ODYSSEY HOUSE VICTORIA

PROTECTING VICTORIA'S VULNERABLE CHILDEN INQUIRY SUBMISSION

CHILDREN EXPOSED TO PARENTAL ALCOHOL AND OTHER DRUG MISUSE

RELEVANT TERMS OF REFERENCE:

1. The benefits and characteristics of a public health model in relation to child protection
2. The role of alcohol and other drug treatment as a specialist adult-focused service in the early identification of, and intervention targeted at, children and families at risk
3. The interaction of departments and agencies, the courts and service providers and how they can better work together to support at-risk families and children

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KEY ASSUMPTIONS AND PRINCIPLES:

- Children have a right to protection from harm, to participation in decisions that affect them, and to services for themselves in their own right *and* for those who care for them
- Substance-dependence is a key feature in many families where children are at risk of neglect and abuse: reducing the number of substance-dependent parents is likely to lead to fewer vulnerable infants and children
- Substance-dependence occurs in a psychosocial context, typically involving social exclusion, intergenerational transmission of problems and experiences of trauma, and it needs to be responded to within a public health approach in combination with a child-rights framework
- Assessment and intervention needs to consider the level and nature of parental substance use, its impact on parenting capacity, and to reflect that it is possible to be a substance-user and to provide adequate care for children
- Given the numbers of children impacted by parental substance use, alcohol and other drug treatment services need to form part of both National and State platforms for addressing child abuse and neglect through integrated service delivery
- Programs and innovations that facilitate greater community responsibility and engagement regarding children and families at risk should be supported
- Evidence-informed programs needs to be adequately and consistently funded

ODYSSEY HOUSE VICTORIA

Odyssey House Victoria (Odyssey) is recognized as a national leader in working with substance-dependent parents and their children. Odyssey has been at the forefront of promoting change in the alcohol and other drug sector to better respond to children and families affected by addiction through a 'no-wrong door' approach. Within its Therapeutic Community, Odyssey has operated an alcohol and other drug free residential rehabilitation program for parents and their children to improve outcomes for Victoria's most vulnerable families. The agency provides a range of additional services including: home-based support to parents and children through the Kids in Focus program; Supported Accommodation which caters for parents and children; the Family Eclipse program, a family inclusive intervention for young people aged 16-24 years with mental health and drug issues and their families; and the Stonnington Youth Precinct that brings together a number of services including local government to offer wrap around, coordinated services to young people experiencing alcohol and other drug issues.

CONSULTATIONS WITH CHILDREN, PARENTS AND STAFF

Odyssey has conducted a number of focus groups and consultations with children, parents and staff which inform this submission. A summary of these are included below.

Summary of children's comments:

- Children want support for themselves, including peer support with other children who have experienced similar things, in addition to support for their parents and other family members or carers
- Children want to be heard and to have their opinions and feelings respected and acted upon
- Children want most support to come from the informal network of family and friends
- Children want a hierarchy of strategies beginning with minimal intrusion into family life to removal from unsafe homes when warranted, with support for reunification after family problems have been resolved

"Do you know why I hate going to counselling? It's because she is old and wrinkly and pretends we are playing games when all she wants to know is my business. Well, it's none of her business and her office is ugly and all the kids in the waiting room always look sad. I told my nanny I'm not going back: I'd rather come to group. (Peer support/therapeutic group facilitated by Odyssey)" (Jaime, 10)

"To mainly help out the family I'd really focus on the children". (Joshua, 17)

"I think DHS needs to assess every situation before going in and doing something. Because, like, many of them, DHS has come in and taken them out of a safe situation and put them in a really dangerous situation, and they've told their DHS workers and nothing's happened… They should look at the situation in full, and then look at the parents' side from each of the parent's perspectives and everyone involved, and the kid, and, like, talk to the kid, and like talk to everyone, so they get how every single party feels". (Sophie, 15)

Summary of parents' comments:

- Parents report mutual mistrust with Child Protection and difficulty working with the service but nevertheless called for more, not less, home visits to facilitate improved assessment not based on hearsay, outdated or irrelevant information
- Parents acknowledged the negative impact of their substance use on children and expressed not only a willingness, but also a desire to engage with services to improve parenting practices and children's outcomes. They did emphasize that the potential for removal of children is a disincentive to honest engagement or treatment
- Parents expressed almost insurmountable problems dealing with the Children's Court including poor quality legal representation, insufficient time to prepare a case in response to Child Protection reports, challenges in proving a 'case' when the 'rules of evidence' may differ to other jurisdictions
- Parents understood there are situations in which children need to be removed from unsafe situations, but argued for more access with children in care and for greater support for reunification

"Child Protection tells you what to do but they don't help you to do it. Programs like Kids in Focus are helpful"

"With Child Protection, you are presumed guilty and have to prove you are innocent but honesty can get you into trouble."

"You need a guarantee that children will not be taken from you if you meet requirements in time."

Summary of staff members' comments:

- The response to children's needs within the AOD sector is largely idiosyncratic and determined, not only by worker skills and knowledge, but also by funding arrangements that either facilitate or impede intervention with clients' children
- Programs for families need to be outcome-based in recognition of the complexity of problems faced by substance-dependent parents and their children

- The AOD sector needs to be represented in Child First alliances
- Non-stigmatized, long-term, cost-effective support for families needs to be further developed and more widely implemented

"Substance use is not really the problem; it's the parent's solution to perceived problems, it's the way they've coped in the past."

