looked at following women in their homes for six months. We certainly got some interesting information.

Mr QUICK—You mentioned that there has been a threefold increase over the last three years. Is this because a percentage of the women are presenting themselves again for a second and third birth?

Mrs Henderson—It is extremely complex. We are very proactive in offering women excellent contraception options before they leave the hospital. We look at offering women informed consent to have contraception that has long activity. But we have to remember that a lot of these women may go back to chaotic lifestyles.

CHAIR—What is a chaotic lifestyle? What do we mean by that?

Mrs Harrison—They have additional comorbidities such as domestic violence. The strongest correlation factor is between substance use and domestic violence. There is a strong degree of homelessness, chronic debt, financial problems and poverty. You asked about whether women come back with subsequent pregnancies. They do. But the other aspect that we are finding is the women might come back with subsequent pregnancies but their previous children are now being looked after by grandparents or they are in care or they are with other relatives. That is the change.

Can I go back to the issue of the discharge of babies from the special care nursery. When they are admitted into the nursery for pharmacological treatment they are followed up through the clinic to our paediatric clinic to a point up to when the babies can be weaned off their medication. We have a home visiting nurse and their discharge home is monitored by the social work department.

CHAIR—Does anybody suggest that the parents should perhaps relinquish them for adoption?

Mrs Harrison—The numbers that we are getting in terms of those children who are being removed from the parents—

CHAIR—No, relinquished—not removed but relinquished.

Mrs Harrison—Yes, but relinquishment is not an offer that people take up very often. We do not have that in the normal population let alone in this population. There are a number of options that are prevalent.

CHAIR—We took evidence in that adoption inquiry in Brisbane. We were told that sometimes when mothers want to relinquish there was active bureaucratic action that says, ‘If

you do that, you're a wicked, dreadful person,' and they were talked out of it. Do you have any evidence of that?

Mrs Harrison—We find with this group of women that they are desperately keen to look after their babies and have these babies. They see it, as the literature has quoted, as a window of opportunity to do the best they can. We do find from the HIT study that the amount of drug use has stopped remarkably through the course of their pregnancy. But there are a whole lot of other what we would call chaotic lifestyle factors that militate against them continuing that about four to six months after the baby has been born.

CHAIR—Yes, but if you have somebody who has had previous children—and those children have presumably been abused and that is why they are being looked after by the grandparents—and they cannot cope and they cannot do it, do you ever do any counselling about what would be in the best interests of the child?

Mrs Harrison—We have no evidence that they have been abused. What we do know—

CHAIR—But you just told me that some of them were with their grandparents.

Mrs Harrison—What we do know is that the grandparents have stepped in when the mothers were not coping with the care of the babies.

CHAIR—I think we might hear some evidence later today that might tell us just how appalling it is for children.

Mrs Harrison—You are probably right. However, for the vast majority of the parents, of those figures that we gave you, a third of those babies will end up in alternative care. As a result of counselling—

CHAIR—They are probably moved around with no security—

Mrs Harrison—Absolutely, and grandparents and all of that.

CHAIR—and they repeat the cycle.

Mrs Harrison—Whilst we have a choice of adoption—and it is not a coercive instrument—these parents want to look after these babies.

CHAIR—There are virtually no adoptions in this country of Australian children.

Mrs Harrison—They want to care for the babies and a good number of them turn their lives around with very good support.

CHAIR—What about the ones that do not? They are just a casualty?

Mrs Harrison—There are some that will be followed up and, if you got figures from the Department for Community Development, you will find that within the first 12 months there is

enough money to get those children whose care falls below what is acceptable removed. The statistics will show you—

CHAIR—We are running out of foster homes. There are 21,000 children in Australia who are in farmed-out care.

Mrs Harrison—Obviously supply is a big issue. The other big issue is the underlying nature of poverty and homelessness. We cannot say what comes first. While substance use is the most overt manifestation of those problems, we target that. But in fact there are profound underlying problems here that can also be managed and are not.

Mr QUICK—Western Australia has the lowest unemployment rate and the perception is that it has the highest house prices, yet there is this underlying social problem that is continuing to repeat itself.

Mrs Harrison—I think it is a structural issue to do with income support and housing. That is what we find when we try to put services in for people. If we do not know where they are going to be, when services are location specific it is very difficult to put enough of a safety net around them.

Mr QUICK—I used to work for a former senator, Michael Tate, who visited some of the hospitals in California when we had the big crack at epidemics 20 years ago, and you saw the withdrawal of babies and the trauma that children go through. What longitudinal evidence is there about the success of weaning children off and their having a normal lifestyle? Are you planning to do some sort of longitudinal study here? Do you have any funding through NHMRC to track these 350 women and their children over the next 10 years? We have this robust inter-agency support network. Do you plan on doing something like that?

Dr Hamilton—I think it is important that it is done. It would be ideal if it were done on a national level; that would make the figures even more meaningful. When you are looking at the children and their outcomes, it would be better to have as many as possible. It is like any research—the more you have the better. A national inquiry or research into this would be very valuable. That is not really our brief, but I agree that it would be fabulous.

Mr QUICK—We could cut your supply off so that you only had to manage half a dozen rather than hundreds. I am interested in your pre-adolescent education program. How would you see that working—bringing young boys and girls into these clinics and seeing some of the trauma that the children experience? As the chair said, at that age, we scare the living daylights out of people, such as with the anti-cigarette advertising showing the horrible faces.

Dr Hamilton—Scaring people is probably the best—to give people a realistic impact of what it is like. The trouble with adolescents obviously is that they think they are invulnerable.

Mrs Henderson—Eighty per cent of substance-misusing women are of reproductive age. We need to get into schools and start getting the message across. The nature of the care giver, in general, is having children, having a family—that is the role. We could start educating by saying, 'If you want to have a family, this is the effect this would have.'

CHAIR—To go into school and say, ‘You are going to have a lecture today on the effect of drugs when you are a mother’ is the biggest turn-off for the class. It just does not resonate. I think we have to look at using the internet—at things that they use—and at television.

Mrs Harrison—I also think that they are a diverse group. There is a group of adults that, if they were going to be turned off by a public education campaign, do not represent the worst, the most resource intensive of our group. The women who are the most resource intensive are the ones who have had other problems. They did not just make a choice; they had no choice. They had been abused in their lives or they had experienced some assault or they are in relationships that are characterised by violence. It is that group that I think causes the most clamour in terms of resources and care. With the other group, who made the choice and who might have been turned off, not many of them fall into this net of really problematic people.

Mr QUICK—These are low socioeconomic status mothers?

Mrs Harrison—Yes, it is the disadvantaged. So any amount of scare campaigns do not help them to struggle with what they have had to deal with.

Mr QUICK—We need to cut the cycle somewhere.

Mrs Harrison—It is the issues of poverty and disadvantage.

Mr QUICK—Intergenerational unemployment.

Mrs Harrison—I am wary of scare campaigns. I think that they have a limited shelf life if you are dealing with a bigger problem. It is a bigger problem that costs society a lot more.

CHAIR—No it does not. The stats of the Australian Institute of Health and Welfare show that, for the people who do not take drugs, education and awareness rates are 2.7 per cent for 12- to 15-year-olds, 2.6 per cent for 16- to 17-year-olds and 2.1 per cent for 18- to 19-year-olds. The people you are talking about, the people who do begin because of trauma experience, would probably fall into the 8.5 per cent for 12- to 15-year-olds, 4.2 per cent for 16- to 17-year-olds and 4.6 per cent for 18- to 19-year-olds. That is a small group of people. The figures we saw the other day showed that something like 30,000 grandparents are bringing up their grandchildren because that is the only way they will have a life. That means that the grandparents must have been reasonably effective parents, so what happened in that breakdown of that relationship? They cannot come into your trauma category; they would be some different category.

We took evidence from a grandmother in Brisbane the other day about the fight that she had had with every government department to be allowed to have custody of her grandchildren. She would give them evidence and they would always say, ‘No, it’s much better for them to be with the mother,’ when it was not. She finally won but the drama and the trauma for the children is just awful. Why do we have this perpetual, ‘They must go back to the biological parent’?

Mrs Harrison—We do not actually.

CHAIR—How many of those children did not go home to the biological parent?

Mrs Harrison—Two-thirds of that 350 were followed up adequately by child health nurses and GPs and they have not presented to child welfare agencies.

CHAIR—How many children did not go back to the biological parent? Were there any?

Mrs Harrison—Yes.

CHAIR—How many?

Mrs Harrison—Twenty-five within three days of birth.

CHAIR—Twenty-five out of 350 did not go back.

Mrs Harrison—There is another figure that we need to face. Out of the 350, the Social Work Department assessed 130 who presented us with enough risk factors such that we were concerned and involved the Department for Community Development. Out of that figure, 25 had statutory action taken so that they were placed in care even before the mother left the hospital. Further on from that, of the others who went home with home-based support within three months of being discharged, another 25 babies were removed. That is in the last financial year. Since 1 July to now the number of babies that have been placed in care has doubled. We should not be proud of that figure. It is a figure that suggests that there are not enough services to support these people to function.

CHAIR—Or the people who are assessing are now taking a more realistic attitude and know that the children remain at risk and therefore they do something about it. In New South Wales, 94 children are dead because they were sent back to the biological parents. In Queensland it was more than that.

Mrs Harrison—What we have found in some of the research—there was a study done in the early eighties and then there was another one that I have a reference to—is that newborn babies who are removed are less likely to be returned to their parents. At that age, when they have been taken into care, the chances of reunification are much less than for the older child. We also find that a large percentage of the parents of these babies who are removed have had other children in care who are still in care. So, from our experience, when the risks are so high that a newborn has to be removed, it is important that they do not fall into the category of children to be taken back to their parents unless there is a very serious attempt at rehabilitation—they have to stick to quite a strict routine of urine testing and counselling before the children are returned. I can only talk about the babies, because it is the Department for Community Development's responsibility to manage that whole aspect of child protection. I only have the babies.

Mr QUICK—You mention on page 8 of your submission community based support and the service at three months. How do you link in with the GPs so that you have additional support there? If your little kid is sick, you go to the local GP. Is there a way of educating the GPs to identify mothers at risk before they present to you? How does that work and how successful is it? Are the GPs onsite?

Dr Hamilton—It varies enormously and, once again, this depends on where the women are situated—their location. In some areas we have some good GP liaison people. Because these

people can be quite transient, the GP has to be willing to give them the time. One of our recommendations would be that GPs be funded adequately for this, because to liaise for these women and be a case manager, which is what these women need, a lot of non-contact time with the patient is required—probably more non-contact time than actual contact with the patient in order to do the liaison and look after these women. I think that at the moment GPs would not find that they were adequately funded to do this in an appropriate way.

Mr QUICK—And some GPs are precious about the sorts of services they provide, and if you have social workers ringing up the GPs to say, ‘This child’s at risk; have they presented to your surgery recently’—

Mrs Henderson—You bring in the child health nurse. We have worked at the coalface for a lot of years and know all the problems that we have in getting community based services to offer support. We are looking at a proactive model where we bring in these health professionals—who are going to be that four-month crutch, really, when we are gone as a tertiary centre—antenatally and we start working together as a team antenatally. Child health nurses are very committed to working with these families. They do it every day. But they are under-resourced. They are looking for extra resources to be able to be more assertive in their outreach to these women, to be in the family home, to be much more aware of what is going on, rather than women having to come to a centre to be monitored and worked with.

CHAIR—We have no longitudinal study that shows what happens to these children, do we? Nothing. What happens to them as the next generation?

Mr QUICK—You have been going for x number of years.

Mrs Harrison—Yes.

Mr QUICK—The first child who ever presented to you guys—do we know what he or she has done and how successful you were?

Mrs Harrison—We do not.

Mr QUICK—And should we?

CHAIR—Yes, we should.

Mrs Harrison—Yes, we should.

Mr QUICK—Would you be happy with that?

Mrs Harrison—Absolutely.

Mr QUICK—We could then say to the Premier, Mr Carpenter, ‘We’re the best.’ For most people, this is the first time it has been aired publicly, which is wonderful; it is on the front page in the national newspapers. Are there any other hospitals in Australia that are doing this? Are you the only one?

Mrs Harrison—No, there are other clinics—

Mr QUICK—I have not heard about it. Why isn't this up in lights?

Mrs Harrison—We have to be very clear that it is not a problem that is pertinent just to King Edward.

Mr QUICK—No.

Mrs Harrison—It is a problem Australia wide. We are the specialist centre. We do have a lot of skills and knowledge, but we want to disseminate those. We want to get good, standardised practice with the use of the national guidelines, which do need funding to be updated and to be kept evidence based. But we want a standardised practice right across Australia and right across the state so that wherever women live they are able to access a specialist service that can meet their needs adequately.

Mrs Harrison—To go back to the GP and the child health nurse, what those women were told as they were followed up, and the impression that we got, is that they were universal, they were non-stigmatising. The stigma attached to the women is one of the biggest barriers for them to seek service, and we achieve nothing from doing that. A lot of the stigma is that 'they should not be parents'. In fact, they want to be, and they are attempting to do the best they can to be parents. So the other side of the literature must be that when we follow these children up we follow up all of them—it needs to be population-wide so that we will then have a realistic perspective of where the problems are.

Mr QUICK—I agree.

CHAIR—Whilst under the influence of drugs, the desire to become a mother can be distorted. They decide, 'I want it for now,' but there is no care—and what happens to those children? The mother has made choices, but this is a newborn baby that has made no choices at all and is incapable of making choices. It is born into this situation where we say, 'Well, back into this lifestyle,' without looking at what is in the best interests of the child.

Mrs Harrison—We actually do not do that.

CHAIR—About 25 only did not go back with the biological parents.

Mrs Harrison—That indicates that a large majority of these women can function with good support.

CHAIR—But you do not know what happens to them finally. Are they the ones who come back 15 years later, pregnant?

Mrs Harrison—What we do know is that some of these women who attend the clinic have been taken off previously. That is a good enough figure, I think, that suggests that perhaps that is not always the best way to go.

CHAIR—Do any of these babies get adopted and get a home or are they all in the ‘move them along’ category—they can be with this foster parent for a while and then they get moved and moved on? What chance do they have?

Mrs Harrison—In the United States the child protection services do have a period when they attempt to make changes and reunify the family, then after that they move on to permanent placement—

CHAIR—We took evidence about that.

Mrs Harrison—So, who knows? We live in a society where you cannot enforce adoption—

CHAIR—We do not want anyone to enforce it but we found there is active bureaucratic action to prevent it—and I see people in the audience nodding. That is why in this country the adoption rate of Australian born children is something like 46 for last year and yet we have 400 overseas adoptions. The agony those parents have to go through to be able to adopt is traumatic, and we are trying to make that easier. There are 21,000 children here in need, of which your 350 children are but a part.

Mrs Harrison—Yes, I know. Counselling does not exclude all of those options—

CHAIR—But it clearly is happening, the antipermanency, and looking after the interests of those children is not there.

Mrs Henderson—We have to be very careful not to collect every woman in one scenario. We have worked with these women for a lot of years. There is a very, very broad spectrum of problematic substance misuse; there are women who have had challenges in their lives and are ready to be motivated and change. It is about getting individualised care that looks at each family individually. That is what we need to do—to address needs individually.

CHAIR—I agree with that, but we do not know how successful you have been. We have not got any follow-on. That is what we need. We are very grateful to you for bringing this out and bringing it to attention, because clearly this area needs attention quickly.

Mr QUICK—One another avenue I would like to follow up is about domestic violence. How are the men being brought into this program? You have the drug problem, domestic violence and homelessness, but what about domestic violence being placated or removed or ameliorated? Do you have any programs working with other people in the community to ensure that this area is addressed?

Mrs Harrison—There is a wide network of domestic violence support services and helplines. The law in this state has changed to an extent where the police and other agencies are far more likely to intervene. It is an issue but there are good services. We need them to be brought together and case managed centrally.

CHAIR—It is always a problem if the police intervene and then the woman will not go ahead.

Mrs Harrison—The state legislation has changed so that the onus is not solely on the woman.

Mrs Henderson—Not putting domestic violence into a separate box can also assist. We are very proactive when we bring women to the clinic that it is not just about the woman. We will always invite the partner into that discussion right at the beginning. Now that we have extended the clinic times we are seeing women in the first trimester of pregnancy, which is an optimum time. Preconception would be wonderful.

