

LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE
**Inquiry into the supply and use of methamphetamines, particularly ice,
in Victoria**

Melbourne — 17 February 2014

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Ms J. Rowe, Chief Executive Officer, Mirabel Foundation.

Ms E. McCrea, Advocacy and Family Support, Mirabel Foundation.

Ms R. Chattey, Family Support, Mirabel Foundation.

The CHAIR — My name is Simon Ramsay. I chair this joint parliamentary Law Reform, Drugs and Crime Prevention Committee, and I now declare the public hearing open and welcome our guests from the Mirabel Foundation. We have Ms Jane Rowe, chief executive officer; Ms Elizabeth McCrea, advocacy and family support; and Ms Ruth Chattey, family support coordinator. I thank the three of you very much for attending our hearing this afternoon. I suspect that Sandy has provided you with background in relation to the inquiry we are currently running into the supply and use of methamphetamines, particularly ice, in Victoria. I understand you also know David well, too. He has joined the committee this year, so I thank David for the introduction. Before we start I might just read you the conditions under which you are presenting evidence to this inquiry this afternoon, so bear with me for a minute.

Welcome to the public hearing of the Law Reform, Drugs and Crime Prevention Committee. All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and, where applicable, the provisions of reciprocal legislation in other Australian states and territories. It is important that you note that any comments you make outside the hearing, including the effective repetition of what you said in evidence, may not be afforded such privilege.

Have you received and read the guide for witnesses presenting evidence to parliamentary committees?

Ms ROWE — Yes.

The CHAIR — That is affirmation. It is also important to note that any action which seeks to impede, hinder or threaten a witness for the evidence they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence as proved by Hansard being here, and we will provide a proof version of the Hansard transcript at the earliest opportunity so you can correct it as is appropriate.

I assume you are going to lead off, Jane. We do invite some introductory statements, and then the committee would like to ask questions of you about your work through the foundation and how it might apply to the inquiry we are conducting at the moment. We have allotted until 1.45 p.m. for this session. Thank you again, the three of you, for your time this afternoon.

Ms ROWE — As you can see, it is going to be very informal. I have not come with loads of notes, so I just thought I would give a quick summary of Mirabel for those who do not know too much about it, and then Elizabeth and Ruth, who work very much at the coalface, can talk about the shift in culture that we have seen and answer any of your questions.

Mirabel was set up 16 years ago to support children who have been orphaned or abandoned due to parental illicit drug use. These children are now in extended family kinship care. My background prior to Mirabel was as a drug and alcohol counsellor working at Windana and TaskForce. Certainly during the many years I have been working in this sector I have seen a huge shift in the drug culture and prevalent meth use, from which we would say from our experience we are seeing a lot more trauma with the children, a lot more complexities. Certainly our services are being asked much more for perhaps educational assistance and a whole range because of the effects of methamphetamine often used in conjunction with alcohol and heroin.

I would also like to point out that Mirabel is a children's charity. We are here for the families, and since my work is as a counsellor we have always steered away from the drug issues or making statements about the whole sort of legality of drugs but are here very much to work with the children and their carers and most importantly to improve the outcomes for these families. I will hand over to Elizabeth, who as I said is dealing directly with these families, and then she will in turn hand over to Ruth.

Ms McCREA — Thank you. Again it is informal, and really the information that we are able to provide to you is what we hear from the families. I do not have a drug and alcohol counselling background, but I have a child protection background in foster care. I have been with Mirabel for

eight years now. Over that time, because of the focus of Mirabel, which is that we help to provide the childhood that often the kids have missed out on in the first few years prior to coming to their extended family, we provide lots of programs for the children as well as for the carers. One of the aims of the organisation that Jane set up was to break that cycle of illicit drug use.

Over the years since I have been with Mirabel there has been an increasing number of families that when we first speak to the carer who makes contact with us, they mention that their son, daughter, sister, cousin or whoever is the parent of the child has been using ice and has been using ice for quite some time and the impact on the children. Have you already heard from people about the impact and effect of ice on people?

