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The Alfred Felton Research Program

Promoting Safety and Well-Being for Children, Young People and Families

THE UNIVERSITY OF MELBOURNE

PROTECTING VICTORIA'S VULNERABLE CHILDREN INQUIRY SUBMISSION

ISSUE: CHILDREN EXPOSED TO PARENTAL ALCOHOL AND DRUG MISUSE

RELEVANT TERMS OF REFERENCE:

1.1.5 The benefits and characteristics of a public health model.
2.1.3 The role of specialist adult-focused alcohol and other drug services in early identification of and intervention with children at risk.
3. The quality, structure, role and functioning of: family services; statutory child protection services…; and out of home care.

KEY ASSUMPTIONS AND PRINCIPLES:

- Parental drug and alcohol misuse is a widespread phenomenon, diverse in nature, severity and duration, often occurring alongside other problems.
- The process of change in substance use tends to be complex and episodic: windows for influence may be fleeting, and service providers must take opportunities to engage wherever they occur. Services therefore need to be flexible and dispersed.
- Children's vulnerability and adaptation to parental substance use varies with their developmental needs and innate characteristics, and with their access to supportive, non-using adults.

SUMMARY OF RECOMMENDATIONS

Primary prevention and early intervention

1. Establish a cross-sectoral working party for whole-of-government policy development and public education with a health promotion and social inclusion focus, in relation to parental substance misuse and the effects on children.
2. Enhance the capacity of the perinatal and maternal and child health systems to respond sensitively and effectively to improve outcomes for children and parents.

Secondary prevention

3. Establish a program of child and family responsiveness development within the drug and alcohol service sector.

4. Extend each Family Service Alliance with active Alcohol and Other drug service membership, for family service improvement and joint program development and training. Align this development with related extension of the family violence service system.

Tertiary intervention

5. Urgently revise and promote the use of the Child Protection/Alcohol and Other Drugs Protocol, with a view to including the service system developments with Child FIRST and the Integrated Family Services program, and establishing a common approach.
6. Pursue with FaHCSIA options for building on the work of Counting the Kids/ Kids in Focus model of child sensitive casework/case management and groupwork with families affected by parental substance misuse.
7. Prioritise the practice implications of parental substance misuse for the protection and care activity sequence, both within Child Protection and Family Services training and in the leadership work of the Principal Practitioner Child Protection and Family Services. Again, this development should and could occur with similar work with the family violence sector given the extent of co-occurrence.

BACKGROUND AND LITERATURE:

A public health model

Australia's *National Drug Strategy 2010-2011* draws attention to the large economic, social, health and legal costs to our society of problematic alcohol and drug use. It notes the immediate and long-term negative effects on children of household drug misuse and also how their exposure to parental drug use leads to intergenerational patterns of misuse and harm. *The Protecting Victoria's Vulnerable Children* inquiry presents a significant opportunity for Victoria to confront this seriously damaging social issue through a whole of government approach.

Scott (2006) has argued that: "While a legal model of child protection is necessary to protect a small number of abused and neglected children, a public health model has much greater potential to reduce the level of child abuse in the community." (p 11) She identifies the key features of such a model as: a focus on populations as entities; an emphasis on health promotion and disease prevention; developing new systems for better outcomes; and tackling underlying causal and contributory factors. Jordan and Sketchley (2009), focusing on the abuse and neglect of infants (a group particularly vulnerable in situations of parental substance misuse), apply this model but also draw attention to the place of secondary and tertiary preventive interventions in any public health model. It is an issue raised in the NT Inquiry to ensure that there is a layer of 'responsive regulation' within the public health model (Bamblett et al, 2010). The National Framework for Protecting Australia's Children 2009-2020 also proposes a public health "pyramid", developed from a broad base of universal initiatives to support all families and children, with progressing reducing numbers of initiatives offering early intervention to vulnerable families of children, then targeted services for those "at risk", leaving a small population of children as the responsibility of statutory protective services. The authors of the

Framework acknowledge, though, that: “In reality, Australia’s child welfare services more closely resemble an hourglass than a pyramid”. (p8)

In this submission we suggest that there is still much to be done if we wish to realize a public health model for reducing risk to children from parental substance abuse, but it provides a useful tool for reviewing the present array of services and proposing new developments at each level. Even so, the nature of the relapsing substance use and misuse case trajectory means that there is no simple progression of clients through the primary/ secondary/tertiary service spectrum, but a family might cycle through the levels of service quite quickly. It can also be argued that, as substance misuse can set up a destructive inter-generational chain of effects, all intervention tailored to the needs of children whose parents abuse substances can be seen as early intervention, preventing not only immediate harm to these children, but also their later adolescent and adult drug use and, in turn, their own parenting difficulties. Constructive intervention on behalf of infants is particularly crucial, both for their immediate safety and development and for the longer term outlook for the family.