CHAIR—There is not always a partner.

Mrs Henderson—Not always but, when there is, we will invite the partner in and include him in options of where we go from there. We do not want to make the mistake of the woman doing well and a guy sitting in the delivery suite whom nobody is paying attention to. We work very much on a family model where everybody is involved and brought into treatment options—where to go from there, how we can help and how we can improve.

Mr QUICK—Could we visit you if we decided to come back to Western Australia? Would you be amenable to our wandering around and talking to some of the mothers and fathers?

Mrs Henderson—That would be a wonderful idea; I was just going to suggest that.

Mr QUICK—We have been to jails, we have spoken to kids sleeping in the streets and we have given ministers a hard time. I, for one, would love to come and see how your service operates. I think what you are doing is absolutely fantastic.

Dr Hamilton—Seeing the women as individuals is what motivates us all to keep going—seeing that these are real women with real problems and real family people.

CHAIR—Dr Hamilton, do not misunderstand me: the women are individuals in our society and we have an obligation to do the very best we can for them, but we also have to consider the child.

Mrs Henderson—And we do, very much so.

CHAIR—We have to know what happens to them—whether or not what we are doing has any impact on the child long-term or whether different policies need to be brought into play. That new child has to be a focus of attention.

Dr Hamilton—We welcome that support.

CHAIR—Thank you very much for coming today. We are very grateful that you have published this material, because it will have to be focused on now. Thank you for what you are doing.

[10.05 am]

HERBERT, Mrs Wendy, Spokesperson, WA Coalition Against Drugs; Fellow, Drug Free Australia

MULLINS, Mrs Geraldine Mary, Founding Member, Adviser and Spokesperson on Illicit Drugs, WA Coalition Against Drugs

KERRY, Private capacity

THELMA, Private capacity

CHAIR—Would you describe the capacity in which you appear.

Mrs Mullins—I am a friend of the Coalition Against Drugs, WA. I wish to put forward my personal story, but also bring up some questions and ask for some action on Australian drug policy.

Kerry—I am appearing for the same reasons. I wish to relate my personal experience in dealing with my children and my nephews. This is my mother. We pretty much have the same story, both as a mother and a grandmother.

Mrs Herbert—I represent the WA Coalition Against Drugs and Drug Free Australia. I have raised four drug-free children in a country which actively, with its drug policy, makes it very difficult to promote abstinence.

CHAIR—Each of you have indicated that you have something that you want to tell the inquiry. So perhaps if you would each like to say something to begin.

Mrs Mullins—It is about the harm minimisation or harm reduction approach to drugs and its impact on the family. I come with my own personal issues. That is why I do what I do now. I have been doing it for 15 years, and it has been a long struggle. The people in the community and the community groups, like our groups, are floundering because of the government groups and the non-government organisations, who have all the benefits to bring what they want into policy. Even Wendy and I sometimes differ on what we are doing because we are out there putting out all the fires that are started by the government agencies and the non-government organisations. Because it is about harm minimisation, I would like to show some evidence that is the face of harm reduction in WA. I would like to leave that with you.

CHAIR—Could you tell us what that is?

Mrs Mullins—Western Australia has been pursuing the deaths of children in custody under the Department for Community Development. A drug addicted fellow who had just been released from jail had bashed children—separate children—one in 1995, one in 1998, and another one in 1998. He was still left to have these children in his care. They were the children of his partners. It came to a head when a baby, Wade Scale—both parents were drug addicted—

picked up a benzodiazepine or something like that, one of the parent's drugs. They left the child in the bath and the child drowned.

This is harm reduction—these people are allowed to continue their drug use without any intervention. The system is just not there to intervene for these children. This was a huge case in Western Australia. It was able to bring down the DCD. At this stage I still think the drug and alcohol authority should be accountable because they have not done anything about this as far as prevention is concerned. I would like to submit that.

An article in the *West Australian* mentions that there are 96 child deaths since 2001 under review and said that 94 per cent involved drug using parents. This is my comment: these children have been recklessly and heinously sacrificed on the National Drug Strategy altar of harm reduction.

CHAIR—We might accept that as an exhibit to the inquiry.

Mr QUICK—Can we accept them all together in one go?

CHAIR—Yes.

Mrs Mullins—I will leave that as an exhibit. That excellent article explains how parents and grandparents are saying that these children are born to be victims from the very start. And there was that idea that you cannot force people to give up their children and you cannot force them to go into treatment. We as grandparents just have to be there. We have to be their primary carers in the worst situation of drug addiction and mental illness.

These are photos of my own daughter. I have compiled three lots. That, to me, is the face of harm reduction and the pharmaceutical treatment of drug addiction. That is why I am terribly concerned now when I hear that is the way that the government is going. The ANCD and the ADCA recommend that now they must use the same drugs that are drugging these people as a panacea. My daughter is a classic case. Here she is at 19 years old—in 1985 she was a Summergirl finalist—looking rather beautiful. The next photo shows her in 1998, by 35. Anna was a late user. That was in the days of the late eighties, when she went to Sydney. She was already in her mid-20s. That was how it was in those days. We did not have the young children that we are seeing today, and the young parents, before they can even get any maturity whatsoever.

That is Anna on her daughter's first birthday. She was well and truly into her drug use then, right on the streets, injecting—the worst drug use. In 2000 she gave birth to her son at St John of God Hospital, courtesy of her father. She did not want to go to King Edward because they treat her so appallingly—so much for treating the drug addict without stigma! So she had the gold card trip again and he paid for her there without any hospital benefit. She had her son, and she walked out on him that day—out of the nursery. Luckily, she called DCD—well, yes, in our case it was that time.

The Vietnamese grandparents have got this child. She lives with her father who is totally a drug addict in bad mental health. The dear man, the grandfather, who came here as a boat person, looks at that man on his bed—his son—and he says, 'I am just waiting for him to die.'

My granddaughter lives with that. There is nothing I can do. They have a court order to look after him. It is the best we can get. She is not achieving at school. She is eight. Her mum sees her occasionally.

There is another photo of Anna. Anna was looking quite slim then, by the time she came back. She came back in 2002 and tried to get help to get off drugs. She contacted me. We did everything we could. There was no help. She was turned away mercilessly. There was no treatment. You see, once these people get into taking mental health drugs as well then that complicates their rehabilitation. Really you need the most expert care as far as psychiatric care goes, and they just do not have it. They do not have rehabilitation of drugs and expert care of 99 per cent of them who are now on a huge menu of hugely mind-altering drugs which they cannot get off. As people in the mental health industry say, 'They're okay as long as they take their drugs.' Well, you are dealing with a drug addict who has no discipline whatsoever. Jack was born in 2000. He will be seven in June. We are lucky that he lives with the best foster parents. She will not let the children be adopted. She will not, from the very word go—from the beginning. DCD have given her more benefits and listened to her more.

I had two days of meetings with DCD—we finally called for a meeting—about the services provided. At the end of the day we were told, 'There is nothing we can do.' The records show that these people have more power than the child. It is supposed to be for the child's best interest, but it is not. The mother has more power than the child. After she had taken her medication, here she was starting to put the weight on in about six months. That picture is of her in 2005.

We now have a seriously mentally ill daughter who was not seriously mentally ill when she came back off the streets. Yes, she had some psychosis. But now we have her with the best care. She is in a private hospital. Her father pays hospital benefits. At the last count, the hospital benefits, since 2004 in March, have paid out \$90,000 for Anna. That is mainly for private hospital care and having teeth replaced which she lost because of methadone and heroine—her whole mouth. Here we have a bill of \$90,000. Today the doctor says that Anna has malignant brain damage. He says she cannot live by herself where we have her, trying to keep her safe. But there is nowhere for her to go. That is what is happening today within the mental health and the drug addiction issue.

I did want to produce also the other situations that are going on in Australia. This is a classic example of harm minimisation. We have just recently had a junior sports star turn into a drug abuser and then killer. That needs to be read. It is all about drugs. Obviously, this person should have been kept in treatment instead of being let out into the community. It says here that he stabbed his mother mercilessly and he strangled his sister. But the mother had been trying desperately to get the health system to do something about him. That is our experience.

I will go on to drug policy. I received a letter from Dr Neal Fong, the Director of the Department of Health in Western Australia. I was asking questions about the inordinate amount of needles and syringes that were being distributed throughout Western Australia without any sign of any real evaluation of how it was going or what was happening with it. He wrote me the usual diatribe. He says, 'Harm minimisation is an evidence based approach to drug use that has formed the basis of the Australian National Drug Strategy since 1985. The Prime Minister tells us, or he told me through Mr Tuckey—I am in his electorate—that there is no safe level of illicit

drug. He says, 'The Howard government supports the premise that there is no safe way to take illicit drugs and that the goal of each addict or user should be to become drug free.' At the end of it he says, 'This is consistent with the strong and consistent view that the Prime Minister has held about the strength and importance of Australia's zero tolerance approach.'

As I said in my submission, we cannot have a zero tolerance approach with harm minimisation as the overriding strategy. It just does not work. We need to have that clarified. The Prime Minister is going out into the community at all sorts of meetings and saying, 'We have Tough on Drugs.' Brian Watters has said, 'We have Tough on Drugs.' But there is a dichotomy. I must say that the Prime Minister's own council on drugs has to be the worst offender on this. Out of this meeting I would like to recommend Kay Hull's recommendations on the substance use report, specifically recommendation 122, which is:

The committee recommends that the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment of substance dependent people.

Some of those recommendations were very important. The fact is that 10 Australian government offices plus the Australian National Council on Drugs and the Alcohol and Other Drugs Council of Australia did the assessment on that substance abuse report and they buried Kay Hull's recommendations.

Mr QUICK—I was on the committee. The federal government took three years before it even reported.

Mrs Mullins—That is right, and we were waiting with bated breath. We solidly followed that because we knew it was the salvation of our people. It had to be. The specific things that Kay Hull said would have really made such a difference if the Australian government under these departments had not buried them. One of them was about the current practice of methadone parking. So the committee were concerned—and you know because you were on it—about the current practice of methadone parking and made strong recommendations to determine the effects of long-term methadone maintenance, including the cost and impact on the workplace, community and family. Second, the dangers of cannabis use were also of concern to the committee, particularly after receiving evidence that indicated cannabis use was considered to be harmless by a great number of the Australian public.

The third one was that effective and proven diversion programs in the judicial system are all-important tools in dealing with abuse sufferers and, in particular, the ability to identify drug users or those young people at risk of substance abuse through their general and associated behaviour that may lead them to presenting to the criminal justice or welfare system. I have a great deal of trouble and a problem in relation to this and I am continually lobbying politicians. If the substance abuse committee or Kay Hull's recommendations referred to drug courts then I fully agree, and that is the practice that should be going on in Australia. Certainly in Western Australia it is really struggling; the Western Australian government does not want to get these up. This is what we need now.

But the illicit drug diversion initiative, which the Prime Minister frequently refers to as being the most wonderful thing that has happened in Australia, is totally against the ANCB and against

the best thing that can be happening for these people. In fact, I say that the illicit drug diversion initiative is driving this amphetamine and drugs epidemic. I need it to be looked at; there needs to be a better evaluation. It has not been evaluated. It was started in 1999 at the MCDS. By 2000 the Australian government had put it up and they were given \$470 million or \$410 million. Four years later, without any evaluation whatsoever, they just brought it up again and gave it another \$4½ million without evaluating it. We still have not seen an evaluation on it.

So here I would like to mention the illicit drug diversion initiative and I would like to promote drug courts. They need to be investigated clearly, to see what America is doing with drug courts. With the illicit drug diversion initiative you have got people on the streets and the police can use their own discretion—this is Australia-wide—about them, presumably if they are not totally out-of-it drug addicts who have always been into drug addiction. But if they have a small part of narcotics—two grams or something—then the police, at their own discretion, at street level, can decide. And they do not decide; they tell this person they can go into counselling. In Western Australia we can show it has not worked. There is no counselling. There are no restrictions put on these people. The police are not keeping records. It is a nightmare. It is fuelling our drug problem and it is a disgrace.

CHAIR—Thank you very much. We will hear from the others.

Kerry—I really enjoyed listening to you all talk. My story is the difference between harm minimisation and drug free, because I have proof of it. I have 12 nephews and two nieces, and only two are drug free. Twelve do drugs. My niece killed herself, being a heroin addict. The others struggle. They are moving along with their lives but they struggle to maintain employment. I have three sons and two do drugs. One, in particular, we had to bring home two years ago. He was a rock addict. He started late. He was about 21 when he started. He was also a prescription drug addict at that time. We brought him home.

For the first 10 weeks he slept, probably OD-ing on his prescription drugs, until I worked out what was going on. In those 10 weeks, we finally realised and I started going to all the doctors with him. He had a very bad back problem from his work, and he left his compo and he went on to rock. I started going to all the doctors with him to try to understand where he was coming from, because they do not always tell you the truth. We went to many doctors, including back specialists, and finally worked everything out. In the meantime, I knew how much he was supposed to have and I made sure that was all he was having. I had a wonderful doctor who gave him a good lecture and told him that he was not to come back until the prescription was finished—in a certain amount of time; if he came back earlier, he would not get any. So we worked with him.

In that time I think Shaun thought: ‘You know what? If I don’t do drugs for a couple of weeks, I can just use at the weekend or take a bit.’ But my son said to me, ‘Mum, once I have one I cannot stop.’ So when he did stop it was because there was no money and nobody else would give it to him. Then he would come home and literally sleep for about seven or eight days to get off them. There was no way he could hold down a job. He lost jobs. We had interviews for him to go to but he could not hold down a job. I do not know if that is what you call harm minimisation. Another two weeks later, when he got his dole money, he would go out and blow it with his mates and with any other friends that he had.

That was two years ago. Right now, to my knowledge he has not touched drugs for six months. I think he worked out that he had to stop. He got a job and his brother came home from Melbourne. We sent my youngest son away because he had two older brothers who were druggies. Apparently the statistics show that if I had kept my youngest son there he would have gone into it. We sent him to a Mormon school that is strict on alcohol and drugs. He loved it there; he had a great time. He is now back. Shaun was just coming out of it when he came back. We had to set some strict rules. He had no money, so our roof was the only roof he could live under. For some reason he talked a lot so we tried to keep that communication open and tried not to get too upset when he did leave. At times he left for a whole week, and my husband and I were beside ourselves because we knew what he was doing.

At one stage I decided to get a counsellor to come to our home. He was getting counselling and so was I, because I needed to know how to deal with it and how to act instead of react. I believe he is now drug free. He has put on weight. He was very thin when he was an addict. He goes to the gym, he works and he is so happy because he does not do any drugs at all. He was just telling his father that. He hangs around with his younger brother's friends, and they are some of the very few who are drug free. My youngest son said, 'Mum, I don't know many people who don't do drugs.' He said: 'Most of them do it on the weekend, at parties or when they go out. They are probably just doing small amounts so they are coping with their jobs and everything, but in time it will take over.'

I own a hairdressing salon. My staff all said that, when they go out in certain different suburbs—like Subiaco with the meth addicts and Northbridge with the alcohol and whatever—they can tell by their dancing what drug they are on. My three girls that I have who work with me do not do drugs. They are pretty stable and they have stable boyfriends and husbands. But they said that there are not many young people that they know who do not do drugs.

I also had a friend who came over from Sydney and stayed with us. He was working on a building site. He said, 'Kerry, I have been in drugs and I have done drugs, but I have seen never seen so many drugs that are openly exchanged and being taken as I have seen here.' He was working here for six weeks. He said he could not believe how much and it is just out in the open. He said: 'It's so easily available. I can only go on drug free.'

My other son is a marijuana smoker. For some reason he is now holding a good job. He is a mechanic engineer. But he does his cone at least once a day and that is what keeps him going. He did stop taking it for three months because he had to do a drug test. He knew it would take at least three months to get it out of his system. Then I think he thought he would just have one cone, thinking it would be fine. But now I am sure he is straight onto it again. He said to me in that three months that he did not have any drugs in his system, 'It is like a cloud that has been taken off me.' He said: 'I cannot believe how clearheaded I am. When I was doing marijuana I did not realise that I was so fuzzy.' He wants to get that back again. He desperately wants to get back to that again. That is my story.

