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**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Reference: Impact of illicit drug use on families

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Tuesday, 19 June 2007

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

Members in attendance: Mrs Bronwyn Bishop, Mr Fawcett, Mrs Irwin and Mr Ticehurst

Terms of reference for the inquiry:

To inquire into and report on:

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

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

WITNESSES

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HIGGINS, Dr Daryl John, General Manager Research, Australian Institute of Family Studies 1

Committee met at 4.44 pm**GRAY, Dr Matthew Cameron, Deputy Director Research, Australian Institute of Family Studies****HAYES, Professor Alan John, Director, Australian Institute of Family Studies****HIGGINS, Dr Daryl John, General Manager Research, Australian Institute of Family Studies**

Witnesses were sworn or affirmed—

CHAIR (Mrs Bronwyn Bishop)—I declare open this public hearing of the House of Representatives Standing Committee on Family and Human Services inquiry into the impact of illicit drug use on families. Today the committee welcomes the Australian Institute of Family Studies to give evidence. The institute has been called today as it has conducted research projects which have helped to form a better understanding of the impact of illicit drug use on families. The institute's submission addresses the factors that may increase the risk of illicit drug use in families and details the dangers to children of living in families affected by illicit drug use.

The transcript of what is said today will be posted on the committee's website. If you would like further details about the inquiry or the transcript, please ask any of the committee staff here at the hearing. This hearing is open to the public. I thank you very much for coming. I am very pleased that we could find a time that suited you to come and appear before us. Would you like to make an opening statement?

Prof. Hayes—Yes. The Australian Institute of Family Studies is very pleased to have an opportunity to make a submission to this important inquiry into the impact of illicit drugs on families. As you are aware, we have conducted a range of research projects and completed a comprehensive review of the literature that have informed our understanding of the impact of drugs, including illicit drugs, on families.

In our written submission we addressed the research relating to three key areas: firstly, the family factors that increase the risk of, or play a protective role against, drug use; secondly, children's unique vulnerability in families affected by drugs, including the risk of intergenerational cycles of drug use; and, finally, the role of families in preventing harm and assisting with treatment options for family members affected by drugs. We also recognise that most of the research in the area highlights the importance of seeing illicit drugs within the context of other substance use issues and, therefore, much of the research we describe in our written submission refers also to tobacco and alcohol use as well as to illicit drugs. In particular, the institute's analyses of findings from the Australian Temperament Project show that children with an easy temperament early in childhood are more likely to have positive adjustment later in childhood and adolescence, which in turn reduces the likelihood of other risk factors for later drug use being present, such as antisocial behaviour or school truancy.

Parental drug use also has implications for children. It is acknowledged as one of the biggest problems in preventing child abuse and neglect. Illicit drugs are part of the intergenerational

cycle of abuse. Experiencing child abuse and family violence places individuals at greater risk of misusing substances later in life. Parents affected by drugs, in turn, can place children at risk of abuse and neglect. Drug facilitated sexual assault of adults and drug taking as a consequence of sexual assault also have impacts on families. In order to address the problem of illicit drugs, the risk factors for child abuse, sexual assault and other family violence and their many impacts, need to be considered.

In conclusion, research shows that families can play an important role in providing a protective environment for children that reduces their risk of later illicit drug use. However, negative early familial characteristics can increase the risk of illicit drug use and how this drug use impacts on other family members, particularly on children and their experiences of inadequate parenting, abuse and neglect. In turn, child abuse, neglect and sexual assault are risk factors for later drug abuse, demonstrating the key role of families in the intergenerational cycle of drug use, including illicit drugs.

Finally, families are also part of the solution, with evidence that family-inclusive practice is more efficacious in the treatment of drug problems. In sum, families need to be considered at each stage of the problem of, and the solutions to, illicit drugs in Australia.

CHAIR—Thank you very much. Can I say at the outset that the reason that we are talking about illicit drug use in this inquiry is that it is of concern to a lot of people that the tendency to mix up legal and illegal drugs tends to give respectability to the illegal drugs. Consequently, alcohol and tobacco are both legal; illicit drugs certainly are not. We think it is important for that distinction to be made. People will have a glass of wine to accompany a meal and enjoy a winemaker's skill, but, if you use illicit drugs, you do it for one reason only—to get off your face. In the context of answering some questions, I wonder whether we could begin with the research you have done about children who are abused, assaulted or sexually abused. Are you concluding that it is likely that those children will become drug addicts?