A focus on populations: Estimates of prevalence

It is difficult to extricate the issue of substance misuse from the social conditions in which it thrives, including financial strain, social disadvantage, poor housing, depleted neighbourhoods, stressed and stressful social networks. While alcohol and drug use crosses the boundaries of social class, children’s outcomes often reflect the degree to which their lives began or became impoverished, with the loss of income, housing, positive social networks and social support. Dawe, Hartnett and Frye (2008) estimate that approximately 13% of Australian children 12 years or less are exposed to an adult who is a regular binge drinker, and just over 2.3% are living in a household with a daily cannabis use. They note the difficulty of estimating the numbers of children affected by these and other drugs such as methamphetamines and opiate use, given the hidden nature of some use and the reliance on self report or in-treatment populations when counting incidence. They conclude that a “substantial number” of children are affected. In addition, of course, tobacco addiction is widespread, and often occurs in families using other drugs, exposing children to passive smoking and poor health models. The scope of the estimates suggests that most families will know of children in their network affected in some way by parental substance misuse, whether or not those children ever come to the attention of authorities as children at risk. Grandparents and other kin bear particular burdens of care (Dawe et al, 2007). In the light of this, a public health perspective on the issue does seem particularly appropriate.

Risks to children

There is now a large body of literature documenting the ways in which children can be harmed by parental substance misuse whether directly through the parent’s intoxication or withdrawal, or indirectly through the accompanying social conditions. Chief among these effects, as documented by Dawe et al (2008) are: periodic or chronic parental neglect of the child’s daily physical needs and safety; reduced responsiveness to the child’s emotional needs; a climate of suspicion and secrecy; and family financial and social isolation affecting the child’s school and community participation. Alcohol fuelled

violence has long been familiar within our community, and the co-occurrence of substance abuse and family violence raises serious concerns for the safety of women and children (Dawe et al, 2007; see also separate submission from Professor Humphreys on Children affected by family violence.) Connectedness to a primary caregiver (perhaps a well parent or kin), and to school and community activities, are often cited as protective factors. Such generalisations, however, hide many differences within the population, in terms of the nature, severity and frequency of the drug use; the resources available to ameliorate the impact; and the parents' own capacities and behaviour.

Of particular concern are risk and opportunities in the perinatal period. Children's exposure to substance use often begins during pregnancy and generally continues in an altered form in the postnatal period (Dunn et al, 2002). Pregnancy is the first time many women seek drug and alcohol treatment (Butler, 2007). Yet fear of judgment and gravity of consequences pose significant barriers to family engagement with service providers (Walsh & Douglas, 2009), particularly between substance-dependent parents who may be concerned with the risk of child removal, and service providers who are often subjected to hostility by substance-affected, anxious parents (Buchanan & Corby, 2005; Forrester & Harwin, 2008; Taylor & Kroll, 2004). The illicit nature of some drug use and the link with criminal activity can heighten workers' fears for their clients and for themselves.

The risks to children of parental substance misuse are very evident in the child and family service sector. Dawe at al ((2007) conclude that:

> Parental substance misuse is a key feature of families identified by child and protective services. Although figures vary considerably, it is notable that most studies suggest that at least half of families identified by child and protective services have a profile that includes parental substance misuse. (p 11)

From a public health perspective, the major concerns are: the dearth of community-wide public education and support for children whose parents misuse substances; the paucity of drug-sensitive services at the secondary level within the child and family sector and of child-sensitive services within the alcohol and other drugs sector; and an over-reliance on statutory protection and care responses, which come after children have already suffered and which deter help-seeking in affected populations generating tensions between the child and family workers and adult-focused alcohol and drug workers.

