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**HOUSE OF
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STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

(Roundtable)

Reference: Impact of illicit drug use on families

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Monday, 2 April 2007

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

Members in attendance: Mrs Bronwyn Bishop, Mr Cadman, Mrs Irwin and Mrs Markus

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

**BELSEY, Mrs Sylvia Merle, Counsellor, Blacktown Alcohol and Other Drugs Family Services
Inc. 1**

NGUYEN, Mr Luat Van, Operation Manager, Sydney, Open Family Australia 1

**NGUYEN, Mr Vuong Van, Coordinator, Moving Forward Program, UnitingCare Burnside-
Cabramatta Multicultural Family Centre 1**

**SIACKHASONE, Mr Voraveth, Intensive Family Support Worker, UnitingCare Burnside-
Cabramatta Centre 1**

**SUHOOD, Ms Tirrania Nehza, Manager, Blacktown Alcohol and Other Drugs Family Services
Inc. 1**

Committee met at 10.11 am

BELSEY, Mrs Sylvia Merle, Counsellor, Blacktown Alcohol and Other Drugs Family Services Inc.

NGUYEN, Mr Luat Van, Operation Manager, Sydney, Open Family Australia

NGUYEN, Mr Vuong Van, Coordinator, Moving Forward Program, UnitingCare Burnside-Cabramatta Multicultural Family Centre

SIACKHASONE, Mr Voraveth, Intensive Family Support Worker, UnitingCare Burnside-Cabramatta Centre

SUHOOD, Ms Tirrania Nehza, Manager, Blacktown Alcohol and Other Drugs Family Services Inc.

Witnesses were affirmed—

CHAIR (Mrs Bronwyn Bishop)—Welcome. I declare open this roundtable public hearing of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drugs on families. Today's roundtable will focus on three themes that are relevant to the damaging impact of illicit drug use: firstly, the consequences for families with a member who has used or is using illicit drugs; secondly, the usefulness of current policies and programs for families; and, thirdly, ways to strengthen families who are struggling with a member or members who are using illicit drugs—in particular, practical ways to help people when they desperately need it.

The public are welcome to observe this roundtable and a transcript of the evidence gathered will be made available on the committee's website. We are very grateful for the attendance of witnesses here today. We hear so many stories in the media about high-profile people using drugs and the impact that might have on young people to take up drugs, because role models are so important.

Everyone will have an opportunity to make an opening statement and then we will move to questions. If there is any point that you want to reinforce, you will be able to do so. We think a roundtable works rather well in facilitating interaction with each other. I invite each organisation to make an opening statement.

Mr V Nguyen—UnitingCare Burnside is a non-government child and family welfare agency in New South Wales. We work with disadvantaged children, young people and their families in different regions of New South Wales. The Moving Forward Program was established in 2001 under the Cabramatta anti-drug strategy to help families affected by drug misuse to cope with the situation and also to help the drug user to work through their treatment and recovery. So far through our program we have worked with more than 300 cases, which have included drug users and the parents, siblings and children of drug users.

In our written submission to the committee, we have put in all the details in terms of the quantitative and qualitative results of our program. Today we would like to suggest to the

committee that this is an important service that families need because the human cost to them is so serious that, besides the drug user, they deserve better services. From our experience we can say that, if the families can cope with the situation, they become an effective supporter in the recovery process of the drug user. It is a twofold program: we are working with the drug user as well as the family. We will discuss more of those things, especially from our own experience, and focus on the cultural and linguistically diverse community backgrounds in our area.

Mr L Nguyen—I want to give a very brief background of Open Family. We are a community organisation that has been working with street young people since 1978. We exist as an independent, not-for-profit organisation. We are not formally aligned with any religious or political group. We are currently operating in Canberra, in Melbourne and suburbs of Victoria and in Sydney, especially Cabramatta, Liverpool, Fairfield and Sydney CBD.

We define the term ‘street young people’ as young people who are less than 24 years of age, who feel alienated and excluded and who have complex problems. These young people are always engaged in significant anti-social and self-destructive behaviour. In 2005-06 we provided intensive support to 590 at-risk young people. In Sydney, New South Wales, there were 221 young people and, of those, 116 were Australian born and 105 were born overseas. Out of this figure, 77.8 per cent have identified problematic drug use.

The majority of referrals were to the health services, 21 per cent, including general practitioner, community health service and hospital; other youth and welfare service, 19 per cent; legal service, 14 per cent; educational institution, 10 per cent; employment agency, 12 per cent; and alcohol and other drugs services.

What we would like to recommend is an early intervention and prevention program with appropriate information provided to communities in their own languages and appropriate treatment services. Since I received the invitation, I went out and spoke to several groups of young people on the street. There were about 10 people in each group, and I asked: ‘How many of you know someone who has used ice in the last 10 days?’ They all raised their hand. Then I said, ‘Leave your hand up if you know more than 10 people who use ice.’ They kept their hands up. I said, ‘Leave your hand up if you know more than 20.’ Only three put their hand down. The problem that we face at the moment is that there are a lot of young people who, because there is no longer availability of heroin, are starting to shift from heroin to ice. It is very easy to get. If you go to a nightclub, this is where you see them.

Young people experience very problematic behaviour when they are coming down from the drugs. We have young mums ringing us up asking, ‘What is going on with my husband? Why isn’t he sleeping?’ Obviously we discuss more later on, but it is definitely an issue. If we do not do anything about it, I reckon it is a major problem.

CHAIR—Thank you very much. Mrs Belsey?

Mrs Belsey—I will refer to my manager to make the opening statement.

Ms Suhood—Blacktown Alcohol and Other Drugs Family Services provides a range of services, including counselling for individuals, couples and families affected by harmful drug use. We also provide community development activities. We have a very strong philosophy

which recognises that drug issues are complex and that we need to build and strengthen relationships at all levels to address drug issues. Our philosophy is called the Bridges philosophy, which has three themes. The themes are: there is more to drug use than drugs, strengthening relationships, and working together.

We also have a very collaborative approach, so we work with a range of agencies. We think we need to be part of a very strong service network where we share our skills and expertise. A number of the counsellors do outreach at a number of agencies to provide specialist counselling that might be useful. We are very well supported by other organisations, so we really do see it as a whole community as well as whole-of-government approach.

You would probably gather that we work from a systems perspective, so we actually see that each member of the family needs to be involved. Each member of the family is affected when there are drug issues. Equally, each member of the family can contribute to making a difference. We recognise that there are social determinants related to harmful drug use. There are broader contextual issues relating to unemployment, poverty, family conflict and peer pressure. There is a whole range of issues that need to be taken into consideration, so we are looking at drug issues from a lot of perspectives. We believe that our community needs to recognise the complexities of the problems as well as working out the solutions together.

CHAIR—Thank you very much. You are all obviously involved in what is very emotionally charged work when you are dealing with young people who are either the users of drugs or are the children of drug users, which is a horrendous problem. In the work that all of you do, are you dealing more with parents taking drugs and the impact that has on the children or with children taking drugs and the impact of that on their siblings and their parents? Is there a pattern?

Mr V Nguyen—In our Moving Forward Program at the Cabramatta Multicultural Family Centre we classify our cases into four subgroups. The first subgroup comprises the people who are drug users themselves—they present themselves to us as individuals. Our focus with them is helping them to get treated and to change their lifestyle in order to assist them in the recovery process. It is about one-fifth of our clientele. The second subgroup comprises parents who are using drugs. These are parents who have children in their care who are struggling to work with DOCS in terms of continuing to care for their children. That is a larger subgroup in our clientele, representing about two-fifths. The third subgroup is children, teenagers or young adults using drugs and still living with their family of origin. They are still living with their parents and their siblings. In that case our work is not only with the drug users but also with the parents and the siblings of the drug user. We have to help the rest of the family to cope and help the drug user to get treated. The two come together. If you work only with the drug user and leave the family aside we find that the result is not sustainable, because the recovery process, as we know, is very long term and they need a lot of support. When we talk about the recovery process, we talk about lifestyle change. It is not just getting treated and going back to society; it is not that simple.

CHAIR—One of our witnesses who gave evidence—I think it was in Perth—said that one of the problems is that, once you get the person off the drugs, you have to create a new culture or otherwise they go back into the drug network and they are captured again.

Mr V Nguyen—Yes, I think that the general term is ‘changing their lifestyle’: to change their lifestyle in terms of their environment and the way they exercise their daily life, their goals,

taking more responsibility and getting back into the family. The whole lifestyle needs to be changed rather than just getting treated—getting detoxed.

CHAIR—We might come back to that—

Mr V Nguyen—We have another subgroup, for what we call at-risk young people. When families see their young children, say, skipping school and attached to the wrong crowd and then see some indication of their using marijuana or some other kind of drug, they come to us, and then we work with the family as well as the at-risk young person in order to work out a solution. That is our fourth subgroup. With each subgroup, we have to have a different mode of service delivery. We could not cope with just one mode of delivery of services; one mode would not suit all those four subgroups of clients.

CHAIR—Thank you very much.

Mr L Nguyen—The majority of our clients are young people who, in turn, have their own early family as well. So we have young mums—young parents—between the ages of 18 and 22 who have kids one or two years old.

I would like to go back to what you asked Vuong before, about changing the whole culture. We find that it all depends on whether you provide support to the young person. If you trigger the motivation for them wanting to give up, then they will give up. The program that we run here in Cabramatta is the Link to Learning program. Out of those who have attended the program, about 80 per cent of young people who dropped out ages ago have gone back to mainstream services and have produced some wonderful work. So, again, if you have that basis and you provide all those things to cater for their needs, the next phase you see is that they actually change. They still decide to stay in the area that they reside in. You can see it through the drug court and the MERIT program—if you push them out of the area, they will eventually come back. But if you provide strong support, even if they still live locally they go through it okay.

CHAIR—What about the groups of people you see? You are concentrating on that young group of people. So the parents you have are going to be young parents?

Mr L Nguyen—Yes; they are normally 24 or 23 years old with children who are one or two years old. We experience a lot of difficulty trying to run recreational programs for them because if we want to take them on a camp, we need to get babysitting or childcare services before they can go to these activities.

Mrs IRWIN—Can you run us through the Link to Learning program—from, say, when you come in contact with these young people?

Mr L Nguyen—Basically, the model that we use is that we do outreach work. We are based most of the time on the street, and we work to build up the support network of the young person. The first stage is to develop trust. The next stage is to bring them into the service. Once they are in the service, we tailor the education to their own personal needs. Within two to six months, or a year, they eventually change and get into the habit of going to the class early and start having that motivation. In the meantime, we still provide other support, like court support, support with

accommodation issues, income support, counselling and referring them on to drug and alcohol services. That is it.

CHAIR—So, to you, Ms Suhood: the sort of people you—

Ms Suhood—In terms of the counselling, most of the people who attend the service would be adults and therefore would be parents, though we certainly do also see young people and have run groups for young people. When I say ‘parents’, that could also include grandparents; they may be seen. With some of the community activities we do, we work with agencies who are also working with young people. So at that prevention level we will also be working with young people.

CHAIR—Does anybody have many older users—people who are middle-aged? What would be the cut-off age? Do you have anyone who is over 50, for instance?

Ms Suhood—Yes.

CHAIR—And still using?

Ms Suhood—Yes, we have had a few cases.

CHAIR—What would they be using?

Ms Suhood—Cannabis, marijuana, seems to be quite prevalent. We have also had a proportion of youth. It depends: sometimes we get more parents coming in; sometimes we get more of the young ones coming in. In the last week I have had, I think, a couple of people over 50—and family members worried about their partners.

CHAIR—Are the majority of the people who come to you referred or do they come of their own volition? What percentage is there? Where would they come from?

Ms Suhood—I have brought our annual report, so you can have some of our statistics. I think about 30 per cent are self-referred or referred by a family member; the rest are referred by other services.

CHAIR—Burnside, do you get people from the drug court?

Mr L Nguyen—Yes, we have older young people—aged maybe 27 or 28. We do not normally cut them off; we basically refer them on. We find that the older youth who used to hang around the area eventually went to jail and have now come back. The majority of these people are hard core—they are probably on a methadone program—and using all the recreational drugs, but the main drugs they use would probably be methadone and, obviously, heroin. When heroin dries up they use another drug. We have also found that the trend in drug use has changed dramatically. In 1992 to about 2000, it was heroin; then from 2000 onwards, it was ecstasy and now it is ice. Most of the people who would have used heroin have moved on to injecting ice.

Mrs IRWIN—Would this have been because of the heroin drought we have heard about?

Mr L Nguyen—Yes, it is. Five years ago you could have bought one kilo of ice for, maybe, \$35,000 street value; nowadays it is \$150,000 street value. Within five years ice has jumped fivefold, so the value is equivalent to heroin if you buy it on the street.

CHAIR—We have heard other evidence that things like ecstasy and speed are quite cheap to buy—in fact, cheaper than alcohol—and this is why a lot of young people use them. Do you have any evidence of that?

Mr L Nguyen—I think they would probably be the same, but it is readily available when people go clubbing. So, if you are under age, you can still get it. If you go to an alcohol outlet and want to buy, you need to produce your ID, but when you go to a club someone else can buy it for you.

CHAIR—No ID.

Mr L Nguyen—No ID at all; it is exchanged under the table. The value would probably be the same. I do not think it is any cheaper; it is just more readily available.

CHAIR—Easier to get.

Mr L Nguyen—Yes, easier to get.

CHAIR—And it has become acceptable, because people talk about them being party drugs.

Mr L Nguyen—Yes—with most of the young people, I think. We have young people who have graduated from university now going clubbing Friday, Saturday and Sunday nights. They start by going to a nightclub in the city and then go on to a morning club. So, after five or six o'clock, they go on to another club which opens from six in the morning until the afternoon. When they are on ice, they can go on for three days of clubbing and dancing all night. At one stage we wanted to go into the clubs to do some sort of early intervention-prevention program, but it is pretty hard. We have tried, but it does not work. It is privately owned and—

Mrs IRWIN—Would you run that sort of program in the clubs if you had access to them?

Mr L Nguyen—We can. With the number of young people we have access to, by turning up to some of these clubs we could eventually gather about 40 or 50—it is about educating them as to the effects of it and what to expect, because they probably just think they are coming for fun. They have no idea that coming down from a high can have an effect on their mental health.

Mrs IRWIN—I would like to ask a question of all of you regarding an education program. But before you answer that, are you finding that our young people are going to ecstasy and ice from heroin because it is cheaper or because—as you answered earlier—heroin is not available at the moment?

Mr L Nguyen—The heroin available on the street now is of a very low grade, whereas ice is in a much more pure form. When people come to us and we ask them why they have changed from heroin to ice, they say, 'Heroin doesn't have an effect on us anymore.' The trend now is that it is cooler to go to a club.

Mrs IRWIN—Are you hearing that from the streets of Cabramatta?

Mr L Nguyen—No. We are working in the Sydney CDB, Fairfield and Liverpool and we go out to all these regions.

Mrs MARKUS—Are you talking about a physical response as well as a psychological—

Mr L Nguyen—Yes.

Mrs MARKUS—You mentioned both.

Mr L Nguyen—That is right.

Mrs MARKUS—You talked about it being cooler to go to the club, so obviously there is a culture.

Mr L Nguyen—Yes. Everybody is using them when you go there. You realise that this is something about which we need to educate young people and the general community with regard to the effects of it, because it becomes so normal. If you go there and do not use it, people wonder what is wrong with you.

Mrs MARKUS—If you had a wish list of everywhere that you would run an education prevention program, where would you do it? You have mentioned clubs but where else? Where and when?

Mr L Nguyen—Open communication—some sort of open forum like this. Maybe open it up to the community, channel it through radio and local newspapers and educate the community about the effects of it so that young families and parents can identify the symptoms earlier. Even the treatment is still unsure at this stage. We refer people on but people are not sure how to treat them; they are just observed. They are put in an observation room, and they just wait for the ice to come down. I have seen a young person go from rubbish bin to rubbish bin and actually climb inside a rubbish bin. He went through each one of them when he was coming off it. He had no idea what he was doing.

CHAIR—Kind of lost his brain.

Mr L Nguyen—Exactly.

CHAIR—But they do not know that, do they?

Mr L Nguyen—They do not; they just go on it for fun. They go to the club and everyone is using it, so they start using it. The effect is obviously great, because they have adrenalin, over-confidence and more energy. But they do not realise what it is like when they come off it. We have had people using it for three weeks without stopping. When one person—a 23-year-old man—stopped, he was just gone. He fell asleep at work and was sent home.

CHAIR—And what happened to him then?

Mr L Nguyen—He is now unemployed. He came to see us. Basically he wanted to have a break from it. We were trying to explain to him that it has to be from him; he has to make the decision. Everyone still thinks independently. The drug is not addictive, although we still argue that point; we are not sure whether or not it is addictive. I think that, if you inject it, you get more addicted than if you snort or sniff it.