The CHAIR — Yes.

Ms McCREA — You can imagine that young children in an environment like that often have to become the parent — particularly the older child has to become the parent for the younger ones. So there is a chaos within the family, and there is a trauma that they experience from various people coming in and out of the house. They witness the adults in the house using drugs, and they witness domestic violence. From my reading on the effects of methamphetamine, it increases the violence — there is often a violent reaction in the adults. The children have experienced all that. Often they have had very unstable education, they have had intermittent dental and medical help and they have had a basically destabilised first few years of their life.

Then they move to the kinship carers, and that is when we become involved. We are not actually involved in placing them with the family. The carers and the children need to be linked to the relevant services to help get the children up to their chronological age, particularly for education. Tutoring would be wonderful to help these kids get up to the age and level that they really should be at. On the medical and dental side of things, many have terrible teeth because it could be that for the first eight years of their life they have not seen a dentist and they have not been encouraged to clean their teeth. As you know, the effects of ice — and all drugs, really — include that they reduce the importance of the dental and health regime for the adults, so to enforce it in young children is probably not seen as a priority. So there is the dental, medical, education — so the tutoring — and also the psychological side.

A lot of the children have seen terrible things happening in the house that they have grown up in for those few years, and they are traumatised. The effect of trauma — and I am sure you have read various research on this — is that it impacts on the neural pathways. To be able to learn in a relaxed and calm environment really helps children to grow, whereas if they are in a traumatic environment they are not able to learn. There is the impact of their ability to concentrate in school. Ruth has brought with her a great booklet called *Calmer Classrooms*, which was put together by researchers through Bernie Geary's office. It talks about the effect of trauma on children and how their behaviours are shown in the classroom.

On the emotional side, I just cannot imagine how some of the kids feel when they come home and possibly find that one parent has died from an overdose or they cannot wake mummy up or there is nothing to eat or mummy has gone to sleep for days at a time. All of that impacts on their emotional wellbeing. When they come to the carers, who often are grandparents or uncles, they then struggle to know how to get the right services involved with helping the children.

Ms ROWE — I will hand over to Ruth. From my experience of having worked in this sector for a long, long time, when Mirabel was established one of the main focuses was that we need to be addressing a deep sense of abandonment that these children have experienced. I would say that it is far more complex now, with ice. There seems to be a lot more psychosis in the drug-using parent and a lot more violence and drug-induced suicide. I believe that the level of trauma we are seeing in the children we are working with is far more extensive than what I was seeing while working in the sector 10 or 15 years ago.

The CHAIR — Are they mainly single parents or are both parents involved in it?

Ms McCREA — It could be either. I have a particular family in mind if you would like to hear a little bit of background of a particularly difficult incident that occurred. Would that be something you would be interested in?

The CHAIR — Yes.

Ms McCREA — We met the family eight years ago. There is Grandma and three grandchildren. The oldest boy was about eight then, so it is eight years down the track. Their mother is a chronic ice user, and she has been in and out of prison for various reasons. She has various friends who also use ice.

The children, particularly the boys, have a real anger within them. The eldest boy will quite openly say, 'I'm angry at my mother. I hate drugs, and I hate the fact that she uses drugs because look what it has done to our lives. We're her children but the drugs come first'. The grandma was dealing with these parts of all three children — their anger, their being behind in school and all of the emotional side. They have been linked up to Royal Children's for that emotional side.

An incident happened a couple of years ago where, due to the children's mum's associates, there was a threat to kill the kids. So Grandma and the three children had to be moved by the police to their great-grandmother's home, which was a unit. So there is Great-grandma, Grandma and the three children all in a small unit whilst the police were trying to track down this chap. How that affected all those people in that family would be something that I could not really understand without having lived it, but hearing them the fear is just so strong.

