



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF  
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

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

WEDNESDAY, 8 AUGUST 2007

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

**Wednesday, 8 August 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, Ms Kate Ellis, Mr Fawcett, Mrs Irwin, Mrs Markus and Mr Ticehurst

**Terms of reference for the inquiry:**

To inquire into and report on:

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

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

**WITNESSES**

**CHEETHAM, Ms Linda, Private capacity ..... 1**  
**GARDINER, Mr Michael, Volunteer, Family Drug Support ..... 1**  
**LLOYD, Ms Jessica, Representative, Family Drug Support ..... 1**  
**TRIMINGHAM, Mr Tony, CEO and Founder, Family Drug Support ..... 1**  
**WOLFF, Ms Catherine, Member and Volunteer, Family Drug Support ..... 1**



**Committee met at 10.20 am**

**CHEETHAM, Ms Linda, Member; and Volunteer, Family Drug Support**

**GARDINER, Mr Michael, Volunteer, Family Drug Support**

**LLOYD, Ms Jessica, Representative, Family Drug Support**

**TRIMINGHAM, Mr Tony, CEO and Founder, Family Drug Support**

**WOLFF, Ms Catherine, Member and Volunteer, Family Drug Support**

*Witnesses were sworn or affirmed—*

**CHAIR (Mrs Bronwyn Bishop)**—I now declare open this public hearing of the House of Representatives Standing Committee on Family and Human Services in its inquiry on the impact of illicit drugs on families. Today the committee will take evidence from Mr Tony Trimmingham, Chief Executive Officer and founder of Family Drug Support. He is accompanied by representatives of families who have been affected by illicit drug use. This hearing is open to the public. I welcome you and thank you for coming. I now invite the representatives of Family Drug Support to make an opening statement.

**Mr Trimmingham**—Thank you, Madam Chair, and thank you very much to the committee for the opportunity to give evidence. We think this is a very important inquiry. For too long families have been sidelined in the drug debate, and it is great to have the opportunity to appear before you. I would like very much to waive my right to make an opening statement—I will rely on the other written submissions that we have already provided—but I would like to give a short presentation which will really tell my story more graphically than I can in words. Each of our members will then briefly introduce themselves so we know why they are here. There is a song that accompanies this presentation.

*A PowerPoint presentation was then given—*

**Mr Trimmingham**—I take this presentation into schools. I have heard Madam Chair mention on occasions that we need to bring back the grim reaper ads or something like that. I can tell you that this has impact with schools particularly.

**Mrs IRWIN**—I understand that. Was that your son?

**Mr Trimmingham**—Yes, that was my son Damien. I will now invite Cate to introduce herself.

**Ms Wolff**—I would like to thank Tony for that and Damien as well. My name is Cate. I am nervous and I am a bit upset after seeing that—I am sorry. I am a registered nurse. I was trained at Sydney University. I have postgraduate qualifications in gerontology—a graduate diploma. I have two daughters and one son. My oldest child is a daughter who is 32. My youngest daughter is 23. My middle child, Philip, is 27. He had a very happy childhood. He enjoyed sailing, basketball and athletics. He excelled in long distance running. He was extremely talented in music and all the arts. When he was in primary school we enrolled him in singing lessons and he

started learning the piano and guitar. He was a popular member of the whole community of Marrickville, which is a multicultural area. Everyone got behind Philip when he attempted to enrol in Newtown High School of the Performing Arts—and he was successful in that.

In years 7 and 8 his talent became very evident to all of his teachers and to visiting performers. He was selected to play the leading role in a musical movie for young people. Philip began experimenting with drugs between years 7 and 12. He was recreationally smoking heroin by year 12 in the mistaken belief that he would not become addicted to that substance by smoking it, which of course we know is not true. Due to the expense of heroin he was injecting drugs by the time he left school.

My approach at that time was zero tolerance. I wanted him to cease drugs. I did not want drugs. I could not believe it had happened to our family. I tried every effort known to get him off drugs. That was my term: 'We will get him off drugs.' All that did was drive him away. I found that that attitude, coupled with the lost opportunities for personal growth that Phil had, meant that he lost many career opportunities by not turning up to appointments and not turning up to auditions. When he was there it was obvious that he was under the influence of drugs and performers do not like to have an unreliable person on their books. We tried so many detoxes, so many rehabs, private and public, home detox—countless numbers. He wanted to stop drugs; he was desperate to stop drugs. He blames no-one but himself. He does not blame anybody else. He said it was his choice.

Things came to a head when, in one week, Philip stole money amounting to \$2,000, the last amount being three hours before my eldest daughter was due to go on a holiday to Fiji. My eldest daughter made the decision to charge her brother, which was a very hard stand, and one that we went along with at the time; we supported her in that. She charged her brother with break and enter and subsequently Philip was jailed, first to Silverwater and then transferred to Parramatta. He was incarcerated for three months and really the end result of that was that he contracted hep C in jail. When he came out that was no incentive to Philip to cease using drugs. To use his own words, the only way you can be on drugs is to be on drugs. The lure of heroin was such that even that was not a deterrent.

Naturally our family was shattered. His sister was guilty. She felt terrible guilt and still does. She blames herself for that, but that is another story. We felt alienated from the community, with statements like, 'How could you kick your son out,' which I have done to protect my youngest daughter when she was doing her HSC. We felt alienated at times. I actually took work as a registered nurse at night because I did not feel I was part of humanity. I could deal with my patients, but I could not deal with the public at large. I did not feel worthy of being a member of society.

This continued until Philip then made the decision at about the time that I contacted Family Drug Support to start a buprenorphine maintenance program, which is an alternative to methadone, but it is the same harm minimisation. Once Philip commenced that, he obtained work as a skilled tradesman. He started writing songs again and was performing in a working band as a drummer. He did not want to be up in the limelight, he is not interested in that. He just likes making music, and he was also singing. He was maintaining a very healthy relationship with a woman who has never used drugs at all.

After 2½ years he had a lapse. Once again, FDS was instrumental in helping my family cope with that situation. I took the opportunity to undertake a Stepping Stones course, which was run by Tony and his wife. That helped me because I found through this whole saga that the support of Philip's family has been the thing that has been most important for him. After he did a very hard non-medicated detox he made a decision. He gave himself the choice of long-term rehab or methadone maintenance. He chose methadone. He has been on methadone maintenance for three months and he is once again working. He is writing songs again. He is playing basketball. He is starting to relearn the social skills that he missed as a young person because they do not; it is arrested development. We had a very happy occasion last weekend when we celebrated my remarriage to my long-term partner. For the first time in three years Phil was able to be there. Thank you.

**Mr Trimmingham**—Thank you, Cate.

**Ms Cheetham**—Thank you for this opportunity. My name is Linda Cheetham and I work in the area of mental health. I am very pleased to be here. I apologise for reading, but it will keep me to time. You have heard some very sad stories, because there are an awful lot of them. I am very fortunate and extremely pleased to say that my story is a happy one for today.

I have three daughters in their late 20s, early 30s. They are very close and very caring of one another and always have been. Two of them are outgoing girls getting on with life. They have friends, jobs, degrees, and are doing what you would expect girls in their late 20s, early 30s to do. My other daughter is a quiet girl. She is reserved in some ways. She is thoughtful, kind, a musician, she plays the violin and she sings. She has chosen to study social welfare and is working hard. She recently achieved 98 per cent in an exam, which we were very pleased about.

She and her partner are delighted to be parents of a young baby. Both of them give significant time to voluntary work. My quiet daughter is already a good and caring parent and, when qualified, I feel she will be a very useful and valued member of society. But it was not always like this. My daughters did not have an easy childhood. Other children may have navigated their way and faced the trauma that they faced, but unfortunately my girls were more vulnerable.

