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Official Committee Hansard

**HOUSE OF  
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

**Reference: Impact of illicit drug use on families**

WEDNESDAY, 13 JUNE 2007

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**HOUSE OF REPRESENTATIVES**  
**STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES**

**Wednesday, 13 June 2007**

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

**Members in attendance:** Mrs Bronwyn Bishop, Mr Fawcett, Mrs Irwin, Mrs Markus and Mr Quick

**Terms of reference for the inquiry:**

To inquire into and report on:

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

1. the financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders;
2. the impact of harm minimisation programs on families; and
3. ways to strengthen families who are coping with a member(s) using illicit drugs.

**WITNESSES**

**DAWE, Professor Sharon, School of Psychology, Griffith University ..... 1**  
**HOMEL, Professor Ross, Director, Key Centre for Ethics, Law, Justice and Governance,  
Griffith University..... 1**



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**Committee met at 10.31 am****DAWE, Professor Sharon, School of Psychology, Griffith University****HOMEL, Professor Ross, Director, Key Centre for Ethics, Law, Justice and Governance, Griffith University***Witnesses were sworn or affirmed—*

**CHAIR (Mrs Bronwyn Bishop)**—I declare open the public meeting of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drugs on families. The transcript of what is said today will be posted on the committee's website. If you would like further details about the inquiry or the transcript, please ask the committee secretariat. I welcome both witnesses. I had the pleasure of meeting Professor Dawe in Brisbane. We had quite a long conversation and explored some ideas. We are delighted that you could both come, because Professor Dawe spoke very highly of Professor Homel on that occasion. Would either of you like to make an opening statement?

**Prof. Dawe**—I would like to elaborate on the submission that I made. I can bring to this inquiry an understanding or some information about the way in which you can do something therapeutically for families where there is substance misuse and lots of other problems. There has probably been a lot of discussion about numbers and prevalence and concerns raised about families, but sometimes it is hard to answer: what do we do next? In my capacity as a clinical psychologist I have been involved in a number of programs over the years that have treated families and treated people with substance misuse. I will briefly talk about some of the key issues that arise and then, if you like, I will elaborate on that a little bit with reference to a particular program.

As a clinical psychologist working in this area, one of the things that always stand out for me is that you are rarely talking about a single problem. Most of the time you are talking about families where there is a lot of chaos—there is domestic violence, there are financial difficulties and there are kids whose behaviour is often out of control. The parents are themselves victims; they have often grown up in really chaotic families with such things as substance abuse and domestic violence and have been in and out of foster care. So in my clinical practice and in my research I see a kind of intergenerational process. I am now seeing kids of 12 or 13 and I know that in five or six years time they will be parents with exactly the same issues that their parents had when raising children. And so it goes on and on.

For me the first key point is that there is no point in just focusing on one particular issue; if you are going to improve outcomes for children in these really difficult, chaotic families, you need to do something across a whole range of areas. It has also been our experience—and a certain amount of research supports it—that there is no point in just trying to shuffle families from one service to another. There is no point in saying, 'Mum's got depression so we'll send her off to mental health; then we'll send the kids to child guidance'—and somewhere along the way somebody might get some immunisation—because that does not happen either. You need to have a model where somebody coordinates a whole range of treatment approaches. That is where my colleague and I started with trying to intervene with families with all of these different problems.

I think we have some very good models of intervention that have empirical support in Australia and also overseas. But the reality is that, if you are going to intervene in the way in which I have described, it is really time consuming and expensive. Instead of social workers and nurses having case loads of 30, 40 or 50 people, they can only really have case loads of five, six or seven families. The whole way we think about delivering services for these multiproblem families needs to shift. We need to have a good conceptual model of what to actually do; it is not just having cups of tea in people's homes. We need to have really realistic case loads for people so that they can do this kind of intensive work.

**Prof. Homel**—I have been involved for some years in developing, implementing and evaluating a large community-based early intervention/prevention program in a very disadvantaged region of Brisbane—the Inala and Carole Park area. It is a region of about 21,000 people that is close to Ipswich Road. Most of it was a housing commission area originally. There is a substantial Indigenous population and there are also Vietnamese people and a whole range of Pacific Islanders. So in a sense it is a microcosm of multicultural Australia. And of course there are Aussie battlers there as well. It is an interesting area with a strong identity. We have been working in this community for some years because it has very substantial social needs. It is a fairly economically-deprived area but there is a functioning community there with a lot of existing services, although they do not necessarily work all that well. So it is not atypical.

**CHAIR**—Where is it?

**Prof. Homel**—It is in the south-west suburbs of Brisbane—the Inala and Carole Park area. I am very happy to follow up with a brief submission. I apologise for not having submitted a specific submission for this committee, but I can provide some of these details.

The Pathways project was built conceptually on work that we published through the federal government in 1999. The report was called *Pathways to prevention*. In the report we reviewed the international literature at that time on the effectiveness of early intervention and early prevention. We talked about programs like the Perry Pre-School Project—which many people have now heard of—and a range of other long-term evaluated early intervention programs, mostly from the US. We then surveyed the Australian situation as it was in the late 1990s. We audited about 45 quite innovative projects throughout Australia, some of which were attempting to do the kinds of things that Sharon talked about. These included the Positive Parenting Program, PPP, which has developed greatly. That was developed by Professor Matt Sanders at the University of Queensland. It was announced last week that he is the Queenslander of the Year in recognition of his enormously influential work with that program.

**CHAIR**—Who is that?

**Prof. Homel**—That is Professor Matt Sanders and the PPP program. We included that in our audit, but we also included a range of other very innovative programs. Many of them were designed to work with families and young children in a community setting and to deal with multiple problems of the kind that Sharon so eloquently described. She mentioned the connectedness of all of these problems—that substance abuse tends to occur alongside family violence and alongside those chaotic child-rearing environments.

Our conclusion was that at the end of the 1990s there was very innovative and creative work going on at the community level. Most of it had short-term funding, very little of it was properly evaluated and we were not building a body of knowledge that was indigenous or native to Australia. I proposed in the report that a large demonstration project be funded for implementation in a disadvantaged community, and carefully evaluated and used to help develop this body of knowledge for Australia. Of course it was not the only initiative that occurred in those years.

