

# Drug use in the family

impacts and  
implications  
for children



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# Contents

List of contributors .....	iii
Acknowledgements .....	iv
Executive summary and conclusions .....	vii
1 Estimating the prevalence of substance misuse in Australian parents .....	1
References .....	35
2 Impact of parental problem substance misuse on children .....	39
References .....	62
3 Impact of problematic drug and alcohol use on parenting capacity .....	71
References .....	88
4 Parental substance misuse in Indigenous communities: a social ecology perspective .....	92
References .....	109
5 Parental substance misuse: the legal framework .....	110
References .....	142
Appendix 5.1 Extracts from United Kingdom child protection legislation .....	143
Appendix 5.2 Excerpts from legislation guiding child protection matters in a sample of Canadian Provinces .....	145
Appendix 5.3 Excerpts from the United Nations Convention on the Rights of the Child .....	150
6 Policy initiatives and practice guidelines relating to service provision for children living with parental substance misuse .....	152
References .....	182
7 Responses to <i>Hidden Harm</i> in the United Kingdom and beyond .....	185
References .....	200
8 Principles of good practice: tackling the needs of children in substance- misusing families .....	202
References .....	211
9 Summary and recommendations .....	222

## List of tables

Table 1.1: Men binge drinkers by household type .....	13
Table 1.2: Women binge drinkers by household type .....	13
Table 1.3: Use of cannabis in the previous year by household type .....	14
Table 1.4: Cannabis use by household type of those who have used in the last 12 months .....	14
Table 1.5: Use of methamphetamines in the previous year by household type .....	15
Table 1.6: Frequency of drinking in the previous year by illicit drug use .....	16
Table 1.7: Composition of family structures .....	18
Table 1.8: Levels of risk drinking by number of children in the household for adults only ..	18
Table 1.9: Alcohol measures by the number of children in the household .....	19
Table 1.10: Alcohol use by NHMRC category for total sample .....	19
Table 1.11: Levels of male binge drinking by household for adults .....	19
Table 1.12: Levels of female binge drinking by household for adults .....	20
Table 1.13: Alcohol use in women (25–30 years) and number of children .....	21
Table 1.14: Illicit drug use in women (25–30 years) and number of children .....	22
Table 1.15: Number (%) of parents engaging in risky and binge drinking .....	23
Table 1.16: Total number of children linked to the community sentence sample .....	26
Table 1.17: Number of target substances used, by lifetime diagnoses .....	28
Table 1.18: Frequency of violence by whether the user has dependent children .....	30
Table 1.19: Frequency of use of drugs and average daily spend in the last six months by parenting status .....	31
Table 2.1: Key protective factors to promote resiliency .....	60
Table 3.1: Summary of the major areas of impact: parental substance misuse and child developmental outcomes .....	86
Table 5.1: Child protection legislation in Australia .....	112
Table 5.2: Minimum thresholds for child protection actions across Australian jurisdictions .....	120
Table 5.3: Mandatory reporting requirements across Australian jurisdictions .....	124
Table 5.4: Common guiding principles in child protection matters across Australian jurisdictions .....	133
Table 5.5: American States that refer to parental substance misuse in child protection legislation .....	137
Table 5.6: Provisions requiring evidence of harm .....	138
Table 6.1: Presence, absence or unknown status of key policy documents relating to the needs of children and practice guidelines by jurisdiction ...	180
Table 8.1: Examples of Australian services and programs that currently target substance-misusing families .....	212

# Executive summary and conclusions

This report has focused on the impact of parental substance misuse, specifically alcohol and illicit drug use, in children aged between 2 and 12 years. The report builds on two prior important documents. The first of these is *The Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems* (Mitchell et al., 2001) commissioned by the National Health and Medical Research Council. The second key document is *Hidden Harm: responding to the needs of children of problem drug users*, commissioned by the Advisory Council on the Misuse of Drugs (UK). *Hidden Harm* arrived at 48 key recommendations, of which 42 were endorsed by a later government response (Great Britain Department for Education and Skills, *Government Response to Hidden Harm*).

The current report begins with a review of the literature on prevalence of substance misuse in families. Additional original analyses were then conducted by the consortium on the National Drug Strategy Household Survey and National Health Survey. Professor Christina Lee, University of Queensland, provided the analysis of the Longitudinal Study on Women's Health and Dr Tanya Caldwell and Professor Bryan Rodgers, ANU, provided the analyses on the Longitudinal Study of Australian Children. Finally, analyses of specialist population databases were conducted (Life experiences of people serving community corrections orders (Qld); Patterns of amphetamine use: Qld). It is clear that the use of alcohol and other drugs in households with dependent children is high. The national databases all point to high rates of binge drinking in particular. While rates vary across each of the studies, there is a clear pattern showing that the highest rates of binge drinking amongst those with children are single mothers and the lowest rates are amongst women in couple households. Analyses from the Longitudinal Study on

Women's Health also found high rates of illicit drug use amongst women with children. Evidence for a 'cumulative parenting disadvantage' is clear from the specialist data sets. Elevated levels of substance use are linked to other significant lifestyle and functioning deficits including exposure to violence, mental health problems and elevated levels of criminality. These occur in adults living with children and in those with children who are financially dependent upon them.

## Key points

1. International household surveys and other population estimates suggest that approximately 10 per cent of children live in households where there is parental alcohol abuse or dependence and/or substance dependence.
2. International research indicates 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.
3. Based on the number of children aged 12 years or less living in Australia (1 755 343 males and 1 666 031 females in this age group, totalling 3 421 374 children; Australian Bureau of Statistics, 2004), we estimate that 13.2 per cent or 451 621 children are at risk of exposure to binge drinking in the household by at least one adult; 2.3 per cent or 78 691 live in a household containing at least one daily cannabis user. Finally, 0.8 per cent or 27 370 live in a household with an adult who uses methamphetamine at least monthly and reports doing so in their home.



While parental substance misuse can affect many aspects of a child's life, it is generally difficult to disentangle the effects of parental substance use from broader social and economic factors that contribute to and maintain the misuse of either drugs or

alcohol. In Chapters 2 and 3, the research literature is reviewed to ascertain the contribution of other factors, in addition to parental substance misuse, that influence child outcome. The key points arising from this review are as follows:

### Key points

4. While there is a good literature documenting the negative impact of parental substance misuse, combined with other life problems, on child outcome, there is no specific comparison between substance classes. For example, it is not possible to determine whether parental amphetamine abuse poses a greater risk to adverse child outcome compared to a substance such as heroin. Australian research into this area needs to be encouraged.
5. Parental substance misuse might be seen as a possible marker of co-morbid parental psychopathology, which may in itself contribute to greater impairments to child outcomes than substance use alone. To improve child outcomes in substance-abusing families, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role.
6. To improve child outcome in substance-abusing families, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role. In practice, this might translate into both improved training opportunities for alcohol and other drug (AOD) workers to help better address mental health issues, and improved liaison with mental health services. It appears likely that employing experienced mental health workers in AOD services will increase the use of such treatment options within substance-using families.
7. Treatment services need to help families with parental substance abuse to better manage the daily stresses associated with socioeconomic disadvantage in order to reduce the impact of this risk factor on child outcomes. Tackling drug use in isolation is unlikely to be effective without addressing the key context issues of unemployment and poor housing that in many cases sustain drug lifestyles.
8. Effective interventions for substance-abusing families need to target the parent's capacity to seek and sustain support systems in their family and social networks. Therapeutic interventions that directly address the parent's access to social services and community supports can effectively reduce child maltreatment risks and also foster adaptive parenting behaviour.
9. Substance abuse problems and partner violence often co-occur for women. Treatment services need to routinely screen for the occurrence of family violence and provide services for these problems. Likewise, services to help address alcohol and other drug problems need to be provided in women's shelters and 'safe houses'.

10. Women with substance abuse problems are also at high risk of being assaulted. This in turn increases the risk of subsequent substance dependence and heavy use. These women need to be targeted to receive self-protection or crime protection training in an attempt to break the vicious cycle that links victimisation, post-traumatic stress disorder and substance abuse in women.
11. The inclusion of couples-based interventions that assist parents to manage their anger and levels of verbal/violent behaviours more effectively within drug and alcohol treatment services is recommended. This can improve psychosocial outcomes in children by reducing family hostility, tension and exposure to conflict.
12. A significant protective factor in a child's life is the experience of a secure relationship with his/her parents through the provision of sensitive and responsive care and appropriate limits. All attempts should be made to enhance this relationship through support of the parent(s) while engaged in treatment.
13. Women drug users who are also mothers typically experience marginalisation and discrimination due to their parenting status. This dynamic needs to be acknowledged. Attention should be directed to the development of realistic methods to appraise and support both the parenting strengths and the difficulties experienced by these women, in particular the internalised view of self as a 'hopeless' parent.
14. Many men who have childcare responsibilities are accessing treatment services, yet the experience of substance-misusing fathers has been largely ignored in the research literature and treatment setting. The alcohol and other drug sector has a unique opportunity to work with fathers on parenting issues, particularly as more men than women access treatment services.
15. Grandparents are increasingly taking on full-time caring responsibilities in response to concerns for the welfare of their grandchildren due to their own children's substance misuse. The support needs of these grandparent carers are many and at present are only erratically addressed. Australian research is urgently needed to determine best-practice models for supporting grandparent carers.
16. The perspective of the child living in a substance-abusing family is important. Giving children an opportunity to express their views and to help them understand the nature of their parents' substance misuse needs to be facilitated. This needs to take into consideration a child's developmental level.
17. To accurately describe how substance misuse affects parenting capacity, further research is required, especially within an Australian context.

A separate chapter has been especially written for this report on the effects of parental substance misuse on Indigenous children (Chapter 4). Whilst many of the risk and protective factors are similar across cultures, the unique historical context resulting from

colonialisation and subsequent social and cultural devastation in Indigenous communities brings an additional set of considerations when looking at the impact of parental substance abuse on children. The following are key points arising from the review.

### Key points

18. Supply reduction strategies are critical to ensure the safety of women and children exposed to violence associated with drunkenness and other substance intoxication. It is stressed, however, that these are short-term emergency measures that have an immediate, albeit partial, impact on the physical safety of the community. Failing to address the fundamental causes of the problems will not ameliorate the long-term effects of substance misuse within Indigenous communities.
19. The provision of harm minimisation services such as 'safe houses', night patrols and sobering-up shelters plays a valuable role in reducing levels of harm that arise as a consequence of substance misuse. These services, however, are akin to bomb shelters in a war. They will in no way serve as a solution to the conflict (substance misuse) or resolve the underlying issues to prevent another war (a new generation of people with substance abuse problems).
20. A major emphasis of 'educaring' is promoting an understanding of the relationship between historical and socio-political influences that result in social trauma and violent behaviour – in particular, how trauma and violence are transmitted – and consequently has inter- and trans-generational effects across societies and populations. In this way, the presence of alcohol and other drug misuse, together with conflicted parenting, are seen within the broader context of its emergence across generations.

Understanding legislative frameworks and current policy initiatives is essential in determining how best to engage families in which there is risk of poor child outcome. Thus, this

report provides a legislative overview (Chapter 5) and a description of current Australian policies (Chapter 6). Key points arising from this are as follows:

### Key points

21. While drug use *alone* is not sufficient to trigger child protection mechanisms within Australia as a primary factor, it may be a contributing cause of neglect, harm or other abuse of a child, which could trigger such a response as a secondary factor.
22. Australian jurisdictions have, by and large, established satisfactory legislative frameworks for tackling adverse impacts upon children associated with parental substance misuse.
23. A website providing links to current national and State policy initiatives (together with the linked websites) for the drug and alcohol sector, in addition to practice guidelines and other resources, is recommended.
24. In terms of policy, a review of the Australian Government's National Drug Strategy indicates that there is no reference to the needs of children raised in substance-misusing families. As this strategy may be viewed as a cooperative venture between the federal and State/Territory governments and non-government sectors, it raises concerns about the relative importance given to providing services to children affected by parental substance misuse across the political spectrum.
25. A National Strategy for the Prevention of Child Abuse and Neglect is currently being developed. This is a critical opportunity to develop a policy that would directly impact on children in multi-problem families with parental substance misuse. The Community and Disability Services Ministers' Advisory Council could also consider the establishment of a working group directly addressing this issue.
26. State policy on treatment and service delivery should identify the needs of children and young people affected by substance misuse, either by use themselves or by exposure to parental substance misuse, as a priority area.
27. Provision of guidelines for drug and alcohol workers for the assessment of child protection issues is strongly recommended.
28. Family-based interventions need to be provided to clients of alcohol and drug services. Research evidence points to the importance of having interventions where such services address many aspects of families' lives rather than focus on a single issue. We recommend that these be made available to clients of drug and alcohol treatment agencies.

The response to *Hidden Harm* (Advisory Council on the Misuse of Drugs, 2003) has varied markedly across the United Kingdom, with Scotland alone developing ongoing action planning and policy interventions based specifically on the recommendations in the *Hidden Harm* report. Nonetheless, there have been significant changes across the United Kingdom as child protection agendas and legislation have dominated the response in England and Wales, and a new drug strategy (including targets around vulnerable populations and young people) for Northern Ireland. Thus, it is reasonable to conclude that, in all four of the home countries, there have been improvements in joint working and in screening and identification of young people at risk. Only in Scotland, however, has there been a commitment to improving the evidence base for quantifying the children at risk as a result of substance-using parents and for developing a legislative framework for supporting drug-using mothers.

As the first step in determining a set of national guidelines to ascertain treatment models of good practice, we generated a set of principles to guide treatment interventions. The following principles of best practice are informed by the research outlined in this document and have application to the work of all service providers who deal directly with substance misusers who are parents.

## Principles of good practice

### Good practice principles for funding bodies and/or organisations

1. Organisations and funding bodies need to recognise the importance of addressing the needs of children of substance misusers and regard this as core business.
2. Organisations and funding bodies need to give recognition to the importance of this work and provide organisational support for such work to take place.
3. Organisations and funding bodies need to endorse a treatment model that addresses many aspects of families' lives. Simply providing a 'play group' as an added extra, for example, will not improve child outcome. However, if a play group was part of a range of family-focused interventions that aimed to enhance a parent's social support and improve parental functioning, this would be a worthwhile endeavour.
4. Organisations need to develop inter-agency practice guidelines that facilitate staff across different agencies working together in a safe, ethical and helpful way.
5. Organisations need to be responsive to the needs of families to ensure treatment engagement.

## Good practice principles for clinicians

1. Clinicians need to receive training in empirically sound treatment models for improving outcomes in substance-abusing families.
2. Clinicians need to be provided with regular supervision.
3. Clinicians need to be provided with adequate time to provide intensive family-focused interventions.

## Good practice principles for treatment content

1. No single treatment is appropriate for all families.
2. Families need immediate access to treatment programs.
3. All treatments should include a thorough assessment of the family's functioning across multiple domains. The family should be involved in assessing their needs and the design of services.
4. Effective programs attend to the multiple needs of the family, not just the parent's use of drugs.

5. Treatment plans need to be continually assessed, monitored and modified to ensure that they are meeting the changing needs of each family.
6. Clinicians need to work actively with all systems that are impacting on families' functioning.
7. Family engagement for an adequate period of time is critical to achieve and maintain change.
8. Clinicians need to work to develop a sound therapeutic alliance with each family.
9. Treatment programs need to be evaluated to determine whether they are achieving their aims and objectives.

## Recommendations of the report

On the basis of the key points and literature reviewed we have derived a series of recommendations for consideration. These have been grouped as follows:

### Recommendations for determining prevalence estimates of children living in families with parental substance misuse

**Recommendation 1:** All national surveys of substance use should collect minimum basic data on number of biological children, number of dependent children, and number of children living in the households of adults.

**Recommendation 2:** Surveys of particular high-risk populations should also collect data on number of biological children, number of dependent children, and number of children living in the households of adults. Additional information on whether children are currently or have ever been taken into social services' care should, ideally, also be collected. This could be done as part of the National Minimum Data Set to allow comparisons to be made across jurisdictions.

**Recommendation 3:** Data collected on harms to children and children taken into care should include clear information on the referral and decision-making mechanisms and, where multiple reasons are given, the primacy of parental substance use should be stated along with the type of substance use involved. Similarly, the relationship between the type of harm (e.g. neglect or abuse) should be cross-tabulated against the profile of parental risk factors.

**Recommendation 4:** Future research needs to be conducted to ascertain whether different substances carry particular levels of risk or harm to children living with parental drug use. The interplay between parental substance use, mental health and child outcome should be a particular focus of this research.

### Recommendations regarding the content of treatment programs to meet the needs of children living in families with substance misuse

**Recommendation 5:** Parental alcohol and drug misuse is only one of many problems affecting children in multi-problem families. Treatments need to focus on the multiple domains affecting children's lives if child outcome is to be improved. Thus, treatment models need to adopt a multi-systemic perspective.

**Recommendation 6:** There is no single treatment program that is right for all families. However, a set of agreed principles of good practice will provide a benchmark for determining program content. The Practice Guidelines developed as part of this report should be used as a starting point in the development of an agreed set of National Guidelines.

## Recommendations for Indigenous communities

**Recommendation 7:** Supply reduction strategies appear critical in improving levels of safety experienced by children and women exposed to violence associated with drunkenness and other substance intoxication. However, further research is required to determine which strategies are most helpful in protecting children and women.

**Recommendation 8:** The provision of harm minimisation services such as ‘safe houses’, night patrols and sobering-up shelters plays a valuable role in reducing levels of harm that arise as a consequence of substance misuse. Existing services should continue to be funded. Further development of harm minimisation strategies should be undertaken – as a minimum, each community should have a ‘safe house’.

**Recommendation 9:** An approach of ‘educaring’ has been proposed as a model that promotes understanding of the relationship between historical and socio-political influences that result in social trauma and violent behaviour in Indigenous communities. Alcohol and other drug misuse, together with conflicted parenting, are seen within the broader context of the emergence across generations. Approaches that allow for consultation and local solutions within communities and across a number of different arms of government are strongly endorsed.

## Recommendations regarding policy and practice guidelines for government

**Recommendation 10:** State policy on treatment and service delivery should identify the needs of children and young people affected by substance misuse, either by use themselves or by exposure to parental substance misuse, as a priority area.

**Recommendation 11:** Provision of guidelines for drug and alcohol workers for the assessment of child protection issues is strongly recommended.

**Recommendation 12:** Research evidence points to the importance of having interventions that are multi-systemic in nature and address multiple domains of family functioning. We recommend that staff within the alcohol and other drug services deliver these interventions.

**Recommendation 13:** Staff involved in the delivery of intensive family-focused interventions need to be supported by the provision of adequate models of practice, supervision and sufficient time to ensure that treatments have a realistic chance of improving outcome in children of problem substance users.



## Scope of the report

Drug and alcohol use is widespread in Australian society. While much of this use is not harmful, a proportion of people use substances in a manner that impacts on their own health and wellbeing and that of other family members. The principal focus of this report is on substance use that is acknowledged to be particularly disruptive to family functioning – alcohol and illicit drugs. While the effects of cigarette use by parents on children is recognised as a significant health problem, this substance will not be included in the current report. Further, the focus of the report will be on the impact of substance misuse on children aged between 2 and 12 years.

It is difficult to determine when parental alcohol and drug use becomes detrimental to child outcomes. Many adults have times when they drink alcohol to intoxication or use substances, but this does not lead to ineffective parenting on every occasion. Parental intoxication may be associated with an acute risk to a child due to parental incapacity to monitor and intervene in risk situations. However, parenting outside of these discrete episodes may not be impaired. Thus, in the first instance, it is necessary to highlight that parental intoxication (and withdrawal) may be associated with acute risks where these states limit a parent's ability to provide responsive parenting. More chronic substance misuse will affect parenting capacity in different ways and will depend on many contextual factors in which the use occurs. For example, individual child characteristics, family structure and the wider social network of the family may provide many buffers against the impact of chronic parental substance misuse.

As a consequence, an analysis of the impact of parental substance misuse requires a complex assessment of both the parent's use and the child's needs, taking into account the child's age and development. The broader social and environmental stresses are also critical factors that influence child outcome. While the link between substance misuse and poverty is complex, it is acknowledged that problem substance users tend to cluster within areas of social disadvantage that are characterised by social exclusion, unemployment, low educational achievement, poor housing, family stresses and high levels of despair and hopelessness. In addition, there is evidence that a significant majority of substance misusers also experience severe psychological pressures, including sexual and physical abuse. Many of these factors manifest themselves as low levels of social capital and low social integration within the larger family and community.

Many children of substance-abusing parents face a preponderance of negative life circumstances that collectively heighten their risk for negative outcome. Some of these children will go on to replicate their parent's social disadvantage. In a sense, there is an accumulation of disadvantage as negative events compound and become cyclical over time. Other children will move forward and lead healthy and productive lives. Thus, in writing this report, each of the authors has taken a broad perspective where the issue of parental substance misuse is considered within a cultural, social and political context.

# 1. Estimating the prevalence of substance misuse in Australian parents

## 1.1 Introduction

The first critical step in deciding how policy and practice should develop to help children raised in families with parental substance misuse is to determine the scope and scale of the problem. However, this task is far from straightforward. The methodological limitations inherent in any estimate of the prevalence of parental substance misuse need to be clearly articulated and caution exercised in interpreting data. In this chapter we have begun with a review of these methodological limitations. We then review current knowledge of the prevalence of children living in households with parental substance misuse. We begin this task by drawing from national household surveys and moving on to surveys drawn from two subpopulations: (i) identified adult substance-misusing populations (the National Minimum Data Set (NMDS)); and (ii) at-risk or identified child populations (data provided by child protection and child death reviews). We then briefly review overseas data with a focus on work conducted in the United States, the United Kingdom and Canada. Comparison will be drawn from the major findings from overseas data sets with the current analyses from Australia to enable a series of recommendations for future practice.

Next, we have undertaken additional analysis of recent Australian data sets to determine whether there is sufficient consistency across these data sets to provide an indication of the number of children living in households with a parent who misuses substances. A secondary goal is to ascertain the numbers who are experiencing adversity as a result. These analyses have drawn from the 2004 National Drug Strategy Household Survey (Australian Institute of Health and Welfare,

2005a), the 2001 National Health Survey (Australian Bureau of Statistics, 2003), the Australian Longitudinal Study on Women's Health and the Longitudinal Study of Australian Children. In addition, we have undertaken further analyses of specialist data sets containing information on subpopulations generally recognised to contain a higher incidence of substance abusers than the general population.

It is important to acknowledge at the outset that any attempts to determine the number of parents who abuse substances is complicated by the imprecise nature of data collection instruments. Respondents in self-report surveys, particularly large national surveys, typically underestimate their use of alcohol and other drugs (Knibbe & Bloomfield, 2001). For example, the 1998 National Drug Strategy Household Survey accounted for only 46.5 per cent of known alcohol sales in the preceding 12 months (Stockwell et al., 2002, as referred to in Stockwell et al., 2004). One of the major reasons for under-reporting is believed to be the use of standard drinks as the primary measure of consumption rather than specific drink sizes and types (Stockwell et al., 2004). There are also significant underestimations associated with the reporting of Indigenous substance use possibly due to the additional factors such as the exclusion of residents living in non-private dwellings (e.g. hostels, caravan parks, prisons, hotels and hospitals), confidentiality issues and problematic data collection (Chikritzhs & Brady, 2006). Thus, with these important limitations in mind, we have obtained estimates of the number of children in families with parental substance misuse across several national data sets and in data sets of subpopulations.

## 1.2 Identifying the risk population

Obtaining an estimate of the number of children affected by parental substance misuse requires, in the first instance, a clear definition of 'parent'. Although most Australian children live in households as members of a family unit, there is considerable variability in family composition and diversity. In 2003, 71.8 per cent of children aged 0–17 years were living with either biological or adoptive parents, whilst 8.2 per cent of children lived in step or blended families (Australian Bureau of Statistics, 2004). The proportion of single-parent families has increased significantly in recent years. In 2003, 19.5 per cent of Australian children resided in one-parent families, and of these 16.9 per cent of children were living with lone mothers and 2.5 per cent were living with lone fathers. Finally, the role of grandparents and extended family members in the parenting of young children has increased substantially. While this may be a caring role that is structured without legal or social policy involvement, it can represent a substantial commitment on the part of the grandparents with caring responsibility for the children residing with them on a day-to-day basis (Patton, 2003; Child Welfare League of America, 1994). However, in almost all data sets these complex relationships are not captured and, at best, 'parent' becomes synonymous with 'primary carer'. It is reasonable to propose that the substance use of the primary carer(s) will have the greatest impact on child outcome. However, it is not always clear who this person may be.

We have used the term 'substance misuse' in this report. However, it is important to note that this term actually falls outside current diagnostic nomenclature. The terms 'substance abuse and dependence' and 'harmful

and hazardous use' are commonly employed to classify the severity of an individual's substance use (DSM–IV – American Psychiatric Association, 1994; ICD 10). Such diagnoses, however, refer to the effects experienced by the individual using the substance, not the effects of an individual's substance use on others. For example, 'harmful and hazardous use' of a particular substance such as alcohol defines harm in relation to increased risk for adverse health outcomes in the drinker. Such levels of use may or may not necessarily map onto adverse child outcomes. Although it is necessary to draw from current diagnostic nomenclature when attempting to determine when parental substance use impacts on child outcomes, the many assumptions inherent in this process may in turn distort findings.

Notwithstanding the above, it is clear that deriving some estimate of the number of substance-misusing parents is a critical step in providing a basis for the development of prevention and early intervention policies and practices. Thus far, there has been little focus on determining the extent of the problem in either general population surveys or subgroups of Australian parents, a finding highlighted by Mitchell and colleagues (2001) in the National Health and Medical Research Council report, *The Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems*. However, it is also important to emphasise that simply knowing the numbers of parents who misuse substances provides little information on the nature of the relationship between parental substance misuse, other risk factors and child outcome. An understanding of the interplay between all of these will provide the information needed to develop interventions to improve child outcomes in disadvantaged families.

### 1.3 Children affected by parental substance misuse: current knowledge

The largest and most detailed population-based survey on drug and alcohol use is the National Drug Strategy Household Survey (NDSHS), conducted every three years. This survey includes detailed information on patterns of drug and alcohol use. However, linking substance use with parental status is somewhat problematic, as the parental status of the respondent is never actually established. Information is available on a respondent's age and gender, household income, household type (e.g. couple living alone, couple with non-dependent children etc) and number of dependent children. Analyses based on household 'type' have been presented in previous reports. For example, Mitchell and colleagues (2001) reported on alcohol and drug use in 'parent households' (defined as households where the respondent was over 20 years and where dependent children lived in the household).

While large-scale population surveys aim to draw a representative sample of respondents, this issue is always a concern with household surveys typically under-sampling minority and disenfranchised groups. Therefore, drawing from surveys of subpopulations adds richness to the epidemiological information from national surveys. There are two surveys conducted annually that sample populations which could provide critical information on parental substance use, as both target drug users. The first of these, the National Minimum Data Set (NMDS), provides demographic and treatment information about clients who use specialist drug and alcohol treatment services, and contains a set of mandatory questions which are collected nationally. However, the mandatory questions do not include any aspects of parental

status. At best, calculations of numbers of children using the NMDS have produced very general estimates based on multiple premises (that may or may not be correct). Gruenert and colleagues proposed a set of assumptions that included allowing for one child per client aged 20–50 years. This led to an estimate of 60 000 children living in households with a parent in drug treatment (Gruenert, Ratnam & Tsantefski, 2004). There are many problems inherent in this estimate, not the least is the small proportion of people with substance misuse problems who are currently in treatment. But, in the absence of other more reliable data, it is arguably a reasonable start at deriving an estimate.

The other national monitoring system in place in Australia is the Illicit Drug Reporting System (IDRS). This is funded by the Australian Government Department of Health and Ageing and the National Drug Law Enforcement Research Fund and is conducted each year in every State by participating research institutions throughout the country. The primary purpose of the survey is to monitor emerging trends in illicit drug use. Again it is notable that there are no questions relating to parental status. However, inclusion of such questions would contribute significantly to our knowledge of parental substance use and child risk status, particularly as this data set captures respondents who may not typically be included in national data sets.

A second area that will also provide information on subpopulations of risk is those families identified through child welfare or child protection systems. Many parents who have children entering the childcare protection system have substance misuse problems (e.g. Ammerman et al., 1999). However, there is a little information on the family characteristics of children identified as being in need of care and protection or on the reasons for being placed in out-of-

home care. This problem has been previously identified and there is some discussion of the introduction of a national monitoring system, at least with regard to children in out-of-home care.

Despite the lack of a national monitoring system for children involved with care and protective services, there have been several key reports published in recent years. Selecting from these, we find that parental substance misuse has been documented as a significant factor in the lives of 'at-risk' families. However, it is certainly not the only, and often not the major, problem facing families identified by child protection services. For example, recent Victorian figures (Victoria Department of Human Services, 2002) report that approximately one-third (31%) of parents involved in substantiated cases of child abuse or neglect in 2000–01 experienced significant problems with 'alcohol abuse', 33 per cent with 'substance abuse', 19 per cent with 'psychiatric disability' and 52 per cent had experienced 'family violence'. Although drug and alcohol misuse were prominent factors in substantiated cases, it was evident that there were many other complex problems in these families. For example, of the parents who had problems with alcohol abuse, 70 per cent had experienced family violence, 18 per cent suffered from a psychiatric disability, and 51 per cent also had a substance misuse problem. For those cases involving primary substance abuse, 63 per cent also experienced family violence, 22 per cent suffered from a psychiatric disability, and 47 per cent also had alcohol abuse problems.

The proportion of cases with a primary characteristic of 'family violence' with an associated issue of substance abuse had increased from 27 per cent in 1996–97 to 41 per cent in 2000–01. The increasing complexity of substantiated cases is also evidenced by the fact that the proportion of substantiated cases involving three or more parental characteristics<sup>1</sup> had increased from 3 per cent in 1996–97 to 19 per cent in 2000–01, with substance abuse, alcohol abuse and family violence showing the largest increases in this period. All three of these parental characteristics were much higher in Indigenous parents – substance abuse (42% vs 22%), alcohol abuse (51% vs 20%) and family violence (56% vs 36%).

Information has also been published on family characteristics of children and young people entering foster care (excluding kinship care and permanent care) in Victoria (Victoria Department of Human Services, 2003). In 2001–02, the presence of substance abuse problems was identified in 43 per cent of parents with children entering foster care and a further 37 per cent were recorded as having alcohol abuse problems. For large numbers of these families there were multiple risk factors recorded. For example, 77 per cent of parents with an alcohol problem also experienced domestic violence, 65 per cent of parents with the primary characteristic of domestic violence also had substance abuse problems, and 62 per cent of parents with a psychiatric disability also had a substance abuse problem (Victoria Department of Human Services, 2003, p.35).

<sup>1</sup> The six parental characteristics are: psychiatric disability, intellectual disability, physical disability, family violence, alcohol abuse, substance abuse.

In Western Australia, two projects have investigated the prevalence of parental alcohol and substance abuse in Care and Protection (C&P) applications raised by the Department for Community Development. The first, based on applications completed during 2000 (134 families representing 251 C&P applications), found alcohol and substance use was recorded as the primary reason for the application in 70.4 per cent of cases analysed (Farate, 2001). The majority of these cases were characterised by polydrug use (73%) with alcohol being the most prevalent substance used by parent(s) (66.3%), followed by cannabis (45.7% of cases), psychostimulants (44.6%) and opioids (42.4%). The prevalence of alcohol as a main factor in C&P applications was consistent across both Aboriginal and non-Aboriginal populations. In cases where alcohol/substance use was identified, there was a much higher incidence of general neglect issues and domestic violence as well as a higher rate of removal of infants under the age of 12 months.

A second study completed by Leek and colleagues (2004) selected every second application referred to the Western Australian Department for Community Development over the course of one year (175 out of a possible 326 Care and Protection applications). Although drug and alcohol use was identified as a contributing factor in 57 per cent of the cases, in only 2 per cent of these cases was drug and alcohol use identified as the 'single' reason for the C&P application (Leek, Seneque & Ward, 2004). More typi-

cally, multiple reasons were cited involving neglect, domestic violence, physical abuse, homelessness/transience, emotional abuse, psychiatric issues and lack of engagement with services. Financial problems were also found to be more prevalent in cases in which drug/alcohol use was given as one of the reasons for the application.

Adding to this picture of multiple disadvantage are data from a case review of care and protection matters in two New South Wales children's courts conducted over a nine-month period. McConnell, Llewellyn and Ferronato (2000) reviewed the court files to determine prevalence rates of care applications for parents with a disability. Almost one-quarter (24.3%) of all cases were found to involve parents with a disability, with substantial over-representation of parents with a psychiatric disability<sup>2</sup> – at 18.4 per cent of cases compared to mean general population estimates of 4 per cent. A content analysis found that 'suspected' drug and alcohol use was the most common concern (38.1%), followed by alleged or history of abuse (27.8%), resistance to statutory intervention (26.3%), domestic violence (25.9%), and the parent's mental state (24.4%). Thus, while data are not routinely collected across all Australian jurisdictions, these data are consistent with international findings (Ainsworth, 2004; Families Australia, 2003).

<sup>2</sup> Parents with substance abuse disorders were excluded from the definition of parents with a disability in this study.



Finally, there are data from a number of child death reviews that highlight the complex nature of parental substance abuse and child abuse and neglect. There is widespread acknowledgement that a comprehensive mechanism is needed to review all child deaths, particularly those where abuse or neglect is suspected, or where issues of preventability are evident. At present, New South Wales, Victoria, Western Australia and Queensland have established child death review teams whilst the Australian Capital Territory is currently in the process of doing so. Factors consistently identified by child death review teams across Australia include substance abuse, domestic violence, homes lacking basic safety measures, and poverty.

In summary, all reviews identified social disadvantage, multiple stressors including abuse of illicit drugs/alcohol by one or both parents, financial stress, domestic violence, parental relationship breakdown and parental criminal history co-occurring across families (New South Wales Child Death Review Team, 2002). Recent figures indicate that co-occurring difficulties were present in the majority of families (85%) where the fatal child abuse occurred (Kovacs & Richardson, 2004). The Victorian Child Death Review Committee also found a pattern of multiple problems including drug use and mental illness, drug use and domestic violence, or drug use and transience in 12 (85%) out of the 14 child deaths reviewed (Victorian Child Death Review Committee, 2005).

In relation to the numbers of Indigenous children in Australia exposed to parental substance misuse and child abuse and neglect, it is important to note that Indigenous people as a whole have more abstainers from alcohol, and more heavy drinkers than non-Indigenous people. While 84 per cent of Australians surveyed in the National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2005a & b) reported alcohol consumption, only 49 per cent of Indigenous adults reported drinking (Australian Bureau of Statistics, 2005). Those who do drink, however, consume more than drinkers in the non-Indigenous population and at levels harmful to health, with approximately 22.7 per cent of Indigenous people drinking at levels considered to be a long-term risk compared to 9.9 per cent in the general population. Thus, it is reasonable to propose that more children as a proportion of Aboriginal families are exposed to risky parental alcohol use.

Data on the impact this may have on children's lives were obtained in the Western Australian Aboriginal Child Health Survey (WAACHS), the most extensive survey of Aboriginal families ever undertaken (Zubrick et al., 2005). By using a combination of personal interview and the completion of self-report questionnaires, a description of the lives of 5289 (approximately one in five Aboriginal children living in Western Australia) was obtained.

Alcohol and drug use was a particular focus of the report and findings point to extensive parental substance misuse. The authors estimated that 15.4 per cent of Aboriginal children aged 4–17 years were living in households in which use of alcohol caused problems (Zubrick et al., 2005, p.119). In addition, child outcome was measured using a reliable and valid index of child behaviour problems, indicating that 35.8 per cent of children living in households affected by overuse of alcohol were at high risk of clinically significant emotional or behavioural problems. Of interest, however, parents in households not affected by alcohol also reported high rates of child behaviour problems. Once again this highlights the complex interplay between risk factors – child outcome is impacted upon by parental substance abuse but this is not a necessary factor for adverse child outcome to occur.

### 1.3.1 Summary

There is a surprising paucity of information on the numbers of children living in Australian households with parental substance misuse. There are no national household data sets that directly inform this issue. Specialist data sets from drug and alcohol monitoring systems do not ask about parental status and are of limited value. There are no systematic monitoring processes in the public domain that allow for an analysis of parental characteristics of children entering the child protection system. There are, however, a series of reports from child protection and child death review teams that provide some data on parental characteristics, including substance misuse. In reviewing these reports, it is clear that parental substance misuse is a key issue for children in the care and protection system. However, these reports also highlight the many complex problems that these families face: parental substance misuse occurs in a family environment of domestic violence, psychiatric problems and extreme financial disadvantage.



## 1.4 International estimates of parental substance misuse

Although many countries now complete general population studies addressing the extent and diversity of drug and alcohol use, little of this research has been analysed according to parental status. There is also much variation in the ways substance misuse has been defined and this makes it difficult to make comparisons across countries. With this caveat in mind, the following is a summary of key surveys from the United States of America, the United Kingdom and Canada.

There have been national household surveys and a number of specialist reports conducted in North America in which estimates of the number of children living in households with parental substance misuse have been made. The National Survey on Drug Use and Health (NSDUH), formerly the National Household Survey of Drug Abuse (NHSDA), is completed annually. Information is obtained using DSM-IV (American Psychiatric Association, 1994) diagnostic criteria on symptoms of dependence/abuse of alcohol and illicit drugs. More specific information on numbers of children living in the household, their age and relationship to the respondent is obtained as well as additional information on family dynamics. Other national databases that address the issue of parental substance abuse are available from within the child welfare system, with at least one national survey (National Center on Child Abuse Prevention Research, 2001) and a series of smaller studies available.

In the 2001 NSDUH survey, an estimated 6.1 million (9%) American children under the age of 18 years were living with at least one parent who met criteria for alcohol abuse or dependence or substance dependence in the previous year, including more than 500 000 who lived with a parent who abused or was dependent on alcohol and an illicit drug (Office of Applied Studies, 2003). Crucially, the study also notes an inverse age relationship – parental substance abuse in the past year was involved for 9.8 per cent of children up to the age of five, 7.5 per cent of children aged 6–11, and 9.2 per cent of youths aged 12–17. For the majority of these children (4 499 000), parental alcohol abuse or dependence was the primary concern, followed by parental abuse or dependence on illicit drugs (953 000), and 657 000 children were living with a parent who abused or was dependent on both alcohol and illicit substances. Alcohol-dependent or alcohol-abusing parents reported higher rates of past-year illicit drug use and higher levels of household turbulence than parents who were not dependent on or abusing alcohol in the past year (Office of Applied Studies, 2004).

Since the mid-1990s, publicly funded treatment services for drug users in England and Wales have routinely recorded a minimum data set on all new clients entering the drug treatment system. This data set included information about social circumstances such as employment, housing, legal circumstances and number of dependent children. This system was reviewed and then replaced in 2001 by the National Drug Treatment Monitoring System (NDTMS) and information on dependent children is no longer collected (Advisory Council on the Misuse of Drugs, 2003). The data reported from 1996 to 2000 in the national data set provided a rich source of information on a range of issues relating to drug use and parenting. Data on parental status were available on 221 124

(71%) of the sample. Of these, 95 143 (43%) reported having dependent children, defined as under the age of 16 years and usually dependent on the respondent. Fifty-three per cent of women and 40 per cent of men were parents. Information on current living situations was available for approximately 77 928 respondents. Just over two-thirds of mothers (64.5%) and one-third of fathers (37.2%) had their children living with them. Approximately 5 per cent of children were in care. A risk profile was created based on eight risk indicators, four of which were drug use factors (daily heroin use, daily alcohol use plus illicit drugs, regular stimulant use, sharing injecting equipment) and four of which were social risk factors (unstable accommodation, living alone, living with another drug user, criminal justice involvement). First, the proportion of parents who had children living with them decreased as the number of risk factors increased. For example, only 10 per cent of parents with six or more risk factors had their children living with them compared to 60 per cent of parents who had no listed risk factors. Secondly, for those parents in treatment, a significant proportion (60%) did not have any current risk factors, as defined by the ACMD report. It would be unwise to extrapolate beyond these data to propose that there were no adverse outcomes for those children in a zero-risk household. However, the data highlight the diversity of risks in a population of drug users in treatment and raise questions regarding the possible diversity of outcomes for children that may be relative to their risk exposure.

The sample of new presentations to treatment represented by the national minimum data set was then combined with two other major data sets: the Department of Health census of all problem drug users in treatment facilities in England and Wales in one year; and an estimate of the number of problem drug users who were not in treatment.

Whilst the latter is a conservative estimate, the authors proposed that a ratio of three 'out of treatment' for every 'in treatment' problem drug user was a defensible estimate. Using both data sets along with the proportion who were parents in the national data set (1996–2000), an estimate was derived. Parental drug problems have been conservatively estimated to affect 250 000–350 000 children under 16 years of age in England and Wales (representing 2–3 per cent of all children under 16) and 41 000–59 000 (or 4–6 per cent) of children in Scotland (Advisory Council on the Misuse of Drugs, 2003).