Mrs IRWIN—What programs are you finding that are helping these users? I would like to hear from everybody on this.

Mr L Nguyen—Correct me if I am wrong, but the way I see it is that there are two sorts of people using drugs at the moment. There is the frequent drug user who has been around for ages—since 1992 until now. They are 25 to 37-years-old and are still around this area. Then you have the young party-goer who has just finished year 10, 11 or 12. They ask their mum and dad if they can go the club; then they start dancing and popping ice. It is quite easy with the younger ones because, once you tell them the effects of it, the chances are that they will try to slowly come off it. But the ones who are heavily entrenched in drug use need to be provided with all the support—

Mrs IRWIN—With what support?

Mr L Nguyen—The basics—making sure that their basic needs are covered. Once that it is fulfilled, they obviously want to give it up and do other things.

Mrs IRWIN—I would like to know about what sorts of referrals, programs, detox or whatever you refer these people to.

Mrs MARKUS—The word ‘support’ is very general. It is a very social worker term, having come from that background. It would be helpful, when you say ‘support’, to describe what that involves.

Mr L Nguyen—I wanted to say that, but I did not want to say it all in saying what we do.

Mrs MARKUS—It would be helpful.

Mr L Nguyen—Firstly, we identify a young person who really needs intensive support—we call it ‘intensive support’. Once identified, we work out what sort of program that young person needs. Then we give him or her our support—that means 24/7. Each worker is allocated about 10 young people. We find that, within three to six months, the need for support after hours decreases. In the first three months, they intensively ring us every couple of hours or at one o’clock in the morning.

Mrs MARKUS—Is that contact available 24/7?

Mr L Nguyen—That is right. We ensure that they think of us straightaway when anything happens. The first thing is trust. The next stage is to provide them with all the services. But firstly are the many instances of support and the after-hours services, because most of the time people feel dreadful after they have left the club and they want to kill themselves—all sorts of

things. Who is open at that hour? No-one—it is normally nine to five. What you find when you go to those services is that it is normally like a soup van; it does not really provide a—

Mrs MARKUS—So after the three months do they start to need less contact?

Mr L Nguyen—Yes. Their need for support starts to decline. Once we have established their need, we link them up with all the services. We find that it is only a call saying, ‘I’m okay.’ Before it might have been be a 45-minute phone call. They ring up on a Friday and they say, ‘Hey, I’m doing fine; I went to work this morning under control.’

Mrs IRWIN—You are talking about 24/7 support and counselling. What types of treatment are some of these people on?

Mr Siackhasone—In terms of support, I want to share my experience. I run a relapse prevention group. I put support under a different label. People need very basic support at the beginning. In my group, all the participants are on a methadone program. They are young couples or single mothers who have children. In the beginning they may need support to maintain and stabilise their diet. After they have finished a 10-week session and know how to maintain themselves, the question is asked: what is next for them?

They want to adopt a different lifestyle but, in their present situation, they find it very difficult. They really need additional support at a different level to learn how to be confident in society and mix with different peer groups and then to move on and get a job and have a normal lifestyle. That is a different level of support, which we have to work on.

Mr V Nguyen—Another type of support relates to families knowing how to communicate with their teenage or young adult children and understanding a little about youth culture. As Luat has just mentioned, the use of a stimulant substance, as you know, is now part of the present youth culture and it is used for their entertainment more than for anything else.

CHAIR—Pardon me for intervening, but it also seems to involve a greater degree of violence—

Mr L Nguyen—Yes.

Mr V Nguyen—Yes.

CHAIR—because it removes inhibitions.

Mr L Nguyen—Exactly. The latest incident would be what occurred at the Wetherill Park Police Station. We knew the guy; he was on ice. He jumped over the counter and grabbed a gun from the constable. We see that every day.

Mr V Nguyen—The family has to cope with that and the violent behaviour of the drug user. If you want to go further, many users, after long-term use of a stimulant, can develop a kind of dual diagnosis of mental illness.

CHAIR—Absolutely. If you attack the brain, you will get crook.

Mr V Nguyen—Yes. That is why we come back to the issue of the cost, which is huge, on the families. I come back to your first question, which was how our program gets its clients. For the last five years or so, about 40 per cent of our clients have come through self-referral.

CHAIR—Really?

Mr V Nguyen—Yes, because we run not only casework but also family drug education. With family drug education, we can focus only on certain communities. With our program, we focus on the Indochinese communities in our area—namely, Vietnamese-, Lao- and Khmer-speaking families. Because we tell the community, when we talk on the radio, that we work with the drug user and their family, we have some credibility, rather than talking from books—

Mrs IRWIN—It is interesting that you say you talk on the radio; I think you also stated that 40 per cent of your clients are self-referred. I was going to ask of all of you: how do they hear about you? Is it through radio, letterbox drops or churches?

Mr V Nguyen—They know about us—especially the three ethnic communities that I have just mentioned—through the radio.

CHAIR—Do you do that through ethnic community radio programs?

Mr V Nguyen—Yes, through programs on SBS radio, which are broadcast in those three languages. We also get referrals from the Cabramatta Street Team, the local DOCS, community organisations and drug programs, including the MERIT program.

You have asked about older drug users. A few of our clients are over 40 years of age, but the majority are in the 16- to 30-year age group. When we work with those drug users, we also work with their families. Some are young parents and others are middle-aged parents. We also work with about 163 children; they are the children of those families. I have mentioned that we work with drug-affected parents who have children in their care. The welfare of the children is our top priority there. We work not just treating them but also supporting them. We run a parenting skills group for those parents. So we have a relapse prevention group, which is for drug users to learn skills to prevent relapses, but we also run a parenting skills group for those parents who have children in their care.

CHAIR—Do you try to get them off the drugs?

Mr V Nguyen—Of course. We help them to get treatment. We do not provide pharmaceutical treatment; but we provide drug counselling. We provide that either ourselves or by working with other drug services in the area. Often we try to engage the family in a number of services, but we are the main one, more or less, to lead them into those services.

CHAIR—What is the main drug that is taken by the people you deal with?

Mr V Nguyen—The main one is heroin but, as Luat just mentioned, we are moving quickly into party drugs. Luat has mentioned ice and speed. The two main ones we are working with are heroin and marijuana, but we are moving fast into working with party drugs.

Mrs Belsey—From the standpoint that there is more to drugs than the drug itself, we work differently. Personally and from what I hear from my colleagues, many inroads are being made into a healthier community, a healthier individual. However, what is coming through is a lack of understanding between parents and children. The young ones do not want to live out on the street; at the same time, they want their parents to understand where they are coming from.

A lot of relationship concerns arise between family members. Because ours is a family service, we get the families in and talk to them. We evaluate whether we need to get all members in at once or individually and then match them up. It appears to be working. The children are being heard. The user either stops totally or cuts down on their drug and eventually, after a period of time, comes off it because they find that they cannot handle it. Having cut down and then gone back, they find they cannot handle it and so they themselves stay off it voluntarily. I am proud to say that there are quite a few successes. We see parents and families coming back. I have had a case where the children kept encouraging the parents to stay off the drugs—and they have. Now a whole family is drug free, which is really wonderful.

We also provide education in healing addiction; we have groups. At Mount Druitt, we have a group for women who are dealing with a dual diagnosis. We have referrals from JJ, Merit and probation and parole. There have been successes. I go out to various areas, like Mount Druitt and Riverstone, because they do not have counselling services. At Riverstone and Mount Druitt, I seem to deal with a lot of grandparents who need assistance; they have taken over the care of the children. We get referrals from DOCS and from hospitals. We network with agencies quite a bit and they refer to us. Also, community development is important to us.

Madam Chairman, I think you referred to ‘going back into the culture’, which is what we are trying to avoid. We are trying to create a different perception, a different culture, and to educate the community and give them something to participate in to give their life meaning.

CHAIR—Yes, to give them something to do that is meaningful.

Mrs Belsey—Yes. When I ask the young ones and even the older ones, ‘What gives meaning to your life?’ they reply, ‘Nothing.’ When I ask, ‘If you had meaning in your life, would it be different?’ they say, ‘Yes.’ So we work therapeutically on that. That seems to hold water and to hold ground.

We take our programs to various areas. We have been asked by areas outside Blacktown to assist at some of the schools, but we cannot because we are in the LGA; so we put them into contact with other people who might be able to help them. But the philosophy of Bridges is having meaning in life: having meaningful relationships, participating in family and community and having personal power and high expectations. We work on those. It is the resilience principle—working together and strengthening relationships.

When we had an outdoor program and I touched on just the drug itself, I hardly got people coming over to engage with me. But, when I spoke about issues like family relationships, having meaning in life and there being more to drugs than the drug itself, people replied, ‘Yeah’ and I got a lot more people wanting to engage. I spoke to them on the spot and also made appointments for them to come and see us. Because there are only four of us, at times we find we have a long waiting list and we need to work our way through it.

Mrs IRWIN—Something that we do not like to hear about is the waiting list. We would like someone who picks up the phone to be there virtually straight away. Tell us a little about your waiting list. How long would some people have to wait to see you?

Mrs Belsey—A month or so.

Mrs IRWIN—That is a long time.

Mrs Belsey—Yes. When we cannot attend to them, we pass them on to Community Health; we refer them to other bodies. Right now, the waiting list is pretty short because we are picking up. We have four counsellors and another—

Ms Suhood—Another counsellor is starting. But sometimes we have to close the waiting list.

Mrs IRWIN—Where does your funding come from?

Ms Suhood—We get ongoing state funding from the Department of Health and the Department of Community Services. We also get federal funding from FaCSIA and the Department of Health and Ageing, which has really supported the work we do.

CHAIR—How much do you get?

Ms Suhood—Each year we get \$250,000 from FaCSIA and \$150,000 from the Department of Health and Ageing; that is temporary. Fortunately, both those programs have extended our funding, so now we are funded well until June 2008. But after that we will go down to—

CHAIR—How much do you get from the state government?

Ms Suhood—In total, \$140,000.

Mrs MARKUS—Sylvia, in the context of building relationships within the whole family and the progress or lack of progress that is made, could you explain the difference between working with one individual and working with the whole family?

Mrs Belsey—When working therapeutically with an individual, I get into areas they are having difficulty in—‘What is it that is holding you to the drug?’ I try to discover that and deal with the issues that the individual brings up. Is that what you are asking about?

Mrs MARKUS—Yes.

Mrs Belsey—I offer them the opportunity to bring other members in, if they want to, to help that relationship and work things through. Obviously, there are times when the other party is not willing or the individual is not willing. That is fine. It is about giving them the power to decide what is best for them and what they want to do. Generally, they come to whatever they need to come to to work things through. It is therapeutically doing—

Mrs MARKUS—Do people make more progress if you can engage more of the family or if the family is more willing? Is it tougher if they have to do more on their own?

Mrs Belsey—Yes and no. If the person is willing, it can and has been done. I can think of one particular case where the family was not brought in but the individual got off the drug because he gained a better understanding of what was happening. He looked at how he interacted with members of the family or the community. It is all about the person himself or herself. It is not about blaming anybody else but looking at what is impacting on them and working that through. It is not pointing a finger at anyone else; it is, ‘Have a look at what is happening with you; how are you viewing the world?’

Mrs MARKUS—You are helping them to take personal responsibility.

Mrs Belsey—Thank you, yes.

Ms Suhood—Working with a substance user is working from a family and community perspective, so it is looking at all those impacts—not only those they are having on other people but also those that the community and the family are having on them—and working those issues through. Sometimes it is the whole family. Often you get only one person coming and it could be the substance user or a family member.

I would like to give an example of a family member we worked with recently. A father was very concerned that his daughter was using drugs. He was highly anxious. Because there is so much stigma and concern associated with drugs, his relationship with his daughter was becoming severed. The daughter was disappearing on weekends; potentially, she was going to become a homeless young person. Generally they had a good relationship but, with the onset of certain behaviours—which at first were not necessarily ascertained as drug related—he was fearful that he was losing her. He was starting to put some quite hard demands on her, which were moving her away.

We worked with him. We said to him, ‘We don’t know what the situation is—what she’s using or whether she’s using—but we do know that it is really important that you maintain good communication and a good relationship with her.’ We asked him what else was happening in the family. It turned out that he and his wife had separated about a year before and his daughter’s behaviours had started in that year. That is not to say they were not teenage behaviours before that, but they had certainly escalated after the separation.

We discussed with him the possibility that perhaps, as well as problems around her behaviours—we were not trying to minimise them—there were underlying issues that his daughter was not able to discuss with him. We suggested that perhaps it might be useful for him to focus on his relationship and communication with her. He did that. He also put strong boundaries in place—‘This is acceptable and this isn’t.’ But couched doing that within a strong relationship as opposed to, ‘This is what you have to do.’ He gave her space to talk to find out what was going on. He discovered that she really was affected by that separation. I do not want to put blame on families, as these things do happen. But we do have a high divorce rate and, around that, communication within the family contributes to some of these issues.

Essentially, they grew closer. He and his wife gained greater clarity about how best to communicate with their daughter. They were both taking different tacks and needed to take a unified approach. The daughter had started to distance herself from her mother and move closer to her father; then she moved closer again to her mother. The parents still separated, but their

family communication has really improved. The daughter is now going into counselling. At that earlier stage, she would not consider counselling. We never saw the mother or the daughter and worked with one member of the family only, the father. That had a big impact on the daughter, who was using drugs.

Mrs IRWIN—Why didn't you see the mother or the daughter? They just did not want to come in for counselling?

Ms Suhood—No, they did not want to come in for counselling at that stage.

Mrs IRWIN—How old was the young girl and what drug was she on?

Ms Suhood—She was 15 and she was on ice.

Mrs MARKUS—But the critical thing there is that, even though you are dealing with the individual, you are talking about their relationships and the contexts that they are living and dealing with.

Ms Suhood—Exactly, and also the father—he is not a heavy, heavy drinker, but he does drink sometimes quite a lot. We discussed his alcohol use and how that modelling could be affecting the daughter. He said, 'Yeah, maybe it is.' Fortunately we are talking about a father who was very open to looking at his issues—

Mrs IRWIN—A father who cared.

Ms Suhood—A father who really cared about his daughter, was doing the best he could. He was mostly doing the right thing; he just needed a bit of extra support. He knew what was right, so when we made those extra suggestions, it was what he believed but it supported him.

CHAIR—And has she stopped using now?

Ms Suhood—No, but she is in counselling. Young people do not always tell you what they are doing, so we cannot ascertain that she has stopped using. We do know that other things are happening for her in her life that are making her safe, where there is less harm to herself and to her family.

CHAIR—But the fact that she is taking it is going to destroy her brain. Does she know that?

Ms Suhood—She knows. This is the thing: young people know—a lot of them, I am not saying there should not be education on the effects—those physical effects. It does not seem to deter them.

CHAIR—Don't they think that it might happen to somebody else and not to them?

Ms Suhood—Yes. They do think that, but they know those things in general. That is what I am saying. Purely education on the effects of the drug does not, on its own, create a—

CHAIR—What if they saw photographs of what could happen to them—that their skin would become old and haggard and their teeth would become revolting and they would probably have bad breath and nobody would want to talk to them.

Ms Suhood—Of course that is going to work for some people, but for the majority of young people, they think they are invincible.

CHAIR—We have been told by the Australian Institute of Health and Welfare that the two campaigns that have been successful—forget the rest, they have not been—were the AIDS grim reaper ad and the smoking ad, particularly the image of the girl with the mouth that has been eaten out and the teeth looking horrible. They might think they could survive death, but they sure do not want to look like that.

Ms Suhood—I think a number of different strategies are needed when you are looking at education. I am not saying that you do not give people information on those kinds of effects.

CHAIR—The Department of Health and Ageing's statistics say that the number of people who do not use drugs because of education and awareness is 2.7 per cent at the age of 12 and it goes down to one per cent at the age of 20. In other words, it is having virtually no effect. Most people do not take it because they are just not interested, for reasons related to health and education, they do not want to be out of control, for reasons related to the law and they do not think it would be enjoyable. They are the major reasons why they do not.

The main reason why they do—and this is ranging from 81 per cent to 77 per cent—is curiosity. Peer pressure was next, and that drops to 45 per cent. Then it was to do something exciting, 34 per cent, and then it drops down to 13 per cent, to enhance an experience or to take a risk. When you come down to family relationship, work or school problems, at 12 to 15 years it is 17.3 per cent and then it drops way down 4.8 per cent for 20-year-olds. In other words: the reason people are taking drugs is mainly peer pressure and curiosity, but there does not seem to be anything out there to balance out curiosity.