Dr Higgins—We house the National Child Protection Clearinghouse at the institute, so we are a major conduit for research throughout Australia as well as internationally. This is certainly one of the areas that we have examined in literature reviews, and we certainly are aware of an extensive range of literature that shows that, as a consequence of child abuse and neglect, one of the ways that that has its impact is in a higher risk of engaging in a range of behaviours in adulthood that are negative. One example of that is use of illicit substances.

CHAIR—Can you put a percentage on it? What percentage of children who suffer that in childhood is likely to become adult users?

Dr Higgins—No, I cannot put a percentage on it because there are a variety of research studies that look at these issues and most of them suffer from methodological limitations in their sampling. It is limited because the samples are usually not representative, and therefore it is hard to extrapolate percentages. It usually depends on where you recruited your participants for the particular research project. For example, a lot of the research in this particular area might look at people who are attending for drug treatment, and, looking at the past history of child abuse and neglect, it will find an overrepresentation of them in that particular population. That does not allow you to then say what percentage of people who are abused or neglected might go on to have an illicit drug problem or any other type of drug problem. So, it really comes down to our

lack of research on the prevalence of child abuse and neglect, which means that we are not able to answer that question.

CHAIR—We have taken evidence from quite a lot of people who have come before us who come from extremely good homes. These are people who come and give their own testimony. In some cases they have brothers and sisters who lead normal lives, and it will be a one-off in that family. In Perth we heard from one particular family where four out of five children went down to drug abuse or drug use—because, if you use it, it is a problem. So, when you put the accent on children who come from those sorts of families, you almost get the reverse conclusions being drawn: if someone is on drugs, they must therefore have been. But that is not true. What about the other cohort of people—the ones who come from really good, regular homes?

Prof. Hayes—This is why you need prospective studies, like the Longitudinal Study of Australian Children. You are perfectly correct: when you look retrospectively at clinical populations you amplify some factors disproportionately. Large-scale longitudinal series are the ways in which you start to see the diversity of pathways for children, and this is why we particularly mentioned the Australian Temperament Project in our submission, where the children recruited in infancy are now into adulthood and starting to form their own families. It provides a Victorian based but rather unique window on the ways in which children from a diversity of backgrounds are led towards risky behaviour, including drug abuse as well as risky driving behaviour or just anti-social behaviour generally. I think we now have some tools to be able to address the issue that you have talked about, but the Longitudinal Study of Australian Children, for example, is only in its second wave. Progressively, as waves are accumulated, we will get a clearer sense of the divergence of pathways.

Dr Gray—It is worth mentioning that the Australian Temperament Project has identified a number of familial risk factors for later drug use. Some of them that we have mentioned are related to child abuse and neglect, which are risk factors. Many children who do not experience any of these things will go on to become drug addicts—and there are a variety of reasons for that—but family factors that increase the likelihood are: having a family history of behavioural problems; poor socialisation practices; ineffective supervision of children and young people; ineffective disciplining skills; a high level of family conflict; chaotic family environment; parental mental illness; family isolation; alienation from mainstream social values; and stress. There is some evidence that sole parent families can be a factor.

CHAIR—Do you have any evidence or statistics about what percentage of drug addicts come from that sort of background as opposed to the people who come from a normal background?

Prof. Hayes—It is difficult, because we do not in this country have a long-run series that can give you those pathways and those percentages, but it highlights the diversity of backgrounds that people come from. The common factors that the Temperament Project also points to are things that are not just related to adverse or risky social circumstances. I do not profess to be an expert in this area, but temperament characteristics—the notion of addictive personalities where people will be drawn to a range of involvements with risky behaviour, be it drug use, gambling or just risky financial management—essentially need to be highlighted. The other thing that we emphasise, though, is that there are groups within the community who are at much higher risk—where you find multiple factors at play—and that is why in our submission we have drawn

attention to the high risk that attends families where there is abuse, neglect and also comorbidity around drug use.

CHAIR—The addictive personality that you talk about is quite interesting. Some people gave testimonies or said, almost as a throwaway line, that there was an uncle who was an alcoholic or there was somebody else who was something else—distant and not in the immediate family. That leads you to ask the question: is there a genetic disposition to addictive behaviour?

