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Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Reference: Impact of illicit drug use on families

WEDNESDAY, 28 MARCH 2007

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Wednesday, 28 March 2007

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

Members in attendance: (Mrs Bronwyn Bishop, Mr Fawcett, Mrs Irwin, Mrs Markus, Mr Quick, Mr Ticehurst)

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

BABINGTON, Mr Brian Keith, Chief Executive Officer, Families Australia Inc..... 1

Committee met at 10.29am**BABINGTON, Mr Brian Keith, Chief Executive Officer, Families Australia Inc.**

CHAIR (Mrs Bronwyn Bishop)—I now declare open the public hearing of the House of Representatives Family and Human Services Committee. Today the committee welcomes Families Australia to give evidence on this most important issue. Families Australia comes to this hearing having convened several public focus groups of health professionals and community members to work through the terms of reference for their submission. We will be interested to hear the consolidated feedback from these forums and the ideas on how we can strengthen the role of families in combating illicit drug use in Australia. I welcome Mr Brian Babington to give evidence. We have just received your submission. Would you like to make an opening statement?

Mr Babington—Thank you very much for the opportunity to give evidence today. Families Australia is the national independent not-for-profit organisation representing the needs and interests of families. We have been going for about six years and now have over 400 member organisations across Australia representing large and small community and family organisations, employing in total of that membership probably over 100,000 paid and volunteer staff in various capacities. We work to advance policy thinking relevant to families at the national level. We do that mainly by conducting coalface primary research with families and with professionals, working with families principally through focus groups and through expert forums such as the ones I will refer to today.

Today I would like to talk about the experiences of families and professionals working in the area of drugs. Our submission makes 11 recommendations and I would like to refer to some of the key ones in my introductory comments. Earlier this month we conducted an expert forum involving more than 30 national level professionals representing Australian state and territory governments and community and research organisations as well as members of families affected by drug use. We also held two focus groups with professionals and family members.

We found that the lives of multitudes of Australians and their families have been ruined and are today being ruined by illicit and licit substance abuse. The exact costs of the problems are unquantifiable but are clearly massive in personal, social and economic terms, and families themselves are bearing an enormous cost in pain as a result. Our submission contains several stories of real personal and family hardship. Worry, shame, alienation and tragedy are common and very disturbing elements.

CHAIR—Let me say right from the beginning that your recommendation is that we look at licit and illicit drugs. Our terms of reference are ‘illicit’ so could you concentrate on our terms of reference?

Mr Babington—Certainly. We found through the many interviews that we conducted that people were saying to us that, while the focus on illicit drugs was very important, it was also very important not to divert attention from both illicit and licit substances. But of course I do respect very strongly the committee’s terms of reference.

Three groups that have been relatively less visible in efforts to overcome substance abuse, but which pay a higher price, are children including siblings, grandparents and, in many senses, families themselves. I would like to talk briefly about those three categories. Children with substance dependent parents have often been overlooked by policy makers and service providers. Sometimes they have been dubbed ‘nobody’s clients’. We were particularly struck by the fact that substance misuse is often accompanied by mental health problems, by severe financial stress and domestic violence, amongst many other problems. Of great concern are the high rates of child abuse and neglect which are found in families with substance abuse problems. Parental alcohol and other drug problems are found in approximately half of all substantiated cases of child abuse or neglect. Given that the rate of not substantiated cases of child abuse is more than four times greater than substantiated cases, there is a burning question about the true extent of child abuse found in families with parental substance abuse.

Children of drug users are themselves at greater risk than their peers from non-drug-using families for a number of harms including developing their own drug and alcohol problems, developing other psychological and behavioural problems, and themselves experiencing poor school and community engagement. An important cost of drug misuse is that Australia’s welfare systems have had to provide for increasing numbers of children who are being taken into the out-of-home care system—that is, into kinship and foster care—due largely to parental drug misuse. We have observed a statistic that there has been a 45 per cent increase in the number of children taken into the out-of-home care system between 1996 and 2003. We hear that there are now real doubts about the capacity of this type of care to cope with the demand.

Turning briefly to grandparents, there are over 22,000 grandparents providing primary care for over 31,000 grandchildren in Australia today. We believe that the number of grandparent-headed households is growing as well. Many of these grandparents—although we do not know the precise figures—take on the primary caring role out of love, of course, but also as a result of their own children’s drug problems, which often co-occur with factors such as mental illness and, increasingly, gambling. Grandparents and other relative carers are increasingly called upon by the state and territory child protection agencies to take children into care as the number of foster carers continues to diminish across Australia. One of the main problems is that the grandparents are not always recognised as foster carers and so do not receive the same level of financial and other support. Training and case work support is often not extended to relative carers and it may depend on whether or not a child has been legally ordered into the care of a grandparent. If there is no court order in place it is less likely that grandparents will receive assistance.

CHAIR—I thought we as a government had done something about that—and I am just right to remember the details. We did something about grandparents being entitled to get benefits where they are in fact the de facto parents. They do not get the payment from state governments for fostering unless they are foster parents, but they are entitled to family tax benefit parts A and B. Quite a few of us spoke very strongly on this point and I think that in fact we did it, didn’t we, Louise?

Mrs MARKUS—I am pretty sure we did.

CHAIR—We will get the precise details of that. It is something that we recognised and did something about.