CHAIR—We will come to questions when we have heard from each of you.

Thelma—I live next door to my second daughter. Kerry is my oldest daughter. We have been living there for 27 years now. I have grown up with her children who have also been in and out of drugs. They have all moved on now. A lot of them have cut down, so they are living

reasonably normal lives. But the youngest son, Liam, is still at home. He is 23. He is still very much into drugs. He has been in and out of Graylands. They clean him up and he comes home, and he is not too bad. Then he gets bad and starts taking it heavier and heavier. Twice now he has grabbed my daughter, his mother—he is very tall; he is over six foot and he is huge—in such a tight squeeze, because he was angry with her, that she has collapsed on the floor. He has done that twice now. So she is very wary. We are learning the signs when he gets dangerous.

CHAIR—Does he take amphetamines? Is that from amphetamines?

Thelma—As far as I know it is marijuana. That is all I know. I do not honestly know what else he is taking.

Kerry—They smoke in the backyard and all of their friends come around. Every time we go to my sister's house the cones and everything are there. It is very open.

Thelma—We have rung the police and the police have come out. I saw them one day. The house on the side was empty and they were walking down there, and then they walked back and never came again. We reported it—

Mrs Mullins—I am sorry to interrupt. At that time my nephew was growing 19 plants and selling them. So I rang up the 1800 crime number. He was cultivating and selling it.

Thelma—Nothing happened then. But now Liam knows when he is getting bad so he will ring the police so that he can be put back into Graylands to clean himself up. But he does get very dangerous. I thought that, because I had a good rapport with him and we talked quite a bit—I always say, 'Good morning, darling, how are you,' and he says, 'Fine thanks, Grandma'—I thought I would be in his good books and nothing would happen to me. But one day he came in and he started on me and I thought, 'Oh my goodness, I never realised,' because this was his other side through the drugs.

CHAIR—He started physically attacking you?

Thelma—No, not physically attacking me; just verbally attacking me. Then I realised that this was not Liam—this was the drugs. It was okay—we got him out of the house and he went back home. But from then on, my doors have always been locked—my back door and my front door. We have a gate between us and we walk in and out of the back door. Even yesterday, when Dianne came in and we had a chat, as she left, she said, 'Lock the door, Mum.' So all of my doors are locked—the three doors are always locked. So I am in and out, locking doors constantly, because of that danger. Yet I could talk to him this morning and everything was beautiful. I just do not know when it is going to not be that way.

He did ring the police once, because he needed to go back in, and the local police who knew him were not able to come out. They are very good with him. They take him into the van and they take him off. But this time it was about two hours later and the police had not arrived, and he had fallen asleep. They sent three policemen from the centre out to pick him up. They came out and there he was, asleep. They knocked, banged, yelled and screamed at the door and he woke up and was not sure what was going on. He was all fuzzy. They got him out the front and then I do not know what they said to him but, whatever it was, he started struggling and then

they started beating him something cruel with their batons. As he was going down, he punched, and when he punched he broke the policeman's jaw. They beat him terribly until he was down. They were screaming, 'On your knees!' but he did not realise what they were saying. They finally got him and took him away. They had a court case because he broke the policeman's jaw, but the judge threw the case out of court. He said there was no reason the police should get compensation for it. That is my story with one grandson who is still on drugs. The others are pretty good. They are able to manage.

Kerry—The others all do it. I am not stupid enough to think they are not doing it, but for some reason they seem to maintain their work and so on, and they have cut down. Because they started when they were 12 and 14—probably even younger—very young. But one of the sons is a heroin addict. He does not do heroin, as far as we know, but he does a lot of marijuana to make up for the heroin that he is not doing. He got so fed up with it he actually went into a rehab. After three days he had to get out because he said that he was being coerced and bullied into buying drugs that people were coming into in the centre. I said, 'What about the nurses?' He said they turned an absolute blind eye. He had to leave, because he was really bullied into buying it there.

CHAIR—The drugs coming into the rehabilitation centre?

Kerry—Yes. He put himself in, and now he will not go into any. Mind you, his live-in girlfriend is a heroin addict as well. I do not know if she is doing marijuana or what. He has tried everything to get off. The only way he can get off is by being drug free, not through harm minimisation.

Mrs Herbert—I came from Rhodesia in 1979 after 13 years of terrorist war which we lost to Robert Mugabe. I have seen the devastation that drugs can cause when it is used as a weapon of war. I wish to contribute to reducing the devastation that drugs are causing in this country, because as far as I can see harm reduction is being used as a weapon of war to destroy so many lives.

I have taken a lot of time and trouble to research the origins of harm reduction. From what I can see, it has been established in this country by a group of extreme idealists who are not loyal to Australia, who do not support our Constitution or our democracy, but are loyal to an international movement or belief, usually far left wing. These people have worked since 1980 to establish harm reduction as the drug policy of this country. People will defend that drug policy over the lives of young children and the addict. The drug policy comes first, before the lives of young children.

That started in 1980 at a meeting in Washington with the World Health Organisation. A committee which two Australian were part of—they are still part of the drug scene and drug policy making in this country today—changed the international drug policy terminology in a publication of the memorandum of nomenclature and classification of drug and alcohol related problems. The terms 'abuse' and 'misuse' were replaced with 'harm' and 'hazardous'. The reason for that was to take the emphasis off the user and accountability to any legal system for their free agency in choosing to use drugs.

The origin of this movement, and the two Australians who participated in this decision-making process to sabotage our drug laws, started in 1970 as an international strategy to overturn UN

anti-drug laws. It was funded by the Ford Foundation and the Department of State of America, and they commissioned two lawyers, Hutt and Wald, to write a report called *Dealing with drug abuse*. *Dealing with drug abuse* said the following:

... the fundamental objective of a modern drug-abuse program must be to help the public learn to understand these drugs and how to cope with their use in the context of everyday life.

This is the foundation of our present harm reduction or controlled drug use policy. So the emphasis is on Geraldine and these women here learning to live with the drug user's habits. The drug user has no accountability to become abstinent again. To achieve this, you have to pervert the drug laws of this country, which has very successfully been done.

One of the key contexts of this crisis is the decriminalisation of drugs, starting with cannabis—and if you have my report there you will see how we were desperate to stop the decriminalisation of cannabis in this state. I held public meetings with a lady from Britain, Julie Fawcett, who had opposed the same thing in London, when they tried to decriminalise cannabis there. We tried to tell people, Princess Margaret Hospital and other places like that, that as soon as you decriminalise cannabis you will have the drug dealers using children dropping out of school, setting up a drug movement that then introduces the next drug because the drug dealers have lost their trade. But they have established a drug-moving pattern using kids. That is exactly what has happened here. In Britain, it was crack cocaine; here, it is methamphetamine.

I simply want accountability for the ideology that is used in forming harm reduction drug policy. I want it evaluated. It is proven not to work. In that latest study of binge drinking that used 3,000 Australian children and 3,000 American children, one of the key factors was to study harm reduction drug policy. That study is one of the first pieces of evidence that show that harm reduction does not work as a drug policy. In the US they do not have control of drinking by teenagers. They have raised the drinking age to 21 and they have zero tolerance of drinking by children. Mothers Against Drunk Drivers did that in America over a period of 16 years and, in the 18 to 25 age group, 16,000 lives have been saved on the roads. There must be accountability for harm reduction. You will have people here defending the ideology over the lives of people.

CHAIR—Thank you. I have a good deal of sympathy for what you have all had to say. The chief executive of the Australian Drug Foundation put out a statement today which attacks me, by defending Professor Margaret Hamilton and her harm minimisation policy. That is because at a previous hearing I mentioned a book called *Drug Use in Australia*, edited by Margaret Hamilton, Trevor King and Alison Ritter. In an essay by Margaret Hamilton she says two things which are important for us to know about:

... debate about—

harm reduction—

in the education area and to young people has continued. This has included the articulation by Prime Minister John Howard of an apparently inconsistent policy stance of zero tolerance in the drug area and a subsequent explanation that this referred to a policy approach in the school context.

She is talking about the Prime Minister, who set the policy, saying he is unhelpful and inconsistent because he wants zero tolerance. She also says:

From the perspective of harm minimisation, drug use per se is neither good nor bad. It does, however, have beneficial and harmful consequences. This morally neutral stance has made it possible to begin to move away from a punitive and condemnatory approach toward a more human framework.

She says harm minimisation avoids the ‘minefield of moralistic arguments’ about whether drug use is inherently ‘good’ or ‘bad’. She complains that the debate about drug issues ‘has been heavily influenced by moral considerations, and the use of certain drugs has been considered to be immoral and a threat to society’. Well, I happen to think drugs are a threat to society. But today:

The Australian Drug Foundation strongly supports the recent statements by the Australian National Council on Drugs—

wish it was against drugs—

and the Alcohol and Other Drugs Council of Australia ... in defence of Professor Margaret Hamilton and harm minimization. Professor Hamilton is ... internationally recognized ... in this field with an immense record of contribution. The derogatory comments were during recent hearings of the House of Representatives—

this committee’s inquiry. The foundation goes on to say that the remarks were:

... inappropriate, ill-informed and blatantly unfair criticism. They demean the role and integrity of the Committee.

This Inquiry is addressing a very important issue. It is ... timely ... The Committee—

which I chair—

appears to be under the mistaken impression that zero tolerance is the official drug policy of Australia. However, according to the National Drug Strategy ... harm minimisation forms the basis of Australia’s national drug strategy. According to the NDS, “harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm ...

And on it goes. Well, I do not resile from the comments that I made earlier. The Prime Minister, in a speech which he made on 3 February 2004 when he announced a Tough on Drugs policy in Carlisle in Perth, said:

Well for the life of me I can’t see why we shouldn’t have a completely zero tolerance, uncompromising approach to illicit drug taking. There is no safe level of marijuana use, there is no safe level of the use of any kind of illicit drugs and the clearer that message can be communicated the better and that is why of course the Government, among other things, has an uncompromising approach at a federal level towards any resort to heroin injecting rooms, and I’m not suggesting all of the states are ... doing that ... but at a Federal Government level we will do everything in our power to prevent states from doing that because we don’t think in the long run it is in the best interests of the community.

And on he goes.

Mrs Mullins—Could I follow on from that statement that you made?

CHAIR—Yes, sure.

Mrs Mullins—That is the issue. The Prime Minister thinks he has done a fantastic thing by stopping heroin clinics. It was, and that is why we got behind him; we said, ‘We’re going to back this man.’ However, he capitulates because of these people. They completely ridicule him continually and he has been backed into a corner where he is staying so he is not polarised and not particularly allowing either side—because that is how it is, and Wayne Hall identified it in 1995. In fact, that is why the ANCD was formed, because the consensus of the academic experts was that drug policy and the way it should be formulated is polarised. So the ANCD was formed, but the ANCD is absolutely on the other side of harm minimisation drug reform.

CHAIR—Can I just say I do not believe the Prime Minister has capitulated. I think the Prime Minister is just as strong as he ever was. But what we are hearing is undermining messages in books like this, which, I might add, came out of the Parliamentary Library.

Mrs Mullins—Yes, that is the part—I mean, the Prime Minister can say, but the real thing that is happening is that we are not having zero tolerance. I just want to confirm that the Australian Drug Foundation is Bill Stronach. Covertly, he actually is the International Harm Reduction Association—I will present this to you; you can keep that. It is funded by Soros in Australia. It has come now to be very highly funded. I believe this is the reason why we are facing such huge problems here. We are just running at all the advocates of drug law reform. This is the article that Wendy and I had published—I have two copies for you. It was just sunk. That shows you what has happened in Western Australia, and Australia, and it gives you Bill Stronach’s quote where he says that little by little they have got all the journalists or most of the journalists working for him and the drug legalisation movement. That is underlined there.

CHAIR—Where did he make that statement?

Mrs Mullins—He made it to the journalist; the journalist rang every person. The Australian Drug Foundation is connected with George Soros through the Drug Policy Alliance. We were coming up to the 2003 cannabis laws and what that journalist was saying was: ‘Why is George Soros so interested in what is happening in Western Australia?’ because, by then, through the Drug Policy Alliance, there were letters to the editor from New York saying—

Mrs Herbert—Saying about it being a political movement and that the Drug Policy Alliance in New York determines our drug policy. I am saying it is not Australian.

Mrs Mullins—Chair, I think you have probably seen this—and Wodak, Stronach and Mugford were there; the same Wodak was there, the same Stronach was there—where he is quoting how he sees cannabis and drug law reform should be. I think you have this. This is the Drug Foundation of America meeting attended by Stronach, Wodak and Mugford.

Mrs Herbert—All the people commenting on drug policy were at that meeting.

CHAIR—Is that the only copy you have?

Mrs Mullins—Yes.

CHAIR—I will arrange for the committee to get a copy.

Mrs Mullins—That is integral. I would like to table it. It is time for it to be tabled because it shows how much—

CHAIR—The committee will accept it as an exhibit, together with the other document you have given us.

Mrs Mullins—Stronach is funded by the Australian government to educate people on drugs under the Australian Drug Information Network. He runs the DrugInfo Clearinghouse, the Good Sports program—and this is why we are getting the rubbish that is coming out of the football situation—and the Centre for Youth Drug Studies. He is funded by the Australian government for all these things, and here is his position on his website stating the ADF's position on the role of zero tolerance in Australian drug strategy. He clearly says, 'Can zero tolerance operate alongside harm minimisation?' and he goes on to bucket zero tolerance in quite emotive terms and to promote harm reduction.

CHAIR—I do not quite understand that. Is he saying that within our ADF we should tolerate the use of drugs?

Mrs Mullins—No, that is the Australian Drug Foundation, the one you got the press release from.

CHAIR—I see.

Mrs Mullins—In that way, he is really criticising the Prime Minister. They are doing that in this way; that is the way they are criticising the Prime Minister. We were speaking about Margaret Hamilton before. Interestingly, Margaret Hamilton, who is vice-chair of the ANCD, is actually an adviser to the Beckley drug policy consortium, which wants the INCB out and WHO in. This is the list of people in Australia who belong to the Beckley Foundation. It is funded by Soros and two other legalisation foundations in Europe, and both of Margaret Hamilton's representations are here—and also Stronach and Turning Point in Australia. That is what she does. She has not declared this in Australia, to my knowledge.

Harm reduction was actually started by the incorporation of a private limited company with these same characters. These are the papers. This is how harm reduction started in Australia, with Wodak and Stronach. This is simply a company registered in Britain by one of the chief people who came out of Britain for the legalisation of drugs, which was following the Mersey example of giving heroin to addicts. They are the papers of this company, and you will see Wodak's signature and Stronach's signature.

Wendy was talking about people who, in the eighties, formulated the Australian drug policy and in 1993 addressed the US drug reform foundation, telling them how brilliantly they were doing in Australia, although they were having a little bit of trouble. Dr Neal Blewett was by then the minister for health and he thought that harm minimisation was the best way to go. He had big trouble with zero tolerance. So there were three of them: Stronach, Wodak and Mugford. I told you about Stronach, and I am now telling you about Mugford. Amazingly, Mugford assessed and evaluated the National Drug Strategy framework from 1998-99 to 2003-04. This is the problem:

we are having the National Drug Strategy evaluated by people who are undermining it in the first instance. There is no independence in the evaluation through and through, and it is just getting worse.

Mrs Herbert—It is a well-established network started by Dr Les Drew, a psychiatrist, who changed the nomenclature in the United Nations and David Hawks, who is here in Fremantle. Once they had done that, they started to write literature in all the medical journals, which said: ‘We’ve got to decriminalise. We can’t make a moral judgement about the drug user.’ So they started right at the professional level and worked through the doctors, then they worked through the education system and then, in 1985, Bob Hawke asked to change the drug policy because of what happened to his daughter. He wanted an American model.

We have Drew’s own words, from their internal documents. He said that ‘someone came to ask him for help on this drug policy’. He phoned up his mates around Australia, drafted a drug policy and, in his own words: ‘It’s nothing like what Hawke wanted. But we told him that was the consensus and it was done.’ It was Les Drew who did that. There is no accountability for this. These are the people who are running our drug policy today. Harm reduction is, in their own language from their own documents, nothing more than legalisation. That is the long-term goal of harm reduction. It is a marriage between international politics, businesses who make money out of addiction, the government and the user—so the user has his pleasure. Once you have that combination you have a very powerful movement which is very difficult to oppose because there is so much money and political power involved.

