To:	**Special Commission of Inquiry into the Drug 'Ice'**
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From:	**Barnardos Australia**
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Subject:	**Submission – Issues Paper 3: Health and Community**
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Barnardos Australia (Barnardos) thanks the Commissioner for the opportunity to comment on the questions raised in Issues Paper 3 (Health and Community).

Barnardos is a family support and out-of-home care (OOHC) agency, which assists over 14,409 children and their families in New South Wales (NSW) and the Australian Capital Territory (ACT) each year and maintains 1,415 children in NSW and the ACT in foster and kinship care. In our family support work we aim to reach vulnerable children at risk of separation from their families, and we work in areas with significant Aboriginal populations[1] such as Western Sydney, Central West NSW, the South Coast and Inner Sydney.

We are committed to supporting families in caring for their children and to ensure permanency for children who cannot safely live at home. In 2017-18 we achieved 38 adoptions from care, which represented 26% of the 140 adoptions in NSW and 27% of all adoptions from care nationally.[2] Of the seven adoptions from care in other Australian states and territories in the same period, Barnardos achieved two in the ACT**.**

We take seriously the need to ensure that the next generation does not suffer the problems of the past. For this reason, we work together with children, young people and families to break the cycle of disadvantage, creating safe, nurturing and stable homes, connected to family and community**.**

Background: Barnardos knowledge of this area

Our relevant expertise lies in the development and delivery of evidence informed service models for interventions targeted at families at high risk or vulnerable to child maltreatment due to, for example, parental substance abuse, parental mental health concerns, or intimate partner violence.

Our comments are informed by our knowledge of how to successfully implement best-practice socio-ecological service models in local communities to provide a multi-disciplinary, child centred program of wraparound support to families who have been affected by substance abuse, material deprivation and intergenerational trauma.

[1] Note that we use the term "Aboriginal" throughout our response to reflect that in the NSW and ACT there are only very small numbers of people who report they are of Torres Strait Islander origin.
[2] Barnardos achieved 36 open adoptions in NSW and 2 in the ACT. NSW achieved 140 of the 147 carer adoptions finalised in Australia in 2017-18.

Barnardos has focussed its response on the specific questions below, based on our depth of knowledge of working with special population groups who have experienced greater harms from amphetamine-type stimulants (ATS) use when compared to users in the community more generally. We have drawn from our practice experience in the following three geographic locations:

- **Nepean Blue Mountains region**: Barnardos operates an integrated Children's Family Centre in the suburb of Cranebrook in the Penrith area. The Penrith Children's Family Centre provides a mix of child, youth and family supports for families in surrounding suburbs, many of which have high levels of public housing.

- **Illawarra region:** In the Illawarra region of NSW, the Barnardos South Coast Children's Family Centre delivers a unique perinatal family support case management service in partnership with the Illawarra Shoalhaven Local Health District Maternity and Drug and Alcohol services, and the NSW Department of Family and Community Services and Justice. This collaborative service (the Substance Use in Pregnancy and Parenting Service or SUPPS) is targeted to pregnant women who are drug and alcohol dependent and provides a sustained home visiting case management service for up to three years.

- **Central Western NSW region**: Barnardos provides a broad range of prevention, early intervention and intensive child, family and youth support services across Western NSW from Orange in the Central West as far west as Cobar. A high proportion of the severely socially disadvantaged populations assisted by Barnardos are Aboriginal families. Several of Barnardos services are delivered in and around the town of Wellington in the Central West, which has a serious ATS problem.

ATS USE IN SPECIFIC POPULATIONS

The experiences of the impacts of ATS use on ATS users and their families who are part of the populations identified above (Q 3.1.6)

Our SUPPS family support service has observed increasing numbers of referrals for women using Crystal Methamphetamine (CMA or 'ice'), with a corresponding decreasing number of referrals for women with opioid misuse issues or women who have entered opioid replacement treatment programs. It appears to be easily accessible in the Illawarra area and within the current SUPPS client cohort CMA and cannabis are most represented in illicit drug use at the time of referral. We note that in the last 12 months 50% of the women referred to SUPPS Family Support have been CMA users at the time of referral.