Prof. Hayes—Increasingly we see these things as determined both genetically and environmentally. Genes inherit environments and environments inherit genes. In a sense, you have, through processes of assortative mating, amplification at times of genetic propensities for things—but you also have environmental triggers. This explains why in the one family, as you mentioned at the outset, you will have considerable difference, because the amount of shared genetic variance within a family is quite small. If you look at the work that has been done for quite a lot of time by people like Robert Plomin, you will find that that is the pattern that comes out in families: you will find considerable non-shared genetic variation. It is when you look across generations that you do find the uncle, the aunt or the grandparent who also showed that propensity. The point is that both the environment determinants and the genetic drivers are quite complex.

CHAIR—In the original briefing we had from the Australian Institute of Health and Welfare, they said to us that curiosity is the biggest driving factor for people trying drugs. But you could add to that that, for some people, the curiosity is going to be greater than for others. Some people are going to be drawn more to the initial taking than others, who are just going to say, ‘It’s not on.’ Do you have a view about that?

Dr Higgins—It highlights that there is a lot of individual variability in the temperament—and Professor Hayes has already alluded to the Australian Temperament Project, which does start to unpack some of those differences in young people that are evident very early on and how that leads to different pathways later on—but I think we need to balance up the two issues of the genetic predisposition and the environmental influences. That is where factors such as having a warm and nurturing attachment to a significant adult, usually the primary caregiver, but also factors such as whether a young person has been exposed to abuse can be the issue that will differentiate someone who is likely to step outside those normal social bounds. There can be a range of factors.

CHAIR—We hear people say, ‘We need education.’ The thing that worries me about that is: what message are we teaching? We may send out a message that says: ‘Recreational drugs are okay. Watch footballers play. They don’t do this; they don’t do that.’ People on the ABC talk about ‘party drugs’. If you are vulnerable and you are getting those mixed messages, aren’t you more vulnerable?

Dr Higgins—The most proximal influences on an individual are going to be the family, and that is what is most influential in children’s development and then ultimately their chances of getting involved in drug and alcohol issues as teenagers and adults. While those broader societal messages are potentially important, so are the messages that are set at home. Certainly the data from the Australian Temperament Project show that, for example, parents who engage in drug use themselves are one of the most important predictors of drug use later on.

CHAIR—Of course it is. Blind Freddy could tell you that!

Dr Higgins—Yes.

Prof. Hayes—The interesting thing is that, in those families, one member of the family may follow that path and three may not.

CHAIR—If you have one or two drug-using parents and three siblings, what is the likelihood of one of the three following? Is the likelihood more or less if only one parent uses and the other does not? Similarly, if you have two parents who do not use drugs and one of the three kids does, what are the likelihoods? What are the streams? It seems that we do not know.

Prof. Hayes—We do not know. Certainly we do not have data on that. There are likely to be multiple causes or multiple pathways to that outcome of illicit drug use, so the drivers in one family may be quite different to the drivers in another family. The drivers in a family where you have the pattern that Dr Gray spoke about of chaos and family violence may be very different—

CHAIR—But, in a way, that is easy to say, isn't it, because everybody understands that. You say, 'This child comes from a chaotic background, abused and neglected and all that sort of stuff; of course they are going to be a drug addict.' But then you hear testimony, as we heard only a matter of weeks ago, from a young person who said that he started taking drugs because it was cool—it was the cool kids who did it, and he wanted to be cool.

Prof. Hayes—That is the balance that shifts across adolescence, where the direct influence—Dr Higgins is correct: the prime drivers and the prime influences are within the family, but—

CHAIR—But the drivers within his family were that everybody was normal and nobody was using drugs.

Prof. Hayes—That is right, but then—

CHAIR—But the cool thing to do from the peer pressure was to be with the cool kids and take drugs.

Prof. Hayes—Yes, because what happens over adolescence is that, for many children, the peer group will become much more dominant and influential than the family's influence. The thing that I find interesting too is that, for all those who experiment—and I do not in any way condone it—it will be a small percentage relatively who go on to the use of it over time and—

CHAIR—This child became a drug addict.

Prof. Hayes—Yes.

CHAIR—It took him years to get over it.

Prof. Hayes—But it depends. Some of the evidence will be that people will have a different propensity to addiction and therefore they will be able, with countervailing influences, to stop. Other people, of course, will get fairly rapidly addicted and will have great difficulty stopping,

particularly if there are not supports around them. That is the other point we are making in our submission. It is around the role of a closer partnership between family and professionals in providing support. I think there is a fair literature that shows that parents often feel alienated from the treatment process, or, alternatively, professionals feel ill at ease in including family members.

