
The Parliament of the Commonwealth of Australia

The winnable war on drugs

The impact of illicit drug use on families

House of Representatives
Standing Committee on Family and Human Services

September 2007
Canberra

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ISBN 978 0 642 79002 6 (printed version)

ISBN 978 0 642 79003 3 (HTML version)

Printed by CanPrint Communications Pty Ltd, Canberra.

Cover design by Lisa McDonald, Department of the House of Representatives
Printing and Publishing Office, Canberra.

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Foreword

The winnable war on drugs: The impact of illicit drug use on families

The destruction of an individual's humanity by the use of illicit drugs is unarguable.

What is required is policy to prevent harm to individuals from illicit drugs, not policy to merely reduce or minimise it.

Prevention necessitates self-control and self-esteem. Thus policies need to be based on higher principles and morality. Those who promote harm minimisation say it has a morally neutral stance, stating that drug use is neither good nor bad.

It is the prevalence of this amoral stance that has allowed the plight of families, particularly vulnerable little children, to be hidden victims of illicit drug use. The aim for these people is not to prevent harm but merely to reduce or minimise it.

One witness, Ryan Hidden, told the committee:

I survived harm minimisation, because it literally threatened to destroy my life and my family's life through the messages that it can implant into that structure and the way it threatened to tear us apart, literally. It was almost like that was its objective; it did not want me to escape my addiction, it wanted me to stay stuck there.¹

Australia needs a prevention policy to protect her young and a rehabilitation policy to save those who slip.

To reduce our outlay on the cost of policing we need to achieve a society where individuals respect the rights of other individuals to function and flourish and where there is agreement on the validity of laws that are in place.

1 Hidden R, transcript, 23 May 2007, p 5.

We all feel free when we agree with the laws that govern us.

As the understanding of higher principles increases, the society becomes more cohesive.

This is not abstract idealism. It is the very basis of individualism.

The evidence received by the committee in the course of this inquiry has shown there is a drug industry which pushes harm reduction and minimisation at the expense of harm prevention and treatment with the aim of making an individual drug free.

An example of this is Dr Alex Wodak, President of the Australian Drug Law Reform Foundation, writing in a published essay entitled 'Beyond the prohibition of heroin: The development of a controlled availability policy' and published by Pluto Press in association with the Australian Fabian Society and Socialist Forum in 1991:

Heroin has relatively few side-effects. Provided careful attention is given to dose and administration, heroin can be safely injected for decades... Most of the present morbidity and mortality related to heroin use is consequent on its illegality.²

Dr Wodak gave evidence to the committee still advocating for drug legalisation, stating that '... the least-worst option for cannabis is to control demand and supply by taxation and regulation'.³ That is, legalise cannabis sales.

A more contemporary and realistic position is that published in the *Lancet* on 28 July 2007, where it admits that its 1995 editorial statement that 'the smoking of cannabis, even long term, is not harmful to health' is wrong. Its editorial now states that in the most comprehensive meta-analysis to date of a possible causal relation between cannabis use and psychotic and affective illness later in life:

Theresa Moore and colleagues found 'an increase in risk of psychosis of about 40 per cent in participants who had ever used cannabis', and a clear dose-response effect with an increased risk of 50–200 per cent in the most frequent users.⁴

and further states:

Research published since 1995, including Moore's systematic review in this issue, leads us now to conclude that cannabis use could increase the

2 Carney T, Drew L, Mathews J, Mugford S and Wodak A, *An unwinnable war against drugs: The politics of decriminalisation* (1991), p 64.

3 Australian Drug Law Reform Foundation, submission 39, p 26.

4 'Editorial', *The Lancet* (2007), vol 370, 28 July, p 292.

risk of psychotic illness. Further research is needed on the effects of cannabis on affective disorders. The Advisory Council on the Misuse of Drugs will have plenty to consider. But whatever their eventual recommendation, governments would do well to invest in sustained and effective education campaigns on the risks to health of taking cannabis.⁵

The committee takes a strong stand and details the strong evidence showing the connection between illicit drugs and mental illness and current research showing DNA damage. It thus recommends a television-focused campaign of the same magnitude as the anti-tobacco campaign against illicit drug taking.

The inquiry uncovered the plight of young children as perhaps the most distressing aspect of the inquiry.

The committee took evidence of how children are put at risk because of drug-addicted parents and the attitudes shared by state departments and many magistrates that force children to be with their biological parents as their preferred policy.

One foster mother of 24 years standing told the committee of experiences she has had in several states:

They just think blood is thicker than water, that the kids should be with their parents. I think they need to know their history. It is not necessarily good for them to be there; in most cases it is not. I cannot see that it is good for children to be with parents in a situation that means you do not know when you come home from school if you are going to be fed or not. In WA we had a 14 year old girl stay with us for two weeks who was responsible for her 11year old brother with ADHD and her seven year old sister with an intellectual disability. Her mother was 28 and a heroin addict. This girl was hiding clothes and hiding food on her way to school so that she would be able to feed her siblings when she got home. She sussed out which church groups had youth groups going and on a Friday night the kids got a hot meal because she would take them to these youth groups that were providing food for 50 cents. She would scab bottles, cans, anything, to get money to take her brother and sister for a hot meal. She used to have to wag school and come home to clean up her mum and her mum's friends so that the kids did not walk into syringes and bongs and things lying around.⁶

Adoption is currently not an option — The interest of the child is not the dominant issue. Again, Mrs Rowe told us:

5 'Editorial', *The Lancet* (2007), vol 370, 28 July, p 292.

6 Rowe L, transcript, 15 August 2007, p 10.

It is having someone who cares if you go to school. We had a 12 year old girl who had 89 days of unexplained absence from school in year 6. I said, 'How am I going to get her into high school?' That is nearly two terms of not being at school, because mum was so drugged out she had to stay home and look after her brothers. Our goal for the year that she was with us was to get her to school every day.

... She is back home with mum, but she knows I am there if she needs me. ... But if there is a problem the girl knows that her mum—this is the mum of the two boys that have just gone home as well—will ring me if she wants some suggestions. I am glad that that has just been a little bit in that child's life but she is actually turning up for school. She is still misbehaving at school because she knows she can manipulate mum. But her brothers came to us when they were one and two and, had they been adopted out, they could be now well on their way to being settled and having a great future.⁷

Another reason mothers seem to approach the department and court to have the child returned is money — the family support payments that move with the child. Evidence was given that:

You have to buy me this because you are getting all my mum's money. The government has given you my mum's money, so you have to buy me Spiderman; you have to buy me this. I want this; I want that, because you are getting my mum's money.' That is the message that mum is sending back through the children—she cannot buy them things because 'your foster carer has got all my money'.⁸

Empirically the evidence of so many children with disabilities being born to drug-addicted mothers is cause for great concern and hence the committee has recommended a long-term longitudinal study be funded.

There has to be change. The new policy must be the best interest of the child not the drug addicted parent:

- In New South Wales, drug abuse was associated with 22 per cent (15) of the 75 child deaths examined in detail where there were suspicions of abuse or neglect over the three year period to June 2002;⁹
- In Queensland, between 1999 and 2002 drug use was present in 41.2 per cent of families in which a child death occurred;¹⁰

7 Rowe L, transcript, 15 August 2007, p 8.

8 Rowe L, transcript, 15 August 2007, p 3.

9 NSW Child Death Review Team, *Fatal assault and neglect of children and young people 2003* (2003), p 28.

- In Victoria, parental drug use featured in nine, or 45 per cent of the 20 child deaths known to child protection authorities in 2005-06;¹¹ and
- In Western Australia, 77 per cent of 44 child deaths since 2003 involved parental drug use.¹²

The following example alone shows how the system lets children perish. One of six children of a heroin-addicted mother ingested 40mg of methadone and died. The coroner found enough evidence for charges to be laid, but none were laid.¹³

The Chief Executive Officer of the Australian Drug Foundation, Mr Stronach told an International Drug Conference in Washington in 1992:

We've focused as [the then Alcohol and Drug Foundation Victoria now the Australian Drug Foundation] quite clearly strategically on the media. We've employed journalists, not to churn out press releases but to get in there as subversives and work with their colleagues in the mainstream press ... So we've got 24-hour availability of those journalists and what we're finding now is that in the last eight months over 50 per cent of the mainstream printed and radio and television reporting on alcohol and drug issues has now been generated by the Foundation, or has been filtered through it.¹⁴

The Australian Drug Foundation in 2005-06 received State and Commonwealth funding totalling \$1.971 million and is listed by the Australian Taxation Office as a deductible gift recipient. The Foundation states 'abstinence is a valid goal for some programs within a harm minimisation framework but it is not the only goal'.¹⁵

Curiosity is shown by the National Drug Strategy Household Survey conducted by the Australian Institute of Health and Welfare to be the greatest reason (77 per cent) that individuals first try an illicit drug.¹⁶

We have a moral obligation as a nation to inform young people of the consequences of illicit drug use on their brain, their appearance, their health, their shortened life expectancy and most importantly what it does to their families.

10 Commission for Children and Young People and Child Guardian (Qld), submission 146, p 7.

11 Victorian Child Death Review Committee, *Annual report of inquiries into the deaths of children known to Child Protection 2006* (2006), p 31.

12 Government of Western Australia, Drug and Alcohol Office, submission 144, p 1.


13 Rowe L, transcript, 15 August 2007, pp 1, 13.

14 International Drug Conference, Washington DC, 1992, exhibit 14.4.

15 Australian Drug Foundation, 'ADF position on the role of zero tolerance in Australian Drug Strategy', viewed on 7 September 2007 at http://www.adf.org.au/article.asp?ContentID=zero_tolerance.

16 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 37.

Those who peddle an amoral stance in association with illicit drug use and fail to see the need for higher principles to underpin policy do the nation and her people a great disservice.



The Hon Bronwyn Bishop MP
Chairman

Statement by the Hon John Howard MP, Prime Minister, 16 August 2007

There is no issue that bothers Australian parents more than the threat of illicit drug use. It represents one of the continuing social challenges to the wellbeing of young Australians, and anything that governments can do to help parents deal with this terrible problem they ought to do. I am very proud of the fact that since 1997 this government has spent more than \$1.4 billion under its Tough on Drugs strategy across education, treatment and law enforcement measures. I am very pleased that over that 10-year period there has been a major change in community attitudes to the use of what used to be called soft drugs, like marijuana. Eight or nine years ago, attempts were made at a state parliamentary level on both sides of politics—both Labor and coalition—to decriminalise marijuana in the mistaken belief that marijuana was harmless. It is now realised by a growing number of Australians, particularly the parents of young people who have taken their lives in deep depression or because of a severe mental illness occasioned by marijuana abuse, that marijuana and other so-called soft drugs represent an enduring menace to the health of many thousands of young Australians. We are making progress in the war against drugs, but we have a long way to go. I say to those cynics who over the years have said it was all a waste of time, and the answer was to legalise it all and the problem would go away, that they could not have been more mistaken. The problem will only get worse if you legalise it all because you are saying to the drug traffickers and you are saying to the parents of children desperately trying to break the habit that it is all too hard and you might as well give up. This government will never give up in the fight against drugs. We will never adopt a harm minimisation strategy; we will always maintain a zero tolerance approach.

Source House of Representatives Debates, 16 August 2007, p 52.

Membership of the Committee

Chair The Hon Bronwyn Bishop MP

Deputy Chair Mrs Julia Irwin MP

Members The Hon Alan Cadman MP

Ms Kate Ellis MP

Mrs Kay Elson MP

Mr David Fawcett MP

Ms Jennie George MP

Mrs Louise Markus MP

Mr Harry Quick MP

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Terms of reference

The Committee shall 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.



List of abbreviations

ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
ADCA	Alcohol and Other Drugs Council of Australia
ADF	Australian Drug Foundation
AIDS	Acquired Immune Deficiency Syndrome
AIFS	Australian Institute of Family Studies
AIHW	Australian Institute of Health and Welfare
ANCD	Australian National Council on Drugs
ATS	Amphetamine Type Substances
CALD	Culturally and Linguistically Diverse
COAG	Council of Australian Governments
DHI	Drug Harm Index
DUMA	Drug Use Monitoring in Australia
EDRS	Ecstasy and Related Drugs Initiative
ERD	Ecstasy and Related Drugs
GHB	Gamma-hydroxybutyrate
HIV	Human Immunodeficiency Virus
IDRS	Illicit Drug Reporting System

MCDS	Ministerial Council on Drug Strategy
MDA	Methylendioxyamphetamine
MDEA	Methylenedioxyethylamphetamine
MDMA	Methylenedioxymethylamphetamine
MMT	Methadone Maintenance Treatment
NDARC	National Drug and Alcohol Research Centre
NDS	National Drug Strategy
NHMRC	National Health and Medical Research Council
NSDES	National School Drug Education Strategy
OECD	Organisation for Economic Cooperation and Development
OST	Opioid Substitution Treatment
PMA	Para-methoxyamphetamine
SKATE	Supporting Kids and Their Environment Program
THC	Tetra-hydro-cannabinol



List of recommendations

1. Introduction

Recommendation 1

The Commonwealth Government continue its allocation of significant resources to policing activity as a highly effective prevention method. *(para 1.39)*

3. Protecting children

Recommendation 2

The National Health and Medical Research Council fund a long-term longitudinal study of the babies of drug-using mothers to look at the impact of maternal illicit drug use, including:

- the long-term implications for the future life of a baby born addicted to methadone and/or other illicit drugs;
- birth outcomes, such as prematurity, birth weight, and neonatal distress;
- physical, mental and social developmental milestones;
- family functioning and family characteristics;
- any later interactions with the child protection system;
- propensity to drug use in adolescent and adult life; and
- comparisons of outcomes for alternatives to methadone, including buprenorphine, naltrexone and supervised detoxification and withdrawal, with regards to which options are in the best interests of the child, both before and after birth. *(para 3.21)*

Recommendation 3

That the Minister for Health disallow the provision of takeaway methadone through the Pharmaceutical Benefits Scheme for drug users who are parents and have children living in their household. (*para 3.55*)

Recommendation 4

The Department of Health and Ageing, as part of the next funding round for the Non Government Organisation Treatment Grants Program, give urgent priority to funding:

- residential treatment services that provide for children to live-in with their mothers during treatment; and
- non-residential treatment services that cater for the needs of parents with dependent children

where the aim is to make parents drug-free individuals. (*para 3.75*)

Recommendation 5

The Commonwealth Minister for Families, Community Services and Indigenous Affairs, in conjunction with state and territory child protection ministers:

- develop a national adoption strategy which acknowledges that adoption is a legitimate way of forming or adding to a family and adoption is a desirable way of providing a stable life for a significant proportion of children with drug-addicted parents; and
- establish adoption as the 'default' care option for children aged 0–5 years where the child protection notification involved illicit drug use by the parent/s, with the onus on child protection authorities to demonstrate that other care options would result in superior outcomes for the child/ren. (*para 3.113*)

Recommendation 6

The Minister for Families, Community Services and Indigenous Affairs include in the Legislative Instrument covering the implementation of the Income Management Provisions of the *Social Security and Other Legislation Amendment (Welfare Payment Reform) Act 2007* requirements that:

- child protection authorities must notify Centrelink when a child protection substantiation detects *any* illicit drug use by a parent/s, and that this notification shall activate the income management regime provisions; and

- that it be mandated that when children are returned to a parent/s following a care and protection order the income management regime provisions be automatically applied. (*para 3.124*)

Recommendation 7

The Department of Health and Ageing, in liaison with state and territory governments, promote the integration of contraception and family planning advice into treatment and general practice services for drug-using women of child-bearing age. (*para 3.132*)

4. The impact of harm minimisation programs on families

Recommendation 8

The Commonwealth Government develop and bring to the Council of Australian Governments a national illicit drug policy that:

- replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free; and
- only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants. (*para 4.79*)

Recommendation 9

The Department of Health and Ageing conduct research to estimate the full cost of pharmacotherapy programs to the Commonwealth, including the cost of medical consultations covered by Medicare. (*para 4.94*)

Recommendation 10

The Commonwealth Government:

- amend the National Pharmacotherapy Policy for People Dependent on Opioids to specify that the primary objective of pharmacotherapy treatment is to end an individual's opioid use; and
- renegotiate funding arrangements for methadone maintenance programs to require the states and territories to commit sufficient funding to provide comprehensive support services to meet the revised National Pharmacotherapy Policy for People Dependent on Opioids objective. (*para 4.108*)

Recommendation 11

The Commonwealth Government list naltrexone implants on the Pharmaceutical Benefits Scheme for the treatment of opioid dependence. *(para 4.118)*

Recommendation 12

The Department of Health and Ageing:

- provide funding for ongoing research into the relative effectiveness of pharmacotherapy programs including naltrexone implants and methadone; and
- form an advisory body comprised of independent research experts to advise on project methodology. *(para 4.122)*

Recommendation 13

The Australian Government Department of Health and Ageing undertake a review of needle and syringe exchange programs to assess whether they are:

- supported by the local communities in which they operate; and
- successful in directing drug users to appropriate treatment to enable them to be drug free individuals. *(para 4.132)*

5. Strengthening families through prevention**Recommendation 14**

Within the framework of the proposed illicit drug policy (see recommendation 8), the Commonwealth Government make a clear unequivocal statement, in line with the Prime Minister's statement to the House of Representatives, that includes reference to:

- the damage inflicted on families by illicit drug use; and
- the positive role that families can play in strengthening prevention and treatment services. *(para 5.16)*

Recommendation 15

The Commonwealth Government take a leadership role in reviewing and updating the National School Drug Education Strategy to re-iterate a commitment to a zero tolerance approach to illicit drugs and reflect the desire of parents for their children not to use illicit drugs. *(para 5.31)*

Recommendation 16

While commending the Government on the media campaign against ice, the committee recommends that the Minister for Health and Ageing fund, as a matter of priority, a fourth phase of the National Drugs Campaign aimed at young people, that draws on experiences from the anti smoking campaign and other campaigns most notably the Montana Meth Project in the United States that:

- moves away from pointing out the ‘harm’ related to illicit drugs to one that highlights ‘damage’, ‘destruction’ and ‘danger’;
- employs compelling and confronting imagery such as that used in local campaigns and the Montana Meth Project campaign (www.notevenonce.com/index.php);
- documents the health effects of illicit drug taking, particularly the ageing and degenerative effects on physical appearance; and
- raises awareness of the mental health consequences of illicit drug use. *(para 5.72)*

Recommendation 17

The Commonwealth Government provide funding only to organisations that adhere to the policy not to use language that glamorises or promotes the use of drugs, such as the terms ‘recreational’ and ‘party’ to describe drugs or drug use in public statements, correspondence and reports and that have implemented this policy to documents available electronically via their website. The Commonwealth Government also withdraw funding from organisations that promote legalisation of all or any illicit drugs. *(para 5.84)*

Recommendation 18

The Commonwealth Government:

- direct the Australian Broadcasting Corporation that its News and Current Affairs Style Guide should apply to all presenters; and
- encourage the Australian Press Council to adopt a similar code. *(para 5.88)*

Recommendation 19

The Minister for Health and Ageing work with states and territories to implement bans on the sale of drug equipment and the Minister for Justice and Customs ban the import of such equipment. *(para 5.94)*

Recommendation 20

The Commonwealth Government work with state and territory police to implement random testing for drivers affected by illicit drugs concurrently with random breath testing for alcohol. *(para 5.109)*

Recommendation 21

As part of the next public hospital funding agreement between the Commonwealth and the states and territories, the Minister for Health and Ageing include a requirement for the implementation of a random workplace drug testing regime to improve safety for patients and other staff. *(para 5.113)*

6. Strengthening families through treatment

Recommendation 22

The Department of Health and Ageing include, as part of the next round of illicit drug treatment funding agreements, requirements that:

- treatment organisations collect and report data on their success rate in making individuals drug free after they have completed their initial treatment; and
- give priority to funding those treatment approaches that demonstrate their success in making individuals drug free.

Further, the Department should maintain a database containing such information and make it public. *(para 6.16)*

Recommendation 23

The Department of Health and Ageing, in conjunction with other appropriate agencies:

- establish a regionally-based information and referral service, modelled on the *Carelink* aged care information service, that incorporates a 1800 telephone number and a regional network and database of service providers, to assist families obtain information about illicit drugs and how they can access treatment; and
- only include treatment agencies on the database that have the objective of making individuals drug free. *(para 6.31)*

Recommendation 24

The Australian Institute of Health and Welfare work with relevant government and non-government agencies to include in the Alcohol and Other Drug Treatment Services National Minimum Data Set measures relating to the use of family inclusive services to treat illicit drug use. *(para 6.54)*

Recommendation 25

The Department of Health and Ageing promote, as part of the next round of funding arrangements for non-government drug treatment agencies, models of explicit informed consent for giving families information, which include a discussion about information management with all drug users on their initial consultation with health professionals.

The Attorney-General, in consultation with state and territory governments and professional bodies, review whether the National Privacy Principles and Information Privacy Principles adequately allow for the position of families of clients with drug addictions, particularly with respect to subclause 2.4 and the definition of a client who is incapable of giving or communicating consent, and particularly where:

- families will be involved in the ongoing care of the client;
- the behaviour or state of the client in treatment suggests that families may be placed at physical risk; and
- families make a compassionate request to know of the client's whereabouts and state of health. *(para 6.76)*

Recommendation 26

The Department of Health and Ageing, as part of the next funding round for the *Non Government Organisation Treatment Grants Program* give priority to funding services that help family members affected by a family member's drug use. *(para 6.85)*

Recommendation 27

The Minister for Health and Ageing, in conjunction with the states and territories, develop:

- a range of standardised screening tools to identify the needs of families affected by a family member's drug use; and
- a set of referral protocols for families that need help in their own right to address the impact that caring for a drug-using family member has had on their lives. *(para 6.86)*

Recommendation 28

The Commonwealth Government:

- enter negotiations with the states and territories to change legislation to allow for children aged up to 18 years to be placed in mandatory treatment for illicit drug addiction with an organisation or individual which has as its treatment goal making individuals drug free; and
- provide the appropriate funds required to increase capacity to assist children and the families of those made subject to mandatory treatment. (*para 6.108*)

Recommendation 29

The Department of Health and Ageing:

- undertake research on the implementation of a rewards-based model for drug treatment participation in Australia that offers drug users positive incentives to undergo treatment; and
- conduct a number of small-scale trials across Australia to examine the effectiveness of a rewards-based treatment participation approach. (*para 6.110*)

7. Social and personal impact on families of illicit drug use

Recommendation 30

That the Department of Health and Ageing, as the funder for the National Drug Strategy Household Survey, the Illicit Drug Reporting System and the Ecstasy and Related Drugs Initiative, require that data collected by collection agencies include:

- whether any biological or dependent children live in the drug user's household; and
- for users aged under 18 years, the status of their regular full-time carers (such as parents or grandparents). (*para 7.12*)

8. Drug-induced psychoses and mental illness

Recommendation 31

The committee notes the prevalence of illicit drug users developing mental illness, and therefore recommends that the Department of Health and Ageing oversee:

- the development of more treatment services that treat both drug use and mental illness together, with the aim of making the individual drug free, and to avoid mental illness being treated without knowledge and consideration of illicit drug use;
- workforce training for primary health care workers to raise awareness of the connections between illicit drug use and mental illness; and
- information and support services for families, including information on how to deal with family members undergoing drug-induced or drug-related psychosis. (*para 8.97*)

Introduction

Background to the inquiry

- 1.1 In the 40th Parliament, the Family and Community Affairs Committee tabled a comprehensive report into substance abuse in Australian communities.¹ Importantly, the committee recommended that the National Drug Strategy's focus on harm minimisation be replaced by a focus on harm prevention and treatment of drug users.²
- 1.2 The government response to the *Road to recovery* report did not set a clear direction for drug policy, particularly with respect to illicit drug policy, and failed to address the damage inflicted on families.³ However the Prime Minister has taken a very strong stance and stated government policy in the following terms:

This government will never give up in the fight against drugs. We will never adopt a harm minimisation strategy; we will always maintain a zero tolerance approach.⁴

1 Parliament of Australia, House of Representatives Standing Committee on Family and Community Affairs, *Road to recovery: Report on the inquiry into substance abuse in Australian communities* (2003).

2 Parliament of Australia, House of Representatives Standing Committee on Family and Community Affairs, *Road to recovery: Report on the inquiry into substance abuse in Australian communities* (2003), p 297.

3 Australian Government, *Australian Government Response to the House of Representatives inquiry into substance abuse in Australian communities* (2006), viewed on 7 June 2007 at <http://www.aph.gov.au/house/committee/fca/subabuse/gresponse.pdf>.

4 Hon John Howard MP, Prime Minister of Australia, *House of Representatives Debates*, 16 August 2007, p 52.

- 1.3 This committee chose to re-examine some of the issues raised in *Road to recovery* in greater detail, limiting the focus to illicit drugs and the impact of their use on families. On 16 February 2005, the committee resolved to conduct an inquiry into the impact of illicit drug use on families.
- 1.4 The inquiry was launched on 8 February 2007, with the Chairman of the committee issuing a media release calling for public submissions. Advertisements calling for submissions were placed in *The Australian* in February 2007 and letters were sent to individuals, peak bodies and state and territory governments inviting them to make a submission to the inquiry.
- 1.5 A total of 188 submissions were received (see appendix D) and 66 exhibits were accepted as evidence (see appendix E). Submissions were received from all states and territories from groups and individuals residing in metropolitan and regional areas. Personal stories from families accounted for around 45 per cent of submissions.
- 1.6 To further involve the community in the inquiry, the committee held 18 public hearings between February 2007 and August 2007 (see appendix F).
- 1.7 Copies of the transcripts of the public hearings are available from the committee's website, as are copies of public submissions.⁵
- 1.8 By concentrating on families' experiences, the true consequences of illicit drug use are made stark, and a clear policy direction to better protect and assist families can be established. This can only support Australia's illicit drug policy in the wider sense, as families have repeatedly told this committee that there is nothing they would like more than for their family members to be drug free individuals.
- 1.9 Rhett Morris of treatment organisation Teen Challenge NSW said that:
- We deal with literally hundreds of families and we have dealt with thousands of families over 40 years. I am yet to see an auntie, uncle, mother, father, daughter, child—any family member—want anything but a complete 180 degree turnaround for a young person involved in a destructive lifestyle.⁶
- 1.10 There is emerging evidence that *any* illicit drug use does damage to a person's physical and mental health, especially during a young person's
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5 Transcripts of the public hearings may be found at <http://www.aph.gov.au/house/committee/fhs/illicitdrugs/hearings.htm>; submissions may be downloaded from <http://www.aph.gov.au/house/committee/fhs/illicitdrugs/subs.htm>.

6 Morris R, Teen Challenge NSW, transcript, 3 April 2007, p 106.

development. Addiction and dependence, which occur when users experience withdrawal when they stop using, leads to additional damage to users and their families.

- 1.11 While families know that extracting a person from addiction and a drug-influenced lifestyle is a long and difficult process, they want to give their family members ‘a real chance at a positive future rather than a future of monitored substance abuse.’⁷
- 1.12 As Louise Smith of parent organisation Toughlove told the committee:
- As parents we believe that our young people have endless potential and are not intrinsically bad. Unfortunately, due to the influences of our society and the increasing infiltration of drugs into our communities, our young people have fallen into bad situations... We are parents and we love our children. We never want to give up on them.⁸
- 1.13 This report highlights the destructive consequences of illicit drug use on families. The correct findings of *Road to recovery* also demonstrate that the conflicting agenda and mixed messages emerging from current drug policies and practices operating under the National Drug Strategy (NDS) are still happening. These mixed messages are present everywhere from the research being produced by government-funded drug research bodies to the advice communicated to drug users in counselling and treatment. This report emphasises a need for governments to promote a prevention-based approach to illicit drugs policy that is supported by abstinence-based treatment. The new Australian Government advertisement focussing on preventing ice addiction and the consequences of using is a strong, much-needed message.
- 1.14 The committee has concentrated on illicit drugs. This approach recognises that alcohol and tobacco are legal drugs, and individuals are generally free to decide for themselves about when, and how much, alcohol and tobacco they consume. The committee believes that while alcohol and tobacco continue to be legal, policies should be limited to reducing or discouraging high risk consumption. It recognises, however, that alcohol is often consumed in conjunction with illicit drugs and can sometimes magnify the damaging impact of illicit drug use.
- 1.15 It was suggested to the committee that as much, or more, harm is caused to the community by the misuse and abuse of alcohol and tobacco than by

7 Morris R, Teen Challenge NSW, transcript, 3 April 2007, p 106.

8 Smith L, Toughlove NSW, transcript, 3 April 2007, pp 2-3.

illicit drugs.⁹ This argument is sometimes used by those who advocate decriminalising or legalising illicit drugs and leads to a mixing of language where illicit drugs are ‘misused’ or ‘abused’. **It should be clear that all use of illicit drugs is misuse and abuse.**

- 1.16 Any policy statement that can be interpreted as suggesting that illicit drugs can be used safely needs to be re-stated to make it clear that illicit drug use is both illegal and damaging.

Illicit drug use in Australia

- 1.17 The proportion of the population using illicit drugs is generally used as a measure of the prevalence of drug use in the community. Surveys of drug use in Australia and overseas have usually covered the population aged 15–64 years as drug use generally occurs during these years. In 2004, more than 2.5 million Australians (15.3 per cent of the population aged 15–64 years) had used an illicit drug in the last 12 months.¹⁰
- 1.18 The percentage of the population aged 15–64 years who have used an illicit drug in the past 12 months has dropped from a level of 22 per cent in 1998 to 15 per cent in 2004. The rate of cannabis use has fallen from an all-time high of 18 per cent in 1998 to 11 per cent in 2004. Heroin use dropped from 0.8 per cent of people aged 15–64 years in 1998 to 0.2 per cent in 2004.¹¹
- 1.19 These statistics show the importance of an intensive television-focused, backed up by other media, negative advertising campaign. Such a campaign against all illicit drugs, not just ice, is needed. To concentrate on ice in isolation can by implication send the wrong message to users of other illicit drugs, that is, that they are somehow acceptable to use.

9 Voice, submission 46, p 3; Western Australian Government Drug and Alcohol Office, submission 82, pp 1, 3; MacQueen R, submission 92, pp 2–3; Victorian Alcohol and Drug Association, submission 100, p 6; Australian Institute of Family Studies, submission 103, p 1; Odyssey House Victoria, submission 111, pp 2, 10; Australian Drug Foundation, submission 118, p 2; Royal Australasian College of Physicians, submission 119, pp 6, 7, 8, 14; Australian Nursing Federation, submission 125, p 2; Australian Psychological Society, submission 131, pp 3, 5; WANADA, submission 138, pp 2, 3; Relationships Australia, submission 143, p 2; Families Australia, submission 152, p 5, 10.

10 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 33.

11 Hon John Howard MP, Prime Minister of Australia, *House of Representatives Debates*, 16 August 2007, p 52.

1.20 While Australia is ranked one of the lowest of all countries in the OECD in terms of tobacco smoking, we have one of the highest rates of illicit drug use in the world (table 1.1), particularly with respect to ecstasy and amphetamines.¹²

Table 1.1 Prevalence of substance use, population aged 15–64 years, selected countries, 2004 (per cent)

Country	Cannabis	Ecstasy	Amphetamine	Cocaine	Opiates
Australia	13.3	4.0	3.8	1.2	0.5
New Zealand	13.4 (-3)	2.2 (-3)	3.4 (-3)	0.5 (-3)	0.5 (-3)
USA	12.6	1.0	1.5	2.8	0.6 (-4)
Canada (a)	16.8	1.1	0.8	2.3	0.4 (-4)
United Kingdom	n.a	n.a	n.a	n.a	0.9 (-3)
England and Wales(c)	10.8 (d)	2.0 (d)	1.5 (d)	2.4 (-1)	n.a
Scotland(c)	7.9 (-1)	1.7 (-1)	1.4 (-1)	1.4 (-1)	n.a
Northern Ireland	5.4 (-1)(b)	1.6 (-1)	0.8 (-1)	0.4 (-1)	n.a
Sweden	2.2	0.4 (-1)	0.2 (-4)	0.2 (-1)	0.1 (-3)
Netherlands	6.1 (-3)	1.5 (-3)	0.6 (-3)	1.1 (-3)	0.3 (-3)
Germany (e)	6.9 (-1)	0.8 (-1)	0.9 (-1)	1.0 (-1)	0.3 (-1)

Note (-1), (-2), (-3), (-4) data from 1, 2, 3 or 4 years previous. (a) Data on opioid prevalence in Canada relate to those aged 18 years and over. (b) For the period 2002–03. (c) All data for Scotland, England and Wales relate to those aged 16–59 years. (d) For the period 2003–04. (e) All data for Germany relate to those aged 18–59 years.

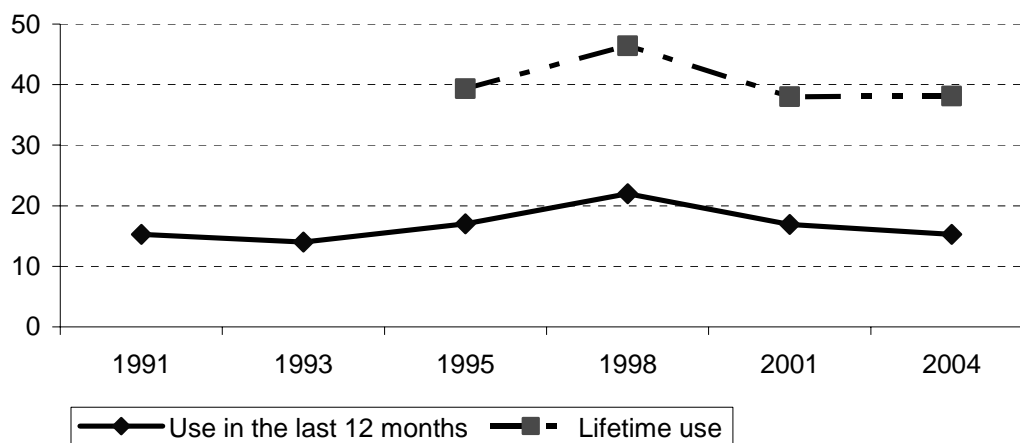
Source Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006 (2007)*, cat no PHE 80, p 24; United Nations Office on Drugs and Crime, *World Drug Report 2006, Volume 2: Statistics (2007)*, pp 383–390.

1.21 A committed government and community campaign against smoking since the 1970s has restricted the availability and visibility of tobacco and transformed attitudes about its acceptability, with impressive results and public health savings. Meanwhile, in the absence of an unequivocal policy direction for illicit drugs, there has been little variation over the past 15 years in the share of the Australian population using illicit drugs (figure 1.1).

1.22 There is a need for a full campaign against illicit drugs which has the same intensity as that which campaigns against tobacco.

12 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006 (2007)*, cat no PHE 80, pp viii, 10.

Figure 1.1 Proportion of Australian population aged 14 to 64 years who have used any illicit drug, 1991 to 2004 (per cent)



Note *Illicit drugs includes illegal drugs as well as steroids and barbiturates for non-medical purposes and methadone for non-maintenance purposes.*

Source *Australian Institute of Health and Welfare, Statistics on drug use in Australia 2006 (2007), cat no PHE 80, p 24.*

1.23 Illicit drugs act on the central nervous system, affecting mood, behaviour, sensory processing, concentration, and physical coordination. Continued or intensive use causes deterioration in physical, mental and emotional health and premature death. Users who become addicted abandon their previous lifestyles, interests, dreams and ambitions.

1.24 The negative effects of illicit drug use are not limited to individuals, but spiral outwards into the community. Illicit drug use imposes significant costs to the Australian economy and community. These costs were recently estimated to be at least \$6.7 billion in 2003,¹³ and include:

- increased criminal activity associated with illicit drug trade and consumption;
- public health care costs, and public health risks associated with infection and other risk-taking behaviours;
- costs to the welfare and health systems of supporting and treating drug users;
- road trauma;
- workplace safety (particularly in health care industries);

13 Australian Drug Law Reform Foundation, *The three billion \$ question for Australian business* (2007), p 8.

- decreased productivity through absenteeism, withdrawal from workforce and impacts on workplace efficiency; and
 - the diversion of resources into illicit activities.
- 1.25 Less tangible, but by no means less substantial, are costs such as perceptions of public safety, and reduced social cohesion and trust.
- 1.26 Each drug user has a family which also bears the costs of illicit drug use.¹⁴ Families are dealing with the daily stresses and problems of a drug user while trying to live their own lives in the community and protect the well-being and safety of the family unit. Drug use by a family member has the potential to cause significant collateral damage to others in the family, including children, parents, grandparents and siblings.
- 1.27 The impacts can vary depending on who in the family is using and the stage of their addiction. While families offer 'protective' factors that provide defences against using illicit drugs, family environments where illicit drugs are used can also create risks for children, including neglect, domestic violence, sexual abuse, long-term effects on stability and education, and in extreme cases, death.
- 1.28 Families face a litany of personal and social impacts as a result of others' drug use. Beyond the initial shock of discovering that a family member is using illicit drugs, families move through cycles of grief, stress, and frustration, often responding to community censure by withdrawing from social contact. Many report that the dynamics of the whole family, including extended family, are affected. Some family members experience violence from users who may be under the influence of drug-induced psychoses, and become fearful for their safety in their own homes (box 1.1). As a parent from Toughlove told the committee, 'drugs take over and it is the drug that the parent is talking to, not the young person'.¹⁵

14 Families Australia, submission 151, p 9.

15 Smith L, Toughlove NSW, transcript, 3 April 2007, p 3.

Box 1.1 Violence related to illicit drug use — A step father's story

I started to get very concerned because Andrew turned around to someone who was parked next to us and started to get aggressive towards him. When the mental health counsellor came out, he did a stupid thing. He stood in front of Andrew, which you never do. You always stand to the side. Andrew is six foot six, and Andrew went berserk. He was flailing his hands around. If Andrew had connected with him, he would have broken his neck. He went away, and all of a sudden we had seven police officers around. It took the seven police officers, one ambulance driver and one of the security guards to pin him down and get the handcuffs on. It was the most terrifying thing. I had never seen this aggression before. He was then admitted as an involuntary patient. They had a lot of problems with Andrew. He refused drug screening. That is the biggest problem.

... At 5.30 on the Saturday morning, I got a call from the detective at Manly police asking if I was Andrew's stepfather. I said, 'Yes.' Andrew had been arrested at two o'clock in the morning. He had severely assaulted two of the other residents in the boarding place where he was staying. He went absolutely berserk.

Source Mercer I, transcript, 30 May 2007, pp 8–9.

- 1.29 Unsurprisingly, one family member's illicit drug use can often be the underlying cause of another's health problems. Many report that they have needed counselling and treatment themselves to cope with depression and anxiety, or that they have developed chronic health conditions through failing to pay attention to their own health needs. The committee heard examples of where siblings also become drug users: a mother in Western Australia told the committee that four of her five children had been addicted to illicit drugs; once one of them had started using, the 'family morality' broke down and 'the other children then saw it as being an okay thing to do.'¹⁶
- 1.30 The financial costs to families can also be significant, with theft and property damage a common experience, as well as continual requests by users for loans to cover drug expenses and debts. Treatment, rehabilitation, and legal fees can mount into thousands of dollars. Families with a small business may find themselves unable to give it the necessary attention and focus, and others stop working or reduce working hours to look after the drug user or cope with their own problems. A family's ability to earn income, take holidays and save for or enjoy retirement, is thus affected. Illicit drug use presents tremendous opportunity costs to users and their families.

¹⁶ Harris S, transcript, 14 March 2007, p 63.

- 1.31 Families bear these costs because they love the person using and hate the drug and what it does to them.¹⁷ One user described drug use as ‘a taunting, scary and life threatening journey’.¹⁸ As drug use progressively alienates a user from their friendships and networks, family members may become the only ones concerned for the health and wellbeing of that person. Families have the greatest interest in seeing their loved one overcome illicit drug use and be free and healthy to pursue their life goals and responsibilities.
- 1.32 At the launch of the National Illicit Drugs Campaign in 2001, the Prime Minister stated:
- I’m quite unashamed in my view that our strongest defence against the drug problem are families. Properly functioning, stable, united loving families, whatever their composition, are still the best antidote against most of society’s ills.¹⁹
- 1.33 The committee would like to thank those families who told their personal stories about how illicit drugs have affected them. Members have been profoundly impressed by their strength and determination. It is important that their stories are shared, and that families are acknowledged as significant stakeholders in illicit drug policy.

Keeping up the war on drugs

- 1.34 A significant amount of damage to families and the community has been avoided by the government’s uncompromising approach to the trafficking and use of illicit drugs. Drug industry elites who have repeatedly claimed that the ‘war on drugs’ has failed are simply wrong. The drug industry elites, comprising a range of peak drug bodies, academics and service providers, receive considerable government support to promote, evaluate and deliver drug education and treatment policies and services. In 2005-06, selected peak non-government agencies heavily involved in promoting, researching or developing harm minimisation responses to

17 Van Damme I, Elements of patho-physiology of drug addiction and related consequences. Presentation to Drug Free Australia Conference ‘Exposing the Reality’ Adelaide, 27 April 2007, p 26.

18 Nikolaidis G, attachment to Australian Drug Treatment and Rehabilitation Programme Inc, submission 132, p 31.

19 Hon John Howard MP, Prime Minister of Australia, Launch of the National Illicit Drugs Campaign, Ermington Community Centre, Sydney, 25 March 2001.

illicit drugs received significant funding from the Australian and state and territory governments:

- Australian National Council on Drugs — \$1.1 million.²⁰ Was established to provide independent advice to the Prime Minister, Australian Government Ministers and Ministers on the Ministerial Council on Drug Strategy on national drug strategies, policies, programmes and emerging issues. Key people on the council include Dr John Herron (Chair), Commissioner Mick Keelty (Deputy Chair), Associate Professor Robert Ali, Professor Margaret Hamilton and Garth Popple (Executive Members);²¹
- Alcohol and other Drugs Council of Australia — \$0.9 million.²² Publicly supports ‘harm minimisation’ and maintains a register of harm minimisation supporters on its website. Key people on the council include Professor Robin Room (President) and Professor Wayne Hall (Vice President);²³ and
- Australian Drug Foundation — \$1.9 million.²⁴ Focuses on alcohol use by people under 30, but also provides education resources on cannabis and other illicit drugs. The foundation describes itself as having a ‘prevention agenda’ delivered on a platform of harm minimisation. The CEO of the foundation is Bill Stronach.²⁵

1.35 The Australian Federal Police (AFP) and its partners have been highly successful in limiting the damage of illicit drugs in Australia. The number and weight of detections for selected illicit drugs are generally higher than before 2000, although there has been substantial variation from year to year in both the number and weight of seizures of different illicit drugs (figure 1.2).

20 Australian National Council on Drugs, *Annual Report 2005-2006* (2006), p 64.

21 Australian National Council on Drugs, ‘About ANCD’, viewed on 23 August 2007 at <http://www.ancd.org.au/about/members/index.htm>.

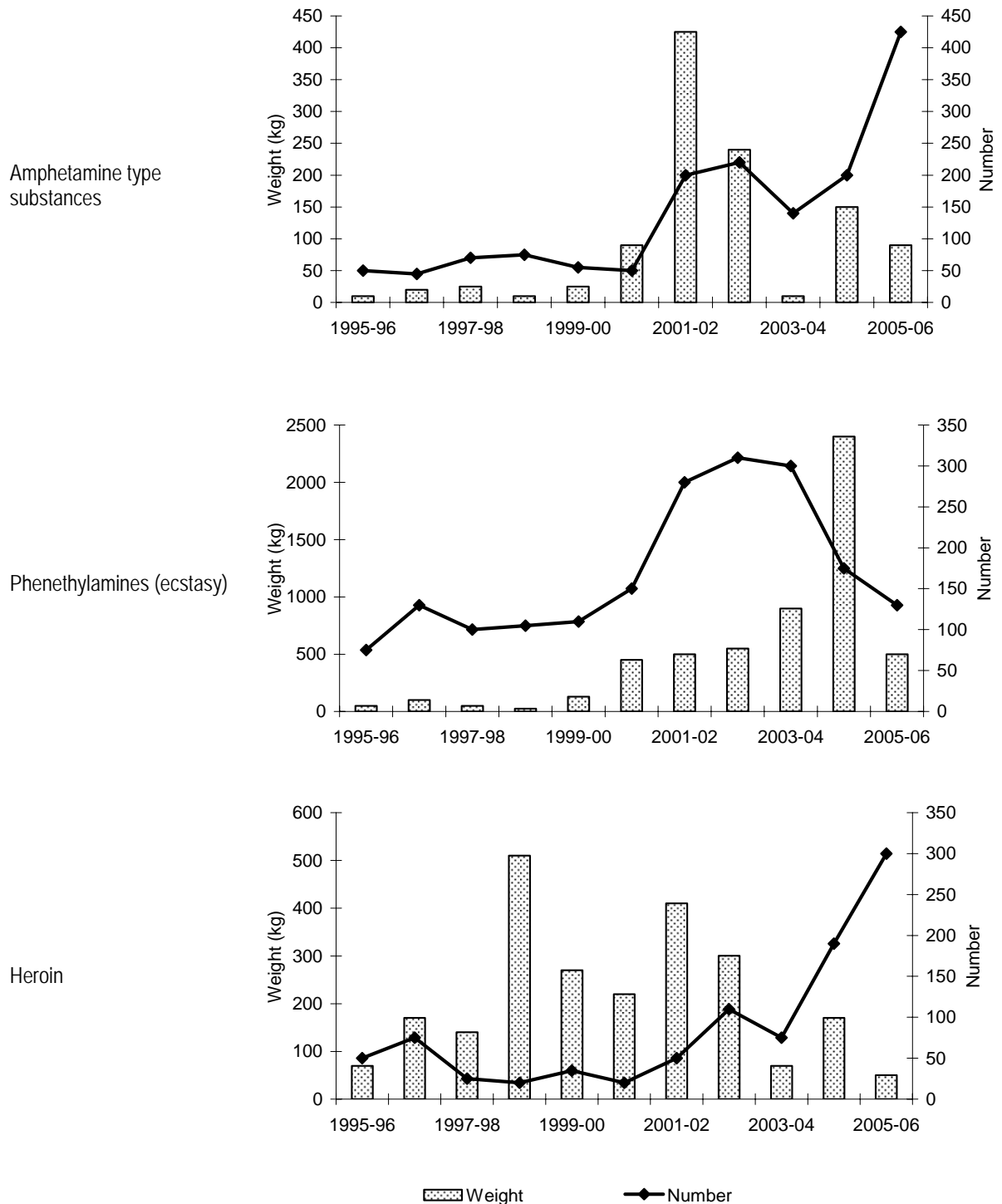
22 Alcohol and other Drugs Council of Australia, *Annual Report 2005-2006* (2006), p 40.

23 Alcohol and other Drugs Council of Australia, ‘About ADCA’, viewed on 23 August 2007 at <http://www.adca.org.au/whoweare/index.htm>.

24 Australian Drug Foundation, *Audited financial statements 2006* (2006), p 8.

25 Australian Drug Foundation, ‘About us: Our principles’, viewed on 23 August 2007 at <http://www.adf.org.au/browse.asp?ContainerID=principles>.

Figure 1.2 Number and weight of detections of selected illicit drugs at the Australian border, 1995-96 to 2005-06

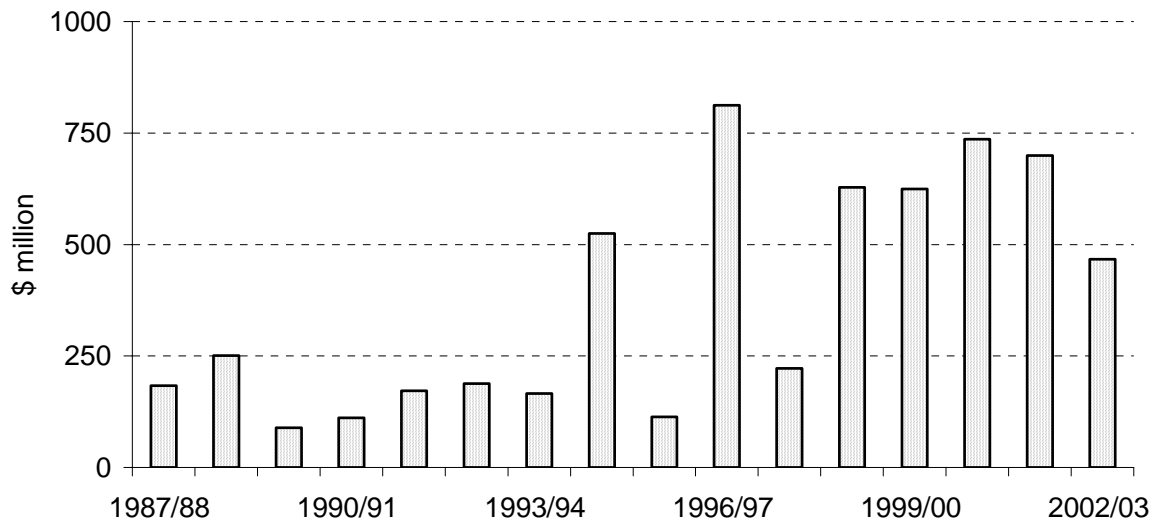


Source Australian Crime Commission, *Illicit drug data report 2005-06 (2007)*, pp 12, 25 and 43.

1.36 These detections represent a vast number of street doses of illicit drugs that would otherwise have found their way into the community. Research conducted by the AFP has found that more than \$5 billion of harm was

avoided through policing activity between 1999 and 2003 (figure 1.3). These calculations represent both tangible and intangible costs to the community, such as labour costs, health care, road accidents, crime, loss of life, pain and suffering.

Figure 1.3 Australian Federal Police Drug Harm Index, 1987–2003 (\$ million)



Source *McFadden M, 'The Australian Federal Police Drug Harm Index: A New Methodology for Quantifying Success in Combating Drug Use', Australian Journal of Public Administration (2006), vol 65 no 4, pp 68–81.*

1.37 Nevertheless, law enforcement agencies will continue to be challenged by criminals who seek to make money by trafficking illicit drugs to, or within, Australia. Some key developments in the international production and supply of illicit drugs noted by the Australian Crime Commission that could potentially impact on Australian drug markets include:

- amphetamines — the global shift towards 'amphetamine-type substances' (ATS) continues, with an increasing trend towards the use and production of crystal methylamphetamine (also known as 'ice'). Globally, methylamphetamine production is most prevalent in North America and in East and South East Asia. Criminal syndicates remain adaptive to law enforcement operations and continue to explore varying methods of obtaining precursor chemicals, including the diversion of chemicals from legitimate businesses;
- phenethylamines (MDMA or ecstasy) — the discovery of a large MDMA (methylenedioxy-methylamphetamine) and ATS laboratory in Indonesia in November 2005 highlighted the continuing presence of large-scale MDMA production facilities in South East Asia. MDMA

trafficking syndicates are continuing in their attempts to avoid detection by shipping MDMA in powder and liquid forms;

- heroin — the primary source of heroin imported into Australia was the Golden Triangle region of South East Asia. However, some domestic seizures indicate that Australia may also be developing as a target for Afghan heroin. Opium production in the Golden Triangle remained in decline with national eradication plans continuing in Myanmar and Laos; and
- cocaine — Colombia remains the primary global supplier of cocaine, followed by Peru and Bolivia. It is likely that syndicates will continue to target Australia through established staging points in Africa and Asia. While some larger shipments may be detected, it is likely that seizures will continue to be in the small to medium range via air passengers and the postal stream.²⁶

1.38 Given the challenge posed by increasingly globalised drug production and transportation networks, continued effective law enforcement is essential. As the AFP's Drug Harm Index (DHI) has articulated, every kilogram of cannabis, amphetamines, ecstasy, heroin and other drugs that is prevented from reaching our streets represents a saving to our community in drug-related harm. For example, the most recent version of the DHI estimated that keeping one kilogram of MDMA off the streets saves the community \$280,000 and keeping one kilogram of heroin off the streets saves \$550,000.²⁷

Recommendation 1

1.39 **The Commonwealth Government continue its allocation of significant resources to policing activity as a highly effective prevention method.**

Preventing damage to families

1.40 Despite progress with the Government's 'Tough on Drugs' strategy, more is needed to prevent damage to families. A policy framework more firmly based on prevention would send the message to the community that the

26 Australian Crime Commission, *Illicit drug data report 2005-06* (2007), pp 10–11, 25, 42, 52.

27 Phelan M, Australian Federal Police, transcript, 9 May 2007, p 1; Australian Federal Police, correspondence, 9 August 2007.

use of illicit drugs is wrong and that there is help for people to get off drugs permanently.

- 1.41 To foster prevention efforts in Australia, there needs to be a long-term community campaign at the forefront of government efforts. As with the 1987 'grim reaper' campaign against HIV/AIDS, this campaign needs to be confrontational in describing the effects of drugs on a person's physical appearance and attractiveness, physical and mental health, and other people, like families, who are damaged in the process. The new 'ice' advertisements are a good start.
- 1.42 As an example of kind of messages that are needed, the committee notes the 'Crackdown on Drugs' print, television and radio advertising campaign launched by the London Metropolitan Police Service in 2004. The campaign featured actual photographs of methamphetamine and heroin users to illustrate how their physical appearance deteriorates dramatically over time. The campaign aimed to make the link between the devastating effect of drugs on individuals and the deterioration of whole communities.²⁸
- 1.43 Using electronic media and information material, the campaign that the committee proposes would:
- counter the widespread belief that illicit drugs can be used safely;
 - overcome the sense of curiosity that leads most children to first experiment with illicit drugs; and
 - help parents communicate to their children the dangers of using illicit drugs.
- 1.44 In the course of public hearings for this inquiry, many witnesses supported the concept of such a campaign, including the Federal Commissioner of Police, the Western Australian Government Drug and Alcohol Office, Families Australia, Drug Free Australia and the Hon Ann Bressington MLC (South Australia), of the Australian Drug Treatment and Rehabilitation Foundation.²⁹

28 London Metropolitan Police website, viewed on 26 July 2007 at <http://www.met.police.uk/drugs/advertising.htm>.

29 Keelty M, Australian Federal Police, transcript, 14 March 2007, pp 13-14; Murphy T, transcript, 14 March 2007, p 7; Babington B, Families Australia, transcript, 28 March 2007, p 18; Thompson C, Drug Free Australia, transcript, 28 May 2007, p 15; Bressington A, transcript, 23 May 2007, p 21; see also Name withheld, submission 106, p 1; Ravesi-Pasche A, submission 47, p 7; Gawler I, submission 64, p 4; Endeavour Forum, submission 22, p 1.

- 1.45 Families also need to be able to access the support they need, when they need it, both for themselves and for the illicit drug user they are trying to assist. Delays in accessing services can result in users not being able to take advantage of the windows of opportunity that sometimes present themselves during the course of their addiction. A well advertised national telephone referral and advice service, similar to the Carelink hotline provided for aged care services, will make it easier for families to access appropriate services and get the advice they need.
- 1.46 Within the treatment sector itself, there needs to be a better defined path from assessment, counselling, detoxification, rehabilitation and aftercare, with consistent messages given to drug users throughout. This inquiry has heard with regularity about counsellors, doctors and people in positions of trust encouraging users to ‘cut back to weekends’ or to use clean equipment, without suggesting that a commitment must be made to a drug-free lifestyle or offering help to achieve this.

Zero tolerance and the Swedish approach

- 1.47 The Commonwealth Government has a zero tolerance approach to illicit drugs. The Prime Minister has publicly stated that:

I can't see why we shouldn't have a completely zero tolerance, uncompromising approach to illicit drug taking. There is no safe level of marijuana use, there is no safe level of the use of any kind of illicit drugs and the clearer that message can be communicated the better.³⁰

- 1.48 The Prime Minister recently re-stated the Government's policy to the federal parliament:

This government will never give up in the fight against drugs. We will never adopt a harm minimisation strategy; we will always maintain a zero tolerance approach.³¹

- 1.49 Two senior government ministers, the Federal Treasurer, Hon Peter Costello MP, and the Minister for Ageing, Hon Christopher Pyne MP,

30 Hon John Howard MP, Prime Minister of Australia, Tough on Drugs Announcement, Carlisle, Perth, 3 February 2004.

31 Hon John Howard MP, Prime Minister of Australia, *House of Representatives Debates*, 16 August 2007, p 52.

have also stated the predominance of zero tolerance in Australia's illicit drug policy.³²

- 1.50 This message is undermined in the community by those who advocate for a harm minimisation or harm reduction approach, that merely seeks to reduce the harm arising from drug use without the goal of seeing each individual drug free.
- 1.51 The definition of harm minimisation adopted as part of the NDS does not make it clear that prevention-based strategies should be our first priority. In addition, the strategy does not make it clear that the aim is for drug-free individuals and that abstinence should be the goal of any treatment.
- 1.52 The zero tolerance approach to drug policy has been hindered by drug industry elites within Australia who advocate for treatment approaches that aim to reduce harm — but do not have the aim of enabling users to become drug free.
- 1.53 Drug industry elites benefit directly from the continuation of current approaches and expanding numbers of people in drug 'treatment' as well as research funding that is applied to finding the 'benefits' of harm minimisation approaches. Several drug industry elites are also associated with the push to legalise drug use under the name of 'drug policy reform', making the mixed messages from current approaches to drug policy even stronger.
- 1.54 The committee heard evidence that families are sometimes confused and confronted by the mixed messages resulting from harm minimisation policies. These families believe that having accessible abstinence-based treatment facilities available when people need them is a more appropriate response to illicit drug use. A requirement for illicit drug users to undergo mandatory treatment is clearly preferable to no treatment.³³ Such an approach ensures that users of illicit drugs get help and that members of the community get a stronger message about the illegality of these drugs.
- 1.55 The zero tolerance policy is also undermined by the commonly implied attitude in the media and everyday language that glamorises illicit drug use and encourages experimentation (for example, the use of terms such as 'party drugs', and the description of the 'recreational' use of illicit drugs). It is important that the language used to describe illicit drugs reinforces the view that illicit drug use is socially unacceptable.
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32 'AFL is too soft on drugs: ministers', *The Canberra Times*, 22 May 2007; Stafford A, 'HIV disaster on our doorstep', *The Age*, 3 May 2007.

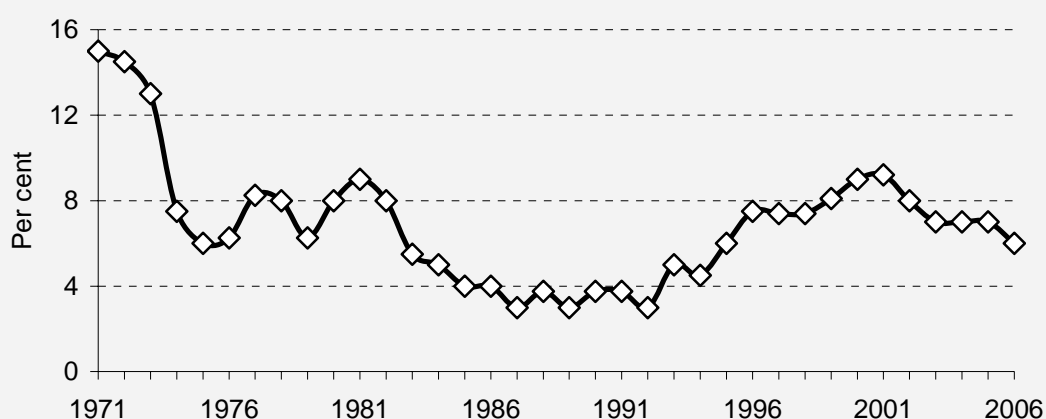
33 Homel R, transcript, 13 June 2007, p 21.

- 1.56 An alternative approach to our NDS is in place in Sweden. This emphasises a restrictive drug policy and provides early intervention and treatment. After a time of decriminalisation of illicit drugs to a system of prescription narcotics in the 1960s, Swedish policy reverted to criminalise all illicit drug use, and regards drug-free treatment as a priority measure in response to addiction.³⁴
- 1.57 As a result of this approach, drug use in Swedish society has been dramatically reduced over recent decades and is now very low relative to the rest of the European Union and other industrialised countries, both on measures of lifetime prevalence and regular use (box 1.2).

Box 1.2 Illicit drug use in Sweden

In 2003, the average level of lifetime prevalence of drug use amongst 15-16 year olds in Europe was 22 per cent. In Sweden it was eight per cent, falling to six per cent in 2006.

Figure Life time prevalence of drug use among 15–16 year old students in Sweden, 1971 to 2006 (per cent)



Source *United Nations Office on Drugs and Crime, Sweden's successful drug policy: A review of the evidence (2007), p 26.*

- 1.58 Maria Larsson, the Swedish Minister for Elderly Care and Infant Health, writes in the preface to a recent United Nations report that 'the Swedish vision is that drug abuse shall remain as a marginal phenomenon in the society... The vision is that of a society free from narcotic drugs... [and]

34 United Nations Office on Drugs and Crime, *Sweden's successful drug policy: A review of the evidence (2007)*, p 20.

preventive measures shall strengthen the determination and ability of the individual to refrain from drugs'.³⁵

- 1.59 This 2007 United Nations report, a review of Swedish drug policy and its outcomes, concluded that:

There has been criticism, and the vision of a drug free society that is guiding policy measures has, on occasion, been derided as 'unrealistic', 'not pragmatic' and 'unresponsive' to the needs of drug abusers... The ambitious goal of the drug-free society has been questioned not only outside the country but in Sweden itself, as a number of research papers on the subject attest.

Nevertheless, despite several reviews of expert commissions, the vision has not been found to be obsolete or misdirected. As shown in this report, the prevalence and incidence rates of drug abuse have fallen in Sweden while they have increased in most other European countries. It is perhaps that ambitious vision that has enabled Sweden to achieve this remarkable result.³⁶

35 United Nations Office on Drugs and Crime, *Sweden's successful drug policy: A review of the evidence* (2007), p 4.

36 United Nations Office on Drugs and Crime, *Sweden's successful drug policy: A review of the evidence* (2007), pp 51-52.

Illicit drugs in Australia

- 2.1 This chapter provides important background on the use of illicit drugs in Australia, and some of the broad effects that illicit drug use has on the community.

Illicit drug use and trends

- 2.2 The most comprehensive source of information about the prevalence of illicit drugs in Australia is the National Drug Strategy Household Survey, a general population survey conducted by the Australian Institute of Health and Welfare (AIHW). This survey, which includes a detailed questionnaire about licit and illicit drug use, was last carried out in 2004. The 2007 survey was being collected at the time of writing.¹ A companion survey, the Australian Secondary Students' Alcohol and Drug Survey, is carried out on a triennial basis and collects responses from 12-17 year olds in school environments.
- 2.3 The Illicit Drug Reporting System (IDRS), Australia's national illicit drug monitoring system, is another important source of information. The IDRS is conducted each year in every state and territory by participating research institutions throughout the country, and is coordinated by the National Drug and Alcohol Research Centre. It monitors the price, purity, availability and patterns of use of the main illicit drugs, as well as acting as an early warning system for emerging trends in illicit drug markets.²

1 Australian Institute of Health and Welfare website, viewed on 6 July 2007 at <http://www.aihw.gov.au/drugs/ndshs07.cfm>.

2 National Drug and Alcohol Research Centre website, viewed on 6 July 2007 at <http://www.med.unsw.edu.au/NDARCWeb.nsf/page/IDRSa>.

The related Ecstasy and Related Drugs Initiative (EDRS) monitors ecstasy, methamphetamine, cocaine, GHB and ketamine markets in Australia.³

- 2.4 Statistics on mortality, morbidity, including hospital separations, emergency department visits, overdoses, and contact with treatment or counselling services are valuable additional data on ways in which illicit drug use is made visible in our community.⁴
- 2.5 The AIHW agreed with the committee that the survey environment could influence results where drug use was self-reported, and stressed that drug policy in Australia needed to draw on all available data sources to build an accurate picture of what was happening:
- There is a bit of a debate in the survey world about whether school based surveys or household based surveys will give you the more correct information. I do not think there is a simple answer. What we like to encourage in this field is triangulation of these results.
- You have a result that comes from a household based survey. You have a result that comes from a school based survey. You have a result that comes with a batch of interviews with current injecting drug users, which again the centre in Sydney [the National Drug and Alcohol Research Centre] does. All of those three or four sources together are corroborating to give you a picture of the trends, patterns and issues.⁵
- 2.6 The available information sources suggest that illicit drugs are used by a significant minority of the Australian population. The 2004 National Drug Strategy Household Survey found that over 2.5 million people, or 15.3 per cent of Australians aged between 14 and 64 had used some type of illicit drug in the previous 12 months. Over six million people, or 38 per cent of Australians aged between 14 and 64 had tried an illicit drug in their lifetime.⁶
- 2.7 As noted in the introduction, Australia has one of the highest rates of illicit drug use in the world. Since the mid 1990s, the United Nations Office on Drugs and Crime (UNODC) has reported that the prevalence of drug use

3 National Drug and Alcohol Research Centre website, viewed on 6 July 2007 at <http://www.med.unsw.edu.au/NDARCWeb.nsf/page/EDRS>.

4 Degenhardt L and Dietze P, Turning Point Drug and Alcohol Centre, *Data sources on illicit drug use and harm in Australia* (2005), pp 10-13.

5 Cooper-Stanbury M, Australian Institute of Health and Welfare, transcript, 7 February 2007, p 8.

6 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey. Detailed findings* (2005), cat no PHE 66, p 33.

in Australia is higher than most developed countries for a range of illicit drugs, including cannabis, ecstasy and amphetamines (figure 2.1).

2.8 Most of the available data records prevalence of use against particular types of illicit drug. The Australian National Council on Drugs (ANCD) has noted:

The use of multiple (poly) substances is increasingly becoming the norm for illicit drug users in Australia, paralleling drug use patterns in the United States and elsewhere.⁷

2.9 Statistical information from various sources suggests use of multiple illicit substances by a substantial number of users. For example:

- Twenty-six per cent of cannabis users have used cannabis together with amphetamines, and 20 per cent have combined cannabis with ecstasy.⁸
- The vast majority (93 per cent) of the ecstasy users interviewed as part of the Party Drugs Initiative (now the Ecstasy and Related Drugs Reporting System) in 2005 reported that they usually used other drugs with ecstasy, and 83 per cent reported using other drugs with ecstasy to come down.⁹
- In a sample of Western Australian injecting drug users in 2006, there was not a single user who had exclusively used just one drug class out of heroin, methamphetamine, opiates or cannabis.¹⁰

2.10 The Queensland Alcohol and Drug Research and Education Centre, Cyrenian House, Odyssey House Victoria, and the Australian Institute of Family Studies also told the committee that polydrug use was common amongst their clients and research participants.¹¹

7 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 45.

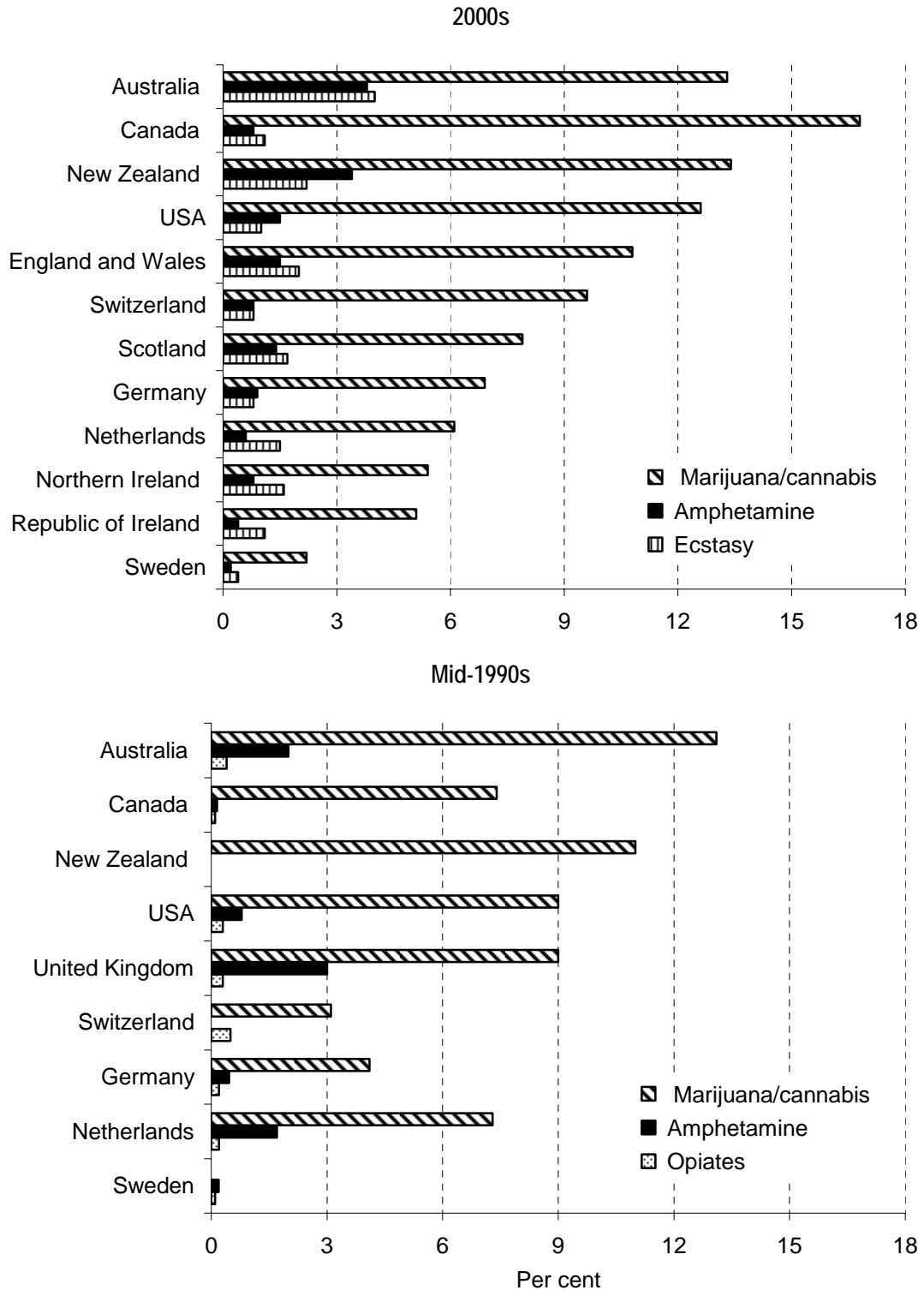
8 Copeland J et al, Australian National Council on Drugs, *Cannabis: Answers to your questions* (2006), p 7.

9 Stafford J et al, National Drug and Alcohol Research Centre, *Australian trends in ecstasy and related markets 2005: Findings from the Party Drugs Initiative* (2006), p 16.

10 Fetherston J and Lenton S, *WA Drug Trends 2006: Findings from the Illicit Drug Reporting System (IDRS)*, National Drug and Alcohol Research Centre Technical Report no 268, p ix.

11 Queensland Alcohol and Drug Research and Education Centre, submission 18, p 1; Cyrenian House, submission 110, p 3; Odyssey House Victoria, submission 111, p 4; Australian Institute of Family Studies, submission 103, p 2.

Figure 2.1 Prevalence of illicit drug use, selected countries (per cent)



Note Mid 2000s data were collected by countries between 2000 and 2004. Mid 1990s data were collected by countries between 1993 and 1997. Data for all countries and all drug types was not available for all years.

Source United Nations Office on Drugs and Crime, World Drug Report 2006 (2006), pp 383–390, United Nations Office for Drug Control and Crime Prevention, Global Illicit Drug Trends 1999 (1999), pp 120, 122, 123, 125.

- 2.11 As the National Drug Strategy (NDS) recognises, polydrug use is a significant contributor to drug-related deaths, illness and other problems, and presents challenges for health and law enforcement responses.¹² Combinations of drugs increase the risks of illicit drug use and the unpredictability of effects on the user, with subsequent implications for the user's family and friends.
- 2.12 Cyrenian House, a Perth treatment and rehabilitation organisation reports, for example, that:
- It is difficult to extract the specific drug-using behaviour from the equation. Most of our clients would identify as polydrug users and as such it is often difficult to ascertain which drug might be responsible for the impact on families.¹³
- 2.13 In considering statistics about illicit drug use in Australia, it is also important to consider that there are large variations across jurisdictions in prevalence of use, and in price, availability and purity in drug markets.¹⁴
- 2.14 In 2004, for example, the Northern Territory had the highest rate of recent cannabis use in Australia, which at 20.9 per cent of the population aged 14 years and over was double the rate of New South Wales and Victoria. The Australian Capital Territory and Western Australia had the highest rates of ecstasy use in the nation, at 6.0 and 4.1 per cent respectively, against the lowest, Tasmania, at 1.6 per cent.¹⁵
- 2.15 Some of these differences may be partly due to the demographic characteristics of each jurisdiction. For example, the national proportion of the population aged between 14 and 25 in 2006 was 13.9 per cent, compared to 16.2 per cent in the Australian Capital Territory, 15.4 per cent in the Northern Territory and 13.3 per cent in Tasmania.¹⁶
- 2.16 The following sections examine illicit drug use in further detail, with reference to international comparisons and domestic trends within Australia.

12 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004-2009* (2004), p 15.

13 Cyrenian House, submission 110, p 3.

14 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach* (2002), p 3.

15 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: State and territory supplement* (2005), cat no PHE 61, p 7.

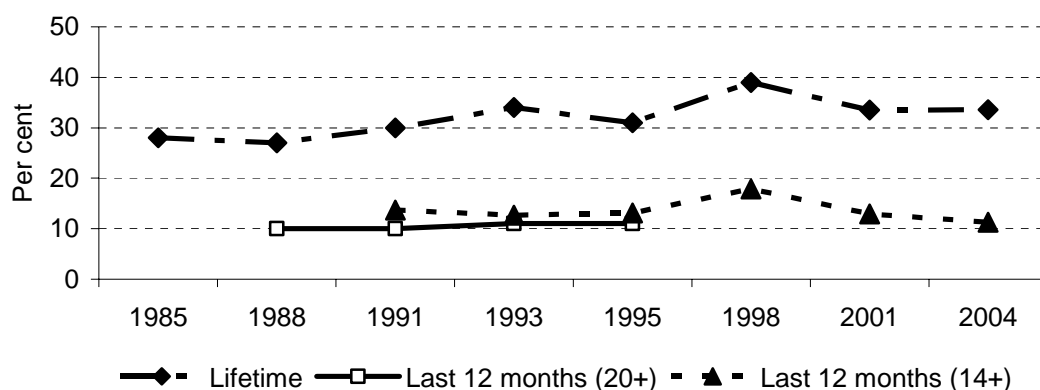
16 Australian Bureau of Statistics, *Australian Demographic Statistics* (2006), cat no 3101.0, p 33.

Cannabis

2.17 The most commonly used illicit drug in Australia, as in most other countries, is cannabis, a drug given a soft reputation which is perpetuated by the drug industry elite.¹⁷ In 2004, nearly 34 per cent of Australians reported having used it at least once in their lifetime.¹⁸ Eleven per cent of Australians had used cannabis in the last 12 months, including almost one in five teenagers.¹⁹ It is estimated that 200,000 Australian adults are dependent users and may experience withdrawal symptoms if they stop smoking cannabis.²⁰

2.18 Cannabis use declined by 37 per cent between 1998 and 2004 and use levels are now below those in 1991 (figure 2.2). Encouragingly, there has been a decline in the number of secondary school students who have used marijuana at least once in their lifetime. Lifetime use amongst 12-17 year olds dropped from 29 per cent in 1999 to 18 per cent in 2005.²¹

Figure 2.2 Lifetime and recent prevalence of cannabis use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985-95 (1998)*, p 34; *Australian Institute of Health and Welfare, Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.19 These results would appear to be consistent with the results of a survey of 1,439 Australians conducted by Pfizer Australia in 2006, which indicated changing community attitudes towards cannabis. Eighty-three per cent of those surveyed (and 78 per cent of under 30s) believed that there were

17 United Nations Office on Drugs and Crime, *World Drug Report 2007 (2007)*, p 30.

18 United Nations Office on Drugs and Crime, *World Drug Report 2007 (2007)*, p 119.

19 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey Detailed findings (2005)*, cat no PHE 66, pp 26-27.

20 Copeland J et al, Australian National Council on Drugs, *Cannabis: Answers to your questions (2006)*, p 7.

21 Australian Institute of Health and Welfare, *Statistics on Drug Use in Australia 2006 (2007)*, cat no PHE 80, p 49.

social problems associated with cannabis use.²² The National Drug Strategy Household Survey also found that between 1998 and 2004, support for legalisation of cannabis for personal use declined from 29.4 to 27 per cent. Amongst teenagers, support for legalisation declined from 36.9 to 23.6 per cent.²³ This is at odds with pro-marijuana stance of Dr Alex Wodak and the drug industry elite.

- 2.20 Nevertheless, cannabis use in Australia remains high relative to the rest of the world. According to the most recent report from the UNODC, only seven countries have a higher cannabis prevalence than Australia: Papua New Guinea, Micronesia, Ghana, Zambia, Canada, Cyprus and New Zealand.²⁴ This reinforces the need for a full campaign against *all* illicit drugs, including cannabis.

Heroin and other opiates

- 2.21 In 2004, 2.3 per cent of the Australian population had used heroin in their lifetime, and 0.3 per cent, equivalent to 56,300 people, had used heroin in the last 12 months.²⁵
- 2.22 Before the year 2000, Australia had one of the highest rates of heroin abuse in the world.²⁶ Heroin use appears to have stabilised and declined in recent years (figure 2.3).

22 Pfizer Australia, in partnership with the National Drug and Alcohol Research Centre, *Health report: Australians and cannabis* (2007), p 3.

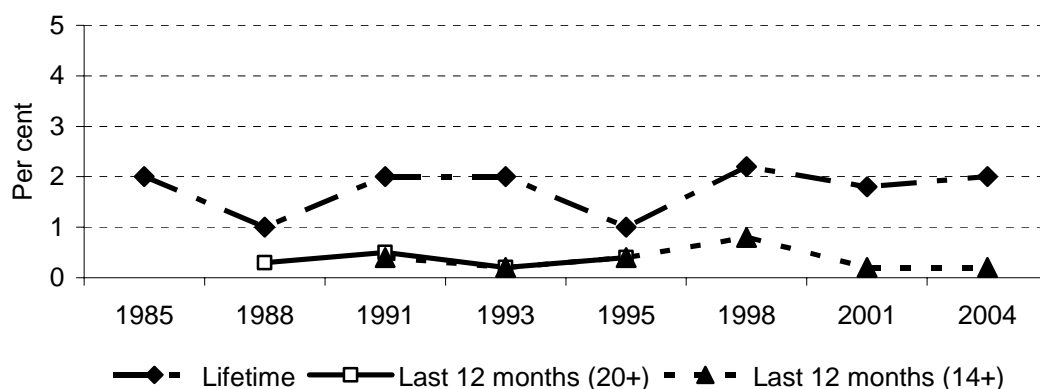
23 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 93; *2001 National Drug Strategy Household Survey: Detailed findings* (2002), cat no PHE 41, p 95, *1998 National Drug Strategy Household Survey: Detailed findings* (1999), cat no PHE 27, p 117.

24 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 244.

25 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, pp 28-29.

26 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 58.

Figure 2.3 Lifetime and recent prevalence of heroin use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95 (1998)*, p 44; *Australian Institute of Health and Welfare, Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.23 The decline in heroin use is widely attributed to a ‘heroin drought’ in Australia at the turn of the century which saw the availability and purity of heroin on the streets fall and prices rise. As described by Associate Professor John Fitzgerald and Tanya Swards of the University of Melbourne’s Department of Criminology:

In 2001, indicators suggested that there were substantial changes to the heroin supply in Australia. There has been widespread speculation about the causes and consequences of this change. Based more on speculation than stable time series analysis, the ‘heroin drought’ has variously been attributed to failing crops in the Golden Triangle, drought and floods in Afghanistan, the low value of the Australian dollar relative to other currencies, price inflation strategies by suppliers, and increased policing success in reducing supply both locally and overseas.²⁷

2.24 The UNODC rationalises the heroin drought as ‘prompted by the dismantling of some major heroin trafficking networks which had supplied the Australian market with heroin from South East Asia’.²⁸ The supply drought does indeed correlate with a sharp spike in heroin and other opiate seizures in Oceania by law enforcement authorities in 1999–2000.²⁹

27 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach (2002)*, p 2.

28 United Nations Office on Drugs and Crime, *World Drug Report 2006 (2006)*, vol 1, p 72.

29 United Nations Office on Drugs and Crime, *World Drug Report 2007 (2007)*, p 52.

- 2.25 Commissioner Mick Keelty of the Australian Federal Police has welcomed the United Nations' acknowledgement of the role of Australian and regional law enforcement in cutting down the supply of heroin:

Authority of analysis has found the shortage of heroin to be attributed, at least in part, to the success of law enforcement—and when I say 'law enforcement', I mean all of the law enforcement: the state police, our territory police, our Customs colleagues and the Australian Crime Commission—and to the strategy of the AFP to take the fight offshore and work with countries that are the source of the drugs coming to Australia.³⁰

- 2.26 The Drugs and Crime Prevention Committee of the Victorian Parliament also recounted a separate occasion in which Commissioner Keelty had posited some additional reasons why international drug syndicates may have decided to move from heroin production into amphetamine production. These included a larger potential market for amphetamines, higher profit margins, the ready availability of precursor chemicals in Asia and the vulnerability of opium crops to weather and satellite or other aerial surveillance.³¹

- 2.27 There are few signs of a heroin market recovery. The 2006 IDRS survey observed decreases in both the prevalence and frequency of use in most jurisdictions, to some of the lowest levels reported since the heroin drought.³²

- 2.28 Internationally, too, the trend in developed countries is for a stabilisation of opiate use, despite increasing opium production in Afghanistan. The UNODC noted that:

Despite the overall increase in the global supply of opiates there is an ongoing stabilisation, or slow-down, in most of the main consumer markets, including West and Central Europe, North America, East and South East Asia and the Oceania region.³³

- 2.29 Possibly, the decline in Australia is a product of heroin users switching to amphetamines or other drugs, or amplifying their use of other drugs when heroin was not available. The AIHW told the committee:

30 Keelty M, Australian Federal Police, transcript, 14 February 2007, p 8.

31 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into amphetamine and 'party drug' use in Victoria: Final report* (2004), p 45.

32 O'Brien S et al, National Drug and Alcohol Research Centre, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System* (2007), p xxiv.

33 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 37.

We are not seeing any resurgence of heroin since the shortage in 2001. You have to consider that most heroin users are already polydrug users—multiple drug users—so when heroin was unavailable they simply switched to something else. The reason why we have not seen a big increase in the use of, say, methamphetamine or ecstasy in the last two surveys is because we are not introducing any new users; it is just that heroin users are switching to these other drugs. So we are not necessarily generating a new group of users; we are just taking the polydrug users who have always told us about their ecstasy and amphetamine use and have not carried on with heroin.³⁴

- 2.30 This phenomenon of drug substitution was noted by many in the drug sector following the heroin drought, although some maintain that it masked what was already a burgeoning problem with amphetamine use in Australia.³⁵ In 2002, for example, the National Drug and Alcohol Research Centre reported that in Victoria, amphetamines and methamphetamines had become the drug of choice for a group who were previously primary heroin users, and that there was increasing availability of both of these drugs.³⁶ The ANCD's position paper on methamphetamines notes that:

An interesting recent phenomenon is the uptake of methamphetamine injection among heroin injectors in the wake of the 2001 Australian heroin shortage. This trend has occurred among both active heroin users and a proportion of people who are enrolled in opioid maintenance therapy. Transitions between methamphetamine and heroin injection are bi-directional and well documented in Australia.³⁷

- 2.31 The decline in heroin use may also be attributable to changing fashions in illicit drug use and perceptions of heroin as a 'dirty' drug associated with destitution and infection. A 2001 study of regular ecstasy users in Northern Ireland found that participants:

... distanced themselves from heroin users not only because of the 'dirty' nature of heroin but also because they associated heroin

34 Cooper-Stanbury M, Australian Institute of Health and Welfare, transcript, 7 February 2007, p 16.

35 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into amphetamine and 'party drug' use in Victoria: Final report* (2004), pp 45-49.

36 Fry C and Miller P, National Drug and Alcohol Research Centre, *Victorian drug trends 2001: Findings from the Illicit Drug Reporting System* (2002), p xi.

37 Australian National Council on Drugs, 'Methamphetamines: Position paper' (undated), p 4.

with injection. In other words, the negative perceptions were to do with both the content of the drug and the way in which it was used.³⁸

- 2.32 Alternatively, former and current heroin users may be increasingly substituting heroin for other opioids and other injectable drugs, including morphine, methadone, benzodiazepines and illicit oxycodone. In 2004, the prevalence of recent use of opiates that were not heroin was in fact equal to the rate of heroin use, at 0.2 per cent of adults. In the most recent IDRS survey, morphine was the most commonly injected pharmaceutical, and notable proportions of injecting drug users also reported oral and injecting use of diverted buprenorphine (Subutex).³⁹
- 2.33 The rate of recent use of illicit methadone was fully half that of heroin, at 0.1 per cent of adults, equivalent to approximately 17,000 Australians.⁴⁰ Despite tight controls, the illicit use of methadone remains common. In a recent survey of injecting drug users, 23 per cent of the national sample reported the use of illicit methadone syrup in the six months preceding interview, with the majority reporting the source as a take-away dose.⁴¹

Meth/amphetamines

- 2.34 Amphetamines are a group of synthetic stimulant drugs commonly known by a variety of street names, including 'speed', 'base', 'pure', 'meth', 'shabu', 'paste', 'crystal meth' and 'ice'. According to the Alcohol and Other Drugs Council of Australia (ADCA), most amphetamine available in Australia today is methamphetamine. Methamphetamine is a little different chemically to amphetamine but has similar effects, albeit more potent and longer lasting.⁴² Crystal methamphetamine or ice is the strongest form available with a high level of purity, and is increasing in use.⁴³
- 2.35 Australia has the second highest rate of meth/amphetamine use in the world, after the Philippines. Our annual prevalence rates are

38 Parliament of Victoria, Drugs and Crime Prevention Committee, *Inquiry into amphetamine and 'party drug' use in Victoria: Final report* (2004), p 122.

39 O'Brien S et al, National Drug and Alcohol Research Centre, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System* (2007), p xxvi.

40 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p 22.

41 O'Brien S et al, National Drug and Alcohol Research Centre, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System* (2007), p xxii.