They have now moved back to their home and various services are involved, but something that the carers are often worried about is how they can continue to make sure the children get all that extra support, because that is an ongoing, long-term investment.

The CHAIR — Was there a father?

Ms McCREA — Yes, he is elsewhere.

The CHAIR — Was she on other drugs prior to crystal meth?

Ms McCREA — Probably. I actually do not know the full history. We come from the perspective of working with the children and the carers. We learn a little bit about what the actual parent has been taking, but our main focus is to try to help the children have their childhood and all those childhood experiences they have often really missed out on. Another aspect is that they are often isolated when they are with their parent; they are isolated from the extended family and from kid things. The money is not there for them to go to school camps.

Ms ROWE — Certainly from my point of view — and as I said I have been working in the sector for 25 to 30 years — it would normally predominantly be heroin and it would be some amphetamine use. Without a doubt there has been a huge increase of methamphetamine, and that has been happening for some years. I will hand over to Ruth in one second, but I think it is often used in conjunction perhaps with heroin or alcohol. My understanding is that meth is accessible, it is cheaper and users get a longer high from it, but it is the violence that this drug brings out in that parent which goes way beyond emotional neglect of the child. What we are seeing is the increased use of methamphetamine and the increased trauma that children are exhibiting when they come to Mirabel.

Ms CHATTEY — I am Ruth. I have only been at Mirabel for two years, but I have 32 years experience in child protection, foster care, counselling and other things. Building on the family that Elizabeth was talking about, just last week the carer was saying that the mother still visits and the boy is still really angry. He is so angry and violent that he goes to hit mum and the carer gets in the way, so she ends up getting hit. She is having to deal with him putting holes in the wall and his general anger, and he is beginning to push her around a bit. That could become an increasing issue as well now. As these young people get older they have all this frustration and anger building up in them, and they direct it at the person who is closest to them. Often they will say, 'It's your fault I am not with my mum and dad'. With him at least he actually understands and hates his mother for

what she has done, but other kids do not. They actually see the grandparent, aunt or uncle who is doing the caring as being the one responsible for them not living a normal life with their parents.

A couple of other things, just building on what Elizabeth was saying about the parents being emotionally and psychologically unavailable for the kids. I remember one carer telling me that children she was bringing up learnt that when mummy and daddy — or mum and boyfriend I think it was — went into a room and closed the door, they were not to interrupt them when they were in there doing drugs. We do not always know if it is meth plus whatever else. They had to knock on the door, and maybe they would get a response and maybe they would not. They could go for hours, days sometimes, without any food. They do not get to school, because the parents are not there to wake them up. They lead these chaotic lifestyles. There is a lack of routine. They do not learn to go to bed. They do not learn how to put themselves to sleep, because they are expected to fall asleep in front of the TV. When they start school, if they get to school, they are tired, irritable and restless.

There is an increasing diagnosis now of ADHD. It could be ADHD, pure and simple, but it could be the effects of meth, which can produce ADHD effects, or it could just be the effect of trauma. They are hypervigilant kids. They are always hyperaroused. They are always watching and looking because they are in survival mode. They have to make sure it is safe, so they are constantly looking around and checking out what is happening.

Another carer last week was telling me that a teacher — and she has complained about this teacher — got a bit angry and slammed books down and the child jumped. She has been with this carer for four years, but any loud noises, loud bangs or raised voices and she instantly goes back into that hypervigilance. If you are in a constantly hypervigilant state, that has an effect on the heart. The girl is left cowering and she goes home and complains to her carer saying, 'I don't like that teacher; I'm not going to school', and then she drops out of school for a while. This carer said, 'I've got four boys, and when this child first came to me I had to tell them, 'You mustn't raise your voices. You mustn't do horseplay''. The normal things this family did took the child back to the home situation where there was domestic violence.