A problem bigger than Child Protection

Almost a decade ago, the UK report *Hidden Harm: Responding to the needs of children of problem drug users* (Advisory Council on the Misuse of Drugs, 2003) documented a wide ranging inquiry and comprehensive detailed recommendations (many of which would apply equally to Victoria today) in this area, that have guided many service developments across the UK since. It pointed to a need for whole of government approaches, and emphasized the need for active collaboration between the drug and alcohol and child and family service providers. Both that report and Australia's *Drug use*

in the family: impacts and implications for children (Dawe et al 2007) provide a sound base for concerted action on this issue.

CONSTRAINTS AND OPPORTUNITIES IN THE CURRENT VICTORIAN SERVICE SYSTEM

Primary prevention and early intervention

Although the alcohol and other drug sector has a long history of public education efforts in areas such as smoking, drink driving and more recently binge drinking, neither that sector nor the child and family sector has given comparable attention to parenting issues and the impact on children when parents misuse substances. Widespread information about the impact of drinking in pregnancy is a welcome exception. Within the health sector, prenatal screening and assistance is available to women who use, but many miss out through late presentation to the obstetric system for fear of scrutiny. While substance use, especially alcohol, remains widely accepted as normative in our society, serious misuse, particularly of illicit drugs, remains socially stigmatized, deterring help-seeking in many instances. Nevertheless there are venues for help.

Tsantefski (2010) researched the experience of 22 mothers presenting to the Royal Women's Hospital Women's Alcohol and Dug Services (WADS) in pregnancy, and followed them up for one year. She found them very receptive to the support available from the hospital during pregnancy, and several were open to the involvement of Child Protection during the pregnancy if it meant that early help could be provided. (Pre-birth notifications to Child Protection and intervention with unborn babies occurred on an ad hoc basis under the previous Act; they are now legitimated under the *Children, Youth and Families Act* 2005.) Some mothers would have preferred the maternity hospital social workers to keep contact after the birth, as they had developed trust with them, but for some this trust was eroded with the escalation of anxiety and child protection involvement after the birth. There were missed opportunities for constructive early intervention when referrals to community services, such as family support, were not actively nurtured and did not result in services being offered, but the methadone-using new mothers did see their General Practitioners for their methadone and would take their babies with them, and they also kept up with maternal and child health appointments, seeing the nurses as helpful.

Tsantefski (2010) found mothers highlighted the lack of detoxification and rehabilitation programs or continuity of support for the family unit following infant discharge from hospital. Also, although most of the infants in that study met the criteria for a Family Group Conference (FGC), that is, they were at risk of removal from parental care by virtue of exposure to continuing parental substance use, and in many cases, family violence, there was only one FGC across a 12 month period. This is a significant omission as inclusion of the extended family increases safe retention of children in kinship networks, promotes placement stability, and reduces the time spent out of parental care (Connolly & Smith, 2010).

While the obstetric setting and the Maternal and Child Health service provide windows of opportunity for help for mothers and babies (to fathers to a much lesser extent), there

is a significant gap in visibility of children until they enter school, where once again there is a need for positive engagement with parents and strong links to both the child and family and drug and alcohol service systems.

Recommendations:

1. That the Department of Human Services prioritise policy development and public education with respect to parental substance misuse with a cross-sectoral standing committee/working party, including representatives of Child Protection, Family Services, Drug and Alcohol services, health services and family violence services. Representation from alcohol and other drugs consumer/recovery groups and from Create would be helpful. A whole-of-government health promotion and social inclusion focus is needed, emphasising the needs of children, mothers and fathers, and the role of the community in supporting them.
2. That, as with the recommendations in relation to the family violence sector, the perinatal and maternal and child health services be strengthened in their capacity to respond sensitively to parental substance misuse in order to maximize the opportunities for safe and mutually rewarding early parenting experiences for parents with drug-related health issues.