The Canadian Addiction Survey (Adalf, Begin & Sawka, 2005) collected detailed information on alcohol, cannabis and other drug use from a random sample of 13 909 respondents, 15 years of age or older, who were interviewed by telephone. Although the survey collected information on the number of children under the age of 18 years who were dependent on the respondent for their well-being and welfare, the level of care-giving or parenting provided by the respondent was not obtained, making it difficult to estimate the number of children directly affected by parental substance misuse. Notably, however, 1.8 per cent of the sample reported that they had sustained harm to 'home life or marriage' due to their drinking and a further 10.5 per cent indicated that they had experienced 'family problems or marriage difficulties' associated with other people's drinking in the last year.

#### Key point

International household surveys and other population estimates suggest that approximately 10 per cent of children live in households where there is parental alcohol abuse or dependence and/or substance dependence.

### 1.4.1 International estimates of parental substance misuse in child welfare settings

There have been a small number of studies that have attempted to estimate the prevalence of parental substance misuse in families involved within the child welfare system. In general, however, such studies have been affected by inconsistent data collection procedures operating across States. This has resulted in significant variation in levels of reporting. Tatara (1990) reports on a national survey of child protection agencies, which found that 24.2 per cent of substantiated reports of child abuse and neglect involved parental use of alcohol or other drugs.

Results from a Child Welfare League of America survey of ten American States conducted in 1991 found that 36.8 per cent of children (11 834) serviced by State welfare agencies and 57.4 per cent of children (64 200) served by voluntary child and protective services were affected by problems associated with alcohol and other drug use<sup>3</sup> (Curtis & McCullough, 1993). However, it is important to note that the rates across participating States ranged from 4.2 per cent in North Carolina to 60.0 per cent in Rhode Island, suggesting significant variations in practices across States. This is a wider range than has previously been reported, suggesting that between 43 and 67 per cent of care proceeding cases found drugs and/or alcohol implicated (Murphy et al., 1991; Famularo et al., 1992).

The 1999 Fifty State Survey (Peddle & Wang, 2001) collected detailed information on levels of reported and substantiated child abuse nationwide and also sought information from each State liaison officer on the

major problems presented by their caseloads. Forty-one State liaisons responded to the latter question with 35 States (85%) identifying substance abuse as one of the top two problems exhibited by families reported for maltreatment (National Center on Child Abuse Prevention Research, 2001). The study is important in that it provides an estimate of the number of children referred to child protective services, calculated as 46 per 1000 children alleged to be victims of child maltreatment, with a substantiation rate of just over 15 cases per 1000 children per year. Additionally, the authors estimated that the mortality rate as a result of child abuse and neglect was 1.99 per 1000 children per year, with 80 per cent of fatalities occurring in those under the age of five years, and 40 per cent occurring in children under the age of one year.

There have been a small number of British studies that have attempted to establish the extent of parental substance misuse within a child protection sample. A study by Forrester (2000) examined the files of 50 families with 95 children on the Child Protection Register (CPR) in an inner London area, as well as drawing on ratings provided by social workers regarding levels of parental substance use and whether it presented as a child protection concern. In total, the social workers identified 26 families (or 52%) in the sample as having a carer or carers who used substances at a level that was deemed a child protection concern. The principal substances used were alcohol (12 families) and heroin (8 families). Substance-using families were found to be significantly over-represented in neglect cases, with heroin use by a carer showing particularly high correlation with a registration of neglect. There was also a

<sup>3</sup> The higher percentages reported by voluntary agencies are claimed to reflect higher levels of routine screening by these agencies for problems with alcohol and drugs.

greater likelihood for legal proceedings to be instigated in substance-using families compared to non-substance-using families.

An attempt to derive an estimate of the impact of parental substance use in cases of child maltreatment has been made by the Canadian Incidence Study of Reported Child Abuse and Neglect (Trocmé et al., 2001). Drawing on a representative sample of 51 child and protective services across Canada, information from a total of 7672 child maltreatment investigations was used to derive a national estimate of the number of cases of child maltreatment reported to and investigated by child welfare authorities. This analysis found that a substantial subpopulation of adults involved in child welfare cases (15%) had confirmed substance abuse problems. There was also evidence that families with substance abuse problems were more likely to have previous referrals to child welfare services and to experience significantly more personal and social disadvantage and less residential stability than those who were not rated as confirmed substance abusers (Wekerle et al., 2004).

Parental alcohol and/or drug abuse was associated with different patterns of child maltreatment, with the highest rates reported in substantiated cases of emotional maltreatment (58%) and neglect (50%) followed by physical abuse (40%) and sexual abuse (40%). The CIS study helped to illuminate not only the rates of substance abuse in neglect cases, but also the profile of risk – with caregiver substance abuse associated with elevated rates of emotional abuse and neglect but not with physical or sexual abuse. Additionally, for substance users, neglect was more strongly associated with single female caregivers.

These figures are consistent with findings from the Quebec Incidence Study of Reported Child Abuse, Neglect, Abandonment, and Serious Behavioural Problems in which workers identified alcohol and drug issues in 45 per cent of substantiated cases of child neglect. For these families, substance abuse was not seen as the direct cause of child neglect but rather a contributing factor that coexisted with other family issues such as domestic violence which coexisted with 41.7 per cent of families where child neglect had been substantiated, criminal activity (32.2%) and mental health problems (31.3%), emphasising the clustering of adverse conditions that may increase the risk of neglect and other harms to both child and parent (Mayer et al., 2004).

#### Key point

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.

## 1.5 Children affected by parental substance misuse: further analyses of Australian data

It is clear that further work needs to be undertaken before a reliable estimate can be made of the number of Australian children living in families with parental substance misuse. Given the paucity of direct research evidence and the intrinsic complexity of identifying causal linkages between parental substance use and harm to children, it is crucial that we use different types of data to initiate a process of estimation and to work out what the key gaps are in our knowledge. The more urgent question regarding the impact this has on children can be answered indirectly only and in a rather unsatisfactory manner. Nonetheless, the following section will be the first Australian attempt to address this question systematically. In the first instance, analysis of national surveys will be undertaken to assess the use of substances in households where dependent children under the age of 12 live, and to examine possible differences in substance use profiles by household structure (in particular, in relation to single parents). Additionally, the Longitudinal Study of Australian Children (LSAC) provides the first wave of information that may enable tentative links to be drawn between parental drinking and child functioning, both as a consequence of child age and by household structure.

Then, an analysis of studies of subpopulations of identified adult risk groups – amphetamine users and individuals identified through the criminal justice system – is presented. This is the beginning of an attempt to account for the concept of ‘cumulative disadvantage’ in adults living with dependent children who may not only be substance users, but may also have a number of comorbidities and environmental deficits that may mediate the relationship between parental substance use and child outcomes.

### 1.5.1 National Drug Strategy Household Survey (NDSHS)

The Australian Institute of Health and Welfare (2005a & b) published findings from the 2004 National Drug Strategy Household Survey (NDSHS) based on 29 445 individuals using drop-and-collect and computer-assisted telephone interviews. Substance use questions were asked only of those aged 14 years and over. Just over 8 per cent of Australians reported drinking at levels considered risky or high risk for both short-term and long-term harm in the previous 12 months. Cannabis was reported to be the most commonly used illicit drug, used by 33.6 per cent of respondents in their lifetime. There were gender differences with 14.4 per cent of men and 8.3 per cent of women reporting cannabis use in the last 12 months. The use of opioids and amphetamines was relatively low, with 0.3 per cent of the sample reporting use of opioids in the last year and 3.2 per cent of respondents reporting amphetamine use in the last year.

Further analysis of this data set was undertaken using household type as the unit of measurement, as parental status of respondents is not recorded in the NDSHS. Thus, the current analysis was restricted to the subsample of adults (defined as more than 17 years of age) who lived in the same household as dependent children *under* the age of 12 years. The analysis presented below refers to a sample of 6629 adults (63% female; mean age 36.3 years), who lived in households with a total of 11 691 dependent children under the age of 12 years (1.76 children to each adult). Within this cohort, 77.8 per cent of the dependent children under 12 live with couples, 16.3 per cent with single parents (79.7% with women and 20.3% with men) and 5.9 per cent within some other form of household configuration. The key analyses for risk exposure to dependent children living in these households are reported according to primary substance of use.

NHMRC definitions of binge drinking (NHMRC, 2001): for short-term risk

	Low risk (standard drinks)	Risky (standard drinks)	High risk (standard drinks)
Males	Up to 6 on any one day, no more than 3 days per week	7–10 on any one day	11 or more on any one day
Females	Up to 4 on any one day, no more than 3 days per week	5–6 on any one day	7 or more on any one day

**Binge drinking and family characteristics:** Binge drinking was defined according to National Health and Medical Research Council (NHMRC) Guidelines for risky and high-risk drinking in the short term. The analyses reported for the NDSHS used this definition to allow for comparability with other large national data sets reported later in this report.

In terms of binge drinking, 16.7 per cent (384) of adult men living in households

with children under 12 years drank at levels that would be classified as binge drinking at either risky or high-risk levels. Similarly, 12.22 per cent (459) of adult women living in households with dependent children also engaged in binge drinking according to the definitions above.

Tables 1.1 and 1.2 present data for men and women separately according to household type.

Table 1.1: Men binge drinkers  
(>7 standard drinks, 2–3 times a month or more) by household type

	Single household with dependent children (n = 234)	Couple household with dependent children (n = 1943)	Other & missing (n = 120)
Binge drinkers	49 (20.9%)	302 (15.5%)	33 (27.5%)
Non-binge drinkers	185 (79.1%)	1641 (84.5%)	87 (72.5%)

Table 1.2: Women binge drinkers  
(>5 standard drinks, 2–3 times a month or more) by household type

	Single household with dependent children (n = 800)	Couple household with dependent children (n = 2643)	Other & missing (n = 237)
Binge drinkers	146 (18.3%)	275 (10.4%)	38 (16%)
Non-binge drinkers	654 (81.7%)	2368 (89.6%)	199 (84%)



When households are defined as ‘couple households with children under 12 years’, 10.4 per cent of adult women reported binge drinking. However, this rises to 18.35 per cent when the household is defined as ‘single woman living with dependent children and non-dependent children’.

**Overall exposure to binge drinking:** Using the survey as indicative, and generalising this to the experiences of 1000 children, an estimated 778 children will be dependent on an adult couple. Of these, 102 will be residing in a household with a male who engages in binge drinking and 58 will be residing in a household with a female who binge drinks. It is probable that in most of these cases the adult will be a parent, although as this NDSHS does not specifically ask for parental status, this can be a reasonable inference not a strong conclusion.

Of the 163 children, who live in single adult households, 130 will live with single mothers and 33 with single fathers. Of these, 26 will be exposed to their mother binge drinking and 4 to their father’s binge drinking. Thus, for 1000 children under the age of 12 years, if we assume (conservatively) 100 per cent overlap within couple binge drinking, 132 children will be exposed to regular binge drinking in the household.

#### Key point

For every 1000 Australian children under the age of 12 years, at least 132 will be exposed to binge drinking.

**Illicit substance use and family characteristics:** The analyses of illicit drug use were restricted to cannabis, methamphetamine (MA) and heroin. As shown in Table 1.3,

Table 1.3: Use of cannabis in the previous year by household type

	Single household with dependent children (n = 1109)	Couple household with dependent children (n = 4960)	Other (n = 387)
Use in the last year	225 (20.3%)	538 (10.8%)	51 (13.2%)
No use in the last year	884 (79.7%)	4422 (89.2%)	336 (86.8%)

Table 1.4: Cannabis use by household type of those who have used in the last 12 months

	Single household with dependent children (n = 225)	Couple household with dependent children (n = 531)	Other (n = 51)
Daily use	54 (24.0%)	97 (18.3%)	9 (17.6%)
Weekly use	57 (25.3%)	122 (23%)	14 (27.5%)
Monthly	28 (12.4%)	59 (11.1%)	7 (13.7%)
Every few months/ once or twice a year	86 (38.2%)	253 (47.6%)	21 (41.2%)

20.3 per cent of single parent households and 10.8 per cent of couple households reported cannabis use in the last year. Further analysis was undertaken to determine frequency of use for those who had used in the last 12 months. As shown in Tables 1.3 and 1.4, 5.46 per cent (353/6456) of all adults living with dependent children under the age of 12 used cannabis on at least a weekly basis, while 2.47 per cent (160/6456) of all adults living with dependent children used cannabis on a daily basis.

Lifetime cannabis users were slightly younger than non-users (35.2 versus 37.5 years) among those with dependent children. There were also no clear gender differences in the likelihood of male or female daily cannabis users being single parents or using cannabis at home.

A risk rate can be calculated for each parent group, stratified by the number of children living in those households under the age of 12. This is a conservative estimate as it assumes that, within couple families, it is always the same mothers and fathers who use. With this caveat in mind, we find that the closest marker we have of risk to dependent children from cannabis is daily use (given that this involves use at home in the majority of cases). The analysis shows that 2.47 per cent (160/6456) of adults in the survey living with dependent children under 12 reported daily cannabis use.

Key point

For every 1000 Australian children under the age of 12 years at least 24 will be exposed to one individual who uses cannabis on a daily basis.

The lifetime use of methamphetamines was reported by 2492 adults (9.4% of respondents), of whom roughly one-third (n = 855) reported recent use (last 12 months). Among those who reported methamphetamine use, 180 had dependent children less than 12 years of age. See Table 1.5 for analysis by household type.

One hundred and eighty adults who lived with children under 12 reported methamphetamine use in the last year, equating to a rate of 2.78 per cent of the adult population 18 or over who are responsible for a mean of 1.76 children. In other words, for every 1000 adults in Australia (assuming the representativeness of the sample), 49 dependent children under the age of 12 are living in a household with an adult who has used methamphetamines in the last year (or slightly under 5 per cent).

A further analysis was conducted using the more stringent risk parameter ‘use within the last month with use at least once at home in the last year’. Thirty-two adults living with children under 12 years fall into

Table 1.5: Use of methamphetamines in the previous year by household type

	Single household with dependent children (n = 1109)	Couple household with dependent children (n = 4960)	Other (n = 387)
Use in the last year	74 (6.7%)	93 (1.9%)	13 (3.4%)
No use in the last year	1035 (93.3%)	4867 (98.1%)	374 (96.6%)



this category. These 32 adult methamphetamine users lived in households with an average of 1.76 children under the age of 12. Thus, using the same method as above, this equates to 0.48 per cent of the population living with dependent children. For every 1000 adults, this equates to 8.4 children living in households with at least one member of the household using methamphetamines at least monthly and having done so at home in the last year.

### Key point

For every 1000 Australian children under the age of 12 years, 8.4 will be exposed to one individual who uses methamphetamine at least monthly and reporting use of this drug in their home.

There was relatively little reported heroin use amongst those respondents with dependent children. Of those living with dependent children, 136 (2.1%) reported that they had ever used heroin, with 15 of these reporting that they had used heroin in the last year (11.1% of lifetime users, but 0.2% of all adults living with dependent children).

Five of this group reported daily use and a further three reported that they had used at least once a week in the last year. Given the low frequency of use in this sample, further analyses were not conducted.

**Overlap between alcohol and multiple drug use:** There is an unusual pattern of drinking in relation to lifetime use of methamphetamines (MA), cannabis and heroin among adults living with dependent children under the age of 12 years, as shown in Table 1.6 below.

Overlaps in last-year use between alcohol and illicit drugs are assessed for alcohol and each of the three target illicit drugs. Among the adults responding to the survey (n = 6629), there are 17 daily users of both alcohol and cannabis, but nobody who used both alcohol and methamphetamines or alcohol and heroin daily. The majority of daily drinkers (96.4%) have not used methamphetamines in the last year, and there is very little indication of increased risk of frequent methamphetamine use among regular drinkers. Only 17.2 per cent of daily drinking adults living in households with fewer than 12 children reported any cannabis use in the previous year (n = 63), while daily cannabis

Table 1.6: Frequency of drinking in the previous year by illicit drug use

	Daily	5–6 days per week	3–4 days per week	1–2 days per week	2–3 days per month	Once per month	Less often	$\chi^2$ , sig
Lifetime MA use	15.9%	18.3%	17.9%	13.4%	12.3%	13.2%	9.7%	40.77***
Lifetime cannabis use	68.1%	67.1%	64.2%	57.8%	51.6%	48.8%	45.1%	149.88***
Lifetime heroin use	4.7%	2.6%	1.5%	1.5%	1.5%	2.8%	2.3%	20.02**

users in this group were most likely to drink less than once a month. Again, with heroin use there is no clear indication of an overlap between patterns of drinking and heroin use, although this would be harder to detect as a result of the low prevalence of last-year heroin use.

**Overview of the secondary analysis of NDSHS:** The focus of this report is on risks to children under 12 from parental substance misuse. The NDSHS survey provides links between patterns of substance activity among adults and the number of dependent children living in the same households. It also allows an analysis of the overlaps between different substances to be examined, although the analysis presented does not suggest that heavy alcohol use is associated with frequent use of the three illicit drugs examined, namely heroin, methamphetamine and cannabis.

Around 16 per cent of dependent children under the age of 12 live in a household with someone who reports regular binge drinking. The rates of exposure are increased for single parents (particularly single mothers), with elevated rates among younger single mothers living with dependent children under the age of 12. This does not establish that the children experience adverse effects as a result, but that there is some regular binge drinking in the household by at least one adult.

Levels of use of the three target illicit drugs were much lower, and only partially linked to drinking patterns, with 49 children per 1000 sharing a household with an individual who reported methamphetamine use in the previous year, 96.6 children sharing a household with an individual who had used cannabis in the previous year, and 0.7 children per 1000 exposed to an individual reporting last-year heroin use.

### Key point

It is possible to derive an estimate of the number of children exposed to adult substance use based on the total number of children aged 12 years or less living in Australia (Australian Bureau of Statistics, 2004). 2004 census data estimated that there were 1 755 343 males and 1 666 031 females in this age group, totalling 3 421 374 children. Thus, 13.2 per cent or 451 621 children are at risk of exposure to binge drinking in the household by at least one adult; 2.3 per cent or 78 691 live in a household containing at least one daily cannabis user. Finally, 0.8 per cent or 27 370 live in a household with an adult who uses methamphetamine at least monthly and reports doing so in their home.

### 1.5.2 The 2001 National Health Survey (Australian Bureau of Statistics, 2003)

This report estimated that 1.8 million people in Australia (9.6% of the population) had a long-term mental or behavioural problem of more than six months duration. Of these, 130 600 (0.7% of the population) were related to alcohol or drug problems. Alcohol and drug problems were estimated to occur in 6700 individuals between birth and the age of 17. While 'high' or 'very high' levels of psychological distress occurred in 12.3 per cent of people without alcohol or drug problems, 50.1 per cent of individuals with alcohol or drug problems reported 'high' or 'very high' levels of psychological distress. People with 'very high' levels of psychological distress were also more likely than those with low levels of psychological distress to be high-risk drinkers (7.3% compared to 3.8%).

The original data analysis undertaken for this report was based on 26 862 cases (52.5% female). On average, there were 3.1 individuals in each household, of whom an average of 1.9 were adults. The typical family composition of the households examined is shown in Table 1.7.

The analysis was restricted to adults; in other words, to the 17 918 respondents aged 18 or over. The first analysis shown in Table 1.8

below is the interaction between number of children living in the household and the alcohol risk category.

Thus, there are no differences in alcohol risk status by the number of children living in the household, although households with no children have both the highest rates of alcohol abstinence and of high-risk drinking adults.

Table 1.7: Composition of family structures

	Frequency	Percentage
Couple and child(ren)	12 500	46.5
Couple only	4574	17.0
Single person and child(ren)	3109	11.6
Single person	4326	16.1
All other households	2353	8.8
<b>Total</b>	<b>26 862</b>	<b>100.0</b>

Table 1.8: Levels of risk drinking by number of children in the household for adults only

	No children in household (n = 11 932)	One child in household (n = 2434)	Two or more children in household (n = 3552)
No alcohol consumption	1345 (11.3%)	220 (9.0%)	253 (7.1%)
No alcohol in last week	3307 (27.7%)	764 (31.4%)	1028 (28.9%)
Low risk	5867 (49.2%)	1225 (50.3%)	1925 (54.2%)
Medium risk	866 (7.2%)	139 (5.7%)	230 (6.5%)
High risk	547 (4.6%)	86 (3.5%)	116 (3.3%)

If alcohol consumption is assessed according to a continuous measure of alcohol, i.e. millilitres of alcohol, by number of children in the household, the effects of no children in the household become more apparent as shown in Table 1.9 below.

In order to compare the NDSHS with the current NHS data set, we also investigated binge drinking for males and females separately using a similar definition of ‘binge drinking’.

For this data set we used a variable reporting the heaviest amount of alcohol consumed in the last three days. For males, binge drinkers were defined as those who had exceeded 70 ml (7 standard drinks) and for females binge drinkers were defined as those who have exceed 50 ml (5 standard drinks). The relationship between binge drinkers, non-binge drinkers and household type is presented in Table 1.11 below. The amount consumed on

Table 1.9: Alcohol measures by the number of children in the household

	No children	One child	Two or more children	F, significance
Average daily alcohol intake over week (ml)	15.4	12.6	13.1	16.86***
Amount alcohol consumed on heaviest day (ml)	37.2	36.5	35.8	0.82

Table 1.10: Alcohol use by NHMRC category for total sample

Alcohol use category	n (%)
No alcohol consumption	490 (6%)
No alcohol in last 12 months	421 (5.2%)
Last drank alcohol >1 week but <1 year	1387 (17%)
Low risk	4733 (58%)
Risky	577 (7.1%)
High risk	556 (6.8%)

Table 1.11: Levels of male binge drinking by household for adults

	Single male without children (n = 2537)	Single male with children (n = 883)	Couple without children (n = 2560)	Couple with children (n = 5611)
Binge	735 (29.0%)	54 (6.1%)	551 (21.5%)	605 (10.8%)
Non-binge	1802 (71.0%)	829 (93.9%)	2009 (78.5)	5006 (89.2%)

the last drinking occasion by men was positively and significantly associated with the total Kessler mental health index ( $r = 0.026$ ,  $p < 0.05$ ).

Rates of binge drinking were somewhat lower in females, with 1482 (1278 according to the table below) females reported binge drinking in the previous week, representing 15.2 per cent of the adult females over the age of 18 in the survey. The amount consumed on the last drinking occasion by women was positively and significantly associated with the total Kessler mental health index ( $r = 0.057$ ,  $p < 0.05$ ). The relationship between binge drinkers, non-binge drinkers and household type is presented in Table 1.12 below.

**Overview of the secondary analysis of NHS data:** Forty-one per cent of the sample reported drinking in the previous week, of whom 749 (6.8%; see Table 1.8) could be classified as drinking at risky and high-risk levels. Two hundred and forty of the 749 high-risk drinkers lived in households with children (32.0% of high-risk drinkers). Thus, 1.3 per cent of adults in the sample are high-risk drinkers who live in households with dependent children.

Six per cent of men living in households with children, but no other adults, reported at least one alcohol binge in the last week. Rates of binge drinking were higher (10.8%) when men reported living in a couple household with children.

In relation to female binge drinking, we found that 15 per cent of females over 18 reported binge drinking in the previous month. Again, breaking this down by household type, we found that nearly 12 per cent of women living in single parent households with children reported binge drinking. However, unlike men, this figure was much lower (6.4%) when women lived in couple households with children.

As with the NDSHS data, there should be a cautious interpretation of these figures. The instruments were not developed with the current study in mind. We have had to examine risk to children in terms of the probability of binge or chronic drinking by adult members of the household, irrespective of their role as a carer of the child. Most importantly, there is no information on child outcome, so it is not possible to determine how patterns of adult alcohol use may impact on children.

Table 1.12: Levels of female binge drinking by household for adults

	Single female without children (n = 2904)	Single female with children (n = 1664)	Couple without children (n = 2625)	Couple with children (n = 5717)
Binge	360 (12.4%)	194 (11.7%)	357 (13.6%)	367 (6.4%)
Non-binge	2544 (87.6%)	1470 (88.3%)	2268 (86.4%)	5350 (93.6%)

### 1.5.3 The Australian Longitudinal Study on Women's Health (Lee et al., 2005)

The Australian Longitudinal Study on Women's Health (ALSWH) is a population-based survey, which examines the health of three large cohorts of Australian women over a 20-year period. In addition to collecting information about factors influencing women's health, the study obtains information on the frequency and quantity of alcohol consumption and use of drugs for non-medical purposes. The project is the largest of its kind in Australia collecting information from over 40 000 women and commenced its first wave of data collection in 1996 with respondents in three age groups – 18–23 years, 45–50

years and 70–75 years. Each cohort is surveyed once every three years via surveys sent in the mail to assess how their health has changed. For further information on the ALSWH, see <http://www.sph.uq.edu.au/alswh>

Data from the third survey of the cohort in the youngest age group were analysed to determine levels of alcohol consumption and illicit drug use. The respondents were aged 25–30 years at the time of data collection (March 2003). Respondents were grouped according to the ages of children who were living at home and were counted twice if the ages of the children fell in two separate categories. It is noted that the relationship of the women to the child was not recorded and for some cases the women may not be the biological mother or primary caregiver.

Table 1.13: Alcohol use in women (25–30 years) and number of children

	No children living in household	Child under 12 months	Child 1–5 years	Child 6–12 years	Child 13–16 years
<b>Weighted n</b>	<b>6074</b>	<b>951</b>	<b>2104</b>	<b>878</b>	<b>97</b>
Alc NHMRC	%	%	%	%	%
Non-drinker	6.13	11.95	12.00	11.30	9.90
Rarely	20.36	36.25	40.01	38.73	31.60
Low risk	69.27	50.34	45.94	45.36	53.46
Risky	3.74	1.24	1.58	3.85	2.05
High risk	0.50	0.22	0.47	0.77	2.99
	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
<b>BINGE</b>	%	%	%	%	%
Never	25.47	49.97	43.76	36.80	35.71
Less than 1/month	37.86	38.39	38.90	36.74	34.77
1/month	21.81	8.02	11.01	15.02	17.75
1/week	12.89	2.56	5.01	8.97	7.28
> 1/week	1.97	1.06	1.32	2.47	4.48
	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Levels of alcohol consumption were analysed according to NHMRC guidelines to assess long-term and short-term risk (binge drinking). Past (lifetime) or present (within the past 12 months) use of cannabis or other drugs was also analysed.

This analysis indicates that, in general, women in the 25–30 year age group have low rates of high-risk and risky alcohol use, with less than 2 per cent with children aged 1–5 years and approximately 5 per cent with children aged 6–12 years falling into this category. Rates of binge drinking are somewhat higher with 11 per cent of women with

children aged 6–12 years reporting a binge of once or more per week. This is somewhat lower (6%) for women with children aged 1–5 years.

There were high rates of illicit drug use with approximately 8 per cent of women with older children (6–12 years) and 5 per cent of women with younger children (1–5 years) reporting current cannabis use. Current multiple/other drug use was reported by 16 per cent of women with older children (6–12 years) and 10 per cent of women with younger children (1–5 years).

Table 1.14: Illicit drug use in women (25–30 years) and number of children

	No children living in household	Child under 12 months	Child 1–5 years	Child 6–12 years	Child 13–16 years
<b>ILLICITS</b>					
Never	36.08	42.38	39.30	33.83	35.14
Past marijuana only	25.84	34.81	32.03	28.22	27.26
Current marijuana only	5.82	2.33	5.06	7.73	8.88
Past multiple/other drugs	12.63	13.66	13.69	13.60	10.20
Current multiple/other drugs	19.63	6.81	9.92	16.62	18.52
	100%	100%	100%	100%	100%

### 1.5.4 Longitudinal Study of Australian Children (LSAC)

This study, also known as *Growing Up in Australia*, (Sanson et al., 2002), is a longitudinal study of over 10 000 children and their families recruited in 2004. Each family will be followed up at two-year intervals until at least 2010. The initial sample consisted of 5104 infants and 4976 4–5 year olds, although refusal rates have meant that children from families with lower income are under-represented.

The data presented in this section were analysed by Professor Bryan Rodgers and Dr Tanya Caldwell, Australian National University, specifically for this report. These data were derived from a preliminary analysis of Wave 1 data for both infant and 4–5 year-old children, and report on alcohol use by parents.<sup>4</sup>

What is unique about the LSAC data is that data on both partners in the family unit are collected (where this applies), and this will be tested against child outcomes, both cross-sectionally and longitudinally. Unfortunately, at the time of the current report,

Table 1.15: Number (%) of parents engaging in risky and binge drinking

	Babies (<1 year old) (n = 5107)	Children (age 4) (n = 4983)
	n = 4630 (90.7% of sample)	n = 4286 (86.0% of sample)
<b>Mothers from couples</b>		
<b>Consumption</b>		
Not in the past year	719 (18.7)	627 (17.8)
Occasional (<monthly)	1091 (28.3)	926 (26.3)
Light	1506 (39.1)	1309 (37.1)
Moderate	425 (11.0)	513 (14.5)
Long-term risky: 15–28 per week	107 (2.8)	137 (3.9)
Long-term high risk: ≥29	7 (0.2)	14 (0.3)
Missing data	775/4630 (16.7% total)	760 (17.7% of total)
<b>Binge drinking (≥5 standard drinks, ≥ 2–3 times a month)</b>		
No	3626 (93.5)	3199 (89.9)
Yes	252 (6.5)	358 (10.1)
Missing	752 (16.2% of total)	729 (17.0% of total)

<sup>4</sup> This report uses confidential unit record files from the Longitudinal Study of Australian Children (LSAC) survey. The LSAC Project was initiated and is funded by the Australian Government Department of Family and Community Services (FaCS) and is managed by the Australian Institute of Family Studies. The findings and views reported in this report, however, are those of the authors and should not be attributed to either FaCS or the Australian Institute of Family Studies.



	Babies (<1 year old) (n = 5107)	Children (age 4) (n = 4983)
<b>Fathers from couples</b>	<b>n = 4630 (90.7% of sample)</b>	<b>n = 4286 (86.0% of sample)</b>
<b>Consumption</b>		
Not in the past year	282 (8.0)	324 (9.9)
Occasional (<monthly)	486 (13.8)	438 (13.4)
Light	2040 (57.8)	1786 (54.7)
Moderate	570 (16.1)	519 (15.9)
Long-term risky: 29–42 per week	120 (3.4)	154 (4.7)
Long-term high risk: >43	34 (0.7)	42 (1.3)
Missing data	1098/4630 (23.7% of total)	1023 (23.9% of total)
<b>Binge drinking (<math>\geq 7</math> standard drinks, 2–3 times a month or more)</b>		
No	2671 (75.4)	2451 (74.9)
Yes	872 (24.6)	823 (25.1)
Missing	1087 (23.5% of total)	1012 (23.6% of total)
<b>Single mothers</b>	<b>n = 474 (9.3% of sample)</b>	<b>n = 660 (13.2% of sample)</b>
<b>Consumption</b>		
Not in the past year	82 (24.6)	70 (14.3)
Occasional (<monthly)	143 (42.9)	161 (32.8)
Light	87 (26.1)	193 (39.3)
Moderate	17 (5.1)	44 (9.0)
Long-term risky: 15–28 per week	3 (0.9)	21 (4.3)
Long-term high risk: >29	1 (0.3)	2 (0.4)
Missing data	141 (29.6% of total)	169 (25.6% of total)
<b>Binge drinking (<math>\geq 5</math> standard drinks, 2–3 times a month or more)</b>		
No	290 (86.6)	399 (90.9)
Yes	45 (13.4)	94 (19.1)
Missing	139 (29.3% of total)	167 (25.3% of total)

insufficient data cleaning had taken place to allow more than basic data to be presented and no analyses were available on child outcomes. Nonetheless, Table 1.15 presents information on consumption levels of parental drinking, using the NHMRC guidelines for couples and for single mothers. As with both the NDSHS and the NHS data sets in households where there are children, we find that the rates of binge drinking are highest amongst single female households and lowest in women who are in couple households with children.

In summary the LSAC data suggest:

For mothers living in couple relationships with children under the age of one year:

- 3/100 mothers consume quantities of alcohol per week that place them at risk or at high risk of long-term damage.
- 6.5/100 mothers engage in binge drinking, two to three times a month or more.

For fathers living in couple relationships with children under the age of one year:

- 4.1/100 fathers consume quantities of alcohol per week that place them at risk or at high risk of long-term damage.
- 24.6/100 fathers engage in binge drinking, two to three times a month or more.

For mothers living in single parent households with children under the age of one year:

- 1.1/100 mothers consume quantities of alcohol per week that place them at risk or at high risk of long-term damage.
- 13.4/100 mothers engage in binge drinking, two to three times a month or more.

For mothers living in couple relationships with children under the age of four years:

- 4.2/100 mothers consume quantities of alcohol per week that place them at risk or at high risk of long-term damage.
- 10.1/100 mothers engage in binge drinking, two to three times a month or more.

For fathers living in couple relationships with children under the age of four years:

- 6/100 fathers consume quantities of alcohol per week that place them at risk or at high risk of long-term damage.
- 25.1/100 fathers engage in binge drinking, two to three times a month or more.

For mothers living in single parent households with children under the age of four years:

- 4.7/100 mothers consume quantities of alcohol per week that place them at risk or at high risk of long-term damage.
- 19.1/100 mothers engage in binge drinking, two to three times a month or more.

# 1.6 Life experiences of people serving community corrections orders

In the first analysis we have used a data set referred to as the ‘Life experiences of people serving community corrections orders (Qld)’. This survey was conducted with 480 respondents, of whom 292 (60.8%) were male. A significant proportion (n = 98, 20.4%) were of Aboriginal and/or Torres Strait Islander ethnicity. Just over half of the sample (53.2%) reported that they had children, averaging 2.43 children. Those who had children who were financially dependent upon them comprised a smaller group (151 respondents). However, 128 individuals reported that they lived with children. Of the 254 individuals who reported that they had children, 121 (48.2%) reported that they lived with them. The number of children is shown in Table 1.16 below.

Women offenders have more children than men (66.5% versus 44.2%,  $\chi^2 = 22.84$ ,  $p < 0.001$ ). Similarly, a higher proportion of women offenders live with their children (43.0% versus 17.0%,  $\chi^2 = 38.84$ ,  $p < 0.001$ ) and more of their children are financially dependent upon them (47.3% versus 31.2%;  $\chi^2 = 12.77$ ,  $p < 0.001$ ).

## Key point

The number of children living in families with an adult serving a community correction order can be estimated. For every 1000 male adults serving a community correction order, there will be 445 who are parents to a total of 1108 children. For every 1000 female offenders, 668 will be parents to a total of 1583 children.

Table 1.16: Total number of children linked to the community sentence sample

	Men (n = 292)			Women (n = 188)		
	Number of offenders	Average no. of children <sup>1</sup>	Total children	Number of offenders	Average no. of children <sup>1</sup>	Total children
No. of natural children	129	2.49	322	125	2.37	296
No. of children living with offender	49	2.22	109	81	1.98	160
No. of financially dependent children	82	1.99	163	77	1.72	133

<sup>1</sup> for each offender with children

**Current patterns of substance use:** A substantial number of respondents ( $n = 270$ , 58.7%) reported that they typically drank seven or more standard drinks on a drinking occasion. In terms of adverse alcohol outcomes, 15.2 per cent of the sample reported that they were not able to stop drinking at least once a month, 13.6 per cent were unable to do things expected of them while drinking at least once a month, 9.8 per cent needed to drink in the morning to get themselves going at least once a month, and 11.1 per cent had experienced blackouts at least once a month.

In relation to parenting, those who lived with children were more likely to be alcohol-abstinent (27.3% compared with 15.1%) and were less likely to drink four or more times a week (9.4% compared to 15.9%;  $\chi^2 = 11.62$ ,  $p < 0.05$ ). However, although those living with children reported drinking less often, they did report higher quantities of alcohol use on each drinking occasion. Thus, those living with children were less likely to typically drink one or two standard drinks per drinking occasion (11.6% versus 16.6%), but were more likely to drink 10 or more standard drinks on each drinking occasion (24.8% versus 18.7%;  $\chi^2 = 14.08$ ,  $p < 0.05$ ). Indeed, the 32 individuals who typically drank more than 10 standard drinks on each drinking occasion and lived with children had an average of 2.5 children in their households, a total of 80 children. Thus, 80 of the 289 (27.7%) children living with respondents in the survey are living with high-dose drinkers, half of whom drank at this level on at least two or more occasions per week.

### Key point

If it is assumed that the sample is representative of a criminal justice population, then for every 1000 individuals receiving community sentences, there are 602 children living in the same households. Of these children, 167 are living with individuals who drink more than 10 standard drinks on a typical occasion.

**Drinking in relation to Australian Alcohol Guidelines (National Health and Medical Research Council, 2001):** Exactly half of the high-risk short-term male drinkers in the group (31/62) were parents, but this was the case for only 25 per cent of the male drinkers who lived with children (15/60). Similarly, only 20.8 per cent of the long-term high-risk male drinkers lived with children. Nonetheless, this would mean that 33 children were living with male respondents who were at risk from high-risk long-term drinking patterns and 47 children were living with male respondents who were at risk of short-term high-risk drinking.

In relation to women, data on a typical drinking day were used to calculate short-term risk. Twenty-nine per cent of the female respondents were low risk, 11.2 per cent risky and 59 per cent high-risk short-term drinkers. In total, 108 children lived with female high-risk short-term drinkers. Only 19 females were identified as long-term high-risk drinkers (10.5%), of whom 11 lived with dependent children, a total of 18 children.

Thus, the overall picture is of more acute short-term risks to children in this population with respondents with children typically reporting less frequent drinking but greater quantities of alcohol consumed on each drinking occasion. A higher proportion of

female short-term high-risk drinkers had children dependent on them (54.1%;  $n = 60$ ) than of either risky (52.4%) or low-risk short-term drinkers (32.1%;  $\chi^2 = 7.41$ ,  $p < 0.05$ ).

**Illicit drug use:** A substantial number of people ( $n = 337$ ; 70.6%) reported that they had used drugs weekly, daily or almost daily – this was the case for cannabis in 54.2 per cent of respondents ( $n = 260$ ), for amphetamines in 35.4 per cent of cases ( $n = 170$ ), for heroin in 17.5 per cent of cases ( $n = 84$ ); 146 individuals (30.6%) reported that their cannabis use had been out of control, 147 (30.8%) that their amphetamine use had been out of control, and 89 (18.7%) that their heroin use had been out of control.

Forty-two daily or almost-daily cannabis users had children financially dependent on them, while 83 daily or almost-daily cannabis users lived with children. Ten daily or almost-daily amphetamine users have children dependent upon them financially, while 21 daily or almost-daily amphetamine users have children living with them. Finally, seven daily or almost-daily heroin users have children financially dependent upon them and 17 live with children.

There were associations between lifetime use of the three target illicit drugs and number of psychiatric diagnoses made in the lifetime. Those who had ever used heroin had significantly more diagnoses than those who had never used (mean of 2.2 versus 1.0;  $t = 7.25$ ,  $p < 0.001$ ). This was also the case for lifetime users of amphetamines (1.8 versus 0.8;  $t = 7.12$ ,  $p < 0.001$ ) and for lifetime users of cannabis (mean of 1.5 versus 0.8,  $t = 3.91$ ,  $p < 0.001$ ).

Forty-six respondents (9.6%) reported that they had never used any of heroin, amphetamine or cannabis, 136 (28.3%) had ever used one of them, 127 (26.5%) had ever used two of them, and 171 (35.6%) had used all three of the target drugs at some point; 40.4 per cent of those who had used all three drugs had children financially dependent on them ( $n = 69$  respondents) and 27.2 per cent of them ( $n = 46$ ) lived with children. The breakdown of lifetime diagnoses by number of target substances used is shown in Table 1.17 below.

Table 1.17: Number of target substances used, by lifetime diagnoses

	0	1	2	3	$\chi^2$ , significance
Depression	26.1%	31.6%	37.0%	59.1%	32.46***
Bipolar disorder	10.9%	2.9%	6.3%	11.1%	8.31*
Personality disorder	6.5%	4.4%	3.9%	10.5%	6.73
Drug dependence	2.2%	6.6%	18.9%	52.6%	106.93***
Schizophrenia	2.2%	5.1%	5.5%	12.3%	9.32*
Anxiety	10.9%	9.6%	20.5%	39.8%	44.81***
Alcohol dependence	8.7%	11.0%	12.6%	17.5%	4.09
ADHD	6.5%	7.4%	8.7%	9.9%	0.92
Other mental illness	8.7%	5.1%	11.8%	11.1%	4.38

**Identifying children vulnerable from offending parents:** Thus, those who have used all three target drugs have the highest rate of each lifetime diagnosis, significantly so for depression, bipolar disorder, schizophrenia and anxiety. A grouping was created for those who have used all three of the target drugs and who have had three or more psychiatric diagnoses at some point in their lives. There were 78 individuals who fulfilled these criteria (16.3% of the total sample). Twenty-three individuals in this group had a total of 36 children financially dependent on them and 20 respondents lived with a total of 36 children.

Thus, for a population of 1000 offenders undergoing community sentences, 42 offenders have psychiatric co-morbidities including multiple substance abuse history and will be living with children.

Nearly 20 per cent of female respondents and 14 per cent of male respondents fell into this multiple vulnerability group. Of those who had their own children and had multiple morbidities, 19 reported that the children lived with the other parent, but nine reported that the child/children lived with them alone, and four that the child/children lived with them and the other parent.

