LAW REFORM, DRUGS AND CRIME PREVENTION COMMITTEE

Inquiry into the supply and use of methamphetamines, particularly ice, in Victoria

Melbourne — 3 February 2014

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Mr D. Giles, General Manager, Family and Community Services, Anglicare Victoria.

The CHAIR — I welcome David Giles, general manager, family and community services, Anglicare Victoria, who is going to present to the committee this afternoon. Thank you very much for your written submission. I have only had a little bit of time to go through it as it came fairly late in the proceedings. I look forward to asking you questions about your submission. As you know, this is an inquiry into the supply and use of methamphetamines in Victoria, particularly ice. We have allotted until 3.45 this afternoon for your session. Before I ask if you would like to make an opening statement, I will read you the conditions under which you will be presenting evidence to the committee this afternoon.

Welcome to the public hearings 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 is further subject to 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 know that any comments you make outside the hearing, including effective repetition of what you said in evidence, may not be afforded such privilege. Have you received and read the guide for witnesses presenting to parliamentary committees?

Mr GILES — Yes, I have.

The CHAIR — Thank you. It is also important to note that any action that seeks to impede or hinder a witness or threaten a witness about the evidence they would give or have given may constitute and be punishable as contempt of Parliament. We are recording the evidence and will provide you with a proof version of the Hansard transcript at the earliest opportunity so you can correct it as appropriate. Thank you for presenting to the committee. We look forward to hearing your contribution. Equally the committee looks forward to asking you some questions in relation to both your written submission and your opening remarks.

Mr GILES — Great. Thank you for receiving me. I apologise in advance if I am a little slow off the mark in answering some of your questions; I have a baby daughter and she picked a convenient time to keep me awake most of last night, so I am sorry if that happens.

I would like to start by thanking you for inviting me here to give evidence in relation to this inquiry. The written submission provided to you by Anglicare Victoria sets out our experiences in various programs in working with individuals and families impacted by ice and some recommendations regarding how the service system might better meet the needs of such individuals and families.

Today I am going to present three case studies to you which I believe will help you contextualise the information and recommendations contained within our written submission. These case studies have been de-identified but no substantive details about family dynamics in the context of ice use have been changed. These cases have not been cherry-picked because they are significantly concerning compared to others, rather they represent a typical experience that our programs have in working with families and individuals impacted by ice use.

The first case study is a family, comprised of a mother, father and three children — an 11-year-old boy, a seven-year-old girl and a five-year-old boy. Both the father and the mother were very damaged people, each having experienced significant abuse in their own childhoods, including sexual abuse. Both parents suffered significant mental illnesses. The father in this family frequently used ice. When he was affected by this drug he would become paranoid and violent. He was extremely controlling of his partner and physically and sexually abusive of her. His ice use exacerbated both the frequency and severity of these behaviours. Police callouts to the family home due to domestic violence were a frequent occurrence and exposure of the children in this family to these violent incidents was constant. This led to them all developing post-traumatic stress disorder. All the children were constantly hypervigilant and any time they heard a loud noise they would become terrified.

In order to cope with the psychological turmoil of her abuse, the mother in this family frequently abused alcohol. As you might imagine, these two substance-addicted and mentally unwell parents

were impeded from being able to provide safety and security for their children. Neither parent was employed, and spending money on ice and alcohol was prioritised over paying rent, bills and groceries. The family had been evicted from multiple rental properties over a period of some years. Every time they moved, the three children had to relocate to a new school. Because of this they never made any friends and were quite socially isolated. The parents were usually able to find a way to provide the children with food. However, this was largely the extent of their care. They were simply unable to provide the warmth, guidance and nurture that are as integral to children's healthy development as having enough to eat.

When our family services worker was allocated to assist this family they were living in temporary housing provided by another community service organisation. The family had exhausted their allotted time in this temporary housing and our worker was attempting to help them secure alternative accommodation. Our worker stated that this was extremely difficult to do as it was very hard for her to challenge the father with regard to his behaviour or even bring up the topic of housing, let alone his ice use. Whenever our worker attempted to do this, the father would become aggressive. He would pace the floor and yell and then not be present for the next few visits from our worker.