"If you're involved with the family, you need to look at the family as a whole and to have the safety of children as the priority."

"We need to be truly working in partnership with statutory agencies."

SUMMARY OF RECOMMENDATIONS

Recommendation 1: As a primary prevention measure, parental substance-use needs to remain on Victoria's public health agenda with particular emphasis placed on the harm caused to children by alcohol misuse

Recommendation 2: Reform to service models is needed to ensure that AOD providers routinely identify and address, either through direct service provision or referral, the parenting support needs of their clients and the needs of their clients' children, and that centralized data systems capture and acknowledge this work

Recommendation 3: Practice guidelines and protocols for services involved with parents and children need to be developed as a matter of priority; these guidelines should be based on a public health approach and support notification to Child Protection as a last resort

Recommendation 4: AOD services need to be integrated with Child First alliances for effective collaborative practice involving Child Protection, Family Services, Mental Health, Domestic Violence and the AOD sector with scarce resources targeted to socially excluded families

Recommendation 5: Ongoing training for workers including Child Protection, family support, the alcohol and other drug sector, mental health and domestic violence services is needed to build relevant knowledge and skills and to better support families and children and to improve inter-sectoral collaboration

Recommendation 6: Innovations in practice need to be evaluated and disseminated across adult-focused service, particularly within the AOD sector where large numbers of substance-dependent parents are service users

Recommendation 7: Operational guidelines for intervention with substance-dependent parents and their children need to be developed and/or revised and to include other services that come into contact with vulnerable children and parents, notably the DV sector, mental health and the child and family support sector, including Child Protection

Recommendation 8: Services need to be adequately resourced with appropriate targets, data systems and service models so that service coordination with shared treatment goals can be better supported, duplication reduced, and workers encouraged to make better use of secondary consultation and cross-sector referrals

Recommendation 9: Comprehensive models of care linking obstetric providers and AOD services, as practiced in the U.K., the U.S. and Canada, need to be introduced to engage pregnant substance-dependent women and their partners, monitor the safety and wellbeing of infants, and to improve family functioning at a critical time in the family life-cycle where there is not only heightened risk but also potential for early intervention

Recommendation 10: The chronic, relapsing nature of substance-dependence, and the negative impact on children, needs to be addressed through outcome-based funding for flexible, enduring service provision, and to include cost-effective innovations to practice that support greater community responsibility for child safety and wellbeing e.g. Mirror Families that create sustainable networks for children to reduce the risk of maltreatment by building protective factors; some service provision needs to be directed to children in their own right

Recommendation 11: Alternative approaches to Child Protection retaining case-management for families well-engaged with services need to be considered to allow parents to acquire skills and practice new behaviours in a safe environment that simultaneously facilitates monitoring and sharing of risk between services, eases burden on the tertiary child protection system and reduces service duplication and/or multiple case managers

Recommendation 12: The voices of children, parents and other carers need to be heard in decisions that affect them; changes to legislation are required to ensure Family Group Conferences become, and remain, central to child protection practice when children are at risk of removal from parental care and that the Children's Court becomes less adversarial

BACKGROUND AND LITERATURE

A public health approach to child protection within a child-rights framework

Public health approaches, which emphasize monitoring, prevention, cost-effectiveness, and population strategies, are commonly applied to medical issues but also have much to offer in addressing child abuse and neglect, which is more typically responded to with a protective approach emphasizing the legal and professional response to maltreatment (Reading et al, 2009). The extent to which the latter approach has successfully reduced incidence of child abuse and neglect in Australia is questionable. The National Framework for Protecting Australia's Children 2009-2020 (Commonwealth of Australia, 2009) indicates that cases of substantiated child abuse and neglect doubled in the decade prior to publication of this key Federal policy document. The increase in substantiated cases of child abuse and neglect has corresponded with an increase in the use of out-of-home care. These figures represent changes to social values and community standards that reflect concern regarding the impact of adult issues, particularly frequently co-occurring factors such as substance-use, mental health and domestic violence on infants and children. The children of substance-dependent parents, the focus of this submission, are over-represented in child protection samples nationally; they comprise a significant number of children in out-of home-care, which they tend to enter earlier, and to remain in longer (AIHW, 2007). Rising numbers of children in out-of-home care largely reflect the duration of time spent out of parental care, rather than an increase in the numbers of children entering care (Ombudsman Victoria, 2009). The net result is a system described as at risk of collapse (Scott, 2006). Clearly, a shift in policy and practice is needed to stem the flow of children in out-of-home care, while ensuring increased responsiveness to child and family needs prior to the development of serious problems warranting removal of infants and children from parental care. A public health model prioritizing universal support for all families, with more intensive early intervention targeted to families where there are infants and children at risk of abuse and neglect, while reserving the statutory child protection system as a last resort (Commonwealth of Australia, 2009), offers a sustainable way forward.

A public health approach may best promote children's safety and wellbeing within a child rights framework. As a core strategy, both aim to change legislation and policy, and the integration between approaches may yield the best results. From a child rights perspective, risk factors are reformulated as violations of children's rights to protection, participation and provision: these rights are indivisible and without hierarchy (Reading et al, 2009). To date, the legal and

professional response to child abuse and neglect in Victoria, and Australia more widely, has largely focused on the right to protection; participation and provision are yet to be adequately conceptualized or operationalized in legislation, policy or practice (Tobin, 2008). The U.N. Convention on the Rights of the Child (UNCRC) prioritizes the interests of the child while upholding the rights of parents. It also expresses the state's obligation to support families in their care of children through services to parents and other carers.