42 Alcohol and Other Drugs Council of Australia, 'Amphetamine-type substances: Fact sheet' (undated), p 1.

43 Australian National Council on Drugs, 'Methamphetamines: Position paper' (undated), pp 1-2.

approximately one and a half times the rate of the United States, two and a half times the rate of the United Kingdom and 19 times that of Sweden.⁴⁴

- 2.36 As the ANCD has noted, the methamphetamine situation in Australia forms part of a broader trend toward increasing supply, use and problems caused by the drug across South East and East Asia. The Council describes a 'significant up-surge in problems' related to methamphetamine use since the late 1990s:

This increase in methamphetamine related problems is likely to be due to the culmination of several factors, including a growing number of long-term users of the drug, a shift from amphetamine to methamphetamine manufacture in the mid-1990s, and recent increases in the availability of high purity imported methamphetamine (i.e., crystal meth or ice).⁴⁵

- 2.37 Methamphetamines are the second most common illicit drug ever used by adult Australians, and the third most common in annual prevalence of use after cannabis and ecstasy.⁴⁶ In 2004, about 500,000 people, or 3.2 per cent of Australians aged 14 and over, had used meth/amphetamines for non-medical purposes in the last 12 months. Of 20-29 year olds, 10.7 per cent had used in the last 12 months, with over one in five (21.1 per cent) having used meth/amphetamines in their lifetime.⁴⁷

- 2.38 There has been a trend of increasing lifetime use of meth/amphetamines in Australia since the late 1990s (figure 2.4). Annual prevalence for this group of drugs as a whole appears to be gradually declining, although it is unclear whether this may be masking an increase in the use of crystal methamphetamine, the most dangerous form of methamphetamine.

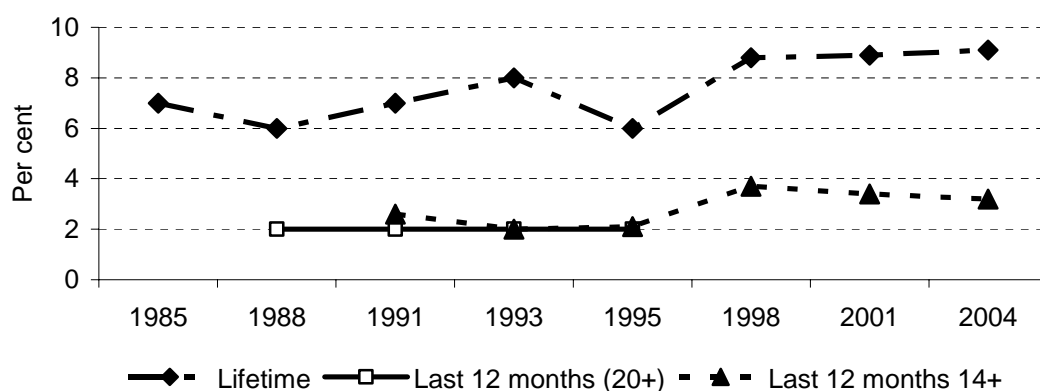
44 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), pp 151, 246.

45 Australian National Council on Drugs, 'Methamphetamines: Position paper' (undated), pp 1-2.

46 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p 21.

47 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 59.

Figure 2.4 Lifetime and recent prevalence of meth/amphetamine use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95 (1998)*, p 49; *Australian Institute of Health and Welfare, Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.39 Crystal methamphetamine has been the focus of much recent media coverage on an ‘ice epidemic’ in Australia. It is clear prevalence has reached ‘epidemic’ levels. Ice has attracted particular attention due to the effects of psychosis, paranoia and violence reported by emergency departments, doctors and police across the country.⁴⁸

2.40 Survey data reveals that the proportion of regular drug users who take ice has increased dramatically from less than a few per cent in the mid-to-late 1990s, to over one-third in 2004.⁴⁹ Also, the 2006 findings from the IDRS reported that prevalence of recent use of ice had increased to varying extents in all jurisdictions.

2.41 The results from the 2007 National Drug Strategy Household Survey may give a more accurate sense, however, the data it collects is for the meth/amphetamine group of drugs and not crystal methamphetamine specifically.

Ecstasy

2.42 Ecstasy is a common term for a range of hallucinogenic stimulants similar in structure to MDMA (methylenedioxymethylamphetamine). Statistically, ecstasy is sometimes grouped with amphetamines, cocaine and other drugs as ‘amphetamine-type stimulants’ (ATS), in recognition of

48 See, for example, Keene N, ‘Epidemic’s cold reality: Ice use could be worse than data suggests’, *Daily Telegraph*, 15 May 2007, p 12; Hart C, ‘Hospitals snowed under by ice storm’, *The Australian*, 2 April 2007, p 5; Munro I, ‘The ice age’, *The Age*, 24 February 2007, p 14; Stephens A, ‘Deadly new ice age: the insidious crystal methamphetamine has triggered a dangerous new drug crisis in Canberra’, *The Canberra Times*, 28 October 2006, p 1.

49 National Drug and Alcohol Research Centre, ‘Ice/Crystal: Fact sheet’ (undated) p 2.

the fact that pills sold as ecstasy are often 'cut' with a variety of substances and may in fact contain no MDMA at all. Pills often contain methamphetamine, and may also contain ketamine (an anaesthetic used primarily in veterinary surgery), chemicals like MDA, PMA or MDEA, and substances like caffeine or paracetamol.⁵⁰

- 2.43 Australian law enforcement authorities continue to confiscate large amounts of ecstasy, and in 2005, were responsible for 27 per cent of global seizures of ecstasy, the highest of any country.⁵¹ Regrettably, however, Australia also has the highest annual prevalence of ecstasy use of any country in the world, with a rate many times the multiple of the United States, the United Kingdom, Sweden, Norway and Canada, all of South America and all of South East Asia.⁵²
- 2.44 The UNODC's most recent report noted a decline in ecstasy use in established, developed world markets, and expressed an expectation that this would continue. There is no evidence to date that ecstasy use is declining in Australia, however.⁵³
- 2.45 In 2004, 3.4 per cent of Australians aged 14 years and over had used ecstasy in the last 12 months, and 7.5 per cent had used ecstasy in their lifetime. These represented the highest figures ever recorded by the National Drug Strategy Household Survey, continuing the upwards trend since 1995 (figure 2.5).⁵⁴

50 National Drug and Alcohol Research Centre, 'Ecstasy: Fact sheet' (undated), p 1. MDA refers to 3,4-methylenedioxyamphetamine; PMA refers to paramethoxyamphetamine; MDEA refers to 3,4-methylenedioxyethylamphetamine.

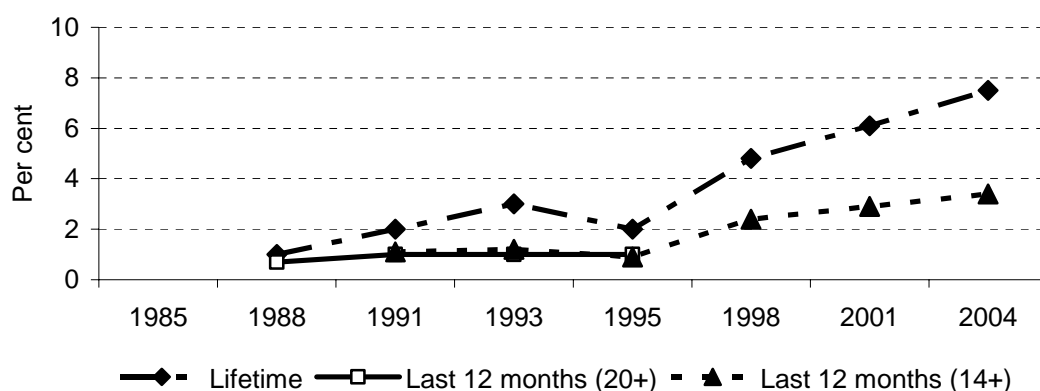
51 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 148. See also 'Customs border detection of ecstasy (MDMA) 1992-93 – 2001-02', in Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2002* (2003), cat no PHE 80, p 82.

52 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 248.

53 United Nations Office on Drugs and Crime, *World Drug Report 2007* (2007), p 36.

54 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p xi.

Figure 2.5 Lifetime and recent prevalence of ecstasy use, 1985 to 2004 (per cent)



Source Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95 (1998)*, p 61; Australian Institute of Health and Welfare, *Statistics on illicit drug use in Australia 2006 (2007)*, cat no PHE 80, p 24.

2.46 Amongst 20-29 year olds, 12 per cent had used ecstasy in the last twelve months and over one in five (22 per cent) had used the drug in their lifetime.⁵⁵ In the most recent survey of Australian secondary school students, 4.0 per cent of students aged 12-17 reported having used ecstasy.⁵⁶ These figures emphasise the need for a full anti-drug use campaign targeted at 12-29 year olds.

Other drugs

2.47 The 2004 National Drug Strategy Household Survey also reported on a number of other drugs. Of Australians aged 14 years and over, in the last 12 months:

- 1.0 per cent, or 169,400 had used cocaine;
- 0.7 per cent, or 116,400 had used hallucinogens, such as LSD or magic mushrooms;
- 0.3 per cent, or 45,000 had used ketamine; and
- 0.1 per cent, or 20,200 had used GHB (gamma-hydroxybutyrate, also known as 'fantasy').⁵⁷

55 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings (2005)*, cat no PHE 66, p 64.

56 White V and Hayman J, The Cancer Council Victoria and the Australian Government Department of Health and Ageing, *Australian secondary school students' use of over-the-counter and illicit substances in 2005 (2006)*, p 4.

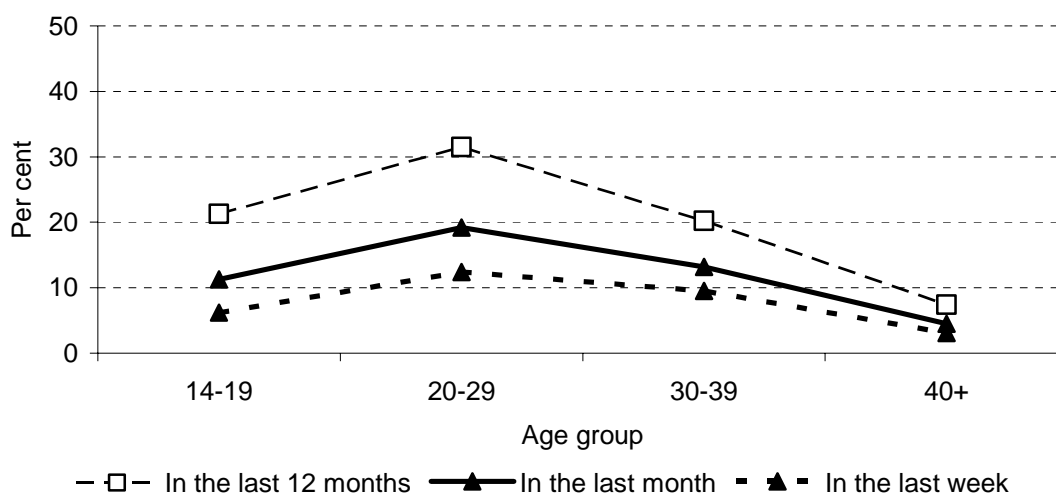
57 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings (2005)*, cat no PHE 66, pp 68, 69, 73.

2.48 One in 25 Australians had used pharmaceuticals for non-medical purposes in the last 12 months. These included painkillers/analgesics, tranquilisers/sleeping pills, barbiturates and steroids.⁵⁸

Characteristics of illicit drug users

2.49 The pattern of illicit drug use varies according to age, peaking when people are aged 20–29 (figure 2.6). The decline in the proportion of the population using illicit drugs after they turn 30 can be attributed to people ceasing their use of illicit drugs and also deaths associated with illicit drug use, as users generally have a lower life expectancy.⁵⁹

Figure 2.6 Use of any illicit drug, persons aged 14 years or older, by age, 2004 (per cent)



Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 33.

2.50 In 2004, the highest proportion of recent drug use across a number of different population subgroups was for people who were unemployed (31.7 per cent), more than twice the total population proportion for recent drug use (15.3 per cent). The lowest proportion of recent users for a subpopulation was for people who were retired or on a pension (5.4 per cent).⁶⁰

58 Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, pp 47-48.

59 Reece S, transcript, 3 April 2007, p 32.

60 Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 37.

- 2.51 A broad examination of some of the other subpopulations reveals that:
- a higher proportion of people who were most socioeconomically advantaged were recent users of illicit drugs (16.6 per cent) compared with the other socioeconomic groups;
 - a greater proportion of people from remote and very remote regions used illicit drugs in the last 12 months (19.0 per cent) than people from other regions; and
 - Indigenous people were almost twice as likely to be recent users of illicit drugs as other Australians (26.9 per cent versus 15.0 per cent) but there was no difference between these two subpopulations with regard to ex-users (22.9 per cent).⁶¹

Choosing to use or not use illicit drugs

- 2.52 People who use illicit drugs in their lifetime are influenced by a range of factors when they make the decision to first use an illicit drug. Some of the social and familial factors were examined in more detail in chapter six.
- 2.53 Regular surveys of illicit drug use in Australia have found that for those who had used an illicit drug in their lifetime, 'curiosity' was the most common factor which influenced their decision to use for the first time (table 2.1). Males and females generally cited similar factors influencing their first use of an illicit drug.
- 2.54 Notably, a relatively small and decreasing proportion of respondents to the survey in 2004 nominated problems with family and other relationships (5.4 per cent) or traumatic experiences (2.5 per cent) as a factor influencing their first use of an illicit drug.

61 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 37.

Table 2.1 Factors influencing first use of any illicit drug, lifetime users aged 14 years and older, by sex, 2001 to 2004

Factor	Males		Females		Persons	
	2001	2004	2001	2004	2001	2004
Curiosity	81.9	77.5	83.0	76.4	82.4	77.0
Peer pressure	54.8	52.7	54.5	56.7	54.7	54.5
To do something exciting	21.6	19.5	22.9	22.0	22.2	20.7
To enhance an experience	na	12.2	na	11.7	na	12.0
To take a risk	9.9	8.4	11.1	10.3	10.4	9.3
To feel better	8.0	5.0	9.8	7.1	8.8	5.9
Family, relationship, work or school problems	6.2	4.3	8.8	6.7	7.4	5.4
Other	2.2	3.3	4.1	3.4	3.0	3.3
Traumatic experience	3.1	1.6	5.1	3.5	4.0	2.5
To lose weight	na	0.5	na	2.1	na	1.2

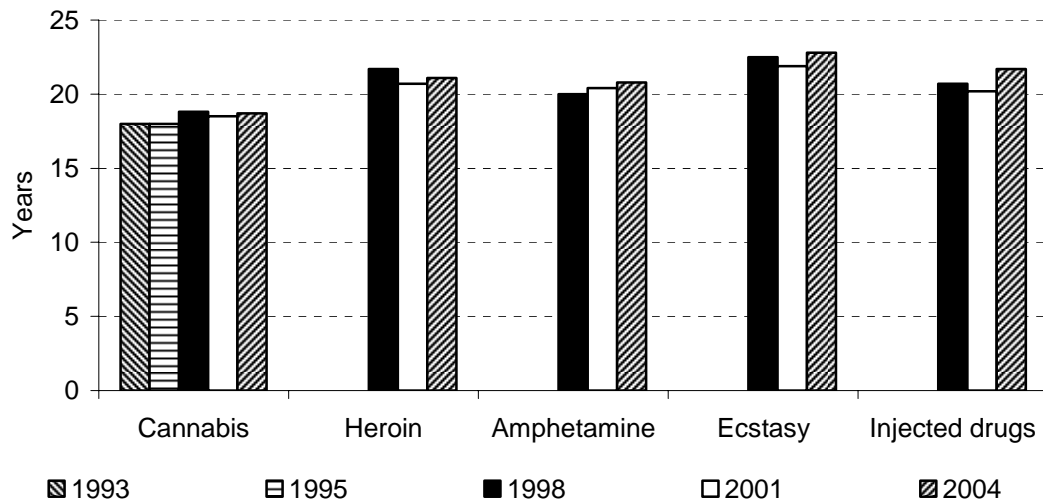
Note na = Not available. Base is those who had ever used an illicit drug. Respondents could select more than one response.

Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 37; 2001 National Drug Strategy Household Survey: Detailed findings (2002), cat no PHE 41, p 40.

- 2.55 The age at which people start using an illicit drug is important because it provides a marker for the age at which anti-drug education should begin. Anti-drug education that commences prior to initiation may be counterproductive, by stimulating experimentation. Equally, if education programs begin after use has commenced, they could be much less effective. A second reason for examining age of initiation is that those who start using a drug at a young age usually report heavier and more extended use later in life.⁶²
- 2.56 The average age of initiation for first trying illicit drugs has remained largely unchanged based on national surveys over the past decade for a number of different illicit drugs (figure 2.7).
- 2.57 While the above results relate to the general population, the average age of initiation for different parts of the population may be lower. An analysis of data from the Drug Use Monitoring in Australia (DUMA) survey, which relates to people who have been brought to selected police stations on a wide variety of charges, indicates that not only do offenders have a lower age of initiation across a range of illicit drugs than the general population, but that also the average age of initiation for offenders is lower for some illicit drugs (figure 2.8).

62 Makkai T and McAllister I, *Patterns of drug use in Australia 1985–95* (1998), p 37. School drug education is discussed in chapter five.

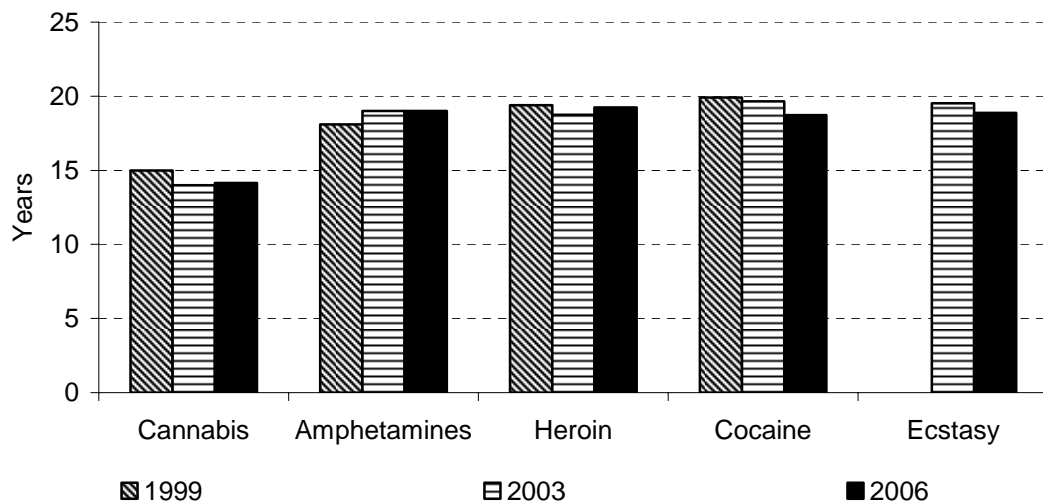
Figure 2.7 Average age of initiation to illicit drugs, persons aged 12 years and older, 1993 to 2004



Note Prior to 2004 the survey related to persons aged 14 years and over. Amphetamine includes methamphetamines. Prior to 2004, ecstasy was classified as 'ecstasy/designer drugs'.

Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 108; Statistics on drug use in Australia 2002 (2003), cat no PHE 43, p 17; 1998 National Drug Strategy Household Survey: Detailed findings (2000), cat no PHE 27, p 3; Makkai T and McAllister I, Patterns of drug use in Australia 1985-95 (1998), p 38.

Figure 2.8 Age at first use, police detainees, 1999 to 2006



Source Australian Institute of Criminology, Drug use monitoring in Australia: 2006 annual report on drug use among police detainees (2007), p 33; Drug Use Monitoring in Australia 2003 annual report on drug use among police detainees (2004), p 18; Johnson D, 'Age of initiation', Australian Institute of Criminology trends and issues (2001), no 201, p 3.

2.58 The most common response for non-users of illicit drugs when indicating the factors that influenced their decision never to try illicit drugs was that

they were 'just not interested', followed by 'reasons associated to health or addiction' (table 2.2). These two reasons were more commonly cited in 2004 than when non-users were asked the same question in 2001. Males and females generally cited similar reasons for not trying illicit drugs.

2.59 People who never used illicit drugs did not cite 'education awareness' or 'seen the negative effects of drugs' as a common reason for influencing their decision not to use illicit drugs.

Table 2.2 Factors influencing the decision not to try illicit drugs, 2001 to 2004

Factor	Males		Females		Persons	
	2001	2004	2001	2004	2001	2004
Just not interested	48.2	73.0	56.3	77.7	52.3	75.6
For reasons related to health or addiction	37.5	56.0	39.2	53.3	38.4	54.6
Didn't like to feel out of control	17.1	24.6	22.0	29.1	19.6	27.1
For reasons related to the law	10.1	26.4	9.0	24.3	9.6	25.3
Religious/moral reasons	13.0	21.3	17.0	24.0	15.0	22.8
Didn't think it would be enjoyable	13.9	20.8	17.4	23.8	15.7	22.4
Pressure from family or friends	7.1	11.9	6.7	9.8	6.9	10.8
No opportunity	na	8.8	na	10.6	na	9.8
Did not want family/friends/employer or teachers to know	6.5	9.5	6.2	7.2	6.3	8.2
Financial reasons	na	9.2	na	7.4	na	8.2
Friends didn't use or stopped using	na	7.9	na	8.3	na	8.1
Drugs too hard to acquire	na	5.0	na	3.8	na	4.3
Seen the negative effects of drugs	na	1.6	na	2.1	na	1.9
Education awareness	na	1.0	na	1.4	na	1.2
Other	na	4.0	na	4.0	na	4.0

Note na = Not available. Base is those who had never used any illicit drug. Respondents could select more than one response.

Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey: Detailed findings (2005), cat no PHE 66, p 37; 2001 National Drug Strategy Household Survey: Detailed findings (2002), cat no PHE 41, p 40.

2.60 Risk and protective factors associated with family relationships and disadvantage are highlighted later in this report as increasing the likelihood of illicit drug use.⁶³ It is apparent that it is also important to develop strategies to educate and build resilience among our children to overcome peer pressures and the desire for experimentation. Possible

63 See chapter ten.

ways of addressing the reasons why people chose to use or not use illicit drugs are examined in detail later in the report.

Effects of illicit drug use

- 2.61 Illicit drug use causes significant illness, including mental illness, and disease, violence and crime, and devastates families. The most recent estimate of the economic cost of illicit drug use in Australia is \$6.7 billion per year.⁶⁴ This estimate does not include the significant physical and emotional trauma and social dislocation caused by illicit drugs.
- 2.62 The effects of illicit drug use are evident in the destructive effects of drug-related deaths, other associated health effects and the damaging impact of drug-related crime on the community.

Health and health care

- 2.63 Illicit drugs have a range of deleterious effects on users that put their health at risk, not only at the time of ingestion but into the medium and long term. Different drug types do, of course, have different effects on the brain, body and personal health. Drugs like cannabis, heroin, meth/amphetamines, ecstasy and cocaine affect the central nervous system differently depending on their chemical constitution as depressants, stimulants, sedatives or hallucinogens.⁶⁵
- 2.64 The health effects of illicit drugs on users also depends on a range of contextual factors such as:
- dosage – how much of the drug is taken;
 - duration – over/in what period of time;
 - frequency of use – how often it is taken;
 - patterns of use – for example, intermittent binges, or regular use of small amounts;
 - mode of administration – including injection, oral ingestion, snorting, and smoking;

64 Australian Drug Law Reform Foundation, *The three billion \$ question for Australian business* (2007), p 4.

65 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 35.

- drug purity;
 - simultaneous use of multiple drugs (polydrug use), which increases the unpredictability of effects even for long-term users;⁶⁶
 - the drug user themselves, including their size, genetic make-up, general health, gender, mood and personality; and
 - the environment in which drugs are taken.⁶⁷
- 2.65 The short-term effects of illicit drugs are the reasons why many people take them, and they include temporary senses of wellbeing, relaxation, euphoria, confidence or alertness. In the short term, drug users can also experience anxiety and paranoia, sweating, increased body temperature, nausea and vomiting, slurred speech and loss of coordination.
- 2.66 In the medium to long term, illicit drug use is associated with the following general health risks:
- poor mental health, including depression, anxiety, paranoia, psychosis, eating disorders and other mental disorders;
 - neurotoxicity (brain damage), which impairs memory and concentration;
 - cellular ageing, which results in a haggard appearance, a greying or balding hairline, diminished bone strength and other typical symptoms of ageing;
 - chronic sleep disturbances;
 - unprotected sex, resulting in pregnancy and/or sexually transmitted disease;
 - increased risk of sexual assault;
 - sexual dysfunction and fertility problems;
 - cardiovascular problems and heart failure;
 - respiratory failure;
 - strokes;

66 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 37.

67 NSW Health website, 'Information for parents', viewed on 11 July 2007 at <http://amwac.health.nsw.gov.au/health-public-affairs/mhcs/publications/5910.html>; Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, pp 37, 47-57.

- seizures;
- hypertension and high blood pressure;
- immune system impairment and reduced resistance to infection; and
- other health problems related to the poor personal care that often accompanies a drug-taking lifestyle.⁶⁸

Figure 2.9 Effects of methamphetamine use: 'Meth bugs' caused by users scratching, picking and digging their skin to relieve itching; and dental decay known as 'meth mouth'



Source The White County Meth Task Force website, viewed on 28 August 2007 at <http://www.anti-meth.org/photos2.html>

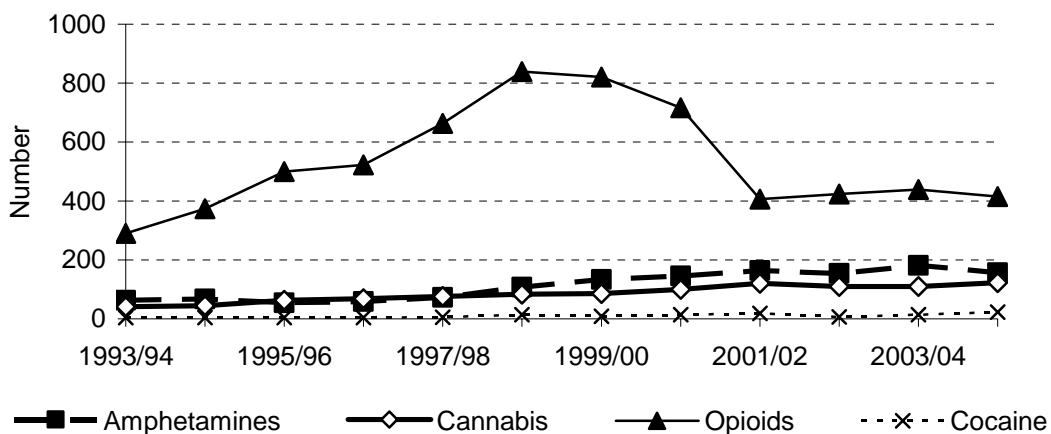
2.67 Particular modes of administration are also associated with health risks in the medium to long term. Injecting drug users face additional risks including contraction of hepatitis C, HIV and other blood borne infections through unsafe injecting practices such as needle sharing. Repetitive injections can also lead to vein damage, abscesses, thrombosis, scarring and tetanus. Marijuana cigarettes have more tar than tobacco, placing cannabis users at an increased risk of respiratory illness such as cancers of the mouth, throat, and lungs, and chronic bronchitis.⁶⁹

68 Where not otherwise indicated with a specific footnote, information in this section is drawn from the following sources: Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, pp 35–57; Australian Drug Foundation, DrugInfo Clearinghouse website, viewed on 11 July 2007 at <http://druginfo.adf.org.au>; National Drug and Alcohol Research Centre website, fact sheets, viewed on 11 July 2007 at <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Fact%20Sheets>; and National Centre for Education and Training on Addiction Consortium, for the Australian Government Department of Health and Ageing, *Alcohol and other drugs: A handbook for health professionals* (2004); Reece S, transcript, 3 April 2007, pp 29–42.

69 Australian Drug Foundation, DrugInfo Clearinghouse, 'Cannabis', viewed on 11 July 2007 at <http://druginfo.adf.org.au/article.asp?ContentID=cannabis>.

- 2.68 Although research continues, the full long-term health risks of some illicit drugs are not known, as most have been used in their current form for only a few decades or years. More research is needed into the long-term effects of ecstasy and crystal methamphetamine, or the long-term effects of illicit drugs on neural functioning, including the implications for mood and behavioural disorders, memory, concentration, psychosis and other disorders typified by a loss of contact with reality.
- 2.69 People seeking treatment for the health effects of illicit drug use impose significant costs on the health system. While the rate of admissions to hospitals for opioid use has declined significantly since 1998-99, there have been steady increases in admission rates for cannabis and amphetamines (figure 2.10).

Figure 2.10 Principal drug-related hospital separations, persons aged 15-54, by drug type, 1993 to 2005



Source Roxburgh A and Degenhardt L, *Drug-related hospital stays in Australia, 1993-2005* (2006), p 1.

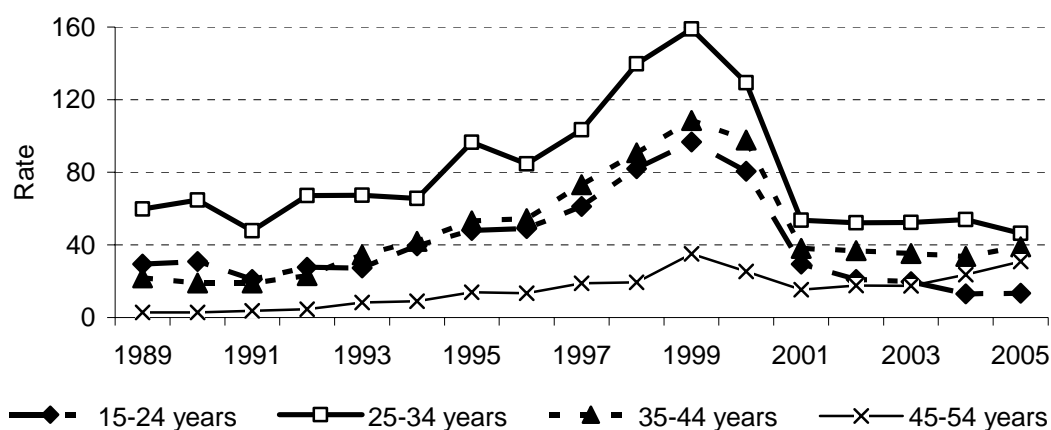
Deaths and loss of potential healthy life

- 2.70 The number of deaths from heroin overdose is often cited as a measure of the impact of illicit drug use on families. In 2005, there were 374 deaths in which opioids were determined to be the underlying cause of death among those aged 15-54 years. This is a significant reduction from the 938 deaths reported in 2000 and the 1,116 deaths of 1999 (figure 2.11). The reason for the decline is largely attributed to the reduction in heroin supply experienced across Australia in 2001.⁷⁰

70 O'Brien S et al, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System (IDRS)* (2007), p 39.

2.71 However, the dangerous effects of taking illicit drugs can also cause deaths amongst drug users, their families or members of the community — contributing to suicides, road traffic accidents, HIV/AIDS and hepatitis infections and complications associated with childbirth.

Figure 2.11 Rate of accidental deaths due to opioids among those aged 15-54 years, Australia, 1989 to 2005



Source Degenhardt L and Roxburgh A, *Accidental drug-induced deaths due to opioids in Australia, 2005* (2007).

2.72 The AIHW recently estimated that in 2003, more than 1,700 deaths and over 51,000 years of 'lost' healthy living were attributable to illicit drug use (table 2.3).⁷¹ This is significantly higher than estimates for 1998, where illicit drugs were attributed to 1,023 deaths and more than 50,000 years of 'lost' healthy living.⁷²

2.73 The scale of collateral damage to families is revealed in specific examples of deaths resulting from illicit drug use:

- A five month old infant died after he was deliberately given methadone by his mother, who, along with her partner, was on a methadone maintenance program at the time;⁷³
- A 20 year old woman died after taking what she thought was an ecstasy tablet. The tablet was laced with the hallucinogenic drug PMA, a toxic substance which is occasionally sold as ecstasy;⁷⁴ and

71 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, p 37.

72 Ridolfo B and Stevenson C, Australian Institute of Health and Welfare, *The quantification of drug caused mortality and morbidity in Australia, 1998* (2001), cat no PHE 29, p 98.

73 Danks K, 'Baby died from mum's methadone: Coroner', *news.com.au*, 4 October 2006, viewed on 4 July 2007 at <http://www.news.com.au/story/0,23599,20524192-1242,00.html#>.

74 Gibson J, 'Bubbly' Annabel's fatal risk', *The Sydney Morning Herald*, 23 February 2007.

- A drug-affected driver, who had traces of amphetamine, methylamphetamine and cannabis in his system, killed two couples and an eight year old boy in a high speed crash. Police estimated the driver was doing at least 100kmh and up to 130kmh just before the crash.⁷⁵

Table 2.3 Number of deaths and disability-adjusted life years (DALYs) attributable to illicit drug use, by condition, 2003

Condition	Deaths		DALYs	
	Number	Per cent (a)	Number	Per cent (b)
Heroin/polydrug use	263	0.2	16,758	0.6
Hepatitis C	759	0.6	11,709	0.4
Cannabis abuse	0	0.0	5,206	0.2
Suicide and self-inflicted injuries	204	0.2	4,458	0.2
Hepatitis B	329	0.2	3,637	0.1
Benzodiazepine abuse	1	0.0	2,656	0.1
Other	149	0.1	7,040	0.3
Total attributable	1,705	1.3	51,463	2.0

Note (a) Of total deaths (b) Of total DALYs. The disability-adjusted life year (or DALY) is a summary statistic used to measure the burden of disease that combines both the years of healthy life lost due to disability and the years of life lost due to premature mortality. One DALY represents one lost year of 'healthy life'.

Source Australian Institute of Health and Welfare, Statistics on drug use in Australia 2006 (2007), cat no PHE 80, p 37.

Crime and potential damage

- 2.74 In addition to criminal activity associated with trafficking and consumption, illicit drug use is also associated with other crime such as property and violent offending.⁷⁶ These crimes can be perpetrated by people using illicit drugs against members of the community and also against members of their family.
- 2.75 In 2004-05, the Australian Institute of Criminology identified that 95 homicides (36 per cent) involved illicit drug use where either victim or offender or both had used illicit drugs. Of 66 intimate partner homicides, 20 per cent of victims and 15 per cent of offenders were found to be using illicit drugs at the time of the death. In regard to the 26 child deaths, 17 per cent of the offenders were found to have been using illicit drugs.⁷⁷

75 Darragh D, 'Drug driver jailed over multiple fatality', *thewest.com.au*, 27 November 2006, viewed on 5 July 2007 at <http://www.thewest.com.au/default.aspx?MenuID=77&ContentID=14643>.

76 Australian Institute of Criminology, submission 120, p 10.

77 Australian Institute of Criminology, submission 120, p 1.

- 2.76 Annual surveys of regular intravenous drug users consistently point to a high prevalence of criminal activity that is associated with illicit drug use including property crime, violent crime and fraud.⁷⁸
- 2.77 Monitoring of illicit drug use by offenders at selected police stations and watchhouses across Australia revealed that in 2005, 33 per cent of detainees had stolen something in the past year and that 25 per cent of detainees reported stealing because they needed money for drugs.⁷⁹ More than one-third of detainees attributed some of their offending to illicit drugs.⁸⁰
- 2.78 In addition to the actual harm imposed on the community, the use of illicit drugs also contributes to a broad range of potential harms due to impairment associated with drug use. In 2004, of Australians aged 14 years and older who had used any illicit drugs in the last 12 months, in the same period:
- 581,000 people had driven a motor vehicle while under the influence of illicit drugs;
 - 115,000 people had operated a boat or hazardous machinery; and
 - 326,600 people had gone to work.⁸¹
- 2.79 Drug use by health care and other workers has potentially fatal consequences. The committee is concerned at the potential numbers of people working under the influence of illicit drugs whilst holding positions of professional responsibility in our community.

78 O'Brien S et al, *Australian Drug Trends 2006: Findings from the Illicit Drug Reporting System (IDRS)* (2007), p 155.

79 Mouzos J et al, Australian Institute of Criminology, *Drug use monitoring in Australia: 2005 annual report on drug use among police detainees* (2006), p 18.

80 Mouzos J et al, Australian Institute of Criminology, *Drug use monitoring in Australia: 2005 annual report on drug use among police detainees* (2006), p xii.

81 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 89.

Protecting children

- 3.1 Children who are exposed to parental drug use are amongst the most vulnerable members of our community. Illicit drug taking compromises a parent's ability to perform basic parenting functions, as outlined in the 2003 UK report *Hidden harm*, such as basic care, ensuring safety, emotional warmth, stimulation, guidance and boundaries, and stability.¹ These functions are ignored because the physical and emotional needs of children are so often deferred to the parent's need to feed their drug habit. By the nature of addiction, addicts are prone to chronic relapse and inconsistent behaviours that do not make for a stable home life.² As further examined in this chapter and later in the report, illicit drug use by parents results in significant 'hidden harm' to children.
- 3.2 In this chapter the committee examines these impacts in detail and considers how they can lead to intergenerational cycles of drug use. To give these children a voice, the committee heard from a foster carer with 24 years experience. The majority of the children she had cared for came from drug-affected families. The committee was profoundly impressed by her evidence, which graphically illustrated how concepts such as 'chronic neglect' are experienced by individual children and families every day.
- 3.3 Evidence on the experience of children living in households affected by illicit drug use is confronting. The Australian Psychological Society considered that parental drug use was one of the most serious issues

1 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), p 31.

2 South Australian Government, submission 153, p 8.

confronting the child welfare sector over the past twenty years. While some parents were able to provide care, this could be:

...punctuated by bursts of substance use which undermine the quality of care provided, leading to risky situations for the child(ren). Abandonment and neglect as a result of parental death from overdose, parental intoxication, or periods of absence due to imprisonment, have also combined to place additional stress on families and the child protection system.³

- 3.4 The children of drug users have been largely overlooked in attempts to address the nation's illicit drug problem and by a treatment ethos that focuses on the drug user as an individual without ties or family responsibilities. Unlike adults, however, children are not always able to assess the situation, identify when someone close to them is doing something wrong, ask for help or protect themselves.
- 3.5 The committee makes several strong recommendations about how children can be better protected. Interactions between the child protection system and treatment system for addicted adults need to be more child-centred with a focus on what is genuinely 'in the best interests of the child', a phrase that appears all too often to merely pay lip service towards protecting children at risk.⁴ Strong approaches to protecting children, such as diverting family support payments and promoting adoption for the children of parents using illicit drugs should be considered.

Impact of parental illicit drug use on children

- 3.6 The following sections examine drug use in pregnancy; the effects of parental drug use on child psychosocial development; and the way in which child safety—even life itself—are compromised by physical and sexual abuse, neglect and inadequate supervision.

Illicit drug use in pregnancy

- 3.7 The committee is extremely concerned at evidence received on the levels of drug use in pregnancy and the ongoing issues faces by

3 Australian Psychological Society, submission 131, p 9.

4 Rowe L, transcript, 15 August 2007, p 8.

newborns and infants when their parent has an addiction to illicit drugs.

- 3.8 There are no national figures for the number of babies being born to mothers who use illicit drugs throughout their pregnancy. There is selective evidence from maternity units around the country, however, that suggests the figure for hospitals with neonatal intensive care units could be as high as seven per cent of all births. King Edward Memorial Hospital for Women in Perth also noted that in addition to these births, there was another cohort of women who did not disclose drug use, delivered their babies without antenatal care and, after the fact, were identified as having used drugs during the pregnancy.⁵
- 3.9 In New South Wales there are 1,000 babies born every year to a drug-affected parent.⁶ A recent study of 10 neonatal intensive care units in New South Wales and the Australian Capital Territory found that of 6,120 babies born between 2001 and 2003, 310 babies or five per cent had mothers who admitted to or had a record of taking drugs during the pregnancy. These included cannabis, amphetamines, heroin, methadone and cocaine. The babies born to these mothers were more likely to be born very premature, have low birth weights and spend longer in hospital than other critically ill infants not exposed to drugs.⁷
- 3.10 The committee heard disturbing evidence from the King Edward Memorial Hospital that of the 5,000 babies born in the hospital every year, approximately seven per cent, or 350 babies, had chemical dependency problems from maternal substance use. In 2005 and 2006 combined, the hospital had 102 babies born addicted and admitted to the neonatal special care nursery for the management of their withdrawal.⁸ The hospital has seen a threefold increase in the past three years in women who are using illicit drugs delivering babies, with methamphetamine use a growing problem.⁹
- 3.11 Because drugs can cross into the placenta, drug use during pregnancy leads to a range of health problems, including abnormal foetal growth

5 Hamilton D, transcript, 14 March 2007, p 11.

6 Morris R, transcript, 3 April 2007, p 109.

7 Cronin D, 'Ill babies linked to drug mothers', *Canberra Times*, 21 February 2007, p 6.

8 Hamilton D and Harrison C, King Edward Memorial Hospital for Women, transcript, 14 March 2007, pp 11, 19.

9 Hamilton D, King Edward Memorial Hospital for Women, transcript, 14 March 2007, p 12; King Edward Memorial Hospital for Women, submission 19, p 6.

and development.¹⁰ These may be exacerbated by other factors associated with maternal drug use, such as poor maternal nutrition and general health, contraction of blood borne viruses, or domestic violence which may damage the foetus.¹¹

- 3.12 Babies born to mothers using opiates, including methadone, are 1.9 times more likely to be smaller at birth, and 5.8 times more likely to be admitted to a special care nursery. They are also 3.9 times more likely to be born premature. Babies born to women using cannabis are twice as likely to be smaller at birth and 1.8 times more likely to be admitted to a special care nursery. They are 2.2 more likely to be born premature.¹²
- 3.13 Neonatal abstinence syndrome (withdrawing from an addiction developed in the womb) is most common where the mother has used opiates (including methadone), cocaine or benzodiazepines during late pregnancy. Symptoms may last for days, weeks or months. Babies with neonatal abstinence syndrome may exhibit excessive high-pitched crying, rapid breathing and heart rate, disturbed sleep patterns, sweating and fever, vomiting and diarrhoea, and feeding difficulties.¹³
- 3.14 Neonatal abstinence syndrome also jeopardises the attachment between a child and his or her mother, as mothers may not be able to respond to the child's bids for attention, help, and protection. Research into the interactions between drug-using mothers and their infants suggests significant risks for difficulties in the mother/child relationship, with ongoing implications for behaviour, relationships and education.¹⁴
- 3.15 Ultimately, however, the true extent of foetal damage due to maternal drug use remains unknown, including, for example, the extent of neurological damage, behavioural problems and potential disabilities.¹⁵ The UK report *Hidden harm* commented that given the

10 Odyssey House Victoria, submission 111, p 5; Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), p 31.

11 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), p 33.

12 'Substance use in pregnancy in Australia – some facts', *Of Substance* (2007), vol 5, no 1, p 14.

13 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), p 37; Wanslea Family Services, submission 97, p 3.

14 South Australian Government, submission 153, p 8; Wanslea Family Services, submission 97, p 3.

15 South Australian Government, submission 153, p 7.

psychoactive nature of the common illicit drugs used, their impact on the developing brain and nervous system in particular was a matter of considerable concern.¹⁶

- 3.16 Inquiry participants told the committee that pregnancy and impending motherhood can act as an impetus for women to seek help to become drug-free individuals, and that pregnancy can present a ‘real opportunity to promote change in a longstanding way.’¹⁷ Professor Gary Hulse of the University of Western Australia told the committee that:

Pregnancy is a great motivational force for women to change direction, to look at change and sustain change. They just need the window of opportunity to do so.¹⁸

- 3.17 On the other hand, sociodemographic data indicates that women with illicit drug habits are a high risk, high need group, many with little or no social support and other children to care for, and some with the experience of having previous children removed.¹⁹ Many women with newborn children are also facing multiple sources of disadvantage including poverty, unstable housing, domestic violence and social isolation.²⁰
- 3.18 There is little research available on outcomes for children born from maternal drug use. King Edward Memorial Hospital estimated that of 350 maternal drug users who had attended the hospital for delivery of their infant in 2005 and 2006:
- Two-thirds of the 350 children were followed up by child health nurses and GPs and they have not presented to child welfare agencies.
 - 130 out of the 350 children were assessed with enough risk factors such that the hospital was concerned and involved the Department for Community Development.

16 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), p 33.

17 Gould B, transcript, 3 April 2007, p 58; Cyrenian House, submission 110, p 4.

18 Hulse G, transcript, 21 March 2007, p 4.

19 Barnados Australia, submission 69, p 19; see also Women’s Health Service (WA) Pregnancy Early Parenting & Illicit Substance Use, submission 26, p 1.

20 Women’s Health Service (WA) Pregnancy Early Parenting & Illicit Substance Use, submission 26, p 1; also noted by Harrison C, King Edward Memorial Hospital for Women, transcript, 14 March 2007, p 15; and King Edward Memorial Hospital for Women, submission 19, p 6.

- ⇒ Out of the 130, 25 children had statutory action taken so that they were placed in care even before the mother left the hospital.
- ⇒ Of the others who went home with home-based support, another 25 babies were removed within three months of being discharged.²¹

3.19 The hospital admitted, however, that they had very little idea what had happened to these children after three months.²² They identified long-term outcomes for children as an area that needed further research, suggesting:

...an investment in research that studies the prevalence of drug use amongst pregnant women, the relationship between drug use and pregnancy, the long-term developmental outcomes and needs of the children and an evaluation of drug treatment and early intervention programs.²³

3.20 The need for such longitudinal research was also supported by the National Drug and Alcohol Research Centre and the National Drug Research Institute, who had applied to the National Health and Medical Research Council to fund a long-term longitudinal study of the babies of drug-using parents to look at the impact on milestones, health effects, later substance use and family functioning.²⁴

Recommendation 2

3.21 **The National Health and Medical Research Council fund a long-term longitudinal study of the babies of drug-using mothers to look at the impact of maternal illicit drug use, including:**

- **the long-term implications for the future life of a baby born addicted to methadone and/or other illicit drugs;**
- **birth outcomes, such as prematurity, birth weight, and neonatal distress;**
- **physical, mental and social developmental milestones;**

21 Harrison C, King Edward Memorial Hospital for Women, transcript, 14 March 2007, p 19.

22 Hamilton D, King Edward Memorial Hospital for Women, transcript, 14 March 2007, pp 12, 17.

23 Hamilton D, King Edward Memorial Hospital for Women, transcript, 14 March 2007, pp 12–13.

24 Lenton S, National Drug Research Institute, transcript, 14 March 2007, p 40; National Drug and Alcohol Research Centre, submission 147, p 25.

- **family functioning and family characteristics;**
- **any later interactions with the child protection system;**
- **propensity to drug use in adolescent and adult life; and**
- **comparisons of outcomes for alternatives to methadone, including buprenorphine, naltrexone and supervised detoxification and withdrawal, with regards to which options are in the best interests of the child, both before and after birth.**

Methadone use in pregnancy

- 3.22 Methadone use in pregnancy is of particular interest to this committee, because the mothers are most often participating in methadone maintenance programs funded by state, territory and federal governments.²⁵
- 3.23 Australia's national clinical guidelines for drug use in pregnancy recommend that heroin-dependent pregnant women are offered stabilisation through a methadone program, combined with counselling.²⁶
- 3.24 As a substitute opiate, methadone does affect unborn babies. Methadone crosses to the unborn child through the placenta. After birth, when the baby's supply of methadone is cut off, it can develop drug withdrawal or neonatal abstinence syndrome.
- 3.25 The national guidelines state, however, that methadone use in pregnancy is nonetheless likely to result in fewer complications than the use of other opiates, such as heroin. In comparison to heroin, methadone maintenance treatment is associated with improved foetal development and infant birth weight.²⁷ Also, there is currently insufficient evidence on the safety of methadone alternatives such as buprenorphine and naltrexone in pregnancy.²⁸

25 See chapter four.

26 NSW Department of Health, for the Ministerial Council on Drug Strategy, *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (2006), p 34.

27 Royal Women's Hospital, submission 142, p 3; NSW Department of Health, for the Ministerial Council on Drug Strategy, *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (2006), p 35.

28 Hulse G, transcript, 21 March 2007, p 3; NSW Department of Health, for the Ministerial Council on Drug Strategy, *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (2006), pp 38–39.

- 3.26 According to the national clinical guidelines for drug use in pregnancy, methadone should always be recommended over detoxification and/or withdrawal for pregnant women, despite the side effects for the baby. While these treatments, if successful, mean that the baby would be born drug free, evidence suggests that the risk of relapse is high, and withdrawal can precipitate abruption and miscarriage.²⁹
- 3.27 Professor Gary Hulse, however, of the University of Western Australia, questioned the assumption that there was no alternative to methadone in pregnancy, and suggested that withdrawal from methadone and heroin had been accomplished without problems overseas.³⁰

Child development

- 3.28 The impacts of parental drug use on growing children were related by many inquiry participants. They included:
- inadequate nutrition and periods without food;
 - a lack of clothing;
 - inadequate health care, including a lack of immunisation, lack of attention to the child's health problems or disabilities, irregular washing, dental decay, a filthy home environment and untreated head lice;
 - poverty and financial disadvantage;
 - physical, sexual and emotional abuse;
 - traumatic and frightening experiences, such as parents overdosing or losing consciousness;
 - family breakdown and conflict;
 - parental mental health problems;
 - frequent change of residence and carers;
 - involvement in criminal activity;

29 Hamilton C, King Edward Memorial Hospital for Women, transcript, 14 March 2007, p 12; NSW Department of Health, for the Ministerial Council on Drug Strategy, *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* (2006), pp 35–36.

30 Hulse G, transcript, 21 March 2007, p 3.

- poor education outcomes due to learning and behavioural difficulties and interruptions to schooling;
- social problems, including social isolation and lack of attachment and connection to others; and
- problems with emotional development.³¹

3.29 A submission from a grandmother who now has custody of her four grandchildren described their former lifestyle in the care of their mother, who was an injecting drug user. The children were frequently implicated in criminal activity and were suffering from a lack of basic nutrition:

Our daughter was a dealer and user and had an association with [name withheld] at Batemans Bay. She ran drugs... with the children on board as cover and was also known to sell to school children... Our daughter was always in the spotlight with the police for shoplifting and she bragged that the four children were her shoplifting gang. She had to shoplift and sell drugs to feed her habit and the children suffered from lack of food and fresh fruit and vegetables, always sick.³²

3.30 Lorraine Rowe, a foster carer, told the committee of a little girl she had known who was first brought to the attention of child protection authorities by her school. Teachers had noticed that she would forage for food scraps in rubbish bins after other students had returned to class from lunchbreak, and realised that she was not getting any food at home.³³

3.31 Interruptions to schooling can have a significant impact on children of illicit drug-using parents. Disruptions to education can arise from homelessness or regular changes to accommodation. Grades can suffer and friendships can be disturbed, causing further psychological disadvantage over time.³⁴ Children of drug-using parents are more likely to demonstrate behavioural problems such as severe aggression and Attention Deficit Hyperactivity Disorder as well as elevated

31 Miller T, submission 78, p 7; Glastonbury Child and Family Services, submission 74, p 9; Centrelink, submission 128, p 2; Dawe S et al, submission 80, p 4; Mirabel Foundation, submission 64, p 1; Odyssey House Victoria, submission 111, p 4.

32 Steep S, submission 183, p 1.

33 Rowe L, transcript, 15 August 2007, p 15.

34 Victorian Alcohol and Drug Association, submission 100, p 11; Commission for Children and Young People and Child Guardian (Qld), submission 146, p 4, 8.

levels of depression. They may be more impulsive, irresponsible and immature than children of non drug-using parents.³⁵

- 3.32 Unsurprisingly, young children often have negative views about their parents' drug use (box 3.1). A 2002 study of 36 children and young people who had grown up in drug-dependent families found that for all children, discovery of their parent's drug use at an early age was met with 'feelings of hurt, sadness, anger and rejection'. Many also felt heightened fear and anxiety about their parent's safety and wellbeing.³⁶

Box 3.1 The children's voices

They always thought I never knew that Mum was on the drugs. I asked why I had to live with my Nanny and they said Mum has gone on a holiday. I knew she was in gaol, cos I heard the adults talking. I told Nanny I saw Mum using the needle drugs and that I sometimes I was with her when she bought them and Nanny nearly fainted. I am more happy at Nanny's she drives me places, washes my clothes and cooks me food. - Ben, 7.

Mum goes crazy on drugs, sometimes she cleans the whole house at night and wakes me up with the vacuum cleaner. Other times they make her tired and she sleeps a lot. I hate it when Mum's on drugs, she doesn't have any energy and she yells more and doesn't like to go to the park. But I still love her because she tells me all the time she loves me. - Jack, 9.

She always ate chocolate and mud cake and stuff like that. Usually she would just give us money to go and get food: fish and chips and stuff. She was around but she didn't have the energy. Now she cooks dinner and stuff like that. - Samuel, 12.

I say my dad got eaten by a dinosaur. He's mean, he does drugs ... they make you go off your face and do bad stuff. We don't see him now. - Ethan, 9.

I'm always sad at my mum's house, because you know, my mum doesn't have any happiness. - Megan, 5.

Source Odyssey House, submission 111, p 6.

- 3.33 Many individuals and organisations noted, however, that the needs of children whose parents are illicit drug-dependent are often overlooked. As 'nobody's clients', they are rarely referred to services

35 National Drug and Alcohol Research Centre, submission 147, p 11.

36 Barnard and Barlow, cited in Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 77-78.

in their own right, and often do not or cannot ask for help.³⁷
Mrs Rowe told the committee:

The kids do not have a voice. They cannot stand up and say, 'My mum is not feeding me. My mum is not dressing me.' If they have learnt that and it is a learned behaviour for their family, they see that as being normal. We have been accused of being really bizarre because we ask the children to have a shower every night, and because I am washing up three times a day, because we are having food on the table and then the kids are confused as to what day it is, how long they have been there because there is another meal on the table. It is heartbreaking but that is what we have.³⁸

- 3.34 The lack of trust and emotional insecurity felt by children from households where parents used illicit drugs was highlighted by Mrs Rowe as having far-reaching impacts on children's relationships with the rest of the world:

The parents are not emotionally available for them. If they are so focused on getting the drugs to manage through their day they are not able to be there when the kids need them—they are not feeding them, they are not clothing them, they are just not picking them up when they fall and skin their knees and all those things are important for all of us to learn how to trust people.

If you are getting rejected—whether it is just going from one home to another, no matter how loving that home may be for that short period of time—all the time you are not going to trust anybody. You are going to learn that we as adults are not reliable to little kids; we are unpredictable, that from one day to the next that bed is not going to be there or available for them. And so then you have teenagers who have no respect for society or for anybody because why should they respect us? We have never been there when they were little, we did not put a bandaid on their knees, we did not kiss them goodnight, we were not there to give them food.³⁹

- 3.35 The committee heard from several inquiry participants that there was often role confusion in the family, with older children becoming

37 Miller T, submission 78, p 9; Odyssey House Victoria, submission 111, p 5.

38 Rowe L, transcript, 15 August 2007, p 15.

39 Rowe L, transcript, 15 August 2007, p 3.

‘parentified’ and taking on the role of carer.⁴⁰ The adoption of these adult responsibilities, behaviours and attitudes by children may occur at the expense of their own later development.⁴¹ Child carers are often at increased risk of suffering the poor educational and personal outcomes as outlined above.⁴²

3.36 In their submission, the Mirabel Foundation told a story of tragic self-possession shown by the grandson of one of their clients:

Jack was eleven years old when he came home from school to discover his Dad unconscious from a heroin overdose. Jack tried to revive him and then phoned an ambulance. It was too late. Two weeks later, Jack awoke to discover his mother lying on the floor. She had also died from an overdose. Jack made up a bottle for his baby brother, found food for his other younger brother and sister and took them all into another room so they would not have to see their mum. He cared for them until a neighbour happened to find them 18 hours later.⁴³

3.37 Hon Ann Bressington MLC, the founder of treatment organisation DrugBeat SA, told the committee that:

I have heard a number of theories cast around that these children can be taught to cope with the drug use of their parents, and I tell you here and now, they do not learn to cope with their parents’ drug use. What happens is, we have children who are looking after their siblings. I have had an example of one five year old who had the responsibility of looking after her two year old sister and her one week old baby brother while the parents were off their face on methamphetamines. That little five year old did remarkably well, but she is now eight and she wears the scars of that emotionally, and also wears the scars of the fact that her little baby brother nearly died from starvation and it became all about her and her responsibility. We have got to remember

40 Commission for Children and Young People and Child Guardian (Qld), submission 146, p 8; National Drug and Alcohol Research Centre, submission 147, p 8; Australian Association of Social Workers, submission 121, p 6; Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 3.

41 National Drug and Alcohol Research Centre, submission 147, p 8.

42 Commission for Children and Young People and Child Guardian (Qld), submission 146, p 8.

43 Mirabel Foundation, submission 64, pp 1-2.

that our children are not born grown-up and that our children will live what they learn.⁴⁴

Child safety

- 3.38 Parental illicit drug use may compromise child safety through increased likelihood of physical and sexual abuse, neglect or inadequate supervision. Parental drug use is not in itself sufficient to trigger a notification to statutory child protection services. It features significantly, however, in the caseload of child protection authorities in all states and territories.⁴⁵
- 3.39 In 2005-06, there were 266,745 reports to child protection departments around Australia and the most frequently substantiated maltreatment types are child neglect and emotional abuse — the maltreatment types most frequently associated with parental drug use.⁴⁶ According to Odyssey House, parental drug or alcohol problems account for approximately 50 per cent of all substantiated cases of child abuse or neglect in the child protection system in Australia.⁴⁷
- 3.40 Given that the rate of unsubstantiated cases of child abuse is more than four times greater than substantiated cases, and that many children may never come to the attention of child protection authorities, the committee agrees with Families Australia that ‘there is an open and urgent question to be answered’ about the true extent of child abuse found in families with parental drug use.⁴⁸ Parental drug use, domestic violence and mental health issues have been increasingly reported as contributing factors in the rise of notifications to child protection authorities.⁴⁹
- 3.41 Children living in the care of drug users are at heightened risk of physical abuse.⁵⁰ Meth/amphetamine use is of particular concern,

44 Bressington A, transcript, 23 May 2007, p 2.

45 Australian Institute of Family Studies, submission 103, p 4; South Australian Government, submission 153, p 7.

46 Australian Institute of Family Studies, submission 103, p 4.

47 Odyssey House Victoria, submission 111, p 4.

48 Families Australia, submission 152, p 10.

49 Australian Institute of Family Studies, submission 103, p 4; South Australian Government, submission 153, p 7; Government of Western Australia Department for Community Development, submission 134, p 1.

50 Odyssey House Victoria, submission 111, p 4; Commission for Children and Young People and Child Guardian (Qld), submission 146, p 8; Alcohol and Drug Foundation ACT, submission 123, p 5; Marymead Child and Family Centre, submission 107, p 4.

given its association with violent behaviour, paranoia and psychosis.⁵¹ The Australian Institute of Family Studies told the committee that ‘the use of amphetamines by parents may place children at heightened risk of child physical abuse, and psychological abuse in addition to child neglect’.⁵²

- 3.42 The potential incidence of sexual abuse to children living with parents who use illicit drugs was also cited by inquiry participants as a danger.⁵³ Mrs Rowe told the committee that the abuse was not always readily apparent:

It is not always apparent to the department when they first come into care. Usually the kids have to build up trust with somebody to be able to talk about something that has happened to them. I think a lot of the public thinks, when they hear ‘sexual abuse’, that it is a situation of full-on intercourse or rape, but it usually starts quite slowly with people infiltrating into families that they see as being vulnerable and separating the children from the parents. They are able to do that by saying things like, ‘He is such a little pest; I will take him to the park for you,’ and mum then thinks she is getting a break. They start that sort of grooming process over a number of months or years. The children do not seem to realise that that is a problem or that that is happening. Then you have children in care—it could be after several months or years—who actually come out with, ‘This is what has happened to me,’ and they are not sure why it is not happening anymore.⁵⁴

- 3.43 Children’s exposure to physical and sexual abuse may be increased by peers or partners of their parents living with the family or spending substantial time around the children. Women who use drugs are more likely to have multiple partners.⁵⁵ The committee heard, amongst other examples, of a heroin-using mother who had six

51 Australian Institute of Family Studies, submission 103, p 4.

52 Australian Institute of Family Studies, submission 103, p 4.

53 Catholic Women’s League of Australia, submission 35, p 7; Australian Institute of Family Studies, submission 103, p 2; Odyssey House Victoria, submission 111, p 4; Commission for Children and Young People and Child Guardian (Qld), submission 146, p 8.

54 Rowe L, transcript, 15 August 2007, p 17.

55 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 84.

children to five fathers.⁵⁶ Mothers' partners may direct violence at children or introduce inconsistent or inappropriate messages in parenting.⁵⁷ While parents are drug-affected, the children are vulnerable to these other adults who may abuse, exploit and neglect them and their care.⁵⁸ A grandmother wrote in a submission, for example, that her granddaughter had been sexually and emotionally abused by her mother's partner:

Imagine you are eight years old. You spend most of your time at your friend's house. You go there whenever you can because being at home is just too painful. Your mother is a drug addict and in your short lifetime she has lived with three abusive, drug-addicted, violent men. The latest one is very scary. He yells and screams all the time and blames you and your brother for everything that goes wrong. He beats your brother and he makes you do things that are scary. He watches pornographic videos and makes you watch them with him.⁵⁹

- 3.44 Children in the care of illicit drug users may also be exposed to unsafe practices in the home environment, including poor hazard detection by parents and exposure to methadone syrup, illicit drugs and drug equipment.⁶⁰ The Royal Women's Hospital also reported that illicit drug use in the family was a risk factor for infant deaths attributed to Sudden Infant Death Syndrome (SIDS).⁶¹
- 3.45 There is currently no nationally agreed framework for classifying child deaths either within the general community or within the child protection population.⁶² However, illicit drug use by a parent or carer has been associated with a significant number of child deaths:

56 Rowe L, transcript, 15 August 2007, p 5; see also Name withheld, submission 155, p 1; Glastonbury Child and Family Services, submission 74, p 6; Centrelink, submission 128, p 8.

57 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 84.

58 Miller T, submission 78, p 7.

59 Name withheld, submission 155, p 4.

60 National Drug and Alcohol Research Centre, submission 147, pp 10–11; NSW Commission for Children and Young People, *Annual report 2005: Child death review team* (2006), pp 69–71; South Australian Government, submission 153, p 8.

61 Royal Women's Hospital, submission 142, p 5.

62 Victorian Child Death Review Committee, *Annual report of inquiries into the deaths of children known to Child Protection 2007* (2007), p 54.

- In New South Wales, drug abuse was associated with 22 per cent (15) of the 75 child deaths examined in detail where there were suspicions of abuse or neglect over the three year period to June 2002;⁶³
 - In Queensland, between 1999 and 2002 drug use was present in 41.2 per cent of families in which a child death occurred;⁶⁴
 - In Victoria, parental drug use featured in nine, or 45 per cent of the 20 child deaths known to child protection authorities in 2005-06;⁶⁵ and
 - In Western Australia, 77 per cent of 44 child deaths since 2003 involved parental drug use.⁶⁶
- 3.46 These are devastating figures, and they represent only those deaths investigated and positively identified as drug-related. Other deaths classified as 'accidental' may be the result of neglect or inadequate supervision in drug-using households.⁶⁷
- 3.47 A 2003 report from the New South Wales Child Death Review Team, on 75 cases of fatal neglect and assault of children between 1999 and 2002, found that 16.1 per cent of these children (five children) died in circumstances in which their parent or carer was intoxicated by alcohol and other drugs. Three children were killed in motor vehicle accidents in which the parents who were driving were grossly intoxicated; one child was killed in a house fire and one died as a result of drowning. In the latter case, a 16 month old was found face down in a bath after being left by her carer, a friend of her mother who had been smoking cannabis and had drunk about 12 glasses of wine. The mother's friend was charged with manslaughter, although he was found not guilty.⁶⁸

63 NSW Child Death Review Team, *Fatal assault and neglect of children and young people 2003* (2003), p 28.

64 Commission for Children and Young People and Child Guardian (Qld), submission 146, p 7.

65 Victorian Child Death Review Committee, *Annual report of inquiries into the deaths of children known to Child Protection 2006* (2006), p 31.

66 Government of Western Australia, Drug and Alcohol Office, submission 144, p 1.

67 Single T, Senior Clinical Psychologist, Child Protection Team, John Hunter Children's Hospital, Newcastle, 'Methadone poisoning in young children: Deliberate or accidental?', presentation to the Ninth Australasian Conference on Child Abuse and Neglect, 24-27 November 2003, Sydney, p 4.

68 NSW Child Death Review Team, *Fatal assault and neglect of children and young people 2003* (2003), p 69.

- 3.48 Similarly, a grandmother gave evidence about the drowning of her two year old granddaughter in Canberra's Lake Burley Griffin in 2002. The girl was in the care of her former daughter-in-law and her then partner. Both of them were long-term heroin addicts and had admitted to taking heroin on the morning of the drowning. A coronial inquest was held, however:
- ...the Coroner's terms of reference were narrowly confined to the site and events on the morning of the drowning. The Coroner found accidental drowning and there were no adverse findings against the mother or her partner.⁶⁹
- 3.49 Takeaway methadone doses are a serious risk to children in the home, as evidenced by a number of child methadone deaths in recent years. For example, the UK report on parental drug use, *Hidden harm*, recounted a case from 2002 in which a 23 year old woman had pleaded guilty of the manslaughter of her two year old son, who had died from drinking his mother's methadone. She had been smoking heroin in another room when the child found the bottle and drank the methadone. He had quickly become ill but his mother ignored the symptoms and took him shopping by bus. On returning home she put him to bed on a sofa and spent the evening smoking more heroin. She went shopping again the next day, before his death, leaving the boy with a 16 year old babysitter who was also a heroin addict.⁷⁰
- 3.50 In Australia, there have been other examples of child methadone deaths, although the absence of a clear methodology for accounting for and classifying such deaths means that it is difficult to place an exact figure on the number of such deaths that have occurred. Additionally, methadone poisoning in children can be easily missed, because some symptoms are similar to poisoning by other substances and other opiates, and methadone is not specifically detected by a general screening for opiates.⁷¹ There is also an unknown number of children who are treated in hospital for methadone poisoning and recover.⁷²

69 Bosworth J, submission 180, p 2.

70 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), p 38.

71 Single T, Senior Clinical Psychologist, Child Protection Team, John Hunter Children's Hospital, Newcastle, 'Methadone poisoning in young children: Deliberate or accidental?', presentation to the Ninth Australasian Conference on Child Abuse and Neglect, 24-27 November 2003, Sydney, p 26.

72 Single T, Senior Clinical Psychologist, Child Protection Team, John Hunter Children's Hospital, Newcastle, 'Methadone poisoning in young children: Deliberate or accidental?',

- 3.51 In a 2005 case, a six year old girl died in New South Wales after her mother and boyfriend administered methadone to her that had been stored in a cough medicine bottle. Two litres of methadone and a large quantity of prescription drugs were later found in the house.⁷³
- 3.52 In some cases, methadone has been deliberately administered to children by their parents, in order to sedate a demanding baby, sleep, engage in social activities, take drugs or prostitute.⁷⁴
- 3.53 Reviews undertaken by the Department of Community Services in New South Wales found, in that state alone, seven cases in recent years where parents had administered methadone to their children, or their children had access to methadone that was not properly stored. In all cases the children died.⁷⁵
- 3.54 The committee questions whether the presence of dependent children was considered in the decisions to allow these parents takeaway doses of methadone. Parents who are using methadone, especially those simultaneously taking other drugs, do not have the alertness, judgement or physical capacity to supervise the presence of dangerous drugs like methadone.

Recommendation 3

- 3.55 **That the Minister for Health disallow the provision of takeaway methadone through the Pharmaceutical Benefits Scheme for drug users who are parents and have children living in their household.**

presentation to the Ninth Australasian Conference on Child Abuse and Neglect, 24-27 November 2003, Sydney, p 26.

73 Kennedy L, 'Medicine mix-up killed Rose, says mother', *The Sydney Morning Herald*, 24 September 2005.

74 Single T, Senior Clinical Psychologist, Child Protection Team, John Hunter Children's Hospital, Newcastle, 'Methadone poisoning in young children: Deliberate or accidental?', presentation to the Ninth Australasian Conference on Child Abuse and Neglect, 24-27 November 2003, Sydney, p 24; see also Benson S, 'Laws to save kids from bad parents', *Daily Telegraph*, 24 October 2006, p 3; Kennedy L, 'Police accuse DOCs after child's fatal overdose', *Sydney Morning Herald*, 16 December 2004.

75 Department of Community Development, 'Methadone safety campaign aims to keep children safe', *InsideOut*, January/February 2007, viewed on 21 August 2007 at http://www.community.nsw.gov.au/html/news_publications/insideout/insideout_2007/JanFeb07/07JF-methadone.htm.

Co-occurring parental drug use and mental illness

- 3.56 The impacts of parental drug use on children, from chronic neglect, physical, sexual and emotional abuse and a lack of basic safety, are magnified when a parent also has a mental illness. As examined later in chapter eight, the prevalence of dual diagnosis (co-occurring illicit drug use and mental illness) is significant, raising further questions about the protection of children in parental care.
- 3.57 In general, there is no definitive data set that identifies how many illicit drug users with dependent children also have mental health problems. The 1996 National Mental Health Report, however, indicated that 29 per cent of mental health service consumers have dependent children, whilst a scoping report undertaken by the Australian Infant, Child, Adolescent and Family Mental Health Association cited figures that anywhere between 29 and 35 per cent of mental health services consumers are female parents of dependent children under the age of 18.⁷⁶
- 3.58 Given the figures cited later in chapter eight, suggesting between 30 and 80 per cent of mental health clients are drug users, and considering that both drug use and mental illness are most common in young adults of child-bearing age, parental comorbidity may be substantial.
- 3.59 Glastonbury Child and Family Health Services, who run a program called SKATE (the Supporting Kids and Their Environment program), said they had observed a close relationship between mental health issues and illicit drug use, 'encountering anxiety and/or depression in the parent(s) of almost all children referred to the groupwork programs'.⁷⁷ Odyssey House Victoria, the Pregnancy and Parenting Substance Use Program and Marymead Child and Family Services also noted mental illness as among a range of additional family risk factors commonly occurring alongside parental drug use in their clients.⁷⁸

76 Hegarty M, Mental Health Co-ordinating Council (NSW) and the Department of Community Services (NSW), sponsored by the Australian Government Department of Family and Community Services, *Mind the gap: The National Illicit Drug Strategy (NIDS) project to improve support for children from families where there are mental illness and substance abuse (MISA) issues - Literature review* (2004), p 9.

77 Glastonbury Child and Family Health Services, submission 74, p 3.

78 Women's Health Service (WA) Pregnancy Early Parenting & Illicit Substance Use, submission 26, p 1; Odyssey Institute of Studies, *The Nobody's Clients Project: Identifying and addressing the needs of children with substance dependent parents* (2004), p 78; Marymead Child and Family Services, submission 107, p 4.

3.60 There are few studies examining the impacts of dual diagnosis on dependent children. A report for the National Illicit Drug Strategy in 2004 noted that:

What is becoming apparent, in both health and child protection fields, is that an increasing number of people with mental illness and substance abuse are also parents... There is little, if any, recognition of the complex needs of these families, and possible risks for their children. In fact, there is only recently emerging evidence in the mental health and drug and alcohol fields to indicate an awareness of children whose parents have either of these disorders, reinforcing the suggestion that these are 'the invisible children', because they are not recognised in service delivery.⁷⁹

3.61 It is likely that parental comorbidity contributes to greater problems in child outcomes than illicit drug use alone.⁸⁰ Parents with a dual diagnosis may be more likely to exhibit behaviours which clearly create problems in the parenting role, including:

- less involvement in and poor communication with their children;
- an inability to respond appropriately to children's needs;
- poor organisation and disrupted family rituals;
- inappropriate expressions of anger or violence;
- poor impulse control, potentially linked to tendencies towards physical, sexual and domestic violence;
- obsessional rituals (particularly with Obsessive Compulsive Disorder) that detract from child-rearing tasks;
- poor self-esteem and self-confidence in relation to parenting; and
- family stress including work problems, illness, marital strain and financial strain.⁸¹

79 Hegarty M, Mental Health Co-ordinating Council (NSW) and the Department of Community Services (NSW), sponsored by the Australian Government Department of Family and Community Services, *Mind the gap: The National Illicit Drug Strategy (NIDS) project to improve support for children from families where there are mental illness and substance abuse (MISA) issues - Literature review (2004)*, p 1.

80 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children (2007)*, p 48.

81 Hegarty M, Mental Health Co-ordinating Council (NSW) and the Department of Community Services (NSW), sponsored by the Australian Government Department of Family and Community Services, *Mind the gap: The National Illicit Drug Strategy (NIDS)*

- 3.62 Both drug use and parental mental illness have been identified as risk factors for child abuse and neglect.⁸² The Australian Psychological Society told the committee that:

People who are coping with both mental health problems and substance use are generally perceived as particularly needy and vulnerable and therefore anyone in their care may be more at risk. Both mental health and substance use feature as significant factors in reported incidents of child abuse, and their coexistence with other interpersonal and social difficulties also increases risk of abuse.⁸³

The intergenerational cycle of drug use

- 3.63 There is little doubt that illicit drug use forms part of an intergenerational cycle of abuse and disadvantage.⁸⁴ Experiencing drug use, abuse and violence places individuals at greater risk of using illicit drugs later in life.⁸⁵
- 3.64 The children of drug addicts usually grow up in poverty, which has serious effects on their lives, including their health, education, social and family relationships, and the likelihood of developing their own addictions. One cause of the intergenerational cycle of deprivation is the lack of parenting skills of illicit drug users. Some drug users whose parents were addicts, and who have had no experience of parenting outside a drug-using lifestyle, may not know how to parent their own children.⁸⁶ Poor parenting practices can include inconsistency, emotional detachment and neglect, mental health problems and family violence.⁸⁷

project to improve support for children from families where there are mental illness and substance abuse (MISA) issues - Literature review (2004), pp 7-14; Dawe S et al, Australian National Council on Drugs, Drug use in the family: Impacts and implications for children (2007), pp 47-48.

- 82 Hegarty M, Mental Health Co-ordinating Council (NSW) and the Department of Community Services (NSW), sponsored by the Australian Government Department of Family and Community Services, *Mind the gap: The National Illicit Drug Strategy (NIDS) project to improve support for children from families where there are mental illness and substance abuse (MISA) issues - Literature review (2004), p 12.*
- 83 Australian Psychological Society, submission 131, p 9.
- 84 See chapter ten.
- 85 National Drug and Alcohol Research Centre, submission 147, p 8.
- 86 Victorian Alcohol and Drug Association, submission 100, p 10.
- 87 Youth Substance Abuse Service, submission 87, p 6.

3.65 The Alcohol and Drug Foundation ACT suggested that 80 to 90 per cent of women and approximately 60 per cent of men undergoing treatment for drug use have been abused as children and/or adults.⁸⁸ Tragic accounts such as the one below highlight the dangers of the intergenerational cycle of abuse and drug use. Dr Bronwyn Gould told of a patient who:

... had endured 13 years of every sort of abuse at the hands of all members of her family—both parents and siblings—before she was taken into the care of the state, and that care was not very containing and life was very difficult. We were seeing her quite regularly and she was a very, very unwell little lass. She used to sit and shake, and sometimes crawl under the desk in the surgery and just rock and say, ‘I need to be safe.’ Then at the end of the consultation off she would go again with her worker. She rang me one afternoon and said, ‘Dr Bronwyn, I’ve found something that really works.’ It was one of those moments you never forget. I asked her what it was. ‘Oh, it’s better than counselling,’ she said. ‘I don’t feel all shaky.’ It was obvious what it was: heroin. Somebody had given it to her. She said, ‘And it lasts for a really long time—all afternoon.’ So she just had a patch of four hours of feeling what she saw as being normal, something we had not been able to offer her any other way.⁸⁹

Residential and child-friendly treatment

3.66 Clearly, the children in situations such as those described previously need love, safety, care and most importantly, a parent who is not using illicit drugs. Drug use and parenting are incontrovertibly conflicting demands, and it is almost always the needs of the child that are neglected and compromised.

3.67 The committee examines Australia’s treatment and rehabilitation system in detail in chapter six. The emphasis will be on ensuring that all treatment services funded by the Commonwealth have making individuals free from illicit drugs as their aim. This is especially important in the treatment of people who are parents, as there are vulnerable people who are relying on them.

88 Alcohol and Drug Foundation ACT, submission 123, p 2.

89 Gould B, transcript, 3 April 2007, pp 58–59.

- 3.68 The committee does acknowledge, however, that parents with dependent children, particularly single mothers, face particular difficulties in accessing treatment.⁹⁰
- 3.69 The committee was particularly interested in family-inclusive practices that addressed the intergenerational cycle of drug use, such as residential treatment services that provided for children to stay with their parent/s while they underwent treatment, or the provision of child care services while a parent/s attended rehabilitation programs on an out-patient basis.
- 3.70 The National Health and Medical Research Council noted the particular benefits of residential programs that also include dependent children:

Studies have shown that women have special concerns leaving their families, particularly children, in order to access residential treatment. ...women with dependent children were more than twice as likely to drop-out of treatment from a service that required them to be separated from their children than a specialist women's service that provided residential childcare and parenting programs.⁹¹

- 3.71 Residential treatment programs that provided for children to be with mothers undergoing drug treatment, such as those at Cyrenian House and Odyssey House Victoria, were highlighted to the committee as a treatment model that addressed a mother's drug use as well as enhancing a mother's parenting skills.⁹² Cyrenian House told the committee:

For a number of years Cyrenian House has been providing the only residential treatment service [in Perth] for Indigenous and non-Indigenous women affected by alcohol and/or other drugs with dependent children in their care. The re-unification between mother and child has become an increasingly important part of women's rehabilitation, importantly; they recognise their ongoing role as parents,

90 Hodson J, Women's Health Service (WA) Pregnancy Early Parenting & Illicit Substance Use, transcript, 14 March 2007, p 72.

91 National Health and Medical Research Council, *The Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems* (2001), p 48.

92 Government of Western Australia Drug and Alcohol Office, submission 82; Cyrenian House, submission 110; Odyssey House Victoria, submission 111.

providing necessary parenting education and role modelling.⁹³

3.72 Similarly, Teen Challenge NSW considered that more residential services should be available for mothers:

With regard to single mothers who have small children, we need more centres prepared to run programs and build purpose-built facilities that cater for embracing the opportunity to care for both mother and child without the trauma of separation. As the mother seeks help from her substance abuse issues they also receive instruction in the keys to being a good parent. This is all conducted in an environment of professional and caring support.⁹⁴

3.73 Providing that they are designed in the best interests of dependent children, the committee considers that programs that allow mothers to undergo residential treatment with their children close by, such as those offered by the Saranna Women and Children's program at Cyrenian House in Perth and Odyssey House in Melbourne, and child-friendly out-patient programs, such as those run by the Perth Women's Centre (PEPISU) and the Gold Coast Drug Council should be made a priority in funding arrangements between the Commonwealth and service providers.

3.74 Without access to such programs, drug-using mothers with children face considerable barriers in accessing treatment, and dependent children in their care are therefore placed at prolonged risk. As Odyssey House write in their submission, drug treatment for parents should be a first priority:

Fewer substance-dependent parents will mean fewer children exposed to risk. Drug treatment must therefore be available and accessible to clients with children.⁹⁵

93 Cyrenian House, submission 110, p 5.

94 Teen Challenge NSW, submission 139, p 3.

95 Odyssey House Victoria, submission 111, p 5.

Recommendation 4

3.75 The Department of Health and Ageing, as part of the next funding round for the Non Government Organisation Treatment Grants Program, give urgent priority to funding:

- residential treatment services that provide for children to live-in with their mothers during treatment; and
- non-residential treatment services that cater for the needs of parents with dependent children

where the aim is to make parents drug-free individuals.

Preventing damage to children

3.76 The neglect and abuse that illicit drug use by a family member can cause to innocent children warrants a strong approach to prevent future damage and avoid the high chances of intergenerational drug use and disadvantage.

3.77 The ideal outcome is clearly for the parent/s to successfully undergo treatment, be able to stop using illicit drugs and assume a positive and responsible parenting role. Treatment is not always successful, however, and drug addiction is a chronic condition prone to relapse. Where illicit drug use by the parent continues, and where children continue to be placed at risk, there are some tough decisions that need to be made about the best interests of the child.

3.78 The committee concurs with the views expressed in a report on this subject from the United States, *No safe haven*, produced by the National Center on Addiction and Substance Abuse at Columbia University (CASA) in 1999. After an exhaustive two-year analysis of the available data on child abuse and neglect, and an unprecedented national survey of 915 professionals working in the field of child welfare, the report called for a complete overhaul of child welfare systems and practices. The report concluded that sometimes, children simply did not have time to wait for their parents to get better:

Drug and alcohol abuse has thrown into doubt a fundamental tenet of child welfare: the commitment to keep the child with his or her natural parents. Child welfare workers have long viewed terminating parental rights as a failure. But alcohol,

crack cocaine and other drug abuse has shattered this time-honoured precept. Where drug- and alcohol-abusing and addicted parents are concerned, the failure often rests in perpetuating such rights at the expense of the child's development.

There is an irreconcilable clash between the rapidly ticking clock of cognitive and physical development for the abused and neglected child and the slow motion clock of recovery for the parent addicted to alcohol or drugs. In the earliest years, the clock of child development runs at supersonic speed-intellectually, physically, emotionally and spiritually. For the cognitive development of young children, weeks are windows of early life that can never be reopened. For the parent, recovery from drug or alcohol addiction takes time-certainly months and often years-and relapse, especially during initial periods of recovery, is common. Quick fixes and cold turkey turnarounds are the rare exception for alcohol and drug addicts and abusers.

Bluntly put, the time that parents need to conquer their substance abuse and addiction can pose a serious threat to their children who may suffer permanent damage during this phase of rapid development. Little children cannot wait; they need safe and stable homes and nurturing adults *now* in order to set the stage for a healthy and productive life.⁹⁶

- 3.79 While the Commonwealth has limited involvement in child protection, there are several practical ways that the Commonwealth can influence policy to provide better opportunities for children and to put their interests and safety foremost.

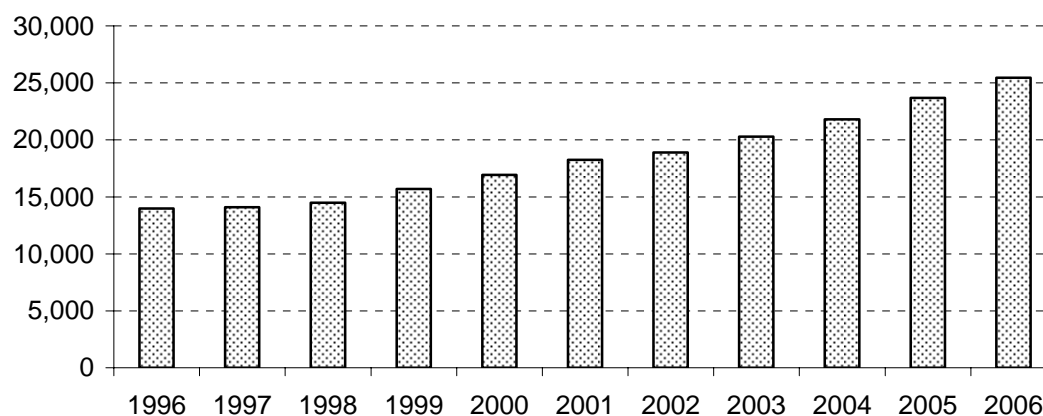
Stability of care and permanency planning

- 3.80 Child protection authorities face difficult choices when they become aware of neglect and abuse — to keep the child/ren in a potentially risky environment or to remove them into other forms of care, such as foster care or permanent adoption. The committee believes that child protection authorities need to always give priority to the safety of children.

⁹⁶ The National Center on Addiction and Substance Abuse at Columbia University, *No safe haven: Children of substance-abusing parents* (1999), p iv.

3.81 In recent years there has been a significant expansion of the number of children in out-of-home care (figure 3.1). The significant involvement of parental drug use in the child protection caseload would suggest that many of these children have been temporarily removed from a family member using illicit drugs.⁹⁷

Figure 3.1 Number of children aged 0–17 years in out-of-home care, 1996–2006



Source Australian Institute of Health and Welfare, *Child protection Australia 2005-06 (2007)*, cat no CWS 28, p 51.

3.82 Families Australia highlighted the shortage of foster carers as a key challenge for child protection agencies:

An important additional cost of drug misuse is that Australia's welfare systems have had to provide for increasing numbers of children who are being taken into the out-of-home (kinship and foster) care system due largely to parental drug misuse. There was a 45 per cent increase in the number of children in out-of-home care between 1996 and 2003. There are now real doubts about the capacity of this form of care to cope with demand. Australia faces an acute shortage of foster carers... The costs — financial, psychological and social — borne by those providing out-of-home care remain inadequately researched, documented and, in many if not most cases, recompensed.⁹⁸

3.83 As recognised later in this report, there are many grandparents caring for children in formal and informal arrangements because their

97 Odyssey House Victoria, submission 111, p 4.

98 Families Australia, submission 152, p 11.

parents do not have the capacity to care for them.⁹⁹ These people have taken on, often quite unexpectedly, the immensely challenging task of bringing up their children's children. Evidence suggests that, in many cases, grandparents are taking on the primary care role for their grandchildren because of their own children's drug problems.¹⁰⁰

- 3.84 According to the Australian Bureau of Statistics, in 2003 there were 22,500 grandparent families with 31,000 children aged 0-17 years in Australia, representing around one per cent of all families with children aged 0-17 years.¹⁰¹ It is thought that the number of grandparent-headed households is growing.¹⁰² In 2001-02, there were 7,439 children in out-of-home care being cared for by relatives, accounting for 39 per cent of children in out-of-home care.¹⁰³ In 2005-06, this had risen to 10,316 children in out-of-home care being cared for by relatives, accounting for 40.5 per cent of children in out-of-home care.¹⁰⁴
- 3.85 One reason is that child protection agencies are giving increasing emphasis to kinship care — where children at risk are cared for by family members other than parents in preference to placing children in foster care. Kinship care in out-of-home care is thought to have significant advantages to children because it provides for a strong sense of identity for the child and greater stability.¹⁰⁵ It comes, however, at personal, social and financial costs to grandparents.¹⁰⁶
- 3.86 The majority of children who are in the child protection system cycle in and out of foster care placements. Children in out-of-home care often face being cared for by a number of different carers. In 2005-06,

99 Canberra Mothercraft Society, *Grandparents parenting grandchildren because of alcohol and other drugs*, from Families Australia, submission 152, p 13; Marymead Child and Family Centre, submission 107, p 4; Wanslea Family Services, submission 97, p 4; Lubach M, Kinkare, transcript, 7 March 2007, p 3.