The two outgoing daughters at different times became distressed in the form of anger. Their behaviour was destructive both to themselves and to others. They turned to drugs as easy medication, but remained connected in some ways to both school and family. Throughout this time we as a family sought professional help when it was available to help the girls with their difficulties. One of the girls missed years of school and the other many of life's opportunities, which would otherwise have been available to her. It took in one case 10 years and the other girl 15 years before they stopped illegal drug use.

My quiet daughter, my gentle one, was not as fortunate. By the age of nine or 10, her response to distress was to stop eating and she developed anorexia nervosa. As with the other girls we engaged professional medical help at all stages. We had a good GP, a social worker and a child psychiatrist. Within two years it appeared that all was well, but this was not the case. The issues that had led my daughter into not eating had now been pushed underground and drug use started which led into full-blown heroin addiction by the age of 18. Heroin was the drug of choice, but any drug would do if heroin was not available—party drugs, speed, ice or prescription drugs.

She was a serious drug user for eight years, with all the self-destructive life behaviours that are necessary to acquire the drugs she needed for her addiction. As parents, we tried to help as best we could. We knew our daughter and we knew that above all else she was a very sick girl and that sickness pre-dated any drug use. We learnt good strategies for coping and keeping the family together through Family Drug Support and their helpful literature. We went to meetings to help reduce the feelings of failure as parents and the inevitable social isolation and stigma.

We offered private detox and rehab facilities to our quiet daughter on more than one occasion, which my daughter willingly took up. This expensive intervention was not successful. My quiet daughter would have died many times over if it were not for the harm reduction strategies employed in this country and funded by the government. Thanks to the needle exchange program she is not HIV positive. Thanks to the methadone program she has had interludes in those eight years when the need for heroin decreased, hence the lifestyle was more conducive to good health. If injecting rooms had been available in our state, my daughter would have used them and come into regular contact with professional staff much earlier in her addiction.

Thanks to the flexibility of the non-government agencies and excellence of their staff, my daughter had contact with professionals who, in time, helped her through the morass of addiction and to good health. The government-funded harm minimisation programs helped to keep my vulnerable and distressed daughter alive until she was able and strong enough to become a fully-rounded human being. I and my family are fortunate. All our children are alive. That, in itself, would be enough, but they are also productive members of society and model citizens. Without the support of the NGOs and harm minimisation strategies this would not be the case.

**Mr Gardiner**—I am retired and I am speaking on behalf of my family. My wife is in the public gallery, and my daughter cannot be here. This was our son. Patrick died in 1996 from a heroin overdose. He was a beautiful human being of whom we were extremely proud. At the age of 13 Patrick started drinking alcohol. That was his gateway to heroin, which happens in many cases. Because of his dependence he was demonised and marginalised by society. Our ignorance did not help much. It was difficult to understand drug dependence at that time and give him support. It is 11 years since he died, but governments have not changed over this time in supporting families whose loved ones are dependent on drugs or who have died from illicit drugs. That is what we have learnt through our experience, and we do not see how anything has changed.

We see a lot of ignorance and fear in the community. There seems to be this continual perception by members of the media and many politicians that sending drug dependent people to rehabilitation or gaol will solve their drug problems. We believe this perception and fear is passed on to the public and exploited by the media for ratings. It is exploited by politicians with gusto and hysteria for political profit. This we believe is an insidious immorality and is now part of our political landscape. I know these are strong words but I feel very strongly about this.

Rehabilitation is important and more money should be spent in this area, but it is not—and the evidence clearly shows—the only solution or the magic bullet. The evidence shows that it can take many years in most cases for drug dependent people to be free of the dependence. Having a relapse is not a failure. Many people have many relapses. Unfortunately, these dependent people, whilst in relapse, are not given the harm minimisation support they deserve and are entitled to, as any other ill person in society rightly deserves and should get. We have observed over the years

since Patrick died that nothing has changed in the attitude of most of our lawmakers who promote punitive drug laws and ignore factual medical and scientific evidence from other countries. It is the same old mantra: vote for us, we will get tough.

I have a heading here of 'Exploiting family tragedy for political profit.' One wonders how long this madness will last. The great tragedy of this insane madness is: how many families have to live in pain, shame, stigma and grief, or be destroyed, before some politicians have the courage, compassion and intellect to see this drug law policy for what it really is, a failed destructive monster cow funded by the taxpayer. Some politicians, religious bigots, the tabloid media and organisations milk their own greedy profit—again an insidious immorality. For many politicians knowing how to exploit tragedy has become an art form. How low can you go?

The next generation of families will be exploited and carry the pain—there will be another generation after my generation. The social cost of the illicit drug markets includes: loss of life, illness, transmission of disease, provision of health care, suffering by family and friends of drug users, traffic accidents, lost productivity, drug related crime and reduced public safety and amenity. Many of these costs are magnified by strict drug laws. Our son Patrick died because of his illness and because of drug policy ignorance. Patrick died from a heroin overdose, a relatively harmless drug that was made dangerous by our laws. There is little doubt that moral arguments have played and will continue to play a major role in drug policy debates in Australia. That is all I have to say.

**CHAIR**—I did not interrupt you at the time and I can understand that you probably have all sorts of emotions in you, but I simply cannot allow your broad sweep against people of integrity who hold views because they believe in things that can be done. I cannot allow that slander to stand unanswered. However, we invited you here to give evidence and we are very interested to know what happened to Patrick, and what happened in those years when he moved from alcohol into heroin and how that was dealt with.

**Ms Lloyd**—I used heroin for the first time when I was 17. I was in my final year of school. Throughout my teenage years, I was definitely someone who experimented and was always open to experimentation. I guess it is in my personality.

**CHAIR**—Were you always a risk-taker?

**Ms Lloyd**—I do not know. I guess that was probably the riskiest thing I have ever done. I do not know that I have ever done anything else that I would consider riskier than that.

**CHAIR**—Why did you do it?

**Ms Lloyd**—I was in my final year at school. I went to a private girl's school on the North Shore and I was under a lot of pressure to do well. Basically, in that year I found a balance between the studying—which was all I did, and I did very well—and I would reward myself with heroin. There was a small group of us. I have to say that I had no idea that this drug could so easily kill you and that it could become addictive.

**CHAIR**—Who introduced you to it?

**Ms Lloyd**—A girl in my year at school.

**CHAIR**—Was she a friend?

**Ms Lloyd**—Yes.

**CHAIR**—Did you like her?

**Ms Lloyd**—Yes.

**CHAIR**—Was she good at her lessons?

**Ms Lloyd**—Yes, we both did very well in our HSC. We both got in the 90s in our HSC.

**CHAIR**—Where did she get it?

**Mrs IRWIN**—Chair, with due respect, I know it is very nerve-racking coming before an inquiry like this. I am just wondering if Jessica could just tell her story and we might be able to ask questions.

**Ms Lloyd**—If I could just speak for a minute and then you can ask questions. I did not develop an addiction while I was at school. We would go out to Cabramatta. It was quite easy to get. It was fun and risky. I just did that and I studied. I got through my HSC. I left home quite quickly because I wanted my independence—at that point, I was not using drugs—and wanted to do my own thing, much to my family's disappointment because they wanted me to go to university and all the rest. I left home, got work and entered into a relationship with somebody who had been a heroin user for many years. Fairly quickly, I slid into using again, thinking: 'I understand this. I am okay with needles and all the things that go with it'—and I was because I had done it on and off for a while. I developed a fairly nasty habit. At that point, I completely cut my family out of my life—having your mum ring you while you are stoned is something that I was very ashamed of. At that point, I know my family had nowhere to go and had nowhere to turn. Eventually, they discovered Family Drug Support. My father was very angry and did not know what to do. He was just angry about the whole situation. My mother thought every day that I was going to die. It has only been in the last 10 years that I realised what I did to them at that time.