Ms Suhood—I am just wondering: that is in terms of taking it, and we know it is illegal, so I am not—

CHAIR—These are influences on first use of illicit drugs, recent and former users aged 12 years and older.

ACTING CHAIRMAN (Mrs Irwin)—I would like to ask Burnside some questions. I was very interested in your submission, and I am going to quote from it, seeing that we are on the first section at the moment, which is financial, social and personal cost to families. On the first page, under 'financial costs' you state that families:

... may spend thousands of dollars on treatments such as rapid detoxification and naltrexone implants, without sufficient knowledge of the treatments and how they work. As a result, the treatment fails and further exacerbates the family's financial situation.

Since we are talking about financial cost, could you tell me how much they are spending on these types of treatments, to your knowledge?

Mr V Nguyen—In private medical practice, it costs \$3,000 or so to get a naltrexone implant for three to six months.

Mr L Nguyen—But if you shop around, you can get it for about \$1,700. You can go to Melbourne and do it for less than \$1,500.

Mr V Nguyen—Unfortunately, when people talk about treatment they think it is a very quick treatment in terms of stopping use on that day or in that week. When we talk to the family we talk about the recovery process rather than a treatment per se. I tried to say in the submission that, unfortunately, families do not understand the comprehensive approach of treatment. Treatment should always be a combination of pharmaceutical therapy plus counselling, because it always involves lifestyle change and behaviour change—not just stopping the use of the drugs for a few days. Some families think that a one-week detox, so that heroin is no longer in the blood, is all that is needed and then the person can stay drug-free for their rest of their life. Unfortunately, it does not work that way.

I mentioned that Vietnamese, Khmer and Lao families send their children back to their country of origin to get away from drugs for a few months, and they think that it has been successful. Then when the person comes back here, they are back to the scene again, or maybe they use drugs in those countries too. Drugs are quite available in those countries.

ACTING CHAIR—Yes, I think you said that in your submission.

Mr V Nguyen—Yes. One thing I would like to add is about working with families. For 40 per cent of the self-referrals we receive, we do home visits. We do home visits. When a mother rings us to say that her son or daughter is addicted to drugs, often that son or daughter is not ready to be treated. Often we have to go into those families to talk to the parents, and that is a way to introduce ourselves to the drug user. That way, casually, we can get involved and engage the drug user. In those cases we can do the two things in parallel: working with the drug user as well as with the rest of the family.

When parents ring traditional drug services, often those drug services will say to them, ‘Please bring your daughter or your son here so that we can help,’ but those young people or drug addicted adults would not come along with their family members to get treated. You need somebody to come inside the family to involve them. Home visits are one of the services that Burnside is providing.

Mr Siackhasone—For example, if the addicted person wants to go into a detox centre they have to make a phone call by themselves. The worker cannot make the appointment. Who will be the person who encourages the young people to make a phone call from home? We work with parents or siblings in the family to strengthen their skill to know how to work with the addicted person and encourage them to make a move. We think that by working with family you support the person in the other way.

ACTING CHAIRMAN—What sort of support do you give to young kids who have come out of the prison system? You are telling us what happens within the family home if you have had a referral there, but throughout the Vietnamese and Chinese communities, as you and I know, to have a drug addicted child who might be in trouble with the police is to lose face. We are finding

now that they are being kicked out of home and they are stealing, getting into trouble and going into the prison system. Do you assist any of these young ones when they come out of the prison system, and do you feel that governments should be doing a lot more?

Mr Siackhasone—In that sort of situation, we work with the family. They have to know how to assess what happened at the beginning when the person got into drugs, whether the problems are still there and what the underlying issues were, and then how to communicate. They need to understand addictive behaviour and how to set a boundary for that, and then have the skill to communicate and encourage the person to adopt a different lifestyle. We look into that. That is the holistic approach we are using. We look at the surrounding issues and what sorts of obstacles there are and then we try to work on that.

Mr L Nguyen—You asked whether we should do something else when they are released from jail. I believe so because, when you look back, a majority of them will go straight back to jail within the next three to six months. When they are let out of the jail system, the only thing they have is the probation and parole service in their local area. Apart from that, there is no connection and they are just wandering. With some, their family is here but their place is in Parramatta. So straightaway, within a week or so, he or she moves out to Cabramatta, they have breached their condition and eventually, within the next three months, they go straight back again.

We do a lot with probation and parole officers. They ring us and ask us whether anything is available in the community. There is not much out there. The waiting list is an issue that we have. When you refer them onto something else you have to wait for a while, and in some of these cases you cannot wait.

ACTING CHAIR—Where do these young people go once they come out of the prison system?

Mr L Nguyen—They would probably have to go to their designated probation/parole local area. If they are still on a condition—on parole or probation—they would have to report monthly or weekly to the services. The officer will eventually write a court report. Apart from that, the people just released have to work out their own way back to the mainstream services, including Centrelink, looking for work, Mission Employment, training, et cetera.

Mrs IRWIN—Do you give them assistance? Do you have a lot to do with them when they come out of the prison system?

Mr V Nguyen—Yes. We have referrals from parole officers to assist those ex-prisoners to get back to a normal lifestyle. We focus on relapse prevention, and offer other kinds of support as well. I have a list, which I can circulate, which shows the categories we classify the type of support into. The first one is drug counselling, which is information on the effects of drug use. We help them to accept drug or alcohol treatment and relapse prevention treatment. We offer support for a stable lifestyle, which includes accommodation, education, social networks, certain recreational activities and skills for personal relationships. For the parents, we offer parenting skills, childcare and children's services. For non-using parents we have coping skills and family communication skills. We also focus on at-risk young people and their behaviour. That is quite a comprehensive list.

Mrs IRWIN—How many people who have come out of the prison system would you see?

Mr V Nguyen—About 10 per cent of our clientele come from the parole officer or the MERIT program.

Mrs IRWIN—How many would reuse—go onto heroin, ice or whatever?

Mr L Nguyen—About 80 per cent.

Mrs IRWIN—That is a lot, isn't it.

Mr V Nguyen—In our case I think it is a bit less than that. Often we try to get them into certain pharmacotherapy treatments in addition to the counselling. Hopefully, with pharmacotherapy treatment they get stabilised in terms of their needs. Then the counselling is to prevent them relapsing. We offer other support in terms of family work. In total we could achieve a bit more than that.

Mrs IRWIN—Why do you think this 80 per cent go back to drugs? What are the reasons they give you?

Mr L Nguyen—There is a range of issues. For some it results from a simple breach of their condition. They are not allowed to go to Cabramatta but most of their families live in Cabramatta. Or it could be that they are bored and have nothing to do—they cannot find work.

We have been around for so long in this area and we get to know so many of them now. At the moment, even though they do not know us, they will turn up to our doorstep and say, 'Can you help?' Sixty per cent of the young people who come to see us are self-referred. In a way it says there is confidence in us, but, at the same time, we sometimes do not know where to push them through to the system. Mainly they just go back to the parole officer. In some cases they do not have anywhere to go and we have to drop them in a temple somewhere and ask people to look after them for one or two days and then get them back again once things settle down.

Mrs IRWIN—We did a similar inquiry to the one we are doing now over two parliaments. In that inquiry we went into Goulburn jail and we had the opportunity to speak privately to people who were in jail because of a drug addiction—they were shoplifting with guns, I should say; they were pretty high level criminals—and we met a few who had come from the Cabramatta area. A majority of them had reoffended. When we talked to them, they said there was no support mechanism in place. When those gates opened at Goulburn jail, they were virtually shuffled out with a piece of paper in their hand and someone saying, 'Here's your Centrelink form, sign it.'

I think governments of all persuasions have a lot to answer for. What sort of programs do you feel should be in place when those gates open? Some of the inmates were saying that they would like to be able to—the reason why they come back to Cabramatta is that is where their family is, that is where their friends are. If they come back to Cabramatta they are reoffending, they might not have taken the drugs, so they are put back in jail. But they said that they would like something like a refuge that they could go to where they could have assistance for a few months to get affordable housing, someone to help them fill out their forms, trying to assist them to get

some sort of employment. They feel that this is not in place. Do you think that governments of all persuasions—state and federal—should be putting more emphasis on things like that?

Mr L Nguyen—I think so, but there are a lot of services around the area already. The next thing we should do is coordinate our services so that all of us are going to do the same work with the same target group. So instead of reinventing the wheel, we should revisit the services already available and put them all into some sort of a system that these guys can filter through. Obviously we can try that or we can open up another service.

Mrs IRWIN—The monks are very good at some of our temples here, and they will help out for one or two nights. You have women's refuges, but a lot of our young ones—I have seen them; they have come into my office—do not know where to turn. The monks help us out because a lot of these refuges and youth refuges will not take a young person with an addiction.

Mr L Nguyen—Yes, that is very true.

Mrs IRWIN—Should you have a refuge for people who are seeking assistance 24/7, where you have the counsellors in place, various programs and support from the other groups?

Mr L Nguyen—They do not want to go to a refuge. It is not cool to go to a refuge, unless you are really ingrained in the system for so long that a refuge for you is fine. But if you are not at that point, you are not going to want to go to a refuge. Your first instinct would be couch surfing with friends. When all of your friends tell you not to go there any more, then you go to your relatives. When they tell you not to go there any more, then you become homeless and that is when you end up worse down the track.

CHAIR—You said earlier that a lot of the people you are seeing now have gone on to ice from heroin. You say that the main place that ice is procured and used is at dance parties, which to me means that the people running the dance parties must know who is supplying the drugs.

Mr L Nguyen—Yes, obviously they know.

CHAIR—So why is there no action taken against the people running the dance parties? And I mean police action.

Mr L Nguyen—Obviously that is at a different level. We are mainly concerned with the social welfare of these young people. I did mention earlier that we tried to go into these places and they were not very friendly to us.

CHAIR—I bet they weren't!

Mr L Nguyen—Louise asked what I would do if I had a magic wand. I was tempted to say: I am going to organise an ice party! That would be quite controversial, but I would get all the ice people who come to that party and start education and that sort of thing. But, yes, that is a matter for the law enforcement people. However, I think the more you put the pressure on, the more the demand will be and the higher the price will be, and you just create a really scary situation like with heroin back in 1992, 1993 and 1995. You put pressure on and it becomes more dramatic;

there is more violence, there is more drug trade, and more is hidden. And then at the end you just have to increase the power over—

CHAIR—Yes, but the trouble is that you have a cultural thing developing that says to kids: it is just fine to go to dance parties and take drugs and dance for three days and destroy your brain—and whatever happens to you at the end of it. The more you say that, the more children who would otherwise make a decision not to go will go.

Mr L Nguyen—Yes.

CHAIR—So it is not only the people who are on drugs that have to be considered; it is the people who are put at risk because of their behaviour. We have got a duty of care to them as well, and we have got a duty of care to make sure that their behaviour does not bring them in as well. This obviously is the case in families. We took evidence in Perth from a mother who had five children—four boys and one girl. All four boys were drug addicts. She said that, first, it broke the marriage and, second, once the first boy was accepted within the family as being a drug user it broke down the moral code of the rest of the family to reject drug taking. So one after another they went into it because their view was: ‘Well, that’s the way it is in our family.’ And yet there was a duty of care to try and protect those other children. So if you have that happening in an environment where they can go to a dance party and know that the drugs are readily available, you are simply increasing the catchment.

Mr L Nguyen—Yes, for sure. When you are there as a witness when they bust these places it is a funny sight because nobody claims the drugs are theirs and they are there on the floor—the moment the lights are turned on everything is on the floor. Obviously, yes, I agree with you, that everything has to be in hand together: the coordination of law enforcement, treatment, intervention programs, community awareness. We can do it together.

CHAIR—But we have to do something about our language, don’t we? Even here we are talking about people moving on to the ‘party drug group’, which gives the impression that it is really okay. We have to have different words.

Mr L Nguyen—Yes.

Mr V Nguyen—Can I add something. From our work with the young people we find that often they start using because they are curious—

CHAIR—Curiosity.

Mr V Nguyen—Yes—and they feel that addiction is about somebody else—‘It’s not me’—

CHAIR—That is right.

Mr V Nguyen—and they talk about control. In our program we try to tell the community in general that the process of getting addicted is a biological process, so it is out of your behavioural control. You develop tolerance: you use one gram today and then next day you might need more than one gram to have the same effect. That is a biological process. It is not a question of strong will; it is not in your control. We are talking to the community about that

concept. In fact that concept of addiction has been spread around, but sometimes it is not made clear enough to the young people, or even to their families, and addiction is seen to be a problem for somebody else who does not have the strong will to control it. So we are saying that it is a biological process and that you cannot control it by using your mind power.

CHAIR—They are destroying it anyway.

Mr V Nguyen—That is something we talk to the community about as part of our family drug education.

Mrs IRWIN—In your counselling sessions with these families, what do they say the state and federal governments should be doing? Surely they must be frustrated with the state and federal governments. Surely they say there needs to be more policing from both a state and a federal perspective. I would like to hear what parents feel governments should be doing.

Mrs Belsey—I have a comment in regard to the support systems for people when they leave prisons, to which you referred earlier.

Mrs IRWIN—Yes.

Mrs Belsey—I hear from some of my clients that they do not know what to do when they come out of prison. In one instance, we took some prisoners from a rehabilitation centre out for the day and one prisoner refused to get out of the bus. Everyone went out to buy an ice-cream, but he absolutely refused. He was petrified. He said: ‘I don’t know what to do with this money. I don’t know how to do it; I’ve been in prison that long.’ And to get housing, they do not know where to go or what to do. So putting them back into the culture that got them into prison in the first place is not helping them. I hear this from families too. Once their loved ones get out of prison, they do not have a clue what to do. The children do not get to see their fathers or mothers. Once they are out of prison, they do not know where to get money from or how to live. There is a whole range of issues that come up.

The other issue is one that you spoke about, Chair, regarding the statistics for recreational drugs—is that the word that you used?

CHAIR—I think we have to use the term that says what they are. They are illegal drugs.

Mrs Belsey—I wonder if that is a smokescreen with individuals who are using drugs that is concealing some deeper issues, though peer group pressure and things like that are involved as well. My clients do not readily come out and say: ‘I’m having relationship problems. I don’t understand this. I’m not accepted.’ Once we build a rapport with them, the things that are holding them to the drug taking seem to come out. Generally when I ask the young ones, they say: ‘My peers do it. I want to be accepted.’ As I persevere and talk to them there are definitely other underlying issues.

CHAIR—There are other aspects to this. I wonder whether any of your clients come into the category to which I am about to refer. Again, going back to Perth, I met two young women who had been addicts—though they were off it when I met them—and they were both nurses, and had been working as nurses in hospitals while drug addicted. I said, ‘You could have killed

someone.’ Maybe they had killed someone. One of them said: ‘That is when I had to get off it. I knew I could kill someone.’ There could be a lot of people who are working who are drug addicts. From statistics, there are people who are working who are actually putting other people’s lives at risk. There is a culture emerging that says that some people are taking drugs and you just have to get used to it. I cannot accept that. We are going to have problems and we have to weed them out. If a person is addicted, they cannot be working in a position of responsibility. Do you have people who are working in positions where they could risk other people’s lives?

Mrs Belsey—No, not that I know of.

Mr V Nguyen—There are those who drink and drive and who use drugs and drive.

Mrs IRWIN—There are a lot of deaths through alcohol, but that is a legal drug.

CHAIR—We are interested, when we go to Victoria, to take evidence from the police down there. It is the one state where they do drug driving tests. For the life of me I cannot understand why we do not do them right across the country.

Mr L Nguyen—I thought that I read an article before I left on holiday that we had tried something.

CHAIR—They do it in Victoria. They have got sufficient apparatus to test them and take them off the road—but nowhere else. There are some people who think that it is a bit of a problem that you get tested for alcohol, so you can take drugs and nobody touches you.

Mrs IRWIN—Getting back to that question before we have a quick cup of coffee for morning tea, as I was saying earlier, you are talking to parents. What do parents say to you that they feel that state and federal governments should be doing better? What programs would they like to see us put in place? Do they feel that we need more policing? Is there a complaint about our federal and state police? Over to you.

Ms Suhood—The first thing they are saying is that there are not enough services for families. We get calls and they say, ‘Thank God I found you.’ There are not enough services for the family members. It is really important.

CHAIR—What do they say when they find you? What is the question they ask?

Ms Suhood—They say, ‘What do I do? My partner’—or ‘my son’ or ‘my daughter’—‘is using drugs, and I do not know what to do.’

CHAIR—We heard evidence from a mother in Queensland who said she had just found out that her 14-year-old son was taking drugs, and she thought that she could ring up, somewhere, and ask, ‘Where do I take my son so we can get him off this drug, and then we can have a treatment program?’ There is no such place.