Mr Babington—Certainly, that is the case. I am talking about at the state and territory government level. Depending on what state or territory a child or grandparent is in and the way in which a child came into grandparent care, that will determine the extent of the financial and other support.

CHAIR—It is the fostering payment which is the big payment and if they are grandparents, as distinct from fostering parents, they do not get it. There was a big argument and we certainly addressed it during our adoption inquiry. We are very concerned about the ‘biology first’ program where children are returned to the biological parent and very often end up bashed or dead.

Mr Babington—We recently looked at the issue of grandparenting and produced a report last month. There were a number of recommendations including some quite practical ones really to help grandparents navigate and find ways to understand what benefits there may be for them. They are not always apparent—things like establishing a national hotline, asking states and territories to re-examine the financial and other supports, and some small grants for support groups are very important—provision of respite services.

Turning to the third of the groups that have been relatively less visible, in a sense families have not always been front and centre in efforts to overcome substance abuse. This has occurred because most attention has been focused on understanding and treating drug problems at the level of the individual of course, and that is rightly important. Although there are some signs that this is changing—and there are some excellent integrated programs in some places—in general, the result has often been the marginalisation of families from treatment services and that has accentuated feelings such as isolation and blame that many families experience as they cope with a loved one using drugs.

Turning more broadly, our soundings reveal the need to know a great deal more about the dimensions of the drug problem, especially as it affects children. Without stopping us taking action, we still think that research should be undertaken in several areas: one of those is early intervention strategies that are aimed at families, children and young people that could guide whole-of-society and whole-of-community approaches for building family wellbeing and resilience; another is evidence based ways to assist drug treatment programs to include families, especially children and high-risk families with parental substance abuse. Also the situation for children, siblings and grandparents in families affected by parental drug use needs further examination as well as the cost borne by those providing out-of-home care.

We think there is a need for greater coherence between national strategies and more emphasis on and funding for effective whole-of-society programs based on early intervention and responses that tackle the co-occurring problems, such as substance abuse and mental health, in an integrated and long-term manner. Hence, one of the very important things that we would like to suggest is that a national family wellbeing framework should be developed to guide at a national level and then cascading, hopefully down to other levels of government, policy research and funding allocations.

We think, importantly too, that a national child protection strategy is overdue in Australia, and a considerable amount of work was done last year at the National Child Protection

Clearinghouse conference, which was funded by the Australian government. We would like to see the outcomes of that conference being reflected in a national child protection strategy.

Governments, through COAG, might be invited to re-examine the connections between the strategies dealing with co-occurring issues such as mental health and substance abuse and to recognise the need for longer term program interventions through multiyear funding cycles, rather than three years at a time. This is a very strong plea from many professionals working in this area.

We think that new and better ways need to be found to strengthen families coping with these issues, and greater emphasis ought to be given in three particular areas: firstly, family support, which is integrated with drug treatment approaches such as through local family support groups and which takes into account the differing needs and requirements of families; secondly, early intervention approaches for high-risk families through, for example, parent education; and, thirdly, programs that address in an integrated manner co-occurring issues of substance abuse and other issues such as mental health.

But, on the ground, the capacities of service providing organisations to provide family support should be further strengthened. While acknowledging that steps are being taken in this direction, including through the Australian government strengthening families program, there is certainly more that could be done, including disseminating good practice in drug support services; developing and replicating programs that offer therapy and support for children; and greater access for family members to counselling and respite, support networks and discussion groups.

Finally, of our catalogue of suggestions, public education and media campaigns are very important but it seems that you get better results—and this is looking at overseas evidence—when those things work as mutually reinforcing and in tandem. So, in summary, we would say six main things: involve families; tackle co-occurring problems together; make national strategies coherent; invest earlier in prevention; target the needs of children and grandparents in particular; and help provide a model for resilience and particularly hope through an emphasis on family wellbeing more broadly.

CHAIR—Thank you very much. I note in the back of your submission at appendix B is the list of people you used for your roundtable, forum and focus groups. I would have thought that they had rather competing attitudes and beliefs as to the best way to deal with things. You have the pro-drug lot there—Families and Friends for Drug Law Reform. You have a very competing lot, shall we say. What association or what connection do they have to your organisation? Or did you just collectively bring them in?

Mr Babington—Some are members of Families Australia but some responded to an open call to be involved in our consultation work. They do come from sometimes different bases of treatment and approach. But it was really interesting that when we got to talking to people through the focus groups and the forum and we started to look at it from the point of view of how families are impacted by this issue, some of the other questions about modalities, I suppose, of drug treatment tended to fall away a bit.

CHAIR—The competing views I am talking about are, firstly, those who say the aim should be to prevent people going onto drugs and if people go onto drugs the aim should be to get them

off. Then you have the other group of people who say drug taking is a way of life and you have got to learn to live with it. They are two very strong competing things. Government policy is zero tolerance. We say we want to prevent people getting onto drugs and help people get off them. We also want to provide treatment so that people are able to do that. Can you tell me a little more about your organisation? What do you do?

Mr Babington—Families Australia is independent and non-sectarian, and we have very broad membership across Australia. It can be individual childcare centres at the grassroots level right through to large state based services working in areas ranging from aged care to family support, counselling and youth support. At the national level we have a number of national organisations, including Mission Australia and Relationships Australia.