CHAIR—I know of the money involved. I was told during evidence at another inquiry that people who are big drug dealers will target 100 young people and supply them free initially, on the basis that 10 will become addicted and they then make them the suppliers. It is a bit like pyramid selling.

Mrs Mullins—Yes, but that is not the only place where the money is being wasted. It is being terribly wasted at the Australian government level. We just have not got any semblance of a fight against the drug problem. It is the fault of these people who are non-government organisations, and also the fault of the Department of Health and Ageing. It has to be really seen what it is doing. I exposed one of their people, Jenny Hefford, who went to this Beckley Foundation, which is under Chatham House rules. As a Commonwealth think tank it is a charade.

Mugford did the evaluation. I went to the internet the other day and put in ‘Stephen Mugford illicit drugs’. You would not believe what I got back: two A4 pages on the fact that he advises the Australian government on human services, the Army, the Navy, the Air Force—every level.

Mrs Herbert—In these documents we got from the Drug Policy Foundation, which is supported and funded by Soros, Mugford and Wodak are described in the foundation’s own language as two extreme left-wing internationalists. And he is advising our Army on drugs policy!

CHAIR—I think we might stop there. Mr Quick, do you have questions?

Mr QUICK—No. I would like to—

CHAIR—I think we need to go through all of this material.

Mr QUICK—Yes. We have a whole heap of information here. There are only two of us and there are 10 on the committee so my advice to you is to provide us with this. This probably will not be the last time we come back to Western Australia before we write the report. Thank you for giving us the human side through Kerry and Thelma. I was on the last drug inquiry. It went through two parliaments over about three years. We have seen and heard just about everything. But there was some additional information here.

CHAIR—Thank you very much for coming. Thank you for the emotion that you were clearly fighting back in telling your story. We do appreciate your coming. We have accepted all of the documents that you have produced for us as exhibits. Thank you very much.

Proceedings suspended from 11.01 am to 11.19 am

LENTON, Associate Professor Simon, Deputy Director, National Drug Research Institute

WILKES, Professor Edward (Ted) Thomas, National Drug Research Institute

CHAIR—I now call on the representatives of the National Drug Research Institute to give evidence. Are there any additional comments you wish to make?

Prof. Wilkes—I work at the National Drug Research Institute in Indigenous research programs. I am particularly here today to talk to you about some of the issues around illicit drug needs of Indigenous Australians.

Prof. Lenton—I am the deputy director at the National Drug Research Institute at Curtin University and I will be here to talk about the research evidence around families and drug use.

Witnesses were then sworn or affirmed—

CHAIR—Would you both like to make an opening statement?

Prof. Lenton—Ted will make an opening statement about Indigenous issues and I will make a brief opening statement just introducing the National Drug Research Institute to you. We will then respond to your questions regarding each of the terms of reference.

The National Drug Research Institute was set up under the National Campaign Against Drug Abuse in 1986. We are based at Curtin University and we are funded by the Australian government Department of Health and Ageing. Our mission is to conduct high-quality research that will contribute to the primary prevention of harmful drug use and the reduction of drug related harm. Our mission is also to contribute to national capacity for research in the drug field and to disseminate research findings to key groups. We have a staff of about 30, of whom about a third are senior research staff, a third are more junior research staff and about a third are administration support, library and so on. We have very professional backgrounds—psychology, public health, epidemiology and anthropology—and our outputs since our inception have been around 250 research projects, of which about 50 are ongoing.

In the last financial year, we conducted 79 research projects, 66 research reports, 33 peer-reviewed articles and were involved in 34 national and international collaborations contributing to 267 media stories. We collaborate often with groups nationally and internationally at a government level, at a state level—national government, state government, local community and so on—and we also have good links to industry, government and community, including of course Indigenous communities. We have about nine PhD students. Our range of research programs include the Indigenous research program, work on legal and regulatory approaches to drug use, work on alcohol monitoring, school drug education, issues around injecting drug use and the use of ecstasy and related drugs, community interventions, issues around alcohol and ageing, an ethnographic research program which targets young people around drugs and alcohol and also for the prevention of blood borne viruses.

Relevant to this committee is the fact that we just have an application in with our colleagues at the National Drug and Alcohol Research Centre for an NHMRC funded project to look at a longitudinal study of babies of substance-using parents to look at the impact on milestones, health effects, later substance use and so on. One of the issues with that of course is that, while we get money from the government, we actually have to go and fund money to do the research. The track record of the drug and alcohol field in getting NHMRC funding has been pretty poor largely because the kinds of studies that they fund are not well suited to this kind of research. So, from our point of view, in the past when there was ring-fenced money for drug and alcohol research, we were much more able to get the kind of work done that we and others think is important.

CHAIR—Have you been successful in getting an NHMRC grant yet?

Prof. Lenton—We have not got this grant yet. We are just in the process of putting it in.

CHAIR—We obviously need that research, as we heard quite clearly from Dr Hamilton this morning.

Prof. Lenton—Certainly, and it is not just an issue for this project; it is an issue for other alcohol and drug projects, which often use the kind of methodology which is not often looked on very kindly by NHMRC committees, which are often focused on drug evaluations and case-controlled methodologies, which are difficult to do in this field. That is all from me for the moment.

Prof. Wilkes—In a sense, I am a little bit fortunate: I hear the diversity of thinking in the area of illicit drugs—and I particularly picked up on the comments of the previous speakers. As an Indigenous Australian and a person who has worked in health for most of my working life I have, along with other Indigenous leaders, had to find pathways through what I might call the whim of government. Some of the difficulties with that are certainly testing of the character of our own leadership. But let me say that I am on the ANCD; I am a member of the Australian National Council on Drugs. I do sit down with people like Professor Margaret Hamilton and I do respect that we do have diversity in our own thinking. I would not agree with everything that Margaret says, but I am certainly a strong advocate for harm minimisation, particularly coming from where I come from.

As an Indigenous Australian I see the adversity of Western systems as they are imposed on Indigenous Australians in the historical context—and I will not go into that; it is about what is happening today. Indigenous Australians today still live what I call a poverty-stricken lifestyle and I think that poverty-stricken lifestyle, for many Indigenous Australians, is entrenched. It is seemingly entrenched. Unfortunately that is the way we look at it. The impact of illicit drugs on Indigenous families is therefore somewhat exacerbated because of the social circumstances of our people.

I chaired the National Drug Strategy's complementary action plan for Indigenous Australians and the development of that plan. I am now the chairperson of NIDAC, which is the National Indigenous Drug Advisory Committee. That committee is a subcommittee to the ANCD. I also work in other areas and sometimes I am able to cross-reference the effort that is going down. I am particularly impressed with what Simon said about finding ways to help in relation to

children and pregnancy. I did work with the Telethon Institute of Child Health Research at Subiaco and still work one day a week with them. I am the chairperson of the Western Australian Aboriginal child health survey. One of the real issues to come out of that survey is that children are prone to, again, the whims of government, in a sense, because their parents and uncles and aunts are caught up in this cycle of poverty and children are somewhat prone to the use of drugs.

While we are talking about illicit drugs, the impact of alcohol and cigarette smoking on our people certainly is very traumatic. I also want to mention that youth caught up in illicit drugs are committing crimes to feed their habits, that these crimes are in many cases crimes against family and some of these crimes are not reported. So we suffer the consequences of some of this use of illicit drugs within our own Indigenous communities. How we minimise or prevent the harm that such activities force on our communities is still something we are not able to categorically state. We do not have a magic wand and we do depend on some of the research that comes out of places like NDRI. We do depend on the goodwill of the ANCD—and, I guess, as the chair of NIDAC I should say many of the Aboriginal community people around Australia are depending on NIDAC to advise government appropriately as to how we can minimise and diminish the impact of drugs in particular and, in this case, illicit drugs.

Families do not have the capacity to deal with family members that are dependent on illicit drugs. In many cases, inaction takes families further into despair. I see this in my own extended Indigenous family and have information related to me through informal and formal networks and discussions with other Aboriginal parents and people working in the field. I might stop there and leave it for further questioning.

CHAIR—Thank you very much. Can I begin by asking you, Professor Wilkes, about some of the problems with Indigenous youth as they start to use marijuana at a younger and younger age, and the impact of that drug on the development of their brain? I know that, the younger the child is when they start to use marijuana, the greater the problem. When I was on Bathurst Island taking evidence in another inquiry from a group of elders and the principal of the school, the principal of the school said that his greatest competitor to having the children in school was marijuana.

Prof. Wilkes—It is an unfortunate reality that marijuana has certainly become available in some very remote parts of Australia. It is now no longer a drug that might have been bounded by the southern regions. There is evidence today that it does have an impact on the brain. Concentration levels in youth and people who use marijuana over the long term is certainly a concern to Aboriginal leaders, as it is to the broader population. The issue for us is how we actually diminish the supply of drugs like marijuana in remote parts of Australia.

We have a complicating issue as well: As a result of previous generations' misuse of alcohol, Aboriginals have also a diminished capacity in some regards. If we go into discussions that I have had with people like Professor Fiona Stanley and others who work at the institute of child health, I could alert you to my major concerns about pregnancy and alcohol and smoking. Commonly our young pregnant women and young fathers do not have the knowledge that we desire that they have about the impact that drugs are having on the womb and their unborn child. I am now more aware of the fact that brain sizes and brain capacities are diminished because of what happens during pregnancy. So we have that complicating factor—that maybe there are

human beings alive today that might very well have been born with foetal alcohol syndrome and are living today as adults and also misusing other substances. So we have a double-whammy type effect. That, on top of what I have already referred to as the social position, social oppression or the social poverty of Indigenous Australians, is certainly something which I believe would make it very difficult for some families to actually survive.

CHAIR—What sort of policy would you see being developed for Indigenous people specifically? You have to be a great role model for them—your success, your standing in the community and your concern about this problem. How do we assist with that?

Prof. Wilkes—I have always maintained that the bigger picture is something that we cannot forget. The bigger picture is about looking at some of what we call the structural determinants or the social determinants. I still maintain that knowledge is a wonderful asset to have and I believe that our children are missing out on good education. I believe that we need to manipulate the education system so that it is more appropriate for Indigenous Australians.

Ours is the lucky state—it has the boom on at the moment. I hope that employment prospects for Indigenous Australians are enhanced. It is about lifting that rate to a level that is compatible with other Western Australians. Income levels amongst Indigenous populations throughout Australia are substantially lower than they are for the remainder.

We need to address some of those social determinants. It is not only about the social determinants; it is also about the treatment programs that are available to Indigenous Australians when they are caught up in drug misuse. We do not have appropriate access to some of the services that are available to other Australians. We need to work diligently and with a maximum effort to improve access, so that Aboriginal people have access to detoxification centres, if they are at the hard end of some of this abuse. We need to know what is happening in relation to early intervention. If early child intervention is about making sure that children have the capacity to use their brains at that time when they are three years old, when some of that maximum brain development is happening, Indigenous children should be allowed to do that as well and not be diminished because they are at home and caught up in a domestic situation where parents are not able to provide that.

There are some clear ways—and early prevention for youth is one. If we can get some of the knowledge to youth before they leave high school that some of their behaviour will impact on the way they live, we can win some of the battle.

CHAIR—I have a vivid picture in my mind from when I was up in Pitjantjatjara land, opening a facility that provided employment for about a dozen young people. The joy of opening this facility and the sense of attainment that these young people had was wonderful—yet, as I walked up to where there was a shop that had some lovely artwork in it, I saw a young mother pushing a stroller with a baby with a can strapped on to her face. The two images, the joy of achievement—those people who were getting an opportunity to work—and this other image was just devastating. It will never leave me.

Prof. Wilkes—It never does. Right throughout the country with what we call the glue sniffers there is a prevalence of glue sniffing which fluctuates, I think, but I think it is still at a level which is most concerning to most Indigenous Australians. I think some of the reasons for glue

sniffing in particularly young women are associated with the poverty that I talk about. I was involved at the Aboriginal medical service in Perth as a long-term director and one of the major issues for me was to diminish the child sexual abuse that happens with our kids. I am not suggesting for one moment that all glue sniffers are children who may have been, but some of the indicators that came to me were that children who are glue sniffing or taking alcohol early as an onset or smoking cigarettes and have behaviours which are about trying to escape from the home life—those indicators are quite clear to me and they indicate that some form of child abuse and neglect in the home environment and the potential for child sexual abuse in our world is quite profound.

CHAIR—I saw that firsthand when we were in Queensland last week and I was talking to a young Aboriginal mother. She was successfully on a particular program and she said she had three daughters and she was going to get well for them. She had been abused as a child. I said, ‘Well, you have to protect your daughters, haven’t you?’ and she said, ‘Yes,’ but their father had abused one of them already—at 3½. But she was determined and I am going to try and stay in touch, because she had a real determination within her that she was going to look after her kids.

Prof. Wilkes—There are some wonderful young women who have come out and exposed some of the older people in this world. It is an unfortunate reality that it is not only the men but there are some cases where women are assisting older men to do this. But I will not go too far into that. It is a very touchy subject.

Mr QUICK—Perhaps I can go on to something totally different. In your little pamphlet you talk about community intervention research. As an ex-teacher, I am interested in benchmarking best practice for drug education in schools. Can you enlighten me about who is doing it best? We pour tens of millions of dollars into the whole issue of drug education for our young people. Are some people doing it better? Is it hit and miss, depending on the school principal or the teachers there, and when they disappear it falls in a hole?

Prof. Lenton—You will know that what goes on in schools is often left to the individual principal level, so it is difficult to make a requirement that all schools do drug education or all schools do it in a certain way. We have been involved in projects—I have not myself, but other colleagues have been—working within particular schools and a very close evaluation of impacts of drug and alcohol education over time, which has been targeted not simply at ‘just say no’ approaches within schools but also looking at young people’s experience of the risky behaviours that they get involved in around alcohol use and the things that they perceive as being particularly concerning and working with them over time to identify not only strategies to say no but also strategy to identify when they and their friends are at risk and how to tackle those risks over time.

It has shown that, if you use an approach which is broad—which includes abstinence approaches but also works with kids who are currently using to help them stop getting into grief as well as working towards abstinence—it has a much deeper impact and many more kids take it on board. It involves lots of teacher training, lots of working with teachers—not just providing resources, but actually training the teachers to do this stuff with the people they know rather than bring in people from outside the school who have no relationship with these kids. So it is not just something that happens in a class called ‘drug education’, but it happens across the curriculum and also obviously in the playground and so on where teachers know these kids and know the

context of their lives. That has been published in international journals and has been shown to be one of the most effective and demonstrated effective approaches. That has now been picked up in other places around the country and internationally. It is work I have not done myself, but we can provide with literature on that.

Mr QUICK—To me, if you can cut the people going through the pipeline—

Prof. Lenton—Yes. One of the issues is that a lot of the people who get into the most difficulty with drugs find themselves being marginalised from school quite quickly. The evidence about early cannabis use and later problems with other drugs and later other physical and psychological problems is that keeping kids engaged in the school system early is a particular protective factor. So it involves looking at school policies. Once a kid gets kicked out of school and is then at home with an Xbox and a bong and there is not a lot else keeping them occupied, that is when the problems really escalate. But it is a difficult process, managing the need to have appropriate policies within schools but also how to reintegrate kids back into the school system. It is a difficult one, but it is one that we need to grapple with.

Mr QUICK—I spoke this morning, when we were talking to the Western Australian government officers from the drug and alcohol office, about linkages with juvenile justice and the police so that. If you can keep that kid in the system, you know where he is from eight to three and you can provide the resources. What is the research saying? We are talking about hundreds of millions of dollars being poured into this area and the money keeps flooding in. How effective are some of these strategies and is best practice being replicated or are we reinventing the wheel in Western Australia, Queensland and Tasmania because the curriculum branch says, ‘We had better do our own particular thing’?

Prof. Lenton—I will not speak about this in detail but rather just say that, in general, the truth is that the money does not follow the effective interventions. The money that goes in does not necessarily go to those interventions that have been shown to be most effective.

Mr QUICK—How do we overcome that? You are battling through NHMRC mazes to get something which the chair and I—and from the evidence I saw today—would think was one of the first things you do rather than perhaps pouring some more money into diabetes research and things, because that perhaps has had a fair share and this area is suddenly front-page news that a lot of us had not heard about.