A higher proportion of the multiple vulnerability group reported that they had 'poor' health (11.5% compared to 4.1%,  $\chi^2 = 21.86$ ,  $p < 0.001$ ) and more reported that they were daily or almost-daily users of cannabis (37.2% versus 22.2%;  $\chi^2 = 18.98$ ,  $p < 0.01$ ) and heroin (15.4% versus 3.0%;  $\chi^2 = 162.14$ ,  $p < 0.001$ ). However, there was no difference in daily or almost-daily amphetamine use (12.2% versus 9.3%;  $\chi^2 = 3.42$ ,  $p = 0.64$ ).

The group rendered highly vulnerable by high number of lifetime psychiatric diagnoses and multiple substance use also reported significantly greater involvement in a number of offence categories.

**Summary:** The database on community offenders is an exceptionally rich source of information that has been only superficially examined for the current purposes. However, this brief analysis has provided further evidence of a complex interweaving of substance-related problems and other mental health issues in a 'vulnerable' population, who both live with and are financially responsible for a significant number of children. While not all of the children born to, living with or financially dependent on the offenders are at risk, there are a range of risk factors including binge and risky drinking, multiple substance use, diagnosed mental health problems and criminal activities that render the overall population vulnerable to cumulative disadvantage.

# 1.7 Patterns of amphetamine use

The second database analysed is 'Patterns of amphetamine use' obtained by the Crime and Misconduct Commission. This sample consisted of 690 individuals (55.2% male), with a mean age of 28.3 years. Two hundred and seven (30.2%) reported that they had children, averaging 1.7 children each. Of these, 115 (56.1%) were women.

A higher proportion of amphetamine users who had children had experienced physical violence from their partners (36.6% compared with 27.2%) and nearly three times as many experienced regular partner violence compared to amphetamine users without children (9.4% versus 3.2%;  $\chi^2 = 11.48$ ,  $p < 0.01$ ). A higher proportion had also been subject to physical violence from friends and

acquaintances than those without children (34.0% versus 24.7%;  $\chi^2 = 6.09$ ,  $p < 0.05$ ). Finally, amphetamine users with children were more likely to experience violence from family members (26.7% versus 19.5%) and to experience violence from strangers (10.1% of amphetamine users with children versus 5% of those without children;  $\chi^2 = 6.84$ ,  $p < 0.05$ ).

Although this may reflect gender differences in the experience of violence (female amphetamine users were significantly more likely to have experienced violence from close friends, acquaintances and strangers, but not from partners or family members, than male amphetamine users), it is also likely to have an effect on the child, irrespective of whether they are present during the acts of violence. Table 1.18 below outlines the rates of different violent behaviours by parental status.

Table 1.18: Frequency of violence by whether the user has dependent children

	Users with children			Users without children			$\chi^2$ , sig
Experience violence from	Never	Once or twice	Often	Never	Once or twice	Often	
Partners	63.4%	27.2%	9.4%	72.2%	24.6%	3.2%	12.48***
Close friends	73.6%	23.4%	3.0%	77.6%	21.1%	1.3%	2.77
Friends	66.0%	30.5%	3.5%	75.3%	22.3%	2.4%	6.09*
Family members	73.3%	20.8%	5.9%	80.5%	17.3%	2.2%	7.92*
Strangers	71.4%	18.6%	10.1%	78.7%	16.3%	5.0%	6.84*

\*  $p < .05$ , \*\*\* $p < .001$



Among women, the likelihood of experiencing violence was markedly increased among those with children. Women amphetamine users with children were more than three times as likely to report violence from their partner occurring 'often' (12.5% versus 3.9%;  $\chi^2 = 8.10$ ,  $p < 0.05$ ). They were also more likely to experience violence occurring often from family members (5.3% versus 0;

$\chi^2 = 9.71$ ,  $p < 0.01$ ) and from strangers (7.3% versus 3.4%), although the latter difference did not attain statistical significance ( $\chi^2 = 4.16$ , 0.13).

**Drug use and expenditure:** For the whole sample, differences in current patterns of substance use are reported, as a function of parenting status, in Table 1.19 below.

Table 1.19: Frequency of use of drugs and average daily spend in the last six months by parenting status

	Users with children	Users with no children	t, significance
Days used base amphetamines	59.1 days	43.4 days	2.78**
Average spend on base amphetamines per day	\$67.57	\$66.82	0.14
Days used ice	55.1 days	27.6 days	2.90**
Average daily spend on ice	\$72.96	\$66.99	0.58
Days used speed powder	42.2 days	37.8 days	0.37
Average daily spend on speed powder	\$76.48	\$61.74	0.06
Days used prescribed amphetamines	24.4 days	17.8 days	0.44
Average daily spend on prescribed amphetamines	\$4.66	\$11.70	0.21
Days used BZD	69.4 days	46.2 days	2.32*
Average daily spend on BZD	\$1.88	\$4.35	2.35*
Days used alcohol	62.7 days	63.5 days	0.89
Average daily spend on alcohol	\$22.81	\$30.05	2.23*

\*  $p < .05$ ; \*\*  $p < .01$

Amphetamine users with children reported more frequent use of base amphetamine and ice, as well as more frequent use of benzodiazepines. Amphetamine users without children reported spending more per day on benzodiazepines and alcohol.

From the data provided it was possible to calculate a total amount spent on any form of amphetamine in the last six months. According to this method, amphetamine users with children spent more on all forms of amphetamines in the last six months (\$6044 compared with \$4351 for users without children), but this difference was not statistically significant ( $t = 1.71$ ,  $p = 0.09$ ). Nonetheless, amphetamine users with children were spending an average of \$235 per week on amphetamines, not accounting for other forms of drug use.

The total amount spent on amphetamines was both significantly correlated with age ( $r = 0.10$ ,  $p < 0.01$ ) and with the total number of children of the amphetamine user ( $r = 0.25$ ,  $p < 0.001$ ).

**Summary:** The amphetamine users study provides important insights into the relationship between parenting status and experiencing violence, with amphetamine-using parents, particularly women, subject to violence from a range of known and unknown sources at a much higher rate than amphetamine users without children, with both groups experiencing elevated rates of violence. There is also some indication that the frequency of amphetamine use among drug-using parents and overall spend on amphetamines is higher than for non-parents.

## 1.8 Summary and recommendations

Although drug and alcohol use by parents generates risks for dependent children, the nature and severity of these risks are not clearly understood, nor do they exist in isolation from a wide range of lifestyle complications and psychological and physical co-morbidities that are also associated with problematic and dependent substance misuse. The difficulty in untangling causal relationships in complex, dynamic and socially embedded phenomena ensures that any prevalence estimation will inevitably be restricted by the methods of data collection used and the context examined.

Nonetheless, we have a wide range of data sources available in Australia and from international sources that can provide us with some basic estimation parameters on which we can build, and which can be framed in the context of existing research evidence bases. That each drug user in treatment parents around one child on average indicates the importance not only of effective prevalence assessment of adult populations, in and out of treatment, but an understanding of what risks may accrue to both the hidden and visible populations of children. So our initial parameters are set by assessing substance use and parenting in both general adult and indicated substance-using populations.

The alternative approach to measurement via the parent is through the child, generally by measures of risk or accrued harms identified through education or social services, or by adverse incident reviews. The huge variability in the proportions of drug and

alcohol indications in such cases, in the studies outlined in the chapter, is likely to be exceptionally useful in assessing the relationship between prevalence and visibility in these populations.

However, in order to improve the accuracy of prevalence assessment and risk profile, there needs to be some overlap between the three broad sources of data. This would allow us to answer two key questions. First, how large is the population of children who are at risk; and secondly, what can we do to manage and minimise that risk. The LSAC database will provide one mechanism for linking parental drinking to child outcomes at two different age points and will enable the evolution of alcohol risk over the longitudinal period of study to be mapped, allowing the research team to start the process of disentangling acute from chronic effects of parental substance activity.

This will always be complicated by the multiple influences that are seen to be at play, indicated in the problems of interpreting the Australian databases employed. For example, information on parenting status of adults, age and number of children, living arrangements, household factors and number of adults and parents living with children is not consistently collected across studies. Similarly, several of the studies (such as LSAC and NHS) have collected data only on alcohol and not on illicit drugs, and most of the data collected has been to enable assessment against the NHMRC guidelines for drinking. Furthermore, this is collected only on the respondent. In most cases combined risks across two parents cannot be calculated.

Nonetheless, there are sufficient data consistencies that it is possible to make some inferences and recommendations about risk and harm. The use of alcohol and other drugs in households with dependent children appears to be high. The national databases all point to high rates of binge drinking. While rates vary across each of the studies, there is a clear pattern indicating that the highest rates of binge drinking amongst those with children are for single mothers and the lowest rates are amongst women in couple households. Analyses from the Longitudinal Study on Women's Health also found high rates of illicit drug use, with approximately 8 per cent of women with older children (6–12 years) and 5 per cent of women with younger children (1–5 years) reporting current cannabis use. Current multiple/other drug use was reported by 16 per cent of women with older children (6–12 years) and 10 per cent of women with younger children (1–5 years).

What is clear, however, is that the profile of risk expands beyond the direct effects of substance use in indicated populations. The evidence for a 'cumulative parenting disadvantage' is clear from both the community crime and amphetamines surveys. Elevated levels of substance use are linked to other significant lifestyle and functioning deficits, including exposure to violence, mental health problems, elevated levels of criminality, which are occurring in both adults living with children and those with children who are financially dependent upon them.

### 1.8.1 Recommendations

All national surveys of substance use should collect minimum basic data on number of biological children, number of dependent children, and number of children living in the households of adults.

Surveys of particular high-risk populations should also collect data on number of biological children, number of dependent children, and number of children living in the households of adults. Additional information on whether children are currently or have ever been taken into social services' care should, ideally, also be collected. This could be done as part of the National Minimum Data Set to allow comparisons to be made across jurisdictions.

Data collected on harms to children and children taken into care should include clear information on the referral and decision-making mechanisms and, where multiple reasons are given, the primacy of parental substance use should be stated along with the type of substance use involved. Similarly, the relationship between the type of harm (e.g. neglect or abuse) should be cross-tabulated against the profile of parental risk factors.

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# 2. Impact of parental problem substance misuse on children

## 2.1 Introduction

This chapter will present an overview of current research on the developmental trajectory of children, aged 2–12 years, who are raised in families where either or both parents misuse substances. It is now widely accepted that child outcome is influenced by a range of factors in the environment – from the individual differences of children and parents in the family, the quality of relationships between members of the family, through to the broader social context of the family, including stressful external demands on the family, the availability of support, and the quality of local community resources such as local schools and accessibility of family support services. This has been referred to as an ecological model of family functioning (Rutter & Sroufe, 2000) and will provide the theoretical framework for the literature reviewed. Within this model, parental substance misuse is not inevitably associated with poor child outcome. Rather, child outcomes are the result of complex interactions of factors within the family ecology. The implication of the ecological model is that improving child outcomes requires intervention strategies and policies that can impact on the risk and protective factors across multiple ecological domains influencing families characterised by parental substance misuse.

## 2.2 Parental substance misuse and child outcome: research limitations

Before reviewing this literature, we must acknowledge that methodological limitations in studies of parental substance abuse limit the conclusions that can be drawn for policy and treatment provision. These limitations include a narrow range of illicit drugs that have been investigated, inadequate study design, sampling bias, and measurement difficulties. More broadly, the results of studies conducted internationally can have limited applicability due to the differing cultural contexts of studies.

### 2.2.1 Limitations due to the range of substances studied

Most of the research studying outcomes for children living with parental substance misuse has focused on parental alcohol abuse/dependence. A relatively small number of systematic studies has examined the effects of parental use of illicit drugs. Of these, the focus has been on heroin and cocaine use. Our literature search has not revealed any study investigating the outcomes of children whose parents misused other illicit drugs, such as cannabis or amphetamines.<sup>5</sup> Differences might be expected given that parents using illicit drugs such as opiates typically spend more time and money in drug procurement and have greater levels of engagement in illegal activity compared to families in which alcohol is the problem substance (Hogan, 1998). These activities increase the likelihood that a child will be exposed to

<sup>5</sup> The exception being those investigations into the effects of in utero exposure to cannabis and amphetamines.

criminal activity as well as directly observe drug-using networks within the home. Illicit drugs also present more serious health hazards within the home environment arising both from the equipment used in drug preparation and use, and from the risks of infectious diseases. The relative contribution of parental engagement in a deviant lifestyle compared with the main effects of parental drug use per se to child outcomes is difficult to disentangle and has not been systematically examined. Finally, the direct effects of the drug will influence the quality of parenting provided for the child; opioids, for example, may be more likely to be associated with child neglect, while drugs such as amphetamine and cocaine, which are associated with serious disturbances of mental state including sub-clinical symptoms of psychosis and hostility, may be more likely to result in physical abuse.

There has also been minimal attention to the impact of poly-drug use. Little empirical research has studied the impact of using multiple substances on family functioning. It could be speculated that high use of multiple substances would be more detrimental to family functioning than the misuse of a single substance.

### 2.2.2 Limitations due to study design

A second concern relates to the cross-sectional nature of most studies. In these studies family functioning, for example, is measured at one point in time, usually when the parent commences drug treatment. Family functioning, however, is not stable, and changes in response to many influences. For example, it has been suggested that maladaptive child behaviours increase in frequency during periods of heavy parental use, while in periods of parental stability

there is a corresponding stabilisation in problem child behaviour (Gruenert et al., 2004). Research is lacking on the impact of fluctuating patterns of drug use on children – an important gap in the literature given that fluctuations in patterns of drug misuse are common in this population (Glantz & Leshner, 2000) and in parents in particular (Kearney et al., 1994). Of particular interest for longitudinal studies would be an investigation of the continuity and discontinuity in child functioning over the course of the parental addiction career. It may well be the case that the trajectory of a child's development varies as the parent moves through the different stages of use; for example, from substance use that is recreational to problematic and finally into treatment. Again the impact is likely to vary for the child whose parent relapses with great frequency compared to those who become drug-free. Such longitudinal studies are important in determining whether there are particular phases of addiction careers that may generate higher levels of risk for children.

### 2.2.3 Limitations due to sampling bias

Research conducted into child outcomes has tended to rely on documenting the outcomes of children whose parents have accessed treatment services. Thus, it is unclear to what extent this population adequately represents the overall population of alcohol and illicit drug users. It is possible that samples of parents in treatment have more problems than many of those who are not seeking treatment. Alternatively, engagement in treatment might indicate these parents are actually less chaotic and possess more resources than those who do not access treatment services. Investigations comparing treatment-seeking and untreated persons

with cocaine or opiate dependence have found similar levels of substance use and psychiatric disorders. However, those accessing treatment were found to have more mood disorders, poorer social functioning and more family problems (Carroll & Rounsaville, 1992). It has been suggested that when a parent's addiction has progressed to a point where they seek treatment, the children are highly likely to have experienced an array of other risk factors such as socioeconomic disadvantage and maternal mental health issues that in themselves have a direct impact on childhood outcomes (Conners et al., 2003). There is also evidence that parents with the most serious drug problems and most chaotic lives are least likely to have their children living with them (Advisory Council on the Misuse of Drugs, 2003).

Further, although the effects of paternal alcoholism on child outcome have been well documented, the vast majority of studies into parental illicit drug use have investigated the impact of maternal drug use; significantly less is known about the psychosocial adjustment of children living in households in which fathers only or both parents use illicit drugs. Although there is some evidence to suggest that maternal substance use has a greater impact on child rearing than paternal substance use (Kandel 1990), recent calls to 'add poppa to the research agenda' emphasise the need to clarify the impact of fathers on child outcomes within the context of chronic drug abuse (McMahon & Rounsaville, 2002). There has also been little investigation into outcomes of children raised by alternative carers such as grandparents, extended family members or elder siblings as a consequence of parental substance abuse.

#### 2.2.4 Limitations due to measurement bias

A further limitation raised by Mayes and Truman (2002) is the restricted range of outcome variables that have been measured. Typically, studies document the incidence of problem behaviours or psychopathologies such as conduct or oppositional disorders, antisocial behaviour, alcoholism or other teenage substance use and criminal involvement. Only recently has research begun to focus on levels of competencies, adaptation or resiliency (Pilowsky et al., 2004). Most studies use self-report measures, typically completed by parents or caregivers with little focus on the perspective of the children themselves (Gruenert et al., 2004). Moreover, there has been little assessment of more specific child outcomes such as affect and impulse regulation, levels of self-esteem and the capacity to establish and sustain effective interpersonal relationships, all of which play an important role in effective adult functioning (Mayes & Truman, 2002).

It is important to recognise that research is not value-free or without biases. Substance-misusing mothers in particular have been stigmatised, labelled as unfit, and targeted for disapproval due to their failure to meet contemporary standards for mothering (Baker & Carson, 1999; Woods, 2000). The possibility that these assumptions have also influenced research agendas, resulting in a focus on deficits in functioning and a relative lack of investigation of competency, needs to be considered.

### 2.2.5 Limitations due to difficulties generalising findings across international contexts

The majority of investigations into the impact of parental substance misuse have been conducted within the United States of America with a smaller number of studies being completed in the United Kingdom. At the time of writing there had been only one study, 'the Nobody's Clients Project', which has attempted to identify the needs of Australian children with substance-dependent parents (Gruenert et al., 2004). This report used an action-research methodology to document the experiences of children and their carers in response to parental drug use. Although Australia, the United Kingdom and the United States share similar levels of economic and social development, there are significant differences in ethnic composition, values and attitudes, drug type and drug availability. For example, many American studies include significant numbers of African-American and Hispanic parents who cite crack/cocaine and/or opiates as their primary addiction. In the Australian study, the ethnicity of parents seeking drug treatment was predominantly Anglo-Celtic and a range of drugs was cited as their primary drug of addiction, including heroin (38%), alcohol (27%), cannabis (17%) and amphetamines (15%) (Gruenert et al., 2004). It is unclear what effect these differences have on the generalisability of findings from overseas. This issue, however, highlights the importance of developing an Australian program of research to examine the impact of parental substance misuse on child outcomes and family functioning. It also draws attention to the need for caution when making broad generalisations of research findings across international contexts.

## 2.3 Parental substance use and child outcomes: findings from research

Despite the limitations above, there is good evidence that parental substance misuse is highly disruptive to family functioning. There are many studies, particularly from the 1980s and 1990s, that directly compare outcomes of children raised in families with a problem substance user, typically alcohol, with children in non-substance-using families. Most investigations have concluded that children of alcoholics are at elevated risk for negative outcomes compared to children of non-alcoholic parents, with specific concerns including higher levels of internalising (e.g. anxiety and depression) and externalising (e.g. conduct disorder and aggression) disorders (Johnson & Left, 1999; West & Prinz, 1987).

Parental alcoholism has been found to be positively associated with high rates of child behaviour problems (Jacob & Leonard, 1986; Sher et al., 1991) and higher rates of diagnosable childhood disorders (Chassin et al., 1999). There is also evidence of higher rates of physical and psychological problems in children living with an alcoholic parent who has relapsed in comparison to children living in remitted or non-alcoholic families (Moos et al., 1990).

Outcome is also poor in families where there is parental illicit substance abuse compared to non-substance-abusing families. In particular, evidence suggests that these children have elevated rates of behavioural and emotional problems, including oppositional, defiant and non-compliant behaviours (e.g. Smith, 1993; Willens et al., 1995). By late childhood, children of opiate- and cocaine-addicted mothers often experience significant emotional problems and an increased incidence of diagnosable psychiatric disorders, including Major Depression, Oppositional Defiant Disorder, Conduct Disorder, Attention Deficit Hyperactive Disorder (ADHD) and substance abuse (Luthar et al., 1998; Pilowsky et al., 2004; Weissman et al., 1999; Willens et al., 1995). It has also been suggested that many children exposed to a drug-using lifestyle are misdiagnosed with ADHD when they are actually suffering from Post-Traumatic Stress Disorder (PTSD) (Greenberg, 1999, as quoted by Patton, 2003).

Anecdotal evidence from service providers suggests that children raised in families characterised by illicit drug use often display a range of dysfunctional child behaviours such as 'fear of abandonment, separation anxiety; fear of losing their carer; fear of being left alone; self-blame for their parent's departure; collecting food and hoarding it; overeating; intense fear of sirens and the police; inappropriate sexualised behaviour; sleeping difficulties; aggression' (Patton, 2003, p.8). However, there has been no systematic study into the prevalence of these behaviours.

Perhaps the most significant outcome for children raised in families characterised by parental substance misuse is the heightened prevalence of child maltreatment among these families. The risk of child abuse and neglect is substantially higher in families with drug-abusing parents (National Center on Addiction and Substance Abuse, 1999; Walsh et al., 2003) and the presence of a substance use disorder in a parent has been identified as the strongest predictor of subsequent new cases of child abuse and neglect 12 months later (Chaffin et al., 1996). United States estimates indicate that approximately 60 per cent of families that come to the attention of the child welfare system also have substance abuse issues (Chaffin et al., 1996). Comparative Australian data are sparse although a recent Victorian report suggests similar outcomes, with substance abuse being recorded as the primary characteristic of a significant proportion of families with substantiated cases of child abuse and neglect (substance abuse 33%; alcohol abuse 31%) (Victoria Department of Human Services, 2002).

The relationship between substance misuse and child abuse, however, remains uncertain. It has been suggested that research linking substance misuse with child abuse fails to take into account demographic and social factors that co-occur in substance-misusing and child-abusing populations (Albert et al., 2000). A recent study by Hogan, Myers and Elswick (2006) found that mothers who used drugs during their pregnancy were at no more risk of child abuse than non-drug-using mothers with similar demographics including race, marital status and education level.

Although accumulated evidence from multiple studies suggests that parental substance abuse is a significant risk factor for maladaptive child outcomes, the fact that a parent is using or even dependent on illicit drugs or alcohol is not necessarily the primary causal factor responsible for the poor child outcomes. It is widely acknowledged that families characterised by problematic substance use typically experience a range of additional problems such as socioeconomic disadvantage, mental health issues and social isolation. For example, of the 48 Australian children who received services from the Nobody's Clients project, just over half (56%) were initially assessed as displaying only minor emotional and behaviour problems, similar to most other Australian children (Gruenert et al., 2004). It appears that adverse child outcomes are associated with a complex interplay between parental substance abuse, parental psychopathology, parenting practices, family environment (including spousal relationship and the availability of social support), and socioeconomic factors such as unemployment and poverty. Each of these factors in and of themselves affects childhood outcomes.

Recent attempts to understand the wide range of outcomes achieved by children raised in adverse conditions have been guided by the ecological model of child development (Cicchetti & Toth, 1997; Cicchetti & Toth, 1998). This model will be used to provide a framework for conceptualising the various factors that impact on the lives of children whose parents engage in problematic drug and alcohol use.

## 2.4 The ecological model of child development

Within an ecological model, child outcome is considered to be the consequence of a complex interaction between personal, developmental, familial and environmental factors, over time and across social contexts. According to Cicchetti and Rizley (1981), risk factors are enduring circumstances that interact with the developing child to compromise positive adaptation. At the same time, protective factors buffer the effect of these risk factors and enhance the emergence of resilience in children otherwise at risk for adverse outcomes. In addition, some negative child outcomes may be more the result of missing or inadequate protective factors rather than resulting from the pull of risk factors (Glantz & Leshner, 2000). For any child, the influence exerted by specific risk and protective factors will vary, with outcome being affected by the dynamic interplay that exists between risk and protective factors at differing developmental levels. Complex behavioural problems such as childhood conduct disorder or adolescent substance misuse are seen not as stemming from a single causal variable; instead, there are several pathways to their development and various risk and protective influences can be identified in the psychological, biological and environmental realms (Bukoski, 1991). Studies have shown that the number of contextual risk factors to which a child is exposed is a more significant predictor of negative developmental outcome than is the particular type of risk factors. Moreover, it is the combination of risk factors that has a greater effect than the sum of effects of each risk factor (Mohr & Tulman, 2000; Pellegrini, 1990). McWhirter et al. (1993, as quoted in Withers & Russell, 2001) refer to the concept of an 'at risk continuum' with increasing intensity of risk being defined in terms of the number and severity of risk factors affecting developmental outcomes.



## 2.5 Parental substance misuse and risk factors

There have been numerous reviews conducted into the range of risk and protective factors that exist within multi-problem families (see Loxley et al., 2004; Marshall & Watt, 1999; Withers & Russell, 2001). All children face some risks predisposing them to negative outcome, but not all children are at equal risk. How well children are able to adapt to these risks is, in part, determined by the intensity of the risk and, in part, by the presence of protective factors that buffer the effect of risk factors. The greater the individual exposure to risk, the greater the need for environmental 'corrective' influences. If the environment exercises ameliorative rather than exacerbating influences on children and adolescents at high risk for negative trajectories, then a more normal and healthy outcome is a reasonable expectation (Glantz & Leshner, 2000).

In the following section the relative role of parental substance misuse and other recognised risk and protective factors will be explored within an ecological model of child development. In this way it may be possible to ascertain what combination of risk factors, in addition to parental substance use, poses the greatest threat to children and alternatively which protective factors provide the best opportunity for reducing the burden of risk for children in these families.

### 2.5.1 Class of substance abused by parent

The specific effect of substance type on child outcome is unclear. Although there have been numerous investigations into the effect of parental alcohol dependence, and a smaller number into the effect of opiates and cocaine, there has been only a small number of studies that have systematically compared child outcomes across substance types. There is some evidence that children living in two-parent families where there is paternal drug abuse (cocaine and opiates) have significantly poorer levels of adjustment when compared to children living with alcohol-abusing fathers (Fals-Stewart et al., 2003). However, many fathers in the illicit drug sample also met criteria for alcohol abuse or dependence, thus confounding the specific effect of substance type on child outcome. There have been a number of studies that have found no significant difference in child outcome across families characterised by maternal opiate use, maternal use of cocaine or use of both opiates and cocaine (Luthar et al., 1998; Weissman et al., 1999). However, the high rates of co-morbid alcohol abuse and multiple drugs of abuse frequently reported in mothers who have primary addiction to opiates and or cocaine (Luthar et al., 1998; Powis et al., 2000; Weissman et al., 1999) make it very difficult to disentangle the specific effects of substance class on child outcome.

The use of multiple (poly) substances is increasingly becoming the norm for illicit drug users in Australia (Gruenert et al., 2004; Swift et al., 1996), paralleling drug use patterns in the United States (National Center on Addiction and Substance Abuse, 1999) and elsewhere (Tunnard, 2002). Substance use problems typically develop in an orderly fashion. Initially tobacco and alcohol are used,

followed by cannabis, and later illicit drugs such as opiates and cocaine (Kandel et al., 1992). Those whose drug use progresses to illicit drugs tend to maintain their use of other substances in response to access, availability and motivation to cease or reduce levels of use. In Australia, for example, the heroin drought in 2000–01 resulted in a significant increase in use of amphetamines across the country as well as more specific changes at a State level, such as increased injection of sleeping tablets in Queensland and Victoria and increased use of cocaine in New South Wales (Topp, 2001). It is common for amphetamine users to report concurrent use of cannabis and benzodiazepines to help manage symptoms of dysphoria that follow an amphetamine binge (Baker & Dawe, 2005). Cannabis and benzodiazepines might also be used to enhance the effects of opiates and alcohol and also as a means of managing withdrawal symptoms. Increased use of alcohol often accompanies stabilisation of opiate-dependent people on methadone maintenance and drinking can often increase during periods of heroin abstinence. Mixing drugs is likely to have more unpredictable consequences and the risk of overdose is significantly increased when multiple drugs are used concurrently or consecutively. It also makes it extremely difficult to isolate the effect of a specific substance when multiple substances are used.

The 2004 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2005) reports that cannabis is the most commonly used illicit drug in Australia (11.3% reported recent use), followed by pharmaceutical drugs such as painkillers or analgesics used for non-medical purposes (5.5%), ecstasy (3.4%) and methamphetamines (3.2%). Significantly illicit drug use is most prevalent within the traditional

child-bearing years of 20–29 years, with 26 per cent of respondents reporting recent use of cannabis, 12 per cent reporting use of ecstasy and 10.5 per cent use of meth/amphetamines. It is of concern that, despite the prevalence of these illicit drugs within the Australian context, there have been no systematic analyses into their specific effects on parenting function or child outcome. Furthermore despite evidence of significant rates of binge drinking within the Australian population (20.7 per cent of Australians drank once or more a month at levels that put them at high risk of alcohol-related harm in the short term), there has been no research into the effects of this pattern of alcohol use on child outcome.

#### Key point

Our understanding of the specific effects of substance type on child outcome is currently incomplete. While there is a good literature documenting the negative impact of parental substance misuse, combined with other life problems, on child outcome, there is no specific comparison between substance classes. For example, it is not possible to determine whether parental amphetamine abuse poses a greater risk to adverse child outcome compared to a substance such as heroin. Australian research into this area needs to be encouraged.



### 2.5.2 Substance use and co-morbid psychopathology

It is well established that significant numbers of substance abusers enter treatment programs with co-existing psychopathology (Rounsaville et al., 1991; Rounsaville et al., 1982; Swift et al., 1996). Australian estimates suggest that up to three-quarters of all clients with drug and alcohol problems present with additional mental health problems (ANCD, 2002, cited in Hegarty, 2004). The results from the 2004 Australian National Drug Strategy Household Survey found that over 50 per cent of heroin users, 20 per cent of amphetamine users, 16.5 per cent of cannabis users and 11 per cent of high-risk alcohol users reported diagnosis or treatment for mental illness in the past 12 months (Australian Institute of Health and Welfare, 2005, p.99). These figures contrast markedly with reported general population levels of 9 per cent.

Women drug users, in particular, have been found to experience elevated levels of psychiatric symptoms compared to men who use drugs, including higher levels of depression, PTSD (Conners et al., 2003; Najavitis et al., 1997), lower self-esteem (Beckman, 1978), as well as higher levels of general distress (Wallen, 1992). An Australian national study of women substance users found over one-quarter of the sample had previously been hospitalised for a psychological problem (27%), nearly half (48%) had received counselling for problems such as depression and anxiety, over half (56%) had experienced eating disorders, and more than a quarter (26%) had engaged in self-harm behaviours, while almost half (44%) had attempted suicide an average of 2.4 times (Swift et al., 1996). These women also reported experiencing a high level of trauma, with almost three-quarters (72%) indicating they had been

victims of physical or sexual violence at some stage in their life. Histories of victimisation are common among women with substance-abuse histories (Conners et al., 2003).

The psychological adjustment of the primary caretaker is recognised as a key factor in the emergence of child outcomes. Maternal psychopathology appears to impact most significantly on the quality of mother-child interactions, resulting in a range of maladaptive child behaviours including extreme withdrawal, disengagement and understimulation to intrusiveness, inconsistency, hostility and over-stimulation (Cummings & Cicchetti, 1990; Field et al., 1990; Goodman & Brumley, 1990; Lyons-Ruth et al., 1986). Maternal depression has been widely studied and the detrimental effects clearly articulated (see Cicchetti and Toth, 1998, for an extensive review). Depressed mothers are described as being less positive, less spontaneous, more critical, more quarrelsome and more physically abusive towards their children than non-depressed mothers (Cummings & Davies, 1994; Fleming et al., 1988; Murray et al., 1996).

Co-morbid forms of maternal disturbance have been linked to more severe child outcomes than a single maternal disorder. Depressed mothers with co-morbid personality disorders have been found to be more critical and psychologically unavailable in their interactions with their children compared to mothers with depression alone (De Mulder et al., 1995; Radke-Yarrow & Klimes-Dougan, 1997). Maternal antisocial personality traits have been linked to unresponsive parenting (Cassidy et al., 1996; Hans et al., 1999) and ineffective monitoring of children's activities (Patterson & Capaldi, 1991). Maternal paranoid personality disorder has been associated with less sensitive caregiving and disorganised, disoriented infant

attachments (Espinosa et al., 2001). Indeed, maternal personality disorders may affect children's development more seriously than maternal depression (Weiss et al., 1996).

A small number of studies have attempted to tease apart the differential effect of parental drug dependence and co-morbid psychopathology. A parental history of major depression coupled with opiate dependence has been found to place boys in middle childhood at an increased risk for conduct disorder and poorer social and cognitive functioning in comparison to boys whose parents were opiate-dependent but did not have co-morbid depression (Nunes et al., 1998; Weissman et al., 1999). Women suffering both maternal depression and alcohol dependence have more problems relating to social relationships, health and parenting than women presenting with clinical depression alone (Woodcock & Sheppard, 2002).

A study by Luthar, Cushing, Merkanguas and Rounsaville (1998) linked greater levels of childhood maladaptation with a range of maternal and child factors, including severity of maternal psychopathology, Caucasian ethnicity (as opposed to African-American), maternal cognitive abilities (among African-Americans), increasing age of child (due to increased exposure to maternal substance abuse), and lower child cognitive abilities (among Caucasians). Significantly, although this study found children of addicted mothers showed greater levels of disturbance than youth in the general population, the degree of child psychopathology associated with maternal drug use was not necessarily *greater* than that linked with other forms maternal psychiatric dysfunction such as depression (Luthar et al., 1998). That is, among socially disadvantaged families, a mother with a prior

history of drug abuse is no more detrimental for her children's wellbeing than her counterpart with a mental illness who is drug-free. Further, it is suggested that 'within the combination of parental substance misuse and depression it is the latter more than the former that seems to be the more "active ingredient" in conferring risks to children' (Luthar, D'Avanzo & Hites, 2003; p.120). It is proposed that levels of stress in the parenting role are a key in the transmission of child maladaptation not drug abuse per se (Luthar et al., 2003). This has important implications for delivery of services to parents with substance-misuse issues, underscoring the need to attend to levels of emotional distress and wellbeing rather than singularly focusing on drug treatment.

### Key point

Parental substance misuse might be seen as a possible marker of co-morbid parental psychopathology which, in turn, may contribute to greater impairments in child outcomes than substance use alone. To improve child outcome in substance-abusing families, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role. In practice, this might translate into both improved training opportunities for alcohol and other drug (AOD) workers to help better address mental health issues, and improved liaison with mental health services. It appears likely that employing experienced mental health workers in AOD services will increase the use of such treatment options within substance-using families.

### 2.5.3 Substance misuse and social economic disadvantage

Many of the samples for studies into substance-abusing families are drawn disproportionately from poor urban households characterised by low levels of parental education and unemployment. Although these demographics set the context for the lives of many children affected by parental substance abuse, it is important to be aware that substance misuse occurs across all social classes, although this may be less evident for those who have less socioeconomic disadvantage (Mayes & Truman, 2002). The variables most studied and reported as characterising substance-abusing families are the confluence of conditions such as low income/poverty, unemployment, low maternal education and unstable accommodation (Connors et al., 2003; Powis et al., 2000). For many families, poverty is said to predate drug use. Families typically reside in communities that have been impacted by long-term unemployment and intergenerational educational disadvantage where drug availability and opportunities for exposure to alcohol and illicit drugs are high (Woods, 2000).

The correlates of low socioeconomic status, and more particularly poverty, on child outcomes are well documented (Duncan et al., 1998). Poor children, in comparison to those from more affluent families, are at greater risk of poor physical health (Jason & Jarvis, 1987; Pollitt, 1994), lower intellectual attainment and school performance (Dubow & Ippolito, 1994; Guo, 1998), and increased social, emotional and behavioural problems (Dubow & Ippolito, 1994; Duncan et al., 1994). There has also been consistent

evidence that socioeconomic status is a key factor in the determination of parenting style (see McLoyd, 1990, for review).

Low-income parents are more likely to use physical punishment and other forms of punitive discipline and less likely to reward children for positive behaviour or be responsive to their expressed needs compared to middle-class families. Individual family poverty is also a correlate of numerous risk factors that have been linked to negative child outcomes such as family discord, large family size and parental psychopathology (Bolger et al., 1995). Psychological distress is also more prevalent among low-income populations as they experience more negative life events and have fewer resources to cope with adverse situations.

Attempts to disentangle the effects of parental substance abuse and socioeconomic status on child outcome have produced inconsistent findings. Chaffin, Kelleher and Hollenberg (1996), drawing on data from a probabilistic community sample, found that demographic and social variables played only a limited role in the prediction of child maltreatment, with the most significant predictor being the presence of a substance-use disorder in the parent. Bernstein and colleagues (1984) found that low socioeconomic status and psychological characteristics of parents were better predictors of poor parenting interactions than opiate use alone.

Suchman and Luthar (2000) propose that socio-demographic factors of families affected by maternal drug addiction confer differential levels of vulnerability to parenting behaviours. Their work compared a group of opiate-addicted mothers with

a demographically matched non-addicted comparison on three parenting dimensions. Although maternal addiction appeared directly related to levels of parental involvement, the parental dimensions of limit setting and autonomy promoting were most strongly related to contextual factors such as single parent status and family size. In this way Suchman and Luthar (2000) argue that socio-demographic risk factors contribute to child outcomes at least as much as, if not more than, maternal addiction per se.

These findings echo the views of many professional workers interviewed in an Irish study of women drug users and their experiences of parenting. They proposed that poverty rather than drug use was the major issue in the lives of the parents and children they encounter (Woods, 2000, p.279).

#### Key point

Treatment services need to help substance-abusing families better manage the daily stresses associated with socioeconomic disadvantage in order to reduce the impact of this risk factor on child outcomes. Tackling drug use in isolation is unlikely to be effective without addressing the key context issues of unemployment and poor housing which in many cases sustain drug lifestyles.

### 2.5.4 Substance use and social support

Active engagement in supportive and satisfying social networks confers a protective role within the parenting process. Social support may be formal (links with services and support workers) or informal (provided by family and friends). Particularly for families that confront multiple socio-demographic adversity, supportive relationships provide the parent with a buffer to help them maintain satisfactory child-rearing responsibilities in the face of emotional distress (Cochran & Niego, 1995).

Social isolation has been identified as a primary cause of many of the difficulties experienced by children of drug users (Hogan, 1998). Families of drug users experience greater levels of community rejection and are less involved in several areas of social life, including religious, neighbourhood and cultural activities (Kumpfer & DeMarsh, 1986). Women in opioid treatment are more likely to report that they have no friends, suffer from loneliness, and receive less social support than either men in treatment or women not using drugs (Tunnard, 2002). Parents who experience isolation and separateness are considered to be at greater risk for caring for their children, especially when their isolation is compounded by the accumulation of other risk factors such as parental psychopathology and socioeconomic disadvantage.

Crockenberg (1988) has suggested that the experience of social support and nurturance develops a 'working model of relationships' within which the mother perceives herself as being deserving of care and capable of caring for someone else. This, in turn, results in the mother engaging in a more nurturing and flexible relationship with her children. However, access to and inclusion within social support systems do not necessarily

translate into a perception of social support availability. It is argued that an individual needs to perceive that the social network is actually offering support before it is realised as such; and it is this level of perceived support arising from the interaction that predicts wellbeing and optimal parenting rather than simply availability (Procidano, 1992, as quoted in Suchman et al., 2005).

Exploratory studies suggest there may be a link between early attachment experiences and adult perceptions of social support availability (Suchman et al., 2005). It is hypothesised that disruptions in early life might result in the development of a generalised model within which social support is perceived as being absent or unavailable. This, in turn, it is proposed, impacts negatively on the parent's psychological wellbeing and thus her ability to provide nurturance for her children. Thus, despite the appearance of being able to access adequate levels of social support, unless this support is perceived as being available by the mother it will have only limited utility. In this way parenting deficits associated with maternal drug dependence may be viewed as being mediated by a generalised model of social support as absent or unavailable (in response to early bonding disruptions), which in turn reflects on the quality of their caregiving relationship with their children (Suchman et al., 2005).

#### Key point

Effective interventions for substance-abusing families need to target the parent's capacity to seek and sustain support systems in their family and social networks. Therapeutic interventions that directly address the parent's access to social services and community supports can effectively reduce child maltreatment risk and also foster adaptive parenting behaviour.

### 2.5.5 Substance use and exposure to violence within the family

Relationship distress, as well as verbal, physical and sexual violence, are commonly described in substance-abusing families. An Australian study examining the psychosocial characteristics of 267 substance-dependent women found that 52 per cent had experienced sexual or physical assault as adults and, of these, the majority (59%) had been assaulted by their partners. Of these, approximately one-quarter (24%) reported they were 'out of it' when the assault happened, while 59 per cent indicated their partners were under the influence of drugs or alcohol at the time of the assault. In the vast majority of cases (83%), the experience of domestic violence was ongoing and lasted a median of 36 months (Swift et al., 1996). These findings are consistent with other studies.

Regan, Ehrlich and Finnegan (1987) found a higher proportion of drug-dependent women had been severely beaten as adults than had non-drug-abusing women, with most of the violence being inflicted by a partner. Significantly higher levels of severe partner-to-women violence have also been reported by women in alcohol treatment relative to a general population sample (Miller et al., 1993). Taylor (1993) found that many drug-using women were in violent and abusive relationships, often so severe as to be life-threatening, but felt powerless to leave such relationships. Although there appears to be a clear relationship between the occurrence of partner violence and female substance misuse, the direction of the relationship is unclear. There is evidence that some women use substances as a way of dealing with past experiences of victimisation. A history of violent assault or diagnosis of post-traumatic stress disorder has been found to increase the risk of later substance dependence (Kilpatrick et al., 1998). However, there is also evidence

that substance misuse problems make women more vulnerable to victimisation such as partner violence (Miller, 1998).