I was very fortunate to form a partnership with Mission Australia, which is a large national community organisation—I am sure you have heard of. Through Mission Australia we were able to attract quite substantial philanthropic funding. We had virtually no government funding for five or six years. We had a bit of support from the Queensland government but no Commonwealth funding at all. We had a lot of support from the Australia Research Council, from the John Barnes Foundation and from the Westpac Foundation. That gave us a lot of freedom to explore different models of delivery of services and programs at the local level. We learnt a lot in the first few years and that is summarised in the report *The pathways to prevention project: the first 5 years 1999-2004*, which I tabled this morning.

In that work we found that community based family support and early intervention can work, and we got some measurable outcomes for children. There were not as many as we would have liked because we had enormous difficulty getting our measurements done systematically. We were only able in the report to document case studies of changes in families. We now have measures of family empowerment and family functioning which we are going to publish in the next couple of years and which will show quantitatively the impacts on families. But in that report we have measurable impacts on children.

**CHAIR**—Could I just stop you there and ask that a committee member move that we accept this report as an exhibit to the inquiry.

**Mr QUICK**—So moved.

**CHAIR**—Thank you.

**Prof. Homel**—The point of Pathways is to do precisely the kind of multifaceted intervention that Sharon mentioned. In the initial phase—the first five or six years—we had a combination of child focused programs through preschools, which at that time in Queensland were run by the state and located in primary schools. That has since been superseded by the prep year, which has just been introduced universally. So we had a communication program and a social skills program for children, but that was paralleled by a very flexible and multifaceted family support and family independence program that was developed and delivered by the Mission Australia-Pathways team, which was built in the local area. It is still there; there are about 15 members in the team.

**CHAIR**—What sorts of things do they do?

**Prof. Homel**—They do one-on-one counselling. They have an assessment process where they work out the nature of the problems with the family. It can often take some months to get to know the family and to gain their trust so as to be able to elicit the information about what is

going on in the family environment. Then they develop a measure of the level of adversity that the family is facing. It often includes substance abuse. My best estimate in that area is that at least one in five of the families—probably more in the Indigenous community—have substance abuse problems, either illicit substances or alcohol. For many of the clients of the Pathways program, the percentage is even higher for substance abuse and alcohol abuse.

**CHAIR**—How would that break down? What would the use of illicit drugs be?

**Prof. Homel**—It is a smaller proportion and again it varies by ethnic group. Amongst Indigenous people, yarndi, the very strong marijuana, seems to be a big factor. Amongst some of the kids there is experimentation with almost anything they can find. In adolescents it is very prevalent. I remember going into the office of a deputy principal in the very early days of this project and seeing a very good looking blonde, blue eyed, nine-year-old boy sitting outside the office. He was in trouble for drug dealing in the playground. This was obviously coming from his family. So we were seeing it right from the beginning. He was also involved in violence, bullying and standover tactics—again, I have no doubt, modelled on father, or father substitute, behaviour.

To go back to your question, the interventions described in the report involved one-on-one counselling, support and assessment. They sometimes involved referral to specialist agencies, but often they involved long-term work with the families, providing practical material support where it was needed—and it often was, as is, needed. There were people who did not have money to put food on the table the next day because of various crises such as mental health problems, disability, being newly arrived immigrants, or having their house burn down, for example, and not knowing where to turn. There were many crises that beset these families and all of them affected outcomes for children of course.

**CHAIR**—Were they stable families or were they a kind of moveable feast?

**Prof. Homel**—Very much moveable in many cases, but not always. Sometimes chronic illness in a stable and otherwise well-functioning family can lead, we have found, to that spiral of poverty.

**CHAIR**—Where the breadwinner becomes the chronically ill person?

**Prof. Homel**—Right, and where mental illness is an element it is even more exacerbated. In addition to one-on-one support and counselling—and I will say something very important about that in a moment—there is a range of group programs and community development programs. There are facilitated play groups that are run for individual ethnic groups as well as for ethnic groups combined. That is a portal or a soft entry for other kinds of activities, including the Positive Parenting Program—or the particular version of it that has been developed. We found that in that area these parents would not come to a school for a group based delivery of PPP; we actually had to take it to their homes. Many of them were illiterate or were not literate in English, so they could not cope with the written material. So although the principles of PPP are excellent, there was a need for a great deal of adaptation of that program to make it meaningful for our population.

**CHAIR**—When you said they were English illiterate—

**Prof. Homel**—They were Vietnamese, for example, and did not speak English.

**CHAIR**—I wondered if that also pertained to the Aboriginal population, because there is some evidence—

**Prof. Homel**—There are some who have a great deal of difficulty with written material, yes. There are a couple of things about the family independence program that are important—and I think this is one of the most significant things for this committee. Over the years the team has managed to engage effectively with some of the toughest families in the community. That has taken time; it does take time to establish trust. But, more particularly, it has been accomplished through the employment of community members as paid members of the Pathways team. For example, we have had for some years a highly respected local Indigenous person, Vivian Bonner, who I think is the niece of Neville Bonner. Her husband is an elder in the area. She is a 24/7 social worker for her community. I do not know how she survives year in and year out with the crises she deals with. Her caseload is double that of the professional members of the team who support the community workers—the Vietnamese, the Pacific islanders, the Samoan.

**CHAIR**—These would just be people in the community who have the facility to connect with these people.

**Prof. Homel**—That is exactly right. They have the ability to relate in a way that I certainly do not, and most professionals—whether psychologists or social workers—

**CHAIR**—People like Mama Shirl and others like that who connect.

**Prof. Homel**—Exactly. They have got the credibility; more particularly, they are highly intelligence, although totally uneducated formally, and they have the people skills. They know when it is getting beyond them and they can refer problems or individuals to the professionals who can provide the particular programs or services that they need. So it is a very long answer to your question about what they do. There is a much more detailed description in the report.

What an individual family receives is variable. It depends on their needs at the time. We have never attempted it and it would be impossible to measure the effectiveness of this strand versus that strand. We do not have an evaluation of the play group program or even of the child behaviour program.