Mr V Nguyen—That is what I mean when I say that we—our program is especially for the Vietnamese, Khmer and Lao communities—are more or less the first stop for them. When a mother rings us, we can more or less start the whole process of helping the family, helping the

user, and linking them into the services. We are like a one-stop shop—of course we cannot use the term ‘one-stop shop’—or first shop.

CHAIR—First port of call.

Mr V Nguyen—We can link them into various things, because it is quite a comprehensive process, especially when you talk about recovery—not just treatment. The recovery demands much more than just treatment. By treatment I mean methadone, naltrexone or Suboxone. My term of understanding is that it is about a recovery process.

Another thing is: I have just mentioned that you need to have the ability to visit the family—to do home visiting. If the family rings you and then comes to you, you cannot really involve the user. It is really hard for them, because they come to you about the user. Often by home visiting we can start the process of engaging the user. In that case we can take a more or less holistic approach.

CHAIR—At the end of the day, you will never get anyone to stop using unless they decide they want to, will you?

Mr V Nguyen—But if the family has a good enough understanding, they can provide a bit of pressure and encouragement. I think that pressure plus encouragement is needed.

Mr L Nguyen—With a holistic approach, you have got to look at the whole thing, including law enforcement and a campaign; you have got to put everything into context, and that is when it is going to work. To go back to what you were saying before, with most of the parents—it was heroin and now it is ice—they tend to think that we are reactive rather than proactive. They think that we should have something in place beforehand and get early intervention rather than waiting for it to come to our doorstep, so it is ready. Our treatment is not up to scratch for this—

Mrs IRWIN—What was that?

Mr L Nguyen—We are not certain how to treat some of these clients. So they are pretty frustrated. Some parents say: ‘What happened? Why do we keep doing this? Why don’t we just put a stop to it?’ That is one thing coming now from the parents. On the jail situation, I thought of something that might work. Maybe we should capture the audience before they get released. Maybe the community should go inside and explain their services and get them to know the faces of the workers before they are actually released into the community so that they could go straight to the service that they are aware of, rather than letting them out and saying, ‘Go over there.’ They have no idea who they are and they do not want to go. We did that a couple of years ago but, unfortunately, funding was not available that much so we stopped it. We brought the service into the prison and ran programs for five to 10 weeks and talked to the clients, bringing all the people in.

Mrs IRWIN—You were actually doing these services in the prison system—is that correct?

Mr L Nguyen—Yes, we did it together with a Catholic priest. We did a Moon Festival. We brought women’s services in. We brought drug and alcohol people in. We mingled with the clients and talked to them about what we do. By the second or third time, before they were

released, they are able to get out into that local area and know that these are the services there and they know the faces.

CHAIR—Basically, those people who have gone in have not gone in for using, though, have they; they have gone in for supplying?

Mr L Nguyen—We have not talked about supply.

Mrs IRWIN—I think you were saying earlier—Chair, you were not here—that a number have gone into the prison system because they have—

Mr L Nguyen—Reoffended.

Mrs IRWIN—They have done hold-ups. They are desperate to get money for their drugs, they offend and hence end up in the prison system.

Mrs MARKUS—There is a federally funded crime prevention program for Western Sydney under the Attorney-General's Department that is going into three of the prisons and doing just that. They have just been awarded the funding so the program has not been started, but it will be very interesting to see what happens as a result of that.

CHAIR—Have you noticed with regard to people who, for instance, do hold-ups and go in and threaten people that those who have been on heroin will threaten them, take the money and go, but people who are on ice are just as likely to bash them or shoot them because the violence is greater on ice?

Mr L Nguyen—The heroin user is normally agitated and aggressive. If you negotiate a little bit, they can't handle it and just walk away or something. But the person on ice would persist and insist, because they are still on it and they have no idea what they are doing. With heroin you normally fall asleep—it is a depressant. Your whole body starts to go to sleep pretty soon. If you need it, you need it quickly; if you don't have it, you have got to go somewhere and get it. With the other one, they stay on and continue on for while. I would not say that all of them would turn violent, but I would say that there would be unpredictable behaviour. They have no idea what they are doing—every single one of them.

Mr V Nguyen—When they are in withdrawal it is really hard for them to control their behaviour, because they more or less need that drug and they would do that sort of thing. I have seen young people threatening their own mothers in order to get dollars for their drug use.

CHAIR—I heard one of our parliamentary colleagues on radio this morning—he was there saying his name, so I will repeat it now—and he was saying how a cousin of his who was in a wheelchair and suffers from MS was brutally bashed by a group of youths down in Sydney by the George Street theatre complex. He has brain damage. He was viciously attacked and is still in hospital. These were drug users. We are hearing more stories like that, aren't we?

Mr L Nguyen—That is right.

CHAIR—It obviously also removes any concern for another human being or value for that other human being's life—using ice removes that part of our civilised behaviour. Why don't we break for morning tea and come back and discuss the sorts of treatment programs that we have got going now. I want to particularly discuss whether there is a need for the whole system to become—I am struggling for the word—I am going to say 'more professional'. I do not mean it in that way, because each of you is very professional. But it is almost like a whole series of cottage industries where you all reach out to the bit that comes to you. But there is no, I suppose, coordinated system so it would be possible for someone, like the mother in Queensland, who says of a 14-year-old boy, 'I need to go somewhere now,' to get help. You have a one-month waiting list. A month is too long.

We heard evidence from another young man who had been a heroin addict for 7½ years. He had got off it. He had really wanted to get off it and is now successfully running his own business. He just turned up. He heard me talking about it on radio and he just wanted to be there. He said that there were times during his addiction where there would be a window. If he could have rung somebody and said, 'Right now,' he would have worked with someone and got off it. But when they would say that there was a two-week wait or whatever, he would just have another hit and continue on. So could we think about some of those things when we come back?

Mrs Belsey—On that, when we have somebody on the other end of the line who is really in need, one of the counsellors will get on and talk to them and find them some place when they need to get that help. I just wanted to say that.

CHAIR—That is good. Thank you.

Proceedings suspended from 11.57 am to 12.19 pm

CHAIR—I now reopen this roundtable in our public inquiry into the effect of illicit drugs on families. Is it the wish of the committee that the report of the Blacktown Alcohol and Other Drugs Family Services Inc., *Through innocent eyes*, and a sheet from UnitingCare Burnside's Moving Forward program, 'Models of Intervention and Provision of Intensive Supports', be accepted as exhibits? There being no objection, it is so ordered. We also have the final report of the Bridges strategy, stage 2, which the Blacktown group have furnished us with. Is it the wish of the committee that this submission be accepted as evidence? There being no objection, it is so ordered.

We will now go back to where we were and talk specifically about the existing programs and their impacts on families. I know that Mrs Markus is very concerned about the issue of methadone and the addictive qualities of methadone, what impact that has on families, and whether or not it really is a suitable treatment permanently for people who begin as heroin addicts.

Mr L Nguyen—Before we get into that, there are a lot of treatments available and I think each one of them will treat each individual differently. I have seen people on the methadone program who come out without using drugs again, but I have also seen people who have been on the methadone program for a number of years. Again, it goes back to the service that provides the methadone and whether it has the genuine objective of providing a service to the user. A lot of times people have come to us and said—and correct me if I am wrong; I am not certain about

this—that, due to funding, some of these clinics are actually encouraging methadone users to stay on their methadone program, whereas the main purpose is to decrease the methadone doses. I am not sure, but that is what I have heard on the street.

CHAIR—Ms Suhood, what do you think?

Ms Suhood—I do not feel I can comment. I can say that clients who come to our service who use methadone are trying to come off it, so it is a problem drug for the clients. But we are talking about a particular end of the client group. I know that there are many other clients, as you say, who benefit from use of methadone, so I do not feel I can comment in general on the methadone program; I can comment only on the clients who come to our service.

Mr V Nguyen—In our experience, we saw people using methadone and other kinds of drugs as a way to stay off the heroin. We saw them as being one step towards being drug free. But I have to say that if they combine the methadone program with other services, especially drug counselling and relapse prevention, and if the drug user is in the family context and there is certain support to get the family functioning again it is very helpful because unfortunately many people addicted to heroin cannot go straight to abstinence. They have to go through the step of using, say, methadone, Subutex, naltrexone or possibly a new drug, Suboxone, in order to stay away from the heroin use.

CHAIR—Naltrexone is a treatment that does not become addictive; it gets them off heroin without the withdrawal symptoms, and then they have to be off it. But methadone is an addictive drug itself, isn't it?

Mr L Nguyen—That is right.

CHAIR—We have instances in New South Wales and other places where children of drug addicts have died because they have taken methadone. I am very concerned about DOCS's policy of putting small children, who are innocent victims, back with drug addicted parents.

Mr V Nguyen—Of course, that is the role of DOCS—to decide whether children are returned or not to that kind of family. But usually we have a number of cases that we work on, along with DOCS, to prepare those parents, with certain skills and motivation, to accept their children back. We have had successful cases where children have been returned and have lived happily with their parents.

Of course, in those cases, the parents have had a systematic way of getting off the drugs—not only heroin but also methadone. Usually, to get off methadone they need to work in parallel—they work on the one hand with their medical doctor to get a schedule to reduce the doses slowly and on the other hand with us as drug counsellors and family support workers. Usually it needs that kind of comprehensive approach, that combination—

CHAIR—That is when they are coming off it, when it is being reduced?

Mr V Nguyen—Yes.

CHAIR—What about the ones who just accept the methadone as part of their drug addiction and top up with other drugs and trade in methadone? What controls are there on the pharmacists who dish it out?

Mr V Nguyen—You are right; you have people who stay quite a long time on the methadone program and some, from time to time, top up with other drugs. But often their context is that of an individual, rather than being in a family context. With those in a family context, if we have a chance to work with them, often we can help them to have a schedule to reduce their dose and to get off it.

Mr Siackhasone—I just want to add to that. How can we work with these kinds of kids, who use methadone and heroin and other drugs to top that up? We try to introduce them to different lifestyles, to look at the other side, the bright side, of their lifestyle. While they have money, they do not use every day, and they can spend that money to experience a different lifestyle. I think if they see the other side of life they will look at how they can get rid of that other, the one that is going to take their money away. We encourage them to move on to just methadone and in the end they can drop the methadone as well. Those are the steps they take to achieve abstinence.

CHAIR—Is there an obligation on pharmacists who are dispensing pharmacists for methadone to only supply it to people who are on a reduction program and not as part of their addiction?

Mr V Nguyen—As I understand it, a pharmacist only provides methadone according to the prescription of a doctor. So in this case that has to do more with the role of the doctor than that of the pharmacist, as I understand it. The pharmacist only provides the number of millilitres prescribed by the doctor. People cannot go straight to the pharmacy in order to get—

CHAIR—So is there a requirement on doctors that they have to be doing a reduction program for those on methadone?

Mr V Nguyen—I believe so—all the registered doctors, because not all GPs can do this job; only a few. Only registered GPs can prescribe methadone or naltrexone or whatever. They have a long waiting list. I do not see that it is in their interests to keep people there long. I have difficulty referring them to our local GPs here. Everyone has a limited number of cases to look after. If they fill that number and a new client is referred they have to say no. They cannot accept more. So I have difficulties finding them. In our area, we see the health department trying to get more GPs involved in this kind of program so that more doctors can treat drug addicted people.

CHAIR—If ice is becoming a more dominant problem then that is not going to be very useful either, is it?

Mr V Nguyen—Ice, unfortunately, is another category of drug and so far the treatment for ice is still being discussed and looked at. I have no authority to talk about the treatment for ice. Generally, we work with families as a way to identify the problem and to intervene as early as possible. That is our role.

CHAIR—During the break I was talking with Luat and I asked the question: has any research been done on the long-term effects of ice usage? I think you indicated something was happening in Melbourne.

Mr L Nguyen—My organisation at the moment is doing the research on that topic. It is still in draft form but once it is produced I will forward it to you. You were saying before that if ice is emerging then maybe there is no need for methadone. But when I speak with most of our young people who are on a methadone program I find that some do not like to use ice because of the difference. One is an upper drug—a stimulant—and the other is a depressant. They use it for the first time and if they like it they get onto it. Almost half of them will not go onto ice. The other half would probably go onto injecting ice. So you are looking at nearly half who try it once and do not like the different effect.

Mrs MARKUS—You commented earlier, Tirrania, on the fact that it is a challenging drug for your clients. Can you, or perhaps Sylvia, explain how it is challenging?

Mrs Belsey—It is challenging in the respect of having difficulty getting off it and the lack of support in getting off it. Quite a few of the clients my colleagues and I have counselled are happy to get off it but there is no support to do that. I have heard from clients whose partners have been on it, and how devastating that is for them because their partners are having difficulty getting off it. It affects their bones and teeth and it is quite a devastating drug.

CHAIR—Is that methadone?

Mrs MARKUS—Methadone.

Mrs Belsey—Yes.

CHAIR—Could you explain a bit more about the bones and the teeth?

Mrs Belsey—It destroys the bones and the teeth—the calcium. That is the degenerative aspect of it. And it is also addictive and they stay on it.

Mrs MARKUS—Sylvia, would you say that your clients who are on a methadone program, which is not necessarily illegal, would be likely to be using other illicit drugs?

Mrs Belsey—No, not the clients that I have seen. I think it would be beneficial for them if they were kept on it for a while and then gradually weaned off it, rather than being given the same dosage. That is also a danger to the children.

Mrs MARKUS—Have you seen evidence of them being weaned off it or is it apparent that there is no support or programs in place for that to happen?

Mrs Belsey—In my experience, there is no support.

Mrs IRWIN—Are you saying that if there were special programs in place to help them get weaned off it that would be good?

Mrs Belsey—It would be good, yes. I am not aware if there is any support anywhere.

Mrs MARKUS—There is MTAR but I think it is such a challenge to get into.

Mrs Belsey—Yes, and I think it is difficult for the clients, too, because when they go to these areas there are a lot of other members around and it just reinforces—

Mrs MARKUS—So having to go to a clinic where there are a lot of other drug users—

Mrs Belsey—They get approached by other members to use other drugs as well. That is the comment that I have been getting from my clients.

Mrs IRWIN—Do they just go to their local chemist to get their methadone?

Mrs Belsey—Some go to the clinics and some go to the local chemist.

Mrs MARKUS—Have any of you had experience in working with the prescribing doctors? Have you had some success in working with those doctors in a reduction program?

Mr V Nguyen—Yes, we have. More and more referrals from our Jacaranda House in Liverpool are where the client comes for methadone or Subutex. We work on certain aspects of the client's life and Jacaranda House continues to monitor the doses of methadone or Subutex used by the client.

Mrs MARKUS—Do they work towards—

Mr V Nguyen—Yes. In conjunction we can get the people into a reduction of their use of methadone or Subutex.

Mrs MARKUS—So does that mean there are instances where people have worked towards reduction and maybe cessation of the use of methadone?

Mr V Nguyen—Yes.

Mr Siackhasone—In my experience working with that, that sort of client is so proud to tell us that they are on 10 milligrams and to reduce is a hard thing. That is how they really want to get off that. We can see the dose is 40 milligrams and that they are working to reduce. I believe they dearly want to get off that at the end of the day.

Mrs MARKUS—There would be many clients that would be up around 100 milligrams—doses that would be a lot higher. There is a lot of effort and support required for them to reduce to a level where they can hopefully not use.

Mr Siackhasone—It does not mean reduce and then get off. I think it depends on how ready they are. They can jump off at any level when they feel that they are ready to get off. And how to determine the dose depends on the history of use of each client. They can start from a very high dose or a low dose. I believe that it depends on whether they are on a methadone program and they do not use other drugs to support them. They will get the other side of their life and see the

bright future of their life. I think that is how they become ready and can jump off at any time. They may need detox as well to get off the methadone.

Mrs MARKUS—Where would they go to detox?

Mr Siackhasone—In our area, we always refer them to Corella—

Mr L Nguyen—There is about a month's waiting list.

Mr Siackhasone—They have a waiting list as well. We have experience there.

Mrs MARKUS—But am I hearing you correctly when you say that clients who would be on methadone want the opportunity to reduce to a point where they would not have to take it?

Mrs Belsey—From the ones that my colleagues and I have counselled, yes, that is what is coming through.

Mrs IRWIN—I think you are saying that methadone and counselling go hand-in-hand.

Mrs Belsey—Yes.

Mrs MARKUS—With the system as it is now, with the limited number of opportunities, programs and support to do that, for many that option is not there. Is that a fair comment?

Mr L Nguyen—Yes.

CHAIR—Is there a statistic anywhere that tells us what percentage of people who go onto methadone come off it—or do they basically stay there until their bones are gone and their teeth fall out?

Mr L Nguyen—I cannot recall where I read it, but I know some methadone research has been done.

Mr V Nguyen—Yes, I think there has been a study about methadone services.