For Indigenous people the term 'family violence' rather than domestic violence is preferred, as it better reflects the often interconnecting and trans-generational experience of violence within Indigenous families and communities (Stanley et al. 2003). Gordon (2006) draws on a range of statistics to describe the 'pandemic' nature of violence within Indigenous communities. In 2002, one-fifth (19.5%) of Indigenous people reported being the victim of physical or threatened violence in the past 12 months, a rate more than double the victimisation rate of non-Indigenous Australians (8.9%) (Australian Bureau of Statistics, 2004). In New South Wales, Indigenous women are six times more likely to be the victim of a domestic violence-related assault than non-Indigenous women. This rate is even higher in Western Australia where Indigenous women are 13 times more likely to be a victim of assault than non-Indigenous women (Steering Committee for the Review of Government Service Provision, 2003). Indigenous family violence is increasingly acknowledged to be interconnected with levels of drug and alcohol misuse. However, the relationship is complex and not one of simple cause and effect (Fitzgerald, 2001). Atkinson (2003) lists a range of factors that contribute to family violence in Indigenous communities including poverty, unemployment, substandard or inadequate housing, limited access to services and resources, loss of identity and self-esteem, abusive styles of conflict resolution, neglect of family responsibilities, lack of respect, emotionally damaged family members, boredom, anomie, suicide and alcohol abuse. The issue of drug and alcohol abuse in Indigenous communities will be addressed more fully in Chapter 4 of this report.

### Key points

Substance abuse problems and partner violence often co-occur for women. Treatment services need to routinely screen for the occurrence of family violence and provide services for these problems. Likewise, services to help address alcohol and other drug problems need to be provided in women's shelters and 'safe houses'.

Women with substance abuse problems are also at high risk of being assaulted. This, in turn, may increase the likelihood of subsequent substance dependence and heavy use. These women need to be targeted to receive self-protection or crime protection training in an attempt to break the vicious cycle that links victimisation, post-traumatic stress disorder and substance abuse in women.

Exposure to violence within the family affects children in different ways depending on the child's age, temperament and wider circumstances. Babies under one year who witness domestic violence are described as experiencing poor health, poor sleeping habits and excessive screaming (Jaffe et al., 1990). Children of preschool age are said to display the highest levels of behaviour disturbance (Davis & Carlson, 1987; Hughes & Luke, 1998), with the behaviour problems continuing as the children commence and move through school. Exposure to domestic violence has been found to lead to increased displays of aggression and antisocial behaviour in some children (Hughes & Luke, 1998; Maker et al., 1998), whilst others exhibit high rates of depression, anxiety and trauma symptoms (McClosky et al., 1995; Sternberg et al., 1993). Cummings and colleagues (Cummings, Hennessy, Rabideau & Cicchetti, 1994; Cummings & Zahn-Waxler, 1992) found exposure



to angry parental behaviours such as parental arguments and fights resulted in more externalising responses by boys whereas girls demonstrated more internalising behaviours. They also reported a dosage effect with children exposed to more anger coupled with a prior history of abuse showing the most negative outcomes.

The inclusion of 'couple' therapy within drug and alcohol treatment programs has been proposed as an effective strategy for addressing levels of relationship distress in substance-misusing families. This is in line with evidence that links partner substance abuse with a quicker escalation of arguments, higher levels of abusive exchanges and a reduced ability to resolve conflict effectively (Fals-Stewart & Birchler, 1996; Kelley & Fals-Stewart, 2002). Participation in couples-based treatment has not only been associated with decreased levels of substance use, but more significantly it has a positive impact on levels of relationship adjustment and partner violence, which in turn have resulted in improved child outcomes (Kelley & Fals-Stewart, 2002). It has been suggested that relationship distress plays a mediating role in determining child outcomes in substance-abusing families (Vellerman & Orford, 1993). Thus programs that address both issues concurrently are likely to have the most positive effects on children.

#### Key point

The inclusion of couples-based interventions that assist parents to manage their anger and levels of verbal/violent behaviours more effectively within drug and alcohol treatment services is recommended. This can improve psychosocial outcomes in children by reducing family hostility, tension and exposure to conflict.

### 2.5.6 Substance use and exposure to community violence

Research has also examined the specific effects of exposure to and the witnessing of community violence, defined as frequent and continual exposure to the use of guns, knives and drugs as well as random acts of violence (Osofsky, 1995). Whereas inter-parental aggression is often kept private, community violence is openly discussed within families and the media, and children who do not directly witness the specific incident often hear and watch repeated accounts of the event and in this way may form their own mental imagery of the violence. United States studies have found that children growing up in some inner-city neighbourhoods are victims of and witnesses to significant amounts of violence (Osofsky et al., 1993; Richters & Martinez, 1993). Most data have been obtained from American urban samples; there is little known about levels of community violence witnessed by Australian children.

Children living with parental substance misuse often experience a range of adversities including poverty, poor housing, overcrowding and parental psychopathology. Such cumulative risk often results in the child residing in public housing within crime- and drug-dense communities. This not only makes it highly likely that children will be exposed to drugs and violence, but it also impacts on levels of parental adaptation, creating further obstacles for the process of recovery. Parental substance misuse also increases the likelihood of exposure to potentially violent situations such as negative police interactions or police raids on home, family physical violence, overdose or death of a parent and exposure to other dangerous and inappropriate situations (Gruenert et al., 2004).

Community violence affects individual and family functioning in many ways (Lynch & Cicchetti, 1998; Margolin & Gordis, 2000; Osofsky, 1995; Richters & Martinez, 1993). For example, young children exposed to traumatic forms of community violence display difficulties in exploration and mastery of the environment, formation of trusting and secure relationships, autonomy, and regulation of emotion (Osofsky, 1995). Child exposure to community violence has been associated with a range of clinical symptoms, including anxiety, depression, aggression and post-traumatic stress (see Lynch & Cicchetti, 1998). The coexistence of substance misuse and violence in Cape York communities is said to have contributed to elevated levels of childhood traumas, physical and sexual abuse, child neglect and malnourishment, sleep deprivation and poor health (Fitzgerald, 2001). Living in a violent community may also heighten levels of family stress, which contribute to an increased probability of violent conflict between adult partners (Osofsky, 1995; Osofsky et al., 1993). Parents themselves are likely to be affected by violence in the community, and their reaction to this violence is likely to have both a direct and indirect effect on their children.

Linares and her colleagues (2001) found the level of distress experienced by the mother mediated the relationship between community violence and the child's behaviour. That is, even after controlling for maternal socioeconomic status and indicators of family violence, many mothers were distressed themselves because of community violence, and it was their stress reactions that accounted in large part for the observed behaviour problems in their children.

### 2.5.7 Conclusion

This brief overview of risk factors highlights the extent of adversity that may characterise the lives of children whose parents engage in problematic drug or alcohol use. Although parental use of alcohol or illicit drugs is clearly a risk factor for adverse child outcomes, it does not in itself equate with maladaptive child outcomes. Specific risk factors tend to coincide and it is the cumulative exposure to multiple risk factors that creates the greatest vulnerability in children. Parental substance misuse is often linked with a constellation of other chronic life conditions associated with a drug-using lifestyle such as parental psychopathology, socioeconomic disadvantage, social isolation and violence. The concentration and co-occurrence of these kinds of adversities make it difficult to establish their independent influence on child outcomes. It has been suggested that those children at greatest risk face a cumulative burden of environmental risk and that certain factors, such as maternal age at birth of first child, level of mother's education and age at onset of substance use, may be predictive of higher exposure to environmental risk factors during the trajectory of the child's life (Kettinger et al., 2000).



Yet clearly not all children from substance-abusing families experience a maladaptive and negative trajectory. Studies of childhood resilience document that many children are able to avoid negative outcomes, despite exposure to multiple risk factors. Resilient children are seen to have the capacity to cope effectively with and overcome adversity, to bounce back and move on to lead productive lives. Such resilience is not seen as a stable characteristic of individual children or families, but as an ongoing transactional process between individuals and the environment (Sayer et al., 1998). Various protective factors have been defined, which operate to buffer or mitigate the negative effects of risk exposure, in turn facilitating positive outcomes. Protective factors are often empirically measured as occurring at the opposite end of the risk continuum and are defined by their ability to moderate and mediate the effect of risk factors (Loxley et al., 2004). The more protective factors that are present in a child's life, the more the child is likely to display resilience (Howard et al., 1999).

One approach to reduce the possible adverse effects of parental drug use and improve child outcome would be to reduce the number of risk factors operating in the child's ecology. There might also be an opportunity to build and strengthen the number of protective factors, moderating the risks to which the child is exposed, thus promoting resilience and competence.

## 2.6 Parental substance use and protective factors

Compared with research on risk factors, there has been relatively little study into the types of protective factors that might operate to improve the trajectory for children exposed to parental substance misuse. Exploratory research by Pilowsky and colleagues (2004) suggests that resilient children from injecting drug-using families may be temperamentally predisposed to cope with stress in a more adaptive way than their non-resilient peers. Although the children identified as resilient showed no difference from their non-resilient peers with respect to socio-demographics, levels of parental drug use or mental health, they were, however, less likely to use avoidance-coping strategies such as internalising and externalising behaviours in response to stressful situations. Furthermore their parents were significantly less likely to experience the parenting role as stressful in comparison to injecting drug-using parents of non-resilient children.

Pilowsky et al. propose that there is a dynamic exchange in which temperamental characteristics of the child and the quality of parenting behaviours may result in either a virtuous or vicious cycle moderating levels of child adjustment. These findings are generally consistent with a broader literature that underlines the importance of personality or temperament factors in determining levels of resilience (Luthar, 1991; Wyman et al., 1991). In addition, work by Luthar and colleagues (1998) found that factors such as the absence of maternal psychiatric disorder, higher child intelligence, younger age of child and ethnicity (African-American children were at an advantage to Caucasian) also had a protective role in the psychosocial adjustment of school-aged and adolescent children of opioid- and cocaine-abusing mothers.

More general research on protective factors has identified a range of individual character traits that are associated with successful adaptation under adverse circumstances. Kumpfer (1999) proposes the organisation of protective factors into five major cluster groups: (1) spiritual or motivational characteristics such as having a belief in oneself and one's uniqueness, an internal locus of control, a sense of hopefulness and optimism and traits such as determinism, perseverance and independence; (2) cognitive competencies such as intelligence, academic achievement, homework skills, moral reasoning, interpersonal awareness, creativity, self-esteem and the ability to restore self-esteem as well as the ability to delay gratification; (3) behavioural/social competencies such as the attainment of social skills, problem-solving skills, communication skills; (4) emotional stability and emotional management skills, which include an ability to be hopeful and optimistic and use of humour as a coping strategy; and (5) physical well-being and physical competencies including good health, physical attractiveness and possessing physical talents or accomplishments (Kumpfer, 1999).

Significantly, although resiliency research is able to identify a range of protective factors that accompany resiliency in the face of adverse circumstances, the more challenging task is in identifying and understanding the transactional process through which these resiliency characteristics are developed within individuals. The focus here is on ways to modify or adapt the child's external environment in order to stimulate and build competencies and skills that will lead

to greater resiliency. Unfortunately little is currently known about the process through which environmental factors interact with individual attributes to promote resiliency, and even less is understood about ways that intervention programs can increase resiliency processes in children (Rolf & Johnson, 1999). There are, however, many clues as to what may be important factors to include within the design of such interventions. In particular, there is much agreement on the importance of promoting relationships with socialisation units such as family, school and community as a strategy to enhance levels of resiliency (Hawkins et al., 1992).

Research indicates that the family plays a critical role in the development of resilience in children and adolescents. A large-scale study completed by Osborn (1990) found that having positive, supportive and interested parents was a decisive determinant in enabling socially vulnerable children to achieve competency. Resnick, Harris and Blum (1993) found that family connectedness was the most protective factor against acting out behaviours in a sample of 36 000 students in grades 7–12. The family connectedness variable referred to a sense of belonging and closeness to at least one caring and competent member of the family.

### 2.6.1 Connectedness to caring pro-social adults within the family network

Research on attachment suggests that the emotional quality of the parent–child relationship is an important predictor of children’s psychological development through school age and adolescence. A secure attachment with an effective caregiver has been found to be associated with better outcomes for children experiencing a range of adversities such as poverty (Owens & Shaw, 2003), child maltreatment (Masten & Coatsworth, 1998) or multifaceted high risk (Werner & Smith, 1992). Longitudinal studies of competent children and adolescents who have experienced serious adversity emphasise the importance of the caregiver relationship for successful adaptation (Masten, 1994). Positive parenting practices such as supportiveness and behavioural monitoring have been found to foster psychological wellbeing, which insulates children against negative environmental influences (Steinberg, 1990). When an effective parent is absent in a child’s life, emerging competency is often linked to a surrogate caregiving figure who provides a mentoring role. When adversity is high and no effective adult is connected with the child, the risk for child maladaptation is at its greatest.

The caregiving relationship has a profound influence on the child’s vulnerability for later dysfunction. Perhaps one of the most important roles is in helping the infant/child learn how to self-regulate their emotions and behaviour in response to the demands of the environment. In the context of a responsive caregiving relationship, the infant learns to how to self-soothe and regulate its emotions whilst establishing a secure base for exploration of the environment. This in turn assists

with the growth of problem-solving skills as a toddler and the development of good peer relationships in middle childhood. The achievement of compliance and pro-social behaviours are crucial for effective functioning in society. The delivery of consistent, sensitive and warm yet firm requests through the caregiving relationship has been linked with the child’s development of self-control and social rule compliance. Child attainment of compliance and pro-social behaviours has been linked to development of social competence, which in turn predicts levels of peer acceptance and popularity. The development of socially appropriate behaviours has likewise been linked to parenting behaviour and the successful transition through school. Caregivers influence the development of academic achievement through showing interest and direct involvement with their child’s school as well as the attitudes and values they hold with regard to school success and academic achievement.

This section highlights the salience of the caregiving relationship in the achievement of multiple domains of competence. The quality of the caretaking role holds enormous potential to assist children overcome hardship and adversity. Fostering strong and supportive relationships between children and their caregivers is a valuable strategy to promote resilience in children experiencing adversity. Researchers are beginning to recognise the value of including parent and family-focused interventions in the delivery of services to multi-problem families and substance-abusing families in particular. This research will be outlined further in Chapter 8 as well as details about other areas of innovative practice within the Australian context.

**Key point**

A significant protective factor in a child's life is the experience of a secure parental relationship through the provision of sensitive and responsive care and the setting of appropriate limits. All attempts should be made to enhance this relationship through support of the parent(s) while engaged in treatment.

**2.6.2 Connectedness to school**

Schools are well positioned to have a powerful protective effect on childhood outcomes. Through their teaching and support staff, schools are able to provide opportunities for students to develop significant relationships with caring adults. They are able to build and enrich social competencies and academic skills, provide the child with experiences of mastery and success, as well as create opportunities for students to take on responsible roles within the school and the community. Schools can develop partnerships with families designed to strengthen the academic, social and emotional success of the student. Importantly they can also work to identify, design and coordinate specific interventions to target the individual needs of children who are experiencing adversity.

Attempts to identify those characteristics that make a school effective in promoting resiliency have highlighted a number of practices relating to classroom management, student–teacher interactions and the

amount and quality of instruction. Students in effective schools spend more time working independently and have a greater frequency of student–teacher interactions. They express a greater satisfaction with their schoolwork, perceive their parents as being interested and involved in their schoolwork, and uphold high expectations as to the importance of academic success. They feel more involved in the school, believe their teachers are supportive and have a clear understanding of school rules (Howard et al., 1999).

**2.6.3 Connectedness to community**

Whereas primary caregivers and later the school environment strongly affect the adjustment of children, as the children grow and move beyond the confines of the home, the wider community assumes a greater influence in the child's life. Although there is much anecdotal evidence to suggest a positive relationship between participation in neighbourhood organisations and reduced levels of problem behaviour, unfortunately there have been few systematic studies into this area and the empirical evidence is thin. Furthermore strong youth-serving community organisations are often sparsely placed in those neighbourhoods with the greatest need, as they typically do not sustain the economic or political resources to sustain high-quality community organisations. After-school activities are generally less available in poorer communities as they are usually fee-for-service and this severely restricts access (Cauce et al., 2003).

## 2.7 Summary

The ecological model provided the theoretical framework to review the impact of the wide range of factors that influence the functioning of families with parental substance misuse. A number of methodological limitations of studies in this field were reviewed that restrict current understandings of the impact of parental substance misuse on child outcomes. These include the narrow range of illicit drugs that have been investigated, inadequate study design, sampling bias, measurement difficulties, and the limited generalisability to the Australian context of studies conducted internationally.

Despite these methodological limitations, there is good evidence that parental substance misuse is highly disruptive to family functioning. Available evidence suggests that children living in households where parents misuse substances are more likely to develop behavioural and emotional problems, tend to perform more poorly in school, and are more likely to be the victims of child maltreatment. From an ecological perspective, however, a direct causal link between parental substance misuse and child outcome is not supported by the research. Parental substance misuse is often associated with a constellation of other chronic life conditions such as parental psychopathology, economic disadvantage, limited social support, and family violence, and each of these risk factors has a powerful influence on child outcomes. It is suggested that those children at greatest risk for negative outcomes face a cumulative burden of

environmental risk factors. The implication for treatment services aiming to improve outcomes for children living in substance-misusing families is that interventions need to address the range of risk factors operating in the ecology of the family rather than just focusing on parental substance use per se.

The review of available research suggests that certain protective factors can buffer the adverse effects of the risk factors associated with parental substance misuse. The two most important of these protective factors appear to be (i) the provision of a secure caregiving relationship that provides sensitive and responsive care and the setting of appropriate limits, and (ii) engagement in school and other community activities.

Overall, this chapter highlights the wide range of factors that interact to determine the outcomes for children living in families whose parents misuse substances. All of these factors are potential candidates to be addressed within interventions aimed at promoting more positive outcomes for these children.

Table 2.1: Key protective factors to promote resiliency

### Individual child factors

- an easy disposition – the ability to get on with parents, friends and teachers
- good cognitive functioning
- normal hearing, good communication and problem-solving skills
- acquisition of social competence and self-regulation skills
- attachment with family
- optimism
- internal locus of control
- moral beliefs
- good coping style

### Family factors

- supportive caring parents
- sufficient income support and good physical standards in the home
- few family stressors
- the presence of a non-substance-using parent who is able to provide a stable environment and can offer the child time and attention
- a stable and cohesive parental relationship that is united in the care of children
- strong family relationships, presence of family affection and family activities
- a nurturing parenting style with consistent rules and clear expectations for behaviour
- adequate parental monitoring of the child
- parental engagement in school activities
- strong family norms and morality
- responsibility for family chores or required helpfulness

### School factors

- positive school environment
- regular attendance at preschool/school
- school success
- promotion of academic achievement, careful monitoring of student progress
- consistent teacher expectations and discipline
- belonging to out-of-school activities, including homework clubs
- pro-social peer group

### Community factors

- regular supportive help to the family from primary health care team and social services, including consistent day care, respite care, accommodation and family assistance
- presence of a positive consistent caring relationship with a non-parental adult (grandparent/teacher/neighbour) who can respond to the emotional needs of the child
- opportunities for the child to engage with others outside the family (e.g. school mates/sport) or with stabilising activities (e.g. a major hobby)
- participation in church or other community activity
- a strong cultural pride or ethnic identity

\* Adapted from 'risk and protective factors for anti-social behaviour' in Spooner, Hall & Lynskey (2001). *Structural Determinants of Youth Drug Use*. Canberra: ANCD.



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# 3. Impact of problematic drug and alcohol use on parenting capacity

## 3.1 Introduction

This chapter will present an overview of current research into the impact of problematic alcohol and drug use on parenting capacity. It is noted that most studies in this area fail to distinguish between the impact of substance misuse on parenting, and the range of other factors known to impair parenting independent of substance misuse (see Chapter 2). There is also a lack of research evidence on the differential effects of specific substances on parenting capacity. These points aside, there is evidence to suggest parental substance misuse has the potential to impair the quality of parenting delivered to the child.

This chapter will firstly review the parenting practices of substance-using mothers as well as the experiences of children who have been directly affected by parental substance misuse. It will then proceed to identify those aspects of parenting behaviours that have been specifically linked to parental substance misuse. Finally, as the impact of parental substance misuse on child outcome will depend on the child's development level, the effects of substance misuse on parenting capacity during early childhood, middle childhood and late childhood will be presented.

## 3.2 Parenting practices in substance-abusing families

Within Australia there is widespread recognition of the importance of providing a caring and nurturing family environment to promote positive outcomes for children. Parenting is recognised as an important role – one that requires commitment, selflessness and responsibility. Although fathers increasingly play a more significant role in the upbringing of children (Shears et al., 2006), for many families the primary responsibility of parenting often rests solely with women. This is particularly evident in research undertaken with substance-abusing families where the words 'parenting' and 'mothering' are often used interchangeably (Clarke, 1994; Kearney et al., 1994; Woods, 2000). Although many substance-misusing men are also fathers and fulfil significant parenting roles, whether it be as primary caregiver, as co-parent or through access visitation, there has been little documentation of the difficulties they experience in trying to balance the competing demands of fathering and substance misuse. Certainly it appears unlikely that what is known about substance-misusing mothers can automatically be applied to fathers.

The role played by grandparents in substance-misusing families has likewise been ignored within the research literature. In 2003, there were 22 500 families in which grandparents were the guardians of their grandchildren, involving some 31 100 children aged 0–17 years (Australian Bureau of Statistics, 2004). The reasons grandchildren come to live with their grandparents are varied, but often include trauma of some kind, such as

a parent's drug or alcohol abuse, relationship breakdown, mental or physical illness, or death (Council on the Ageing, 2003). For many grandparents this role is exhausting and demanding and creates a great deal of emotional and financial stress (Orb & Davey, 2005). There is a dearth of information available on how grandparents cope in this role and the impact of this caregiving arrangement on child outcomes.

### Key points

Many men who have childcare responsibilities are accessing treatment services, yet the experience of substance-misusing fathers has been largely ignored in the research literature and treatment setting. The alcohol and other drugs sector has a unique opportunity to work with fathers on parenting issues, particularly as more men than women access treatment services.

Grandparents are increasingly taking on full-time caring responsibilities in response to concerns for the welfare of their grandchildren due to their own children's substance misuse. The support needs of these grandparent carers are many and at present are only erratically addressed. Australian research is urgently needed to determine best-practice models for supporting grandparent carers.

### 3.2.1 The voices of mothers: substance misuse and parenting

Substance misuse is generally viewed as being incongruent with mainstream cultural ideals of femininity and motherhood. Drug-using mothers are portrayed within the media as desperate, impulsive and selfish. They are depicted as 'unfit mothers', 'victims of the frantic pull for drugs' which overrides the biological urge for motherhood, 'unable to care for others', 'unable to provide nurturance' (Alicia & Friedman, 1999). While attitudes and policies are extremely negative, there has been a small number of studies that have directly engaged with drug-using mothers for their perspective on mothering (Alicia & Friedman, 1999; Baker & Carson, 1999; Irwin, 1995; Kearney et al., 1994). This literature presents an alternative story, one that speaks of the agony experienced by these mothers as they attempt to reconcile their substance use with the demands of parenting. It tells of the concerns they hold for their children's futures, the pride they experience in the mothering role, the importance and value they place on providing high-quality care for their children. Yet it also speaks of the emotional distress women experience when they fail to achieve their mothering goals as the day-to-day pressures associated with their substance misuse overwhelm (Kearney et al., 1994; Rosenbaum, 1979).

For many mothers who misuse substances, the parenting role is the *central*, and often the *only*, legitimate social role they perform (Baker & Carson, 1999). Parenting provides these women with a point of stabilisation and purpose (Rosenbaum, 1979), a reason

for their day-to-day existence. The drive to be a better parent is a key reason given by mothers on entrance to treatment services (Gruenert et al., 2004; Kearney et al., 1994; McMahon et al., 2002). Ironically, the lack of child care in treatment facilities is a major obstacle for women seeking drug treatment (Swift et al., 1996). Mothers seeking residential treatment express a preference for programs that enable physical custody of children to be maintained. Absent children are said to create an 'emptiness' which makes concentrating on program content difficult. 'They cannot stand the loneliness of not knowing what their children were doing and not being able to contact their significant other' (Bass & Jackson, 1997, p.666). Concerns about children can lead to premature termination of residential treatment and re-engagement in parenting duties.

The task of parenting coupled with the demands of substance dependence create significant stress and strain for women. 'They have to take care both of the business of child caring and the business of raising funds for their drug use and often that of their partners' (Woods, 2000, p.280). There is a strong view that social deprivation rather than drug use is the major issue in the lives of substance-abusing women and their children (Hogan, 1997). For many women poverty predates their drug use and is linked to the experience of adverse childhoods, the experience of violence, both past and present, lack of education, poor housing, nutrition and a general lack of support (Klee et al., 2002). It has been argued that mothers who use drugs face a set of norms and standards far harsher than those confronting fathers who are also drug users. They receive less

family support when they relapse than their male counterparts and often receive harsher penalties from the criminal justice system (Woods, 2000).

Of particular concern is the expressed reluctance of substance-abusing mothers to access treatment, particularly those most severely dependent upon both illicit drugs and alcohol (Powis et al., 2000). Although drug treatment is regarded as a way of keeping children 'out of care' (Powis et al., 2000), women are less likely to engage with drug treatment services due to anxiety that discovery of their drug problem will lead to the removal of their children (Kearney, 1995; Klee et al., 2002). Woods (2000) quotes the words of a nurse working in the field of drug treatment, 'because of the way the drug users themselves perceive, say, social workers, that they're in the business of taking rather than supporting them to keep their kids, they don't tend to access those services because of the fear that because they're a drug user the kids are going to be lifted' (p.281).

It is noted that evidence for this comes primarily from the United States where substance use, in some States, is regarded as a sufficient ground for child removal. The legislation in the Australian context is not as clear-cut on this issue (see Chapter 5). A recent United Kingdom report found evidence that women, many of whom would be parents, did seek and were engaging in drug treatment services in England (Best & Abdulrahim, 2005). This report found the ratio of men to women in treatment agencies was 3:1. This ratio was consistent with available epidemiological evidence of the prevalence of drug use for men and

women in England. However, the authors do acknowledge that the lower prevalence rate for women may be affected by under-reporting of drug use levels. Nonetheless the report was encouraging in showing that many women are prepared to seek treatment. It is likely that seeking treatment is facilitated by policies that do not endorse automatic removal of children.

Currently in Australia there have been no investigations into levels of service uptake among women substance users and it is unclear whether issues of stigma and types of treatment provision create barriers to service access. There is a need for Australian research to clarify these issues in order to better inform policy regarding levels of treatment provision. Certainly Australian treatment services need to be mindful of the many barriers that might restrict treatment access for substance users who are also parents. Few Australian treatment services provide facilities that welcome children, such as child-friendly waiting rooms or child care services to cater for the needs of children while their parents access treatment. Few residential treatment programs provide additional facilities and services to manage the day-to-day needs of children, while their parents are undertaking long-term treatment.

### 3.2.2 The place of children in residential drug treatment

In Australia there are currently only a very small number of rehabilitation programs that offer women co-residency with their children. There is evidence that women are more likely to seek residential treatment when child care and support services are provided for their children (Beckman & Amaro, 1997). They tend to stay for longer periods of time (Fry McComish et al., 2003; Hughes et al., 1995) and, importantly, follow-up outcomes including reductions in criminality and abstinence rates appear to be better when children reside in treatment with their mothers (Metsch et al., 1995; Stevens & Patton, 1998). The number of children co-residing with the mother appears to exert a mediating impact on treatment outcome. For example, Knight and colleagues found that women with two or more children in treatment are more likely to leave treatment prematurely (Knight et al., 1999), possibly due to the competing demands between child care and program content. The risk of early departure also appears more likely when program demands are high (Strantz & Welch, 1995).

There is evidence that family-focused residential treatment can not only improve the retention of women, but gains have also been shown in areas such as maternal psychosocial functioning and also parenting attitudes (Fry McComish et al., 2003). Co-residency with children has also been shown to significantly increase the likelihood that the family will remain intact post-treatment (Kalling & Wallace, 2003).



While co-residency programs provide opportunities for women to maintain custody of children while engaging in drug treatment, not all women seek this form of accommodation. Children might be living with other family members who might be reluctant to allow the child to enter rehabilitation treatment with the mother. Mothers often choose to bring only their preschool children and leave school-aged children with relatives so as not to disrupt schooling or peer relationships. Unfortunately, long-term outcomes of this type of intervention for the resident child are yet to be determined. Although the inclusion of children in treatment programs provides a mechanism for the early identification of developmental concerns, the initiation of a specialist response as well as an opportunity to strengthen family relationships, longitudinal studies are required to determine whether children who receive these services do better developmentally than children of women without specialised early intervention.

### 3.2.3 Balancing the demands of mothering and substance misuse

Although it is not the intention of this report to minimise the impact of maternal substance misuse on child outcomes, it is important to acknowledge the central role that children play in the lives of substance-abusing women and the range of strategies used to manage the complex interaction between mothering and substance use. Kearney, Murphy and Rosenbaum (1994) interviewed 68 mothers who were actively using cocaine but had not accessed treatment services. These mothers expressed firm standards for child rearing

and strove for positive child outcomes. They employed a number of strategies to help compensate for their drug use to maintain their mothering standards. These included: (a) keeping children physically isolated from drug use; (b) separating their drug user status from their identity as a mother; (c) separating family money from drug money; and (d) isolating themselves and their households from unwanted influences or to avoid the temptation of drugs and the drug-using community.

For many women, however, use of these compensation strategies became increasingly difficult over time. What began as recreational use, which minimally impacted on mothering, escalated into a downward slide of greater drug use and decreasing engagement in mothering. A vicious cycle is described where mothers use drugs to relieve the pressures of mothering, yet when 'straight' they find the damage they have committed when using so intolerable that they use again to escape the pressure of increasing worry and guilt. Kearney and colleagues (1994) report that enduring drug use required increased effort to compensate and a decline in mothering standards. Each mother in the study reported having a personal bottom line that, when crossed, became a signal for action. For some it meant the re-establishment of mothering standards and the reduction or cessation of drug use. For others, pressures arising from unforeseen negative events led to an escalation of drug use and pushed them further on the downward slide.



For over half of the women interviewed, obstacles to adequate mothering eventually became insurmountable and ‘giving up’ children was seen as one form, albeit the least desirable form, of good mothering. ‘By relinquishing custody, mothers met the goal of role-modeling by keeping their drug use behavior out of sight of children, and they met nurturing goals by placing them with a more attentive and economically stable caregiver’ (Kearney et al., 1994, p.356). Unfortunately this option was also associated with little direct engagement in mothering and high frequency of drug use. It was noted that mothers who experienced involuntary custody reported more grief and distress than those who retained some control over their children’s living situation. In either situation, mothers often grieved the loss of their children through increased drug use. For some women a fourth context of mothering was reported wherein they tried to restructure their lives away from the drug scene in an attempt to regain custody of their children. These mothers felt they had too much at stake to use, and instead they invested all of their energy into the goal of family reunification.

There has been little systematic study of the women who are able to successfully make the transition from ‘giving up’ to ‘regain-ing’ the mothering role. One study suggests that the longer a mother had identified as a good mother, the more likely they were to fight for family reunification (Kearney et al., 1994). Women who had lost custody, who felt themselves to have failed in the parenting role and who believed their children were happier and healthier with an alternative caregiver were very unlikely to fight for reunification (Kearney et al., 1994).

After a child has been placed in foster care, numerous requirements, often poorly specified, need to be addressed in order to prove ‘parental fitness’. Typically a woman must show drug and alcohol abstinence, financial stability, attainment of appropriate and stable accommodation and that she is not involved in any criminal activity (Dodge & Pogrebin, 2001). These requirements often prolong the period of mother–child separation and further compound issues of maternal guilt and inadequacy. Factors that appear to help mothers achieve reunification include economic security, maternal education, family support especially with child care and distance from the drug lifestyle. Unfortunately, there is little research to guide therapeutic services aiming to reunify children with parents after removal due to parental substance abuse.

### Key point

Women drug users who are also mothers typically experience marginalisation and discrimination due to their parenting status. For many, the main form of assistance they receive is scrutiny of their parenting practices and the subsequent removal of their children – children who often provide a key source of stability and self-worth in their otherwise chaotic lives.

This dynamic needs to be acknowledged and attention directed to the development of realistic methods to appraise and support both the parenting strengths and the difficulties experienced by these women, in particular the internalised view of self as a ‘hopeless’ parent.

### 3.3 The experiences of children living with parental substance misuse

Children's views about their parent's substance misuse are sparsely represented in the research literature. What is known comes from two sources. First, there are adult recollections of their childhood experiences (for example, Greenfield, 1993; McCord, 1990; Tweed & Ryff, 1991). Secondly, there are a small number of accounts gained from children who are currently, or have been in the recent past, living with parental substance misuse (for example, Advisory Council on the Misuse of Drugs, 2003; Childline, 1997; Hogan & Higgins, 2001; Laybourn et al., 1996; Moore, 2005). Various methodological problems are encountered in this area. Concerns have been expressed about the reliability of adult recollections, definitional issues relating to how the status of a child of a drug or alcohol user is derived, lack of control of other variables which may in themselves play a significant role in levels of child adjustment such as parental psychopathology, socioeconomic disadvantage, social isolation, and finally concerns relating to sample bias and the significant implications this has for generalisation of findings across the broader populations (Kroll, 2004). As a consequence it is wise to remain cautious in interpreting this information.

There is considerably more information on children's reports of the effect of alcohol than other drugs, perhaps because alcohol misuse does not carry with it the same level of public stigma and parents appear more willing to allow freer access to their children by researchers (Kroll, 2004). In contrast,

drug-using parents are reported to be reluctant to directly involve their children in research (Hogan & Higgins, 2001) due to fears and anxieties regarding the potential of child removal (Kroll, 2004). What seems to arise in many drug-using families is 'a conspiracy of silence' – problem drug use is hidden and discussion of the topic considered taboo (Barnard & Barlow, 2002; Kearney et al., 1994). Drug-using parents report being extremely concerned about their children's exposure to drugs and openly report strategies they use to try to conceal this behaviour within the family (Hogan & Higgins, 2001). Yet hiding drug use requires considerable control and planning. As a drug-using father of an eight-year-old boy explains, 'When you are on drugs, you always slip up. He might have seen me injecting once. He might have barged into the room once. I might have been neglectful and forgot to lock the door. If you're using five times daily, of course you drop your guard' (Hogan & Higgins, 2001, p.15). Drug-using parents collectively express a general reluctance to talk directly about their drug use with their children and, as a consequence, report being uncertain about how much their children actually know (Barnard & Barlow, 2002; Hogan & Higgins, 2001).

Barnard and Barlow (2002) interviewed 36 children and young people who had grown up in drug-dependent families. The majority of these children reported knowing earlier and in greater detail about their parent's drug use than their parents believed to be the case. For many this understanding developed incrementally 'as they pieced together such seemingly disparate things as the trappings of drug use (like the omnipresent tin foil), their exclusion from certain areas (bathrooms

and bedrooms) and dramatic mood swings' (p.49). Usually the children chose to keep this newly formed understanding from their parents for a number of reasons. 'The data suggests that many children did not raise the subject because they did not feel it was their place to do so or they were rebuffed at the first mention of it, or indeed they were scared to' (p.51). Rarely did the children indicate their parents spoke openly to them about their drug problem and when they did it was explained within medical terms as an illness requiring treatment by methadone or illicit drugs. All children interviewed expressed an intuitive awareness of the importance of keeping their parent's drug use secret outside of the family home. They reported covering up their parent's problem behaviour through the construction of stories, which normalised their home life while restricting access to the house for peers and others. Unfortunately such behaviours served to isolate the children from available support networks both outside and within the family that might have helped foster resilience.

For all children, the discovery of their parent's drug use was primarily met by feelings of hurt, sadness, anger and rejection. The continual experience of being shut out or not included triggered the painful realisation that they took second place to their parent's relationship with drugs and this contributed to feelings of being unwanted or not important (Barnard & Barlow, 2002; Kroll, 2004). For many children the discovery of their parent's drug use was accompanied with heightened fears and anxiety about their parent's well-being and safety. They are aware from the media that drugs cause harm and even death, yet they are powerless to intervene.

Kroll (2004) likens the secret of parental substance misuse within the family to the presence of an elephant in the living room, 'a huge, significant, but secret presence which takes up a lot of space, uses considerable resources, and requires both a great deal of attention and adjustment of all those in its vicinity' (Kroll, 2004, p.132). The presence of the 'elephant', denied by the parent, obscures the child from the parent's care, and creates anxiety and confusion in the child as they question their own perceptions of the world and their place in it. For Barnard and Barlow (2002) these findings highlight the need for professionals working in the field to encourage parents to break the burden of silence by speaking directly about their drug use with their children. Equally they argue for the design of services that might facilitate disclosure to the child.

Kroll (2004) reviewed a number of studies which featured the voices of adults and of children who had been directly affected by parental substance misuse. What emerged as the most significant problem for the children was the level of violence that arose as a consequence of parental substance misuse (particularly alcohol). She writes that 'children's accounts vividly convey that one major consequence of living with substance misuse is fear – the fear of arguments, actual physical violence or the threat of it, either to a parent (usually the mother) or to themselves and, at times, fear of sexual abuse' (Kroll, 2004, p.135). Perhaps of equal concern is the fear expressed by the children about the consequences of disclosure to outsiders. Fuelled by feelings of loyalty to their parents, they were concerned that such admissions might result in their separation from parents or exposure of their parent's problems and

possible imprisonment. Such fears trapped children in a position where they felt unable to ask for help. They remained in a sense hidden, 'invisible to professionals unless the child or adult came to the attention of welfare services for some other reason. Even then, the needs of the child often remained unseen or secondary to those of the adult concerned' (Kroll, 2004, p.136).

This overview highlights the distressing world that often accompanies parental substance misuse. It is emphasised, however, that the experiences of these children are not representative of the lives of *all* children who live with parental substance misuse. The literature clearly shows that the response of families is diverse and that many children experience very supportive and well-functioning family environments despite the presence of parental substance misuse (Hogan & Higgins, 2001).

A recent report by the Youth Coalition of the Australian Capital Territory (Moore, 2005) interviewed 50 children and young people who were deemed the 'primary carer' within families affected by disability or illness. It is notable that just under one-third (29%) of the young carers were caring for a relative who had an alcohol or drug issue. Although some of the children reflected on the negative ways that caring had impacted on their lives, there was also mention by the children of the positive impact it had had, including ways it had provided them with practical skills and a sense of responsibility: 'they now knew how to cook, clean, do washing, "look after money", garden, fix the car, and look after younger siblings' (p.34). Most of the young carers also felt their caring experience had made them stronger: 'It'll have a big impact on my life. I've gone through a

lot of stress and pain which will make me stronger in the end. I will be more aware of the world' (p.48). The report emphasises that, by providing the young carer with adequate levels of support, the task of caring can be an affirming rather than problematic role which creates an empowering, nurturing and positive experience.

This body of work has clear implications for clinical practice. For too long clinicians have focused single-mindedly on the issues of the adult user and ignored the broader impact of parental substance use within the home/family environment. The children of substance misusers need to be given opportunities to develop 'helping relationships' with professionals and, with that, the time and space to do so at their own pace. Children need to be encouraged to access resources and supports that might enhance the family capacity. Importantly professionals need to show patience when confronted by a child's reluctance to disclose. Although there is great diversity in the reactions of children to parental substance misuse, the possibility that a child presenting with emotional and behavioural problems has substance-misusing parents should be considered (Kroll, 2004).

#### Key point

The perspective of the child living in a substance-abusing family is important. Children need to be provided with opportunities to express their views and help to understand the nature of their parents' substance misuse. They also need access to appropriate resources and supports to enhance family capacity. This work needs to take into consideration the child's developmental level.

### Australian findings

The Nobody's Clients Project undertaken by Odyssey House Victoria documented the experiences of 48 children of primary school age, whose parents accessed treatment for substance dependence (Gruenert et al., 2004).

- By age seven each child on average had attended two schools and moved house over five times.
- Most of the primary carers of the children were unemployed and relied on government benefits and family payments for their income.
- Over 70 per cent of parents reported that their child's exposure to active drug use had been 'distressing'.
- Over 50 per cent of parents reported that children had been negatively affected by their substance misuse; for example, through exposure to family physical violence, abandonment or separation due to family breakdown, incarceration or raids in their homes, including times in which children had been removed in the middle of the night or when backyards/sandpits had been dug up.
- About one-third of parents reported that their children had been negatively affected by finding drug-using equipment, from being verbally abused, from finding parents passed out or unconscious and not being able to wake them up, and from exposure to other dangerous or inappropriate situations.
- Some parents reported that their children had been exposed to periods without food, school or clean and safe home environments, physical and sexual abuse and parental psychotic episodes.
- 24 per cent of children were displaying behaviour that scored within the clinically abnormal range on the Strengths and Difficulties Questionnaire (SDQ).
- 56 per cent of the children were displaying 'normal' behaviour according to their scores on the SDQ.
- During the course of the project, child protection services were actively involved with 41 per cent of the children and had past involvement with 67 per cent of the children during the course of their lives.
- Only 15 per cent of the children had attended child mental health services.
- Higher-functioning children were found to be co-supported by at least one non-drug-using parent or by the child's grandparents.
- Those with the most severe problems generally lived with a single parent with a long history of chronic relapsing substance misuse.