CHAIR—What do you do?

Mr Babington—We try to be a peak body representing broadly the interests and needs of families.

CHAIR—But you are more than a post box.

Mr Babington—Absolutely.

CHAIR—What sort of staff do you have? Do you do research? Do you deliver any programs? Do your members do that? What does your organisation do?

Mr Babington—We do three things. We inform, we represent and we try to celebrate families. Information providing is really being a two-way conduit between what is happening at the national level, understanding national family policies and practices, and trying to render that back to our membership base as well as to the public.

CHAIR—What sort of staff have you got?

Mr Babington—Only about six staff—not all full time. We are funded in large part through the Department of Families, Community Services and Indigenous Affairs to run our secretariat program as well as to run some national—

CHAIR—You act as a secretariat for various bodies.

Mr Babington—We do not act as a secretariat.

CHAIR—What sort of grant do you get from the federal government.

Mr Babington—There are two main grants. One is for the national secretariat program, which is approximately \$280,000 per year. We also receive funding for National Families Week, which is \$100,000 a year. That provides about 70 per cent of our funding; the rest of our funding comes from Families Australia member subscriptions.

CHAIR—What do they pay for that?

Mr Babington—There is a sliding scale. We have two categories of members. There are approximately 35 general members, and they pay about \$275 a year. The bulk of our members are what we call associates, and they pay between \$27 and \$55 a year.

CHAIR—So without a government subsidy you could not exist.

Mr Babington—At the moment it would be very difficult for us to exist.

CHAIR—How many associate members do you have?

Mr Babington—We have 355.

CHAIR—What sort of accountability do you have for that grant? What do you have to report back to the department on?

Mr Babington—We discuss with the department each year a program of endeavours or projects. This year, for example, we have undertaken with the department to do a series of expert forums and focus groups as the main parts of our deliverables to the department. The choice of topics and the way we go about doing those consultations is in practice what we suggest. Those topics arise from issues like the ones being discussed by this committee.

CHAIR—When I look at the list of the people that you had in your focus groups, I have been doing this inquiry long enough to almost tell you precisely what each of them had to say. Did you reach out further? I notice, for instance, TOUGHLOVE is not there. Did you reach into families and ask them what they thought?

Mr Babington—Yes, we did. In the focus group that we held in the lead-up to the expert forum, we consulted local families and at the forum some of the participants were family members who had gone on to either form their own advocacy groups—

CHAIR—I notice Tony Trimmingham, who has been part of the industry for a long time. One of the things I am starting to see is that there is an industry of people who get government grants, publish papers, make their reputations and become spokespeople. There is a whole industry out there which is dependent on these people being there, so I would like to focus more on those people. For instance, Harry and I took evidence in Perth and we saw two families. Harry, remember the lady with five children: four sons, all of them drug addicts? She gave evidence that when the first child became a drug addict, it broke down the morality of her other children to make a moral judgement to say no because it was kind of accepted. We talked to another family: there were 12 nieces and nephews and whatever, and 10 out of the 12 were addicts and there seemed to be a flow-on effect. Those families were destroyed. Obviously, marriages broke up and we had tears and all sorts.

What do you find in your families? Have you looked at the proposition of: is it better to take the child who is affected somewhere else and let the rest of the family try and survive whilst providing treatment and care for the one who is affected? Have you looked at those sorts of things?

Mr Babington—We have certainly heard very similar stories—every one is terribly tragic and I would not like to generalise in any way. My feeling is that, when you look at the way that welfare and the removal of children has been done in Australia over some decades, there have been fads and trends that at times have taken children out of homes sometimes with the most appalling consequences—and I am thinking of the Senate inquiry two years ago into the forgotten Australians, a group that we are very closely involved with. These are the people who were in institutional or out-of-home care. So there are instances where this system can go—

CHAIR—I am sorry: who were those people?

Mr Babington—The so-called forgotten Australians.

CHAIR—Who are they?

Mr Babington—These are the group of people—and there are believed to be over 500,000—who were in institutional and foster care between the 1930s and the 1970s when a lot of the institutions and orphanages were closed down, and so it became more of a fashion. It is very difficult. Going to your point about—

CHAIR—I am not talking about that; I am talking about a situation where mum and dad have four kids and suddenly they discover one of them is a drug user, an addict. They start to see behaviour from the other siblings and the disruption it causes to the family—personal anecdotes. I have spoken to parents where the impact on the other siblings means that they almost lose them as well. What I am trying to get at is: has anyone done any work on strategies to try and save the other kids?

Mr Babington—It is impossible to generalise how that should be treated. The feedback that we get from respected professionals working in this field is that at times families present risk to their members; at times families present protection to their members. We know that there are very high rates of correlation between child abuse and drug users who themselves have been abused. You need to look at each family on a case by case basis.

CHAIR—We are talking about different things here. We have already taken evidence that it is the children who are abused and at risk because the parents are drug addicts. This policy of saying, ‘We will force those children back to the biological parent,’ has meant that in New South Wales 94 kids are dead. In Queensland we took similar figures and Western Australia has similar figures. It is a policy which is resulting in the deaths of children. But you could have a situation where you think you have a perfectly normal mum and dad, a perfectly normal family, until you discover one of them—say there are four kids—has become a drug addict. What do we do to try to save the others?