Secondary prevention

The entry of parents to an *alcohol and other drugs treatment agency* is an important window of opportunity for help for their children, because parents often trust their drug and alcohol workers. We need a system of multiple doorways to service, with no wrong door, in order to capture moments of readiness for change. Although this sector has been focused on treatment and harm reduction for adults and some young people, with limited specific attention to the challenges of parenting, there have been some promising initiatives. It does appear that drug and alcohol workers are now more aware of children and more willing to ask after their well-being than in the past, but this is not a systematic practice. FADNET (the Family Alcohol and Drug Network), a group of drug and alcohol workers interested in making services more child and family friendly, meets regularly and has hosted staff development workshops. It has not yet achieved a spread of influence comparable to the now national Children of Parents with a Mental Illness (COPMI) initiative, for many reasons, but including, perhaps, the relatively high social stigma of drug misuse, and the lack of strong public consumer voice from either the parents with drug issues or their children.

Despite some long held fears that providing child-related service sin drug and alcohol settings might shift the focus from the needs of adult clients and deter clients who are parents from asking for help with their drug problems, specific services for children within Victorian drug and alcohol services have shown that these negative effects need not be feared. Examples include: Moreland Hall's Intensive Playgroup for parents and young children; Windana's family program; Odyssey House's development for the Department of Human Services of the Parenting Tool Kit for alcohol and drug workers, and its "Nobody's Clients" research project and "Counting the Kids" initiatives. The latter program has continued under Commonwealth Government family support program as "Kids in Focus", with three-year funding, in conjunction with Good Shepherd Youth

and Family Services and Glastonbury Child and Family Services, but with only one funded program for the State it has limited reach. Though intended as an early intervention program, such a specialist service inevitably attracts clients with serious and long term needs, and demonstrates the need for more specialist secondary intervention programs that can continue working intensively with families even through their journey through the protection and care system from time to time.

Despite the prevalence of drug and alcohol use in its target population, the *child and family services sector* has had few initiatives targeting substance using parents, apart from the visionary Substance Abuse Family Support Service initiated by St Anthony's Family Services (MacKillop) with Commonwealth money well over a decade ago, and a very small State funded Alcohol and Other Drugs parenting support services (through Kildonan and Uniting Care Connections) for parents in drugs and alcohol supported accommodation, which unfortunately did not continue beyond its pilot phase. Although not an AOD-specific initiative, one example of a community-based child and family program within a community development context, utilising intensive casework, mentoring and social inclusion strategies, is Family Life's "Community Bubs" program. This has successfully targeted parents with serious substance misuse issues, and provides a model of a service that reflects a public health approach while successfully managing risk to children from both parental substance misuse and from family violence.

These demonstration programs reflect the recommendation of Dawe et al (2008) for intensive parenting interventions targeted to this population, but such services are still not widely available across the State.

Recommendations:

3. That guidelines and incentives be created for parent and child programs within the drug and alcohol service sector, across the State, informed by those organisations (in both the drug and alcohol sector and the child and family sector) that have already developed such initiatives, and by FADNET. While advocacy for children is needed across the AOD service spectrum, particular attention must be paid to detoxification for parents with children in their care, and to recovery-oriented programs that help children and parents deal with the relational and lifestyle consequences of parental drug misuse. In particular the co-occurring issue of family violence will need to be addressed within this service matrix.
4. That each within the Integrated Family Services program, each family service alliance includes active representation of the drug and alcohol service sector, with a view to better informed family services programs and practices, collaborative service development and joint training.

Tertiary intervention

The Child Protection system has long recognized that drug and alcohol misuse (often in combination with mental health issues, violence, poverty and correctional issues) poses significant risk factors for children, and a Protocol between Child Protection and Drug and Alcohol services does exist, but appears to be marginal to practice, and does not appear to have been updated to take account of the introduction of Child FIRST and

Integrated Family Services. KPMG (2010) reported that while there is now a stronger imperative for child and family services to work with universal and specialist children's services, "Less progress is perceived to have been made with adult services, including mental health, disability and alcohol and drug services."(p28)

While there is a high representation of children of substance abusers in the protection and care population, services are not explicitly tailored to this aspect. There is a specialist drug and alcohol assessment practice guideline for child protection staff, but in the absence of strong inter-sectoral working relationships, there is a danger of misinterpretation of information gathered and of its significance in the life of the family. An example commonly given by AOD workers is the reliance of Child Protection staff on the results of urine testing for drug use, which may be a poor measure of a parent's drug use and parenting capacity. This appears to encapsulate a serious sticking point in cross-sectoral understanding: while the Alcohol and other drugs sectors primarily presumes substance misuse to be a health problem, the child and family sector (concerned as they are with the impact on children) tends to treat it as a behavioural, if nor moral, issue. The implications of these perspectives, and how they interact at the frontline of services, need to be understood and resolved collaboratively.