Source: Gruenert, S. et al., *The Nobody's Clients Project: identifying and addressing the needs of children with substance dependent parents*. Full report, December 2004, pp.71–76.

### 3.4 Substance misuse and parenting capacity: findings from research

Substance misuse in itself does not equate to problems with parenting. Parenting competencies vary widely in substance-abusing populations as they do among parents who do not misuse substances. Parenting is a complex role that includes many different responsibilities including providing for the child's basic physical needs, protecting the child from harm, giving guidance and consistent care to help the child learn to behave in a responsible way, as well as responding with sensitivity and warmth to the child's need for attention (Hans, 2004). A large body of research indicates that the optimal combination of parental behaviours involves the establishment of a warm, supportive and nurturing caregiver relationship and the establishment of firm behavioural limits that are consistently supervised and maintained (Amato & Fowler, 2002; Darling & Steinberg, 1993; Dawe et al., 2000; Masten & Coatsworth, 1998).

It is difficult to clearly identify how parenting capacity is affected by substance misuse as there are a range of ways parents manage their drug use and the way it interacts with parenting. Although there have been a number of studies into this area, existing research draws predominantly from case studies or small samples and this makes it difficult to establish strong conclusions. There have also been limited attempts to control for broader risk factors which also have an impact on parenting practices such as parental psychopathology, socioeconomic disadvantage and family violence.

The parenting style of opiate- and cocaine-addicted mothers has been described as vacillating between the extremes of authoritarian over-control and excessive permissiveness or neglect (Suchman & Luthar, 2000). The authoritarian style (Baumrind, 1971) has been characterised by over-involvement, harsh verbal criticism, and a predominant focus on punishment and control, whereas the permissive or neglectful style includes behaviours such as diminished responsiveness, limited involvement, ambivalence and withdrawal (Luthar & Suchman, 2000). Parental substance misuse has been associated with low supervision and monitoring, inconsistent, explosive discipline practices and high levels of verbal and physical aggression (Mayes & Truman, 2002; Miller, 1999).

Kandel (1990) identified a consistent negative relationship between increasing levels of drug/alcohol involvement and effective parenting practice. That is, as levels of drug/alcohol consumption increased, mothers engaged in less supervision of their children, used more punitive forms of discipline, had less positive involvement in the child's life and entered into a greater number of spousal conflicts over child rearing. In turn, higher levels of maternal drug/alcohol involvement were associated with decreased child obedience and a range of other maladaptive behaviours. Nonetheless it appears that changes in levels of parental drug use do not in themselves impact on parenting style. Miller (1999) found that maternal punitiveness remained constant, regardless of whether the mother's alcohol or drug problems were current or in remission.



Whilst accepting an association between drug use and poor parenting, a number of researchers have questioned whether this association is about drug use per se or rather the interaction of parental drug use within a stressful environment (Kettinger et al., 2000; Suchman & Luthar, 2000). Clearly the impact of drug use on parenting is determined in part by the level of use, the presence of a non-drug-using caregiver or the involvement of extended family members who may be able to assume some of the responsibilities of the drug-using parent. However, it is extremely difficult to separate out and to measure the influence on parenting capacity of additional variables such as parental psychopathology, socioeconomic disadvantage and social isolation in a context where these factors often coexist (McKeganey et al., 2002).

It seems likely that there is no single profile that defines the parenting behaviours of all parents with substance misuse problems. Although commonly grouped together because of levels of abuse and dependence, the differing constellations of risk and protective factors operating in each family's ecology result in a diversity of outcomes. In many ways it becomes meaningless to refer in general terms to 'the effects of substance use on parenting capacity' or 'child outcomes'. Categorising parents as substance misusers provides limited understanding into their functioning and/or dysfunction in their parenting role. A more valuable perspective might be to identify specific vulnerabilities in parenting function that have been unambiguously linked to substance misuse. These links have been made by substance-using parents themselves (Hogan & Higgins, 2001; McKeganey et al., 2002; Woods, 2000) and their children (Kroll, 2004) and in a number of qualitative studies (Gruenert et al., 2004).

### 3.4.1 Vulnerabilities in parenting function

#### 3.4.1.1 *The family environment*

The most visible impact of parental substance misuse is in the area of material deprivation and neglect. Money spent on alcohol and illicit drugs is money not available for other things (Childline, 1997; Hogan & Higgins, 2001). Women drug users report having to pawn their possessions in order to support their families, and some may engage in prostitution, petty crime or begging as a means of financial support (Powis et al., 2000). With increasing patterns of dependence, substance use becomes the central organising principle of the family. Household routines such as mealtimes, bedtimes and school attendance are said to take a secondary role to the parent's focus on the attainment of drugs (Hogan & Higgins, 2001). Family rituals such as bedtime reading and engagement in child play are said to rarely occur during periods of active use (Gruenert et al., 2004). Prolonged periods of parental use can have a profound impact on levels of parental functioning and the family environment.

The more people told me I had a problem, the more I would deny I had a problem. And it was one night when I'd sold all the furniture in the house and the children were really starving and, instead of running about trying to get them food, I was running about trying to get my drugs. In the end I think shame caught up with me and the guilt. (Pauline, from McKeganey et al., 2002, p.237)



In response to the parent's preoccupation, many children take on adult responsibilities with regard to their own care, that of younger siblings and often the care of their parents. As a result children are perceived as missing out of an important part of their childhood.

I think the fact that I had my wee boy helped me. At the same time I knew I was destroying his life. I felt helpless but there was still a part of me that wanted to be responsible for him and stuff like that... It got to the stage when he was having to look after his wee brother. He was sort of having to play mummy and daddy, you know? He'd get up in the morning and make his bottle because mummy and daddy are lying on the bed sparked from the night before. (McKeganey et al., 2002, p.238)

#### *3.4.1.2 Exposure to drugs, drug dealing and criminal behaviour*

Although substance-misusing parents clearly state their intention to keep their drug use physically separate from parenting responsibilities, many children, often unintentionally, encounter their parents or others using drugs in the family home. For some children this discovery becomes a source of anxiety and fear, while for others it heightens their sense of being unwanted, rejected and unimportant (Kroll, 2004). Parental drug use increases the likelihood that children will be exposed to drugs and drug dealing at an earlier age than their peers. Although for some children this exposure creates awareness of the problems of substance use and builds the determination not to travel the same path as their parent, for others, however, early childhood exposure results in early initiation and use. 'I started bonging when I was 9 with my Aunty. I used with my family all the time – it was normal' (Moore, 2005, p.33).

Children are also more likely to be exposed to criminal behaviour such as shoplifting, burglary or prostitution as parents attempt to finance their drug habits and this in turn may influence the child's developing attitudes towards criminal behaviour and criminal justice agencies. The long-term implications of exposure to parental drug use and criminal activities are largely unknown. Further research is needed to determine the impact it has on the trajectory of children and, in particular, the choices that they make regarding later involvement with drugs.

#### *3.4.1.3 The emotional wellbeing of the child*

There are a number of ways that parental substance misuse will impact on the emotional wellbeing of the child. Children raised in substance-misusing families have been found to experience greater instability in their daily life due to the physical absence of their parents, arising from imprisonment, admission to treatment programs and hospitalisation for drug-related illness, as well as the emotional absence of the parent as they move through the different phases from intoxication to withdrawal (Hogan & Higgins, 2001).

There were a lot of expanses of time that I cannot remember my son's childhood. I know that I was there. I did not physically abuse him, but I'm sure that I neglected him a lot. I did not go to his Little League games or his school programs, I could not because I was high. I thought I was taking care of his emotional needs, but I'm sure I wasn't. (Baker & Carson, 1999, p.355)

Issues relating to the quality and consistency of parenting have implications for the child's social and emotional development. Secure attachment with the primary caregiver operates as a protective factor in high-risk environments and insecure attachment combined with family adversity may contribute to later behavioural problems (DeKlyen & Speltz, 2001). Disruptions to parental care, especially early disruption of maternal care, have been linked to problems in peer relationships in middle childhood (Coleman, 2003) and the development of mood disorders in later childhood and adolescence (Cicchetti & Toth, 1998). Low levels of involvement by parents who are present in the home have been linked to a range of child behaviour problems including non-compliance and delinquency (Lazalere & Patterson, 1990).

For some children, parental substance misuse might translate into increased exposure to people and experiences that are unsafe. 'Every time she drank she'd have people over at her house: bad people, violent people, people who'd rip you off and hit her and I'd have to protect her' (Moore, 2005, p.39). Substance-abusing women are also more likely than the general population to participate in risky sexual practices and to have sex with multiple partners (Cooperman et al., 2005). This may be an important issue in many family settings. Such practices might introduce unsafe persons into the family home, which in turn may increase the child's exposure to potential situations of violence – physical, sexual or psychological – directed at the child, the parent or other occupants of the house. Exposure to multiple partners also introduces variability in child management strategies and may heighten the risk of inappropriate parenting practices which can be detrimental to a child's psychological development and wellbeing.

While most drug-using parents express confidence about their ability to meet their child's physical needs, many report concerns relating to the emotional impact that their drug use has on the children. Active drug use results in unpredictable behaviour and fluctuating mood swings. In response, children become closely attuned to the needs and feelings of their parents and their actions become governed by the way their parents are behaving and the need to avoid conflict. Australian parents in drug treatment describe clear differences in their parenting style as a consequence of drug use.

... during times of active drug use, more than half of carers reported becoming irritable, intolerant, or impatient toward their children. This often resulted in parents using harsher discipline than they normally would, and being less flexible and open to children's needs ... Other themes reported included yelling more often, being inattentive, regularly feeling guilty and overcompensating with generosity that was unaffordable, reactive and authoritarian parenting, creating an atmosphere of secrecy, not getting the children to school, and letting the children take on parental responsibilities during periods of active drug use. (Gruenert et al., 2004, p.75)

Parenting that is characterised by irritability, intolerance and verbal criticism has been found to affect children negatively, leading to social withdrawal and wariness (Rubin et al., 1995).

#### 3.4.1.4 *The child's progress at school*

Children of drug-using parents were more likely to have difficulties in school, both academically and socially, and were perceived as experiencing more worry and distress in their lives. Hogan (1997) explored the school

experience of a small group of Irish children whose parents were opiate users. School teachers reported that three of the six children had very poor school attendance and lateness, which had resulted in the need for remedial education to compensate for time missed. All children were more likely to be reported as being below average than average or above average in areas of academic ability such as writing, reading, comprehension and mathematics. Their parents were generally described as being disengaged from the schooling process and in most cases they had not interacted previously with the teacher. The children were described by their teachers as displaying a range of concerns including concentration problems, difficulties mixing with peers, lack of motivation or interest in learning, and evidence of maladaptive behaviours. Notably Hogan found inconsistency between parental reports of the child's school performance and that of the teacher. 'Where parents were able to answer questions concerning their child's school progress, almost all reported no significant problems or areas of concern. This was contradicted by the teacher's reports where academic problems and a number of concerns were identified' (Hogan, 1997, p.27). This finding underscores the importance of obtaining collaborative evidence when seeking to identify levels of psychosocial functioning in this population.

It is important to note that while there are no definite effects of parental drug use on the child, it does place the child at increased risk of negative outcome. Furthermore the impact of parental substance misuse on parenting capacity can have a differential impact according to the developmental level of the child. Table 3.1 highlights some of the ways that parental substance misuse can interfere with the child's development in different domains of functioning.

### 3.5 Conclusions

In summary, it is important to note that substance misuse does not automatically result in diminished capacity to parent adequately. It does, however, increase the *potential* for negative family consequences or behaviours to occur that in turn may impact negatively on child outcomes. At present our understanding of this area is hindered by a lack of systematic research, in particular longitudinal research that enables the observation of parenting behaviours over the cycle of addiction and the concurrent impact this has on child behaviours both in the short and long term. There is much evidence of variation in the way drug use impacts on parenting capacity. Levels of parental availability and sensitivity appear to change over time in response to frequency and intensity of drug use and levels of engagement in treatment. It is noteworthy that comment has also been made of the parenting strengths displayed by some substance-misusing parents. Even mothers leading quite chaotic and inconsistent lifestyles have been described as being 'very concerned', 'proud' and 'loving' – 'the same as any other ordinary parent' (Hogan, 1997, p.33). Although the impact of parental substance misuse varies according to the developmental age of the child, most research has focused on the impact during the early childhood years and there are only a small number of studies addressing the middle childhood and even fewer examining the impact of parental substance use in the adolescent years.

#### Key point

To accurately describe how substance misuse affects parental capacity, further research into this issue is necessary, especially within the Australian context.

**Table 3.1: Summary of the major areas of impact:  
parental substance misuse and child developmental outcomes**

Age	Cognitive development and education	Social development
2–4 years	<p>Parental absence due to restricted focus on drug/alcohol leads to reduced availability to stimulate child</p> <p>Irregular attendance or non-attendance at preschool results in lack of school readiness</p> <p>Late detection of developmental delays</p>	<p>Problematic attachment relationships due to intermittent absence of major caregiver</p> <p>Acceptance of antisocial norms due to exposure to drug-using lifestyle</p> <p>May be required to take on age-inappropriate activities</p>
5–9 years	<p>Irregular school attendance</p> <p>School lateness</p> <p>Non-completion of homework</p> <p>Parents not engaged with schooling process</p> <p>Lack of school connectedness</p> <p>Academic difficulties and lack of achievement</p>	<p>Restricted peer friendships</p> <p>May be required to take on age-inappropriate activities</p> <p>Adoption of antisocial norms may result in early participation in antisocial behaviour</p>
10–14 years	<p>Increased risk of early school leaving or exclusion due to continued school failure</p> <p>Lack of school success increases probability of involvement in deviant antisocial activities</p>	<p>Restricted friendships</p> <p>Engagement with antisocial peers due to rejection by ‘mainstream’ peers</p> <p>Early initiation to alcohol/drug use/criminal activities</p>

	Emotional and behavioural development	Health and safety
	<p>Difficulties regulating emotions due to lack of sensitive and responsive caregiver relationship</p> <p>Non-compliant behaviour due to inconsistent parenting</p> <p>Increased risk of trauma from sexual, physical abuse/exposure to violence</p>	<p>Immunisation not up to date</p> <p>Routine medical and dental checks missed</p> <p>Inadequacies in diet</p> <p>Lack of supervision may result in accidents and exposure to physical danger</p>
	<p>Emergence of problem behaviours at home and school</p> <p>Emotional regulation difficulties</p> <p>Increased risk of trauma from sexual, physical abuse/exposure to violence</p>	<p>School medicals missed</p> <p>Limited recreational activities</p> <p>Dental health checks missed</p> <p>Inadequacies in diet</p> <p>Lack of supervision may result in accidents and exposure to physical danger</p>
	<p>Emotional disturbances more common both externalising and internalising behaviours</p>	<p>Little parental support in puberty</p> <p>Early drinking, smoking and drug use likely</p>

### 3.6 References

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## 4. Parental substance misuse in Indigenous communities: a social ecology perspective

‘[There are] families [in this region] where we can trace the trauma back five or six generations. The 1860s, the generation of our great-grannies, was for some the generation of first contact, the massacre times, the poisoned water holes, stock whips and hobble chains. The 1890s, the next generation, saw the setting up and removal of people to reserves. The 1930s to the 1960s, the third generation, the period of assimilation, saw children forcibly taken from their families and placed in state run institutions. My generation has seen massive changes. And now there are my children and grandchildren. Through the generations we have seen too much violence, too much pain, too much trauma. In its multi-layered context, it sits on us like a rash on the soul, and it stays in our families and communities to destroy us. This violence comes as forms of self abuse, and abuse of others, as in alcohol and drug misuse, suicides and homicides, domestic violence and sexual assault.’ (Atkinson, 1994, p.4)

### 4.1 Introduction

‘If I didn’t drink, I would kill myself’

These are the words of a 45-year-old Indigenous woman living on the north coast of New South Wales. She is what could be called an ‘alcoholic’. She drinks every day, and alcohol and cannabis control every facet of her life. Her physical health is adversely affected by her drugs use. She acknowledges that drinking severely impacts on her parenting capacity to the extent that she wants her son given into the care of someone in her extended family in the hope that they may be able to provide the parenting she feels unable to give. She is terrified that the New South Wales Department of Community Services (DoCS) may become involved, and remove her son from her care.

This appears to be contradictory. At one level this woman acknowledges she cannot provide her child with the quality of parenting he deserves and is willing to transfer his care to a member of her extended family, yet she

has real fear of DoCS legally and formally taking her parenting responsibility from her. To understand this woman’s situation we need to examine how her fears and perceived failures relate to the trauma and distress in her life, the lives of her extended family and her community across generations.

This chapter firstly provides a brief analysis of the social and structural factors that have led to the current situation with regard to drug and alcohol issues in Aboriginal and Torres Strait Islander communities. It then provides a review of approaches that address substance abuse in Indigenous communities with a focus on family- and community-based approaches. Finally it considers future directions – What sort of systemic change is needed in Aboriginal and Torres Strait Islander communities? What are the structural impediments that impact on service access and delivery?

## 4.2 Social and structural factors contributing to drug and alcohol use in Indigenous communities

To understand the use, and misuse, of alcohol and other drugs within Indigenous families, it is necessary to critically examine and understand the circumstances that have formed Aboriginal and Torres Strait Islander lives, into the present. A complex combination of social and structural factors created across the historical, physical, institutional and psychosocial domains are all interactive and continue to reverberate across generations.

This chapter began with the words of a 45-year-old Indigenous woman living on the east coast of Australia. In explicating the context within which alcohol and other drugs are used, the reader is now located to the west coast of Australia, within the milieu of a younger generation of Indigenous women. In December 2005, a social and emotional wellbeing unit of a medical service ran a workshop with a group of young women who had been involved with, and affected by, suicide.

During the workshop, discussions provided a poignant context to the construct of suicide and self-harm that moved beyond a description of 'impulse behaviour'. This population of young women experienced childhood histories of sexual abuse, current and past involvement in domestic violence situations, and concurrent use of drugs and alcohol. Their own use of alcohol and other drugs was the only available option for them to medicate, and hence dull, the inner pain that they were experiencing. Three levels of violence, inflicted across generations, have had a profound effect on the identity of these women.

First, the physical violence of the frontier that was associated with invasion, starvation, disease and dislocation. Physical violence, as in military invasion, wife assault, rape, is the quickest, most effective way to establish power over others (Schechter, 1982).

Secondly, the structural violence that stemmed from legislative processes and social policies as part of the so-called protection era. The Protector, the legal guardian of every Aboriginal child in the State under the age of 21, could authorise marriage and adoption at the flick of a pen, determine that a husband be sent to one place, his wife to another and the children located in a dormitory at another location (Kidd, 1997, p.140). The protection legislation was supposed to create safety for people who had been traumatised. Instead, it enforced dependency and obstructed access to basic essential services. It gave authority to people who used their power abusively. It tore families apart. It destroyed any sense of self-worth and value in culture as it outlawed ceremonial processes and use of language. Feelings of frustration, fear, anxiety, anger, rage, hatred, depression, as well as the essential need to suppress these feelings, became part of the day-to-day experience. By 1959, the 'protector' or Director of Native Affairs, O'Leary, could proudly state of this total control system: 'We know the name, family history and living conditions of every Aboriginal in the State' (Kidd, 1997, p.189).

The third form of violence that has shaped these women is the psychosocial dominance that resulted in cultural and spiritual genocide (Baker, 1983). Indigenous people would call this the greatest violence, the violence that brings the loss of spirit, the destruction of self, of the soul. Cultural and spiritual genocide is also associated with the child removal policies which have been extensively documented in *Bringing Them Home*,

the report of the National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families (Human Rights and Equal Opportunity Commission, 1997).

This tragic experience [of removal] across several generations has resulted in incalculable trauma, depression and major mental health problems for Aboriginal people. Careful history taking during the assessment of most individuals and families identifies separation by one means or another – initially the systematic forced removal of children and now the continuing removal by Community Services or the magistracy for detention of children, rather than the provision of constructive support to families and healing initiatives generated from within their own communities. The process has been tantamount to a continuing cultural and spiritual genocide both as an individual and a community experience. (*Bringing Them Home*, submission 650, pp.4–5)

The *Bringing Them Home* inquiry was ‘not raking over the past’ for its own sake, but acknowledging that ‘the past is very much with us today, in the continuing devastation of the lives of Indigenous Australians’ (ibid, p.3). The report details ‘multiple and profoundly disabling’ layers of abuse in the lives of all those affected, causing ‘a cycle of damage from which it is difficult to escape unaided’ (ibid, p.177).

Within a generation of colonisation, the experience of family life for Indigenous Australians changed dramatically from how it had been for 60 000 years, with no hope of the traditional social structures returning.

The dramatic changes resulted in a group of profoundly hurt people living with multiple layers of traumatic distress, chronic anxiety, physical ill-health, mental distress, fears, depressions, substance abuse and high imprisonment rates. For many, alcohol became the treatment of choice, because there was no other treatment available. Throughout Indigenous society are seen what can only be described as dysfunctional families and communities, where interpersonal relationships are very often marked by anger, depression and despair, dissension and divisiveness. These effects are generational. It is not the drug or alcohol use that is the whole problem. Take the substances away and the pain – the distress – the trauma remain.

Some of us Indigenous peoples still live in our own communities. Many of us have moved to big cities. Wherever we are, we often feel torn between the Aboriginal way and the mainstream culture way. Very often we seek escape from our problems through alcohol. As time goes on, we drink more and more. When we get into trouble through our drinking we just drink more. Some of us want to stop drinking but when we try to stop, we find out we can’t. Then we ask ourselves: ‘Why can’t I stop drinking on my own? Why do I drink again after making many promises? Whether I am in the white man’s world, with or away from my ancient healing practices, I still get drunk. Why?’ (Alcoholics Anonymous for the Indigenous Australian)

### 4.3 Barriers to success

Acknowledgement that change is necessary across multiple domains is clearly explicated within government policy. The *National Drug Strategy: Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006* (Ministerial Council on Drug Strategy, 2003) recognises that government, non-government and Aboriginal and Torres Strait Islander community-controlled organisations must work together to address the social, economic, environmental and physical health inequalities experienced by Aboriginal and Torres Strait Islander peoples. It further emphasises that health is not just the physical wellbeing of the individual but also the social, emotional and cultural wellbeing of the whole community. The strategy calls for a holistic approach to achieve improved health outcomes for Aboriginal and Torres Strait peoples' licit and illicit use of alcohol, tobacco and other drugs. In turn, each of the State governments has developed a set of policies that have resulted in many different points of action for intervention across Indigenous communities (see Chapter 6).

However, the translation from government policy into effective change for communities is a complex process. The simple adaptation of Western approaches to treatment is now widely recognised to be largely unworkable. Within many treatment settings, the uniqueness and importance of Indigenous spiritual beliefs have been poorly addressed and cultural sensitivity has tended to be an 'add-on'. For example, many residential programs do not incorporate the cultural integrity needed to support Indigenous substance abusers, as the programs do not address issues of culture or race in any specific way.

The issue of remaining abstinent is further complicated for Indigenous people. The community they go home to following residential treatment is often racked with trauma and violence and unable to support a newfound resolution to remain free from substance misuse. Family and community (albeit fractured) are often all they have. They may not have jobs, they may not own houses, they may not drive or own cars, and they do not generally have access to strong support groups or structures such as clubs or societies. They and their children often have deficits in educational opportunity or outcome. These are the words of an Indigenous woman:

You know, it was really hard for a long time. I was so lonely for my people. My sisters and brothers, all of my mob, they were all still drinking grog and using dope. The welfare had my kids, they used to be with my mother but in the end she couldn't put up with them, so they took them. I tried to get them back a few times but I was always stoned in court. They finally took them away from Mum. I know where they are and they are being looked after OK, I suppose. When I was really ready to get off drugs, I couldn't go near my family. They were always drunk and fighting. I had to be by myself. It was so hard. I went to AA meetings all the time cause there was nothing else. I made some mates there and got an Aboriginal sponsor and that got me through.

More recently, progress has been made in identifying a list of factors that contribute to the success of Indigenous alcohol and other drugs projects (Strempel et al., 2003). This list recognises the importance of developing projects that have:

- Indigenous community control with clearly defined management structures and procedures
- adequate funding to reach service objectives
- services that utilise multi-strategy and collaborative approaches
- appropriately trained staff and effective staff development programs
- clearly defined realistic objectives aimed at the provision of service to address identified community needs.

## 4.4 A review of approaches that influence children's lives in Indigenous communities

There has been a range of approaches initiated to address substance abuse issues in Indigenous communities. For the purposes of this chapter, approaches to be reviewed have been grouped into three categories. First, there have been a number of strategies implemented which aim to reduce the *supply* of substances within Indigenous communities. Secondly, there are strategies that have been designed to *reduce levels of harm* associated with substance misuse. Finally, there are approaches that provide a *multi-faceted* approach to service provision. Examples of each type of intervention will be reviewed in turn. It is emphasised that included examples are generally those that have been published within the literature and recognised as models of good practice. Whilst it is disconcerting that there have been so few publications in this area, it highlights the importance of providing future opportunities for sharing and elaborating on models of best practice in Indigenous communities.

### 4.4.1 Strategies that have influenced supply of substances in Indigenous communities

Strategies to control or restrict the supply of substances to Indigenous people are not new and have been applied in a variety of ways across time. Restrictions might operate continuously or for a specific period of time and might encompass all or only particular types of alcohol. The declaration of restricted alcohol communities or dry communities serves to restrict or forbid the consumption of alcohol within a certain area. For example, the Ramingining Community in northern Arnhem Land, after a long attempt to overcome its



alcohol problems, requested the assistance of the Northern Territory Liquor Commission to declare a restricted area with no liquor permits to be issued to individuals. It should be noted that while some substances are still smuggled into the community, the incidence of alcohol-related violence has dropped dramatically. This community appears to have had greater success than some other dry-declared communities. A crucial ingredient for success was that the initiative came from the community members themselves (d'Abbs, 1990). The majority of residents wanted restrictions and the traditional owners shared their views

Alternative supply reduction strategies have focused on restricting hours of take-away sales and the supply of cask wines. For instance, the trial of alcohol restrictions implemented in Alice Springs in 2002–03 involved a ban on alcohol sales in containers greater than 2 litres, reduced takeaway trading hours and a provision that only light beer be sold in bars before noon. One of the key findings from the subsequent official evaluation was that the trial restriction period did not result in a significant reduction of quarterly wholesale sales of pure alcohol. In response to the removal of 4-litre and 5-litre wine containers, there was a corresponding shift in the market to cheap 2-litre port (1000% increase in sales). Although less volume of port was purchased, the volume of alcohol content consumed remained the same. Even though there has been some comment on the 'positive outcomes' from the trial such as reduced levels of community violence, including levels of alcohol-related assaults, public drunkenness and hospital admissions, concerns expressed by Gray (as quoted in Hogan et al., 2006) regarding the methodology used in the official evaluation of the trial make it difficult to draw strong conclusions. The major outcome of the trial

was the establishment of an evidence base for price-related supply reduction strategies within a large Indigenous community. This has led to calls for further exploration into the potential for reducing per capita alcohol consumption through the trial of price-based mechanisms (Hogan et al., 2006).

A more recent initiative has been the introduction of non-sniffable Opal fuel in areas where petrol sniffing is prevalent. Opal fuel, a low aromatic petrol blend, has been designed to replace the use of regular unleaded petrol in remote communities. There are 52 Indigenous communities who use Opal fuel with plans for a further roll-out as part of the Australian Government's eight-point plan to combat petrol sniffing in the Central Desert Region of the Northern Territory, Western Australia and South Australia (<http://www.health.gov.au>, retrieved 28 November 2006).

#### Key point

Supply reduction strategies are critical to ensure the safety of women and children exposed to violence associated with drunkenness and other substance intoxication. It is stressed, however, that these are short-term emergency measures that have an immediate, albeit partial, impact on the physical safety of the community. Failing to address the fundamental causes of the problems will not ameliorate the long-term effects of substance misuse within Indigenous communities.

#### 4.4.2 Strategies that have influenced the harms associated with misuse of substances

A number of strategies have been developed that aim to reduce levels of both individual and community harm as a consequence of substance misuse. For communities racked with ongoing abuse and violence, it is imperative that people on the receiving end of violence have a *safe place* to be. As Indigenous people have strong kinship ties and connection to the land, removing victims of abuse from their communities is not a culturally appropriate way of ensuring 'their safety'. Each community must have, if the community requests it, a safe haven or overnight shelter for those who fear harm. Refuges and safe houses will not stop substance abuse, they will not prevent the recruitment of a younger generation into substance abuse, but they might keep people alive or unharmed, just for now!

Night patrols are likewise important as they serve to lessen the number of people being brought before the criminal justice system, prevent harmful interactions with police and lessen the impact of alcohol-related violence within communities. The *Tangerentyre Night Patrol* in Alice Springs is a multi-service program staffed by Indigenous people and created in response to community concern. One of the significant strengths of the *Tangerentyre Night Patrol* is its strong collaboration with other service providers and use of Indigenous workers who ensure cultural appropriateness. This program also has an effective service delivery with weekly skills training for workers, has secure funding and is a multi-service program — the night patrol being only one component of a wider intervention program (see Stempel et al., 2003, for more information on this project).

The *Milliya Rumurra* Alcohol and Drug Rehabilitation Centre in Broome, Western Australia, manages the *Walangari sober-up shelter*, which has been influential in reducing the numbers of Indigenous people incarcerated from 173 in 1999 to 33 in 2001. The programs initiated by the *Milliya Rumurra* Alcohol and Drug Rehabilitation Centre play a valuable role in creating immediate safety for people. Aside from the sober-up shelter, *Milliya Rumurra* also has a residential substance-misuse program that incorporates a harm minimisation approach. Note has been made of the Centre's sustainability over time, its strong and respected presence in the community, its flexibility, collaborative practice, good governance, and the expertise and qualifications of staff (Stempel et al., 2003).

#### Key point

The provision of harm minimisation services such as 'safe houses', night patrols and sobering-up shelters plays a valuable role in reducing levels of harm that arise as a consequence of substance misuse. These services, however, are akin to bomb shelters in a war. They will in no way serve as a solution to the conflict (substance misuse) or resolve the underlying issues to prevent another war (a new generation of people with substance abuse problems). No one would deny the usefulness and necessity of a bomb shelter in a war, nor would the same mind consider a bomb shelter a solution to war.

## 4.5 Making differences in Indigenous communities: a multi-systemic approach

Services that have demonstrated a multi-faceted approach to service provision stand out as examples of good practice. The *Wu Chopperen Health Service* based in Cairns, Queensland, is an Indigenous community-controlled health service for Indigenous people in the region. This holistic service provides a wide range of programs addressing the health needs of clients including a comprehensive medical and oral health unit and health promotion unit. The service also delivers a Drugs, Alcohol and other Substances program (DAOS), which aims to delay the uptake and reduce the use of alcohol, tobacco and other substances by Indigenous people. As well as providing counselling and support for Indigenous families, DAOS also provides various preventative and training services such as health promotion, staff and the development of culturally appropriate health resources. It has taken action to address volatile substance misuse in the community and introduced a home-based detoxification program. The *Wu Chopperen Health Service* draws on the dedication and experience of staff, strong leadership, good teamwork and rigorous reporting activities to help achieve such positive outcomes (see Strempel et al., 2003, for more information about this project).

### 4.5.1 Council for Aboriginal Alcohol Program Services Inc. (CAAPS)

CAAPS located in Darwin, Northern Territory, differs from most Indigenous interventions as it is family-focused and has a commitment to providing a culturally appropriate continuum of care for Indigenous families and communities through a holistic approach based on individual empowerment. It is a fully Indigenous-managed and staffed organisation that developed as a result of the recognition that the existing services were not meeting the needs of Indigenous people in the area. The service provides a Return Home Support Initiative, which encompasses a 21-day program for residential withdrawal along with comprehensive support for people wanting to move from an itinerant lifestyle. Through this initiative, clients are provided with support and assistance to address the challenges of achieving ongoing change in lifestyle. There is also an eight-week residential training program, which provides awareness of the physical, mental, emotional, spiritual, cultural and social effects of alcohol and other drugs within Indigenous families. CAAPS has been cited as a service with unparalleled commitment to staff training and support (Strempel et al., 2003). It is a Registered Training Authority providing training for workers in substance-misuse prevention and treatment programs that are delivered using culturally appropriate learning styles. Through security of funding, the service provides ongoing treatment and training with a strong focus on traditional Indigenous culture and values. It is backed by good governance and strives for excellence in service provision (see Strempel et al., 2003, for more information on this project).

#### 4.5.2 The Mt Theo program

The *Mt Theo program* is a community initiative, which began in 1994, to address the petrol-sniffing crisis in Yuendumu, Northern Territory. This community had previously attempted to deal with sniffers through night patrols, taking kids to other communities, public floggings and youth activities. These strategies were found to produce change only in the short term. In response, the Mt Theo program was initiated – a program wherein petrol-sniffing children are removed from their community and sent to live on entirely Indigenous-run Mt Theo Outstation and participate in a program designed to strengthen their cultural identity. The program has developed over time and is now cited as a ‘best-practice model’ in preventing petrol sniffing. The program has been successful in eradicating petrol sniffing in Yuendumu and it has now been extended to address petrol-sniffing issues across all Warlpiri communities. Services have also expanded to address broader substance misuse issues in the community, the development of youth activity programs as well as providing educational workshops at a local, regional and national level. One of the key factors in the success of the Mt Theo program is its strong community roots – it is community initiated, supported and operated, and this extensive community engagement has created, developed and strengthened a whole-of-community endorsement of the anti petrol-sniffing campaign (Preuss & Napanangka Brown, 2006).

#### 4.6 Indigenous substance abuse treatment centres

For historical and structural reasons Indigenous residential treatment programs have tended to be insular and tied to a narrow range of organisations and individuals. Over the last hundred years treatment approaches used with Indigenous communities have been influenced by different paradigms. These may be briefly summarised as follows:

- moral and religious – in which drinking or drug use is viewed as wrong, sinful or immoral; this leads to an abstinence goal
- biomedical disease concept arising in the late 19th century and culminating in the work of Jellinek. The medical view of alcoholism took various forms including the view of addiction as an allergic reaction to the substance. Other explanations that have since emerged trying to explain biological bases of addictions have proposed that addiction is caused by metabolic differences, genetic vulnerability and other biological predeterminants. For the medical profession this model tends to fit well, but it negates the spiritual component of explanations and healing. The goal of treatment is usually to aim for abstinence as a part of treatment
- psychological approaches vary enormously and encompass a range of different theoretical approaches from a psychodynamic perspective to contemporary models based on cognitive behavioural principles. The important feature of these approaches for the treatment of Indigenous substance misuse is the almost complete lack of focus on (i) social and cultural context of the substance use, and (ii) a spiritual aspect deriving from traditional Aboriginal beliefs.

Many Indigenous treatment programs have been developed by people who have experienced addictions themselves. As a consequence, this is the most common approach offered in indigenous programs. However, the focus on alcoholism as a disease raises problems. Effective programs need to engage in an open-minded search for intervention and counselling strategies that meet the needs of clients, particularly in the light of the review by Gray, Saggars, Sputore and Bourbon (2000) of Indigenous treatment programs. They report that, of the three treatment studies they located, only inconclusive or modest gains were recorded, with few clients achieving the goal of abstinence, although more general improvements in health status were noted.

Treatment models, whether couched within a disease/medical model or a harm minimisation framework, tend to 'add on' cultural components. Whilst this practice gives some recognition of the impact of culture on substance misuse, alternative approaches need to be initiated, developed and evaluated by communities in response to conditions unique to each community.

The cultural/spiritual model integrates Indigenous culture into the treatment process. However, the process is dominated by traditional orientations, using ceremonies, spiritual activities and the involvement of elders alongside traditional western therapeutic techniques. This model has some merit as it uses strengths from both traditional and western cultures. Placing primacy on Indigenous cultural values is more likely to support the establishment of a stronger sense of internal identity and increase self-esteem.

Notwithstanding the cultural and recreational components of any program, there needs to be a more creative and broader range of treatment approaches tailor-made for individual clients. The high incidence of dual diagnosis (i.e. people who have mental illness as well as substance abuse issues) requires innovative treatment options.

Indigenous treatment programs need to be strengthened to improve the functioning of boards of managers, the quality of staff, linkages between Aboriginal and other programs, and the content in residential programs. The boards of management need to have a broad understanding of the proper conduct of committees, and issues surrounding the treatment of substance abuse, over and above their own personal experience and histories. Too often in the past there have not been sufficient formal training opportunities or the encouragement to engage in training, and least of all the funding to provide training.

In terms of identity and community, the sad fact is that many clients in residential treatment are placed there by the courts and those who enter treatment voluntarily, due to scarcity of places and the referral system (which does not work with informed cultural considerations), are often placed in centres a long way from their families and communities. There are just not enough centres to place people close to family networks or community of origin. In turn, this means that family healing and community healing are not initiated as components of the treatment process. Extended family members are not able to access treatment and the community is not consulted or integrated into the treatment process. It has already been

stated that Indigenous connection to community and family is crucial to health and wellbeing. Treatment modalities that do not involve family and community are likely to have very limited outcomes.

Residential treatment centres need to become integrated into the communities in which they are placed. Old stigmas surrounding substance abuse along with the need to protect clients have led centres to become insular and disconnected from the communities in which they are situated. It is possible to build treatment modalities that ensure the safety of clients, whilst at the same time enabling healing for community, the family and the individual. Keeping Indigenous clients locked away and then releasing them to an unhealed family and community will not create enduring change.

## 4.7 The way forward

There are some underpinning philosophies that enhance the chances of improving the wellbeing of children and families when working in Indigenous communities. The most important is the concept of cultural safety. Cultural safety, initially introduced by Irihapeti Ramsden in her work with health professionals in New Zealand, refers to 'an environment that is spiritually, socially and emotionally safe, as well as physically safe for people ... It is about shared respect, shared meaning, shared knowledge and experience of learning together ... Cultural safety extends beyond cultural awareness and cultural sensitivity. It empowers individuals and enables them to contribute to the achievement of positive outcomes. It encompasses a reflection of individual cultural identity and recognition of the impact of personal culture on professional practice' (Bin-Sallik, 2003, p.21).

Operating from a perspective of cultural safety ensures that the western medical ethos of 'first do no harm' is employed. The re-abuse of abused people is the first outcome of a lack of proper regard to cultural safety. One of the most fundamental aspects of cultural safety is the invitation to engage. This acknowledges a respect for the Indigenous custom, of always obtaining permission from the right people at the right time in the right way to be in a place or to do something in a place. It is a custom closely tied to the obligation and responsibility to care for the land and all within it. It acknowledges traditional ownership and the unique understandings of the people in each place. It is considered disrespectful to not ask permission to engage or to wait patiently for an invitation to engage. Services need to be created in response to



requests from communities, not as policies imposed by a distant government. Each community has a unique experience, and an understanding of its own strengths and frailties. A successful engagement is likely to require much time and patience. Time and patience usually will cost money in service provision. Services need to be funded for the proper development of relationships with those who are honestly seeking to enhance the wellbeing of their communities.

Family, in its varied and extended forms, is at the heart of Indigenous society. Colonisation tore families and communities apart. Social structures were altered permanently. For example, mission life forced Indigenous people from different geographical locations, language groups and cultural beliefs to live a shared existence and in this way they had to develop new ways of interacting. Institutional living for many became the experience of childhood in the absence of traditional family structure. While the trauma of colonisation resulted in much suffering, where Indigenous cultural influences have endured and adapted to the post-colonised world, Indigenous people have shown enormous resilience.

The process of developing social structures based on traditional cultural beliefs about family and communities is ongoing. It is important that programs and services demonstrate that they honour and are prepared to promote Indigenous concepts of family and wellbeing as the primary objective of their service. Indigenous people cling very closely to their families and their communities as a natural process. They do this by tradition and as a defence against external threat. Where communities are ravaged with problems of violence, poverty, abuses of all

kinds and oppression from the outside, a safe supportive social environment provided by family and community is vital for the person attempting to break away from patterns of substance abuse. To say to an Indigenous person who has been clean and sober for a few months 'don't go back to your community because everyone there uses and if you go back you will most likely use again' is to ask them to deny the very dynamic that gives them identity and purpose.

Substance abuse in families, as it impacts on parenting, is not the only issue that needs to be addressed. Education has an important role as a health and healing response to substance abuse in families. This has largely been ignored in previous evaluations of Indigenous alcohol and drug programs. The word 'education' as it is used in mainstream language, however, raises serious concerns for Indigenous peoples, bringing up memories of abusive western educational approaches where the 'student' is forced to learn and perform with outcomes which are often unrelated to real community issues and needs. When Indigenous people talk about 'healing through education' and 'the educational processes in healing', they are giving value to the origin of the word 'education', from the Latin *educare*, to rear up, to nurture the children, to draw out from, to lead, to show the way. 'Educaring', a word coined at Gnibi, the College of Indigenous Australian Peoples at Southern Cross University, is used as an activity of experiential learning where the 'teacher and the taught together create the teaching'. It is a process of drawing out the deeper knowledge, which will show the way forward, and is the most important activity in working in the area of alcohol and drug misuse related to generational patterns of abuse.