Mr Babington—I suppose what I am saying is that you need to look at the family, each family, as an individual case, and to look at the interventions—

CHAIR—That is not rocket science, but is there any research?

Mr Babington—In a way, I do not know of the research.

CHAIR—You do not know?

Mr Babington—No, except what the professionals are telling us: that it is now very important to involve families.

Mrs IRWIN—I think the people here are in another field as well.

CHAIR—I wanted to know if they had any research.

Mr Babington—No, not that we have heard, except what we have picked up from our own efforts.

Mrs IRWIN—I want to have a talk to you about some of your recommendations. I do support some of them. I might come back to it.

Mr QUICK—Brian, in the area of domestic violence, when it came out of the cupboard we actually recognised it and put in place changes in police training, strategies and then legislation to pick up the women at risk and to deal with the men. When it comes to drug violence, there are similar circumstances where people are disruptive, with the emphasis now on young people taking ice and the like. Is anyone doing anything constructive in the area of training police, rather than just coming in and removing the person? If so, which states are doing it better, or is it in embryonic stages?

Mr Babington—I am sorry, I have not had specific information about that.

Mr QUICK—Is it raised at all in the forum?

Mr Babington—It was not raised in the forum. Except that I do know, more broadly, from talking to organisations like the Police Federation of Australia, particularly in relation to campaigns to do with combating domestic violence, that there is greater training for police in handling these types of situations. I do not know specifically, however, the extent to which they are trained in the area of drugs. It certainly would be one that we would support.

Mr QUICK—The reason I raise it is that it has actually happened to me. Because I am who I am, I managed to get the police to my place (a) to protect me and (b) to remove the person. But if you do not have my clout, and you have lots of cases of single parents trying to deal with this situation, the police basically are not really interested in it; it is all too hard. How do you not only remove that person but key that single parent into some support services? Because, basically, they are not open seven days a week, 24 hours a day. Depending on where you live in Australia, you are whistling in the wind in most cases, unless you live in one of the five big capital cities.

Some of us were on the previous committee hearing. My other point is that on page 6 of your submission you mention Collins and Lapsley, where we actually do quantify \$34.4 billion, which is a huge amount of money. But apparently there is no recognition out there that this is a hell of a drain on Australian taxpayers—\$34 billion. If some Commonwealth government department suddenly said that they had to find this huge amount of money, there would be screams and it would be front page in all the media, but because it is a touchy subject and no-one wants to

really get involved, \$34 billion floats away in the ether and there is no recognition of the significance of the problem.

Mr Babington—Yes. And that is, I suppose, why we also say that early intervention where you invest money, resources and time up-front in the early stages of family life and also in the early stages of a problem saves you money much later on. It is very interesting—the studies that have been done by people like Jim Heckman, the Nobel prize winner in the States, say that even just on the economics the money should be put into very enriched early childhood programs because the returns later on are tremendous and you are not bearing those massive things.

Mr QUICK—But the average lifespan of a federal member of the House of Representatives is six years or two terms. They do not actually see the long-term benefits. So there is reluctance on the part of federal politicians, especially in the House, where your survival comes first, to look at long-term strategies and investment because there is not this longitudinal understanding of the problem. Trying to convince politicians of both persuasions, let alone some of our state colleagues, to invest in this is really difficult.

Mr Babington—My opinion is that both are needed. It is getting the balance between the early intervention and the tertiary end that is the tricky thing really.

Mr TICEHURST—At what age do you find drug-taking begins?

Mr Babington—The families and the experts that we were interviewing were saying that this can really come in almost at any age. I suppose the actual act of drug-taking might be more frequent in maybe the early teenage years. I suppose what we would say is that, looking at the precursors, what are children picking up behaviourally, maybe from within their family context, that predisposes them to that higher risk? In terms of age, we do not know how far that puts it back in a child's life.

Mr TICEHURST—What was the value of anti-drug education in schools? Have you looked at any value judgements there?

Mr Babington—It is a bit controversial. I have looked at the American evidence. Some of our Australian experts were saying that you need to be very careful and very targeted about public awareness campaigns. The message that I kept getting when I looked at the US research was that, if you just do broad public awareness campaigns, they have some effect but they may not have the strong effect on changing behaviours. When you marry those with programs in schools, it seems to produce a greater effect. So it is actually about gathering a bit more evidence before we splash money around very broadly on these things.

Mr TICEHURST—I noticed that in some of your recommendations here you are saying that there is a high level of agreement between members and professionals on harm minimisation, whereas our government approach is zero tolerance. How are we going to marry those two ideas together? Harm minimisation has acceptance as part of it—it is really fundamental.

Mr Babington—Certainly, the consensus from the people we spoke to—and I think it was a pretty broad group, but it did include families—reminded us that harm minimisation has been the core of the national drug strategy since 1985. There were so many stories—and I think we

tried to render them in the submission—which said that, within the spectrum of harm minimisation measures, things like abstinence as well as the other measures have a place. It is a matter of looking at each case according to the needs of the individual. There were stories about keeping kids alive. Parents did not like that their children were using drugs—of course they didn't. But what they did not like more than that was having kids who were dead.

Mr TICEHURST—Fair enough. Thank you.