Reading et al (2009) point out that there are three interrelated issues at the heart of child protection legislation, policy and practice: the role of parents in relation to the state when there is disagreement about child's need for protection; the scope of the state's intervention; and the nature of government intervention. Nowhere are these issues more pertinent than in the context of parental substance use, which from a public-health model is a major risk factor for child abuse and neglect, but it is also a major child-rights issue that has long remained hidden or neglected (Reading et al, 2009). The UNCRC draws attention to the need to protect infants from illicit use of narcotic drugs and psychedelic substances and violence (Article 33); the parental factors most prevalent among child protection samples internationally (Forrester & Harwin, 2006; Hogan, 1998). Article 3(1) of the UNCRC expresses the 'best interests' principle as a primary consideration rather than the only consideration in decisions or actions concerning children. As infants are highly vulnerable and unable to make decisions or take actions on their own behalf, it is reasonable that Article 3(1) should guide policy and practice, particularly as Article 19 draws attention to the child's right to protection from abuse from those who have care of him or her including parents, legal guardians or others. However, compliance with Article 3(1) distorts the integrity of the UNCRC unless the document is considered in its entirety. The rights and duties of parents and legal guardians are highlighted in Article 3(2), while Article 3(3) points to the need for provision of institutions, services and facilities for the protection and care of children. Also mentioned, but often unnoticed, are the child's rights to social programs to provide necessary support for the child *and* for those who have the care of him or her (19.2) and the child's right to non-interference in the family except for when his or her best interests are not met (Article 16.1) (Tsantefski, Humphreys & Jackson, 2011). As human rights are interdependent, indivisible and without hierarchy, the Articles need to be considered as whole to maximize the potential for infants and children to remain safely with parents, or when this is not feasible, to increase the likelihood of removal in a timely manner with placement in an appropriate family environment (Reading et al., 2009).

As a major provider of services to families affected by parental substance-use, with the only family residential alcohol and other drug treatment service funded by the State Government, and as the only provider in the State of Victoria of the federally funded Kids in Focus (KIF) program, Odyssey House Victoria (Odyssey) is well-placed to provide the perspective of both the service provider, and following a recent consultation process with clients, the service user, on child protection in Victoria. The remainder of this submission will draw upon relevant literature, the experience of Odyssey in researching and addressing the needs of the children of substance-dependent parents, and the agency's extensive experience in providing residential and home-based services to parents and children through the "Nobody's Clients" Project, Counting the Kids and Kids in Focus programs. The voices of children and parents, often marginalized and rarely heard, will be used to illustrate how protection, provision and participation can be achieved to enhance outcomes for families.

PROTECTION

From a public-health perspective, child protection can be improved by strategies that reduce demand for drugs by parents at a whole of population level (while supply reduction is an important component of Australia's Harm Minimization Framework, receives considerably greater resources, and may not be as effective as demand reduction or treatment). Prevention is also an important component of a public health campaign to reduce adolescent substance use which can progress into adult life to become a parenting issue. The burden of disease associated with alcohol is extremely costly but has not been afforded the same level of attention as other drug use. While much stigma has been directed towards pregnant women who use illicit substances, there is little evidence in the literature to suggest that these substances cause long-term developmental problems for children in the absence of poor maternal nutrition, infection or antenatal care (Elgen et al, 2007). The same cannot be said for the two most widely used drugs in Australia: alcohol and tobacco. There is significant evidence linking both with detrimental effects on neonatal, infant and long-term child outcomes (Johnson, Vicary, Heist & Corneal, 2001). As 80% of Australian women consume some alcohol during pregnancy, and the effects of low to moderate alcohol intake on the unborn child are unclear, greater emphasis needs to be given to the risk of foetal alcohol spectrum disorder (FASD) in public health campaigns (Powers et al, 2010). Although some progress has been made, this message is especially pertinent to marginalized groups among whom public health campaigns have been less successful. Advertising for alcohol could be further regulated or banned.

Recommendation 1: As a primary prevention measure, parental substance-use needs to remain on Victoria's public health agenda with greater emphasis placed on the harm caused to children by alcohol misuse

Families involved with Child Protection (CP) in Victoria (Campbell et al, 2000) and other Australian jurisdictions tend to be the most marginalized and disadvantaged in the community (Harries, Lonne & Thomson, 2007). Frequently co-occurring risk factors, in addition to almost all pervasive poverty, include psychiatric disability (18%), family violence (52%) alcohol (42%) and substance abuse (41%) (Humphreys, 2007). Substance-use and family violence feature heavily among families who are re-notified (Victorian Department of Human Services, 2007). Families are likely to enter the service system at various points, including alcohol and other drug treatment services, all of which offer some potential for prevention or intervention. However, the primary role of alcohol and other drug (AOD) services is treatment for problematic substance use, which is reflected in funding arrangements that count the number of adult clients only. This is a serious impediment to family-focused intervention as it acts as a disincentive for workers' time and efforts in acknowledging or addressing children's needs. Various data sets are in operation without a centralized data system which make it more difficult for policy makers and service providers to understand and respond to children's needs.