Furthermore, when Indigenous peoples use the word 'healing' in the context of alcohol and other drug misuse, and parenting practice, the concept is not given value within a western paradigm. Warry provides a Canadian Aboriginal definition of healing that is particularly relevant in other Indigenous contexts (Warry, 1998, p.240):

Culture, identity, tradition, values, spirituality, healing, transformation, revitalization, self-determination, and self-government: a spiral of ideas and actions constitute community healing. At the most basic level, when Aboriginal people speak of community healing they suggest that there are many individuals within their community who must heal themselves before they will be capable of contributing to the many tasks that lie ahead. They talk of finding ways to help support individuals who must heal deep wounds. This can only be accomplished if people are provided with opportunities for spiritual growth and cultural awareness. More generally, people must acquire new skills so that the capacity of their communities to engage in discussion, planning and control over their institutions is increased. There is a need to build supportive and healthy environments so that debate and dialogue can be conducted on the many complex issues that comprise self-government.

A healing educational approach is cross-disciplinary, integrating Indigenous cultural processes with a number of disciplines. These include health care practice and promotion, sociology, psychology, social sciences, western biomedical and complementary medicines, law, history and political sciences. Under an Indigenous definition the approach

is holistic. Educational curriculum should be blended into educational modalities that provide cognitive approaches, critical reflection and reflective practice, explication and the insight that comes from experiential learning experiences. Such educational approaches would contain a training syllabus for the multi-skilling of all workers employed in the health, social sciences, violence prevention and trauma recovery fields.

#### Key point

A major emphasis of 'educaring' is promoting understanding of the relationship between historical and socio-political influences that result in social trauma and violent behaviour – in particular, how trauma and violence are transmitted – and consequently it has inter- and trans-generational effects across societies and populations. In this, the presence of alcohol and other drug misuse, together with conflicted parenting, are seen within the broader context of its emergence across generations.

Indigenous people need programs to address the deprived and degenerating circumstances under which they live. Such support should promote resilience and resonance, a social learning model that draws on the strength of Indigenous world views of relatedness. There is an urgent need for projects that focus on rebuilding community spirit and responsibility with a particular emphasis on protecting and nurturing Indigenous children and their parents.

Projects such as the Kalunga Research Network, a collaboration between the Institute for Child Health in Western Australia and the West Australian Aboriginal community (through Aboriginal community-controlled health organisations), argue for the need to build capacity in Aboriginal research to bring together ideas and experiences of Aboriginal communities and the research expertise of Aboriginal people (<http://www.ichr.uwa.edu.au/kulunga/>).

The Collaborative Indigenous Research Centre for Learning and Educare (CIRCLE) at Gnibi, the College of Indigenous Australian Peoples at Southern Cross University, works with communities at their invitation, to promote community growth from within. Using a sensitive and culturally safe approach to research, which privileges Indigenous research theory and practice, the question is asked by one Indigenous PhD student: Will community-based educaring approaches strengthen and enrich community governance capacity? (<http://www.scu.edu.au/schools/gnibi/>)

In this way research that is drawn directly from an Aboriginal community by Aboriginal health researchers will allow for culturally informed practices and policies to develop. The focus of the Kalunga Research Network on child and maternal health is particularly welcomed in the context of this report into the welfare of families with parental substance abuse.

The conceptual development of building resilience and developing resonance is derived from an Indigenous educational approach which also reaffirms the New Public Health model supported by the World Health Organisation, and referred to previously. The model for 'educaring' involves developing

mental, emotional and spiritual health and wellbeing; the creation of healthier lifestyles; preventing child trauma; and increasing participation and inclusion in ongoing healing education. The most critical need is to strengthen capacity to respond to issues of alcohol and other drug misuse in families, as they impact on parenting and child development, through education designed to address the needs of people 'at the coalface', and through participatory action and through process evaluation research which shows evidence-based practice in policy development and service delivery.

The foundations of Indigenous society, the culture and the collective identity of the people have been weakened by a history of repeated assault and have contributed to the alienation that creates substance abuse among Indigenous people. Substance abuse springs from a collective experience; therefore, solutions need a collective response. Acting alone, Indigenous people cannot shift the weight of disadvantage and discrimination but solutions that lift the weight collectively shift it for everyone. Whole health comes from shared prosperity, a clean and safe environment, and a sense of control over life circumstances – as well as high-quality illness care and healthy lifestyle choices.

## 4.8 Summary

Educational, health, mental health, social services, welfare and criminal justice strategies imposed on Indigenous communities to date have failed to impact significantly in improving outcomes for Indigenous children, their families and communities. Indigenous children are sometimes immersed in families and communities that often have been fractured across generations as a result of colonising agendas. High levels of alcohol and other drug misuse in families, and the resultant impact and implications for children, are an indicator of that fracturing. Evidence is clear that those children who have come from environments of addiction are more likely to become victims of addiction than those who come from environments where addiction is not evident. Indigenous families have wide kinship systems and therefore children are bound to come under the influence of adults who abuse. In fragile communities the younger members are more vulnerable to becoming addicted to substances.

Most approaches to the treatment of substance abuse focus on the individual and the family system at the neglect of the wider social, cultural and political influences that contribute to, and in a sense shape, the face of substance abuse amongst Indigenous people. The strong co-relation between violence and outrageous substance abuse among Indigenous people has been established and it is impossible to talk about health outcomes without addressing substance abuse. At the same time it is clear that addiction cannot exist until the person uses the substance. Once addiction is established, it has its own dynamic and must be addressed within the individual as well as from a wider cultural perspective. Rehabilitation serves to peel

people off the end after careers of abuse. At best it maintains a state of equilibrium. We need to help those who are currently addicted but we also need to develop mechanisms to prevent novices to addiction. We need to develop policies that comprehend and address problems of generational substance abuse.

Indigenous people need programs to address the deprived and degenerating circumstances in which they live. Such support should promote resilience and resonance, a social learning model that draws on the strength of Indigenous world views of relatedness. Projects that focus on rebuilding community spirit and responsibility, with a particular emphasis on protecting and nurturing Indigenous children and their parents, are urgent. Services need to work from the strengths of the communities and the enhancement of those strengths rather than focusing on what is not working well. Strengthening of families, strengthening of eldership, strengthening of culture through the arts, strengthening of ceremony and ritual, and revival of language are but a few potentialities in any Indigenous community. Substance abuse will not go away until communities are strengthened. This strengthening also applies to current services in any community. Don't defend: evaluate and strengthen! Sometimes existing services whilst needing improvement may be the only one giving hope to a community.

Services need to be owned, managed and controlled by the people of the community in which they operate. People who manage need to be educated in the business of management prior to engaging in their work. If their work is valued, it should be paid work!

Services need culturally appropriate, ongoing internal and external evaluation with a view to being open to changing ideas in an ever-changing world view. This ensures the potential for the attainment of the goals of services whilst at the same time ensuring that services remain open and transparent.

As far as possible, Indigenous managers and workers need to be drawn from the community in which the service operates. This means real funding for education at all levels of service provision and ongoing training with career structures developed in the general area. Paid professional mentorship is an absolute necessity for coalface workers, especially if they live in the community they serve, as these workers are likely to be direct victims of abuse or at least suffer from the vicarious trauma of their community.

What may be perceived as a good idea in one place will not necessarily be the desire or need of another community. Although there may be common denominators of substance abuse, violence, poverty and cultural loss across communities, each community's expression and experience of this will be unique. The Indigenous way appreciates and celebrates diversity in all its forms. Services must be initiated by and tailored uniquely to serve each community.

Services need sustainable adequate ongoing long-term planning strategies and funding. It is just not possible to deal with the complex and entrenched despair of a race of people in two- and three-year, short-term projects. This is especially true where programs are created ad hoc without interrelatedness to other programs within the community. A whole-of-community approach acknowledges the Indigenous understanding of the connectedness of all things and the spiritual essence of all things.

Services need to be diverse and responsive to the cultures and priorities of Indigenous people and to the special dynamics of Indigenous substance abuse. Existing services need to be restructured such that we establish healing centres that are truly holistic in approach and ideology. Then these centres can fill the acute need for residential programs for people overwhelmed by social emotional and spiritual distress. They must serve children and families and be safe places. They need to enhance wellbeing and offer new ways of learning for people who have been abusive and want to deal with anger and frustration.

Substance abuse is the final outcome of societal and personal alienation, the dynamics of which are complex and cannot be resolved by dealing with the substance abuse alone. This must come first, as it has its own dynamic force, but it is intertwined with so many other aspects of Indigenous experience that it cannot be resolved without looking at the broader socio-historical context that impacts on the daily experience of Indigenous people. Of necessity is a focus on children and families, so pivotal in Indigenous culture. Treatment centres must be adapted to house families in order to create places of healing for future generations.

Only when communities are strong, have identity and purpose, and are actively engaged in energetic and vibrant pursuits which are nurturing to the spirit, will Indigenous people be able to successfully address individual drug and alcohol problems. The huge task is to address the wellbeing of the entire community whilst at the same time addressing the need of the individual who is abusing a substance.

Indigenous programs need to address the following areas:

- enhanced capacity for Indigenous people, both individually and as a community, to address current and future issues of substance abuse to promote their own health and wellbeing
- a whole-of-government approach to implement, evaluate and improve community-based strategies to reduce drug-related harm
- a range of services, programs and interventions to be introduced that address substance abuse from a holistic framework
- workforce initiatives to be introduced to enhance the capacity of Indigenous community-controlled and mainstream organisations to provide quality services. There needs to be increased ownership and sustainable partnerships of research, monitoring and evaluation and dissemination of information between Indigenous and non-Indigenous people
- substance abuse policies, interventions and treatment services to focus on implementing and instilling Indigenous values, principles and procedures in all spheres of prevention, education and treatment of substance abuse with Indigenous people
- support ethno-cultural responsiveness in the development and delivery of services, in order to meet the needs of Indigenous people in terms of substance abuse treatments
- training in cultural competence, designed to respectfully challenge misconceptions, is essential. Cultural safety is an essential and non-negotiable element in working with all Indigenous people, especially those who are seeking assistance with substance abuse problems
- regaining identities is an important element of treatment and sensitivity and responsiveness in the provision of culturally competent services that ensure access to treatment and prevention initiatives
- most importantly, the recognition of the right of Indigenous people to promote, develop and maintain their own institutional structures, distinctive traditions, customs and practices and procedures; pathways to empowerment and self-determination will be pivotal.

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# 5. Parental substance misuse: the legal framework

## 5.1 Introduction

It is well recognised that parental substance misuse is a common feature in a large number of child protection matters. Along with such issues as financial distress, family violence, mental health problems and unemployment, parental substance misuse forms one of a series of frequent precursors to child abuse or neglect. Figures quoted in a number of jurisdictions in Australia suggest substance misuse is a central issue in child abuse and neglect cases. For example, Western Australia's Department for Community Development submission to the Senate Community Affairs References Committee (2005) reported that 'approximately 70 per cent of care and protection applications result from parental drug and alcohol abuse in combination with other factors such as family violence and mental illness' (p.86). The same Senate report stated that up to 80 per cent of child abuse incidents investigated by the New South Wales Department of Community Services involve concerns about drug- and alcohol-affected parents.

This does not, however, mean that child protection legislation in Australia has been drafted as a specific response to this fact. On the whole, the general presumption contained within child protection legislation is a clear focus upon the condition and rights of the child or young person. From a purely protection standpoint, *causes* of abuse are often a second order priority when it comes to legislation aimed at facilitating *responses* to instances of children in need of immediate protection. However, if clear links can be drawn between parental substance misuse and elevated levels of child abuse or neglect, the case for a more rigorous investigation of child protection legislation arguably becomes compelling.

The primary responsibility for investigation and resolution of child protection matters in Australia rests with the States and Territories, resulting in eight different approaches to child protection across the jurisdictions. Although this chapter will address the various regimes in place and proposed across these jurisdictions, it does not seek to provide a comparative review of child protection legislation across the country. Such reviews have been carried out in other forums, most recently by Bromfield and Higgins (2005) for the National Child Protection Clearinghouse. Instead, this chapter is concerned with the specific relationship between existing child protection legislation and the specific issue of parental substance misuse. The fundamental question that this seeks to address is: In situations where a child's parents have a substance misuse problem, what protections (if any) does the system afford that child?



In terms of legislative frameworks there are three issues that arise in the consideration of parental substance misuse as a factor in child protection matters. First, an examination needs to be made of the various legislative regimes in Australia and the position they take with respect to the nature of the association between parental substance misuse and child welfare/child protection. Importantly, this includes whether or not substance misuse is being understood from a legislative perspective as a *necessary indicator* of abuse or neglect, or alternatively whether it is being understood as a *causal factor* in abuse and neglect cases.

Secondly, this chapter will examine the reporting requirements in the various Australian jurisdictions to determine whether or not parental substance misuse is sufficient to trigger such action and what responsibilities members of the public have to report parental substance misuse as part of a broader child protection obligation.

Finally, an international comparison will be undertaken with three other jurisdictions – the United States of America, the United Kingdom and Canada. The purpose of the comparative exercise is to examine the approach taken to parental substance misuse in other jurisdictions and to determine what advantages or disadvantages different approaches may have. Reference will also be made to the United Nations Convention on the Rights of the Child and the implications this has for child protection legislation.

## 5.2 Parental substance misuse and legislative definitions of child protection

The legislation that this chapter considers is set out below in Table 5.1. References in this chapter to an Act in a jurisdiction will, unless otherwise noted, refer to the legislation in force listed in Table 5.1.

Throughout this chapter, a number of terms are used that should be clarified. The first is ‘child protection action’. Because there is no uniform procedure or language surrounding child protection mechanisms in Australia, the phrase ‘child protection action’ is used throughout this chapter to refer to any action taken by a government to assess or intervene in a child protection matter. The term is used to describe any government activity ranging from the receipt and processing of a notification of potential harm to a child, the conducting of an investigation into alleged harm of a child, through to taking action to remove a child from their parent or guardian.

Table 5.1: Child protection legislation in Australia

Existing legislation	
Commonwealth	<i>Family Law Act 1975</i>
Australian Capital Territory	<i>Children and Young People Act 1999</i>
New South Wales	<i>Children and Young Persons (Care and Protection) Act 1998</i>
Northern Territory	<i>Community Welfare Act 1983</i>
Queensland	<i>Child Protection Act 1999</i>
South Australia	<i>Children's Protection Act 1993</i>
Tasmania	<i>Children, Young Persons and their Families Act 1997</i>
Victoria	<i>Children and Young Persons Act 1989</i>
Western Australia	<i>Children and Community Services Act 2004</i> (replaced the <i>Child Welfare Act 1947</i> on 1 March 2006)
Legislation not yet in force	
Northern Territory	<i>Care and Protection of Children and Young People Act 2005 (Draft)</i> – would replace the <i>Community Welfare Act 1983</i>
Victoria	<i>Children, Youth and Families Act 2005</i> – to replace <i>Children and Young Persons Act 1989</i> (scheduled to commence in March 2007)

Consistent with earlier discussions, the terms 'primary factor' and 'secondary factor' are used in this chapter to describe the relative importance of parental substance misuse as a trigger for child protection action. The central distinction drawn between these two terms for this particular chapter is as follows:

- Primary factor:** a behaviour or outcome which *necessarily* can result in child protection action. For example, if a child is found to be physically abused, the fact of physical abuse alone is sufficient to result in child protection action.
- Secondary factor:** a behaviour which on its own may not necessarily result in child protection action, but may give rise to further behaviour or a result that triggers a child protection action. A secondary factor may also be one of a series of factors which combine to give evidence of conditions causing harm or neglect. For example, a parent's alcohol abuse may be a factor in preventing a child from receiving suitable emotional support and care. It would be the lack of emotional support and care that may trigger a child protection action, not simply the fact that a parent abuses alcohol.

### 5.2.1 Australian Government jurisdiction in child protection matters

Before considering State and Territory legislative responses to child protection concerns, it is important to briefly note the interaction between the federal government and the States and Territories on matters involving child protection. The States and Territories have primary carriage of child protection policy and practice within Australia. However, the *Family Law Act 1975* establishes the functions of the Family Court and the Federal Magistrates Service, both of which may hear cases in which allegations of child protection concerns may be raised. The Australian Government's role in protecting children is reflected in the provisions of Part VII of the Act concerning parental responsibility and children's rights in family law cases. As noted in the Family Law Council's final report (2002), 'Dealing with cases involving allegations of child abuse and violence is part of the "core business" of courts exercising jurisdiction under the *Family Law Act 1975*' (p.19). However, although it is estimated that 25 per cent of cases before the Family Court involved child abuse claims (Senate Community Affairs References Committee, 2005), the Family Court has no independent power or capacity to investigate such matters. When allegations of child abuse or ill-treatment are made within the Family Court, the matter is referred to the relevant child protection welfare authority by the Registrar of the Family Court pursuant to the reporting requirements of sections 67Z–67ZA of the Act. Any responsibility for the investigation and resolution of those claims then rests with the State or Territory concerned. For the purposes of this chapter, therefore, the response of State or Territory bodies to reports or notifications, whether received from the Australian Government or from any other party, is the more important consideration.

### 5.2.2 Parental substance abuse under child protection legislation

Child protection legislation in Australia is not uniform. With respect to the language adopted by the drafters in each jurisdiction, three issues are of note. First, the language used to describe a child in need of protection; second, the language used to define the scope of behaviour constituting a basis for action under law; and third, the threshold of seriousness required to trigger action under law. Each of these three elements varies across jurisdictions.

Variations on the first issue are primarily questions of legislative wording (e.g. 'at risk of harm' as opposed to 'in need of care and protection'), and for the purposes of clarity in this chapter, the phrase 'in need of protection' will be used to describe the legislative grounds for child protection action. However, while these variations may be more semantic than substantive, the variations in the range and/or seriousness of behaviours that could trigger child protection action are neither merely semantic nor unimportant.

#### 5.2.2.1 Range of behaviour triggering action

With respect to the type of behaviour that would lead to the view that a child was in need of protection, all jurisdictions include the core concepts of *physical abuse* and *emotional/psychological abuse* as constituting behaviour that would trigger child protection action. *Sexual abuse* is also expressly included in the definitions of all jurisdictions. In contrast with its predecessor, the recently commenced Western Australian Act includes specific mention of sexual abuse as constituting a child in need of protection. *Neglect* of a child is also expressly included in all jurisdictions except the Northern Territory, New South Wales and Victoria (both current and proposed), though the language

used in both Acts is sufficiently broad as to include behaviour constituting neglect. The proposed Northern Territory legislation includes situations where a parent has failed to 'adequately care for a child', which would cover circumstances of neglect.

Beyond these four core concepts, a range of descriptors are used in various Acts to explain behaviour that could be evidence of the inability or incapacity of a parent or guardian to provide for a child's welfare, including:

- adequate control not exerted over the child (Tasmania)
- child engaging in dangerous conduct due to lack of control exerted over child (Northern Territory)
- child at risk due to domestic violence in the household (Australian Capital Territory, New South Wales)
- child abandoned (Northern Territory, Victoria)
- child's basic needs not being met (New South Wales)
- medical care not being provided for a child in need (New South Wales, Western Australia)
- inability to maintain child (Northern Territory, Western Australia)
- unwilling to maintain child (Northern Territory, Tasmania)
- child being exploited (Queensland)
- child not attending school regularly (Tasmania)
- parents dead or incapacitated and there is no other suitable person willing and able to care for the child (Victoria).

When examining all of the existing and proposed child protection legislation, the simple fact of parental drug use alone is not a specific behaviour mentioned in any *current* Act. However, section 4(1)(c) and (f) of the *repealed* Western Australian *Child Welfare Act 1947* stated the following:

*child in need of care and protection* means a child who –

- (c) associates or dwells with any person who has been convicted of vagrancy, or is known to the police as of bad repute, or who has been or is reputed to be a thief or habitually under the influence or alcohol or drugs;

...

- (f) is found in a place where any drug or prohibited plant is used and is in the opinion of the court in need of care and protection by reason thereof...

On a straightforward reading of the above words, in paragraph (c) of the Act it would seem that child protection action might be triggered solely on the basis that drugs were present where a child was found, while paragraph (f) of the Act indicates child protection action would be triggered where a child was found in the described circumstances and, as a result, the child was in need of care and protection. Paragraph (f) was therefore somewhat circular, as it defined a child in need of care and protection as being a child who was present in a place where there were drugs and who needed care and protection. In this way parental drug use alone may not, therefore, have been sufficient to trigger child protection action unless such use caused a risk of harm to the child. The express mention of drug use in the section does, however, high-

light the increased inherent risk that such activity may present to a child. While it may be a secondary indicator of harm or neglect, it is nonetheless an important one.

It is critical to bear in mind that the *Child Welfare Act 1947* (WA) was repealed on 1 March 2006 with the commencement of the entire *Children and Community Services Act 2004*. This Act now governs child protection matters in Western Australia and does not include a section similar to either paragraph (c) or (f). The definition of ‘in need of protection’ included in the new Act adopts language more consistent with an amalgam of other jurisdictions in Australia.

#### 5.2.2.2 Parental substance misuse as a ‘secondary factor’ of harm or neglect

The specific consideration of drug use and the presence of drugs in the *Child Welfare Act 1947* (WA) is a convenient entry-point at which to consider the issue of parental substance misuse as a secondary factor in cases of harm or neglect. While drug use simpliciter is not sufficient to trigger child protection mechanisms within Australia as a primary factor, it may be a cause of neglect, harm or other abuse of a child, which could trigger such a response as a secondary factor. The issue then becomes what role parental substance misuse has in contributing to or being the cause of identifiable abuse or neglect.

#### Key point

While drug use alone is not sufficient to trigger child protection mechanisms within Australia as a primary factor, it may be a cause of neglect, harm or other abuse of a child, which could trigger such a response as a secondary factor.

With respect to the various definitions of a child in need of protection, it is important to bear in mind those legislative definitions that are based on *actions* of the parent, as distinct from those based upon *consequences* to the child, and as distinct from those based upon *action* by the parent causing a *consequence* for the child. In their comparison of national child protection legislation, Bromfield and Higgins (2005) describe the restrictions on legislative grounds for intervention in the eight jurisdictions by reference to these three categories – action only, consequences only, and actions and consequences. To complicate matters, however, it is not as if jurisdictions can be characterised by legislative frameworks based upon one or other of these categories. Rather, they incorporate two or possibly three categories in subsequent definitional paragraphs (discussed further in Bromfield & Higgins, 2005).

With regard to parental substance misuse, the distinction between the three categories may have some effect upon the emphasis placed upon causative factors triggering child protection action. For example, where a provision is drafted as ‘consequence only’, the cause of any harm or neglect suffered by a child is irrelevant for the purposes of the legislative trigger. Child protection action can occur where there is actual harm

or an unacceptable risk of that harm to the child. Parental substance misuse may not immediately be a relevant factor in making determinations as to whether a child is ‘in need of protection’.

As a case in point, the Queensland legislation adopts ‘consequence only’ language for the relevant provisions of the *Child Protection Act 1999*, and notes in the explanatory memorandum to the Bill that:

When determining whether a child is ‘a child in need of protection’ the main focus of the court is upon the child’s needs and whether an order is required to meet them, rather than upon the parents’ action, omissions or incapacity which may have led to the harm or risk of harm.

Under ‘consequence only’ provisions, the role played by parental substance misuse will be relevant only when determining causative, or secondary, factors in the course of an investigation, not in triggering an investigation to begin with.

Legislation that is concerned primarily with the actions of the parents, such as the Tasmanian and Australian Capital Territory legislation, may allow for greater scope in moving parental substance misuse towards being a primary causative factor when making determinations for child protection action. Under these legislative constructions, it is the actions of the parents that form the critical component in triggering child protection action. Whether or not the child actually suffers or has suffered harm is not the key issue.

However, as shown in the *Children, Young Persons and their Families Act 1997* (Tas.) where section 4(1)(c)(ii) defines a child at risk as including circumstances where ‘the guardians of a child are unable to exercise adequate supervision and control over the child’, the specific action or omission may be the result of a number of behaviours. Parental substance misuse may be the behaviour that leads to the action of neglect, but it is the action of neglect that will trigger child protection action, not simply parental substance misuse.

There are some cases where the legislation has used an ‘action and consequences’ provision which may be broad enough to enable a direct consideration of parental substance misuse. For example, section 23(e) of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) defines a child as being at risk of harm where:

a parent or other caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm.

Parental substance misuse may therefore be sufficient, on its own, to constitute behaviour likely to put the child at risk of psychological harm. It is important to note that, in the 2005 New South Wales Inter-agency Guidelines, advice is provided on types of behaviour that may cause psychological harm including ‘acts that exploit or corrupt a child by promoting or exposing the child to self-destructive, anti-social or criminal behaviours such as violence or drug use’ (p.161). Although this is discussed in the context of the New South Wales *Ombudsman Act*, undoubtedly parallels can be drawn with how psychological harm is defined under child protection legislation.

Section 4(3)(b) of the *Community Welfare Act 1983* (NT) includes a similar intent in stating that a child shall be taken to have suffered maltreatment where:

he or she has suffered serious emotional or intellectual impairment evidenced by severe psychological or social malfunctioning measured by the commonly accepted standards of community to which he or she belongs, because of his or her physical surroundings, nutritional or other deprivation, or the emotional or social environment in which he or she is living or where there is a substantial risk that such surroundings, deprivation or environment will cause such emotional or intellectual impairment.

The fact of the child living in a household in which there is ongoing parental substance misuse may constitute a social environment sufficient to trigger this provision of the Act; only, however, if there is evidence of serious emotional or intellectual impairment.

Thus, as noted in the previous section, substance misuse is not a necessary trigger, but it may be a causative factor in triggering child protection action where such use is likely to play a causal role in serious emotional or intellectual impairment. To a large extent it would seem the trigger provisions of the legislation in all jurisdictions are unconcerned with secondary factors, including parental substance misuse. Where parental substance misuse causes neglect, the provision allowing intervention is based upon either the action of abuse or the consequence of abuse itself. Nowhere is substance misuse defined as, in itself, an action of abuse.

In the context of at least four jurisdictions there is a further important factor to note. In the Australian Capital Territory, Northern Territory, Queensland and Victoria the definitions of ‘a child in need of protection’ involve a dual requirement in order to trigger the legislation, namely that the child’s parents have not been willing or able to protect the child from abuse or neglect. In these jurisdiction, therefore, parental substance misuse may impact upon child protection matters in three ways: first, it may be directly responsible for causing behaviour amounting to abuse or neglect; second, it may be instrumental in preventing a parent from protecting a child from parental behaviour which constitutes abuse or neglect; and third, parental substance misuse may be a factor in preventing a parent from protecting a child from the abusive or neglectful behaviour of a *third party*.

Parental substance misuse may be a factor in any behaviour that leads to abuse or neglect, but may also be an important indicator in demonstrating *psychological* or *emotional* abuse. Due to the effects of drug use and, in particular, chronic or regular drug use upon a parent’s lifestyle, behaviour that includes no actual physical harm to a child may nevertheless still require a child protection response.



In addition to psychological or emotional abuse, the issue of parental supervision may also be relevant in considering the impact of substance misuse upon a parent's ability to protect their child from harm. Both Tasmania (*Children, Young Persons and their Families Act 1997*, s.4(1)(c)(ii)) and South Australia (*Children's Protection Act 1993*, s.6(2)(c)(i)) include the inability to adequately supervise a child as being behaviour requiring potential child protection action. Similarly, child protection action may be triggered where a parent's substance misuse:

- prevents a child from attending school –
  - *Children's Protection Act 1993* (SA), s.6(2)(d): 'the child is of compulsory school age but has been persistently absent from school without satisfactory explanation of the absence'
  - *Children, Young Persons and their Families Act 1997* (Tas), s.4(1)(d): 'the child is under 16 years of age and does not, without lawful excuse, attend school regularly'
- prevents a child's needs from being met –
  - *Children's Protection Act 1993* (SA), s.6(2): 'Are unable to care for and protect the child, or are unable to exercise adequate supervision and control over the child; or (ii) are unwilling to care for and protect the child, or are unwilling to exercise adequate supervision and control of the child'
  - *Children and Community Services Act 2004* (WA), s.28(2)(d)(ii): 'the child has suffered, or is likely to suffer, harm as a result of the child's parents being unable to provide, or arrange the provision of, effective medical, therapeutic or other remedial treatment for the child'
  - *Children and Young Persons (Care and Provision) Act 1998* (NSW), s.23(a): 'the child's or young person's basic physical or psychological needs are not being met or are at risk of not being met'
  - *Children and Young Persons Act 1989* (Vic), s.63(f): 'the child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or other remedial care'
  - reduces greatly a parent's capacity to maintain a child –
    - *Children, Young Persons and their Families Act 1997* (Tas), s.4(1)(c)(i): 'the guardians of the child are unable to care for and protect the child'
    - *Children's Protection Act 1993* (SA), s.6(2)(c)(i): 'the guardians of the child are unable to maintain the child...'
    - *Community Welfare Act 1983* (NT), s.4(2)(b): 'the parents, guardians or the person having custody of the child are or is unwilling or unable to maintain the child'.

5.2.2.3 *Seriousness of behaviour triggering action*

In addition to understandings about the types of behaviour that would indicate that a child was in need of protection (or the range of secondary factors that may contribute to or cause such a need), there are also differences between the eight jurisdictions with regard to how serious that behaviour or its results must be before a child protection action is triggered. This is referred to as the ‘threshold’ that such action must reach. For example, one threshold may be that the child suffers ‘significant harm’ as a result of physical injury while another, less onerous, threshold may be that the child is physically injured. The differences between jurisdictions in this respect may be important, as reaching the threshold is the first step towards triggering child protection action – the more extreme the activity required to satisfy the threshold, the more limited the number of successful child protection actions.

Table 5.2 below compares the language in the relevant provisions of the legislation across the eight States and Territories as used to describe the minimum threshold for intervention for the four main behaviours of physical abuse, sexual abuse, emotional/psychological abuse and neglect. The darker shading indicates those provisions that require a higher threshold level of detriment or harm to the child.

As noted by the Senate Community Affairs References Committee (2005), these variations across the jurisdictions can ‘lead to a lack of consistency as to whether a child’s maltreatment allegation will be investigated’ (p.29).

With respect to the impact of these differences upon the issue of parental substance misuse, it is worth noting both the New South Wales and current Northern Territory legislation. Both Acts may be interpreted to include parental drug as a behaviour or ‘social environment’ respectively that would cause psychological harm. The higher threshold, therefore, means that the parental substance misuse must not simply cause harm to a child, but must cause significant harm or serious impairment as evidenced by severe malfunctioning. This may be a more rigorous test than proving the alternatives of neglect or physical abuse.

Table 5.2: Minimum thresholds for child protection actions across Australian jurisdictions

	Physical abuse	Sexual abuse
ACT	Physical abuse	Sexual abuse
NSW	Physical abuse <sup>1</sup>	Sexual abuse
NT	Permanent disfigurement, serious pain, or impairment	Sexual abuse
QLD	Significant detriment	Significant detriment
SA	Injury detrimental to child's wellbeing, or development in jeopardy	Sexual abuse
Tas.	Injury detrimental to child's wellbeing, or development in jeopardy	Sexual abuse
Vic.	Significant harm	Significant harm
WA	Significant detriment	Significant detriment
NT (new)	Significant detriment	Sexual exploitation
Vic. (new)	Significant harm	Significant harm

<sup>1</sup> In all other jurisdictions the criminal defence for parents of reasonable chastisement exists. However, in the interpretation of what is 'reasonable', New South Wales is the only jurisdiction to have specifically stipulated what is and is not permitted. New South Wales modified the defence of lawful correction in the *Crimes Amendment (Child Protection Physical Mistreatment) Act 2001*. The principal Act, the *Crimes Act 1900* (section 61AA), now reads:

In criminal proceedings brought against a person arising out of the application of physical force to a child, it is a defence that the force was applied for the purpose of the punishment of the child, but only if: (a) the physical force was applied by the parent of the child or by a person acting for a parent of the child, and (b) the application of that physical force was reasonable having regard to the age, health, maturity or other characteristics of the child, the nature of the alleged misbehaviour or other circumstances.

In addition, the Act specifies areas of a child's body to which force cannot lawfully be applied:

The application of physical force, unless that force could reasonably be considered trivial or negligible in all the circumstances, is not reasonable if the force is applied: (a) to any part of the head or neck of the children, or (b) to any other part of the body of the child in such a way as to be likely to cause harm to the child that lasts for more than a short period.

Emotional/ psychological abuse	Neglect
Significant harm	Significant harm
Significant harm	Needs not being met
Serious impairment	Unwilling or unable to maintain
Significant detriment	Significant detriment
Injury detrimental to child's wellbeing, or development in jeopardy	Injury detrimental to child's wellbeing, or development in jeopardy
Injury detrimental to child's wellbeing, or development in jeopardy	Injury detrimental to child's wellbeing, or development in jeopardy
Significantly damaged	Significant harm
Significant detriment	Significant detriment
Significant detriment	Harm
Significantly damaged	Significant harm

### 5.2.3 Conclusions

Parental substance misuse is not a factor that under any legislation will necessarily trigger child protection action. This is not, however, to say that parental substance misuse will never trigger child protection action. In at least two jurisdictions (New South Wales and the Northern Territory) it is open on the face of the legislation to include parental substance misuse as a potential behaviour or social factor that causes harm or risk of harm to a child. In both cases, however, taking the matter further would be a judgement

made on the behalf of the child protection agency. Secondly, in all jurisdictions parental substance misuse may be a secondary factor that causes harmful action by a parent or otherwise causes harm to a child. In these cases the question of parental substance misuse will be most important not in triggering child protection action, but in forming one of the factors that child protection agencies will consider in making a determination as to what type of child protection action to undertake.

### 5.3 Legislative requirements to report parental substance abuse

All child protection regimes in Australia are based upon a system of community reporting. Allegations or suspicions of child abuse or neglect are reported to the relevant child protection agency which then assesses the report and takes appropriate action. By and large, the reporting of child protection matters is broad and voluntary, meaning that any person can report to the agency regarding child protection matters within that jurisdiction, and that the range of behaviour that may be reported and then acted upon is limited only by the legislative definition of a child in need of protection. Any behaviour, consequence or circumstance, which may satisfy the definition in that jurisdiction, is sufficient to warrant a voluntary report. This is reflected in those Acts that expressly note the voluntary capacity of all persons to report child protection matters (ACT: *Children and Young People Act 1999*, s.158; NSW: *Children and Young Persons (Care and Protection) Act 1998*, s.24; Vic: *Children and Young Persons Act 1989*, s.64).

Parental substance misuse may be reported through the voluntary reporting mechanisms, but child protection action would only be possible where the report was consistent with the statutory definitions discussed in the previous section.

#### 5.3.1 Mandatory reporting of parental drug abuse

In addition to a voluntary reporting capacity for child protection matters, all Australian jurisdictions also include some form of mandatory reporting requirements. These mandatory reporting requirements are rarely general and are normally required only of certain classes of person. Table 5.3 below sets out a summary of the mandatory reporting requirements across the eight jurisdictions. A similar table can be found in the Bromfield and Higgins report (2005, p.6).

It is important to recognise that the requirements for mandatory reporting in Western Australia differ from those in the other States and Territories. First, there is no mandatory reporting requirement in the Western Australian child protection legislation; rather, a small number of childcare persons are mandated to report under subordinate regulations. The requirements to report in the *Family Court Act 1997* (WA) simply reflect the provisions of the Commonwealth *Family Law Act 1975*. Secondly, there is no penalty provision attached to these limited reporting requirements. In all other Australian jurisdictions with mandatory reporting requirements, there are varying penalties, predominantly financial, for failure to notify the relevant authorities of a child in need of protection.

In all States and Territories, the report is to be made to the relevant child protection agency as represented by the Director-General, Secretary or Minister responsible for that agency. As noted earlier in this chapter, the Australian Government has no independent child protection agency, and therefore any reports made under the *Family Law Act* are made to the child welfare service in the jurisdiction relevant to the case at hand.

All mandatory reporting requirements, despite being applicable to differing classes of persons across each jurisdiction, require that a reasonable belief or a reasonable suspicion be formed by the reporter that the child in question is at risk of some specified level of harm or has suffered some specified level of harm. With respect firstly to the question of who is mandated to report, only two jurisdictions (Northern Territory and Tasmania) have a general reporting requirement. All other jurisdictions limit the classes of persons required to report to medical personnel, police, child welfare providers or some mix of these broad groups.

Secondly, the behaviour or outcomes that are required to be reported upon are often more limited than the range of behaviours or outcomes that would otherwise normally trigger child protection action. In most jurisdictions, the range of behaviours subject to mandatory reporting is limited to more apparent severe forms of abuse, predominantly sexual or physical abuse. Only in New South Wales and Queensland is the range of behaviour that it is mandatory to report upon as broad as the range of behaviours that may trigger child protection action under the relevant Act, including, for example, the possibility of reporting upon emotional or psychological abuse.

In the Australian Capital Territory, the specified classes of persons are required to report only upon sexual abuse or non-accidental physical injury. This means that there is no mandatory requirement upon those same specified classes of person to report emotional or psychological abuse, or the presence of domestic violence or neglect. The latter categories may still constitute a child in need of care and protection and could be reported upon voluntarily, but there is no requirement under the law that this be done.

A similar situation exists in the Northern Territory, Tasmania and Victoria. The new Western Australian Act does not implement mandatory reporting mechanisms in that jurisdiction.

As discussed previously, parental substance misuse alone has an increased likelihood of triggering child protection action in those jurisdictions where the legislation includes such matters as conduct leading to psychological or emotional harm, lack of control or an inability to maintain the child. In the five jurisdictions noted above, however, evidence of these behaviours falls outside the mandatory reporting mechanism. It is unlikely, therefore, that parental drug abuse could be the subject of a mandatory report in these jurisdictions, nor would it form the basis of a report in Queensland where the primary concern is with harm to the child and not actions by the parents.

In New South Wales, parental substance misuse could form conduct sufficient to require a mandatory report by the classes of persons listed in the Act if it was decided that the behaviour of the parents satisfied section 23(e), namely that 'a parent or caregiver has behaved in such a way towards the child or young person that the child or young person has suffered or is at risk of suffering serious psychological harm'. The mere fact of a parent using illicit drugs would not therefore trigger the mandatory reporting provisions of any Australian child protection legislation, except perhaps in New South Wales.

Table 5.3: Mandatory reporting requirements across Australian jurisdictions

	Legislation	Classes of person
ACT	<i>Children and Young People Act 1999</i> , s.159	Limited (doctor, dentist, nurse, teacher, police officer, children's counsellor, childcare employee, care coordinator, public servant providing health or welfare services to children, community advocate, official visitor)
NSW	<i>Children and Young Persons (Care and Protection) Act 1998</i> , s.27	Limited (persons employed to provide health care, welfare, education, children's services, residential services or law enforcement to children)
NT	<i>Community Welfare Act 1983</i> , ss.13 & 14	Limited (police) General
QLD	<i>Child Protection Act 1999</i> , s.148	Limited (employee of the Department involved in administering the Act, employee of a childcare service)
	<i>Health Act 1937</i> , s.76KC	Limited (doctor or registered nurse)
	<i>Education (General Provisions) Act</i> , ss.146A–146B	Limited (principal of a State or non-State school)
SA	<i>Children's Protection Act 1993</i> , s.11(2)	Limited (medical practitioner, pharmacist, registered or enrolled nurse, dentist, psychologist, police officer, community corrections officer, social worker, minister of religion, person who is an employee or volunteer in an organisation formed for religious or spiritual purposes, teacher in an education institution, any other person who is an employee or volunteer in a government department, agency or instrumentality or a local government or non-government organisation that provides health, welfare, education, sporting or recreational childcare or residential services)



	Behaviour/consequences	When must belief be formed
	Sexual abuse or non-accidental physical injury	During course of or from person's work
	Child is at risk of harm	During course of person's work
	Child has or is suffering maltreatment	
	Child has or is suffering maltreatment	
	Becomes aware or reasonably suspects that harm has been caused to a child in residential care	Any time
	Child likely to be harmed and no other professional has notified the chief executive	During the practice of profession
	Student has been sexually abused by an employee of the school	Any time
	A reasonable likelihood of the child being killed, injured, abused or neglected by a person with whom the child resides	In the course of the person's work or official duties

	Legislation	Classes of person
Tas.	<i>Children, Young Persons and Their Families Act 1997</i> , ss.13 & 14	Limited (medical practitioner, nurse, dentist, psychologist, police, probation officer, teacher, childcare worker or provider, public servant providing health or welfare services to children) General
Vic.	<i>Children and Young Persons Act 1989</i> , s.64	Limited (medical practitioner, nurse, teacher or principal, or police officers)
WA	<i>Family Court Act 1997</i> , s.160	Limited (person performing functions of Registrar, family and child counsellor, welfare officer, family and child mediator, or arbitrator)
	<i>Community Services (Child Care) Regulations 1988</i> , reg.53A	Limited (licensee or permit holder of childcare facility)
	<i>Community Services (Outside School Hours Care) Regulations 2002</i> , reg.34	Limited (licensee or permit holder of childcare facility)
NT (new)	<i>Care and Protection of Children and Young People Act 2005</i> , s.23	General
Vic (new)	<i>Children, Youth and Families Act 2005</i> , s.112	No change to existing reporting arrangements
	<i>Children, Youth and Families Act 2005</i> , s. 29	General (voluntary)
Cwth	<i>Family Law Act 1975</i> , s.67Z	Limited (Registry manager)
	<i>Family Law Act 1975</i> , s.67ZA(2)	Limited (member of court, counsellor, mediator or arbitrator)

	Behaviour/consequences	When must belief be formed
	Abused or neglected or at risk of being killed by a person with whom child resides	In carrying out official duties or in course of work
	Abuse or neglect	Any time
	Child is in need of protection from significant harm as a result of sexual abuse or significant harm resulting from physical injury	In the course of practising profession
	Child being or at risk of being abused	In the course of performing function
	Any allegation of abuse, neglect or assault made against the licensee or permit holder or staff member	Any time
	Any allegation of abuse, neglect or assault made against the licensee or permit holder or staff member	Any time
	Child is in need of protection	Any time
	Significant concern for the wellbeing of an unborn child	Before birth of child
	Any notice detailing abuse filed by a party to proceedings with the court	No belief necessary; upon receipt of notice only
	Child being abused or at risk of being abused	In the course of carrying out duties

The reporting distinction between physical abuse and psychological abuse can also be seen to be reflected in the Commonwealth legislation. Section 67ZA of the *Family Law Act 1975* has two reporting provisions, one mandatory and one voluntary. The mandatory provision, s.67ZA(2) as included in the table above, requires any court personnel to report reasonable suspicions of abuse to a prescribed child welfare agency. The voluntary provision at subsection (3) states that:

(3) If the person has reasonable grounds for suspecting that a child:

- a. has been ill-treated, or is at risk of being ill treated; or
- b. has been exposed or subjected, or is at risk of being exposed or subjected, to behaviour which psychologically harms the child

the person may notify a prescribed child welfare authority of his or her suspicion and the basis for the suspicion.

