Fams response to the NSW Drug Summit

Strengthening Families, Strengthening Healing: Family as the Foundation for Change

Contents

Acknowledgment of Country

The Gadigal are the Traditional Custodians of the land on which our offices stand, and we pay our respects to Elders past, present and emerging.

We also acknowledge the Traditional Custodians of the land on which our member organisations operate and the lands on which we travel across for our work.

About Fams

Fams is the peak body in New South Wales that supports the early intervention and prevention sector. This sector provides critical services for children, young people, families, and communities.

Fams works collaboratively with Government, Policy and decision-makers, non-government organisations, academic organisations, peak bodies, family and community services sector, Aboriginal Community Controlled Organisations and organisations working with diverse communities. We advocate for improved policies and resources for children, young people, families, communities and services.

Children and family's safety, health and wellbeing are at the heart of all our work. Fams is committed to children and families receiving the support they need, evidence-informed and outcomes-based service delivery, government and sector accountability and influencing policy outcomes.

Strengthening Families, Strengthening Healing: Family as the Foundation for Change

Introduction

Across the world, one of the most powerful motivators for change is a parents love for their children.

Fams is pleased to present this submission to the NSW Drug Summit Committee, contributing to bold and innovative reforms aimed at improving the lives of people who use or have used drugs, as well as their families, across NSW.

Love, family, and connection are essential elements in supporting healing and fostering change for those experiencing AOD issues. This submission will highlight the needs of families in the context of AOD policy reform, emphasising that the impacts of AOD addiction and dependence affect the whole family.

Fams response will focus on four of the NSW Drug Summit key focus areas: Health and Wellbeing, Equity and Inclusion, Safety and Justice and Integrated Support and Social Services. This response has been informed by the early intervention and prevention sector which comprises of organisations who deliver Family Connect and Support, Targeted Earlier Intervention, and Family Preservation services funded by the NSW Department of Communities and Justice. Input was sought via the Fams Drug Summit Sector Consultation Survey, the Fams Family Preservation Network Consultation, and the Fams/ NADA NSW Drug Summit working group.

Drug use, as a child protection concern, is one facet in an intersection of complexities of individual and systemic harms and barriers, including domestic and family violence, poverty, housing insecurity, unaddressed mental health issues, systemic violence and racism, and impacts of trauma both individually and intergenerationally.

The child protection, domestic and family violence (DFV), and alcohol and other drugs (AOD) sectors are deeply interconnected. However, parents' attempts at making positive changes to drug use behaviour are often undermined by siloed responses, poor system coordination, limited cultural understanding and inclusion in system responses, and a lack of recognition of the crucial role family plays in motivating and sustaining change to AOD use. Further, the systems themselves in attempts to reduce child risk can amplify distress and pain to both parents and children, causing trauma and exacerbating challenges by interrupting essential relationships that are foundational to healing.

The Analysis of linked longitudinal administrative data on child protection involvement for NSW families with domestic and family violence, alcohol and other drug issues and mental health issues (Luu, 2024) found that of the children who had a first report to the Helpline between January 2004 and June 2018 (n = 584,365), 193,705 children (about 33%) had either parental DFV or DFV alongside parental AOD use and/or MH issues as identified concerns in Helpline reports in the subsequent 12 months. The most frequent concern was DFV on its own (82%). The most common concern identified alongside DFV was parental AOD use (16%).

The report reveals that children and families who come to the attention of child protection are likely to be experiencing parental DFV, often in concert with parental AOD use, MH issues or both. Moreover, these children are more likely to enter OOHC, with that likelihood particularly marked for those experiencing all three risk factors.

Children whose families had more co-occurring risk factors for DFV or DFV alongside parental AOD use and/ or MH issues were younger at first report, had more child concern reports and more reports that met the threshold for Risk of Significant Harm (RoSH) throughout their interactions with the child protection system. Child protection reports present an opportunity to proactively mobile support early to meet child and family health and social support needs.

This research highlights the significant role that alcohol and other drug (AOD) use can play for victim-survivors, as substance use may serve as a coping mechanism for trauma and poor mental health resulting from experiences of violence. A crucial response is to provide early and comprehensive support to families, addressing AOD, mental health, and domestic and family violence (DFV) needs concurrently in ways that are both family-inclusive and culturally safe.