Over time, as our worker persisted in engaging with this family and trying to secure their trust, she came to the view that the father was likely to be experiencing some kind of psychotic disorder. He was increasingly paranoid and thought that people were trying to poison him.

Throughout this period of persistent engagement efforts our worker was able to build a good relationship with the mother. Eventually, through counselling and support, our worker motivated and assisted the mother to engage with a mental health service in order to attend to her psychiatric problems. An unintended and very positive outcome of the mother's engagement with this service, in addition to the improvement of her own mental health, was that the father saw firsthand the benefits of this type of service and decided to access it himself. Upon doing so, he was formally diagnosed with a psychotic disorder and commenced treatment both for this disorder and his concurrent substance abuse issues.

Whilst all this was going on, the children's school was working hard to support them via intensive, frequent, school-based counselling, which seemed to be improving their wellbeing. At the time our worker ceased involvement with this family the children were faring much better and both the father and mother have much better and more stable mental health as a result of accessing this mental health service.

What is noteworthy about this case is that all this took a very long time. The '10 office-based sessions and you're done' model of mental health treatment plan simply would not have worked for this family. The successful outcomes of this case were only achieved because our worker was able to keep trying with this family for months and months, driving out to their home and driving the mother to her sessions at the mental health service to ensure that she went to them. This is often what it takes in order to effectively help a vulnerable family that is impacted by ice use.

The second case study I wish to present to you concerns a family comprising a mother, father and three children — a 10-year-old girl, a six-year-old boy and a five-year-old boy. The children lived with their mother, who was actively using ice at the time of our involvement with the family. The father did not live in the house, although he did see his children frequently and he often behaved abusively towards them. The mother and father had an on-again, off-again-type intimate relationship.

One of the children's grandparents was very involved with the children and the children frequently stayed with this grandparent at their house. There was some extensive child protection history with this family. The mother was a long-term drug user who had engaged in substance use whilst pregnant with all three children. As with the parents in the first family I discussed, the mother was what we call a dual diagnosis client. It is a term I am sure by now you are familiar with. She experienced clinically significant drug abuse and dependence problems simultaneously with other mental health problems.

The six-year-old boy in this family had a serious neurological disability. He is what social workers, child protection and family services frequently refer to as a high-needs child. The care he required at home was extensive and he needed to frequently see specialist doctors. Unfortunately his mother's recurrent incapacitation arising from her drug cycle meant that he frequently missed these appointments and seldom received from his mother the care that he needed at home. Ultimately it was left to the supportive grandparent involved with the children as well as the boy's 10-year-old sister to provide this care.

When the children were at home and not staying with their grandparent the mother injected ice in front of them and left syringes around the house. The 10-year-old girl, who herself had developed an anxiety disorder, had recurring nightmares about people trying to steal her blood using syringes. The girl was also diagnosed with attention deficit hyperactivity disorder and was appropriately prescribed methylphenidate, or Ritalin, as treatment. Unfortunately her mother would frequently withhold this medication, which is amphetamine based, and abuse it herself rather than giving it to her daughter.

All three children missed a substantial amount of school and were reported by teachers to be very behind academically. On the days when they did attend this was invariably due to the efforts of their supportive grandparent or, if they were staying at home, the 10-year-old girl whom we would describe as parentified. This young girl would wake her younger siblings up, bathe them, dress them and make them breakfast so that they were ready for school. Even then the children would invariably present to school late and so miss important lessons that took place in the morning, including those related to literacy and numeracy, which the school had a preference for teaching first thing during the school day. One time the children failed to attend school because their mother, whilst driving them there under the influence of ice, crashed the family car.

As you might well imagine, this was a significantly difficult case for our family services worker who was allocated to work with the family. Child protection were not involved with the family during this period as they deemed the protective influence of the grandparent sufficient so they could justify this decision. This is a very common scenario with the incredibly overburdened child protection system, which needs to find some way to prioritise their response to the great many families about whom concerning reports are made.