What this means is that the chance of a report being made from the Family Court or Federal Magistrates Service, where parental substance misuse is known but does not appear to have resulted in psychological or physical harm to a child, is reduced.

With regard to the State and Territory reporting provisions, there are two important points to bear in mind. First, as already noted, where parental substance abuse is having a negative effect upon a child, there may be sufficient cause to trigger the mandatory reporting requirements. However, the fact that there is a report would not immediately be based on parental substance misuse, but rather that there was potential harm to the child. For example, if the parent's drug abuse caused them to neglect the child, or resulted in psychological harm to the child or prevented the

parent adequately supervising the child, then there may be sufficient evidence to require a mandatory report. However, the trigger for the mandatory reporting would be the risk presented to the child, not the mere fact of parental drug abuse. For example, in Tasmania, South Australia, Queensland, Northern Territory and New South Wales, the definitions of 'abuse or neglect' (Tas and SA), 'harm' (Qld and NSW) and 'maltreatment' (NT) are broad enough to encompass situations of general parental neglect which could be related to lifestyle factors caused by drug abuse in parents. This is also true where parental substance abuse has or is likely to cause significant serious physical harm, especially in the case of inadequate supervision.

Secondly, even if the nature and extent of parental substance misuse on a child was not sufficient to trigger the mandatory reporting mechanisms in each jurisdiction, it is still possible for any person, including extended family members, to make a voluntary report of concern to the relevant child protection agency. This is a more likely scenario in some jurisdictions due to the more limited scope of the mandatory reporting requirements. For example, in the Australian Capital Territory and Victoria, mandatory reporting is concerned only with sexual abuse or non-accidental physical abuse.

In conclusion, there is therefore no mandatory reporting in Australia of parental substance misuse simpliciter. Only in circumstances where parental drug abuse resulted in a sufficient level of risk or harm to a child would mandatory reporting be required; and, even then, only with respect to the *consequence* of harm to the child, not the *reason* (i.e. parental drug misuse) such harm may have come about.

### 5.3.1.1 Concerns with mandatory reporting

There continues to be a debate over the virtues of mandatory reporting within the child protection system, as discussed by numerous bodies, including the Senate Community Affairs References Committee (2005) and the Crime and Misconduct Commission (2004). The arguments in favour of mandatory reporting claim that it provides more detailed and accurate information and that there is a higher substantiation rate. Conversely, the arguments against include that there is no advantage to be gained from flooding a system with no capacity to respond and that higher substantiation rates are not guaranteed. The latter argument is based upon a comparative study undertaken by Ainsworth (2002) into the New South Wales and Western Australian models.

A report by Harries and Clare (2002) discusses in further detail the debate over mandatory reporting. Among those issues discussed is the question of whether mandatory reporting acts as an inhibitor to self-disclosure (p.46). Though it is unclear as to whether this concern has been realised to date, it bears considering as having the potential to further marginalise those persons with substance misuse problems, and put children at risk in no better position to access services or care.

### 5.3.1.2 Reports concerning unborn children

It is important to note the change in the *Children, Youth and Families Act 2005* in Victoria, which would implement a voluntary reporting mechanism for unborn children. Section 29 states:

A person may make a report to the Secretary or a community-based child and family service, before the birth of a child, if the person has significant concern for the wellbeing of the child after his or her birth.

Unlike a report concerning a child, a report made under section 29 concerning an unborn child cannot result in a protective intervention report and action. Rather, a section 29 report authorises the child welfare agency to provide advice to the reporter, provide advice and assistance to the mother or to refer the mother to a community-based service for assistance and advice (s.30).

In the Victorian Government's white paper accompanying the discussion draft of the legislation entitled *Protecting Children: The Next Steps* (2005), the example was given of an expectant mother with a serious drug problem who was likely to place a newborn infant at risk (p.45). The white paper notes that 'Child Protection's role will be to work with health and community services to plan appropriate services and supports. The protective worker will be required to record the report, but as is the case now, none of Child Protection's statutory powers will apply until after birth.'

A report under section 29 would not, therefore, mean that an expectant mother with a substance abuse problem would have their child removed by child protection upon its birth, but it does mean that this would be an option where a determination was made according to existing protection standards and based upon a report originating during pregnancy.

New South Wales includes a similar provision at section 25 of the *Children and Young Persons (Care and Protection) Act 1998*. The *New South Wales Interagency Guidelines for Child Protection Intervention* (2005, pp.86–87) make the following comment (emphasis added) with respect to pre-natal reporting:

Reports can be made before the birth of a child where there may be risk of harm after the child is born. Pre-natal reporting is not mandatory ...

Pre-natal reporting may be particularly helpful for pregnant women in domestic violence situations, with mental health or *hazardous drug use* during pregnancy because reporting can provide the catalyst for assistance. However, pre-natal reporting should only be used where there are clear indications that the infant may be at risk of harm. It is not intended to be used as a punitive measure against women under stress.

In Queensland, section 21A of the *Child Protection Act 1999* also has a section pertaining to unborn children. This section applies if, before the birth of a child, the chief executive reasonably suspects the child may be in need of protection after he or she is born. The chief executive must take the action the chief executive considers appropriate including, for example:

- a. having an authorised officer investigate the circumstances and assess the likelihood that the child will need protection after he or she is born; or
- b. offering help and support to the pregnant woman.

The purpose of this section is to reduce the likelihood that the child will need protection after he or she is born (as opposed to interfering with the pregnant woman's rights or liberties). The Explanatory Notes to the amending 2004 Bill note that 'The Bill enables the Department of Child Safety to respond to notifications made before a child is born that the child may be at risk of harm after birth' and then 'This new section enables the chief executive to respond to reports made before the birth of a child that the child may be at risk of harm after birth. The purpose of this new section is to enable the chief executive to offer assistance and support to a pregnant woman where there are concerns that the child may need protection after the child is born. Nothing in this provision enables the chief executive to take any action to compel a pregnant female to do or not do something. In this section it is intended that the word "action" includes a decision of the chief executive to take no further action. The term "pregnant woman" is intended to include a pregnant adult or a pregnant girl.'

The same tests for ‘harm’ and ‘child in need of protection’ apply to this power. The power, however, applies only to the risk of harm after the child is born, not during the pregnancy. With respect to a parent using drugs during pregnancy, that behaviour may be indicative of a risk of harm to the child after it is born, and may authorise the chief executive to take such action as is reasonable and necessary in the circumstances. This action may include support and provision of assistance. The section does not foreshadow the removal of the child from the parents simply because the mother or father may be drug users. However, as the section has the stated intent of reducing the risk of harm to a child after it is born, the provision of assistance during a pregnancy to prevent self-harming behaviour or other behaviour that is deemed likely to reduce the capacity of a parent to be able to adequately care for the child (resulting in neglect), or to increase significantly the risk of a parent abusing the child, would appear to fall within the scope of the section.

One issue may be whether or not it is possible to argue that drug use itself during pregnancy by an expecting mother would be sufficient to trigger the section, providing that a clear link between the drug used and damage to the unborn child could be proved. The *Child Protection Act* definition of ‘harm’ states that it is ‘immaterial how the harm is caused’ and that harm is ‘any detrimental effect of a significant nature to the child’s physical ... wellbeing’. A ‘child in need of protection’ is one who ‘is at unacceptable risk of suffering harm and does not have a parent able and willing to protect the child from the harm’.

If the harm is a mother’s use of a drug that has a risk of causing physical deformity or developmental problems for an unborn child, and the mother is unable or unwilling to stop, then there is a case to be made that the unborn child is in need of protection. The question may arise, however, as to whether or not the child is only in need of protection during the pregnancy when the mother’s drug use would place the unborn child at risk of immediate harm. After the child is born, albeit with physical or psychological harm caused by the drug use, it may be argued that the child is no longer necessarily in need of protection. Intervention by the chief executive officer during the pregnancy must be focused upon protecting the child after the pregnancy, according to a strict reading of the section.

It is not certain, therefore, that drug use by an expecting mother would strictly be considered a form of ‘harm’ that necessarily leads to a child being in need of protection. Once the child is born, they may have suffered ‘harm’ prior to birth, but after birth could then be said to have a parent able and willing to protect them from the harm. The spirit of the section would seem to indicate, however, that, upon an appropriate notification, the chief executive could take action during the pregnancy, if only to provide a mother with assistance to stop taking drugs.



## 5.4 Legislative principles guiding child protection in Australia

The legislative regimes in most Australian jurisdictions establish a variety of guiding principles that govern the implementation of child protection action by government agencies. Any person or body having a role in the implementation of the relevant legislation in a State or Territory must uphold these principles.

The only jurisdictions that do not have an existing set of enshrined general guiding principles are the Northern Territory and Victoria. Both jurisdictions have principles set out within the legislation, but these apply to courts only when making decisions on child protection matters, and not to all persons or agencies when engaged in child protection matters. The Northern Territory's *Child Welfare Act 1983* lists a set of matters that a court should have regard to in determining applications for transfers of proceedings, though only a small number of these are substantively similar to the broader principles set out in other jurisdictions. Victoria's *Children and Young Persons Act 1989*, in addition to a general set of guiding principles, includes a set of matters that courts should have regard to specifically when making determinations in any protection applications, a broader category of matters than provided for in the Northern Territory.

However, it is important to note that in both of these jurisdictions new legislation has been proposed to replace the existing Acts. In both of the proposed Acts – the *Care and Protection of Children and Young People Act 2005* (NT) and the *Children, Youth and Families Act 2005* (Vic) – general principles have been adopted to cover all persons and agencies engaged in child protection matters.

In the majority of jurisdictions, the paramount consideration is that the best interests of the child be considered when administering the Act. See, for example:

- *Children and Young People Act 1999* (ACT), s.13(1)(b)(i)
- *Children and Young Persons (Care and Protection) Act 1998* (NSW), s.9(a)
- proposed *Care and Protection of Children and Young People Act 2005* (NT), s.9(2)(a)
- *Child Protection Act 1999* (Qld), s.5(1)(a)
- *Children's Protection Act 1993* (SA), s.4(1)(a)
- *Children, Young Persons and Their Families Act 1997* (Tas), s.8(2)(a)
- *Children and Young Persons Act 1989* (Vic), s.87(1)(aa)
- *Children, Youth and Families Act 2005* (Vic.), s.10; and
- *Children and Community Services Act 2004* (WA), s.8(1)(a).

The New South Wales Act and current Victorian Act do not adopt this exact language, but instead note the need to protect a child's safety and welfare.

Table 5.4 below highlights a number of common guiding principles across Australian jurisdictions.

Table 5.4: Common guiding principles in child protection matters across Australian jurisdictions

	ACT	NSW	NT*	QLD	SA	TAS	VIC*	WA
Best interests of the child are paramount	✓	✓	✓	✓	✓	✓	✓	✓
Family is the primary caregiver	✓		✓	✓		✓	✓	✓
Government should support families in caring for children	✓	✓		✓		✓	✓	✓
Intervention should be as a last resort			✓	✓		✓	✓	✓
Intervention should be as unobtrusive as possible	✓	✓		**			✓	
A child removed from family should be encouraged to maintain contact with family	✓	✓	✓	✓	✓		✓	✓
A child's identity, relationships and values should be preserved	✓	✓	✓	✓	✓	✓	✓	✓
A child should have an opportunity to participate in decisions	✓	✓	✓	✓	✓		✓	✓
Special consultation should be undertaken where children and families are of Aboriginal or Torres Strait Islander descent	✓	✓	✓	✓	✓	✓	✓	✓

\* These principles are taken from the new or proposed legislation in each jurisdiction

\*\* implied s.6(e); s.59(i)(e)

### 5.4.1 Defining ‘child’s best interests’

As noted above, most jurisdictions state that the ‘child’s best interests’ should be the paramount guiding consideration in implementing child protection intervention. However, currently only the Australian Capital Territory in section 13 of the *Children and Young Persons Act 1999* actually expands upon what issues make up ‘best interests’ in general application. Of the eleven issues outlined, it is interesting in the context of this report to note subsections (iii) and (vi), which are as follows:

- iii. the capacity of each parent, or anyone else, to provide for his or her needs;
- ...
- vi. the attitude to the child or young person, and to parental responsibilities, demonstrated by each parent.

In making an assessment of a matter brought before a child protection agency in the Australian Capital Territory, the agency would clearly be acting within the spirit of the law to consider the impact of parental substance abuse upon a child’s best interests. Parental substance abuse may offer both an indicator of attitude towards parental responsibilities in addition to an inhibitor of parental capacity. Though a determination of such matters would ultimately turn upon the facts in each case, the inclusion of these issues within the list of considerations on a ‘child’s best interests’ does provide insight into the desire for agencies to assess both capacity and willingness as evidenced by behaviour, including substance abuse.

Language almost identical to that of subsections (iii) and (vi) in the ACT legislation is included in the Tasmanian *Children, Young Persons and Their Families Act 1997* at section 55(1)(e) and (h). These paragraphs, however, discuss the use of the ‘best interests’ principle solely within the context of a court making a determination under the Act, as opposed to any agency or individual engaged in enforcement of the Act. Further, legislation in Victoria, Western Australia and the Northern Territory includes similar considerations within the context of defining the ‘best interests’ principle. See *Children and Community Services Act 2004* (WA), s.8(1)(c) and (e); *Care and Protection of Children and Young People Act 2005* (NT), s.9(2)(b); *Children, Youth and Families Act 2005* (Vic), s.10(3).

It is important to note that the expanded lists of factors included in these Acts are not exclusive and all are offered as a guide only. The same considerations may, and are likely to, form part of the deliberations in other jurisdictions where no such legislative expansion is provided. Importantly, the range of matters that may be in a child’s best interests is not limited to considerations of a parent’s actions. Equally important considerations include such matters as the importance of continuity in a child’s life, the importance of relationships the child has with parents or guardians, and practicalities of the child maintaining relationships with siblings and family members.

### 5.4.2 Conclusions

The importance of the legislative descriptions of ‘child’s best interests’ must be understood in the context of the entire legislative scheme. Agencies and individuals engaged in the administration of child protection in a jurisdiction should have regard not only to the specific definitions of harm that may be provided in the legislation and their attendant action trigger, but also to how these definitions interact with the guiding principles. In the context of the discussion concerning parental substance abuse, there are few, if any, substance abuse-specific legislative triggers for action.

In many jurisdictions, substance abuse alone may be insufficient on the face of the legislation to trigger child protection action. There are included in the legislative regimes, however, principles that highlight an over-riding concern for a child’s welfare and what action will be in the best interests of the child. Parental substance abuse may potentially be picked up by child protection agencies in executing their responsibilities in accordance with the guiding principles on a number of grounds beyond those circumstances where the child is suffering apparent harm directly due to parental substance abuse.

Based upon the causes for intervention set out in the legislation and the guiding principles, these may include:

- The child is likely to suffer harm due to parental incapacity to provide for them as caused by parental substance abuse.
- The parents display no willingness to care for the child as caused by parental substance abuse.
- The parents display no willingness to protect the child from potentially dangerous conduct, namely parental substance abuse.

Whether or not an agency would have grounds to intervene, or what level of intervention may take place, would depend greatly upon the circumstances of the individual case. What can be concluded, however, is that although parental substance abuse is not mentioned specifically in any of the legislation, it does not mean that it is behaviour incapable of provoking a child protection response.

## 5.5 International responses to parental substance abuse

### 5.5.1 United States of America

United States federal law provides a definition of 'child abuse and neglect' in the *Child Abuse Prevention and Treatment Act* (42 USCA §5101 at §5106g), as follows:

(2) the term 'child abuse and neglect' means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.

This establishes a *minimum standard*, with all States then providing their own definition under State law. The State law definitions will then determine the grounds upon which State child protection authorities may intervene to protect a child at risk. As in Australia, the primary categories of abuse across all 50 States are physical abuse, sexual abuse or exploitation, emotional or psychological abuse, neglect and abandonment. A number of States, however, also include specific provision for the inclusion of parental substance misuse as being a ground for intervention.

There are three issues addressed in American State law:

- pre-natal harm to children caused by substance misuse by the expectant mother;
- harm to children caused by substance misuse by a person the child lives with; *and*
- harm to children caused by other illegal drug activity in the place a child lives.

Table 5.5 below lists the 30 States and the District of Columbia that include specific mention of parental substance misuse either in the legislative definition of abuse or neglect, or in the reporting requirements for various agencies or individuals.

It is important to note that, in most United States jurisdictions, the mere presence or use of illicit drugs in a home is not sufficient alone to constitute a child in need of protection. It is necessary that the presence of drugs or drug use be the cause of neglect or abuse, or prevent the parent from providing for the needs of the child. Examples of causative provisions (emphasis added) are provided in Table 5.6.

It is worth noting here that, in the District of Columbia, a 'neglected child' includes one who 'is regularly exposed to illegal drug-related activity in the home'. This would no doubt include the manufacture and distribution of an illicit drug, though may also include repeatedly witnessing the use of an illicit drug. Similarly, North Dakota defines a 'deprived child' as being one who is 'present in an environment subjecting the child to exposure to a controlled substance or drug paraphernalia'.

In these two jurisdictions at least, therefore, it is possible that the mere taking of drugs by a parent may be sufficient to trigger child protection action. It should be kept in mind, however, that no detailed analysis of the application of these laws has been undertaken and the comments concerning possible triggers for child protection are based solely upon what could be possible upon a plain reading of the relevant legislative provisions.

Table 5.5: American States that refer to parental substance misuse in child protection legislation

	Prenatal	Substance misuse	Illegal activity
Arizona	✓		✓ Manuf.
California	✓ *		
Colorado			✓ Manuf.
District of Columbia		✓ **	✓
Florida	✓	✓	
Georgia			✓ Manuf.
Idaho			✓ Manuf.
Illinois	✓		
Indiana	✓		✓ Manuf.
Iowa	✓		✓ Manuf.
Kentucky	✓	✓	
Maryland	✓	✓	
Massachusetts	✓		
Michigan	✓		
Minnesota	✓	✓	
Missouri	✓		
Montana			✓ Manuf./Dist.
New Mexico			✓ Manuf.
New York		✓	
North Dakota		✓	✓
Ohio			✓ Manuf.
Oklahoma	✓		
Rhode Island		✓	
South Carolina	✓		

	Prenatal	Substance misuse	Illegal activity
South Dakota	✓		✓ Manuf.
Tennessee			✓ Manuf.
Texas		✓	
Utah	✓		
Virginia	✓		✓ Manuf./Dist.
Washington		✓	✓ Manuf.
Wisconsin	✓		

\* In the absence of other factors, report shall be made to welfare agencies and not law enforcement

\*\* Mandatory reporting for licensed health professional or law enforcement officer

Manuf. = Manufacturing of an illicit substance

Dist. = Distribution of an illicit substance

Table 5.6: Provisions requiring evidence of harm

	Provision requiring evidence of harm
California	Report may be made where there is 'the inability of the parent to provide the child with regular care <i>due to</i> the parent's substance abuse'
District of Columbia	Report must be made where 'a child is abused <i>as a result</i> of inadequate care, control, or subsistence in the home environment due to drug-related activity'
Florida	'Continued chronic and severe use of a controlled substance or alcohol by a parent <i>when</i> the child is demonstrably adversely affected <i>by</i> such usage'
Kentucky	'engages in a pattern of conduct <i>that renders</i> the parent incapable of caring for the immediate needs of the child including, but not limited to, parental incapacity due to alcohol or other drug abuse'
Minnesota	'use of alcohol or a controlled substance by a parent ... <i>that adversely</i> affected the child's basic needs and safety'



	Provision requiring evidence of harm
New York	‘child ... has been impaired ... <i>as a result</i> of the failure of his parent ... to exercise a minimum degree of care ... <i>by</i> misusing a drug or drugs’
Rhode Island	‘child whose physical or mental health or welfare is harmed or threatened with harm when his or her parent ... fails to provide the child with a minimum degree of care or proper supervision or guardianship <i>because of</i> his or her unwillingness or inability to do so <i>by</i> situations or conditions such as ... the use of a drug, drugs or alcohol’
Texas	‘the current use by a person of a controlled substance ... in a manner or to the extent that the <i>use results in</i> physical, mental or emotional injury to a child’
Washington	‘whether it is probable that the use of alcohol or controlled substances is a <i>contributing factor</i> to the alleged abuse or neglect’

In other jurisdictions, the legislation still requires some evidence of negative impact upon a child’s welfare before child protection action would be triggered. This is consistent with the predominant practice in Australia. However, the distinction found in the United States legislation is that it expressly notes parental substance misuse as a potential cause of abuse or neglect and links such misuse directly to child protection action. This

provides child protection agencies with far more clarity when dealing with cases involving parental substance misuse and brings to the forefront parental substance misuse as a direct causative factor behind abuse. In Australia, these direct links are not made, and the grounds for intervention are not based upon any specific behaviour, despite its prevalence in child protection matters.

### 5.5.2 United Kingdom

The *Children Act 1989* establishes the child protection regime in the United Kingdom, in association with the *Children (Scotland) Act 1995*. Social service departments are required to determine whether a child is in need of services, as defined in the *Children Act* in section 17 and the *Children (Scotland) Act* in section 93, and to respond accordingly. Such responses may include a care or supervision order (*Children Act*, s.31), an assessment order (*Children (Scotland) Act*, s.55) or a child protection order (*Children (Scotland) Act*, s.57).

In making determinations pursuant to these Acts, the emphasis is upon the child's condition as opposed to the parent's conduct. However, in assessing levels of risk to a child, evidence of parental substance misuse may be a key indicator of potential harm. A report by the Advisory Council on the Misuse of Drugs (2003) notes both the requirement to assess children of parental substance misusers and the increased potential for a negative impact of parental substance misuse upon a child's development and welfare.

Included in Appendix 5.1 are a series of extracts from the United Kingdom legislation. As in Australia, no direct mention is made of parental substance misuse or of pre-birth abuse through substance abuse. Though the mechanics of the child protection system and orders involved may differ, the approach from a legislative perspective is not dissimilar to that taken in Australia.

### 5.5.3 Canada

As is the case in Australia, the primary responsibility for the provision of care and services to ensure children's welfare lies with the Canadian Provinces and Territories. The federal government has the responsibility of ensuring that the Criminal Code provides protection through the enactment of offence provisions relating to child abuse.

In general, the Canadian legislation also adopts a similar definitional approach to the Australian legislation, in that it does not specify parental substance misuse as grounds for child protection action. It is left open, however, as to whether parental substance misuse could constitute a causal factor triggering action. Included in Appendix 5.2 are excerpts from the legislation guiding child protection matters in a number of the Canadian Provinces.

### 5.5.4 United Nations

The United Nations Convention on the Rights of the Child (UN CROC) entered into force on 2 September 1990, with Australia ratifying the Convention on 17 December of that year. Under the Australian Constitution, the Australian Government has responsibility for international affairs, though the States and Territories are still bound by the Convention pursuant to the presumption in international law that, unless a different intention appears, a treaty is binding upon each party in respect of its entire territory. Some argument remains, however, as to the extent to which the national government can force States to accept the Convention. This debate notwithstanding, with respect to child protection matters, Australian State and Territory governments have adopted legislative regimes that bring child protection regimes in line with the CROC provisions.

The most pertinent CROC articles are included in Appendix 5.3 and cover such issues as ensuring the primacy of a child's 'best interests' (Article 3); preservation of a child's identity (Article 8); the fundamental role of the family to care for a child, not be separated from a child, to participate in decisions, and the child's right to maintain contact with family where they are separated (Article 9); the right of a child to express views upon matters affecting them (Article 12); and, where a child is removed from their family, the State must provide for them in a humane manner and do so in a way to ensure continuity in the child's life (Article 20).

In line with the ratification obligations of a party to the convention, the States have largely adopted the 'best interests' approach while the other principles set out in the Articles listed above largely reflect consistent elements of child protection legislation and practice across all Australian jurisdictions.

#### Key point

Australian jurisdictions have, by and large, established satisfactory legislative frameworks for tackling adverse impacts upon children associated with parental substance misuse.

## 5.6 Summary and conclusions

This chapter aims to provide a clear sense of how different jurisdictions, both nationally and internationally, seek to manage the issue of parental substance misuse within regulatory frameworks intended to protect the wellbeing of children.

Despite considerable variation in the details of the various regulatory frameworks considered, a reasonably consistent picture, with few exceptions (and these are outside Australia), nevertheless emerges. When it comes to ensuring the physical and psychological wellbeing of children, legislators have seemingly shied away from viewing parental substance misuse *in and of itself* as a matter capable of triggering a child protection response. Such behaviour is, however, widely recognised as an environmental factor that may be significantly implicated in elevating child protection concerns to some (varying) threshold point where under certain conditions a child protection action may be warranted.

In considering this prevailing view it is perhaps not unreasonable to speculate as to its basis. That is, given that child protection matters are accorded significant importance in all the jurisdictions considered, this apparent orientation towards 'accommodation' rather than punitive action is unlikely to have developed in the absence of a carefully considered, more general policy position.

It does not seem unreasonable to suppose that the general policy position at work here is the view that there is something fundamentally important about the bond between parents and their children and that parents engaging in 'bad' behaviours can nevertheless be 'good' parents. And further, that great care needs to be taken to strike a balance between ensuring children are adequately protected and allowing for legislative over-reach when defining the acceptable character of parent-child relations.

It is significant that, notwithstanding the fact that the frameworks considered appear to accommodate a degree of parental substance misuse, in every instance such behaviour can provide leverage if required for the triggering of a child protection action. Arguably what this all means is that jurisdictions have, by and large, established satisfactory legislative frameworks for tackling adverse impacts upon children associated with parental substance misuse. The challenge, therefore, is not so much the development of new regulatory frameworks of some sort or another, but rather the enhancing of the system's capacity to appropriately respond to the human services needs of both parents and children within the existing frameworks.

## 5.7 References

- Advisory Council on the Misuse of Drugs (2003). *Hidden Harm: responding to the needs of children of problem drug users*. London: Home Office.
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- Bromfield, L. & Higgins, D. (2005). *National Comparison of Child Protection Systems*. (National Child Protection Clearinghouse Issues No. 22.) Melbourne: Australian Institute for Family Studies.
- Crime and Misconduct Commission (2004). *Protecting Children: an inquiry into abuse of children in foster care*. Brisbane: Crime and Misconduct Commission.
- Family Law Council (2002). *Family Law and Child Protection: final report*. Canberra: Commonwealth of Australia.
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- Victoria Department of Human Services (2005). *Protecting Children – The Next Steps*. Melbourne: Department of Human Services.

## Appendix 5.1

### Extracts from United Kingdom child protection legislation

#### *Children Act 1989*

##### Section 17

- (10) For the purposes of this Part a child shall be taken to be in need if –
- (a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision for him of services by a local authority under this Part;
  - (b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
  - (c) he is disabled.

##### Section 31

- (2) A court may only make a care order or supervision order if it is satisfied –
- (a) that the child concerned is suffering, or is likely to suffer, significant harm; and
  - (b) that the harm, or likelihood of harm, is attributable to –
    - (i) the care given to the child, or likely to be given to him if the order were not made, not being what it would be reasonable to expect a parent to give to him; or
    - (ii) the child's being beyond parental control.

- (9) 'harm' means ill-treatment or the impairment of health or development;
- (10) Where the question of whether harm suffered by a child is significant turns on the child's health or development, his health or development shall be compared with that which could reasonably be expected of a similar child.

#### *Children (Scotland) Act 1995*

##### Section 52

- (1) The question of whether compulsory measures of supervision are necessary in respect of a child arises if at least one of the conditions mentioned in subsection (2) below is satisfied with respect to him.
- (2) The conditions referred to in subsection (1) above are that the child –
  - 1. is beyond the control of any relevant person;
  - 2. is falling into bad associations or is exposed to moral danger;
  - 3. is likely –
    - (i) to suffer unnecessarily; or
    - (ii) be impaired seriously in his health or development, due to a lack of parental care;
  - 4. is a child in respect of whom any of the offences mentioned in Schedule 1 to the [1975 c.21] *Criminal Procedure (Scotland) Act 1975* (offences against children to which special provisions apply) has been committed;

5. is, or is likely to become, a member of the same household as a child in respect of whom any of the offences referred to in paragraph (d) above has been committed;
6. is, or is likely to become, a member of the same household as a person who has committed any of the offences referred in paragraph (d) above;
7. is, or is likely to become, a member of the same household as a person in respect of whom an offence under sections 2A to 2C of the [1976 c.67] Sexual Offences (Scotland) Act 1976 (incest and intercourse with a child by step-parent or person in position of trust) has been committed by a member of that household;
8. has failed to attend school regularly without reasonable excuse;
9. has committed an offence;
10. has misused alcohol or any drug, whether or not a controlled drug within the meaning of the [1971 c.38] Misuse of Drugs Act 1971;
11. has misused a volatile substance by deliberately inhaling its vapour, other than for medicinal purposes;
12. is being provided with accommodation by a local authority under section 25, or is the subject of a parental responsibilities order obtained under section 86, of this Act and, in either case, his behaviour is such that special measures are necessary for his adequate supervision in his interest or the interest of others.

## Section 93

- (4) Any reference in this Part of this Act to a child –
  - (a) being ‘in need’, is to his being in need of care and attention because –
    - (i) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development unless there are provided for him, under or by virtue of this Part, services by a local authority;
    - (ii) his health or development is likely significantly to be impaired, or further impaired, unless such services are so provided;
    - (iii) he is disabled; or
    - (iv) he is affected adversely by the disability of any other person in his family.

## Appendix 5.2

### Excerpts from legislation guiding child protection matters in a sample of Canadian Provinces

#### 1. British Columbia

*Child, Family and Community Service Act, section 13*

- (1) A child needs protection in the following circumstances:
  - (a) if the child has been, or is likely to be, physically harmed by the child's parent;
  - (b) if the child has been, or is likely to be, sexually abused or exploited by the child's parent;
  - (c) if the child has been, or is likely to be, physically harmed, sexually abused or sexually exploited by another person and if the child's parent is unwilling or unable to protect the child;
  - (d) if the child has been, or is likely to be, physically harmed because of neglect by the child's parent;
  - (e) if the child is emotionally harmed by the parent's conduct;
  - (f) if the child is deprived of necessary health care;
  - (g) if the child's development is likely to be seriously impaired by a treatable condition and the child's parent refuses to provide or consent to treatment;
  - (h) if the child's parent is unable or unwilling to care for the child and has not made adequate provision for the child's care;
  - (i) if the child is or has been absent from home in circumstances that endanger the child's safety or wellbeing;
  - (j) if the child's parent is dead and adequate provision has not been made for the child's care;
  - (k) if the child has been abandoned and adequate provision has not been made for the child's care;
  - (l) if the child is in the care of a director or another person by agreement and the child's parent is unwilling or unable to resume care when the agreement is no longer in force.



## 2. Manitoba

### *Child and Family Services Act, section 17*

#### Child in need of protection

17(1) For purposes of this Act, a child is in need of protection where the life, health or emotional wellbeing of the child is endangered by the act or omission of a person.

#### Illustrations of child in need

17(2) Without restricting the generality of subsection (1), a child is in need of protection where the child

- (a) is without adequate care, supervision or control;
- (b) is in the care, custody, control or charge of a person
  - (i) who is unable or unwilling to provide adequate care, supervision or control of the child, or
  - (ii) whose conduct endangers or might endanger the life, health or emotional wellbeing of the child, or
  - (iii) who neglects or refuses to provide or obtain proper medical or other remedial care or treatment necessary for the health or wellbeing of the child or who refuses to permit such care or treatment to be provided to the child when the care or treatment is recommended by a duly qualified medical practitioner;

- (c) is abused or is in danger of being abused;
- (d) is beyond the control of a person who has the care, custody, control or charge of the child;
- (e) is likely to suffer harm or injury due to the behaviour, condition, domestic environment or associations of the child or of a person having care, custody, control or charge of the child;
- (f) is subjected to aggression or sexual harassment that endangers the life, health or emotional wellbeing of the child;
- (g) being under the age of 12 years, is left unattended and without reasonable provision being made for the supervision and safety of the child; or
- (h) is the subject, or is about to become the subject, of an unlawful adoption under *The Adoption Act* or of a sale under section 84.

### 3. New Brunswick

#### *Family Services Act, section 31*

31(1) The security or development of a child may be in danger when:

- (a) the child is without adequate care, supervision or control;
- (b) the child is living in unfit or improper circumstances;
- (c) the child is in the care of a person who is unable or unwilling to provide adequate care, supervision or control of the child;
- (d) the child is in the care of a person whose conduct endangers the life, health or emotional wellbeing of the child;
- (e) the child is physically or sexually abused, physically or emotionally neglected, sexually exploited or in danger of such treatment;
- (f) the child is living in a situation where there is domestic violence;
- (g) the child is in the care of a person who neglects or refuses to provide or obtain proper medical, surgical or other remedial care or treatment necessary for the health or wellbeing of the child or refuses to permit such care or treatment to be supplied to the child;

- (h) the child is beyond the control of the person caring for him;
- (i) the child by his behaviour, condition, environment or association, is likely to injure himself or others;
- (j) the child is in the care of a person who does not have a right to custody of the child, without the consent of a person having such right;
- (k) the child is in the care of a person who neglects or refuses to ensure that the child attends school; or
- (l) the child has committed an offence or, if the child is under the age of twelve years, has committed an act or omission that would constitute an offence for which the child could be convicted if the child were twelve years of age or older.

## 4. Saskatchewan

### *Child and Family Services Act, section 11*

A child is in need of protection where:

- (a) as a result of action or omission by the child's parent:
  - (i) the child has suffered or is likely to suffer physical harm;
  - (ii) the child has suffered or is likely to suffer a serious impairment of mental or emotional functioning;
  - (iii) the child has been or is likely to be exposed to harmful interaction for a sexual purpose, including involvement in prostitution and including conduct that may amount to an offence within the meaning of the Criminal Code;
  - (iv) medical, surgical or other recognized remedial care or treatment that is considered essential by a duly qualified medical practitioner has not been or is not likely to be provided to the child;
  - (v) the child's development is likely to be seriously impaired by failure to remedy a mental, emotional or developmental condition; or
  - (vi) the child has been exposed to domestic violence or severe domestic disharmony that is likely to result in physical or emotional harm to the child;
- (b) there is no adult person who is able and willing to provide for the child's needs, and physical or emotional harm to the child has occurred or is likely to occur; or
- (c) the child is less than 12 years of age and:
  - (i) there are reasonable and probable grounds to believe that:
    - (A) the child has committed an act that, if the child were 12 years of age or more, would constitute an offence under the Criminal Code, the *Narcotic Control Act* (Canada) or Part III or Part IV of the *Food and Drug Act* (Canada); and
    - (B) family services are necessary to prevent a recurrence; and
  - (ii) the child's parent is unable or unwilling to provide for the child's needs.

It is noted that, despite the lack of express reference in the legislation, the Saskatchewan Department of Community Resources and Employment, which has carriage of child protection matters in the Province, notes on its website that among the issues which may lead to child abuse is 'alcohol, drug or other substance abuse'.

## 5. Yukon

### *Children's Act, section 116*

- (a) the child is abandoned;
- (b) the child is in the care of a parent or other person who is unable to provide proper or competent care, supervision or control over the child;
- (c) the child is in the care of a parent or other person who is unwilling to provide proper or competent care, supervision or control over the child;
- (d) the child is in probable danger of physical or psychological harm;
- (e) the parent or other person in whose care the child is neglects or refuses to provide or obtain proper medical care or treatment necessary for the health or well-being or normal development of the child;
- (f) the child is staying away from the child's home in circumstances that endanger the child's safety or wellbeing;
- (g) the parent or other person in whose care the child is fails to provide the child with reasonable protection from physical or psychological harm;
- (h) the parent or person in whose care the child is involves the child in sexual activity;
- (i) subject to subsection (2), the parent or person in whose care the child is beats, cuts, burns or physically abuses the child in any other way;
- (j) the parent or person in whose care the child is deprives the child of reasonable necessities of life or health;
- (k) the parent or person in whose custody the child is harasses the child with threats to do or procures any other person to do any act referred to in paragraphs (a) to (j); or
- (l) the parent or person in whose care the child is fails to take reasonable precautions to prevent any other person from doing any act referred to in paragraphs (a) to (j).

## Appendix 5.3

### Excerpts from the United Nations Convention on the Rights of the Child

#### Article 3

1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the *best interests* of the child shall be a *primary consideration*.
2. States Parties undertake to ensure the child such protection and care as is necessary for his or her wellbeing, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.

#### Article 8

1. States Parties undertake to respect the right of the child to preserve his or her *identity*, including nationality, name and family relations as recognized by law without unlawful interference.
2. Where a child is illegally deprived of some or all of the elements of his or her identity, States Parties shall provide appropriate assistance and protection, with a view to re-establishing speedily his or her identity.

#### Article 9

1. States Parties shall ensure that a child shall *not be separated from his or her parents* against their will, except when competent authorities subject to judicial review determine, in accordance with applicable law and procedures, that such separation is necessary for the best interests of the child. Such determination may be necessary in a particular case such as one involving abuse or neglect of the child by the parents, or one where the parents are living separately and a decision must be made as to the child's place of residence.
2. In any proceedings pursuant to paragraph 1 of the present Article, all interested parties shall be given an opportunity to *participate* in the proceedings and make their views known.
3. States Parties shall respect the right of the child who is separated from one or both parents to maintain personal relations and direct *contact* with both parents on a regular basis, except if it is contrary to the child's best interests.
4. Where such separation results from any action initiated by a State Party, such as the detention, imprisonment, exile, deportation or death (including death arising from any cause while the person is in the custody of the State) of one or both parents or of the child, that State Party shall, upon request, provide the parents, the child or, if appropriate, another member of the family with the essential information concerning the whereabouts of the absent member(s) of the family unless the provision of the information would be detrimental to the wellbeing of the child. States Parties shall further ensure that the submission of such a request shall of itself entail no adverse consequences for the person(s) concerned.

## Article 12

1. States Parties shall assure to the child who is capable of forming his or her own views the right to *express those views* freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.
2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.

## Article 20

1. A child temporarily or permanently deprived of his or her family environment, or in whose own *best interests* cannot be allowed to remain in that environment, shall be entitled to *special protection* and assistance provided by the State.
2. States Parties shall in accordance with their national laws ensure alternative care for such a child.
3. Such care could include, inter alia, foster placement, kafalah of Islamic law, adoption or if necessary placement in suitable institutions for the care of children. When considering solutions, due regard shall be paid to the *desirability of continuity* in a child's upbringing and to the child's ethnic, religious, cultural and linguistic background.

Note: Emphasis added.

# 6. Policy initiatives and practice guidelines relating to service provision for children living with parental substance misuse

## 6.1 Introduction

This chapter provides an overview of the current policy initiatives and practice guidelines that inform the provision of services for children living with parental substance misuse within drug and alcohol services and also in the field of child protection. First, we will examine the response by the Australian Government through the National Drug Strategy as well as the role it plays in the area of child protection through the Department of Families, Community Services and Indigenous Affairs (FaCSIA). Secondly, we will undertake a State-by-State analysis of relevant policy initiatives and practice guidelines and, when possible, briefly review how such guidelines appear to be implemented in the field. This review was written between June and October 2006 and thus should be read as an indicative snapshot of the field at that time.