CHAIR—But, again, what is the message that comes across? This particular young man said that he was nearly destroyed because the counsellor said, ‘It’s okay to use at weekends.’ How do you stop that sort of message?

Prof. Hayes—I think that is around the education of professionals—

CHAIR—But that is the whole point—

Prof. Hayes—to have more nuanced—

CHAIR—Everybody says ‘education’, but we do not look at the message.

Mrs IRWIN—I think you have stated that in your submission to us.

Prof. Hayes—That is right. We have, yes. There is a lot that needs to be done. The other invidious factor about drug use is of course that the nature of the drugs that are out there is shifting and changing. A decade ago, methamphetamine would not have been a major issue, but you look at it and the sequelae psychiatrically and you see it is a terrible problem. What you get is of course psychiatric sequelae that make it much harder for people to engage with the world of work, to live productive lives and to have anything that, in a sense, increases the probability that they can change.

Mrs IRWIN—If you were legislators—and I hope you will answer this question on the public record—what would you suggest for the best prevention programs?

Dr Higgins—That is a very difficult question to have to try and answer. I think the research that is available shows that there are two basic types of prevention programs: universal ones and targeted ones. There are risks and benefits associated with both. Obviously universal services are likely to be able to influence more families or more individuals, so they are the kinds of supports that we can offer to every family. Examples of those are things like maternal and child health services, and the publication that we have placed on the record entitled *The effectiveness of parent education and home visiting child maltreatment prevention programs* documents examples of those kinds of universal programs that are provided to all families. But also there is the second kind which is the targeted ones. The research shows that those targeted ones tend to be more efficacious because they are focused on just those families that are at high risk. However, it does need to be cautioned that there are many families who would still benefit even though they are not as high risk as the families that you would be targeting through those particular programs.

My view would be that we need broad supports for families that include mentoring and opportunities for new parents—particularly young parents, who may not have had those appropriate modelling experiences themselves. I think that cuts across issues to do with, for

example, Indigenous communities, where we know that past removal practices have left families without that connection to their own parents, to being parented and having that kind of modelling first hand. There is a great opportunity for those services to be of real benefit to those families.

Mrs IRWIN—I am interested to know more about the Community Bubs program. Is that only being run out of Victoria? How is it going?

Dr Higgins—Yes. It is a very innovative project, which won a National Child Protection Week award from NAPCAN. It is a community based program that is dealing with an issue at a community level, recognising that it is not just about what is happening in individual families but something that a whole community can take control of to bring about a solution. It is focused in Melbourne at the moment, but there has been, since our publication of the program, some wider interest nationally about the issue.

Mrs IRWIN—I have never been aware of this program. It just seems interesting. Please go on.

Dr Higgins—The focus is on some particular communities in public housing in a bay side suburb of Melbourne. It is a suburb in a mixed socioeconomic status area. It does include some high-rise housing. There have been particular problems there. Obviously child protection was a major one, but there was also general community violence and poor relationships with police. There was a range of strategies that Family Life, which is the agency that has been running it, were trying to put in place there. Community Bubs is really about assisting the community to take responsibility for the welfare of children through supporting vulnerable parents. It was about them being able to set up a system of mentoring so that parents would be able to feel as though they had someone that they could talk to, that they could phone in the middle of the night. It is mimicking, I suppose, what we would hope good functional networks of extended family have traditionally offered in the past. Where communities do not necessarily have those supports immediately, there are ways of being able to build community. As I said, it is not just about individualising the problem but about trying to get the whole community to take on board the responsibility of caring for children and supporting families. A range of agencies has been involved. For example, the police have been focused on trying to build positive relationships with the community so that they are seen as a resource rather than the big bogeyman. So they have got alongside the community, and they play soccer with them, and they serve breakfast at their breakfast program et cetera.

CHAIR—I want to look at the other side of the coin: perfectly normal families where the child becomes an adult and abuses the family. We heard from one couple, and the story is horrendous. The child started taking cannabis at the year 10 formal, was picked up and taken to the police, and the policeman said: ‘I take marijuana, too, you’re just being silly. Only use it at weekends.’ The counsellor said, ‘Just be careful of the way you use it.’ The child went on to become a major user throughout its life. The person is now an adult who is totally psychotic, using marijuana and now ice as well. When he has an episode it takes eight policemen to hold him down. He is currently on remand for bashing two individuals. The story about the threats to the parents is horrendous also. He went and lived in a flat not far from home, because they wanted him out of the house to try and save the other child. The drug dealer gave him an ex-

prostitute for a girlfriend, who was also pushing drugs. She stole \$6,000 worth. The drug dealer came in and said, 'I'm going to kneecap you if you don't find the \$6,000.'