Mr L Nguyen—I read an independent report about three years ago, when heroin was around. I guess what we are saying is that whether they are encouraged depends on the interview. Also, for most of the clients we work with, no clear information is given to them about the effects and the expectations you can have when you get on the program. When you get into the program there is no follow-up and no guidelines. Therefore, we tell the client that they need to get off, otherwise they will be down forever. So the ideas we have raised here are only myths; this is what people say—that it is not real. We need to have the professionals say that, when they get on the program, they need to get off within the next year or so. But none of that is happening.

Mrs MARKUS—The evidence would indicate that, because it is a synthetic drug, in a sense it has more addictive qualities. You are saying that it relies a lot on the determination of the individual and on their moving to support structures or other services they can find for

themselves. That means it is even tougher for them than for somebody who may be on other drugs.

Mr L Nguyen—Yes.

Mr V Nguyen—It does not really depend on their determination; it depends on their life situation. If a parent gets into a methadone program, and gets more and more responsibility for their own life and for their children's lives and gets back into their extended family network, they will say: 'I don't need this drug for a long time; I just need it to stop me shaking and to stop my body from aching,' and then they will try to come off.

CHAIR—But they can do that with naltrexone.

Mr V Nguyen—I cannot really comment on that from a medical perspective. The medical people say that some people should get involved with methadone and that other people are more suited to naltrexone.

CHAIR—Naltrexone works for everyone.

Mr V Nguyen—Yes.

CHAIR—When you build a system with a lot of outlets, and a lot of government money is going to the medical profession and to the suppliers of methadone, you have built an industry, haven't you? If someone offers another product which is going to wipe that out, you get a lot of resistance from people who like the system that is in place, because their job is associated with it. I have been to a naltrexone clinic. I watched a long-term implant and I talked to the person who was having it. He wanted to get off it because he had a three-year-old son and his partner was supporting him to give that child a life.

To my horror, I heard evidence, again in Perth, about a large maternity hospital where, of 5,000 children born, 350 of them, seven per cent, were born to drug addicted mothers. That is 350 babies and 103 of those were born to mothers who were being given methadone during their pregnancy, so the children were born addicted to methadone. I then heard a description of what it is like to watch a baby withdraw from methadone. It is just hideous. Yet there was no consideration really being given to a way of getting the mother off that drug for the benefit of her child during the pregnancy. Do you see many instances of children born to addicted parents? Do they come into your purview for care?

Mr V Nguyen—Yes. With the new responsibility of being a mother, quite a few of our clients decide to reduce and get off drugs. Often in that case, we have the support of the standard family. We have support in those cases from the extended families—the drug affected mothers' parents.

CHAIR—What about the baby? Is the baby addicted?

Mr V Nguyen—Yes. The babies are treated. Often those babies are not allowed to be taken home immediately.

CHAIR—Quite right.

Mr V Nguyen—The mothers have to come back to the hospital to look after the babies for a certain period of time. Then later they are allowed to take the babies home.

CHAIR—What happens to those children?

Mr V Nguyen—The mother is now learning the skills to care for the baby.

CHAIR—What about the ones who do not?

Mr V Nguyen—In our cases we really focus on those kinds of skills for those mothers. Often, if they do not really care about the baby, DOCS would intervene very quickly.

CHAIR—Well, they don't, actually. They stay there.

Mr V Nguyen—We often work along with DOCS, so they see any kind of progress and have to be confident that the mother can care for the child.

CHAIR—What about the child who is born addicted? What is the child's prognosis? If a child is born addicted, what then happens to that child in terms of vulnerability to further addiction?

Mr Siackhasone—These are questions to be asked of someone highly expert. The child will need detox as well but detoxification is much easier for babies than for adults. It takes a quarter of the time.

CHAIR—What happens to that child when it is 12?

Mr V Nguyen—If it is exposed to the environment, then obviously it will be like any other child, but if it is a different environment, then it is different. We are talking about all this treatment, but you need to have everything in context: counselling, with everybody having clear guidelines as to what they are doing and making a coordinated effort. You need to have a clear direction on this—as we were talking about with methadone before.

CHAIR—What chance has a child that is brought up in a drug addicted household got of having a successful life? What is the likelihood of that child also ending up a drug addict?

Mr L Nguyen—It is very difficult to say because you have to look at the whole context. We have had young people who have graduated through our Back to School Program who are now lawyers in Melbourne and we have one who is a doctor in Melbourne as well. As Vuong says, it is the whole structure and if the service is there—

CHAIR—But what are the odds; what are the chances?

Mr L Nguyen—I would say, and correct if I am wrong, one in five or one in 10.

Mr V Nguyen—It is hard to say.

Mr L Nguyen—One in five.

Ms Suhood—I am not sure of the odds, but of course there is a higher risk. That is a risk factor for children. That is an identifier. That is why the supports that are in place are absolutely critical for the family and for the children.

Mrs MARKUS—That is why an integrated approach is required that looks at the medical treatment, the plan for reduction and all the other supports—the counselling. You have to have that whole approach for there to be real change.

CHAIR—Collectively among all the agencies, of which there are lots, what percentage of drug addicts would you reach? What percentage of people who are drug addicted would come to any agency?

Mr V Nguyen—I do not know about the total; it is hard for us to get the percentage. We know about the people who are referred to us and the self-referrals, because we have that category as well. When we have a chance to work with them, around 50 per cent of drug users quit drugs or achieve a stable lifestyle. When we talk about success, we are talking about a drug user achieving a stable lifestyle rather than about the treatment.

CHAIR—They are off drugs?

Mr V Nguyen—Yes.

Mr L Nguyen—People who are on heroin are more in tune with getting onto a program. They will readily go onto methadone, naltrexone or Subutex. But the people we are currently experiencing are on ice and they do not think that they have a need for treatment. They do not think that they have a dependency or an addiction. That is the contrast we are seeing nowadays. People on heroin know that psychically and psychologically they need to get onto something else, and they have no money so they know they have to get on a program. With ice, there are those people who say it is not addictive and those who say it is addictive. When we say, ‘Why don’t you seek help?’ they say, ‘There’s no need to seek help.’ We keep getting the same response, ‘I’m not addicted to it.’ But the same people keep using it time and time again. That is the thing we are seeing now.

CHAIR—Have any children been born to mothers who are addicted to ice?

Mr L Nguyen—No. It is a new thing for us.

Mrs IRWIN—You would see a lot who have been addicted to alcohol, would you not?

CHAIR—And cannabis. There are a lot on cannabis. Can we talk about cannabis? We have not talked about it much.

Mrs Belsey—Cannabis creates depression, paranoia and mental illnesses. It exacerbates schizophrenia, if it is in the family. When a person is in that state, it is very difficult for them to see the good that parents or friends see in them or to see that they want them to get off the drug. It takes a while for them to come around to determining whether they want to get off it. A lot of people do. When they are off the drug for a little while, they know there is a marked difference in their thinking. Cannabis is mind-altering like many other drugs. They know there is a

difference once they are off it and they like what they feel, and most of them continue to stay off it. When on cannabis, they get to the point where they think people like the mafia are after them, and things get blown out of proportion.

Mr CADMAN—Of the people that you come across, what proportion uses which drug? You say that the majority use cannabis.

Mrs Belsey—The ones that I see, yes; and one or two use speed.

Mr CADMAN—We will go through the rest of the drugs. Heroin?

Mrs Belsey—Not many—very few actually.

Mr CADMAN—Ice or amphetamines—the so-called recreational drugs?

Mrs Belsey—I have had only one on ice. I do not know whether my colleagues have seen others. I think I have seen just a couple.

Ms Suhood—It is about the same ratio.

Mr L Nguyen—Most of the clients that we see smoke marijuana, use heroin and then take party drugs.

Mr CADMAN—Would 90 per cent smoke marijuana?

Mr L Nguyen—They all use marijuana, but they are not really heavily into marijuana. If they have \$50 in their hand, they prefer to purchase their drug of choice.

Mr CADMAN—So the test is: how can I get the cheapest high?

Mr L Nguyen—Exactly. They are not going to go for marijuana when ice or heroin is available to them. They go straight to the one that gives them the best high.

Mr V Nguyen—The majority of our clients who are drug users use heroin. Some of them have also turned to marijuana for a while but when we work with them we address all those things—not just the heroin but the marijuana use as well. Recently we had cases with ice.

Mr CADMAN—Is that right?

Mr Siackhasone—Yes, I agree with that.

Mr CADMAN—Is there a progression of use? There is a theory—and I do not know whether it is the right theory or not; you have the on-the-ground experience—that people tend to commence with marijuana and move to other so-called harder drugs.

Mr L Nguyen—That is what some of my clients say. They use marijuana. When they do not get the high anymore, they put the heroin on top of the marijuana and then they use the heroin. Seven out of 10 would say that they did that when they were young.

Mr CADMAN—Is there a higher risk of predictability if—

Mrs Belsey—I see it the other way around too: from other drugs down to marijuana. I see the switching from one drug to another to maintain the drug level. So I could not say whether it is one or the other.

Mr V Nguyen—We have seen people who, after they stop using heroin, use a bit of marijuana to replace it. When they work with us they try to reduce and then quit it. That happens in our successful cases.

Mrs Belsey—I am often amazed to hear my clients say that marijuana is a soft drug. They have got that in their heads, so I go through an education program with them about the damage it does. When they can identify the damage that it is doing to them, they tend to cut down on its intake and eventually they stop it.

Mr CADMAN—Can it cause long-term permanent damage, like psychotic occurrences and those sorts of things?

Mrs Belsey—If people combine it with alcohol and other drugs, they can go into psychosis. But I have seen them recover successfully. I cannot speak about the others.

CHAIR—Have you seen some who do not recover?

Mrs Belsey—They just drop out and do not turn up for counselling. That happens.

Mrs MARKUS—Are you saying that anybody who commits to the process and with whom you can stay engaged has a high chance of moving all the way through?

Mrs Belsey—Yes. From my experience that has happened. I get a lot who do not turn up; they do not want to do it. But there are a lot who want to do it and get off it.

CHAIR—The ones who go away are the ones who do not recover?

Mrs Belsey—Hopefully, they will be picked up by some other organisation. I believe that, if I sow the seed, somewhere along the line they might pick it up, run with it at a later stage and seek help.

Mr L Nguyen—At the Open Family we tend to get the ones that everyone has rejected. We normally get the hard core, the end of the scale of the street young people. They eventually drop out of these programs and they cannot turn back so they end up with us. We build up a bit of confidence and then we send them back to where the service is available. It is a continuous cycle. They might try drug and alcohol counselling two, three or four times and on the fifth time they will probably get through it.

CHAIR—The cost of dealing with someone who becomes an addict, of putting them through all of these programs, is really quite high per individual. Has anyone ever done a costing on getting somebody off and rehabilitated?

Mr L Nguyen—I met somebody in Melbourne from the Macfarlane Burnet centre who had done research. They did a calculation and I think they found out that to put somebody in jail is more costly than getting all these services available, because basically this is outsourcing—the management structure is already there; you are just outsourcing the funding to a specialist service or an NGO. I understand from the conversation I had with that person from the Macfarlane Burnet centre that the Footscray area was closed off and they did that calculation. I can get that figure.

CHAIR—Yes, if you would not mind doing that, and also finding out the methodology for calculating the cost. That would be interesting, because it may not count in all the infrastructure costs as well.

Mr CADMAN—Could you tell us about detoxification. We hear a lot about detoxification units. From a service provider's point of view, if you had somebody front up who wanted to change their lifestyle, have you got units or people readily available that you can send them to for a diagnosis and a recovery program? Do you have that readily available when you want it?

Mrs Belsey—I refer them on to the Centre for Addiction Medicine, which is at Westmead Hospital. Most of my clients go there and seek help. They are put on various tablets, like naltrexone and anti-anxiety and sleeping tablets—those are basically the three things they are given. Or there is the Nepean Hospital. We contact them.

Mr CADMAN—Do you regard that as a full service? I do not mean a continuing service. Do you regard that as a good body to help people who come to you?

Mrs Belsey—Initially, yes—because they come back to us. We keep that contact, and the hospitals keep that contact too—they give us a call and say, 'Your client is ready; he has completed the detox.'

Mr CADMAN—Are those services available immediately you need them?

Mrs Belsey—It appears to be; I cannot speak on that. My clients get assistance. I do not know whether it is immediate.

Mr CADMAN—So some may come to you first and some may come back to you from that centre—is that right?

Mrs Belsey—They come to me and then I refer them on to these places. They go and seek assistance; and if they are not in-house they come back every week and see me and then go back and get their medication and speak to the doctors and counsellors there.

Mr V Nguyen—We have clients in both cases. We have clients that we get into detox once they have decided to quit the illicit drugs. Unfortunately, in our area it takes about one month—

Mr CADMAN—One month's delay?

Mr V Nguyen—Yes, in the cases that I have experienced there is a waiting list of a month or so. But we also have clients who were in the detoxification units and who were then referred to us for us to work with them. So we have both situations: we refer clients to the detox units or we accept clients released from the detox units.

Mr CADMAN—And would the ones referred back to you tend to have a Vietnamese or Cambodian or Lao—an Indochinese—background?

Mr V Nguyen—An Indochinese background, yes; you are right there. Also we do have a few English-speaking clients.

Mr CADMAN—Yes; I noticed your statistics. They are very helpful. Thank you for preparing them.

Mr V Nguyen—Thank you.

Mrs IRWIN—I think you were saying earlier, Mr Nguyen—I don't think Mr Cadman was here—regarding naltrexone, that it is very expensive for the families involved; they can pay \$3,000 and up to get their children into treatment.

Mr CADMAN—It is not on the pharmaceutical scheme, is it?

Mrs IRWIN—That is right.

Mr V Nguyen—Yes, if they go through a private practice, because the way they do it is what they call 'rapid detox'. This means that they use naltrexone to get through the blood system in order to really minimise the withdrawal symptoms. And then they use an implant as well. So it costs a lot of money.

Mr CADMAN—I guess within that month of waiting there will be a number of clients who will change their mind?

Mr V Nguyen—That is true.

Mr CADMAN—You have to grab them while they are hot?

Mr V Nguyen—Yes. In those cases we have to continue to work with those clients in order to keep them at the right level of motivation, to educate them enough to get into that.

Mr CADMAN—That would be difficult. The longer the period, I guess, the more difficult it becomes.

Mr V Nguyen—Yes. Usually they have to go through the steps as well—they have to have the interview first, and then they will be given a time when they can get into the clinic for detoxification.

Mr CADMAN—Mr Nguyen, is your experience with waiting periods similar?

Mr L Nguyen—Yes. It takes a while to get them onto any program at all. For instance, with methadone it normally takes a week to two weeks. If you want to detox, if you want to go to the hospital, you need to know your way around, otherwise you can wait forever. Normally we get them to go through Pathway—

Mr CADMAN—I am sorry?

Mr L Nguyen—Pathway is a session together with the detox unit here in Fairfield. We send the client to that unit, they do an assessment and then they will refer that client straight into the hospital, rather than the client referring themselves. We find that it is actually quicker to go through that way.

Mr CADMAN—How much time would it normally take to go through the Fairfield detox unit and then to hospital?

Mr L Nguyen—It depends. Some can take weeks; some can take months. It depends on the season: for instance, if a lot of people are finding there are no drugs available, or there are a lot of people making a New Year's resolution to give up—all that sort of stuff.

Mrs Belsey—I have to say, though, that I have had no experience of clients waiting a month; a month would be a very long time. It would be perhaps a couple of weeks at the most. And they do change their minds in between.

Mrs IRWIN—I would like to ask a question of Uniting Care Burnside about the material on harm minimisation that was in your submission, and then Open Family Australia and Blacktown Alcohol and other Drugs Family Services might like to follow on. I was very interested to see in your submission the part on the impact of harm minimisation programs on families. I will read from the UnitingCare Burnside submission, page 6:

In working with drug-affected families and drug users in particular, Moving Forward workers take the time to explain the significance of harm minimisation practices, such as prevention of overdose, awareness of suicidal thoughts, dangers of sharing needles and syringes, safe sex, and diseases such as Hepatitis C and HIV. Harm minimisation messages are a critical part of a holistic approach to addressing the illicit drug use.

But then you go on to say:

In our experience, the importance of harm minimisation is generally not well understood ...

So I gather that you support harm minimisation but it is not understood in the community. Is that correct?

Mr V Nguyen—When the general community sees a needle exchange program, for example, they do not know why drug users seem to be supported. But drug affected families know they have to do everything to keep their drug-using member alive, because, after all, to be alive is to then have the chance of recovery from their addiction. So the main thing is how to keep the drug user alive and not being affected by certain long-term diseases like hepatitis C and HIV. Families

always hope that the user will stop using at a certain time and become a healthy member of the family again. Unfortunately, sometimes it is only when you are facing the problem that you appreciate the whole program—like the needle program that I just mentioned. If you are not in that situation—if you are not suffering and you do not have a member of the family using drugs or addicted to drugs—you can hardly understand it.