Prosecution of Protection Applications in these families can be difficult, as parenting practice can fluctuate between good and poor. Neglect is often the presenting issue, and as noted in other submissions (on Family Services and on Excluded Families) these cases are often not pursued and are referred on to the Family Services sector, where the funding model discourages the intensity and long duration of service that many of these families require, and that has been successfully achieved in the small Commonwealth -funded Counting the Kids (now Kids in Focus) program.

Once children are placed in care, family contact is often fraught with problems for children and parents alike. On the basis of a substantial file audit, Humphreys and Kiraly (2009) documented the many problems with family contact arrangements for infants in care, noting: "Substance abuse featured in the overwhelming majority of cases, usually involving both parents. Domestic violence was also prominent. Risk factors frequently coexisted."(p34) Given the grief, shame and guilt often reported by drug using mothers who have lost care of their children, the volatile trajectory of use and misuse, and the disrupted social and material circumstances around drug use, it is not surprising then that Humphreys and Kiraly found that in nearly half of all high frequency contact orders, contact visits were 50% or less of what had been ordered, largely because of parental circumstances (p36.)

Later case decision making, particularly reunification, is problematic because of the uncertain trajectory of recovery and relapse even for those parents who do wish to stop using, and because of the complications that arise from the association between substance abuse, mental health issues and domestic violence. Although the protective system is quite alert to infants born of substance dependent mothers, with the relatively low visibility of cumulative harm as a result of neglect, older children may enter care after considerable long-term deprivation and trauma, and their treatment needs and the support

needs of carers need to be acknowledged, in particular the grief and frustration of kinship caregivers, especially grandparents. (See separate submission on kinship care.) In this context, stability planning (whether reunification or permanent care planning) is made more difficult by poor practices in the protection and care process,and the alienation of parents from their children's best interests.

Recommendations:

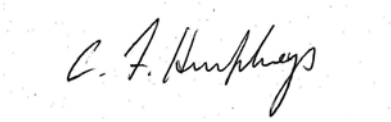
5. That the Department of Human Services urgently revise and promote the use of the Child Protection/Alcohol and Other Drugs Protocol, with a view to including the service system developments with Child FIRST and the Integrated family services program, alongside developments in the family violence sector and establish a common approach to these issues.
6. That the State government pursue with FaHCSIA options for building on the work of Counting the Kids/ Kids in Focus model of child sensitive casework/case management and groupwork with families affected by parental substance misuse to ensure continued and widespread program development of this intensive service which spans the secondary/ tertiary service spectrum.
7. That the practice implications of parental substance misuse for protective intervention, case planning, case management, the treatment of children in care, their contact with their parents, the needs of their carers, family reunification and stability planning be given high priority as a focus for practice enhancement and training through the work of the Principal Practitioner Child Protection and Family Services.

CONCLUSION

The exposure of children to serious parental substance misuse creates significant present and future harm for those children and for the wider society. Given the substantial knowledge base now available, it is perhaps regrettable that The *National Drug Strategy 2010-2015*, is not strongly oriented to the needs of children. Nevertheless, we highlight *Objective 2: Reduce harms to families*, and within this, calls for actions that 'Enhance child and family sensitive practice in alcohol and other drug treatment services and build links and integrated approaches with community, family and child welfare services' (Ministerial Council on Drug Strategy p29). We would also argue that 30 years of evidence of the significant co-occurrence of family violence and the cumulative impact on children of both family violence and drug and substance misuse requires that new developments and strategies take into account this interface.

It is impossible to imagine any improvement to Victoria's Child Protection and Family Services systems that does not confront this problem with new well-informed and wide-reaching strategies for harm reduction, parental recovery and family support and social inclusion. It is time for Victoria to act, and bi-partisan political support for a whole-of government nuanced approach to this very socially sensitive issue would be most welcome.

Signed



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Date 14th April, 2011

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