CHAIR—Can somebody move that, pursuant to the standing orders, a subcommittee be formed consisting of me and Mrs Irwin and that I be the chair of that subcommittee?

Mr TICEHURST—So moved.

CHAIR—Thank you.

Mrs IRWIN—I think this is on page 18. I am going to quote from the recommendations. It says:

3. *Harm minimisation should be reiterated and supported* as the central guiding principle for all national drug policies and programs.

4. Greater effort should be made by governments to promote public *understanding of the meaning of 'harm minimisation'*.

How do you feel that we could promote out in the public the understanding of harm minimisation? People understand zero tolerance, but they think, 'What do you really mean by harm minimisation?' How would you like to see that promoted?

Mr Babington—I think the term is problematic in a way. I had difficulty in really grasping what the elements of harm minimisation were. Then it was explained to me that harm minimisation has been effective in terms of people wearing bike helmets, wearing seatbelts—they are all harm minimisation.

Mrs IRWIN—No, that is nothing to do with the drug scene.

Mr Babington—But these are about making people alert to the various ways that harm can be minimised. I think it is part of public awareness campaigns. I am afraid I do not have any specific strategies, but I do think that they need to be integrated into those awareness and education programs, particularly for parents. I think that parent education programs—more broadly than just about the drug issue, but about other ways that parents can be supported in their parenting—could include those messages, and the earlier the better. Someone suggested putting some information for parents about drug issues in baby packs, because not very much of these things is given to parents.

Mrs IRWIN—With the families and the groups that you are also working with, I think also on page 16 you were talking about drug treatment services. What sort of drug treatment services would you see as working or would you like to see?

Mr Babington—There are some very good examples now, including in Canberra, where we have a service called Karrilika, which on one campus has drug treatment programs but also other ways of supporting families. So it will organise family support meetings every week or every fortnight. It will even have early child care provided so that the children in those family circumstances can be brought in, maybe in the care of the grandparent or whatever it is, at the same time and the same place. So it is that sense of integration of services which seems to be working really well. They are the ones that we would like to see—thinking about what the main elements are that people have learned from those integrated approaches and how we can replicate that, what the factors are that will enhance the replication.

Mrs IRWIN—From an education point of view, what sort of program would you like to see to educate our kids, say, in the schools? I know it has been suggested that we do those pretty hard sorts of ads on television like they do with AIDS and so forth.

Mr Babington—I think the schools programs need to target different age groups—being the father of a 12-year-old and a 16-year-old, I know they understand different things in different ways—and the times when they make transitions. I think what concerns a lot of teachers and a lot of parents is particularly those transitions between primary school and secondary school, those very stressful years, and particularly the years where young people are planning to leave school or going through years 11 and 12. So the needs are different, and I think that the sophistication of the message needs to be targeted in different ways. I suppose that is the best I can say at this stage.

CHAIR—I want to go through a couple of very specific things. When we were in Queensland taking evidence on the Gold Coast, we had a mother who came and gave evidence and said that she had a 14-year-old son who she had found had started taking drugs. She thought that she would be able to ring somebody up, find somewhere that she could take that son, get the son off the drugs and then work out a way that she as the mother could look after her son and keep him off them. She found that there was absolutely nothing—there is no such place.

We heard from a man who came in off the street. He had heard an interview I had done on the radio and he came to give evidence—we had a community section where you can just come and give evidence. He said he had been a heroin addict for 7½ years. He said it took him 7½ years to get off it. He is now in his late 20s, and he is running his own business. But he wanted to tell us this: he said that, during that period of addiction, every now and again a window would open up. He would really feel he could get off it, and he would ring up and try and find someone who would help him do it. They would say, ‘Oh, we can give you an appointment in three weeks.’ Then it was gone, and he would just take another hit.

So there seems to be absolutely no emergency place that people can go. We have plenty of experts, all getting funding. I just took a look at the list of people who turned up at your group, including you. Without doing a thorough search, I identified straightaway Commonwealth government funding of \$4.78 million. That is paying for a lot of research, a lot of salaries, but the kids are not getting anything.

I am trying to work out a model where a mother, who is faced with that problem, has somewhere to go. I had another example of somebody who came into my office who found that their child had been smoking marijuana at the year 10 formal. She took him along to a drug

counsellor, who told the kid to be more careful so his mother does not find out. What sort of society are we becoming? This is the stuff that can cause kids to become schizophrenic, it rots the brain. Question one: can you see any way that you could work on a model where a parent can go and say: 'I've got this problem; I need help now, not in a fortnight and not to be told to be counselled.'

Mr Babington—Can I briefly respond to that. I share the core of what you are saying. So much of our feedback is about where do parents go? Where is the one-stop shop? You are absolutely right: there are a lot of services, there are helplines and so on, but one of the things we found in talking to families—and we found this with the grandparenting report that we did late last year and early this year—is understanding where to go when you have a problem.

CHAIR—There isn't anywhere.

Mr Babington—Navigating the system is very hard—

CHAIR—There isn't anywhere.

Mr Babington—and so that is why, in relation to grandparents, we are suggesting having one national hotline so that it becomes very well—

CHAIR—We do not need another hotline; I have got a list of hotlines. I have got a list of people who are getting government money, and I am finding kids and parents are not getting anything.

Mrs IRWIN—But those hotlines also refer them on to services.