**CHAIR**—What about outcomes?

**Prof. Homel**—The outcomes that we were able to measure in those early stages were the behaviour of the children at the beginning of preschool and at the end—we had a number of measures of that—and also their language and communication skills and their social skills. We were able to show improvements on all of those dimensions. Very interestingly, although it is not in the report, 12 months later, at the end of grade 1, the teachers gave us an assessment of the overall academic achievement of the children in their classes. We were able to compare the scores for the children who had been in the preschool program in the previous year with those who had not. The teachers did not know which children had been in the preschool program. The results for academic achievement at the end of grade 1 exactly mirrored the results at the end of preschool in terms of behaviour.

**CHAIR**—That is good, isn't it.

**Prof. Homel**—This suggests that, as we know, there is a direct link between improved behaviour and improved academic performance. Of course we would like better and more comprehensive data and we are working very hard on that. We are particularly working hard on this measure of family empowerment, of parental efficacy, which does seem now to be working. We have some very encouraging preliminary data showing that this program is having a very significant effect on the quality of the family life and on the capacity of parents to be effective in their parenting.

**Mr QUICK**—I taught at a disadvantaged school in Tasmania.

**Prof. Homel**—Yes, I know. I met you last year.

**Mr QUICK**—One of the problems is that the services are not located in those suburbs, so the professionals have to come out there. Most of the support services that are working there are underfunded, so they work seven days a week and get paid for three, and there is a high burnout. Housing, health, education and juvenile justice all have social workers who are usually dealing with those families in a variety of ways, depending on what sort of crisis is there. How did you manage to drag all of those bureaucracies together so that one person could make a phone call—for example, if housing was a problem they could ring someone in housing and they could be relocated, or if a school principal was having problems someone could be removed rather than being expelled and then creating other problems. How do you get that sort of cohesive atmosphere within the community?

**Prof. Homel**—We have not attempted to create a formal interagency partnership. To some extent that already exists in the area—there are strong interagency groups that have been there forever. The way it works is that when you need to refer a family or a child to a specialised service, it is the advocacy role of the Pathways worker who is working with that family to do that. They will take the family or the parent or the child in many cases to that service. Going back one step, we have found that there are three essential ingredients of early intervention: food, transport and child care. You have actually got to provide the tangible material basis for these people to be involved in anything you do. We found that transport is probably the most critical. A lot of their time is spent transporting people to services or to particular programs that the Pathways program itself runs.

**Mr QUICK**—How do you remove the stigma? One of the problems we faced in bringing the community together was that of not blaming people. It is a matter of saying: 'Your kids are at risk. It is not necessarily your fault. We are here to ensure that the risk stops now, and we will put in place a whole series of strategies.' If we empower this family, someone further down the street who is going through the same problems but who we have not identified yet is then willing to participate. We should do this rather than saying: 'Look, there is a meeting of these people and they are hopeless. They have got financial problems and there is absolute chaos.'

**Prof. Homel**—Like many other services, we use a strength based approach. I said we assess needs and work out this measure of adversity, but we do not put that in terms such as: 'This is a list of all the deficits in your family.' It is critically important in terms of the dynamics of your relationship with that family not to do that. What I should perhaps have emphasised too is that

family programs are available to everyone in the region, particularly the group based programs—the play groups and the parent programs. A lot of parents come who are not in crisis. Also, the child focused programs in that early phase were open to all the children in all of the schools that participated. There were not particular children who were singled out, although some children would have received extra attention within the classroom because of their need. Everybody in the classroom participated in the program. It was a universal delivery within that region. By supporting family fun days, events at the school and a lot of community development activities, as well as these programs that everybody benefits from—like the parent training—you get past a lot of that problem of stigma. You have then got the acceptance of the local families to do the more intensive work with those who need it. That has been quite a journey.

**Prof. Dawe**—In our experience a lot of that shuffling between services happens because nobody has been designated as ‘being in charge’, if you like. Everybody has different agendas: Child Safety are concerned about one set of things et cetera. One of the advantages of the kind of community based approach that Ross has suggested, and certainly in the work that I do, is that you clearly define who is a particular case manager. It becomes core business of the agency. For example, if it were a methadone clinic, instead of just being an agency that dispenses methadone it becomes an agency that coordinates care of the family as a whole. It starts to look at the needs of the mother, the accommodation and the needs of the children, and to liaise with Child Safety. Often those two agencies are at loggerheads; often they do not work well together. You start to have somebody who says, ‘Yes, it is my job to coordinate all of these different parts of the family’s life.’

**CHAIR**—How can you have someone who is dispensing—‘doling out’ was what you were going to say in the beginning—methadone in charge of the welfare of people?

**Prof. Dawe**—You select those people very carefully. There are some extremely well-trained people who work in methadone clinics. The people we have trained to do our Parents Under Pressure work are often people who have a background in community nursing or Child Safety.

**CHAIR**—Those people have committed themselves to giving a toxic drug to an individual who is going to die of it—they are going to lose 46 years of their life—and they think that is okay. How is that going to be a good attitude to try to save other people in the family?

**Mr QUICK**—One of the issues that I see as important is the stabilisation of the family unit. Quite often you have to come up with a range of things in order to stabilise the family; otherwise, if they fall apart you are going to create a heap more problems. In some cases the distribution of methadone enables that family to cope to a stage where people can intervene and change behaviour.

**CHAIR**—I accept that, but we have seen documented evidence that in other families the children are fed the methadone and end up dead.

**Prof. Dawe**—One of the findings, and it is a very small study—

**CHAIR**—And that is where there is an agency intervening.

**Prof. Dawe**—One of our key findings in the only evaluation of a parenting program in substance-misusing families in Australia—it is the only evaluation—

**CHAIR**—Somebody could be using a legal drug for a purpose for which it is not intended. Ritalin is a good example. I am interested in this book where it says that Ritalin is mixed with other amphetamines. Ritalin is legal but there is a black market for it and it can be misused. With illegal drugs it is not a question of ‘misuse’ but a question of ‘use’—once you use it you are in trouble. There is no such thing as good use of illegal drugs. There is no such thing as a good use of methadone—it does not exist. So can we be careful about our language? Can we talk about ‘misuse’ where something is legal and ‘use’ where it is illegal?

**Prof. Dawe**—The other important bit of language is when we talk about ‘abuse’ and ‘dependence’. If you look at the continuum, there could be somebody who uses Ritalin once a year. That is not a good thing but it is a very different pattern of use from someone who uses Ritalin daily. So there you are talking about ‘use’, ‘misuse’ and ‘dependence’. That is also an important distinction.