100 See for example, Relationships Australia, submission 143, p 2; Commission for Children and Young People and Child Guardian (Qld), submission 146, p 9; Canberra Mothercraft Society, *Grandparents parenting grandchildren because of alcohol and other drugs*, from Families Australia, submission 152, p 13.

101 Families Australia, submission 152, p 12; Baldock E, transcript, 28 May 2007, p 28; Relationships Australia, submission 143, p 2; Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 9.

102 Families Australia, submission 152, p 12.

103 Australian Institute of Health and Welfare, *Child Protection 2001-02 (2003)*, cat no CWS 20, p 41.

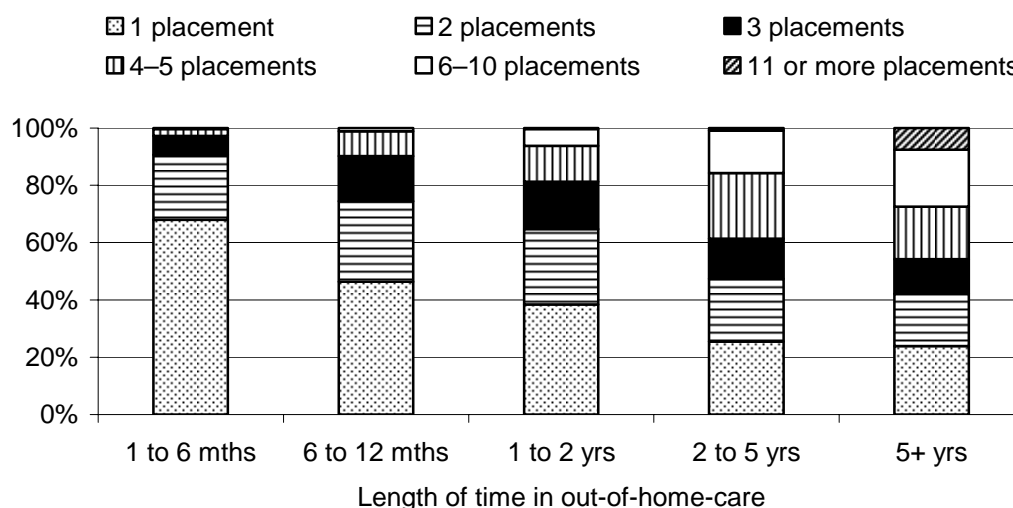
104 Australian Institute of Health and Welfare, *Child Protection 2005-06 (2007)*, cat no CWS 28, p 52.

105 Name withheld, submission 86, p 1.

106 See chapter nine.

one-third of children in an out-of-home placement of between one and six months had more than one placement, rising to three quarters of children when out-of-home placements were for a period greater than five years (figure 3.2).

Figure 3.2 Children on a care and protection order and exiting out-of-home care during the year by number of placements, by the length of time in out-of-home care, 2005-06 (per cent)



Source *Steering Committee for the Review of Government Service Provision, Report on Government Services 2007 (2007), table 15A.19.*

3.87 The Catholic Women's League of Australia also noted that 'if children are removed and placed in temporary care they return to the same nightmare — long-term care is scarce.'¹⁰⁷ Even when children are on permanent care and protection orders and are in long-term foster care, they can face the uncertainty of being placed back with their parents or moved on to another carer. For example, in New South Wales, children in long-term foster care under supposedly 'permanent' orders can face the prospect of being returned to their parents by a court order, introducing more instability into their lives.¹⁰⁸

3.88 Foster carers such as Mrs Rowe are doing admirable work, but the increase in children at risk is putting increasing pressure on the foster care system. Current policies, which are biased against adoption, lead to too many children being left in at-risk situations because of a

107 Catholic Women's League of Australia, submission 35, p 7.

108 Rowe L, transcript, 15 August 2007, p 5.

shortage of out-of-home placements, or to children being moved from carer to carer.

- 3.89 Wanslea Family Services noted that children who experience serial foster placements have ongoing issues around abandonment, loss and trauma:

Having entered the out-of-home care system, a child risks serial placements, many different schools, educational disadvantage, difficulties with peer relationships and oversights in regard to health care.¹⁰⁹

- 3.90 Mrs Rowe told how the five year old girl currently in her care had acquired terrible insecurity and anxiety from 'repeated rejections' by her parents and other adults in her life and the seemingly constant changes in her living environment:

Even just how much food I put in her lunchbox for preschool determines her emotional stability for the day: 'Why am I having that much food, how long am I going to be gone, when are you coming back?'¹¹⁰

- 3.91 Mrs Rowe also told the committee about the confusion and complexity that could arise when children were continually trying to negotiate the different rules and expectations of their home and their foster parents' homes:

They see their mum every Thursday for a couple of hours' visit, which the kids just love because it is a party time. They get lollies, they get hot dogs, they get filled up with all this guilty food and mum is overcompensating so as to be shown to be a good mum and 'the kids still love me because I am giving them presents.' While they have a really good time with their mum on the Thursday, which is supervised access, on Thursday night we have nightmares. We have two children who scream in the night, who cannot tell you why they are frightened, and usually my husband is in one room and I am in the other comforting children, just telling them over and over again how safe they are and that nobody is getting hurt. I understand that some kids should go back, but I just do not understand why our system allows them to go back and come back and go back and there is no guarantee.¹¹¹

109 Wanslea Family Services, submission 97, p 3.

110 Rowe L, transcript, 15 August 2007, p 2.

111 Rowe L, transcript, 15 August 2007, p 2.

- 3.92 Marymead Child and Family Centre also reported that such contacts could be erratic and upsetting. ‘Sometimes these children experience quality contact time with their parents and other times the parents might not turn up at all when using’.¹¹²
- 3.93 Child protection services, therefore, face many difficult questions in assessing a child’s welfare. As described by the US report, *No safe haven*:
- when is it safe to return a child to an addicted parent?
 - how best can the child welfare system help families with substance abuse problems?
 - how many relapses should addicted parents who enter treatment be permitted before they permanently lose rights to their children?
 - how do answers to these questions change when parents say they love their children and children express love for their parents and a desire to stay with them?¹¹³
- 3.94 Mrs Rowe considered that some parents received too many chances to break their drug habit and improve their parenting, leading to even greater damage being done to their children. Additionally, the courts failed to consider the parenting history of a family. A younger sibling of the child she was currently caring for had died as a result of ingesting her mother’s methadone:

With the children I have now, the magistrate is the one who said, ‘If mum presents as doing this, this and this, then they can go home.’ She seems not to look at the history of the family. It might just be me, but when I look back at the history—with the baby having the methadone and the constant stuff going on—I truly cannot see any reason for those kids to go home and be put back in that situation that is going to fail again and they will come back in. It will fail because of the history—of mum’s history as a child and her history now as an adult. Sure, she has been clean for a few months but she has done that before.¹¹⁴

112 Marymead Child and Family Centre, submission 107, p 4.

113 The National Center on Addiction and Substance Abuse at Columbia University, *No safe haven: Children of substance-abusing parents* (1999), p 30.

114 Rowe L, transcript, 15 August 2007, p 5.

3.95 A similar frustration was expressed by the Canberra grandmother, mentioned above, whose granddaughter had drowned whilst in the care of her mother and mother's partner, both long-term heroin addicts. 'While the drug addiction', she said, 'caused huge distress to our family, the most difficult and ongoing struggle has been with the authorities that have responsibility for the care and protection of children'.¹¹⁵

3.96 The coronial inquest into the drowning did not acknowledge that the mother and her partner were heroin addicts, that the mother was working as a prostitute and the partner had a criminal history of drug trafficking. After a finding of accidental death was returned, a second daughter, an infant, was returned to the mother's custody within three days:

I have continuing concerns about the safety and wellbeing of my remaining granddaughter who I believe (based on considerable evidence) is still exposed to an unsafe environment. My granddaughter now has chronic health problems that require attention, including an eye defect that is and will continue to be an impediment to her progress at school unless it receives appropriate treatment. I have repeatedly brought my concerns to the attention of the ACT Care and Protection Services. However, it is my overriding impression that the rights of the mother have been protected to the detriment of both my granddaughters.¹¹⁶

3.97 Another grandmother, a kinship carer, had had a similar experience in fighting to gain custody of her grandson despite grave concerns about his safety:

In spite of repeated reports of concerns of illicit drug use by my daughter made by both myself and mandatory reports to the NSW child protection jurisdiction, very little was done to ensure my grandson's safety. In fact 42 per cent of mandatory reports made about my grandson were assessed as being 'high risk' and yet these were not adequately responded to. Whenever I spoke with officers from this particular NSW child protection office I was always treated like a neurotic grandmother who didn't know what I was talking about.¹¹⁷

115 Bosworth J, submission 180, p 2.

116 Bosworth J, submission 180, p 3.

117 Name withheld, submission 86, p 4.

- 3.98 Yet another grandmother wrote to the committee with great anxiety for the welfare of her grandchild, and a feeling of hopelessness towards child protection authorities' willingness to act. Her daughter and her daughter's boyfriend were drug addicts, and the boyfriend had a criminal conviction for assault:

Our daughter fell pregnant and gave birth to a still born child 16 months ago at 20 weeks gestation... During this pregnancy I tried to alert welfare officers at [a medical centre] of my concerns as to the suitability of the couple as parents given their lifestyle however I was reminded of the privacy act and the fact that it was none of my business... My daughter once again was pregnant and gave birth to a premature baby three weeks ago. This child is still in intensive care and all medical expenses are being covered by the public health system. Once again an attempt was made to make welfare aware of the situation and concern as to suitability as parents. This time they did give us a hearing as they too had been building up their own picture at regular check ups and were also concerned. However, the matter was reported by the hospital welfare officer who was told that not enough evidence was available to raise concerns at this stage. I am assuming therefore that until some physical evidence of abuse is available nothing will be done. This child is extremely small and our concern is that a death may occur.¹¹⁸

- 3.99 Kinkare, an agency for grandparent and relative carers on the Gold Coast, also felt that the child protection system was biased towards keeping parents with their children, whether for reasons of money (the state governments save on paying fostering allowance for those children) or because child protection workers are not always well trained in drug issues and addicts can find it relatively easy to present well for assessment.¹¹⁹
- 3.100 The committee has noticed a view in the treatment sector that children are instruments of a mother's rehabilitation, and potentially this parent-focused bias is leading to children being kept for longer with their families than is in their best interests. Cyrenian House noted, for example, that, 'the re-unification between mother and child has become an increasingly important part of *women's*

118 Toughlove Victoria, submission 112, pp 1-2.

119 Lubach M, Kinkare, transcript, 7 March 2007, p 26.

rehabilitation',¹²⁰ while Glastonbury Child and Family Services cautioned that:

Frequently observed practice experience is that if a young child is removed it often leads to the parent(s) becoming disheartened and the illicit substance use worsening, occasionally with fatal results.¹²¹

3.101 Wanslea Family Services said in their submission that:

Parents who have a baby removed from their care also experience long-term issues around loss and grief. The removal of a child projects parents into complex welfare and legal systems. Children in those same systems will have advocates, but parents whose children have been removed are usually without anyone who supports or advocates for them.¹²²

3.102 The committee does not share this view. On the contrary, the evidence received has demonstrated that children have few advocates, or access to support services which might be available to their addicted parents or adult family members. In many cases children have not yet even developed the basic emotional maturity and communication skills to articulate and represent their feelings.

3.103 In a previous inquiry into the adoption of children from overseas¹²³, the committee also uncovered a strong anti-adoption attitude within state and territory bureaucracies that likely explains the extremely low rate of local adoptions in Australia. The number of carer adoptions has continued to decline from 172 in 1998-99 to 59 in 2003-04, before increasing to 95 in 2005-06.¹²⁴ As with intercountry adoption, Australia lags behind other countries in relation to adoptions of children in care. In 2000, the estimated rate of children in care for Australia was 1 per cent, compared with 4 per cent in the United Kingdom and 6-7 per cent in the United States.¹²⁵

120 Cyrenian House, submission 110, p 5, emphasis added.

121 Glastonbury Child and Family Services, submission 74, p 12.

122 Wanslea Family Services, submission 97, p 3.

123 House of Representatives Standing Committee on Family and Human Services, *Overseas Adoption in Australia: Report on the inquiry into adoption of children from overseas* (2005).

124 Australian Institute of Health and Welfare, *Adoptions Australia 2005-06* (2006), cat no CWS 27, p 40.

125 Cashmore J, 'What can we learn from the US experience on permanency planning?' *Australian Journal of Family Law* (2000), vol 15, p 225.

- 3.104 The committee heard evidence in the overseas adoption inquiry that children were placed in foster care when adoption may be a more suitable outcome for them. Witnesses suggested this attitude was caused by the stigma attached to past adoption practices. Further, parents were reluctant to give up their children when the foster system relieves them of the responsibility of looking after them. Dr Judith Cashmore of the University of Sydney Law School said that:

Unfortunately, what tends to happen is a lot of children get lost in the foster system. Unless the birth parents relinquish their rights to the child, many children end up in foster care, going from one foster home to another, because the parents do not want to sign on the dotted line to give up their rights but do not want the kid, either. These children would do amazingly in a permanent family but there is such a 'blood is thicker than water' mentality out there.... I do not know if it is blatantly anti adoption or just pro blood relation. I personally feel that some of this may be a swing back from the stolen generation pendulum. It was so extreme 40 or 50 years ago—I have a close friend who was one of the stolen generation—and, to me, it is like it has swung so far the other way. Now you put the kids back with their biological parents regardless of the child's safety.¹²⁶

- 3.105 Mrs Rowe agreed that an anti-adoption attitude was entrenched in child protection agencies:

They just think blood is thicker than water, that the kids should be with their parents. I think they need to know their history. It is not necessarily good for them to be there; in most cases it is not. I cannot see that it is good for children to be with parents in a situation that means you do not know when you come home from school if you are going to be fed or not.¹²⁷

- 3.106 Mrs Rowe told the committee that many of the children that had been in her care would have been better off had they been adopted rather than being shuffled between carers and their parents:

126 Cashmore J, 'What can we learn from the US experience on permanency planning?' *Australian Journal of Family Law* (2000) vol 15, p 225; in House of Representatives Standing Committee on Family and Human Services, *Overseas adoption in Australia: Report on the inquiry into adoption of children from overseas* (2005), p 125.

127 Rowe L, transcript, 15 August 2007, p 10.

We need to look more along the lines that, okay, some mistakes were made there but some of these children need to be in permanent homes, regardless of their colour, to help them learn and to give them emotional stability. If we have problems and we have been brought up in a family where we know we can go to somebody and have a cry and get a cuddle—and maybe not told that everything will be all right but ‘I will help you through it’—then we are better able to cope when things go wrong than if we are all alone and have not learnt those coping skills. These children are never going to learn them if they keep on being chopped and changed. I think it comes back to the fact that with the case workers and the department it is all individual. You get some people who are gung-ho about ‘Let’s get them in a placement. Let’s keep them there and let’s support those workers and the children and give them a chance.’

[Adoption] would be great, especially for the little ones. Then they have a chance. I still think that they need to have maybe phone contact and photos and things like that so that they still have an understanding of where they have come from. But I think having a home and a name is so necessary.¹²⁸

- 3.107 In evidence to the committee’s inquiry into overseas adoption, one of the key determinants of a child’s welfare in out-of-home care was the stability of placement, or permanency. If a child could not obtain a stable placement within 12 months, his or her behaviour tended to deteriorate. If a child had two or more placement breakdowns (due to behaviour, for example) within the previous two years, then that child was significantly more likely to deteriorate over time and experience placement breakdowns in future. Dr Howard Bath, a clinical psychologist at the Thomas Wright Institute, said that:

I believe that permanent care options such as adoption or long-term parenting orders provide the majority of good news stories, successes if you will, that we experience in child welfare.¹²⁹

128 Rowe L, transcript, 15 August 2007, p 6.

129 Bath H, ‘Rights and realities in the permanency debate,’ *Children Australia* (2000) vol 25, p 13; in House of Representatives Standing Committee on Family and Human Services, *Overseas adoption in Australia: Report on the inquiry into adoption of children from overseas* (2005), p 126.

3.108 While the Commonwealth Government has a limited role in child protection,¹³⁰ the committee considers that the Commonwealth needs to provide some leadership in this area. One inquiry participant commented that:

The lack of any consistent approach to child protection laws across the state and territory jurisdictions is a major problem. Each state and territory has different reporting conditions for child abuse and neglect. This fragmented approach to child protection undermines the ability of state and territory child protection jurisdictions to adequately respond to allegations of child abuse and neglect and also raises serious concerns about the effectiveness of information gathering on child protection policies, issues and data collection.¹³¹

3.109 The current anti-adoption attitude held by many making decisions about children's lives is placing impossible demands on the availability of foster carers. Meanwhile, there are many people who would like to establish or add to a family but are unable to have children of their own.

3.110 The committee considers that adoption should be established as the 'default' outcome for child protection authorities, where a child is found to be at risk and where the parent's previous attempts at rehabilitation and treatment within a set period have failed. This would be a way of giving greater stability and certainty for children in out-of-home care, particularly for younger children. As a result, the onus will be on child protection authorities to demonstrate that forms of care other than adoption are in the best interests of the child.

3.111 The Commonwealth Minister for Families, Community Services and Indigenous Affairs should therefore initiate policy reform in out-of-home care and local adoptions. The minister should, through the Community and Disability Services Ministers' Conference, develop a policy framework which acknowledges that adoption is a legitimate way of forming or adding to a family and adoption is a desirable way of providing for a significant proportion of children at risk.

3.112 Responsible departments could also collect and publish performance information on the extent to which the risk assessments made prior to

130 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 5.

131 Name withheld, submission 86, p 4.

returning children from foster care to their biological parents are borne out by actual outcomes.

Recommendation 5

3.113 **The Commonwealth Minister for Families, Community Services and Indigenous Affairs, in conjunction with state and territory child protection ministers:**

- **develop a national adoption strategy which acknowledges that adoption is a legitimate way of forming or adding to a family and adoption is a desirable way of providing a stable life for a significant proportion of children with drug-addicted parents; and**
- **establish adoption as the ‘default’ care option for children aged 0–5 years where the child protection notification involved illicit drug use by the parent/s, with the onus on child protection authorities to demonstrate that other care options would result in superior outcomes for the child/ren.**

Applying income management to family support payments

3.114 While gaining custody of children was sometimes an incentive for a parent/s to seek treatment and become drug-free individuals,¹³² the committee was concerned to hear that parents’ desire to regain custody of children was connected to the income support paid to parents under the Commonwealth’s family assistance programs.¹³³ The committee was disturbed to hear that for some parents, care of their children was linked to monetary reward. Mrs Rowe told the committee that:

When parents lose their kids to the department and they get angry, a lot of the time it seems to me that they are not angry that the children have been taken. Sometimes, maybe, they

132 Hulse G, transcript, 21 March 2007, p 4; Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 76.

133 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 15; Centrelink, submission 128, p 3.

are a little bit relieved that the kids are gone, but then they get really angry because their payments are cut dramatically.¹³⁴

- 3.115 Mrs Rowe said that parents gave their children the impression that welfare payments were for their parents' benefit, rather than their own:

'You have to buy me this because you are getting all my mum's money. The government has given you my mum's money, so you have to buy me Spiderman; you have to buy me this. I want this; I want that, because you are getting my mum's money.' That is the message that mum is sending back through the children—she cannot buy them things because 'your foster carer has got all my money.'¹³⁵

- 3.116 Centrelink also reported that the transfer of family support payments along with care of the children was an issue. Grandparents who assumed care of the children were 'emotionally blackmailed' into not claiming the payments they were entitled to:

Grandparents in particular, may be emotionally blackmailed by their child into NOT claiming or pursuing entitlement to a Centrelink payment so they are able to support grandchildren. Usually it is not until an extreme event occurs that grandparents or relatives eventually claim a payment. They are very aware that when they claim a payment, the parent's payment will cease or be dramatically reduced and there will be work obligations for the parent of the child.¹³⁶

- 3.117 Centrelink also reported a case in which two men were attempting to gain custody of their respective children. 'Both males reported that their partners had drug issues, and did not care for the children but wanted the money for their own drug use'.¹³⁷

- 3.118 The Federal Parliament has recently passed legislation that adopts a stronger approach to protecting children at risk of neglect through the establishment of an income management regime that applies to a person in receipt of welfare payments, whose child is at risk of neglect, is not enrolled at school, or fails to attend school adequately.¹³⁸ This reform was introduced in the context of broader

134 Rowe L, transcript, 15 August 2007, p 3.

135 Rowe L, transcript, 15 August 2007, p 3.

136 Centrelink, submission 128, p 3.

137 Centrelink, submission 128, p 6.

138 Social Security and Other Legislation Amendment (Welfare Payment Reform) Bill 2007

reforms to protect Indigenous children in the Northern Territory, but can also apply generally to all Australian parents receiving welfare payments.

- 3.119 Under the income management regime, a proportion of welfare payments may be withheld, which can then be allocated by Centrelink through a range of mechanisms including vouchers, stored value cards, the payment of expenses and payments to various accounts (including stores, debit cards and bank accounts).¹³⁹ The income management regime will also provide for the payment of the Baby Bonus (currently \$4,133 per child) in 13 fortnightly instalments.¹⁴⁰
- 3.120 The full details of the income management regime are yet to be established. It is intended, however, that the provisions will be triggered at the request of a state or territory child protection officer. They will be subject to the principles to be set out in a Legislative Instrument yet to be made by the Minister.¹⁴¹
- 3.121 The committee welcomes the Commonwealth's tougher approach to ensuring that family support payments are used in the child's best interests and in recognising that the interests of the child **must come first**. In this inquiry it has heard how often money that is intended for food, clothing and family welfare is siphoned off to pay for illicit drugs.¹⁴²
- 3.122 The committee considers that child protection substantiations that involve *any* illicit drug use by parents should be a 'trigger' for activating the income management provisions for Commonwealth family support payments. Such an approach would ensure early intervention for families where children are at risk of missing out on basic necessities.
- 3.123 The committee also believes that where children are being returned to a parent/s after a period of out-of-home care, the income management provisions should be automatically activated to ensure

Explanatory Memorandum, p 6.

139 Hon Mal Brough MP, Minister for Families, Community Services and Indigenous Affairs, House of Representatives transcript, 7 August 2007, p 2.

140 Parliamentary Library, *Bills Digest: Social Security and Other Legislation Amendment (Welfare Payment Reform) Bill (2007)*, p 12.

141 Parliamentary Library, *Bills Digest: Social Security and Other Legislation Amendment (Welfare Payment Reform) Bill (2007)*, p 8.

142 National Drug and Alcohol Research Centre, submission 147, p 9; Chang T, submission 28, p 3; see also chapter nine.

that family support payments flow through to children rather than being diverted to pay for illicit drugs.

Recommendation 6

3.124 The Minister for Families, Community Services and Indigenous Affairs include in the Legislative Instrument covering the implementation of the Income Management Provisions of the *Social Security and Other Legislation Amendment (Welfare Payment Reform) Act 2007*

requirements that:

- **child protection authorities must notify Centrelink when a child protection substantiation detects *any* illicit drug use by a parent/s, and that this notification shall activate the income management regime provisions; and**
- **that it be mandated that when children are returned to a parent/s following a care and protection order the income management regime provisions be automatically applied.**

Contraception for illicit drug users

3.125 There is little information available on whether Australian illicit drug users are using contraception. King Edward Memorial Hospital told the committee that 80 per cent of female drug users are of child-bearing age.¹⁴³ According to the 2004 National Drug Strategy Household Survey, 1,039,600, or one in eight Australian women had used illicit drugs in the last 12 months, the vast majority of these being between the ages of 14 and 39.¹⁴⁴ Typically, female drug users are more likely than the general population to engage in high-risk sexual behaviours, including having sex with multiple partners, and not asking partners to use condoms.¹⁴⁵

3.126 A recent survey of 109 women in NSW and the ACT who had hepatitis C, most of whom were current injecting drug users, found low levels of contraceptive use. Condom use was primarily associated

143 King Edward Memorial Hospital for Women, submission 19, p 3.

144 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings (2005)*, cat no PHE 66, p 33.

145 Cooperman et al, cited in Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 84.

with sex work only, and many women cited problems with the pill, such that it was difficult to remember to take it, it was 'unnatural' or 'bad for you', and that they feared weight gain.¹⁴⁶

- 3.127 The United Kingdom report, *Hidden harm*, found that despite low levels of contraceptive use amongst drug users in the UK, most services in contact with women drug users paid no attention to planning and contraceptive advice in providing health care.¹⁴⁷ In Perth, King Edward Memorial Hospital said that:

We are very proactive in offering women excellent contraception options before they leave the hospital. We look at offering women informed consent to have contraception that has long activity.¹⁴⁸

- 3.128 It is difficult to know if this is the norm, however, amongst services that come into contact with women drug users.
- 3.129 The contraceptive pill and condoms may not be the most suitable methods of contraception for drug users because they require planning and consistent compliance. The intrauterine progestogen coil and contraceptive implants, however, which are effective and reversible long-term methods of contraception, may be appropriate.
- 3.130 It is important that women drug users are also made aware of emergency contraception, colloquially known as the 'morning after pill', which has been available from pharmacies without prescription since January 2004.¹⁴⁹
- 3.131 The Royal Australasian College of Physicians suggested that information about the effects of illicit drug use on unborn children be made available to all women of child-bearing age prior to a pregnancy occurring. By the time a woman finds out that she is pregnant, significant damage may already have occurred in the critical early weeks of foetal development.¹⁵⁰

146 Dance P, Banwell C and Olsen A, 'Preliminary findings: Choice or chance? Women's experiences of illicit drug use, contraception and hepatitis C', National Centre for Epidemiology and Population Health, Australian National University, presentation to the Hepatitis C Research Forum, 23 February 2006.

147 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), p 76.

148 Henderson C, King Edward Memorial Hospital for Women, transcript, 14 March 2007, p 15

149 Family Planning NSW Emergency contraception fact sheet, viewed on 23 August 2007 at <http://www.fpahealth.org.au/sex-matters/factsheets/76.html>.

150 The Royal Australasian College of Physicians, submission 119, p 12.

Recommendation 7

- 3.132 **The Department of Health and Ageing, in liaison with state and territory governments, promote the integration of contraception and family planning advice into treatment and general practice services for drug-using women of child-bearing age.**

The impact of harm minimisation programs on families

- 4.1 From the evidence taken by the committee in the course of its inquiry it has become quite evident that there is no universally agreed definition of harm minimisation. It clearly means different things to different people.
- 4.2 The greatest point of difference in illicit drug policy is between those who see minimising harm as a means of achieving the illicit drug user being drug free and those who see continued use as acceptable. The term harm minimisation has been captured by those who consider themselves to be the policy elite, who want so-called reform of drug laws, such as calling for cannabis to be treated like other legal drugs and therefore legalised and taxed and treated like any other commodity. The committee considers this to be a pro-drug stance. These people also share the view of the international movement funded by George Soros to change international treaties outlawing some drugs.
- 4.3 Harm minimisation is referred to in the national policy on drugs, the National Drug Strategy (NDS), which was developed into the framework for Commonwealth, state and territory government responses to drug issues.¹ The committee has several concerns about the prominence of the harm minimisation philosophy and the approach of some of its proponents in Australia, which are examined in this chapter:
- In general, the debate on ‘harm minimisation’ is shrouded in ill-defined terms which mean different things to different people;

1 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004).

- The strategy contains similarly ill-defined terms which leave room for confusion and mixed messages about its goals, particularly in relation to how illicit drug use is addressed;
- The committee finds the lack of written policy explicitly relating to illicit drugs unacceptable;
- The strategy's lack of focus leaves room for misinterpretation of the federal government's zero tolerance approach by drug industry elites, as well as state bureaucracies, thereby giving mixed messages to the community about the acceptability of illicit drug use;
- The interpretation of the term 'harm minimisation' by the drug policy elites that illicit drug use is morally neutral is completely at odds with the government's stated policy of zero tolerance which has harm prevention as its aim, and forms an illogical basis to a national drug policy framework; and
- The safety of children is compromised by treatment and child protection approaches for drug-using parents.

4.4 This chapter demonstrates that 'harm minimisation' means different things to different people. The range of possible interpretations leaves room for the Australian Government's approach to illicit drug use, as stated by the Prime Minister and discussed throughout this report, to be distorted. The position was recently restated by the Prime Minister in Parliament:

This government will never give up in the fight against drugs. We will never adopt a harm minimisation strategy; we will always maintain a zero tolerance approach.²

4.5 The committee considers that the ultimate goal of a national illicit drugs strategy should be harm prevention — that is, to prevent people becoming drug users and to enable individuals who break the law and use illicit drugs to become and remain drug free for the benefit of themselves, their families and the nation.

2 Hon John Howard MP, Prime Minister of Australia, *House of Representatives Debates*, transcript, 16 August 2007, p 52.

Defining harm minimisation

- 4.6 Harm minimisation is sometimes viewed as having commenced in the early 1980s in response to the emerging AIDS epidemic amongst intravenous drug users.³ The usage of the term also coincided with the public disclosure of the heroin problem of the then Prime Minister's daughter.⁴ The term also emerged from 'public health' policies in a range of areas that shifted the focus from the health of individuals to the general health of the population as a whole.⁵ In particular, needles and syringes were controversially supplied to injecting drug users in order to decrease the rates of contraction of HIV/AIDS and other blood borne viruses. There was also a recognition of the need for individuals to change behaviour with the launching of the 'grim reaper' campaign.⁶
- 4.7 Harm minimisation, with its public health roots, emphasised 'expert' knowledge and 'evidence-based policy' to the exclusion of ordinary people's experiences and opinions.⁷ Drug policy in Australia was thereby captured by influential drug industry elites.
- 4.8 An example of how the term was captured was an early definition of harm minimisation as applied to drug policy set out by a Canadian academic from the University of Toronto in 1995:
- A policy or program directed towards decreasing adverse health, social and economic consequences of drug use even though the user continues to use psychoactive drugs at the present time.⁸
- 4.9 There are a number of difficulties in defining harm minimisation, including what is meant by the terms 'harm' (such as health, economic, personal, third party 'opportunity' costs) and also the term 'minimisation'

3 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 13.

4 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach* (2002), p 11.

5 Zajdow G, 'A critical sociological perspective on harm minimisation' in Mendes P and Rowe J, *Zero tolerance and beyond: the politics of illicit drugs in Australia* (2004), Pearson Education Australia, p 73.

6 Winn M, 'The Grim Reaper: Australia's first mass media AIDS education campaign' in World Health Organisation, *AIDS prevention through health promotion: Facing difficult issues* (1991), pp 33-34.

7 Zajdow G, 'A critical sociological perspective on harm minimisation' in Mendes P and Rowe J, *Zero tolerance and beyond: the politics of illicit drugs in Australia* (2004), Pearson Education Australia, p 80.

8 Single E, 'Defining harm reduction', *Drug and Alcohol Review*, vol 14, pp 287-90.

(reducing harm as much as possible, or a reduction of harm in the context of competition for resources, or making drug-related harm less visible).⁹

Harm minimisation and the National Drug Strategy

4.10 National drug policy is developed by the National Ministerial Council on Drug Strategy. The council was established in 1985, at the time of the disclosure of the Prime Minister's daughter's heroin use. The council was established by the Special Minister's Conference on Drugs and is supported by a secretariat in the Commonwealth Department of Health and Ageing.¹⁰ The council comprises Commonwealth, state and territory ministers responsible for health and law enforcement.¹¹ The Commonwealth is also represented by the Minister for Education and Training. Council decisions are reached on the basis of consensus with dissensions and abstentions on specific items being noted.¹²

4.11 The council is one of 33 ministerial councils that operate under a framework developed by the Council of Australian Governments (COAG)—the peak intergovernmental decision-making body in the Australian federation.¹³ In recent years, COAG has discussed illicit drug policies on two occasions. On both occasions the National Ministerial Council on Drug Strategy was charged with reporting to COAG on the implementation of national strategy initiatives:

- November 1997 — Heads of Government agreed to join in a National Illicit Drug Strategy, which would 'make a balanced attack on both demand and supply and on minimising the harm drugs cause'. The Commonwealth's intention to establish an Australian National Council on Drugs was also announced.¹⁴

9 Parliament of Victoria Drug and Crime Prevention Committee, *Harm minimisation: Principles and policy frameworks* (undated), Occasional paper no 1, pp 3–4.

10 Council of Australian Governments, *Commonwealth-State Ministerial Councils: a Compendium* (2006), p 36.

11 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 23.

12 Council of Australian Governments, *Commonwealth-State Ministerial Councils: a Compendium* (2006), p 35.

13 Council of Australian Governments, *Commonwealth-State Ministerial Councils: a Compendium* (2006), pp 16–88.

14 Council of Australian Governments, *Council of Australian Governments Communique 7 November 1997*.

- April 1999 — Heads of Government agreed to work together to make a new investment in prevention, early intervention, education and the diversion of drug users to counselling and treatment. They agreed to a major shift in the practice of law enforcement and treatment and a clear message about the unacceptability of illicit drug use. The measures proposed increase the availability of information about the dangers of drug use and the impact of police action.¹⁵
- 4.12 The term ‘harm minimisation’ has been used in reference to both licit and illicit drug policy in NDS documents since the early years of the Hawke Government in 1985.¹⁶ The meaning of harm minimisation in the NDS documents has changed over time. When the initial strategy was launched, the then health minister Neil Blewett claimed:
- The National Campaign has as its aim to ‘minimise the harmful effects of drugs on Australian society’. Its ambition is thus moderate and circumscribed. No utopian claims to eliminate drugs, or drug abuse, or remove entirely the harmful effects of drugs, merely to ‘minimise’ the effects of the abuse of drugs on a society permeated by drugs.¹⁷
- 4.13 The current national policy framework is comprised of a number of documents that support prevention and treatment approaches practised by government and non-government agencies. The overarching policy statement for both licit and illicit drugs is the current NDS, covering the period 2004–2009.
- 4.14 The NDS lists a number of objectives that claim to ‘contribute to reducing drug use and supply, and preventing and minimising harm caused by licit drugs, illicit drugs and other substances’:
- prevent the uptake of harmful drug use;
 - reduce the supply and use of illicit drugs in the community;
 - reduce the risks to the community of criminal drug offences and other drug related crime, violence and antisocial behaviour;
 - reduce risk behaviours associated with drug use;
 - reduce drug-related harm for individuals, families and communities;

15 Council of Australian Governments, *Council of Australian Governments Communique 9 April 1999 (Special Meeting)*.

16 Success Works Pty Ltd, *Evaluation of the National Drug Strategic Framework 1998-99 – 2003-04* (2003), p 17.

17 Ministerial Council on Drug Strategy, *No quick fix: An evaluation of the national campaign against drug abuse* (1992), p 20.

- reduce the personal and social disruption, loss of life and poor quality of life, loss of productivity and other economic costs associated with harmful drug use;
- increase access to a greater range of high-quality prevention and treatment services;
- increase community understanding of drug-related harm;
- promote evidence-informed practice through research, monitoring drug-use trends, and developing workforce organisation and systems;
- strengthen existing partnerships and build new partnerships to reduce drug related harm;
- develop and strengthen links with other related strategies; and
- develop mechanisms for the cooperative development, transfer and use of research among interested parties.¹⁸

4.15 As discussed later in this report, it is important to note that some drug policy elites do not believe that all illicit drug use is harmful, despite the accumulating scientific evidence on how drug use affects the brain and physical development.

4.16 According to the NDS, ‘harm minimisation’ encompasses:

- supply reduction strategies to disrupt the production and supply of illicit drugs, and the control and regulation of licit substances;
- demand reduction strategies to prevent the uptake of harmful drug use, including abstinence-oriented strategies and treatment to reduce drug use; and
- harm reduction strategies to reduce drug-related harm to individuals and communities.¹⁹

4.17 The strategy also makes the following remarks about harm minimisation:

Harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm. It aims to improve health, social and economic outcomes for both the community and the individual, and encompasses a wide range of approaches, including abstinence-oriented strategies.²⁰

4.18 This is a much stronger statement on harm minimisation showing movement from the soft on drugs approach to a tougher approach.

18 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 5.

19 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 2.

20 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 2.

4.19 There is open disagreement in the community about the meaning of harm minimisation and other terms, and the relative priority that should be placed on different strategies to reduce illicit drug use and make individuals drug free. In discussing the language underpinning the drug policy framework, the confusion was observed by Melbourne University academics Professor John Fitzgerald and Tanya Swards:

The policy community, like any community, shares a common language. Our policy framework establishes the policy community's common language. Without a consensus about the meaning of key terms, the community can lose coherence, purpose and effectiveness.²¹

4.20 The committee considers that although the language in the NDS has changed direction since 1985 and can be interpreted to support the current Commonwealth Government policy of tough on drugs, many of the 'objectives' of the NDS, as well as the description of the 'harm minimisation' principle are poorly defined and open to misinterpretation. Conflicting views on the meanings of key terms such as 'harm reduction' (discussed below), leave the strategy open to distortion by members of the drug industry and 'policy experts'. Further, the committee considers it of utmost importance to recognise the various agendas of sections of the drug industry, who have a vested interest in forcing their views on drug policy at a national level.

Drug industry elites' involvement in policy development

4.21 The committee considers that the involvement of the 'drug industry elites' in the development of national illicit drug policy is undermining the implementation of the Commonwealth's stated 'zero tolerance' approach to illicit drugs. The committee believes the Commonwealth needs to wrest back control of illicit drug policy development from the states and territories and the drug industry elites.

4.22 Many of the key national illicit drug policy documents are developed by the drug industry elite:

21 Fitzgerald J and Swards T, Australian National Council on Drugs, *Drug policy: The Australian approach* (2002), p viii.

- the National Drug Strategy 2004–2009 was developed by a joint working group of senior bureaucrats on the Intergovernmental Committee on Drugs and the Australian National Council on Drugs;²²
- the development of the National Cannabis Strategy 2006–2009 was managed by the National Drug and Alcohol Research Centre (Director— Richard Mattick) and a project management group comprised of senior bureaucrats on the Intergovernmental Committee on Drugs, members of the Australian National Council on Drugs (see below) and representatives from the health, education and law enforcement sectors;²³ and
- the national amphetamine-type stimulants strategy currently in development will be undertaken by the National Drug Research Institute (Director — Professor Steve Allsop).²⁴

4.23 As stated in chapter one, the drug industry elites, comprising a range of peak drug bodies, academics and service providers, receive considerable government support to promote, evaluate and deliver drug education and treatment policies and services. In 2005–06, selected peak non-government agencies heavily involved in promoting, researching or developing harm minimisation responses to illicit drugs received significant funding from the Australian and state and territory governments:

- Australian National Council on Drugs — \$1.1 million.²⁵ Was established to provide independent advice to the Prime Minister, Australian Government Ministers and Ministers on the Ministerial Council on Drug Strategy on national drug strategies, policies, programmes and emerging issues. Key people on the council include Dr John Herron (Chair), Commissioner Mick Keelty (Deputy Chair), Associate Professor Robert Ali, Professor Margaret Hamilton and Garth Popple (Executive Members);²⁶
- Alcohol and other Drugs Council of Australia — \$0.9 million.²⁷ Publicly supports ‘harm minimisation’ and maintains a register of harm

22 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p ii.

23 Ministerial Council on Drug Strategy, *National Cannabis Strategy 2006–2009* (2006), p 3.

24 Register of Australian Drug and Alcohol Research, ‘Development of the National Amphetamine-Type Strategy - 2007–2009’, viewed on 7 August 2007 at <http://www.radar.org.au/viewproject.aspx?projectid=860&index=127&ongoing=yes>.

25 Australian National Council on Drugs, *Annual Report 2005–2006* (2006), p 64.

26 Australian National Council on Drugs, ‘About ANCD’, viewed on 23 August 2007 at <http://www.ancd.org.au/about/members/index.htm>.

27 Alcohol and other Drugs Council of Australia, *Annual Report 2005–2006* (2006), p 40.

minimisation supporters on its website. Key people on the council include Professor Robin Room (President) and Professor Wayne Hall (Vice President);²⁸ and

- Australian Drug Foundation — \$1.9 million.²⁹ Focuses on alcohol use by people under 30, but also provides education resources on cannabis and other illicit drugs. The foundation describes itself as having a ‘prevention agenda’ delivered on a platform of harm minimisation. The CEO of the foundation is Bill Stronach.³⁰

4.24 Comments by Mr Stronach that caused the committee great concern were:

‘We’ve focused as [the then Alcohol and Drug Foundation Victoria] quite clearly strategically on the media. We’ve employed journalists, not to churn out press releases but to get in there as subversives and work with their colleagues in the mainstream press. And that’s been done through developing, very slowly and very gently a level of trust, a level of credibility. More importantly, the ability to respond, because the press want instant answers and they want instant responses. So we’ve got 24-hour availability of those journalists and what we’re finding now is that in the last eight months over 50 per cent of the mainstream printed and radio and television reporting on alcohol and drug issues has now been generated by the Foundation, or has been filtered through it.

It’s a wonderful opportunity when the press ring up, as they invariably do, with some sensational story, asking for comment, for us to talk, often for an hour, and try and turn that around and get the reporting perhaps presented a different way. Because we know that the nature of reporting that we’ve seen in the past has been sensational, it’s been inaccurate, often dangerously inaccurate, and it’s not always but by and large, focused on those drugs which are illicit and their usage within Australia, and the harm caused by them is miniscule compared to the legal drugs.

So we’re having a significant impact there I believe and I think that’s an exciting project. So the thrust of the organisation is to move via the media the public perception which we hope will

28 Alcohol and other Drugs Council of Australia, ‘About ADCA’, viewed on 23 August 2007 at <http://www.adca.org.au/whoweare/index.htm>.

29 Australian Drug Foundation, *Audited financial statements 2006* (2006), p 8.

30 Australian Drug Foundation, ‘About us: Our principles’, viewed on 23 August 2007 at <http://www.adf.org.au/browse.asp?ContainerID=principles>.

move towards legislative change in those areas that we would see as desirable.’³¹

4.25 Significant funding is also given to the dominant drug research institutions established under the NDS to examine drug policy approaches within the harm minimisation framework:

- National Drug and Alcohol Research Centre — spent \$3.6 million in research funds in 2005 on a range of information, evaluation and best practice information activities;³²
- National Drug Research Institute — received \$1.7 million in core funding from the Commonwealth in 2005 to undertake a range of licit and illicit drug research projects;³³ and
- National Centre for Education and Training on Addiction — received \$0.5 million in funding from the Commonwealth in 2005 to undertake a range of research projects on workforce and prevention initiatives.³⁴

4.26 The committee is concerned that the entrenched position of members of the drug industry elite in the policy community is a barrier to the open discussion of an addiction prevention policy for this country. Drug Free Australia considered that various harm minimisation studies by Australia’s leading drug policy researchers are substantially flawed:

Of greatest concern is that these demonstrable errors and irregularities have consistently been in favour of the harm minimisation and/or drug law reform interventions being evaluated and corrections of these errors and irregularities consistently to their detriment.

... almost all government-funded Australian ‘evidence-based’ research in the last 15 years has been adduced to the support of a single ideology, that of harm reduction and its drug normalisation substrates, to the exclusion of research comparing the effectiveness of abstinence-based strategies in relation to these harm reduction/minimisation strategies.³⁵

4.27 High quality research is important in informing policy development. Undertaking most of the research within a soft harm minimisation framework limits the opportunity to examine alternative policies and

31 International Drug Conference, Washington, 1992, exhibit 14.4.

32 National Drug and Alcohol Research Institute, *Annual Report 2005* (2006), pp 35–36.

33 National Drug Research Institute, *Annual Report 2005* (2006), p 40.

34 National Centre for Education and Training on Addiction, *Annual Report 2005–2006* (2006), p 7.

35 Drug Free Australia, submission 167, p 2.

reinforces the soft harm minimisation approach as the dominant policy paradigm.

4.28 Changing this dominant policy paradigm is likely to encounter significant resistance by some of those involved in soft harm minimisation treatment approaches, who have a vested interest in supporting harm minimisation approaches that do not necessarily lead to the cessation of drug use. The committee was told that the soft harm minimisation workforce was likely to cost around \$500 million annually.³⁶

4.29 A further barrier to examining alternative policies is the support by prominent members of the drug policy elite for decriminalisation and legalisation of some illicit drugs.³⁷ In a written submission to the committee, Dr Alex Wodak, president of the Australian Drug Law Reform Foundation, stated that:

Taxed and regulated provision of cannabis could:

- broaden the base and lower the rate of general taxation revenue;
- generate a new revenue stream for government enabling generous funding for the prevention and treatment of alcohol and drug problems;
- enable mandatory warning labels to be required for all cannabis packages e.g. 'Medical authorities warn that smoking cannabis may cause severe mental health problems including schizophrenia';
- ensure that the concentration of the most active constituent of cannabis (THC) remains within a narrow band;
- enable mandatory help seeking labels to be required on all cannabis packages e.g. 'If you want to stop smoking cannabis now, ring 24 x 7 the national cannabis help line (02) 6277 4382';
- enable proof-of-age cards to be required thereby dramatically reducing sales of cannabis to persons under the age of, say, 18 years of age; and
- reduce cannabis sales to other vulnerable groups, e.g. pregnant women.³⁸

... the least-worst option for cannabis is to control demand and supply by taxation and regulation, introduce strict proof of age measures for all sales, ban all cannabis advertising and donations from the cannabis industry to political parties and mandate that all

36 Reece S, transcript, 3 April 2007, p 27.

37 Mullins G, submission 124, p 19; Coalition Against Drugs (WA), submission 150, p 1.

38 Australian Drug Law Reform Foundation, submission 39, p 6.

cannabis packaging must include government health warnings and information about availability of help.³⁹

- 4.30 As discussed in chapter eight, these views are irresponsible given the emerging evidence of links between cannabis use and mental illness and the progression from cannabis use to other drugs including ice. The committee believes that accepting Dr Wodak's proposal to decriminalise and legalise cannabis is irresponsible and contrary to contemporary recognition of the significant damage to the community and should be rejected.
- 4.31 The mixing of this legalisation/decriminalisation debate within the harm minimisation framework also contributes to the mixed messages that illicit drug use is tolerated by the community and blurs the message that illicit drug use has significant negative effects on drug users and their families.
- 4.32 It is concerning to see the interlinkages between a number of publicly funded organisations.

Harm reduction or harm minimisation – cause for confusion?

- 4.33 The term 'harm minimisation' is sometimes used interchangeably with 'harm reduction', and in the past, they were in fact synonymous.⁴⁰ Under the NDS, harm reduction is defined in terms which are unacceptably vague, as:

...strategies that are designed to reduce the impacts of drug-related harm on individuals and communities. Governments do not condone illegal risk behaviours such as injecting drug use, they acknowledge that these behaviours occur and that they have a responsibility to develop and implement public health and law enforcement measures designed to reduce the harm that such behaviours can cause.⁴¹

- 4.34 The NDS definition is so broad as to be meaningless in practical terms: it fails to provide a focus or boundary to the concept, and significantly, can cover **both** licit and illicit drugs and allows for whole of population

39 Australian Drug Law Reform Foundation, submission 39, p 26.

40 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 13.

41 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004–2009* (2004), p 22.

interventions as well as those targeted at individuals. As a result, it can be used to refer to both a philosophical approach and specific types of programs or interventions.

4.35 There does, however, appear to be some broad agreement that harm reduction refers to policies and programs that are aimed at reducing the harms from drugs, but not drug use per se. A useful distinction is drawn between 'use reduction' interventions and harm reduction interventions, emphasising the focus on reducing harms rather than use within the harm reduction approach.

4.36 The NDS notes that the key features and principles of harm reduction include:

- that the primary goal is reducing harm rather than drug use per se;
- that it is built on evidence-based analysis (strategies need to demonstrate, on balance of probabilities, a net reduction in harm);
- that there is acceptance that drugs are a part of society and will never be eliminated;
- that harm reduction should provide a comprehensive public health framework;
- that priority is placed on immediate (and achievable) goals; and
- that pragmatism and humanistic values underpin harm reduction.⁴²

4.37 The acceptance of illicit drug use within the harm minimisation framework is unacceptable. The New South Wales Government highlights such an attitude by announcing in its state plan its target to 'hold the proportion of people using illicit drugs below 15 per cent'.⁴³ It is similarly unacceptable that this view of 'success' is shared by some drug treatment service providers:

One Australian family support service redefines the concept of 'success' and utilises harm reduction in its work with families. 'Our definition of success does not incorporate drug-free status as a definite and primary outcome. Instead we find that the by-product of having support, collective wisdom and coping skills is that the drug user is often healthier and moving more positively and quickly through his or her 'Stages of Changes'.⁴⁴

42 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's Integrated Framework 2004-2009* (2004), p 22.

43 NSW Government, *State Plan: A new direction for NSW* (2006), p 7.

44 Australian Injecting and Illicit Drug Users League, submission 94, p 6.

4.38 Further, the Australasian Society of HIV Medicine considered that:

A harm minimisation approach, as it is applied to drug use, considers the actual harms associated with the use of a particular drug (as well as, but not exclusively of the drug itself), and how these harms can be minimised or reduced. It recognises that drugs are, and will continue to be, a part of our society and that prohibition has historically been a counterproductive policy.⁴⁵

4.39 This approach was also referred to by Youth Substance Abuse Service, who considered that:

While the National Drug Strategy 2004-2009 reinforces non-use as a desirable option it retains a level of pragmatism and recognises legal and illegal drug use and misuse will occur, despite the best efforts of all who seek to address illicit alcohol and drug use in the community.⁴⁶

4.40 The committee condemns these views and believes that they highlight the intrinsic ambiguity of the harm minimisation approach. Of further concern to the committee were comments by Professor Margaret Hamilton, a deputy chair of the Australian National Council on Drugs (ANCD), that the harm minimisation approach accepts that:

- psychoactive substances are and will continue to be part of our society;
- their eradication is impossible; and
- the continuation of attempts to eradicate them may result in maximising net harms for society.⁴⁷

4.41 Other elements of harm minimisation cited by Professor Hamilton were that 'harm minimisation assumes that an acceptance of abstinence is irrelevant',⁴⁸ and that it was a value-neutral term that avoided moralistic arguments about whether drug use is inherently 'bad' or 'good', noting that:

From the perspective of harm minimisation, drug use is neither good nor bad ... This morally neutral stance has made it possible

45 Australasian Society of HIV Medicine, submission 140, p 7.

46 Youth Substance Abuse Service, submission 87, p 4.

47 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 134.

48 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 133.

to begin to move away from a punitive and condemnatory approach toward a more humane framework.⁴⁹

- 4.42 Professor Hamilton has also questioned the Prime Minister's policy stance of zero tolerance, stating that:

Debate about [the application of harm minimisation] to the education area and to young people has continued. This has included the articulation by the Prime Minister John Howard of an apparently inconsistent policy stance of zero tolerance in the drug area and a subsequent explanation that this referred to a policy approach in the school context.⁵⁰

- 4.43 The committee considers taking a morally neutral stance to illicit drug use is entirely at odds with the Prime Minister's stated policy of zero tolerance. Further, it is dismissive of the damage to families and deflects responsibility for that damage away from the drug taker. The committee totally rejects Professor Hamilton's views.

- 4.44 The committee was pleased that many organisations reject these views. Organisations such as Teen Challenge NSW, Toughlove, Drug Free Australia, Australian Drug Treatment and Rehabilitation Programme, and Family Drug Support made it clear to the committee that illicit drug use should not be accepted as a normal part of society's function and that the ultimate goal of harm minimisation was abstinence.

- 4.45 Tony Trimingham, founder of Family Drug Support, told the committee about what the goal of drug treatment should be:

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.

49 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 137.

50 Hamilton M and Rumbold G, 'The case for harm minimisation' in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 139.

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.⁵¹

Mixed messages from harm minimisation

- 4.46 Given the difficulties in defining harm minimisation, inquiry participants referred to a range of definitions in their response to the inquiry terms of reference. Many submissions referred to the definition of harm minimisation as articulated in the NDS.⁵² Other participants referred to harm minimisation as encompassing the sorts of interventions that would meet the strategy’s definition of ‘harm reduction’, such as needle and syringe programs.⁵³
- 4.47 It is clear that by continuing to adopt a national drug policy framework that promotes soft harm minimisation as a central theme, members of the community get mixed messages about whether using illicit drugs is wrong. Several submissions expressed the view that the adoption of harm minimisation as a central part of drug policy had resulted in an ‘acceptance’ of drug use by the community, highlighting their own experiences in contacts with counsellors and drug treatment service providers (box 4.1).
- 4.48 A former drug addict told the committee that:
- As the harm minimisation mentality has infiltrated our national psyche drug use has become not only accepted but expected. At a societal level, we have been conned into believing that:
- drug use is normal teen behaviour
 - drugs can be taken safely
 - that drug users have the right to ‘choose to use’

51 Trimingham T, Family Drug Support, transcript, 8 August 2007, pp 12–13.

52 See for example Hepatitis Australia, submission 54, p 1; National Centre in HIV Social Research, submission 61, p 1; Western Australian Government Drug and Alcohol Office, submission 82, p 3; Drug and Alcohol Multicultural Education Centre, submission 90, p 4; Australian Drug Foundation, submission 118, p 11; Hepatitis C Council of NSW, submission 129, p 5; National Drug and Alcohol Research Centre, submission 147, p 4; Australian Injecting and Illicit Drug Users League, submission 94, p 5.

53 See for example Catholic Women’s League of Australia, submission 30, p 10; Morrissey J, submission 12, p 3; Lopez J, submission 24, p 2; Name withheld, submission 55, p 2; Name withheld, submission 77, p 2; Festival of Light Australia, submission 85, p 5; Name withheld, submission 108, p 2; Australian Association of Social Workers, submission 121, p 6.

- that their impacts on the broader community are minimal and manageable
- that drugs are not necessarily addictive and if users do become addicted it is because of their own flaws or the flaws of their parents; and
- that drug use does not cause mental illness, it only exacerbates an underlying condition.⁵⁴

4.49 Many submissions to the inquiry from drug treatment agencies supported the adoption of a harm minimisation approach to treating illicit drug use.⁵⁵ Submissions from individuals also supported this approach.⁵⁶

4.50 Holyoake, a drug treatment provider operating across several jurisdictions noted that:

Generally the harm minimisation framework has a positive impact on family relationships. When working with people who have substance use issues within a harm minimisation framework it is important to meet the person where they are at and sometimes, at that point, their priority may not be abstinence. Utilising the harm minimisation perspective means that often the person with substance use difficulties may be able to implement less harmful patterns of use or reduced use. Over the long term this often results in the person changing their goals, from reduced use, to cessation of use.⁵⁷

54 Hidden R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 6.

55 Western Australian Network of Alcohol and Other Drug Agencies, submission 138, p 4; Family Drug Help, submission 76, p 8; Glastonbury Child and Family Services, submission 74, p 8; Barnardos Australia, submission 69, p 2; National Centre in HIV Social Research, submission 61, p 1; Hepatitis Australia, submission 54, p 1; The List, submission 49, p 7; Family Drug Support, submission 15, p 4; Manly Drug Education and Counselling Centre, submission 25, p 3.

56 See for example McIntyre, R, submission 81, p 5; Miller, T, submission 78, p 3; Name withheld, submission 77, p 2; Name withheld, submission 70, p 2; Name withheld, submission 68, p 2; Sutherland P and J, submission 66, p 1; Lawrence L and J, submission 57, p 1; Name withheld, submission 55, p 1; Damen P, submission 53, p 2; Hersee P, submission 48, p 3; Ravesi-Pasche A, submission 47, p 1; Cleere M, submission 44, p 2; Ryan P and W, submission 43, p 3; Lines S, submission 41, p 3; Westaway J, submission 40, p 2; Ennik M, submission 13, p 1; Stevens M, submission 23, p 2; Name withheld, submission 29, p 1; Perry J, submission 5, p 2; Clementson G, submission 9, p 1.

57 Holyoake, submission 117, p 5.

Box 4.1 Personal experiences with harm minimisation and drug education

Several families told their own stories to the committee about their experiences with drug education and treatment providers and how the emphasis was not on getting off drugs, but 'minimising harm':

Rachel is 17 years old. She was referred to a local youth service by her student counsellor and they have involved her in a program with other girls displaying risk taking behaviour. In this program there is a focus on harm minimisation and safe drug use was discussed with the girls. Rachel's parents were aware of the drug use and told their daughter that if she did not stop she would have to leave their home. One night Rachel was picked up by the police and was under the influence. Her parents asked her to leave. The youth service had attempted to involve the parents in counselling some months ago at Rachel's initiation. However the parents are adamant that they will not go to a service that encourages their daughter to use drugs and that if their daughter seriously wants to be part of the family she must stop her drug use. Rachel does not believe that she has an addiction and she believes that she is well in control of her drug use. She reports that the information given by the youth service was new and has helped her be aware of unsafe practices but she had been using prior to this information and would have continued anyway. Rachel does not intend to stop using drugs and says that it does not affect her life in any way.

Source Centrelink, submission 128, pp 5–6.

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*Another woman whose family attends church regularly has told us about her son who had been given 'drug education' at school which was completely counterproductive. The drug education consisted of being told, at age 14, to 'do a project on drugs' - with no further instructions. Her son and his friends decided to research glue sniffing by trying it themselves. They were apprehended by a teacher, and suspended from school for two weeks. The mother said she felt helpless — she and her son were given no advice, and no assistance by school counsellors or anyone else.*

Source Festival of Light Australia, submission 85, p 4.

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When Andrew was 15 years of age, I was aware that there was a marijuana smoking problem. I felt that there was no support for me. I went to drug and alcohol counselling that was close to the high school. They told me not to worry; that Andrew was only experimenting, and that they knew of lots of worse cases. I became aware that he was smoking marijuana on the night of his year 10 formal. I was rung up at 2.00 am and told that the police had my son, and that they had him for possession. I had to ring up a neighbour to go up and get him. A couple of days later, we had to go up to the police station for the talk by the sergeant, and, as we went in to the talk, one of the police officers said, 'Andrew, you were silly. I smoke marijuana. You should have been more careful.'

Source McMenamin H, transcript, 30 May 2007, p 1.

- 4.51 The harm minimisation framework was also supported by Family Drug Support, who had provided information and support to almost 30,000 families in 2006:

Harm minimisation is accepted in all areas of human life — bushfires, swimming pools, electricity and of course road safety — all have built in harm minimisation strategies that are acceptable and logical. For some reason when it comes to drugs some people lose their sense of logic, pragmatism and compassion.

Accepting harm minimisation does incorporate abstinence as an acceptable goal and does not condone or support drug use. Although sometimes the policy is misrepresented by those who don't like it.

We should be proud of Australia's successful harm minimisation leadership and families would like to see more services available that help keep people alive.⁵⁸

- 4.52 These sentiments were also expressed by a volunteer with Family Drug Support:

The simple and clear message from families is that despite moral, ethical, political and spiritual disagreements, harm minimisation/reduction SAVE LIVES.

I can safely say that no families want their loved ones to take drugs and universally would like them to stop. However, through devastating and heart wrenching experiences, and over an extended period of chaos, families have had to accept the following hard realities of dependent drug use:

- there simply is no logic as to why their loved ones make up the relatively small percentage of people who go on to dependent use;
- things are simply unfair;
- it may take many attempts over a number of years (for some decades) to achieve success (whether that is abstinence or reduction etc);
- set backs are an ever present reality; and
- each person reacts positively to different approaches and no one solution fits all.

Despite all this, many families still choose to stay connected through their love and commitment to their drug dependent loved one. They recognise and remain hopeful that their loved one will

58 Family Drug Support, submission 15, p 4.

change for the positive. In the meantime, harm minimisation provide various pragmatic alternative [sic] that can keep them alive until they reach their moment of change. You CANNOT RECOVER FROM DEATH.⁵⁹

4.53 An individual with a partner and son using illicit drugs supported the harm minimisation approach:

The emphasis on zero tolerance that appears to have infiltrated the drug discussion is distressing and disturbing as it negates the pain and silent suffering that individuals and their families experience dealing with these problems. It ignores the facts that harm minimisation saves lives and provides us with a realistic foundation for addressing an overwhelming and often complex problem. The harm minimisation model avoids blame and judgement and provides a compassionate approach that allows us to continue to see the worth of human life within a broken physical exterior.⁶⁰

4.54 Hon Ann Bressington MLC, a member of the South Australian Legislative Council and founder of an effective drug treatment service, told the committee about how harm minimisation had failed the community:

I think the most disturbing thing for me in the 11 years that I have been involved in this is the way that the message of harm minimisation has been manipulated. I do not think that anybody could argue that to reduce the harm, reduce the supply and reduce the demand are not noble objectives for any drug policy. However, we have seen that reducing the harm does not actually mean that. On the ground at the grassroots level it actually means minimising the harm, which is making it appear to be less than it is.

... There are many hidden harms to drug use, to the way that our drug policy is implemented and the conflict that exists between the harm minimisation approach and the Tough on Drugs strategy. I believe that there is a way to bring these together to meet in the middle; that it cannot be all harm minimisation or all abstinence. However, I do believe harm minimisation needs to be reeled in.⁶¹

4.55 The mixed messages that the harm minimisation framework gives to the community were highlighted by Toughlove NSW:

59 Chang T, submission 28, pp 5–6. Emphasis in original.

60 Ravesi-Pasche A, submission 47, p 4.

61 Bressington A, transcript, 23 May 2007, p 2.

Needle exchange programs provide health benefits, but what is the real message being conveyed? That it is okay to use illegal substances? That it is okay to harm or kill yourself? That it is okay to continue treating the closest people to you like the scum of the earth? That it is okay to steal, rob and mug?

A serious contradiction is in existence where, on the one hand, the federal government operates a Tough on Drugs policy, which Toughlove parents wholeheartedly support, and on the other the government spends thousands of dollars on introducing harm minimisation programs in our education system. What message is this giving to our young people? How can harm minimisation possibly be promoted when, at the same time, these drugs are illegal? Our messages are seriously mixed. Such programs are simply enabling, educating and helping our young people to get onto the drugs bandwagon. The cycle and impression that drug taking is cool must be broken.⁶²

- 4.56 A retired magistrate also highlighted how the terminology used normalised drug taking:

Harm minimisation programs whilst educating young people in aspects of drug use, tend to 'normalise' the taking of such substances. In my view, this has not proven to be as effective as it might have been.⁶³

- 4.57 A former drug user, Ryan Hidden, told the committee about his attitude to harm minimisation and his perception about the contradictions in the policy approach:

While I tell most people that I am a recovered drug user and I survived my addiction, to my friends and people who I trust, I tell them I survived harm minimisation, because it literally threatened to destroy my life and my family's life through the messages that it can implant into that structure and the way it threatened to tear us apart, literally. It was almost like that was its objective; it did not want me to escape my addiction, it wanted me to stay stuck there.⁶⁴

62 Smith L, Toughlove NSW, transcript, 3 April 2007, p 3.

63 Hanrahan J, submission 14, p 1.

64 Hidden R, transcript, 23 May 2007, pp 4-5.

Taking account of the 'hidden harm' on children

- 4.58 The harm minimisation approach can involve the health and welfare of drug users being balanced against others, including other family members such as children and potentially, unborn children. The committee has concerns that a harm minimisation approach to familial drug use can privilege the rights and needs of drug users over children in their care.
- 4.59 While harm minimisation measures may be effective at alleviating short-term risk, they may ultimately mean prolonged exposure to parental drug use for children. This includes exposure to drug equipment and paraphernalia, domestic violence and abuse, a lower standard of living and exposure to people associated with the drug culture and lifestyle that puts children at risk.⁶⁵
- 4.60 A 2003 report from the United Kingdom, *Hidden harm*, examined the extent of damage parental drug use caused to children, highlighting the negative effects of illicit drug use during pregnancy and child social and emotional development.⁶⁶ The committee received evidence from a range of inquiry participants about treatment approaches to pregnant women who are using illicit drugs, the neglect and abuse that children suffer when their parents use illicit drugs, and the intervention of child protection agencies.⁶⁷ As mentioned in the previous chapter, illicit drug use by parents is a significant contributory factor in the child protection caseload for all states and territories.⁶⁸
- 4.61 Some inquiry participants felt that harm minimisation had been positive for children in the care of drug users. Sydney Women's Counselling Centre, for example, said that harm minimisation provided some 'containment' for users, reducing the severity of drug-related chaotic and destructive behaviours in the family environment. The centre said that harm minimisation provided the time and opportunity to engage users and their families in treatments that led to recovery, and that through pharmacotherapy programs, families had a better chance of staying

65 See chapter three.

66 Advisory Council on the Misuse of Drugs, *Hidden harm: responding to the needs of children of problem drug users* (2003), pp 10–17.

67 Newman M, Grandparents Assisting Grandkids Support, Gold Coast Region, transcript, 7 March 2007, p 8; Name withheld, submission 86, p 2; Wanslea Family Services, submission 97, p 2; Marymead Child and Family Centre, submission 107, p 1; The Royal Women's Hospital, submission 142, p 7; South Australian Government, submission 153, p 7; Name withheld, submission 155, p 2; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 28.

68 See chapter three.

intact.⁶⁹ Once again, however, the emphasis is on the adult drug user not the vulnerable child.

4.62 The Victorian Alcohol and Drug Association (VAADA) told the committee that harm minimisation programs improved the safety of children, including unborn children, helped drug users remain within family and friendship networks, and reduced health care costs for families. It noted, however, a potential conflict between the interests of drug users and those of their children, which was inadequately addressed by harm minimisation as it was practiced in the drug treatment sector:

Several service providers consulted by VAADA describe a particular problem for families of illicit drug users arising from a conflict between harm minimisation programs and child protection agencies. While harm minimisation programs focus on preventing harms to drug users, child protection agencies focus on preventing harms to children.⁷⁰

4.63 While supporting the principle of harm minimisation, Glastonbury Child and Family Services noted that there were some disadvantages of the current harm minimisation policies for child protection workers:

- Many children can stay in parental care for too long and at the time of removal can be significantly damaged both emotionally and behaviourally. Placements are then not always successful due to the level of trauma the child has experienced and sadly children are often 'lost' within the system, without realistic hope of recovery.
- There is inconsistency between professionals around what constitutes harm minimisation. Different workers within the child protection continuum can vary in their expectations around illicit drug use, with some expecting zero tolerance and others being more flexible. It can be confusing for both the professional and client when they are unclear of what the expectations are.
- There is also inconsistency within the community around what is satisfactory around harm minimisation. Many practitioners are unable to tolerate any form of illicit drug use and can be quite judgmental in working with families with these issues. It leads to mistrust, lower take up of the support system and potential lack of safety for children.
- Increasingly child protection is expecting the community to manage significant risk issues and monitor parents' involved with illicit substances. Many staff report feeling ill-equipped to

69 Sydney Women's Counselling Centre, submission 36, p 3.

70 Victorian Alcohol and Drug Association, submission 100, p 12.

understand the impact of substances on parents and their capacity to make changes.⁷¹

- 4.64 No-one could argue that it is not desirable to reduce harm, whenever and however feasible, to children rendered vulnerable by familial illicit drug use. However, the committee has concerns about how children are taken into account in reckonings of ‘net harm’, given that they are often not able to articulate or draw attention to what is happening in their family. The recent ANCD report *Drug use in the family: Impacts and implications for children* made the damning observation that within the standard diagnostic nomenclature that assesses a person’s drug use, impacts on dependent children do not even exist:

The terms ‘substance abuse and dependence’ and ‘harmful and hazardous use’ are commonly employed to classify the severity of an individual’s substance use. Such diagnoses, however, refer to the effects experienced by the individual using the substance, not the effects of an individual’s substance use on others. For example, ‘harmful and hazardous use’ of a particular substance such as alcohol defines harm in relation to increased risk for adverse health outcomes for the drinker. Such levels of use may or may not necessarily map onto adverse child outcomes.⁷²

- 4.65 Given the potential invisibility of dependent children within such a treatment culture, harm inflicted on children will continue to be, as the UK report described — ‘hidden’.
- 4.66 Approaches that could function as alternatives to harm minimisation in child protection, or better emphasise the rights and safety of dependent children, were explored in chapter three.

An alternative approach to illicit drug policy

- 4.67 The committee is attracted to the alternative approach developed in Sweden, particularly the overall aim of achieving a drug-free society. Despite historical and cultural differences, the committee believes that several practical aspects of the Swedish model for prevention and treatment can be implemented in Australia, through a high principled commitment to a drug-free individuals policy. These are explored in later chapters.

71 Glastonbury Child and Family Services, submission 74, p 8.

72 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 2.

4.68 Many inquiry participants nominated the Swedish approach to illicit drugs as a model for Australia (box 4.2).⁷³ A key feature of the Swedish approach is the overall goal of achieving a drug-free society.

Box 4.2 The Swedish approach to illicit drug policy

The Swedish drug control policy is guided by the vision and the ultimate goal of achieving a drug-free society.

The overriding aim of the Swedish approach to drug policy is to prevent abuse, strengthening the determination and ability of the individual to refrain from drugs.

Following the proclamation of a drug-free society, the focus of Swedish drug policy was increasingly on the abuser. Laws commit adult abusers of alcohol or drugs to coercive care.

A compulsory care order in Sweden can only be issued if certain legal conditions are met:

- that the person is in need of care/treatment as a result of ongoing abuse of alcohol, narcotics and volatile solvents; and
- the necessary care cannot be provided.

The *Swedish Anti Drug Policy (2004–2007)* involves no tolerance of drug abuse. Drug-related crime should always lead to prosecution and criminal sanctions, and drug-free treatment is seen as a priority measure in response to addiction.

There is wide consensus about the overall goal of drug policy — a drug-free society — and its objectives:

- to reduce the recruitment of young people to drug abuse;
- to enable drug users to stop their drug abuse; and
- to reduce the availability of illicit drugs.

Swedish police target drug users as well as drug dealers, even if the infringements are small, because they want to stop early experimenters from progressing along the ‘crime ladder’ from minor nuisances to theft, property damage and acts of violence.

There is joint drug training for police, social workers, psychologists and counsellors so that they share a common language and common strategy for dealing with drugs.

Source United Nations Office on Drugs and Crime, Sweden’s successful drug policy: A review of the evidence (2007), pp 9–21; Eva Brannmark, Swedish Police Board, ‘Law Enforcement – The Swedish Model’, Presentation at Drug Free Australia Conference, Adelaide, 27–29 April 2007.

73 Morrissey J, submission 12, p 3; Endeavour Forum, submission 22, p 1; Lopez J, submission 24, p 1; Catholic Women’s League of Australia, submission 35, p 12; Drug Advisory Council of Australia, submission 37, p 1; Drug Free Australia, submission 42, p 2; Australian Family Association, submission 59, p 1; Australian Family Association SA Branch, submission 72, p 1; Festival of Light Australia, submission 85, p 11; Coalition Against Drugs (WA), submission 124, p 7; Catholic Women’s League of Australia, submission 171, p 2; Bressington A, transcript, 23 May 2007, p 3.

- 4.69 A volunteer with a family support organisation considered that other countries' approaches offered a better solution than the approach adopted in Australia:

The best argument against harm minimisation policies has been provided by Sweden. There, drug use and dependence is a fraction of that of their European Union neighbours, even neighbouring Denmark. This has been in spite of Sweden's proximity to Russia and Eastern Europe, from which the spreading effects of drug-related crime have afflicted the rest of area. This can only have resulted from Sweden's holistic approach to illicit drugs, which punishes possession, use and dealing, and mandates both detox treatment and maintenance of a drug-free state, under pain of prison. Sweden's policy is to achieve a drug-free society, rather than one which accepts and compromises with the problem. National statistics show a steep climb towards achieving this goal, interrupted only by a flat spot during the mid-1990s when funding for programs was cut.

Australia's preference for harm minimisation reflects not only a fuzzy optimism, but a belief that it can all be done on the cheap - with a dollop of good intentions.⁷⁴

- 4.70 The Coalition Against Drugs (WA) told the committee that:

Sweden now has a restrictive policy on drugs. The overriding aim of Swedish drug policy is a drug-free society. This aim for a drug-free society is to be seen as a vision reflecting society's attitude to narcotic drugs. The aim conveys the message that drugs will never be permitted to become an integral part of society, and that drug abuse must remain an unacceptable behaviour, a marginal phenomenon. This overriding aim, then, indicates the direction of a restrictive drug policy.⁷⁵

- 4.71 Professor Hulse supported the committee's view that harm minimisation should never be the final objective of illicit drug policy:

Harm minimisation should be, if anything, a stepping stone to stabilise someone to move them towards abstinence. Getting people out of the narcotic network should be the final objective. I am yet to meet a heroin dependent person who says, 'I love being where I am. I love doing these things. I love ripping off people. I love having to do tricks for men down the road.' They love heroin.

74 Morrissey J, submission 12, p 3.

75 Coalition Against Drugs (WA), submission 124, p 7.

It is an issue of breaking that nexus. Harm minimisation is very fine. Harm minimisation for those people who relapse is a necessary component, but it should be focused at then trying to shift them along that process back to where they are not using.⁷⁶

- 4.72 Under the current NDS framework there is no clear policy document that applies to illicit drugs only. While the Prime Minister launched the National Illicit Drug Strategy ‘Tough on Drugs’ in 1997, in its current form it is no more than a collection of programs funded by the Commonwealth, states and territories.
- 4.73 The Department of Health and Ageing notes that the National Illicit Drug Strategy ‘demonstrates the Australian Government’s leadership in the fight against illicit drugs and strengthens its commitment to combat illicit drug use through a sharper focus to reducing the supply of drugs and on reducing demand’.⁷⁷ Programs included under the National Illicit Drug Strategy banner include:
- the Illicit Drug Diversion Initiative;
 - the Non-Government Organisation Treatment Grants Programme;
 - the Community Partnerships Initiative; and
 - identification, promotion and dissemination of good practice in treatment of illicit drug dependence.⁷⁸
- 4.74 The absence of a single national policy document that refers to illicit drugs with the objective of harm prevention and drug-free individuals is a key weakness of the current approach to national illicit drug policy.
- 4.75 Another weakness is the attempt to develop national policy at Ministerial Council level — where the consensus approach to decision-making leads to nebulous policy designed to accommodate competing interests.
- 4.76 Under the previous NDS document (covering the period 1998-99 to 2002-03), a National Action Plan on Illicit Drugs 2001 to 2002-03 was developed to ‘provide a nationally agreed direction for addressing illicit

76 Hulse G, transcript, 21 March 2007, p 4.

77 Department of Health and Ageing, ‘Illicit Drugs: National Illicit Drug Strategy’, viewed on 7 August 2007 at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publth-strateg-drugs-illicit-index.htm>.

78 Department of Health and Ageing, ‘Illicit Drugs: National Illicit Drug Strategy’, viewed on 7 August 2007 at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-publth-strateg-drugs-illicit-index.htm>.

drug issues.’⁷⁹ This plan did not have an overarching objective, and was primarily concerned with ‘preventing the uptake of illicit drug use and reducing harm associated with use.’⁸⁰

- 4.77 The committee considers that an explicit national illicit drug policy document should be developed that has as its key objective the prevention of illicit drug use — preventing harm from commencing and preventing the continuation of any harm. A zero tolerance policy does not mean that the committee fails to recognise that some people will relapse, but that these people are consistently encouraged by the treatment sector and the broader Australian community to become and remain drug free.
- 4.78 The policy should be developed at a Heads of Government level, by the Council of Australian Governments, rather than being determined at Ministerial Council level.

Recommendation 8

- 4.79 **The Commonwealth Government develop and bring to the Council of Australian Governments a national illicit drug policy that:**
- **replaces the current focus of the National Drug Strategy on harm minimisation with a focus on harm prevention and treatment that has the aim of achieving permanent drug-free status for individuals with the goal of enabling drug users to be drug free; and**
 - **only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants.**

Harm minimisation programs

- 4.80 Programs that are generally referred to under the harm reduction framework in an illicit drug context include:

79 Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs 2001 to 2002-03* (2001), p 1.

80 Ministerial Council on Drug Strategy, *National Action Plan on Illicit Drugs 2001 to 2002-03* (2001), p 1.

- methadone and buprenorphine maintenance programs – which aim to replace an illegal, short-acting, expensive opioid (heroin), which is usually injected, with a legal, longer-lasting, inexpensive opioid (methadone or buprenorphine), which is taken orally;
- needle and syringe programs — which aim to reduce the spread of infectious diseases, particularly HIV, through various services such as provision of clean injecting equipment, education and information and counselling and testing services;
- supervised injecting facilities — legally sanctioned and supervised facilities designed to reduce the health and public order problems associated with illegal injecting drug use which enable the consumption of pre-obtained illicit drugs;
- non-injecting routes of administration — which has the goal of reducing initiation into injecting drug use and promoting transition away from injecting for those already doing so;
- overdose prevention interventions — reducing the risk of an overdose and improving the likelihood of a positive medical response to an overdose; and
- other programs— such as pill testing kits, ‘rave-safe’ interventions and tolerance zones.⁸¹

4.81 The committee received considerable comment from families and organisations about how specific harm minimisation programs (sometimes referred to as harm reduction programs), such as methadone maintenance, safe injecting rooms and needle and syringe programs impacted on families.

Community and family support for harm minimisation programs

4.82 The committee believes that harm minimisation approaches can result in significant damage to families — especially the children of drug users — where drug treatment interventions do not protect children. Lorraine Rowe, a foster carer with 24 years experience, gave the committee an insight into the reality of how children are damaged by their parents’ illicit drug use:

There are hundreds of thousands of kids going through this across our country every day and they are not getting just the basic

81 Ritter A and Cameron J, Turning Point Alcohol and Drug Centre, *A systematic review of harm reduction* (2005), pp 14–47.

necessities. The parents are not emotionally available for them. If they are so focused on getting the drugs to manage through their day they are not able to be there when the kids need them—they are not feeding them, they are not clothing them, they are just not picking them up when they fall and skin their knees and all those things are important for all of us to learn how to trust people.

If you are getting rejected—whether it is just going from one home to another, no matter how loving that home may be for that short period of time—all the time you are not going to trust anybody. You are going to learn that we as adults are not reliable to little kids; we are unpredictable, that from one day to the next that bed is not going to be there or available for them. And so then you have teenagers who have no respect for society or for anybody because why should they respect us? We have never been there when they were little, we did not put a bandaid on their knees, we did not kiss them goodnight, we were not there to give them food.⁸²

4.83 The committee examined the impact on children of parental illicit drug use in more detail in chapter three and made several strong recommendations about how child safety can be strengthened to break the intergenerational cycle of illicit drug use and better protect children.

4.84 Some inquiry participants took the view that harm minimisation programs do not necessarily address drug use. The mother of a daughter with a drug addiction considered that:

Harm minimisation programs ... do not address the real problem. They cater to the symptoms and in essence hide, or mask the situation, and in fact make it easier for addicts to continue with their habit. In a sense it is one of the enabling factors that encourages substance abuse. ... There is one way only to deal with addiction, and that is for the addict to abstain totally from the use of all substances - illicit drugs, alcohol where that is the problem, and the prescription medication. In turn, this can only be achieved by addicts undertaking recognised rehabilitation and counselling programs.⁸³

4.85 Professor Hulse told the committee that harm minimisation programs should be a stepping stone to abstinence:

82 Rowe L, transcript, 15 August 2007, p 3.

83 Fairclough R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, pp 21–22.

You always need an exit. ... We should have facilities where people who are currently dependent attend where they have options provided to them and they are told, 'These are the options that are available to you in terms of maintenance treatments. This would be the first one to go on to. This would be the next one.' That range of services gives them some alternative other than continuing to inject. If, while they are there, as a person who uses three or four times a day, they self-administer, that is just the nature of the beast. But to focus on simply having an environment where people come and inject is not the goal. The goal is to use that as an opportunity to then look at where you are going to shift those people.⁸⁴

- 4.86 Teen Challenge NSW argued that harm minimisation does not deal with the issue but only medicates a symptom:

We believe that if we can address the issue and tackle the problem at the original cause, things such as family breakdown, abandonment, self esteem/image and teaching the skills necessary to deal with disappointment and move on in life, we stand a real chance of seeing a positive future for the young person, rather than a future of monitored substance abuse.⁸⁵

- 4.87 A former parole officer considered that:

Harm minimisation undermines families because children are able to access government needle exchanges which hastens the induction to addiction by supplying needles and syringes for free, and education in their use, thus effectively subsidising the addiction of these children. All of this can happen without the knowledge or support of parents.⁸⁶

- 4.88 Further, harm minimisation programs were seen by the Catholic Women's League of Australia to be of minimal benefit to families:

Reducing the harmful consequences of drug use, by giving drugs to addicts, making sure they have clean needles and by teaching people how to use drugs 'safely' does little to reduce the suffering of spouse, children and parents. Harm reduction does not avoid deterioration of brain function and nothing to correct the addict's behavioural problems. To help the addict it is imperative to stop

84 Hulse G, transcript, 21 March 2007, p 5.

85 Teen Challenge NSW, submission 139, p 2.

86 Lopez J, submission 24, p 2.

all drug use as Australia can no longer endure the haemorrhage of young lives lost to drugs.⁸⁷

4.89 The following sections examine selected harm minimisation programs in more detail.

Pharmacotherapy

4.90 Pharmaceutical drugs have been used in the treatment of opioid dependency in Australia for several decades. There are a number of different drugs and approaches that are used (box 4.3).

Box 4.3 Pharmacotherapy treatment for opioid dependency

Pharmacotherapy approaches to treating opioid dependence consist of two separate methods:

- Opioid Substitution (or maintenance) Treatment (OST) involves the substitution of an illegal, short-acting, expensive opioid (heroin), which is usually injected, with a legal, longer lasting, inexpensive opioid (methadone or buprenorphine), which is taken orally. The user remains an addict to methadone or buprenorphine.
- The second approach, detoxification, involves the use of opioid-antagonist medication (such as naltrexone) to bring about an opioid-free state in opioid users, while minimising withdrawal-related problems.

Whereas detoxification using naltrexone is typically a rapid-withdrawal technique, OST seeks to control a person's drug use on a long-term basis.

The Australian Government funds the cost of methadone for treatment of opioid dependence supplied as pharmaceutical benefits through clinics and pharmacies approved by State and Territory governments. Methadone typically comes as a liquid that is swallowed. A single daily dose of methadone will stop cravings for heroin for 24 hours or longer.

Buprenorphine is listed on the Pharmaceutical Benefits Scheme (PBS) for treatment of opioid dependence for supply through clinics and pharmacies approved by State and Territory governments. Buprenorphine comes in tablet form and is taken sublingually (dissolves under the tongue).

Naltrexone can be taken orally, but is also be administered through the insertion of an implant (typically into the abdomen). The implant overcomes the requirement to take a dose daily. It is listed on the PBS for 'use within a comprehensive treatment program for alcohol dependence with the goal of maintaining abstinence' — but not for treatment of opioid dependence.

Source O'Connor P, 'Methods of detoxification and their role in treating patients with opioid dependence', *Journal of the American Medical Association* (2005), vol 294 no 8, p. 962; Mattick R et al, *National evaluation of pharmacotherapies for opioid dependence: Report of results and recommendations* (2001), pp 1–4; Hulse G, *submission 16*, p 5.

87 Catholic Women's League of Australia, submission 171, p 5.

- 4.91 There were almost 39,000 people receiving pharmacotherapy treatment in June 2006.⁸⁸ Almost two-thirds received treatment from a private prescriber, with the remainder receiving treatment from a prescriber under a state or territory government program (28 per cent) or from a practitioner in a correctional facility (7 per cent).⁸⁹
- 4.92 Of clients receiving their pharmacotherapy doses from private prescribers, 89 per cent received their dose at a pharmacy with the remaining 11 per cent receiving their dose at a private clinic in 2006.⁹⁰ The use of private clinics to provide doses is more prevalent in New South Wales, where almost one-third of doses provided to clients in 2006 were dispensed.⁹¹
- 4.93 The Commonwealth makes a significant contribution to the cost of pharmacotherapy programs in Australia, providing Pharmaceutical Benefits Scheme (PBS) funding in 2005–06 of \$4.2 million for methadone and \$18.1 million for buprenorphine and a buprenorphine/naloxone product.⁹² The Commonwealth also funds a range of medical consultations under Medicare for around 25,000 people receiving treatment from a private prescriber. Unfortunately, the Department of Health and Ageing does not collect the data that would allow for an estimate of these costs.⁹³

Recommendation 9

- 4.94 **The Department of Health and Ageing conduct research to estimate the full cost of pharmacotherapy programs to the Commonwealth, including the cost of medical consultations covered by Medicare.**
- 4.95 While there is therefore no cost to clients for the methadone and buprenorphine, they can pay up to \$60 per week in dispensing fees.⁹⁴

88 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 43.

89 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 44.

90 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 45.

91 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 45.

92 Australian Government Department of Health and Ageing, submission 184, pp 1–2.

93 Australian Government Department of Health and Ageing, submission 184, p 2.

94 Bickle K, submission 186, p 1; Victorian Alcohol and Drug Association, submission 100, p 7; Winstock et al, 'The impact of community pharmacy dispensing fees on the introduction of buprenorphine – naloxone in Australia', *Drug and Alcohol Review (2007)*, no 26, p 413.

- 4.96 The general benefits of pharmacotherapy programs have been demonstrated in a number of Australian and international evaluations and include reduced illicit drug use, reduced medical comorbidity, decreases in the transmission of human immunodeficiency virus, reduced mortality and improved social functioning.⁹⁵
- 4.97 The committee received numerous submissions about pharmacotherapy programs from clinicians and treatment agencies, with participants raising issues such as the relative benefits of different types of treatment, their effectiveness, mortality and cost.⁹⁶
- 4.98 The committee was made aware of some of the difficulties in evaluating the effectiveness of pharmacotherapy programs, and disagreements about the use and safety of methadone, naltrexone implants and oral naltrexone.⁹⁷
- 4.99 Families and Friends for Drug Law Reform, which believes that drug prohibition laws are more the problem than the solution, outlined what it saw as the negative impact of methadone maintenance programs:

It should also be made clear that, like many therapeutic drugs, methadone may have unpleasant side effects. It is addictive. Like other opiates it is a 'drying' drug and can cause constipation and reduced saliva production. Long term effects can include tooth decay from reduced saliva and loss of libido. Methadone can be harmful for people with kidney and liver diseases. Further drawbacks associated with methadone arise from the restrictive, demeaning and alienating regime often prescribed for its

95 O'Connor P, 'Methods of detoxification and their role in treating patients with opioid dependence', *Journal of the American Medical Association* (2005), vol 294 no 8, p 962; Mattick R et al, *National evaluation of pharmacotherapies for opioid dependence: Report of results and recommendations* (2001), pp 1-4; Hulse G, submission 16, p 5.