I got to a point where I wanted to stop, as you do, and I went through home detoxes at my parents' house. I went to detox centres to do a detox but did not last. I went cold turkey. I just stopped taking drugs and thought that would work. This was a cycle that went on for a long time. Eventually, I decided to go on a methadone program. That was what stabilised me really. It allowed me to reconnect with my family, who had always been there but I just did not welcome them into my life. I would go back to them, I would stay with them and then I would leave again. I guess, for them, having an understanding of what a drug user goes through helped them to handle that.

I went on a methadone program and I got work. I did an introduction to hospitality course—anything normal was good. I would get my daily dose and my life had some sort of normality to it. I got into a much healthier relationship and I fell pregnant. So I spent the next nine months

going off methadone. About three days before I gave birth, I was off it altogether. This is still such emotional stuff—you think it has gone, but it is still there.

In the last eight years, I have raised a beautiful little girl. I have not touched drugs. I have two university degrees. I think the reason I did not want to give my name is because there is so much stigma and negativity around drugs that it does not look good. It does not matter that I have not used for 10 years. It does not matter that I have got a social work degree and an arts degree. That stuff does not matter when you have been a heroin addict. I think certain policies can perpetuate that. We need to support people to get out of their drug use and support families to help them. The methadone program and having my family support me were what saved my life and my daughter's life.

**CHAIR**—Thank you, Jessica.

**Mr Trimmingham**—I would just mention to the committee that we have 2,000 members on our mailing list. We received 27,000 calls to our help line last year. We literally could have had hundreds of people here today with stories—different circumstances but similar stories. We got these five people and I am so grateful to them. We are now open to any of your questions.

**CHAIR**—Jessica, I am sorry that I interrupted you in the beginning. What you were saying was so interesting. You said that you did not know what happened to you, you did not know what the drug would do to you when you started.

**Ms Lloyd**—I was very naive about heroin. Obviously, I did choose to put a needle in my arm. I did allow someone to do that to me. That was a choice. Becoming a heroin addict was not a choice; it was not something I chose to do.

**CHAIR**—But you did not know that that would automatically happen. Nobody told you that.

**Ms Lloyd**—No, I did not know that.

**CHAIR**—That is why I asked if the person who introduced you to it was a peer. If you had not had that group of friends, you may never have started, or would you?

**Ms Lloyd**—I may well have. I do not know whether there is a personality. Drug use is rampant throughout society. People take drugs. People take risks. They experiment with things. It is not that there are good people and bad people; there are so many shades of grey.

**CHAIR**—Is that because you thought that society said it was somehow okay?

**Ms Lloyd**—Okay to take heroin?

**CHAIR**—Yes.

**Ms Lloyd**—No.

**CHAIR**—At the time, did you think, 'This is no big deal; it's okay; lots of people do it'?

**Ms Lloyd**—No, I saw it as a risk I was taking. I cannot remember thinking about it like that. It was put to me as, ‘This stuff was amazing.’ It is something that I have hidden. It is not okay. I know it is not okay. I did not want to give you my name because I know it is not okay. I did use it for a long time, but I used it for quite a few months without developing an addiction. I did manage.

**CHAIR**—Without having the cravings.

**Ms Lloyd**—Yes, without having a need. I used it recreationally. I completed my HSC.

**CHAIR**—You did not know that that would inevitably lead you into—

**Mr Trimingham**—It is actually not inevitable that people who use heroin will become dependent—

**CHAIR**—Yes, right.

**Mr Trimingham**—Six out of every seven people who use heroin are not addicted.

**CHAIR**—Terrific.

**Mr Trimingham**—It is not terrific; it is a fact.

**CHAIR**—We had a young man, Ryan, who appeared before the committee. He said that he was nearly killed by being given social advice that he could just use it at weekends.

**Mr Trimingham**—It is not social advice; it is just the facts, Madam Chair.

**CHAIR**—He went into taking drugs because of peer pressure. He thought it was cool. Cool kids do it, so he did it. I was wondering if you thought that too.

**Mrs IRWIN**—Do you think it might have been the thrill because it was illegal?

**Ms Lloyd**—Yes, like anything—like the fact that I had tried marijuana.

**CHAIR**—Did you try that first?

**Ms Lloyd**—Yes.

**CHAIR**—How old were you when you tried marijuana?

**Ms Lloyd**—I was 16. I tried alcohol well before that—

**CHAIR**—That is legal.

**Ms Lloyd**—I was probably about 14 when I first drank.

**Mr Trimingham**—That is not legal being under the age of 18, Madam Chair.

**CHAIR**—I know that. You tried marijuana first. Was that with the same group of people?

**Ms Lloyd**—No, it was not.

**CHAIR**—Were you still at school?

**Ms Lloyd**—Yes, the same school. At a private, prestigious girls' school, you could get anything you wanted, and people did. Not everyone decided that they were going to try heroin, but there were plenty of people who experimented and would get drunk in the park, smoke dope or try speed. This was definitely pushing the limits. I know it was not everywhere.

**CHAIR**—Where did the marijuana come from?

**Ms Lloyd**—I cannot remember, probably through a friend.

**CHAIR**—At the pub, at school or through a friend?

**Ms Lloyd**—It would have been through a friend. I cannot say exactly where it came from.

**CHAIR**—So you did not go to heroin straight off, you went through marijuana first?

**Ms Lloyd**—Yes. If I was going to say how it happened, I would say that I drank alcohol, I tried marijuana and somewhere in there I smoked cigarettes too. I know plenty of people who have smoked marijuana, and do smoke marijuana, and have no inclination to take any other drug at all.

**CHAIR**—But for you this was the next step?

**Ms Lloyd**—I do not know if it was the next step. I think I was just somebody who was open to it. I was a very anxious person. I felt like I was under a lot of pressure at school to do well. I am not trying to excuse it or anything, but for me it was such a nice release. It was something that escaped me from everything. In the end, it was what put my life on hold for years because everything stopped. You can hide away from it all. At the time, studying and treating myself with that was—

**CHAIR**—How did you meet your partner, the one who was a drug addict?

**Ms Lloyd**—Through a work colleague; through a friend.

**CHAIR**—Did you know he was taking heroin when you started going out with him?

**Ms Lloyd**—No, not initially. I got to know him as a person. But, yes, I did find out. I think I was still quite dismissive of what heroin was.

**CHAIR**—What made you leave home? You got good results, your mum and dad wanted you to go on and you were always close to your family, and suddenly you wanted out of there. Why?

**Ms Lloyd**—I have always wanted my independence. I was raised to be an independent person. My grandmother went overseas for a few months, so I had three months of free rent and an apartment on my own, and it was the best thing ever. I had a ball. I got a job and I did my own thing. I guess because the gate had already been opened to me, it was something that I was open to when it came. And I had not been in a relationship and I wanted to be.

**Mrs IRWIN**—Do you feel that the methadone program saved your life?

**Ms Lloyd**—And my child's, yes, definitely. I do not know what other option I had at that point. I had tried everything. I guess being pregnant gave me the motivation that there was someone else and it was not just me anymore. It gave me the motivation to reduce. But, again, I know people who have been on methadone for a long time and may be on methadone forever. If that means they can go to work every day, raise their families and do everything, then great.