**CHAIR**—Ritalin is a drug available on prescription. It is not in a category—as it is put in this document—with a whole lot of amphetamines. Basically, I suppose you can say it is speed. Whether or not it should be prescribed is quite another question. Nonetheless, it is, so I think we have to know what we are talking about. We are talking about illicit drugs. Ritalin is not an illicit drug; it is available on prescription like other prescription drugs. What we are talking about here is illicit drugs. Certainly, cannabis is the entry drug—there is plenty of evidence about that—and then you go on and top up or whatever. Ice is becoming a huge problem. Sitting in those very chairs last week we had people talking about their 30-year-old son who had a psychosis from marijuana but who is now on ice. They need to call eight policemen to hold him down.

**Prof. Dawe**—It is a growing problem and it is going to have a whole set of different ramifications for children.

**CHAIR**—And DNA damage.

**Prof. Dawe**—Certainly, the behaviour of parents is much more erratic when they are using methamphetamine, and that again is a whole different set of major concerns.

**CHAIR**—They become dangerous—they can kill parents.

**Prof. Dawe**—Yes; they become dangerous, hostile, aggressive and irrational.

**CHAIR**—This particular man is being treated so he can be charged for assault. There you go.

**Mr QUICK**—Professor Homel, we had evidence from ANCD about frightening statistics. How accurate is this data that you collect—one in so many is this and one in so many is that—when you have a national survey?

**Prof. Dawe**—I actually wrote that report. Would you like me to comment on the data?

**Mr QUICK**—Yes. There are some areas where the statistics are absolutely frightening. It is something like one in five men over the age of so-and-so is going to get this or that. Hopefully, I am not one of them. How do we ensure that we have some consistency and we actually know the numbers and someone can quantify them and say: ‘This program, which is excellent, ought to be replicated around Australia. It is going to cost X amount of dollars and the intervention does work. We are going to save six times the amount of money compared with having to incarcerate them in juvenile justice institutions when they are 16 or 17?’

**Prof. Dawe**—There are lots of questions about data. Your first question about data is how many kids. The ANCD report that I was the lead author on made a stab at estimating that. The major recommendation from that data is to do with the questions asked. We do not ask the question in any of our national data sets or any of our surveys of illicit drug users: ‘Are you a mum or dad?’ I think it is absolutely astonishing that we do not ask such a simple, straightforward question. So we do not know the answer.

**Mrs IRWIN**—What is the reason they would not ask that sort of question?

**Prof. Dawe**—I need to be fair; the illicit drug reporting system is relatively new. It has only been going for a couple of years. The issue of children and families has really been on the backburner for quite a long time. It is really only just coming to the fore and I suspect that one of the most important consequences of the ANCD report will be that people will start putting in those questions: ‘Are you a parent? If so, how many kids do you have? What are their ages?’

**CHAIR**—I would have thought that that would be the first thing you would put in.

**Prof. Dawe**—Yes, you would. It is absolutely astonishing.

**Mrs IRWIN**—It is commonsense.

**Prof. Dawe**—People wear different hats. I wear a child and family hat so for me it is astonishing that you would not ask somebody that question. It was not asked so we have best guesses. So that is the first thing: we do not really know the number.

**Mrs IRWIN**—Yes.

**Prof. Dawe**—Your second question relates to evaluations of programs, and that is where it becomes very difficult to evaluate lots of things at the same time. You need to focus on a particular aspect of a program and evaluate that intensively, which is one of the things we have done with the Parents Under Pressure Program—we have evaluated that intensively. The biggest question—and I think it is an enormously important question—is a question for the health economics field. If we provide these kinds of interventions and we track kids over a really long period of time, how much money do we save—

**CHAIR**—Enormous amounts.

**Prof. Dawe**—in relation to foster care, unemployment, juvenile justice, hospitals, overdoses et cetera? You start saying, ‘Hold on, it is going to cost us millions to provide this intervention,’ because suddenly we are going to need eight additional staff members trained in a family based

intervention for each agency. That is a lot of money, but compare that to what it costs to keep someone in prison.

**CHAIR**—In our inquiry into balancing work and family we found that one of the factors that keeps our birth rate up is that a very large number of people—I forget the figure, but it is huge; it is getting close to half—have children out of wedlock. Of that cohort, there will be some who will be in a stable relationship and there will be lots who are not, where partnering does not occur. You could say that that group is an ‘at risk’ group, particularly if you are taking on new partners on a regular basis and your children get in the way.

**Prof. Homel**—I am not going to disagree with that.

**CHAIR**—There are going to be other people who will cope quite well too. The group that you are dealing with are described as being part of the problem. We heard from ordinary families with a large number of children where only one member was a problem and we heard of the impact that one person can have. Some of them have chosen to send that person away because they have to save the rest of the family. They are perfectly ordinary families. They are not disadvantaged; they are regular families. When you talk about your group—and they would be relevant as potential criminals too—what sort of percentage of the drug-using population would be in that group?

**Prof. Homel**—We do not have a very good answer to that question either. What is your best estimate, Sharon?

**Prof. Dawe**—They have done a number of longitudinal studies where they take birth cohorts of kids and follow them through—the Dunedin study followed them through. That birth cohort is about 25 years of age now. They look at how things cluster, if you like, and what predicts substance use and abuse later on. The more risk factors you have, the greater your chances are of not doing so well.

**CHAIR**—I know that, but I am trying to identify it as a percentage of the total problem.

**Prof. Dawe**—I suspect it is small.

**CHAIR**—Yes. I thought that might be the answer. I am interested, because Harry and I took evidence in Perth. We were knocked off, weren’t we, Harry? We did not believe what we were hearing. Out of a birth of 5,000 children in one particular hospital, 350 of them were born to drug-addicted mothers and 125, I think, were born to mothers who were fed methadone through the pregnancy. The babies were born addicted to the methadone, and the description of having to take them off was dreadful. Yet somebody tried to tell us that it would have no impact on the child. You think how careful we are with an ordinary pregnancy—you do not even take a Panadol. People are so careful that they do not take anything because of the impact that it will have. For somebody to tell me that when a child is born to a drug-addicted mother who is being fed methadone by the hospital—and the child is born addicted—it is going to have no impact, I think they live in cloud cuckoo land. The rest of the evidence was that there was no follow-up study on what happened to those children. Twenty-five of them were kept and were not allowed to go back with the mother, another 25 or 30 were taken back, I think, three months later, but we have no idea what happened to the rest. Nobody had followed it up.