96 Hulse G, submission 16, p 5; Perth Naltrexone Clinic, submission 27, p 7; Reece S, submission 33, pp 12-13; Australian Drug Law Reform Foundation, submission 39, p 8; Hepatitis Australia, submission 54, p 2; National Centre in HIV Social Research, submission 61, p 2; Queensland Alcohol and Drug Research and Education Centre, submission 98, pp 1-2; Alcohol and Drug Foundation ACT, submission 123, p 7; Association for Prevention and Harm Reduction Programs Australia, submission 130, p 9; Australian Psychological Society, submission 131, p 11; The Royal Women's Hospital, submission 142, p 3; Australian Drug Law Reform Foundation, submission 148, p 1; Hall W, submission 156, p 1; Drug Free Australia, submission 167, pp 4-6, Queensland Government, submission 173, pp 4-5.

97 Reece S, submission 33, pp 12-13; submission 154, p 2; Hall W, submission 156, p 1; Hulse G, submission 16, p 5; Australian Drug Law Reform Foundation, submission 148, p 1; Drug Free Australia, submission 167, pp 4-6.

dispensation. Moreover, it is not effective for some heroin dependents.⁹⁸

- 4.100 There can be considerable negative effects of methadone on a person's health, with prolonged use of methadone causing tooth decay and weight gain. Common side effects include:
- aching muscles and joints;
 - skin rashes and itching;
 - accelerated ageing;
 - loss of appetite, nausea and vomiting; and
 - abdominal cramps.⁹⁹
- 4.101 As a harm minimisation measure, methadone also has consequences for babies born to maternal drug users. These include significant health complications as the baby is born an addict and develops drug withdrawal, referred to as neonatal abstinence syndrome.
- 4.102 In addition, children growing up in households where parents are using methadone are exposed to significant risks, which have resulted in a number of deaths. Risks to children from a parent/s use of methadone were discussed in the previous chapter.
- 4.103 In its inquiry into substance abuse in Australian communities in 2003, the House of Representatives Standing Committee on Community Affairs made several recommendations relating to Methadone Maintenance Treatment (MMT) programs, including:
- establishing that the ultimate objective of MMT was to assist people to become abstinent from all opioids (including methadone);
 - that comprehensive support services must be provided to achieve this outcome; and that
 - research be undertaken to determine the extent of long-term use of methadone and its effect on the user, community and family roles.¹⁰⁰

98 Families and Friends for Drug Law Reform, submission 122, p 13; DrugInfo clearing house, 'Methadone', viewed on 19 July 2007 at <http://www.druginfo.adf.org.au/article.asp?ContentID=Methadone#advantages>.

99 DrugInfo clearing house, 'Methadone', viewed on 19 July 2007 at <http://www.druginfo.adf.org.au/article.asp?ContentID=Methadone#advantages>; Reece S, transcript, 3 April 2007, p 30.

100 Standing Committee on Family and Human Services, *Road to recovery: Report on the inquiry into drug abuse in Australian communities* (2003), pp 156–158.

- 4.104 It is disappointing that, four years later, the committee received serious criticisms of MMT programs including:
- access to methadone maintenance programs was difficult, particularly for women;¹⁰¹
 - there was an increase in the number of people undergoing pharmacotherapy, even though the number of people using heroin has declined due to the heroin drought — indicating that that it was likely that people were finding it difficult to ‘get off’ methadone;¹⁰² and
 - significant quantities of diverted methadone remained available in the community.¹⁰³
- 4.105 The committee noted that Sweden adopted an approach to methadone maintenance therapy that included stringent guidelines for entry to the program, six-month residential treatment and daily drug testing (box 4.4).
- 4.106 The committee is attracted to the Swedish model for MMT, and is disappointed that the recently revised National Pharmacotherapy Policy for People Dependent on Opioids has as its primary objective a qualified aim to ‘bring an end *or significantly reduce* an individual’s illicit opioid use’.¹⁰⁴

101 Royal Women’s Hospital, submission 142, p 3.

102 Reece S, submission 33, p 10.

103 Bressington A, transcript, 23 May 2007, p 12.

104 Intergovernmental Committee on Drugs, *National Pharmacotherapy Policy for People Dependent on Opioids* (2007), p 10. Emphasis added.

Box 4.4 The Swedish approach to methadone maintenance

Methadone treatment in Sweden is administered on a stricter basis than in Australia. The Swedish approach to methadone maintenance stipulates certain conditions that users must satisfy before they are accepted into the program:

- a history of at least four years of intravenous opiate use
- earlier attempts at drug-free treatment judged to be of negligible value to the patients
- at least 20 years of age
- opiates must be the dominant drug; and
- they must not be in prison when admitted to the program.

Social support from local government is a prerequisite and a referral from a medical specialist is required.

People undergoing treatment enter a six-month day care treatment where they get a personally tailored dose (the patient is not aware of the magnitude of the dose, but as a general rule doses are higher than in most programs around the world, which minimises risk of relapse) of methadone and undergo a training program during a full working day. Urine specimens are taken daily to confirm that doses are taken (which is taken in the premises) and that no illegal drugs have been used. After six months a person's contact with the clinic is gradually reduced and doses can be collected at a selected pharmacy, where urine specimen are also delivered to confirm that they remain drug free.

Source National Institute of Public Health – Sweden, 'Sweden: Drug situation 2002', Report to the EMCDDA by the Reitox National Focal Point (2004), pp 59-61; European Monitoring Centre for Drugs and Drug Addiction, 'Sweden: New development, trends and in-depth information on selected issues', 2005 National Report (2004 data) to the EMCDDA by the Reitox National Focal Point (2005), pp 26-27.

4.107 The Commonwealth needs to take a leadership approach with the implementation of MMT in Australia, particularly given the extent of its funding commitment through the PBS and consultation fees covered by Medicare. This should involve the Commonwealth specifying a range of outcomes in return for its funding of methadone and related medical services, and a reconsideration of the objectives in the national pharmacotherapy policy to emphasise that the goal of pharmacotherapy treatment is an ultimate cessation of illicit drug use.

Recommendation 10

4.108 The Commonwealth Government:

- **amend the National Pharmacotherapy Policy for People Dependent on Opioids to specify that the primary objective of pharmacotherapy treatment is to end an individual's opioid use; and**
- **renegotiate funding arrangements for methadone maintenance programs to require the states and territories to commit sufficient funding to provide comprehensive support services to meet the revised National Pharmacotherapy Policy for People Dependent on Opioids objective.**

4.109 The committee was particularly interested in the use of naltrexone, particularly the benefits of using naltrexone implants to treat opiate dependency. Naltrexone 'blocks' the effects of opiates and also has an anti-craving effect — eliminating the desire to use opiates.¹⁰⁵ Professor Hulse told the committee about the different expectations for treatment using naltrexone compared to methadone:

If you enter people onto methadone or buprenorphine and your expectation is that a proportion of those people will dabble—they are not heroin dependent; you may have arrested the heroin dependence, but they may relapse back into heroin dependence—and if that is your objective, all you need to do is provide a bit of methadone and perhaps a bit of counselling and hope that they will shift along and not go back to use. The difference with providing a program such as naltrexone—a sustained release program—is clearly that the objective is that they are not going to use.¹⁰⁶

4.110 Oral naltrexone, taken in tablet form, has been available in Australia for some time. A drawback of naltrexone in tablet form is that it relies heavily on compliance with the daily dosage, which people are often unable to meet unless they are strongly motivated and have family or other support. More recently, a naltrexone implant, lasting up to six months, has been

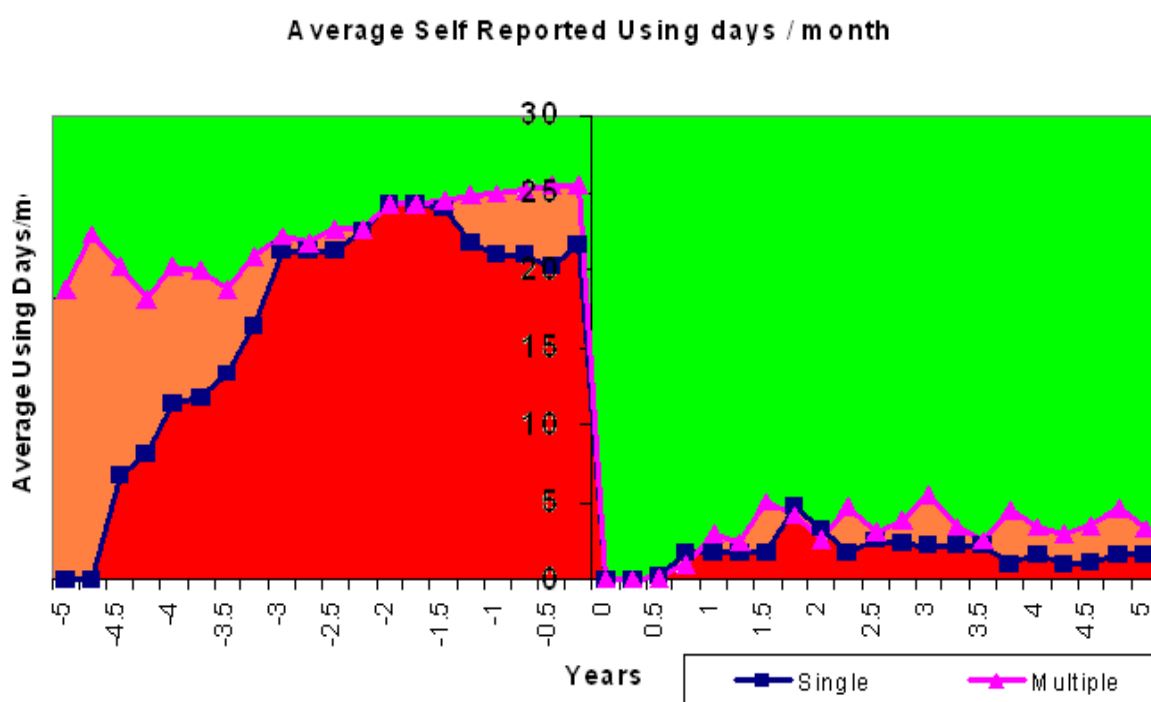
¹⁰⁵ Hulse G, transcript, 21 March 2007, p 16.

¹⁰⁶ Hulse G, transcript, 21 March 2007, p 6.

developed and is being used in Western Australia, where more than 4,500 people have received it.¹⁰⁷

- 4.111 Dr George O'Neil, who runs the Perth Naltrexone Clinic, provided the committee with some interim results on the effectiveness of naltrexone implants for a sample of clients treated. The results showed an impressive reduction in self-reported use of heroin in the five year period after the implants were administered compared to the five year period before treatment (figure 4.2). The centre of the graph shows the date of naltrexone treatment.

Figure 4.2 Average self-reported using days per month for the five year period before and after single and multiple naltrexone implants



Source Perth Naltrexone Clinic, submission 27, p 21.

- 4.112 The Australian Government Department of Health and Ageing noted that naltrexone implants may be an effective treatment to add to the options currently available, and subsequently achieve the highly desirable goal of abstinence from all opioids.¹⁰⁸ Various grants had been provided by the National Health and Medical Research Council (NHMRC) for clinical

107 Freemasons Western Australia, 'A man with a Mission - Dr. George O'Neil', viewed on 6 August 2007 at <http://www.gl-of-wa.org.au/subscribemb.asp>.

108 Department of Health and Ageing, submission 169, p 8.

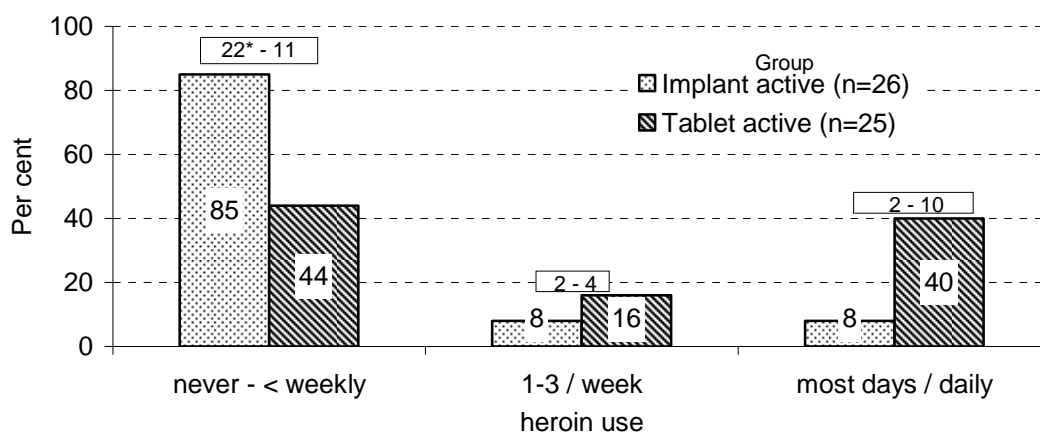
trials and studies associated with comparing the safety and efficacy of naltrexone implants.¹⁰⁹

4.113 Professor Hulse, who is conducting the trial at the University of Western Australia, provided the committee with some interim data from the NHMRC-sponsored randomised clinical trial that was comparing oral naltrexone with naltrexone implants (figure 4.3), noting that at four months after treatment commenced:

Fifty-six per cent of the oral naltrexone group—that is, the TGA registered treatment group—were using heroin in excess of either one to three times a week or more, whereas 16 per cent of the implant group were using one to three times.¹¹⁰

... At four months 2.4 per cent of urine tests from the active implant group showed opioid use compared to 14.7 per cent in the active oral group.¹¹¹

Figure 4.3 Heroin use by clinical trial participants after four months of naltrexone implant and oral treatment for heroin addiction



Note Results are from a randomised double blind placebo controlled clinical trial conducted at the University of Western Australia.

Source Hulse G, submission 16, p 3.

4.114 The committee believes that it is important to offer people a genuine choice about what pharmacotherapy program will work best for them. The committee believes that the time has come to include naltrexone implants on the PBS.

109 Department of Health and Ageing, submission 169, p 8; Hulse G, submission 16, p 2.

110 Hulse G, transcript, 21 March 2007, p 9.

111 Hulse G, submission 16, p 3.

- 4.115 The drug policy elites ostensibly oppose the broader introduction of naltrexone implants on the basis that they are yet to be proven safe and effective. They also question the evidence for the effectiveness of the implants because of the objectivity and credibility of those conducting research into naltrexone implants.¹¹²
- 4.116 Opposition to alternative pharmacotherapy approaches may also come from those with a financial interest in the prescribing of methadone. The committee heard that the operators of private methadone clinics in New South Wales received around \$3,016 per patient per year in dispensing fees.¹¹³
- 4.117 It is important that funding arrangements for naltrexone implant treatment, via the PBS or alternative mechanisms, should be put in place to ensure that naltrexone implants treatment programs are as accessible as other pharmacotherapies for heroin. This should be able to be done very quickly, unimpeded by the drug policy elites.

Recommendation 11

- 4.118 **The Commonwealth Government list naltrexone implants on the Pharmaceutical Benefits Scheme for the treatment of opioid dependence.**
- 4.119 Professor Hulse proposed additional research should be conducted to compare the effectiveness of naltrexone implant treatment compared to alternative pharmacotherapies including:
- a multi-centre trial of naltrexone implant compared with methadone or buprenorphine in the management of heroin-dependent persons;
 - a comparison of long-term mortality in opioid users treated with naltrexone implant, buprenorphine or methadone maintenance;
 - a follow-up of neonates and infants exposed to naltrexone; and
 - examining the impact of naltrexone implant, buprenorphine or methadone maintenance on the course of HCV/HBV/HIV infection.¹¹⁴

112 Wodak A, Australian Drug Law Reform Foundation, transcript, 3 April 2007, p 91; Hall W, submission 156, p 2.

113 Bickle K, submission 186, p 1.

114 Hulse G, submission 16, p 4.

- 4.120 The practical difficulties of conducting a multi-centre trial of naltrexone implants compared to methadone or buprenorphine were acknowledged by Professor Hulse:

We need a study which basically says that these people have been randomised to methadone, buprenorphine or naltrexone implant and looks at how they fare over the next six months. This probably needs to be a multisite study. That would be something that I would hope to run in Perth and in somewhere like St Vincent's Hospital in Melbourne, because then, if you can produce data at two sites which says that this is the outcome, you have a much stronger case.

I believe it is difficult to run a blind study when you are delivering methadone, buprenorphine and implant naltrexone. In the current study everything was blind. People did not know what treatment they were getting. But, if you are going to attempt to do that with a comparison between methadone, buprenorphine and implant naltrexone, what you would have to do is withdraw everyone to start off with. But you do not do that with methadone and buprenorphine. Furthermore, you would have to implant everyone. If you tell me that a long-term or even short-term opiate/heroin user, when you stick methadone or buprenorphine in the system, will not be able to tell you that they are on an opiate rather than naltrexone, I will tell you that you have not been talking to heroin users. You can go through all of this elaborate hoax of trying to blind all of this and you are going to give someone an opiate and they are going to say, 'Well, I know what treatment I'm on.' This is just fanciful. That is what we need to be running there.¹¹⁵

- 4.121 The committee supports the need for further research on the effectiveness of naltrexone implants compared to other pharmacotherapies. The committee believes that the Commonwealth, through the NHMRC or directly through the Department of Health and Ageing, should fund this research. The research also needs to be guided by an expert group that is open minded about different forms of treatment.

115 Hulse G, transcript, 21 March 2007, pp 11–12.

Recommendation 12

4.122 The Department of Health and Ageing:

- **provide funding for ongoing research into the relative effectiveness of pharmacotherapy programs including naltrexone implants and methadone; and**
- **form an advisory body comprised of independent research experts to advise on project methodology.**

Other harm minimisation programs

4.123 As noted earlier, there are a range of harm minimisation programs provided to drug users including needle and syringe programs (box 4.5), safe injecting rooms and overdose prevention initiatives.

4.124 Critics of the drug policy elite's definition of harm minimisation programs highlighted several issues relating to their effectiveness including:

- needle exchanges hasten the induction to addiction by supplying needles and syringes for free, and education in their use, thus effectively subsidising the addiction of children;¹¹⁶
- needles are now simply given away in ever-increasing numbers — six million a year in Victoria alone — needles are discarded rather than returned. Used syringes are employed as weapons to threaten people during robberies and home invasions;¹¹⁷
- evidence to support needle exchanges leading to an increase in the rate of needle sharing and that hepatitis C is spread among users of needle exchanges even when they refrain from sharing needles but share drug ampoules, water, cotton swabs, and other paraphernalia;¹¹⁸ and
- methodological errors in studies supporting needle and syringe exchange programs that overstate the effect of these programs on HIV and hepatitis C infection rates.¹¹⁹

116 Lopez J, submission 24, p 2.

117 Catholic Women's League of Australia, submission 35, p 10.

118 Festival of Light Australia, submission 85, p 8.

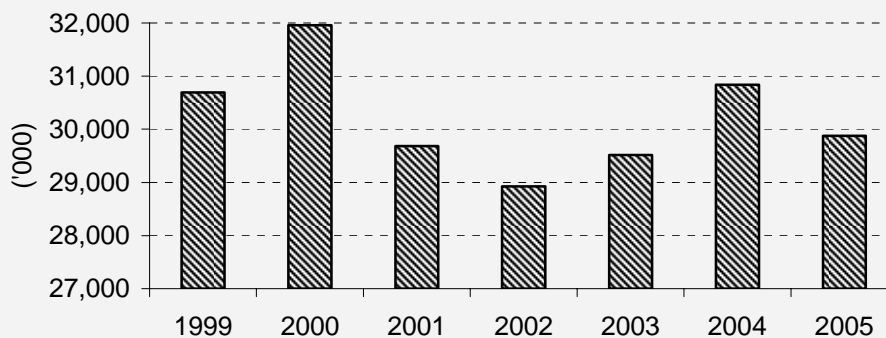
119 Drug Free Australia, submission 167, pp 17–18, see also Kerstin Kall, Chief Medical Officer Addiction Clinic, Linkoping University Hospital, Norway, 'Flawed Research into Needle & Syringe Programs', presentation to Drug Free Australia conference, 'Exposing the reality', Adelaide, 27-29 April 2007.

Box 4.5 Needle and syringe programs

Needle and syringe programs (NSPs) were introduced to Australia in 1986 due to concerns about the increasing HIV prevalence among injecting drug users. There are currently over 3,000 needle and syringe programs, of varying types, across Australia.

In 2005, almost 30,000 units of injecting equipment were distributed in Australia, with the majority distributed in NSW (29 per cent), Victoria (25 per cent) and Queensland.

Figure 4.4 Needle and syringe distribution (units of injecting equipment) ('000)



It was estimated that, in 2002-03, state and territory governments spent \$33.7 million on NSPs with the Commonwealth contributing \$4.6 million. The Commonwealth's current funding of supporting measures relating to NSPs totals \$48.1 million over the five year period to 30 June 2008 — \$44.5 million is provided to states and territories to increase education, counselling and referral services through NSPs and to diversify existing NSPs to increase accessibility through pharmacies and other outlets.

Needle and syringe programs currently operate in over forty countries including Belgium, Canada, Denmark, Finland, France, Germany, the Netherlands, New Zealand, Norway, Spain, Sweden, the United Kingdom, and the United States of America.

In the United States, there is a Congressional ban on the use of federal funds to operate NSPs.

Forty-three states and the District of Columbia have drug paraphernalia laws that penalise injecting drug users for needle and syringe possession. There are approximately 140 NSPs across the remaining states.

Source Dolan K et al, Needle and syringe programs: A review of the evidence (2005); Moore T, Turning Point Drug and Alcohol Centre, What is Australia's 'drug budget'? The policy mix of illicit drug-related government spending in Australia (2005), Christopher Pyne Blog, 13 June 2007, accessed 19 July 2007 at http://www.pyneonline.com.au/?id=blog&_action=showArticleDetails&articleID=1248&categoryID=416.

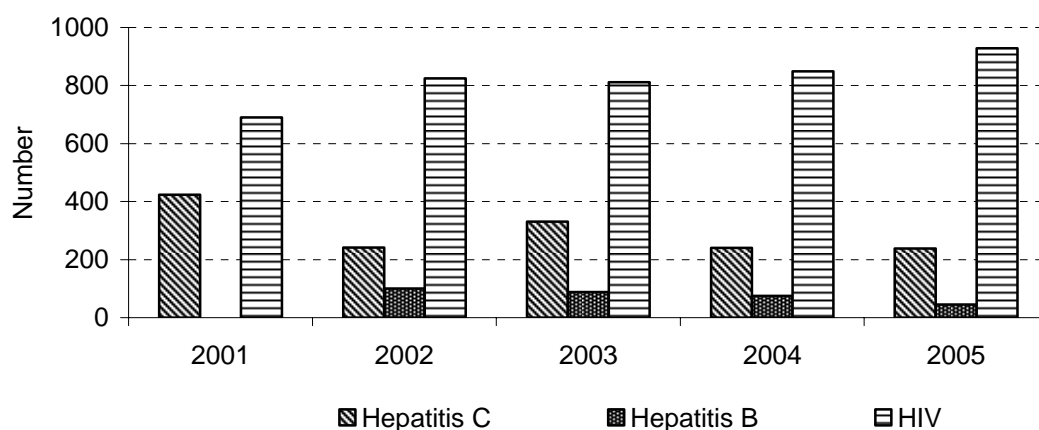
Discussion

4.125 The committee considers that it is important that drug users should be supported to get off drugs. Drug policy elites can give mixed messages to

the community about the acceptability of illicit drug use and perpetuate the myth that drug taking is an individual choice that the user may or may not perceive as destructive.

- 4.126 While the objective of needle and syringe exchange programs is to reduce the risk of infections, the number of new HIV diagnoses has increased steadily in recent years.¹²⁰ Possible explanations for rising infection rates given to the committee include that there is trivialised view of illicit drug taking,¹²¹ and an increasing incidence of risky behaviour (attributed partly to the rise in the consumption of ice).¹²²
- 4.127 Among injecting drug users, the number of newly acquired hepatitis B infections has declined in recent years with the number of newly acquired hepatitis C infections remaining relatively stable (figure 4.4).

Figure 4.4 Number of diagnoses of newly acquired HIV, hepatitis B and hepatitis C infection, 2001–2005



Note HIV infections refer to the general population. Hepatitis B and C refer to infections in injecting drug users only.

Source National Centre in HIV Epidemiology and Clinical Research, 2006 Annual Surveillance Report (2006), cat no PHE 78, pp 21, 62, 65.

- 4.128 Some inquiry participants expressed their support for the continuation or expansion of needle and syringe programs and safe injecting rooms.¹²³

120 National Centre in HIV Epidemiology and Clinical Research, 2006 Annual Surveillance Report (2006), cat no PHE 78, p 1.

121 Reece S, submission 33, p 2.

122 Australian Institute of Family Studies, submission 103, p 7; McLean T, 'Ice users 'in danger' of getting AIDS', *Canberra Times*, 19 July 2007, p 8.

123 The List, submission 49, p 5; Australian Injecting and Illicit Drug Users League, submission 85, p 8; Western Australian Substance Users Association, submission 113, p 2; South Australian Government, submission 153, p 12; Queensland Government, submission 173, p 5; Lines S,

4.129 While the key original intent of the safe injecting room at Kings Cross in Sydney was to reduce the morbidity and mortality associated with drug overdoses, the committee was concerned with reports that only 38 per cent of injections in the injecting room in 2006 were heroin injections. Substances such as cocaine and ice, highly destructive in the longer term but not presenting high risks of immediate overdose, are commonly injected, as is prescription morphine.¹²⁴

4.130 The Festival of Light said in its submission that:

The Commonwealth Government [should]... immediately cease all financial support for harm minimisation programs including needle exchanges, cannabis infringement notice schemes, and methadone substitution programs (unless these have as their goal a proven pathway to complete abstinence). ...The Commonwealth Government [should direct] ... the federal police to actively enforce the provisions of Section 307.10 of the Criminal Code against any person in the vicinity of the Sydney Medically Supervised Injecting Centre who is in possession of heroin, cocaine or any other 'border-controlled drug reasonably suspected of having been unlawfully imported' in order to send a clear message to all states and territories that the Commonwealth will not allow any such breaches of its commitment under the Single Convention on Narcotic Drugs of 1961 as amended by the 1972 Protocol and the Convention on Psychotropic Substances of 1971.¹²⁵

4.131 Drug Free Australia submitted that:

Needle exchanges should be reviewed and practices completely overhauled in all [local government areas] that have adopted them in Australia. They need to be held more accountable. For example, in Sweden such measures are required to: (1) be endorsed by their local community and (2) demonstrate that they have directed clients to treatment services that lead to rehabilitation.

submission 41, p 3; Hepatitis Australia, submission 54, p 2; National Centre in HIV Social Research, submission 61, p 1; Name withheld, submission 77, p 3; Miller T, submission 78, p 3; Quon M, submission 8, p 7; Royal Australian College of Physicians, submission 119, p 15; Families and Friends for Drug Law Reform, submission 122, p 32; Hepatitis C Council of NSW, submission 129, p 9; Association for Prevention and Harm Reduction Programs Australia, submission 130, p 12; Australasian Society of HIV Medicine, submission 140, p 7; Ravesi-Pasche A, submission 47, p 5.

124 Drug Free Australia, *The case for closure: The King's Cross injecting room* (undated), p 3.

125 Festival of Light, submission 85, p 9.

The medically supervised injecting room at Kings Cross needs to be closed without delay. Apart from the fact that there is a possibility of it being replicated in other states and the fact that a large percentage of ice is being injected there, the reasons for its closure are well documented in the attached summary report and further explained in a research document on our website www.drugfree.org.au.¹²⁶

Recommendation 13

4.132 The Australian Government Department of Health and Ageing undertake a review of needle and syringe exchange programs to assess whether they are:

- **supported by the local communities in which they operate; and**
- **successful in directing drug users to appropriate treatment to enable them to be drug free individuals.**

126 Drug Free Australia, submission 42, p 10.

Strengthening families through prevention

- 5.1 Prevention is nominated as one of the priority areas for action in the National Drug Strategy (NDS). In 2002-03, it was estimated that government spending on preventing illicit drug use was \$303.9 million, with the Commonwealth contributing \$57.4 million and the state and territory governments \$246.5 million. The largest portion of funding went to school-based drug education programs, which received \$56.3 million in federal funding and \$207.9 million in state and territory funding. The remaining funds went to general drug prevention activities such as public education campaigns.¹
- 5.2 Under the NDS:
- Prevention refers to measures that prevent or delay the onset of drug use as well as measures that protect against risk and prevent and reduce harm associated with drug supply and use.²
- 5.3 Prevention initiatives may be categorised into primary, secondary and tertiary approaches. Delaying the uptake of drug use is primary prevention; intervening early or targeting high risk populations is secondary prevention; and reducing the harm to people who already use illicit drugs is tertiary prevention. Further, prevention strategies may be universal, targeting an entire population, or selective, targeting sub-groups of the population considered at particular risk, for example, teenagers, pregnant women, or homeless youth.³

1 Moore J, Turning Point Alcohol and Drug Centre, *What is Australia's 'drug budget'? The policy mix of illicit drug-related government spending in Australia* (2005), p 9.

2 Ministerial Council on Drug Strategy, *The National Drug Strategy: Australia's integrated framework 2004-2009* (2004), p 6.

3 Alcohol and Other Drugs Council of Australia, 'Prevention', for Drug Action Week, viewed on 1 August 2007 at <http://drugactionweek.org.au/Prevention.html>; The National Drug Research Institute and the Centre for Adolescent Health, for the Department of Health and

- 5.4 The committee suggests that the community would understand prevention as efforts towards stopping the uptake of illicit drug use, more so than preventing harm that occurs as a result of this act. This supports the committee's recommendation in the previous chapter about the objectives of illicit drug policy and the need to help individuals become drug free. It is also in line with the Commonwealth Government's illicit drug policy that is to maintain a zero tolerance approach.⁴
- 5.5 A definition of prevention that includes harm reduction or minimisation may contribute to the vexed terminology issues and philosophical confusion that this committee has already encountered. It notes that this issue was raised in a study which interviewed senior drug policy bureaucrats across Australia about the priority areas for action:
- Prevention was the second most commonly identified priority area [after policy action on methamphetamines]. The most significant priority was the lack of a clear conceptual framework for prevention. Respondents spoke of the problem with the very broad definition of prevention. The prevention agenda is 'amorphous' with a 'lack of shared understanding'.
- The priority area in this context was to undertake conceptual work to clarify and limit the scope of prevention. The implication was that 'prevention' has been defined too broadly, and the consequence is difficulty specifying the potential range of interventions that governments could apply in responding to prevention needs. (Those that did suggest a definition confined prevention to interventions that occur prior to the commencement of drug use).⁵
- 5.6 Under the NDS's multi-pronged definition of prevention, the Alcohol and Other Drugs Council of Australia classifies needle and syringe programs (NSPs) as a type of tertiary prevention activity.⁶ Dr Margaret Hamilton, a well-known proponent of harm minimisation and Executive Member of the Australian National Council on Drugs (ANCD), has written that,

Ageing, *The prevention of substance use, risk and harm in Australia: A review of the evidence* (2004), p 6.

4 Hon John Howard MP, Prime Minister of Australia, *House of Representatives Debates*, 16 August 2007, p 52.

5 Ritter A, National Drug and Alcohol Research Centre, *Priority areas in illicit drugs policy: Perspectives of policy makers* (2007), p 5.

6 Alcohol and Other Drugs Council of Australia, 'Prevention: Fact sheet' (undated), p 1.

‘prevention is about more than reducing drug use, and is better focused on minimising drug-related harm’.⁷

- 5.7 Similarly, a review of prevention programs for the Department of Health and Ageing in 2004 suggested that a national prevention agenda include strategies that ‘seek innovative approaches to harm minimisation’. This same review also found, however, that: ‘in some cases, there may be conflicts and tensions between the goals of different prevention programs... Efforts to prevent harmful drug use need to be well integrated with broad-based prevention efforts.’⁸
- 5.8 Preventing harm has great merit, particularly for the most vulnerable members of our community, such as babies and children who have no influence over their parents’ decisions to use illicit drugs. But given the damage caused by illicit drug use to families, as described in detail in this report, and the broader burden on society in crime and public health costs, priority must be given to preventing the use of illicit drugs wherever possible. The committee understands prevention as the framework that draws together and reinforces a societal message that any illicit drug use is unacceptable.
- 5.9 Mechanisms for prevention action range from the international treaties and conventions on drugs to which Australia is signatory, to the bureaucratic and philosophical framework set out in the NDS; law enforcement and drug control measures; government information campaigns; school education; the professional training of health workers; and activities on a local and community level such as programs that build resilience, community engagement and parenting skills.⁹ This chapter outlines some of the areas where the committee sees an imperative for preventative action.
- 5.10 Families have a key role to play in preventing illicit drug use by family members, by building self-esteem, confidence, decision-making skills, offering support and communicating about the risks inherent in illicit drugs. It is important that the messages broadcast in the community through school-based education, media and law enforcement reinforce what parents talk about with their children. The community also has an

7 Hamilton M, ‘Preventing drug-related harm’, in Hamilton M et al (eds), *Drug use in Australia: Preventing harm* (2004), 2nd ed, Oxford University Press, p 134.

8 National Drug Research Institute and the Centre for Adolescent Health, for the Department of Health and Ageing, *The prevention of substance use, risk and harm in Australia: A review of the evidence* (2004), pp 3, 147.

9 National Drug Research Institute and the Centre for Adolescent Health, for the Department of Health and Ageing, *The prevention of substance use, risk and harm in Australia: A review of the evidence* (2004), p 9.

obligation to prevent the abuse of those children and babies who are most vulnerable and for whom parental drug use represents an irreconcilable risk to their health and safety.

Upgrading the role of families in the National Drug Strategy

- 5.11 Family Drug Help noted that while the NDS mentions the desire to reduce drug-related harm for families and that the family shares responsibility for reducing the risks associated with drug use, it does not clearly articulate the role of families:

Apart from a range of other vague references to ‘community’ which is presumably speaking much more broadly than families, the strategy does not identify policy or roles that would provide the necessary support and strengthening of families to assist them to become a substantial force in the prevention or reduction in the use of illicit drugs. Furthermore, the needs of families who are by far the most affected group in the community (often more affected than the family member using drugs) is not recognised or considered.¹⁰

- 5.12 The absence of families or children within the priority areas for future action in the current NDS was also noted by the ANCD, raising concerns about the importance given to protecting and providing services to children affected by parental drug use.¹¹

- 5.13 Family Drug Help considered that this oversight suggested two factors were not recognised nor given sufficient priority within the strategy:

One is the substantial impact on families when one member has an addiction to illicit drugs, even though within the Strategy Objectives this was recognised in the statement ‘reduce drug-related harm for individuals, families and communities’. But without any follow through or recommendations related to the objective, it has no outcome.

Secondly, the strategy fails to recognise the value of the potential therapeutic relationship between people with an addiction and their family. If the value of this relationship was recognised, then

10 Family Drug Help, submission 76, p 4.

11 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 154.

the value of a clear strategy targeting families (where one member has an addiction to illicit or licit drugs) which included strengthening families would seem a logical component of the strategy.¹²

- 5.14 Many families told the committee about the important role they played in preventing drug use and treating a family member. Three views from parents are outlined below:

Based on my own experience, I firmly believe families need support and empowerment to make their own decisions. Information, coping strategies and being able to talk to someone and not be judged or dismissed is extremely powerful. We after all know our children better than anyone. We are the experts - we just need help along the journey.¹³

As there are simply not the resources to provide consistent twenty-four hour services for drug users, the reality is that families and carers carry the majority of the burden. By better supporting families and acknowledging their contributions, we reduce the risk that individuals will become estranged from the family unit.¹⁴

Nobody benefits when there is a drug user in the family. We, the families are the real losers; but at the same time we are absolutely essential in the recovery process of an addict. We provide strength and support to our drug user and we usually have good knowledge, which can be used in tackling drug problems and discouraging drug use. I firmly believe that the majority of illicit drug users who do not have some sort of family support, are destined to failure. I doubt my son would ever have pulled himself together without our financial and emotional support. We families need to be supported by good public policy on drugs.¹⁵

- 5.15 The committee agrees with Family Drug Help that the NDS should give greater consideration to the damage inflicted on families and the role they play in prevention and treatment. By giving families greater recognition and priority in the strategy, the committee expects that prevention and treatment services operating under the strategy will become more 'family friendly' in their outlook.

12 Family Drug Help, submission 76, p 4.

13 Lines S, submission 41, p 3.

14 Ravesi-Pasche A, submission 47, p 7.

15 Name withheld, submission 56, p 3.

Recommendation 14

- 5.16 **Within the framework of the proposed illicit drug policy (see recommendation 8), the Commonwealth Government make a clear unequivocal statement, in line with the Prime Minister's statement to the House of Representatives, that includes reference to:**
- **the damage inflicted on families by illicit drug use; and**
 - **the positive role that families can play in strengthening prevention and treatment services.**

School drug education

- 5.17 Having the attention of school-aged children and adolescents is a prevention opportunity, given that the average age of initiation to tobacco is 15.9 years, to alcohol 17.2 years, to cannabis 18.7 years and other illicit drugs a few years higher. In 2004, amongst those 12–19 year olds who had already used drugs, the average age of initiation to cannabis was 14.9 years, ecstasy 16.5 years and amphetamines 16.2 years.¹⁶ The available evidence on school-based drug prevention programs suggests that they have a significant positive impact both in the short and long term.¹⁷
- 5.18 Australia has a National School Drug Education Strategy (NSDES), which was established in 1999. Between 1999-2000 and 2007-2008, \$47.5 million has been provided under this strategy for school drug education and the management of drug-related issues and incidents in schools. The committee notes that a review of school drug education resources is scheduled to conclude in October 2007.
- 5.19 The NSDES recognises that states and territories have primary responsibility for education, but aims for a national approach to strengthen the attack on drug pushers and respond to drug use within schools. The focus of the strategy is on illicit drugs and the goal is 'no

16 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 108.

17 Soole D et al, Griffith University Key Centre for Ethics, Law, Justice and Governance, *School based drug prevention: A systematic review of the evidence of effectiveness on illicit drug use* (2005), p 53.

illicit drugs in schools'. This goal, as stated, 'is based on the belief that illicit and other unsanctioned drug use in schools is unacceptable'.¹⁸

- 5.20 The strategy aspires to build resilience in young people and give them the skills to make positive life choices. It is based on research that demonstrates that young people who have strong relationships - with their friends, family, school and within their community - are more resilient and less likely to engage in a range of high-risk behaviours, including taking drugs.¹⁹
- 5.21 Despite the overarching framework of the NSDES, the committee received reports of variable access to school drug education. In 1996, Carruthers estimated that to change knowledge required 15 hours of education, to change attitudes required 30 hours, and to change behaviour required 50 hours.²⁰ The Australian secondary school students 2005 survey found, however, that only 44 per cent of school students aged 12-17 had received more than one lesson on illicit drug use in the last year (table 5.1).

Table 5.1 Percentage of students indicating they had received lessons about the use of illicit substances in the previous school year, Australia, 2005

Age	12	13	14	15	16	17	12-17
No lessons	27	25	15	14	12	22	19
Part of a lesson	20	19	16	13	16	21	17
One lesson	21	20	20	19	18	18	19
More than one lesson	31	37	50	57	52	39	44

Source White V and Hayman J, for the Australian Government Department of Health and Ageing, Australian secondary school students' use of over-the-counter and illicit substances in 2005 (2006), p 43.

- 5.22 There also appears to be a great variation in the messages being taught to students. As Professor Lenton of the National Drug Research Institute told the committee, what goes on in schools is often left to the individual principal level, 'so it is difficult to make a requirement that all schools do drug education or that all schools do it in a certain way'.²¹

18 Department of Education, Training and Youth Affairs, *National School Drug Education Strategy* (1999), p 1.

19 Department of Education, Science and Training, submission 141, p 1.

20 Carruthers S, 'Drug education: Does it work?' in Wilkinson C and Saunders B (eds), *Perspectives on addiction: Making sense of the issues* (1996), William Montgomery, cited in Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, p 104.

21 Lenton S, National Drug Research Institute, transcript, 14 March 2007, p 43.

- 5.23 This committee has heard several stories of school drug education experiences that, whilst not necessarily representative, are concerning in their implications. Festival of Light Australia recounted that:

A woman whose family attends church regularly has told us about her son who had been given 'drug education' at school which was completely counterproductive. The drug education consisted of being told, at age 14, to 'do a project on drugs' - with no further instructions. Her son and his friends decided to research glue sniffing by trying it themselves. They were apprehended by a teacher, and suspended from school for two weeks. The mother said she felt helpless - she and her son were given no advice, and no assistance by school counsellors or anyone else.²²

- 5.24 Hon Ann Bressington MLC, a Member of the South Australian Legislative Council and founder of the DrugBeat rehabilitation centre in Adelaide, said that:

I was involved in the primary school in our area that started drug education, getting all the kids together and talking to kids, parents and teachers about drugs. I was horrified when they were comparing taking illicit drugs to taking vitamins, or taking illicit drugs to taking medication for illness. I was horrified when the person who delivered this education to these children and parents flashed up on a projector on the wall a picture that said 'Columbian street party', with five big black men with huge white straws up their nose and a pedestrian crossing, obviously supposed to be cocaine, and the thing underneath there was 'a Columbian street party'. Half the kids in the room did not get it. Parents and teachers got it, and there was a giggle. Then the kids had to ask, 'What are you laughing at.' Guess what? The harms of these drugs was minimised immediately. This was the message to those kids who are eight, nine, 10 years old. How irresponsible is that?²³

- 5.25 Some families who gave evidence to the committee felt that the teaching of harm minimisation principles in schools undermined parental authority and confused students about the relative risks of illicit drug use. The Australian Family Association said that:

[The harm minimisation] approach gives very mixed messages to our youth, who see it as the green light to engage in illicit

22 Festival of Light Australia, submission 85, p 2.

23 Bressington A, transcript, 23 May 2007, p 18.

behaviour. This completely undermines parental authority... Parents instinctively know that these things are harming their children, but they feel powerless to combat this influence. This is exacerbated by drug education programs in schools, which recommend themselves to students by drawing attention to their parents' use of legal drugs and lack of understanding of the realities of the drug scene.²⁴

5.26 A parent commented that:

The government needs to be pro drugs in the form of better drug education to solve this issue. Australia needs to educate children with the real life story they will face if they choose drugs, not educating them how to use drugs or supplying needles.²⁵

5.27 Moffit, Malouf and Thompson in their book *Drug precipice* argue that:

Policy decisions [about school drug education] have been influenced by those who advocate a 'normal' [normalising] approach to drug use. In consequence, teaching policies and methods and reflect this attitude. They are in conflict with and disregard the government prohibition of all use. There is no premise or requirement that children be taught the basic dangers of drugs, and the reasons for their prohibition. It seems that Australia's education system aims to teach children to make their own choices about illicit drugs in a way that will 'minimise harm', and to avoid use that is not 'responsible'. This must give children the idea that illicit drugs can, in fact, be used safely and responsibly and that they are able to and should make such decisions, even though drug use remains illegal. The education system accepts that experimentation with dangerous drugs is normal child behaviour.²⁶

5.28 Dr Judy Pettingell, of the Faculty of Education and Social Work at University of Sydney, told the journal *Of Substance* in 2006 that ambivalence about harm minimisation was creating a rift between schools and the attitudes of the broader community, including parents. Dr Pettingell said that while most governments saw the pragmatic benefits of harm minimisation, there was wide community support for abstinence,

24 Australian Family Association, submission 59, pp 2-3.

25 Name withheld, submission 75, p 2.

26 Moffit A et al, *Drug precipice* (1998), University of New South Wales Press, p 153.

and 'until as a society we've sorted that out, it will be difficult for drug education to really move forward'.²⁷

- 5.29 Hon Ann Bressington MLC agreed that drug education could not appropriately allow for the 'recreational' use of illicit drugs:

I am saying that we have got to change our focus to as much prevention and education as possible. We have to change the message in our drug education as well, that you cannot use these drugs recreationally and not be affected by it: 'safe use', 'party drugs'.²⁸

- 5.30 In parent surveys for the National Drugs Campaign, more than three quarters of parents described their attitude towards drugs as 'no drug or drug taking is okay'.²⁹ The committee would like to see parents' desire for their children not to use illicit drugs at all be accorded more prominence in school drug education. School drug education will not in itself address Australia's illicit drug problems, and parents, teachers, other adults and supportive peer groups need to cooperate in offering support and guidance to young people.

Recommendation 15

- 5.31 **The Commonwealth Government take a leadership role in reviewing and updating the National School Drug Education Strategy to re-iterate a commitment to a zero tolerance approach to illicit drugs and reflect the desire of parents for their children not to use illicit drugs.**

- 5.32 Tonie Miller, a mother, drug educator and Toughlove representative, emphasised that while a school drug education from a motivated teacher was invaluable, there were limitations to school-based education. A more complete approach was necessary for prevention:

Education and school participation in community acceptance of families is essential with the ability to refer families in difficulty to local services for assistance. School based education provides some wonderful material but some people working in education have little awareness of, and are threatened by drug use issues, and

27 Rossmanith A, 'School drug education: Looking for direction', *Of Substance* (2006), vol 4, no 4, p 16.

28 Bressington A, transcript, 23 May 2007, p 18.

29 Department of Health and Aged Care, *National Illicit Drugs Campaign: Evaluation of Phase One* (2003), p 38.

their own responses are at times, destructive. At the same time, some committed and gifted individuals within the system, who contribute wonderfully to resilience building in children and young people. Their work is invaluable.³⁰

Public education campaigns

Young people's education needs

- 5.33 Regular surveys of illicit drug use in Australia have found that for those who had ever used an illicit drug, 77 per cent nominated 'curiosity' as a factor which influenced their decision to use for the first time. The next most common factors were peer pressure (54.5 per cent), to do something exciting (20.7 per cent), or to enhance an experience (12.0 per cent).³¹
- 5.34 These figures suggest that although a small percentage of drug users take drugs in order to feel better, to overcome problems, and to cope with trauma or family issues, most drug use is opportunistic and motivated by the perceived benefits of illicit drugs. A former addict told the committee that there was a need to change the attitudes of young people towards illicit drugs:
- [What] made me join in it? It was cool. There is a society perception and the youth culture out there that says... It is not just okay, it is the cool thing to do. This was my way of reaching the cool kids, of getting up to that level, of getting the girlfriend that I want. The cool kids take drugs. From there, you get into the drug culture which is totally different.³²
- 5.35 Amongst the reasons why people had never tried illicit drugs, the most common responses were 'just not interested' (75.6 per cent) and 'for reasons related to health and addiction' (54.6 per cent). Illegality was an issue for one quarter (25.3 per cent), while only 1.2 per cent of respondents nominated drug education/awareness.³³ Possibly, general knowledge or awareness about the negative effects of illicit drugs might contribute to someone saying no for the first two reasons. Respondents were, however,

30 Miller T, submission 78, p 10.

31 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, pp 36–37.

32 Hidden R, transcript, 23 May 2007, p 28.

33 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 41.

able to nominate as many factors as they chose, so the low recognition given to drug education and awareness suggests that such campaigns are not particularly visible or don't have much impact on the public. In light of these findings, the committee believes that there is a clear role for public information campaigns to educate and build resilience amongst potential drug users to overcome peer pressures and the desire for experimentation.

- 5.36 Dr Stuart Reece of Brisbane told the committee that there was a paucity of reliable official information on illicit drugs in Australia in comparison to other countries:

Good educational programs in addiction studies exist in several nations and include web based computer interactive learning, cartoon like adventures of the chemical factories inside patients' brains, and the inclusion of addiction in all other school subjects which have been used successfully in the USA, Sweden and New Zealand. This is in addition to fact packed Government web sites. Of course there is little such material available in this country, particularly on official websites. Good sites do exist in this country (Drug Arm, Drug Awareness Council of Australia) but they only show up the gross inadequacy of the publicly funded sites which of course should be the standard bearers in this battle for truth. And official Australian sites are also grossly inadequate in comparison with their counterparts overseas.³⁴

- 5.37 The main online sources of drug information for young people are currently:

- Somazone, managed by the Australian Drug Foundation, a website for young people that provides an anonymous Q&A service to any questions visitors may have about drugs, sex, sexual health, mental health issues, harassment, relationships, body image and eating disorders. The answers are provided by a panel of health professionals. The site also allows for visitors to post their own stories on these themes, and a searchable database of Australian youth-friendly health services and organisations. It is receiving 80,000 visitors a month;³⁵
- DrugInfo Clearinghouse, also managed by the Australian Drug Foundation, is designed more for a drug and alcohol sector audience,

34 Reece S, submission 33, p 14.

35 Somazone website, viewed on 1 August 2007 at <http://www.somazone.com.au>; Australian Drug Foundation, *Annual review 2006* (2007), p 7.

but also has fact sheets for download, news, events and access to research findings;³⁶

- The National Drugs Campaign youth site, 'Where's your head at?', published by the Department of Health and Ageing, publishes factual information about drugs, provides referral contact information, and posts profiles of drug-free sportspeople, artists and musicians to complement campaign materials.³⁷ The youth sub-site received 32,131 visits in the first six months of the campaign;³⁸
- The National Drug and Alcohol Research Centre has a research rather than information focus but produces fact sheets and publishes contact details for alcohol and drug services across Australia;³⁹ and
- Youth mental health website Reach Out!, produced by not-for-profit The Inspire Foundation, publishes alcohol and drug information.⁴⁰

5.38 There is also some information available on the websites of state-based drug and alcohol information services. The Drug Aware campaign in Western Australia, for example, is the longest running youth drug prevention campaign in Australia, and has a comprehensive website with fact sheets on the major illicit drug groups and a toll-free 1800 information number.⁴¹

5.39 The committee notes also that the Australian Government Department of Education, Science and Training is currently developing a website to educate students, teachers and parents on the dangers of psychostimulant use, including methamphetamines and ecstasy and related drugs. This project responds to recent research commissioned by the Department, which identified a lack of school-based materials for students and teachers on ecstasy and methamphetamines.⁴²

36 DrugInfo Clearinghouse website, viewed on 1 August 2007 at <http://www.druginfo.adf.org.au/>.

37 National Drugs Campaign youth website, 'Where's your head at?', viewed on 1 August 2007 at <http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/youth-home>.

38 Pennay D et al, for the Department of Health and Ageing, *National Drugs Campaign: Evaluation of Phase Two* (2006), p 163.

39 National Drug and Alcohol Research Centre website, viewed on 1 August 2007 at <http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/Drug%20Information>.

40 Reach Out! Website, viewed on 1 August 2007 at <http://www.reachout.com.au/home.asp>.

41 Drug Aware website, viewed on 1 August 2007 at <http://www1.drugaware.com.au>; Drug and Alcohol Office of Western Australia/Western Australian Network of Alcohol and Other Drug Agencies, 'Amphetamines the focus of new Drug Aware program', media release, 20 June 2006, p 2.

42 Department of Education, Science and Training, submission 141, p 1.

- 5.40 Despite this information being available, it is not clear that drug users are fully aware of the risks of illicit drugs before, and even after, they begin to use them. For example:
- a recent Victorian study of current and active ecstasy and related drugs (ERD) users aged 18-36 found that ‘it was striking how difficult it was for young people to articulate the risks and harms associated with ERDs use, suggesting that these are not salient issues or concerns for many in this group’. Not all of the participants accepted that ERDs use is dangerous, and almost all interviewees reported that they intend to continue to use ERDs for the foreseeable future;⁴³
 - an Adelaide survey of illicit drug users with an average age in their late twenties found that over half of all participants (58 per cent) believed it was not at all dangerous to drive under the influence of cannabis and 40 per cent believed it was not at all dangerous to drive under the influence of methamphetamine;⁴⁴ and
 - treatment and rehabilitation organisation Turning Point reports that: ‘methamphetamine users are relatively naïve about the risks and harms associated with methamphetamine use.’⁴⁵
- 5.41 Of course, the provision of online information, while it does reflect a popular way for young people to communicate and access information, exists in a wider domain outside of the control of information providers like those above. There is a large amount of competing information available that users can access with equal ease. One parent, for example, said that her son continued to tell her that illicit drugs were not harmful in the long term, and that ice and cannabis were safer than alcohol. ‘Much of the information to support his belief structure, he said, came from the internet’.⁴⁶

Parents’ education needs

- 5.42 Australian Parents for Drug Free Youth told the committee it was essential for parents to become informed and educated about illicit drugs:

43 Duff C et al, for the Premier’s Drug Prevention Council, Victorian Government, *Dropping, connecting, playing and partying: Exploring the social and cultural contexts of ecstasy and related drug use in Victoria* (2007), p vi.

44 Donald A et al, *Risk perception and drug driving among illicit drug users in Adelaide* (2006), p viii.

45 Lee N et al, Turning Point Alcohol and Drug Centre, *Methamphetamine dependence and treatment* (2007), p 29.

46 Name withheld, submission 106, p 2.

Many of today's parents are not able to teach drug information to their children, because they do not have the background data necessary to do so, in fact, it was not a part of our learned experience or information passed down from generation to generation, because it is a relatively new phenomenon in our history. It is necessary, therefore, for parents to become educated and informed about drugs and their effects and for parents to recognise that drugs are a part of their children's world. Parents must become credible sources of information to their children, or their children will accept the street knowledge of their peers instead.⁴⁷

- 5.43 Parents who had experienced illicit drug use in the family stressed the value of accurate information about drugs for their ability to empower themselves in a distressing situation. In a case study provided by Centacare Catholic Family Services, a bereaved parent who had lost her daughter to illicit drugs said that:

I learnt that knowledge is power, that obtaining accurate and up to date information about drugs and their effects, about drug treatments, about withdrawal, about legal issues, about the history of drug prohibition, about agencies - all this learning is a vital ingredient in helping parents in their coping journey.⁴⁸

- 5.44 Parents also thought that had they known more about drugs and the risks involved, they might have been able to intervene earlier in their son's or daughter's drug use. Parents were not always able to pick up the signs of drug use as they weren't aware of the possibility, or not sure what to look for. Two families told the committee:

We had noticed personality and behavioural changes in our daughter over recent years, and, perhaps stupidly, had put these down to teenage rebellion, a quest for independence, and an eating disorder (for which she had started to receive treatment.) ...Before last year we had no really accurate knowledge about drugs or their effect on people and their bodies, or how to 'speak' to an addict. Our knowledge consisted of the odd newspaper report of a drug death, or watching a movie in which people used drugs (usually in an unrealistic setting). The result of the confrontation with our daughter may have been very different if we had accurate information and knowledge.⁴⁹

47 Australian Parents for Drug Free Youth, submission 4, p 1.

48 Centacare Catholic Family Services, submission 116, p 15.

49 Name withheld, attachment to Australian Drug Treatment and Rehabilitation Foundation,

He always appeared to be normal except for one occasion when I thought his sister and his eyes looked strangely paler than normal (being blue I didn't realise it was because their eyes were pinned and therefore appeared lighter in colour). I did question them saying your eyes look strange, you both look sleepy, and my daughter said they had a big day at school and they were both very tired. I had no reason to distrust them so I believed her. Both my husband and I had no real understanding of drug use other than seeing a few people in Footscray who were on the nod or staggering which was very obvious. We had never seen our children in that condition so we had no reason to believe they had ever used heroin.⁵⁰

- 5.45 Similarly, the Queensland Alcohol and Drug Research and Education Centre considered that:

When families are educated about drugs and drug-related issues they are empowered to engage their loved one with credible information, and to assist them in any intervention or treatment plan that they may wish to undertake. It is important that families remain hopeful, and any government strategy should take such issues into consideration.⁵¹

- 5.46 Interestingly, adolescents may also welcome parent drug education, where it also encourages open and informed discussion about drug taking. For example, in the Victorian study of regular ecstasy and related drugs users mentioned above:

Many interviewees spoke about the importance of open communication with parents as an important ERDs prevention strategy. Indeed, many interviewees expressed a desire to speak more openly with their parents about these drugs; yet most stated that their parents were too anxious and ill-informed about ERDs to permit open and frank discussion.⁵²

submission 132, p 14–15.

50 Name withheld, submission 145, p 8.

51 Queensland Alcohol and Drug Research and Education Centre, submission 98, p 3.

52 Duff C et al, for the Premier's Drug Prevention Council, Victorian Government, *Dropping, connecting, playing and partying: Exploring the social and cultural contexts of ecstasy and related drug use in Victoria* (2007), p vi.

The National Drugs Campaign

- 5.47 The National Drugs Campaign is a major component of the National Illicit Drugs Strategy - Tough on Drugs and is intended to both address the education needs of both young people and parents, as outlined above. Administered by the Department of Health and Ageing, it aims to educate and inform young people and their parents about the negative consequences of illicit drug use.
- 5.48 Phase One of the campaign, launched in March 2001, targeted parents of children aged 8 to 17 years with the tools to discuss drugs with their children. The campaign components included three television commercials, print media and billboard advertisements, a telephone information line and a campaign website. The key messages were that:
- parents need to be aware that all teenagers are potentially exposed to, and at risk from, illicit drugs;
 - parents need to be better informed about drugs to facilitate productive discussion; and
 - parents are important role models and can influence children not to initiate or continue illicit drug use.⁵³
- 5.49 The evaluation from Phase One was primarily positive, with 97 per cent of parents surveyed recognising at least one campaign element. Sixty-eight per cent of parents surveyed had seen the parent information booklet, and of those who had read it, 76 per cent found it useful. Of those who had seen at least one element of the campaign, 48 per cent had been prompted to take some action as a result, whether talking to their children about drugs, thinking more about drugs or reading the parent booklet.⁵⁴
- 5.50 Phase Two of the campaign was launched in April 2005 and was targeted at young people.⁵⁵ It consisted of print ads, posters, wallet cards, stickers, temporary tattoos, an information booklet, a campaign website and three television commercials focusing on the three most commonly used illicit drugs :
- an ecstasy television commercial featuring a girl collapsing in a nightclub, sweating profusely, a dentist telling a young man that he's done quite a bit of damage from teeth-grinding, a boy complaining that

53 Department of Health and Aged Care, *National Illicit Drugs Campaign: Evaluation of Phase One* (2003), p 19.

54 Department of Health and Aged Care, *National Illicit Drugs Campaign: Evaluation of Phase One* (2003), pp 30, 33, 34.

55 Australian Government Department of Health and Ageing, submission 169, p 5.

his girlfriend gets depressed when she is coming down, and a boy undergoing thermal meltdown as his parents look on and paramedics try to save his life;

- a marijuana television commercial showing the consequences of cannabis use and the reactions of peers: a boy who becomes socially alienated, a young woman who kills someone while driving under the influence, a depressed young man, and a footballer who fails to perform on the field; and
- a speed television commercial showing a young man having a panic attack, a girl on life support, a girlfriend complaining that her boyfriend is violent on speed, and a dirty drug lab in a suburban house.

5.51 The message that followed all of these commercials was is 'You don't know what it will do to you'.⁵⁶

5.52 The Department of Health and Ageing told the committee that they considered Phase Two to also have been highly effective:

An evaluation of the Phase Two campaign found that two in three parents of 8-17 year olds felt that the campaign had made it easier to talk to their children about illegal drugs. Around two in three young people aged 13-20 years felt that the campaign had influenced what they do and how they think about drugs, and more than half felt that the campaign had made it easier to discuss illicit drugs with their parents. Further, there appeared to be an increase in young people's confidence in their parents' ability to source information about illegal drugs and their credibility in being aware of drug-related issues to which youth may be exposed. Compared to findings from the pre-campaign survey, there was increased awareness among young people of mental and other health problems associated with using marijuana, ecstasy and speed.⁵⁷

5.53 Phase Three of the campaign was launched at the time of writing this report. Additional funding of \$9.2 million was added to develop a new television commercial on ice, adding to existing education and awareness

56 Commercials available for download from the Department of Health and Ageing website at <http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/media-scripts#ecstasy>;
<http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/media-scripts#speed>;
<http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/media-scripts#marijuana>.

57 Australian Government Department of Health and Ageing, submission 169, p 6.

commercials on cannabis, ecstasy and amphetamines, bringing total investment to \$32.9 million. An updated version of the parents booklet 'Talking with your kids about drugs' is also being distributed to all households in Australia.⁵⁸

- 5.54 The committee heard that Phase Three of the campaign would again target parents:

Stage Three is coming out again to remind parents and to support them in meeting their information needs about drugs. There are new drugs on the community's radar, and there is concern around substances such as ice or methamphetamines. This has been a new issue since the previous campaign was designed. We are looking at advertising to support parents in dealing with that substance.⁵⁹

Future public education campaigns

- 5.55 Despite the generally positive outcomes from the National Drugs Campaign to date, the committee found that many inquiry participants were negative about the value of public education campaigns, with the chief criticisms being that they were not proven to be effective, they were expensive, and that it was difficult to deliver information to young people in a way that they accepted as credible.

- 5.56 The Australian Psychological Society, the Alcohol and Drug Foundation ACT and Families and Friends for Drug Law Reform warned against mass media campaigns.⁶⁰ The ANCD was also ambivalent:

Media campaigns have been used successfully to reduce unhealthy behaviours (e.g. tobacco smoking), but their application in relation to illicit drug use is limited and unfortunately not well evaluated. Successful media campaigns are also expensive and require substantial planning and research. In particular, they require a segmented marketing strategy that identifies and successfully targets the 'at-risk' audience (e.g. use media channels that are accessed by drug users and a delivery that is appealing to this audience), research on the target audience to understand their attitudes, beliefs and values (including pre-testing of media campaigns), and most importantly, the campaign must receive

58 Department of Health and Ageing, submission 169, p 6.

59 Van Ween L, Department of Health and Ageing, transcript, 28 February 2007, pp 4-5.

60 Alcohol and Drug Foundation ACT, submission 123, p 1; Australian Psychological Society, submission 131, p 12; Families and Friends for Drug Law Reform, submission 122, pp 17, 19-22.

adequate and sustained coverage. Media campaigns run the risk of unintended increases in drug use if they are not adequately researched and focus tested.⁶¹

- 5.57 The Australian Drug Foundation warned against depending on large-scale mass media campaigns without strategies for integrating them into community programs:

While such campaigns have a role in raising awareness of issues, they are ineffective unless they are underpinned by a whole raft of community linked strategies, initiatives and services. The evidence does not support stand alone, once-off media campaigns as a successful strategy in changing behaviours.⁶²

- 5.58 The use of scare campaigns was specifically rejected by some. The Australian Drug Foundation said: 'Nor is there evidence to support the use of "shock tactics" in persuading people to avoid or reduce the use of drugs'.⁶³ The Western Australian Network of Alcohol and Other Drugs Agencies said that consumers were unable to identify with the information provided in prevention campaigns that 'focused on the extreme consequences of drug use, including health deterioration or even death, criminal behaviour leading to imprisonment, or psychosis'.⁶⁴
- 5.59 In the course of public hearings for this inquiry, however, many other witnesses did support the concept of such a campaign, including the Federal Commissioner of Police, the Western Australian Government Drug and Alcohol Office, Families Australia, Beyondblue, Drug Free Australia and Hon Ann Bressington MLC, of DrugBeat South Australia.⁶⁵
- 5.60 The committee's attention was drawn to drug prevention campaigns overseas that have taken a more uncompromising approach than we have in Australia, with immediate impact. The Crackdown on Drugs advertising campaign launched by the Metropolitan Police Service in 2004, for example, featured actual photographs of methamphetamine and heroin users to illustrate how their physical appearance deteriorates

61 Australian National Council on Drugs, *Position paper: Methamphetamines* (undated), p 8.

62 Australian Drug Foundation, submission 118, pp 12–13.

63 Australian Drug Foundation, submission 118, pp 12–13.

64 Western Australian Network of Alcohol and Other Drug Agencies, submission 138, pp 2–3.

65 Keelty M, Australian Federal Police, transcript, 14 March 2007, pp 13-14; Murphy T, transcript, 14 March 2007, p 7; Babington B, Families Australia, transcript, 28 March 2007, p 18; Thompson C, Drug Free Australia, transcript, 28 May 2007, p 15; Bressington A, transcript, 23 May 2007, p 21; Beyondblue, *Submission to the National Cannabis Strategy* (2005), p 3; see also Name withheld, submission 106, p 1, Ravesi-Pasche A, submission 47, p 7; Gawler I, submission 65, p 4; Endeavour Forum, submission 22, p 1.

dramatically over time. Supplied by the US police and accompanied by a letter of support from one of the women, the images record a shocking deterioration of the skin, teeth and hair in the space of a few years.⁶⁶

- 5.61 Similarly, the Montana Meth Project in the United States graphically portrays the ravages of methamphetamine use through television, radio, billboards, and internet ads. The campaign's core message, 'Not even once,' speaks directly to the highly addictive nature of methamphetamine. Print and television advertisements show images such as scabs and body sores as a result of drug use, yellowed and decaying teeth, and destitute and bloodied bathrooms. They also focus on the disappointment and hurt felt by parents, girlfriends and boyfriends, siblings and peers when someone close to them starts to use a dangerous drug.⁶⁷

Figure 5.1 Images of the physical deterioration of a methamphetamine user employed in a 2004 public campaign by the London Metropolitan Police



Source *London Metropolitan Police website, viewed on 25 August 2007 at <http://www.met.police.uk/drugs/advertising.htm>, reproduced with permission.*

- 5.62 A report from the Montana Attorney General's Department on a statewide survey found that 81 per cent of teens reported that the ads show that methamphetamine is dangerous to try even once (more than for heroin),

66 Metropolitan Police website, viewed on 1 August 2007 at <http://www.met.police.uk/drugs/advertising.htm>.

67 Montana Meth Project website viewed on 1 August 2007 at <http://www.notevenonce.com/index.php>.

with 75 per cent saying that the ads show it is more destructive than they had originally thought. Ninety-six percent of all parents surveyed had discussed drugs with their children in the past year, and since the commencement of the campaign, methamphetamine use amongst teens had fallen 38 per cent.⁶⁸ The advertising campaign had attracted international recognition, including a prestigious award at the 2007 Annual Cannes International Advertising Festival.⁶⁹

- 5.63 Hon Ann Bressington MLC referred to this campaign in evidence, and supported the concept of something similar in Australia to genuinely impress on young people the risks they were taking with illicit drugs, particularly with something as important to them as their appearance:

There is evidence that [a hard-hitting prevention campaign] is working in the United States for crystal meth. I believe crystal meth in its form now and level of use now requires an aggressive approach as far as education goes, because it is not just the speed of the past. I believe our kids need to know about the DNA damage that it does and the genetic damage that it is doing. Imagine young girls who love to look at *Dolly* magazine seeing a picture of someone who has been using methamphetamine for 18 months, and it is a drugged out person who looks twice their age. Those are the sort of messages that will appeal to young girls.⁷⁰

- 5.64 The committee also considered two examples of highly effective campaigns from within Australia not related to illicit drugs: the 'grim reaper' campaign for HIV/AIDS awareness in 1987, and our current National Tobacco Campaign.
- 5.65 The 'grim reaper' campaign was a landmark in public health awareness campaigns. It featured frightening television advertisements showing a cloaked grim reaper bowling over human skittles, as well as the provision of follow-up information for the duration of the campaign.⁷¹
- 5.66 The campaign was enormously successful in creating awareness that all Australians, not just homosexual men, were threatened by AIDS. Even though the campaign only ran for three weeks, 97 per cent of those

68 Montana Meth Project, 'New Montana Meth project survey shows dramatic shift in attitudes toward meth', media release, 7 March 2007.

69 Montana Meth Project, 'The Meth Project wins international advertising award at Cannes Festival', media release, 27 June 2007.

70 Bressington A, transcript, 23 May 2007, p 22.

71 Winn M, 'The Grim Reaper: Australia's first mass media AIDS education campaign' in World Health Organisation, *AIDs prevention through health promotion: Facing difficult issues* (1991), pp 33-34.

surveyed eight weeks after the commencement of the campaign recalled seeing the television advertisements. Surveys also found that 95 per cent of respondents thought the campaign had increased public awareness, 81 per cent thought it had increased people's knowledge, 61 per cent thought they had learned something personally and 44 per cent reported changes in their attitude or behaviour.⁷²

- 5.67 More recently, decades of public health information and research have changed the face of smoking in Australia. Commitment by governments and health professionals has changed community attitudes towards what was once considered a normal and relatively harmless activity. The committee observes with interest that the website for the National Tobacco Campaign, quitnow.info.com.au, takes a notably more hardline approach to tobacco smoking than the National Drugs Campaign, despite the latter dealing with illegal drugs.
- 5.68 Unlike many illicit drug information sources, which seek to rationalise or 'balance' the decision to take drugs by listing the positive as well as negative effects of illicit drugs, there is no recognition of the benefits of smoking, such as a description of its relaxant properties. Nor is there any advice on harm reduction or smoking 'safely' or 'responsibly'; rather, the message is that 'every cigarette is doing you damage'.
- 5.69 Print and television advertisements have focused on graphic images that confront viewers with the damage that smoking causes to the body: for example, on the website currently and in advertisements around the country, viewers can see a doctor's hand squeezing out the deposits accumulated in the artery of a 32 year old; the brain tissue of a smoker damaged by blood clots; and a full beaker of tar being poured onto healthy lung tissue. A section of the website called 'Damage – The cold hard facts' supports this imagery with expert information sheets for download on the health effects of smoking.⁷³
- 5.70 According to the Department of Health and Ageing, the campaign has generated considerable international interest with adaptations of the television advertisements being used in the United States, New Zealand, Singapore, Cambodia, Iceland, Poland and Canada. The campaign has also received recognition through several industry awards both in

72 Taylor in Pyett P, 'Social and behavioural aspects of the prevention of HIV/AIDS in Australia: A critical review of the literature', *Centre for Health Program Evaluation Working Paper 13* (1991), p 22.

73 Quitnow website, viewed on 1 August 2007 at <http://www.quitnow.info.au/internet/quitnow/publishing.nsf/Content/damage-lp>.

Australia and overseas.⁷⁴ Most importantly, it is achieving positive results. While Australia has one of the highest rates of illicit drug use in the world, particularly with respect to ecstasy and amphetamines, we are ranked one of the lowest of all countries in the OECD in terms of tobacco smoking.⁷⁵

- 5.71 The committee commends the work done to date on the National Drugs Campaign, and believes that public campaigns do have value in preventing the uptake of illicit drugs and giving the community facts to counteract assumptions and attitudes circulated in the media and peer groups about 'safe' or 'recreational' use. It believes that there is a need for a campaign in the future that highlights the dangers of illicit drugs in much stronger terms.

Recommendation 16

- 5.72 **While commending the Government on the media campaign against ice, the committee recommends that the Minister for Health and Ageing fund, as a matter of priority, a fourth phase of the National Drugs Campaign aimed at young people, that draws on experiences from the anti smoking campaign and other campaigns most notably the Montana Meth Project in the United States that:**

- **moves away from pointing out the 'harm' related to illicit drugs to one that highlights 'damage', 'destruction' and 'danger';**
- **employs compelling and confronting imagery such as that used in local campaigns and the Montana Meth Project campaign (www.notevenonce.com/index.php);**
- **documents the health effects of illicit drug taking, particularly the ageing and degenerative effects on physical appearance; and**
- **raises awareness of the mental health consequences of illicit drug use.**

74 Department of Health and Ageing, 'Tobacco – Education', viewed on 1 August 2007 at <http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-drugs-tobacco-education.htm>.

75 Australian Institute of Health and Welfare, *Statistics on drug use in Australia 2006* (2007), cat no PHE 80, pp viii, 10; see table 1.1 for international comparisons.

Research to inform prevention campaigns

- 5.73 The committee's attention was drawn to a range of overseas research into gaining a better understanding the physical bases of addiction.⁷⁶ A better understanding of the biology of addiction will better inform future prevention campaigns and contribute to improved treatment outcomes.
- 5.74 Images of the brain using single photon emission computerised tomography (SPECT) provide a 3-dimensional view of brain functioning. Figure 5.2 shows SPECT images of the brain after exposure to cannabis. Dr Daniel Amen, an Assistant Clinical Professor of Psychiatry and Human Behavior at the University of California noted that:
- SPECT has demonstrated a number of abnormalities in substance abusers in brain areas known to be involved in behaviour, such as the frontal and temporal lobes. There are some SPECT similarities and differences between the damage we see caused by the different substances of abuse. ... There tends to be several similarities seen among classes of abused drugs. The most common similarity among drug and alcohol abusers is that the brain has an overall toxic look to it. In general, the SPECT studies look less active, more shrivelled, and overall less healthy. A 'scalloping effect' is common amongst drug abusing brains. Normal brain patterns show smooth activity across the cortical surface. Scalloping is a wavy, rough sea-like look on the brain's surface. I also see this pattern in patients who have been exposed to toxic fumes or oxygen deprivation. My research assistant says that the drug brains she has seen look like someone poured acid on the brain. Not a pretty site [sic].⁷⁷
- 5.75 Several inquiry participants proposed that greater attention should be given to researching the impact of illicit drug addiction on physical and mental wellbeing and development, including the link between illicit drug use and degenerative processes.⁷⁸ In a submission to the committee, Dr Stuart Reece noted that:

76 Li T et al, 'The Biological Bases of Nicotine and Alcohol Co-Addiction', *Biological Psychiatry* (2007), vol 61, pp 1-3; Lemonick MD, 'The science of addiction', *Time* (2007), pp 40-43.

77 'Welcome to Brainplace: Brain SPECT Information and Resources, Chapter 15 - Images of alcohol and drug abuse', viewed on 28 August 2007 at <http://amenclinics.com/bp/atlas/ch15.php>.

78 Reece S, submission 33, pp 13-14; Christian G, Drug Free Australia, transcript, 28 May 2007, p 23.

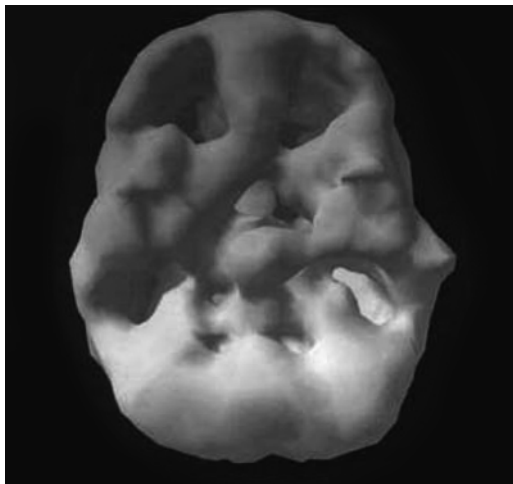
The decrepit and dishevelled state of many drug affected persons is well known [to] both the community and the committee. It is established in addiction science that all addictive drugs impair cell growth and division. They also accelerate cell death processes, either when used singly, or in the common combinations in which they are used by patients. These changes, combined with the DNA toxicity which has been previously demonstrated for cannabis and tobacco, are the cellular and molecular underpinnings of ageing at the cellular level. These findings suggest that the poor appearance of addicted persons, together with many well known features of their pathology including poor teeth, high rate of infections, high rate of tumours and very high death rate, actually reflect an accelerated pattern of ageing at the level of the whole organism.

- 5.76 Similarly if these changes could be better understood, it is well possible that significant gains could be made in other related health areas. If addiction accelerates ageing, then it stands to reason that the addiction blocking agents may well slow this change down. Clearly this needs to be quantified by further research. Similarly if addiction accelerates the development of hardening of the arteries and of cancer, then understanding such molecular pathways may well teach us valuable lessons about the causation of these diseases, including the yielding of important new molecular targets for major drug therapies.⁷⁹
- 5.77 The committee supports such research, noting that there is enthusiasm within the Australian research community to progress this work and that the cost of such research would be in the order of \$50 million.⁸⁰ The committee considers that this research should be given higher priority by the National Health and Medical Research Council.

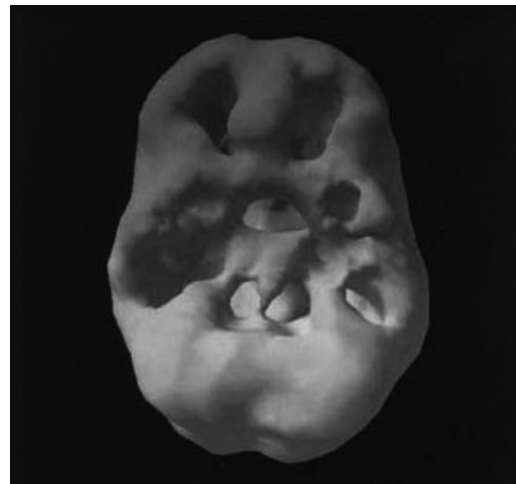
79 Reece S, submission 33, pp 13–14.

80 Reece S, submission 33, p 14.

Figure 5.2 Brain SPECT images – Cannabis users



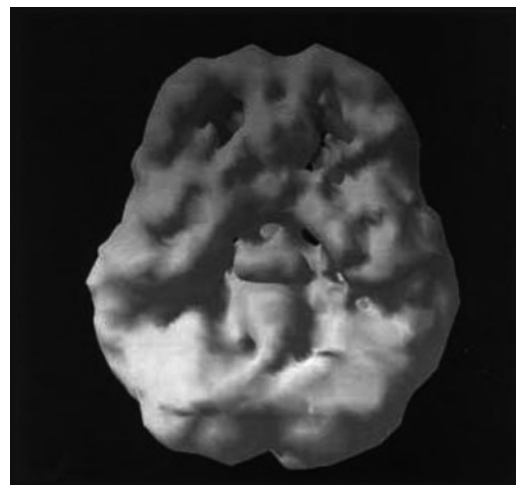
*18 y/o
3 year history of 4 x week use
underside surface view
decreased pfs & temporal lobe activity*



*16 y/o
2 year history of daily abuse
underside surface view
decreased pfs & temporal lobe activity*



*38 y/o
12 years of daily use
underside surface view
decreased pfs & temporal lobe activity*



*28 y/o
10 years of mostly weekend use
underside surface view
decreased pfs & temporal lobe activity*

Source 'Welcome to Brainplace: Brain SPECT Information and Resources, Chapter 15 – Images of alcohol and drug abuse', viewed on 28 August 2007 at <http://amenclinics.com/bp/atlas/ch15.php>, reproduced with permission.

Strengthening the anti-drug message in our community

5.78 As noted in chapter four, harm minimisation, because of the way certain groups have interpreted the term, provides mixed messages to the

community about the acceptability of illicit drug use. These mixed messages are also disseminated through the use of language that glamorises drug taking, such as the terms 'recreational' and 'party' drugs. The legal sale of drug paraphernalia also sends the wrong message to the community about the acceptability of drug use.

- 5.79 The committee considers that there are opportunities to strengthen the anti-drug message in the community by increasing the use of random testing for drugs in drivers and in some workplaces to further support the vision of drug-free individuals outlined in chapter four.

Avoiding the 'glamorising' of drug taking

- 5.80 It is important that discussions about illicit drug use in the community do not glamorise the taking of illicit drugs. Several inquiry participants noted that some terms used to describe illicit drugs in the community, such as 'party drugs' and 'recreational drugs' have resulted in a culture of acceptance in the community about the use of illicit drugs and that these drugs can be used safely.⁸¹
- 5.81 The dangers of illicit drug use mean that the continued use of these terms may work against efforts to promote drug-free individuals. The committee endorses the comments from Beyondblue about how the use of terms such as 'party drugs' and 'recreational drugs' work against the message that illicit drug use is unsafe (box 5.1).

Box 5.1 Beyondblue comments on messages glamorising illicit drug taking

Beyondblue has been active in the media addressing the language used to refer to methamphetamines decrying the terms 'party drugs' or 'recreational drugs' and the popular perception that this creates that these drugs are 'safe'... From a mental health perspective, the use of illicit drugs can precipitate or exacerbate the potential for an anxiety or depressive disorder to occur, beyondblue has a role in highlighting the extent to which there is no predictably safe level of illicit drug use and its implications for mental health, particularly anxiety and depression. One way in which beyondblue intends to further achieve this is to develop a concerted campaign that focuses upon tackling the language of 'party and recreational drug use'.

Source Submission 151, p 4.

- 5.82 The committee is disappointed that in late 2006, the Ministerial Council on Drug Strategy agreed that all jurisdictions notify their government

81 Drug Free Australia, submission 42, p 11; Australian Parents for Drug Free Youth, submission 4, p 2; Australian Drug Treatment and Rehabilitation Programme, submission 132, p 2; Beyondblue, submission 151, p 4;

agencies, and the organisations in receipt of government funding, of the *preference* not to use language that glamorises or promotes the use of drugs. This included the terms 'recreational' and 'party' to describe drugs or drug use in public statements, correspondence and reports.⁸²

- 5.83 Presently, a wide range of existing literature, such as that produced by the Australian Drug Foundation, which received \$1.9 million in government funding in 2005-06, contains language of the above type which permits or promotes the use of illicit drugs.⁸³ The committee therefore believes that the Commonwealth Government should only fund those organisations that do not use language that glamorises or promotes the use of drugs, including changing previously produced information that is accessed electronically on their website.

Recommendation 17

- 5.84 **The Commonwealth Government provide funding only to organisations that adhere to the policy not to use language that glamorises or promotes the use of drugs, such as the terms 'recreational' and 'party' to describe drugs or drug use in public statements, correspondence and reports and that have implemented this policy to documents available electronically via their website. The Commonwealth Government also withdraw funding from organisations that promote legalisation of all or any illicit drugs.**
- 5.85 The Western Australian Government Drug and Alcohol Office told the committee how it had worked with WA Police to develop a policy to avoid the use of words such as 'party', 'recreational' and 'dance' in order to not afford illicit drugs a positive connotation.⁸⁴
- 5.86 It is important that the language used by the media is also addressed (box 5.2). Research has concluded that for non drug users, the mass media is the primary source of information about drugs.⁸⁵

82 Ministerial Council on Drug Strategy, 'Joint Communique 15th December 2006', viewed on 29 July at <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mcds-15deccommunique>.

83 DrugInfo Clearinghouse, 'What are party drugs?', viewed on 31 July 2007 at http://www.druginfo.adf.org.au/article.asp?ContentID=what_are_party_drugs.

84 Murphy T, transcript, 14 March 2007, pp 7-8.

85 Hoare D, in Mendes P and Rowe J (eds), *Harm minimisation, zero tolerance and beyond: The politics of illicit drugs in Australia* (2004), Pearson SprintPrint, p 62.

Box 5.2 Recent selected print media headlines relating to illicit drug use

- ‘Who needs party drugs when paying taxes gives you a high?’, Skatsoon J, *The Canberra Times*, 17 June 2007.
- ‘Crackdown on party drugs’, Glumac T, *The Canberra Times*, 6 October 2006, p 1.
- ‘Speed tops recreational drug list’, Prichard J, *The Australian*, 21 May 2007, p 5.
- ‘Workers hooked on party drug’, Dunn E, *The Sydney Morning Herald*, 28 September 2006, p 1.
- ‘Party drug’ disguise for danger and death’, Kamper A, *The Daily Telegraph*, 16 May 2006, p 4.
- ‘Rising toll from party drug’s use, say doctors’, Pollard R, *The Sydney Morning Herald*, 1 April 2006, p 8.

5.87 Although the government cannot direct the media generally on this issue of language it can direct the Australian Broadcasting Corporation (ABC). The ABC has advised the committee that under its News and Current Affairs Style Guide of August 2006, journalists are instructed to avoid using the terms ‘recreational drugs’ or ‘party drugs’ unless they are attributed to someone.⁸⁶ However, these guidelines only apply to news and current affairs and not all presenters. The committee believes that this policy should be extended to all presenters — particularly those in its youth media.

Recommendation 18

5.88 **The Commonwealth Government:**

- **direct the Australian Broadcasting Corporation that its News and Current Affairs Style Guide should apply to all presenters; and**
- **encourage the Australian Press Council to adopt a similar code.**

Banning the sale of drug equipment

5.89 The sale of drug equipment, such as cannabis smoking equipment and ‘ice’ pipes, detracts from educational messages about illicit drugs and the damage they cause. Imposing a ban on sales would also make it difficult for first time drug users to experiment with illicit drugs.

86 Advice from ABC Audience and Consumer Affairs, correspondence, 1 August 2007.

- 5.90 Ryan Hidden, a former drug user, told the committee about the mixed messages that can arise with the sale of equipment used to consume illicit drugs:

Like I said, it was a culture that drugs were cool. It is mainly because of that discourse that happens between firstly alcohol and cigarettes when they all get mashed together; there is a lot of discourse out there. You walk down the street and see a shop selling bong, and all that type of stuff. You just cannot entertain the thought in the present environment that drugs are really all that bad.⁸⁷

- 5.91 Ice pipes are banned for sale in Victoria, New South Wales, South Australia and Western Australia.⁸⁸
- 5.92 The committee notes that in May 2007, the Ministerial Council on Drug Strategy agreed that the Commonwealth should prepare a discussion paper on banning or regulating the importation, sale and advertisement of equipment for the use of cannabis for consideration at its next meeting.⁸⁹
- 5.93 The committee welcomes the approach adopted by South Australia, which has agreed to ban the sale of bong and other drug implements since the meeting.⁹⁰ Rather than wait for the outcomes of the paper being prepared for the Ministerial Council on Drug Strategy, the committee urges states and territories to implement policies to restrict the sale of drug equipment. Such action will be another step to reducing the impact of illicit drugs on families.

Recommendation 19

- 5.94 **The Minister for Health and Ageing work with states and territories to implement bans on the sale of drug equipment and the Minister for Justice and Customs ban the import of such equipment.**

87 Hidden R, transcript, 23 May 2007, p 12.

88 Hon C Pyne MP, Parliamentary Secretary to the Minister for Health and Ageing, 'Pyne disappointed at failure to back ice pipes ban', media release, 14 December 2006.