**Mrs IRWIN**—Firstly, Tony, thank you very much for that short film. As Linda said, unfortunately Damien is no longer with us, but we do thank you and Damien. You say that you actually take that film into schools. I found that very moving. I could be walking in your shoes as well. What is the reaction you get when you take that into schools?

**Mr Trimmingham**—I have been showing those slides for about eight years. Every time I show them, it cuts deeply into me. It is not easy for me. It is an old story now. It is 10 years old. I sometimes wonder if it is still relevant. But the schools I go to keep asking me to come back and the number of schools that I go to is increasing. The main schools I go to are Catholic and private schools. I get far more invitations from that system than I do the public system.

**Mrs IRWIN**—That is sad to hear.

**Mr Trimmingham**—I can go into any year from Year 8 to Year 12 and as soon as I put those slides on there is absolute silence, and I then spend an hour talking to those kids with absolute respect. Like you, I think people can relate to those pictures. I show the slides because people remember them when they have forgotten what I had to say. It has that kind of impact. I do not even have to give them a message of, 'Do not do drugs,' 'Just say no,' 'Use minimisation,' or 'Do it safely.' I do not have to say any of that. I just tell Damien's story and they can see a young man who they could be. That is why I do it. It is not our main work; our main work is supporting families. The school work I do is incidental to that, but I get at least one invitation a week to talk at a school.

**Mrs IRWIN**—What sort of programs that are in place now do you feel are working and which programs are not working? What sort of programs would you actually like to see in place?

**Mr Trimmingham**—We have a board member who has been involved in the drug and alcohol field since the early eighties and he says that in the eighties—and this is long before I came into the scene—families were seen as the enemy; they were the cause of the problem. All workers were taught to actually avoid discussion with families. In 1996, when we discovered Damien had been using heroin for 12 months, we found that things had not changed much from that. Families

were no longer seen as the enemy, but were seen as a nuisance and we were not invited into knowing about any program. Family Drug Support came about by accident. I was running a business and my son got involved in heroin and he died of an overdose, and that tragedy and the need that we saw—

**Mrs IRWIN**—And the lack of support.

**Mr Trimingham**—and the lack of support that families were getting was what started Family Drug Support. I had no idea that 10 years later I would be sitting here doing this as the whole of my life. Unless you took a ‘tough love’ approach, unless you went to the 12-step programs there was absolutely nothing else. So we filled that gap.

I come from a background of counselling and social work and group work. I worked in the relationships area for 25 years before. I had never done anything in the drugs field at all, but I brought along this client-centred approach, which is a bit different to the way drug and alcohol services traditionally work. They are a very medicalised model, and I come from a very different background in psychotherapy. I guess I brought that with me and I found that it actually worked. It worked with the people who were members of Family Drug Support in the early days. We started with no programs. We built them up. We started with the telephone line and that is the first step that many people take. On that telephone line we do not offer advice, we do not give expertise on drugs and alcohol. We refer people who need that. We just simply listen. That, in itself, is what people need. Especially when you think that they have kept it in the family. They have not been able to speak out to any of their friends because as soon as they do, they get stigmatised. They go to the doctor and the doctor is like anybody else in society: there are occasional good ones and there are a lot of very negative ones and often their responses are negative. To have somebody sitting on a telephone line was invaluable. From that, we have developed the support groups where people gather and share their wisdom and their strategies, and we have developed the Stepping Stones program, which is a structured course.

Everybody who finds their kid on drugs has one goal: get them off. We go through this process of trying to achieve that and we want to achieve it as quickly as possible. What we inevitably find when we try that kind of strategy is that everything falls apart. It is like Jessica’s story; it is like Cate’s story; it is like Linda’s story. It is not as easy as simply getting them into the treatment centre. A treatment centre is a first step and it is a brilliant step forward, but it is not the end of the road. What we try to do now is to educate people to survive what we call the ambivalence period where people are working out whether to get off, if they do get off how to do it and whether to go via methadone, whether to go via detox and rehab, whether to do it cold turkey or whether to get a good counsellor. We have found that different things work for different people, that we need a broad strategy.

One of the things that this government has done is to give more money to the drug and alcohol field than any other government previously, and I applaud the federal government for that. I think there is more money for treatment now. We have got John Herron in the room who is chair of the Australian National Council on Drugs. I think that organisation has played a remarkable part. If anybody asks me what has changed most in the last 10 years, I say the attitude towards families. Despite what Michael said—and I understand where he is coming from on this—families now are starting to be accepted. Programs like Odyssey, WHOS and Ted Noffs are introducing family based programs that welcome families. People have even been welcomed

into the methadone programs and shown how they work. I think that is a huge step forward. There is still a long way to go. We are the only national service for families and we get a paltry \$150,000 a year from the New South Wales government. That is about one-third of our budget and we only have four staff. We rely on 200 volunteers to keep our service going. We have groups running in Brisbane, Byron Bay, Coffs Harbour, Port Macquarie, Newcastle, Central Coast, Hunter Valley, ACT—

**Mrs IRWIN**—You do all that on \$150,000?

**Mr Trimingham**—We do that on \$150,000, and we take 27,000 calls from all parts of Australia. Until very recently there was very little funding at all directly to families. One of the things we have discovered is that if you support the family, you support the drug user. Once the family starts to cope and actually gets help, support and awareness for themselves, it rubs off. I think everybody sitting at this table would say that. Once we lose our expectations, understand the reality of what we are dealing with and know it is a long-term problem, we can actually accept that and learn how to communicate better.

A lot of people go into detox, stay two days and run away. That used to be seen as a great failure. Now we see it as a step forward because they actually went in. Next time they may stay longer. It is an incremental thing when you are dealing with addiction like alcohol or heroin which we know has a 15-year dependency on average. Obviously, I am here to advocate for family support, for services that support families, and that is what we need more of now.

With regard to treatment, we are always going to need more treatment. I am not against any form of treatment that helps. I think there is a place for everything, but we should not take this either/or attitude. I hate this debate about zero tolerance versus harm minimisation. The idea that people who support harm minimisation somehow support drug use is anathema to me. It is ridiculous.

**CHAIR**—I think what we have discovered is that harm minimisation means different things to different people. It has no one definition.

**Mr Trimingham**—It shouldn't. It is a simple thing.

**CHAIR**—You are saying that the aim for you is this: you can use all sorts of methods, but the aim at the end of the day is to have that person drug free.

**Mr Trimingham**—That is the goal that every family would have.

**CHAIR**—That is the goal, but not everyone agrees to it.

**Mr Trimingham**—Not everybody achieves it.

**CHAIR**—No, not 'achieves'—that still remains the goal for you.

**Mr Trimingham**—Absolutely. We would never want—

**CHAIR**—It is not what everybody agrees on, but I am delighted that you do.

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**Mr Trimingham**—As far as I am concerned it is the end result.

**CHAIR**—That is what I mean. The term ‘harm minimisation’ is being used by different people with different spins.

**Mr Trimingham**—Yes.

**CHAIR**—I know my other colleagues have questions. Ken?

**Mr TICEHURST**—I would like to congratulate you all for coming in today and presenting the issues as you have in such an open and free way. I have never come across drugs really in my lifetime. I think the closest I have come to it was a party one time where someone was poking around—

**Mr Trimingham**—You probably have used drugs! You have probably used a prescription drug or two!

**Mr TICEHURST**—No, I haven’t; I suppose—

**CHAIR**—We are talking about illicit drugs.

**Mr TICEHURST**—I was talking about illicit drugs—exactly. But I do know now from the several cases—and I am pleased to see that you have your service up there—that there is a big drug problem up there and there are big problems—

**Mr Trimingham**—Everywhere.

**Mr TICEHURST**—with suicide. We also have a place they call the Glen which is—

**Mr Trimingham**—A wonderful place.

**Mr TICEHURST**—yes, a terrific set-up. Yes, in fact I was in there talking to Cyril only a few days ago.

**Mr Trimingham**—One of our members has somebody in there right at this moment, and it is the best place they have been to.