As a result, in this particular case it was our worker, the community services worker, who was left to try to assist this family. The worker had studied social work, a course which does not provide extensive or practical education around how to work with families affected by ice use. The only training this worker had undergone with regard to this issue was a half-day seminar that she had attended the year before. Unfortunately the Department of Human Services, which funds family services programs, does not pay a sufficiently high unit price for agencies like Anglicare Victoria to be able to provide our workers with all the extensive training that we would otherwise wish to. As a result, this worker said to me that she did not feel confident about her ability to accurately assess, engage or assist this family, particularly in light of there being no assessment and practice frameworks, which are both family focused and specifically informed regarding ice-related issues, for doing so.

Our worker found providing this family with casework assistance to be very hard. As with the first case I discussed, it was virtually impossible for her to challenge the mother, even very gently, about those behaviours which were particularly damaging to her children, such as shooting up in front of them. If our worker tried to do this, the mother would become aggressive and paranoid. Many subsequent planned sessions with the family would then be missed due to no-shows.

Of most frustration to our worker was the lack of availability of specialist services for her to refer this mother to. A good primary mental health care service which had operated nearby to this family would have been best placed to assess and treat this woman's concurrent substance abuse and mental health problems. However, this service had been defunded and closed just prior to our worker picking up this case. This was exactly the same service that assisted the parents in the first case I presented and had demonstrated both willingness and capability in assisting such complex clients.

Our worker did not attempt referral to any other mental health services in the area, as she knew firsthand that the remaining services would not effectively engage this mother. Despite all the rhetoric of the no wrong door policy, many mental health services continue to insist that people experiencing concurrent mental health and drug problems deal with their substance issues before they can provide them with assistance regarding their mental health issues. The same is true in reverse, with many alcohol and other drug services insisting that people deal with their mental health problems before the substance problems can be addressed. In the end our worker ceased involvement with this family when the mother volunteered to give up care of her children to the supportive grandparent. In all likelihood this was a very positive outcome for these children.

This outcome also contrasts, however, quite significantly with that of the first case I presented. Whilst these are two different families with two different sets of dynamics, one has to wonder at the impact of service availability when comparing how each of these cases turned out.

The third and final case study I wish to present to you concerns a family comprised of two parents, their 12-year-old daughter and eight-year-old son and their six-month-old nephew, who was placed with them by child protection as part of a kinship care arrangement. The nephew had been removed from his parents due to their ice use. Unfortunately the couple with whom he was placed, the parents in this case study, had their own problems with ice use as well as family violence. In fact the 12-year-old girl and eight-year-old boy in this family had only just been returned to the care of these parents after having lived in foster care for some years by order of the Children's Court due to these drug and family violence problems. At the time these children were returned to their parents' care, which was soon followed by the six-month-old nephew being placed in the parents' care, these parents were not using ice, though they were daily cannabis smokers and had a history of known ice use. Child protection had referred the family to our family services program in the hope that one of our workers could help build the attachment between these parents and their children. In the meantime child protection remained involved with the family.

As our worker engaged with these parents over some months she watched as signs emerged that they had begun using ice again. They began to look gaunt and malnourished, with scabby skin, and they presented with volatile moods. Our worker received reports that the father was again abusing both ice and alcohol and was prone to becoming aggressive and violent when affected by these two substances. As a condition of their own birth children being returned to their care both parents were court ordered to take urine screens to test for drug use but they were not complying with these court-ordered conditions.

When our worker and her team leader discussed this with child protection they were advised by the child protection worker that there was no evidence that the parents were using drugs and so no reason for child protection to push for court-ordered drug screens to take place. This was despite observations made by not only our worker but workers from other services and teachers at the children's school. In fact these teachers had advised both our worker and child protection that the parents had recently presented at the school and asked school staff to ignore stories the children might tell of drug use and family violence in the home. Meanwhile, school staff became increasingly concerned that the children were being neglected as the parents came later and later to pick them up and then started to not pick them up at all. What is more, at this time our worker was advised that some local supermarket employees had made a report to child protection about these parents after they were apparently observed trying to sell baby formula in front of the Safeway car park. Assuming this allegation was true, this was likely to have been baby formula given to the parents by child protection for them to care for their six-month-old nephew.