Another carer told me about a situation involving a woman who used not just meth but also fentanyl patches. She boiled them up, extracted the morphine from them and then injected herself with it, but she had an overdose and died. A four-year-old and a two-year-old woke up in the morning to find mum dead. They had been trained to never open the door to a stranger, so these two children were in the house for hours until they saw a neighbour they knew going past and went and got that neighbour. Just being alone in the house with a dead parent — you cannot imagine what it is like.

I think one of the key things is that these children need good paediatric assessments when they come into care. A lot of the carers do not get DHS caregiver payments. If it is an informal arrangement when the children are placed with them and DHS are not involved, they do not get caregiver payments from the state. They might get Centrelink payments, but that not get caregiver payments, and often they cannot afford the paediatric assessment. They do not always know if the child was born addicted to meth or alcohol or anything else. It could be still in their bloodstream, and it could be still affecting them. They have learning delays, maybe partly through the substance abuse, but also maybe through lack of stimulation, lack of opportunity to play and lack of being able to be children.

Good paediatric assessment is important, as is the money to have the follow-up appointments and then the education assessments when they get to school. There needs to be understanding from teachers and other professionals that they are behind the eight ball to start with, they are acting like younger children and their disruption in the classroom is not because they want to be bad or naughty, but because they are just not able to attend — again often because of this hypervigilance. They cannot control their emotions. I do not know if any of you have seen this document, but I highly recommend it. I will leave one copy with you, if that is useful. You can get more copies. It talks about some of the key elements, and I will read them out — 'affect dysregulation, making the children hyperise or dissociate'. The other thing is that if they are not hypervigilant, they can also just withdraw and become silent. They can be overlooked in school because a quiet kid is a good

kid to some teachers. They do not get drawn into what is happening in the school life. They do not make friends. They are full of shame, which can produce an overwhelming effect. They have reduced cognitive capacity due to early deprivation and affect dysregulation, difficulties with their memory — which makes it harder to learn — and language delays. Again, if they do not come to their carers until they have already started school, they have not had speech therapy. To get speech therapy once you have started school is extremely difficult and extremely expensive. For preschool children you can usually get it through community health centres at a reasonable price. Once they start school, it is through the public system and very expensive.

There is a need for control. Because these kids have not been able to have any control in their life they actually feel the need to control things, and so they find it hard to make friends and often they put teachers offside because the teachers cannot understand why they cannot just let things go a bit. They have great difficulty in making friends and attaching to other carers. They have an unstable living situation. Even when they have been with carers for some time, they can still be unsure about whether they are going to stay. They might have to move again. If they are in foster care, as you probably know, they can be moving around for a number of different placements. That can make them even more unstable and traumatised. We could say a lot more, but maybe you want to ask us some questions.

The CHAIR — Thank you, all three of you, very much.

Mr SCHEFFER — Thanks for that presentation. It was very compelling, really, listening to all that. We have an overview of what you do, but could you, Elizabeth, step us through just how it happens that a carer — a grandparent or other relative — knows about you and then after they have telephoned you what you actually do and what goes on until you get to the end? As a bit of an evaluation question, how do you know that what you do kind of works? What is your sense of how you modify your programs and so forth in response to the effect they have on the carer and the child or children involved?

Ms McCREA — How they find out about us is often through word of mouth. There might be one carer at the school who notices that there is another grandma who is constantly bringing the kids along. Part of what I and also Ruth do is go and speak to various groups about what we do. It could be the community service organisations such as the Anglicares and the Berry Streets as well as the DHS officers. We always encourage the carer to actually call us. The carer makes the contact with Mirabel, and that then creates a relationship. They invite us into their lives; we do not ring them and say, ‘Hi, I’ve been given your number’.

We then do something that is like a needs assessment. So it is getting a list of those obvious things such as names, addresses, dates of birth, who is involved and how the children came into their care, and possibly how we could assist them. We cover the whole state and also New South Wales, and we have one office, in Caulfield, so we have long arms and we try to do as much as we can. We do a lot of referral, especially for rural families.