CHAIR—Yes, to get an appointment in two or three weeks, but they need help now.

Mr Babington—The experience that is coming through now with the family relationship centres is that, when you have a more centralised way—there is a relationship line there—and when these things become more publicised, people do pick them up. We know that there is take-up—

CHAIR—Relationship centres have been established to try to help keep families together. It is giving out all sorts of advice. I have sent people there. When their marriage is starting to break up, they are told, 'Let's get you in there before it happens.' That is not talking about the situation where the mother says: 'This 14-year-old kid of mine is taking drugs. Where do I take him today?'

Mr Babington—That is not my point. My point is this—

CHAIR—No, but it is my point.

Mr Babington—I am saying that there are sometimes centralised places that, if they are well publicised, people know they can go to them and they can be referred on. They can be very useful.

CHAIR—I am telling you there is not anywhere that you can go.

Mr Babington—Yes, but my point is that I think that could be a very good model, to have a one-stop shop approach.

CHAIR—So if we could have a one-stop shop, you would like that. That is great.

Mrs IRWIN—What do you mean by ‘they have got to wait two or three weeks’—to get counselling or to get on a program, whether it be methadone or whatever?

Mrs MARKUS—I have not heard everything that has gone before, so forgive me at the outset if I reiterate anything that has been said or a question that has been asked. I worked with families as a social worker for 25 years before I came into this place. I understand some of the points that you raise, including that services do not always cater to the broader needs of the family in treatment, in assessment et cetera—whether it is tertiary or prevention. I do not disagree with you, but we have here a situation where there is not an approach that provides a negative consequence for behaviour that is criminal at every point in time.

We also do not have enough treatment services available. If somebody needs help at the point where they want help and are ready for help, not all of the services are available, whether they want to get off methadone, whether they want to break the pattern of use of illicit drugs, whatever those drugs may be. I could go on, but we do not have all day. At the same time there are babies, children who do not have a voice and who continue to be abused or even die. We need to do something about that. So I hear what you are saying about the integrated services that incorporate families—and I agree with you—but I think we need to have a much tougher approach.

This government has a Tough on Drugs policy, and compassion is a mix of action and not just saying, ‘We’re sorry for you; let’s try to make it easy for you.’ I think our approach and other government approaches at state level are often too much of that. We need to have consequences for people who use drugs and break the law, but at the same time we need to have treatment for those who are ready and want it. We need to have treatment that tackles families and at the same time we need to protect our children.

Recently, a police officer in my office talked to me about a four-month-old baby who died, and the autopsy showed five drugs in that four-month-old baby’s body. That is unacceptable. The mother of that child or the parents of those children are valuable individuals, but somewhere along the line too many people have let their behaviour pass. We have to get this right. It is very challenging for families and we have to help them.

I do not think another hotline is the answer, I have to tell you. I understand your one-stop shop may be helpful, but that is no help if the treatment programs are not in place, if there is nowhere to refer people. That is of no value if there is no additional treatment. You cannot treat someone and not give them the consequences. There needs to be a balance between negative consequences for criminal behaviour, for breaking the law, and the availability of treatment services to tackle all the social, behavioural and psychological issues that develop for that individual and for their family. At the same time we need to figure out how we are going to protect our children. I do not know that I have a question for you, Brian.

Mr Babington—I really support so much of what you have said, and I would not like any of our submission to be in a way reduced down to one idea of a one-stop shop. We did not even recommend that. But we do support the notion of very wide-ranging, whole-of-society approaches, as well as very targeted ones in the service delivery end of the spectrum. If there are better ways of helping families to navigate and understand how they can get help, we would be the first to line up and say that that would be a great idea, because there is a fragmentation. Often the services that we are speaking to will throw their hands up in the air themselves and say, ‘We’re a drug treatment service but this client, this patient or this person has a mental health problem and they have to go off to a mental health service and then they have to go off to another sort of service.’

Mrs MARKUS—It is not much fun for them either.

Mr Babington—If I can broaden the idea of a one-stop shop—and I do not particularly like the term—is there a way that we can help with all those co-occurring issues and wrap the services around the people rather than wrap the people around the services? Finally, with regard to child protection, one of the most central things that we would like to say in the submission—and I hope it comes through—is that not enough emphasis has been given to the plight of children in these situations. Our strong plea would be for a national approach that supplements and works with state and territory child protection approaches which are so overloaded. If we could have a national approach on this matter, that would be very beneficial.

Mrs MARKUS—There is terminology like ‘harmonisation minimisation’ and so on through the submission and, while it is important to eliminate the risks for all individuals in this situation, I think that if we do not take a stand and say, ‘This behaviour is unacceptable,’ then no-one will ever want to change. Change happens in people’s lives when they are confronted with the real consequences of their behaviour. I think only taking a harmonisation approach is not effective. In my experience, when you confront people—and they can be charged, whether it be with domestic violence, child abuse or whatever; in this instance let us take the use of illicit drugs which then results in other negative behaviour like child abuse and so on—there needs to be consequences that people are faced with for them to want to change.

Some people will want to take steps to change before that happens but for others, without that confrontation, there will not be any change and then we are relegating this nation’s children to a future that I cannot see as being acceptable. So in my view there needs to be a tough approach mixed with services. There have to be treatment services. If there is a tough approach and there is nowhere to send them for them to change, that is not helpful. There has to be both. Having lots of treatment services without the tough approach is not going to work either. A tough approach and no treatment services that work with the whole family is not going to work. It has to work together. That is the view I have formed in my experience. Others may disagree with me, but I will stand by that view.