89 Ministerial Council on Drug Strategy, 'Joint Communiqué 16th May 2007', viewed on 29 July 2007 at <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/mcde-16may07-communicue>.

90 Hon C Pyne MP, Minister for Ageing, 'Pyne welcomes SA move to 'ban the bong'', media release, 21 May 2007.

Drug driver testing

- 5.95 Illicit drug using drivers are responsible for a significant number of road traffic accidents. In 2004, of the 2.5 million Australians aged 14 years and older who had used any illicit drugs in the last 12 months, in the same period 581,000 people had driven a motor vehicle while under the influence of illicit drugs.⁹¹
- 5.96 Recognising this, all Australian jurisdictions have examined roadside drug testing and are at different stages of implementation, with some states and territories yet to commence regular drug driver testing.⁹²
- 5.97 Laboratory studies have shown that cannabis compromises reaction time, attention, decision making, time and distance perception, short-term memory, hand-eye coordination, and concentration.⁹³ Central nervous system stimulants, like amphetamines, ecstasy and cocaine, can impair coordination and judgement through hyperactivity, aggressiveness, overconfidence, blurred vision, hallucinations and fatigue; while narcotic analgesics such as methadone and heroin slow reflexes and blur vision.⁹⁴ All of these effects pose significant risks to those driving under the influence, their passengers and others on the road.
- 5.98 A survey in 2005 by insurer AAMI found almost one-quarter of young Australian drivers (22 per cent) reported taking illicit drugs such as marijuana, cocaine, speed or ecstasy before driving.⁹⁵
- 5.99 Preliminary results from roadside random drug testing by police suggest that drug driving is a reality on our roads. Victoria was the first jurisdiction to introduce random drug tests for drivers in 2004.⁹⁶ Tasmania, South Australia, New South Wales and Western Australia now have

91 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 89.

92 Australian National Council on Drugs, *Of Substance* (2007), vol 5 no 3, p 26.

93 National Drug and Alcohol Research Centre, 'Cannabis and driving: fact sheet', viewed on 4 July 2007 at [http://www.med.unsw.edu.au/NDARCWeb.nsf/resources/NDARCFact_Drugs3/\\$file/CANNABIS+AND+DRIVING+FACT+SHEET.pdf](http://www.med.unsw.edu.au/NDARCWeb.nsf/resources/NDARCFact_Drugs3/$file/CANNABIS+AND+DRIVING+FACT+SHEET.pdf)

94 Queensland Government, 'Drug driving: Fact sheet', viewed on 4 July 2007 at http://www.transport.qld.gov.au/resources/file/ebb929084058b75/Pdf_rs_fact_sheet_drugs.pdf.

95 Butler M, 'Australia's approach to drugs and driving', *Of Substance* (2007), vol 5, no 3, pp 24-25.

96 Victorian Government, 'Drugs and Driving', viewed on 31 May 2007 at http://www.arrivealive.vic.gov.au/c_drugsAD.html.

driver drug testing programs, with Queensland and the Northern Territory expected to follow in 2008.⁹⁷

- 5.100 In the first year of testing in Victoria, from December 2004 to December 2005, 13,176 drivers were tested and 287, or two per cent, tested positive for illicit drugs. 199 drivers, or 1.5 per cent, tested positive to methamphetamine only. Nineteen drivers, less than one per cent, tested positive to cannabis only, and less than one per cent tested positive to both drugs. MDMA (ecstasy) was not at that point part of the testing program, although it has since been added.⁹⁸
- 5.101 After four months of operation, the NSW Police random drug testing unit reported in May 2007 that of the 1,600 drivers stopped and given a swab test, one in 46, or two per cent, tested positive to illegal drugs, mostly amphetamines.⁹⁹
- 5.102 Studies of drivers involved in major vehicle crashes suggest that those under the influence of drugs pose a risk far in excess of the general population. In 2003, 31 per cent of drivers killed on the roads in Victoria tested positive to drugs other than alcohol. This is a higher figure than the 28 per cent of drivers who were killed who had a blood alcohol content of 0.05 or more (although some drivers had both alcohol and illicit drugs in their bloodstream).¹⁰⁰
- 5.103 A study published in the journal *Emergency Medicine Australasia* in 2007 found concerning levels of illicit drugs in the bloodstream of drivers involved in accidents. A blood sample was obtained from 436 patients who had been taken to The Alfred Emergency & Trauma Centre in Melbourne following a motor vehicle collision. The study found that over one in three drivers in major car accidents had illicit drugs in their system.
- 5.104 Of the above drivers tested, 46.7 per cent had cannabis in their bloodstream (7.6 per cent had used recently enough to impair driving ability); 11 per cent had opiates, 4.1 per cent had amphetamines, 3 per cent methadone and 1.4 per cent cocaine.¹⁰¹

97 Butler M, 'Australia's approach to drugs and driving', *Of Substance* (2007), vol 5, no 3, pp 24-25.

98 Victoria Police, 'Random roadside drug testing program expanded', media release, 28 February 2006.

99 Cubby B, 'More drivers test for drugs than drink', *Sydney Morning Herald*, 16 May 2007.

100 Victorian Government, 'Drugs and Driving', viewed on 22 May 2007 at http://www.arrivealive.vic.gov.au/c_drugsAD.html.

101 Ch'ng C et al, 'Drug use in motor vehicle drivers presenting to an Australian, adult major trauma centre', *Emergency Medicine Australasia* (2007).

- 5.105 A study published in 2007 by the National Drug Law Enforcement Research Fund found similarly high, although not as high, levels of illicit drug use in patients admitted to the Trauma Centre at Royal Adelaide Hospital over the course of a year. Cannabis was found in 17.4 per cent of injured car drivers, amphetamines in 6.9 per cent and opiates in 3.3 per cent (totalling 27.6 per cent), as against 22.6 per cent of injured drivers with alcohol in their bloodstream.¹⁰²
- 5.106 Victoria Police, the first enforcement agency to implement a random drug testing program in Australia, gave the committee an overview of the results of random roadside drug testing results over the two years to December 2006:
- A total of 25,273 drivers screened comprising 18,121 car drivers and 7,152 heavy vehicle drivers;
 - A detection rate of 1:50, with 503 drivers testing positive to the three target drugs (methamphetamines, ecstasy and cannabis) including:
 - ⇒ methamphetamines only found in 328 drivers;
 - ⇒ ecstasy only found in seven drivers;
 - ⇒ cannabis only found in 37 drivers;
 - ⇒ a combination of methamphetamines and ecstasy was found in 16 drivers;
 - ⇒ a combination of methamphetamines and cannabis was found in 16 drivers; and
 - ⇒ all three drugs were found present in four drivers.¹⁰³
- 5.107 The effects of the testing program on driver attitudes and behaviour were likely to be longer term, with Victoria Police telling the committee that:
- While random alcohol screening as an enforcement and deterrence strategy has significantly reduced road trauma in Victoria, it took several decades to change attitudes and behaviour. The implementation of a random drug screening campaign has the potential to reduce the incidence of drug driving and road trauma in much the same way. The random drug screening program has now been in operation for 30 months and it will take some time to effect drug driver attitudes and behaviour. However, operation of

102 Griggs W et al, National Drug Law Enforcement Research Fund, *The impact of drugs on road crashes, assaults and other trauma – a prospective trauma toxicology study* (2007), monograph series no 20, p viii.

103 Victoria Police, submission 175, p 4.

the program thus far clearly indicates the potential for reducing drug drive related trauma in Victoria.¹⁰⁴

- 5.108 The committee considers that it is important that police have the resources to enforce laws relating to drug driving in the same way that they enforce drink driving laws and that random testing for alcohol and illicit drugs should be done concurrently — so that the ‘booze bus’ can also conduct testing for illicit drugs. Active enforcement, involving a high profile drug driving testing regime, will contribute to negative attitudes to illicit drug taking, in a similar way to that achieved by drink driving campaigns.

Recommendation 20

- 5.109 The Commonwealth Government work with state and territory police to implement random testing for drivers affected by illicit drugs concurrently with random breath testing for alcohol.**

Random drug testing for health workers

- 5.110 In 2004, 326,600 people used illicit drugs and had gone to work while they were under the influence of these drugs.¹⁰⁵ During its inspections, the committee heard from a former registered nurse who had continued to work through the initial stages of her heroin addiction, potentially putting patients in danger. A parent also told the committee about illicit drug taking by nursing students, which could have continued once these nurses completed their training.¹⁰⁶ The committee is concerned at the potential numbers of people working under the influence of illicit drugs whilst holding positions of professional responsibility in our community.
- 5.111 The implementation of random drug testing in the workplace is part of ensuring a safe working environment for employees and also increasing safety for customers, clients and patients. Random testing is widely used by companies in the mining and transport industries.
- 5.112 The committee considers that workplace random drug testing sends a strong message that illicit drug use is unacceptable. While there have been calls for random testing for a wide range of professions, including

104 Victoria Police, submission 175, p 4.

105 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 89.

106 McMenamin H, transcript, 30 May 2007, p 3.

footballers, doctors, lawyers, politicians and police¹⁰⁷, the committee considers that a first step could be introducing random testing at our public hospitals. Such a measure could be implemented as a condition of the Australian Health Care Agreements.

Recommendation 21

- 5.113 As part of the next public hospital funding agreement between the Commonwealth and the states and territories, the Minister for Health and Ageing include a requirement for the implementation of a random workplace drug testing regime to improve safety for patients and other staff.**

¹⁰⁷ See for example, Kelton G, 'Random drug test urged for doctors', *Adelaide Advertiser*, 25 July 2007, p 30; Sherlock E, 'Politicians mixed on drug-testing', *The Canberra Times*, 1 July 2007, p 22; Silvester J, 'Stand-off on drug testing of police' *The Age*, 4 June 2007, p 1; 'Lawyers should face drug testing, QC says', *The Canberra Times*, 17 May 2007, p 8; Timms D, 'Our policy is fine: Players' association says no to government's amendments', *Herald Sun*, 26 March 2007, p 35.

Strengthening families through treatment

- 6.1 A significant and rising number of Australians are seeking treatment for illicit drug use. In 2002-03, it was estimated that government spending on treatment activities was \$229.2 million, with the Commonwealth contributing \$65 million and the states and territories \$164.2 million.¹
- 6.2 There is a clear need to make it easier for drug users and their families to be able to access treatment services that give them the best chance of becoming drug-free individuals. Inquiry participants have consistently noted the need to include families in treatment to improve the outcomes for their family member using drugs. The committee also acknowledges that family members often need treatment in their own right as a result of the stress and anxiety caused by drug problems in the family.
- 6.3 Families seek information from a wide variety of sources about illicit drug use. Several inquiry participants provided examples of the significant demand for advice from families:
- Family Drug Support, an NGO that operates a national telephone information and support service for families affected by drug use, received almost 30,000 calls in 2006. The average length of support calls to the helpline in 2006 was 33 minutes;
 - in Victoria, Family Drug Help, a non-government support service for family members of people who have drug or problematic alcohol use received more than 5,400 calls to its helpline and

¹ Moore J, *What is Australia's "drug budget"? The policy mix of illicit drug-related government spending in Australia* (2005), p 12.

involved more than 800 family members in support group meetings in 2006;

- in Western Australia, Parent Drug Information Service, a government agency operating a 24-hour confidential telephone service for parents and families, receive more than 1,400 calls per year; and
- Toughlove NSW, a peer-based non-government support service, received over 450 calls for help from parents over a 14 month period to February 2007.

Getting drug users into treatment that works

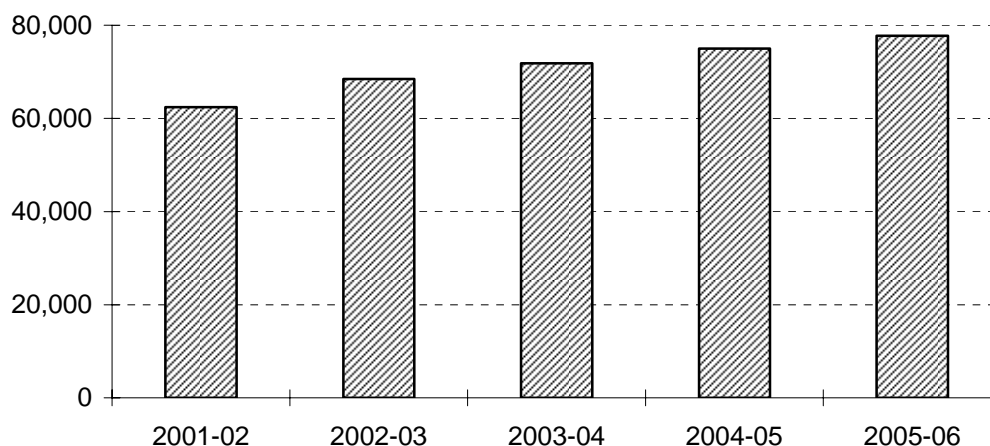
- 6.4 People seeking treatment and support for illicit drug use can access a variety of services, including specialist drug treatment agencies, general practitioners, pharmacists, school counsellors and psychologists. There are also a number of non-government organisations (NGOs) that provide support and information to parents about their children's illicit drug use. However, the quality and nature of counselling advice and treatment given is very uneven with no consistent message.
- 6.5 While there has been an increase in the number of people getting treatment for illicit drug use there remains a large gap between those undergoing treatment and those using illicit drugs. Particularly concerning is the gap between those in treatment and the heavily addicted users.
- 6.6 In 2004-05, there were 635 specialist drug treatment agencies in Australia, an increase of 130 agencies since 2000-01.² Treatment agencies are mostly located in capital cities and inner regional areas, with only 90 agencies located in outer regional and remote areas in 2004-05.³
- 6.7 There has been a steady increase in the number of people seeking treatment from drug treatment agencies for illicit drug use, with the number of closed treatment episodes (a period of contact between a

2 Australian Institute of Health and Welfare 2006, data cube, accessed 12 March 2007 at http://www.aihw.gov.au/cognos/cgi-bin/ppdscgi.exe?DC=Q&E=/Drugs/aodts_prov_0102.

3 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2004-05: Report on the National Minimum Data Set (2006)*, cat no HSE 43, p 10.

client and treatment agency that has a defined start and end date) relating to illicit drugs rising from 62,500 in 2001-02 to 77,700 in 2005-06 (figure 6.1).

Figure 6.1 Closed treatment episodes for illicit drugs, 2001-02 to 2005-06 (number)



Source Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 68.

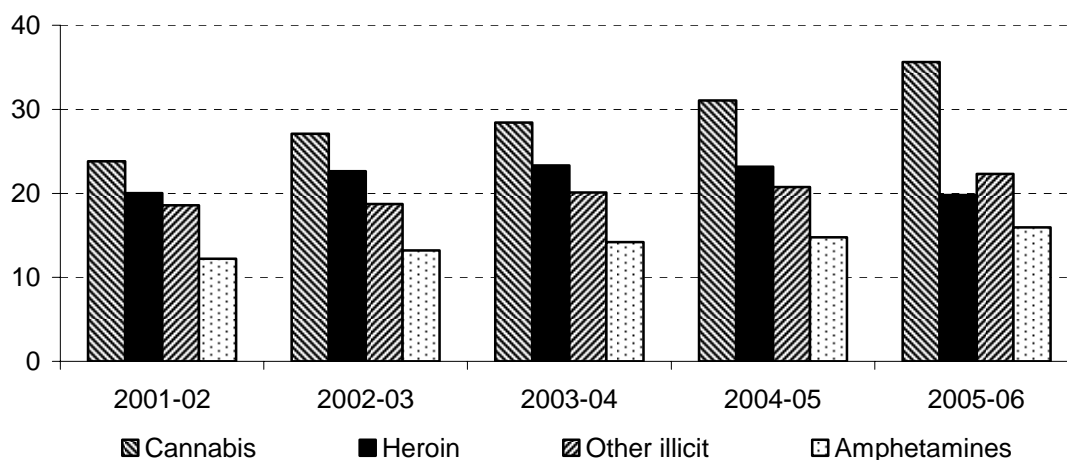
6.8 Much of this expansion in treatment capacity has been funded by the Commonwealth Government, which has lifted its contribution to non-government treatment agencies from \$58.6 million over the five years to June 2002, to \$115.5 million over the five years to June 2007, then to \$170 million over the next four years.⁴

6.9 Almost 80 per cent of the increase in treatment episodes for illicit drug use over the period 2001-02 to 2005-06 was for people nominating cannabis as the principal drug of concern, with the people seeking treatment for amphetamines accounting for the rest of the increase (figure 6.2). While the number of people nominating ecstasy as the principal drug of concern more than tripled over the period 2001-02 to 2005-06, it was cited as the principal drug of concern for only 897 treatment episodes in 2005-06, or 1.2 per cent of the total episodes of treatment for illicit drugs.⁵

4 Australian Government Department of Health and Ageing, submission 170, p 3.

5 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 68.

Figure 6.2 Closed treatment episodes for illicit drugs, by type, 2001–02 to 2005–06 ('000)



Source Australian Institute of Health and Welfare, Alcohol and other drug treatment services in Australia 2005–06: Report on the National Minimum Data Set (2007), cat no HSE 53, p 68.

6.10 Despite this increase, there are clear gaps between the number of people in treatment for using illicit drugs and the number of drug users. Based on comparisons of recent users of drugs with those undergoing treatment, a very low proportion underwent treatment in the same year (table 6.1). For example, in 2004 only 31,000 people were undergoing treatment where cannabis was nominated as a principal drug of concern, despite there being over 300,000 people that used cannabis every day.

Table 6.1 Recent illicit drug use and frequency of use for selected illicit drugs compared to number of closed treatment episodes by principal drug of concern

	Cannabis	Ecstasy	Meth/ amphetamines	Heroin
<i>Recent use</i>	1,848,200	556,600	532,100	56,300
Frequency of use (a)				
Every day	303,105	35,066	57,467	25,335
Once a week or more	421,390			
About once a month	219,936	82,933	85,668	14,525
Every few months	328,980	174,216	155,373	
Once or twice a year	574,790	264,385	233,592	16,496
<i>Treatment episodes</i>	31,044	580	14,780	23,193 (b)
Withdrawal management (detoxification)	4,335	28	1,945	5,454
Counselling	11,101	284	6,225	6,645
Rehabilitation	1,535	31	2,158	1,906
Support and case management only	3,090	73	1,202	2,610
Information and education only	7,590	73	526	285
Assessment only	2,823	83	2,331	3,104
Other	570	8	393	3,189

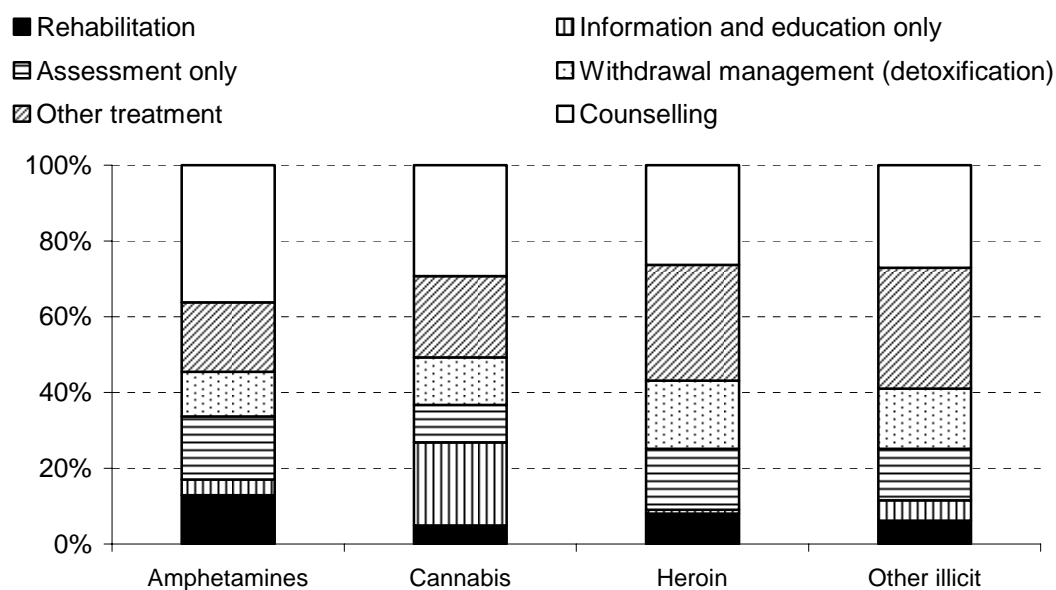
Note (a) Categories combined for some drug types (b) In 2004, around 38,000 people were participating in pharmacotherapy programs for opioid dependence, which are excluded from these treatment data.

Source Australian Institute of Health and Welfare, Alcohol and other drug treatment services in Australia 2004-05: Report on the National Minimum Data Set (2006), cat no HSE 43, p 109; 2004 National Drug Strategy Household Survey Detailed findings (2005), cat no HSE 66, pp 43, 57, 60, 65.

6.11 The committee is also concerned that the main form of treatment for illicit drug use is counselling. In 2005-06, the main treatment type provided to people seeking treatment for illicit drug use varied with the principal drug of concern (figure 6.3). Overall for illicit drugs, counselling accounted for the highest proportion of closed treatment episodes when amphetamines (39.2 per cent), cannabis (32.4 per cent) and heroin (29.6 per cent) were the principal drug of concern.⁶

⁶ Australian Institute of Health and Welfare, Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set (2007), cat no HSE 53, p 86.

Figure 6.3 Illicit drug closed treatment episodes by selected principal drug of concern and main treatment type, 2005-06



Note 'Other treatment' includes support and case management.

Source Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 86.

- 6.12 **Counselling** — which generally involves a range of approaches such as motivational interviewing, problem solving skills, drug refusal skills and relaxation⁷ — relies on people being willing to change their behaviour and does not necessarily address the physiological aspects of addiction. As noted in chapter four several inquiry participants questioned the quality of counselling that was provided within the harm minimisation approach. The committee also heard from one treatment provider that was funded to provide 'counselling' as part of a drug diversion program that involved nothing more than sitting participants in front of a video.
- 6.13 It is important that resources are directed to treatment approaches that have the most success in getting individuals drug free. While there are agencies that have a high rate of success in making individuals drug free — such as the Australian Drug Treatment and Rehabilitation Programme whose average success rate over the last five intakes has been 93 per cent of people remaining drug-free and who have also gone back to either work or study — the committee

⁷ Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set (2007)*, cat no HSE 53, p 33.

found it difficult to assess how most treatment providers were in meeting this goal.

- 6.14 The committee considers that it is important that the success drug treatment providers have in making individuals drug free is the most important indicator for assessing treatment approaches. In chapter four the committee recommended that the Commonwealth Government should only provide funding to treatment and support organisations which have a clearly stated aim to achieve permanent drug-free status for their clients or participants.
- 6.15 While the committee recognises that individuals undergoing treatment for their illicit drug use can relapse, it is important that the significant funds that are spent on treatment approaches are channelled to those approaches that are more likely to achieve the outcome of a drug-free individual. This could be measured by looking at an individual's drug-free status at intervals of two and five years after their initial treatment.

Recommendation 22

- 6.16 **The Department of Health and Ageing include, as part of the next round of illicit drug treatment funding agreements, requirements that:**
- **treatment organisations collect and report data on their success rate in making individuals drug free after they have completed their initial treatment; and**
 - **give priority to funding those treatment approaches that demonstrate their success in making individuals drug free.**

Further, the Department should maintain a database containing such information and make it public.

Commonwealth support for drug treatment

- 6.17 The Commonwealth Government provides significant support to families through a range of general programs, as well as support for drug treatment services.
- 6.18 The Department of Families, Community Services and Indigenous Affairs and the Department of Health and Ageing provided an overview of the programs and payments to families to support the general community and particular population subgroups.⁸ Some aspects of general programs that assist specific population groups include:
- Grandparent initiatives — from July 2007, strengthening social security legislation to make it easier for Centrelink to ensure that income support payments for principal carers, including grandparents, are provided to the person who is actually providing the majority of day-to-day care for the dependent child (discussed in chapter nine); and
 - The Emergency Relief Program (ERP) provides immediate assistance to people in financial crisis to deal with their immediate crisis situation in a way that maintains the dignity of the individual and encourages self-reliance. Funding is provided to a range of community and charitable organisations to assist them to carry out their normal emergency relief activities. Assistance from emergency relief providers is usually in the form of purchase vouchers for goods, part-payment of accounts, or material assistance such as food or clothing. Approximately 800 community organisations, operating through more than 1300 outlets, received \$31.2 million funding through the program in 2006-07.⁹

8 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172; Australian Government Department of Health and Ageing, submission 169.

9 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, pp 9–18.

6.19 In addition to general programs, both departments fund services to deliver drug treatment (box 6.1). Examples of some of the services funded include:

- Strengthening Families program:
 - ⇒ Focus on the Family — How to drug proof your kids project (national);
 - ⇒ Early Support for Parents — Grandparents Raising Grandchildren Support project (Hobart, Launceston and Ulverstone, Tasmania);
 - ⇒ Women’s Health Service — Pregnancy, Early Parenting and Illicit Substance Abuse project (Perth, Western Australia);
 - ⇒ Odyssey House Victoria — Counting the Kids National Brokerage Fund project (Victoria, ACT and Tasmania);¹⁰
- Non-Government Organisation Treatment Grants program:
 - ⇒ We Help Ourselves — supported withdrawal (New South Wales);
 - ⇒ Gold Coast Drug Council (Mirikai) — youth dual diagnosis program (Gold Coast, Queensland); and
 - ⇒ Western Australian Council on Addictions — Saranna Women’s Residential program (Perth, Western Australia).¹¹

10 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 187, p 6.

11 Australian Government Department of Health and Ageing, submission 170, pp 5–9.

Box 6.1 Commonwealth funding for drug treatment

In addition to funding provided to the states under general revenue funding agreements, the Commonwealth funds a range of initiatives that specifically target illicit drug treatment. There are a number of specific programs that aim to reduce illicit drug use in Indigenous communities.

Non-Government Organisation Treatment Grants Program — provides funding for the establishment, expansion, upgrading and operation of non-government treatment services. The funding aims to strengthen the capacity of non-government organisations to achieve improved service outcomes and to increase the number of places available. To date, over \$142 million has been provided to over 200 organisations:

- \$58.6 million over five years to June 2002;
- \$115.5 million over five years to June 2007; and
- \$170 million over the next four years to better equip organisations to tailor treatment and services to amphetamine type stimulant users (\$22.9 million) and provide more flexible family therapies and detoxification arrangements to people and their families who are trying to fight drug addiction. Additional treatment and residential places will also be provided to better meet the particular needs of young people in drug and alcohol treatment.

Illicit Drugs Diversion Initiative — The primary objective of the initiative is to increase incentives for drug users to identify and treat their illicit drug use early. It also aims to decrease the social impact of illicit drug use within the community and to prevent a new generation of drug users committing drug-related crime from emerging in Australia. The Department of Health and Ageing administers the initiative through funding agreements with State and Territory Governments. The Commonwealth has allocated more than \$340 million to the initiative since 1999.

Strengthening and Supporting Families Coping with Illicit Drug Use — provides support for families, including parents, grandparents, kinship carers and children of drug-using parents. This is achieved through the provision of education, counselling support services, advice and referral services, and targeted projects for families. The projects, including a brokerage fund, support children of drug using parents by giving them the opportunity to participate in normal childhood activities like playgroup, music lessons and sporting activities. The 2004 budget allocated \$13.6 million over four years to the program. There are currently 21 services being provided on a local and national basis by 20 non-government organisations.

Source Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172; Australian Government Department of Health and Ageing, submissions 169 and 170.

A single point for advice and referral

- 6.20 Families need easy access to information and advice about drug treatment services that will enable their family member to become a drug-free individual.
- 6.21 Many inquiry participants noted the difficulties they had in accessing information about the effects of illicit drugs and where to go to access treatment and help. A parent told the committee that:
- The earlier families can get help the greater the chance that they are in the best position to support themselves and the member(s) using. In my case it took a crisis with my brother before help was accessed. This help needs to be more readily available so as to avert a crisis and give understanding and support to families and friends. When family and friends are supported through improved communication and education in variety of areas this leads to a better outcome.¹²
- 6.22 The Australia Drug Foundation (ADF) noted that:
- As shown by the numbers of family members who contact the ADF, there is a huge demand for information and support from the community. However, a common complaint from families is that they find it difficult or confusing to know where to go to for assistance. This is particularly true when they are seeking to access treatment, other intervention or support services.
- Not all situations require the same response and many families need a range of services from different disciplines. Lack of identifiable services is a source of frustration to many. Many family members have been on a merry-go-round of services before they find the information and support best suited to them.¹³
- 6.23 Better informing families, particularly parents, about the dangers of illicit drugs is an important part of strengthening a family's capacity to prevent the use of illicit drugs. The committee believes that it should be easier to access information about drugs and where to get

12 Ennik M, submission 13, p 2.

13 Australian Drug Foundation, submission 118, p 13.

help. It is also important that information is available at all times of the day.¹⁴

6.24 The Australian Drug Foundation favoured a centralised approach to providing help to families:

A centralised information system is required to assist families to identify the type of service(s) they require and what is available in their locality or region. A centralised, 'one-stop-shop' service for families could offer a comprehensive range of support services including telephone, website and online networks (for example, online counselling, chat groups, question and answer forums etc).¹⁵

6.25 A centralised approach could also lead to the development of a more 'client-centred' approach to treatment:

In the context of co-occurrence of drug and other issues being an expectation rather than an exception, a dilemma noted by many experts is that clients are often not treated in a holistic manner. Instead, they are referred from one service to another, each dealing with part of a client's problems. Experts suggested that better integrated client and family support services (a 'one-stop shop' approach which wrapped services around clients and families) would be a major step forward. Such an innovative practice model would mean that funding for a client's treatment and family support would be seen as a whole and would follow the client through different services.¹⁶

6.26 The committee is in favour of centralising for families where they go to get information and help. An approach applied to aged care services in recent years is a possible model that could be applied to drugs (box 6.2).

14 Toughlove Victoria, submission 112, p 3.

15 Australian Drug Foundation, submission 118, p 14.

16 Families Australia, submission 152, p 15.

Box 6.2 Carelink — Coordinating information and support — A possible model for drug treatment and information services?

Carelink Centres were established in 2000 to provide a single point of contact for older Australians to a range of service providers including health professionals, carers and aged care facilities. The centres are regionally-based and are operated by organisations that already provide services in the region, including community based, religious, charitable, private, and local and State government providers.

The centres are connected nationally by a 1800 telephone number and a shopfront in each of the 54 regions. Each Commonwealth Carelink Centre has extensive regional networks and maintains comprehensive databases containing community aged care, disability and other support services. Shopfronts are operated by organisations that already provide established services within their region. Their extensive local knowledge ensures they provide a quality service. This regional focus enables each Centre to develop an awareness of the entire range of services available, to establish networks with local providers and ensure information is up to date.

Source Commonwealth Carelink Centres, 'Welcome to the Commonwealth Carelink Centre Website', viewed on 23 July 2007 at <http://www9.health.gov.au/ccsd/index.cfm>.

- 6.27 It is also important that families know that when they make contact with an information and referral service they will get the right advice and information about who to contact for drug treatment.
- 6.28 The committee is concerned that not all treatment services funded by the Commonwealth and the states and territories identify that abstinence is the goal of treatment. A survey of the managers of alcohol and other drug specialist treatment services conducted in 2002 found that only 15 per cent of managers identified that their service practised an exclusively abstinence approach, with a harm minimisation approach (which *could* include abstinence) used in 77 per cent of services (table 6.2).

Table 6.2 Treatment approaches in the alcohol and drug treatment sector, 2002

Agency	Government	Non-government organisation	Private	Total
	<i>n (%)</i>	<i>n (%)</i>	<i>n (%)</i>	<i>n (%)</i>
Harm minimisation (a)	88 (90)	83 (71)	10 (53)	181 (77)
Exclusively abstinence	6 (6)	23 (20)	6 (32)	35 (15)
Other approaches (b)	3 (3)	10 (8)	1 (5)	14 (6)
Missing (non response)	1 (1)	1 (1)	2 (10)	4 (2)
Total	98 (42)	117 (50)	19 (8)	234 (100)

Note (a) Managers identified a continuum of harm minimisation that could include abstinence. (b) Other approaches identified: a client directed approach and abstinence that can include harm minimisation.

Source Roche A et al, 'Alcohol and other drug specialist treatment services and their managers: findings from a national survey', Australia and New Zealand Journal of Public Health (2004), vol 28, no 3, p 255.

6.29 Hon Ann Bressington MLC told the committee about the different messages that drug users can get when they seek treatment:

The messages that drug users are given when they seek out treatment is to cut down, 'Only use weekends; there is no need to stop altogether; you can recreationally use these drugs.' These are counsellors: 'I used to, and I still recreationally use; I have managed to keep my drug use under wraps on weekends only for quite some time now.'

The addict in a person will grab onto that and run with it, and Ryan will tell you himself that he heard those messages and it put him off getting involved in treatment for some months, to the point where he was suicidal and misdiagnosed with a mental illness.¹⁷

6.30 The committee notes that the Commonwealth Department of Health and Ageing is undertaking a project with states and territories to develop a national database of alcohol and drug treatment services to 'comprehensively describe the number and nature of these services'.¹⁸ An initial version of the database was expected in mid 2007.¹⁹ It is important that this database is able to identify whether treatment agencies have making individuals drug free as the goal of treatment. This database can then be used by a Carelink-like service to assist families find a treatment service.

17 Bressington A, transcript, 23 May 2007, p 4.

18 Australian Government Department of Health and Ageing, submission 170, p 3.

19 Australian Government Department of Health and Ageing, submission 170, p 3.

Recommendation 23

- 6.31 **The Department of Health and Ageing, in conjunction with other appropriate agencies:**
- **establish a regionally-based information and referral service, modelled on the *Carelink* aged care information service, that incorporates a 1800 telephone number and a regional network and database of service providers, to assist families obtain information about illicit drugs and how they can access treatment; and**
 - **only include treatment agencies on the database that have the objective of making individuals drug free.**

Timely access to services

- 6.32 Evidence was given to the committee on numerous occasions that without timely access to services, drug addicted users found it impossible to take advantage of the ‘window of opportunity’ that would present itself to have the desire to get off drugs. A former drug addict told the committee that:

I became addicted and it took seven years for me to realise that I had to stop. In those seven years—this is where it is important to this forum—I would get windows of opportunity to get out. I would feel like I could go to rehab or detox and everything like that but, when I would get on the phone to get in contact with [a treatment agency], there would not be a place available. The feeling of ‘okay, I’ve had enough, I can get out’ would disappear. I would go back into it.²⁰

- 6.33 Glastonbury Child and Family Services told the committee that:

Staff in the Family Services Program within Glastonbury report a need for more immediate rehabilitation responses. The impact of illicit substance use is such that when a decision is made to cease use then a prompt service system response is required. Frequently when trying to address their illicit substance use clients have to telephone during intake

²⁰ Christopher, transcript, 7 April 2007, p 68.

hours or wait several weeks before they can be admitted to withdrawal, rehabilitation or other drug treatment services.²¹

6.34 After accessing initial treatment, it is also important that individuals are able to seamlessly progress through different treatment stages. Often people undergoing treatment require several different forms of treatment as they progress through their rehabilitation. In 2005-06, 15 per cent of closed treatment episodes reported more than one treatment type.²² Where detoxification was the main treatment type reported, 39 per cent of episodes included as least one other treatment type.²³

6.35 To take advantage of the small window of opportunity to get people off drugs, services need to be available at the right time. Professor Gary Hulse of the University of Western Australia told the committee:

We cannot have this mentality where you have these huge waiting lists, you make people jump over hurdles, and where they have to ring up and make an appointment in a week's time to come down and have an assessment: 'Yes, now you have to be seen by a medical officer next week.' These are heroin users. People report and say, 'Of those people who enter our program, this is our success rate.' What about the people who have not entered that program because of the hurdles that you have made them jump? Set up services, which are opportunistic, which allow you to assess people and provide good medical assessment and psychosocial assessment at that time, withdraw them and get them onto a treatment. Don't lose that 30 per cent or 40 per cent who then do not come back for treatment.²⁴

6.36 Professor Hulse gave the committee an example of how integrating hospital services with a drug treatment clinic led to improved outcomes for drug users:

Referrals from the Perth naltrexone clinic used to be made up to the hospital for treatment of hepatitis C. Very few patients—perhaps two out of every 10 referrals—used to come up, which is what you can imagine. Heroin users have

21 Glastonbury Child and Family Services, submission 74, p 12.

22 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set*, cat no HSE 53, p 33.

23 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set*, cat no HSE 53, p 33.

24 Hulse G, transcript, 21 March 2007, p 7.

better things to do than simply make another trip to another place, especially to a hospital; it is very daunting. It is a bit like coming to parliament. You do not understand it; there are people running around corridors doing who knows what.

[The hospital] set up a room at the Perth naltrexone clinic. Every Tuesday, that becomes a hospital room. A general practitioner room is next door. It is a basic one-stop shop. They go and see the GP and get a referral to the hospital. They walk from one door to the next door, see the hospital and then enter into ribavirin and pegylated interferon treatment. This is how services should run. This is about integrating different services so you provide the easiest convenience to the maximum number of people. ... The results from this service are good in terms of resolution of hepatitis C. Patients were not lost from treatment. Patients remained in contact with the hospital, and there was good resolution of HCV for those patients.²⁵

- 6.37 Despite the growth in treatment capacity, many inquiry participants expressed frustration at not being able to access drug treatment services in their area, being told that they would need to wait until places became available or that there would be delays in moving between different stages of treatment, such as detoxification and rehabilitation.²⁶ It is important to note that detoxification can be a necessary first step to entering rehabilitation. In some cases, this can be done rapidly using medicinal drugs. For example, as used for some patients prior to the insertion of naltrexone implants at the Perth Clinic. A parent told the committee:

There are countless facilities that can help to a point but these all have waiting lists and most in my opinion appear to work independently of each other.²⁷

- 6.38 A seamless transition between different types of services, such as detoxification and rehabilitation, is important so that people undergoing treatment do not relapse.²⁸ Nar-Anon Family Groups Australia told the committee that:

25 Hulse G, transcript, 21 March 2007, pp 18–19.

26 Bowman D, submission 38, p 1; Hayes H, submission 51, p 2; Moore M, submission 95, p 1; Families and Friends for Drug Law Reform, submission 122, pp 13-14; McMEnamin H, transcript, 30 May 2007, p 34.

27 Bowman D, submission 38, p 1.

28 Australian Family Association, submission 59, p 4.

Many addicts attempt many times to overcome their addictions, and they have incredibly difficult times trying to find rehabilitation beds after detoxification. It can take literally weeks for them to keep ringing rehabilitation centres, daily, to find a bed. No wonder so many relapse and can end up overdosing and sometimes dying.²⁹

- 6.39 Service providers were also frustrated that they were not able to help all people seeking treatment.³⁰ A drug treatment provider told the committee that:

I am now the facilitator of a support group in the City of Hume, which has been established for five years. The group offers education, accurate information and support. I assist families to make changes in their lives which in turn has an effect on their loved one's drug use.

Recovery from addiction is not just a matter of ceasing the drug of choice; it is about learning a whole new life.

Moreover, treatment seems to be very poorly coordinated especially the gap between detoxification and rehabilitation.³¹

- 6.40 The expansion in treatment capacity being funded by the Commonwealth should go some way to improving timely access to services. The committee believes that the implementation of its recommendation regarding the 'one-stop-shop' telephone hotline should also lead to better coordination and integration at a local level to reduce the delays and interruptions in accessing treatment.

29 Non-Anon Family Groups (Australia), submission 115, p 5.

30 Association for Prevention and Harm Reduction Programs Australia, submission 130, p 11; Family Matters SA, submission 158, p 2; Blatch C, Goldbridge Rehabilitation Services, transcript, 7 March 2007, p 25; Harris S, Parent Drug Information Service, transcript, 14 March 2007, p 57; Besley S, Blacktown Alcohol and Other Drugs Family Services, transcript, 2 April 2007 p 12.

31 Hayes H, submission 51, p 2; Morrissey J, submission 12, p 4; Moore R, submission 155, p 2; Newman M, Grandparents Assisting Grandkids Support, Gold Coast Region, transcript, 7 March 2007, p 37; Bressington A, transcript, 23 May 2007, p 3; Dawe S, transcript, 13 June 2007, p 21.

Promoting family-inclusive treatment

- 6.41 'Family-inclusive' treatment involves treating the drug user in the context of their significant relationships with their family members and community.³² Copello, Velleman and Templeton note that there are three general types of interventions for substance abuse that involve family members:
- working with family members to promote the entry and engagement of drug users into treatment;
 - the joint involvement of family members and drug-using relatives in the treatment of the drug user; and
 - responding to the needs of the family members in their own right.³³
- 6.42 A wide range of family-inclusive treatment and support models are already used by some treatment providers. Examples provided to the committee include:
- family-friendly rehabilitation services that provide for live-in arrangements for children whose mothers or parents are undergoing treatment;³⁴
 - grandparent support groups;³⁵
 - counselling and peer support for family members with a member using illicit drugs;³⁶ and
 - parenting and communication skills training.³⁷
- 6.43 The Government of Western Australia Drug and Alcohol Office provided examples of services provided as part of its 'family sensitive practice project' that assists agencies within the sector to provide more family-inclusive services including:

32 Centacare Catholic Family Services, submission 116, p 3.

33 Copello A et al, 'Family interventions in the treatment of alcohol and drug problems', *Drug and Alcohol Review* (2005), vol 24, p 371.

34 Cyrenian House, submission 110, p 5.

35 Glastonbury Child and Family Services, submission 74, p 6; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 31.

36 Glastonbury Child and Family Services, submission 74, p 9; Government of Western Australia Drug and Alcohol Office, submission 82, p 7; Smith L, Toughlove NSW, transcript, 3 April 2007, p 1; Holyoake, submission 117, p 2; Centacare Catholic Family Services, submission 116, p 3.

37 Cyrenian House, submission 110, p 5; Relationships Australia, submission 143, p 5; Van Nguyen V, UnitingCare Burnside, transcript, 2 April 2007, p 10.

- family counselling — providing for family members of a drug user to attend treatment services with or without the user being present;
- a family counsellor based at rehabilitation centres — to keep the communication flowing between the resident, the agency and family members;
- structured parent support groups — parents attend a set weekly program which provides information and strategies for management and coping; and
- peer support groups — where parents support one another in a safe and confidential environment.³⁸

6.44 Family-inclusive treatment approaches may not be appropriate for all individuals where family relationships have broken down. As noted in chapter ten, however, they can often be more effective than conventional approaches that focus only on treating the drug user. Odyssey House stated in their submission that family-based treatment for adolescent substance abuse has been found superior to other treatments in the following:

- improved engagement and retention in treatment services;
- reduced drug use;
- improved behavioural and emotional problems associated with drug use;
- improved school attendance and performance; and
- improved family functioning.³⁹

6.45 Many participants considered that treatment services needed to involve families more in the treatment of drug users.⁴⁰ Centacare NT noted that historically services had an individual focus, focusing on the user to the exclusion of all others. Families have been seen as an

38 Government of Western Australia Drug and Alcohol Office, submission 82, pp 6–7.

39 Odyssey House Victoria, submission 111, p 8.

40 Family Drug Support, submission 15, p 5; King Edward Memorial Hospital for Women, submission 19, p 10; Hayes H, submission 51, p 2; Colquhoun R, submission 73, p 1; Family Drug Help, submission 76, p 4; Dawe S et al, submission 80, p 4; Name withheld, submission 86, p 9; Australian Institute of Family Studies, submission 103, p 8; Odyssey House Victoria, submission 111, p 3; Centacare Catholic Family Services, submission 116, p 2; Australian Drug Foundation, submission 118, p 14; Royal Australasian College of Physicians, submission 119, p 20; Alcohol and Drug Foundation ACT, submission 123, p 4; Relationships Australia, submission 143, p 6; Families Australia, submission 152, p 4.

adjunct to the treatment of the substance misuser rather than being helped in their own right.⁴¹ Family-based models recognise that:

- living with a drug user is devastating;
- it impacts on all family members physically and emotionally; and
- family members have generally tried all manner of things prior to accessing help to try and cope; some work and some do not.

6.46 Despite the benefits of further including families in treatment, there may be significant barriers to expanding family-inclusive treatment services in the drug treatment sector. Dr Christopher Walsh highlighted a number of impediments including:

- conceptualising the patient's substance use problem in isolation from the broader family context;
- blaming families for their loved one's addiction;
- lack of staff education about family issues, such as how to deal with families, including how to diplomatically engage with family members without alienating the patient;
- a lack of staff education about the issues facing families and a resulting therapeutic arrogance in a significant minority of therapists. This further alienates families and makes it more difficult for them to obtain the help and understanding they need;
- not thinking of the drug user's family as a potential resource when appropriate;
- a lack of organisational structure that is supportive of family sensitivity:
 - ⇒ appropriate forms and intake procedures;
 - ⇒ screening tools to identify family issues;
 - ⇒ appropriate funding contingencies that include time for communicating with family members; and
 - ⇒ appropriate family sensitive professional supervision; and
- a practical interpretation of the harm minimisation paradigm that has become reductionist in many drug treatment services. It should include minimisation of harm to family and the broader community as well as to the substance users.⁴²

41 Centacare NT, submission 60, p 5.

42 Walsh C, submission 84, p 3.

- 6.47 Dr Walsh also outlined the cultural impediments to expanding family involvement in treatment :

The cultural impediments to family sensitive practice are deeply entrenched although improving somewhat in recent years. ... This reflects a general attitude that our patients are only the people in front of us not the systems of the families to which they belong.

In its worst form, this reductionistic view can manifest in rehabilitation and detoxification services refusing to tell families if their loved one is currently under treatment at their service. This is supposedly to protect the privacy and confidentiality. However, this reluctance to give out information is often against the drug user's wishes and the family is left wondering if their loved one has become uncontactable because they have died or disappeared on the streets.⁴³

- 6.48 The committee considers that the role of families needs to be more strongly promoted to clinicians and treatment service providers. This will require a change of mindset and approach by the health system and drug treatment sector — moving away from a 'patient-doctor' model towards a model that is based on information sharing and bringing in family members for support as required.
- 6.49 The committee also considers that cultural change within the drug treatment sector could be accelerated by adopting other suggestions about restructuring funding arrangements to encourage family-sensitive practices, such as setting funding aside for family contacts and other family interventions, and using measures of family satisfaction as part of the assessment of service delivery.⁴⁴
- 6.50 As a direct funder of many non-government organisations involved in the drug treatment sector, the Commonwealth is well positioned to directly influence the inclusion of family-inclusive practices.
- 6.51 The committee also considers that there is an opportunity to improve data collected by drug treatment services to include information on family-inclusive treatment.
- 6.52 By including such information in the Alcohol and Other Drug Treatment Services National Minimum Data Set, an annual collection
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43 Walsh C, submission 84, p 5.

44 Walsh C, submission 84, p 4.

coordinated by the Australia Institute of Health and Welfare, it will be possible to monitor the extent to which family-inclusive treatment models are being used.

- 6.53 By collecting and reporting data on family-inclusive treatment services, the committee considers that it will be easier to monitor whether families are being given a higher priority under the National Drug Strategy and the extent to which services are able to incorporate these treatment models into their services.

Recommendation 24

- 6.54 **The Australian Institute of Health and Welfare work with relevant government and non-government agencies to include in the Alcohol and Other Drug Treatment Services National Minimum Data Set measures relating to the use of family inclusive services to treat illicit drug use.**

Privacy issues for family members

- 6.55 Many inquiry participants whose children had been using illicit drugs registered their frustration with 'the Privacy Act', which appeared as an impediment to every attempt they made to find out if their son or daughter was in treatment, how they were progressing, and how they could best be cared for and supported.
- 6.56 This observation was made by the Alcohol and Drug Foundation ACT:

Families talk about their frustrations with a system that excludes them once their family member or friend is in treatment. Having worked hard to support their family member to get into a treatment program, they are often then blocked from the process, with treatment agencies refusing to engage with them. This may leave them feeling angry and confused; increasing their feelings of guilt and further delay the family's healing process.

When we finally managed to get some help for our daughter we were excluded, rather than included in the process. We'd call up to see how she was going, and we were told that because she was an adult and because of privacy laws, they

couldn't give us any information. We didn't even know if she was still there. We went back to not sleeping all over again.⁴⁵

6.57 A clinician treating people on maintenance programs told the committee that:

Often families are excluded from involvement, including the use of family resources to support the person in recovery to being denied any information about the course of treatment. This policy is highly prejudicial to facilitating recovery and almost invites the person to relapse to drug use. The family is the unit that often is the most caring and resourced to assist in recovery and knowledge of the person's status is the most potent weapon in assisting them to be drug free.

Involvement of the family from the beginning and throughout treatment can also benefit the family by helping them understand the effect of the addiction, the mechanisms that sustain it and the strategies to combat it. Involvement also means that dysfunctional and negative behaviour and misinformation about drug use can be modified to assist the person. Moreover, involvement can also be a healing process for the family.⁴⁶

6.58 Three families told the following stories:

Our son went to a psychologist which turned out to be very expensive over many months and in the end, of no use. When we rang this man up to see how the counselling sessions were going we were told that because of the privacy laws he could not tell us.⁴⁷

We approached the staff of [a treatment centre] on a number of occasions trying to access our son's medical records but this was denied us as he was not a minor. This is the law and we accept it, however there are times when some flexibility is needed in order to assist the addicted person. Families are the strongest, most loving link the drug user has and to be 'shut out' from being able to help is distressing in the extreme.⁴⁸

My son was not capable of making an informed decision about anything even to go to the toilet; he wanted help, could

45 Alcohol and Drug Foundation ACT, submission 123, p 4.

46 Colquhoun R, submission 73, p 1.

47 Toughlove Victoria, submission 112, p 3.

48 Riley M, submission 34, p 5.

not speak because of the drugs, slurred and dribbled. I rang agencies, detox centres but they would not help me, they told me they could only speak with him, I explained he couldn't speak. Families need to be able to advocate on behalf of their drug-affected child.⁴⁹

- 6.59 Families highlighted that information about another person's treatment was especially important in circumstances where the family could be put at risk. A family with a son with a mental illness and illicit drug addiction said that:

There is a big problem about privacy. When we went to the drug counsellor a few years ago, when [our son] agreed to go, they refused to discuss anything with us, so we had to go to a separate one. With mental health it is a bit different—they involve the loved one. You can go and see their psychiatrist, you can sit in family meetings, but for some unknown reason, with drugs it is completely private and it really encourages the drug user to use that. What is really scary now with [our son] is that, when he finally gets out, we are going to have to be very careful about how we deal with him. I do not think we should have him in the car. We will most probably meet him in open places because, if he has had some speed or some ice, he could kill us. So if he or any drug user is going to a counsellor, it should be mandatory for the counsellor to warn their family that their loved one is becoming dangerous because they are starting to use speed, they are starting to use ice. You have to protect.⁵⁰

- 6.60 A couple described a similar incident in which a family felt at risk due to the lack of information provided about their daughter's aftercare:

We have encountered recently an incident involving a person whose illicit drug use combined with antidepressants has seemingly resulted in mental disorder. The family wishes to be supportive, but can get no information from the doctor or hospital about the drugs used, the cause of the problem, or possible outcomes. The person was discharged still in a frightening condition, a danger to themselves and others. The family was (and is) faced with the prospect of housing an aggressive and possibly dangerous daughter, or leaving her out on the street with nowhere to go. All too often this is the

49 Quon M, submission 8, p 6.

50 Mercer I, transcript, 30 May 2007, p 11.

choice ... danger to the family, or relegating a loved one (who is unable to take care of themselves) to life on the streets.

Without the benefit of knowing exactly the nature of the problem they are facing, the family is powerless to help (the addict or themselves) in any realistic way.⁵¹

- 6.61 Health information and privacy in Australia is a complex area, regulated by common law obligations of confidence that health professionals must abide by, as well as a set of overlapping federal, state and territory legislation.⁵² Health information is a particularly sensitive type of information, with particular conditions attached to its disclosure.
- 6.62 At the Commonwealth level, the handling of health information is regulated through the Privacy Act by the National Privacy Principles (NPPs) (for the private sector), the Information Privacy Principles (IPPs) (for the public sector) and Public Interest Determinations.⁵³
- 6.63 Some state and territory jurisdictions (New South Wales, Victoria, the ACT and the NT) have developed their own privacy legislation for their public sectors; Queensland relies on administrative arrangements. Victoria, New South Wales and the ACT have also enacted law that regulates the handling of health information in the private sector.
- 6.64 The disclosure of client information is also regulated by ethical and professional codes of conduct, such as the Australian Medical Association Code of Ethics and the recently released code of ethics and values for the drug sector. Produced by the Alcohol and Other Drug Council of Australia (ADCA), it calls for 'privacy and confidentiality to the extent permissible by law', given that the illegal nature of drug use and the stigma attached to drug dependency make confidentiality an issue for clients.⁵⁴ The enabling legislation of many health agencies may also contain secrecy provisions that apply to its staff.⁵⁵

51 Glover C and C, submission 45, p 1.

52 Australian Government Office of the Privacy Commissioner, *Getting in on the Act: The Review of the private sector provisions of the Privacy Act 1988* (2005), p 64.

53 Australian Government Office of the Privacy Commissioner, *Getting in on the Act: The Review of the private sector provisions of the Privacy Act 1988* (2005), p 64.

54 Alcohol and Other Drug Council of Australia, *Making values and ethics explicit: A new code of ethics for the Australian alcohol and other drug field* (2007), p 9.

55 Australian Government Office of the Privacy Commissioner, *Getting in on the Act: The Review of the private sector provisions of the Privacy Act 1988* (2005), p 65.

- 6.65 The fact that a person is over the age of eighteen does not necessarily change the way in which their health information can be disclosed, as the Privacy Act does not specify an age at which a person is considered of sufficient maturity to make his or her own privacy decisions. Doctors address each case individually, having regard to the child's maturity, degree of autonomy, understanding of the relevant circumstances and the type and sensitivity of the information sought to be accessed. The Australian Medical Association suggests, for example, that in the case of a young teen, 'the doctor might quite properly take the view that access to the records without the child's consent would be a breach of confidentiality'.⁵⁶ The committee believes, however, that parents are entitled to know when their children are engaging in illegal acts.
- 6.66 Some disclosures are permitted or mandated by law, regardless of whether the patient gives consent, such as notifications of communicable diseases that pose a public health risk, or in reporting child abuse.⁵⁷ In nearly all cases, however, health professionals will be extremely averse to disclosing *any* information to a third party about a current or past client without explicit consent, for legal reasons and to preserve the client relationship.
- 6.67 A model based on the consent of the person, consistent with current privacy principles, was suggested as a way of involving families more in treatment:

I strongly recommend that when people voluntarily enter treatment that families are involved and that policies that specifically exclude families be reviewed. This can be facilitated by having the client sign an authority to release information that specifically names family members, family doctor etc. and that it be made clear that the family, client and treating professionals will work together to facilitate recovery. The client maintains control of who is able to have information if sensitively handled. It is also important to understand the dynamics of the family and to identify those who have been harmful in the past and to prevent harm during the recovery process.⁵⁸

56 Australian Medical Association, 'Privacy questions and answers', viewed on 28 August 2007 at <http://www.ama.com.au/web.nsf/doc/SHED-5G58KD>.

57 Australian Medical Association, 'Privacy questions and answers', viewed on 28 August 2007 at <http://www.ama.com.au/web.nsf/doc/SHED-5G58KD>.

58 Colquhoun R, submission 73, p 1.

- 6.68 The National Health Service in the United Kingdom has published a document about privacy and confidentiality principles in health practice, and its model of 'explicit informed consent' may be useful to apply to individuals undergoing treatment for drug problems:

Explicit informed consent means that the [individual undergoing treatment] should understand the nature and extent of the disclosure that is to be made, who is likely to receive the information and how it may be used. A general release form, which gives permission for the release of 'any relevant information', is not likely to be consistent with the principles of explicit consent. Consent does not need to be written, though a signed consent form is good practice. Informed consent does not last indefinitely. [An individual undergoing treatment] can withdraw consent at any time and should periodically be given the opportunity to do so.⁵⁹

- 6.69 The use of an informed consent framework should be encouraged by service providers as a means of getting families more involved. Clients undergoing treatment drug problems should be offered this option as a matter of course at their initial appointment.
- 6.70 Obtaining informed consent is obviously difficult, however, from someone who is drug dependent, and may well also have co-occurring mental health issues (chapter eight). This committee has heard evidence that drug users often think or behave irrationally, often underestimate the extent and nature of their drug addiction, and may suffer from recurring psychoses and other mental illnesses.⁶⁰
- 6.71 There may be scope within the existing regulations to disclose information to a family member where a person is deemed 'incapable' of giving or communicating consent. Under the National Privacy Principles, a health service can provide information to a 'person responsible' (a parent, spouse, sibling, close friend or carer) where the individual is physically or legally incapable of giving consent to the disclosure, or physically cannot communicate consent to the disclosure.

59 National Health Service, National Treatment Agency for Substance Misuse, *Confidentiality and information sharing* (2003), p 5.

60 Colquhoun R, submission 73, p 1; Toughlove Victoria, submission 112, p 3; Riley M, submission 34, p 5; Quon M, submission 8, p 6; Mercer I, transcript, 30 May 2007, p 11.

- 6.72 Disclosure can occur:
- because it is necessary for the provision of appropriate care or treatment to the individual; or
 - for compassionate reasons.
- 6.73 The disclosure should be limited to the information that is reasonable and necessary to achieve either of the above purposes. Also, it cannot occur if this is contrary to wishes expressed by the individual before losing the ability to give or communicate consent. Importantly, disclosure of information to a 'person responsible' does not, in itself, represent an entitlement for that person to make health care or medical treatment decisions for the individual.⁶¹
- 6.74 The extent to which this principle is translated into everyday clinical practice is unclear; certainly family members who gave evidence to this inquiry felt that they were unable to obtain information either for compassionate reasons or reasons of ongoing care, even when the drug user was thinking and behaving irrationally, unable to communicate or psychotic. This issue, with respect to ongoing care, was in fact raised by the Australian Medical Association in a submission to the 2004 review of the Privacy Act:
- The access provisions together with restrictions on access to patient information fail to take sufficient account of the patient's carer's need to know information about the patient. Not only is a carer required to provide an appropriate environment for the patient being cared for, but may need to know what medication the patient is required to take, the patient's condition on discharge from hospital, what problems they may encounter, and details of follow up appointments. Disclosure of this information to the carer is necessary for the patient's ongoing care, whether or not the patient consents.⁶²
- 6.75 Health information privacy is complex, and the committee suggests that a review is needed to assess whether the current set of laws, regulations and ethical codes allow reasonable access to information

61 Australian Government Office of the Privacy Commissioner, National Privacy Principles (Extracted from the *Privacy Amendment (Private Sector) Act 2000*), subclause 2.4; Australian Government Office of the Privacy Commissioner, *Guidelines on privacy in the private health sector* (2001), p 23.

62 Australian Medical Association, *Submission to the Review of the Private Sector Provisions of the Privacy Act* (2004), p 16.

for family members. Because disclosure, where it may occur, is still at the discretion of doctors, nurses, and drug counsellors, there also needs to be cultural change so that professionals better understand families' position and allow them access to information about another's treatment.

Recommendation 25

6.76 The Department of Health and Ageing promote, as part of the next round of funding arrangements for non-government drug treatment agencies, models of explicit informed consent for giving families information, which include a discussion about information management with all drug users on their initial consultation with health professionals.

The Attorney-General, in consultation with state and territory governments and professional bodies, review whether the National Privacy Principles and Information Privacy Principles adequately allow for the position of families of clients with drug addictions, particularly with respect to subclause 2.4 and the definition of a client who is incapable of giving or communicating consent, and particularly where:

- **families will be involved in the ongoing care of the client;**
- **the behaviour or state of the client in treatment suggests that families may be placed at physical risk; and**
- **families make a compassionate request to know of the client's whereabouts and state of health.**

Treating affected family members

6.77 Many families with a drug user experience high rates of anxiety, depression, affected job performance and marital stress and breakdown.⁶³ A parent told the committee that:

Family members need long-term, robust support and training to ensure an integrated, empathetic approach to recovery. A family that is 'healing' from their exposure to addiction, who understands their role in the recovery process and is willing

63 Centacare NT, submission 60, p3.

to be involved can be of great assistance in the recovery of the person coming off illicit drugs.⁶⁴

- 6.78 Tonie Miller, a former member of the Australian National Council on Drugs (ANCD), told the committee that:

Parents need to be encouraged to focus on their own needs and the needs of their other children, while the drug-using member can be referred to assistance, IF they will accept it. The needs of parents and other siblings are likely to have been forgotten in the family's efforts to impact on the drug-using member. It may have become the family's focus.⁶⁵

- 6.79 Family Drug Help told the committee about some of the problems that can arise in a family where a member is using illicit drugs:

Family members start to change when they acknowledge they have their own problem, and start to let go of forever trying to fix their addicted family member. The family member's problem is typically related to the drug use, but separate, such as:

- I have no real relationship with my child;
- All the family income goes on drugs;
- My partner is not emotionally available to me;
- I am scared to ask for my basic needs;
- I am placing the needs of the addicted member above the needs of other family members;
- My partner/child does not respect my home/my right to a peaceful/clean space; and
- My friends no longer visit our house.⁶⁶

- 6.80 Inquiry participants highlighted a range of treatment services that were specifically aimed at treating non drug-using family members.⁶⁷ Some examples of services targeting families funded under the Commonwealth's *Strengthening families* program include:

- The Women's Health Service in Perth through the Pregnancy, Early Parenting and Illicit Substance Use project has conducted support

64 Drug Free Australia, submission 42, p 9.

65 Miller T, submission 78, p 4.

66 Family Drug Help, submission 76, p 7.

67 Glastonbury Child and Family Services, submission 74, p 6; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 31; Smith L, Toughlove NSW, transcript, 3 April 2007, p 1; Family Drug Support, submission 15, p 2; Family Drug Help, submission 76, p 7.

groups for new mothers and their babies, children's art therapy groups, a recreational physical activity program and a training program for other service providers;

- Grandparents Raising Grandchildren (Tasmania) - the project aims to assist grandparents and other kinship carers raising children of drug-using people. Services provided include support and counselling (including regional support groups); case management (including brokerage for specialist services); advocacy; information and skill development for grandparents; and referral; and
- The Aboriginal Kinship Program in Adelaide assists Indigenous families by providing intensive case management to families and individuals affected by illicit drug use. Key strategies include case management, linking clients with other support agencies and brokerage funds. Work is also focused on case managing Aboriginal people who use illicit drugs through agencies such as corrections, police, prisoner support services and community health services.⁶⁸

6.81 The main objectives of treatment programs for family members include:

- providing opportunities for non drug-using family members to engage in some normal social activities because the family has concentrated on supporting a drug user;⁶⁹ and
- peer support for parents/grandparents to share experiences and build self esteem.⁷⁰

6.82 The Victorian Alcohol and Drug Association suggested that there was a need for resources to be provided for specialist family-oriented drug treatment services to develop capacity to advocate for and consult with families of drug users and that resources be given to general drug treatment services to develop referral protocols to family-oriented agencies.⁷¹ A further suggestion was that the drug treatment

68 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 4.

69 Odyssey House Victoria, submission 111, p 5.

70 Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 31; Family Drug Support, submission 15, p 5; Family Drug Help, submission 76, p 7.

71 Victorian Alcohol and Drug Association, submission 100, p 3.

sector develop standardised screening tools for clients that includes a method for gauging the needs of clients' families.⁷²

- 6.83 The committee supports the provision of services to allow families to regain a sense of normal functioning and re-integrate into community life. It is important that drug treatment service providers are aware of the strains imposed on family members and are able to provide services to them or direct them to support services available elsewhere. The committee also believes that there is a need to both increase awareness about the need for family members to get treatment and support and to let families know where they can go for help.
- 6.84 The adoption of the committee's recommendation for a single point of contact about illicit drugs should provide an important access point for families to services for their drug-using family member, but also for themselves. It is important that the promotion of this new contact point, if adopted, highlights to families that they can also get help for their own needs.

Recommendation 26

- 6.85 **The Department of Health and Ageing, as part of the next funding round for the *Non Government Organisation Treatment Grants Program* give priority to funding services that help family members affected by a family member's drug use.**

Recommendation 27

- 6.86 **The Minister for Health and Ageing, in conjunction with the states and territories, develop:**
- **a range of standardised screening tools to identify the needs of families affected by a family member's drug use; and**
 - **a set of referral protocols for families that need help in their own right to address the impact that caring for a drug-using family member has had on their lives.**

72 Victorian Alcohol and Drug Association, submission 100, p 3; Walsh C, submission 84, p 3.

- 6.87 Services have emerged that do assist families get support and advice. These include Toughlove, Family Drug Support, Grandparents Assisting Grandkids Support, Kinkare and Family Drug Help.⁷³ Local Drug Action Groups, a not-for-profit organisation in Western Australia that focuses on locally-based prevention strategies told the committee that:

One of the most powerful ways of helping families is through the peer self-help process. Parents can listen to how others cope, realise they are not alone, possibly hold their heads up with pride again as they see other 'normal' parents in the same position, understand more about what their child is dealing with, pick and choose from approaches they hear in the group to suit their own situation. They need the input of professional information along the way, so that the choices they make are based on knowledge, not rumour or misinformation as is common in the drug field.⁷⁴

- 6.88 A member of Toughlove, a not-for-profit parent support group, told the committee that:

Toughlove has given us hope and strategies to take back control of our home and our lives. We have like minded parents who can support us at any time of the night or day when we are in crises not just during business hours. These parents have been through what we have gone through or similar. They are not judgemental and believe what we say we are going through, having gone through the heartache themselves.⁷⁵

- 6.89 Another parent highlighted to the committee the benefits of belonging and contributing to parent support groups:

I have been attending Parent Support Group meeting for around three years. Going to 'Group' has been the single most and best coping strategy for me. Just knowing that every other parent attending knows what you are going through and understands gives/gave me the strength to keep going. One of the best things about our 'Group' is the gentle but

73 Lubach M, Kinkare, transcript, 7 March 2007; Family Drug Support, submission 15, p 2; Local Drug Action Groups, submission 159, p 1; Toughlove NSW, submission 126, p 2; Toughlove Victoria, submission 112, p 1; Family Drug Help, submission 76, p 3.

74 Centacare Catholic Family Services, submission 116, p 15.

75 Toughlove Victoria, submission 112, p 3.

constant reminder to look after ourselves. My family have and are also very supportive of myself.⁷⁶

- 6.90 Peer-support groups provide an invaluable resource for members of families affected by drug use, building confidence, disseminating information and sharing experiences that can be crucial in improving family functioning. These groups can also strengthen a family's protective factors to prevent others in the family taking up drugs.
- 6.91 The committee considers that treatment services need to be aware of peer-support groups in their region and make parents and grandparents aware of the potential benefits that belonging to such a group can bring. Public campaigns about illicit drugs should also raise awareness about peer-support groups as a way of sharing experiences and building a defence against drug use in the rest of the family.

Mandatory treatment

- 6.92 By definition, illicit drug users are making impaired decisions, and are usually unable to realise the impact and consequences of their drug use. Compulsory treatment is successfully used in Sweden and logically should have a role to play in Australia.
- 6.93 Several inquiry participants expressed their support for a mandatory treatment regime, whereby drug users were coerced into treatment rather than relying on voluntary treatment models.⁷⁷ The committee understands that the ANCD have sponsored some Australian-based research into compulsory treatment models.⁷⁸
- 6.94 The brother of a former drug addict told the committee about his frustrations in waiting until his brother was 'ready' to undergo treatment:

... at no time during his dealings with 'the system' was my brother required to enter into a drug and alcohol treatment/rehabilitation program. During the times when I was feeling desperate about my brother's health, I rang

76 Name withheld, submission 161, p 1.

77 Name withheld, submission 155, p 2; Lopez J, submission 24, p 1; Drug Advisory Council of Australia, submission 37, p 2; Australian Family Association, submission 59, p 4; Australian Family Association SA Branch, submission 72, p 2.

78 Vumbaca G, Australian National Council on Drugs, transcript, 28 May 2007, p 43.

different service providers for advice/help, to be told every time there was absolutely nothing could be done except to wait until my brother was ready to accept help for himself.⁷⁹

6.95 There are various forms of coercive treatment that are in place in Australia built around the judicial system. Opportunities for directing drug users into treatment programs are provided along the various steps that drug users encounter as they progress through the judicial system. Spooner, Hall and Mattick summarised the general steps as:

- pre-arrest — when an offence is first detected, prior to a charge being laid. Diversionary measures here can include police discretion (e.g. offence detected but no action taken); an infringement notice (e.g. fine but no record); informal warning (no record); formal caution (verbal warning with record kept, but no further action); and caution plus intervention (i.e. warning and record, plus information or referral to an intervention program);
- pre-trial — when a charge is made but before the matter is heard at court. Measures can include treatment as a bail condition (e.g. no conviction recorded if treatment program completed successfully); conferencing; and prosecutor discretion (e.g. treatment offered as alternative to proceeding with prosecution);
- pre-sentence — after conviction but before sentencing. Includes measures such as delay of sentence where the offender may be assessed or treated. The process can include sanctions for non-compliance and incentives such as no conviction recorded;
- post-conviction/sentence — as a part of sentencing. Diversionary measures here include suspended sentences of imprisonment requiring compliance with specific conditions (e.g. participation in treatment, abstinence from drugs, avoidance of specific associates, etc.); drug courts (i.e. judicially supervised or enforced treatment programs); and non-custodial sentences involving a supervised order, probation or bond requiring participation in treatment as part of a sentence; and
- pre-release – i.e. prior to release from detention or gaol on parole. Options include transfer to drug treatment (e.g. while still in custody, being transferred to a secure residential treatment program which is supervised 24 hours a day) and early release to treatment such that an

79 McIntyre R, submission 81, p 4.

inmate may be released early from detention into a structured, supervised treatment program.⁸⁰

- 6.96 In 2005-06, almost 15,000 closed treatment episodes for illicit drugs were referred by police or court diversion initiatives.⁸¹ This represents an increase of over 8,000 closed treatment episodes referred by police or court diversion programs compared with 2001-02.⁸²
- 6.97 As noted previously, the Commonwealth is supporting the *Illicit drugs diversion initiative* to divert drug users from prison to undergo drug treatment. This is an important area to be pursued. The committee notes with interest that the Department of Health and Ageing has commissioned an evaluation of this initiative to assess:
- the costs and benefits of the initiative — conducted by the Allen Consulting Group;
 - the long term impact of police drug diversion on reducing contact with the criminal justice system, including the identification of factors that contribute to delayed or reduced levels of re-offending and the seriousness of offending — conducted by the Australian Institute of Criminology; and
 - the effectiveness of the initiative in rural and remote Australia — conducted by the Australian Institute of Health and Welfare.⁸³
- 6.98 The committee looks forward to the public release of the evaluation reports, expected in the near future, following their consideration by the Intergovernmental Committee on Drugs.
- 6.99 The Tasmania Government noted that it will commence a pilot diversion program from July 2007 providing diversion for offenders at three different stages:
- bail diversion — allowing for shorter-term treatment as a post-plea option;

80 Spooner C et al, 'An overview of diversion strategies for Australian drug-related offenders', *Drug and Alcohol Review* (2004), vol 20, pp 281-294.

81 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set* (2007), cat no HSE 53, p 70.

82 Australian Institute of Health and Welfare, *Alcohol and other drug treatment services in Australia 2001-02, Report on the National Minimum Data Set* (2003), cat no HSE 28, p 76.

83 Australian Government Department of Health and Ageing, submission 169, p 6; Australian Government Department of Health and Ageing, 'Senate Order on Departmental and Agency Contracts', viewed on 4 September 2007 at [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D4F19A7423043FFCCA256F1800502554/\\$File/Health%20Senate%20Order%20Listing%200607.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/D4F19A7423043FFCCA256F1800502554/$File/Health%20Senate%20Order%20Listing%200607.pdf).

- sentencing into drug treatment — allowing for longer-term treatment through the current range of sentencing options; and
- drug treatment order — allowing for supervised community-based drug treatment as an alternative to incarceration.⁸⁴

6.100 The Queensland Government noted that an extensive evaluation of its diversion initiatives was also underway and was showing some evidence of a positive impact:

An evaluation of the Drug Court Program in Queensland found that recidivism was reduced; few graduates re-offended and; average time to re-offending was longer than for comparison groups.

... Evaluation of the Queensland Court Drug Diversion and Police Diversion programs (which fall under the Queensland Illicit Drug Diversion Initiatives) showed that both programs were very well received by all stakeholders and participating offenders. Offender self-reports indicated a 56 per cent reduction or cessation of use of cannabis at 6 month follow-up. A key point was a 28 per cent reduction in the number of court cases that would otherwise have occurred in the first two years of the program.⁸⁵

6.101 Outside of the justice system, coercive treatment models can still be used by providing incentives, or disincentives, to participate in treatment programs. The Canadian Centre on Substance Abuse noted that:

Coerced treatment refers to the delivery of substance abuse treatment services to individuals who are either reluctant or refuse to enter treatment unless they risk losing something important to them. For a single mother, it may be the thought of losing custody of her children; others may respond to a spouse's threat to leave unless the problem is addressed. In such cases, personal choice remains part of the process since the person can still refuse to attend treatment.⁸⁶

6.102 A key benefit of community-based coercive treatment is that it leads to people undergoing treatment who otherwise may not seek

84 Tasmanian Government, submission 174, p 6.

85 Queensland Government, submission 173, p 5.

86 Canadian Centre on Substance Abuse, 'Mandatory and coerced treatment', viewed on 20 July 2007 at <http://www.ccsa.ca/NR/rdonlyres/379BFB3A-02A1-49B3-9ABB-CCE7EF9A811/0/ccsa0036482006.pdf>.

treatment. This may be because they are in denial or do not recognise the impact of their drug use on those around them.⁸⁷

6.103 In an Australian context, the committee considers that there are opportunities to introduce various forms of coercive treatment. In the words of one witness, 'coerced treatment is preferable to no treatment'.⁸⁸ Options include:

- linking welfare payment to undergoing drug treatment. One model requires mandatory drug testing for welfare recipients with those returning positive tests may be required to receive treatment and abstain from drug use or risk losing their benefits;⁸⁹
- referral to treatment for drug use in pregnancy, as discussed in chapter four – this could include intervention by child protection authorities and imposing requirements for parents to graduate from treatment programs and stay drug-free in order to retain custody of children;⁹⁰
- laws providing for parents and legal guardians to apply to a court to order their children into treatment for severe addictions. As part of a program implemented in Canada, a court will only grant forced confinement if a child is in danger to himself or others and all other means of treatment have been exhausted. During their confinement, which can last up to five days, service providers give supervised detoxification, assessment and support. Families also undergo counselling;⁹¹ and
- mandatory random drug testing in schools, with children returning a positive test required to undergo treatment.⁹²

6.104 A further option explored by the committee was the use of a 'rewards' or 'voucher' system to give people an incentive to be drug free (box 6.3).⁹³

87 Name withheld, submission 164, p 2; Centrelink, submission 128, p 6; Susan, transcript, 3 April 2007, p 74.

88 Homel R, transcript, 13 June 2007, p 21.

89 Macdonald S et al, 'Drug testing and mandatory treatment for welfare recipients', *The International Journal of Drug Policy* (2001), vol 12 no 3, pp 249–257.

90 Butler M, 'Pregnancy: Opportunity or invasion', *Of Substance* (2007), vol 5 no 1, p 7.

91 Canadian Foundation for drug policy, 'Families using mandatory treatment program for youth', viewed on 20 July 2007 at <http://www.mapinc.org/newscfdp/v07/n847/a06.html>.

92 Bressington A, transcript, 23 May 2007, p 19.

93 Homel R, transcript, 13 June 2007, pp 21–22.

Box 6.3 Rewarding drug users to stay in treatment

Rewarding drug users for returning 'clean' drug tests during treatment or for continuing to attend treatment has been part of a number of relatively small-scale programs in North America.

Some examples of rewards-based incentives offered to drug users include:

- attendance at a clinic three times per week for drug testing. If testing clean, participants were granted as much as \$US40 worth of vouchers that could be redeemed for things like food, gift certificates and rent money;
- a 24 week outpatient program for cocaine users involving one or two individual counselling sessions per week. Patients submit urine samples two or three times each week and receive vouchers for negative samples, with the value of vouchers increasing with consecutive clean samples. Patients may exchange vouchers for retail goods that are consistent with a cocaine-free lifestyle; and
- a program for homeless crack addicts that, for the first two months, required them to spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual assessment and goal setting, individual and group counselling, multiple psychoeducational groups. After two months of day treatment and at least 2 weeks of abstinence, participants graduate to a four month work component that pays wages that can be used to rent inexpensive drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

Source Ornstein C, 'Meth users respond to reward program', *The Seattle Times* (2005), viewed on 22 July 2007 at <http://www.uchc.edu/ocomm/newsarchive/news05/dec05/methusers.html>; National Institute of Drug Abuse, *Principles of Drug Addiction Treatment: A research based guide, Community reinforcement approach plus vouchers*, viewed on 22 July 2007 at <http://www.nida.nih.gov/PODAT/PODAT11.html>.

6.105 Professor Dawe told the committee about the experiences of rewards-based treatment approaches in North America:

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 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.⁹⁴

- 6.106 In terms of the models presented here, the committee believes that a mandatory referral and treatment model for children aged up to 17 years is attractive, where voluntary-based treatment approaches have failed. Such an approach recognises the importance of intervening early to prevent long-term damage. Implementing such a model, however, is likely to require significant changes to state-based legislation and an expansion of treatment service capacity.
- 6.107 The committee considers that given the importance of such an initiative, the Commonwealth should make an appropriate contribution to the likely additional cost in expanding the drug treatment system. In the short term, the Commonwealth could examine implementing the model on a staged state-by-state basis.

Recommendation 28

6.108 **The Commonwealth Government:**

- **enter negotiations with the states and territories to change legislation to allow for children aged up to 18 years to be placed in mandatory treatment for illicit drug addiction with an organisation or individual which has as its treatment goal making individuals drug free; and**
- **provide the appropriate funds required to increase capacity to assist children and the families of those made subject to mandatory treatment.**

- 6.109 The committee is also attracted to rewards-based treatment models for drug users. The committee considers that the Commonwealth should undertake further research on implementing such a model in Australia and fund several small-scale trials of various approaches.

⁹⁴ Dawe S, transcript, 13 June 2007, p 21.

Recommendation 29

6.110 The Department of Health and Ageing:

- undertake research on the implementation of a rewards-based model for drug treatment participation in Australia that offers drug users positive incentives to undergo treatment; and
- conduct a number of small-scale trials across Australia to examine the effectiveness of a rewards-based treatment participation approach.

Dual diagnosis treatment

- 6.111 As noted in chapter eight, dual diagnosis presents many difficulties for treatment and rehabilitation that are a frustration to families as well as a cost to the community. In addition to the complications brought on by uncertain interactions between illicit drug use and mental illness, the committee heard how the shifting back and forth of responsibility between mental health and drug treatment services ultimately puts an added burden of care on families.⁹⁵
- 6.112 Many of the recommendations above will assist sufferers of dual diagnosis as well as their families, as they too need access to information about services and treatments, family-inclusive treatment, and transitions between counselling, detoxification, rehabilitation and aftercare.
- 6.113 Treatment for dual diagnosis can be more complex, however. Firstly, given that clinical recognition of co-occurring drug use and mental disorders is fairly recent, there is not consensus on the best form of treatment.⁹⁶
- 6.114 Some of this derives from disagreement over the scientific evidence on the basis for co-occurring mental disorders and illicit drug use. There is also a lack of research on the potential interactions between prescription psychiatric drugs and antidepressants with illicit drugs of uncontrolled quantity, purity and content. For example, both the ANCD and Beyondblue note that more research is needed on

⁹⁵ Walsh C, submission 84, p 3.

⁹⁶ NSW Health, *The management of people with a co-existing mental health and substance use disorder: Discussion paper* (2000), p 15.

potential for toxic side effects between the use of psychiatric medications (antipsychotics) and methamphetamines.⁹⁷

6.115 There are three basic models of service provision for treating people with comorbid disorders:

- serial treatment – treating one disorder before treating the other, often the one that presents the most acute problems (such as psychosis);
- parallel treatment – treating both disorders at the same time through different providers, for example, a patient in a drug rehabilitation program also attending a psychiatrist having first detoxed; and
- integrated treatment – in which the same individual, team or service provides both mental health and drug use treatments simultaneously.⁹⁸

These models have advantages and disadvantages, and may need to be individually suited to drug users depending on the severity of their drug use relative to their mental health problems and other circumstances surrounding their treatment – for example, if they have dependent children, or if they are able to travel to access services.

6.116 As a NSW Health report noted in 2000, despite the fact that people with dual diagnosis use health services more than people with a single disorder, there are very few specialist services which focus on the ongoing care and management of individuals affected by both disorders.⁹⁹ For most drug users, a lack of communication and cultural differences between the mental health and drug treatment sectors mean that they are ‘falling through the gaps’ in the treatment system.

97 Beyondblue, submission 151, p 2.

98 Teesson M and Proudfoot H, eds, National Drug and Alcohol Research Centre, *Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment* (2003), p 133.

99 NSW Health, *The management of people with a co-existing mental health and substance use disorder: Discussion paper* (2000), p 9.

Box 6.4 Involuntary legal scheduling for mental health patients

There are different mechanisms for involuntary treatment and care according to state or territory mental health legislation. The states and territories also differ in who has the authority to 'schedule' a patient, what length of time they can be detained and for what purposes.

In New South Wales, a person may be detained in a psychiatric hospital if they fall within the definition of 'mentally ill' or 'mentally disordered' and have an 'involuntary legal schedule' applied to them. A person cannot be considered mentally ill solely because they take drugs.

A mentally ill person is defined as someone experiencing hallucinations, delusions, serious thought disorder, serious mood disorder or sustained irrational behaviour suggesting the presence of one of these symptoms.

A mentally disordered person is defined as someone whose behaviour is so irrational that they place themselves or someone else at risk of serious physical harm. A mentally disordered person can only be kept in hospital for a maximum of three working days and a doctor must examine them every 24 hours. A person cannot be admitted this way more than three times each month.

The most common way a person is detained in a psychiatric hospital is by a doctor completing a certificate that states that the person is mentally ill or mentally disordered. This certificate is called a Schedule 2. The doctor may only complete the certificate if she or he has seen the person and considers that no care other than hospital treatment is appropriate and available.

As soon as possible after admission to hospital, the person will be examined by another doctor. If that doctor considers the person to be mentally ill or mentally disordered, a second examination will be arranged. If not, the person will be discharged. If after two (or, in some circumstances, three) examinations, the medical superintendent considers the person to be mentally ill, then she or he will be brought before a magistrate. The magistrate will conduct a hearing to decide whether the person needs to remain in hospital. The person must be represented by a lawyer at the magistrate's hearing unless she or he decides otherwise.

There is no national data for the use of involuntary treatment orders. In New South Wales in 2005, 10,015 mental health patients were involuntarily admitted to hospital on a doctor's certification.

*Source NSW Health website, viewed on 28 August 2007 at <http://www.health.nsw.gov.au/legal/pdf/mentalhealthip1.pdf> and <http://www.health.nsw.gov.au/legal/pdf/mentalhealthip2.pdf>; New South Wales Government, *Mental Health Review Tribunal, Annual Report 2005 (2006)*, p 41; *Mental Health Act, Frequently Asked Questions about the Mental Health Act 1990 (NSW)*, http://www.cs.nsw.gov.au/Mhealth/consumer/faq_mentalhealthact.html#3.*

- 6.117 King Edward Memorial Hospital for Women, for example, said that existing services did not have the necessary capacity or expertise to manage clients they were seeing who were undergoing drug-related psychoses shortly after giving birth:

Mothers who become psychotic in the peri-natal period require specialised support for themselves as well as their infant. This is likely to become an increasing problem with the rise in use of methamphetamines with its serious associated risks on mental health. Existing services do not adequately manage these mothers who have a dual diagnosis of mental illness and substance misuse issues.¹⁰⁰

- 6.118 Also in Perth, the Western Australian Network of Alcohol and other Drug Agencies reported that the demands of clients with co-occurring mental health disorders, psychosis in particular, were putting strain on drug treatment services. This was stretching existing resources, adding to workload and training issues, and causing occupational health and safety concerns.¹⁰¹

- 6.119 The Gold Coast Drug Council also reported an acute shortage of dual diagnosis counsellors and treatment options on the Gold Coast:

There are no specialist counsellors on the ground in the Gold Coast. You really have to understand this. We have this huge growth... We just do not have the resources and counsellors on the ground to deal with this. The person who is seeking help is turned away versus their parents versus their grandparents. There are simply not the services to go around.

As we said, we are expecting an explosion at Coomera. I treat one in 10. As far as I understand, Mirikai is the only dual diagnosis therapeutic community in the country that is public. We are just saying no, no, no.¹⁰²

- 6.120 The committee anticipates that significant recent investments by the Commonwealth may alleviate some strain in this area of health service delivery. As detailed in chapter eight, the National Comorbidity Initiative (2003-04 to 2007-08) and the Council of Australian Governments (COAG) National Action Plan on Mental Health 2006–2011 have allocated over \$105 million to co-occurring

100 King Edward Memorial Hospital for Women, submission 19, p 5.

101 Western Australian Network of Alcohol and other Drug Agencies, submission 138, p 3.

102 Alcorn M, Gold Coast Drug Council, transcript, 7 March 2007, p 31.

drug use and mental health disorders; to provide more services, train and develop the workforce, and raise community awareness.¹⁰³

- 6.121 Other jurisdictions have also invested in dual diagnosis services. The Victorian Government, for example, has established four dual diagnosis teams to assist clinical and mental health services and drug treatment services across the state to achieve better outcomes for clients with dual diagnosis.¹⁰⁴ In 2006, dual diagnosis was identified as a state-wide training priority for all clinical mental health services.¹⁰⁵
- 6.122 The committee commends the substantial investment in dual diagnosis by the Commonwealth and State governments.

103 Australian Government Department of Health and Ageing website, 'National Comorbidity Initiative', viewed on 25 July 2007 at <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-publth-strateg-comorbidity-index.htm#project7>; Council of Australian Governments, *National Action Plan on Mental Health 2006-2011* (2006), pp 9–10.

104 Victorian Government Department of Human Services, *Dual diagnosis: Key directions and priorities for service development* (2007), p 12.