In light of these concerns our worker and her team leader engaged in continued consultation with child protection to try to get them to escalate their response to this family, which seemed, by all accounts, to be descending further into ice-induced chaos. Whilst this was occurring, children within the family continued to face cumulative harm. The 12-year-old girl was very prone to fight and had to provide care for her otherwise neglected brother and nephew whilst her parents were incapacitated by the sleep-wake cycle of their ice use. Furthermore, this girl was the one to call the police when her father would become aggressive. As our worker described it, the girl and her brother showed signs of having been traumatised by exposure to family violence.

This case is actually still continuing, and thankfully child protection have now begun employing a much more protective response to these vulnerable children. Firstly, the six-month-old nephew has been placed back in the care of his mother and both of them are living in a professionally supervised facility where his safety can be assured. Secondly, after the mother of the 12-year-old and 8-year-old in this family admitted that she had once again begun using ice, child protection began enforcing that she undergo urine screens so that they could monitor this; however, the 12-year-old and 8-year-old continued to live with these parents.

I have raised this last case study with you because the findings and recommendations you make as part of this inquiry are likely to have both direct and indirect influence on the rate and type of referrals made to the child protection system by police, doctors, teachers and other professionals when they identify that parents are problematic ice users and children are thus at risk. The actions of child protection in this case up until this point may appear to be outrageous, but I do not wish to give the impression that this is due to the unprofessionalism of any particular worker or workers. Rather, this is a reflection of the statutory child protection system already being stretched to breaking point. That this six-month-old boy was placed with these two parents to begin with reflects the fact that there are so few foster carers available now, and such kinship care arrangements are increasingly the only option for children who cannot live with their parents due to problems like ice use. In the case of this boy, his being placed with his aunt and uncle rather than staying with his parents probably was the lesser of two evils, although I would assert that it is unacceptable all the same.

What is more, poor decision making in child protection with regard to this case, particularly around the issues of enforcing drug screens, needs to be understood in a systemic context. In the few months that our family services worker had worked this case, the family had three different child protection workers managed by two different team leaders. The inevitable communication problems and knowledge shortfalls about this family that occurred within child protection are no surprise, given this movement of staff in relation to the one case. This in itself is a reflection of the child protection system reeling from a constant and massive influx of extremely high-risk cases. Unfortunately governments are being very effective at passing legislation and developing systems which encourage and facilitate easy referral of families to child protection but have not adequately increased the number of child protection workers who are available who will appropriately manage these referrals.

I hope that these case studies have been helpful in contextualising the information and recommendations that Anglicare Victoria provided to you in our written submission. I will be very pleased to answer any questions you have in relation to this submission or any further questions you might have with regard to Anglicare Victoria's work with people and families impacted by ice use.

Before I do, I would like to make one suggestion to you. When you are arriving at your findings and producing recommendations for this inquiry, anytime you consider individual ice users — whether they are referred to as offenders in the law and order context, or patients or clients in a health care and social services context — I would ask you to add in your thinking about these ice-using people the words 'and their families'. For every person who abuses ice there are, left in their wake, other people, including vulnerable children and young people. The impact that having an ice-using partner, sibling or parent can have on a person is substantial. The impacts of related trauma and disadvantage can ripple through families, communities and across generations, causing incalculable human misery and staggering financial cost to the state and country.

Police, hospital and child protection workers are the ones who respond to the violence and chaos caused by people using ice when incidents of such nature flare up; however, it is often community services provided within the not-for-profit sector that try to help individuals and families pick up the pieces when these crises have died down, with the aim being to avoid the slide towards further crises. We do this with mixed results. Our workers have usually not had sufficient training and education to conduct this work as effectively as possible and lack much-needed tools, such as a common risk assessment and practice framework for families affected by ice use and the effective referral opportunities to alcohol and other drug and mental health services that actually practise the no-wrong-door policy they preach.