The parents finally contacted the police. They actually paid the \$6,000. They had tapes of all this, gave them to the police and absolutely nothing was done; nothing. This sort of criminality is going on all the time and, if we have a culture that says, 'Please don't worry about drug users. Caution people who are using them,' police are not going to prosecute things because at the end of the day they think they are just going to go through the revolving door and get off.

Have you done any research on those sorts of cases and the impact that that is having on the community at large? The net result is that in my electorate last Saturday night a young adult, probably autistic, was violently stabbed to death at a bus shelter. The suspects are obviously people who are on drugs. How do we deal with those questions because the drug using population is relatively small? The number of people who are actually involved in taking drugs and pushing drugs is quite small. Our policies are quite successful in maintaining a society where most people do not, but the havoc that they wreak is appalling and it is getting worse. How do we deal with those problems?

Prof. Hayes—We have not done research specifically on that issue, but I think clearly supply reduction has to be a major priority. There have to be strong messages about the unacceptability and the harm that illicit drugs create. I think that there has to be a broad based approach to helping families deal with the reality of this threat and the consequences. As Dr Higgins has suggested, the solutions are likely to be where you do get that connecting of family, community and the wider services.

CHAIR—Police and counsellors are part of the community giving bad messages and bad advice. How do we clear that up?

Prof. Hayes—I think legislators in the Australian government and the states and territories can do something about it. If you look at—and I will use an example that is not related to drugs—road trauma in the 1950s and sixties, it was accepted at a level that we would not accept as a casualty rate in war. You had a concerted national effort. You had a concerted partnership between the police, for example, and road safety authorities. You had commitment to research on the causes of road trauma and death and, essentially, you had engagement of the community through broad based information programs about the unacceptability of driving when you are drunk.

I am old enough to remember the time when the only way that you could get a drink on a Sunday was to drive because then you were a bona fide traveller. Nowadays, that is totally unacceptable so I think there are examples from other areas where we have been able, as a society, to address the problem. The difference is that there are large sums of money to be made out of the sale of illicit drugs. In the small community in which I live, last Friday an ice factory in a rented house, which is directly related to the supply of drugs in that community, was discovered. The perpetrators have been arrested, and in our community it has been taken as an extremely serious wake-up call.

I am not a pessimist about these things. I think that there are levers through public policy, and I think parliaments have a profound role to play in raising issues to the point where they are

seriously considered and then mobilising a concerted, combined community effort to address the problem. I do not think that these are problems that we have not addressed in other forms. The Dickensian problem with gin was addressed, for example. These things are well addressed through the broad based prevention efforts that Dr Higgins has spoken about. I think you need all of those elements—a comprehensive strategy which, from my understanding, the National Drug Strategy is attempting to do.

CHAIR—If we take another example—and we have talked about it in hearings before—when AIDS was finally recognised as a huge problem, we had the ‘grim reaper’ campaign. It worked. But now we have AIDS on the rise again, because we have got a whole generation of people who never saw that campaign. Leaving aside the need to renew the campaign for that program, if we had a campaign like that—which was saturation and in your face—on illegal drugs, do you think that would help?

Prof. Hayes—I think it would help. I think the messages have to be refined and tailored for each generation, but I think those sorts of things do give a strong signal that the community at large does not accept this behaviour. The difficulty in this area is the difficulty of prediction. It is extremely difficult to predict which individuals will fall prey to which problem. Even when we know the genetic drivers to an illness, for example, it is very difficult to predict who will have that illness expressed. It is usually only expressed when you have an environmental correlation—something that potentiates the genetic potential.

We will never get to a situation where you will be able to protect every person in the society, but of course social policy is about shifting the percentages so that you have big multiplier effects across the whole of the community. I do not want to labour the example of road safety too much, but it is interesting. If you look at the road safety statistics, you will see a rise again in road trauma. That is made up of, in a sense, the slippage that occurs because people become complacent; but it is also made up of a very small percentage of very high-risk individuals who are quite resilient and resistant to change.

CHAIR—There is another aspect too. You get the young people, in particular, who say: ‘I won’t use alcohol, because I’ll get tested and I’ll get busted,’ so they use drugs instead. We have found statistics that were published from, I think, one of the hospitals in Melbourne, and something like 48 per cent of trauma patients in that hospital had illicit drugs in their bodies. I am told we are now testing for it in New South Wales, but I am yet to see one. I think that when they have got the booze bus they should be doing drug testing simultaneously. Have you done research on that?