The most powerful motivating factor for change for many parents is the love they have for their children. And for many, the pain and grief of separation away from their children and associated feelings of powerlessness can be the critical tipping point into increased use. Early, proactive, family-inclusive support presents a powerful opportunity to mobilise resources and prevent escalation into crisis—especially crises driven by the very systems designed to prevent harm. Early intervention also creates opportunity to break

intergenerational cycles of systemic disadvantage and violence and prevent ongoing engagement and monitoring by child protection agencies.

The early intervention and prevention child protection sector needs to be at the table of the NSW Drug Summit to ensure that cohesive responses are designed to meet the needs of families, prioritising child safety and wellbeing while ensuring everything is done to keep children and families together through supporting family-centred alcohol and other drug responses.

Focus Questions

Focus 1: Health and wellbeing

The NSW government describe this as "quality of life and the ability to contribute to the world with a sense of meaning and purpose. Health promotion includes education, campaigns, laws, and creating environments that encourage healthy behaviour"

Question: How can we improve health promotion to reduce drug harms?

Health promotion and harm reduction education are essential strategies for improving the quality of life for parents and children affected by drug use. These strategies include supporting parents in understanding the impacts of their substance use and learning ways to reduce harm to themselves, as well as implementing safety plans and other measures to minimise the impact of alcohol and other drug (AOD) use on their children.

Children and young people in environments with drug use also need education and support to prevent or reduce drug related harm. The child protection early intervention sector is well-placed to deliver proactive education, harm reduction, and referrals to AOD support as part of comprehensive child and young person assistance.

Opportunities for parents to build social connections outside of their AOD networks are crucial for ongoing support as they navigate parenting, with 77% of respondents in the Fams sector consultation highlighting this as a key support need.

"Recovery capital (RC)" (Best D, 2022) has been described as "resources and capacities that enable growth and human flourishing", an asset-based definition that focuses on an individual's strengths. RC research and models address individual-level factors (oftentimes labelled 'personal RC' or 'human and financial RC'), inter-individual-level factors ('social RC'), and the larger environmental context ('community RC')". Investing in community based social supports

that can support connection and belonging and build parental social capital is an essential component of health promotion for families.

"Families need to build networks of support. Maybe connection to peer support from other parents experiencing similar challenges? And knowledge and resources on how manage the challenges which arise in parenting, and the personal and relational challenges. "

Recommendations:

- Recognise the early intervention child protection NGO sector as crucial to mitigating AOD impacts, reducing harm and providing support in accessing referral pathways.
- Provide resources to these NGOs for training in health promotion, harm reduction, relapse prevention, and family support strategies. Focus on harm reduction in relation to personal drug use, alongside harm reduction strategies to ensure child safety.
- Fund social supports as an essential AOD intervention strategy, including peer networks and opportunities for community and relationship building. Social isolation and loneliness are significant contributing factors to alcohol and other drug (AOD) use. Individuals working to change their drug use need opportunities to form new, positive, and supportive relationships, promoting sustained well-being through community connections and peer networks.

Focus 2: Equity and Inclusion

The NSW government states "outcomes are improved when access to services is based on need, is inclusive, and people are treated with fairness and respect. Health is a fundamental human right and supporting equitable service access and health outcomes has far reaching social benefits."

Question: What could improve equitable access and inclusion for people seeking support for drug use?

The lack of family inclusive service design is an equity issue

Family inclusive service delivery is essential to ensure equity and inclusion for parents seeking treatment and support around their alcohol and other drug addiction and dependence. Parents need to be able to access a range of treatment options, including family inclusive residential support, to ensure family relationships are maintained and healing supported.

For many parents, the love of their children is the primary motivating factor for change. Department of Communities and Justice (DCJ) plans for families where drug use is present

frequently identify residential support as an essential action in family plans, however parents face major barriers to accessing residential treatment.

Being required to leave their children to access residential support, being physically far from their children and support networks and unable to have them visit are all significant barriers parents face when considering residential treatment support. This is compounded by being without family available to care for their children during treatment and fearing child removal while in treatment. For First Nations people, treatment is often off country, creating another level of disconnection from support.