We then link them up for our various programs. I have a couple of cards here with the list of our programs. On the dates of birth side of things, obviously we like to know how old the children are but we also have a birthday program, so something will appear in the post. Often children have not received birthday presents for many, many years until they come to their carer’s home and then they link up with us.

Mr SCHEFFER — If I can just stop you there, if a carer contacts you from Albury, Hamilton or somewhere else and you have one office in Caulfield, what happens at the provincial town end?

Ms McCREA — We do a lot of work by phone. That person will phone us and say, ‘I’d like to become part of Mirabel family support’. There are five of us in family support, and we would speak with that carer. It could be an hour or 2-hour conversation on the phone. Obviously we do not do case work, because we cannot go to their homes, but we do a needs assessment. As well as getting all that important information on how to be in contact, the dates of birth and the children’s names, we put together a genogram, which is a kind of picture of the family, so that we understand the dynamics between the various family members, where the parents are and how many children

there are. Sometimes there might be a couple of siblings with a grandparent, and then the other side of the family has another couple of the children or they could be with an aunty and uncle. We also go from 0 to when they turn 18, and if, say, the carer calls up and she has got a baby, a two-year-old and a four-year-old, we will remain with that family set-up until the youngest of those children turns 18 — that is, providing the various activities. So for the younger children we have family days and the carers come along with the children. It is just an opportunity to meet each other and meet us.

Mr SCHEFFER — If they are in Hamilton, what do they come along to?

Ms McCREA — We go to regional areas, so we will go to regional areas.

Ms CHATTEY — We also link them into other regional groups, like an Anglicare or Berry Street. If there is a Kinship Care organisation down there, we will link them into that as well.

Ms McCREA — We go to the areas. We link with the local resources. We run various things around the Melbourne metropolitan area. There is another worker and myself who travel up to New South Wales, and we are very much in connection with the various services and the local groups in those areas.

Mr SCHEFFER — That is sensible; really good.

Ms McCREA — Because obviously we cannot be all things to everyone, so we try to be part of that network of non-government as well as government organisations. We have a recreation program from when they turn 8 up to when they turn 18, and that could be camps, day activities — again, we go to different regions. We organise bus pickups at railway stations. Carers will bring the children from, say, Morwell or Traralgon on the train into Caulfield station, and we will have a bus pickup. The whole idea is to break down the sense of isolation that many of the children and carers feel. For the children to come along to a camp, it is explained to them that they are all from a similar background in that they do not live with their parents and the reason why that is is because of illicit drug use. You see all those little faces going, ‘So I’m not the only one’. They join with a group of children with similar backgrounds. They are involved in activities which help them learn lots of things, whether it is teamwork or how to climb ropes. The carers come to support groups, and we go to regions as well. As well we might do guest speaking out at Ballarat or something like that.

Ms CHATTEY — Another really big important referral point is Centrelink. Centrelink now has grandparent advisors. There is one for Victoria that covers Victoria and Tassie, and there are two for New South Wales. For anybody who applies for Centrelink payments with grandchildren, there is one worker who knows about us and so she refers people on to us a lot.

You are asking: how do we evaluate our services? It is probably not done as scientifically as we could do; it is mostly anecdotally. We do run support groups throughout the region. Every year we do some feedback on how they are finding the support groups, and we do get lots of letters of support and thank you. We like to think we are doing a good job, and we always ask for suggestions and take those suggestions on board, but we have never done a rigorous evaluation. No, we have done an evaluation, haven’t we?

Ms ROWE — Yes. We have done quite a few evaluations; but how do you evaluate it? For me personally, if a child who has gone through a whole range of ups and downs completes school, that is fantastic. It is very much based on our fans, but that would be what I would call a success for us — that is, a child who may have looked at dropping out of school or was so behind before they even started primary school. To see them complete school and now be in the workforce or still studying, they are the sorts of things. We are wanting to ensure those basic foundations in a young person’s life that everyone needs; so they would be the sorts of measures I guess we would look at.