Prof. Hayes—No, not directly.

Dr Gray—You were making the point earlier about why some people in a well-functioning, normal, healthy family go on to become addicted to drugs. Professor Hayes has spoken about peer relationships becoming more important as young people enter their teenage years. I think that one of the key things is the capacity of parents to teach their children how to resist peer pressure. We know that all generations do things that their parents would rather they did not, and so it is obvious that if drugs are readily available people will be more likely to use them. That is why I think supply reduction is very important. Nonetheless, a key aspect is for parents to be

encouraged to teach their adolescent children how to resist that peer pressure or, if they do slip, how they can deal with that without going into the slide of becoming addicted to drugs.

We have good ways of dealing with licit drugs. A young person will go out and drink far too much, and their family will say to them: ‘That wasn’t very good; what happened?’ and so on. Illicit drugs are more difficult. People have a glass of wine with a meal which, in most cases, is not harmful. But with illicit drugs, you cannot have that.

CHAIR—That is right. The whole intent and purpose of most people’s usage of alcohol has nothing to do with getting off their face, whereas the use of drugs is always for that purpose.

Dr Gray—With illicit drugs, it is about teaching people how they can resist that peer pressure and, if they do have a slip-up, how they can prevent that from happening again.

Dr Higgins—To build on what Dr Gray has said, building parenting capacity is a critical part of that. So while, yes, a broad public campaign may have value, I think it is at the individual family level that there is likely to be greater impact in terms of giving parents the appropriate skills to set—

CHAIR—Dr Higgins, when you were a young man—around 20—and your parents told you what you may and may not do, did you always do that?

Dr Higgins—I think that 20 is probably too late.

CHAIR—Okay, what about when you were 16 and your parents told you, ‘You may not do this and you must do this and you must do that,’—did you always do that?

Dr Higgins—I was a particularly compliant child!

CHAIR—Well, I’ll give you a gold star!

Dr Higgins—I saved my rebellion until my 30s! There are individual differences, and it is about the capacity of parents to manage difficult behaviours in children and to manage when children are being rebellious. I am not saying that it is about preventing that.

CHAIR—But what you are almost saying to me is that it is all the parents’ fault.

Dr Higgins—No.

CHAIR—I cannot buy that—not from what we have heard. What parents say is that when they find it, there is absolutely nowhere they can go to get the backup and the help immediately. It just does not exist.

Dr Higgins—That is exactly the point that I think is very important to follow up on—that is, what is the capacity of parents to be able to cope and deal with and respond to—

CHAIR—But there is no backup for them. There is no-one they can pick up the phone and call and say, ‘Give me this help.’ It just does not exist. You get told: ‘Would you like to wait for two weeks?’

Prof. Hayes—I know personally, as I am sure you do, of instances where it has started with problems that related to difficulty at school to segue to the emergence of some psychiatric or psychological problems and then the person has become alienated and started to experiment with drugs. Part of what we are trying to focus on is the issue of the convergence of multiple factors that lead to the problem. Clearly, there are inadequate supports. It is one of the costs that I think we have because the waiting times and the supports to get help are, in many communities, very unacceptable. There is the problem of people not knowing where to go, so they do not have useful pathways or entry points to the systems. I preface this by saying that I am not an expert in this area—it is not my field: but the impression I form is that there is a dearth of support services for people, or they are short-term services.

CHAIR—And then you do not know what sorts of services they are.

Mr TICEHURST—On the subject of rehabilitation, there is a facility in my electorate called The Glen. It is primarily, but not necessarily, for Indigenous males. They take about 20 young or not-so-young fellas at a time. How do you find the effectiveness of rehabilitation? They tell me that some of these fellas finish up in jail, primarily through alcohol abuse, and the jail time can then lead into drugs, and unless they get into a rehabilitation program that takes them off both of those substances then they are not really sufficiently rehabilitated to go back and live a normal life. Have you found any evidence that these rehabilitation centres can have long-term benefit?