We note that the use of social media platforms to enable access to drugs or alert users when drugs are in town is common place in rural settings such as Wellington, where isolation, limited or distant police locations provide greater opportunity for undetected or hidden use.

ATS use within vulnerable populations is further impacted by small town gossiping, lack of anonymity within those small towns as well as a stigma and shame that is different to cannabis use.

Amongst teenagers, small time drug dealing or transporting drugs is a recognised way to make quick money and build their street reputation. This is an enticing option for teenagers

who may have limited means of income and whose future hopes and or aspirations seem unachievable.

Are high-risk population groups disadvantaged by current service delivery models and location of services? (Q 3.1.8)

We note that rural locations do not have the same access and availability as metropolitan centres to drug rehabilitation or detoxification units. For those who can gain access to facilities within some of the larger rural centres, such as Orange NSW, obstacles such as payment of admission fees (by already financially disadvantaged and vulnerable families) along with transport to and from these facilities are further barriers to successful treatment plans for clients. There are limited services offered specifically to young people around drug addiction and specifically ATS use.

Outreach into the smaller townships from the larger rural centres seems to be the preferred method for Drug and Alcohol support services. However, these services can be unreliable at times.

Transport disadvantage around ownership of registered vehicles, limited public transport, minimal timetables and high cost within existing public transport networks further impacts access to ATS treatment services in rural areas serviced by Barnardos.

Are outreach models sufficient in servicing rural/regional locations, particularly in areas of high prevalence of use? If not, why not? (Q 3.1.10)

Whilst the 'fly in fly out' outreach model may be economically sensible this does very little to form the important and ongoing personal and community connections between client and workers who find it difficult to invest themselves in a local community and its people. In our view, these elements of the outreach model seem counter therapeutic.

ATS USE AND FAMILIES

What current services and programs are available to support families in NSW affected by ATS use? Are they adequate? (Q 3.2.1)

Specialised services for families impacted by ATS use are extremely scarce or non-existent in Central Western NSW. For example, within Barnardos Western NSW we are able to access services such as Marathon Health, Headspace (teenagers), Aboriginal Health Corporation, Lives Lived Well, Mac River (teenagers) Mental Health Unit, CAMHS Dubbo and MERIT. These are a few of the 50 services listed under the Health direct Online directory of Drug and Alcohol Treatment Services for Western NSW. However, there are no ATS specific services and none are based in Wellington.

Support services within the Nepean Blue Mountains areas, where available are under-resourced and have very limited referral criteria. This often results in clients being ineligible for service provision. For example:

- NSW Health funded services (with service provision provided by non-government services) in this area are very rigid in criteria, with most offering service provision to clients who are exiting the criminal justice system or being directed to use services as part of their involvement in this system.

- There are no detoxification or rehabilitation services within the Nepean Blue Mountains area other than the service offered by NSW Health and fee-for-service private facilitates. Beds are very hard to get, and criteria can be tricky to navigate. For example, clients are not allowed to smoke on hospital premises. Often our clients are withdrawing from one substance - not being able to smoke tobacco can be a significant stress during this period.

- Criteria for acceptance to detox or rehabilitation health facilities may be based on a client's eligibility for Centrelink payments. For many of our clients this excludes them accessing detox, rehab and relapse prevention services. For instance, clients who are homeless and have no access to Centrelink, clients who earn more than the Centrelink payment criteria, and young people whose parents are not eligible to receive Centrelink payments are precluded from entry.

- Clients with drug usage often report trauma with this being a catalyst for their drug usage. No current treatment services for ATS users in the Nepean Blue Mountains region provide a service where trauma is addressed as part of treatment.

- Clients with mental health issues are precluded from drug and alcohol service provision. Drug and Alcohol services refer these clients to mental health services for treatment. However conversely mental health services refuse to provide assistance until the drug and alcohol issues are addressed. Consequently, many of Barnardos clients who require ATS treatment and have mental health problems miss out on a service.