CHAIR—I would not agree with diminishing research into diabetes; that is an enormous problem across the board.

Mr QUICK—I will probably get into trouble from the diabetes people, but to my mind this is one key area. It has been like throwing a bucket of water and some get a whole lot and others miss out on the periphery.

CHAIR—But I do sincerely hope you are successful in getting this grant because, having listened this morning, the need for that research data to be available is huge—because the whole policy of this—biology first, child back to the biological parent—would have to be reviewed in the light of that research. That is how important it is.

Prof. Lenton—It needs to be very carefully examined over time. A lot of stories will come out of it which will inform practice. But, as I said, the difficulties in getting research funded in this area are not just about getting research funded on kids and families and drug use.

CHAIR—Can we go back to that question of education? Again I go back to the Australia Institute of Health and Welfare saying that education plays a very small part for people who decide not to use illegal drugs. Would you welcome, as others have said, a full-on campaign, the likes of which we have had for smoking, for AIDS?

Prof. Lenton—We have had big full-on campaigns.

CHAIR—No, we have not—not like that.

Prof. Lenton—Okay. We have had mass education campaigns.

CHAIR—That is what I am saying: the evidence suggests that it does not work.

Prof. Lenton—I tend to agree with you. One of the issues with education is that everyone says it is a good thing and we should have more of it.

CHAIR—Like motherhood; it is good.

Prof. Lenton—Yes, and it is relatively easy to do, because you produce a campaign, you put it out and then it is evaluated—people recognise the brochures and we kind of move on. But of course the impacts of that are difficult to determine. It comes back to some of the comments that Professor Wilkes was making earlier about probably the biggest answers to a lot of these issues are not just in the strategies that are targeted at drug use per se but in the much broader strategies that are focused at more macro issues.

CHAIR—Again, the question we have addressed all morning is of language, of attitude. I will use the term again, ‘party drugs’. I see even that one of the programs here was called a party drug program. It has had its name changed, which I think is a very sensible thing, to say this is about damage; it is not about harm, which rhymes with ‘calm’.

Prof. Lenton—It is important that the language that is used to describe issues in this area is tailored to the audience which it is given. One of the issues for us is that, in the international literature and in the world where we publish, that is a term that is used to describe this kind of research. Should that be used in a mass public education campaign? Definitely not. But should we be able to publish research in international journals where people know what they are talking about? I think we should. It is not a black-and-white question, this issue of terminology; it is one that needs to be carefully thought through.

Mr QUICK—But what is the role of the media?

CHAIR—On the ABC.

Mr QUICK—What worries me is that in Queensland, where we took evidence last week, schoolies week is the big thing around Southport, and it is great for tourism and you have all the

kids there, although only a certain percentage take drugs—big deal, because it is a boon to the economy. What sort of message are we sending to our kids, that this is a formative part of their life?

Prof. Lenton—That is absolutely right.

CHAIR—And we also heard evidence that crystal meth, speed and ecstasy are cheaper than alcohol, so it is a preferred drug.

Prof. Wilkes—Some of the discussions we have had in the ANCD in relation to the early onset are that the information now is that if, through these sorts of education programs or awareness programs, if we need to call them that, we can prevent the early onset of drug misuse, actually—

CHAIR—When we say ‘drug misuse’, there is no such thing as good use. So simply using it is bad.

Prof. Wilkes—That is right.

CHAIR—But see how mixed up the language has become?

Prof. Wilkes—Yes, I know, and with words we can play semantics. But let me say this: I actually do not believe that zero tolerance and harm minimisation cannot work together; I think that they can. I hear people saying it is one or the other. I think we can have a zero tolerance policy but we still have to minimise the harm for those people that are out there that are actually defying the policy.

CHAIR—Don’t we have to have a prevention policy—that we want to prevent young people from taking drugs?

Prof. Wilkes—That is right. We do.

CHAIR—But we do not have such a statement anywhere.

Prof. Wilkes—No, but information suggests to us that if we can prevent that early onset—there are studies that suggest that kids who actually do not take up drugs until they are well and truly over 18 or in their 20s are actually more likely not to take them up at all or are more likely to be able to deal with the issues around illicit drugs or drug misuse or alcohol.

CHAIR—We heard from somebody today whose daughter started taking drugs at 21 and we saw the consequences.

Prof. Wilkes—Yes. There are anomalies in everything—I know that.

CHAIR—We saw the consequences.

Prof. Wilkes—But I have people in my own family and I can say to you that at the moment I am dealing with a young fellow who is 35 years old and is dependent on speed. He and his father

have been in conflict for a very long time and I have had to say to the father, 'Make him own up to the fact that he has an issue and we might be able to deal with it.' It is about when these people own up and—

CHAIR—And want to do something.

Prof. Wilkes—Yes—and say they want to do something about it.

CHAIR—That is why I am keen to see a prevention policy, a drug addiction prevention policy, and that the language has to match the message. I think we have to recognise that there is a body of people in our community who want drugs legalised. They want them legalised. I think we have to recognise that as a fact. We therefore have to look at how we then deal with that. We do not want people using and we do not want them legalised—which is the majority opinion of the community, and this is a democracy—but there are people who want them legalised.

Prof. Lenton—There are. Can I just address this issue of harm reduction? I think a lot of the criticisms and antipathy towards harm reduction come from a caricature of what harm reduction is about. I would like to address that because it is an important term of reference of the committee. There is no doubt in the world—and people who support a harm reduction approach would agree with this—that abstinence is without question the best way to avoid harm.

CHAIR—Not all people do agree with that, I am afraid.

Prof. Lenton—If you would let me give my opinion. The best way to avoid the harm from drug use is not to use at all. There is a lot of literature to support that. But the issue that we have already mentioned—and the chairman, Professor Wilkes, has also acknowledged this—is that not all people are willing or able to stop at any particular time. If you take any group of people, you will have some people who have never engaged in any problematic drug use; you will have some people who are engaging in it but are not really recognising the cost but just focusing on the things that they like about that drug use; you will have some people who are starting to recognise the problems and are starting to contemplate change; you will have some people who are starting to change their drug use; and you will have other people who have started to change but might have slipped back—relapsed, if you like, to some level of use. If everyone who was using was prepared to stop tomorrow, all we would need to do is offer abstinence oriented treatment. But the reality is that we need to respond to people right across that continuum. Of course we need to encourage abstinence, encourage people not to take drugs in the first place, but we also need to recognise that the person who is using today might be an abstainer in three months time. We need to keep that person alive today—

CHAIR—Do not forget the pusher or the kid in school who has been strong to date and suddenly is pushed over.

Prof. Lenton—They might be. I am not supporting drug use or supporting pushing drugs at all and I think we need to have appropriate penalties that need to be enforced. What I am saying is that we need to recognise that people move through these cycles and we need to do what we can to reduce the cost to individuals, the community generally and to families. Unfortunately, if all we offer is abstinence oriented treatment, we are only going to be responding to the needs of

a small group people and we need to make sure that we offer interventions across the board so that some of those people go on to become abstinent, because that is the long-term goal.

CHAIR—That has to be the aim.

Prof. Lenton—That is the long-term goal.

Mr QUICK—Like we saw in Brisbane last week at that excellent shelter in Southport, where people got up and made statements that this was their second and third go, but they were determined that they were going to beat this.

CHAIR—To keep off it—that is what they wanted.

Mr QUICK—Yes, that is right. But they wanted us as lawmakers and politicians to understand it, because we had not gone through, thank God, the trauma and—

CHAIR—This particular facility is starved of funds.

Mr QUICK—That is right.

CHAIR—Because its aim is to get people off it and it will take people more than once. It is starved of funds. But somebody else who might have a policy of keeping people on the drip drip drip gets money.

Prof. Lenton—I think the whole treatment sector in the alcohol and drug field needs to be appropriately resourced; I do not think too many people in this room would agree that it is at the moment. We need the best available treatment for people to abstain that is evidence based, that works and that can be evaluated.

CHAIR—I cannot tell you the number of parents who come into my office and say, 'Mrs Bishop, do you support mental health programs and more mental health beds,' and I say, 'Of course I do, but what's the problem,' and the problem is the same—marijuana use usually, psychosis. They go into the bed where the legal processes can monitor them. But those orders do not go across borders. They leave. They get themselves out and go to another jurisdiction. They are under a bridge. Our jails are full of people who otherwise would have had alternative places to go once upon a time. Through not telling people what could happen to them, we have created a huge burden, which we must meet. They are still our citizens.

Prof. Lenton—Absolutely. That is exactly what we are saying too.

CHAIR—We have to provide for them.

Prof. Lenton—Exactly right. That is what we are saying too.

CHAIR—We have to alert them and we have not done it.

Prof. Wilkes—Simon and I work together, so we are going to find compatibilities; we have to. But I have already said it: I do not agree with everything that comes down. In an Indigenous

context, if we move for zero tolerance and we say, 'Okay, you're in trouble if you get caught with drugs'—the prisons are already overpopulated with Indigenous persons. We already have that. My real fear is that, if we do not come up with other strategies to try and minimise the harm of drugs so that people can keep themselves out of prison and not get themselves into trouble, all we will really be doing is manifesting a prison population or a phenomenon within prisons, and Indigenous people already know that we have to try to cut back the other way.

CHAIR—If you talk about soft language, you are never going to get the message through. What about words like 'damage' and 'destroy'?

Prof. Wilkes—We do. We talk about the fact—

CHAIR—No, we do not.

Prof. Wilkes—Some of the discussion I want to have today is about a particular program, and this is again operating at the whim of government. In 2000, leaders of the Aboriginal community here in Perth set up a community response and we called it the Indigenous Family Program. When you look at drugs and illicit drugs, they impact on the families. It is not necessarily about the individual. So we set up this Indigenous Family Program, run through what we call the Coalition of Aboriginal Agencies. The response was an effective community response to the despair facing families caught up in what I call abject poverty. These families were caught up in a cycle of poverty that included the misuse of alcohol and other drugs. Consequently, these families were also caught up in domestic violence and were regularly caught up in the justice system. This program also began to expose complicated forms of child abuse, including child sexual abuse.

An integral principle for the successful delivery of the program is that it be run by the Aboriginal community. To the detriment of the program, it is now run by a mainstream organisation. I could say to you that there were issues around how the funds were being administered, but we began to expose some things which governments, people working in government and other Aboriginal leaders were not comfortable with. You know what I am talking about. So I too want to see that drugs do not have this impact. I do not want to see those kids that you referred to that are walking around glue sniffing and those kids that are down on the streets begging for five bucks for a burger when they are really slipping around the corner to buy themselves a bottle of glue. I do not want to see the young fellow out there hassling his mother. I do not want to see a situation like when the young niece came to my house and asked me, 'Uncle Ted, can I stay with you for two weeks? I need to dry out,' and I then found that she had also stolen a couple of good dresses from my partner and a bit of jewellery, and someone saw her in the casino walking around with all this jewellery and this dress on. We do not want to see that, but we do not want to see our kids being put into jail either. So there has to be some sort of way of finding middle ground on this.

Mr QUICK—All the research papers and things, how do we disseminate those out to the ordinary average punter? When we have state elections, we have law and order and all these issues are up there, then once the election is over they all disappear, but you have all this wonderful research there. How do we get it out to the ordinary average person in the street? As we heard evidence of today, they do not realise the kids are on it, then suddenly half their belongings have disappeared and, if they are doing marijuana and a whole mixture of drugs, they

are psychotic and they threaten mum or dad. Then it is: 'Hell, I've got a problem'. How do we get it out?

Prof. Lenton—We are well known for getting our research findings out into the community in a number of ways. Obviously, we do briefings for people in government and so on, but we also package research findings in ways that are appropriate for the media. As I said, we have done nearly 300 media stories in the last 12 months on drug issues and responses to them. So that is important. But it is also important to recognise that there are other agencies that are set up to actually work with the public generally and with people who are experiencing problems and families who are experiencing problems. I think you are going to be hearing from the Parent Drug Information Service after today. I work as a clinical psychologist in private practice as well, working with people with drug related problems. Invariably, PDIS get referred to families of people whom I am seeing in my private practice. So we work through agencies like that as well.

Mr QUICK—And yet we heard this morning from the antenatal clinical dependency unit that there has been a threefold increase over the last three years of pregnant mothers presenting. The messages are out there, but do we need to target more directly?

Prof. Lenton—The frustration—it gets back to what we were saying before about education—is that it is not just about information. It is not just about giving people information. It is also about some of these bigger picture issues as well. It is actually relatively easy to get information out. That does not necessarily result in changing behaviour. So we need to tackle these broad questions that Ted was talking about but also, importantly, identify young people who are at risk—kids within the school system and outside of the school system who are at risk. The more research that is being done, we see that things tend to go together. Early onset of drug use, mental health problems, school conduct problems, later antisocial behaviour and so on, truancy—all those things tend to coalesce. Where you have a young person who is experiencing some of those kinds of problems there is an opportunity for early intervention in that person's life, rather than waiting until they are in their late teens or 20s when they are experiencing significant problems.

CHAIR—One of the things that was said to us in Queensland—and it really resonated—was a mother had found that her 14-year-old child was using drugs, and she thought you would ring up and find somewhere you could go and put a child to get the child off the drugs and then deal with the problems. There is no such place. People started to talk to her: 'Well, he'd have to agree.' But there was nowhere and then the problem just escalated. Why can't we have such a place?

Prof. Lenton—I have provided you with some research papers from the recent literature looking at new approaches for responding to parents of substance-using kids and looking at addressing the needs. I was here for some of the earlier discussion. I was also going to provide you with evidence that confirms a lot of the important reports we had from people who presented to us as well. This is an issue that is gaining an increasing research focus. There are now appropriate interventions that are being targeted, some of which you will hear about after we finish talking, at assisting families—parents, grandparents and others—who have a substance-using person within the family about how to get support for themselves, because it often has huge impacts on them; about how to identify when the person is likely to be using; about

appropriate responses in the family and outside the family; and helping them to make sense of what is going on. The evaluations are very positive in terms of impacts on parental wellbeing, mental and physical health, and feeling much better able to tackle the problem, and also that it has impacts on the drug-using behaviour of the individuals themselves. So there are some new and very positive evidence based approaches for assisting families with a drug-using person within them, which we need to be talking more about.

Mr QUICK—Is it accepted across political parties that there is this need to do this?

Prof. Lenton—I think there is a growing recognition of some of the carnage that can occur as a result of drug use in families.

Prof. Wilkes—The thing about political parties is again, Mr Quick, you know very well that in the Indigenous context we always ask for bipartisan support for our effort and we very seldom get it. But it would be a great initiative, wouldn't it, to have bipartisan support for issues around illicit drugs?

Mr QUICK—Yes. There but for the grace of God go my two daughters. I think it is incumbent upon us as legislators and federal politicians to understand this in a most serious way. As I have said before, many, many times, it is not as if we do not have enough money. It is just that it does not appear to be a concerted effort right across. As you said, we heard in Brisbane, 2007, the services are not there. And yet you talk to the state bureaucrats and we heard this morning that there is this concerted interagency approach and the safety net is there, but it is not. We need to make sure that all of the research that you present is listened to and acted on, not only in Western Australia or here in Perth but up at Broome and Carnarvon—the Pitjantjatjara homelands—where the problem is enormous, and in the CBD in Sydney. It is a national issue, not a state issue or a regional issue. It is our kids who tend to wander, once they gain some education, across the country and have families.

CHAIR—I will conclude, and then we will have to move on to our next witness, by saying that you said right at the beginning, Professor Wilkes, that you were aware of the diversity of views in the drug arena.

Prof. Wilkes—Yes.

CHAIR—I think that is a very soft way of putting it too. How are we to expect young people to respond in a responsible way if we keep sending out mixed messages?

Prof. Wilkes—Certainly as adults we need to make sure we sharpen our blade. The fact is that young people do look to older people for their comfort zones to be a part of what they might consider their adult life. I do know that respect for elders has diminished somewhat as a result of elders not living up to what is expected of them. But those elders and those leaders who do offer consolidated ways forward need to be harnessed. I believe that we need to work in partnership with one another. I believe that today—from what I see in the city and what I see with my children—I do not think there is the indifference that I saw as a young fellow coming through. I think those other agencies that were reluctant to engage with Aboriginal people in the past need to come forward.