"Accessing rehabilitation centres that accept children is critical. Mothers are worried about losing their children, so they either do not go or do not last long in the treatment centre. Most mothers do not have any family members to look after their children."

"Parents obviously worry that they won't get their kids back, especially if they've had previous child protection intervention. It doesn't matter what you say."

"Where do people without support like family, get the support with their kids? It's a massive challenge."

Parents need diverse support options, including but not limited to residential treatment, that prioritise family connection. Listening to parents' voices and addressing their needs and concerns is crucial for ensuring the best treatment match, recognising that while residential rehabilitation may be an option, it may not suit everyone.

"For outpatient assistance, parents, in particular Mums are at times willing to access treatment. But inpatient is not an option due to the care of their families as well as the significant cost."

"Rehabilitation is often not accessed by the families we support due to them not having access to family friendly rehabs. We find this is a particular issue for mothers"

Creative solutions that reflect the reality and complexity of family life are needed to support positive and sustained change.

"In Victoria, there are services where the AOD worker works alongside the whole family, and the outcomes for those services were great. The other parents might still go to work, and workers were flexible – risk isn't always between 9-5pm."

Culturally and spiritually safe and supportive treatment options are critical for First Nations families

First nations families are significantly overrepresented in the NSW child protection system due to deeply rooted systemic disadvantage and the pervasive and ongoing effects of colonisation on individuals, families, and communities. This disadvantage is often compounded by current

and intergenerational systemic violence and oppression experienced by First Nations families. Colonial practices, which marginalise and disenfranchise First Nations communities, continue to impact interactions with Australia's legal, child protection, and justice systems.

Critical for change is access to early support for parents and children, in ways that are culturally and spiritually meaningful, led by community. Investment in ACCO AOD services to provide a range of support options is essential, including access to family inclusive supports that are provided on country and reflective of the importance and understanding of connection to country, kin and community.

Respond to the needs of Culturally and Linguistically Diverse people

Services report that a lack of culturally inclusive and supportive options makes it harder for families from Culturally and Linguistically Diverse (CALD) backgrounds to seek help. Stigma and shame surrounding AOD use and treatment access can deter some communities from seeking support, resulting in missed opportunities for parents to receive the assistance they need.

Cultural safety and responsiveness is essential for whole-of-person and family support. This critical need requires investment in developing the CALD AOD, DFV, and child protection workforces, while simultaneously equipping the non-CALD workforce with the necessary skills, resources, cultural supervision and coaching, and opportunities to build relationships with key community members. This will help ensure cultural safety and address support needs more effectively.

"Families are reluctant to seek (AOD) support from non-CALD workers due to cultural sensitivity of families. This often impacts on front CALD line workers (child protection) as they try to meet this need."

"Supporting and educating family members from CALD communities in how to support a person experiencing addiction is crucial. Culturally, addiction can carry significant stigma and shame, leading to disownment and further isolation. This deepens the impacts and can make matters worse."

Providing culturally sensitive and inclusive education and support for extended families is crucial to improve service access and strengthen family support for those seeking AOD treatment. There is also a need for community-based, community-led, relationally focused education to CALD communities who traditionally see drug use as taboo. Providing community-wide education and fostering compassionate understanding and responses has the potential to galvanise the power of community support for these families and help maintain children's fundamental need for connection to culture and community. CALD community members, and

those with lived experience can play a powerful role in leading community perception change, empowering communities to better respond to AOD issues.

"I know of a family with 3 children from a CALD family. Both parents are from South-East Asian backgrounds and from religions that would see drug use as significant taboos. In their respective countries of origin, corporal or capital punishment and cultural shunning would be the punishment for their addiction.

All their children, who have had contact with the child protection system because of issues related to parental drug use, no longer have connection to culture or community due to the cultural shunning elements. This is despite the immediate family having substantial knowledge of AOD and access to AOD education.

In this instance, it's not so much the culturally sensitive education or support for the extended family that is the cause of the shame or stigma impacting the family's ability to heal holistically. It's the need for a community-based, relational education for the broader SE Asian community. "

Service gaps for geographically isolated people must be addressed

Rural and regional communities deal with service scarcity broadly, and this proves a significant barrier for families needing AOD treatment and support. And the further away from a metro centre, the greater the impact.