Ms McCREA — Another one is that many of those young people who are over 18, 19, 20, they make contact with us and want to remain a part of Mirabel and to give back to the organisation. I think that is huge.

Ms ROWE — Yes, and what we are trying to do — and we say that at the beginning — is give these children the skills or opportunities so they do not repeat the bad choices of their parents. In a very simplistic way, that is what we are trying to do by breaking that cycle. Obviously that means working very closely with the grandparents or the carers, but that is what we are ultimately trying to do, because these children are far more likely — if there is not intervention and they do not have a sense of hope or belonging or a basic education or have not even begun to address their trauma — to use drugs later in life or attempt suicide. It is very simplistic. What we are trying to do is prevent that from happening.

The CHAIR — Are those carers assigned by the court?

Ms McCREA — There is a mix.

Ms ROWE — There is a mix. We have no say in where a child should be placed.

The CHAIR — I understand that. I was just wondering if they are court directed or the grandparents just take over responsibility because the mother is not responsible.

Ms CHATTEY — Often the mother has just said, ‘Mum, can you look after the kids for a weekend?’, and she goes away and does not come back.

The CHAIR — I am just trying to work out the payment, because I assume that once the court assigns a carer then it comes under DHS.

Ms CHATTEY — But if it is an informal arrangement, there is no payment. They can apply for Centrelink.

The CHAIR — That is true. That is why I was trying to understand the payment issue.

Ms McCREA — Also, if it is through the family law court, there is no payment. Say they are caring for the grandchildren for a few years and they decide that they are going to go to the family law court. They go there and that proceeds. If they obtain custody, then they continue to care, but there are no caregiver reimbursements like those with DHS involvement through the Children’s Court.

Mr McCURDY — With the increase in methamphetamine use, are you seeing a change in the type of parents you are becoming involved with? I suppose the picture that I have in my head is of a long-term heroin addict who may be unemployed moving towards a methamphetamine user who may have been in the workforce at some stage recently, then people seeing a change in their nature and then cycling down the path to you. By the time they get to you is it one size fits all, just parents using illicit drugs?

Ms CHATTEY — I probably have not been with Mirabel long enough to know whether there has been a change, but certainly there are a number of parents who can present quite well. They can go to court and present quite well, and they may still be holding down a job and look quite presentable.

Ms ROWE — Either Elizabeth or Ruth can add to this, but from what I hear from my team and the carers I meet and again going back to my counselling days, I think there is much more violence, much more psychosis and much more abuse of children. So I would say that, yes, there is an absolute shift in the culture, all damaging. I think methamphetamine is used in conjunction with other drugs; I do not think it is used in isolation. From my own point of view I think it is one of the most damaging drugs out there, as far as the long-term effects not only on the user but on what the child has witnessed and experienced.

The CHAIR — Would you be able to give us some statistics on that? It would perhaps tell the story a bit more vividly. I am not sure how many you have had traditionally.

Ms ROWE — Currently we are supporting about 1300 children and we average five new referrals a week. They are our actual numbers. Ruth, have you got an example of any families?

Ms CHATTEY — No, because, as I say, we do not always ask what drugs the parent has been using, and often the carers do not know. They will say, ‘A mixture of drugs’. They do not always know because often it has been a secret. It is such a secret that the carers do not know, so they cannot tell us.

Ms ROWE — Just last week there was a request from a carer for a whole range of early intervention and educational help. The mum had been a long-term methamphetamine user. Again I would say that we are seeing much more of a demand on educational assessments and paediatric and developmental delays. We are probably just beginning to see it now, but I think if we went back and looked at where things were at some years ago there is definitely an increase in all of that as far as the demands on our service goes.

Ms CHATTEY — Certainly with nearly all the children the carers say they have got ADHD and learning difficulties and developmental delays.

Mr SCHEFFER — I am not been critical in any way at all at about what you are saying or doing, but it is very difficult in your position to get a statistical assessment because you do not even know what the drug is that they are on because it is not what you really do.