Recommendation 2: Reform to service models is needed to ensure that AOD providers routinely identify and address, either through direct service provision or referral, the parenting support needs of their clients and the needs of their clients' children, and that centralized data systems capture and acknowledge this work

Odyssey works in accordance with the principles of harm minimization which underpin the AOD sector. The agency acknowledges the chronic, relapsing nature of substance-dependence, which generally occurs within the child bearing years, and the need to protect children from harm, and attend to their developmental needs, while engaging parents in treatment. However, harm minimization can conflict with abstinence requirements sometimes adhered to by CP (Jackson & Klee, 2002; Humphreys, Regan, River & Thiara, 2005) to become a barrier to effective intersectoral collaboration. There is, therefore, an urgent need for practice guidelines to reconcile these long-standing, conflicting policies for effective assessment and intervention. Careful use of monitoring and sanctions need to be applied to prevent these becoming barriers to support or treatment, which would further isolate families and place children at greater risk of harm. In

order to establish and maintain real engagement, rather than compliance, parents need to receive non-judgmental services in a safe environment where they are able to make mistakes and acquire new skills without fear. At the same time, services need to ensure that the safety of children is being addressed. This requires some level of holding and sharing of risk, rather than simply shifting risk to the tertiary Child Protection service.

Recommendation 3: Practice guidelines and protocols for services involved with parents and children need to be developed as a matter of priority; these guidelines should be based on a public health approach and support notification to Child Protection as a last resort

The interface between the AOD sector and CP needs to be better developed and capacity built across service sectors. The AOD sector is largely reliant on linkages forged between individual agencies to ensure service provision and has a restricted role in working with parents and children. While the mental health sector is represented in Child First alliances, the KIF program, which regularly receives referrals from Child Protection, has not, to date, been included in this partnership. Integration of AOD specific family support with CP and Child First (Child and Family Information Referral and Support Teams) would help to bring the AOD sector in line with the Victorian *Child Wellbeing and Safety Act 2005* (which does not specify the role of adult services in relation to child wellbeing) by providing earlier, more intensive support to prevent tertiary intervention and out-of-home placement of infants and children. It would also support the *National Framework for Protecting Australia's Children* (Council of Australian Governments, 2009), specifically Supporting Outcome 3, which highlights the need to address major, frequently co-occurring risk factors for infants and children associated with parental mental health, domestic violence and AOD use. Integration between the AOD sector and child and family services, a readily rectifiable gap in service provision, would be a cost-effective strategy in improving collaborative practice. Scarce resources should be reserved for socially excluded families. Services (e.g. MCHS, AOD providers, family support and schools) could be co-located to improve intersectoral communication and collaboration and client access. Co-location could also facilitate joint staff training and the exchange of expertise among diverse service providers.

Recommendation 4: AOD services need to be integrated with Child First alliances for effective collaborative practice involving Child Protection, Family Services, Mental Health, Domestic Violence and the AOD sector with scarce resources targeted to socially excluded families

Family-focused interventions require skills in engaging parents and working with a range of presenting issues and concerns: mental health issues, social exclusion and intimate couple and/or family violence. AOD workers are skilled in assessing the effects of substances on individual functioning; however, skills and knowledge about children's needs are still very limited across the sector. Conversely, child-focused services do not see themselves as expert in issues related to substance-use. To date, there is no child-centred training in the nationally recognized and accredited Four Core Competencies in Alcohol and Other Drug Work**.** Training is needed by the AOD sector to increase workers' understanding of responsibilities under the *Children, Youth and Families Act, 2005*. Odyssey is currently developing a module on family-inclusive practice in collaboration with other Registered Training Units. If roll out of this unit is supported by government, it will assist workers to better consider the parenting support needs of adult clients and promote greater service coordination, leading to improved identification of and response to vulnerable children. The unit, however, is not specifically targeted to addressing children's own issues and support for these services needs to be maintained.

Recommendation 5: Ongoing training for workers including Child Protection, family support, the alcohol and other drug sector, mental health and domestic violence services is needed to build relevant knowledge and skills and to better support families and children and to improve inter-sectoral collaboration

The public health model is compatible with the philosophy of the AOD sector which typically views substance use as the presenting symptom that brings an individual into contact with services. As alcohol and other drug treatment services are often the first, or only, service accessed by substance-dependent parents, Odyssey attempts to work as holistically as possible with families, while prioritizing children's safety and wellbeing by utilizing a range of strategies, some targeted to whole families, others are directed to children (discussed further under Provision). Services to families include addressing the need for housing, education and financial assistance, assisting to build sustainable 'non-using' networks, providing parenting education and home-based support. Odyssey has specialist knowledge of alcohol and other drug issues, and the ability to engage parents in a therapeutic relationship that facilitates a 'one-stop shop' for substance-dependent parents, many of whom are reluctant to access family support programs through fear of scrutiny by service providers (Klee, 2002).

The Kids in Focus (KIF) program (discussed further under Provision) is an example of a family support program embedded in an alcohol and other drug treatment service. Families have readily embraced this program, and its predecessor, Counting the Kids (CTK). The success of these programs in reaching marginalized families suggests the need for specialist intervention programs targeted to specific populations. As such, both programs serve as innovations in practice that could be replicated in other services. In a report commissioned by FaHCSIA, by Courage Partners (2007) stated that CTK provided a model that can be applied and extended in other settings. CTK was externally evaluated and found to be effective in addressing parents and children's needs. Additionally, workers from within and beyond Odyssey reported changed attitudes and practices in their work as a result of collaboration with the program (Contole, O'Neill, Mitchell & Absler, 2009). It is understood there are risks in replicating services that are not effective (Salveron, Arney & Scott, 2006). As both evaluations largely relied on qualitative methodology, which is generally not considered 'gold-standard' research, it is important that programs such as these are rigorously evaluated, and if shown to be promising, to be disseminated across adult services, particularly the AOD sector where attention to family needs is not as developed as the mental health sector (Scott, 2009).