Service gaps and costs associated with accessing support and treatment are additional barriers experienced by people living in rural and remote areas. These issues include:

- Lack of local support options meaning parents need to travel large distances away from children, family and community. This increases anxiety and distress for both parents and children.
- Rotating GP's impact continuity of care. Trust and relationships critical to quality support.
- Costs associated with accessing AOD support when living rurally including petrol, transport and accommodation.

"Cost of living impacts on if they attend appointments or not, i.e. enough petrol in the car or available funds for transport"

There is a lack of AOD service support in regional areas, both in-home withdrawal management and support particularly when intimate family violence is co-occurring with AOD use."

Stigma and gender expectations as contributors to inequitable support

Stigma and discrimination can significantly impact people who use drugs, from outright denial of care, limited opportunities for service access, through to impacts on policy and funding decisions (NADA, 2023).

Mothers in the child protection system face intensified gendered stigma and discrimination, facing intense blame judgement and shame for drug use. Mothers face disproportionate responsibility and are held to higher standards and scrutiny compared to fathers in similar situations. This bias impacts the system's ability to recognise progress and acknowledge parenting capacity, regardless of the positive changes a mother has made. The stigma associated with illicit drugs leads to predetermined outcomes, such as child removal, without assessing contextual factors or change progress. First Nations mothers face further amplified stigma and discrimination due to systemic and individual biases, leading to over surveillance of families and decontextualising of mother's responses to challenging circumstances.

Recommendation:

- Commit to whole-of-family responses to AOD use by developing policies and funding streams that prioritise the parent-child relationship as a crucial factor in treatment success.
- Invest in ACCO's to deliver culturally safe and supportive options for First Nations families.
- Encourage creative and flexible treatment models that accommodate the realities of family life, inclusive of but not limited, to residential treatment options.
- Prioritise investment in culturally responsive supports for CALD families, including workforce development, education and support to immediate and extended family members, and community-based education to shift perceptions and increase compassion and responsiveness to families impacted by substance use.
- Recognise and tackle systemic gender and racial biases by enacting comprehensive policy reforms.
- Develop holistic policies and programs that consider individuals' physical, psychological, emotional, and social well-being, as well as their connections with family and community.
- Address service access barriers for rural and remote families to ensure equitable access to support.

Focus 3: Safety and Justice

The NSW government has framed this focus area by stating "part of a comprehensive response to drug use includes law enforcement, to ensure safety and justice in our communities"

Question: How can NSW ensure the community is safe, and its law enforcement response to drug use is fair, proportionate, and effective?

Supporting family-focused responses that prioritise safety by addressing co-occurring risk factors

For many families, domestic and family violence (DFV), mental health challenges, and AOD use are deeply interconnected, increasing the risk of harm and removal for children exposed to these co-occurring risk factors. (Luu, 2024).

Families, especially those fearful of child removal, often face significant barriers to treatment, with limited availability of family-inclusive residential services. This is particularly true for families with more than two children or with children over the age of 12.

There is opportunity to concurrently address AOD treatment needs, stabilising mental health (including supporting mental health needs resulting from living in violence), and supporting healthy relationships while keeping families together and supported. This could include whole of family focused practice approaches, such as Safe and Together (Mandel). This practice approach addresses family violence by focusing on partnering with the victim/survivor to improve adult and child victim/survivor safety and wellbeing, holding partners accountable for their abusive behaviour. In cases involving parental drug use, the model addresses the complex dynamics of substance misuse as part of the broader pattern of abuse, along with its impact on victims and children.

The model recognises behaviours such as the parent who uses violence supplying drugs and undermining efforts toward drug use behaviour change as forms of abuse. It also acknowledges that the victim/survivor may use substances as a means of coping with trauma and poor mental health, which are consequences of surviving violence. Furthermore, the model highlights the strengths of victims/survivors, such as their attempts at cessation or harm reduction, recognising these efforts as protective. The approach aims to empower victims/survivors by building on these strengths.

Drug monitoring

Throughout the Fams consultations, frontline specialists spoke about the need for systems to be responsive to individual needs, respond with curiosity rather than assumption, and prioritise child safety and wellbeing while holding these complexities in mind.