Mr L Nguyen—Most of the clients we deal with are young, so that context is already there. They go straight in and ask you, ‘Where is the needle exchange?’ They expect that to happen. But I agree with Vuong: it is a pretty hard concept to grasp from the general community.

Mrs IRWIN—People tend to know what zero tolerance means—just say no, virtually—but they do not understand harm minimisation. You are nodding your head. Do you agree with that?

Ms Suhood—Yes, people do not know what it is, so they actually think: ‘Oh, my God, that is a really terrible thing. You are actually condoning drug use.’ Harm minimisation is not—

Mrs IRWIN—It is about saving lives.

Ms Suhood—It is about saving lives and decreasing risk—decreasing the risk of contracting further disease. It is also actually contributing to disease prevention in the broader community and not just for the individuals. It includes looking at the harms associated with children, the partners or the families. It is actually looking at it in a very broad context. It is looking at how to engage. We know that if you say to everybody, ‘Say no,’ they are just not going to do it. That would be the ideal situation.

CHAIR—Zero tolerance means that the aim is to get everyone off drugs. Harm minimisation has become one of those terms which means different things to different people. It certainly means to certain groups of people that drugs are here to stay and you have just got to get used to it—that drugs are going to be used and that that is acceptable in the community.

Mrs IRWIN—I see that differently to the chair. I would like that noted in *Hansard*.

CHAIR—As I said, it means different things to different people. You get people like the Greens who have now come out and said, ‘Give everybody ice’—an appalling, shocking statement that has to be condemned. So in terms of the government’s policy—that people should be drug free—the aim of all our policies is to get people off it and not say, ‘We will give you a little bit less and try to keep you a little less harmed,’ or whatever. It is to get people off it.

Ms Suhood—I know this is not a committee about alcohol, but it also applies—

CHAIR—No, this is about illegal drugs. Alcohol is legal.

Ms Suhood—I guess when you look at illicit substances, from our perspective, it is important to look at it from a contextual perspective. That actually includes looking at other substance use and that context.

Mrs IRWIN—That is right.

CHAIR—If you wanted to construct an argument as to why all drugs should be legal, then the best thing you could do is mix it up with everything else.

Ms Suhood—No, I am not saying that at all.

CHAIR—You are not, but there are others who do. They mix it up with all other drugs that are legal and say: ‘Oh, look, they are all the same. They are all this, that and the other thing.’ If you look at the Institute of Health and Welfare, 39 per cent of people say alcohol is the biggest problem and 60 per cent of people say drugs is the bigger problem. We have got into a culture—

Ms Suhood—Sorry, could you repeat that. I missed that last point.

CHAIR—I will find it for you in a minute—the problem that is caused in our community by the use of illegal drugs. We have got into situation where there are a whole lot of messages out there telling people that it is really okay. Even the word ‘harm’ is such a gentle, gentle word, isn’t it?

Mrs IRWIN—Harm means hurt, doesn’t it?

CHAIR—Does it? What we are talking about here is destroy and destruction and damage.

Mr L Nguyen—From our point view, we see the practice of harm minimisation as part of giving the family hope that negative behaviour can be changed, can be treated and changed.

CHAIR—But that has got to be the aim.

Mr L Nguyen—Yes. We have to give them hope so their addicted member needs to be alive and needs to be at a certain level of health in order to recover from that kind of drug addiction.

CHAIR—They are still individuals; they are part of our community. We have to provide services and look after them; we have to get them back to a situation where they are free of it, off it. If we say that the aim of the policy is that we are going to have to live with it, then it will spread.

Mr Siackhasone—When we talk about harm minimisation for the Indochinese community, there are people out there who still do not understand the ideology of that. It will take a while. The way we explain it to the community is that we say that at the end of the process we want to help them to be drug free but prevent that long-term effect that is going to happen to them. Say this problem comes into your life: we can get rid of it later on, but it is going to be such a long time that it will be hard to deal with it later on. That is how we explain to the family the impact and that there is a program to reduce that long-term effect, like the syringes exchange or something. At the beginning you said the government gives them some sort of equipment to support them, but maybe later on some of them understand the situation.

Mrs IRWIN—I want to follow on from that. As you were saying, people find it hard to understand what harm minimisation is, and sometimes even zero tolerance. I would like to discuss education. What I am hearing in a number of the submissions that we have received so far is they do not feel there is enough education within our schools or even the wider community.

I am wondering if you have any ideas for an education program. I know the government recently did the Tough on Drugs program. In hindsight, it was all right, but there were complaints coming out of my community in Cabramatta that it was in English and they could not read English. It would be good to have different languages. Do you feel that more should be done in the early years at school? You have sex education classes in school and they deal with drugs.

Mr Siackhasone—Instead of education in schools, I look at the community. There is a community perception, for example, that a drug addicted person is a bad element in the community. They do not really provide any support; that just comes in via the government. We do not have any programs to look at it any other way. They do not know the reasons why people get into drugs. They guess that they do not like to do the right thing. That sort of perception is not really good; it has a negative impact on the user. When they see the harm minimisation that is why they jump to the conclusion that the program is to support them to do such a bad thing in the community. That is why I go back to how to educate them to look at changing the community's perception about how to provide support, how to talk about that openly and to go to professional support earlier in order to achieve better results.

Mr L Nguyen—With job education, I have observed an increase in the awareness of drugs and their effects on the younger generation. But there is a gap of knowledge between that generation and their parents, especially in the Indochinese community. There is always that conflict when a young person grows up. We touch on zero tolerance and harm minimisation. Obviously we will probably talk about it later, but that is what we face every day within families around this area. The parents probably do not want drugs to be around at all. The young people are aware that they are there, but it is up to them as to whether or not to take them. We need to have an intervention program that brings information and education to these communities about the effects and all the consequences—a program related to both harm minimisation and zero tolerance.

Mrs Belsey—While early intervention is great, and education about drugs is also great, I think that too much focus on the drug itself could make it an enticing thing—bringing it out into the open. I think kids also need to be told that, if there is an issue, if they have a problem, there is someone they can go to for help. They can talk to their teacher, an adult or, maybe—if there is one—a safe group within a school. Something can be organised in those areas where children can go so that they do not feel the need to just blot everything out and take drugs. While education on drugs is excellent, I also think that children need to have a safe space to go to talk about it.

CHAIR—The problem with the word 'education' is that it becomes such a carryall. I have seen pamphlets authorised by state governments—the New South Wales state government, for that matter—which literally describe the lovely things that will happen to you and the wonderful effects of taking a drug. It is almost an enticement. There are people who have this nice, soft attitude to drugs and put it out there that it is okay. How can we do that?

Mrs IRWIN—Is this funded by a state government?

CHAIR—Yes, I have seen it in my libraries. I was appalled.

Mrs IRWIN—It would be lovely to have a coffee and have a table. I have never seen one of them yet.

CHAIR—I should get them out of the library and bring them along. With those soft attitudes, what hope do we have?

Mr L Nguyen—Which generation or age bracket was that pamphlet targeted at?

CHAIR—It is part and parcel of this culture that it is okay.

Ms Suhood—I want to follow on from the general question on education. We have been providing education on the alternatives to substance use and looking at issues of resilience. It educates people to recognise the complexity of substance use and the importance of strengthening their relationships within their families and with their peers. There is the stuff we talked about earlier about what kind of meaning people have in their lives, what else can be in people's lives so that they will not want to use substances or use them harmfully, and the opportunities available to them to participate in their communities and make a contribution. Those are the kinds of—I do not know whether you would call them education programs—relationship building programs that include education in them which we have found have really supported engagement. We have found that people get meaning from that. They say, 'This has real meaning to us; we actually want to participate in this.' It is a building community. We know that drug issues come along with other issues such as crime and bullying. It is a question of what comes first and what comes next. We are trying to look at it very holistically, as very much an integrated approach, with a number of organisations as well as with a number of target groups. We find that people say, 'Yes, that is a positive.'

Mr CADMAN—One of the things I hear from parents and family members is: 'How can we trust this person? They've just about done everything to destroy our family with their attitudes and addiction.' What you seem to be saying is that the addicted person needs to have some sort of a mindset change before that education process can start because it is their outlook that needs to change before the family will start to reassess their relationships.

Ms Suhood—I think it is all of our outlooks that need to change. We are talking about two groups here. When I was talking about education, I was talking about it for the broader population. It is also relevant for families where there is clearly a drug problem. You were not here this morning when we were talking about the importance of working with the family system where we recognise that—

Mr CADMAN—I assumed that from your conversation.

Ms Suhood—When you are working with someone who has a drug problem, that is one of their behaviours. They can be behaving in a way that is really not useful and is harmful for themselves and family members. They also have another part of them that operates and can be engaged in a way that says, 'Actually, I really care about my partner, family or community.' As much as we can, we work with the strengths of that person and the family. We also see whether there are communication issues in the family. If one person can understand another, then you open up dialogue and communication and change can happen from that place. That is the same

for individuals and families as for the community. There is a lot more to say than that but that is essentially what I am talking about.

Mr CADMAN—It sounds like a very long-term process.

Ms Suhood—It is long term for our community. For a family it is not necessarily long term. I described a situation this morning where we worked with a father whose child was using ice. Very few conversations with that father resulted in him changing the way he related to his daughter. The daughter was about to go on the streets. He was losing her. Their relationship was disintegrating. He looked at the relationship above the drug. They came closer; he looked at all the surrounding issues which included the recent separation with his partner—

Mr CADMAN—I think you have used that example in your submission somewhere.

Ms Suhood—I have not put in a submission but I described it this morning and it made a major difference in that family's life.

CHAIR—I think the point Mr Cadman was trying to make was that there are families where the destructiveness of the member's behaviour is such that they are stealing things and engaging in all sorts of behaviour that is totally unacceptable within a family structure. These are the sorts of stories you hear from people who then go to something like ToughLove because they are absolutely distraught and desperate.

Ms Suhood—Certainly in those instances communication still needs to be looked at in terms of what boundaries need to be set. You still want communication that is going to be constructive.

CHAIR—They have done all that. They have been there, done that. The boundaries are not paid attention to, the communication is abused, the theft and manipulation go on.

Ms Suhood—When you are at that end you are talking about sometimes people parting.

CHAIR—And then you are talking about saving the rest of the family.

Mrs MARKUS—Sometimes families think they have done that. This is no criticism of families but they think they have done that and they may not have. They are using old patterns that are not working anymore. That is why somebody coming in from the outside can help them evaluate whether they have changed things.

CHAIR—The families I have described to you have been through that. They have had the evaluations, they have had all that and that is why they are looking for something else. We are going to hear from a couple of them.

Ms Suhood—We find lots of families who come in who think they have been through that but they have not. We do work with families at that end of the spectrum. I guess we are talking about different stages that we can work at.

CHAIR—You are not telling me you have a 100 per cent success rate, are you?

Ms Suhood—No, of course I am not. I am not saying—

CHAIR—I do not think anything could have a 100 per cent success rate.

Ms Suhood—No, I am just saying that we do find that when you look at communication issues that actually makes a major difference.

CHAIR—But it does not work for everyone?

Ms Suhood—No, but if you look at communication generally in our community, if people understand the drug issues in general, it lessens the anxiety. We start to look really constructively at what we can do and we start to care about each other.

CHAIR—Absolutely. The other person has got to want to do something about it, haven't they? In your example, the daughter wanted to keep the relationship with the father. If she didn't want to do that—

Ms Suhood—Most young people do. Most people do want that. They just do not know how.

Mrs Belsey—Quite often it is about being heard. The other party is not being heard, so they get into the destructive behaviours. It escalates. But once they have been heard, and they understand that there is more to drugs than the drug itself, there seems to be a coming in between.

CHAIR—We do not want to kid ourselves that we are going to solve every problem, because we are not—

Ms Suhood—No, we are not.

CHAIR—Of course, then we would not have any problems if we could solve them all.

Mrs Belsey—Sure. Either way, it applies, I think.

Ms Suhood—I understand where you are coming from. I am just saying that if we look at it first and foremost from that communication perspective, and then we also know that, within that, boundaries have to be set.

CHAIR—I accept that, but if they then will not accept the boundaries—

Ms Suhood—Yes.

Mr CADMAN—Dr Nguyen, how long have you practised in this area?

Mr V Nguyen—I started the Moving Forward Program in 2001. Before that, I had various employment related to family welfare.

Mr CADMAN—In the Fairfield area?

Mr V Nguyen—Before that I was in Melbourne.

Mr CADMAN—I was going to ask you for a long-term assessment about drug use and programs to assist drug users, whether they have improved over a longer period or whether they have maintained. How effective are the programs that are in place?

Mr V Nguyen—Right now I can only tell you a few things that I have observed. Firstly, I think the comprehensive approach is more appreciated, rather than just treatment, especially medical treatment alone. That is the first thing. It is very encouraging to see that happening. Your inquiry, I think, also recognises the role of the family. We know for sure that once we involve the family we get more of the drug user cases at an earlier stage. Parents will tell you about their concern if they know that you are working in the field and you are trusted in the field. They will come to you and ask for help. People will come to you a bit earlier, rather than spending 10 or 20 years addicted to heroin. That is the second thing. It is stated in our report that 40 per cent of our referrals come from the families.

The third thing is the dual diagnosis. The cooperative work between the mental health service and the AOD services has been closer. A lot needs to be done, but with dependency the two have come closer. We have some pilot projects in Liverpool with dual diagnosis cases. They are the three things that I have already observed, but there may be more. Now that drug issues education is across culturally and linguistically diverse backgrounds and communities, there is more and more community understanding of drug issues. We are working towards not just getting over the crisis but also preventing or intervening in it at the earliest possible stage. Those indications to me are very good.

Mr CADMAN—What about other professional support services, such as psychiatric or psychological support services? Are they more available, less available, about the same? And what would you like to see happen?

Mr V Nguyen—Mental health services is another field altogether. But I have observed how the two have come closer, in terms of dual diagnosis, and I can see that there are, more and more, some good indications. I understand in Melbourne there is a certain kind of project already well established. Here, in Liverpool, we have had that project for the last few years and it is very encouraging as well. Working with ethnic communities, we have also seen the training of D&A workers in the field in these communities. That is important.

Mr CADMAN—Bilingual workers?

Mr V Nguyen—Yes, I mean bilingual, bicultural workers, like me and my colleagues. That is important because working with the families, especially, you cannot really use English—not with our clients' middle-aged parents. So, to me, such a thing is very encouraging.

Mrs IRWIN—Have you seen improvements within the Liverpool-Fairfield-Cabramatta area over the last, say, eight, nine or 10 years? There were big problems—let us be honest.

Mr V Nguyen—What I see in the Cabramatta area now is much different from what I have seen in the past; the Cabramatta area is much different. In the past, say four years ago, if you travelled around you would get people offering you drugs and whatever. But it is really different

now. Of course the problem has never gone away, but what we can say is that, at the control level, we can manage, because new users can quickly get into services rather than being addicted for a long time before getting help.

Mrs IRWIN—Do you feel that it has got better because of law enforcement or because of the programs that we have had in place in Fairfield, Liverpool and Cabramatta?

Mr V Nguyen—I think that the Cabramatta anti-drugs strategy has a very balanced approach—using both law enforcement and, at the same time, support services like ours. That kind of balance is quite good.

Mr L Nguyen—I agree with Vuong, but we also have to be careful because when we target one area we find that it has moved to another area, and the services in that area are not up to date with what is happening over here. So I think it was a great initiative, but the workers that we found in Fairfield, the city and Liverpool experienced a huge number of people shifting from Cabramatta and going into these areas.

Mrs IRWIN—I think that is what we were talking about during our morning tea break. We have had big problems in this area. Things have got better but we still have a long way to go. But we have also got to look at the big picture. As you were saying, people are moving out into other areas—I think Bankstown and Warwick Farm have been mentioned. It is better to have programs in place so that you look after your own.

Mr L Nguyen—Yes, otherwise, if they make an operation in that area, these people will come back to our area again; they just move around.

Mrs IRWIN—So we have to look at good programs in other areas as well.

Mr L Nguyen—Yes.

Mr V Nguyen—I believe that they move away but not with the whole strength that was here in Cabramatta. They move in much reduced strength—the number of people addicted to drugs is much smaller. Of course we have to help them, to work with them, but not on the same scale as we have seen here in the past.

Mr CADMAN—Were you aware that international figures seem to indicate that in Australia about 20 to 25 per cent of teenagers have experienced drugs whereas in Sweden it is now down to six per cent, and some say four per cent. I was wondering whether you have had a chance to examine any of the Swedish programs, which appear to be working, or the statistics for teenagers and young people experimenting with drugs. It is an exception in Europe, and commended by the United Nations as being a great success.