Recommendation 6: Innovations in practice need to be evaluated and disseminated across adult-focused service, particularly within the AOD sector where large numbers of substance-dependent parents are service users

The recent focus group with staff, conducted as part of the agency's preparation for the current submission, indicated lack of consensus regarding the extent to which a child-focus has permeated practice across Odyssey, with some arguing this is still largely limited to specific programs, for example, KIF and Supported Accommodation, which routinely provide services to families. Staff discussed limited understanding of child-centered practice across the AOD sector and the need for continuous work-force development, including between domestic violence, mental health, family services, obstetric providers and alcohol and other drug treatment. For example, the Victorian Government document *Towards a New Blueprint for Alcohol and Other Drug (AOD) treatment Services: A Discussion Paper* (Victorian Department of Human Services, 2007b) mentions families but is still focused on treatment for adults. The existing *Protocol between Drug Treatment Services and Child Protection for Working with Parents with Alcohol and other Drug Issues* (Victorian Department of Human Services, 2002) a little known, and rarely used document, needs to be updated, particularly since it pre-dates Child First. The association

between substance-dependence and domestic/family violence is of serious concern, not only between parents or adult partners, but also from parents to children and from adolescents and young adults towards parents. However, domestic or family violence is rarely identified or addressed within AOD services. The overlap in characteristics of families involved with CP-alcohol and other drug use, domestic/family violence and mental health-suggests urgent need to align the disparate services that address these parental factors with the child protection system more broadly. A shared framework, or universal screening tool, should be considered for all services working with vulnerable children and families.

Recommendation 7: Operational guidelines for intervention with substance-dependent parents and their children need to be developed and/or revised and to include other services that come into contact with vulnerable children and parents, notably the DV sector, mental health and the child and family support sector, including Child Protection

Odyssey endeavours to work collaboratively with Child Protection when significant risk to an infant or child has been identified. Even within Odyssey, there is significant variation among staff members and programs in the required skills and knowledge to do this within funded practice models. Staff members report a shared perception that most AOD workers are regarded as "blind, deaf parent advocates" by Child Protection workers. However, Odyssey's recent focus group with its own staff members indicated lack of consensus regarding the extent to which a child-focus has permeated the practice across the agency, with some arguing this is still limited to specific programs such as KIF, the Therapeutic Community and Supported Accommodation, which routinely provide service to families. Staff concurred there is limited understanding of child-centred practice across the AOD sector and agreed upon the need for continuous joint work-force development with domestic violence, mental health, family services, CP and obstetric providers. The AOD sector needs a highly skilled workforce able to respond to the complexity of client needs. Workers need career structures and pathways to ensure that skilled workers remain in the sector and support those at the frontline of practice.

Recommendation 8: Services need to be adequately resourced with appropriate targets, data systems and service models so that service coordination with shared treatment goals can be better supported, duplication reduced, and workers are encouraged to make better use of secondary consultation and cross-sector referrals

PROVISION

The prevalence of substance use among child protection samples, locally and internationally, has resulted in a 'daunting' need for service provision (Jones, 2004 p. 47). The UNCRC acknowledges that availability of resources is problematic for child protection and other service providers (Mathews, 2008). It is unlikely there will ever be sufficient funds to fully deal with the scale of parental substance use. Clearly, more needs to be done within existing service systems: a move beyond inter-professional and inter-organizational communication and collaboration is overdue and needs to involve shared community and professional responsibility for children.

There has been an increase in notifications of unborn infants since introduction of the *Children, Youth and Families Act 2005* (enacted in 2007) which formalized pre-birth reports to Child Protection, however, the service system has been unable to intervene in an effective and timely manner (Ombudsman Victoria, 2009). A human/child rights approach has successfully been used to advance maternal and child health in the developing world (Gruskin et al, 2008) and could be used to tailor services to highly vulnerable mother/infant dyads in the local context. Although Victoria has provided legal sanction for Child Protection involvement with unborn babies, the infants of substance-dependent women are largely over-represented in child protection samples, locally and nationally, which is reflected in numbers in out-of-home care (AIHW, 2007). Most infants are placed within the first two months of life (Humphreys & Kiraly, 2009) with potentially serious consequences for attachment and long-term outcomes. Infants are also over-represented in annual child death reviews, particularly when substance-use, mental illness and domestic violence are present (VCDRC, 2008). While infant vulnerability must be acknowledged, it is important that child deaths do not drive reactive child protection policy which may cause greater harm to significantly larger numbers of children (Connolly & Dolan, 2006) and that support to whole families is available to enable parents to provide adequate care. Research conducted by Odyssey's Institute of Studies indicates that substance-dependent parents are accepting of services targeted to the needs of their children (Gruenert, Ratnam & Tsantefski, 2004). The Victorian Maternal and Child Health Service (MCHS) is a critical early intervention and prevention strategy with widespread community support. All women in a study of substance-dependent mothers in the first year of their infant's lives reported regular contact with the service (Tsantefski, 2010).