Dr Higgins—We have not looked specifically at evaluation of rehabilitation centres, but I can give an example of one program that we looked at as part of an evaluation that we were doing of some innovative programs that were funded by the Telstra Foundation. The institute was responsible for conducting an evaluation. It looked at people in late adolescence who were using drugs and were at risk of dropping out of school. The focus was on engagement with education and vocational opportunity. It was about balance—not just about getting the young people away from harmful situations but about finding positive things that they could look towards to give them a sense of achievement. Often these young people had a low sense of self-worth, they were living in communities where unemployment was rife and so there was a sense of, ‘There’s nothing for me anyway.’ They were living in families where no-one was working, they were living in communities where they were subject to discrimination based on their race et cetera. It was about trying to build a more holistic program that built in mentoring and opportunities for skill development and linked with education to try to give a sense of hope for the future. That is where I think we can focus more efforts when we are looking at positive examples of rehabilitation.

Prof. Hayes—We make disproportionate investments in, for example, institutions like jails compared to those that support people in re-engaging with the community. Mission Australia and the Australian Catholic University run a program called Catalyst-Clemente. I have talked to people involved with that. It takes people who have multiple threats and risks in their life and starts to build up a sense of their self-esteem and their capacity through education. It is modelled on a program in the United States that gets people doing things like studying university subjects like philosophy, values or ethics, or other cultural things. The impact it has—it is a bit like the

Choir of Hard Knocks—is that all of a sudden you see that people that the community may regard as having no strengths still have strengths and can still build those up. Jail, of course, is terrific for amplifying all the negatives and professionalising your capacity to get drugs and get the money you need to purchase the drugs more efficiently. It is not the way. We need support for people to re-engage after prison with the community. The other issue that Good Beginnings and other organisations have been involved in is minimising the punishment of children of prisoners, by trying to maintain the family links, connections and bonds. When people transgress we can be very harsh in our punishment because we punish not only the person who has transgressed but the whole of the extended family. In that way we breed the intergenerational cycle that our submission talks about.

CHAIR—But that is only a small percentage, isn't it? We have 21,000 people in jail. Two-thirds of that population of 21,000 are recidivist. So one-third have a chance. Yet, according to the 2004 National Drug Strategy Household Survey, 73,800 people in Australia over the age of 14 had recently injected drugs. That does not take into account people who had taken drugs in other ways. Plus, the last time I heard it, we had 38,000 people on methadone. People become addicted to methadone, and many of them top up, and yet we never talk about the fact that—we heard evidence on this—the loss of years of expectant life for a methadone addict is 46. People die from methadone, and yet we do not count their deaths as drug deaths.

Prof. Hayes—I think, though, that is the story you get—that quite often the prison population is the tip of a pretty big iceberg. Of course, the factors that lead people to be incarcerated are not necessarily evenly distributed across the community. There are groups that have a much higher probability of engaging in practices that lead to a criminal conviction and a high probability of being incarcerated. With regard to incarceration, I think the US example shows that unless you have things that build effective rehabilitation and people find pathways out of the recidivist population then you essentially get the revolving door. I accept your point that it is a small percentage, but these small percentages create disproportionate harm.

CHAIR—They do. I was interested in Mayor Giuliani's first experience when he tried to implement the 'broken window' theory. In a conversation I had with him, he said one major problem was the 'squeegee' people who insisted on washing your windscreen. If you did not agree, they might thump you or kick your car door in. It was an extortion practice. He thought there were about 2,000 of them. He wanted the police to prosecute them but the police came back and said: 'We can't. They haven't done anything, so we can't stop them.' So he said, 'When they step off the footpath to go across to demand that they be allowed to clean the windscreen, they are actually jaywalking. Book them for that.' So they did and they found out that there were not 2,000 of them; there were 500 of them. But the 500 people who were doing that were also doing the big stuff. His point was that the people who were doing the little crimes were also doing the big crimes. It was the same population.

Put that together with other evidence I have taken, not in this inquiry but in another inquiry, that says that a potential drug pusher will very often target a school and give out drugs to 100 kids on the basis that 10 will become addicted. It is pyramid selling. Those 10 then become the pushers for that area, and so on up the chain. So when we have an enforcement program that says we should not do anything about this and to just let it go, what we are really doing is breeding it, aren't we?

Prof. Hayes—The difficulty for us is that we really—

CHAIR—He could clean up New York.

Prof. Hayes—Yes. We have not done a lot of work that relates specifically to prison populations, for example, so it takes us a bit beyond our expertise, which I think is not useful to the committee. We have tried to illustrate in the evidence we have presented today some of the common elements across a range of problems as well. For us, though, I think there are issues here about the family factors that can provide protection on the one hand or vulnerability on the other. The other thing—and Dr Gray has done this work—is that it is quite clear that among OECD countries Australia does spend a considerable amount on its families; in fact, it has one of the patterns, if I am correct, with the steepest increase in family supports. So I think that is a great policy start.