**Prof. Homel**—Can I just go back to your question about the percentage. I cannot give you a percentage. We may be able to work that out, actually, by looking at the data from the Dunedin or Christchurch longitudinal studies. In fact, we should inquire and see if we can come up with an estimate. Having said that, going back to the issue of the long-term cost to society, I think that although it may be a smallish percentage of total drug users who are in that socially disadvantaged category, the outcomes for those children—or for the parents, for that matter—tend to be worse because of the existence of this constellation of other problems, and the costs tend to be greater.

Sharon has mentioned the criminal justice costs. The US research that has done the cost-benefit analyses of these early intervention programs almost always finds that by far the greatest savings from the improvements that have come from these programs are to the criminal justice system and to crime victims. That is where the huge costs are. We are talking about America, where they really do prison in a big way, as we are seeing with Paris Hilton. They really do prison. We do not here, yet. The rate of imprisonment in this country is 163 per 100,000, which has gone up by about 50 per cent over the last 20 years.

**CHAIR**—We have 21,000 prisoners in Australia, counting those on the mend.

**Prof. Homel**—The rate has gone up nationally from about 100 to 163 over the last 10 or 15 years. Anyway, we certainly do not do prison in the way they do it in the US. But, having said that, a lot of the savings of these early intervention programs are savings to the criminal justice system, and one of the difficulties is that the initial expenditures are often borne by education, health or welfare departments, yet they do not, as it were, accrue the savings. The whole nation does, of course.

**Mr QUICK**—That's right, yes.

**Prof. Homel**—But there is an issue there.

**CHAIR**—On exactly that point, I remember having a very interesting meeting in New York with former Mayor Giuliani. One of the things he did, along with introducing his zero-tolerance laws, was to look at getting extra resources for single parents, particularly in areas where there were very large, deprived black populations. He worked the system so that they got access to federal health money and he said the improvement in the crime rate was just astonishing.

**Prof. Homel**—Yes.

**Mr QUICK**—If we go back to your point, if the schools and the communities are able to achieve a lot of these positive outcomes, we ought to be saying to them, 'We're going to resource you even better.' But then you have the converse of some suburbs saying: 'Look, we don't have any problems because we're middle class and we do the right thing. There's a reallocation of resources to the wrong area.' How do we convince the rest of the community to take on the load so they do not get robbed and their houses do not get knocked off and the like, so that society benefits?

**Prof. Homel**—One of the answers is what we have done in our report, where we have a chapter devoted to our cost comparison. We costed everything we did down to the nearest cent. I

have an economist working with me, doing his PhD on these very issues. He put a dollar cost on everything I did for the time I was involved in this work, including the commercial rental value of my office, I might add. We then compared our costs with the costs to the education department of their existing behaviour management teams and also the special schools that they run for kids who are expelled from the local schools and do not have anywhere else to go. Although we do not have any data on the effectiveness of those remedial programs that Education Queensland runs, we assumed they were 100 per cent effective, and even making that assumption, and assuming that our program was far less effective by comparison, we were still able to show that what we were doing per child improved was cheaper than the tertiary option of trying to do it when the kid's behaviour was already getting out of control.

So the point of that chapter is that there ought to be a rebalancing of resources away from picking up the pieces after they have fallen off the cliff, back to the front end. It is what we say all the time in health, in education and in criminal justice, but it is never done and it is never resourced. But the immediate benefits actually flow to the schools, as we saw with those grade 1 teachers, because they were getting better performance and better behaviour in grade 1. If that flows through, you have an immediate benefit to that school. So that is what I would be pushing.

**CHAIR**—I think the reality is that when you talk about rebalancing, when you try and disaggregate and take funds away from a service being delivered, it is pie in the sky. What you are really saying is that this is an effective program and it needs to be funded in its own right because it is effective. That is a much better argument to run.

**Prof. Dawe**—Yes.

**Prof. Homel**—And because there are immediate benefits which also save money, and that is not just 20 years later in savings to the criminal justice system. I think that is a very important point.

**CHAIR**—It has a long-term benefit. If you can save someone from a life of addiction and crime, or indeed non-addiction and crime, you are producing a citizen who is going to contribute to the GDP of the nation, as distinct from detracting from it.

**Mrs IRWIN**—You have told us a bit about some of the good models for early intervention. What are the bad models?

**Prof. Dawe**—There are a lot of well-meaning people spending a lot of time 'saving' families—doing things for families. In lots of families every man and his dog is involved and there is no sense of trying to look at what the underlying causes are. People respond to crises, and these are families where there are always crises. So it becomes a response to the next crisis and the next crisis, and somewhere along the way people are not trained enough in a clinical model to change their behaviour or the family's behaviour. I guess one thing, if it were appropriate, would be to have a look at the program we have, which attempts to use a problem-solving approach. You have to help parents do a number of different things. If you look at the table of contents, you will see that a therapist trained in this approach has a full set of different modules that they can work through with a particular family at any point in time. There is an accompanying parents workbook that you use sensitively and sensibly. You would start using the workbook with somebody who, for example, could read and write English. If they could not

read and write English you would be creative in taking the examples. This is not the only program that does this; there are a number of different programs like this. You provide a framework for the therapist—the social worker, nurse or psychologist—which gives them a series of exercises and goals. Specific components of the program help parents understand how to regulate their own emotions, and specific aspects of the program help parents relate to their children in a more nurturing fashion.

**CHAIR**—Are you talking about learning self-control too?

**Prof. Dawe**—Absolutely. Self-control is really critical. If you have grown up in a chaotic, dysfunctional family and cannot manage your own emotions, and if you also have a history of drug use behind you—and, again, that is about loss of control—you need to get to a point where you can learn to say: ‘Okay, take a deep breath, I am nervous but that’s okay; I can get through it,’ or, ‘I am angry but I do not have to hit.’ It is about having the ability to step back. If that is not part of your program, it keeps on—

**CHAIR**—Is that what you are really aiming to do with early intervention—to teach people to control their own behaviour and teach children that they too have to control their behaviour and fit into norms because we live in a society?