Clearly, infancy offers a valuable opportunity for early intervention but more can be done to engage women during pregnancy and to reduce the likelihood of Child Protection intervention in the postnatal period. Many substance-dependent women first seek alcohol and other drug treatment during pregnancy (Butler, 2007). Early engagement with services is more likely to result in open disclosure of substance-use, more information seeking, increased referral options and supportive, voluntary engagement with services rather than mandated intervention (Macrory & Harbin, 2000). However, we are yet to see the types of services for substance-dependent pregnant women in operation in the U.K. (Macrory & Harbin, 2000; Macrory, 2002; Scully et al, 2004), the U.S. (Arthur & Gerken, 1998) and Canada (Marcellus, 2002) that bridge the gap between obstetric providers and alcohol and other drug treatment agencies. Postnatal support could assist in monitoring at-risk infants after discharge from hospital, contribute to improved health of all family members, increase AOD treatment by parents and assist them to work towards achievable family goals including changing the domestic and social context in which drug use (Klee, 2002) and family violence occur (Humphreys, 2005).

Recommendation 9: Comprehensive models of care linking obstetric providers and AOD services, as practiced in the U.K., the U.S. and Canada, need to be introduced to engage pregnant substance-dependent women and their partners, monitor the safety and wellbeing of infants, and to improve family functioning at a critical time in the family life-cycle where there is not only heightened risk but also potential for early intervention

There is still a paucity of evidence-based interventions and programs within Australia for children of substance-dependent parents but there is evidence to suggest that programs, designed for other populations are unlikely to be effective partly due to the need for long-term work with both parents and children. The evidence that is available suggest the need for ecologically-based interventions of sufficient range, intensity, duration and flexibility to target multiple domains of child and parent functioning with small caseloads of four to six families per worker and interagency liaison and case-management to coordinate services (Dawe, Harnett & Frye, 2008) with *direct support to children in their own right* (Dawe & Harnett, 2007). Yet most services are short-term and restricted in their focus, addressing parenting or substance-use and are therefore unlikely to provide the range, intensity or duration of support required to improve child safety and wellbeing or family functioning. Services need to be flexible and targeted to the needs of individuals and families with assertive case-management as a core component (Dawe & Harnett, 2007). With this in mind, Odyssey administered the Counting the Kids (CTK) program between

2005 and 2010. The CTK model was to support a small number of families with the most intractable problems, including parental histories of significant substance use, mental health and incarceration, while providing secondary consultations and training to workers from the alcohol and other drug sector and child and family services. Key features included flexibility to respond to family needs. For example, at times of heightened risk to children, the program increased the number and duration of visits to the family home, with two or more workers engaged with some families during critical periods (Contole et al., 2009). The current program, KIF, extends the work commenced by CTK by addressing significant gaps in service provision, notably:

- respite care, which enables parents to access detoxification and rehabilitation services, reduces parenting stress and increases children's own networks
- long-term, enduring support for families through the Mirror Families Project to build and strengthen enduring social networks, increase protective factors, improve developmental trajectories, and to reduce the likelihood of children's placement in out-of-home care.

Both programs have been funded by the Commonwealth Government's Strengthening Families Program, as part of the National Illicit Drug Strategy, through the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and have demonstrated the ability of an AOD provider to: identify and address risk to infants and children; reduce the need for mandated intervention; and assist parents retain children safely in their care, thereby reducing burden on tertiary Child Protection service and out-of-home care.

KIF receives referrals from a range of sources, Child Protection among them. Families receive flexible, in-home support until children's protective concerns and adult factors have been addressed. The program is largely reserved for excluded families (please refer to the submission by Dr. Gaye Mitchell and Dr. Lynda Campbell on the need for a new approach to excluded families) with entrenched AOD use and other problems known to seriously compromise parenting capacity and children's outcomes: family violence, transience, poverty and unemployment. Approximately 90% of families accessing the service have a dual diagnosis. The functioning of a small number of parents is affected by acquired brain injury or intellectual disability. As parental factors are sometimes only minimally amenable to intervention, *the program focuses directly on children* where differences in outcome are more likely. The vast majority of children remain with their families. KIF aims to increase social and emotional wellbeing in children by:

- addressing psychosocial problems including experiences of trauma through individual counselling and therapeutic group-work
- improving school attendance rates and levels of school connectedness
- increasing participation in social and recreational activities
- providing school holiday programs (times of high parenting stress)
- detecting developmental delays and referring to early intervention programs

Brokerage funds are critical to the program's ability to facilitate children's engagement with the wider community (sporting and recreational services), to addressing material deprivation (e.g. purchasing of school uniforms) and to enhancing educational outcomes (e.g. through tutoring). Respite care, which is generally only available at the tertiary end of the Child Protection spectrum through the out-of-home care system, is included as a primary prevention and early intervention service through linkage with family support. Mirror Families, an important innovation, is a departure from current practice which is largely reliant on service providers to deliver short-term interventions for chronic problems which generally results in the most vulnerable children being repeatedly renotified to CP without resolution of family problems (AIHW, 2009). The aim is to support children through to adulthood through formal intervention in the informal network. The aim of Mirror Families is to create enduring, self-sustaining networks that do not rely on service providers (Brunner & O'Neill, 2009). With sustained engagement, most parents have either ceased or significantly reduced AOD use. The vast majority of children remain with their families. A telephone advice line provides secondary consultations to workers from the federally funded Family Support Program to assist workers identify risk and protective factors for children and to support effective interventions with families affected by parental substance use.

As with CTK, KIF is federally funded: Short term tendering cycles risk loss of expertise from programs when workers left due to job insecurity. While the State Government needs to assume greater responsibility for programs targeted to the most vulnerable children in the community, the community generally needs to assume more responsibility for children rather than pushing responsibility onto service providers, particularly the tertiary child protection system. KIF is an expensive program that aims to build safety nets around children through greater community involvement in child protection. The program aims to be cost-effective through reduced need for mandated intervention, reduced reliance on Contested Hearings in the Children's Court, and reduced numbers of infants and children entering or remaining in the out-of-home care system.