This could include recognising that a parent may choose to use alcohol or other drugs but has implemented strategies to ensure their child's safety, such as arranging care for the weekend while using. However, current drug screening systems do not take this child-focused decision into account and instead penalise the parent, regardless of the context.

"In this example, she can't use when the children are in her care. She's drug testing but if she had a weekend when the kids were away, they'll screen her with drugs in her system, but she wasn't using when her kids were around. The drug testing wasn't adequately showing when she was actually using. There is certainly a way to do harm minimisation and safety planning and building people up with choice about what this looks like. It's almost like they don't want to or can't hear it. I did ask for a group supervision with DCJ about it because I felt like we were on different planes here."

Comprehensive assessment and prompts for practice that do not equate drug use with automatic child risk issues are vital to ensuring children are not unnecessarily reported to child protection and removed from families, and the use of proactive harm reduction strategies by parents are supported, keeping families together.

Understanding the nuances of family support

Family relationships are complex entities, that can change and evolve over time, and dichotomous assessments without thorough understanding of the context can have the child protection system penalise parents for using the supports they most trust and rely on. This is particularly challenging when systems stressors are placed on parents who are yet to develop other supportive relationships.

"We're finding a difference with families where there is entrenched generational drug and alcohol use and how the service system reacts to this. For example in a DCJ family plan it will say, "you can't have contact with family because they are using or drug dealing" but that's cutting off their whole world.

A specific example, a mum we were working with came out of rehab and had 3 of her 4 children restored. It was supposed to be staged with support, but it happened almost immediately, a reactive decision because everyone (foster carers) had had enough, rather than it being the best thing for the children.

Dad's best mate was supporting mowing the lawn and helping out as the kids dad was in jail. But because Dad was a known dealer, DCJ saw this as a red flag. There's real blanket thinking in the child protection space about how we view people with AOD issues, and we make big assumptions and that's around functionality when they aren't using."

Recommendations:

- Prioritise supporting families experiencing co-occurring risk factors, early, in ways that are meaningful to the family.
- Implement trauma-informed, family-centric intervention models to reduce child protection involvement and promote long-term family safety, stability and cohesion. This includes responding to DFV using evidence-based interventions, prioritising family safety and holding the person who uses violence accountable for their behaviour.
- Invest in sector capacity building for DCJ and NGO child protection practitioners to ensure comprehensive risk assessment includes understanding the context in which drug use is occurring, alongside safety planning that could better support children and ensure they remain safely with family.
- Strengthen assessment skills and capacity in intersecting sectors that collaborate with AOD service support to promote compassionate, person-centered, and non-punitive approaches for individuals who use AOD.

Focus 5: Integrated Support and Social Services

The NSW government has said "Support and social services can significantly improve health, wellbeing, financial stability and engagement with family, friends and the community."

Question: How can we ensure that integrated support and social services are available and working effectively?

Develop coordinated and accountable responses

Ensuring effective social support delivery involves understanding the interconnectedness of alcohol and other drugs (AOD), mental health, and social wellbeing. Service and policy responses should be coordinated to address the needs of the whole person within their family system, centring the voices of parents and children. This includes fostering collaboration between AOD, domestic and family violence (DFV), child protection, and community mental health services, along with investing in expanded access to these supports.

"A parent was doing really well after being able to do a rehabilitation program instead of custodial sentence. Then on her return she had no support to assist with safe options for housing, relapse prevention etc."

"We often get parents and children stabilised on psychiatric medications with 6 months plus of no AOD use. However, Community Mental Health Services (CMHS) are then unwilling to take clients because they are not acute or in crisis. This leaves many of our clients extremely vulnerable as there is a high turnover in GPs and a lack of psychiatric services available to ensure long-term success."

Address the social and economic determinants of AOD use

Failures in the system, like insecure housing, restricted access to proper mental health care, poverty, lack of support for parents managing children with additional needs, and prolonged AOD support wait times, significantly heighten parental stress, and can contribute to relapse into previous drug use behaviours. For First Nations families, this is concurrently occurring within the context of living with the ongoing impacts of colonisation, racism and system harm adding additional levels of distress.

System reform and investment in early support to address the social and economic determinants of AOD use is critical.

"Relapse can be triggered by systems failure to provide service, e.g. housing, psychological support, assessments for children that may have un-diagnosed issues. There are huge waiting lists to use or access public services."