CHAIR—It is good.

Prof. Hayes—I think that is a great foundation. It is then a matter of thinking of ways in which we can mirror what happened in the road trauma area or mirror the approaches that people are taking with child abuse to get this connection between families, communities and the wider supports that government can directly influence, such as the police, the prison system and rehabilitation counsellors.

CHAIR—I had a graph done, which I am trying to find among my papers, to show what the statistics say about drug usage, because a lot of the figures say that 39 is a cut-off point when drug usage drops right away. Here it is. It is interesting.

Mr TICEHURST—Is that because they die out?

CHAIR—There used to be an old adage: by the time they were 27 they were either off it or dead. This shows that the peak of it is 29. After that it falls away pretty dramatically. It builds up over the period of time from 14 to 29. Equally, I found from inquiring into crime that people who commit the biggest proportion of crime are young men between the ages of 17 and 25.

Prof. Hayes—Correct.

CHAIR—They are also more likely to be victims.

Prof. Hayes—That is right.

CHAIR—I suspect that we are looking at the same cohort of people.

Dr Gray—There will be a lot of overlap.

Prof. Hayes—Some interesting work has been done that looks at the factors that do lead juvenile offending males to desist from crime. The two things that seem to explain most of the variants are engagement with the world of work and formation of stable family relationships. Work and a good partner are likely to be the two things that change the pattern. Look at violent

offending men, for example: four per cent of the child population are heavily antisocially violent before the age of eight.

CHAIR—Is that right?

Prof. Hayes—That is the work of Tremblay in Canada. A small percentage of that four per cent go on to a life of recidivist crime.

CHAIR—What percentage?

Prof. Hayes—I cannot tell you off the top of my head, but it is a small percentage of the four per cent. But the four per cent is pretty resistant to modification. Of the others who experiment with property crime or other things, there is a fair chance, as you say, that after the age of 29 they will not be involved. There is that window where, in addition to reducing supply, there is a sense in which we have to as a community try to maximise the chance that the highest percentage possible are rehabilitated and go on and recover. That is the harm minimisation aspect of it. The example you gave us, Mr Ticehurst, is one in which social systems paradoxically increase the harm—they increase the probability that people keep engaged with a mal-adaptive lifestyle. We know a heck of a lot about this. We can take some knowledge from other areas and apply it but obviously, given our remit, we are most interested in family factors and how they can be mobilised to reduce the risk that people get engaged at the outset.

CHAIR—Have you done much work on saving other members of the family? The evidence we have heard is how users can become violent and threaten—hands around the throat, choking and all sorts of things. In the end, they have to banish that person from the house to try to save the rest of the family, yet they still love that person. But if they do not get them out, they will all be dead. Have you done much work on that?

Dr Higgins—No, that is a very specialised area of interest and I am not aware of there being a lot of research. It is a particular problem that is most likely to be seen by family practitioners who are working in that area rather than in large-scale research projects. That is certainly something where further research would be valuable. Returning to the graph that you were showing before, the thing that struck me from that data is that age 29 is also the age when a lot of adults are forming relationships and families. The area that I am coming from is child protection and child abuse and neglect, and many of the children of these drug users or people who are trying to come off drugs are likely to be affected by the experience. Certainly, that is borne out by the experiences of child protection agencies in each of the states and territories—a large proportion of their workloads is the children of these families. I think that is an area of particular concern that states and territories are grappling with. If we look at the rise in notifications and substantiations over the last five years, we can see that there is certainly a large problem of which drugs are a part.

CHAIR—The problem is a lot of children are the result of very casual relationships where there is no sense of responsibility, and those children are tremendously at risk. Thank you very much for appearing today. Perhaps we could get in touch with you if we need additional information. We are very grateful for you being here.

Prof. Hayes—Thank you. As a postscript, we will send through to you the next edition of *Family Matters*, which will be published at the end of this month, on families caring. Dr Higgins has been the executive editor of that. We will also send through copies of the Indigenous families and communities edition of *Family Matters*, which was the previous edition. Dr Gray edited that. I think both of those will be useful to you—one is out and one is about to be published. Thank you very much for accommodating our problems in this time period.

CHAIR—Thank you very much. We are grateful to you.

Resolved (on motion by **Mr Ticehurst**):

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

Committee adjourned at 5.47pm