Ms ROWE — Absolutely right. I totally acknowledge that.

Ms McCREA — We have very limited contact with the parents unless we are at court.

Mr SCHEFFER — Yes, sure. It is just one of the things we are grappling with: the quantum of what is out there and who is using it. I guess that is the basis of the question.

Mr CARROLL — Thanks for your presentation and the good work you are doing in trying to break the cycle. I wanted to ask: is there a waiting list and what about cost to access your services? Is there a cost?

Ms ROWE — Neither. When we started Mirabel it was all about there not being a waiting list. If someone is in crisis, they are in crisis now, so there is no waiting list. It is a voluntary service that we provide where we raise our own funds, so no, there is no cost to families or carers.

Mr CARROLL — I have taken note of some of the things to assist the children, like tutoring, paediatric assessments, the DHS caregiver payments, but with the grandparents you have got a young person and they are in a completely different world.

Ms CHATTEY — Generation difference.

Mr CARROLL — It is almost like a digital divide; they are digital natives. You have grandparents who come from a completely different world. How could we support grandparents who are in many respects raising their own kids’ kids? Have you thought?

Ms McCREA — What the grandparents actually will say over and over is that they need help with school homework. That is a huge thing. Then there is respite. Some sort of respite arrangement would be wonderful, because often the grandparent could be in their late 60s or 70s and their adult, say, daughter has had six children, which you often find in these circumstances, and that grandmother has cared for various ones along the way. A couple may have gone to the dads. I know of one who is 74 and her grandson is 10 and she has brought up two others who are about 19 and 25 now. Yes, it is hard. It is the energy level and the need for regular respite. It is a bit like an extended family, because often they lose the extended family. And the school, homework — —

Ms ROWE — I think homework, technology. There is such a massive generation gap now with those things.

Mr CARROLL — That is what I was thinking really — the generation gap. Kids today are growing up in a completely different world to their parents and another world altogether to their grandparents.

Ms ROWE — And even things like Facebook and cyberbullying. It is a different world completely.

Ms CHATTEY — And you are asking how could you help. More and more schools require the kids to have iPads. You might have a carer struggling on a pension having to find \$600 or more for the kid's iPad. If she has two or three children, that is a huge drain on her resources.

Another interesting thing is that there might be a couple of carers but then the grandchildren come along and often then the carers split up. The grandfather might live out the back or in a caravan or he has moved away and sometimes because it is a second marriage these are not his grandchildren, or sometimes that is just not how he envisaged his retirement. It was not how she envisaged hers either, but the grandmothers see it as their responsibility. They cannot afford to get sick, they cannot afford to go around Australia, they cannot even go out for meals with their friends anymore because they have kids to think about, babysitters to think about.

Ms McCREA — And to be able to pay for the food and the iPads and all of this for the children they often do not buy their medication. They say, 'Oh, well, I won't buy the latest script for blood pressure tablets' or whatever.

Ms CHATTEY — And they delay operations like hip replacements and knee reconstructions because they cannot afford to take time off, because who is going to look after the kids?

Ms McCREA — Yes, knee replacements, all of those.

Mr CARROLL — Jane, you were talking about the importance of breaking the cycle. It is a massive saving to the taxpayer, amongst everything else, and to the community at large if you can break the cycle and they can go off and become contributing adults. Your success stories: you mentioned how some people want to stay in touch with Mirabel.

Ms ROWE — Fabulous success stories.

Mr CARROLL — Have they gone off to be well-functioning adults in many respects?

Ms McCREA — They have gone to university, and they have gone on to become very wonderful young people.

Mr CARROLL — That is fantastic.

Ms ROWE — We did not want to inundate you, but if anybody wants anything, this is a book we put out some years ago for children, because often there is literature for adults but not for children. This is an annual report that talks about all of our different programs, and this is a book we give to carers that is all about trying to empower carers with different organisations. So we will leave those with you. If you want anything, just ask.