105 Victorian Government Department of Human Services, *Dual diagnosis: Key directions and priorities for service development* (2007), p 19.

Social and personal impact on families of illicit drug use

- 7.1 Social and personal costs to families as a result of illicit drug use are extensive. They include the stigma and social isolation resulting from a family member's drug addiction and in many cases, associated medical conditions arising from stress and trauma. Different impacts are felt depending on the nature and extent of the addiction, and also on the strength of relationships between family members.
- 7.2 For many, drug use can be accompanied by poverty-related issues, instability of housing, domestic violence, mental health problems, chronic illness and social isolation.¹ Families from a culturally and linguistically diverse background, including Indigenous Australians, may feel additional impacts because of deeper involvement of the broader community in family life.
- 7.3 The deeply personal nature of the experiences recounted in this chapter shows the intangibility of grief and pain and the extent and depth of damage. Some hope is placed, however, in a prevention-based approach to illicit drug use; such as the practical approaches discussed in chapter five.

1 Women's Health Service (WA) Pregnancy Early Parenting and Illicit Substance Use, submission 26, p 1.

Improving our knowledge about illicit drug use in families

7.4 The committee is aware of a lack of research and data into some elements which are of critical importance in understanding the nature and extent of the impact of illicit drug use on families. Although some evidence on the number of family members affected by another member's illicit drug use is available (including numbers of children at risk because of parental drug use, and of grandparent carers as a result), estimates are based on a range of assumptions which are affected by problems of under-reporting and survey methodology.²

7.5 Professor Dawe told the committee that the range of estimates that we have about family members affected by others' illicit drug use, particularly children, should be made more accurate:

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.³

7.6 A reported co-authored by Professor Dawe for the Australian National Council on Drugs (ANCD) made the following comments about information on the numbers of children living in Australian households with parental substance use:

There are no national household data sets that directly inform this issue. Specialist data sets from drug and alcohol monitoring systems do not ask about parental status and are of limited value. There are no systematic monitoring processes in the public domain that allow for an analysis of parental characteristics of children entering the child protection system.⁴

7.7 Recommendations in the ANCD report included that:

- all national surveys of substance use should collect minimum basic data on number of biological children, number of dependent children, and number of children living in the households of adults;

2 Dawe S et al, submission 80, p 3.

3 Dawe S, Griffith University School of Psychology, transcript, 13 June 2007, p 9.

4 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 7.

- surveys of particular high-risk populations should also collect data on number of biological children, number of dependent children, and number of children living in the households of adults. Additional information on whether children are currently or have ever been taken into social services' care should, ideally, also be collected; and
 - data collected on harms to children and children taken into care should include clear information on the referral and decision making mechanisms and, where multiple reasons are given, the primacy of parental substance use should be stated along with the type of substance use involved. Similarly, the relationship between the type of harm (e.g. neglect or abuse) should be cross-tabulated against the profile of parental risk factors.⁵
- 7.8 Several other inquiry participants also supported the collection of data such as that outlined in the recommendations of the ANCD report.⁶ The Royal Australasian College of Physicians noted in its child protection policy that limitations on available baseline data prevent any accurate estimate of the dimensions of child abuse and neglect, which makes evaluation of the efficacy of intervention in such cases problematic.⁷
- 7.9 The committee considers that, as a matter of priority, information should be collected in the major data sets on illicit drug use in Australia about the relationships users have to other members of their family, such as whether they have dependent children or whether children are being cared for by their biological parents or other carers.
- 7.10 The major datasets that should collect this information include:
- the National Drug Strategy Household Survey;
 - the Illicit Drug Reporting System (and the associated Ecstasy and Related Drugs Initiative); and
 - child protection systems administered by state and territory governments.

5 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 34.

6 Miller T, submission 78, p 8; Dawe S et al, submission 80, p 3; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2005, p 27.

7 Royal Australasian College of Physicians, submission 119, p 5.

- 7.11 While the committee cannot direct state and territory government agencies to collect the data identified in the ANCD report, it strongly encourages them to do so.

Recommendation 30

- 7.12 **That the Department of Health and Ageing, as the funder for the National Drug Strategy Household Survey, the Illicit Drug Reporting System and the Ecstasy and Related Drugs Initiative, require that data collected by collection agencies include:**
- **whether any biological or dependent children live in the drug user's household; and**
 - **for users aged under 18 years, the status of their regular full-time carers (such as parents or grandparents).**

General impact on families

- 7.13 Families of illicit drug users feel isolated and ashamed because of the stigma attached to drug use, and other reactions follow according to the severity of the situation. Glastonbury Child and Family Services summarised the feelings that family members experienced:

The family members surrounding the person using illicit drugs can experience denial, fear and anxiety, guilt or blame, shame and stigma, isolation, helplessness, grief, and anger. They travel on a parallel journey to the person using illicit drugs, moving through the cycle of use and managing chronic stress and chaos for long periods of time.⁸

- 7.14 Centacare NT notes that in many cases, family members have been living with the negative impacts of the user for extended periods of time, and they present with issues such as anxiety, depression, marital stress and breakdown, affected job performance and reliance on alcohol and drugs for their own self care.⁹
- 7.15 A 'stress-strain-support' model was presented by Centacare NT to show the broader impact of a person's illicit drug use on the family

8 Glastonbury Child and Family Services, submission 74, p 9.

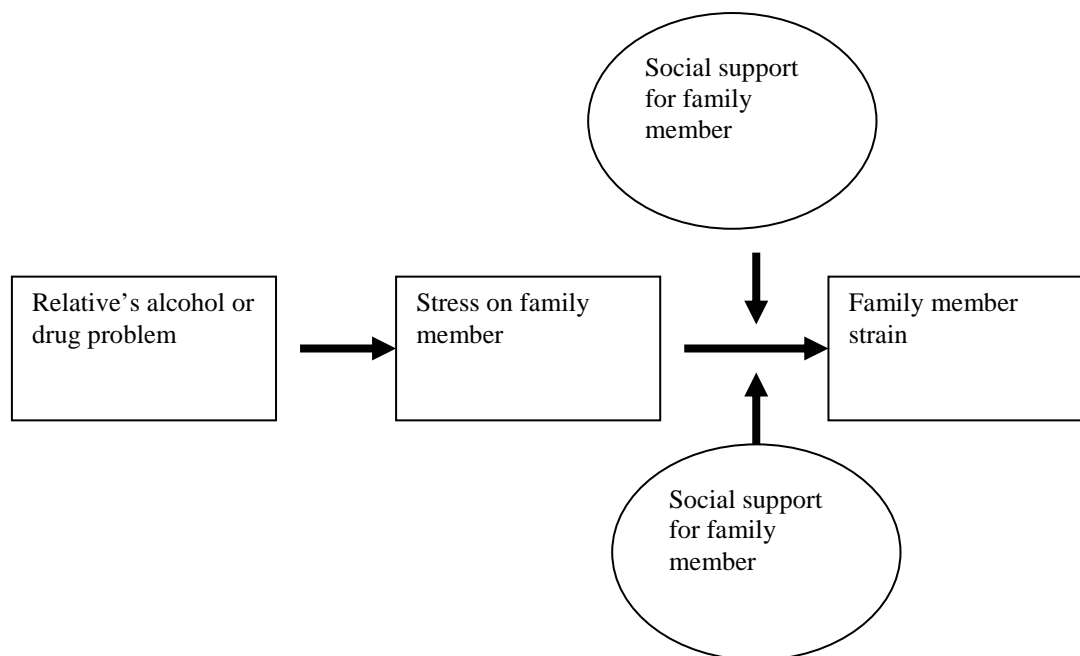
9 Centacare NT, submission 60, p 3.

(figure 7.1), noting that while someone in the family is causing difficulties, the whole family is affected. This is a view echoed strongly by many families who provided evidence to the committee.¹⁰

7.16 Centacare NT noted that the model:

...recognises that the support that families receive is crucial in mitigating stress on the family. Support can be family members, informal and formal, and this model looks at increasing the quality of this support to achieve better outcomes for families experiencing family stress.¹¹

Figure 7.1 Stress-strain-support model



Source Centacare NT, submission 60, p 8.

7.17 Centacare NT observed that there is typically one family member who appears to 'hold it all together', putting everyone's needs ahead of their own, and that everyone in the family, especially the user, relies on that person who is demonstrating an acute responsibility for others to the detriment of their own well being.¹²

10 Family Drug Support, submission 15, p 3; Ryan W and P, submission 43, p 2; Relationships Australia, submission 143, pp 3-4; Australian Drug Treatment and Rehabilitation Programme, submission 132, p 40.

11 Centacare NT, submission 60, p 8.

12 Centacare NT, submission 60, p 3.

Factors that shape the impact on families

- 7.18 The real and perceived impacts of illicit drug use on families will differ according to who in the family is using drugs, what type of drugs they use, and the severity of their addiction. The Australian Institute of Family Studies (AIFS) noted that a young person's drug-taking behaviour can affect:
- siblings, especially younger siblings (including their decisions about drug use);
 - parents;
 - the family as a whole (including quality of relationships, family 'stability', financial wellbeing); and
 - relationships with the extended family (including provision of support in either direction).¹³
- 7.19 Where the drug-affected family member is a parent or adult partner, drug-taking behaviour can affect:
- the children (parenting behaviour in general as well as specific child protection concerns ...);
 - the partner (including relationship breakdown);
 - the family as a whole — including quality of relationships, family 'stability', parental separation/divorce, financial wellbeing; and
 - relationships with the extended family — including provision of support in either direction.¹⁴
- 7.20 The impact of illicit drug use on families can also vary greatly. Illicit drug use falls across a continuum:
- It ranges from non-users, to experimental users, to regular users, through to what I would call problematic users, who are the people that we would all call addicts. Regular users often float beneath the horizon because they manage so well to cope in their ordinary day-to-day life. It is amazing how many of those people are out there. It is not until the wheels start to fall off or relationships wobble or they run out of money for cocaine that they present for treatment.¹⁵

13 Australian Institute of Family Studies, submission 103, p 3.

14 Australian Institute of Family Studies, submission 103, p 3.

15 Gould B, transcript, 3 April 2007, p 57.

7.21 The South Australian Government also highlighted that polydrug use (where multiple drugs are being used) and method of administration also play a part in determining the impact of drug use on a family.¹⁶

7.22 It will also often depend on the stage at which drug use is discovered or is being treated. Odyssey House noted that:

There appears to be different phases for families, for instance upon first learning about the problem they are often shocked and a panic reaction begins, family members and in particular parents at this stage seem to search for information to better understand the effects of drugs and access treatment, they may begin to police the child's activities and family tension can build quite quickly. Family members who have lived with a drug problem for many years often live in a constant state of stress and anxiety, responding to crisis at any time of the day and night... Depending upon the extent and length of drug use behaviour, family members can either have raised hopes about treatment or be ambivalent.¹⁷

Shock, grief, fear, anger, guilt

7.23 A typical first reaction by families to illicit drug use by a family member is shock.¹⁸ When confronted with the initial discovery of illicit drug use, this shock does not always lead to effective communication, or productive ways of managing and coping with the revelation:

Many emotions came with this discovery. Anger, sadness, amazement, grief, horror, despair, shame, a sense of failure, but mostly helplessness. Unfortunately due to our highly emotional state, and lack of accurate information, when we confronted our daughter about her drug use, we had no success in communicating with her.¹⁹

16 South Australian Government, submission 153, p 5.

17 Odyssey House Victoria, submission 111, p 10.

18 Nar-Anon Family Groups, submission 115, p 5.

19 Australian Drug Treatment and Rehabilitation Programme, submission 132, p 14.

- 7.24 Anger and guilt, often interlinked, are common emotional responses.²⁰ The Australian Association of Social Workers noted that:

The anger can be aimed at the fact that their child has placed themselves in danger. The guilt may stem from a feeling that they should have known, that there was something that they could have done to stop this from happening.²¹

- 7.25 As a mother reported, in the early stages of awareness of her daughter's drug problem there had been:

Anger somewhere in all this, an irrational anger that she had taken this path, anger at what we all had to go through, anger that she could not stop using... And there was guilt... my guilt was about my inadequacy, how hopeless I seemed to be at managing, how utterly lost and confused I felt.²²

- 7.26 Fears for the health and safety of the drug addicted family member are also common, with families concerned about the risk of infection from HIV and hepatitis C, the risk of fatal overdose, risk of imprisonment, as well as the risk of coming to harm through association with criminality and prostitution.²³ The mother mentioned above described 'an overwhelming fear, terror more like it, that she could die, the fear that she could never get over this'.²⁴

- 7.27 Families also commonly experience grief at the realisation of the change in status and sometimes loss of the relationship as they notice the change in the addicted individual's personality. One parent described it as 'the grief we feel for the loss of a normal life.'²⁵ Moreland Community Health Service expressed the feelings of loss and grief that families felt:

Loss and grief is also another issue families need to negotiate, this can be the result of a death or the result of those things that are not so tangible, e.g. loss of dreams they had for their

20 Morris R, Teen Challenge NSW, transcript, 3 April 2007, p 106; Centacare Catholic Family Services, submission 116, p 13; Ryan W & P, submission 43, p 2; Australian Psychological Society, submission 131, p 8; Australian Drug Foundation, submission 118, p 5; Moreland Community Health Service, submission 32, p 2.

21 Australian Association of Social Workers, submission 121, p 6.

22 Centacare Catholic Family Services, submission 116, p 13.

23 Association for Prevention and Harm Prevention Programs Australia, submission 130, p 8.

24 Centacare Catholic Family Services, submission 116, p 13.

25 Lowy M & S, submission 11, p 1.

child, loss of hopes and dreams of a relationship, for children the loss of a healthy attachment or loss of their childhood.²⁶

Loss of trust

- 7.28 The reaction by families, parents especially, to blame themselves for their family member's addiction, is common, and leads family members to question their own judgement.²⁷ Additionally, many family members report being constantly lied to and deceived by the drug user. This can manifest itself in a loss of trust towards themselves and towards the user, as well as placing constant strain on family relationships.²⁸

Shame and stigma

- 7.29 The sadly common feeling of shame and stigma among families of illicit drug users causes considerable disruption to relationships. It can also lead to an actual or perceived loss of support in the community, and an increasing sense of social marginalisation. Marymead Child and Family Services described the stigma that families sometimes experience:

The effects on families of having been illicit drug using are multi-layered and can continue for a very long time beyond the actual drug use. For example, families often live daily with being labelled a 'druggy' family by the neighbourhood; children are often subject to teasing and bullying from other children at school because they come from a 'junkie' family. Each time something 'goes wrong' the effects for these families are magnified. These families are very sensitive to setbacks and to real or perceived criticism...²⁹

- 7.30 Parents can also feel that they are to blame for the drug addiction of their child.³⁰ Families and Friends for Drug Law Reform described how parents sometimes felt:

26 Moreland Community Health Service, submission 32, p 2.

27 Riley M, submission 34, p 1.

28 Bowman D, submission 38, p 1; Name withheld, submission 106, p 1; Toughlove Victoria, submission 112, p 4; Families and Friends for Drug Law Reform, submission 122, p 4; Alcohol and Drug Foundation ACT, submission 123, p 3; Name withheld, submission 145, p 5; Teen Challenge NSW, submission 139, p 1.

29 Marymead Child and Family Centre, submission 107, p 10.

30 See, for example, Centacare Catholic Family Services, submission 116, p 6; Bowman D, submission 38, p 1; Damen P, submission 53, p 3.

...you, the parents, have failed in your responsibility in bringing up your child. You have brought up a criminal. Shame is a pervasive experience of families when illicit drug use is involved... The shame is isolating and corrosive of the capacity of the family to respond usefully.³¹

- 7.31 High levels of shame and stigma can also prevent families from seeking appropriate treatment and support.³²

Social isolation and marginalisation

- 7.32 The stigma of drug use leads to higher levels of marginalisation of families from their communities and this limits the assistance that arises from isolation.³³ A counsellor for a family support group noted that:

As families disconnect from friends and society, they become increasingly cut off from critical sources of support. Support is exactly what families need most. In some extreme cases, family members become house bound.³⁴

- 7.33 Other siblings are often unable to have their friends visit the family home due to the unpredictability of the using member's behaviour.³⁵ A mother told the committee that:

As my son's behaviour and drug use escalated fewer family and friends came to visit our home or include us in social activities in case he came. We had little respite and on reflection as I write I can see my younger children locked themselves away in their rooms, no longer eating together as a family, no longer watching TV together or talking together. We would covet brief times together away from him to share school activities, illnesses, fear, loneliness or wonder where our belongings had gone to. Sometimes we would cry together, hug and just hope everything would change. For many years nothing changed except to worsen.³⁶

31 Families and Friends for Drug Law Reform, submission 122, p 4.

32 Ravesi-Pasche A, submission 47, p 2; Koningen S, Gold Coast Drug Council, transcript, 7 March 2007, p 4.

33 Victorian Alcohol and Drug Association, submission 100, pp 8–9; Chang T, submission 28, p 4; Family Drug Support, submission 15, p 3.

34 Chang T, submission 28, p 4.

35 Centacare Catholic Family Services, submission 116, p 6; Ravesi-Pasche A, submission 47, p 3.

36 Quon M, submission 8, p 3.

- 7.34 Another mother described the social isolation she felt because of her husband's drug addiction:

When my husband was using heroin and became a walking corpse, there was nothing I could do to stop or control what was happening to our once perfect life. I experienced so much judgement from those around me including other health professionals that I stopped talking about my home life consequently I lived in social isolation, carrying the shame of having 'made the choice to love someone who was dependent on heroin'.³⁷

Health impacts on family members

- 7.35 Many parents told the committee how their own health was adversely impacted by a family member's drug use.³⁸ The South Australian Government noted that there was strong evidence that the experience of living with drug use in the family can cause high levels of stress and this can result in a range of physical and psychological health problems.³⁹
- 7.36 The Catholic Women's League of Australia summarised the impact of a family member's drug use on the mental health of other family members:

The incredible mood swings, and dangerous, erratic and unpredictable behaviour of the addict, has family, friends and colleagues walking on egg-shells. Living with an addicted person is a recipe for madness that frequently results in nervous breakdown and serious physical illness in people riding the roller coaster of pain and uncertainty that is the daily experience of those living with addiction.⁴⁰

- 7.37 A mother of a drug user wrote of her sustained and high level anxiety:

It got to the stage I was too nervous to answer the front door in case it was a police officer to say my son had overdosed. I would not answer the telephone due to the threatening phone

37 Ravesi-Pasche A, submission 47, p 2.

38 Raeside L, Parent Drug Information Service, transcript, 14 March 2007, p 54; Odyssey House Victoria, submission 111, p 10; Australian Drug Foundation, submission 118, p 5; Name withheld, submission 20, p 2; Name withheld, submission 56, p 2.

39 South Australian Government, submission 153, p 10.

40 Catholic Women's League of Australia, submission 35, p 4.

calls from strangers, there were nights that I would leave it off the hook. My stomach was constantly in a knot.⁴¹

7.38 Another reported:

My current health situation seems to have been affected by the stress of three years ago. I am now at risk of a stroke due to an irregular heart beat because of the stress of five-six years of uncertainty regarding my son's life.⁴²

7.39 Many affected family members reported that they had sought counselling or were taking medication in order to cope with stress, depression and anxiety.⁴³

7.40 Families also told the committee about a range of other medical conditions that they attributed to drug use by a family member including strokes, high blood pressure, heart conditions and panic attacks.⁴⁴ A family also noted how the constant strain within a family experiencing problematic drug use can mask other serious health problems:

My parents' relationship was always under an amazing amount of strain. The consistent stress helped to mask my father's illness (Alzheimer's Disease) for a considerable time as everyone assumed his illness was 'stress related' due to my brother.⁴⁵

7.41 Drug use in the home can also pose a serious safety risk to others in the domestic environment, which can contain equipment to use or manufacture drugs. One mother reported, for example, 'We have had many spoons bent, sheets and towels burnt as a result of our son falling asleep whilst smoking'.⁴⁶ Another told the committee:

I personally sustained a needle stick injury with the blood filled syringe as I was going through my child's things searching for drugs and drug paraphernalia. That would have been the most harrowing three months of my life

41 Mary, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 12.

42 Name withheld, submission 2, p 2.

43 Name withheld, submission 20, p 2; Alcohol and Drug Foundation ACT, submission 123, p 3.

44 Name withheld, submission 2, p 2; Name withheld, submission 56, p 2; Family Matters SA, submission 158, p 2.

45 Name withheld, submission 70, p 2.

46 Name withheld, submission 68, p 1.

waiting for the end results from that. To me that is totally unacceptable and unwarranted.⁴⁷

Culturally and linguistically diverse families

- 7.42 While research has shown that illicit drug use is lower among culturally and linguistically diverse (CALD) populations, data also suggests that CALD clients are underrepresented in treatment services.⁴⁸
- 7.43 The Drug and Alcohol Multicultural Education Centre considered that additional shame and isolation was experienced by these families due to cultural perceptions surrounding drugs:
- Among many CALD communities in Australia there is a self-reliant approach when dealing with personal or familial problems. Often CALD families will attempt to hide the drug use, which can further exacerbate family depression, turmoil and angst, as well as family conflict and breakdown.⁴⁹
- 7.44 The centre further observed that CALD communities face obstacles to recognise that a problem exists, including:
- ...shock, feelings of parental failure, embarrassment, family depression, inability to talk about the issues, and illicit drug often being a taboo topic of discussion.⁵⁰
- 7.45 The use of professional services to assist in the rehabilitation and recovery of an addicted family member may be limited by several factors including a lack of culturally appropriate translated material and non-specialist interpreters or bilingual workers in treatment services.⁵¹ Further, professional and effective family intervention can be hindered by the likelihood that:
- ...they or people in their community are more likely to tolerate stress as a matter of personal sacrifice for their drug-affected children. This belief may be supported by religious or cultural beliefs.⁵²

47 Smith L, Toughlove, transcript, 3 April 2007, p 4.

48 Drug and Alcohol Multicultural Education Centre, submission 90, p 2.

49 Drug and Alcohol Multicultural Education Centre, submission 90, p 1.

50 Drug and Alcohol Multicultural Education Centre, submission 90, p 2.

51 Drug and Alcohol Multicultural Education Centre, submission 90, p 2.

52 UnitingCare Burnside, submission 99, p 6.

- 7.46 To overcome these barriers, culturally relevant treatment approaches are required. The committee also notes the concerns of some CALD community organisations that sensationalised portrayals of ethnic stereotypes in the media can impact negatively on community perceptions, 'as was the case in the 1990s with the Indo-Chinese community and heroin use and recently Arabic youth in Lakemba'.⁵³

Indigenous families

- 7.47 In Indigenous communities the concept of family is fundamental to identity. A 'family systems theory' approach recognises that families are a complex system of interdependent parts, each of which affects the other.⁵⁴ In the stress-strain-support model used earlier in this chapter, Centacare NT notes the ability to:
- ...incorporate a spiritual component which is compatible with traditional cultural practices and beliefs...in particular the model provides opportunity for group sharing and support which has proved to be a valuable part of the program.⁵⁵
- 7.48 The influence of the family environment in Indigenous communities is strong, with the Royal Australasian College of Physicians noting that connections to the immediate and extended family are significant and culturally expected.⁵⁶
- 7.49 Broader social influences are also important, with the effects of illicit drug use on Indigenous families needing to be understood in the context of unresolved intergenerational trauma, ongoing racism, frustration, and entrenched disadvantage.⁵⁷
- 7.50 One aspect of the complexity of Indigenous families was provided by Centrelink in its submission:
- In the Alice Springs region the nature of Aboriginal child-rearing practices can mean that extended family members are caring for several children other than their own. In particular, anecdotal evidence indicates that there are many Indigenous

53 Drug and Alcohol Multicultural Education Centre, submission 90, p 3.

54 Centacare NT, submission 60, p 7.

55 Centacare NT, submission 60, p 8.

56 The Royal Australian College of Physicians, submission 119, p 16.

57 Relationships Australia, submission 143, p 5.

grandmothers caring for large numbers of children (six and over is not uncommon).⁵⁸

- 7.51 The committee welcomes the Commonwealth's recent actions to address child protection issues in the Northern Territory, many of which are caused by illicit drug use.

Impact on parents

- 7.52 Several inquiry participants noted that the stress of having a child in the family using drugs often had a significant negative impact on the relationship between parents. In some cases, this led to separation, leaving an even greater burden on the remaining parent.⁵⁹ The Alcohol and Drug Foundation ACT told the committee that:

Some parents agreed that their relationship had become stronger as they were able to support each other. Others talked about the arguments, and... in the end, the strain becoming too much for their relationship.⁶⁰

- 7.53 In some cases, the despair experienced by parents led to them considering desperate solutions, including suicide.⁶¹ A volunteer with Family Drug Help told the committee that:

Many callers to the help line are often so depleted by the time they desperately reach out for help that they will openly talk of suicide as they can see no other way out of their situation. We are talking here of the parents, not the person using drugs!⁶²

- 7.54 Many parents told the committee in their own words how dealing with drug use in the family affected them. A selection of their stories in their own words is included in box 7.1.

58 Centrelink, submission 128, p 3.

59 Odyssey House Victoria, submission 111, p 10; Alcohol and Drug Foundation ACT, submission 123, p 4, Youth Substance Abuse Service, submission 87, p 6, Australian Drug Foundation, submission 118, p 7; Australian Psychological Society, submission 131, p 3; Australian Institute of Family Studies, submission 103, p 3.

60 Alcohol and Drug Foundation ACT, submission 123, p 4.

61 UnitingCare Burnside, submission 99, p 6; Mary, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 12; Hayes H, submission 51, p 1.

62 Kerlin G, submission 62, p 1.

Box 7.1 A selection of parents' stories

We had received a phone call from our son one night and knew he was very low. He had been walking the streets for hours, he was upset, had no money and no friends. He wanted to come home. Seeing my beautiful tall, handsome, and intelligent son slumped in an inner west fast food outlet so alone and disorientated was the saddest night of my motherhood. I cannot describe to anyone my feelings; my absolute despair... we were living every parent's nightmare.

Source Name withheld, submission 56, p 2.

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*What is the personal cost? How do you begin to describe the loss of a child through an overdose? How do you explain to your boss the real cause of why your work is suffering? How do you cope with the endless sleepless nights, wondering where your child is and if they are safe, continually feeling fearful about what they are doing to themselves and maybe what they are doing to you? And what of the impact on the rest of the family, the other siblings and society in general? How do you cope with the theft, lying and deceit? We are parents and we love our children. We never want to give up on them.*

Source Smith L, transcript, 3 April 2007, p 3.

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My son had no concept of what his addiction was doing to the family and me. He was consumed in his drug use; he couldn't see the ripple in the pond effect on the family. Parents and siblings experience an intense range of emotions and often feel helpless. On many occasions I longed to share the rollercoaster of emotions I was experiencing with somebody outside the family, to relieve the pressure on other family members who too were feeling the strain. As a family you can only discuss so much before you begin going round in circles, causing disharmony and unwanted tension between the remaining family members.

Source Name withheld, submission 51, p 1.

Impact on siblings

7.55 There can often be resentment by siblings towards the addict for causing problems within the family, and towards parents for what is perceived as poor handling of the situation.⁶³ A sibling described how

63 Chang T, submission 28, p 4; Youth Substance Abuse Service, submission 87, p 6.

having a drug-addicted brother or sister had impacted on their own ability to enjoy friendships:

As a teenager with a drug-affected brother I was definitely restricted to certain activities, for example the ability of having friends to socialise at my home as restricted due to my brother's behaviour.⁶⁴

7.56 There is also often a degree of jealousy at the amount of attention that the addicted sibling is receiving, to the detriment of the non-addicted sibling/s.⁶⁵ Relationships Australia noted that:

...other family members such as siblings are also often the forgotten victims due to their emotional needs being sacrificed in order to meet the more urgent needs of their substance-abusing brother or sister.⁶⁶

7.57 Some parents were able to recognise how their sons and daughters missed out on opportunities because of a sibling's drug use. A mother told the committee how she had to make a conscious decision to ensure that all her children received the love and support they needed:

You put so much time and energy into trying to fix the problems of the oldest two that you seem to forget that you have another two children there. They are not doing anything wrong: their schoolwork is fine, their work is fine, their friends are fine and they are doing everything right. And then one day it just hits you: 'What about these other kids? I have forgotten that I have four children.' I made a conscious decision one day and said: 'I have put too much time and too much energy into trying to fix the problem with my two older ones. I am now going to concentrate on my youngest ones and give them what they have missed out on for the last few years'.⁶⁷

7.58 The committee also heard stories of siblings witnessing disturbing events and incidents as a result of their brother's or sister's drug use,

64 Name withheld, submission 70, p 1.

65 See for example, Alcohol and Drug Foundation ACT, submission 123, p 4; Families Australia, submission 152, p 12.

66 Relationships Australia, submission 143, pp 3-4.

67 Smith L, Toughlove, transcript, 3 April 2007, p 10.

including physical violence and aggression.⁶⁸ A mother told the committee:

My daughter was traumatised. She found him gasping and twisted in pain dying in front of her. Level headed she called me, phoned 000 and helped try to revive him. No younger sister should have to revive their brother.⁶⁹

7.59 Siblings moving away or seeking respite from the family was a common occurrence for some families.⁷⁰ A parent told the committee that 'older siblings may move away from the family prematurely to avoid the horrible fights, theft, physical assault and constant emotional turmoil'.⁷¹ Where siblings stayed, there was a risk that the breakdown in the boundaries of what was acceptable behaviour could lead to some siblings following a similar path into drug use.⁷²

7.60 One mother noted how two of her children were negatively affected by their brother's drug use:

My youngest son, desperate to deal with his pain at the loss of his brother, resorted back to drugs, leaving a path of financial and personal ruin. He is now having to face and deal with that. My daughter, who won a music scholarship in a renowned secondary school and had plans to become a lawyer, is now failing Year 11 and considering leaving school due to chronic depression and an inability to concentrate.⁷³

7.61 Another mother had a similar story:

One child became seriously depressed mainly because of her inability to make our daughter well. The other sibling lost focus, left school early, worked in lowly paid unskilled employment, did not complete her education and became a major marijuana user. Five years passed in this way before she accessed further education and gained stability in her life.⁷⁴

68 Name withheld, submission 165, p 6; Name withheld, submission 70, p 2; Smith L, Toughlove, transcript, 3 April 2007, p 13.

69 Quon M, submission 8, p 6.

70 Name withheld, submission 29, p 1.

71 Miller T, submission 78, p 2.

72 Miller T, submission 78, p 2; see also the discussion in chapter two.

73 Russ C, Drug Free Australia, transcript, 28 May 2007, p 6.

74 Name withheld, submission 77, p 1.

7.62 The siblings of children using drugs have been traditionally overlooked by support services.⁷⁵ Some of the programs targeting siblings were examined in chapter six.

⁷⁵ Family Drug Help, submission 76, pp 6–7; Youth Substance Abuse Service, submission 87, p 6.

Drug-induced psychoses and mental illness

- 8.1 The co-occurrence of drug use and mental illness is referred to as a 'dual diagnosis' or 'comorbidity', including where the illness is a consequence of illicit drug use.
- 8.2 Dual diagnosis represents further challenges for families by intensifying the range of concerning behaviours they have to cope with, some of which may be physically threatening. In addition to assuming an increased burden of care, families may also be affected by increased stress and worry about their family member's ability to function and have any expectation of recovery.
- 8.3 In a clinical sense, 'dual diagnosis' or 'comorbidity' can refer to the co-occurrence of any two mental disorders in an individual. Indeed, under many diagnostic classifications, illicit drug addiction is categorised as a type of mental disorder alongside diagnoses such as anxiety, depression, personality disorders and psychotic disorders. 'Comorbidity' commonly refers, however, to drug use co-occurring with another or several mental health issues, and it is in this sense that it is used here.¹

Prevalence of dual diagnosis

- 8.4 Illicit drugs are associated with a range of mental disorders including:
 - depression;

1 Teesson M and Proudfoot H, eds, National Drug and Alcohol Research Centre, *Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment* (2003), p 10.

- anxiety disorders (including panic disorder, agoraphobia, social phobia and obsessive compulsive disorder);
- drug-induced psychoses and longer term chronic psychotic illnesses, including schizophrenia and bipolar affective disorder;
- eating disorders; and
- mania.

8.5 In the public mind the group of mental disorders most commonly associated with illicit drugs is schizophrenia and other psychoses. Psychosis has a clearly debilitating impact on drug users, and places enormous demands on frontline workers, families and the public health system. There is also public concern about rising levels of crystal methamphetamine or ice use in Australia, a potent drug associated with violent psychosis.² It is worth noting, however, that in terms of rates of prevalence, anxiety and depression are the disorders most reported by users of illicit drugs.³

8.6 Unlike in the United States, where large scale population surveys have been conducted, there is no definitive data set in Australia to tell us how prevalent co-occurring illicit drug use and mental disorders really are.⁴ This is because diagnoses can vary, where users are diagnosed at all, and treatment services are rarely integrated and can differ between states and territories. There are also some definitional issues about what qualifies as 'comorbidity'. The National Youth Affairs Research Scheme identified in 2004 that:

...the frequent use of different terminologies, such as 'mental health disorder', 'mental illness', 'mental health problem' and 'mental health issue' to explain a range of conditions, also serves to exacerbate confusion as to what exactly is defined as a valid mental health condition that can then be diagnosed as comorbidity when placed alongside problematic substance use.⁵

2 Australian National Council on Drugs, *Methamphetamines: Position paper* (2006), p 4.

3 Hall W, 'Comorbidity: A different picture', *Of Substance* (2006), vol 4, no 2, p 2; Teesson M and Proudfoot H (eds), National Drug and Alcohol Research Centre, *Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment* (2003), p 143; Murphy T, transcript, 14 March 2007, p 1.

4 Australian Institute of Health and Welfare, *National Comorbidity Initiative: A review of data collections relating to people with coexisting substance use and mental health disorders* (2005), cat no PHE 60, p 46.

5 Szirom T et al, National Youth Affairs Research Scheme for the Australian Government Department of Family and Community Services, *Barriers to service provision for young people with presenting substance misuse and mental health problems* (2004); Australian Institute of Health

- 8.7 Nevertheless, a range of data sources suggests that dual diagnosis is a problem for a significant proportion of illicit drug users and their families. These include self-reporting on mental health by drug users through the National Drug Strategy Household Surveys and Illicit Drugs Reporting System; national morbidity, mental health and hospital data; and reporting by service providers on clinical populations. The committee has also received a substantial number of submissions from families with experience of caring for someone with a dual diagnosis.
- 8.8 In 2004, 9.1 per cent of Australians were diagnosed or treated for a mental illness in the last 12 months, inclusive of depression, anxiety, bipolar disorder, an eating disorder, schizophrenia, and other forms of psychosis. Of those who had used an illicit drug in the last month, this figure was substantially higher: 16.0 per cent for ecstasy users, 16.5 per cent for cannabis users, 19.8 per cent for meth/amphetamine users, and 50.1 per cent for heroin users.⁶
- 8.9 Those who had used illicit drugs in the last month reported double the rate of high or very high levels of psychological distress compared to the general population.⁷ Most notably, 31.1 per cent of recent users of methamphetamines and 64.9 per cent of recent heroin users reported high or very high levels of psychological distress, as against 9.9 per cent of the general population.⁸
- 8.10 In a 2006 survey of 914 injecting drug users, 38 per cent reported experiencing a mental health problem other than drug dependence in the six months preceding interview. The most commonly reported mental health problems were depression (27 per cent of the sample) and anxiety (14 per cent). Twenty-seven per cent of the sample reported using antidepressants in the previous six months, against approximately five per cent of the general population.⁹ Drug-induced psychosis, schizophrenia,

and Welfare, *National Comorbidity Initiative: A review of data collections relating to people with coexisting substance use and mental health disorders* (2005), cat no PHE 60, p 62.

6 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 99.

7 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, pp 100–101.

8 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, pp 100–101.

9 Australian Bureau of Statistics, *National Health Survey: Summary of Results Australia, 2004-05* (2006), cat no 4364.0.

panic, manic depression, paranoia, obsessive compulsive disorder and phobia were each reported by 5 per cent or less of the national sample.¹⁰

- 8.11 Counselling, treatment and service providers confirmed to the committee that there is a sizeable level of dual diagnosis amongst their clients. Theo Chang, a counsellor with Family Drug Support, reported that, 'a significant amount of families who access [our] services are dealing with the coexistence of drug use and mental disorders'.¹¹
- 8.12 King Edward Memorial Hospital for Women in Perth also said that they were dealing with women with dual diagnoses, and that, 'evidence now suggests that substance use among patients with mental disorders must be considered as usual rather than exceptional.'¹² The Australian Psychological Society reiterated this point, stating that, 'we need to accept that co-occurring disorders are the expectation, rather than the exception amongst substance users'.
- 8.13 Prevalence rates of drug use involvement in mental health settings have been consistently reported at between 30 and 80 per cent (inclusive of alcoholism).¹³ A range of similar estimates exist in the literature and in the evidence provided to the committee:
- The Australian Psychological Society estimated that the proportion of people in each clinical population with comorbid mental health and drug use disorders ranged from 50 to 90 per cent.¹⁴
 - Dawe, Harnett and Frye reported that co-occurring mental disorders, in particular depression, were high, with rates of 40 to 70 per cent of drug-using populations.¹⁵
 - NSW Health reported in 2000 that depending on the population sample, 30 to 80 per cent of people with mental disorders had a coexisting drug use disorder.¹⁶

10 O'Brien S et al, National Drug and Alcohol Research Centre, *Australian drug trends 2006: Findings from the Illicit Drug Reporting System (IRDS) (2007)*, pp 140, 151.

11 Chang T, submission 28, p 5.

12 King Edward Memorial Hospital for Women, submission 19, p 5.

13 Hegarty M, Mental Health Co-ordinating Council (NSW) and the Department of Community Services (NSW), *Mind the gap: The National Illicit Drug Strategy (NIDS) project to improve support for children from families where there are mental illness and substance abuse (MISA) issues - Literature review (2004)*, Australian Government Department of Family and Community Services, p 2.

14 Australian Psychological Society, submission 131, p 9.

15 Dawe S et al, submission 80, p 3.

16 NSW Health, *The management of people with a co-existing mental health and substance use disorder: Discussion paper (2000)*, p 1.

- The National Youth Affairs Research Scheme in 2004 suggested even higher rates of comorbidity, from 10 to 40 per cent for some services to 70 to 90 per cent in others.¹⁷
- 8.14 There is some evidence that women drug users are more at risk of mental illness than male drug users.¹⁸ A national study of women drug users conducted by Swift, Copeland and Hall in 1996 found that 27 per cent had previously been hospitalised for a psychological problem; 48 per cent had received counselling for problems such as depression and anxiety; 56 per cent had experienced eating disorders, 26 per cent had engaged in self-harm behaviours; and 44 per cent had attempted suicide, an average of 2.4 times.¹⁹
- 8.15 Given the data gaps that currently exist and the variation in reported rates of dual diagnosis, it is difficult to tell whether they are increasing over time. NSW Health, in the report mentioned above, cited a ‘worrying trend’ of increasing prevalence of dual diagnosis. Speculative reasons advanced for this included the fact that de-institutionalisation had brought many mental health patients into contact with drug cultures on the streets; that rates of mental illness were increasing in Australian society, with a corresponding increasing risk for drug use; and that clinicians were more aware of the issue and were possibly diagnosing it more often.²⁰
- 8.16 As many as half of the submissions to this inquiry from individuals mention the association between mental illness and the illicit drug use of a family member or their own drug use.²¹ Half of these again refer to cases of psychosis, from direct drug-induced psychoses to the development of schizophrenic or bipolar disorders.²² Many others refer to depression and anxiety in conjunction with illicit drug use.²³

17 Szirom T et al, National Youth Affairs Research Scheme for the Australian Government Department of Family and Community Services, *Barriers to service provision for young people with presenting substance misuse and mental health problems* (2004), p 2.

18 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 46.

19 Swift W et al, ‘Characteristics of women with alcohol and drug problems: Findings from an Australian national survey’, *Addiction* (1996), vol 91, pp 1141-1150, cited in Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 47.

20 NSW Health, *The management of people with a co-existing mental health and substance use disorder: Discussion paper* (2000), p 6.

21 See for example Name withheld, submission 106, p 2; Toughlove Victoria, submission 112, p 3; Hersee P, submission 48, p 2; Chang T, submission 28, p 5; Bowman D, submission 38, p 1; Ravesi-Pasche A, submission 47, p 5; Morrissey J, submission 12, p 1.

22 See for example Name withheld, submission 2, p 1; Lowy S and M, submission 11, p 1; Toughlove Victoria, submission 112, p 4; Name withheld, submission 162, p 1; Ryan W and P,

- 8.17 This is not, of course, representative of all drug users or all families affected by drug use, and the committee prompted comment on psychosis through this inquiry's terms of reference. The high number of mentions of mental illness in families' stories, however, is likely to indicate that comorbidity is not uncommon, and that where it does occur, the family bears significant additional costs.

Connections between illicit drug use and mental illness

- 8.18 While there is near universal scientific consensus that there are strong connections between illicit drug use and mental illness, the causality in these connections is still a matter of contention.
- 8.19 There are a number of general theories advanced about the relationship between illicit drug use and mental illness:
- illicit drug use and mental illness are not necessarily causally related at all; rather, their presence together is rendered more likely by confounding variables or common risk factors and life pathways.²⁴ For example, evidence suggests that factors such as social disadvantage, parental psychiatric illness, family dysfunction and alcohol and tobacco use increase the likelihood of both illicit drug use and mental illness;²⁵
 - drug users have pre-existing mental health issues that they 'self-medicate' with drugs – that is, that mental illness is pre-existing and drug use is a consequence rather than a contributory factor. Users may continue to 'self-medicate' even when the chosen 'medicine' is not efficacious. In many cases, illicit drug use will exacerbate pre-existing symptoms;
 - illicit drug use causes or contributes to mental illness in individuals with a genetic vulnerability. For example, in those with a family history

submission 43, p 1; Name withheld, submission 3, p 1; Nikolaidis D, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 32.

23 See for example Name withheld, submission 145, p 14; Hidden R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 4; Name withheld, submission 161, p 1.

24 Hall W and Deghenhardt L, 'What are the policy implications of the evidence on cannabis and psychosis?' *Canadian Journal of Psychiatry* (2006), vol 51, no 9, p 566.

25 Teesson M and Proudfoot H, eds, National Drug and Alcohol Research Centre, *Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment* (2003), pp 18-19.

of mental health problems, it may contribute to an early onset, increase the severity of the disease or prolong the duration of symptoms; or alternatively

- illicit drug use directly causes and contributes to mental illness that would not have occurred in the absence of drug use.²⁶

- 8.20 The ‘self-medication’ hypothesis was invoked by a number of service providers and individuals who gave evidence to the inquiry.²⁷ Evidence for this hypothesis is not strong, however. The Parliamentary Library, considering the evidence on cannabis and mental illness, concluded that most research which has specifically examined the self-medication hypothesis is weak.²⁸ Rey and Tennant of the University of Sydney found that although the number of studies examining cannabis and mental illness was small, they ‘provide little support for the belief that the association between marijuana use and mental health problems is largely due to self-medication’.²⁹ Degenhardt, Hall, and Lynskey observed that there was ‘less than compelling evidence’ that drug users used specific drugs to ameliorate specific characteristics of their mental illness; rather, that patterns of drug use amongst the mentally ill were similar to those found in the general population.³⁰
- 8.21 There is stronger support for the theory that drugs exacerbate pre-existing mental conditions, or precipitate illness in vulnerable individuals.³¹ That is, ‘while the majority of cannabis users will not develop mental illnesses as a consequence of their cannabis use, a vulnerable minority appear to be at risk of experiencing harmful outcomes’.³² A person may be vulnerable

26 Buckmaster L and Thomas M, Parliamentary Library, *Research note - Does cannabis lead to mental-health problems?: Findings from the research* (2007), no 21, p 1.

27 Ravesi-Pasche A, submission 47, pp 5–6; Glastonbury Child and Family Services, submission 74, p 8; The Sydney Women’s Counselling Centre, submission 36, p 4; McIntyre R, submission 81, p 2.

28 Buckmaster L and Thomas M, Parliamentary Library, *Research note - Does cannabis lead to mental-health problems?: Findings from the research* (2007), no 21, p 2.

29 Rey J and Tennant C, ‘Editorial - Cannabis and mental health: more evidence establishes clear link between use of cannabis and psychiatric illness’, *British Medical Journal* (2002), no 325, p 1183.

30 Degenhardt L et al, ‘What is comorbidity and why does it occur?’ in Teesson M and Proudfoot H, eds, National Drug and Alcohol Research Centre, *Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment* (2003), p 15.

31 Buckmaster L and Thomas M, Parliamentary Library, *Research note - Does cannabis lead to mental-health problems?: Findings from the research* (2007), no 21, p 2; Jorm A and Lubman D, ‘Promoting community awareness of the link between illicit drugs and mental disorders’, *Medical Journal of Australia* (2007), no 186, p 5.

32 Buckmaster L and Thomas M, Parliamentary Library, *Research note - Does cannabis lead to mental-health problems?: Findings from the research* (2007), no 21, p 3.

because of their genetic history. There is particular evidence that cannabis use precipitates schizophrenia in people who have a family history of that illness.³³ In a person already showing symptoms of a mental illness, illicit drug use will invariably worsen those symptoms.³⁴

- 8.22 Ryan Hidden, a former drug user who gave evidence to the committee, felt that he was predisposed to depression and anxiety, but that illicit drugs exacerbated the severity of his symptoms and their impact on his ability to function:

While I had exhibited behaviours that could be diagnosed as a mental illness in the past, such as depression and anxiety and of course violence, it was nothing in comparison to how I ended up. With nothing to do besides smoke marijuana and use other drugs, as by this time I had progressed on to MDMA and methamphetamine... I quickly deteriorated into social phobia and was verging on agoraphobia.³⁵

- 8.23 Similarly, a mother wrote that:

Our eldest son began experimenting with marijuana when he was about 15. For the past two years he has been suffering from mild to moderate psychosis which while there is no evidence that it is drug-induced, it has been amplified by drug use.³⁶

- 8.24 Finally, illicit drugs may induce mental illnesses that may not otherwise have been present. Much of the research on links between illicit drugs and mental illness examines cannabis and psychosis specifically.³⁷ Neurological research, revealing the short and long-term effects of illicit drugs on the brain's mood, behaviour and cognition systems, suggests that the direct causal hypothesis is biologically plausible.

- 8.25 Recent evidence suggests that the timing of drug exposure may be critical, with one study finding, for example, that cannabis increased the risk of later psychosis if consumed in adolescence.³⁸ Those users who were the

33 Mental Health Council of Australia, *Where there's smoke...: Cannabis and mental health* (2006), p 7.

34 Mental Health Council of Australia, *Where there's smoke...: Cannabis and mental health* (2006), p 11, p 29.

35 Hidden R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 2.

36 Toughlove Victoria, submission 112, p 4.

37 Fergusson D et al, 'Cannabis and psychosis', *British Medical Journal* (2006), no 332, pp 172.

38 Jorm A and Lubman D, 'Promoting community awareness of the link between illicit drugs and mental disorders', *Medical Journal of Australia* (2007), no 186, p 5.

earliest, together with heavy users, are considered at greatest risk of later mental disorders.³⁹ Adolescence is a critical period of vulnerability, and neurobiological research is now suggesting that brain structure and function continue to mature until the mid-twenties. The ‘remodelling’ of brain tissues in adolescence is thought to be especially pronounced in brain regions associated with regulating our emotions and behaviours, so disruption of this process may have implications for mental health.⁴⁰

Box 8.1 What is psychosis?

Psychosis is a condition in which a person loses contact with reality. Symptoms of psychosis include seeing or hearing things or people that are not there (hallucinations), feeling everyone is against them (paranoia), and having beliefs that are not based on reality (delusions).

Many people can experience a single psychotic episode, perhaps in response to a traumatic event, and recover fully. Others may develop a chronic psychotic illness.

Drug-induced psychosis refers to psychotic symptoms associated with the use or withdrawal from drugs. Usually, the symptoms will resolve as the effects of the drugs wear off.

The two major psychoses are schizophrenia and bipolar disorder.

Schizophrenia is a mental illness characterised by a disintegration of the process of thinking, of contact with reality, and of emotional responsiveness. Schizophrenia is diagnosed only if symptoms persist for a period of time. The illness can spontaneously remit, run a course with infrequent or frequent relapses, or become chronic.

Bipolar disorder, which used to be known as manic depression, is characterised by both periods of depression (feeling low) and mania (high). People with bipolar disorder experience extreme moods that can change regularly and may not relate to what is happening in their lives, although their mood swings may be triggered by certain events.

Source Parliamentary Library, Oxford Reference Online, Early Psychosis Prevention and Intervention Centre, Beyondblue, SANE Australia.

39 Jorm A and Lubman D, ‘Promoting community awareness of the link between illicit drugs and mental disorders’, *Medical Journal of Australia* (2007), no 186, p 5.

40 Lubman D and Yücel M, ‘Drugs and adolescent development: Insights from neuroscience’, *Of Substance* (2006), vol 4, no 2, pp 18–19.

Mental disorders commonly associated with illicit drugs

8.26 Illicit drugs are associated with a range of mental disorders. This section examines the disorders associated specifically with cannabis, meth/amphetamines and ecstasy - the three most commonly used illicit drugs in Australia.⁴¹

Cannabis

8.27 As noted previously, cannabis has long been promoted as a benign drug by drug industry elites in Australia and internationally. The committee notes, however, an increasing number of cannabis users seeking drug treatment and was extremely concerned by the evidence received about the risks of cannabis use. Changing community attitudes towards the drug may in part reflect increasing awareness of the links between cannabis and mental illness.⁴²

8.28 In the short term, cannabis use induces mood changes, which may include feelings of panic, anxiety, mild paranoia and hallucinations, particularly in heavy users.⁴³ Some people may experience acute transient psychotic symptoms such as hearing voices and unwarranted feelings of persecution.⁴⁴ There is increasing evidence, as well, that cannabis contributes to psychoses (including schizophrenia), depression and anxiety in the longer term, although this area of research is still in development.⁴⁵

Cannabis and psychosis

8.29 There is a strong association between cannabis and psychosis. The Mental Health Council of Australia reports that among people with mental illness, particularly psychosis, the rates of cannabis dependence are significantly higher than the general community.

41 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, pp 33–34.

42 Pfizer Australia, with the National Drug and Alcohol Research Centre, *Australians and cannabis* (2007), Health Report no 33.

43 SANE Australia, 'Cannabis and psychotic illness: Fact sheet' (2007), viewed on 28 June 2007 at http://www.sane.org/information/factsheets/cannabis_and_psychotic_illness.html.

44 Australian Medical Association, 'Position statement: Cannabis' (2006), viewed on 30 May 2007 at <http://www.ama.com.au/web.nsf/doc/WEEN-6WP6MH>.

45 Buckmaster L and Thomas M, Parliamentary Library, *Research note - Does cannabis lead to mental-health problems?: Findings from the research* (2007), no 21, p 1.

- 8.30 In an Australian study conducted in 2000, Jablensky and others found that 24 per cent of people with psychotic disorders in contact with treatment services had used cannabis at least weekly for the past six months.⁴⁶ This study showed weekly cannabis use to be 3.3 times more prevalent among people with psychosis than among the general population.⁴⁷
- 8.31 The committee received a number of submissions referring to psychosis deriving from cannabis use, three of which are quoted below:
- My son's drug use began in university and continued for about five-six years. I believe his drugs of choice were marijuana and alcohol. The innocent marijuana, the soft social drug. The drug that is legal in some countries eventually caused psychosis in my son.⁴⁸
 - June is in her forties and she is caring for an elderly mother. About 12 months ago her 19 year old son Sam, who was living with his father, experienced a drug-induced psychosis. He had become paranoid and believed his father was leading a campaign against him, involving police and spy agencies. He also reported feeling disconnected from his body as though his mind was floating freely. He was hospitalised until stabilised on medication. June knew he had been using marijuana but did not know that he was smoking up to four times per day.⁴⁹
 - A family whom I have known most of my life includes two sons, now around 50 years old, who have used drugs on a long-term basis and now have symptoms indistinguishable from schizophrenia. They have been unemployed for nearly 20 years, as a result of dabbling in a multitude of drugs and especially from their long-term use of marijuana. Both receive disability pensions. One is loud but usually gentle. The other is aggressive, capable of violence and speaks in a number of voices when disturbed, some of which are reminiscent of the character in *The Exorcist*.⁵⁰
- 8.32 There is an ongoing debate about causality, however. Studies are usually unable to rule out the possibility that cannabis use was a result of emerging schizophrenia rather than the cause of it, given that

46 Raphael B and Wooding S, 'Comorbidity: cannabis and complexity', *Of Substance* (2004), vol 2, no 1, p 8.

47 Mental Health Council of Australia, *Where there's smoke...: Cannabis and mental health* (2006), p 7.

48 Name withheld, submission 2, p 1.

49 Centrelink, submission 128, p 5.

50 Morrissey J, submission 12, p 1.

schizophrenia is usually preceded by psychological and behavioural changes in the years before diagnosis.⁵¹

8.33 The link between cannabis use and psychosis is biologically sound given what we know about the operation of the active ingredient in cannabis, tetra-hydro-cannabinol (THC). THC interferes with the body's dopamine neurotransmitter systems, the disturbance of which is associated with psychotic disorders.⁵² Researchers from the Institute of Psychiatry in London also found that in tests on human volunteers given THC, there was significantly reduced activity in the frontal lobe, the part of the brain responsible for coordination and emotional behaviour.⁵³

8.34 Recent studies have produced results in favour of cannabis as a causal factor in schizophrenia and other psychotic disorders. Raphael and Wooding, writing in *Of Substance* in 2004, refer to a:

...clinical consensus among mental health professionals that cannabis worsens symptoms and outcomes, probably precipitates and can cause episodes of mental illness such as depression, anxiety and psychosis.⁵⁴

8.35 The writers cited:

Recent research [that] found that cannabis use increased the risk of both the incidence of psychosis in psychosis-free persons and a poor prognosis for those with an established vulnerability to psychotic disorders. In this study, length of exposure to use of cannabis predicted the severity of the psychosis, which was not explained by other drugs. Participants who showed psychotic symptoms at baseline and used cannabis had a worse outcome, implying an additive effect.

Another recent study by Zammit and others reported that 'cannabis use [was] associated with an increased risk of developing schizophrenia, consistent with a causal relation'. In this study, cannabis was associated with an increased risk of developing schizophrenia in a dose dependent fashion both for

51 Australian Medical Association, 'Position statement: Cannabis' (2006), viewed on 30 May 2007 at <http://www.ama.com.au/web.nsf/doc/WEEN-6WP6MH>.

52 Raphael B and Wooding S, 'Comorbidity: cannabis and complexity', *Of Substance* (2004), vol 2, no 1, p 10; also Fergusson D et al, 'Cannabis and psychosis', *British Medical Journal* (2006), no 332, pp 172.

53 Owen J and Goodchild S, 'Simple DIY kit will show mental health dangers of cannabis', *The Independent*, 21 May 2007.

54 Raphael B and Wooding S, 'Comorbidity: Cannabis and complexity', *Of Substance*, vol 2, no 1, p 8.

subjects who had ever used cannabis, and for subjects who had only used cannabis and no other drugs. The finding was most significant for the group who had used only cannabis more than 50 times.⁵⁵

- 8.36 A recent Dutch study of 4,815 individuals, followed up after three years, found that the use of cannabis at baseline increased the risk of mania, with subsequent risk for development of bipolar disorder. This remained true even after adjustment for age, sex, educational level, ethnicity, single marital status, neuroticism, use of other drugs, depressive symptoms and manic symptoms at baseline.⁵⁶
- 8.37 Most recently, *The Lancet* published a comprehensive meta-analysis of the available evidence on cannabis and psychosis, and found that there was an increased risk of psychosis in individuals who had used cannabis, independently of confounding factors and transient intoxication effects (box 8.2).⁵⁷

Box 8.2 *The Lancet recants its earlier position on cannabis*

As recently as 1995, *The Lancet* editorial had begun with the words ‘The smoking of cannabis, even long term, is not harmful to health’. In 2007, the editors recanted this statement, saying that research published in the interim had led them to conclude that cannabis *did* increase the risk of psychotic illness, and that governments ‘would do well to invest in sustained and effective education campaigns on the risks to health of taking cannabis’.

Source ‘Editorial’, *The Lancet* (2007), vol 370, 28 July, p 292.

- 8.38 The committee finds, in contrast, a reluctance amongst members of the drug industry elite in Australia to admit that attitudes have shifted and cannabis can no longer be considered a benign drug. Dr Alex Wodak, for example, a doctor in a position of leadership in the drug industry elite, did not appear to accept that the evidence on cannabis and psychosis is increasingly conclusive, even for users without a prior history of mental illness. Dr Wodak told the committee:

55 Raphael B and Wooding S, ‘Comorbidity: cannabis and complexity’, *Of Substance* (2004), vol 2, no 1, p 10.

56 Henquet C et al, ‘Cannabis use and expression of mania in the general population’, *Journal of Affective Disorders* (2006), vol 95, no 1-3, pp 103–110.

57 Moore T et al, ‘Cannabis use and risk of psychotic or affective mental health outcomes: A systematic review’, *The Lancet* (2007), vol 370, p 319.

In relation to cannabis and psychosis, it is an important question... Two propositions are generally made: firstly that cannabis, when taken by people who have no history of mental illness, can develop a psychosis. The second proposition is that people with an established history of psychosis or severe mental illness can be adversely affected by taking cannabis. I think the majority view on both questions is that the first question is negative, that is, that the cannabis probably does not precipitate severe mental illness in people who have not been previously mentally ill. But there is probably now a majority in favour of the second proposition. Let me say two things about this question. The first is that, in medicine, we commonly argue about the toxicity of drugs for decades before we work out what is really going on... The debate may continue for some decades about cannabis and psychosis.⁵⁸

8.39 Dr Wodak then suggested that should cannabis psychosis be found to exist, it would be best controlled by a regulated system of taxation and distribution similar to that applied to tobacco.⁵⁹

8.40 In another example, a fact sheet on cannabis and psychosis produced by the Australian Drug Foundation has a noticeably less compelling tone than the recent editorial in *The Lancet*:

It has been suggested that heavy cannabis use can cause mental illness such as schizophrenia, but despite significant increases in cannabis use in Australia during the past 30 years, levels of schizophrenia in the population have not increased. There is mounting evidence that regular cannabis use increases the likelihood of psychotic symptoms occurring in an individual who is vulnerable due to a personal or family history of mental illness... People with a family or personal history of psychotic illness should avoid using cannabis.⁶⁰

8.41 Given that such misinformation is being distributed in Australia by many with medical credentials and positions of power in public institutions and non-profit organisations, the committee agrees that public information campaigns about the dangers of cannabis are vital, as recommended in chapter five.

58 Wodak A, transcript, 3 April 2007, p 91.

59 Australian Drug Law Reform Foundation, submission 39, p 26; Wodak A, transcript, 3 April 2007, p 91.

60 Australian Drug Foundation DrugInfo website, 'Cannabis and mental health: The facts', viewed on 26 August 2007 at <http://druginfo.adf.org.au/article.asp?ContentID=cannabismentalhealth>.

Cannabis and depression

- 8.42 The relationships between cannabis and depression and anxiety are less documented than those for cannabis and psychosis.⁶¹ As with psychosis, the association is generally accepted, but the nature of the interaction is still being explored in research.
- 8.43 An American study that followed up 1,920 participants showed that the use of cannabis increased the risk of major depression by fourfold, and that cannabis use was particularly associated with suicidal thoughts and anhedonia (an inability to experience pleasure from normally pleasurable life events).⁶² Similarly, a New Zealand study found that young people who had used cannabis three times or more by the age of 18 were more likely to have a depressive disorder at age of 26.⁶³
- 8.44 A prospective cohort study of 1,601 Victorian school students, published in the *British Medical Journal* in 2002, found that frequent cannabis use in students aged 14-15 predicted later depression and anxiety at age 20, with daily users carrying the highest risk. Daily use in young women, particularly, was associated with a fivefold increase in the odds of reporting later anxiety or depression, although other studies have not found sex differences.⁶⁴ Weekly or more frequent use incurred an approximately twofold increase in risk for later depression and anxiety.⁶⁵
- 8.45 The Australian Medical Association has suggested that the relationship between cannabis and depression can partly be explained by confounding factors such as family and personality factors and other drug use.⁶⁶ That is, cannabis use and depression may have no inherent relationship but be predicated by similar factors such as a background of social adversity, and use of cigarettes, alcohol and other illicit drugs. The study cited above,

61 Moore T et al., 'Cannabis use and risk of psychotic or affective mental health outcomes: A systematic review', *The Lancet* (2007), vol 370, p 319; Australian Medical Association, 'Position statement: Cannabis' (2006), viewed on 30 May 2007 at <http://www.ama.com.au/web.nsf/doc/WEEN-6WP6MH>.

62 Bovasso G, 'Cannabis abuse as a risk factor for depressive symptoms', *American Journal of Psychiatry* (2001), vol 158, pp 2033-2037.

63 Arseneault L et al, 'Cannabis use in adolescence and risk for adult psychosis: Longitudinal prospective study', *British Medical Journal* (2002), vol 325, pp 1195-1198.

64 Rey J and Tennant C, 'Editorial - Cannabis and mental health: more evidence establishes clear link between use of cannabis and psychiatric illness', *British Medical Journal* (2002), no 325, p 1183.

65 Patton G et al, 'Cannabis use and mental health in young people: Cohort study', *British Medical Journal* (2002), no 325, p 1195.

66 Australian Medical Association, 'Position statement: Cannabis' (2006), viewed on 30 May 2007 at <http://www.ama.com.au/web.nsf/doc/WEEN-6WP6MH>.

however, found that the association of depression and anxiety with cannabis use persisted after the results had been adjusted for concurrent use of alcohol, tobacco and other illicit drugs as well as indices of family disadvantage.

- 8.46 Support for the 'self-medication' hypothesis, which would suggest that teenagers were using cannabis in order to medicate pre-existing problems with depression and anxiety, was weak. While earlier cannabis use did predict later depression and anxiety, depression and anxiety at the ages of 14 and 15 did not predict cannabis use at the age of 20, as one would expect if cannabis use developed to cope with emerging mental health problems. In summary, the study concluded:

The persistence of associations in the multivariate models and the evidence for a prospective dose-response relation are consistent with a view that frequent use of cannabis in young people increases the risk of later depression and anxiety... These findings contribute to evidence that frequent cannabis use may have a deleterious effect on mental health beyond a risk for psychotic symptoms.⁶⁷

- 8.47 This evidence is corroborated by a number of submissions received by the committee from people who had observed family members who were chronic users of cannabis struggle with depression and other mood disorders. These quotes are from two mothers, for example:

While using marijuana [from age 18-20 years] my son's mental performance was at his worst; he became paranoid bordering on delusional, moody, deeply depressed and sometimes physically aggressive. The strange part was many people thought they were helping my son's addiction problem by encouraging him to use marijuana or alcohol instead; they associate heroin with overdose and marijuana and alcohol as being harmless. While chronically smoking bongs everyday I witnessed my son becoming increasingly depressed to the point of suicidal thoughts and actions; during that time my son was the least motivated that I had ever seen him; he stayed in bed with this curtains closed the entire day until nightfall then did nothing except eat junk food while watching TV alone in his bedroom.⁶⁸

67 Patton G et al, 'Cannabis use and mental health in young people: Cohort study', *British Medical Journal* (2002), no 325, p 1196.

68 Name withheld, submission 145, p 14.

My son started using cannabis at around 14 years of age - 11 years ago. Over the following three to four years his usage increased. He became moody, depressed, unmotivated, aggressive and out of control.⁶⁹

8.48 Festival of Light recounted a comparable story:

By the time he reached his twenties he had become very depressed. 'He was talking suicide', his parents said. 'We became very alarmed and hid all our guns. We couldn't get through to him. Finally his sister managed to persuade him to give up the marijuana. Now, six months later, he is back to normal. He can now see what it was doing to him - but he couldn't see it at the time'.⁷⁰

Meth/amphetamines

8.49 Meth/amphetamines, including speed, amphetamine, base and crystal methamphetamine or ice are associated with a number of mental health problems, including:

- psychosis (both transient and chronic), characterised by delusions, feelings of persecution and hallucinations;⁷¹
- paranoia;
- depression;
- anxiety disorders;
- panic attacks;
- personality disorders;
- formication (sensation of bugs crawling under the skin);⁷² and
- hostility, aggression and violence.⁷³

69 Name withheld, submission 161, p 1.

70 Festival of Light, submission 85, pp 1-2.

71 McKetin R, McLaren J and Kelly E, National Drug and Alcohol Research Centre, University of New South Wales, with funding from the National Drug Law Enforcement Research Fund, *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences* (2005), pp 109-111.

72 Bryan M, 'On deeper palpation', *Medical Observer Weekly* (2006), 1 December, p 23.

73 Australian National Council on Drugs, *Methamphetamines: Position paper* (undated), p 11; National Drug and Alcohol Research Centre, 'Amphetamines: Fact sheet' (undated).

8.50 A 2005 study of Sydney's methamphetamine market by the National Drug and Alcohol Research Centre found that:

Poor mental health among methamphetamine users was particularly pronounced, with two thirds experiencing some degree of mental health disability and one in five suffering severe disability in their mental health functioning.

Common psychological problems experienced by methamphetamine users included increased aggression, agitation, depression, poor motivation, impaired concentration and memory, and symptoms of psychosis. Self-reported diagnosis of mental disorders also suggested elevated levels of depressive and psychotic disorders among this population.⁷⁴

8.51 There has been greater awareness of methamphetamine psychosis in recent years in Australia, as the increasing use of high purity methamphetamines like ice and base has resulted in a rise in hospital admissions.⁷⁵ A study published in the *Medical Journal of Australia* in 2007 found that the number of hospital separations with drug-induced psychoses as the primary problem increased from 55.5 per million population in 1993-1994 to 253.1 per million population in 2003-2004. Amphetamines accounted for the largest proportion of these, ranging from 41 per cent in 1999-2000 to 55 per cent in 2003-2004.⁷⁶

8.52 The 2005 Sydney study found that psychosis among regular methamphetamine users was eleven times more likely than amongst the general population, and was not restricted to those who have a history of mental health.⁷⁷ As with cannabis, having a history of schizophrenia was a very strong risk factor for experiencing psychosis, but one in five methamphetamine users *without* a history of schizophrenia had experienced clinically significant psychotic symptoms in the last year.⁷⁸

74 McKetin R et al, National Drug and Alcohol Research Centre, *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences* (2005), p xvii.

75 McKetin R et al, National Drug and Alcohol Research Centre, *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences* (2005), p 111.

76 Separations among those aged 10-49 years. Degenhardt L et al, 'Hospital separations for cannabis- and methamphetamine-related psychotic episodes in Australia', *Medical Journal of Australia* (2007), vol 186, no 7, p 343.

77 Alcohol and Other Drugs Council of Australia, 'Drug use and mental health fact sheet for Drug Action Week 2007', viewed on 25 June 2007 at http://drugactionweek.org.au/Drug_use_and_mental_health.html.

78 McKetin R et al, National Drug and Alcohol Research Centre, *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences* (2005), p 109.

- 8.53 Psychotic episodes were strongly related to dependent use. A 2006 study found that even after excluding participants with a history of a psychotic disorder, the prevalence of psychosis among dependent methamphetamine users was 27 per cent, compared with 8 per cent among non-dependent users.⁷⁹
- 8.54 For many methamphetamine users, psychosis will be a transient, albeit severe side effect of heavy use. Symptoms of methamphetamine psychosis usually only last up to two to three hours, but sometimes symptoms become more severe and can last for days.⁸⁰
- 8.55 Methamphetamine psychosis appears to leave a person with an ongoing vulnerability to further episodes of psychosis, even when they re-use with only small quantities of the drug. In some cases, psychosis appears to be retriggered by stress, even when the person is not using methamphetamines anymore.⁸¹ This is possibly due to sensitisation to the effects of the drug caused by its neurotoxic effects on the brain. Studies have shown that heavy use of methamphetamine can permanently damage dopamine neurons and can reduce brain tissue volume.⁸²
- 8.56 Observational studies in humans and animals also tell us that methamphetamine use leads to violent behaviour, particularly in acute doses or in a chronic pattern of use. A 1996 study found that almost half of the methamphetamine users surveyed reported violent behaviour. Identification of the neurobiological pathway between methamphetamine use and aggression is still speculative at this stage.⁸³ However, a 2006 study found that chronic methamphetamine users were found to have higher levels of aggression than people who did not use drugs and decreased levels of serotonin in areas of the brain involved in regulation of aggression.⁸⁴
- 8.57 A former drug user described to the committee his 'taunting, scary and life threatening' journey into mental illness, which included elements of

79 McKetin R et al, 'The prevalence of psychotic symptoms among methamphetamine users', *Addiction* (2006), vol 101, no 10, pp 1473–1478.

80 National Drug and Alcohol Research Centre, 'Methamphetamine psychosis: Fact sheet' (undated).

81 National Drug and Alcohol Research Centre, 'Amphetamines: Fact sheet' (undated); Dore G and Sweeting M, 'Drug-induced psychosis associated with crystal methamphetamine', *Australasian Psychiatry* (2006), vol 14, no 1, p 87.

82 Bryan M, 'On deeper palpation', *Medical Observer Weekly* (2006), 1 December, p 23.

83 McKetin R et al, National Drug and Alcohol Research Centre, 'The relationship between methamphetamine use and violent behaviour', *Crime and justice bulletin* (2006), no 97, p 4.

84 McKetin R et al, National Drug and Alcohol Research Centre, 'The relationship between methamphetamine use and violent behaviour', *Crime and justice bulletin* (2006), no 97, p 4.

psychosis, paranoia and aggression. He had smoked cannabis from the age of 14 and in adult life had become dependent on amphetamines and ice:

After having speed every day and night, I started to begin to accuse my wife of having affairs, people watching me, people crawling in the roofs, police surveillance. Pretty clear I had developed a sickness known as psychosis. My wife was now pregnant with our third child, I had beliefs that this was not my child and began to doubt if the kids that I already had were mine. So I had this plan set out to catch my wife thinking she was having an affair, I had beliefs that she was meeting someone in our home whilst I would be sleeping, so I would take massive amounts of speed to stay up every night and day to pursue this idea that I had developed as a result of abusing the speed on an obscene level.⁸⁵

- 8.58 The use of both amphetamines and cannabis is not uncommon. A Victorian dual diagnosis service, Northern NEXUS, reported that of a sample of clients experiencing problems with cannabis use and mental illness, 40 per cent concurrently used amphetamines and cannabis. The most common psychiatric diagnosis in this group was schizophrenia.⁸⁶

Ecstasy

- 8.59 Although marketed as a drug of euphoria, ecstasy is also associated with depression and anxiety disorders. The submission from Beyondblue notes the 'depression' or 'coming down' effects that users often refer to as 'Eccy Monday' and 'Suicide Tuesday' that can arise from ecstasy use.⁸⁷ Panic disorders, 'flashbacks' and delusions have also been related to ecstasy use. The risks appear to increase after a day or two of excessive use, or repeated use at high doses over a period of months. A family or personal history of psychiatric disorders may also be relevant.⁸⁸
- 8.60 There is some ambivalence over whether ecstasy use can lead to persistent clinical depression. A recent Victorian study of current and active ecstasy and related drugs (ERD) users found that:

85 Nikolaidis D, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 32.

86 Cole M and Ryan K, 'Agency snapshot: Psychosis and drug use', *Of Substance* (2006), vol 4, no 2, p 21.

87 Beyondblue, submission 151, p 3.

88 National Centre for Education and Training on Addiction Consortium, for the Australian Government Department of Health and Ageing, *Alcohol and other drugs: A handbook for health professionals* (2004), pp 97, 99.

Very few interviewees raised issues around any lingering or enduring depression in relation to their personal use of ERDs. Whilst some spoke of being on antidepressants at different times, very few linked this clinical depression to their drug use, though naturally this was impossible to confirm or disconfirm. Nevertheless, few of the interviewees were prepared to make this link themselves, suggesting more work needs to be done in relation to mental health issues for ERDs users. Certainly all interviewees spoke to some extent of feeling down or moody in the two or three days after using ecstasy, but this was almost always dismissed as an inevitable part of the comedown rather than as a depressive episode.⁸⁹

8.61 On the other hand, the regular ecstasy users interviewed as part of the Party Drugs Initiative (now the Ecstasy and Related Drugs Reporting System) in 2005 typically nominated mental health problems, in particular depression, as one of the risks associated with taking ecstasy.⁹⁰

8.62 A recent inquiry into synthetic drugs conducted by the Parliamentary Joint Committee on the Australian Crime Commission attracted a large number of anonymous submissions from adolescents and young adults through the ABC's Triple J radio station. While many reported positive experiences with ecstasy, a number also wished to draw attention to the mental health risks of ecstasy use, three of which are reproduced below:

I used to use ecstasy and speed on occasion... from about 18 years of age until maybe a year ago (I'm almost 26). The last few experiences made me consciously weigh up the benefits of using these drugs and whether it was worth the come down. I would become quite depressed and often contemplated hurting myself which is completely against character.⁹¹

I have suffered anxiety disorders, as has my girlfriend who may be on medication permanently to cope with this disorder. Medical advice has suggested that previous synthetic drug use may be responsible for the serotonin imbalances believed to cause this condition, despite a period of years having passed since drug use.

89 Duff C et al, Premier's Drug Prevention Council, Victorian Government, *Dropping, connecting, playing and partying: Exploring the social and cultural contexts of ecstasy and related drug use in Victoria* (2007), p vi.

90 Stafford J et al, National Drug and Alcohol Research Centre, *Australian trends in ecstasy and related drug markets 2005: Findings from the Party Drugs Initiative (PDI)* (2006), pp 38, 39, 44.

91 ABC Triple J Hack program, submission 28, Parliamentary Joint Committee on the Australian Crime Commission, *Inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs in Australia* (2007), p 9.

I find this element of damage to be lacking in the education I have seen.⁹²

At home with my partner, my cousin and his partner (both regular users) we all took the same pills and they had a ball and I never recovered. I was really lucky to be left with a long list of 'disorders' rather than something worse. I have a severe panic disorder, post traumatic stress disorder, clinical depression and a decent list of phobias. Before the ecstasy, I had never experienced real anxiety. The x I took was tested in front of me and it was pure MDMA.⁹³

- 8.63 Vuong Van Nguyen, a family and youth worker at UnitingCare Burnside-Cabramatta Multicultural Family Centre, confirmed that many young people were embarking on 'binges' of ecstasy or amphetamine-type stimulants in clubs or at dance parties without awareness of the mental health risks. 'They probably just think they are coming for fun', he said, 'but they have no idea that coming down from a high can have an effect on their mental health'.⁹⁴

Impacts of dual diagnosis on families

- 8.64 While chapters seven and nine describe in detail the impacts that illicit drug use has on families, the following section acknowledges the additional or magnified difficulties faced by families who are dealing with a drug-using family member with a co-occurring mental health issue. Impacts on the dependent children of such drug users were examined separately in chapter three.

Risk of physical abuse

- 8.65 As already noted in chapter seven, many family members of drug users live with the fear of physical harm. Drug-related mental illnesses, particularly drug-induced psychoses, can further threaten the physical safety of family members. As the Australian Drug Foundation notes, the

92 ABC Triple J Hack program, submission 28, Parliamentary Joint Committee on the Australian Crime Commission, *Inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs in Australia* (2007), p 22.

93 ABC Triple J Hack program, submission 28, Parliamentary Joint Committee on the Australian Crime Commission, *Inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs in Australia* (2007), p 24.

94 Van Nyugen V, UnitingCare Burnside, transcript, 2 April 2007, pp 6-7.

feelings of persecution and the potential subsequent defensive aggression that typify a drug-induced psychotic episode can be directed at family members.⁹⁵

8.66 The National Drug and Alcohol Research Centre describes the following as behavioural symptoms of methamphetamine psychosis:

- alert, agitated, jumpy behaviour;
- rapid incessant speech and confused thought processes;
- irrational and unpredictable behaviour, like talking to people who are not there, and arguing with and yelling at people for no apparent reason; and
- signs of methamphetamine intoxication, such as dilated pupils, widened eyes and sweating.⁹⁶

8.67 Recent media coverage of the ‘ice epidemic’ has focused on the dangers that such behaviours represent to frontline health workers in emergency departments and ambulances, and to police.⁹⁷ A 2005 survey of police officers in Sydney reported in summary that:

People suffering from methamphetamine psychosis who exhibited aggressive behaviour were very dangerous because they were unpredictable, impulsive and irrational as well as being extremely hostile. They exhibited a high level of sustained energy and were hyper-alert, which made forced restraint extremely difficult and risky.⁹⁸

8.68 It is important to acknowledge the increased occupational health and safety risk that frontline workers face as a result of the increase in the use of crystal methamphetamine. Less publicised, however, has been the impact on families, who receive no guidance on how to react to such challenging behaviours and are much more emotionally implicated in the management of an ‘offender’.

95 Australian Drug Foundation, submission 118, p 6.

96 National Drug and Alcohol Research Centre, ‘Methamphetamine psychosis: Fact sheet’ (undated).

97 For example, ‘Ice linked to NSW mental health crisis’, *ABC Online*, 8 January 2007; Catalano C, ‘Ice abuse leads to rise in psychotic episodes’, *The Age*, 2 April 2007; Keene N, ‘Epidemic’s cold reality: Ice use worse than data suggests’, *The Daily Telegraph*, 1 May 2007; Hart C, ‘Hospitals snowed under by an ice storm’, *The Australian*, 2 April 2007.

98 McKetin R et al, National Drug and Alcohol Research Centre, *The Sydney methamphetamine market: Patterns of supply, use, personal harms and social consequences* (2005), p 133.

8.69 As Rhett Morris of Teen Challenge NSW told the committee:

Family members are not trained in or aware of how to deal with the erratic and often violent nature that stems from drug-induced psychosis. Family life moves from incredible highs to incredible lows with basically threats of violence and self-harm between those times.⁹⁹

8.70 A woman described her family's experience with her brother, who had been diagnosed with drug-related paranoid schizophrenia:

The family has experienced violent rages and assaults from my brother. I witnessed my father being beaten up by my brother (resulting in the need for stitches), my mother was punched on this occasion and I was kicked hard enough to cause me back problems until this day.¹⁰⁰

8.71 A mother described how the physical threat posed by her son's psychosis frequently resulted in giving him money for drugs:

When you have a six foot psychotic standing over you, you help in any way you can.¹⁰¹

99 Morris R, Teen Challenge NSW, transcript, 3 April 2007, p 106.

100 Name withheld, submission 70, p 2.

101 Name withheld, submission 2, p 2.

Box 8.2 A mother's story of drug-induced psychosis

Due to my husband's substance abuse he developed symptoms of drug-induced psychosis causing him to experience paranoia and hallucinations. This caused him to see, hear and feel things which were not there, he also feared that others wanted to hurt him. He had set traps on the roof and all over the house and had put grease on the fence line so as he would know if someone was entering into our house. He became hostile and aggressive, violent for no reason, agitated, manipulative and his behaviour was irrational and frightening.

I feared for my life and my children's as he would continuously yell at us, lock us in the house for hours, take my house and car keys away from me, be extremely violent and abusive towards me mentally, physically and emotionally, destroy my belongings and turn all the power and lights off for hours at a time.

[After returning home from several months of psychiatric treatment] he was still visiting with the psychiatrist which was really pointless as he wasn't dealing with his emotional issues. So eventually he turned back to drugs and alcohol and became hostile and aggressive again. The kids were frightened so we moved to my sister's house where they could feel safe. After a week he was apologetic and promised he would continue to see his doctor and that things would improve.

I returned back home as it was difficult for me staying at my sister's with four kids, even though they didn't want me to leave as they were afraid. The abuse was less than before, so I battled and kept on going for the sake of my children. Until one day I woke up and he was cutting a chunk of hair from my head with a knife, this was extremely scary and I phoned his aunty who lived down the road to come immediately.

I once again moved, this time to his aunt's house where we stayed for a week. His uncle stayed with him in order to ensure that he was taking his medication and going to his appointment with his psychiatrist. Once again things had calmed down and we moved back home. They remained calm for the next three months.

But once again we were on the same rollercoaster ride, the kids were crying every night. My husband was always on the roof setting up sensor lights and cameras around the place or putting bugs everywhere. If he wasn't there he would take off and most often he would lock us in the house while he was gone. At night he would keep all the windows open so he could hear any noises, we were cold and afraid. The mental and physical abuse was happening on a regular basis and the kids were afraid and would constantly be by my side.

Source Nikolaidis D, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, pp 23–26.

Grief and stress for the future

- 8.72 The altered states exhibited by drug users with a dual diagnosis compound the grief of family members who can no longer recognise the person that they know and love, nor rationalise their behaviour:

We use to feel like we were walking on egg shells. It is just horrible and frightening to see someone you love acting like they are a monster while under the control of a drug. You literally are dealing with a split personality. The one YOU know is a gentle and sensitive person and then when the drug, in our son's case it was ICE, is in control you are dealing with a very angry, aggressive and foul-mouthed stranger.¹⁰²

- 8.73 The distress of families is made worse by the fact that they may not know whether the mental health of their loved one will ever be fully recovered. Three families noted that:

[Our son] no longer uses and is currently studying at university and is coping so far, but under high levels of stress tends to digress to an agitated, sometimes psychotic, state.¹⁰³

My brother has recently been diagnosed as paranoid schizophrenic with brain damage (not sure if permanent or not at this stage) from drug use.¹⁰⁴

[My son] claims to have medically diagnosed depression and drug-induced psychosis. He also claims he has only a few years left of a 'normal life' and then his mental problems will impair his activities.¹⁰⁵

- 8.74 In their submission, the parents of an ex-user of cannabis and amphetamines noted that the mental health effects of illicit drug use could persist after the drug use itself had ceased, and even when the prognosis for recovery was good:

We now know the depression was a direct result of his marijuana use and takes at least 12 - 18 months to subside completely. It has now been two years since Ryan has been clean but it has really only been the last six months that he hasn't suffered some level of depression, anxiety or paranoia.¹⁰⁶

102 Name withheld, submission 135, p 2.

103 Toughlove Victoria, submission 112, p 4.

104 Name withheld, submission 70, p 2.

105 Name withheld, submission 106, p 2.

106 Hidden P and N, attachment to Australian Drug Treatment and Rehabilitation Programme,

8.75 Other families, however, cannot see the way forward so clearly. A mother said that although her son did not appear to have any long-term mental health effects from his addiction to heroin and cannabis, her sister's child had not been so lucky:

Her lovely sweet talented 34 year old daughter has been left with a life-long mental illness. Constant injections to keep her stable. After constant cannabis misuse from a young age (16-17) her life is empty — no friends, no relationships, no interests etc.¹⁰⁷

8.76 A permanent loss of the ability to lead a normal life represents a great worry for families who try to focus on hope for recovery. Centrelink noted amongst its client base that, 'parents talk of the difficulty in dealing with their children's long-term effects of drug use, such as ongoing mental health problems and the loss of intellectual ability'.¹⁰⁸

8.77 The committee commends the publication *In my life*, a collection of personal stories about families affected by co-occurring illicit drug use and mental illness published in 2006 by the Department of Health and Ageing as part of the National Comorbidity Initiative. A mother featured in the book witnesses the damage wreaked on her daughter's mind by methamphetamines and can only hope for recovery at some point in the future:

She started doing ice and the effect of the psychotic drugs over the past three years has been devastating. Paranoia, delusions, madness. I wasn't living too far from the Cross then and I'd be waking in the street and there would be my daughter, my daughter in this crazy out of her head state digging in a park. With a shovel digging for buried treasure... At the moment, if you saw her you'd think she was pretty much an ordinary young girl... It's hard to know whether she has a little bit of selective madness or whether her mind has been permanently affected by the amphetamines. She's been taking it so long however I believe that my daughter's mind is recoverable. I believe that.¹⁰⁹

submission 132, p 9.

107 Hersee P, submission 48, p 2.

108 Centrelink, submission 128, p 2.

109 Sayer-Jones M, Australian Government Department of Health and Ageing, *In my life* (2006), pp 48, 50.

Increased burden of care due to treatment difficulties

- 8.78 Dual diagnosis presents many difficulties in treatment and rehabilitation that distress families and frustrate drug users who genuinely desire to change their lifestyle.
- 8.79 Treatment can be complicated by:
- a potential reduction in the accuracy of diagnoses (symptoms of mental illness may be obscured by drug use, or the effects of drug use may lead clinicians to misdiagnose a mental illness);
 - increased behavioural problems;
 - low or erratic compliance with medication;
 - heightened side-effects of medication or unknown interactions between medications and illicit drugs; and
 - a higher risk for suicide attempts and suicide.¹¹⁰
- 8.80 The biggest issue reported to the committee, however, was the lack of integrated care. Many psychiatric clinics will not treat people until they have stopped using drugs, and some drug clinics will not treat people until they have resolved their mental health issues. In many people, of course, the problems are entwined.
- 8.81 The Western Australian Department of Community Development confirmed that:
- The complexity of working with people with a dual diagnosis of drug addiction and mental illness is heightened by a lack of willingness by services to engage clients, using either the mental illness or the drug use as an exclusionary criterion for service entry.¹¹¹
- 8.82 King Edward Memorial Hospital for Women also reported similar problems for its clients:
- Women with mental health issues have difficulties accessing available treatment. In women with comorbidity this poses further difficulties in accessing substance counselling. Both of these issues

110 Department of Community Services (NSW) and the Mental Health Coordinating Council (NSW), for the Australian Government Department of Family and Community Services, 'The National Illicit Drug Strategy NIDS MISA Project: Improving Support for Children in Families where there are Mental Illness and Substance Abuse Issues', *Project brief* (2003), p 4.