I was talking to a lady at Palmerston, whom I think you might be talking to after. But we do recognise that in the past we have been a little bit indifferent towards one another. I think that drugs do not hold any boundaries in relation to race, skin colour or eye colour. It is about time that we unified our effort. I know that sometimes we do—and we Aboriginal leaders will say that we do—need to have specific ways to do it for our people, but that is not to say that we cannot also harness the mainstream. Kids see that that is occurring, and I think that is a positive.

CHAIR—We certainly need to get the message out, don't we, that they are bad?

Prof. Lenton—Certainly. Could I just briefly make a comment in relation to that too?

CHAIR—Yes. We might accept these papers as exhibits.

Prof. Lenton—What we know has currency and what we know young people respond to is issues that address the real harm that they experience as a result of drug use.

CHAIR—What about 'damage'?

Prof. Lenton—'Damage' or whatever. 'Damage', 'harm'—use whatever term you like: the adverse consequences of drug use. Up until recently, we have simply relied on the law to affect people's behaviour. We need to do much more than simply the law in terms of focusing on the harmful consequences of drug use.

CHAIR—First we have to enforce the law.

Prof. Lenton—True.

CHAIR—When you say to police, 'You can make up your mind, when you find someone breaking the law, whether you will do anything about it,' you are undermining the law, whether it be robbery, murder or taking drugs.

Prof. Lenton—I understand that opinion—

CHAIR—It is not an opinion.

Prof. Lenton—but what I am saying to you is that we need to do a lot more about focusing on harmful consequences. Up until now, we have not been doing enough of that—

CHAIR—I agree.

Prof. Lenton—and we need to do a lot more of it. I am totally in agreement with you about that.

CHAIR—If I said to you that you could tell your son or your daughter: 'Please be careful, dear. Don't run out on the road. You might get harmed if a car ran over you,' you are not going to say that, are you? You are going to say, 'If you run out on the road and a car hits you, you are going to be severely injured, damaged, killed or whatever,' but you are not going to say, 'You'll be harmed.'

Prof. Lenton—You can use the term ‘damaged’; that is fine. All I am saying is that we need to talk about not just saying these things are bad; we need to say they are harmful and can cause damage.

CHAIR—And they are bad.

Prof. Lenton—The damage is what we need to be focusing on, because that is what people respond to.

CHAIR—You certainly cannot remove morality from the question either.

Prof. Lenton—I agree. I think morality needs to be there. I think there are things that are done which are entirely immoral. You cannot take morality out of this issue. It is an important question. But we need to do a lot more in terms of focusing on damage, adverse consequences and harm.

CHAIR—Thank you very much for coming. Professor Wilkes, may you be very successful in your work.

Mr QUICK—Yes. We wish you well. We might do a bit of lobbying.

Prof. Wilkes—All the best with your inquiry.

CHAIR—Thank you very much. I hope you get your grant.

Prof. Wilkes—Yes, so do we.

Proceedings suspended from 12.09 pm to 12.20 pm

ALCOCK, Mrs Judith Ann, Parent/Volunteer, Parent Drug Information Service

HARRIS, Ms Sandra, Parent/Volunteer, Parent Drug Information Service

RAESIDE, Mrs Lee-Anne, Coordinator, Parent Drug Information Service

Witnesses were then sworn or affirmed—

CHAIR—Welcome. I now invite you to make an opening statement.

Mrs Raeside—I am going to talk about some themes that were derived from some Parent Drug Information Service call statistics and from the small qualitative study, conducted in 2006, of 20 parents who were living with their drug-using child. The overarching theme that evolved from the data was that families become fragmented and sometimes disintegrate totally when a young member of the family is significantly using drugs. The following themes were identified as contributing to this breakdown. Parents, out of love for their children, can become extremely fearful and will do what they can, within their capacity, to try to fix the drug problem. However, the stigma associated with illicit drug use can often mean that parents will not seek outside help and support for fear of judgement around their parenting capabilities and judgement around their child. Further, parents can feel very isolated from their extended family and their social ties due to these fears. They tend to battle on silently and alone.

The statistics from PDIS certainly support this notion. A high percentage of parents call about their adult child who has developed a significant drug problem during their adolescent years. This suggests they have been living with this for a long time before they seek help. Although parents, and increasingly grandparents, want to help their child they often feel underresourced and ill-equipped to effectively support the young person. Parents report feeling overwhelmed, despairing, exhausted and confused. They often state that they cannot cope anymore on a day-to-day basis. Parents proffered the following reasons for feeling underresourced. There is communication breakdown. Parents or other family members cannot communicate with their drug using child on a rational basis and their own marital or partner relationship often becomes fragmented. Parents report mental health concerns such as depression, anxiety and extreme stress. The research certainly supports this notion. High rates of parental attendance at the doctor and high rates of diagnosis of trauma and stress were identified for parents living with their drug-using child.

Of course, we know that some family members are also dealing with their young person thieving from them, which can be ongoing. They pay their child's fines or their loans for fear of them ending up in the justice system and they often give in to demands for money for fear that their child will find other ways of acquiring money. This can lead to some families becoming financially crippled.

The Parent Drug Information Service recognises these issues and is therefore unique in its approach to strengthening families by utilising the wisdom of parent volunteers who have experienced their own offspring's drug use. In addition, the Parent Drug Information Service

recognises that parents in crisis do not fit into business hours and thus provides 24-hour, state-wide telephone support.

Further, PDIS considers that it is an effective harm reduction strategy for families that aims to decrease parents' sense of isolation by listening and sharing experiences, providing support and information and linking parents into the alcohol and other drugs for family sensitive services. However, an issue of concern we have identified is the immediate risk of harm to family members.

A major theme is that some families are living with the impact of domestic violence and psychosis as a result of the young person's drug use—that is, the child is violent and threatening towards their parents, particularly when their demands are not being met or the user is experiencing psychosis. This situation is baffling for parents, who claim that they feel totally powerless in their own home to support their child and do not know who to turn to for help.

Under the current harm reduction strategy for family members, parents' options are to call the police, who may take the young person away for a period of time, but then when they return the cycle begins again. They can lay criminal charges on their child to stop the cycle, but this ensures their child will be involved in the justice system. They can obtain a violence restraining order to maintain the safety of the whole family, but this can result in the loss of opportunity to rebuild parent-child relationships and the removal of any support the young person may have. Or they can live with their current situation until their child moves towards contemplating change around their drug use, but at a great personal cost.

Parents are often reluctant to choose any of these options as they view them as too severe and challenging. Although parents, and in particular single parents, have said they require an authority figure to assist in establishing boundaries, many parents will not act on this course of action due to fear of severe repercussions such as: the young person may become homeless or may even die; a drug problem might become worse; their feelings of failure as a parent to protect and nurture their child; fear of being involved in the justice system and going to jail or the fear of complete parent-child relationship breakdown.

Families require a more therapeutic response to assist them with this immediate risk of harm. One strategy for strengthening families could be to provide a less threatening option that did not solely involve the police or the justice system. One concept for consideration could be the notion of separate accommodation for juveniles whose families can no longer cope with the impact of their drug use. This accommodation could provide a front line information and referral counselling service with outreach options for parents and other family members with the aim of breaking the domestic violence and drug use cycle and to rebuild family resilience.

CHAIR—Would you like to add to that, Mrs Alcock?

Mrs Alcock—Yes. I am a wife, a mother and a grandmother whose life has been badly affected by the drug use of a family member and its tragic consequences. Our daughter used drugs, sometimes with long periods of abstinence, over a period of 14 years until her death from a heroin overdose at the age of 28. Ironically, this happened at a time when she had been clean for several months. During that time our family encountered all of the financial, social, personal

and legal problems with which the families of a drug user are so familiar, and we lived with the feelings of despair and hopelessness that resulted.

The situation became much more complicated with the birth of our daughter's baby six years before her death. In that time, the conflict arising from our roles as both parents and grandparents caused us much pain and impacted severely on family relationships. We have been the legal guardians of our granddaughter since her mother's death and found attempting to fill the dual roles of parents and grandparents extremely difficult and stressful, and I know our granddaughter shares these feelings.

Anything I have to say is based on personal experience, but also a long and extensive involvement with many of the aspects of the alcohol and other drug field as outlined below. I will give you a copy of these rather than take the time to read them all out; they are from all of these various agencies and things that I have gained—

CHAIR—We will accept that as part of your submission. Is it the wish of the committee that that be accepted as evidence? There being no objection, it is so ordered.

Mrs Alcock—Thank you. In all the roles that I have outlined there, I maintained constant contact with families whose lives are affected by the drug use of one of their members. Lee-Anne has outlined the problems faced by parents of drug users. These problems magnify in both size and complexity when the user is a parent and the safety and wellbeing of young children becomes an issue. During questions I hope to address these problems and discuss possible ways in which families can be strengthened and become more resilient when dealing with this difficult situation. I also wish to address the question of harm reduction programs from the perspective of the many family members with whom I come into contact. I listened to the tragic stories that we heard this morning. I hear these tragic stories every day in my role. I have lived a tragic story. I would like to say that, from my experience, the views we heard this morning are not necessarily representative of all parents of drug users.

CHAIR—I do not think there is a consistent view. You have a view, which is different, and it does not represent everybody either.

Mrs Alcock—No, certainly not. I am just saying that what I am about to give you is not just my personal view; it is gained very much from—

CHAIR—The people you deal with.

Mrs Alcock—Yes, all those organisations. I am very wary of just giving a personal view.

Ms Harris—I am proud to be part of the Parent Drug Information Service as a volunteer/parent. I have been part of PDIS since the beginning. I am also very proud of the fact that I sit on the reference group. I guess I could describe myself as just being an ordinary mum living in Hamilton Hill and just been part of everything with five children. Twenty-two years ago things changed drastically. I have seen four of my five children problematically use drugs since then. My eldest child commenced using cannabis at 13 and was injecting amphetamines by 17. For four of my children the drug of choice has always been amphetamines, though I lost a 19-

year-old son to a heroin overdose 10 years ago. I was intrigued by that, because it is like I have an oldness of drug use. My oldest child will soon be 36, yet my youngest child is only 22.

During that time I have had an understanding of what amphetamine use has been about and the changes that have occurred. I look at the differences. What are the ways to strengthen families? How do we do this? It was wonderful to hear Simon a few minutes ago say quite a lot about what families are about. How do we empower families? How do we make them strong? How do we reclaim our families and our children so that we can make a difference as families? PDIS is very much a part of that. I looked at my own journey and thought, 'What is different?' Things are very different from when all I had was a 12-step program. I have been very blessed and very lucky, because in Western Australia we have some very fine agencies and the support I have been given has been incredible. I have been offered family counselling and my children have been given counselling, and large differences have occurred because of that.

I guess that if there is any way to make a difference it is exactly what Simon was talking about: give us more. I guess that is the only thing I can ever ask for—more detox, more rehab, more family counsellors, so that we do not have waiting lists, so that families can get access straightaway when there is a crisis in an agency and so that they do not have to wait as long. I believe that by changing strategies, by educating families and by looking for different ways for families to treat and be part of a family system, we can make a difference in what our children are doing.

CHAIR—Of your five children aged from 22 to 36, which child does not use?

Ms Harris—The youngest, my daughter. But she still has a very laid-back understanding of what drugs are about. She talks about party drugs and has a different type of understanding. I recognise what you are saying around language.

CHAIR—Do you see it as a problem?

Ms Harris—No, I do not see it as a problem at all. I think I have gone home and I have educated my children and we have made a difference. The problems are still there. I have certainly seen my grandchildren born to drug using parents. I have seen all of those things, but I have made a difference in my family by being given the resilience and the support that I have been given through the agencies that I have been connected with.

CHAIR—Did your marriage survive?

Ms Harris—No, my marriage did not survive. I have lost large volumes of what my life was about. My family did not survive. My family is lost. It is fragmented in many ways. My mother is lost because my mother cannot understand what I did to have caused my children to use like they have. So there are huge fragmented areas in my family and yet there is a resilience and a strength that is incredible as well. My 26-year-old son is clean. He has been clean for over two years. He was also supported by the agency that I have been connected with. He is very blessed. He is doing extremely well.

CHAIR—Is he in employment now?

Ms Harris—He is in employment. He has an extremely good job. He has just got engaged. He is doing very well.

CHAIR—So he is off it.

Ms Harris—Life has changed and he is off amphetamines totally. Life has changed but, as I say, it is about empowering we families. We are the umbrella in so many ways.

CHAIR—Do you think one sibling affected the other sibling to use?

Ms Harris—Absolutely. It broke down the family morality, I believe, in many ways. It became accepted. As I say, I was sitting at home breastfeeding my youngest child while my other children were smoking cannabis.

CHAIR—And you did not know in the early part?

Ms Harris—It takes time and in the beginning, no, I was not aware, other than the fact that the eldest child became very violent. His behaviour quickly changed drastically and noticeably. That is the interesting part: when we talk about amphetamines I think, ‘Oh my goodness, I have such an ‘oldness’ in my knowledge of amphetamines and what they are about.’

CHAIR—Could you tell me about your granddaughter? What happened to her during the six years that she was with her mother?

Mrs Alcock—This is where the agony comes in for grandparents. As I said, our daughter would have periods of abstinence in which she was a very beautiful mother and, when watching the two of them together, there was just the most incredible bond. I do reject the notion that all drug-using parents are necessarily bad parents, although certainly when she would go on a real binge of drug using we feared very much for our granddaughters’ safety and wellbeing, I guess you could say. We tried very much to just be supportive in that time. We would take her for weekends and during the week as much as possible. We would try to support our daughter to go back into treatment. Once we simply took our granddaughter and kept her against our daughter’s will until it was pointed out to us that you actually cannot do that.

CHAIR—It is against the law.

Mrs Alcock—Yes, it is very much against the law.

CHAIR—And yet you could have been saving her life, at the extreme of things.

Mrs Alcock—Yes, but it was also not the best thing to do long term. I guess we feared ringing the authorities because we loved our daughter very much and she loved her daughter. So you do not necessarily want to damage that relationship. We were also aware that our daughter needed our relationship. Once you break family ties, you are often destroying avenues of support. It is like Sandra said—the family must be made strong.

CHAIR—Did your daughter have a partner who stayed with her, the father of your granddaughter?

Mrs Alcock—The relationship had ended before she found out she was pregnant. She then took out violence restraining orders against him when he found out. She ended the relationship because of his—

CHAIR—He was violent. Was he a user as well?

Mrs Alcock—Yes, he was. But the interesting thing is that our granddaughter is now 16 and from about the age of 13 all she wanted to know was: ‘Who is my father, where is my father and when can I meet him?’ I think we enter a minefield when we remove children from their drug-using parents because I think all children have this huge—

CHAIR—They all want to know who they are.

Mrs Alcock—And they also want to know their parents. From the work I do with Wanslea Grand Care, I believe that most children living with their grandparents, when asked, still want to live with their drug-using parents or at least maintain close contact with them.

CHAIR—That is some; that is not all.

Mrs Alcock—I said ‘most’. Certainly in my experience, most do. There is just this: ‘They’re my parents.’ They will defend them—like a little boy the other day at one of the support meetings for grand care. Grandmother was sounding off about mother and he came in and said, ‘That’s my mummy you’re talking about; don’t say awful things about her.’

CHAIR—It sounds like the awful situation where women are being repeatedly bashed and they still stick up for the husbands who are bashing them. All sorts of strange things go on.

Mrs Alcock—I think with children there is a parent-child bond that is very hard, and I think very unwise, to destroy.

Mr QUICK—Has there been an increase in the volume of calls you have received in the last 12 months compared with those you have received over the previous couple of years? Do you monitor those? Obviously, you would keep statistics.

Mrs Raeside—We do. I do not have that with me. We receive around 120 calls per month, through our service, solely from parents. Through ADIS, the Alcohol and Drug Information Service, we receive about 190 calls per month. That is what I have with me today that I can talk about, but I can get the statistics for you.

Mr QUICK—And you have a statewide thing, so is the breakdown mainly metropolitan?

Mrs Raeside—It is mainly metropolitan, yes.

Mr QUICK—Is that because the services are more freely available here rather than in such a huge state as WA?