**Prof. Homel**—That is part of it. You also need to give people—

**Mrs MARKUS**—It is about teaching them skills.

**Mr QUICK**—You need learning and coping skills, so that when you identify a point in your life you do not automatically react in a negative way; you see it as a challenge. You get over that challenge and you then have a skill with which you can empower not only yourself but people in the same sort of neighbourhood.

**CHAIR**—So it would mean, Harry, for instance, that, if a parent’s normal response to several things going wrong at the same time—like something as simple as the milk boiling over, someone crying, someone demanding a new set of socks, whatever—if they have not learnt the behaviour of being calm and controlled in that situation, they are likely to break out and strike—

**Prof. Dawe**—Yes. They hit, lash out.

**CHAIR**—or take a pill or whatever. Somewhere along the line they have missed out themselves on learning that control mechanism. So what do you teach them? Do you teach them to count to 10?

**Mr QUICK**—Lots of things.

**Mrs MARKUS**—There are lots of different strategies.

**Prof. Dawe**—We do lots of things. If I could tell a little clinical story about a case I am supervising at the moment of a five-year-old who was very anxious—and this is the whole family we are working with. Actually, maybe she was six. She had to do her morning talk and so one of the things—

**Mrs IRWIN**—Is that the show-and-tell at school?

**Prof. Dawe**—Yes. So one of the things we were talking with this little girl about was taking deep breaths. We get children to blow on a candle flame but not blow it out. So you have to take a really deep breath and, in order for that flame not to go out, you have to actually blow it really gently. In the very act of doing that, you calm yourself down. If you then, in turn, say to mum, ‘We really want you to practise doing this with your child, and you’re going to do it together,’ you are immediately introducing the concept of learning to slow down and regulate your breathing. You have almost therapy tricks, if you like. You have all sorts of exercises like that embedded in a program so that you are constantly getting people to reflect and take a moment to think, take a moment to breathe.

**CHAIR**—I find that very helpful. Louise, you are trained; you understand that.

**Mrs MARKUS**—Yes.

**CHAIR**—But when people say ‘early intervention and counselling’ what on earth are they telling people?

**Mrs MARKUS**—What does it mean?

**Prof. Homel**—What does it mean in practice—yes. Well, it is described in great detail in the report with the case studies.

**CHAIR**—But that is the aim?

**Prof. Dawe**—Yes, it is.

**CHAIR**—And that is the how, is it?

**Prof. Homel**—Yes, and social skills are very important for children and for parents.

**CHAIR**—Even to the extent of manners. We have manners to fit in in society, don’t we?

**Prof. Homel**—Absolutely. I do a lot of work on violence, mainly amongst men and adolescents, and the use of violence is a resource for desperate people who do not have any other way of solving problems—or who enjoy it. But often, even in the most serious violence, men who kill, it is because they genuinely get to a point where they cannot see any alternative, in solving this problem, to killing the other person. It is extraordinary; it is very hard to understand. You look at some of these cases and you think, ‘How—

**CHAIR**—But they are totally out of control, aren’t they?

**Prof. Homel**—Well, they may not even be out of control. But they do not have the social resources, the social skills, the communication skills to find any other way out of this particular dilemma that they think they are in.

**CHAIR**—But if you are drug crazed and your brain is out—

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**Prof. Homel**—You are rationality or alcohol affected.

**CHAIR**—The first thing that drugs do is get rid of conscience.

**Prof. Homel**—I think it varies from drug to drug. But, certainly, the disinhibiting process, so-called, can be important with some drugs. Alcohol has complex effects on decision making, more in terms of one's risk-taking propensity and so on and some other dimensions. But the point is that, when you are working in these programs of the kind that Sharon is describing, you are actually giving people additional resources to fall back on which most middle-class families already have. It is not that they do not need help; actually, they do, because I have had the experience twice with drug use and abuse in my own extended family, and I can tell you it is devastating. It is terribly difficult.

**CHAIR**—Because everybody feels guilty: 'What have I done?' But they may not have done anything.

**Prof. Homel**—But you also do not know where to turn for help.

**Mr QUICK**—That is right.

**CHAIR**—That is what we hear all the time: 'Where do we turn?'

**Prof. Homel**—I think it is an enormous hidden problem in the middle classes, where a son or daughter starts to use illegal substances heavily, particularly marijuana in those late teenage years. We now know the results of the Christchurch study and so on, that it can heighten the risk of psychosis. I cannot give personal examples because we are on the record, and I am not going to do that.

**CHAIR**—No, I understand that.

**Prof. Homel**—Nevertheless, just knowing that does not necessarily change behaviour, so you have actually got to do a lot more.

**Mrs IRWIN**—Do you think that we should have a one-stop shop for these programs? That is what I am hearing from people within my community. It seems that there are programs for mum and there might be a program for dad and then one for the two of them.

**Prof. Homel**—Often families turn to a GP, psychiatrist or psychologist for help. I think that is the most common response of a middle-class family. A major problem is that the privacy professional ethic is such that the family cannot know the result. So there is no concept of family treatment if you like. It seems to be highly individualised in my experience. I do not know whether Sharon has a comment on that.

**Prof. Dawe**—I am not sure that a one-stop shop is the only solution. I think we are going to have to have lots of different solutions. One of the times, which I think is a fantastic point of intervention, is when children go to school. Unfortunately, that is five years down the track.

**Mr QUICK**—In lots of cases that is too late.

**Prof. Dawe**—I do not think it is too late. I think it is a hugely missed opportunity because there is a point at which you can access a really large number of families, from really disadvantaged environments, whom you can engage with via the school. When you go to primary schools, they are full of mums dropping off really little kids. Even tricky families mostly walk their kids to school. There is a point in that first year of school where you can connect with a whole range of families in the community that you probably cannot reach anywhere else—even in that first term. So that would be a really important place to start doing some of the work that Ross has done.

**CHAIR**—That is also where kids sense out who they are going to pick on, who they do not like and who is a bit different. In many cases they are going to exacerbate the problems for some kids. Kids are very cruel.

