3

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

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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

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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.

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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]

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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

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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,

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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

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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:

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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]

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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]

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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]

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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]

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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]

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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.

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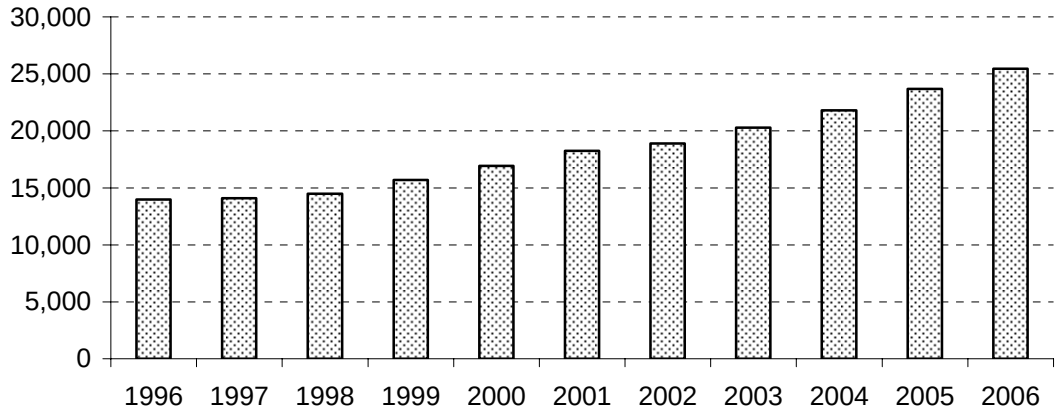
96 The National Center on Addiction and Substance Abuse at Columbia University, *No safe haven: Children of substance-abusing parents* (1999), p iv.

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.

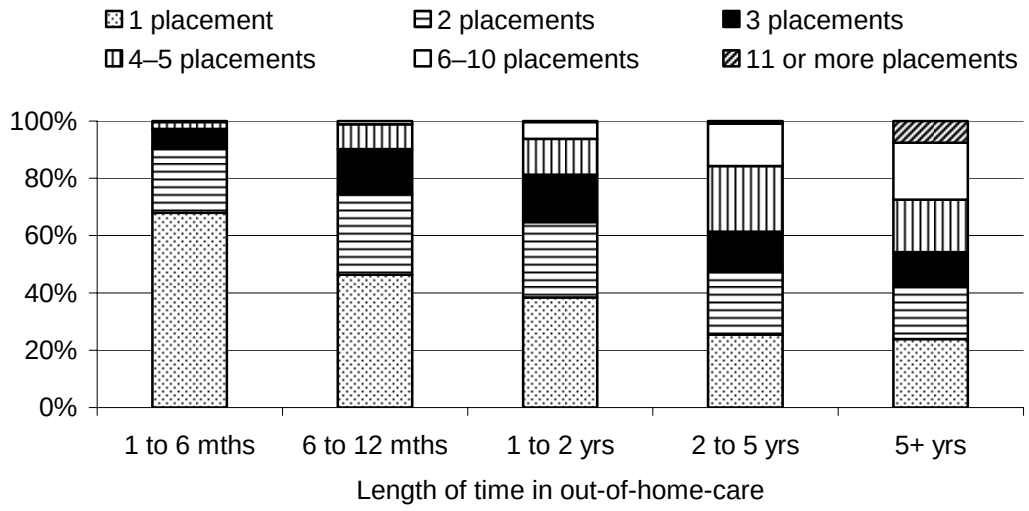
104 Australian Institute of Health and Welfare, *Child Protection 2005-06* (2007), cat no CWS 28, p 52.

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 overseas[123], 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]

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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:

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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]

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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 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

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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]

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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.**