It is my great hope that this inquiry will result in effective action towards closing these service gaps, as well as addressing the other issues which were raised in Anglicare Victoria's written submission of information and recommendations to your committee. Thank you.

The CHAIR — Thanks, David. Well done, given you are a man who has had little sleep. Also, my apologies; we have an updated paper on your submission which you submitted back in October, so it certainly was not a late submission; it was one of the earlier ones, which has been in our file for some months now. We have an abridged version that was given to us today.

Mr SCHEFFER — Thank you, David, for your presentation. I am interested in the first page of the summary we have got on the frequency of ice use. You write there that most programs report somewhere between 10 and 40 per cent of clients being known to have abused ice in the past or in a continuing fashion, and then you elaborate that in a quote. Do you have at your disposal what the raw figures are, roughly, on what are we talking about there, because a 10 per cent increase could be huge or very small in terms of numbers?

Mr GILES — Yes, it can be. At any one time our family services programs across our agency in all divisions see about 1000 families, so it would be 10 to 40 per cent of those families where ice use is a factor, either current use or past use. Typically that would be a parent or an older adolescent in the family. In terms of the exact figures, I am afraid I do not have those at my disposal.

Mr SCHEFFER — No, that is all right. That is a lot of people.

Mr GILES — It is, and as I said in that section as well, it is probably underreported because of the stigma of ice use. The families with which we work are often afraid of reporting to child protection or the police with regard to those sorts of issues, so we would estimate it would in fact be higher.

Mr SCHEFFER — That 40 per cent out of a sample of 1000 is over what period of time? How has that increased over the last, say, three or four years?

Mr GILES — I do not have specific statistics. Anecdotally — —

Mr SCHEFFER — Sorry to interrupt. Would Anglicare have them?

Mr GILES — We may do. I can attempt to get them, but with the way the family services systems are designed in terms of their information reporting, that can sometimes be difficult, but I can endeavour to supply those. It was 40 per cent in some programs and 20, 30 or 10 in others. I would wager the average is around halfway between those; I would say that for something like a fifth of the families we work with it is an issue, either in the past and it is still having rippling effects, or current use.

Mr SCHEFFER — There is another matter I wanted to ask you to comment on too. In the three case studies that you gave, which are very sobering stories, you talked very graphically about the very complex interweaving of issues — psychological, social and economic — and I think I am correct in saying that you referred to ice as the only drug, which of course we know is not the case; polydrug use is the norm.

Mr GILES — Yes.

Mr SCHEFFER — Could you comment on that in terms of the case studies

Mr GILES — Yes, absolutely. We frequently see ice used along with alcohol and cannabis. Interestingly we have worked with a great many families over the years, and there are some which are quite horrifying and difficult to work with. Where families contain parents or adolescents abusing other drugs, it was dangerous and it was worrying, but all of our workers have consistently said that once you introduce ice into the mix it is such a rapid deterioration. You are absolutely right that it is polydrug use, which is the issue here, but ice seems to be a factor which completely changes the game once it is introduced into that context.

Mr SOUTHWICK — Thank you, David, for your presentation. We had evidence some months ago from Les Twentyman, who was talking about some of the situations of children who are living in ice-affected homes — similar to the evidence you have given today. At what point would you suggest that those children should be removed from that home?

Mr GILES — It is difficult to make a general statement. There always needs to be a case-by-case consideration of the balance of risk and protective factors. Removing children is a last resort in the child protection system, but there are other interventions that the child protection system is able to put in place. They have access to the Children's Court. They can seek court orders that mandate treatment and all other kinds of interventions and protections, such as a grandparent having to be around when the parents are with children and so on and so forth. These are tailored to the unique situation.

I would say anytime ice is a known factor there should be a child protection response. That would not automatically mean removal of the children. The Children, Youth and Families Act and conventions of good practice would dictate that we do not do that, except as a last resort, but certainly there should be a child protection response from that statutory system with all the powers that it has. That is the most efficacious way to deal with these sorts of issues, because unfortunately it is a profoundly addictive drug and families deteriorate very quickly, so you need a system with those sort of teeth to be able to deal with it on a case-by-case basis as well. That is not to detract from the role that community services, such as Anglicare Victoria, can play. We feel that we would make a very useful contribution in the context of that sort of statutory response.