The Illawarra Shoalhaven Area Health local district (ISLHD) provides a number of referral, treatment and support services to the community and works in partnership with the Barnardos SUPPS Family Support Team, by means of an innovative, integrated case management approach. A targeted Stimulant Treatment Program is available and accessible to clients, alongside other local area health treatment options. However, there are no long-term residential treatment facilities in the Illawarra Shoalhaven area. The nature of CMA usage would suggest it is best treated in residential treatment services, and that it requires both community and residential options. Other community and shorter-term treatment services are available locally.

Where CMA is the primary substance in use, we note that that this misuse may interfere in accessing mental health treatment services. For example, rejection from mental health services occurs where it is assessed that the presentation is that of drug related psychological impact. There is a need for collaborative and cohesive alcohol and other drug and mental health services to address the co-morbidity. Further, the lack of mother-baby units in NSW limits the treatment options that acknowledge the importance of maternal-infant connection for the well-being of both the mother and her baby.

How could the therapeutic and practical support to families of ATS users be improved? (Q 3.2.3)

Engaging women during pregnancy, identified as a period of increased motivation, is the approach of SUPPS to provide an informed, integrated and adaptable intervention that acknowledges that drug misuse necessitates a long-term approach; that providing support must persist through lapse and relapse to achieve best outcomes. The value of maternal attachment as a protective factor for children is a determinant in ameliorating the impact of CMA and other substance misuse on children, that is, can a parent adequately redress their

substance use to develop an attachment relationship that provides safety, warmth, connection and security for their child? And how can services seek to support traumatised individuals to develop a secure attachment, attune to their children's needs and establish safety across all aspects of parenting.

We note that the vulnerability to substance misuse is best understood in the context of their trauma histories. The exposure of childhood trauma and parenting experiences themselves is regularly reported. The replication of intergenerational harm such as exposure to violence, criminality, homelessness, disconnection, social isolation, poor health and sexual health outcomes are frequently assessed as contributing to the impact of substance use on parenting. The identification and application of Adverse Childhood Experiences (ACEs) as a measure of assessing the impact of substance use on children indicates that it is rarely only the drug use, rather it is the concurrent and pervasive risk in the environments in which children are growing up. The impact of CMA and other illicit substance use in utero on the unborn, and the early exposure to trauma which is evident in the later physical and psychological harm to infants, are the reasons for SUPPS service provision.

Trauma informed approaches regard addiction as a form of ritualised comfort seeking, often in response to childhood trauma. The use of CMA, like any other drug, may then be viewed in context of trauma and this has implications for treatment. This includes the approaches to comorbid mental health presentations and treatment. The link with mental health issues and treatment in the context of CMA use is critical. Accessing mental health services for clients using CMA is difficult and requires an integrated holistic, integrated health approach There is a need for collaborative and cohesive alcohol and other drug (AOD) and mental health services to address this co-morbidity and broaden this approach to CMA use as an issue of trauma that requires a response based in understanding and compassion embedded in evidence informed treatment services and programs.

In our view, other ways that therapeutic and practical support to families of ATS users could be improved include:

- Services in the location where drug users are, that is both community and hospital based.

- Services which provide wrap around support (including detox, rehab and relapse prevention) as well as assistance or support around housing, health needs (GP/Nurse clinics), education and employment.

- Trauma informed service provision, including access to mental health services as part of treatment for drug and alcohol usage.

- Families of ATS affected clients being included in planning and treatment.

- Families having access to ongoing trauma informed counselling and support as part of service provision.

- Services that can provide a service immediately. Our experience is there is a short window of opportunity when clients are engaging around detox and rehab. Unfortunately, we often cannot get a bed until such a time that the client is no longer willing to access a service.

Does family support improve treatment outcomes for those with problematic ATS use and is it a protective factor against relapse? (Q 3.2.4)

In our experience, relapse is strongly linked to the peer group and environment in which users may return to after treatment. Family supports may benefit those close to and directly affected by a loved one's ATS use however this does not provide a protective factor against relapse in the majority of cases we see. Rural settings where there are limited options around peer group choices, housing options, employment opportunities, education, and transport all combine to provide ongoing barriers to strengthening protective factors against relapse.

Disconnection from family and other social support networks further isolates those individuals, often leading to social networks consisting of others with similar issues. Developing a new support network is challenging; being complicated by poor self-esteem, shame and guilt, and social isolation. This may also occur where one parent may be able to engage in treatment and/or service but is not joined in their efforts by their partner and this undermines the viability of this attempt.