**Prof. Dawe**—Yes, they are. You would need to do it sensitively. This is where the skill of your program developer and implementer lies. It is not about stigmatising kids or identifying kids. It is about engaging members of the community so that everybody wants to come along to an afternoon session at 3.30 about X, week 1 of term 1 for a preschool or grade 1. Most of your mums and dads will actually turn up—not all but most.

**CHAIR**—Really?

**Prof. Dawe**—Yes, in the local communities that I work in, you get—

**CHAIR**—I know communities where you would be likely to get six people turn up because mum and dad are working.

**Prof. Dawe**—There is not an awful lot of employment in some of the communities I work in.

**CHAIR**—You are dealing with a different community then.

**Mr QUICK**—There are moves to include child care on the school grounds in lots of places so that there is an identification even earlier than formal schooling. When it comes to nutrition, there is having a fruit bowl at home rather than getting stuck into chips and the like. It is about knowing how to sing songs and read stories to your kids so that when they do get to kindergarten they are not two or three years behind. There are things like cutting and pasting—little simple middle-class things that parents do with their kids that a lot of these families do not do because it is easier to have Foxtel beaming 24 hours a day.

**CHAIR**—But maybe nobody ever read to them and it is not in their experience.

**Prof. Dawe**—The earlier you start the better. I am just using the grade 1 example because it is a great way to have community outreach but there are going to have to be other specialist groups. For example, a very large number of families are referred to child protection services and my understanding is that about half of those families who are referred are not actually formally taken on as notified cases. But if they were referred as a family, which somebody else in the community has identified as being problematic, even if they do not become a notification then, the chance of it happening two years down the track is huge. So why not have a whole set

of interventions for those families who have been identified as being at some risk but who do not meet child protection concerns?

**Mrs MARKUS**—I think you have highlighted something very valid—I can speak mostly for New South Wales, but I suspect it is very similar across the rest of the nation—and that is that funds have increasingly moved down to the tertiary end, which means they are picking up people. There is less and less funding—in fact, I do not think there has been any growth in funding for most family support services on the ground. In terms of catering for, identifying and dealing with families that face challenges and may not have picked up from their own family background all the skills they require to negotiate life today, if we have programs where we can provide intervention in the early stage then there is a chance of minimising the problems. That does not mean that more funding is not needed down at the tertiary end. From the hearings we have had to date, it has become quite clear that there is not enough access to or availability of programs not just for families but also for young people and adults engaged in using illicit drugs. But I do not think you can negate the importance of providing that early intervention.

**CHAIR**—Louise, we are talking about different services, aren't we?

**Mrs MARKUS**—Yes, we are.

**CHAIR**—This is a model that deals with an identified cohort of people at risk to give them the skills to be part of civil society.

**Mrs MARKUS**—And some of that is about showing them how to build social networks. I want to highlight one point that I think has been threaded through some of the conversations this morning. We use the term 'disadvantage', but what does that mean? We look at communities where there may be unemployment and a high percentage of public housing tenants et cetera and they have particular needs, but there is also a whole group of people who may not necessarily immediately meet all the criteria of disadvantage but may have a dysfunctional family history. They may have all the trappings of the middle class or they may even be quite wealthy, but we cannot assume that this group has all the skills required to ensure that somebody in their family is able to negotiate and overcome some of the problems they face—for example, with drugs at school. In Western Sydney, for example, there is lots of money going into Mount Druitt—and I do not want to say that there are not needs there—but there is a whole population of new families in new estates where there is no money for services. I am not necessarily focusing just on state issues, but there are no extra police. There is nothing extra for them. We are expecting them to negotiate life. We have young people drinking in the parks. But we think, 'They are middle class so they'll be okay.'

**CHAIR**—In my own electorate we have the phenomenon of swarming.

**Prof. Homel**—The mobile phone is a very important key to that.

**CHAIR**—It is terrifying; you find hundreds of them.

**Mrs IRWIN**—We have to look at the example of the Brown family on page 62. The grandmother was self-referred through the Department of Child Safety. The length of contact with the family was three years. I think there were three workers involved with this particular

family. There was a number of issues: the mother's drug addiction; peer group culture; the potential jail sentence; the father's access visits were violent and harmful; problems with the grandmother and sexual abuse of the children. Then there are the intervention programs that you had in place for that family and their outcomes: the mother has successfully completed rehabilitation; the mother is still drug free; the mother is rebuilding relationship with children and the adult women in the family are finally working together. It is a pity that we do not have those sorts of programs.

**Mrs MARKUS**—There are many family support programs, psychologists and social workers around the traps who are doing this, but there is not enough of it.

**Mrs IRWIN**—We are not giving enough money to them.

**Prof. Homel**—As far as the outcomes for children is concerned—which, I think, is one of the major focuses of this inquiry—the needs of the child, and therefore the needs of the family and the parents, should be central. Perhaps the key challenge that we are currently facing in our pathways work is to work with agencies, including schools, so that their institutional practices on a routine basis are better organised around the needs of children so that there is a better connection between families, parents, children and these institutions which are so important to the development of children.

**CHAIR**—You are also going to have a problem in the schools. Because there will be schools in disadvantaged areas, you will not have the really experienced, good teachers there. They will be the young ones just out of school—

**Mr QUICK**—No, the best teachers—

**Prof. Homel**—Often they are there because they want to be.

**CHAIR**—That is good. Thank you, Harry.

**Prof. Homel**—You would be encouraged, I think, if you looked at the quality of some of the teachers, particularly the principals.

**Mr QUICK**—How would you feel if some of the members of the committee actually came on-site and talked to people in a non-threatening way?

**Prof. Homel**—We would be happy to look at that. There is a bit of a problem with the fishbowl phenomenon.

**Mr QUICK**—I know; I understand that.

**Prof. Homel**—People in this area say: 'Oh, not another bloody—

**CHAIR**—'They've come to look at us.'

**Prof. Homel**—Yes. 'We're the poor, disadvantaged victims and they're coming to look.' I know that occurs. We can do it, but we have to manage it carefully.