Mrs Raeside—I do not think people call because they think about where the services are; they call because they are in crisis, regardless of where they are. We try to link them into the services,

wherever they are. We do have community drug service teams dotted around the state—there are 12—and we do what we can to link them into family services, counselling support.

Mr QUICK—Is there an average age?

Mrs Raeside—For the users?

Mr QUICK—If parents ring up, what is the youngest and what is the oldest?

Mrs Raeside—We are finding what is increasing is the age: parents are calling about their adult children who have been significantly using drugs that began in their adolescent years.

CHAIR—And are amphetamines involved?

Mrs Raeside—The greatest number of calls involve amphetamines as the drug of concern, yes.

Mr QUICK—Sandra, you mentioned the resilience of families. What is the state government, with all its plethora of agencies, doing? What does it do to make you more resilient so you can survive and not fall over?

Ms Harris—It offered me family counselling. It offered me systemic counselling—looking at the whole family and looking at ways to support the parents so the parents could support the child. It could be challenged in many ways that that is a form of harm minimisation. I guess another thing that I find quite interesting is that we were talking about old amphetamine users. Nobody will want to take my eldest child into rehab, if he chooses to get clean at any time. He is violent, he is angry. He has reached a point where he has no teeth. He has a tic of some sort now. There is massive damage there. I guess that is what we look at: where do we go with these angry, violent young men?

CHAIR—That is what the drugs have done to them.

Ms Harris—Absolutely.

CHAIR—Did he know that? Did you know that?

Ms Harris—I went to drug education the year that my child went to high school. It was a very good, actually. I went along and took note of it well and truly, but I do not think it made any difference. I think my children are risk-taking kids. They were out there thinking: ‘Hey, this is pretty cool; why not try it? Why not give it a go?’ I reacted, very much so. As I said, I very quickly tried to find help. In those days there was not a lot of support. I had a 12-step program, and I would not want families to go through those lengthy periods that I went through. As I said, the birth of PDIS around eight or nine years ago was probably the most wonderful thing that could have happened in Western Australia—as well as family sensitive practice models and the post-modernist understanding of the agencies that are in Western Australia. We are very fortunate, but there are just not enough services to go around. If I were that young new mum waking up today at 35, I would have to join the queue. The queue is such that my eldest child is still sitting there in many ways. Is there enough? I do not think there ever is.

CHAIR—Once you had identified that your youngest child was a user, did you get any help to allow you to try to save the siblings?

Ms Harris—Absolutely.

CHAIR—What did they recommend?

Ms Harris—Very much that whole family system type of way—being out there, being honest, talking about drugs, exposing it, opening it up in our family.

CHAIR—You went through it—

Ms Harris—The first four children, in particular, were quite close and I think it percolated very quickly through the family. There is a moralism around it, and I think it breaks down the morals within the family system. Of course at that stage there was minimal education. I had minimal education. My husband was at one end of the spectrum; I was at the other end of the spectrum. When he was too soft, I was too hard. When he was too hard, I was too soft. There was not a consistency, which is now encouraged in agencies.

CHAIR—Were they all users at the stage when your marriage fell apart?

Ms Harris—Yes, I would say probably so. It was not long afterwards that Adam died, and I think that was the huge crunch in our family. To lose a child is incredibly difficult.

Mr QUICK—We hear a lot about *TOUGHLOVE*.

CHAIR—But *TOUGHLOVE* takes a different approach.

Ms Harris—Yes, *TOUGHLOVE* uses a very different approach.

Mr QUICK—Do you encourage that when you are talking—

Ms Harris—No, I believe in the systemic approach—about supporting parents to support their children. As I said, it could be argued that that is a harm minimisation type of role. We support families.

CHAIR—We will be hearing from *TOUGHLOVE*. It uses a totally different approach.

Ms Harris—It is altogether different.

CHAIR—It reports successful outcomes.

Mr QUICK—Is the stigma still here in WA? Are people reluctant to put their hand up and say, ‘I’ve got a problem?’

Ms Harris—I guess for some people it is still very difficult to expose their families. I always put out that I am not exposing my family; I am talking about what it is like to be a parent

affected by my children's drug use so that there is still anonymity for my children. But I think things are changing and I would hope that they are. We are out there now, talking about it. The agencies are there. Things have to be different.

Mr QUICK—As a male, it really worries me that all we are seeing today basically, apart from professionals, are women telling their stories about this. What have we done as fathers and as grandfathers to address this problem? Why is it that the women have set up these things? The women are the resilient people. The blokes, for whatever reason, are opting out.

CHAIR—Or walking away.

Mrs Alcock—I would like to come in there, if I could.

Mr QUICK—I would like your views.

Mrs Alcock—I have an extremely supportive husband, father, grandfather. I am probably here today because I like talking more than he does. He is here today too. We are one of the lucky couples, because it does put enormous strain on any partnership and there were times we felt just torn apart by what was happening.

We survived with a lot of hard work and I think probably a little bit of luck. There are a lot of fathers and grandfathers out there who are just as caring and who work just as hard to try to support their children. But I think it is something to do with our social mores that it is the women who go and talk about these things and who talk from the heart.

CHAIR—It is the women who stay—they do not walk.

Ms Harris—I guess it is also the knowledge that my ex-husband has supported my children during their adulthood period. So he has come onboard again and has been very complimentary about what I have tried to achieve during those years.

Mrs Alcock—There are many parents—and I have talked to them—that, even when the marriage or partnership does not survive, will work together when this problem arises with one of their children.

Ms Harris—If they can keep the subsystem together, strong and supportive, I think that makes a huge difference.

CHAIR—What would have happened in your family if vulnerable children had not remained in the household but had perhaps gone to live with another member of the family or whatever? Would they have been saved, do you think?

Ms Harris—Probably not. Once the oldest child broke down the real moral issue of what our family was about, the other children then saw it as being an okay thing to do. So it probably would not have made a lot of difference.

CHAIR—What if he had been removed from the family and the others had stayed? Would that have made a difference?

Ms Harris—That would have been interesting—absolutely. I do not know. I guess I would have been devastated because the one thing that I wanted more than anything was a connected, joined family in some way and yet it is hugely fragmented now because of the final outcomes.

CHAIR—You did not want the other children to become users.

Ms Harris—No, I did not. I certainly did not.

CHAIR—You obviously did not think it would happen.

Ms Harris—I was devastated by that. The loss of my third child and what that represented to me has been huge. The grief that stays in a family affected by drug use is eternal. I will take that to my deathbed.

CHAIR—I was talking to a mother the other day whose child was addicted and had an overdose in a vehicle. The steering wheel prevented the death but it stopped the oxygen to the brain. He is now a paraplegic and can only move one arm.

Ms Harris—I have worked in the nursing home industry over the years. Unfortunately, I have been exposed to and have seen the outcomes of near overdoses.

Mrs Alcock—Sandra, I think you would agree with me that, despite your experience, all of our research shows us that, when a family can stay together and be involved in the user's treatment, the outcomes are better.

CHAIR—Better than what?

Mrs Alcock—The outcomes for the users stopping using drugs are better for them.

CHAIR—Do you have other children or just the one?

Mrs Alcock—Yes, we did.

CHAIR—Are they all right?

Mrs Alcock—Yes, they are fine.

CHAIR—Why do you think they were able to, where Sandra's children could not?

Mrs Alcock—I have no idea. I think these are the unanswerable questions. Why did one of mine go into drug using so heavily?

CHAIR—Sandra said that she thought that the morality was broken down—they thought it was all right to do it too. But your children did not think that.

Mrs Alcock—Every family system is different and I do not think there is any such thing as a right and a wrong or—

CHAIR—What effect did your daughter, who was the user, have on her siblings? What happened to their lives as a result?

Mrs Alcock—Our oldest son at that stage was older and he was very much making his own life away from—

CHAIR—So he had left home?

Mrs Alcock—He was away at uni and we were in the country at the time he was away at uni college.

CHAIR—So he was not affected?

Mrs Alcock—It did not have the impact on him. Our youngest son was very close in age to his sister. They were very close and very good friends. He was absolutely devastated. But he learned what I think was a very good way to deal with it. When she would be on using binges he would just withdraw. As soon as she would stop using, he was always there for her.

A real wake-up call came for me one night when he said something about her and I said, ‘You must hate what she is doing.’ This is the wisdom of a 15-year-old. He said, ‘I don’t like it, but I don’t hate it as much as I hate the way that you and Dad are dealing with it.’ That was when I realised that our whole family focus was just on this user and we were not looking at our family operating any more as a family.

CHAIR—You were concentrating on this and ignoring the others?

Mrs Alcock—Yes. That is why we come back to this strengthening of families to deal with it.

CHAIR—Out of that, the effect on families can be that, if you concentrate on the child who is the user to the exclusion of the others, that becomes an impact on the family in its own way?

Mrs Alcock—It can be, yes, I am sure. This is why I find this term ‘harm minimisation’ and the way it is used and misused interesting. I think that a harm minimisation strategy is to strengthen the family and make it more resilient. That in itself to me is one of the ways of minimising the harm that drug use causes, or the damage or whatever term you want to use. Even going further to general harm reduction strategies, sadly, the reality is that most of our teenage and adolescent kids will try drugs and they will experiment. I do not believe that fear campaigns work because they believe: ‘I am immortal. I am a teenager. I am untouchable.’

CHAIR—That is exactly the evidence we heard with regard to the success of the smoking campaign. It was not because they think they are going to be dead. They do not want to be disfigured. They do not want to be unattractive. That they can identify with.

Mrs Alcock—Young teenagers, particularly females, are still taking up smoking at alarming rates. We are certainly decreasing it in our older population. What I would get back to is that most will try something and, for most, drug dependence will not become a problem. They will deal with it. I believe strongly that we must educate them in harm reduction. There is no doubt

that in an ideal world abstinence is what we would all aim for. I think we have to keep aiming for it.

CHAIR—We have to be very careful, don't we, that, in being very soft, we do not open it up so that somebody else is destroyed.

Mrs Alcock—I do not think that we are being soft by accepting the fact that there is a percentage of our population who will continue to use drugs no matter what is said to them. If we can keep them alive through that period then we have some chance. I know from bitter personal experience that you cannot rehabilitate a dead user. While they are alive there is still hope. Once they are dead, there is no hope. They will never stop drug using. So I see it as a major thing. I agree with you that it is a fine line between that and encouraging drug use. But I do not think that having harm reduction strategies is necessarily encouraging drug use.

CHAIR—I have read the material put out by state governments that describes the euphoria or pleasure that can come from drugs. I think that is immoral.

Mrs Alcock—Any teenage kid will tell you that, though.

CHAIR—But this is the government is telling you. I think that is immoral.

Mr QUICK—I have a question about strategies and techniques that you used when you first set up the program and those you use now. Has anything really changed, apart from the basic tenet of giving the person who rings up some hope and some support?

Mrs Raeside—That is basically what we do, and we link them into other alcohol and other drugs services. We also have a presence at the Perth adult drug court, where we have parents to support, in the Children's Court and in the youth withdrawal respite service. So we are not just on the telephones, but that is our primary role.

Mr QUICK—On behalf of the absent members of the committee, thank you for telling us, warts and all, your stories and experiences.

CHAIR—Except this as a submission—

Mrs Alcock—We did not get to talk about my problems of grandparents raising grandchildren, but they are there.

CHAIR—Thank you very much for coming and sharing what is obviously a very emotional story. It has been very valuable to hear what you have had to say. Thank you very much.

[1.03 pm]

HODSON, Ms Jo-Anne Lynn, Manager, Pregnancy, Early Parenting Illicit Substance Use Mums and Children Program, Women's Health Services

REID, Ms Fiona Katrina, Outreach Counsellor, Pregnancy, Early Parenting Illicit Substance Use Mums and Children Program, Women's Health Services

Witnesses were then sworn or affirmed—

CHAIR—Welcome. Would you like to make an opening statement?

Ms Hodson—First of all, we want to thank you for the opportunity to come before you and talk about our experiences working with the women and children and the families in our program who are affected by illicit substance use. It is a wonderful opportunity. It is also very timely for us. I spent the last two days in a child protection conference here, where that issue was paramount.

We are both having turns at this. First, we thank you for the opportunity to appear before the committee and to talk about our experiences working with the women and children and the families that are affected by illicit substance use in our program. It is a wonderful opportunity. It is also very timely for us. I spent the past two days at a child protection conference here, where that issue was paramount. That conference was gratifying for us in terms of the work we do. Often we are off doing our work busily. The conference provided a lot of the latest information about the best way to protect children and gave direction, particularly for this state. We found that many of the strategies that the researchers and frontline workers alike were discussing were things that we are using now in our women's and children's program.

When Fiona and I were invited to appear, our initial response was sheer terror because neither of us has ever done anything like this before. It presents an opportunity to be reflective about the work we do. As I said, often we are so busy doing what we do and not thinking much about it. I would not want to give the impression that our intervention is not evidence based. We are drawing from the best of the research and the programs that work well. In fact, we have contributed to some of the available evidence.

However, our presentation today is fundamentally informed by the families we work with; that is the biggest source of our information. We spend a lot of time talking to them about their ideas, opinions and so on. That includes the children, which is quite unusual. One of the first things to understand that we struggled with when doing this—and I know you have probably heard this again and again today—is the fact that it is difficult to isolate the impact of illicit substance use alone, particularly on the families we are working with. In fact, we struggled to identify any of our families that were 'only dealing with illicit substance use'. Many of them are also severely impacted by poverty. Most of our women are poor. They have inadequate, unsafe or poor housing. Housing is an enormous issue in this state, as I am sure it is in others. Domestic violence also breaks our heart on a daily basis. There are also mental health problems. Some

have chronic illness, and some of it is related to drug use, such as hepatitis C. Obviously, social isolation presents significant risk of harm to these families.

Within this context, it is hard to separate it out, and that is supported by our experiences. These families tell us that some of the impact—and this is borne out in the research—is the result of early child-parent attachment issues. The more we study attachment, the more we establish that it can lead to a host of problems later on in life. There is a strong lack of connectedness to the community on all levels—to schooling, services, health services, physical recreational activity and participation in community life; in fact, a lot of the stuff that so-called normal families do. There is also social exclusion over time. Isolation and social exclusion has an impact.

Ms Reid—Perhaps the best way to illustrate the impact of illicit drug use on families is through the children we work with and what they had to say. It should be noted that many of the children, particularly the young children, do not name the family's problems as mum's drug problem. In fact, many do not know that they or their mum come to the little pink house because of their parent's drug use.

Ms Hodson—That is where we work.

Ms Reid—In a small study of mine, which I did with the children we work with, and presented at the international conference on reduction of drug-related harm, the children themselves identified some of the problems they experienced. This is a quote from a young daughter of one of our mums: 'It was pretty hard for my brother because we have like sports carnivals and stuff, and mum never came. It was the good stuff, not when we needed her. She was always there when we were in trouble or needed her, but not in the good times.' From a young boy: 'She was depressed; she was sleeping most of the time. She took these anti-depressant that made her sleep. Not very organised most of the time. I thought of her as a bad parent.'

Overall, the children who knew about the drug use of their mothers believed that their mums were less emotionally available to them when they were using drugs and/or alcohol. Encouragingly, none of the children whom I spoke with in this study believe that the drug use of their mother is a reflection of how much their mother loves them; particularly in relation to connectedness and parent-child attachment, that is significant.

The mums too are deeply concerned and affected by the impact of their drug use on their children and families during pregnancy and parenting. The belief that they are uncaring or indifferent to the wellbeing of their families is simply not supported in our experience. In terms of specific financial, social and personal costs, some of the observations we have made are that many of the families that we work with come from impoverished circumstances, and even if they successfully free themselves from drug use many continue to struggle financially. For example, one of the single mothers we have worked with for a number of years has made amazing changes in her life and that of her children. She gave up drug use a long time ago and returned to study. She works part time and has worked hard to repair her relationships with her family and her community. Nevertheless, she finds it very difficult to meet the needs of her children financially.

As a result of the stigma and secrecy that surrounds illicit substance use, particularly for women and mothers, the social costs for these families can be very high. One of our clients on a methadone maintenance treatment program has often discussed her fears of being found out by her son's school community and that he might be ostracised by his peers as a result. So his friends do not get to visit the house. Children, particularly adolescents, share this fear if they know what is happening in their family. There is commonly a deep sense of unworthiness, guilt and shame felt by all family members, not just the user themselves. Many believe they have very little say or control over their lives and they lack any sense of self-efficacy.