CHAIR—I would like to go to your recommendations and follow up on something that Mrs Markus had to say. You say:

Harm minimisation should be reiterated and supported as the central guiding principle for all national drug policies and programs.

I would like to refer to a letter written by the then senior adviser of policy study, Mr Perrin, from the office of the Prime Minister, on 10 October 2005. He says, 'the National Illicit Drug Strategy Tough on Drugs is a comprehensive and balanced approach to the problem of drug abuse. It aims to disrupt the production and supply of illicit drugs; reduce drug use, including abstinence-orientated strategies; and, discourage the uptake of illicit drugs. The initiative has received more than \$1 billion since 1997, making it the most comprehensive and extensively funded national illicit drug program in Australia. Zero tolerance is a better description of current policy than harm minimisation, which I agree is the description of a failed approach of the 1980s and early 1990s.' So he is saying that harm minimisation has failed.

Australia's approach to addressing drug issues is well regarded internationally and is consistent with international drug control frameworks. Recent figures have shown declines in drug overdose death and illicit drug use and an increase in illicit drug seizures. The 2004 National Drug Household Survey showed the proportion of Australians who had used illicit substances had dropped from 16.9 per cent in 2001 to 15.3 per cent in 2004. These statistics are very encouraging and highlight the importance of government strategy in addressing illicit drug use in Australia.

The government's policy makes it very clear: zero tolerance is the policy of the government. It is aimed at stopping people. Harm minimisation is one of those terms that have been used as people want it to serve their purpose. For instance, as I have put on the record before, Margaret Hamilton, who is the co-deputy chair of the Australian National Council on Drugs, which receives \$1.5 million a year of taxpayers' money, says:

Harm minimisation avoids the minefield of moralistic arguments about whether drugs use inherently is 'bad' or 'good'.

... ..

From the perspective of harm minimisation, drug use per se is neither good nor bad.

We are funding her \$1.5 million. She also says:

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 humane framework.

In other words, her policy is: just get used to the fact that some people like drugs. She says;

... debate about the application of harm minimisation 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.

In other words, she says that the Prime Minister can get lost: 'I know better than he does.' You are funded \$380,000 a year to carry out government policy and to do work for the government and you have to report to the government on the work that you are doing. I would be amazed, having heard your evidence, if you agreed that drug taking is morally neutral and is not good or bad—if you want drugs, it is okay.

Mr Babington—We as an organisation are deeply concerned about drug abuse in Australia and believe it should be combated in all its forms.

CHAIR—And it is bad?

Mr Babington—It is bad and it has very negative and even fatal consequences for individuals and deeply negative, tragic consequences for families. Our own evidence from the organisations, individuals and families that we spoke to—

CHAIR—Including Professor Hamilton's lot!

Mr Babington—said that the National Drug Strategy has used harm minimisation as a guiding principle.

CHAIR—This is from the Prime Minister's office: 'Zero tolerance is a better description of current policy than harm minimisation.' That is government policy.

Mr Babington—The feedback we have received suggests that harm minimisation is supported by families and by professionals working in the field.

CHAIR—This is the policy.

Mrs MARKUS—When you talked to them did you ask them about their understanding of what the words 'harm minimisation' and 'zero tolerance' mean? All these words are bandied about, but do people understand what they mean and what impact it will or will not have? Are you exploring that with them when you talk with them?

Mr Babington—We were interested in your term of reference No. 2, about harm minimisation. Our focus, though, was to look at the effects on families and how families can be better supported. That is our view of the world. We are not an organisation that has particular expertise of a longstanding nature, as do many organisations that we consulted and many others. Our view of the world is to try to understand better how families are coping. We had a number of families saying to us that they understood harm minimisation to mean keeping kids alive—I am just trying to paraphrase one or two of the people who spoke to us—and that was a good outcome.

Mrs MARKUS—What they are saying is that they want their kids to come off drugs. They want their children or grandchildren to be free of drugs and they want to head back in the right direction somehow as a family. But they want their child alive for the opportunities.

Mr Babington—That is very accurate.

Mrs MARKUS—That is what they are saying. If harm minimisation does not achieve that then they would not want it.

Mr Babington—I do not think any family member that we spoke to was saying they wanted to endure the situation forever. No-one was saying that. They were saying that, while they were in this chaos, while a lot of them live their lives with drug use in families, they wanted to find a

way just to get through it until the user says, 'Enough is enough,' or other people around the user say: 'Surely, enough is enough. This has got to change and you must go for some sort of treatment.' Getting to that day, almost like keeping the ball in play, is better than abandoning the drug user and the family. I can only try to honestly report what we heard from families who were devastated by this.

CHAIR—At the end of the day they want the child off the drug and they want them to come back into the fold of the family.

Mr Babington—Yes.

CHAIR—That is what we all want.

Mrs MARKUS—I think what zero tolerance stresses is personal responsibility and we have to come back to people being accountable for their actions and behaviour. That is what develops mature contributing people, hopefully, to our society. We have got to come back to a place where families can be helped to help the individual in that family who is using illicit drugs of whatever nature to begin to take personal responsibility and want to change, and then the right kind of help is provided. I keep coming back to the fact that if there is no zero tolerance it takes a lot longer for people to get there. They can stay dependent on other things for a very long period of time without ever having to take personal responsibility.