**Mr TICEHURST**—Yes, one of the things that Cyril has told me on a number of occasions is that the worst thing you can do with some of these people is actually put them into jail because that is really a factory that makes things worse. The issue I am interested in is the age that these kids start. Is there an age where they start experimenting? Jessica talked about her experience at school, but is that typically a starting point, or is there another age where people get involved in these illicit drugs?

**Mr Trimingham**—The point I was trying to make earlier, and I think this is a really important one, is that, whilst there is widespread drug use out there, not all of it is problematic. By saying that, I am not in any way saying that you can use drugs and not get into trouble. We do not know who is going to get into trouble. That is the problem. Drug use is widespread.

**CHAIR**—But that is at odds with your aim that you said.

**Mr Trimingham**—The evidence that is out there and very available is that the earlier people start on any substance—and the first substance they usually sample is alcohol—predicts the likelihood of problematic drug use later. Kids who are experimenting at 17 and 18 are less likely to have long-term dependency and problematic drug use than those who start at 12, 13 or 14.

**Ms Wolff**—Can I just say something about that. In that situation—in the case of my son, who started using not heroin but other drugs at a fairly young age—I feel that, in their social skills, they are going through almost a period of arrested development, and they are not able to use their innate qualities such as a lovely nature, charm, wit or whatever for positive outcomes. They actually stop developing, and therefore they are not able to cope with larger issues later on in life.

**CHAIR**—It eats into the brain.

**Mr Trimingham**—If they are a 29-year-old that started at 16—

**Ms Wolff**—It is more the psychological—

**Mr Trimingham**—physically they continue developing. Even intellectually they go on developing, but psycho-socially they stay at 16.

**Mr TICEHURST**—What do you think you can do to prevent this experimentation? You have talked about taking your slide show to schools, and that is certainly very effective, but I guess it is limited to how many schools you can physically go to.

**Mr Trimingham**—I do not want to be defeatist, but I have to be realistic. I think we are battling the Red Sea.

**Mr TICEHURST**—There is too much money involved, isn't there, in supplying it?

**Ms Lloyd**—It is what kids do.

**Mr Trimingham**—My main problem at the moment—and I know this is not the purpose of this committee, and I take the point that this is about illicit drugs—is that young people are drinking alcohol at a rate they have never used it before because there are drinks out there now that taste like soft drinks and milkshakes but are very, very potent. That is the first drug anybody uses usually—that or nicotine; more so alcohol these days. So how can we fight illicit drugs when we have this industry that is legal and available and it is literally pushing its products at the sorts of people that we are trying to prevent getting into trouble? I think we need another committee to look at alcohol and its impact.

**CHAIR**—We have had a lot of committees look at alcohol. What we are looking at specifically here is the impact of illicit drugs on families.

**Mr Trimingham**—I understand. I do have to make that point because—

**CHAIR**—Linda, for instance, has a tragic story but—

**Ms Cheetham**—Happy story.

**CHAIR**—a happy end, with a new beginning. You had three children of different temperaments. Do you think that the behaviour of the first two resulted in the behaviour of the third?

**Ms Cheetham**—My quiet and gentle daughter is the middle child. I believe that is a possibility, but I think the trauma that they suffered as children, which other children would have overcome—

**CHAIR**—What trauma did they suffer?

**Ms Cheetham**—Again, I do not particularly want to go into that, but other children—

**CHAIR**—Would you tell us off the record if we closed the meeting and went into a closed session?

**Ms Cheetham**—No, I do not think so. It is too personal.

**CHAIR**—Okay. But it was very difficult?

**Ms Cheetham**—Other children would have adapted and coped with that, but the facilities and resources 20 years ago were not there for my children. The assistance through—although we had an excellent GP, I could and will say that the psychiatrists my daughter saw told us to buck up.

**CHAIR**—Told you to what?

**Ms Cheetham**—To buck up. Those sorts of things. Those things have changed in 20 years. But I do not actually see that my children have influenced each other; it was the society in which they were growing up, the acceptance within their peer group that drugs were okay, and because of this initial background trauma affecting them, they were looking for self-medication.

**CHAIR**—It eased their pain, whatever it was.

**Ms Cheetham**—Yes.

**Ms KATE ELLIS**—Can I just follow on from what Ken was asking—but, first, thank you all for coming in and sharing your very personal stories. We will certainly do our best to try and get some good results out of the information that you have provided to us. Following on from Ken's point about the education in schools, I wanted to ask you, Jessica, because you actually said that you took heroin because it was a risk and you knew it was a risk and that was part of the rebellious—

**Ms Lloyd**—I think using a needle is probably—I did not know it could kill me.

**Ms KATE ELLIS**—Do you think that that education program would have changed your decision?

**Ms Lloyd**—It may well have if I had known more. It may well have influenced my decision, yes. The drug education that I was given was very limited. I still think, about things like marijuana, that I still would have tried that regardless of what I had been told. If someone said, ‘This could well kill you from one injection of it,’ then perhaps that would have been enough for me. There are so many different factors—there are drugs everywhere. There are not bad people that take drugs, necessarily, and you do not do it only if you have suffered some terrible thing in your life. It is like it is human instinct for some people.

**CHAIR**—But it is human instinct for the majority of people not to, so what is different about—

**Mr Trimingham**—I disagree.

**Ms Lloyd**—There is a huge number, a massive number, of people that experiment with—

**CHAIR**—But the stats simply are that most people do not. It is the minority of people that do.

**Mrs IRWIN**—Look at alcohol.

**CHAIR**—Marijuana is different. Alcohol is legal, which is why more people have access to it. Illegal drugs—

**Mrs IRWIN**—There are more deaths and violence through alcohol—

**Mr Gardiner**—Could I ask a question?

**CHAIR**—Yes.

**Mr Gardiner**—A lot of people use alcohol and nicotine, which are the most destructive and kill most people.

**CHAIR**—They are legal.

**Mr Gardiner**—So they do experiment.

**CHAIR**—One of the things that I am interested in is the way we count. We see an ad on the television that says 19,000 people die a year as a result of tobacco. We count those as deaths from the time—people can be nine months to 99 years. If we find that the disease or whatever it is they die from has a connection to whatever the evidence base is, then they are counted in. We have taken evidence that people who stay on methadone without an end—not coming to an end like you did—will lose 46 years off their life. To me, that is a death from methadone, but we do not count it.

**Ms Lloyd**—What do you mean by ‘lose 46 years off their life’?

**CHAIR**—In other words, instead of living the normal life span—and, say, for women it is 80-whatever, and for men 79-whatever—they will live 46 years less than that.

**Mr Trimingham**—That is simply not true. That is not true.

**CHAIR**—We have had that evidence from Dr Reece.

**Mr Trimingham**—From Dr Reece. Who is Dr Reece? A charlatan.

**CHAIR**—I think that is something you could take back if you do not know who he is.

**Mr Trimingham**—I do know who he is. He was investigated by the Queensland Medical Board.

**CHAIR**—All right; well, you obviously disagree with someone who has given evidence to our committee.

**Mr Trimingham**—That is nonsense, that statistic. If he said that, he is just telling lies.

**Mrs IRWIN**—For the record, I have a friend who has been on the methadone program for many, many years and is a top lawyer.