The impact of these ongoing fears about children being removed because of parental substance use should not be underestimated. It can get in the way of families accessing services that they need, and then they are further marginalised. It is important to note here that many of the families involved in our program do not experience such serious problems, especially when only one parent has problematic drug use. When they are attached to at least one other adult they have good communication and social skills, they have consistent family routines and rituals and they have resources available to them and mental stimulation. That is supported by the Nobody's Client project in Victoria.

Ms Hodson—In terms of the impact on families of the harm minimisation programs—I was present during the last conversation that you had so I am a little scared to bring this up—PEPISU and the PEPISU children's program operate within a harm minimisation framework, which is government policy, and employ a number of harm reduction strategies in our work with families. Some easy examples include that some of our adult clients are involved with pharmacotherapy programs such as a methadone. Some are part of diversion programs which try to intercede on the harm caused by, say, imprisonment—like drug court. We continue to engage with women and their children, regardless of the presence or absence of parental drug use. So we encourage them, particularly the children, to continue to have contact with services whether drug use is present or not in a parent; however, that does not say that we permit, allow or condone drug use at our place. Our place is a break from that life; it is a place separate from that life; it is a place free from that life. By and large, the women honour that.

CHAIR—So when they come to you, it is no drugs?

Ms Hodson—Not in our home, not on our premises.

CHAIR—In your home you have zero tolerance?

Ms Hodson—Yes. In fact the reduction of psychological and physical effects to children of parental substance use is a key objective of the children's program. So one of the things we have to look at when we talk about reducing harm is reducing the harm to kids if they are cut off from services if we have too many rules around turfing out parents.

Our program was evaluated, but it has not been published yet, through the FaCSIA funding that we received. I have some quotes from some of the women we have worked with: 'The whole process is good in that you can stay.' That again is one of the benefits that the women talk about in relation to our program. So many programs available are very short term, and this is not a short-term issue for the women we deal with. Another comment is: 'You're not sent away when you get over the crisis period, or even when you get clean; you can keep coming and

continue your involvement in counselling. There is no discrimination here. You can tell them anything and not be made to feel bad.' She thinks the program is so good she has referred others to come for counselling.

It is different to other services. In this way it is awesome. They will even come and see you at home if you cannot get yourself together to come to the centre. Another woman had been at a residential rehab centre where she was allowed to take the kids, but in her experience the focus was more on treating the parent and the kids were not as involved in the program as she had hoped. It is important as there is a lot of guilt about your life choices and how they affect your kids. Unlike other services, the kids are integral to their planning. In fact, we have planning every year where the kids actually participate in the planning program about what we are going to do in the year ahead, as do the mums.

Unfortunately, there still seems to be a popular misunderstanding that harm reduction strategies somehow do not hold people adequately responsible enough for the negative impacts of their drug use. Instead, we at PEPISU and at many other agencies—we are certainly not alone here—see these strategies as a more helpful response to the many problems these families face, including the lived reality of problematic drug use. They can provide—

CHAIR—All drug use is problematic. How can it be otherwise?

Ms Hodson—They can provide an opportunity and encouragement for women to act upon their concerns about their families' wellbeing even if they have not completely been as successful in freeing themselves from drug use. We operate from the position that you can achieve positive outcomes for these families if you can continue to engage them in the programs you offer. The longer you can keep them engaged and involved, the better your chances are.

This is a really important aspect of the harm minimisation and reduction strategy that we have taken on board. I heard you mention earlier the fact that women are very much forming a big part of this family conversation around substance use, and where are the men? I think that women are treated in a very different manner in this culture when it comes to drug use. We do hold men less accountable in terms of the fathering aspect and the impact their illicit substance use has.

CHAIR—Many of them just walk.

Ms Hodson—Yes. It was interesting—we did a case study yesterday about a young woman who was a drug user. As part of the case study, the first part of it was where, during the pregnancy, he walked. Then we got to the next part of the case study. Somebody in the group said: 'Can we bring him back into the picture? We just let him walk so easily. We didn't hold him accountable at all.' I thought, 'We are very accepting of these men just walking out of these situations.' We are quite blind to it too. We are really committed to reducing the harm attached to stigmatising families. It gets in the way of them getting services. If it was effective, we would probably be all for it. But it does not work. We hear this again and again.

Mr QUICK—Fiona mentioned the child not being able to bring his mates home.

CHAIR—But that is a good thing because the other child could be exposed to it.

Mr QUICK—Yes. But I know of the converse side as an ex-teacher. My daughter is a teacher in a high school in Melbourne, where she has problems. She wanted to know the aspects about a particular child because she wanted to be there as a resource for him. The father was in a witness protection program. This kid could not relate to anybody and was angry not only with his father but also with society because he had this secret and he could not share it with anybody. A teacher is another parent in lots of cases. I would be interested if you talk to any teachers about what strategies you use. There must be some decent teachers out there in the system that you can relate to to share the secret so that, if things are going tough at home, that child can go to the teacher, male or female, and that can be another resource person.

Ms Hodson—Exactly. A lot of mothers through the process of this are very separated from schools and have little contact. For a lot of them the process of getting well is about actually going in and being real about what is going on in their family and about getting support, because they do not want their kids to be doubly punished. If there is some behaviour that is unacceptable because of stuff that is happening at home, the kid gets punished for it instead of being able to talk about it. It is very difficult to deal with secret things.

CHAIR—Is this all part of your aim to get the mothers off the drugs?

Ms Hodson—I would say that, more importantly, it is the aim of most of the mothers that we are working with. It is their aim; our aim is much less important than the women who are actually experiencing the problem.

CHAIR—So the people who come to you have already made that decision?

Ms Hodson—Some have.

Ms Reid—Some are directed to come to us.

CHAIR—A young man who had been a heroin user came to our forum in Brisbane and he said that it took him 7½ years to get off it. He said there were moments in that journey when he would feel a surge—‘I think now I can do it’—and he would reach for help on the phone and there wasn’t any, so he would go right back on it. There was nowhere that could take him then and there.

Ms Reid—That is one of the things that we discuss here in terms of active engagement—

CHAIR—So if a mother is feeling like that and she says, ‘I know what I’m doing is really rotten and I want to get well,’ she can come to you straightaway?

Mr QUICK—Are you five days a week or seven days a week?

Ms Hodson—We do not have a waiting list. We always see women as soon as possible.

Ms Reid—As soon as we can.

CHAIR—Is that straightaway?

Ms Reid—Within a week or two weeks we will if we have to go out and see them—

Ms Hodson—It does not even take that long most of the time.

Ms Reid—We have women that come into the centre in crisis that we have not met before and we will always have a duty officer—someone at some time that day will be able to see them. We make every effort—

CHAIR—So if it was a woman like the man I mentioned and she felt she wanted to do it then, she could come to you straightaway?

Ms Reid—Except we work four days a week, and that is what we have funding for. That is where you hit the road blocks.

Ms Hodson—We do have a weekly coffee morning, though. We are quite flexible in terms of the whole staff, and we will talk about this a little bit later. Every Tuesday we have a coffee morning where the women come and often they bring their children. That is an opportunity for anybody who wants to come in. It is an institution now, so women that we might have seen years ago that have moved along know that they can come and reliably know that the coffee morning is going to be happening, that the PEPISU staff are going to welcome them and that they can see somebody.

Mr QUICK—If you are in Bunbury, you do not have a pink house, do you?

Ms Hodson—No, there is no pink house in Bunbury that I know of. But there are services that are available.

Ms Reid—The south-west have started a program—the community drug service team—

Mr QUICK—FaCSIA are funding you. How often does the state branch of FaCSIA come out and spend time with you guys? Once a year?

Ms Hodson—We certainly have an accountability structure that is pretty strong—I write very big reports on a regular basis.

Mr QUICK—I know, but you can send reports ad nauseam to the state office of FaCSIA. How often do they actually come out and spend a day with you and see what is going on?

Ms Hodson—Last time they are invited us there. That was nice.

Ms Reid—With the National Illicit Drug Strategy money that we get, we used to see them quite regularly because our funding officer was based here.

Ms Hodson—Our program is about to be evaluated by independent evaluators hired by them. They will be coming out next month.

CHAIR—I would be interested to know how they choose the independent evaluators. Who are they?

Ms Hodson—I do not know. It is a firm. I could certainly give you that information; it is in my office.

CHAIR—That would be helpful.

Ms Hodson—They are coming out, so they will see. We have objectives, outcomes and performance indicators and all the things that you need to have attached to a program. We also do a lot of evaluation about every activity that we run.

Mr QUICK—How much funding do you get a year?

Ms Hodson—Total?

Mr QUICK—Yes.

Ms Hodson—We have several funders. We have the National Illicit Drug Strategy: Commonwealth Health fund us to about 150.

Ms Reid—I think it is a bit less than that.

Ms Hodson—And we have FaCSIA funding.

CHAIR—How much is that?

Ms Reid—I think it is about 110 each.

Ms Hodson—It is a bit more than that—about 130, maybe 140; I am not 100 per cent sure because we have just had a slight change. We also get Drug and Alcohol Office funding, which is state funding, and that is about 50. And we make lots and lots of requests. We adore Lotterywest here; we write them a lot to give us assistance to fund some of the recreational activities. For example, we do an annual retreat—in fact, we have just done one at the sport and recreation facility in Bicton. We took 45 women and children for three days. It is really about them having an opportunity to spend positive time with their families. The emphasis is on health, recreation, fun and spending some quality time with families. It is very popular and we have lots of interest in doing it. Lotterywest assists us with the funding so that we are able to bring that about. For some of the women and children we deal with it is the only holiday they have ever had in their entire lives and it is certainly the only holiday that many of them are going to have in the year.

CHAIR—Three days.

Ms Hodson—It is three days. They look forward to it all year. They use it as a disciplinary thing with their children!

Mr QUICK—So is your linkage with the Western Australian housing authority for crisis accommodation part of your strategy? You mentioned homelessness; would that be—

Ms Hodson—There is a long waiting list for priority housing in this state.

CHAIR—Everywhere.

Ms Hodson—Everywhere, and it is a real issue.

CHAIR—How many women would you reach?

Ms Hodson—Our last statistics, for the last six-month period, were 130. Some of those are children; some of them are adults.

CHAIR—How many mums?

Ms Reid—Before we included the children's stats, we had on average about 80, was it?

Ms Hodson—A little bit higher than that—around 100.

Ms Reid—Around 100 mums a year.

Mr QUICK—So Susan, who came 10 years ago when you first set up—what is she doing now?

Ms Hodson—Sometimes we do get to hear the end of the story, and this might shock and horrify you, but some Susans are still coming; you know what I mean? We have to accept the reality of these family situations. Many of them have very little support and they look to us. We have constant ethical dilemmas around this, about whether we are fostering dependency et cetera, but it is their lived experience. For a lot of the women, we commonly hear that we are the only adult company, for example—us and the other women—that they might have in an entire week.

Ms Reid—That is, away from their previous lives.

Ms Hodson—So we have been lucky enough to witness some great change and also some heartbreak—

CHAIR—Are the women you deal with all single mums?

Ms Hodson—The majority of them but not all of them.

CHAIR—Do they work?

Ms Hodson—Some of them do.

CHAIR—So how do they have their children looked after?

Ms Hodson—Some of them have children that are in school, and they work around school hours and stuff. Some access child care, which is a difficulty. We provide child care as part of our services, because it is a recognised barrier: transportation and child care are recognised

barriers to women accessing treatment. So we provide child care at our centre and we provide assistance for transportation. And we provide outreach services.

Mr QUICK—What suburb are you based in?

Ms Hodson—We are in Northbridge. We are sort of in the heart of the city.

CHAIR—What part of it?

Ms Reid—We go from Rockingham to Armadale to Midland to Sorrento.

Ms Hodson—Our hearts sink a little bit if somebody is in Rockingham—

Ms Reid—And they need outreach.

Mr QUICK—How many staff have you got—how many full time and part time?

Ms Hodson—Everybody is part time. There are six of us in total.

Ms Reid—Seven.

Ms Hodson—Yes, we have Avril now. Among Indigenous women there is a very poor uptake in terms of our services, but we certainly have Indigenous children. Individually, the women will come in for counselling and access some other services, but they do not feel comfortable in some of the group services because they are in the vast minority, so we have recently hired a part-time Aboriginal worker to try to increase the uptake of services by Indigenous women. We have a specialist art therapist. She designs all of the children's programming we do. She does an esteem group; she uses art and play therapy as her preferred approach. We have a resource worker, who is fundamental to our services—and what I mean by 'resource' is that basically we have a very small emergency relief fund, and we might provide MultiRiders so they can access appointments that they need to go to. These are all things that maximise the chances of them connecting to the services that they need.

CHAIR—Are you dealing with situations in which the children are quite small? Do you have anyone with adult children?

Ms Hodson—Zero and up.

CHAIR—Is there an evidence of the children becoming addicts like their parent?

Ms Hodson—We are seeing them at an age where many of them—the adolescents we see, in particular—based on their mother's experience, are adamant that they are never, ever going to use drugs. Their mothers share that hope that their children will never, ever go down the same path.

CHAIR—And you help them in maintaining that strength.

Ms Hodson—It is certainly part of the program. We are focusing on very young children at the moment—infants. The information that is coming out is about good attachments and relationships in terms of better outcomes for entire families. We run a couple of baby groups that provide an opportunity to develop a good, solid relationship.

CHAIR—The entire family might be mum and one or two kids.

Ms Hodson—We were very grateful to see PDIS here, because when we have mums that come in and they have the support of family members—they have had family members that have hung in there—we are absolutely thrilled because we see that they have better outcomes if they still have some sort of intact family support or cheer squad—some people on their side.

Ms Reid—Grandparents, brothers, sisters.

Mr QUICK—Is there anything similar to your organisation anywhere else in Australia?

Ms Hodson—I am sure there are quite a few programs, but I still think we are in a very small minority.

Ms Reid—There is Odyssey House.

Ms Hodson—There is Wesley Hearth here that runs a similar service to us, although they focus more on the parents and home support for mums with alcohol or other drug issues.

Ms Reid—Holyoake and Sarana women's program have been working with families for a long time, perhaps not in exactly the same way, but certainly trying to provide services where they can.

Ms Hodson—We cannot claim that all these ideas we use are original.

Ms Reid—We steal a lot.

Mr QUICK—Do many organisation shop like doctor shopping? If they cannot get in to see you, do they go to Holyoake or if they cannot go there go to Families West, or wherever?

Ms Reid—We find, particularly if there are mental illness issues or other general health issues, that the more services or supports they have the better off they are because they may not have anyone else. It is about communicating with each other.

CHAIR—Do you try to help get them into jobs; do you refer them?

Ms Hodson—We are just starting because of the new requirements to return to work. We started a program called Back in Business. You do not want to reinvent the wheel because there are good programs out there. However, because of the marginalisation, a lot of the women feel they do not fit into the programs. They are much more likely to attend if it is in a place they feel safe and comfortable. We have begun that; we have had our first session. We have other sessions planned around this successful re-engagement in the work force.

CHAIR—If a person is still using drugs, they are very unlikely to be successful in getting work.

Ms Reid—At the same time, some of the women we work with are still struggling but they are already working.

Ms Hodson—Or they reduce their use substantially. There are longer periods of time between use. You have to look for improvements everywhere and provide some encouragement.

Mr QUICK—Next time we come back, can we visit you?

Ms Hodson—We want you to come to the little pink house. We would love you to come. The women and children are very happy to speak to you.

Ms Reid—I like it when politicians come. was the mum. It was great.

CHAIR—Thank you very much.

Mr QUICK—It has been great.

CHAIR—It is very helpful to look at all the perspectives. Harry, before we close, I ask you to move that the committee authorise the publication of the evidence given before it at the public hearing today, with the exception of the surnames of the witnesses with the first names Kerry and Thelma, who gave evidence on behalf of the Coalition Against Drugs WA.

Mr QUICK—So moved.

CHAIR—There being no objection, it is so resolved. I declare this meeting closed and thank everyone for their attendance today.

Committee adjourned at 1.35 pm