The CHAIR — Thank you. We have not quite finished yet, Jane. Mr Southwick may like to summarise and perhaps pose the last question.

Mr SOUTHWICK — When we first met you, Jane, your aim was to do your organisation out of work, so you did not have people coming in and presenting with all the issues they do. Your earlier comments were that you were getting five parents a week coming in. What can we do to break the cycle in a broader context, and what can the government do following its inquiry in terms of supporting families? Are there some initiatives in the preventive-type area, the support-type area or in the educational space to reduce the harm we are seeing in the community?

Ms ROWE — That is such a big question. We all know that drug use in our community is huge, and I think all aspects of it have to be addressed. It is a community issue as well, and children will not talk about it because of the shame. It is so multifaceted, and it just needs to be addressed from every level. There is also the breakdown of the community. It is all those things.

Mr SOUTHWICK — At what age should kids be educated about the problems associated with drug use?

Ms ROWE — It is about how you educate children. I do not think it is ever too early, but in a way it is almost about learning through osmosis. What I believe is that if children do not have a sense of hope and belonging or a sense of self, then you have nothing to build on. In a very simplistic way, that is what we need to be equipping children with when they are very young so they feel that sense of belonging and hope then the other things will hopefully fall into place. We all know you can tell young people not use drugs or whatever, but they are still going to be irresponsible and reckless. However, these children are very different.

Mr SOUTHWICK — One last thing — I want to ask about the suitability of kinship care compared to other forms of care. We have heard some evidence that has suggested that having a grandparent may not be as suitable because of the connection with the parents and whatever else.

Ms ROWE — Probably Ruth or Elizabeth should answer that. We do not say where children should be placed. The whole catalyst for me starting Mirabel was seeing a young child being taken away from his mum's funeral, and his biological grandparents did not know he existed or that he was going to be put into emergency care. I think that for all children, when appropriate, if you can keep them with family, with a sense of belonging and a sense of history, that has to be optimum. That is not to say that it is always appropriate, but I think it has to be far more beneficial when appropriate.

Ms CHATTEY — I would agree, because when children are growing up there certainly is a difficulty for grandparents when they have to take a stand against their son or daughter. They may have to take out an intervention order against them because of the threats and the violence, but if they can do that and then separate themselves, there is a sense of history. They are the ones who can talk about, 'I remember when you were born. You looked just like your mum when she was born', and they can talk about the positive side of mum or dad. Whereas with a foster carer, they can certainly do it with the best of intentions, but they do not know that family history, and they do not have that sense of coming together as a family.

Ms ROWE — And keeping siblings together is crucial.

Ms CHATTEY — Absolutely.

Ms ROWE — If you do not do that, any sense of belonging is gone.

Ms CHATTEY — Some siblings cannot be kept with one set of carers. We had one family with four children, and the grandparents could not look after them all. One child had to go into residential care because he had severe intellectual disabilities, but then another family member came forward. They are still within the extended family, and they meet up regularly. The three of them are regular Mirabel attenders; they do not live next to each other but they meet up at Mirabel events and other family events.

Ms McCREA — Can I just say that drug abuse is not always intergenerational, so the families we meet are regular families.

Mr SOUTHWICK — Sure.

Mr SCHEFFER — Chair, just a comment to you, and I do not want Jane, Elizabeth or Ruth to answer this question. Could I have an agreement with you that Sandy follows up with Mirabel about how it is funded, by whom and something about its governance; and also what it knows about the families it helps — their socioeconomic level, ethnicity and language. Perhaps Sandy could pick that up another time.

The CHAIR — Is there a quick answer to those three?

Mr SCHEFFER — No, I am happy to just flag it.

Ms ROWE — We can always get all of that on request, and some of that is in here.

Mr SCHEFFER — Thank you.

The CHAIR — Thanks very much for this afternoon.

Witnesses withdrew.