CHAIR—A classic example is the AFL football player. He has got a father who is finally saying 'We're going to take responsibility here,' yet the policy of the AFL is: use drugs; three and you're out but we don't care. But this father is taking a stance.

Mrs MARKUS—I wonder what would have happened the first time—if he would have made different choices earlier.

Mr Babington—I do not want to sound too philosophical about this, but one of the things that I and my organisation would like to see is a greater strengthening of family life and family wellbeing, and that is why we talk about family wellbeing a lot. It is about strengthening the relationships within the families, the quality of relationships; it is not about two cars parked in a garage and a fantastically high mortgage. It is about the other things and the connection between families and the outside community, and health and safety. It is about establishing or maybe re-establishing some of those settings that make our families strong. It is a pretty simple message, but it seems to be hard to get traction on this when there are so many opposing forces pulling families apart in the sense of working hours—I know you have been through the issue of work and family recently—and the tensions there. We are looking to truly try and buttress those factors that add to the protective factors that enable parents to have, say, a better engagement with their children, ideally before drugs become an issue. If drugs become an issue, at least provide a good basis for a relationship between parents and children about how to deal with the issue.

CHAIR—If they need help, they need somewhere to go. The Institute of Health and Welfare, who you had on your focus group or your round table, list for us the influences on first use of an illicit drug in recent and former users aged 12 years and older in 2004. The biggest reason was curiosity—81 per cent of 12- to 15-year-olds, over 12 it goes down to 77 per cent. The next

biggest was peer pressure—45 to 55 per cent. To do something exciting is next, then enhance an experience, then take a risk. Feel better comes down to 18 per cent. Family relationship, work or school problems is only 17 per cent; traumatic experience, eight per cent; lose weight, 1.6 per cent; other, whatever.

They found that the reason why people do not do it is that they are ‘just not interested’, which was the response from the vast majority, broken down into 64 per cent of children aged 12 to 15 and 74 per cent aged over 12. In the 12- to 15-year-old age group 73 per cent gave the reason, ‘for reasons related to health or addiction.’ And 55 per cent of children over the age of 12 gave responses such as, ‘Do not like to be out of control’, ‘for reasons related to the law’, ‘don’t think it would be enjoyable’, ‘religious or moral pressure from family and friends’, and on it goes.

In other words, what seems to be missing is a big campaign to tell young people what it can do to them. We have talked about this before. I am not going to say, ‘Because it can kill you,’ because kids think they are infallible, but what they can end up with—for instance, somebody who has been on drugs for a long time and all their teeth fall out, their skin starts to look hideous, they look horrible and nobody would want to be with them—and to warn them that these are the sorts of things that come: you can become schizophrenic; you can become psychotic.

The Australian Institute of Health and Welfare told us that the two biggest successful campaigns were the AIDS campaign, and the smoking campaign that uses the picture of young woman with the teeth and the mutilated mouth. They have been the most effective. Yet, in this area where people’s lives are being destroyed forever, we have no such thing. We talk about things like ‘harm’, ‘recreational drugs’ and ‘party drugs’. For those people who want to see it—and we have the Greens who go out there and say, ‘You can have as much of the drug ice as you like.’ I think they should be like One Nation: no party should decently take their preferences, because of what they do and what they stand for. If we have those sorts of messages out there, what hope have these kids got? So I like your recommendation that says: ‘Additional resources should be devoted to public education and media campaigns which are mutually reinforcing, evidence based and comprehensive.’ Would you welcome a campaign that is a bit like the smoking one or the AIDS one?

Mr Babington—We would welcome a campaign based on what we know works. I have seen those campaigns as well, and I know that they are very dramatic.

CHAIR—And we have evidence that they work.

Mr Babington—Yes. I think you have to look at the evidence of what works.

CHAIR—Mr Keelty, the commissioner of the Australian Federal Police, would he welcome a campaign?

Mr Babington—We also have to look at the various audiences. As I said in response to an earlier question from Mrs Irwin, I think they need to look at the key target groups, at the most vulnerable groups. I am not a public communications expert but I think they need to look at how best to get the message across.

CHAIR—But what is the message?

Mr Babington—I think it is the message that we have talked about today.

CHAIR—Which is?

Mr Babington—The message about the effects of drugs—

CHAIR—To tell them what can happen to them.

Mr Babington—on yourself, on your family and on the people you love and who love you.

CHAIR—Yes.

Mrs MARKUS—I do not think there is much more I can say, but I think treatment programs do need to focus on the whole family not just on the individual.

CHAIR—We are grateful that you have come today, thank you. You have given us an insight of the interaction of various publicly funded groups and the importance of what you as an organisation stand for, as distinct from the people who have given you input. I think the points you make about building stronger families, which seems to be your main thrust, is something that is certainly needed; it is certainly in line with government policy as well. We talk about research, and there are plenty of people who are getting funded to write papers and publish them, but we desperately need as a first line that there is someone to take the child and somewhere you can go.

Mr Babington—Yes.

Resolved (on motion by **Mrs Markus**):

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 11.39 am