Unfortunately the child protection system is so overburdened now that they will very quickly refer these kinds of cases through to us and close rather than give that response, and it falls to us to monitor the situation and, if we deem it appropriate, to try to work the cases back into that system, but it is very hard. There are pressures to not work cases back in — to have that statutory response because of those demand pressures on that system. I would say as a rule that when ice is involved, child protection should be involved.

Mr SOUTHWICK — You mentioned issues with foster care and kinship care. Could you elaborate a bit further in regard to those?

Mr GILES — Yes. There are fewer and fewer foster carers every year. The system was built in another time, basically when it relied on there being women at home to look after children. We have obviously had massive societal shifts, and that is no longer the case, so there are fewer people signing up to be foster carers. Because we have got so much better at funnelling referrals through to the child protection system by mandating the way police reports on things like family violence and by providing assistance to teachers and doctors to report, at a time when we have fewer and fewer out-of-home care options there is more and more demand for them because we are uncovering more of these very concerning cases.

As a result, the child protection workers will push for what they call kinship care arrangements, which are essentially a more informal type of foster care arrangement with extended family or friends. Unfortunately when children have been removed from the family the odds are higher that their extended family will also potentially be dysfunctional — not all the time, but these things tend to move in social circles and communities in that way, so it is actually more risky to go down that road. The problem is that they do not really have much choice; these children cannot live at home, and there are fewer and fewer options for them to choose.

Mr SOUTHWICK — Are you suggesting, for instance, the screening of kinship care as part of that process?

Mr GILES — Absolutely. The system is actually much more relaxed when it comes to screening kinship carers and monitoring than it is for the sort of formal volunteer foster carers, which seems quite ludicrous to me, because with the kinds of people who are functional, committed and motivated enough to sign up to be a foster carer of someone they are not biologically related to or is not part of their community, you probably have less to worry about than with the extended family of a family unit where there is such dysfunction and risk that child

protection has had to remove the child. That is a convention in certain policies that I would like to see reversed in child protection.

Mr SOUTHWICK — Thank you.

Mr CARROLL — Thanks for your presentation, David. You mentioned grandparents. Is that common — where grandparents are raising the children of methamphetamine parents? Following what Mr Southwick raised, in controlled services is that an easier avenue in many respects for the children of methamphetamine users?

Mr GILES — Yes, it is fairly common. In many families where there are grandparents or siblings of parents who are available and who are fairly functional and involved in the lives of their grandchildren or nieces and nephews, they will step in and play a role. We see it frequently, and a lot of the time it is actually a very good solution. The children have an established relationship with these people, so it is not like yanking them out of their family unit and sticking them with people they do not know. It does happen a lot. It probably happens informally, when services are not even aware of these cases — it is just something families arrange — or it is something that social workers may try to get families to volunteer to do or that the Children's Court will actually step in and order when required. As to whether it is in the best interests of children, that is always a case-by-case decision, but I reiterate my earlier point that we need to be quite vigilant in screening grandparents and other people in these families to ensure that that is the case.

Mr CARROLL — Have you seen the full circle, where the grandparents have raised a child for five years and there has been a successful transition back to the family home once things are stabilised and drug free?

Mr GILES — I am not aware of that. That sounds like a commendable program.

The CHAIR — David, we will have to leave it there. We have a teleconference lined up for the next witness at a quarter to four. I was going to ask you: do we have the case studies as part of the submission? Are you happy to table those case studies you referred to?

Mr GILES — Yes, certainly.

The CHAIR — Thank you. Thank you very much for your evidence to this committee this afternoon. Sandy will get in touch if we require further information in relation to what you have presented today. We appreciate your time. Thanks, David.

Mr GILES — Thank you. I appreciate you receiving me.

Witness withdrew.