Mr V Nguyen—I have just seen a book published in the UK talking about the impact of drug use on families—exactly what we are doing here. Only recently have they had that kind of study on the impact on the family. In a sense we have already done that here with Family Drug Support Australia, established by Mr Tony Trimmingham. The focus of our program is the family. We are trying our best here, I think.

CHAIR—Has anybody looked at the Swedish material?

Mr L Nguyen—I have seen it before but that was two years ago. I have not updated my knowledge of that.

CHAIR—There is a conference in Adelaide this month where they have got someone from Sweden speaking. I am going to listen. We will take a break now and when we resume we will discuss ways we can reinforce additional support for families with a drug-using member.

Proceedings suspended from 1.42 pm to 2.21 pm

CHAIR—We now reconvene for our afternoon session. We said we would discuss the way in which we could strengthen families who are struggling with members using illicit drugs. That might include what sort of things we have to do for children who are totally defenceless and cannot argue for themselves and what part do people such as DOCS play. Indeed, we might even put the question of adoption into the mix. I might actually start with that question. With some of those children who are born to drug addicted mothers and even where the father is an addict as well, do you think there is a case that the children might have a better chance if they were to be adopted?

Mr L Nguyen—It is a very difficult question. We have had a client come in and say: ‘They are taking my kid away from me. I could have done better.’ But then we have also had the situation where, from our own observation, we believe it is best for DOCS to take away the child. So it is very hard to come up with a clear and concise solution.

CHAIR—Do you think where a child is taken away like that it would be better if the child could be adopted and be in a permanent home rather than just being fostered out? I can tell you that we have got 21,000 children in Australia who are just fostered out or are in out of home care. I can also tell you that we only had 64 adoptions in Australia last year but we had more than 400 from overseas. Do you think there would be a lot of homes that could be good homes for children who are really at risk?

Mrs IRWIN—Mr Nguyen, I think you said earlier—sorry for interrupting, Chair—that your role was to keep that family unit together.

Mrs Belsey—I was going to say that. My first preference would be to keep the family unit together and try to rehabilitate the parents. Failing that, and for the safety of the child, then there could be adoption.

Mrs IRWIN—Mr Nguyen, you quoted the case of one mother who came to you who was very concerned that DOCS were going to take her child away. Can you explain how you assisted that mother?

Mr L Nguyen—With a situation like that we normally ring up the worker and there would be a case conference to try to come up with a better solution, to try work out whether there is any other way. But normally the authority lies within DOCS. As much as we might intervene, we believe that normally—and correct me if I am wrong—it is up to DOCS going through the process if they decide that would be the case.

CHAIR—Why would you be against adoption for a child who was going into such a dangerous circumstance?

Mr L Nguyen—From my own experience, I believe in the family unit. My culture believes the family unit is very strong. It can take many years and involve many hardships to get a family together. The case of a child being taken away would probably involve a strong reaction within the community, especially the Indochinese community that has been through wars. That is the first thing. The second thing is that when people are on drugs they do it without acknowledging the consequences. When they are addicted they still want their family and their life. Unfortunately, that social network might not be readily available and they go off the tracks.

CHAIR—We have taken evidence from grandparents who have wanted to adopt children and they have had to fight people because of the concept that biological parents come first. We find this throughout the bureaucracy and we found it in our adoption inquiry. There is no willingness to really look at what is best for the child. I hear what you say about consideration of different ethnic groupings but, at the end of the day, I am concerned about an innocent child. In New South Wales last year 94 children who were returned to their biological parents are now dead because they were returned to those parents.

Mr L Nguyen—We are not experts in this area, unfortunately. I think we should go back and look at the reasons for these things. I think that is the only way to go.

CHAIR—I am asking why you would not consider it. You obviously have not considered it.

Mr L Nguyen—We hear about it.

CHAIR—But you have not considered whether a child would be better off adopted and given the opportunity of a new life.

Mrs Belsey—I am sure there are a few success stories, but I have also heard from clients who have been adopted and who are on drugs. They have all the issues that come from being adopted—losing their identity, feeling devalued.

CHAIR—You do not have to lose your identity anymore.

Mrs Belsey—Yes, but, unfortunately, those who have been adopted perceive it that way. That is what I am finding. I guess it is the lesser of two evils. It is hard to say what is best for them.

CHAIR—I would like to see minds being opened up a bit.

Mr V Nguyen—I think it is hard for me to comment on adoption in general. In many cases when we work with families we work with DOCS to give the drug affected parent a chance to do things better. Sometimes the children have been taken away and the parents have to do certain things as defined by DOCS. They have to quit the drugs, re-establish the family and obtain stable accommodation and a stable income in order to get their children back. We know that much. We have been successful with cases like that, and families have returned to a nurturing environment where parents and the children live happily together.

CHAIR—You also have cases where the child has been fostered out for a number of years and the foster parents would like to adopt the child, and then the parents, who are still drug addicts, intervene and force the return of the child. Do you think that is good?

Mr V Nguyen—If the parent has no capacity to care for the child, somebody else has to have the duty of looking after it. But I have no authority to talk about adoption. In extended families we have seen a grandparent come in and give some kind of assistance for a period of time. We also see that a young mother having a child is motivation for her to change.

CHAIR—Sometimes.

Mr V Nguyen—There are a variety of situations, rather than a one-off situation.

CHAIR—We have had evidence from grandmothers who have had to fight—and fight very firmly—the system to be able to take custody of a child, and then there will be intervention from the parent, who wants to take it back. The children are very unhappy; they are very exposed. It seems to be that more attention is given to the addict than to the child, and that worries me. Yes, we have to look after the mother and find ways to get her off drugs and rehabilitated, but the child is innocent.

Mr Siackhasone—From my perspective of working with parents, the safety of children is our priority. Some parents work towards gaining custody of the child. They try to work on a lot of things. I think there is some kind of hope if the addictive person can aim for something. That can be an ultimate goal for them and they can try to confront a lot of—

CHAIR—Sometimes it is about money, isn't it, because of all the benefits that come with having custody?

Mr Siackhasone—Yes. We look at individual cases. We look at which one is more suitable as an individual case and we then look at that. If they are working hard to gain that back that means their determination is quite high. I think that a system that can provide support at the beginning for them to take off will be a good thing for them.

CHAIR—But it can be about money, can't it?

Mr Siackhasone—It is going to be—

CHAIR—But it can be about money. If you get custody, you get money.

Mrs Belsey—That sometimes does not work. I have a grandparent—the best person for the child to be with—who is not getting the money, and she is—

CHAIR—We have changed that so that the family tax benefit does—

Mrs Belsey—Right up until last week she was in despair.

CHAIR—If you let me know about her, we will have a look at that.

Mrs Belsey—Okay; I will have to speak to her because of confidentiality.

CHAIR—What I am saying is that if the mother gets the child back she will get the money. That is the point I am making. Often it can be about things like that.

Mrs IRWIN—The chair talked about a similar case. You liaise a lot with DOCS if you have a child and—

Mr V Nguyen—We work very closely with DOCS, because the welfare of the child is really paramount. DOCS make very clear their requirements.

CHAIR—Not always.

Mrs IRWIN—But everybody deserves a second chance, don't they?

Mr V Nguyen—Yes. Let us say, for instance, that a young girl of 16 has a boyfriend who is using drugs and, because of that, she gets hooked on heroin. But the parents are very keen to save the young girl—

CHAIR—That is the grandparents. They are going to look after the child.

Mr V Nguyen—Yes. But once the young girl got pregnant, she moved very quickly into treatment. Once she had the baby, she changed. The grandparents were assisted by us—we continually talk about family communications. In that case, we helped the grandparents and the young girl quit the drugs, and the welfare of the baby was fully observed.

CHAIR—That is a fabulous story. That is terrific. What about the ones that are not like that, where the mother stays on the drugs? They go back to the drug addicted mother? That happens?

Mr V Nguyen—Yes. DOCS would take the baby away—

CHAIR—But they do not.

Mr V Nguyen—Yes. There is a limited number that we work with; that is the case. There may be other cases, but we do not know.

CHAIR—Okay. Has someone else got some questions?

Mrs MARKUS—Obviously many of you work with families where there is some success, and so it is beneficial to the children, but there are other cases—as Bronwyn said, there were 94 deaths, I think, last year. Not so long ago I had a police officer in my office saying that a four-month-old baby had five drugs, including methadone, in its body. The reality is that we do have children who are seriously at risk who fall through all the cracks. I would like to see us somehow remove the cracks. That is all I have to say. If you have got any ideas about how to remove the cracks please tell us.

Ms Suhood—I think it is also the question that Bronwyn raised earlier—we could not answer the question, actually. It was: what percentage of the population that is harmfully using

substances are we reaching? We actually do not know. I have always felt with my own service that we could triple or quadruple the funding and we would still have waiting lists.

While I still advocate for more funds for treatment services, I also think we have to have other interventions that are more community focused. Everything that we all seem to be doing—which is working with communication issues or the dynamics or whatever in the family, as well as looking at the specific information that people need—needs to be done at a community level as well, so as well as building stronger families we are building stronger communities.

CHAIR—So are you looking at communities at risk as well?

Ms Suhood—Yes.

CHAIR—That is, a community which is comprised of a lot of people at risk?

Ms Suhood—Yes, I think that is what we need to be doing as well. And we need to be using the expertise of clinicians. I guess that is what we are doing at our service. We are actually using a strategy where we are looking at how counsellors and community development workers can work together, where we can learn from each other and bring our skills together. For instance, we have held community events where we have promoted these themes—the Bridges themes, ‘There is more to drug use than drugs’, ‘Strengthening relationships and working together’—but created a sense of community and discussion in those events. We have had children at those events, and while we have not been specifically looking at their drug issues—there has been face painting and so on—it has been an event where new connections have been formed, so that resilience is happening. We have had counsellors at those events so that family members who would not normally come to our service can talk to a counsellor on the spot. They go: ‘We didn’t know Bridges existed’ or ‘We didn’t know your service existed.’ Drug Arm was at that service. Youth Service was at that event. So it is agencies working together, I guess with hope, knowing that these are difficult issues but trying to work from a perspective of hope and building relationships.

As you can see, we all have different expertise and we can answer your questions from different perspectives. I really believe that when we work together and learn from each other we can tackle this problem—not just in our own centres but in the communities as well.

Mrs IRWIN—I was very interested to read in the Bridges strategy stage 2 final report a clipping that was probably from one of your local newspapers. I will read a little bit of it for the *Hansard*. I found this interesting and I would like you to give me a bit more feedback on it. It states:

Community Service students from Nirimba TAFE are organising a drug education awareness event for Year 9 students of Terra Santa College and Mt Druitt High School.

The project aims to give students the opportunity to voice their concerns and thoughts on drug use.

The emphasis will be on whether or not drugs are the real issue or a symptom of other concerns, and strengthening relationships with friends, family and the community.

What were the outcomes of this initiative? What did you hear from the students? I find it interesting that you were looking at whether or not drugs are the real issue or a symptom of other concerns.

Ms Suhood—That is not to say there are not concerns about needing to give students information about specific drugs. When we present the Bridges strategy to groups of young people we tell them we want to hear their stories about the issues. One young person came up to me and said, ‘I’m so glad that you presented today—

Mrs IRWIN—This was presented at a school? They actually went into the schools?

Ms Suhood—Sorry, I am talking about another initiative. I was at that initiative, but it was about capacity building. TAFE students took the Bridges strategy to other students. It was about how you share something. It was not just a team of seven people doing the work; it was a broader team and interagency approach. I am giving you an example of some of the conversations that have happened in general with this initiative. One young person came up to me and said: ‘I’m so glad that you have come to speak to us. My boyfriend died of a cocaine overdose. His mother had an alcohol problem and that was never discussed.’ She was not saying that that was the only problem, because one has to look at a whole range of issues, but she said that if the larger issues had been discussed her boyfriend might be alive today—that is, if we were not just focusing on his cocaine use.

Mrs IRWIN—But looking at the reasons why he was using cocaine?

Ms Suhood—Yes. There was another initiative where a group of school students did skits. We did not tell them what to do; we just gave them this and said, ‘Does this mean anything to?’ They came up with skits in which one person would say, ‘I’ve got a headache,’ and another would say, ‘Here, have a pill.’ They were saying that, if you have a problem, people just tell you to take a substance—whatever the substance. That was one of the skits they came up with.

CHAIR—The bottom line is that most people do not take drugs; the vast majority of people do not touch them.

Ms Suhood—I guess that, in that instance, we were looking at legal drugs and illegal drugs.

CHAIR—The vast majority of people do not take illegal drugs. The Institute of Health and Welfare makes it very clear why that is so. We readily identify with people who have traumatic instances in their life, because that gives them a reason to take illegal drugs, but the statistics say they are a small minority of people who do use drugs. When the committee took evidence on the Gold Coast, one young man, having heard somebody else say they had a traumatic event in their life, stood up and said: ‘I come from a very good home and I had a very good education. I thought I could use heroin twice a week and be just fine. Then I used it more, and I was gone. I have to get off it now because I have a son.’ He had no reason to take drugs, other than curiosity or something, and that is the case for most of them. Do you have people who have a reason to take drugs coming to you?

Ms Suhood—Most of the people we are seeing in the counselling centre are those where it has become a reason or problematic.

CHAIR—Or something that they can say is a reason.

Ms Suhood—Yes. One young person came up to me at the Bridges event and said, ‘I’m so glad you’ve got this because I have nothing to do on a Sunday.’ It was as simple as that. There are comments in this report about some of the things that people have said. Families stayed and watched some of the events. It was a family day. There is not enough community building. We know from the social determinants—

CHAIR—Okay.

Ms Suhood—You have got the gist.

CHAIR—Yes. That is great. If you find a community of people at risk, you can put in networks so that there is support for them and they do not become isolated, bored and so on.

Ms Suhood—Yes.

CHAIR—I think that has a lot going for it.

Mrs IRWIN—Although this inquiry is mainly looking at illicit drugs—we are not looking at licit drugs—I would love to ask this question: are you finding that a lot of young ones are coming in for counselling because of drinking problems and that that has escalated?

Mr V Nguyen—No.

Mrs IRWIN—So you deal more with illicit drugs?

Mrs Belsey—It is not so much the case with the young ones. But there are a lot of alcohol problems. We have a lot of clients on alcohol.

Mrs IRWIN—I want to ask a question tongue in cheek. If you were legislators, what types of policies would you like to see in place? We are holding this public hearing because we need to talk to the families, to our young people and to the counsellors who are working at the coalface. Have we good programs? Are there some that you would like to do away with or new ones put in place?

Mr V Nguyen—We need new programs that enable us to work with the families, to strengthen the families and to work with them at an earlier stage of the problem. In New South Wales we have the Early Intervention Program, EIP, in which the family with a problem is one of the categories that is to be assisted. That is a move in the right direction. Policies that include the friends and the families of the users are the right ones to pursue.

Mrs IRWIN—You would like to see more early intervention programs?

Mr V Nguyen—We should have a balanced approach here. We need some kind of intervention when people are in a critical situation because if you help them you might have a chance of getting them back to a normal life. At the same time I agree that we should go further in terms of early intervention. We need an early intervention approach that, besides working with

the group and the individual family, includes some kind of family education as well. We need that component to make a program strong and effective.

Mrs IRWIN—Open Family, what is your wish list?

Mr L Nguyen—Everywhere I go people ask for a wish list, but it never comes true. Are we serious? Are we making decisions here?

Mrs IRWIN—Your wish list might come true.

Mr L Nguyen—I reckon the first thing we have to do is review existing programs that run successfully elsewhere and bring them to our local area so that we do not have to reinvent the wheel. The second thing we have to do is review ourselves and our government departments and agencies. The crack or hole you mentioned earlier could be a case of a worker who does not have enough training and does not follow guidelines or policy. We have to continuously improve ourselves through our working years. I think that is very important. By reviewing it we are actually securing better programs for young people and their families. Law enforcement has to be some sort of an issue. I mentioned earlier that the value of ice has jumped up three to five times during the last five years.

CHAIR—Who owns ice, by the way? Which criminal groups control ice? Is that part of the methamphetamines?

Mr L Nguyen—In my limited knowledge of street work, I reckon the majority is now coming out of South-East Asia—the majority probably from China. We are aware that within the jail system now there are a lot of middle-aged Indochinese, who are the couriers because they lack financial stuff. It is coming out from South-East Asia.

CHAIR—But there must be gangs here in Australia who are handling the ice and who are responsible for the distribution.

Mr L Nguyen—Unfortunately, that is a bit difficult to answer.

Mrs IRWIN—I think we had Commissioner Keelty at a public hearing in Canberra actually saying that you could make it out of the boot of a car.