Recommendation 10: The chronic, relapsing nature of substance-dependence, and the negative impact on children, needs to be addressed through outcome-based funding for flexible, enduring service provision, and to include cost-effective innovations to practice that support greater community responsibility for child safety and wellbeing e.g. Mirror Families that create sustainable networks for children to reduce the risk of maltreatment by building protective factors; some service provision needs to be directed to children in their own right

Programs such as Kids in Focus are regarded as helpful by parents who called for more AOD sensitive family support. Parents regarded the shortage of detoxification and rehabilitation programs as serious gaps in service provision. One Odyssey staff member drew attention to the fact that there is no long-term family rehabilitation service able to take children over twelve years of age. As the AOD sector currently works with a high proportion of men, treatment programs and interventions, including detoxification and rehabilitation, need to be targeted to the specific needs of women. More services could also be directed to men's parenting role from within AOD services.

Removal of children into out-of-home care is a costly and disruptive outcome that should always and only be used as a last resort. A number of alternative strategies should be piloted prior to this occurring. Odyssey House Victoria strongly recommends the establishment of an innovations pool that could resource such initiatives. Odyssey House itself is currently finishing the completion of a number of family units at its Therapeutic Community in Lower Plenty. With this infrastructure and an existing established residential program, Odyssey would be interested in exploring the use of these units for a short-term and intensive program to prevent family breakdown.

PARTICIPATION

The perspectives of children and the large international movement of consumers (including those who have recovered from substance-dependence) are rarely used to inform public health campaigns or service design and delivery. There are developmental limitations to children's ability to exercise agency. In the child protection arena, the child's participation could be operationalized through engagement with the family and the state. However, while family engagement is a means by which the child's interests could be represented, it is dependent upon engagement with child protection (Connolly & Smith, 2010). There are significant barriers between substance-dependent parents, who fear judgment and significant, potential consequences of involvement, including the risk of child removal (Walsh & Douglas, 2009), and service providers who frequently experience hostility from substance-affected and highly anxious parents (Forrester & Harwin, 2008). Participation by reluctant, substance-dependent parents, and their children, therefore remains a major challenge in child welfare practice.

Children need a stronger voice in adult-focused services. Odyssey has conducted interviews with the children of service users. Children recognize that parental substance use affects them and argue they should be consulted in service provision. However, children also recognize that a younger child's ability to make decisions is developmentally limited. They consider family and friends to be the most significant source of support and therefore want services to help facilitate and strengthen these relationships. Children and young people want parents to be supported and are concerned by stigma and overly intrusive intervention. They want service intervention to occur within the context of the whole family, with holistic assessment including multiple perspectives of all involved. Children recognize that when informal support is no longer sufficient, formal services, including Child Protection, must intervene but they argue that services should continue to build family relationships and to maximize family-decision making (Colverson, 2009).

During the recently conducted focus group with service users, parents reported very low levels of support, a significant risk factor for child abuse and neglect. Parents expressed the need for service involvement with their families. In principle, they were not rejecting of the role of Child Protection which was viewed as potentially helpful. Some parents reported increased child safety (unfortunately, usually through removal), but most described a stigmatized and unduly harsh response that separated parents and children with little, if any, support for reunification. Parents described a culture of blame in which they are not listened to or trusted by Child Protection but

are “guilty until proven innocent”. Parents regarded intervention by Child Protection as divisive of family life wherein parents are regarded as “the good guy or the bad guy” and called for improved assessment of both parents. They also suggested the service meets with General Practitioners, neighbours and others known to families prior to Children’s Court action being taken. Engagement with Child Protection was experienced as a ‘lottery’ dependent in no small measure on the allocation of individual workers as much as the presenting concerns (Buchanan & Young, 2002 p. 195). Parents called for the employment of older workers with life experience as these workers were considered more helpful and less judgmental. A small number of parents were also concerned by the lack of coordination between child protection services in different States and Territories, for example, children can be returned to parental care in one state and then removed again after crossing the border. Parents are also concerned by the lack of coordination between the Family Court and the Children’s Court. A problematic practice occurs when CP places infants and/or children with a separated biological while the other parents is directed to attend detoxification or rehabilitation services; upon completion of the program the parent who formerly had care of the children, often the mother, is informed they must appeal to the Family Court to have children returned to their care. Women report that this practice occurs even after being directed to separate from the fathers of their children following intimate partner violence (Please refer to Professor Cathy Humphreys’ submission: Children Affected by Family Violence).

Parents argued that assumptions are made about the impact of substance use on parenting capacity without evidence. They discussed reluctance to disclose substance-use to Child Protection and recounted cases of child removal after honest discussion while other parents who concealed drug use were able to keep children in their care. Parents also mentioned that assessments are frequently based on outdated information. Several parents mentioned practice is not transparent, that they met the requirements for children to be returned to their care, including Conditions on Children’s Court Orders, only to find that the “goal posts have been shifted” and that assessment does not acknowledge progress. Parents argue they have no ‘right of appeal’ in the Children’s Court, that reports contain incorrect information they are unable to repudiate, and called for a more open system with rules of evidence similar to other legal jurisdictions with adequate time to prepare a case and greater contact with children while Children’s Court reports are being prepared.