**Mrs MARKUS**—Would some people speak with us?

**Prof. Homel**—Yes. Some have been used in Mission Australia advertising, so they are quite happy to talk. Just following up those comments Sharon was making, there are some activities which you would be welcome to look at—the playgroups, for example, are a non-threatening environment. The family rooms that we have created within each of the primary schools, where parents come with kids as a place of belonging within the school, have been a major breakthrough. There are things you can look at, but you have to realise that much of the work is sensitive and—

**Prof. Dawe**—It certainly is.

**Prof. Homel**—you cannot use people as specimens.

**Mr QUICK**—This committee has a wonderful reputation for handing down really good reports. I would like to think that our recommendations would be taken up by whoever is in government, and the more evidence you can find, the better. What could be better than talking to people? You can come here and extol all the virtues, but if we can go and ask them: ‘Does it really work?’ then that would be helpful.

**Prof. Homel**—I have not talked about all the problems and challenges that we are facing, and where it is not working.

**Mr QUICK**—I can imagine.

**CHAIR**—Tell us about some of the things that are not working?

**Prof. Homel**—We are currently having a great deal of difficulty in our relationship with the schools. They are complaining, quite rightly, that they do not feel ownership of this program; yet they are an integral part of it. They feel that they do not have the skills to engage effectively with their families, which is one of our major goals. It is not that there is any ill will whatsoever. We had a very honest meeting a few weeks ago—one of those honest meetings that sends you grey—where many of these issues were discussed out in the open. It is very difficult to work with schools in a way which moves them outside of their routine activity: the mission, as it were, of educating.

**CHAIR**—What you are saying is that it is too much to ask them to take on this extra burden?

**Prof. Homel**—It has to be redefined so that it is part of their routine business and not an extra burden.

**Mrs MARKUS**—I think that is a challenge.

**Prof. Homel**—That is exactly the point: it is a big challenge.

**Mrs MARKUS**—And without resourcing them to do that with an extra person or extra resources.

**Prof. Homel**—Which is why we are trying to get to see the Director-General of Education.

**Mrs MARKUS**—You have probably already thought of this, but if you could incorporate a school liaison person who was responsible for doing what needs—

**Prof. Homel**—We have that.

**Mrs MARKUS**—Somebody who was operating within the school.

**CHAIR**—If the Chapman program was introduced at these schools it would be quite useful, wouldn't it?

**Prof. Homel**—These are all resources that are helpful. We have a trained preschool communications teacher who is employed under the program, who is very good with parents. Unfortunately, she currently works only half time on this project as the liaison between schools and the community work.

**Mrs MARKUS**—How is that funded?

**Prof. Homel**—Through the Australian Research Council.

**Mr QUICK**—We had a community development officer teacher at my disadvantaged school, and she worked herself out of a job, which was great.

**Prof. Homel**—Ultimate success.

**Mr QUICK**—We had two or three demountables that were given over to the parents, and they saw the school as part of their—

**Prof. Homel**—That is the goal; that is exactly right. Can I suggest that if some of you do come on-site then you also have a look at the work Sharon is doing. She was describing in my daughter's car a very innovative whole-of-government Parents Under Pressure program, so there are probably a couple of things you can look at. Is there anything yet in your program to look at?

**Prof. Dawe**—Probably not right at the moment. The Queensland government have a diversion from jail program for Indigenous people up north who have alcohol problems and they are doing it very sensibly. There is lots of community liaison. People are being given a chance to take ownership of parts of the program, and we are involved with that as part of the Parents Under Pressure program advising ways in which you could think about doing parenting programs in Indigenous communities.

**CHAIR**—Do you think that, where diversion programs are put in place, rehabilitation programs should be compulsory? In other words, you are not going down the mainstream—you have been moved over here. There is not much point in going through the revolving door and sending them out again. We have heard the plea. There is actually one member of this committee who has opened her soul up and talked about it. She said, 'It is terrible—as soon as they are starting to get somewhere, it is through the revolving door.'

**Mr QUICK**—I am sorry to interrupt, but I have to leave.

**CHAIR**—As Mr Quick is leaving, we will form a subcommittee.

**Prof. Homel**—Generally the evidence in criminology is that coerced treatment is preferable to no treatment, particularly if the alternative is going to prison and this is your choice—go to the drug court and go on their program. We have to be careful, because there is a process of selection for the people, as always. So I do not want to be dogmatic. But, if pushed to the wall, I would say that that is the way you are going to get people into treatment, and it is better than sending people to jail. That is my view.

**Prof. Dawe**—Even in the drug literature, mandatory treatment has been found to benefit people more than no treatment at all.

**Mrs MARKUS**—Professor, could you point us to that particular literature?

**Prof. Dawe**—I cannot think of a review off the top of my head.

**CHAIR**—If you wouldn't mind finding one, that would be helpful.

**Prof. Dawe**—We can send it down to you. It is North American. The thing the North Americans are doing very well is evaluating mandatory treatment for drug use. The other thing they are doing is evaluating the effectiveness of rewarding people for clean urines for non-drug use. There is actually a lot of evidence that giving people, for example, supermarket vouchers and clothing vouchers et cetera for clean urines is effective. I think that is really interesting. You are not giving people money to buy drugs but you are rewarding people and helping people in that early stage of their recovery. Obviously there is a point at which you are going to have to stop giving people \$20 gift vouchers for a clean urine, but in those early stages of recovery that has also been found to be really effective, particularly with cocaine, because, of course, there is no replacement therapy available for cocaine addiction. So they need to look at more creative—

**CHAIR**—Cocaine is pretty low on the usage scale here.

**Prof. Dawe**—Yes, but amphetamines are not. I think we need to start looking at the North American models for cocaine treatment when we think about amphetamines, and start looking at some of these token reinforcement models.

**Prof. Homel**—Paying kids to finish high school has been found in the US to be very effective.

**CHAIR**—Could you please repeat that?

**Prof. Homel**—Paying teenagers to stay on at school and not drop out improves educational outcomes.

**Mrs MARKUS**—What terminology did you use, Professor? Did you say 'token'?

**Prof. Dawe**—They call it a token rewards system or a voucher system. There is literature on that. I am happy to do a bit of a literature search and see if I can find a Cochrane review for you on it. That is what you want.

**Prof. Homel**—I will look at the Australian evaluations of the drug courts and I will also get some expert advice on how reliable they are and give you a little commentary. At least it will be what we now know.

**CHAIR**—There is a division in the chamber, so we will have to adjourn the proceedings. Thank you for your evidence today.

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

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

**Committee adjourned at 11.45 am**