"Community Health Services no longer have effective local programs they used to like psychologists, counsellor, case managers or options for long term support."

Early intervention child protection NGO services are a critical resource to utilise, but need ongoing investment, capacity building and training. Addressing continuity of care challenges, particularly high staff turnover and service fragmentation, while tackling systemic stressors like insecure housing, poverty, and unsupported parenting needs is essential. The Fams sector survey identified 4 key training priorities-

- Understanding harm reduction strategies (individual) for both parents and young people who use drugs
- Understanding harm reduction strategies in relation to parenting for parents who use drugs
- Parenting capacity building for parents whose children use drugs
- Understanding treatment options and referral pathways.

Recommendation:

- Reform the system to tackle social and economic drivers of AOD use, such as insecure housing, poverty, and barriers to mental health care. Strengthen the safety net for families by reducing service waiting lists and enhancing accessibility to critical public health resources.
- Prioritise investment in culturally responsive support for First Nations families, addressing the compounded effects of colonisation, racism, and systemic harm.
- Develop and fund integrated support frameworks, including cross-sector training and case conferencing for holistic family support. This will reduce some burden on the AOD sector while also utilising existing supportive, trusting relationships.

- Increase coordination and accountability between government and non-government organisations in health, education, child protection, disability and justice systems to address the full spectrum of family needs.

Case studies

*All names and identifying details have been changed in these case studies.

Milly

Milly, a 29-year-old mother of 2 children (Tom, 7 years and Harry, newborn) from Sydney. Milly has faced significant challenges including surviving domestic and family violence, which has resulted in her experiencing trauma and mental health impacts and symptoms. Her former partner and father of the children was assessed as inappropriate to care for the children due to his use of violence and substance dependence. The significant stress, isolation and the impact of experiences of violence has led Milly to use alcohol and methamphetamine to cope. This resulted in the Department of Communities and Justice's (DCJ) involvement at the birth of her son, Harry.

Her eldest son, Tom, has been relocated across the state to live with Milly's mother, his grandmother, while Harry has been placed in temporary foster care. Milly was referred to an Intensive Family Preservation Service by DCJ as part of a plan to reunify her family.

DCJ identified that Milly needed to access a residential program to support her in addressing her AOD use. Although she completed a supervised detox process, she was left without support for six weeks waiting for a bed in a residential rehabilitation service. During this wait, Milly was at a high risk of relapse. With Tom living far away and Harry in temporary care, Milly experienced profound loss, grief, and hopelessness. The extended wait times for treatment placed immense strain on Milly and prolonged her separation from her children.

At the time, all residential programs in Sydney were full and the only available option was in rural Western NSW. This option presented significant barriers for Milly, as it separated her from her family and support networks and imposed substantial travel costs for both Milly and her visiting family.

Tom continued to live with his grandmother throughout this time as he was not allowed to accompany Milly to the rehabilitation service. He struggled to understand why he had been separated from her and showed signs of emotional distress including withdrawing from his friends and school. He reported feeling confusion and sadness and wanted the security of being back with his mum. He missed his mum deeply and the limited opportunities to communicate of see her intensified his feelings of distress, sadness and abandonment.

While the residential service provided Milly with the support she needed, the physical and emotional distance from Tom weighed heavily on her. She felt isolated from her child and local

support networks. She felt cut off from her greatest motivation—reuniting with her children. The physical distance from her children added to her fears of not having her children restored to her care.

Milly's experience underscores the urgent need for more accessible, family-inclusive treatment options. The lack of available beds in Sydney forced her into a rural facility, adding strain to already limited rural resources and causing additional emotional hardship for her family. Accessible, family-centred treatment options could have enabled Milly to remain close to family and community, reducing the trauma and fear of separation, and providing her children with a greater sense of stability and connection. The family could have been supported to rebuild vital connections and relationships, provide stability and safety, and support Milly to be the mother to her children she desperately wanted to be in an environment of compassion and healing.

Vivian

Vivian is a 26-year-old mother with 2 children and has been dependent on methamphetamine since she was a teenager. Vivian's parents migrated from Vietnam to Cabramatta and raised her in a Buddhist home. Vivian was raised in a loving home, however as a child, both parents worked 2-3 jobs and long hours to make ends meet.