The practice of penalizing parents for honesty regarding substance use is an impediment to assessment and a disincentive to engagement which potentially places infants and children at greater risk of harm. Mothers also mentioned being considered unable to protect their children from witnessing domestic violence and children being placed with the perpetrator of violence. The unintended outcome of such decisions could be that women may not report domestic violence through fear of CP involvement (Humphreys, 2007). Some parents argued for longer involvement and agreement between all parties, including both parents, before Child Protection closes cases. Parents called for support for the family unit with removal of infants and children as a last resort, more support for reunification of infants and children to parental care and for greater contact with infants and children who have been removed from their care. Parents also reported the need for continuity in legal representation and stated that the quality of legal aid representation is often poor, which poses a further barrier to retaining children or having them returned to their care in a timely manner. Not surprisingly, parents expressed feelings of powerlessness when involved with Child Protection and called for advocacy from other services. Odyssey staff members regard advocacy is an important function for AOD providers who are able to allay parental anxiety about involvement with a statutory service and to facilitate engagement between Child Protection and families. Parents argued that services are difficult to access and that CP does not actively assist them to fulfill the Conditions of Children's Court Orders. Parents called for: early rather than crisis driven intervention, improved communication by CP workers and for greater accountability by CP. Parents also called for more home visits from Child Protection in order to improve the quality of assessments and to provide valuable support. They want removal of children to occur only if they fail to meet requirements/conditions in a timely manner; consistency in practice; to not be discriminated against but given a chance; and reliance on past information to be time-limited. Parents mentioned that children in care are not listened to by service providers when they express the desire for greater contact with parents and the extended family. The current practice of Child Protection retaining case-management when clients are well-engaged with other services was considered problematic by Odyssey clients and staff.

An alternative model would be to allow families to select the agency that best suits their need for case-management. This would require partnership with Child Protection with shared responsibility for assessment and the development, implementation and monitoring of case-plans. Effective information sharing and clarification of roles and responsibilities between service providers (which are often poorly defined resulting in minimal follow-up after referral) would

need to feature in practice and be supported by interagency protocols (Recommendation 3). Such an approach would need to be undertaken with caution to ensure that families are not deterred from accessing support through fear of monitoring by service providers and the risk of child removal (Klee, 2002). The approach has the potential to improve assessment and therapeutic outcomes through the establishment of an open and trusting relationship between parents and workers that enables workers to take risks and confront child maltreatment (Connolly & Smith, 2010; Howe, 2010). It could also serve to reduce service duplication and multiple case-managers, and to improve outcomes for children and parents.

Recommendation 11: Alternative approaches to Child Protection retaining case-management for families well-engaged with services need to be considered to allow parents to acquire skills and practice new behaviours in a safe environment that simultaneously facilitates monitoring and sharing of risk between services, eases burden on the tertiary child protection system and reduces service duplication and/or multiple case managers

It is clear from parents' comments that the adversarial nature of the Children's Court is disempowering and distressing. Originating in New Zealand, Family Group Conferences (FGC), operationalize partnership and empowerment by drawing upon the extended family and professionals, including various services that generally function separately from one another for example, domestic violence (Pennell & Burford, 2000) and AOD treatment services (Weigensberg, Barth & Guo, 2009), to address problems in a family-led decision-making forum (Morris & Connolly, 2010; Pennell, Edwards & Burford, 2010). FGC were made mandatory in New Zealand in 1989 (Connolly, 2006a) but largely remain discretionary in other countries (Sundell, Vinnerljung & Ryburn, 2001). While there are significant advantages in including families in child protection e.g. children are more likely to remain safe within kinship networks, placements are more stable and the amount of time spent out of parental care is reduced (Connolly & Smith, 2010), resistance among child protection practitioners to family involvement has been noted (Morris & Connolly, 2010), with low uptake of the model in Sweden (Sundell et al., 2001), the U.K. (Brown, 2007; Sundell et al, 2001) and Australia (Harris, 2008). In Victorian DHS Regions, Family Group Conferences are occurring but in an ad hoc manner (Harris, 2008). While the *Children, Youth and Families Act 2005* explicitly mentions the use the use of Aboriginal Family Decision Making (albeit without specific details regarding implementation), there is no reference to family-decision making for non-indigenous children.

Recommendation 12: The voices of children, parents and other carers need to be heard in decisions that affect them; changes to legislation are required to ensure Family Group Conferences become, and remain, central to child protection practice when children are at risk of removal from parental care and that the Children's Court becomes less adversarial

CONCLUSION

As a society that has dangerously overloaded its tertiary child protection system, we need to promote greater community engagement in, and responsibility for, children's safety and wellbeing. Serious consideration needs to be given to changes to legislation, policy and practice to provide incentives and supports for communities to assume this function. Investment of finite resources needs to be targeted to "excluded families" when they enter secondary services e.g. the AOD or mental health sectors. Innovative programs such as Mirror Families may offer a sustainable way forward by using formal intervention to build informal, self-sustaining networks. In addition, secondary services need to be attuned to their clients' parenting needs, to work in collaboration with other services to promote children's safety and wellbeing, while providing advocacy and support for parents. The tertiary child protection system could be more supportive of this approach through less reliance on an adversarial legal system and greater use of Family Group Conferences prior to action in the Children's Court. For these changes to occur, government will need to be less risk adverse and design systems that work for the majority, not the very small number of cases that hit the media. The prospect of reform is exciting and welcomed by service users and staff alike at Odyssey House Victoria.

Signed: 

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