CHAIR—But you have got to bring in the precursors.

Mrs IRWIN—Correct.

Mr L Nguyen—Most of the ingredients are already available in Australia. It is just that it is harder to get these ingredients. It is easier for them to import them from overseas. If we somehow put more pressure on, we might find that there is more domestic manufacture of ice.

CHAIR—That is why it is very hard to buy certain cough and cold remedies these days.

Mr L Nguyen—That is correct.

CHAIR—You have got to go through a few hoops to get it.

Mr L Nguyen—I was talking about reviewing existing programs, reviewing the current workplace and then looking at the law enforcement side of it. It has to be a holistic approach. If I had that magic wand, I would get rid of both of you!

Mrs IRWIN—That is on the public record. Blacktown Alcohol and other Drugs Family Services, if you were legislators what policies would you like to see in place?

Mrs Belsey—If all the systems—DOCS, Centrelink and so on and other systems such as the prisons—were working together without one falling short and failing to pick up the support where it is needed, that would be terrific. I would like to see support for clients when they are leaving prisons—getting jobs, community service or whatever it is—and linking them with families and dealing with issues that need to be dealt with. We need also need support for children and families of prisoners. They are on the outer. Also, with non-government organisations, the funding is so tentative. When you work under threat of closure I am not sure that the service you can really give to the clients out there is appropriate; it is hard to give your heart and soul. We need to know that we are safe too. We need to know that we can go out there and do these projects without suddenly thinking, ‘Right, there is no money to continue with this.’ That would be great.

Ms Suhood—To add to that, because I think together everyone has come up with something holistic, there are the community interventions on top of that that are focused on the positives and strengths of individuals, families and their communities.

Mr V Nguyen—The training of staff is very important too. When a family support worker is with a family affected by drugs, sometimes they are themselves very confused and do not really know how to do the whole lot in terms of the drug user, the parents and the rest of the family. If they do not do it properly, they might be seen as taking sides—either this one or the other one. You want to work with all in order to move the whole lot. Moving the whole lot is sometimes hard but it is the right way to go.

The Fairfield community’s Drug Action Team meets here every month. We are going to have training for family support workers to work effectively with affected families. This is coming from our own experience. When we first started our program only one or two of us had enough knowledge of the drug and alcohol problem and the program, and we had to train the Khmer-, Lao- and Vietnamese-speaking staff in order to work effectively with the families.

CHAIR—Going back to the question of methamphetamines, ice is crystal methamphetamine and speed is the powder variety. It used to be that the powder would be injected and the crystal would be taken a different way, but that is now being injected as well. That is different again from ecstasy. Ecstasy used to be the prevalent drug at dance parties. Are you saying that now ice has replaced ecstasy as well as heroin?

Mr L Nguyen—Most people we are dealing with turn to ice. I mentioned earlier that we did try to look at the extent to which people are using ice at a known club. It is quite obvious that the number of people using ice is increasing.

CHAIR—It is ice, not ecstasy.

Mr L Nguyen—No, not ecstasy. Ecstasy was on for about two years. There were local ecstasy tablets and then imported tablets. Now it has changed; they are using ice. We do not know the reason. That is research that Open Family is looking at—asking people what makes them use ice. Obviously, it is for that energetic euphoria feeling that they get.

CHAIR—It has had repercussions in hospitals too, hasn't it? There have been injuries to nurses.

Mr L Nguyen—That is right.

CHAIR—Thank you. We appreciate all of you coming. We are very grateful for your being with us. The information that we have gained from you is most interesting and will be very useful in our deliberations. Mr Luat Nguyen, if you would not mind getting that information for me it would be appreciated.

Mr L Nguyen—During the break I spoke with Melbourne and they emailed it to the secretary.

CHAIR—Thank you.

[3 01 pm]

CHAIR—We will now take short statements from members of the audience. This is a little earlier than we had planned but we already have some people here who want to make community statements. We believe this is a valuable part of our hearings where people can just rock up and tell us as much about themselves as they wish and give us their point of view.

Mark—Thank you for the opportunity to speak. I am employed as the youth development counsellor for south-west Sydney by Cabramatta Community Centre. I work across the local government areas of Bankstown, Liverpool and Fairfield and have done so for the past 15 years. I work predominantly with young people from across those areas who are homeless and at risk and, indeed, at times with the families from which they are estranged.

I would firstly like to introduce the members of the inquiry to a harm minimisation needs analysis of young injecting drug users in the Fairfield and Liverpool local government areas. This is a report prepared by the Cabramatta Community Centre and it was tabled in July 2005. I have the executive summary here and I would like to allude to some of the recommendations in it. They include an increase to and development of new support programs and, as was alluded to earlier here today, capacity building within the community and developing links between government and non-government agencies to address some of the risks associated with this. There is also a recommendation to increase access to injecting drug equipment and harm minimisation information as there is some concern about the increases in the spread of hepatitis C, for example, throughout the communities.

CHAIR—Does that mean you are in favour of drug-injecting rooms?

Mark—Yes, as a matter of fact, I am. The recommendations also include the development and support of prevention and education strategies with regard to harm minimisation practice and the ongoing monitoring of the needs of this group and how they may impact upon the broader community. To this end, Cabramatta Community Centre has employed a health promotions position for 12 months to identify the needs of young injecting drug users within the first 12 months of them having begun injecting drug use and to see how patterns develop with regard to either the development of blood borne diseases or what access might have prevented that. There is also examination of the issues to do with hepatitis C transmission, issues surrounding sex workers and, as well, the issue of people who were new arrivals to this country who then travelled abroad and returned with communicable diseases such as hepatitis in its various forms and also tuberculosis, which we had not seen for some time.

Indeed, Cabramatta's Community Centre's youth team—and I, in particular, as the youth development counsellor—have seen an increase in the number of young people presenting with psychosis, predominantly linked to the use of methamphetamine, or 'ice', as it has been referred to. As this became an issue, Cabramatta Community Centre's youth team developed a series of forums. Three have been held so far across Fairfield and Liverpool, aimed at workers involved in working with the target group.

Also in Liverpool a broader community forum was held, preparing information sessions for parents and students. From that we have had a large number of inquiries from local high schools. Community liaison officers at several schools attended the forum held in Liverpool, and we have received a number of invitations to go into a number of high schools across Liverpool and Fairfield and develop packages for them, for their young people and also for their parents and committees, in regard to illicit drug and alcohol use, and information on services of support et cetera for those young people.

In this area we also have the 2166 Coalition, which is a coalition of local service providers who lobby and raise awareness about drug and alcohol issues. They also lobby to secure services in the area.

We ran a very successful program, the Established Lease Project, which was aimed specifically at people post detoxification from the use of various illicit drugs. It was funded initially through the Premier's Department, and also through the Office of Community Housing. Subsidised leases were provided, and a small amount of funding was provided to establish people in accommodation. Bare necessities were provided for those young people—I beg your pardon: those people; it was a broad age group—and local support services, including some of those who have given evidence here today, were part of that process. We have had very good success rates in ongoing abstinence from drug use for people involved in that project, and several reports have been forwarded to the Department of Community Services regarding that. Unfortunately, no further funding has become available for that project and so it is in limbo at the moment. The Office of Community Housing is willing to continue it, but we have not received any funding from the Department of Community Services yet, which is sad because it was quite a successful program.

Intensive support is one of the things that I think has been really valuable in reducing the use of illicit drugs amongst those who do use and individuals who have become estranged from their communities—and also, at large, other service providers—by virtue of their drug addiction, criminal history, or violence that they may have perpetrated in the past; that often restricts their access to various services, including health services. That is about all I would like to say. Thank you so much for the opportunity to speak.

CHAIR—Thank you very much. Could you tell me: was the state government the source of your funding?

Mark—For the Established Lease Project, yes it was.

Mrs IRWIN—Do you get federal funding as well?

Mark—No, not for that particular—

Mrs IRWIN—No, not for that program, but for others?

Mark—Yes, at the centre we do; indeed, my project is funded through SAP, which has half federal and half state funding.

CHAIR—So what are you federally funded for?

Mark—We are not federally funded for any of the programs that I have alluded to, except my own, SAP, which has joint federal-state government funding.

CHAIR—Okay, thank you very much. Who wants to be next?

Evan—I would like to thank the committee for the opportunity to talk to you this afternoon. I have been a volunteer for the Family Drug Support telephone line since it commenced about nine years ago. I have calculated that I have taken about 3,000 calls over that period, and I have heard the most horrific stories of family trauma over that time. The FDS submission provides the statistics of what we do but not the drama that unfolds every hour over our line.

Some evidence as to why people start using drugs, both legal and illegal, evolves over time. It is probably the risk-takers and those who have an underlying mental or personality disorder who are the most vulnerable, but I am sure the professional experts who have been talking to you have given you very many other reasons.

Supply is a key ingredient in the illicit drug mix. If drugs were prevented from being imported or manufactured or grown then volunteer organisations like FDS would not be needed. That is obvious. If one uses the amount of money expended as a guide to government priorities, government strategy is directed primarily towards reducing or preventing the supply of drugs. Clearly, if there were no drugs there would be no abuse.

The Commissioner of the Australian Federal Police, Mr Keelty, has, I understand, given evidence to the effect that AFP activities have saved Australia \$3 billion over the period 1998-99 to 2002-03 in terms of doctors, nurses, hospitals and all the other services that are involved. I have to say that this evidence by the AFP puzzled me somewhat, as callers to our helpline tell me that there is no shortage of any illicit drug.

There are two studies into aspects of illicit drug trends conducted annually and coordinated by the National Drug and Alcohol Research Centre. They are called the Illicit Drug Reporting System and the Ecstasy and Related Drugs Reporting System. Neither of those studies has reported any supply shortage of any illicit drug in 2006 or in any other period except back in 2000 when there was the so-called heroin drought.

So if drugs are not in short supply, how did the AFP save us any money? And worse, it is well known that drug abusers switch to other drugs if they cannot obtain their drug of choice. Their alternative choice may well be more dangerous to their health than their preferred drug. In fact, it is possible—and this is speculation—that the periodic shortages of heroin and the lower quality of heroin may have motivated heroin users to switch to ice. Consequently, the shortages of drugs may exacerbate public health costs, not reduce them. That is the end of my statement.

CHAIR—Thank you. I notice that you have given us a submission today.

Evan—That is what I just read.

CHAIR—Thank you for that. Is it the wish of the committee that we accept that as evidence and authorise its publication? There being no objection, it is so ordered.

I think that Mr Keelty, in his evidence, made it quite clear that stopping drugs coming here prevented so many extra users being created and therefore resulted in great savings. He has had that modelled and it is a saving in excess of \$3 billion, so I think he is doing a pretty good job for us.

Evan—Right.

CHAIR—Thank you for coming today.

Matthew—I am the NSW Program Coordinator for Drug Arm, New South Wales. We currently operate two programs throughout the Western Sydney region: the Street Outreach Service and the Drug and Alcohol Response Team program, which is a counselling and support program for people with illicit drug problems as well as for the significant others of those people. It was interesting to listen to the comments made by my colleagues today and it is interesting to see that we tend to find similar issues and concerns throughout the region.

However, two of the things that did stick out in my mind were that in the past six to eight months we have seen a significant increase in the number of clients with dual diagnosis issues—that is, issues not only with illicit drug use but also mental health—and the impact that is having on their families. We see a strong need for drug and alcohol services to form strong partnerships and linkages with area mental health teams to help counter that problem.

One of the other issues that has also sprung to mind relates to the issue of the impact that illicit drug use has on families. One of the common findings that we have is that families will contact our organisation wanting to get help for a significant other, but unfortunately, due to legislation, we are unable to contact these people if they do not come forward themselves or do not give us permission to call them. There is a lot of stress and further heartache associated with that for the families. Unfortunately it is an issue that we cannot do much about, but it is a way that we are then able to get the family component to interact with the counselling program and provide them with support and assistance in dealing with their issues. Thank you for the opportunity to present to you and have a chat.

CHAIR—Can you say one more time the two programs that you are running?

Matthew—Yes. We run the Street Outreach Service—

CHAIR—What do you do with that?

Matthew—That program operates on Friday and Saturday evenings. It operates across the state—Newcastle, Wollongong, Sutherland, northern beaches, Western Sydney, Fairfield, Liverpool and Blacktown. That service commences at around 8.30 to 9 pm and is out in hot spots—parks, skate parks, football fields—where young people may tend to congregate drinking or doing any type of illicit drug activity. We make contact with those people and provide them with information about the harms associated with their particular activity as well as providing them with information and referral to not only our program, the DART program, but also to other agencies in that particular region that may be able to assist them with their problem.

It is not about us trying to fix everybody's problems; it is about forming good partnerships in the regions in which we operate, having a solid understanding of what programs are able to help people with particular issues. It may be accommodation issues or linking young people back with TAFEs or schools, getting them back into that system, employment—a whole range of different issues.

CHAIR—You said that you operate on the northern beaches.

Matthew—Yes, we do.

CHAIR—That is my neck of the woods. We certainly do have problems with kids who swarm—that is the only way I can describe it. There are hundreds of them and they are all obviously off their faces and you have to be very careful driving along the road sometimes because they will just walk out in front of cars. How do you effectively outreach to 200 or 300 kids who are off their faces and from good homes?

Matthew—We find that is often the case on the northern beaches.

CHAIR—How do you deal with that? How do you outreach to them?

Matthew—It can be difficult at times. One of the key things is we try to establish good relationships over a period of time. It is not about going in for one night and making a difference; it is about building good relationships, building a rapport with these young people. At times when we are dealing with big numbers, like we have seen in the northern beaches lately, it is about working with the police. We will contact the police before and at the end of each shift to let them know that we are about that particular night.

CHAIR—Where are the police, because they are nowhere in sight? I have not come across them.

Matthew—That can be the case on many an evening, but we will try to get as much information from them as possible about any particular parties that have been registered.

CHAIR—They gatecrash; that is the next thing they do.

Matthew—Yes, they certainly do.

CHAIR—And they wreak havoc for some people.

Matthew—We try to have a calming effect in those instances, moving people on, getting them out—that is, moving 200 kids at a particular park on as opposed to disbursing that huge number of young people in a particular area.

CHAIR—How do they contact each other? Is it mobile phones?

Matthew—That is often the case.

CHAIR—Is this the creation of mobile phones?

Matthew—Yes; SMS and email are generally the feedback that we get. SMS is obviously a lot more convenient because it can be done instantaneously. But throughout the lead-up to a particular event, email is often utilised as well.

CHAIR—So if they hear that somebody is having a party, they will SMS—

Matthew—They will SMS their friends who perhaps were not invited, and then there is a flow-on effect from that. They will then send the SMS to someone else and that is how they end up with problems.

CHAIR—Why do they do it?

Matthew—I suppose it comes down to boredom. Having nothing to do is the common feedback that we get. We evaluate our programs—

CHAIR—There is actually lots to do. They do not elect to do any of the things available.

Matthew—That is right.

CHAIR—There are kids who do things like sport, or the whole range of other things that are available, and there are these kids who elect not to do anything like that.

Matthew—A lot of the people who we tend to see are in the age group from 15 to 17. On a Friday or Saturday night, they say that there is nothing to do. They cannot get into licensed premises because they do not have ID. They often will not want to spend the time at home. They do not want to go to a movie or something like that. So they meet up with friends at a central location, usually a park or at the beach in the northern beaches area, and that is how it starts. They will get a six pack from a brother, sometimes they will take it from home, and they will drink together in numbers, and then we generally see the problems escalate from there.

CHAIR—I was reading an Institute of Health and Welfare document which stated that of those who used ecstasy in 2004 only one in 10 did not use it in combination with another drug. I cannot image it is going to be different with ice.

Matthew—We have not noticed a huge number of our clients using ice.

CHAIR—Ecstasy?

Matthew—It is ecstasy, cannabis and alcohol primarily. Generally the clients who are using ice are usually taken to hospital or into custody by police before we make contact with them. That is the Street Outreach Service program. The other one, the DART program—the Drug and Alcohol Response Team program—is a counselling and support program for people with illicit drug issues and significant others involved with the drug user. It could be a mother, a father, a brother, a sister or a spouse of someone who is using drugs and may not want to receive help themselves. We provide support mechanisms for the family to best cope with the issues that they are facing.

CHAIR—Thank you very much for coming.

Matthew—Thank you.

CHAIR—On our program we said we would do community statements at 3.30. If there is nobody else who wants to make some comments, we will suspend for a short time and then we will do the formal wrap-up of the meeting.

Proceedings suspended from 3.23 pm to 3.40 pm

CHAIR—As there are no further statements, I thank you all for your attendance today, and thank you also very much to Hansard.

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

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

Committee adjourned at 3.40 pm