**Mr Trimingham**—The statistic on heroin is that people who die from heroin, on average, lose 35 years of their life. That is, people who die from a heroin overdose lose 35 years of their life. It is simply not possible that anybody can lose 46 years of their life on methadone.

**Mrs IRWIN**—My friend is older than me and a lot healthier than me.

**CHAIR**—The point that I am making is that people counted as dying from illicit drugs are usually overdose deaths; that is what they count as a death. They do not count anything else. I just want the same methodology used; that is all.

**Mr Trimingham**—You do not overdose from a cigarette.

**CHAIR**—Correct, and you do not commit crimes under the influence of tobacco.

**Mr Trimingham**—No.

**CHAIR**—And you do not eat your brain away.

**Mr Gardiner**—You do with alcohol.

**CHAIR**—Cate, I was interested in your search for help. We have heard from many people that, when they have encountered a child who takes drugs—

**Ms Wolff**—Yes.

**CHAIR**—they immediately want to pick up the phone and call someone for help—instant help. But when they get on to someone they will say, ‘Well, we could fit you in in a fortnight.’ There is no point that says, ‘I can come to your help now.’ Did you find that?

**Ms Wolff**—When I was looking for in-house detoxification and rehabilitation for my son, absolutely. If someone, particularly a young person, makes a monumental decision to make a change such as giving up a narcotic substance, you need to get them right at the time when they have made their decision. The person themselves has to ring, and usually at 7 o’clock in the morning, and when they ask if there is an available bed, they are told no. So you go through that process the next day and the next day and the next day. So by day four you are pretty well over a home detox.

**Ms Lloyd**—Or you have used again.

**Ms Wolff**—Yes—well, in Phil’s case, Phil could actually get through the home detox. He has done countless detoxes; it is the pain of whatever, coming afterwards. The other thing I found, too, when he made a decision to commence on a methadone or buprenorphine program, was that often you can go through the process of getting there, but it takes such a long time that, at the end of the day, they say, ‘We won’t be able to dose you tonight. Come back tomorrow.’

**CHAIR**—Did anyone offer you naltrexone?

**Ms Wolff**—Yes, and as a registered nurse I researched naltrexone because, to my way of thinking, it was a panacea to all ills and I thought ‘Hallelujah! We have an answer here.’ In my research—and, as a registered nurse with postgraduate qualifications, I am used to doing research—I found that it was not approved by the federal drug administration authority. The stories that I heard ranged from ‘The efficiency was good’ to ‘It did not do a thing’, and I heard that people were paying \$3,000 every three months, and that often people were digging their implants out, with resulting serious complications. I would be very loath to take a doctor’s order—and I do not think a doctor would ever do it, to my knowledge—to administer to someone a drug that has not been approved by the federal drug authority. That was my—

**CHAIR**—There is a pilot program, which I certainly visited in Western Australia, which is approved.

**Ms Wolff**—Yes, I know about that one. There are also side effects. In the MIMS annual, which is the pharmaceutical book that medical practitioners, pharmacists and nurses use, there are side effects of that listed.

**CHAIR**—Side effects of what?

**Ms Wolff**—Of using naltrexone. With a great deal of discussion with Philip, that was the thing that was most distressing to him, and to me—that it had not been cleared by the federal drug authority.

**CHAIR**—That is important to hear. So one of the things we have learnt of course is that you cannot go into rehabilitation until you are detoxed.

**Ms Wolff**—That is right.

**CHAIR**—Did you find that there was a gap between the detox and the ability to go into the rehabilitation program?

**Ms Wolff**—Yes, I did.

**CHAIR**—So the desire could kick in again in that time?

**Ms Wolff**—Yes, but I also found that when there was not a gap, the desire would still kick in. I have experienced it—I cannot honestly say that the gap between going from detox to rehab caused Philip to use heroin because he would often not use heroin in the gap and tried very hard. Sometimes rehabilitation itself can be a trigger because there is a lot of angry people and a lot of distressed people in a rehabilitation program and they are often triggers for each other.

**CHAIR**—Different programs; they are not all the same, are they?

**Ms Wolff**—No. I think different programs work for different people. In the case of my son, he is very intelligent and despite his drug use he did quite well in his HSC. The cognitive behaviour therapy seemed to work for Phil. In fact, when I was doing research in a textbook called *The Concepts of Chemical Dependency*, which was put out in 2002, they recommended that the methadone program be augmented with three sessions of CBT a week. At the moment that is what Philip is trying to do.

**CHAIR**—The evidence that comes to us is that detox, rehab, and being taken out of the milieu of people who are your druggie mates, basically, so that you move into a different environment, because that is needed, and back-up as well. In other words, it is a long process.

**Ms Wolff**—It is a long process and I can see that, ideally, of course you are removing the triggers there, but the reality is that there are druggie mates everywhere.

**Ms Lloyd**—If you want it, you can find it.

**Ms Wolff**—There are druggie mates everywhere—in small country towns. We have taken Philip everywhere. They appear all over.

**CHAIR**—Going to the question of when he was in jail and he came out with hepatitis C, that meant he was using in jail.

**Ms Wolff**—Yes, he was.

**CHAIR**—Did he know where the drugs came from in jail?

**Ms Wolff**—I have not asked him. I don't know. I ask him questions like that and he says, 'Look, I don't really want to talk about that.' I can only imagine, and I do not think that is a very good thing to be doing. So I do not know.

**CHAIR**—All of us can ask the question, can't we?

**Ms Wolff**—Yes. I don't know.

**Mr FAWCETT**—Thank you for telling us your stories. They are particularly of interest to me. I have two teenage daughters and I talk to them occasionally about what they are being told at school. My question is a bit like Kate's: I am particularly interested in terms of how we communicate, how we break through the fog of just normal teenage development, exploration et cetera with the message that these are substances that will harm you. You said that if somebody had told you that you could die just from the one injection, that may have made a difference. It is probably stretching back a while, but if somebody had sat down and in great detail over a period of a term stepped through the longer term implications of the use of marijuana or the potential for addiction with other drugs et cetera, do you think that would have made a difference, or is it that real fear factor that breaks through?

**Ms Lloyd**—I think any knowledge is good, and if it is given as it is, and not as 'These nice girls on the North Shore don't do that' kind of thing—smoke marijuana. Also, with families as well; I think education across the board is always going to be a good thing. Hiding stuff from your parents or having a parent say, 'Just say no,' is all good and well but it does not work. You need to be able to communicate with—

**Mr Trimingham**—Would this presentation have made a difference, do you think?

**Ms Lloyd**—Yes.

**Mr FAWCETT**—Tony, my question to you is: do you have any metrics of schools that are similar in terms of their demographics et cetera that have welcomed you in and those that have not and have a non-existent or very superficial drug policy in terms of the difference regarding experimental drug addiction?

**Mr Trimingham**—As I mentioned earlier, most of my invitations come from the private sector, and particularly the Catholic sector. I think state schools are loath to bring in any outsider to present programs. I think that is probably because they have had negative experiences with some ex-users and some people with agendas. I do occasionally get invited to state schools, but the ones that welcome me, the ones that invite me back and the ones that spread the word tend to be the private schools. One of the questions I always ask at every school I go to is: is there education on drugs in the school? And the answer is either no or extremely little.

**Mr FAWCETT**—If we are going to try and convince governments to spend money, one of the things we need is an evidence base to say, 'This clearly works.' I am wondering has there been any—

**Mr Trimingham**—I do not know if my presentation stops anybody using drugs, but I do know it causes them to stop and think. How long that lasts in their minds and whether it lasts to the next time they encounter a drug, I have no idea. I do not think we have any way of measuring that. That is why I asked Jessica the question: if she had seen that, might it have made a difference? Her answer was a definite yes.