111 Western Australian Government Department for Community Development, submission 134, p 2.

are compounded by services placing exclusion criteria on mental health illness or substance abuse use [sic] problems. Community mental health services often insist that these women address their substance use issues prior to accepting them into their service.¹¹²

- 8.83 It was reported that outside of the drug treatment workforce, a stigma was attached to illicit drug use that obscured opportunities for progress on mental health outcomes:

Our son suffered periods of depression which I believe predated his [heroin] addiction. However many of the health professionals he consulted treated him as a second class citizen and especially in the early times refused to consider his mental health needs.¹¹³

- 8.84 Psychiatrist Dr Christopher Walsh suggested to the committee that the shifting back and forth of responsibility between mental health and drug and alcohol services ultimately put an added burden of care on families.¹¹⁴

- 8.85 A professional working in the drug treatment sector, who had also experienced the drug use of her partner, brother and cousin, agreed, writing that:

There are few drug rehabilitation programs willing to accept people with a serious mental illness. Clients are often turned away from psychiatric facilities and are told to wait until they become psychotic before being admitted (and even then this does not guarantee them a bed) and in many thousands of cases it is the tired, exhausted and often aging families left to pick up the pieces.¹¹⁵

Government responses to dual diagnosis

- 8.86 The committee acknowledges and welcomes increased federal funding for mental health in recent years and for co-occurring drug use and mental health problems in particular.
- 8.87 Under the National Comorbidity Initiative, the Australian Government allocated \$9.7 million over five years from 2003-04 to 2007-08 to improve

112 King Edward Memorial Hospital for Women, submission 19, p 5.

113 Corrigan R, submission 52, p 1.

114 Walsh C, submission 84, p 3.

115 Ravesi-Pasche A, submission 47, p 6.

service coordination and treatment outcomes for people with dual diagnoses.

- 8.88 The Initiative aims to improve service coordination and treatment outcomes for people with coexisting mental health and drug use disorders. It focuses on the following priority areas:
- facilitating resources and information for consumers;
 - providing support to general practitioners and other health workers to improve treatment outcomes for comorbid clients;
 - improving data systems and collection methods within the mental health and alcohol and other drugs sectors to manage comorbidity more effectively; and
 - raising awareness of comorbidity among clinicians/health workers and promoting examples of good practice resources/models.¹¹⁶
- 8.89 On 5 April 2006, the Prime Minister announced new Commonwealth funding of \$1.9 billion over five years as part of the Council of Australian Governments (COAG) package on mental health. The COAG National Action Plan on Mental Health 2006–2011, released on 14 July 2006, included:
- \$73.9 million for improved services for people with drug and alcohol problems and mental illness for the non-government drug and alcohol sector, including identification of best practice models for clients and workforce training; and
 - \$21.6 million for alerting the community to links between illicit drugs and mental illness, and to encourage individuals and families to seek help or treatment.¹¹⁷
- 8.90 Also of relevance is the Australian Government's \$50 million commitment to the establishment of *headspace* – the national youth mental health foundation which will address issues relating to both mental health and alcohol and other drug use for people aged 15-25 years.

116 Australian Government Department of Health and Ageing website, 'National Comorbidity Initiative', viewed on 25 July 2007 at <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubhlth-strateg-comorbidity-index.htm#project7>.

117 Council of Australian Governments, *National Action Plan on Mental Health 2006-2011* (2006), pp 9–10.

Conclusion

8.91 As Jorm and Lubman of the University of Melbourne said recently:

The issue becomes whether we can afford to wait and see if increasing early use of illicit drugs actually does lead to a rise in the incidence of mental disorders.¹¹⁸

8.92 Reported rising prevalence of crystal methamphetamine use is of particular concern given its demonstrated association with psychosis and violent behaviour, with consequent dangers for police, emergency workers, medical staff and families.

8.93 So too is the accumulating evidence about cannabis and mental health. As Raphael and Wooding write in *Of Substance*:

Of primary importance is the fact that cannabis use does have a number of significant association harms... It is not a soft or a safe option and its notable comorbidity with psychotic and non-psychotic illnesses make it a significant and growing health issue – a fact increasingly reflected in both the national and international scientific literature.¹¹⁹

8.94 It is encouraging that the proportion of population who are recent cannabis smokers is declining, particularly amongst teenagers, and that there are signs of hardening community attitudes towards cannabis.¹²⁰ It remains, however, our most commonly used illicit drug, and evidence about its potential mental health impacts needs to be better publicised in the community. As the authors of the recent article in *The Lancet* stated, 'There is now sufficient evidence to warn young people that using cannabis could increase their risk of developing a psychotic illness later in life'.¹²¹

8.95 The committee believes that given the high numbers of Australians using illicit drugs, the available evidence on the connections between illicit drug use and mental illness is deeply concerning. It agrees with the assessment of the national depression and anxiety initiative, Beyondblue, that although further research needs to be done, the known mental health risks

118 Form A and Lubman D, 'Promoting community awareness of the link between illicit drugs and mental disorders', *Medical Journal of Australia* (2007), no 186, p 5.

119 Raphael B and Wooding S, 'Comorbidity: cannabis and complexity', *Of Substance* (2004), vol 2, no 1, p 8.

120 See chapter two.

121 Moore T et al, 'Cannabis use and risk of psychotic or affective mental health outcomes: A systematic review', *The Lancet* (2007), vol 370, 28 July, p 319.

presented by illicit drug use mean that there can be no safe level of personal use:

Beyondblue has a role in highlighting the extent to which there is no predictably safe level of illicit drug use and its implications for mental health, particularly anxiety and depression.¹²²

- 8.96 Given the reported growing prevalence of co-occurring drug use and mental health disorders and the disproportionately heavy burden borne by families, the recent investments made by governments will need to be maintained and reviewed to ensure that they are adequate.

Recommendation 31

- 8.97 **The committee notes the prevalence of illicit drug users developing mental illness, and therefore recommends that the Department of Health and Ageing oversee:**
- **the development of more treatment services that treat both drug use and mental illness together, with the aim of making the individual drug free, and to avoid mental illness being treated without knowledge and consideration of illicit drug use;**
 - **workforce training for primary health care workers to raise awareness of the connections between illicit drug use and mental illness; and**
 - **information and support services for families, including information on how to deal with family members undergoing drug-induced or drug-related psychosis.**

122 Beyondblue, submission 151, pp 2, 4.

Financial impact on families of illicit drug use

- 9.1 Illicit drug use presents significant financial, psychological and social costs on individuals and families. This chapter assesses the direct and indirect financial costs of illicit drug use on families. As with the other aspects of illicit drug use, the financial costs extend beyond the immediate impact on the user to bear on their wider family and ultimately the community.
- 9.2 This chapter examines the extent of the actual or direct costs associated with drug use, including activities which may be involved in maintaining a habit (including criminal activity and its ramifications) and the costs associated with treatment. Further, the committee acknowledges the indirect costs which may be borne by the family of a drug user, including loss of income (particularly for carers) and additional housing costs.
- 9.3 The committee pays particular attention to the situation faced by the increasing number of grandparent carers in Australia today. The committee has received extensive evidence from representative organisations and grandparents themselves concerning the level of emotional and financial support provided as a direct result of their children's inability or incapacity to adequately care for their own offspring. This has significant implications for the prevention of child abuse and neglect in our society, as acknowledged in chapter three. While the committee pays particular attention to the plight of grandparent carers, it also acknowledges the difficulties faced by other relatives (particularly aunts and uncles) who may have to care for children whose parent(s) use illicit drugs.

- 9.4 Although much of the evidence from families contains common elements and experiences, each family situation is individual. Families Australia told the committee that:

There are, for example, particular burdens on sole parents compared with dual parent households in coping with the pressures of a family member who is using drugs. Former prison inmates and their families were cited as another group with unique needs as they face the challenge of re-establishing life within the community and family.¹

- 9.5 Importantly, there is usually no single financial cost to families of drug use and resources can be drained for a variety of reasons. The Western Australian Network of Alcohol and Other Drug Agencies outlined this complexity:

There are a multitude of overlapping issues ... including child protection, domestic violence, justice issues, physical and mental health, housing and employment etc. As a result it is difficult to ascertain the specific financial, social and personal costs to families impacted by drug use on its own, other than to note that together with co-occurring complexities including illicit drug use the cost to families is obviously significant.²

Immediate costs of drug use

Costs to the individual

- 9.6 The immediate cost of drug use for the user is the purchase of the drugs. The greater the use the greater the costs. Money spent on drug purchases cannot be used on other expenses such as rent or mortgage repayments. The Australian Association of Social Workers noted the interrelated nature of the problems surrounding addiction and the type of payments families may feel they need to make on the addicts' behalf:

Alcohol and illicit drug abuse may also lead to other legal concerns such as crimes committed in order to raise sufficient money to support ongoing substance use, and violent

1 Families Australia, submission 152, p 12.

2 Western Australian Network of Alcohol and Other Drug Agencies, submission 138, p 2.

assaults. The cost of maintaining ongoing substance use may mean that there is not enough money left to pay for a range of goods and services. Irregular employment or unreliability at work frequently accompanies heavy substance misuse. This will impact on regular bills such as rent or mortgage, food and clothing, and other purchases that are the staples for survival.³

- 9.7 Drug users may also embark on high-risk behaviour to finance their addiction, typically including drug dealing, burglary and prostitution.⁴

The costs of theft, loans and outstanding debts

- 9.8 It is unfortunately a common experience that families' money and possessions are stolen by the addicted family member in order to fund their habit. One mother described that:

From personal experience in my home, we have had to deal with thousands of dollars, literally, being taken from my wallet—to the point that I have had to lock all my personal possessions in my bedroom when I am at home. We have had things taken from our home to be pawned so that they can get enough money to get their next hit.⁵

- 9.9 A stepmother explained:

My stepdaughter started injecting speed. This was devastating to all of us in the house. Belongings from her older and younger sister as well as myself and her father were stolen and taken to pawn shops. The pain of watching your child seeing things, losing weight, stealing, lying and becoming withdrawn is more than a mother can bear.⁶

- 9.10 Another parent recounted that:

A couple whom I have met have a son who graduated from marijuana to heroin. He fed his habit by stealing from his parents. His mother had been an internationally acclaimed dancer on ice and had been awarded many trophies and much jewellery in her European career. The father was a

3 Australian Association of Social Workers, submission 121, pp 6–7.

4 Australian Drug Foundation, submission 118, p 5.

5 Smith L, Toughlove NSW, transcript, 3 April 2007, p 4.

6 Ennik M, submission 13, p 1.

builder and had acquired many expensive tools. Both suffered the theft of all of their possessions at the hands of their son.⁷

9.11 Other experiences reported to the committee included:

- theft of a father's identity and the sale of property belonging to him;
- fraudulent use of a parent's credit card through appropriation of the card number and signature on receipt slips; and
- families returning home to find all the household furniture, cash and jewellery gone.⁸

9.12 It is not uncommon for a family to extend financial loans, pay fines or settle outstanding debts incurred by an addicted family member in order to stave off legal proceedings.⁹

9.13 More frightening is when families face violence associated with criminals seeking to recover drug debts from users. Families may see no option but to settle debts with drug dealers on behalf of family members.¹⁰ Toughlove NSW told the committee that many families became involved with dealers and gangs who blackmailed them into becoming further involved in criminal activity.¹¹

When to cease support

9.14 Families agonise over whether to continue to provide financial support or not. Paying bills and providing loans to a drug addict may be the only way to keep a child from becoming homeless or criminally active. On the other hand, such financial support may only subsidise and prolong a drug habit.¹² Resolving this dilemma can cause great tension within families:

I did not want my son to go hungry and get beaten up so I would take him money and food even at midnight ... I was so stressed my husband and I would argue constantly. My

7 Morrissey J, submission 12, p 1.

8 Centacare Catholic Family Services, submission 116, pp 5, 17, 20.

9 Teen Challenge NSW, submission 139, p 1; see also Raeside L, Parent Drug Information Service, transcript, 14 March 2007, p 54.

10 Centacare Catholic Family Services, submission 116, p 5.

11 Smith L, transcript, 3 April 2007, p 2.

12 Australian Therapeutic Communities Association, submission 102, p 3; Chang T, submission 28, p 3.

younger son and wife told me ... not to give Peter any money or food as I was helping Peter with his addiction. Well I did not like to hear that as I thought I was doing the right thing as a mother and I argued with them...¹³

9.15 Another mother explained the pressure on her family:

He stole from us, his family. His father endeavoured at this stage to talk to him but all to no avail. The next few years caused a lot of grief ... I continued to travel down the path of handing out money to keep my son out of serious trouble. By this time his father wanted no part of his son's life... At this stage I was going down hill fast as was my marriage.¹⁴

9.16 Financial pressure on families can play a role in the breakdown of the family structure, and separation and divorce can further exacerbate the financial impacts.¹⁵ The obvious personal and social costs of such family breakdowns were discussed in chapter seven.

9.17 The downward spiral associated with providing on-demand financial support to an addicted family member often ends only after difficult decisions are made as to what is reasonable or sustainable.¹⁶ As a mother told the committee about the financial support she provided to her drug addicted son:

I started paying for his food, his Metro-10 and his telephone. I got his dental work done—his back molars taken out. I paid for his health society to keep him on. I paid for his clothes and his cigarettes. As it kept going on and on, I kept cutting down, and right at the end I was just paying for his food.¹⁷

13 Mary, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 12.

14 Name withheld, submission 163, p 1.

15 Australian Drug Foundation, submission 118, p 6.

16 Centacare Catholic Family Services, submission 116, p 5; Drugs in the Family, submission 108, p 2.

17 McMenamin B, transcript, 30 May 2007, p 7.

Indirect costs of drug use

Cost of treatment

- 9.18 While many families baulk at, or cannot afford to support an addict, most are more willing to pay for detoxification and rehabilitation treatments in order to get a loved one drug free.¹⁸ In fact, in many cases an addict may only be able to maintain therapy with the financial support of his or her family.¹⁹
- 9.19 The Australian Injecting and Illicit Drug Users League noted that a fee for service approach by treatment agencies often meant that families paid for treatment:
- Currently Australia's drug treatment programs are based on a 'user-pays' principle. If the person who has been using drugs cannot afford to pay for the treatment then the service will often automatically look to the family to provide financial support...²⁰
- 9.20 The costs for pharmacotherapy programs such as opiate replacement medication (methadone and buprenorphine) can be a financial drain on families, particularly given that prescription can continue for a number of years.²¹ An indicative cost of methadone treatment is \$30-\$35 per week or \$1,600 a year in Victoria, meaning that 'often, the cost of pharmacotherapy prevents families from buying good quality food'.²² As an alternative, a three to six month naltrexone implant can cost up to \$3,000 from a private clinic.²³
- 9.21 Residentially based detoxification and rehabilitation services can also vary widely in cost and be beyond the financial reach of many families.²⁴ One addict was more lucky:

18 Moore M, submission 95, p 1.

19 Families Australia, submission 152, p 7; Association for Prevention and Harm Reduction Programs Australia, submission 130, p 11.

20 Australian Injecting and Illicit Drug Users League, submission 94, p 4.

21 Ryan W and P, submission 43, pp 2-3.

22 Victorian Alcohol and Drug Association, submission 100, pp 7-8.

23 Van Nguyen V, UnitingCare Burnside, transcript, 2 April 2007, p 16.

24 Faull J, submission 17, p 1.

His father knew of a private rehabilitation clinic in Victoria. After a period of a few days he agreed (reluctantly) to go... The cost was in excess of \$20,000. My son was told he would need to be there for between four to six months. He stayed for six months, leaving in January of this year. He was very fortunate that his father was in a position to pay for his treatment.²⁵

9.22 The burden on families increases further when treatment is unsuccessful, and given that addiction is a condition prone to relapse this is not unusual. One man explained to the committee that he had resumed taking drugs the day after his return from a ten week residential rehabilitation program that had cost his parents \$2,500.²⁶ The committee further heard of an unsuccessful treatment at another private clinic at a cost of \$20,000 per week.²⁷

9.23 Often initial treatment requires follow up which can be a further financial drain on families with no guarantee of success or efficacy.²⁸ Unfortunately, as a representative of UnitingCare Burnside explained:

Some families think that a one-week detox, so that heroin is no longer in the blood, is all that is needed and then that person can stay drug-free for the rest of their life. Unfortunately, it does not work that way.²⁹

9.24 Some families with overseas backgrounds may see the best treatment as being to send a drug addict back to their homeland, away from harmful influences:

Some parents from Vietnamese and Khmer backgrounds send their drug-using child to live in their home country, in the hope that a different environment will improve the management of their child's addictive behaviours. This places financial stress on the parents, as they are required to stop work and take extra holidays in order to spend time with their child. This situation also places financial stress on the extended family members, often grandparents, who are

25 Name withheld, submission 161, p 1.

26 Hidden R, transcript, 23 May 2007, p 7.

27 Name withheld, submission 2, p 1.

28 UnitingCare Burnside, submission 99, p 4.

29 Van Nguyen V, transcript, 2 April 2007, p 16.

required to support the drug-using child while he/she is overseas.³⁰

- 9.25 Other costs can be associated with the treatment of conditions brought about by drug use. Dental problems are extremely common in methamphetamine and opiate addicts, and that treatment of these conditions (e.g. removal of teeth, reconstructive dental work) can impact on a family's financial resources.³¹ One addict's use of heroin and methadone necessitated a \$14,000 full mouth reconstruction, only made possible by the fact that her father had continued to pay her private health insurance cover.³²

Loss of income

- 9.26 Addicts themselves not only have to pay to support their drug habit but often suffer from an inability to retain employment. As the Australian Drug Treatment and Rehabilitation Programme noted for one individual:

The direct cost of drugs ... purchased over the ten year period would have run into many thousands of dollars. However, compounding this is money forgone from not being physically and mentally fit enough to work and earn sufficient income to live without government and parental support ... this latter cost is even greater than that of the drugs used.³³

- 9.27 It is not only drug users, however, who may be affected by a loss of income or decreased ability to work. Family members may decide not to work in order to focus on caring for a drug using family member.³⁴ A client of the Alcohol and Drug Foundation ACT, for example, said, 'I gave up an important job, but I couldn't stand the thought that he might die while I was at work'.³⁵
- 9.28 Others find that the stress of coping means that they cannot keep a job.³⁶ One family member believed that:

30 UnitingCare Burnside, submission 99, p 4.

31 Australian Drug Foundation, submission 118, p 6.

32 Coalition Against Drugs (WA), submission 124, pp 6-7.

33 Fairclough R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 20.

34 Name withheld, submission 29, p 1.

35 Alcohol and Drug Foundation ACT, submission 123, p 3.

36 South Australian Government, submission 153, pp 10-11.

... my father missed out on several career opportunities and [was] made suspiciously redundant at one company because he was unable to give the mental energy required because he was too worried where his son was sleeping that night.³⁷

9.29 Another admitted to the committee:

As a registered nurse, I have not been able to return to the workforce due to my inability to function at my normal level.³⁸

9.30 The financial impact on families owing to the loss of income earned by the carer is heightened by the lack of government assistance, as a parent observed:

There is no Carer's Allowance for families dedicated to saving their loved one's life — no tax deductions for a child who is now costing much more money than they ever did as a young child... I'm not talking in the hundreds of dollars but the thousands of dollars spent on debts, clothing, food, healthcare, doctors, nutritionists, psychologists and the list goes on including the costs of the family's health needs as this suffers also.³⁹

Housing and homelessness

9.31 Having a family member using illicit drugs and living under the same roof as the rest of the family can become untenable for many. Parents may feel that they have no choice but to expel an illicit drug user from home to reduce the disruption to the rest of the family. Where the parent is the drug user, the family may struggle to meet mortgage or rental payments and face eviction. The ever present risk is homelessness or crisis accommodation for the drug user and possibly for his or her family.

9.32 In some cases families try to meet housing costs for family members using illicit drugs:

To assist the young struggling family, my wife and I, and the parents of our daughter's partner, purchased in 1999 the house they were renting at the time. The property was

37 Hidden R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 6.

38 Russ C, Drug Free Australia, transcript, 28 May 2007, p 6.

39 Name withheld, submission 20, p 1.

purchased with the agreement that the tenants - our adult children - would pay rental which would assist with repayments of the loan acquired to purchase the property. The rental was heavily subsidised. Over the period the property was occupied, payments made consistently fell well short of the already subsidised rental. Thus the real subsidy over the six year period equated to between \$23,000 - \$26,000. Following the breakdown of the relationship between the partners the property was sold.⁴⁰

9.33 The additional risk in cases such as this is that the parents trying to support a drug user may have to sell their own houses because of the financial strain of supporting the addicted person.⁴¹

9.34 Inappropriate housing can have considerable socially destructive flow-on effects:

Housing problems can cause drug users and their children to be separated, and foster care systems to become overburdened. Often, when drug users and their families are rehoused by social services, they are placed in accommodation in close proximity to other people struggling with drug misuse problems. This can slow down or prevent drug users from recovering, placing additional strain on their families.⁴²

9.35 The loss of stable housing and additional strain on families adds to the financial deprivation and longer term financial burdens on families.

Opportunity costs

9.36 Opportunity costs refer to what is foregone as a result of an activity, in this case because of illicit drug use. The opportunity costs for an addict can be acute:

Severe dependence problems that go unchecked can lead to terrible loss of educational, employment and social opportunities for the young people involved. For example, a young man of 28 can appear to have an emotional age of only 15 or 16 due to the loss of normal social and educational

40 Fairclough R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, p 20.

41 Victorian Alcohol and Drug Association, submission 100, pp 9–10.

42 Victorian Alcohol and Drug Association, submission 100, pp 9–10.

development as a result of the need to pour personal energies and survival instincts into supporting a drug habit...The chance for leading a normal, healthy life and contributing one's full potential to society is reduced. This is over and above the obvious longer term general and mental health consequences of ongoing drug abuse and addiction.⁴³

9.37 Families too can suffer opportunity costs, which can be as basic as having to go without food and necessities because all or most of the family's income is being spent on maintaining a drug habit.⁴⁴ In a household where the parents are drug users, children's material needs for food, shelter, clothing, hygiene and medical care may be neglected as a result of money being diverted into drugs.⁴⁵

9.38 Non drug-using family members in all types of families suffer as the burden of drug use is spread between family members:

Some financial costs to families are more obvious ... others are less obvious – such as ... having to channel money to the drug problem that may have been earmarked for other family members.⁴⁶

9.39 There are also broader social costs arising from the wasted potential of drug users. As Toughlove warned:

Drugs are being openly sold on the streets, outside schools and most railway stations. This is doing irreparable damage to our young people. They are the future of our country and without them we are at risk of losing a whole generation. Imagine the total loss of continuity to our society.⁴⁷

Costs to the whole community

9.40 The report has already mentioned the Australian Federal Police's Drug Harm Index, which calculates the financial benefit to the community of drug interdiction. Participants in the inquiry also noted the costs to the community as a whole of illicit drug use:

The reality is that whether or not you are directly affected by someone's drug use you pay a price. The cost to the tax payer

43 Relationships Australia, submission 143, p 4.

44 Victorian Alcohol and Drug Association, submission 100, p 7.

45 National Drug and Alcohol Research Centre, submission 147, p 9.

46 Chang T, submission 28, p 3.

47 Smith L, transcript, 3 April 2007, p 4.

of law enforcement, of an ailing psychiatric health system, having your home broken into by a person seeking the means to buy drugs ...⁴⁸

9.41 The Australian Family Association was also aware that :

The escalation, in drug-related vandalism, crime and violence in society also drains the public purse - it places pressure on hospital beds, ambulance and medical services, insurance costs, prisons, police and parole services, charitable organisations, local council amenities and so on.⁴⁹

Grandparent carers

9.42 According to the Australian Bureau of Statistics, in 2003 there were 22,500 grandparent families with 31,000 children aged 0-17 years in Australia, representing around one per cent of all families with children aged 0-17 years.⁵⁰ It is thought that the number of grandparent-headed households is growing.⁵¹ One reason is that child protection agencies are giving increasing emphasis to kinship care — where children at risk are cared for by family members other than parents, in preference to placing children in foster care.

9.43 The result is that in 2005-06, there were 10,316 children in out-of-home care being cared for by relatives, accounting for 40.5 per cent of children in out-of-home care.⁵² In 2001-02, there were 7,439 children in out-of-home care being cared for by relatives, accounting for 39 per cent of children in out-of-home care.⁵³

9.44 Evidence suggests that, in many cases, grandparents are taking on the primary care role for their grandchildren because of their own

48 Ravesi-Pasche A, submission 47, p 7.

49 Australian Family Association, submission 59, p 2.

50 Families Australia, submission 152, p 12; Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 28; Relationships Australia, submission 143, p 2; Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 9.

51 Families Australia, submission 152, p 12.

52 Australian Institute of Health and Welfare, *Child Protection 2005-06* (2007), cat no CWS 28, p 52.

53 Australian Institute of Health and Welfare, *Child Protection 2001-02* (2003), cat no CWS 20, p 41.

children's drug problems.⁵⁴ Suddenly being asked to care and provide for grandchildren can place considerable stress on grandparents.⁵⁵ Many have already endured years of anguish with their drug-using young people and are exhausted. They may be obliged to undertake care of the grandchildren, however, as there is no one else who can outside of the foster care system.⁵⁶

Financial impact on grandparent carers

9.45 Many grandparent carers have reduced their working hours or retired and may be unprepared for the additional financial costs they face in caring for young children. Grandparent carers may be faced with a myriad of unexpected costs:

Grandparent support required has included payment of fines, buying and replacing essential items, rehabilitation and mental health services, etc, and providing recreational and educational supports for children.⁵⁷

9.46 Marymead Child and Family Centre, who operate a 'grandparents raising grandchildren support network', report that many grandparents are on a fixed income, and some are dependent on charities for food and clothing. Physical care issues for children, such as orthodontic treatment, can be left untreated due to the high costs. Marymead said also that the cost of activities such as sports, music lessons and school excursions was outside the budgets of most grandparents raising grandchildren.⁵⁸

9.47 In order to meet the costs of living, grandparents may be forced to expend their retirement savings:

The other common story is them having to mortgage their homes, which they have paid for, when they were about to tour the country in their four-wheel drive and caravan, or maybe they were just planning retirement. They are having to sell off property or take out a mortgage on the home that they

54 See for example, Relationships Australia, submission 143, p 2; Commission for Children and Young People and Child Guardian (Qld), submission 146, p 9.

55 Canberra Mothercraft Society, *Grandparents parenting grandchildren because of alcohol and other drugs*, from Families Australia, submission 152, p 13.

56 Miller T, submission 78, p 6.

57 Glastonbury Child and Family Services, submission 74, p 6.

58 Marymead Child and Family Centre, submission 107, pp 5-6.

have paid off after many years of working in order to take out legal proceedings to gain custody of their grandchildren.⁵⁹

- 9.48 Of course, there are not just financial costs facing grandparent carers in these situations.⁶⁰ Grandparent carers can become socially isolated as their friends of similar age may be unused to or uninterested in having young children around. The shift in lifestyle can also lead grandparents to worry about their own health and what will happen to their grandchildren when they can no longer care for them.

Access to financial assistance

- 9.49 Kinship or relative care is an attractive alternative to providing foster care for children at risk because some of the costs of the child protection system can be shifted to grandparents. It also gives children a greater sense of continuity and family identity. However, grandparent and other kinship carers may be doubly disadvantaged, because not only do they face the direct costs of child rearing, but they have limited access to the financial and other support offered to foster carers.⁶¹ As Families Australia described:

Grandparents and other relative carers are increasingly called upon by state and territory child protection agencies to take in children as the numbers of foster carers continues to diminish, yet grandparents are not always recognised as foster carers and so do not receive the same level of financial and other support. In addition to the issue of financial support, training and casework support provided to foster carers is often not extended to relative carers and may depend upon whether or not a child has been legally ordered into the care of a grandparent. If there are no court orders in place, it is less likely that the grandparent/s will receive assistance.⁶²

- 9.50 One person speculated that:

Another possible reason for the increased use of family and kinship carers could be related to the shortage of foster carers. It is widely reported that limited resources given to child protection jurisdictions makes the use of family and kinship

59 Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 29.

60 Odyssey House Victoria, submission 111, p 10.

61 Families Australia, submission 152, p 13; Wanslea Family Services, submission 97, p 3.

62 Families Australia, submission 152, pp 13–14.

carers a more attractive option since it is a cheaper option as kinship carers tend to receive lower levels of support than foster carers.⁶³

- 9.51 One difficulty is that grandparents or other family carers are often looking after their grandchildren through informal arrangements, even if they have been brokered by child protection agencies.⁶⁴ This means that the child is not eligible for assistance from some state-based programs and that the carers will find it difficult to access important information such as birth certificates and immunisation records. Such documents are required for school enrolments and for placing grandchildren on their grandparent's Medicare or Health Care cards.⁶⁵
- 9.52 Grandparent carers can be caught in an invidious position, caught between wanting to formalise their caring role in order to receive benefits, and pressure from their children who do not want to lose their benefits:

Grandparents in particular, may be emotionally blackmailed by their child into NOT claiming or pursuing entitlement to a Centrelink payment so they are able to support grandchildren. Usually it is not until an extreme event occurs that grandparents or relatives eventually claim a payment. They are very aware that when they claim a payment, the parent's payment will cease or be dramatically reduced and there will be work obligations for the parent of the child. The grandparents are very reluctant to take this step. They are 'torn' between 'dobbing in' their child and the extreme financial hardship they find themselves under.⁶⁶

Australian Government support for grandparent carers

- 9.53 In the absence of state government support the Australian Government has introduced a range of measures to assist grandparent carers, including:

63 Name withheld, submission 86, p 1.

64 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 9.

65 Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 9.

66 Centrelink, submission 128, p 4.

- waiving the Child Care Benefit work/study/training test for grandparent carers;
- providing a special rate of Child Care Benefit called Grandparent Child Care Benefit for grandparents on income support, covering the full cost of approved child care for those children;
- providing all children in grandparent/relative care with access to a Health Care Card;
- expanding the eligibility criteria for the Transition to Independent Living Allowance to include young people in grandparent care;
- providing \$400,000 per annum until 2009-10 to enable legal aid commissions to provide or expand dispute resolution processes, such as family conferencing, that involve grandparents and/or extended family members; and
- from 1 July 2007, strengthening Social Security legislation to make it easier for Centrelink to ensure that income support payments for principal carers, including grandparents, are provided to the person who is actually providing the majority of day-to-day care for the dependent child.⁶⁷

Non-financial assistance for grandparent carers

9.54 In addition to the financial impacts on grandparents in caring for their grandchildren, grandparents may need additional support in undertaking a parenting role. Tonie Miller highlighted how the change in role affects grandparents and the children they care for:

In undertaking primary care of their grandchildren, grandparents are denied the role of grandparent. They suffer from social isolation from their peers, anger, fear, fatigue and increasing demands in negotiating the inadequate assistance systems available in their jurisdictions, while they experience declining health and often the continual high stress levels induce mental health issues. There is great variation of assistance from different jurisdictions, states and territories, regarding state assistance being offered to these families. Most do not come near the real costs involved financially, let alone emotional, health and social costs.

⁶⁷ Australian Government Department of Families, Community Services and Indigenous Affairs, submission 172, p 9.

Respite care is rare for these families, and tensions may result in further fracture of the family, and breakdown of lengthy and important marriages/relationships. The relationships between the natural parents and the grandparents undertaking primary care and responsibility are often hostile and complex, with the children caught in the middle. The grandparents care passionately for their grandchildren and some become hypervigilant due to threats from the natural parents to harm or take the children if the grandparents do not comply with their demands.

Grandparents are not a homogenous group, and some find difficulties accessing the limited assistance offered to them and accessing relevant and helpful information. Most are permanently exhausted with diminished quality of life in their senior years. Children who have begun their lives as described above, come with behavioural and emotional 'baggage', often well beyond the capacity of the grandparent to deal with. They may also present with physical as well and emotional disabilities.⁶⁸

9.55 Non-financial effects on grandparents caring for their grandchildren nominated by inquiry participants are generally similar to those experienced by families generally (see chapter seven). However, grandparents may be more susceptible to the negative impacts because of their health or social activities and networks. Some of the concerns expressed by grandparents include:

- high levels of stress and greater susceptibility to loneliness and depression;⁶⁹
- isolation from friends and social networks and a feeling that they don't 'fit in' with younger social activities such as play groups;⁷⁰ and
- stigma associated with a perception that they have 'failed' at raising a child the first time around.⁷¹

68 Miller T, submission 78, p 6.

69 Marymead Family and Child Centre, submission 107, p 6.

70 Centrelink, submission 128, p 3.

71 Baldock E, Canberra Mothercraft Society, transcript, 28 May 2007, p 31.

- 9.56 Some of the particular difficulties experienced by grandparents highlighted by inquiry participants included:
- they are less likely to know their rights and have access to formal channels of support;⁷²
 - a lack of recognition from employers in supporting kinship carers to allow for additional leave similar to leave available to maternity leave;⁷³
 - the need for information on child management and behavioural issues.⁷⁴

Other possibilities for support

- 9.57 The committee sympathises with grandparents who are torn between support for their children and their concerns for the safety and welfare of their grandchildren. Suggestions by inquiry participants to increase support to grandparent carers included:
- a national 24-hour telephone support line;
 - further consideration by state and territory governments of the payment of the foster carer allowance to grandparents who are providing primary care;
 - further consideration by state and territory government of the adequacy of financial support for grandparents to meet the needs of grandchildren in their care who are not under formal care and protection orders;
 - small grants provided to communities through local, state/territory and Commonwealth governments for support groups, respite services and local information;⁷⁵ and
 - flexible financial aid be provided to family carers (grandparents, siblings, etc) of drug users' children, preferably through the expansion of welfare packages. For example, family allowance payments could be paid to the children's care-giver, with this being arranged by professionals.⁷⁶

72 Name withheld, submission 86, p 1.

73 Name withheld, submission 86, p 1.

74 Government of Western Australia Drug and Alcohol Office, submission 82, p 4.

75 Families Australia, submission 152, p 25.

76 Victorian Alcohol and Drug Association, submission 100, p 8.

- 9.58 The committee welcomes the initiatives of the Commonwealth in assisting grandparents access a range of financial benefits. The committee expects that a review currently underway by Centrelink and the Department of Human Services on service delivery implications for grandparents will lead to further measures to streamline access to support and make it easier for grandparents to get information about what is available.⁷⁷
- 9.59 The committee understands that some grandparents do not want their carer status formalised, even if this makes them ineligible for state and Commonwealth benefits. However, in cases where child protection agencies have facilitated the carer arrangements, those state and territory agencies should provide grandparents with the full array of financial and support services available to foster carers.

⁷⁷ Centrelink, submission 128, p 3.

Illicit drugs and the family

- 10.1 Nearly all users of illicit drugs are members of a family. Relationships between family members can be an important factor in both protecting family members from using drugs and developing risk factors that can lead to illicit drug use. Evidence demonstrates the influence of the family in how we communicate, how we cope with stress and emotional problems, and our attitudes towards the use of illicit drugs and other intoxicating substances.¹
- 10.2 Given the availability of illicit drugs in Australia; mixed messages about drug use; and the identified major reasons for trying drugs of curiosity (77 per cent) and the strength of peer pressure (54 per cent), particularly for adolescents, it is a sad reality that *all* families are at risk from illicit drug use.²
- 10.3 Nevertheless, evidence suggests that families influence the likelihood of illicit drug use in important ways, and that the family can represent a double-edged sword for its members. Certain family characteristics and behaviours, while not excusing illicit drug taking, can explain a person's increased propensity to engage in such practices. Conversely, the family can be a strong protective factor against illicit drug use. By building resilience and self-confidence, the family can be a person's strongest defence against drugs and their most steadfast support in rehabilitation and treatment.

1 Velleman R et al, 'The role of the family in preventing and intervening with substance use and misuse: A comprehensive review of family interventions, with a focus on young people', *Drug and Alcohol Review* (2005), vol 24, p 94.

2 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 37.

Defining the family

- 10.4 Given that this inquiry is about the impact of illicit drugs on families, it is important to define what the committee understands by 'family'.
- 10.5 A 'family' is a group of people who will each be impacted differently depending on the structure of the group and their relationship to the drug user as parent, child, partner, sibling, niece, nephew, aunt, uncle, cousin, grandparent or other family role. Australian families are diverse and each has a unique set of relationships between individual members.
- 10.6 According to the most recent Australian Bureau of Statistics (ABS) Family Characteristics survey, there were 2.5 million families with at least one child aged 0-17 years in 2003. Seventy-one per cent of those were couple families and 22 per cent were one parent families. There were 1.1 million children aged 0-17 years (23 per cent of all children in this age group) who had a natural parent living elsewhere, which in the majority of cases was their father.³
- 10.7 Four per cent of all families with children were step families, formed when parents repartner following separation, and where there is at least one step child of either member of the couple present. Three per cent were blended families, defined by the ABS as a family that contains a step child as well as a child born to both parents.⁴
- 10.8 As diverse as these statistics are, they do not begin to describe the range of families and family types affected by illicit drug use. As the Australian Drug Foundation has pointed out in their submission, to only consider the impacts of adolescent drug use on nuclear families would be to neglect the impacts felt by many others in a family or family-like relationship with drug users. These might include:
- families in which the parents are drug users;
 - extended families, particularly important in cultures where the extended family model is the norm, such as in Indigenous communities;
 - grandparents, who are increasingly bearing more and more responsibility for grandchildren growing up in at-risk environments;
 - siblings;

3 Australian Bureau of Statistics, *Family Characteristics Australia 2003* (2004), cat no 4442.0.

4 Australian Bureau of Statistics, *Family Characteristics Australia 2003* (2004), cat no 4442.0.

- partners, who may see their relationship placed in jeopardy by illicit drug use;
- adult drug users, who may be much more dependent on their family than other people their age who have left the family home; and
- non-biological families.⁵

10.9 There is no complete data on the familial characteristics of illicit drug users. However, some partial information is available on illicit drug use and how many family members may be affected:

- children living in households where parents are regularly using illicit drugs — Over 78,000 children aged 12 years or less live in a household containing at least one daily cannabis user and over 27,000 children live in a household with an adult who uses methamphetamine at least monthly and reports doing so in their own home;⁶
- children of parents accessing treatment for illicit drug use — In 2002-03, at least 60,000 children in Australia may have been affected by the illicit drug use of their parents, amounting to 1.5 per cent of children under the age of 15 years;⁷
- children of mothers using illicit drugs during pregnancy — In 2005, more than 255,000 women gave birth to children.⁸ Recent state-wide surveys of maternity hospitals in New South Wales and the Australian Capital Territory in 2000 and 2004 consistently estimated that 1.3 per cent of women who reported for delivery reported some form of dependency or substantial exposure to illicit drugs during their pregnancy;⁹
- grandparents caring for their grandchildren due to parental illicit drug use — In 2003 there were 22,500 grandparent families with 31,100 children aged 0-17 years in Australia, representing around one per cent of all families with children aged 0-17 years.¹⁰ Many of these grandparents (precise figures are not known) take on the primary

5 Australian Drug Foundation, submission 118, pp 3-4.

6 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 17.

7 Odyssey Institute of Studies, *The Nobody's Clients Project: Identifying and addressing the needs of children with substance dependent parents* (2004), p 11.

8 Australian Bureau of Statistics, *Births Australia* (2006), cat no 3310.0, pp 7, 14.

9 Oei J and Lui K, 'Management of the newborn infant affected by maternal opiates and other drugs of dependency', *Journal of Paediatrics and Child Health* (2007), vol 43, p 9.

10 Australian Bureau of Statistics, *Family Characteristics Australia 2003* (2004), cat no 4442.0, p 40.

caring role as a result of their own children's drug problems, which often co-occur with factors such as mental illness and gambling;¹¹ and

- Victims of drug-related incidents that occurred in the home — In 2004, 27 per cent of victims of verbal abuse, 37 per cent of physical abuse and 31 per cent of incidents where a victim was put in fear occurred in the home.¹²

10.10 As the Australian Drug Foundation and the Australasian Society of HIV Medicine both noted, many drug users have experienced family breakdown problems and identify their friends as being a non-biological family:

In the absence of a 'functional' biological family, others step into the breach to fulfil the role of family members and thereby encounter the same difficulties and challenges of caring about and for someone who does not or cannot manage and maintain their health and lifestyle in a generally accepted way.¹³

10.11 For the purposes of this inquiry, the committee has focussed on families as a group of biological or legally adopted members, rather than networks or households of close friends.

All families are at risk

10.12 Many people using illicit drugs come from families with no signs of disadvantage. Factors such as curiosity, peer pressure, external social attitudes towards the acceptability of drug use, individual temperament or simply bad decision-making can have much more explanatory power than family background in illicit drug use. This is particularly so given that the average age of initiation to illicit drugs is in adolescence and young adulthood, when the influence of the family is typically waning relative to that of the peer group.¹⁴

10.13 The message came through strongly in evidence to the committee that illicit drugs are a risk to all families. While clinical experience and research suggests that some families may be particularly prone, the pervasiveness

11 Australian Institute of Family Studies, submission 152, p 12.

12 Australian Institute of Health and Welfare, *2004 National Drug Strategy Household Survey: Detailed findings* (2005), cat no PHE 66, p 88.

13 Australasian Society of HIV Medicine, submission 140, p 8.

14 Hayes A, Australian Institute of Family Studies, transcript, 19 June 2007, p 5.

and addictive power of illicit drugs can affect anyone. Five families told the committee about their experiences:

Do not think that this will never touch your life, because it could be a grandchild if not a child of your own. The people in my support group are some of the nicest people I have ever met, certainly not monsters or social outcasts who you would suspect have drug-dependent loved ones.¹⁵

Imagine this. Sitting next to one of the kindest people in the world, who has never even been intoxicated by alcohol before, who adored her son, loved him, supported him, admired him, stood by him... imagine letting her know that he was a drug addict.¹⁶

My brother [an illicit drug user] and I come from a close and loving family and extended family. My brother was a high achieving scholar, sportsman, businessman and community contributor, winning many scholarships and awards in these arenas.¹⁷

I have had the very sad experience of seeing my daughter's best friend die from a drug overdose. She was a very well-educated girl from a loving, caring middle class family.¹⁸

My 23 year old son is recovering from heroin addiction. Raised in a happy home with two parents, no violence, no sexual abuse, no dysfunction; he was private school educated, a good student, a cadet and a rugby second rower... My message is that this can happen to anyone; it happened to us.¹⁹

- 10.14 If a loving and stable family is not necessarily a protective factor against illicit drug use, nor is a higher family socioeconomic status. Some of the literature, which normally comes from researchers and academics working with dysfunctional groups, suggests that drug use is more likely to occur in families with a lower socioeconomic status, given that problems of illicit drug use, domestic violence, sexual assault, poor housing and poor parental mental health can cluster together.²⁰ However, a drug and alcohol counsellor commented that:

15 Name withheld, submission 20, p 2.

16 Name withheld, submission 165, p 2.

17 MacIntyre R, submission 81, p 1.

18 Perry J, submission 5, p 1.

19 Name withheld, submission 56, pp 1, 3.

20 Dawe S et al, Australian National Council on Drugs, *Drug use in the family: Impacts and implications for children* (2007), p 53.

Family Drug Support receive as many, if not more calls from the affluent suburbs in Australia. Drugs do not discriminate. When I run group meetings or Stepping Stones to Success courses all parts of society are represented. The car park has as many 'old bombs' as there are the latest expensive vehicles.²¹

10.15 Similarly, Nar-Anon Family Groups said that:

Drug abuse... spans all socioeconomic levels of our society. It is not just a problem existing only in stereotyped groups of wrong doers.²²

Box 10.1 Ryan Hidden's story

My parents epitomise the Aussie-battler. Starting with nothing, both have worked incredibly hard and now own their home and can afford all the luxuries of upper middle class. I grew up in a stable, loving and happy family home. Living just outside of Gawler on a 20 acre property, I spent my time riding horses and travelling this beautiful country of ours with my parents.

I have always been one of those kids who was full of potential. Going to a public primary school I always excelled and in year seven made the switch to Trinity College, where I continued to stand out in the class. What I'm trying to establish is that I am not the stereotypical drug user (although I personally believe one doesn't exist).

This young man, now an advocate for the treatment and rehabilitation of drug users, developed an addiction to marijuana and amphetamines that led him to leave the family home and live, for short periods, in a caravan park and a car.

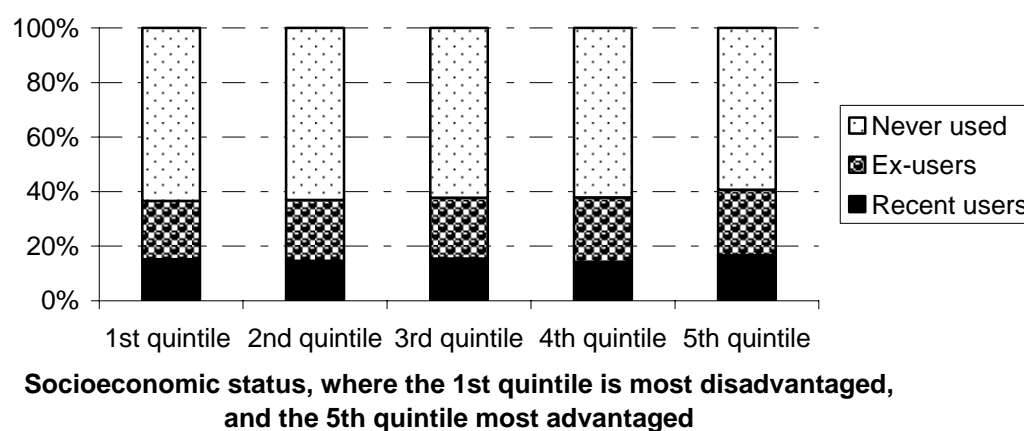
Source Australian Drug Treatment and Rehabilitation Foundation, submission 132, p 3.

10.16 This appears to be supported by the 2004 National Drug Strategy Household Survey, which found a remarkable lack of disparity between the socioeconomic backgrounds of those who had never used, ex-users, and those who were recent users of drugs (figure 10.1).

21 Chang T, submission 28, p 3.

22 Nar-Anon Family Groups Australia, submission 115, p 1.

Figure 10.1 Socioeconomic status of illicit drug users in Australia, 2004



Source Australian Institute of Health and Welfare, 2004 National Drug Strategy Household Survey (2005), cat no PHE 66, p 38.

Family risk factors for illicit drug use

10.17 Some family characteristics and behaviours do appear to be more common amongst illicit drug users. Family factors associated with later drug use, identified in a comprehensive review by the Australian Institute of Family Studies, include:

- a family history of behavioural problems;
- poor socialisation practices;
- ineffective discipline skills and ineffective supervision of children;
- poor parent-child relationships;
- high levels of family conflict;
- child maltreatment (physical, sexual or verbal);
- parental mental illness;
- family isolation;
- alienation from mainstream social values;
- difficulties with acculturation; and
- stress — particularly in sole-parent households.²³

23 Australian Institute of Family Studies, submission 103, p 2.

- 10.18 Similarly, rehabilitation and counselling organisation Odyssey House Victoria told the committee that:

Specific aspects of family life and family relationships have strong and consistent connections to the initiation, exacerbation, and relapse of drug problems.

Relationship factors such as poor parent-adolescent relationships consistently predict adolescent drug use across cultures and time even more so than salient factors such as family structure.

Parenting practices including low monitoring, ineffective discipline, and poor communication are also important factors in the initiation and maintenance of drug abuse problems among youth, although parenting clearly interacts with a host of other social and emotional factors in predicting the onset of drug abuse and related problems.²⁴

- 10.19 Factors such as family conflict, ineffective discipline and family stress inhibit a parent's ability to monitor the activities of their children and teach them skills for coping with drugs in their school or peer environment.

The intergenerational cycle of drug use

- 10.20 Many inquiry participants had observed patterns of drug use replicated across several generations in a family (box 10.2).

- 10.21 A report published by the National Health and Medical Research Council in 2001, *The role of families in the development, identification, prevention and treatment of illicit drug problems*, found that, unsurprisingly, children of drug users were more likely to use drugs themselves, even though the type of drug used might differ across generations:

Family history of substance abuse is an important family-level risk factor for substance abuse. Australian data confirm parent substance use to be an important predictor of more frequent youth substance use. The more members of a household, including siblings, who use a drug, the greater the child's risk of early initiation of use of that drug.²⁵

- 10.22 Medical professionals and drug treatment and service agencies noted that they commonly saw generational patterns of drug use in their clients. The
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24 Odyssey House Victoria, submission 111, p 8.

25 Mitchell P et al, National Health and Medical Research Council, *The role of families in the development, identification, prevention and treatment of illicit drug problems* (2001), p 6.

Victorian Alcohol and Drug Association noted that drug service providers they had consulted with reported dealing with clients who were third generation drug users.²⁶ A physician in regional New South Wales reported that clinical contact with extended families was common, and that he treated children of parents he had treated previously with drug and alcohol problems.²⁷ Similarly, the Royal Australasian College of Physicians reported that two and three generations of opiate addicts from one family were seen at methadone units in NSW.²⁸

- 10.23 The Palmerston Association, a Perth-based provider of services to people affected by drug use, suggested that this was a function of parental use of drugs normalising illicit drug use and modelling a particular kind of coping behaviour:

We have observed a dynamic where illicit drug-using parents use drugs to manage challenging personal experiences and pass this form of coping behaviour onto their children. We view this as a major cost to the children of drug-using parents: the lack of opportunity to learn the very skills which may afford them protection against illicit drug use.²⁹

- 10.24 For those children whose mother used drugs whilst pregnant, their susceptibility may be even more fundamental. As discussed in chapter three, drugs can cross through the placenta and result in the foetus becoming addicted, causing a range of abnormalities in its development.³⁰ Babies undergoing withdrawal (neonatal abstinence syndrome) may require additional medical treatment, and frequently exhibit irritability, temperament problems, sleeping and feeding difficulties and high-pitched crying, often for long periods.³¹ Due to a dearth of longitudinal research in this area, however, it is not known if such children are more neurologically prone to addiction in later life as a result of prenatal exposure.

26 Victorian Alcohol and Drug Association, submission 100, p 10.

27 MacQueen A, submission 92, p 3.

28 Royal Australasian College of Physicians, submission 119, p 10.

29 Palmerston Association, submission 91, p 2.

30 King Edward Memorial Hospital for Women, submission 19, p 4; Advisory Council on the Misuse of Drugs, United Kingdom, *Hidden harm: Responding to the needs of children of problem drug users* (2003), p 31.

31 Advisory Council on the Misuse of Drugs, United Kingdom, *Hidden harm: Responding to the needs of children of problem drug users* (2003), p 37.

Box 10.2 Ryan Betts' story

Dad left home when I was five years old. He left my mother alone with the kids—at that time, me and my brother. He was arrested at Sydney airport not long after—he was bringing heroin into the country. Our stepfather was a very violent and very abusive alcoholic. He used to beat us and mum. She ended up having two more kids with him—my two sisters.

Growing up in that environment, fatherless and then with this father figure that was so abusive and carried on the way that he did, meant that we grew up with a lot of issues. We grew up bitter, hurt and aggressive, with a lot of walls and with no identity. Just before I went into the training centre we were fighting with the people in the units next door. It was all over drugs and everything else. One ended up having his throat cut, there were shots fired and all sorts of things. That is just how it was, and that is how we grew up, seeing all those sorts of things. It is generational. I ended up going down the same road. A lot of our family members are in jail and many others have died. Along the way, I have also seen a lot of my friends die. Two of my friends committed suicide just before I went into the program, and others were in jail.

I remember thinking to myself at the time about the way that I was living. My girlfriend was a prostitute and on drugs, and she had a little girl. The way that I was living was as though a baton had been handed down from one generation to another, and I thought it had to stop.

Source Betts R, transcript, 3 April 2007, p 113.

10.25 Should these children remain in the care of their biological parents, as most will do, environmental and behavioural factors may conspire to perpetuate an intergenerational cycle of drug use. The UK report *Hidden harm* (2003) found that:

If the child's circumstances after birth are unfavourable, it may also be hard to tell whether any observed problems result from damage or disadvantage before or after birth, or indeed may be a combination of the two. For example, following prolonged exposure to opiates or benzodiazepines during pregnancy, the baby is likely to be very irritable and cry constantly (the neonatal abstinence syndrome). If the mother is also oscillating between drug-induced stupor and withdrawals, mother-infant bonding is likely to be poor and she may neglect the child.³²

10.26 As previously noted, children with parents who use illicit drugs are more at risk of child abuse, neglect, and sexual assault.³³ As the Australian

32 Advisory Council on the Misuse of Drugs, United Kingdom, *Hidden harm: Responding to the needs of children of problem drug users* (2003), p 31.

33 Advisory Council on the Misuse of Drugs, United Kingdom, *Hidden harm: Responding to the needs of children of problem drug users* (2003), p 38; see also chapter three.

Institute of Family Studies (AIFS) told the committee, many children who do not experience any of these things will go on to become drug addicts. However:

Child abuse, neglect and sexual assault are risk factors for later drug abuse, demonstrating the key role of families in the intergenerational cycle of drug use.³⁴

- 10.27 Professor Sharon Dawe from Griffith University, who authored the recent Australian National Council on Drugs report *Drug use in the family*, also said that parental substance abuse was likely to be related to other factors that made it more difficult for the children of drug users to learn strategies and skills that might protect them from drug use:

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... 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.³⁵

- 10.28 As personal stories to this committee attest, even intergenerational cycles of drug use can be broken with determination and support, although it may be important to acknowledge that such people will have intensive treatment, counselling and skill development needs.

Sibling drug use

- 10.29 Attitudes to, and use of illicit drugs by siblings can also have a powerful effect on the likelihood that other siblings will use drugs. Odyssey House Victoria suggests that this effect could even be stronger than that of parental drug use or parental attitudes towards drugs:

Sibling modelling of alcohol and illegal drug use and parental attitudes towards children's drug use are also associated with

34 Hayes A, Australian Institute of Family Studies, transcript, 19 June 2007, p 2.

35 Dawe S, transcript, 13 June 2007, p 1.

adolescent alcohol and other drug abuse. Non-use by older brothers has been shown to mediate the influence of parental drug use. Drug use by older brothers and peers has been found to be more predictive of younger brothers' use than parental modelling of drug use.³⁶

- 10.30 The committee took evidence from a mother in Perth who had five children, four of whom had used illicit drugs:

I guess I could describe myself as just being an ordinary mum living in [a Perth suburb] and just been part of everything with five children. Twenty-two years ago things changed drastically. I have seen four of my five children problematically use drugs since then. My eldest child commenced using cannabis at 13 and was injecting amphetamines by 17. For four of my children the drug of choice has always been amphetamines, though I lost a 19 year old son to a heroin overdose 10 years ago...

- 10.31 Consistent with the evidence provided by Odyssey House Victoria, the mother described this devastating familial capitulation to illicit drugs as a function of a strong sibling influence, a breakdown of family standards and inconsistent, if well-intentioned, parenting:

The first four children, in particular, were quite close and I think it percolated very quickly through the family. There is a moralism around it, and I think it breaks down the morals within the family system. Of course at that stage there was minimal education. I had minimal education. My husband was at one end of the spectrum; I was at the other end of the spectrum. When he was too soft, I was too hard. When he was too hard, I was too soft. There was not a consistency.³⁷

- 10.32 Similarly, a mother in Sydney described how her son's illicit drug use had put her younger daughter at risk through premature exposure to drugs and by breaking down parental authority:

My daughter was witnessing things at nine and ten that no child should have to witness... When my son heard me coming he shoved about five kilos of speed at my daughter and said, 'Hide this under your jacket, mum's coming.' She did not think there was anything wrong with that because she was too young to understand, so she did it. It was only in the last two years that she

36 Odyssey Institute of Studies, *The Nobody's Clients Project: Identifying and addressing the needs of children with substance dependent parents* (2004), p 25.

37 Harris S, transcript, 14 March 2007, pp 55, 56, 60.

gave me this information. When my husband and I used to go out for a night, they would invite their friends over and would be running up and down the hallway of the house with bongos in their hands in front of my two youngest children. These kids are just too young to experience things like that. You then come back to the 'monkey see, monkey do' syndrome: they see it happening in the home and they think it is okay. It is not okay, and she could not understand why we were being so anti drugs.³⁸

- 10.33 But the drug use of older siblings will not always influence younger siblings to mimic their behaviour. A Glasgow study on the impacts of drug use on the family interviewed many siblings of drug users for whom witnessing the effects of drugs had been a powerful deterrent to experimentation:

Many siblings said they could not understand the attraction of drugs or the associated lifestyle. They saw their brothers or sisters as sad, angry people and considered that it was their drug problems that had largely brought this about.³⁹

- 10.34 Certainly, this committee received a number of submissions describing how siblings developed a repulsion to illicit drugs having witnessed the impacts on their family and on a brother or sister who may formerly have been much admired:

My son overdosed twice at home and we still could not get help. My youngest son who is very gentle and loving said that 'next time we would let him die'. And wears a T-shirt stating *you may as well inject battery acid you dumb f...* [It is] his only way of letting his brother know how he is feeling and his pain of watching this all happen to his big brother who he loves.⁴⁰

- 10.35 Often, the reasons for divergent behaviour on the part of siblings or indeed other family members are not easily explained. Ryan Betts, a recovered drug user and now staff member at rehabilitation organisation Teen Challenge NSW, told the committee his story of a violent and abusive upbringing under an alcoholic stepfather, which appears in box 10.2. He notes that while he became enmeshed in the pattern of intergenerational drug use, his brother's response was inexplicably different, even though they shared similar familial issues:

38 Smith L, Toughlove, transcript, 3 April 2007, p 10.

39 Barnard M, *Drugs in the family: The impact on parents and siblings* (2005), p 33.

40 Quon M, submission 8, p 6.

My brother is the complete opposite to me. He never touched drugs. He never touched alcohol or anything like that. Without invading his privacy or confidentiality, I see the path that he has gone down. I say to him: 'Joel, you never hit the bottom like I did in that sense. You've always aimed for the top, but it doesn't mean that your heart is not broken. We saw the same things. One reached out to the bottle and one reached out to success'.⁴¹

- 10.36 The AIFS, giving evidence to the committee, suggested that individual temperament, including such things as a propensity for risk-taking, compulsive or addictive behaviours, could play a role in explaining why some siblings are more resilient to exposure to illicit drugs:

The Institute's analyses of findings from the Australian Temperament Project show that children with an easy temperament early in childhood are more likely to have positive adjustment later in childhood and adolescence, which in turn reduces the likelihood of other risk factors for later drug use being present, such as antisocial behaviour or school truancy.⁴²

Genetic vulnerability

- 10.37 Many witnesses casually mentioned, in giving evidence to this inquiry, that other members of their family had a history of addictive behaviour, be it an addiction to alcohol, gambling, prescription drugs or other substances. Two families noted that:

I wish to tell you a little of my life with a heroin addict daughter, who is now in jail for armed robbery... My sister's only two children are both opiate addicts also.⁴³

I have 12 nephews and two nieces, and only two are drug free. Twelve do drugs. My niece killed herself, being a heroin addict. The others struggle. They are moving along with their lives but they struggle to maintain employment. I have three sons and two do drugs.⁴⁴

- 10.38 There may be such a thing as genetic predisposition towards drug use and addiction, although the research to date is inconclusive. It is obviously difficult to isolate the genetic from the learned behavioural culture of a

41 Betts R, Teen Challenge NSW, transcript, 3 April 2007, p 113.

42 Hayes A, Australian Institute of Family Studies, transcript, 19 June 2007, pp 1, 3.

43 Name withheld, submission 75, p 1.

44 Kerry, transcript, 14 March 2007, p 28.

family, although attempts have been made in studies of identical twins reared separately, and of the children of drug users who were adopted at an early age.⁴⁵ The National Health and Medical Research Council (NHMRC) report in 2001 concluded from the literature that genetic factors play 'a modest but significant role' in determining whether a person will use illicit drugs.⁴⁶

- 10.39 Dr Ivan van Damme, of the Flemish Platform Against Drugs, told a Drug Free Australia conference in April 2007 that each person had a unique genetic susceptibility to addiction, although no single responsible gene had been identified:

Genetic vulnerability, or predisposition, to substance dependence is likely to be tied to several distinct genes, each producing a small effect, which might increase risk of developing substance dependence. Any one of the genes on its own will be insufficient to cause dependence, but several different genes may all contribute to the vulnerability. Substance dependence is polygenically inherited, and each gene is likely to account for only a small per cent of the variance. Not everyone who carries a 'risk gene' for substance use or dependence will become dependent, and likewise some of those who become dependent will not carry that particular risk factor.⁴⁷

- 10.40 As the NHMRC report stated, 'It is the gene-environment interactions that determine whether an inherited vulnerability will be expressed as drug abuse'.⁴⁸ In other words, even a person with a predisposition to addiction is unlikely to develop that without ready access to drugs and a social milieu that deems drug-taking acceptable in the first place. Genetic tests to identify 'addiction genes' are as yet in their infancy, are not particularly useful in themselves and run the risk of diminishing perception of other risks present for drug users with no family history of drug use. The committee believes that Dr Van Damme's advice is salient:

45 Ryder D et al, *Drug use and drug-related harm: A delicate balance* (2006), 2nd ed, IP Communications, pp 52-54.

46 Mitchell P et al, National Health and Medical Research Council, *The role of families in the development, identification, prevention and treatment of illicit drug problems* (2001), p 3.

47 Van Damme I, 'Elements of patho-physiology of drug addiction and related consequences', presentation to the Drug Free Australia Conference 'Exposing the Reality', Adelaide, 27 April 2007, p 5.

48 Mitchell P et al, National Health and Medical Research Council, *The role of families in the development, identification, prevention and treatment of illicit drug problems* (2001), p 3.

The single best way to avoid the risks of addiction, no matter what one's genetic makeup, is not to use the substance at all.⁴⁹

Family protective factors

10.41 The AIFS noted that families can also play a positive role in protecting against later illicit drug use, and in many cases, they are the converse of the risk factors explored above. They include:

- positive family attachment;
- parental harmony (low parental conflict);
- positive family relationships (providing social supports and coping skills); and
- low parent-adolescent conflict.⁵⁰

10.42 Odyssey House Victoria, in the full report for the Nobody's Client's project, concluded that exposure to risk, such as susceptibility to peer pressure, can be influenced by the presence of protective factors:

Protective factors within the family include strong bonds, clear rules of conduct and involvement of parents in the child's life. A further range of protective factors has been identified in children exposed to extreme stress in highly disturbed families. These include positive temperament, a range of problem solving skills, an internal locus of control, a supportive family milieu, and an external support system that encourages the child's coping and reinforces positive values. Protective factors beyond the family include successful school performance, strong bonds with positive institutions such as school and religious organisations and the child's perception of the acceptance of drug use.⁵¹

10.43 The UK report on the children of problem drug users, *Hidden harm*, also found that protective factors existed that gave children greater resilience against the risks and disadvantages posed by parental use of illicit drugs.

49 Van Damme I, 'Elements of patho-physiology of drug addiction and related consequences', presentation to the Drug Free Australia Conference 'Exposing the Reality', Adelaide, 27 April 2007, p 1.

50 Australian Institute of Family Studies, submission 103, p 2; The Royal Australasian College of Physicians, submission 119, p 10.

51 Odyssey Institute of Studies, *The Nobody's Clients project: Identifying and addressing the needs of children with substance dependent parents* (2004), p 27.

While the report concluded that the emerging picture was ‘depressing’, and that ‘parental drug use has the potential to interfere with virtually all aspects of a child’s health and development’, it also noted that some children appeared to be remarkably resilient.⁵² Some features in the family environment of these children were:

- the presence of at least one unconditionally supportive parent or responsible adult who was helpfully involved in the child’s care;
- one or both parents were receiving effective treatment;
- the family’s routines and activities were maintained; and
- there was a stable home with adequate financial resources.

10.44 These are, admittedly, difficult things to achieve for some families with parental drug use which may be characterised by financial insecurity and inconsistent and erratic schedules. Other protective factors came from outside of the home environment, and included:

- strong social support networks;
- a committed mentor or other person from outside the family; and
- regular attendance at school, support from teachers, and positive school experiences.⁵³

Discussion

10.45 Why do some families experience problems with illicit drugs and not others? Are they families with poor parenting, poor communication skills, multiple disadvantages and a prior practice or ancestry of addiction? Were family members born with a particular temperament or personality that predisposed them to drug use? Were family members exposed to drugs through peer group, social influences or sheer ubiquity outside of the family’s control? Were they unlucky?

10.46 The answers could be all or one of these. Odyssey House Victoria’s 2004 report on the Nobody’s Clients project for children of drug users noted that:

52 Advisory Council on the Misuse of Drugs, United Kingdom, *Hidden harm: Responding to the needs of children of problem drug users* (2003), p 41.

53 Advisory Council on the Misuse of Drugs, United Kingdom, *Hidden harm: Responding to the needs of children of problem drug users* (2003), pp 37-41.

There is no conclusive evidence on the relative importance or the interaction of various risk factors in the development of drug problems. It is also difficult to establish which risk factors are the most critical, which are amenable to change and which, if any, are specific to the development of drug abuse as opposed to general adolescent problem behaviours.⁵⁴

- 10.47 The committee is sensitive to the fact that many parents of drug users experience guilt, anxiety and bewilderment over whether their family environment could somehow be to blame for their son or daughter's actions. In the past, this has been encouraged by a clinical bias that assumed the family was either the root of the drug user's problems or an irrelevant adjunct with little to contribute to the treatment and rehabilitation of addicts.⁵⁵
- 10.48 An Adelaide mother gave evidence to committee about her son, who committed suicide in 2006 after struggling with cannabis, amphetamines, ecstasy, magic mushrooms and intense depression. Asked whether she felt some families were more at risk than others, her response revealed the searching self-doubt that others parents have reported as well as a pragmatic sense of the influences of the world at large on her son:

I wondered about that; you do question yourself as a parent. No. There are people I am aware of from good wholesome families where parents have good positions in life, who offer to our community in positive ways—in organisations, in groups they are with—and their children have goals and ambition. All it takes is that one: they take one smoke and think, 'That was all right, that didn't harm me.' The next thing you know, peer pressure, they are at a party, they are given more.

Some people can have a pre-existing addictive nature and possibly genetically, too, people are predisposed to drug abuse. My family has a history of alcoholism on my father's side; a grandfather and all five of my cousins have been alcoholics. We have a predisposition, I consider, to perhaps becoming addicted to substances, in which case perhaps we need to tread more

54 Odyssey Institute of Studies, *The Nobody's Clients project: Identifying and addressing the needs of children with substance dependent parents* (2004), p 23.

55 Families Australia, submission 152, p 14; Australian Psychological Society, submission 131, pp 7-8; Walsh C, submission 84, p 3; Copello A et al, 'Family interventions in the treatment of alcohol and drug problems', *Drug and Alcohol Review* (2005), vol 24, p 376.

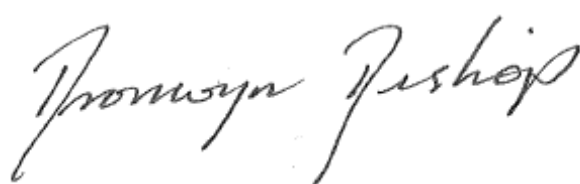
carefully. My understanding is anyone can become addicted with continual use of anything.⁵⁶

10.49 As Velleman, Templeton and Copello write:

Family influence... does not occur in a vacuum: clearly there are other determinants on drug and alcohol use and misuse, including intra-personal factors, peer influence, and wider — community and environmental — factors such as media influences, advertising, availability and environmental deprivation; these cannot be ignored in any comprehensive analysis of aetiology and correspondingly of prevention and intervention strategies.⁵⁷

10.50 Nevertheless, it is important to acknowledge potential family influences on drug use, both protective and negative, at the same time as acknowledging the grief and damage wrought on families by illicit drugs. There are clear implications for enhancing prevention measures that:

- apply across the spectrum of Australian society;
- harness the family to influence against drug use;⁵⁸ and
- protect those rendered most vulnerable by intergenerational cycles of drug use and associated risks of neglect and abuse.

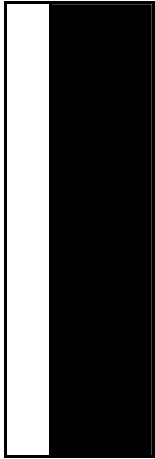


The Hon Bronwyn Bishop MP
Chairman

56 Russ C, Drug Free Australia, transcript, 28 May 2007, p 5.

57 Velleman R et al, 'The role of the family in preventing and intervening with substance use and misuse: A comprehensive review of family interventions, with a focus on young people', *Drug and Alcohol Review* (2005), vol 24, p 94.

58 Velleman R et al, 'The role of the family in preventing and intervening with substance use and misuse: A comprehensive review of family interventions, with a focus on young people', *Drug and Alcohol Review* (2005), vol 24, p 103.



Dissenting Report — Mrs Julia Irwin MP, Ms Kate Ellis MP and Ms Jennie George MP

The inquiry process

Federal Labor committee members believe it is important that House of Representatives Standing Committee inquiries provide taxpayers with value for their money.

This inquiry and the report which has eventuated do not meet this basic test.

Four years ago, in August 2003 the House of Representatives Standing Committee on Family and Community Affairs finalised a report into substance abuse in the Australian community.

The Inquiry spanned sixteen months of investigation, received submissions from some 300 individuals and organisations, and the final report, *Road to Recovery*, contained some 128 recommendations.

It is difficult then to justify the cost of another inquiry covering similar subject matter within such a short space of time.

Road to Recovery detailed the experiences of parents dealing with a child with addiction to illicit drugs. One individual noted how her sister's addiction and prostitution in support of her habit *had torn the family to its heart*.

That family, along with many of the other interested people who gave testimony would be perplexed and disappointed that their very personal accounts of the terrible impact of illicit drug use detailed in the Committee's report did not warrant immediate action from the Federal Government.

In fact the Government's response to *Road to Recovery* was not tabled in the Parliament until August 2006; some three calendar years after the Committee

completed its work and just six months prior to the initiation of this Inquiry by the Chair of the Family and Human Services Standing Committee.

The absence of any substantial response to the initial inquiry and then such a hasty return to the same subject so soon after, demonstrates a profound lack of respect for the Australian families affected by illicit drug use and the professionals who help them and want their elected representatives to take decisive action.

It is important to also record Federal Labor Member's concerns at the conduct of the present inquiry. While many witnesses to the earlier inquiry were asked to present their views again, not all who did this were treated with respect by individual committee members.

Some experienced outright hostility because their expert views did not accord with the personal beliefs or political aims of those questioning them.

Such behaviour brings no credit to the committee process and puts at risk future inquiries which may rely on expert opinion to help shape future policies aimed at improving the health and wellbeing of Australians.

Inquiry findings

From its terms of reference, the Committee's inquiry and report might have been expected to deal with specific issues related to the impact of illicit drug use on Australian families.

Instead the inquiry has focused on attempting to legitimise the political stance of the Government. From the outset, (1.2), the Report's introduction takes its lead from a quotation attributed to the Prime Minister of 16 August 2007 which advocates the maintenance of a "zero tolerance approach."

In practice, there is a gap between Federal Government rhetoric, the conclusions its members reach in Committee processes, the services funded by the Government, and the National Drug Strategy adopted by the Council of Australian Governments. For example, the recent report of the Parliamentary Joint Committee on the Australian Crime Commission Inquiry into the manufacture, importation and use of amphetamines and other synthetic drugs in Australia recommended that in the execution of the Government's National Drug Strategy, harm reduction strategies and programs receive more attention and resources.

Labor members strongly condemn illicit drug use and support a "tough on drugs" approach as a means of protecting Australian families from the terrible consequences of drug use and abuse.

This is evidenced by a series of recent Labor policy announcements.

On 15 April 2007 Federal Labor committed to a National Strategy to crack down on methamphetamines or “ice.” This included:

- a ban on importing ice pipes and other drug paraphernalia and either further restrictions or a complete ban on sale of pseudoephedrine - a key ingredient of methamphetamine - over the internet; and
- the extension of the special reference to the Australian Crime Commission to conduct a national investigation into the criminals engaged in the manufacture, sale and use of methamphetamine.

On 24 June 2007 Federal Labor committed to boost Australian Federal Police numbers by 500 including tackling the importation of illicit drugs.

On 14 July 2007 Labor announced a plan to quarantine up to 100% of the income support payments of parents who are addicted to drugs and alcohol. This initiative recognised the need for a robust intervention to ensure payments to parents battling addiction are spent on their children.

Labor members support the aim of helping those who use to become drug free.

It must be recognised that illicit drug use and drug addiction in particular, can be complex.

Despite the best efforts of families, Governments and health professionals and community groups such as churches, a small number of people still engage in drug taking behaviour. This is a tragedy that families across the social spectrum face.

How best to deal with those who are resistant to intervention is not an easy task but society should not give up on trying to engage them in treatments that will see them become drug free and minimise the harm they do to themselves and their families.

Labor members believe that health professionals need to be able to use a range of intervention approaches and that these must be seen as part of a continuum that has freedom from drugs as an end goal.

Labor Members are concerned that the construction of many of the Committee’s recommendations are either flawed or deliberately worded to prevent acceptance by a reasonable person.

Labor supports a majority of the Report’s 31 recommendations.

However for the reasons described above, some cannot reasonably be supported or rejected in whole.

The following general observations are intended to inform an incoming Government of Labor Committee members views on some of the key issues raised in the report.

What works

The Committee's rejection of evidence-based analysis puts at risk the valuable work of government and non-government agencies which lead the world in addressing the health, social, economic and law enforcement consequences of illicit drug use.

In some cases the Committee's report even contradicts the Federal Government's August 2006 response to the *Road to Recovery* report. For example, the Commonwealth's response to *Road to Recovery* points to a recent review confirming the efficacy of Government needle programs while the current report seeks a review of the same.

The current report seeks to impose a one size fits all approach to the dispensing of methadone, despite the effectiveness of the current approach which relies on the professional judgement of qualified pharmacists.

It also advocates Government sponsorship of individual treatment options without normal tests of efficacy and cost effectiveness that are applied to all other medications.

Child protection

The report's approach to the protection of children is at odds with State and Territory child protection practice and inconsistent with the intent of current Federal Government welfare policy.

Government Committee members argue that addiction alone should determine whether a child is separated from their parent rather than the more robust test of the best interests and safety of the child administered in the field by a qualified child protection practitioner together with Police and doctors.

In practice, such an approach could place children at greater risk, as Dr John Herron, head of the Australian National Council on Drugs noted recently:

“Overcoming drug or alcohol dependencies is not an easy task, particularly when caring for children. Having a system that encourages treatment is far better for the children than a system that drives parents away from assistance for fear of being separated from their children.”

Labor members believe that a more robust approach is the one that operates currently in child protection systems in all jurisdictions where the best interests and safety of a child determines whether they are separated from their parents.

Further, the bipartisan commitment to quarantining of welfare payments of parents in contact with child protection agencies is intended to provide a corrective option for those with a drug or alcohol addiction to overcome their problems.

Other issues

Labor supports workplace based strategies that target illicit drug use. However, such initiatives must be cost effective for employers and be implemented with the cooperation of State and Territory Governments. Labor Members advocate the development of a strategy to target illicit and licit drug use in the workplace through the Council of Australian Governments.

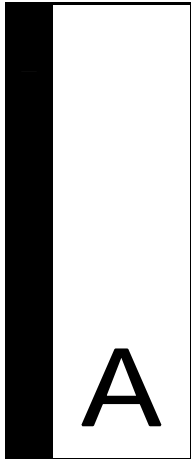
Labor members note the Government's response to *Road to Recovery* endorses the role of the Australian National Council on Drugs in promoting appropriate media treatment and reporting of drug and alcohol issues. Labor members believe the Australian National Council on Drugs should be given a more formal mandate to develop national guidelines for the responsible reporting of these issues.



Julia Irwin MP
Deputy Chair

Jennie George MP

Kate Ellis MP



Appendix A – Transcript of public hearing, 15 August 2007

Official Committee Hansard

House of Representatives

Standing Committee on Family and Human Services

Reference: Impact of illicit drug use on families

Wednesday, 15 August 2007

Canberra

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, Mr Fawcett, Mrs Markus and Mr Quick

WITNESSES

ROWE, Mrs Lorraine, Private capacity

Committee met at 10.13 am

CHAIR (Mrs Bronwyn Bishop)—I declare open the public hearing of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drugs on families. I welcome Mrs Lorraine Rowe, who has fostered many children needing out-of-home

care, nearly always because their parents have been drug users. We are grateful that Mrs Rowe is prepared to share her personal experiences with us today and it will be most valuable evidence. Would you like to make an opening statement?

Mrs Rowe—I am from Tamworth and I am 49 years old. My husband and I have been fostering for 24 years and we have had several children during that time. We started in South Australia when my husband was in the Air Force. We fostered in South Australia, Western Australia and New South Wales. He retired from the Air Force about six years ago and we have settled in Tamworth, so for the last six years we have been working with the community service centre in Tamworth. I currently do support work for the Defence special needs support group, full-time fostering and also help train and support foster carers in Tamworth and our area. I am on the advisory group to the director for our regional area with regard to concerns and issues raised by children in care and their carers. We currently have two children in our care aged five and three, who are from a family with a really long history involving illicit drug use. So I come today to talk about their story and our story and to give you some insight into some of the things the children face day to day dealing with these things with their parents.

CHAIR—We would like to hear that and also what the prospects for those two children are. What is going to happen to them?

Mrs Rowe—Their mum has been in and out of the care of the department since she was a child. The term ‘ward of the state’ is not used much any more, but she was a ward. She has been heavily involved in heroin use. She has had six children, one of whom is deceased. He was 18 months old and he ingested 40 milligrams of methadone. No charges were laid. That was some time ago. She has a 15-year-old daughter who has lived most of her life with her paternal grandparents and relatives who also are heavily involved in drugs. That side of the family is extremely well-known to the police and department within our town. She has three children currently in care—a seven-year-old boy who is in an intensive support placement. He has extreme behavioural problems; he is very aggressive and violent. The two children that I have in care are a five-year-old girl and a three-year-old boy, both with special needs that are not related to the drug use, but all six of her children were born drug affected. The two children that I have actually have a final order with Community Services so they are supposedly to stay in the care of the department until they are 18, but the order has had what they call a section 82 attached by the magistrate which means mum can petition the court again which she plans on doing in November to gain custody again of the children. The five-year-old and the three-year-old have been in and out of care several times since they were born. The five year-old was born 11 weeks premature

and we had her for 18 months when she first came into care as an infant. She was then returned home to mum who was clean at the time and then everything fell apart again for mum—the kids went back into care and mum went back into rehab. She has done rehab and parenting programs several times over the last five years. At the moment she is clean and seems to be managing with the two children she has at home. She has, I think, almost a one-year-old baby at home who has not been removed because there has been no reports made on her care or wellbeing.

CHAIR—How old is the other one?

Mrs Rowe—The one-year-old and the 15-year-old she has at home. The 15-year-old has just returned home to mum. My concerns with the three-year-old and the five-year-old are that with their special needs—they both have rare types of dwarfism, for want of a better word, growth problems—and they need to have somebody who is responsible and reliable to meet their needs as they grow and mum is just not able to do that. When she is using drugs she is just so consumed with the drug use that she is just not able to meet their emotional needs. She just cannot—she focuses only on the drugs and how to obtain them. So those kids are left unfed, uncared for. I know that the seven-year-old at one time when they were home set fire to the house. The children have been there when police have had to go in and remove the children from the home, when they have arrested the parents, and it just plays havoc with the children's emotional stability. This coming and going to them comes through as a rejection, and so repeated rejections lead the kids to not trust anybody. The five-year-old and I have had several phone conversations, just from my coming down here yesterday, to reassure her that I am coming home. She has asked her current carer where we are; she is checking that Auntie Lorraine is in Canberra, Uncle Geoff is at home and that, yes, we are coming to pick her up on Thursday morning—because she needs to know. Even just how much food I put in her lunchbox for preschool determines her emotional stability for the day: 'Why am I having that much food, how long am I going to be gone, when are you coming back?' They see their mum every Thursday for a couple of hours visit, which the kids just love because it is a party time. They get lollies, they get hot dogs, they get filled up with all this guilty food and mum is overcompensating so as to be shown to be a good mum and 'the kids still love me because I am giving them presents.' While they have a really good time with their mum on the Thursday, which is supervised access, on Thursday night we have nightmares. We have two children who scream in the night, who cannot tell you why they are frightened, and usually my husband is in one room and I am in the other comforting children, just telling them over and over again how safe they are and that nobody is getting hurt. I understand that some kids should go back,

but I just do not understand why our system allows them to go back and come back and go back and there is no guarantee. We fought hard to get these two children placed back with us because we had a history with them. In the last six months they have had four different placements within the department. That is an abuse in itself—it is just more rejection. I get really passionate about these kids and they are just one little symbol of all the kids.

Tamworth is a town of 50,000 people. We currently have approximately 250 kids in care and our client services manager said that 80 per cent of those would be as a result of illicit drugs. That is 200 children going through these sorts of issues on a day-to-day basis just in our town. There are hundreds of thousands of kids going through this across our country every day and they are not getting just the basic necessities. The parents are not emotionally available for them. If they are so focused on getting the drugs to manage through their day they are not able to be there when the kids need them—they are not feeding them, they are not clothing them, they are just not picking them up when they fall and skin their knees and all those things are important for all of us to learn how to trust people. If you are getting rejected—whether it is just going from one home to another, no matter how loving that home may be for that short period of time—all the time you are not going to trust anybody. You are going to learn that we as adults are not reliable to little kids; we are unpredictable, that from one day to the next that bed is not going to be there or available for them. And so then you have teenagers who have no respect for society or for anybody because why should they respect us? We have never been there when they were little, we did not put a bandaid on their knees, we did not kiss them goodnight, we were not there to give them food. We have just recently had two children who came for one night over an incident that was not drug related at the time but then they ended up staying for 2½ years—it was a very long night— and during the next few weeks after they arrived a lot of information came out about the drug use. The family of the father that was involved with these particular boys is extremely well known and they are also involved with the children that I currently have in care. The police and the department and the magistrate all know this name and I assume they cringe like I do when they hear the surname. When it became evident that there were drugs involved in that family, the children ended up having to stay a lot longer. They have just recently gone home. This is the first time mum has had the children removed, and we are hoping that she is going to keep it all together for them. When they came to us they both were wearing a nappy, and the 12-year-old that came with them had boxers and a T-shirt on in the middle of the night. No clothes came, ever. They had no clothes; they had nowhere to live. They were living from one place to another. They owed the housing department tens of thousands of dollars for damages and unpaid rent and everything because all

the money was going on drugs. When parents lose their kids to the department and they get angry, a lot of the time it seems to me that they are not angry that the children have been taken. Sometimes, maybe, they are a little bit relieved that the kids are gone, but then they get really angry because their payments are cut dramatically.

CHAIR—And the tax benefits go.

Mrs Rowe—Yes, everything goes. That seems to be the big focus. The kids are always coming home—

CHAIR—The kids represent money coming back to them.

Mrs Rowe—That is right: ‘You have to buy me this because you are getting all my mum’s money. The government has given you my mum’s money, so you have to buy me Spiderman; you have to buy me this. I want this; I want that, because you are getting my mum’s money.’ That is the message that mum is sending back through the children—she cannot buy them things because ‘your foster carer has got all my money.’

Mr QUICK—You have experienced three different states. Does the bureaucracy vary? Is the understanding greater or lesser in any of the states? Is anyone doing it better?

Mrs Rowe—I cannot answer that. We started in South Australia. Until the last six years we have only done emergency and crisis because Geoff was in the Air Force, and 24 years ago we used to only get six weeks notice that we were moving, so we could not commit to a child for a long period of time. I think that the problems are still the same. I would hope that it is a lot better managed now within the department. I know there are still a lot of issues around communication, and there is still that ‘us and them’ mentality between the department and the foster carers. It is like a really bad triangle—parents, foster carers and department—and they keep spouting ‘teamwork’ and everything, but I do not see a lot of teamwork where we are.

Mr QUICK—Do you have the same case manager or do you have a variety?

Mrs Rowe—They change; they get burnt out. For the two boys who just went home we have had three case workers. Each one comes with their own baggage and their own way of thinking. It constantly went from ‘These children are being restored’ to ‘These children are staying in care’ to ‘These children are being restored’ to ‘These children are staying in care.’ There is no stability, even within the placement, for us to be able to plan schooling or preschooling. I had the 4½-year-old in preschool, but his mother now cannot afford for him to go to preschool or actually get him to that preschool. I

cannot plan his future or help him out because we did not know whether they were going back or staying.

Mr QUICK—What is the department's answer to that? There should be not necessarily a triangle but with the education system you are talking about intergenerational dysfunctionality.

How do you break that by giving the kids at least a chance to get a decent education?

Mrs Rowe—I think the department says that preschool is part of their formal education in their social skills development. They were assisting mum with preschool fees. I think the children still have eight months of a 12-month supervision order to go. With the children I have now, the magistrate is the one who said, 'If mum presents as doing this, this and this, then they can go home.' She seems not to look at the history of the family. It might just be me, but when I look back at the history—with the baby having the methadone and the constant stuff going on—I truly cannot see any reason for those kids to go home and be put back in that situation that is going to fail again and they will come back in. It will fail because of the history—of mum's history as a child and her history now as an adult. Sure, she has been clean for a few months but she has done that before.

Mrs MARKUS—So the risk of failure is not counted in the assessment?

Mrs Rowe—It depends on the magistrate. With these children, I know the department has assured me that they want the children to stay in care. They want them to have a stable home life but then we could get another case worker who is more sympathetic towards mum and the fact that mum has met the goals laid out by the magistrate.

Mrs MARKUS—Without understanding the history.

Mrs Rowe—Yes. A lot of them do not even read the file. The paediatric file on these children is this thick—I have no idea how thick it would be within the department. But I get a new case worker and it seems to be my responsibility to inform the case worker about the baby who has died, the 15-year-old who is living at home and the family makeup—that the eldest and the youngest are half-sisters and also cousins because mum has had both the children to brothers. Does that make sense?

CHAIR—So there are two fathers to the six children?

Mrs Rowe—No, there are five fathers to the six children, but the eldest one's brother is the father of the youngest child. And it becomes very incestuous when we have these families—when we walk down the street and everyone is a cousin because they are all mixed in with the drugs and so on.

Mrs MARKUS—So the permanent order—because there is a permanent order—in a sense does not have the real impact that it is meant to have.

Mrs Rowe—No.

Mrs MARKUS—Because there is section 82.

Mr QUICK—So you have been doing it for a long time. Tell us about the successes and why they succeeded. You would get burnt out—

Mrs Rowe—Yes, but I do have breaks.

Mr QUICK—But there must be ways of you tackling it to say, 'I have achieved it with Susan or Billy.' Can you tell us about that as well and why it worked and was it all your doing or the department's too or a combination?