Whilst the provision of family support does improve outcomes, services within the health system may refuse to engage with extended family as they are not viewed as the 'patient'. This means that family members often feel excluded and do not receive accurate information about the client's treatment plan. Families tell us that often they are not involved in treatment plans for the client which again impacts on treatment outcomes in the long term.

Are current services and programs adequate for the needs of Indigenous families affected by ATS? If not, how can they be improved? (Q 3.2.5)

It is our strong view that current services and programs are inadequate for the needs of Indigenous families affected by ATS. For example, no drug and alcohol services in the Nepean Blue Mountains take into consideration culture as part of treatment plans.

Improvement may come if program design centres around supports or services that are 'wrap around,' in one place, not multiple points of access or referral that in a rural context is often exacerbated by distance or limited hours of service due to the outreach nature of that service provision.

More consultation is needed with Indigenous Elders, leaders and health workers within specific locations who would provide cultural insight and solutions especially in responding to ATS users within Aboriginal families and communities.

Residential and day programmes held on Country for Aboriginal people to access are recommended. This could be done for example by providing a "circuit" service with a week or more long stay in each town in the circuit.

Has ATS use changed the nature and/or prevalence of DFV? If so, how? (Q 3.2.7)

Observations taken from casework would suggest that CMA and other drug use is frequently present as a means of power and control in violent domestic and intimate partner relationships. Anecdotal reports indicate the manipulation of a women's use of CMA can be utilised as a means of exerting the power to control. For example, the provision of drugs in relationships or the offer of drugs to entice women to return has been commonly observed in the Barnardos SUPPS Family Support service. This is of particular note where the intervention of the Child Protection system will be assessing parental capacity, child safety and wellbeing. Clients themselves report an increase in domestic and family violence, specifically stalking type behaviours due to an increase in paranoid thinking which appears to be associated with ATS usage.

However, despite the prevalence of domestic and family violence, in Barnardos' experience, because of the stigma and shame connected to ATS use it is almost impossible to obtain any admission of ATS use from perpetrators of domestic and family violence. We often hear from domestic and family violence specific services that there is reluctance to engage by services with perpetrators if they are using ATS. These services often site risk to staff as a reason. It is unclear around how this assessment of risk is supported as often the judgement seems to be based around information of possible drug usage.

Further, we note that safety plans around domestic and family violence often do not address the drug usage (if present) as part of this safety plan, and there is a dearth of services that address both domestic and family violence and ATS usage. Clients must access different services to address these separate issues and often multiple services to access different parts of the service provision network.

Are services working with children and families able to make appropriate referrals or provide ongoing support for children and families identified as being affected by ATS use? If not, what can be done better? (Q 3.2.13)

Yes, referrals can be made, however, lengthy wait times into referred services can often be detrimental to meeting their immediate needs. We would recommend holistic and wrap around services approaches wherever possible.

What evidence is there of a correlation between inadequate housing and homelessness and ATS use? (Q 3.2.14)

In the Nepean/Blue Mountain region, the community at Cranebrook and suburbs like Wilmott, Lethbridge Park, Oxley Park with high levels of public housing we have seen increased usage of ATS dealing and usage. In each of these suburbs it is well known which streets are associated with drug dealing.

Are mainstream housing services able to recognise and respond to the particular needs of ATS users? (Q 3.2.17)

We note that the issue of ATS use is not managed as a ATS issue by the NSW Department of Family and Community Services and Justice (FACSJ) and not addressed unless there are significant issues which impact on the property, that is damage to property, rent arrears etc. Our experience is with ATS users there is no referral on from FACSJ to services to address ATS usage. Anecdotal evidence suggests Community Housing Providers don't receive

sufficient funding to deliver or access the required social wrap-around supports that their tenants need.

Further, ATS users who seek treatment options are placed back into the communities where there is significant drug usage. This has significant impacts on recovery and relapse prevention.

The shortage of affordable housing means that there are little options around declining a property for clients (i.e. they get one chance to decline a property) so often clients have little say or voice around where they live and often are placed in areas where there is high drug usage/dealing.