**Mrs IRWIN**—David, have you actually seen the slide show?

**Mr FAWCETT**—No. I was at another meeting.

**Mrs IRWIN**—I am wondering, Chair, if it would be possible—because I know that all members of the committee could not be here—if we could have a copy of that slide show that we could distribute to other members?

**Mr Trimingham**—Certainly. There is also a second slide show, which I will not show because we do not have time, about a group of 35 people who have died from overdose in the last 10 years. It just shows you the broad cross-section of people. One of the things I am very conscious of is that there is a stereotype out in the community that heroin users are these people who live in the gutter, who look like wrecks and whose lives are wrecks. The reality is that that is a very small percentage. Most people look like Jessica—you pass them in the street and you would not know. Many of them have jobs and are struggling to try and survive. So one of the reasons I show that particular slide show is just to show that it could be the person sitting next to you at the cafe. Yes, certainly you can have a copy of that.

**Mrs IRWIN**—Would it be a good idea if we could get the second one that we didn't see, Chair?

**CHAIR**—Yes, sure.

**Mr Trimingham**—You can take a copy of that.

**Mr FAWCETT**—Tony, if you were Nick Minchin, Peter Costello, and Mal Brough all in one for a day and you had the power to set a policy direction and fund it, what would be the one thing that you would ask the government to do that would help the whole process of education?

**Mr Trimingham**—If I had one choice, I would probably pick something that is outside the scope of this committee and I would take a very serious look at alcohol. If it was restricted to illicit drugs, I would just say, 'Take a longer term view and start implementing programs that look not just at getting your kid into detox or rehab in the next two months but at the possibility that this could be a 15-year problem. Look at how we are going to cope with these ongoing issues that people are going to have recurring over and over again.'

**Mr FAWCETT**—My question specifically was about education.

**Mr Trimingham**—Education.

**Mr FAWCETT**—If we were going to try and make the education more accessible, more effective et cetera, what would you do?

**Mr Trimingham**—This is probably going to be longwinded, but the federal government did some research recently which identified that there are six different types of people in any school group. There are people who abstain, people who experiment and people who abuse. In each category, there are two subgroups: those with lower self-esteem and those with higher self-esteem. What we have to do is find a program that addresses all six categories. The 'Just say no' campaign will appeal to some of those groups. The harm minimisation will benefit some of those groups. But none of the programs we have got currently will appeal to all of those groups. One

of the things that is, I think, borne out by our presence today is that people who often get into trouble with drugs are high self-esteem risk takers. They are sensitive, artistic, creative people who often find life not interesting enough.

**CHAIR**—But a lot of those people who meet that description do not do it. They are the majority of people.

**Mr Trimingham**—Of course.

**CHAIR**—Here are the statistics that bear it out. It is not helpful to try and say everybody is like it. They are not.

**Mr Trimingham**—I never said that.

**Mrs IRWIN**—I do not think Tony was trying to say that, Chair.

**Mr Trimingham**—I said there is a lot of high self-esteem abstainers, but I am saying that there are six categories of people and there are some categories who do not need drug education because they are never going to use. But it is like treatment: you can't take a one-size-fits-all approach to everything. I think that the curriculums that have worked well are the sorts of curriculums that include everything, not just drugs; they are curriculums that take into account bullying, outsiders in groups, looking after each other and peer support, communication skills and looking after your mate. We should not just go in with a drug program or a bullying program. We should take a holistic approach that gets people to think about their schoolmates as part of their community. We are thinking about inclusion, not exclusion. That is where I would start from.

**Mrs IRWIN**—I have to go because I have to speak in the chamber. Tony and the team, thank you very much for appearing before the inquiry. I admire you all very greatly.

**Mrs MARKUS**—Thanks Tony, Jessica, Cate, Linda and Michael for sharing your stories. It takes great courage to really open up and share personally the impacts. As somebody who worked with many families for over 25 years before I was in this place, I agree that there needs to be additional family focus. I think there has been a shift, but certainly any kind of response at any point in time, whether it be education or whether it be early intervention prevention, whether it be intervention down at the tertiary end, where people, families and individuals are well and truly struggling, it always needs to incorporate families. Anything that focuses only on the individual is not going to bring about any change. So I absolutely agree.

I am greatly encouraged, Jessica, that methadone was of benefit to you. I need to note some of my concerns about methadone. While it has worked for you, and I know for others it offers a pathway, my concern is where there is not the additional counselling, there is not the support of the family, there is not the end goal, because not all methadone programs or however it is dosed to people actually have people being linked or integrated into a service where the goal is a drug free lifestyle. I think we would all agree that that would be where we would ideally want people to head.

My concern is that people are on methadone for many, many years and it is not benefiting their lifestyle. They do not have work; they do not have the supports in place; things are not working for them. Other alternatives are needed. I suppose I am interested, Jessica, in knowing what made the difference for you. I would like to hear about your choices and what prompted that. I know you have talked a little bit about it. Also, what was it about the methadone problem that you were linked into that was helpful?

**Ms Lloyd**—I would say a couple of major motivating factors that made me reduce and get right off it were definitely being pregnant. At the clinic I was going to, there was counselling, there was support and on a daily basis I saw the same faces. That definitely made a difference, as well as my family. Ideally, if you have got any program, if it is holistic, if it does incorporate all those other things, that is fantastic. I think that is what would help people more and would motivate them towards that. But there is also the argument that if staying on methadone for a long time means that those people are not going to die of a heroin overdose, I do not know if that is a bad thing either.

**Ms Wolff**—Or commit crimes.

**Mrs MARKUS**—I suppose that is not always—

**Ms Wolff**—Even if that is the only improvement.

**Mrs MARKUS**—Some, I suppose, still do commit crime. I am not saying all. I am just saying it does not always work.

**Mr Trimmingham**—We have to be realistic. Methadone is a substitute for heroin. It is a drug of addiction. It is an opiate, so to get off it is at least as difficult as getting off heroin.

**CHAIR**—A lot of people top-up, too.

**Mrs MARKUS**—Jessica, was the counselling in that clinic available to your family as well?

**Ms Lloyd**—No.

**Mrs MARKUS**—Would that have been beneficial?

**Ms Lloyd**—I would say so—any support, any involvement. Any supports other than just stopping me from hanging out for a drug would have been a good thing, definitely.

**Mrs MARKUS**—Was it you that instigated that you wanted to reduce? Was it you that asked for that or was it in consultation and as a result of counselling? How did that come about?

**Ms Lloyd**—It was me. I was aware enough to know that my child would be born addicted, and that is the last thing I wanted. There was counselling available at this clinic, but there could have been a lot more. I do not think any other supports in place would ever be a bad thing. I think they would increase the chance of people—

**Mrs MARKUS**—Was there resistance at all to the fact that you wanted to reduce?

**Ms Lloyd**—From?

**Mrs MARKUS**—Anybody that you spoke to. Did anybody resist?

**Ms Lloyd**—No. It was explained to me that the baby would probably be taking most of the dose anyway, and that is all I concentrated on for that period. I did not work. I was quite sick. I had a really good reason. I had a really good thing to drive for.

**Mrs MARKUS**—I congratulate you, Jessica, for being able to stick with it. It is wonderful that you have made so much progress in your life. Well done.