When Vivian was 12 years old, she became involved in a gang, leading her to engage in drug use. Her family were not aware of this and had limited knowledge about drug use and its impacts. She is a victim/survivor of domestic violence, with the father of her children incarcerated following assaulting Vivian.

Vivian works evenings as a cleaner, and her parents provide support and care for the children while she is at work.

The day her children were removed, Vivian had been required to appear in court in relation to the DFV case against her ex-partner. The hearing itself was incredibly fear inducing for Vivian and afterwards outside court her ex-partner's family made threats against her, leading Vivian to feel scared and distressed. She used substances to manage her distress and arrived to pick up her children from school drug affected.

DCJ removed her children after arriving at school drug affected. Both children were placed with an authorised foster carer, rather than with the children's grandparents. Vivian wanted her children to be with family that they know and love, rather than strangers, and was distressed about not knowing who was caring for them and how that might be impacting her children. DCJ said they made this decision as they assessed Vivian's parents lack of knowledge about drug use would impact their capacity to provide care to the children.

DCJ told Vivian that she would need to complete a residential rehabilitation program before they would consider restoration of the children to her care. They identified the service they believed would be the best fit, however this was out of Vivian's community and away from her children and support networks.

Vivian was reluctant to agree to the residential rehabilitation program for fear she would lose her job and her house. Attending the residential program required her to move out of her private rental, with no options for her to store her belongings. She was worried that she would not have accommodation for herself or her children on returning from treatment, and that lack of housing would impact her chances of having her children restored to her care.

Vivian felt angry and distressed that she was not given a choice in how she addressed her drug use. She was distressed that her parents were not allowed to care for their grandchildren even after committing to not attending the home. The distress and anger were assessed by the departmental staff as refusing treatment and denial of the impacts of her drug use.

The disempowerment in her choice of treatment left Vivian feeling defeated and powerless. Vivian's drug use increased to cope with the grief and loss of her children, and the frustration and hopelessness she felt. Vivian told her Vietnamese caseworker that she felt so much shame for herself and her family in the community, that she felt hopeless, and it would be better if she was not around anymore. When Vivian tried to access mental health support the health system triaged her primary concern as drug addiction, referring her alcohol and other drug services.

The caseworker strongly advocated to the Department for an assessment of Vivian's parents as potential caregivers for their grandchildren. This culturally responsive approach enabled the identification of culturally sensitive ways to support the family in understanding drug use and the associated risks of harm. The caseworker, who spoke Vietnamese, was able to clearly explain concepts and rules. As a result, DCJ authorised the grandparents to care for the children.

Vivian's parents deeply feared that contact with Vivian would lead to DCJ removing the children from their care, leaving her unsupported and isolated from those who she loved and needed most. This distress led to Vivian isolating and ceasing contact with her case worker. Despite this, the caseworker continued to make efforts to locate Vivian and encourage her to participate in a family action plan for change. The caseworker's persistence and nonjudgmental approach gradually built trust with Vivian, and she eventually agreed to see a counsellor.

Vivian's drug use increased as a means of coping with her situation. She lost her job and began experiencing financial distress, including difficulty paying rent, which led to arrears. The caseworker collaborated with Vivian and the community housing provider to establish a payment plan for the arrears and apply for Centrelink benefits. Vivian also agreed to access a

rehabilitation service. She successfully reduced her drug use and was supported by her GP and a counsellor while waiting for a spot in the identified rehabilitation program.

The agency continued to support the children in their placement with their grandparents while working with Vivian to achieve the goals of her family action plan, including advocating to the Department for the restoration of her children to her care.

Vivian's story demonstrates the impact of blame, shame and stigma in amplifying distress and contributing to risk factors that can lead to increased drug use. The 'village' approach to child-rearing was dismissed due to culturally non-responsive decision-making, without proper assessment of the family's support network. Cultural consultation and leveraging the strengths of cultural and community connections could have positively influenced outcomes for Vivian and her children. Approaching the contextual factors surrounding Vivian's drug use with compassion could have enabled better treatment matching and empowered Vivian with a sense of agency. Honouring Vivian's love for her children and keeping her connected to her family and support network might have prevented the escalation of symptoms, distress, and drug use, fostering connection and healing with her children sooner.

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