Mrs Rowe—I think there has to be a combination of everything. I think you have to have family members—and I think grandparents are really overlooked and underrated in this. There is a lot of kinship carers out there taking on these children to keep them out of the system. They are not privy to the financial support that I get, which I think is really wrong because they are doing the same sort of job and it is harder for them emotionally because they are their children or their children's offspring. I think with us having had so many children in short bursts, for the emergency in crisis, is that we do not get to see a lot of the final impact but we do see them moving on, hopefully to a stable home—whether that is in another foster care home or whether it is with the family. My personal preference would be that they went to family members because I think it is important that you have those roots. With the two boys that have gone home, as I have reassured their mum, my goal now is to help her keep those kids at home. I feel very fortunate and blessed that she is willing to let me still be a part of their home after 2½ years of caring for them. She probably has felt it but she has not actually said that she felt I was taking them away from her. I think it is important they know who their past is—no matter how bad it is—so that it gives them a healthy mental outlook and how to deal with problems and how not to perpetuate them. If they have a different system— 'Okay, this is how mum dealt with her problems and it wasn't that great but this is how Aunty Lorraine dealt with hers and taught me how to deal with this,' then that might stand them in a better stead in their life.

Mr QUICK—One would hope that the department has a longitudinal approach so that the supply into the pipeline is being reduced over a period of time, but all the evidence that we have received is that there are tens of thousands of these kids and there is not a structure put in place—

Mrs Rowe—To keep them anywhere stable, no.

Mr QUICK—and when they do enter relationships and have children the problem is just exacerbated.

Mrs Rowe—I have high hopes for these boys who have just gone home but it is all sort of hanging on whether mum can stay away from this other family. If she has a bad time or something I am concerned that she will then slide, that it is a lot easier to go back to your friends that are using and block the day out than it is to deal with naughty children or dirty nappies and a washing machine that has blown up. Once again they have not had that stability if we cannot get the kids into stable homes and support them in those homes. I know the department has history about the stolen generation and so on, but we need to look more along the lines that, okay, some mistakes were made there but some of these children need to be in permanent homes, regardless of their colour, to help them learn and to give them emotional stability. If we have problems and we have been brought up in a family where we know we can go to somebody and have a cry and get a cuddle—and maybe not told that everything will be all right but ‘I will help you through it’—then we are better able to cope when things go wrong than if we are all alone and have not learnt those coping skills. These children are never going to learn them if they keep on being chopped and changed. I think it comes back to the fact that with the case workers and the department it is all individual. You get some people who are gung-ho about ‘Let’s get them in a placement. Let’s keep them there and let’s support those workers and the children and give them a chance.’

CHAIR—What about some of them being adopted?

Mrs Rowe—I think that would be great, especially for the little ones. Then they have a chance. I still think that they need to have maybe phone contact and photos and things like that so that they still have an understanding of where they have come from. But I think having a home and a name is so necessary. The two children we have now have the same mother. We have so much trouble with the names. We have to give three names because it is ‘one surname also known as this surname also known as this surname.’ I tried to get a mobility sticker for the fiveyear-old because of her disability, but she has one name on her Medicare card and another name on her Centrelink, and I had to go and get a letter from the department linking the two together. The RTA manager gave me the thing because I must have looked like a crazy woman, but he said, ‘She has to pick a name by the time she is 16. She will not get a licence with a whole string of “also known as”.’ I can’t enrol her at school until we access a birth certificate that has her name on it, because the school will not give her ‘also known as’, so we are struggling because mum cannot really remember what name she registered her birth under.

Mr QUICK—And this is not an unusual case.

Mrs Rowe—This is day-to-day stuff. I want that little girl in school and I cannot get her into school. I have to take Medicare and health care cards for ID and they have got different surnames on them. To be adopted and to be able to have a family and to know that ‘this is my family’ is important. Our youngest child has profound cognitive and intellectual disabilities. We adopted her and we have an open arrangement with her mum who chooses not to have anything to do with Jessica but she knows she can contact us. And in the beginning we sent lots of photos and information backwards and forwards on Jessica’s development. I think that is healthy for us as an adoptive family and if Jessica were able to understand I think it would be very important for her. It is also important for her biological brother if down the track he wants to track down his sister. So I think that way would be a great way to go. These two little kids I have at the moment are just brilliant but they need to have some stability and I do not see any other way other than that or permanent foster care.

Mrs MARKUS—But permanent foster care is not permanent either.

Mrs Rowe—Mum can come forward any time in that 18 years and put—

Mrs MARKUS—One of the challenges with permanent foster care is that, say for example you could no longer foster—for whatever reason—the child is moved and the child just moves from foster placement to foster placement. And I have heard people say before that the state is not necessarily the better parent.

Mrs Rowe—It is like a bandaid. We look at it like we are sticking bandaids on arterial bleeds.

CHAIR—But there is still a definite anti-adoption attitude, isn’t there, from the department?

Mrs Rowe—Yes. We are fortunate at the moment in that we have a new casework manager who is really for it. I know she is pushing it—at the moment I think she has seven that she is trying to get before the court. But they say that it costs \$30,000 on average for each adoption. But give the kids a chance. These are kids that have been with these foster carers for years and years. Why can’t they have their name? Why can’t they live there?

CHAIR—This is a very important point.

Mrs MARKUS—So the \$30,000 cost they are referring to is?

Mrs Rowe—I have no idea. I assume that it is legal costs.

CHAIR—They tell you that government fees are \$30,000 for a domestic adoption?

Mrs Rowe—That is what she told me last week.

Mr CADMAN—We have done the adoption inquiry and there are hoards of people out there that want to adopt children. They are going overseas looking for kids with disabilities in any country they can find.

Mrs Rowe—To have a baby, to have a child to care for and to give it a better chance—and not everybody wants a tiny baby.

CHAIR—Some will take children.

Mrs Rowe—Some will take children. Then people say that when they are teenagers they will play up. We all play up when we are teenagers, whether we are adopted or come from good homes; we all do that. It is about giving them those skills. There is a lot out there for people to be able to support each other if it was out and not hidden all the time. There is no shame in adopting a child from a background of drugs or anything like that—

CHAIR—None at all.

Mrs Rowe—and I see only benefits in that these children will have a home. It is having a home and having a name.

Mrs MARKUS—And opportunities for the future.

Mrs Rowe—It is having someone who cares if you go to school. We had a 12-year-old girl who had 89 days of unexplained absence from school in year 6. I said, 'How am I going to get her into high school?' That is nearly two terms of not being at school, because mum was so drugged out she had to stay home and look after her brothers. Our goal for the year that she was with us was to get her to school every day. The only time we had off was when she was suspended in the first few months that she was with us—we had several suspensions. She decided she did not like being suspended and home with me because, 'You're up, you're dressed, you're at the table and you should be at school.' That is not fun. But she now is not being suspended. She is back home with mum, but she knows I am there if she needs me. She has been involved with sporting groups at school. But if there is a problem the girl knows that her mum—this is the mum of the two boys that have just gone home as well—will ring me if she wants some suggestions. I am glad that that has just been a little bit in that child's life but she is actually turning up for school. She is still misbehaving at school because she knows she can manipulate mum. But her brothers came to us when they were one and two and, had they been adopted out, they could be now well on their way to being settled and having a great future.

CHAIR—We found in the adoption report—and it sounds like it all over again—there is this biology first: you must send the child back to the biological parents. The consideration for what is in the best interests of the child is non-existent.

Mrs Rowe—It is just lip service. I have not met the magistrate in Tamworth, but it is really common between all of us carers that we are all terrified when our children go before that woman because she seems to have the outlook that ‘That is their mother; they should go back.’ That is how we all feel. November is coming up for us and so we will be getting worried and worked up about that too. We are not able to go into court and talk about the children because the department sees it as protecting us as carers from anything. We do not actually know what case they are presenting. They can tell me that they are in there fighting for five hours to keep those kids in care and safe.

CHAIR—They cannot stop you going into the court. It is a public hearing.

Mrs Rowe—Can’t they?

CHAIR—No. If it is not a closed court, you can go in.

Mr QUICK—We have had changes to the Family Law Act to enable a greater number of people to be involved in the decision making process rather than have this adversarial between husband and wife.

Mrs Rowe—That is how they are treating the department, though. It seems to us that she is looking at it not as a children’s court; she is treating it like Family Court and that DOCS are the recalcitrant parent. So they are being made to prove why they should keep the child. And she is not even looking at the act. We have had the manager of client service say that he has had solicitors who have had to put the act highlighted in front of this magistrate to prove their point and then she will still go against it.

CHAIR—Do DOCS not appeal? Do they never appeal?

Mrs Rowe—I do not know. I am not privy to that.

CHAIR—One thing magistrates loathe is having appellate courts tip a bucket on them. I would think that, if this is happening, DOCS ought to be appealing and having this happen.

Mr QUICK—But surely in the best interests of the children you would widen it as far as possible to people who have some impact, even to schoolteachers and school principals that are responsible for the kids so you can get a better picture of what is going on.

Mrs Rowe—They are supposedly getting this —and clinician reports are being ignored. There are two little girls in another town whose father has

mental health issues and they have been brutally abused. They have had clinician reports saying that those children should not go home but they are still getting lots of contact with their family in the hope that dad is suddenly going to be miraculously cured and they will be able to go home. These are preschoolers who, once again, could be in a permanent family and living a really good life that would hopefully soften some of those horrific memories that they have.

Mr CADMAN—What is the magistrate's name?

Mrs Rowe—Vivien Swain.

Mr QUICK—How would you feel if there was a recommendation to say that the children should be adopted as a matter of course except for the following things, rather than that they should be fostered out with perhaps the view long term of being adopted? So if we said, 'We'll mandate adoption and you prove that that is wrong,' how would you feel about that?

Mrs Rowe—Within an age frame, would you say?

Mr QUICK—Yes.

CHAIR—Remember, Harry, when we took evidence in the adoption inquiry, we took note of what was happening in some states in America where they would give the parents a chance and another chance and, if they had not stabilised and were really able to give the children care, automatically that was the end of it and the children could be adopted or placed in permanent foster care. Did you hear what Mrs Rowe said about seven cases that a caseworker knows about where the foster—

Mrs Rowe—She is trying to get them adopted.

CHAIR—And there is this anti-adoption attitude.

Mr QUICK—That is right.

Mrs Rowe—And that is within her own department too, I think. She is really struggling against other people within that department.

CHAIR—That is what we found. That is what Deborah-Lee Furness and Hugh Jackman have found when they have tried to adopt. They have found this same attitude that we have found.

Mrs Rowe—They just think blood is thicker than water, that the kids should be with their parents. I think they need to know their history. It is not necessarily good for them to be there; in most cases it is not. I cannot see that it is good for children to be with parents in a situation that means you do not know when you come home from school if you are going to be fed or not. In

WA we had a 14-year-old girl stay with us for two weeks who was responsible for her 11-year-old brother with ADHD and her seven-year-old sister with an intellectual disability. Her mother was 28 and a heroin addict. This girl was hiding clothes and hiding food on her way to school so that she would be able to feed her siblings when she got home. She sussed out which church groups had youth groups going and on a Friday night the kids got a hot meal because she would take them to these youth groups that were providing food for 50c. She would scab bottles, cans, anything, to get money to take her brother and sister for a hot meal. She used to have to wag school and come home to clean up her mum and her mum's friends so that the kids did not walk into syringes and bongs and things lying around. The caseworker's biggest problem was that I allowed her to continue to smoke.

CHAIR—What?

Mrs Rowe—That is all they could go on about.

Mrs MARKUS—I am sorry, I missed that. You allowed who?

Mrs Rowe—I allowed the 14-year-old to smoke. I said I would not buy her cigarettes, I would not give her money for cigarettes but if she had them I considered it was the least stressful thing. This kid needed something. That was it—I was not taking that away from her. That is all the caseworker at that time focused on—that she was still smoking while she was in my care, not about everything that this kid had to do on a day-to-day basis to protect her family. And they sent her home. She was dragged from my arms screaming because she did not want to go back to her mother, but they did not have anywhere else. That was probably nine years ago.

Mrs MARKUS—Why couldn't she stay with you?

Mrs Rowe—Because we were only doing emergency short-term and the department said she had to go home.

Mr QUICK—Do you know what has happened to her?

Mrs Rowe—No, I do not. We are not allowed to. When they leave our care, we are not allowed to follow up. If we have a good relationship with the social worker, you can sort of use what we term the underground—go around and find out where the kids are and how they are doing, which is how I found these other two children were back in care, which is not that hard in a town of 50,000 people. Then, when I found that they were drifting, I said, 'No, that is it.' My husband and I said, 'We want them in our home until we know that they are settled'—and I will fight for them.

Mr QUICK—So who holds the department accountable—anybody?

Mrs Rowe—I do not know. It is supposed to be the commissioner of children and young people, isn't it? I do not know.

CHAIR—Is there such a person in New South Wales?

Mrs Rowe—The Ombudsman. There is supposed to be a commissioner.

Mr QUICK—Yes. I know in Tasmania we have a commissioner for children, but they do not seem to have any clout or any teeth.

Mrs Rowe—Unless there is an allegation made against us and mums can do that—I am waiting for one now because I have had the five-year-old's hair cut. I have to get permission to get her hair cut because I can be charged with assault. I have to get—

Mrs MARKUS—For cutting her hair?

Mrs Rowe—This particular mum, back when this baby was first in our care, put in a complaint that I was not feeding her and I had clinic sisters coming every week to check. She put in complaints that I blew raspberries on the baby's tummy which was sexual impropriety. All these things then go to the allegations against employees. I then have to be investigated. It is kept against my name on a file and that is looked at, but her history is not looked at.

Mr QUICK—That is ridiculous.

Mrs Rowe—It is definitely an us and them, and for us as foster carers it seems more focused towards 'Let's get the kids back with mum and dad regardless'. I think everybody deserves a chance. We have all done things wrong as parents and we should not have to have our children removed straightaway. But I do think if there is a continuum of exactly the same sorts of things, then—

Mrs MARKUS—Particularly over a number of years and over a number of children.

Mrs Rowe—That is right, and you say no to your own children. They do certain things, they get to a point and you say, 'Right; this is the consequence.' There are no consequences anymore. Everything is just too soft. They are using drugs that are illegal but they are not being sent to jail.

CHAIR—That is right, or reprimanded even.

Mrs Rowe—Or reprimanded. It is like, 'Oh well, it is only drugs.'

Mrs MARKUS—There was no change laid when that baby died.

Mrs Rowe—Initially it was supposed to have been a SIDS incident. Then evidence came forward that she had actually administered the methadone to

the child. So it was then reopened—and I cannot actually remember when it was—it was about five years ago that it was reopened.

Mrs MARKUS—And people want to support methadone; I do not think so.

Mrs Rowe—It was from the take away. I have a big problem with this take away methadone. She had been out working—and this is public knowledge because it was all on the news and on the internet when the second coroner's inquest was opened. She had been out working. There were four drug addicts living in the house.

CHAIR—Working doing what?

Mrs Rowe—As a prostitute. She came home and they were going to be too tired or something and so they got their take aways from the clinic and they brought them home. That was what the baby allegedly accessed and gave himself.

CHAIR—How old was the baby?

Mrs Rowe—Eighteen months old.

CHAIR—So the 18-month-old self-administered.

Mrs Rowe—Self-administered 40 mils, which is a whole medicine cup of methadone. My understanding is that the coroner said that there was evidence to have a charge laid but that then it was determined that there was not enough evidence—

CHAIR—You mean that the coroner said that there was sufficient evidence and the DPP decided that there was not.

Mrs Rowe—Said there was not.

CHAIR—What a cop-out.

Mrs Rowe—And the actual witness was her brother, who was deceased at that stage, so they did not have anything. To my way of looking, she got away with it.

Mrs MARKUS—Which actually brings into mind that any statistics about death from methadone of children is really not—there are really no adequate statistics.

Mrs Rowe—It is happening all the time. Once again, it is her need overlooking the wellbeing of that baby. Four of them in that house, why is she the only one responsible? Why weren't the other three supposed adults responsible for caring for that child? How did he get it—if all four adults are drug addicts then none of those people were showing sufficient care for that

child. So I have a personal problem with that part of this family and my concern is, if that is how she felt about an 18-month-old, and all I can imagine is he was probably whingeing or something, what about these two with special needs who are going to need this constant care—one of whom may have a life limiting disease that we are still trying to look through? Is she going to become a burden and then mum slips her something?

Mr QUICK—What do they do with the \$4,000 they get when the children are born?

Mrs Rowe—They probably stock up, I guess. I don't know. I mean, when the kids come into care, anything that is provided for them through the department such as prams, cots, clothing, we get an initial \$350 in New South Wales to buy emergency type stuff, that is expected to go with that child if it moves placement or goes back to mum. But then when it comes back into care, there is none of that property.

Mr QUICK—How much do you pay per child per week?

Mrs Rowe—Under five years of age now I get \$380-something a fortnight. Five years to 12 years I think is \$425 a fortnight.

Mr QUICK—So you are certainly not in it for the money.

Mrs Rowe—No. It works out to a dollar something an hour, and that is to provide their medical, clothing, food, education, all that sort of stuff.

CHAIR—What about the family tax benefit: do you get that?

Mrs Rowe—I can claim the family tax benefit and the child-care benefit.

Mr CADMAN—That is where you are stealing mum's money, aren't you?

CHAIR—That's right.

Mrs Rowe—That's right, because mum loses all that. She would lose significantly more than what I am getting because my husband is on a wage. She would lose quite a substantial amount, I should imagine, if she had five children and all of a sudden five were taken into care.

CHAIR—She would still get the \$3,000 stay at home money because she would be the sole parent. There would be only one income, so she would still get that.

Mrs Rowe—And they get food vouchers.

Mr CADMAN—I guess we touched the tip of some of the things you have spoken about during this inquiry and previous inquiries. I guess you brought it home to us more starkly than anybody that we have had before us as to

what it is like day to day on the ground. It is really distressing that so much of the responsibility for this is outside the sphere of the Commonwealth and the next steps as to what should be done are pretty important, but it is obvious that this cannot be allowed to continue. What the Commonwealth's role is, we have some responsibilities but the day-to-day stuff is very hard. The drugs program is obviously not working on the ground.

Mrs Rowe—I just think they are very manipulative. Drug users are very good liars and they are very good at being able to present themselves in a good light. We can all be well-behaved and present ourselves before the court and then go home and everything falls in a heap when nobody is looking.

CHAIR—What about if her child is in this situation and the mother decides that she wants it back because she wants the money, the family tax benefit and the child-care benefit does not go back, but there are food vouchers given for the child. In other words, a bit like what is happening in the Northern Territory.

Mrs Rowe—I think that would be great.

CHAIR—So they do not get the cash.

Mr CADMAN—So what you are thinking of extending is some of the principles that are being applied in the Northern Territory to drug users in particular.

CHAIR—Yes.

Mr CADMAN—I do not think we can go wider than that at this point.

CHAIR—No.

Mr CADMAN—To drug users right throughout our society.

CHAIR—To stop them using the family tax benefit money for drugs and so they become food vouchers if the child is forced back by the magistrate.

Mr CADMAN—Obviously our program has got to become more child focused than looking after mum or whatever. The children are the sufferers.

Mrs Rowe—The children do not have a voice. They do not have a say. A three-year-old cannot stand up and say, 'I'm not being fed.' When they go to school, the school starts to notice that the child is coming to school and going through the rubbish bins at lunchtime to get food out after everyone has gone into class. I know a little girl who has done that. When everyone goes into class, she asks to go to the toilet and then she is going through taking scraps out to eat. That is how the school knew that something was wrong in that family and reported. Of course those children were removed. But the kids do

not have a voice. They cannot stand up and say, 'My mum is not feeding me. My mum is not dressing me.' If they have learnt that and it is a learned behaviour for their family, they see that as being normal. We have been accused of being really bizarre because we ask the children to have a shower every night, and because I am washing up three times a day, because we are having food on the table and then the kids are confused as to what day it is, how long they have been there because there is another meal on the table. It is heartbreaking but that is what we have. Trying to explain to kids, 'This is how we live,' and without saying—because I try not to be judgemental, especially in front of the children, that your parents are wrong, but in our home this is how we do it. So it is not a case of your mum is wrong, although I have been known to say that, but when they are not looking after them, it just leaves the door open for so much more to go wrong, for paedophiles to get involved and infiltrate families. There is so much more that can go wrong when mum is making, I believe, a choice. She is making a choice. If you have had all those opportunities to go to rehab, to have these parenting programs and the government has spent all this money on you, you then have a choice to go back to that life or to keep sticking the hard yards out. My focus is more on the children and they do not have a voice.

CHAIR—Do you think that there is an attitude in DOCS that says, 'If we put the children back that will be a prop for mum?'

Mrs Rowe—It will be an encouragement, yes.

CHAIR—In other words, it does not matter what happens to the child, we are looking after this mum.

Mrs Rowe—And sometimes in my more cynical moments I think that there is a success tick for DOCS, that we have had the placement restored. I really do not think that they are child focused. They say it all the time.

Mr CADMAN—That relates to a philosophy that permeates from the top down; that is what you are talking about.

Mrs Rowe—Yes. I am not saying everybody is like that, but I just think that is how it appears.

CHAIR—If you have actually got someone who actually feels that you are talking about a case officer who really is focusing on the child, trying to do something for the child but is fighting the culture of DOCS itself—

Mrs Rowe—Within the department; that's right.

CHAIR—We go right back to that anti-adoption biology first culture that we discovered.

Mr QUICK—As public servants, they know that their decision can be altered further up the tree, so they do not have that confidence in the decision they make. It would be good if they did have that capacity and any review would be not done reasonably but really high up with due consideration to involving as many people as possible in the process and consultation before it even got to a magistrate.

Mrs Rowe—That is right, and keeping it as open and transparent as possible. It is too much closed in, but I know that the case worker cops it because she has worked within the department not as a case worker and I think that is where they are saying, ‘You have no case work experience,’ but what she is doing is looking at it from the child’s perspective. She is really struggling at the moment, but it is something she is really committed to. So they may beat her down in a few of these cases, which I hope they don’t, because these are children that have got a good chance.

Mr QUICK—Lorraine, I have to go, but can I thank you on behalf of not only the committee but all of us who are interested in kids’ welfare. Thank you for the wonderful things you and your husband are doing.

Mr CADMAN—You have not wasted your time coming here.

Mr QUICK—It has been wonderful.

CHAIR—So that we can complete the business today, the committee has agreed to continue the hearing as a subcommittee. I cannot tell you, Mrs Rowe, how valuable your coming to talk to us today is.

Mr CADMAN—We need to analyse very carefully what you have said. There are a lot of implications for government, departments and policy. It is good to see somebody like you, but I can understand the departmental attitudes to some degree where you have got abusers in the guise of being foster parents out there that want to grab kids.

Mrs Rowe—That is right. There have been lots of cases. We know in our town where the kids have been put into care by their parents in the hope that they are safe and they have been badly treated by carers. But I think it is the same for everybody. It is when they are showing a continued pattern and they are not pulling themselves up—when it is just over and over again— that I would be really strongly recommending that the kids did not go home. I think everybody needs a chance.

Mr CADMAN—I agree. With most children, do you think it would be possible to identify continuing parent conduct before the kids get to the age of five?

Mrs Rowe—They are starting the Brighter Futures program in Tamworth—and I am assuming that it is going across New South Wales—where they are trying to introduce an early intervention team, whereby they go into families in which they are getting initial reports about the child not being fed or the child crying all night, to try and put supports in for families before they get to the stage where the children are actually removed. So they may be able to pick things up there. Maybe with the children before the age of five for adoption—

Mr CADMAN—That is what I am driving towards.

Mrs Rowe—With these particular children I have now, if they had taken into account the history of the children that have come through from the 15-year-old down then maybe the five-year-old, the three-year-old and the one-year-old could have been placed somewhere—and not necessarily together. I do not think they need to be adopted into a family together, as long as there is still that openness and connectedness so that they can still have contact with their siblings. I guess that is sort of sacrificing the two older children as the example of mum not being able to hold it together to save the three—

Mr CADMAN—It is salvation for three, though.

Mrs Rowe—That is right. If there is that history that she has done that with these two children then there is a good likelihood that she is going to continue that pattern, so let's get these three out. Does that make sense? I am not sure if that answers what you asked.

Mr CADMAN—It does make sense.

CHAIR—Can I ask you about sexual abuse?

Mrs Rowe—Yes.

CHAIR—Have many of the children that you see or that are you aware of been sexually abused?

Mrs Rowe—Yes, a lot of them. It is not always apparent to the department when they first come into care. Usually the kids have to build up trust with somebody to be able to talk about something that has happened to them. I think a lot of the public thinks, when they hear 'sexual abuse', that it is a situation of full-on intercourse or rape, but it usually starts quite slowly with people infiltrating into families that they see as being vulnerable and separating the children from the parents. They are able to do that by saying things like, 'He is such a little pest; I will take him to the park for you,' and mum then thinks she is getting a break. They start that sort of grooming process over a number of months or years. The children do not seem to realise that that is a problem or that that is happening. Then you have children in

care—it could be after several months or years—who actually come out with, ‘This is what has happened to me,’ and they are not sure why it is not happening anymore.

CHAIR—So do they associate that with kindness?

Mrs Rowe—Yes, and love. Because if they sit on somebody’s lap and touch them, then they might get a bike or they might get a PSP or something like that if they don’t tell anybody. So then when they are feeling loving towards you or I when they come into our home and they want to sit on our lap and touch us, it is our responsibility to say they cannot do that, that we do not do that in our home. And they are confused because that has been an accepted way of behaving. We have very strict rules as foster carers about disclosure, how we react to disclosure and what we have to do. It is horrifying when children do disclose to you the things that have happened. I guess it is just so damaging. It is just another breach that we as normal, responsible people see as such a breach of trust that somebody could do something like that. I do not think people understand how damaging it can be over years and years. Things that are supposed to be private and special and they are turned dirty and nasty and hurtful and the kids are always used. Probably more damaging than the actual physical contact are the emotional threats that they use to get that silence and that cooperation from the kids.

CHAIR—What sorts of threats are they?

Mrs Rowe—If you tell anybody the police will come and take you away, which of course if they do tell somebody, somebody does come and take them away so that is borne out. Other threats are threats against family members, threats against their pets: ‘I will kill your sister; I will kill your mother; mummy won’t love you any more; you will never see your family again.’ Of course if they do tell somebody—particularly if they have told someone at school—with the mandatory notification DOCS will come, or somebody will come, and take that child away so they may not see mum or their siblings for a few days or a couple of weeks until things get sorted out. So those things are borne out and then those deeper threats being made about killing somebody or something just manifest more. It is horrible. It is a much worse thing, I think, than physical scars. They will heal but that sort of stuff drags in the emotional side of everything as well. It is really big to me that you understand just how damaged they can be by not being able to trust someone just for their day-to-day things. They do not trust me; even these kids who I love and who have been with me for a long time do not trust me. This little girl does not trust that I am coming home this afternoon. She cannot be sure that I am coming home this afternoon.

CHAIR—She is probably frightened that if she does give that trust and she is let down, how is she going to cope with that?

Mrs Rowe—Say the plane is late—which is why I am not picking her up until tomorrow. If I say I am going to be there at 3 o'clock—she cannot tell the time, but she will ask everybody, 'What is the time? What is the time?' If I am not there when I tell her I am going to be there, it is just catastrophic for her. Our children will say, 'Mum's late'—it is no big deal. But it is catastrophic for her and that is the thing that gets me the most: they just cannot trust. So they cannot have an adult relationship with anybody because they cannot trust anyone unless we get them in a situation where they can learn to trust and have that stability.

Mr CADMAN—They have been trained for so long to distrust people—

Mrs Rowe—That's right.

Mr CADMAN——that to break that down is hard. Men are pretty bad at training their families not to trust them by not being home when they say they are going to be and arrive a couple of hours late. I found that in our family that I had trained them not to sort of expect me and I had to stop that.

Mrs Rowe—But your family knew that you were going to put food on the table.

Mr CADMAN—Yes, but I can see even from our small example how easy it would be to have that grow into a massive problem.

Mrs Rowe—A lot of people think it is a nothing. We do not promise the kids that we are going anywhere or doing anything because we do not want to be part of that process of breaking promises and breaking that trust. I am sure we do it on a day-to-day basis anyway just as normal human beings, but we try not to do it as much as we possibly can. We are very focused on it in our family because we know how detrimental it can be.

CHAIR—Lorraine, without putting words into your mouth but just to go back over what you have said, you think it would be in the interests of many of these children if when they were small they could be adopted and have a life?

Mrs Rowe—Yes, I do. If there were a family history of these things, yes, I do.

CHAIR—Perhaps there can be an extension of the policy we have got in the Northern Territory that where a child is ordered back the money does not go—it is food vouchers so that they do not spend the money that is meant to look after the child on drugs.

Mrs Rowe—That's right.

CHAIR—We have to seriously think about that.

Mr CADMAN—There are a number of initiatives there. I think that is good.

CHAIR—On the other hand, the parents who are addicts, the sort of background that they come from by and large, the ones that you see the children of —six children, five fathers, brothers being two of the fathers—is this intergenerational?

Mrs Rowe—Yes.

CHAIR—Have those parents themselves come from that destabilised background as well?

Mrs Rowe—That is what we are seeing in our family. That is what we see. I know that drug use is over the whole of the community but I would say most of what we see has been from the low socioeconomic areas and it has been generational.

Mr CADMAN—Is there a fairly large Indigenous community in Tamworth?

Mrs Rowe—I am not really sure. We have cared for Koori children in our home because we do not have a lot of carers, but over the years most of them have been from white families relating to the drugs.

CHAIR—Is it predominantly heroin that you are seeing? Are any amphetamines starting to come through?

Mrs Rowe—Yes, and I think they tend to offer up to the department that they are only using marijuana as though it is a nice little thing. As a yoyo dieter, I can say, ‘I only had one piece of cake’ when I had a whole packet of Tim Tams as well. That is why I am always suspicious if they are going to say, ‘I am only on marijuana.’ If they are offering that up, what are they hiding?

CHAIR—Why aren’t they having a blood test?

Mrs Rowe—They give them blood tests and urine tests and I do not know what those results are because they do not seem to have any impact. You get told that yes, they are not coming back clean, but it still goes to court and the kids still go home.

CHAIR—Thank you so much for your evidence. It just gives us an insight into the responsibility we all have to those little kids. Thank you for what you do to bring some love into their hearts.

Mrs Rowe—You are welcome.

Mr CADMAN—It is wonderful.

Resolved (on motion by **Mr Cadman**):

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

Committee adjourned at 11.18 am

B

Appendix B – Selected personal stories

This appendix includes 13 selected edited personal stories from families that highlight the devastating impact that illicit drug use has on families. The committee would like to thank those families who told their personal stories about how illicit drugs have affected them. Members have been profoundly impressed by their strength and determination. It is important that their stories are shared, and that families are acknowledged as significant stakeholders in illicit drug policy.

...his downward spiral...

Through conflict about the drugs and the subsequent lifestyle including some criminal activity my son chose to live away from the family home. At the time we were relieved and grateful for the peace until eventually he was brought home by friends who could see his downward spiral and knew he needed to be cared for. He weighed 45 kgs, by now the father of a one year old son who I was helping to raise. The heartbreak of watching his toddler son try to rouse his dad as he lay drug riddled on the couch was too much to bear. My son would slowly raise his arm and tousle his son's hair, the deep love fighting against the grain of the addiction.

I learnt to live with my fear. I was fearful he would die; he would be bashed, hurt in an accident, attacked by other drug users, jailed, bashed by police or just disappear. My body jarred with the sound of a siren, a newsflash, a sudden thud until silence became a sign of death. {Overdose}

My grieving began. I grieved for his lost potential, his lost personality, his own peace, and my wants for him as a person. Constantly I have had to re-evaluate my own values, I have let go of my need to have a house with walls intact, furniture that matches, and my own career and I have peeled back the layers to value the person, to value keeping him alive at all costs.

Source Quon M, submission 8, pp 2, 3.

Imagine... Lives of grandchildren through a grandmother's eyes

Imagine you are three years old.

You wake in the morning and your mother is in bed asleep. You cannot wake her. You are very hungry. There is no food in the cupboard or the fridge. Your brother and sister have gone to school. You eat dry dog food from the bowl on the floor. You get out all your toy cars. These are the only toys you have so you sit in your room for the next 4 - 5 hours playing obsessively with the cars.

... Your mother and her boyfriend are in the kitchen. You are not allowed in there. They are smoking dope. You do not like the smell. You play in your room with the cars. Your mother brings you some burnt food for dinner. It tastes awful but you are very hungry so you eat it. Later you will get some more dog food when your mother is asleep again. The dog food tastes good.

Imagine you are eight years old.

You spend most of your time at your friend's house. You go there whenever you can because being at home is just too painful. Your mother is a drug addict and in your short lifetime she has lived with three abusive, drug addicted, violent men. The latest one is very scary. He yells and screams all the time and blames you and your brother for everything that goes wrong.

... You have a brother who is one year old. You have to look after him all the time because your mother stays in bed most of the day. If he wakes up your mother she yells at you and belts you. ... Sometimes you lock yourself in your bedroom and put towels at the bottom of the door so you can't hear the noise in the house. This is when your mother and her friends are having drug parties. There are a lot of scary people in the house.

Imagine you are twelve years old.

You have grown up and lived with violence since you were born. Your mother delivers drugs to people in the neighbourhood and to schools transporting them in your stroller. ... You watch your mother through three drug addict, abusive and violent partners. You see her bashed and abused time and again. You watch pornographic videos and see pictures of your mother and her partner naked on the walls of the house. You are forced to live in a caravan in the backyard with drug addict men, friends of your mother and her partner. They abuse you but you can't tell anyone.

... By the time you are 18yrs you will have been expelled from three schools and have been in and out of a Juvenile Detention Centre several times. You will be addicted to drugs, petrol sniffing and alcohol. You will have a criminal record. At 18yrs old you will be treated in the Courts as an adult. No one has ever taught you how to be one.

Source Name withheld, submission 155, pp 3-7 (extracts).

...how did we miss the signs?

We started to notice a difference in behaviour regular visits seemed to get less ... happy to believe any excuse and brush it aside rather than admit there was something wrong, but you knew deep down inside the pit of your stomach things were not as they should be. The day all the truth was revealed will be a day that I will never forget, it was full of bewilderment and despair. I can picture my husband still, sitting in the car unable to move or say a word. ...face to face with my son, I could see the condition he was in and that it was not going to be just marijuana. ... when I heard the word 'heroin' the panic and fear was overwhelming all I could think about was overdose and that he was going to die. ...It was so difficult to absorb I was in total disbelief at what I was hearing this was never going to happen to our family asking the counsellor how did this happened and how did we miss the signs. I felt so sad full of sorrow my whole world in pieces and no idea where to go from here.

Over the uncertain weeks and months that followed the full impact of the chaos my sons were in had begun to surface: the unpaid bills and fines, final demands, debt collectors, personal belongings in hock, loss of jobs even down to the dealers wanting to be paid, and so began to pick up the pieces and stick them back together determined to bring some normality back into my life, ... all I knew was that I loved my children and had to protect them at what ever cost! So paid off the dealers so they would not be harmed, reclaimed the tools so they could return to work, supported them in court when in front of the magistrate, allowed them back home when they had lost their own, shared their pain when they lost a friend to overdose and each time believed it would be the turning point and they would be well never wanting to ever admit they were addicted.

The chaos returned time and time again with the never ending anxiety and worry... disillusioned with the broken promises,... tired from lack of sleep, depressed and miserable but trying hard to smile and put on a brave face for family and friends... the situation was destroying our lives. I no longer wanted to be consumed with the turmoil or on edge waiting for the next crisis to arise, I had stopped enjoying my life. I needed to face reality that my denial and enabling was putting off the inevitable and needed to be dealt with as I wanted my life back and knew I would need the assistance from a professional counsellor to help me deal with my sons addictions. So the road to recovery began facing the destruction that had entered my world, coming to terms with how it had affected me, the realisation that I was not to blame, learning that the way I had responded was out of fear of losing the ones you love, gaining information, knowledge, support and guidance and finding comfort from other people travelling the same hard road, slowly acknowledging your fears, regaining strength and that there is a visible light at the end of the dark tunnel and hope and recovery are very real.

It has been a very hard road to travel and although both my sons have been through rehabilitation, I can see that they have to work hard at their addictions each and every day so I never really believe it will be finally over. Unfortunately the older son battles with his demons often and lapses back in and out of the drug scene, but I truly know he does not want to be there, it still hurts badly to see him go 3 steps forward with great effort and then 8 back but over the past years have learnt that I have no control over anyone's life but my own, which at the moment is peaceful enjoying my grand-daughter, grateful to all the true valuable friends made on my journey, living one day at a time, but so very thankful that we have all survived intact. I will be honest and say that whilst writing my story it takes you back to all the horrors you have endured and shed those tears once more but realise how you have grown and the strength you have gained to fight another day.

Source Name withheld, submission 164, pp 1-2 (extracts).

The Parents' voices

When not using (drugs) I'm a super-mum. I have more time for him. I set boundaries. We have good communication. We play a lot. When using, he becomes the parent. He gets out pre-prepared food from the freezer, he misses school, he gets bored, he gets worried about me ... I snap at him, yell, I have no patience. There's not much affection or supervision. I feel a lot of guilt. I tried to protect him from it.

Source Cathy, 28, mother of Travis, 7.

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*She must have witnessed me using, she made gestures of putting a pen into her arm, like a syringe. She was found to have an old break in her right leg, broken elbow in three places, depressed skull fracture and a broken wrist before starting school.*

Source Penny, 34, mother of Julie, 6.

### **...they are born addicted...**

*Five years ago I took over the care of a little boy who was born addicted to drugs. His mother was a chronic drug addict and prostitute. She came to me knowing she was unable to care for this child ... He is now five years old and the first nine months of his life were absolute hell, absolute hell. We do not hear about how many babies are born addicted in this country. Now he was not just a heroin baby; he was a methamphetamine baby, a methadone baby, a dope baby, a pill baby. God knows how he turned out normal.*

*The first nine months of his life were absolute hell ... He is five now and twice a year now he still wakes up with his sweaty little hands and feet and he does not feel well: his appetite changes, his behaviour changes and do you know what? He has learned to manage that. He says to me, 'This is not one of my good days.' At five!*

*There is evidence from the United States ... that these children are genetically changed, that their DNA now is different. They will not have the opportunity of their parents to muck around with these drugs for a little while before they become addicted; they are born addicted. They live with that central nervous system disorder. If he has one cone when he is 12, 13 or 14, he is gone. If he has one drink, he is gone. If he has one shot of heroin, he is gone.*

*What are we creating? What future are we creating with what we are doing? How do we pull this back? It is by getting that side and that side to sit down and accept that there are things from abstinence-based treatment programs that people within harm minimisation do not understand. There are things within harm minimisation that people from abstinence-based programs do not understand. We need to have a coming together of the minds before this is all way too late.*

Source Bressington A, transcript, 23 May 2007, p 24.



### **Is this really the beginning of a truly healed life?**

*In 1986 our much loved mother died a traumatic death from cancer, followed a year later by her much loved brother, who had lived with our family. Not long after these events my brother, who had been operating his own successful insurance/financial services business for about five years, at the age of 28, lost his business and suffered bankruptcy. These events, I believe, were the catalyst for my brother experiencing an emotional illness, underpinned by some genetic predisposition and some previous illicit drug experimentation.*

#### Impact on my father:

- *As my father was financially involved with my brother, he suffered the loss of his home and most of his personal finances, assets and investments (in the millions of dollars);*
- *Chronic humiliation, conflict, grief, anger, confusion, fear, trauma and loss of relationship with his son for some time (now healing) - over a nearly-20 year period; and*
- *Disruption of family relationships, serious impact on physical health (recovered well at the age of 82).*

#### Impact on me:

- *As I was also financially involved with my brother, I suffered the loss of my home and a large proportion of my personal finances;*
- *Chronic humiliation, conflict, grief, anger, confusion, fear, trauma and intermittent loss of relationship with my brother - over a nearly-20 year period (accompanying him to court appearances/remand centre visits, antagonistic phone calls and visits from his associates and police, not knowing his whereabouts for months at a time, fearing his death etc.);*
- *Disruption of family relationships, including with my husband (adversely financially and emotionally affected by my brother's illness);*
- *My brother living in my family home for over a year whilst unwell and intermittently at other times;*
- *Negative impact on my daughter (now 13) and on my own health;*
- *My family GP's view that the medical profession considers 'people like your brother to have a terminal illness'; my reply that the situation can be healed with a lot of love, knowledge and support; and*
- *Impetus to study (and graduate with) diplomas of alcohol and other drugs/youth work/massage therapy, and other study (philosophy/spirituality) over last 10 years, and now working in these fields.*

*...I realised that my attitude towards my brother had mostly alternated between subtly judgemental (with some moralising and lots of advice-giving thrown in for good measure) and profound grief/pity (including self-pity) and sorrow (with a lot of love and compassion in between), with no real acceptance of the situation. It was not until I allowed myself to just listen to him - be with him - that healing took place for both of us. I was then able to articulate to him in a positive manner (without judgement) how I felt about certain of his [behaviours] and set more positive boundaries for myself, which he was consequently more able to respect than previously. ...It is 11.30 am on Thursday 21 March, 2007. My brother has just rung me to say he has had a successful first day in a new job. He is sounding positive, determined and committed, he has somewhere stable to live, and is preparing to further pursue his own legal case. He has told me he has moved on from his illicit substance use and is working on giving up his legal substance use. I have had about fifty phone calls like this over the past nearly 20 years. Dare I believe that 'this is it' - is this really the beginning of a truly healed life? Time will tell, and I will never give up believing it is possible.*

Source      McIntyre R, submission 81, pp 1–7 (extracts).

### **An appreciation of human life**

*I have felt powerless and helpless and yet bound by a love and commitment to support and be there for my husband, brother and cousin. I held onto the times when they did well, felt devastated when they relapsed. There is also the constant fear and shame; fear of the police coming to your house, being targeted, the shame of having your car searched in the main street of town, the shame of being raided, the fear that one day they will overdose and die. There is the awareness of other people's opinions, their judgement, the pity in their eyes; the scorn when you attend the probation and parole service with them or visit them in prison.*

*It also teaches you to become tough and resilient and forces you to draw on a depth of love and compassion you never believed you had. It allows you to have an appreciation of human life, to treasure the beauty in every person and trains you to have an eagle eye for the sacredness of humanity often buried deep inside the soul. It gives you a perspective of human suffering that while difficult, also provides a richness that those untouched by tragedy are oblivious to.*

Source      Ravesi-Pasche A, submission 47, pp 3, 4.

### **...an invasion of her privacy...**

*The realisation that a child you have brought into the world is using a narcotic drug does not happen overnight. It takes a while to recognise the subtle personality changes, the avoidance manoeuvres and later 'the look'. The 'look' is that haunted, desperate appearance about the eyes. The 'look' of you don't know me; you don't know what I have done; you can't enter my world. So you discuss the issues with your partner but we're both really in a state of denial - this can't be. We are middle class professionals, our daughter is a lively, intelligent, sporty university student. She can always cogently justify why she never has any money despite our supporting her and a part time job. We try to probe and are reassured by her- of course all is well. How comforting to hear that, nevertheless our suspicions grow.*

*Do her siblings share our suspicion? Have they noticed anything? We don't want to ask them. We don't know what to think or do, we feel strained, an inner turmoil, a tension and distancing within the family and our circle of friends. We keep our anxieties to ourselves, concerned about the stigma associated with illicit drug use should others become aware of it. So, in this way months and months go past, and eventually it comes down to an invasion of her privacy. A look through her personal space, clothes, drawers - inside, under and behind, under the mattress, in bags, the bin.... and then the evidence and our disbelief- is this white powder what we think it is. Our intuition tells us it is but our reality doesn't want to accept it.*

Source      Name withheld, submission 133, p 1.

### **...I loved her so much and she was suffering.**

*...I am person who has experienced illicit drug use in my own family and from this perspective I shall begin by describing some of the personal costs that I experienced as a result. These were largely emotional costs and took many forms ... my own experience centres around the short time I had to cope with the crisis of discovering my daughter's drug use and my own attempts to come to grips with it.*

*...firstly, an overwhelming fear, terror more like it, that she could die, the fear that she could never get over this. This fear leads to anxiety and a constant sense of dread. There was the fear that I would say the wrong thing, make the wrong decision, take the wrong path ...*

*And there was anger somewhere in all this, an irrational anger that she had taken this path, anger at what we all had to go through, anger that she could not stop using...*

*And then there was the aloneness, the feeling of terrifying isolation, that I and my family were alone with this problem, there was no one to help and no one could understand ...*

*And there was guilt, ... my guilt was about my inadequacy, how hopeless I seemed to be at managing, how utterly lost and confused I felt ... I was clueless and pathetic and I felt ashamed... Somehow, I lost my internal wisdom, my inner frame of reference, I could not centre myself ...*

*And then there was shame. Not my shame, because I never felt it, not for a minute. Why should I be ashamed that my daughter was using a drug, even it is was illicit? Maybe because I did not blame myself as a parent, I did not feel the shame that many parents feel. But it was her shame, the terrible shame that my daughter experienced - this is what was so painful to me.*

*And finally, the terrible grief and sense of loss, the perceived loss of the path I had perceived my daughter to be on... Grief and sorrow over the pain she was experiencing in trying to cope with and master the compulsive urge to use the drug. Just plain grief over the fact that I loved her so much and she was suffering.*

*How could I begin to describe the grief when we lost my beautiful daughter, the shining light of our lives. Yet this grief, this terrible crushing bereavement that one never recovers from, is part of the personal cost for many parents in this situation. I should add that this is a grief that I would never want to fully recover from, this deep sorrow is part of my relationship with my daughter now, along with the joy and bliss of having her in my life for 24 years. I have re-organised my whole life, retrained in my professional life, experienced new joys with my three beautiful grandsons, but I still and will always burst into tears without warning when I think of her. It could be something I have read, a person walking by who reminds me of her, kind and loving words about my daughter from a friend, a song she loved, photos, reading her copious volume of writing, looking at her paintings and photography, reminiscing with friends and family.*

*In amongst my grief that rendered me powerless and paralysed for a long time, there stirred eventually in me a kind of anger, an anger that society treats people with drug use issues as pariahs, or they did then. Hundred of young people died in the 1990s from heroin overdose in what I describe as a heroin epidemic. Yet what was there to help the families, how many families were out there struggling and desperate, just as I had been? And if families were not getting support, then what help could the family offer to the person with drug use problems.*

Source      Anonymous case study attached by Centacare Catholic Family Services – Mary of the Cross Centre, Submission 116 , pp 13, 14.

### **Is 'good enough' in the best interests of children?**

*At the time of [my granddaughter's] drowning she was in the care of her mother (my former daughter-in-law) and her mother's then partner. My granddaughter's twelve month old sister was also in the mother's care at that time. Both the mother and the partner were long term heroin addicts and admitted to having taken heroin on the morning of the drowning. In the mother's case she claimed not to have used heroin until after the drowning... The mother worked in a brothel at the time of my granddaughter's death to support her heroin addiction. The partner had a long criminal history and was subsequently convicted and given a goal sentence for heroin trafficking. A coronial inquest was held into the death of my granddaughter on 25 February 2003 (by then another child, my granddaughter's half sibling had been born...). The Coroner's terms of reference were narrowly confined to the site and events on the morning of the drowning.*

*The Coroner found accidental drowning and there were no adverse findings against the mother or her partner. Restoration of my remaining granddaughter to her mother commenced three days after the Coronial Inquest, ... through a Family Court Order... I had sought a shared arrangement... my application was unsuccessful. ... We accepted the court decision and focused on supporting and nurturing my granddaughter during our contact, now restricted to overnight every second Thursday, every second weekend and half the school holidays. Following the court decision both I and my granddaughter's father (my son), who resides in our family home, developed a constructive and cooperative relationship with my granddaughter's Care and Protection Services case worker... We have continued our efforts to work cooperatively with case workers that followed and have attended all of the Review of Arrangements. Ongoing concerns about my granddaughter's care... persuaded me to seek to vary the Family Court Orders to maintain the arrangements in place prior to 2006. An interim hearing was conducted in February 2006. However, the Court accepted a report made by the Department and argument put forward by its legal representative in Court that the while the mother would never be 'mother of the year' and her 'parenting is chaotic' the care provided by the mother was sufficient.*

*While the drug addiction, in this case involving my son and his former wife, caused huge distress to our family and over time has drained our financial resources and totally changed our lifestyle and expectations for a happy and comfortable retirement, the most difficult and ongoing struggle has been with the authorities that have responsibility for the care and protection of children. I have continuing concerns about the safety and well being of my remaining granddaughter who I believe (based on considerable evidence) is still exposed to an unsafe environment. My granddaughter now has chronic health problems that require attention, including an eye defect that is and will continue to be an impediment to her progress at school unless it is receives appropriate treatment. I have repeatedly brought my concerns to the attention of the ACT Care and Protection Services. However, it is my overriding impression that the rights of the mother have been protected to the detriment of both my granddaughters. In particular I note that the ACT Care and Protection Service appear to have adopted an arbitrary 'good enough' principle as the basis for meeting 'the best interests' principle under section 11 of the Children and Young People Act 1999. ... It is my view that there is an urgent need for the federal government to take the lead and address this serious issue by identifying this as a national issue followed by approaches to the States and Territories suggesting changes in current legislation, policy and practices to ensure that the interest of the child is paramount and that parental rights do not dominate at the expense of the child. Otherwise, the current drug epidemic is a potential time bomb likely to produce a generation of children, many of whom, as a result of neglect and abuse, may not be able to function adequately and contribute productively to our society. Clearly the financial and social cost to the nation would be huge but the personal cost to the children and their families, immeasurable.*

Source Bosworth J, submission 180, pp 1-4 (extracts)

**...the current drug epidemic is a potential time bomb...**

*...My husband... and myself are raising our four grandchildren, and have for the past nine years. [Some time ago, we were asked by DOCS] to pick up the children, if not they were going to be fostered out to separate families. ... for D.O.C.S. to require this drastic step was a culmination of the children left many times with many people and all involved in the drug world. Our daughter was a dealer and user ...She ran drugs ...with the children on board as cover and was also known to sell to school children. The children also were used to pick up drugs ...these things we know because of evidence obtained during our custody hearings in the family law court. Our daughter was always in the spotlight with the police for shoplifting and she bragged that the four children were her shoplifting gang. She had to shoplift and sell drugs to feed her habit and the children suffered from lack of food and fresh fruit and vegetables, always sick and as a result from all the visits to the doctors and antibiotics the children all have soft teeth. ...[She] returned [and] demanded her children back and as we had no legal papers for their custody we had to hand them back. Over the next couple of months we learnt they were staying with approx seven different people in Canberra ... We decided to go for custody. This wasn't a prolonged affair as my daughter didn't fight for her children. All up we paid approx \$17000 for our legal people and the only time [she] appeared at the family court for counselling she had track marks between her toes as she had no veins left in her arms to shoot up in. ... [We were awarded] full custody of the children in February 2000.*

*We came to Canberra in 1969... We raised our three children ... and did all the same things as everyone else did. Struggle. But we got there. Now we had four children to care for and love. My husband worked for 35 years in the fire brigade and retired early in 2000 to help with the raising of the children. The money he received from his C.S.S. Super was used to extend our home and give them each a bedroom as well as a bit more room for all of us as the original house was 9.8 squares. We also had a four bedroom house... that my husband owner built which we had to sell to finish off our house in... . We manage the children's welfare on my husbands C.S.S. pension plus family tax benefit A. and I get \$180 parenting for which Centrelink has been hassling me to go to work even though I am exempt under large family i.e. 4 children under our care. My husband receives a part pension as he turned 65 in Feb this year. We do okay as we shop carefully and the children want for nothing. They are involved in music both at school and with piano with a teacher all play musical instruments as they are quite good. Three of the children are in high school and 2008 we will have all of them there. As we have full custody we are not entitled to careers money and not entitled to legal aid as we own our home and have too many assets. The only respite we have had is we found out we are entitled to full child care during the holidays under the grandparent's benefits which enabled us to put them into a holiday program for 8 days. Our daughter died in November 2000 from heroin and we also had to pick up the pieces and bury her as her husband wasn't there for even this sad occasion we have hid nothing from the children and emphasise the importance of honesty and not stealing respect for each other and others around them. It's been a long hard slog as the children had bad habits when we got them but slowly as they mature they are learning the values of life but we have had a lot of interference along the way too detailed to go into but suffice to say it has added to the stress we have had to endure with raising these children as our only intention was to give them love and affection and a safe and stable environment that they now call home. When we were awarded custody [the magistrate] commented as we left the court 'best of luck, you have a long hard row to hoe' and he was right. Even with all we have had to put up with we wouldn't change anything as we regard children as the jewels of our future and they deserve all the help and understanding that we are capable of.*

Source Steep S and C, submission 183, pp 1-2 (extracts).

### **...the spectre of the estranged family member...**

*The addict retreats into a world of unreality where there are no commitments or responsibilities. Principles and ethics are completely subsumed by the all consuming need for money to pay for drugs and/or alcohol. It is bad enough when only the addicts themselves are affected, but a new dimension of issues and problems is created when a child is involved ...*

*Our daughter currently is homeless, apparently with very little income ... She has a partner who also is an addict. We have no idea where she is or how to contact her. When she has made contact, she invariably subjects us to verbal abuse. She loves her son, but cannot control her abusive behaviour towards us (her parents) and others when she has come to see him or speak to him on the phone whilst he is in our care, which causes him major upset even though the abuse is not directed at him. As a consequence of this totally unacceptable behaviour, caused by drugs and/or alcohol, we can not permit her access to her son, and at this point she has not seen him for a number of weeks. It is very uncertain when she may see him again. We know she is distraught about this and it hurts us deeply also, but there is no way evident to move forward. Her son also is distressed about the situation. Not only is he upset about not seeing her, but he is old enough to know she is in serious difficulty, and he is very worried about her safety and welfare.*

*Members of the family of an addict - my wife and I have two other adult children each of whom has a partner - must get on with their lives, and we are doing that. However, there is always present the spectre of the family member who has estranged themselves, and each member of the family in a sense is a prisoner of this. There is no way out unless either the addict recovers and rejoins the world, or as terrible as it is to even think it, eventually dies directly or indirectly in the long if not short term, as a result of their addiction.*

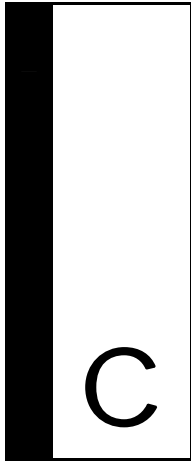
*Many others are affected: My wife's siblings and their families share our deep concerns over the damage to a life, and the consequential impact on others.*

Source Fairclough R, attachment to Australian Drug Treatment and Rehabilitation Programme, submission 132, pp 20-21.

### **Addiction is addiction is addiction**

*Unless we are actually prepared to deal with the fact that addicts have different wants to the rest of the community, that they think very differently to the rest of the community, that we are not doing them any favours whatsoever by keeping them addicted or enabling or rescuing them, then their lives are miserable. We say to addicts, 'We've got to keep you alive,' and I have had many of them respond, 'There's worse things than death, believe me.' Their life is not enjoyable. The party is over a very short period of time after they start using. I can remember my daughter telling me when she first started using heroin, 'Look, you know, it's all right. I'm not going to end up like that junkie on the street corner. I've seen that happen to all my friends, I know what not to do.' Six months later she is ringing up with the intention of injecting herself with an overdose of heroin because it is all too hard. 'I can't do this anymore.' That is how short the decline was. Do not think that junkies have a great time out there. Do not think that methamphetamine addicts when they are not stoned and out of their mind are enjoying their life and partying. They are not free and easy people. They are miserable. They scream out for help and they cannot get it. When they go to doctors, they are told just to cut down. Addicts cannot control their use. Controlled drinking was dispelled in the United States and Great Britain. We are still doing it here. ...Addiction is addiction is addiction. If you do not fix it, people remain trapped in that for a very, very long time.*

Source Bressington A, transcript, 23 May 2007, p 13.



## Appendix C – Address on the death of Annabel Catt by her brother Antony<sup>1</sup>

Good morning. My name is Antony Catt and Annabel Catt was my little sister.

On Sunday the 18th of February, just after six am, I was lying in my bed telling myself to get up. I'd moved to Canberra three weeks prior and had decided the night before that I would drive to the South Coast and go surfing.

When my phone rang I didn't think anything of it. My girlfriend was on holidays in the US and I just thought that it was her. When I picked up the phone there was a stranger on the line. His voice was shaky and he told me that he was from the intensive care unit at Mona Vale Hospital. It was obvious that he had really bad news because he couldn't find the words to say what it was he had rung to tell me. I told him to just give it to me but instead he put Dad on the phone.

Dad told me that Annabel had taken ecstasy and that she was gone. He then passed the phone on to Mum who offered words of comfort. I told both my parents that I loved them and they said how much they loved me. The phone call was very brief; none of us really knew what to say.

That is how this nightmare began.

Some people will always think poorly of Annabel because of the manner in which she died but defending Annabel isn't why I am here today. Annabel had everything to live for and those that knew Annabel well will always remember a happy person, beautiful in every way, and that is what is

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<sup>1</sup> House of Representatives, *Debates*, 28 May 2007, pp 69 – 71.

important to me. I am here to tell you about the tragic death of my little sister to illustrate the very real dangers of drug use, in the hope that what happened to her, doesn't happen to you.

On the 17th of February Annabel went to the Good Vibrations music festival with her best friends. I want to pause at this moment to let you know that my family is very close to Annabel's friends and we bear no grudge toward them. They loved her and she loved them. They are devastated just like us.

This is what Annabel took the day before she died—a capsule. It looks harmless enough doesn't it?—

I know what's in it, but do you? Annabel didn't know what was in the capsule that she took at Good Vibrations either. She thought that it was ecstasy. It wasn't—it was the far more toxic substance PMA. Street names for PMA include red Mitsubishi, Dr Death, red death, red killer and death. Because of its lethal reputation, PMA generally isn't a sought after drug. Despite this, drug manufacturers sometimes pass PMA off as ecstasy because the chemicals that go into ecstasy are harder to obtain. The great worry with PMA is that when it kills, it usually kills in clusters. I am extremely grateful that nobody else has died as a result of taking a capsule from the same batch as Annabel.

After Good Vibrations Annabel went to a friend's house to stay the night. Annabel and her best friend had a temperature and were acting a little weird—but they had taken what they thought was ecstasy; these were not abnormal symptoms.

Sometime after four in the morning, Annabel's friend was awoken by Annabel suffering violent fits. An ambulance was called but by the time it got there my little sister was effectively dead. Annabel's temperature was so high that her body just couldn't cope anymore. To put it bluntly, this tiny little capsule had cooked and destroyed Annabel's body from the inside out.

Like all of our family, Annabel was on the organ donor register. We would have been pleased if every part of Annabel's beautiful body could have been used to save the life of another human being. Despite this, there was only one part of Annabel that the doctors could use to help someone else—the corneas in her eyes have restored the sight of two people. Her corneas could only be used because they do not receive any of the body's blood flow. Every other part of her body had been so destroyed by the drug rushing through her system that it was useless to anyone else. It's horrible and it's extremely scary, but this is perhaps the best example of how much damage this little capsule can do to your body.



I can just imagine what was going through Annabel's mind when she took the capsule that killed her. She would have realised it was dangerous, but she wouldn't have believed that of all the people who took ecstasy that day, that she was holding the capsule with the deadly dose of poison.

The people who made the capsule that killed Annabel knew how deadly it was but they didn't care; they just wanted to make a quick buck, even if it killed someone. That's the thing with these types of drugs, you have no idea what's really in them and there is no way you can trust the people making or supplying them, no matter who they are.

It wouldn't have mattered if it was the first, second or hundredth time Annabel took ecstasy, the result would be the same, she would be dead. Annabel's death demonstrates that you can experiment with drugs just once and end up in a coffin. What happened to Annabel could happen to anyone.

While Annabel's death proves how easily drugs can kill, it would be dishonest of me to stand here and try to convince you that instant death is a common result of taking ecstasy, I'm not. People do die from taking ecstasy, but it wasn't ecstasy that killed Annabel—it was the similar yet far more toxic PMA; but don't let this make you think that ecstasy use is safe. The long-term effects of ecstasy and other drugs are almost as frightening as what happened to Annabel.

I'm twenty-five now and have been around long enough to see the long-term effects of drug use on people my age. I have seen physical sickness, mental illness, accidental death and suicide. It's terrifying, it's real and I'm not exaggerating— these are the consequences of frequent drug use.

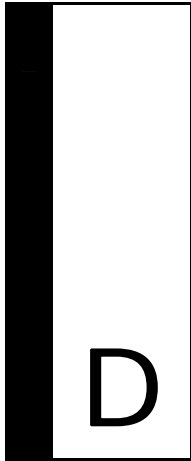
What I really want you to take away from this point is that most people I know who have suffered the long-term effects of drug use started their journey at your age, experimenting with friends. Some stopped, but others were always looking for a new rush and searched for it over time by moving from one drug to the next.

You might be one of those people. If you are, I am asking you to seriously think about the path you are taking, because you're not going to have any fun if you wind up debilitated, institutionalised or in a coffin.

It is sad fact that no matter how well the dangers are known, people will continue to use drugs. If you or any of your friends ever take drugs and suspect that something is going wrong, please, get help. Ambulance officers are only interested in saving your life; they won't call the police and they won't get you into trouble. Annabel's friends did call an ambulance but unfortunately for everyone, she couldn't be saved.

Annabel had also taken the so-called precautions with ecstasy use the day before she died. The toxicology report showed that she had no alcohol in her system and she had drunk plenty of water throughout the day. Annabel's death really demonstrates that no matter how much care is exercised, using drugs is never safe.

You'll make up your own mind about drug-use but there is one last thing that I want to emphasise. Annabel was a very special person, she was very much loved and she is immensely missed. You too are very special; you too are loved and if you too departed today, you would be grieved in exactly the same way as we grieve for Annabel. If you ever consider taking drugs I urge you, think about what has happened to Annabel, think about what has happened to those who are dependent on drugs and think about what impact their death or dependency has had on their loved ones. Think about whether you want to be dead or dependent. Then ask yourself, is this really worth the risk? Thank you for listening.



## Appendix D – List of submissions<sup>1</sup>

- 1 Mr Ralph Seccombe
  - 2 Name withheld
  - 3 Name withheld
  - 4 Australian Parents for Drug Free Youth
  - 5 Ms Jennifer Perry
  - 6 Australian Federal Police
  - 7 CONFIDENTIAL
  - 8 Ms Margaret Quon
  - 9 Ms Glenda Clementson
  - 10 Ms Shirley Carroll
  - 11 Mr & Mrs Michael & Susan Lowy
  - 12 Mr John Morrissey
  - 13 Ms Mariette Ennik
  - 14 Mr James Hanrahan
  - 15 Family Drug Support
  - 16 Professor Gary Hulse
  - 17 Mrs Joan Faull
  - 18 CONFIDENTIAL
- 

<sup>1</sup> In above list (supp) indicates supplementary submission

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- 19 King Edward Memorial Hospital for Women, WA
- 20 Name withheld
- 21 Ms Sandra Bell
- 22 Endeavour Forum Inc
- 23 Mr Michael Stevens
- 24 Mr Joe Lopez
- 25 Manly Drug Education & Counselling Centre, NSW
- 26 Women's Health Service (WA), Pregnancy, Early Parenting & Illicit  
Substance Use
- 27 Perth Naltrexone Clinic
- 28 Mr Theo Chang, Family Drug Support
- 29 Name withheld
- 30 Centre for Harm Reduction, Victoria
- 31 CONFIDENTIAL
- 32 Moreland Community Health Service Inc
- 33 Dr Stuart Reece
- 34 Mrs Margaret Riley
- 35 Catholic Women's League of Australia Inc
- 36 Sydney Women's Counselling Centre
- 37 Drug Advisory Council of Australia Inc
- 38 Mr David Bowman
- 39 Australian Drug Law Reform Foundation
- 40 Ms Joan Westaway
- 41 Ms Sandra Lines
- 42 Drug Free Australia Inc
- 43 Mr & Mrs William & Patricia Ryan
- 44 Mrs Marjory Cleere
- 45 Mr & Mrs Colin & Carmel Glover
- 46 Voice, WA

- 
- 47 Mrs Antonia Ravesi-Pasche
- 48 Mrs Patsy Hersee
- 49 The List, SA
- 50 Mrs Dianne Beckingham
- 51 Mrs Hazel Hayes
- 52 Ms Ruth Corrigan
- 53 Mrs Patricia Damen
- 54 Hepatitis Australia
- 55 Name withheld
- 56 Name withheld
- 57 Mr & Mrs Leo & Judith Lawrence
- 58 CONFIDENTIAL
- 59 Australian Family Association (NSW)
- 60 Centacare NT
- 61 National Centre in HIV Social Research, University of NSW
- 62 Mr Greg Kerlin
- 63 Mrs Judith Alcock
- 64 Mirabel Foundation
- 65 Mrs Isobel Gawler
- 66 Mr & Mrs Peter & Janice Sutherland
- 67 CONFIDENTIAL
- 68 Name withheld
- 69 Barnardos Australia
- 70 Name Withheld
- 71 CONFIDENTIAL
- 72 Australian Family Association SA Branch (supp to 59)
- 73 Dr Ross Colquhoun
- 74 Glastonbury Child & Family Services, VIC

- 
- 75 Name withheld
- 76 Family Drug Help
- 77 Name withheld
- 78 Ms Tonie Miller
- 79 Anglicare Victoria
- 80 Prof Sharon Dawe, Dr Paul Harnett & Dr Sally Frye
- 81 Ms Robyn McIntyre
- 82 Government of Western Australia Drug and Alcohol Office
- 83 CONFIDENTIAL
- 84 Dr Christopher Walsh
- 85 Festival of Light Australia
- 86 Name withheld
- 87 Youth Substance Abuse Service
- 88 Mr Bruno Anfiteatro
- 89 A Collective of Harm Reduction Outreach Workers South East Queensland
- 90 Drug & Alcohol Multicultural Education Centre
- 91 Palmerston Association Inc
- 92 Dr A R MacQueen
- 93 CONFIDENTIAL
- 94 Australian Injecting & Illicit Drug Users League
- 95 Ms Mary Moore
- 96 Ms Margaret Graham
- 97 Wanslea Family Services, WA
- 98 Queensland Alcohol & Drug Research & Education Centre
- 99 UnitingCare Burnside, NSW
- 100 Victorian Alcohol & Drug Association
- 101 Australian National Council on Drugs
- 102 Australasian Therapeutic Communities Association

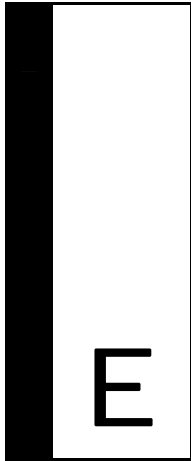
- 
- 103 Australian Institute of Family Studies
- 104 *not assigned*
- 105 Mr Brian Tierney
- 106 Name withheld
- 107 Marymead Child & Family Centre, ACT
- 108 Drugs in the Family
- 109 City Mission, Tasmania
- 110 Cyrenian House: Drug Treatment & Rehabilitation Centre, WA
- 111 Odyssey House Victoria
- 112 Toughlove Victoria
- 113 Western Australia Substance Users Association
- 114 CONFIDENTIAL
- 115 Nar-Anon Family Groups (Australia) Inc
- 116 Centacare Catholic Family Services – Mary of the Cross Centre
- 117 Holyoake Tasmania Inc
- 118 Australian Drug Foundation
- 119 Royal Australasian College of Physicians
- 120 Australian Government Australian Institute of Criminology
- 121 Australian Association of Social Workers
- 122 Families & Friends for Drug Law Reform (ACT) Inc
- 123 Alcohol & Drug Foundation ACT Inc
- 124 Coalition Against Drugs (WA)
- 125 Australian Nursing Federation
- 126 Toughlove NSW
- 127 Mrs Mary McInerney
- 128 Centrelink
- 129 Hepatitis C Council of NSW Inc
- 130 Association for Prevention & Harm Reduction Programs Australia Inc

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- 131 Australian Psychological Society Ltd
- 132 Australian Drug Treatment & Rehabilitation Programme Inc
- 133 Name withheld
- 134 Government of Western Australia Department for Community Development
- 135 Name withheld
- 136 CONFIDENTIAL
- 137 Family Drug Support (supp to 15)
- 138 Western Australian Network of Alcohol & other Drug Agencies
- 139 Teen Challenge NSW
- 140 Australasian Society for HIV Medicine
- 141 Australian Government Department of Education, Science & Training
- 142 Royal Women's Hospital, Victoria
- 143 Relationships Australia
- 144 Government of Western Australia Drug and Alcohol Office (supp to 82)
- 145 Name withheld
- 146 Commission for Children & Young People & Child Guardian (Qld)
- 147 National Drug & Alcohol Research Centre
- 148 Australian Drug Law Reform Foundation (supp to 39)
- 149 Public Health Association of Australia Inc
- 150 Coalition Against Drugs (WA) (supp to 24)
- 151 Beyondblue
- 152 Families Australia Inc
- 153 South Australia Government
- 154 Dr Stuart Reece (supp to 33)
- 155 Name withheld
- 156 Professor Wayne Hall, University of Queensland



- 
- 157 Mr Lee & Ms Christine Rush
- 158 Family Matters SA Inc
- 159 Local Drug Action Groups Inc
- 160 Name withheld
- 161 Name withheld
- 162 Name withheld
- 163 Name withheld
- 164 Name withheld
- 165 Name withheld
- 166 CONFIDENTIAL
- 167 Drug Free Australia (supp to 42)
- 168 Coalition Against Drugs (WA) (supp to 150)
- 169 Australian Government Department of Health & Ageing
- 170 Australian Government Department of Health & Ageing (supp to 169)
- 171 Catholic Women’s League of Australia Inc (supp to 35)
- 172 Australian Government Department of Families, Community Services & Indigenous Affairs
- 173 Queensland Government
- 174 Tasmanian Government
- 175 Victoria Police
- 176 Australian Federal Police (supp to 6)
- 177 CONFIDENTIAL
- 178 Coalition against Drugs (WA) (supp to 168)
- 179 Dr Stuart Reece (supp to 33, 154)
- 180 Ms Jette Bosworth
- 181 Dr Stuart Reece (supp to 33,154, 179)
- 182 Name withheld
- 183 Mr & Mrs Clarrie & Suzanne Steep

- 184 Australian Government Department of Health & Ageing (supp to 169)
- 185 Mrs Maureen Connelly
- 186 Mr Ken Bickle
- 187 Australian Government Department of Families, Community Services & Indigenous Affairs (supp to 172)
- 188 Name withheld



## Appendix E – List of exhibits

- 1 Australian Crime Commission, *Illicit Drug Data Report 2004-2005*, Commonwealth of Australia, 2006. Provided by Australian Federal Police.
  - 2 Hamilton, Margaret et al (Eds), *Drug Use in Australia: Preventing Harm*, Second edition, Oxford University Press, 2004.
  - 3 Department of Health and Ageing, *National Cannabis Strategy 2006-2009*, Commonwealth of Australia 2006.
  - 4 Hon John Howard MP, Prime Minister of Australia, *Tough on Drugs Announcement*, transcript, Carlisle, Perth, 3 February 2004.
  - 5 Australian Medical Association, *Resolution on Harm Reduction and Principles in Relation to Harm Caused by Substance Use and/or Compulsive Behaviour*, letter dated 12 March 2007.
  - 6 Perth Naltrexone Clinic, compilation of published articles authored by several staff at the Perth Naltrexone Clinic. (Related to Sub<sup>1</sup> 27)
  - 7.1 The Mirabel Foundation, *What Happens to the children? Brochure*. (Related to Sub 64)
  - 7.2 The Mirabel Foundation, *The Effects of Parental Drug Use - Children in Kinship Care: A Review of the Literature*, by Nicole Patton; design layout by Vince Patton, Braemar Graphic Reproductions, 2003. (Related to Sub 64)
  - 7.3 The Mirabel Foundation, *Parental Drug Use - The Bigger Picture: A Review of the Literature*, by Nicole Patton; design layout by Vince Patton, Braemar Graphic Reproductions, 2003. (Related to Sub 64)
  - 7.4 The Mirabel Foundation, *Parental Drug Use - A Recent Phenomenon*, By
- 

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- Nicole Patton; design layout by Vince Patton, Braemar Graphic Reproductions, 2003. (Related to Sub 64)
- 8.1 Morcombe J, A need to say their goodbyes, Manly Daily, 14 March 2007. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.2 Masters C & J Hildebrand, We must be tough on drugs, Newspaper article. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.3 Jordan B, Love guides tough decisions, Newspaper article. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.4 McIntosh E, Love turns the tide, Newspaper article. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.5 Jordan B, A kind of caring called tough love, Newspaper article. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.6 That's Life! Kids who need tough love, Magazine article, 21 February 2007. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.7 Holborow B, Tough love, That's Life! Magazine article. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.8 Manly Daily, Helping parents pull kids into line, Newspaper article. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.9 Taylor N, For Families in Crises, Newspaper article, Central Coast News. Provided by Toughlove NSW. (Related to Sub 126)
  - 8.10 Good Weekend, Enough is enough, Newspaper article, 16 November 2002. Provided by Toughlove NSW. (Related to Sub 126)
  - 9.1 TOUGHLOVE: Illicit Drugs and Effects on Families, Presentation at Public Hearing 3 April 2007. Provided by Toughlove NSW. (Related to Sub 126)
  - 9.2 TOUGHLOVE: Welcome to Toughlove, Parent Support Group Programme. Provided by Toughlove NSW. (Related to Sub 126)
  - 9.3 TOUGHLOVE: Problems with your son or daughter's unacceptable behaviour? Pamphlet. Provided by Toughlove NSW. (Related to Sub 126)
  - 9.4 TOUGHLOVE: Welcome the Toughlove Parent Support Group Programme: Introduction, 2005. Provided by Toughlove NSW. (Related to Sub 126)
  - 9.5 TOUGHLOVE: Toughlove NEWS (NSW) Newsletter, Volume 4, Issue 3, Nov-Dec 2003. Provided by Toughlove NSW. (Related to Sub 126)
  - 9.6 TOUGHLOVE (NSW) Inc: Newsletter, Volume 5, Issue 1, April 2004. Provided by Toughlove NSW. (Related to Sub 126)
  - 9.7 TOUGHLOVE (NSW) Inc: Newsletter, Volume 4, Issue 2, Sept-Oct 2003. Provided by Toughlove NSW. (Related to Sub 126)

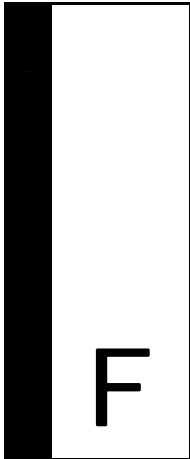
- 9.8 TOUGHLOVE (NSW) Inc: Data provided on phone calls received by Toughlove between Dec 05 and Feb 07. (Related to Sub 126)
- 10.1 Reece Dr Stuart, Powerpoint presentation to the Family and Human Services Committee on 3 April 2007. (Related to Sub 33)
- 10.2 Wolinski K & others, Workforce Issues and the Treatment of Alcohol Problems: A Survey of Managers of Alcohol and Drug Treatment Agencies, Report for the Australian Government Department of Health and Ageing, NCETA, 2003. Provided by Dr Stuart Reece. (Related to Sub 179)
- 10.3 Roche A & others, Alcohol and other drug specialist treatment services and their managers; findings from a national survey, Article, Australian and New Zealand Journal of Public Health, Volume 28, no. 3, 2004. Provided by Dr Stuart Reece. (Related to Sub 179)
- 11.1 Teen Challenge NSW, One 80TC: Turning Lives Around, CEO Report. (Related to Sub 139)
- 11.2 Teen Challenge NSW, One80TC: Turning Lives Around, a Vision Plan. (Related to Sub 139)
- 11.3 Teen Challenge NSW, Is it possible ... to turn your life around? Leaflet. (Related to Sub 139)
- 11.4 Teen Challenge NSW, Building Future Champions ... A Place to Call Home, Leaflet. (Related to Sub 139)
- 12.1 Blacktown Alcohol and Other Drug Family Drug Services Inc, Through Innocent Eyes, Annual Report 2005–2006, October 2006.
- 12.2 Blacktown Alcohol and other Drugs, Family Services Inc, Bridges Strategy Stage II: Young people and adults working together around drug issues in the Blacktown Local Government Area & beyond, Final Report. [Received 2 April 2007]
- 13.1 Mother's handwritten list, Reasons to Quit Dope. Provided by Drug Free Australia. (Related to Sub 167)
- 13.2 Olsson O, Liberalization of drug policies, Swedish National Institute of Public Health, & the Swedish Council for Information on Alcohol and Other Drugs, Stockholm 1996. Provided by Drug Free Australia. (Related to Sub 167)
- 14.1 International Network for Global Drug Legalisation by 2008, Data. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.2 Murray P, Their crime: born to be victims, Newspaper article. Provided by Geraldine Mullins. (Related to Sub 124)

- 14.3 Photographs of Anna Mullins. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.4 Wodak, Mugford and Stronach, International Conference on Drug Reform, DVD, 1992. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.5 Aisbett N, The billionaire, drugs and us, The West Australian, 30 November 2002. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.6 ADF (Australian Drug Foundation) Position on the Role of Zero Tolerance in Australian Drug Strategy, Paper, 1999. Webpage: [http://www.adf.org.au/article.asp?ContID=zero\\_tolerance](http://www.adf.org.au/article.asp?ContID=zero_tolerance) – viewed 2 June 2007. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.7 International Harm Reduction Association, News Articles from Webpage, 2005. Webpage: <http://www.ihra.net/> - viewed 12 May 2005. Provided by Geraldine Mullins. (Related to Sub 124)
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- 14.9 Adshead G, Don't let Wade's death be in vain, The West Australian, 2 September 2006. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.10 Adshead G, Someone must Pay, The West Australian, 12 August 2006. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.11 Herbert W, email to Geraldine Mullins, The International Drug Policy Consortium, 12 January 2007. Webpage: <http://by135fd.bay135.hotmail.msn.com/cgi-bin/getmsg?curmbox=00000000%2d0000%2...> – viewed 15 January 2007. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.12 Australian Drug Foundation, Information Sheet from webpage, 2005. Webpage: <http://www.adf.org.au/index.asp> - viewed 20 April 2005. Provided by Geraldine Mullins. (Related to Sub 124)
- 14.13 Certification of Incorporation of a Private Limited Company, for the International Harm Reduction Association, File Copy, 1996. Provided by Geraldine Mullins. (Related to Sub 124)
- 15.1 Wilkes T, Associate Professor, The impact of Illicit Drug use on Families, March 2007. Provided by National Drug Research Institute.
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- 19 Canberra Mothercraft Society Inc, *Grandparents Parenting Grandchildren because of alcohol and other drugs*, Report, 2006, commissioned by ACT Health Alcohol and Drug Policy Unit, funded by Commonwealth Department of Family and Community Services, *Strengthening Families National Illicit Drug Strategy*.
- 20 Adelaide DFA Conference Talk - *A parent's perspective: what one needs to know about drug policy to raise a drug-free child*, 27 April 2007. Provided by WA Coalition Against Drugs & Drug Free Australia. (Related to Sub 166)
- 21 Homel R et al, *The Pathways to Prevention Project: The First Five Years 1999-2004*, Sydney: Mission Australia and the Key Centre for Ethics, Law, Justice & Governance, Griffith University, 2006. Provided by Griffith University. (Related to Sub 80)
- 22 Harnett P and S Dawe, *Parents Under Pressure Program, Parents Workbook*, University of Queensland and Griffith University, 2005. Provided by Griffith University. (Related to Sub 80)
- 23 Winton M, copy of letter written to Queensland Department of Child Safety, 24 July 2007. Provided by Mr Stephen and Mrs Margaret Winton.







## Appendix F – List of hearings and witnesses

### **Public hearings**

**Wednesday, 7 February 2007 - Canberra**

**Australian Institute of Health and Welfare**

Dr Penny Allbon, Director

Mr Mark Cooper-Stanbury, Head, Population Health Unit

Ms Susan Killion, Senior Executive, Health and Functioning Group

Ms Chrysanthe Psychogios, Project Manager and Senior Analyst

Dr Christopher Stevenson, Head, Functioning and Disability Unit

**Wednesday, 14 February 2007 - Canberra**

**Australian Customs Service**

Mr John Valastro, National Manager, Border Targeting

Mr Demetrio Veteri, National Manager, Law Enforcement Strategy

**Australian Federal Police**

Mr Michael Keelty, Commissioner

**Wednesday, 28 February 2007 - Canberra****Department of Health and Ageing**

Ms Jennifer Bryant, First Assistant Secretary, Population Health Division

Ms Virginia Hart, Assistant Secretary, Drug Strategy Branch

Mr David Learmonth, Deputy Secretary

Ms Laurie Van Veen, Assistant Secretary, Communications Branch

**Wednesday, 7 March 2007 - Gold Coast (Roundtable)****Alcohol and Drug Foundation, Queensland**

Ms Laura Lynch, Manager, Logan House

**Gold Coast Drug Council Inc.**

Ms Mary Alcorn, Executive Director

Ms Sue Koningen, Family Support Worker

**Goldbridge Rehabilitation Services**

Mr Charles Blatch, Chief Executive Officer

**Grandparents Assisting Grandkids Support, Gold Coast Region**

Ms Maree Newman, Chairperson

**Kinkare**

Mrs Maree Lubach, Chairperson

**Palm Beach Currumbin Clinic**

Mrs Joanna Burnett, Social Worker

Dr Gregory Pearson, Director of Psychiatry

**Youth Enterprise Trust**

Ms Glenda Feasey, Community Liaison Officer

**Community statements**

Four individuals

**Wednesday, 14 March 2007 - Perth****Government of Western Australia**

Mr Terry Murphy, Executive Director, Drug and Alcohol Office

**King Edward Memorial Hospital for Women**

Dr Dale Hamilton

Mrs Celine Harrison, Head of Department, Social Work Department

Mrs Claire Henderson, Chemical Dependency Service

**National Drug Research Institute**

Associate Professor Simon Lenton, Deputy Director

Professor Edward (Ted) Wilkes

**Parent Drug Information Service**

Mrs Judith Alcock, Parent/Volunteer

Ms Sandra Harris, Parent/Volunteer

Mrs Lee-Anne Raeside, Coordinator

**WA Coalition Against Drugs & Drug Free Australia**

Mrs Wendy Herbert, Spokeswoman and Fellow

Ms Geraldine Mullins, Founding Member, Adviser and Spokesperson

Kerry

Thelma

**Women's Health Services**

Ms Jo-Anne Hodson, Manager, Pregnancy, Early Parenting Illicit  
Substance Use Mums and Children's Program

Ms Fiona Reid, Outreach Counsellor, Pregnancy, Early Parenting Illicit  
Substance Use Mums and Children's Program

**Wednesday, 21 March 2007 - Canberra****University of Western Australia**

Professor Gary Hulse, Professor of Addiction Medicine

**Wednesday, 28 March 2007 - Canberra****Families Australia Inc**

Mr Brian Babington, Chief Executive Officer

**Monday, 2 April 2007 - Western Sydney (Roundtable)****Blacktown Alcohol and Other Drugs Family Services Inc.**

Mrs Sylvia Belsey, Counsellor

Ms Tirrania Suhood, Manager

**Open Family Australia**

Mr Luat Van Nguyen, Operation Manager, Sydney

**UnitingCare Burnside-Cabramatta Centre**

Mr Voraveth Siackhasone, Intensive Family Support Worker

**UnitingCare Burnside-Cabramatta Multicultural Family Centre**

Mr Vuong Van Nguyen, Coordinator, Moving Forward Program

**Community statements**

Three individuals

**Tuesday, 3 April 2007 - Sydney****Australian Drug Law Reform Foundation**

Dr Alexander Wodak, President

**ONE80TC, Teen Challenge New South Wales**

Mr Ryan Betts, Graduate Student

Mr Rhett Morris, Chief Executive Officer

**Toughlove Inc**

Mrs Jennifer Sher, Trainer

Mrs Louise Smith, Representative

**Individuals**

Dr Bronwyn Gould

Dr Albert (Stuart) Reece

**Community statements**

Three individuals

**Wednesday, 9 May 2007 - Canberra**

**Australian Federal Police**

Ms Meredith Bassett, Team Leader, Organisational Performance Team

Assistant Commissioner Michael Phelan, Assistant Commissioner

Commander Julian Slater, Manager, Performance and Planning

**Wednesday, 23 May 2007 - Canberra**

**Recovered Drug Users League**

Mr Ryan Hidden, Spokesperson

**Individual**

Hon Ann Bressington MLC (SA)

**Monday, 28 May 2007 - Canberra**

**Australian National Council on Drugs**

Dr John Herron, Chairman

Mr Gino Vumbaca, Executive Officer

**Canberra Mothercraft Society Inc**

Ms Emma Baldock, Client Counsellor & Community Development Officer

**Drug Free Australia**

Ms Josephine Baxter, Executive Officer

Mr Gary Christian, Board Member

Mrs Carol Russ, Parent

Mr Craig Thompson, Chair

**Wednesday, 30 May 2007 - Canberra****Individuals**

Mrs Hazel McMenamin

Mr Ian Mercer

**Wednesday, 13 June 2007 - Canberra****Griffith University**

Professor Sharon Dawe, School of Psychology

Professor Ross Homel, Director, Key Centre for Ethics, Law, Justice and Governance

**Tuesday, 19 June 2007 - Canberra****Australian Institute of Family Studies**

Dr Matthew Gray, Deputy Director Research

Professor Alan Hayes, Director

Dr Daryl Higgins, General Manager Research

**Wednesday, 20 June 2007 - Canberra****Department of Families, Community Services and Indigenous Affairs**

Mr David Hazlehurst, Group Manager, Families

Ms Gwenda Prince, Branch Manager, Youth Bureau

Ms Vicki Rundle, Branch Manager, Child Care and Children's Policy, Children's Group

Ms Michelle Wilson, Section Manager, Youth and Family Services Youth Bureau

**Wednesday, 8 August 2007 - Canberra****Family Drug Support**

Mr Michael Gardiner, Volunteer

Ms Jessica Lloyd, Volunteer

Mr Tony Trimingham, Chief Executive Officer and Founder

Ms Catherine Wolff, Volunteer

Ms Linda Cheetham

**Wednesday, 15 August 2007 - Canberra**

**Individual**

Mrs Lorraine Rowe

**Site inspection**

**Wednesday, 7 March 2007 – Gold Coast**

**Mirikai House**

Ms Mary Alcorn, Executive Director, Gold Coast Drug Council