**Ms Cheetham**—Could I make a comment on methadone. My daughter used methadone on more than one occasion. It was not successful for her in the long term, but in the short term it reduced her need for heroin and it reduced the lifestyle that was putting her at permanent risk of serious damage. It also gave her the opportunity to meet up with professionals who she would not otherwise meet and who were able to help her to get information about detoxes, rehabs and whatever. So the methadone program was an intermediary step and helped significantly, although it was not successful in getting her away from drugs. That was detox, rehab and counselling.

**CHAIR**—Are you saying that by taking the methadone she could actually reason better; that people would talk to her about what options were available and because she was not on the drug and spaced out she could take it on board?

**Ms Cheetham**—I suppose it is not the reasoning. She just came into contact with them. When you are living a full drug life, it is very hard to meet normal people. We put a lot of effort into keeping her in choirs, all sorts of things, so she would meet normal, ordinary, kindly people who would treat her as an ordinary person. But in the methadone clinic and particularly in other NGOs, she would meet up with people who were both kindly and accepting, but would have that information and background which she would not ordinarily meet.

**Ms Wolff**—I would support that 100 per cent. That is my experience, too.

**Mrs MARKUS**—I have also come across instances where people have wanted to reduce and trying to find the support for them poses the same challenge that you have if you are trying to find support for somebody to get off if they are using only heroin or cocaine, or whatever. You face the same challenges: the access to detox, the right kind of support, a doctor who will agree, and so on. There are a number of people I have worked with who have wanted to reduce and it has been just as much of a battle to get them off the methadone as with anything else. Also, catching them at the right time, at that point in time where they have made that decision—

**CHAIR**—A window of opportunity.

**Mrs MARKUS**—Also, more integrated services, where people can be linked into various pathways, with all the kinds of support that they need. There is not enough of that.

**Ms Lloyd**—Methadone is not the answer for everybody at all. Everyone is going to be different. Some people can just stop. They detox, they go into rehab, they get on top of it and they stop, and other people don't.

**Ms Wolff**—And that is great when that happens.

**CHAIR**—In your case, Jessica, you actually made a decision, didn't you? You thought about it. You were already on methadone when you fell pregnant and then, as you just told us, you were told that the baby would take the major hit, and that really resonated with you.

**Ms Lloyd**—Definitely.

**CHAIR**—Which means that your strength of character came through, because it sure doesn't with everyone.

**Ms Lloyd**—Everyone is different, though, that is the thing. I don't think you can lump anyone together. Everyone is so individual and there is not one blanket approach.

**CHAIR**—You made a conscious decision that the health of your baby was more important than you. That must have been very strong for you, so that when you were in counselling they were actually reinforcing that for you, weren't they?

**Ms Lloyd**—Yes.

**Mr Trimmingham**—That is a really important point that you make, Madam Chair—that these decisions come to people. A woman contacted me some years ago and I went and had coffee with her. She was in her 50s and she gave me her card; she was a GP. When she was 15 she got involved with a man of 23 who got her into heroin. She used heroin for 14 years. She had children taken away from her by DOCS. She had served a prison term and she tried many forms of treatment. At the age of 29, she woke up one day with a burning thought that she would like to go to university. That day, she enrolled in a methadone program and enrolled at TAFE to do her HSC. She graduated eight years later. On the day she graduated, she took her last dose of methadone. She is now a doctor. Those decisions come out of the blue for many people.

**CHAIR**—There is something about the ages of 27, 28 and 29 too.

**Mr Trimmingham**—Possibly.

**CHAIR**—There is something about that age when people are able to make a decision, and the brain is still maturing. We hear that, don't we, in regard to road rage.

**Mr Trimmingham**—That is the biggest argument for harm minimisation. My son, I believe, would eventually have conquered his drug problem. Not everybody does, but I believe Damien would have, because he was a strong person.

**CHAIR**—With harm minimisation, it has no definite definition. It means so many different things to different people.

**Mr Trimingham**—I am talking about strategies that keep people alive.

**CHAIR**—It means strategies that keep a person alive with the aim of them becoming a functioning person who is off it and clean at the end of it. That is one definition of it. Then you have got people who say, ‘Drugs are a fact of life, they’re here to stay, get used to it.’ And there are people who advocate it. They are all in that same bunch of people. They come under that heading of harm minimisation which distorts the meaning of what you and I—

**Mr Trimingham**—I do not know anybody who is—

**CHAIR**—Well, I do.

**Mr Trimingham**—involved in harm minimisation who thinks or talks that way.

**CHAIR**—I do. They want to overturn Australia being members of treaties that are against illicit drugs. They have a whole second agenda. But we will not go there today because you are not part of it.

**Mr Gardiner**—Louise made a good point with respect to coming in contact with other people in different agencies. As Linda said, with her daughter, you would meet people and it was another way to get out of your dependence. The safe injecting room in Sydney is a good example of that. These people are coming in contact with social workers, people are getting good advice and that is very helpful.

**CHAIR**—There are other descriptions that come out of there, too.

**Mrs MARKUS**—I have an opinion about safe injecting rooms which may differ from yours.

**Mr Trimingham**—When Damien died he was one kilometre from where the injecting room now stands. He travelled 90 kilometres by train and walked 5½ kilometres and bought clean needles. If that room had been there, and he had used it, he would not have died that night.

**Mrs MARKUS**—Tony, no-one would want to see anybody’s child die.

**Mr Trimingham**—For me, that is the argument for injecting rooms.

**CHAIR**—On the other hand, it induces other people to take drugs.

**Mr Trimingham**—No, it doesn’t.

**CHAIR**—We won’t go there.

**Mr Trimingham**—That is ludicrous.

**CHAIR**—It is interesting that today we have only talked about heroin. Of course, the new scourge is amphetamines.

**Mr Trimingham**—Absolutely.

**CHAIR**—Again, we have had people who have sat in this very room and told us about their son who started on marijuana, heroin, amphetamines—

**Mr Gardiner**—Alcohol.

**CHAIR**—who was on a charge and it now takes eight policemen to hold him down.

**Mr Trimingham**—Most of the families ringing us now are talking about ice, amphetamines and speed.

**Ms Wolff**—Yes, there has been a huge increase.

**Mr Trimingham**—The problems are just as big, but different. It is more of a behaviour program; it is crisis intervention.

**CHAIR**—We have heard stories of where the child has physically attacked the parent and tried to kill them.

**Mr Trimingham**—Two things that families do urgently need attention with: one is crisis intervention when people are out of control, and getting effective, immediate help. The other is respite; getting a break from the ongoing trauma.

**CHAIR**—Going right back to your opening statement, your taking that story into schools could be the precursor to a campaign—grim reaper—to tell people, to take your point, that if you had known you may not have done it. We will never really know, but there is bound to be a good percentage of those who would never do it. They are the ones we can save.

Thank you all very much for coming. I know it is heart wrenching. Jessica, thank you for your courage. If you would have liked to have done it in a private session, we could have done that, too. I think your evidence is very courageous. There are lessons for many.

**Ms Lloyd**—I think it is important to hear it.

**CHAIR**—It is. Linda, I hope the happiness in your story continues on.

**Ms Cheetham**—As I say, a good outcome today—

**CHAIR**—Narcotics Anonymous was wonderful for you; is that the case?

**Ms Cheetham**—I think it has been instrumental in the wellbeing of my daughter, and she gains great strength from it.

**CHAIR**—Michael, thank you for coming. We can see you have suffered a great loss.

**Mr Gardiner**—A great loss, yes.

**CHAIR**—Thank you, Tony, for coming.

**Mr Trimingham**—Thanks.

**CHAIR**—I hope all goes well with you.

**Ms Wolff**—Thank you.

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

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.

**CHAIR**—I declare this meeting closed. Thank you for your attendance, and thanks also to Hansard.

**Committee adjourned at 11.57 am**