In addition to accessing information via the internet, a request for information on policies and practice guidelines relating to substance-misusing families was made to each State and Territory department that had responsibility for overseeing (i) drug and alcohol services, and (ii) child protection. The current review is not an exhaustive list of all possible policy documents and practice guidelines relating to the topic, although we hope that those that are most significant for the field have been represented. We understand that many of the sub-issues in child protection, such as substance abuse, domestic violence, psychological harm and parenting skills, are inter-related and that policies that have an impact upon one are likely to have a similar impact upon another. For example, it is likely that a policy initiative that aims to reduce substance abuse amongst parents may also reduce levels of domestic violence, while an initiative to improve parenting skills may result in reduced psychological harm to children.



## 6.2 Australian Government policy

The Ministerial Council on Drug Strategy (MCDS) is the peak policy and decision-making body on licit and illicit drugs in Australia. It is responsible for the development of the National Drug Strategy which provides a broad policy framework that informs the States and Territories on the key objectives and areas of national priority. Although the National Drug Strategy provides an umbrella framework to address the needs of all Australians, there is recognition of an additional responsibility to pursue policies and strategies that are specifically relevant to Aboriginal and Torres Strait Islander peoples. Thus an accompanying document, the *Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003–2006*, has been written to supplement the national plans, making them more relevant for Indigenous people.

The 2004–2009 National Drug Strategy supports the principle of harm minimisation and incorporates twelve key objectives that aim to reduce levels of drug use and supply, and prevent and minimise harm caused by licit and illicit drugs. These objectives are wide-ranging and serve to set a common direction and framework to Australia's response to drug issues. Objective 5 of the Strategy provides a general recognition of the need for policy and program development to 'to reduce drug related harm for individuals, families and communities' (Ministerial Council on Drug Strategy, 2004, p.5).

The National Drug Strategy also identifies eight priority areas for future action within the timeframe of 2004–2009. Notably, there is no mention of families or children in these priority areas although it is possible to argue that this may be subsumed under priority area 8: '*Identification and response to emerging trends*'. Each priority area is further elaborated upon and it could be argued that impact on children or families should be covered. For example, in responding to emerging trends, reference to the need to 'continue to seek opportunities to improve data collections' would justify extending current Minimum Data Set requirements to include questions about parenting status.

The priority area '*Reduction of drug use and drug related harm*' appears pertinent to the issue of parental substance misuse. However, further reading indicates that this priority area is targeted more specifically to address the needs of individuals and communities and does not refer directly to families or children. Thus, while families and the needs of children may be covered indirectly, there is a notable absence of any direct mention in either the overall objectives or the priority areas.

The Aboriginal and Torres Strait Islander Peoples Complementary Action Plan, by way of contrast, is far more detailed and is structured around six key result areas, each of which contains a number of objectives, key action areas and examples of actions. Within key result area 4, objective 4.1 provides support for the 'development of culturally

appropriate Aboriginal and Torres Strait Islander programs and services to address the impact of the use of alcohol, tobacco and other drugs on families and within their communities' (p.25). However, the way this objective is to be achieved remains vague, with 'improved care and protection of children' given as an example of an action that fits within this objective with no elaboration on how this action might be put into effect. Throughout the document the needs of children are not articulated as a primary target of the plan, but rather their needs are embedded within a broader raft of key objectives and action areas that endorse the importance of extending opportunities for the provision of culturally appropriate and family-inclusive practice.

The 2004–2009 National Drug Strategy, in particular, and the Aboriginal and Torres Strait Islander Peoples Complementary Action Plan, to a lesser extent, do not prioritise the needs of children who are negatively affected by parental substance misuse, nor do these documents provide clear operational guidance on how this objective might be achieved. In turn, the States have interpreted their role with regard to children and parental substance misuse in a range of ways. A continuum of responsiveness exists wherein some States/Territories have addressed the issue through a diversity of policies and strategies, whilst in others the issue has received only minimal attention.

### Key point

In terms of policy, a review of the Australian Government's National Drug Strategy indicates that there is no reference to the needs of children raised in substance-misusing families. As this strategy may be viewed as a cooperative venture between the federal government and State/Territory governments and non-government sectors, it raises concerns about the relative importance given to providing services to children affected by parental substance misuse across the political spectrum.

Child protection responsibilities at a federal level are subsumed by the Department of Families, Community Services and Indigenous Affairs (FaCSIA). However, under the Australian Constitution, child protection intervention services are the responsibility of the community services department in each State and Territory. Thus, although the Australian Government provides funding through FaCSIA to a range of initiatives aimed at the prevention of child abuse, including the REACH Program, the National Plan for Foster Children, Young People and their Carers (2004–2006), the National Child Protection Clearinghouse and the Stronger Families and Communities Strategy, it has no direct responsibility or role in the delivery of child protection services.

In recent years there has been a campaign for increased federal investment in the prevention of child abuse and neglect (Families Australia, 2003). It has been proposed that the Australian Government develop a *National Strategy for the Prevention of Child Abuse and Neglect* similar to the National Drug Strategy.

Such a national approach would include: (a) agreed principles and outcomes for the prevention of child abuse and neglect; (b) an agreed action plan to implement specific strategies to address issues; and (c) a commitment to cross-program/sector/government integration and collaboration.

In March 2005, the Senate Community Affairs References Committee released a report titled *Protecting Vulnerable Children: a national challenge. Second report on the inquiry into children in institutional or out-of-home care*. Following this report, a National Child Protection Forum was held in June 2006, facilitated by Mr Brian Babington, chief executive officer of Families Australia and deputy chair of the Australian Council for Children and Parenting (ACCAP). The forum brought together service providers, researchers and policy makers from all jurisdictions and key support and advocacy groups for children in care and their carers, to identify a practical way forward in developing a national approach to child protection in Australia.

Delegates at the forum drafted an outline that could form the basis of a national strategy, with the aim of having it submitted to relevant Ministers for consideration. A small working group, including the forum facilitator and a representative of FaCSIA, was established to refine the paper and report back to all participants. As the proposed National Strategy for Child Protection has not yet been finalised, it is not yet clear whether the issue of parental substance misuse will be specifically addressed in the national strategy. However, we would recommend that a working party be established to consider how best to develop a policy that has broad applicability both to the drug and alcohol sector and to child protection.

One of the agreed aims of the two-day National Child Protection forum was, wherever possible, to link in with or build on work already being done in other forums such as the Community and Disability Services Ministers' Advisory Council (CDSMAC). Of particular relevance for the current report are the CDSMAC National Foster Care working group and the National Approach for Child Protection working group. Whilst issues relating to children raised in substance-misusing families will be covered indirectly by these two groups, the extent of the problem and complexity of future policy and service development would suggest that one way to build upon what is already being done would be to establish a separate working group to address the issues related to children raised in substance-misusing families.

#### Key point

A National Strategy for the Prevention of Child Abuse and Neglect is currently under development. This is a critical opportunity to develop a policy that would directly impact on children in multi-problem families with parental substance misuse. The Community and Disability Services Ministers' Advisory Council could also consider the establishment of a working group directly addressing this issue.

## 6.3 Australian Capital Territory

### 6.3.1 Policy initiatives on alcohol and other drugs

The *Australian Capital Territory Alcohol, Tobacco and other Drug Strategy 2004–2008* forms part of the ACT Government's vision which is committed to 'protecting the vulnerable and supporting those in need ... [and]... Gives its children every chance to realise their potential' (p.5). There is acknowledgement within the strategy of the range of social determinants that impact on health and wellbeing, including factors such as 'Early life – the importance of ensuring a good environment in early childhood ... [and] ... family relationships (parent/child and significant other)'.

The Alcohol, Tobacco and other Drug Strategy 2004–2008 outlines a series of actions aimed at reducing the harm associated with the misuse of alcohol, tobacco and other drugs. Each action contains a rationale, evaluative suggestions and identification of the lead agency responsible for implementation. There is no explicit mention of the need to target or provide treatment for children who are currently living in families with parental substance misuse. There is an acknowledgement that the need to provide adequate and safe care for children might present an obstacle for women accessing residential treatment. In response, Action 20 proposes that 'supervised withdrawal services for women, women with children and families with children' need to be developed (p.36). In addition, Action 49 proposes to 'conduct research on alcohol and other drug use issues for women and women with children' (p.42).

#### 6.3.1.1 Practice guidelines and methods of implementation

At the time of writing, the Territory Government had not developed specific practice guidelines to assist drug and alcohol clinicians in assessing the needs of children who might be exposed to parental substance misuse.

### 6.3.2 Policy initiatives on child protection

The department responsible for operating the child protection system within the Australian Capital Territory is the Office for Children, Youth and Family Support and the relevant legislation is contained within the *Children and Young People Act 1999* (amendments effective 6 March 2005) and *Adoption Act 1993* (amendments effective 9 April 2004) (Bromfield & Higgins, 2005).

#### 6.3.2.1 Operational review of *Children and Young People Act 1999*

The *Children and Young People Act 1999* (ACT) governs child protection in the Australian Capital Territory and provided for an operational review within three years of the Act's commencement. This review was conducted by the Department of Disability, Housing and Community Services (DHCS) in 2002 and a report of the key findings was released in December 2005.

Although the issue of substance abuse was not specifically addressed as part of the review process, the report outlines a number of recommendations with implications for the issue of parental substance misuse. For example, consultations undertaken as part of the review supported legislative amendments to strengthen families through the provision of early intervention services. These include

broadening the use of family group conferencing at all stages of statutory intervention, but particularly at the early stages of notification, and the (cautious) introduction of pre-natal reporting.

Further, consultations supported legislative amendments to expand the criteria of a child in need of care and protection to include children and young people experiencing serious and substantial neglect, as well as pre-natal reporting. Were action to be taken by the ACT Government based upon these results, it may have an impact upon addressing issues of parental substance misuse both at an identification stage and at the stage of intervention.

#### *6.3.2.2 Implementation of the recommendations of the Vardon and Murray reports*

The ACT Government commissioned two reports into child protection, both of which were tabled in the ACT Legislative Assembly in 2004. The first, titled *The Territory as Parent: review of the safety of children in care in the ACT and of ACT child protection management*, was released on 25 May 2004 and is known as the Vardon Report. The second, titled *The Territory's Children: ensuring safety and quality care for children and young people: audit and case review*, is known as the Murray Report.

In commenting upon increasing the effectiveness of child protection intervention in the Australian Capital Territory and recognising the negative role that parental substance abuse has upon child welfare, the Murray Report recommended that a family support program be funded 'specifically in response to parents who have drug and alcohol dependence where their children are at risk' (Recommendation 3.8). This recommendation was agreed to in principle in the second

six-month status report when the Minister for Children, Youth and Family Support reported in August 2005 that implementation was 'in progress' and that:

A framework for an integrated family services system for the ACT is being developed which will link services from early intervention and prevention to tertiary services. This research will inform service demand for targeted services. (Legislative Assembly for the Australian Capital Territory, 2005)

Notably, the later progress report (February 2006) also reports that the status of this recommendation remains 'in progress'. (p.13)

Recommendation 7.7 stated that 'a targeted, intensive parenting service be provided for Indigenous families where children are being neglected or abused, with a specific focus upon a range of issues including alcohol and drug abuse' (p.22). The second status report noted that the 'expansion of family support services, including services for Aboriginal and Torres Strait Islander families, are a priority for 2005–06'. A further funding submission was made to FaCS in August 2005 to implement an intensive family support program for Indigenous families similar to the Families Together program. No further information on the status of this submission was made in the third report (February 2006).

## 6.4 New South Wales

### 6.4.1 Policy initiatives on alcohol and other drugs

The New South Wales Drug Summit was held in the New South Wales Parliament in May 1999, bringing together Members of Parliament, experts and professionals as well as community representatives with the aim of developing more effective ways of dealing with drugs in the community. In response to recommendations made at the Drug Summit, the New South Wales Government developed a plan of action for service delivery. This resulted in the *NSW Drug Treatment Service Plan 2000–2005*, which outlines future directions of service delivery with the goal of ensuring more equitable access to treatment. This document clearly notes the importance of making drug treatment services such as detoxification, pharmacology and residential rehabilitations services inclusive of the needs of women and children. However, in light of the literature reviewed (see chapters 2 and 3), reducing parental drug use alone will not improve outcomes in children. Thus, whilst it is plausible that parents should not be excluded from residential treatment due to demands of child care, simply ensuring that short-term accommodation needs of children are provided (for example, see pp.21, 47) is necessary but not sufficient.

The Drug Treatment Service Plan makes one reference to the provision of services that may impact on child outcome. This occurs in the context of a government action point to provide case management to people on methadone maintenance that consists of 'life skills, literacy skills, parenting skills and counselling support' (p.43). It is likely that if these areas were targeted systematically and

effectively, many areas of parental functioning, not just drug use, would improve and this in turn would have a significant impact on child outcome.

#### 6.4.1.1 Practice guidelines and implementation

There have been a number of initiatives and practice guidelines that have flowed from the New South Wales Drug Summit that address issues relating to parental substance misuse. First, there was a draft Memorandum of Understanding between the New South Wales Department of Community Services and the Department of Health concerning arrangements to facilitate the sharing of information relating to parental substance use and child protection concerns.

Secondly, the Summit recommended the establishment of a centralised intake line for all new presentations at Area Health Services in order to provide brief problem identification and referral to treatment options matched to client needs. Intake procedures are documented in NSW Health's Centralised Intake Guidelines (June 2004) and included are three core intake questions that briefly assess child protection concerns. Thus, under the guidelines, if immediate and pressing concerns were raised at intake about the safety of children living with parental substance misuse, mandatory reporting procedures operating in New South Wales would require the intake officer to make a formal notification to the Department of Community Services (DoCS) in parallel to an additional referral to other services.

The Centralised Intake Guidelines recognise that the area of child protection is one of great sensitivity for parents and recommends further exploration of this issue in face-to-face assessment. A system-wide health policy requires that child protection



concerns are assessed during the full drug and alcohol assessment and it is understood that each Area Health team has its own specific interview assessment procedures that have been adapted to meet its own needs and priorities.

A third initiative relates to the need for government-funded services to include the provision of drug and alcohol interventions as core business. The Drug Treatment Service Plan 2000–2005 identified that the ‘sheer number of people, their geographical distribution and the services they are most likely to access, point to the necessity to involve other service providers’ in drug treatments. In response, NSW Health (2005) produced the Interagency Guidelines for the Early Intervention, Response and Management of Drug and Alcohol Misuse, which aim to assist agencies identify and respond appropriately to drug use among their service users. The interagency guidelines provide a strong and clear message about the importance of assessing levels of child safety when engaged in adult drug and alcohol interventions. On repeated occasions throughout the document the following information is clearly boxed.

All drug and alcohol interventions with parents/carers must have a child protection perspective whereby the safety and wellbeing of the child or young person is a paramount consideration. Mandated reporters under the *Children and Young Persons (Care and Protection Act) 1998* must comply with the interagency guidelines on child protection intervention (2000). (NSW Health, 2005, pp.12, 15, 17, 19, 21, 24)

In addition to the above, NSW Health’s Frontline Procedures for the Protection of Children and Young People (2000) provide all health workers with information on how

to recognise abuse and neglect, reporting responsibilities under the *Children and Young Persons Act* and how to respond to requests for information or service from the Department of Community Services. The document also provides health services with guidance on the systems, policies and procedures needed to ensure they are able to respond effectively to their child protection responsibilities. It states: ‘Intake procedures for services providing intervention for primarily adult clients should take into account presenting issues that may impact on the care of any children that the client may have’ (p.45).

The document also highlights issues that are relevant for specific program areas. Under issues for drug and alcohol services, it states: ‘staff who are involved with counselling or treating people with alcohol and other drug issues need to be pro-active in making routine enquiries about their capacity to cope with the care of children. All assessments should include questions to find out whether the client has any children in their care and if there are any concerns about the care of these children’ (p.54).

However, apart from noting alcohol and drug use as one of a range of factors to take into consideration in assessing potential risk of harm to a child, the document does not outline how to make more detailed assessments on the impact of parental substance misuse on levels of child safety.

New Intake Assessment Guidelines were trialled in New South Wales from December 2004 in addition to the development of a policy on drug testing in child protection matters to assist in casework. The Department of Community Services currently uses parental drug testing as a means of verifying parent/caregiver statements about level of substance use and as a source of evidence for



making assessments about parenting capacity. The National Drug and Alcohol Research Centre (NDARC) recently undertook a review of the practice of parental drug testing and these findings will be incorporated into the development of new DoCS guidelines for the drug testing of parents. In response to questions in Parliament concerning the rebuilding of the Department, the Minister for Community Services, Ms Reba Meagher, stated:

The department is upgrading its policy framework to better respond to the complex issues facing struggling families. DoCS estimates that up to 80 per cent of child protection reports involve drug and alcohol misuse. That is why the Department of Community Services, in consultation with the National Drug and Alcohol Centre, is developing new guidelines for the drug testing of parents. (NSW Legislative Assembly, Hansard, 30 November 2005, p.20364)

It is unclear at this stage how the new Intake Assessment Guidelines will be informed by the results of the drug-testing policy, or whether these programs will alter the general approach to parental substance abuse set out in the Interagency Guidelines. A summary of the key findings from the report into parental drug testing is provided on page 161.

In line with the initiative to strengthen the expertise of generalist staff in responding to drug and alcohol issues, NSW Health has developed a training package and a set of resources for use by generalist community workers. The Families and Carers Training (FACT) Project aims to equip generalist frontline workers (that is, non-drug and alcohol specialists across New South Wales) with information and resources on how to respond more effectively to drug and alcohol issues with families they are working with.

A support toolkit – ‘Families and Carers Affected by the Drug or Alcohol Use of Someone Close’ – provides information about drugs and alcohol use, and treatment and referral options, as well as information on the impact that the drug-affected person might have on other family members or carers. This resource is primarily directed towards improving levels of support and self-care for family members. However, the information provided on the impact of parental substance use on children is limited. Further, the referral options for family-based interventions seem limited. If the research literature reviewed in Chapters 2 and 3 were to be used as a basis for determining the nature and intensity of interventions required for families with parental substance misuse, it would appear that the options outlined under Card 13, Family Support Services, will go little way in helping to improve family functioning and child outcome in multi-problem families.

### Key point

It appears that the issues relating to the identification of children who may be at risk in families with parental substance misuse have been addressed in terms of State-level policy and practice guidelines. There are clear assessment models and information resources available. However, the treatment options are limited and would not be indicated as treatments that were likely to improve family functioning in multi-problem families with parental substance abuse.

### Parental drug testing in child protection cases

A recent review of the practice of parental drug testing within the area of child protection by Wood and colleagues (2006) found:

- The literature on the value of parental drug testing in the context of child protection is limited but it is a viable means of monitoring drug use levels and referral to treatment.
- Parental drug testing should not be seen as an endpoint in itself. It needs to be linked to supportive staff, appropriate motivating techniques and opportunities for treatment if beneficial outcomes for the child and parent are to be obtained.
- Urinalysis and hair testing appear to be the most cost-effective methods of testing. The use of frequent (weekly or more often), regular, urine testing, conducted on a random basis, is preferred but expensive. Less expensive is hair testing, as hair is easily obtained and analysed in Australia for a long observation window.
- It maybe beneficial to employ the use of a third party (other than the caseworker) to undertake collection of the samples to avoid any negative impact on the therapeutic alliance between caseworker and client.
- Drug testing is limited in its ability to determine substance dependence and/or impairment in relation to parenting ability.

#### 6.4.2 Policy initiatives on child protection

The department responsible for operating the child protection system within New South Wales is the Department of Community Services and primary legislation under which it operates is as follows: *Child Protection Legislation Amendment Act 2003*; *Children and Young Persons (Care and Protection) Act 1998*; *Commission for Children and Young People Amendment (Child Death Review Team) Act 2003*; *Commission for Children and Young People Act 1998*; *Crimes Amendment (Child Protection – Physical Mistreatment) Act 2001*; *Ombudsman ACT 1974* (Bromfield & Higgins, 2005).

The New South Wales Interagency Guidelines for Child Protection Intervention (New South Wales Department of Community Services, 2005) were produced to ensure a coordinated, interagency response to child protection issues. With respect to matters of assessment and intake, the Interagency Guidelines note that an initial assessment of a reported child protection matter will take place via the Department of Community Services Helpline. Further, that one of the factors that should be considered during the initial assessment is parental drug and alcohol dependency (New South Wales Department of Community Services, 2005, p.93). Following an initial assessment, a child's risk of harm is determined and a protection plan or immediate protection action undertaken if appropriate.

## 6.5 Northern Territory

### 6.5.1 Policy initiatives on alcohol and other drugs

Within the Northern Territory, the alcohol and other drugs program is coordinated through the Territory Department of Health and Community Services. The area of 'tackling substance abuse' is identified as a key focus area in the document *Building Healthier Communities: a framework for health and community services 2004–2009*, which outlines the government's vision for health and community services in the Northern Territory. The document highlights three priority areas: promoting healthy approaches to drugs and alcohol; assisting people with abuse problems; and petrol sniffing and inhalant use. Although it is stated that the government has future intentions to 'support research on how alcohol and other substance abuse affects the health of infants and children, to ensure we are using best practice interventions to give kids the best start in life' (Northern Territory Department of Health and Community Services, 2004, p.23), the needs of children affected by parental substance misuse are not directly referenced within this document.

At the time of writing the Northern Territory had not produced any procedural guidelines to assist clinicians when working with individuals with substance abuse problems who had children under their direct care.

### 6.5.2 Policy initiatives within the child protection system

The department responsible for operating the child protection system within Northern Territory is Family and Children's Services in the Department of Health and Community Services and relevant legislation under which it operates is as follows: *Community Welfare Act 1983* (amended May 2004); draft proposed legislation: *Care and Protection of Children and Young People Act 2005* (Bromfield and Higgins, 2005).

#### 6.5.2.1 'Caring for our children' reform agenda implementation

The Northern Territory is currently undertaking a review of its child protection system as part of the reform agenda, 'Caring for our children'. This review is considering new legislation as well as undertaking an ongoing review of the child protection system itself. As part of the latter, a paper prepared by Dr Adam Tomison (2004) outlining the current issues in the Northern Territory was circulated by the Department of Health and Community Services. In addition to reaffirming that substance abuse plays a central role in child protection considerations, Tomison notes that service providers need to recognise the potentially important role they play in collaborative efforts in preventing social ills, including substance abuse (2004, p.31). While the report itself offers no recommendations and the reform agenda is ongoing, it is important to note that addressing substance misuse is frequently linked to a need for a broader government response than simply child protection. Not surprisingly, this is a theme reiterated not only in the Northern Territory but also throughout all State and Territory jurisdictions. There are a number of initiatives that have taken place that directly affect children at risk in the Territory. These initiatives were funded by Family and Children's Services (FACS) in December 2003 and are listed in Chapter 8.

## 6.6 Queensland

### 6.6.1 Policy initiatives on alcohol and other drugs

The *Queensland Drug Strategy 2006–2010* is the most recent policy document that frames the Queensland approach to drug and alcohol services in the areas of prevention, treatment and research. There is a welcome section on prevention in which the importance of providing broad-based interventions to address common determinants of social and health problems are outlined. Of particular importance for the current report is the recognition that substance use is one of many risk factors that shape people's lives and that it should be viewed within a social and health context (p.8). This policy is striking in the explicit recognition that, in order to improve outcome in children, a whole-of-government approach is required that addresses the common determinants of social and health problems.

Queensland Health's Alcohol, Tobacco and Other Drug Services (ATODS) Branch has not developed specific guidelines or policies in relation to working with clients in treatment for substance abuse who are also parents. Information regarding the importance of assessing the area of child risk is available in both the ATODS Information System (ATODS-IS) User Manual (which all ATOD services use) and the Queensland Illicit Drug Diversion Initiative (QIDDI) Service Provider Orientation Manual. These have been updated in the ATODS-IS manual and were due for release in July 2006 (personal communication, Tanya Grant, ATODS, June 2006).

At the time of writing there were no specific procedures developed for use by Queensland alcohol and other drug clinicians to guide assessments and interventions for clients who are also parents. However, there is some recognition within many ATODS agencies of the importance of addressing the needs of children. During 2005–06 a small number of ATODS clinics trained clinicians in the delivery of the Parents Under Pressure program (Dawe & Harnett, in press), an intensive intervention designed specifically to improve outcomes for children in multi-problem families. This small pilot study is currently being evaluated and data are not yet available on the effectiveness of the training for and clinical supervision of clinical practice. Notably, the funding was limited to the provision of training and clinical supervision to existing staff and no additional resources were provided to the clinics. Thus, each clinic was required to make a decision about resource allocation that allowed for the time to be spent working with parents and their children.

### 6.6.2 Policy initiatives on child protection

In 2003 the Queensland Department of Families underwent investigation by the Crime and Misconduct Commission (CMC) and the resulting report released in January 2004, *Protecting Children: an inquiry into abuse of children in foster care* (Crime and Misconduct Commission, 2004), detailed 110 recommendations and produced sweeping changes to the way that child protection is delivered within Queensland. Significantly it resulted in the creation of a new Department of Child Safety whose role was to focus exclusively upon core child protection functions and to be the lead agency in a whole-of-government response to child protection matters.

The legislation relevant to the functioning of the Department is contained in the following: *Child Protection Amendment Act 2001*; *Child Protection Act 1999*; *Health Act 1937* (amended 2004); *Commission for Children and Young People Act 2000*; *Education (General Provisions) Act 1989* (amended 2003).

In January 2006, a comprehensive report detailing the major achievements and changes flowing from the CMC report was released (Queensland Department of Child Safety, 2006). The report showed that 89 of 110 recommendations for reforming the State's child protection system had been completed and significant progress has been made on implementing the remaining 21.

Although the CMC did not make any specific recommendation relating to assessment and treatment of cases where parental substance misuse is identified, there is acknowledgement within the report that parental substance misuse is an identified risk factor associated with child maltreatment. For example, the report notes that 'Communities plagued by high rates of alcohol and substance abuse and disturbing levels of family violence are not surprisingly also characterised by having unacceptably high numbers of children who are vulnerable to neglect and abuse' (Crime and Misconduct Commission, 2004, p.227). In line with this observation, the CMC recommended that the Department of Child Safety provide 'culturally appropriate child protection services that take into account drug and alcohol related problems besetting some remote communities' (Crime and Misconduct Commission, 2004, p.239). The Department of Child Safety reported in January 2006 that it was in the process of establishing and reinvigorating those services in remote communities in order to satisfy the CMC recommendation (Queensland Department of Child Safety, 2006).

The Department of Child Safety (2006, p.78) also reported that the Department of Communities had developed the Safe Haven model to address family violence which incorporated strategies to deal with issues including substance abuse. This model would be an outreach service developed to meet the needs of each community and would draw upon existing infrastructure and capacity to address the issues of parental substance abuse and family violence.

One significant government strategy relating to Indigenous communities that will impact on the welfare of children and the community is the Meeting Challenges, Making Choices (MCMC) initiative. The aim of MCMC is to improve the quality of life in Queensland's Indigenous communities through a range of reforms that have both an immediate and long-term focus. The primary goal is to foster Indigenous community capacity and develop locally based solutions, with a focus on improving the health and wellbeing of those living in Indigenous communities. There are eight priority areas identified and clearly improvement in each of these will improve the life and welfare of children. Of particular relevance to the current report is priority area 3 – 'Children, youth and families' – which includes a stated purpose of 'taking immediate steps to protect children, women and Elders from sickness, suffering and fear by forging stronger links between local health clinicians, schools and police to further strengthen child protection strategies' (<http://www.mcmc.qld.gov.au/about/priorities/children.php>).

### 6.6.2.1 Practice guidelines

The Queensland Department of Child Safety has published a *Child Safety Practice Manual* (2005) which draws the attention of the child safety officer to the potential impact that parental substance misuse may have upon the child and assists the officer to decide the extent to which this risk factor should impact on decision-making procedures. In addition, structured decision-making tools have been incorporated into the practice manual to assist in this process. For example, in discussing the interviewing of notifiers during intake procedures, a child safety officer is directed to gather specific information about: 'Drug use: type of drug use and regularity and extent of use. How does the drug use impact on the parents' ability to meet the needs of children?' (Queensland Department of Child Safety, 2005).

Parental substance misuse is also noted as a key factor for consideration when the child safety officer is negotiating issues of participation or agreement. Alcohol or substance abuse is listed as a factor that will make the desirability of parental agreement to intervention inappropriate (Queensland Department of Child Safety, 2005, pp.4.2 and 5.6) or make parental participation in decision making undesirable (p.4.1). With respect to the latter, the practice manual states:

The only circumstances where it may not be possible for parents to actively participate in decision making may include: ... when the parents may be unable to contribute in the decision-making process for the child, for example, due to current drug or alcohol abuse or a psychiatric illness. (Queensland Department of Child Safety, 2005)

It is difficult to ascertain why current drug use or alcohol abuse would lead to impairment in a parent's ability to contribute to a decision-making process. While periods of intoxication or acute withdrawal will temporarily impair judgement, to make a proviso of exclusion based on substance use alone seems both contrary to the legislative intention of the *Child Protection Act* and inconsistent with research evidence regarding parenting capacity and drug use.

Finally, in the structured decision-making flowcharts and assessment summaries provided in the practice manual, parental substance misuse is noted on numerous occasions as a critical factor in determining neglect (Queensland Department of Child Safety, 2005, pp.C.6 and C.11), as an immediate harm indicator (p.C.8), and as the most substantial negative indicator on a strengths and needs chart (p.C.12). This seems to be overstating the role played by parental substance misuse and invites undue attention to be focused on substance use at the risk of consideration of the range of risk and protective factors operating in a child's life.



## 6.7 South Australia

### 6.7.1 Policy initiatives on alcohol and other drugs

The *South Australian Drug Strategy 2005–2010* acknowledges that drug use and misuse have an impact not only on individuals but also on their families and communities. The strategy provides recognition of the need to address the particular concerns of children exposed to parental substance misuse in two priority areas. First, the demand reduction strategies proposed by the South Australian Government aim to foster community resiliency through the provision of ‘support to ... parents with drug use (or mental health) problems’ as a means of preventing future drug misuse and harm (Government of South Australia, 2005, p.11). Second, within the Government’s priority harm reduction strategy there is recognition of the need to ‘increase protection for the children living in drug using families by providing support to parents and pregnant women’ (Government of South Australia, 2005, p.15).

Drug and Alcohol Services South Australia provides statewide services and policy advice for tobacco, alcohol and other drug issues and expresses a strong commitment to working with families. The *Alcohol, Tobacco and Other Drug Guidelines for Nurses and Midwives* (de Crespigny et al., 2003) provide information for clinicians on assessment and intervention procedures. There is no specific information included within the guidelines on assessing the needs of children under the care of parents who are substance users.

However, the Community Services Division of Drug and Alcohol Services SA is working in collaboration with Families SA to develop a number of initiatives to respond to child protection issues and problematic alcohol and drug use in families. Of particular relevance to the current report is the Parenting Capacity Assessment Training Project: this project aims to develop and deliver a training package for Families SA social workers and other relevant field staff on ‘Conducting Parenting Capacity Assessments’ with sections on parenting and mental health, parenting and intellectual disability, and parenting and substance use. A training program will then accompany the package and there is an intention to develop service agreements with the organisations involved to assist Families SA with the implementation of the training package.

### 6.7.2 Policy initiatives on child protection

The department responsible for operating the child protection system within South Australia is Families SA within the Department for Families and Community Services and this is governed by the following legislation: *Children's Protection Act 1993* (amended 1 July 2000); *Young Offenders Act 1993*; *Adoption Act 1988*.



### 6.7.2.1 Implementation of 'Keeping Them Safe' reform agenda

In its 2004 reform agenda for child protection, *Keeping Them Safe* (2004), the Government of South Australia noted that substance misuse (both parental and by a child) was one of the underlying and interrelated factors that contribute to an environment where children may be harmed. This agenda followed on from the March 2003 final report of the child protection review by Robyn Layton QC, entitled *Our Best Investment: a State plan to protect and advance the interests of children*. That review noted that 'substance abuse was found to contribute to neglect or an incident of emotional abuse in 15% of families and was either a past or a current problem in a further 12% of these cases' (Layton, 2003, p.3.7).

The Children's Protection (Miscellaneous) Amendment Bill 2005 introduced a series of legislative amendments to implement *Keeping Them Safe*. This resulted in a number of collaborative projects involving both Drug and Alcohol Services SA (DASSA) and Families SA. For example, following amendments to sections 20 and 37 of the *Children's Protection Act 1993*, it is now possible to direct parents to undertake a court-ordered assessment for substance misuse problems. This legislative change was intended to link families identified by the child protection agency, Families SA, into existing DASSA services. As a first step, draft guidelines were produced by Families SA and DASSA outlining the principles of best practice, providing key definitions of drug use and abuse, and detailing the assessment process. This collaborative

effort fits well with literature reviewed in Chapters 1–3 highlighting the importance of child protection and substance misuse services sharing information and working with agreed guidelines of good practice.

What now needs to be more clearly articulated is the nature of the treatment that families will receive as part of a court-ordered drug treatment within a Care and Protection Order. The literature reviewed in this report would propose that an appropriate treatment 'properly tailored to the presenting problem and designed to eradicate it' (Court Ordered Illicit Drug Assessment, October 2006, p.6) needs to extend far beyond merely engaging a parent in an opioid replacement treatment program. Indeed, there is strong evidence that problems in families with parental substance misuse and concurrent child maltreatment will not be resolved merely by substitution therapy (Dawe & Harnett, in press). Further, parental substance misuse is one of many other factors contributing to child abuse in high-risk families (Hogan et al., 2006). The literature review in Chapters 2 and 3 of this report emphasise the need for a multi-systemic approach in which multiple risk factors are addressed within the context of a treatment program.

## 6.8 Tasmania

### 6.8.1 Policy initiatives on alcohol and other drugs

The *Tasmanian Drug Strategy 2005–2009* (Tasmania Interagency Working Group on Drugs, 2005) aims to provide a whole-of-government and community response to reduce levels of harm associated with the use of licit and illicit drugs in Tasmania. The strategy recognises that children and young people are particularly vulnerable to the negative impact of alcohol and drug use within the family (p.20), and identifies children and families as a ‘particular focus’ for program and policy development. The strategy states:

While it is important to ensure that programs and policy development under the Tasmanian Drug Strategy [apply] to all groups in our community, particular focus is on families, children, young people, older people, remote and rural residents, people with co-morbid issues, culturally and linguistically diverse people and Indigenous peoples. (Tasmania Interagency Working Group on Drugs, 2005, p.20)

Unfortunately the identification of such a large number of ‘focus’ groups limits the priority that each might be given and in a sense devalues their importance. It would appear that while the Tasmanian policy provides acknowledgement of the vulnerability of children exposed to parental substance misuse, it affords them no special priority other than that received by other high-risk groups. Furthermore, the strategy does not define what inclusion as a ‘focus’ group means in terms of program and policy development.

Aside from this single reference, the *Tasmanian Drug Strategy 2005–2009* makes no further mention of the needs of children who are exposed to parental substance misuse.

The Department of Health and Human Services in Tasmania has not provided specific guidance or assistance to drug and alcohol clinicians regarding parenting responsibilities of clients. There are no published guidelines that underline clinical responsibilities with regard to assessment of the needs of children exposed to parental substance misuse, nor are there procedural guidelines available to assist with decision making in child protection issues.

### 6.8.2 Policy initiatives on child protection

The Department of Health and Human Services is the primary agency concerned with child protection in Tasmania and reported during 2004–05 that its focus was finding better ways to identify families in need of support. This was necessary in order to help focus early intervention to assist families and communities to reduce abuse, neglect and separation of children into care and protection services of the State, youth homelessness and involvement in the youth justice system. As one of the initiatives involved in this policy, a statewide Family Violence Counselling and Support Service for children and adult victims was established in line with the government’s ‘Safe at Home’ initiative.

A consultation project between staff and management of Child and Family Services in 2005 identified there were inadequate resources available for clients in terms of mainstream services including accessibility to ‘alcohol and drug assessment’ (Crowley et al., 2005, p.5).

The Department of Health and Human Services has initiated a number of recent projects with a focus on improving early intervention and parenting support, while also ensuring greater stability for children who are identified as at risk, and who are re-notified to the care and protection system. These include a child protection service development and operational improvement project being undertaken jointly by the Department with the Commissioner for Children, and a KPMG report on family support services (personal communication, Engels, October 2006).

The Tasmanian Department of Health and Human Services lists as priorities for the next year a series of projects aimed at enhancing the safety and wellbeing of children, including efforts to:

- enhance the professional development framework for staff and carers assisting children and youth and provide training opportunities in conjunction with key educational partners
- improve the provision of after-hours emergency services for child protection
- develop a pilot project with Tasmania Police, in collaboration with the Commissioner for Children, for the joint investigation of sexual abuse and serious physical abuse of children.

#### 6.8.2.1 Child protection practice guidelines

The Tasmanian Government has adopted a risk framework based upon the *Victorian Risk Framework* (VRF). For further discussion of the VRF, see discussion below.

## 6.9 Victoria

### 6.9.1 Policy initiatives on alcohol and other drugs

The department with primary responsibility for child protection in Victoria is the Child Protection and Family Services Branch, Office for Children, governed by the *Children and Young Persons Act 1989* with additional legislation scheduled to commence in March 2007: *Children, Youth and Families Act 2005* (Bromfield & Higgins, 2005).

#### 6.9.1.1 Improving health, reducing harm: Victorian Drug Strategy 2006–09

Victoria's drug policies and programs are based on the objectives of preventing illegal drug use and legal drug misuse, intervening to assist those with problematic drug use, and reducing the harms associated with drug use. Accordingly, the *Victorian Drug Strategy 2006–2009* identifies eight priority areas, outlines achievements made to date in these areas, and establishes future actions in the achievement of the key objectives. Although the key objective of 'reducing harm' recognises the importance of minimising as far as possible the levels of harm arising from drug use, this objective is linked to priority area 7: *Reducing deaths, disease and injury caused by drugs*, and priority area 8: *Reducing drug-related crime*. There is no explicit reference to the importance of reducing levels of harm to children exposed to parental substance abuse.

### 6.9.1.2 Practice guidelines and procedures

The Victorian Alcohol and Drug Treatment Services use a specialist assessment form for general client populations (2000) to assist alcohol and drug clinicians to develop a thorough understanding of the client's needs and to formulate an individual treatment plan. The form requests information regarding the client's childcare responsibilities, involvement of child protection services, whether they require child care while attending drug and alcohol services and the level of impact their drug use has on their family relationships. The collection of this information enables the parenting responsibilities of the client to be raised within the assessment procedure. The intention is to ensure, where a clinician perceives that the client's child/ren are at risk due to adverse exposure to parental substance use, that referral to child protection authorities takes place.

The *Protocol between Drug Treatment Services and Child Protection for Working with Parents with Alcohol and Drug Issues* (2002) provides alcohol and other drug clinicians with information on the process of making a notification, reasonable grounds for a notification and the role of the worker in relation to a child protection intervention.

In 2004 Victoria's Department of Human Services funded Odyssey House Victoria and the Victorian Parenting Centre to develop and disseminate the Parenting Support Toolkit for Alcohol and Other Drug Workers to assist clinicians within alcohol and other drug agencies to address parenting issues with clients. The toolkit was developed through a consultative process and trialled with a small number of alcohol and other drug (AOD) clinicians and parents. In March 2005 training sessions were conducted with over 100 AOD personnel. Results indicated that clinicians were highly satisfied with the training, with 80 per cent of trainees reporting that they felt 'confident to highly confident' that they could use the toolkit.

The parenting toolkit aims to help AOD clinicians to identify the needs of parents and their children when parents attend drug treatment. It provides clinicians with resources and strategies to effectively respond to the parenting needs of clients. The Parenting Support Toolkit has now been rolled out to alcohol and drug treatment agencies across Victoria and is also being made available to maternal and child health agencies on request. The Parenting Support Toolkit can be accessed at [www.health.vic.gov.au/drugservices](http://www.health.vic.gov.au/drugservices).

### Comment on outcomes from a telephone survey of Victorian alcohol and other drug clinicians concerning their knowledge and confidence

As part of the development of a Parenting Support Toolkit for Alcohol and Other Drug Workers, a survey of 105 Victorian AOD clinicians was conducted in 2004.

The survey comprised a simple one-page questionnaire conducted over the telephone aimed to randomly sample clinicians across Victoria's eight Department of Human Services regions. The survey focused on the knowledge and practice of current alcohol and drug workers in regard to child and parenting needs in their client group. The mean length of time the surveyed clinicians had been employed in the sector was approximately seven years. 85 per cent of clinicians reported that they always know whether clients are parents.

Clinicians were asked to rate a number of items in relation to their relative importance, confidence and practice in dealing with a range of topics with their clients. Topics included: relationships, health, parenting and child health, employment and training, and diet and physical health. In addition, clinicians were asked to rate their knowledge of risk and protective factors, parenting services and resources and to list actual services or resources that they had used or were aware of.

Findings from the survey indicated that clinicians believed it was important to address parenting and child issues with their clients. Addressing parenting was rated as equal third in importance with dealing with other health issues. Housing and relationship issues were considered most important.

In relation to confidence, clinicians reported feeling *only moderately confident* to address parenting issues, rating their confidence in dealing with parenting as second-last when compared to issues of housing, health and relationships. Confidence was only lower for dealing with employment issues. These results were replicated for actual time spent dealing with parenting issues.

In relation to knowledge of risk and protective factors in children's lives, most clinicians were able to list an average of two to three risk factors but fewer could identify factors that lead to positive outcomes for children (75 per cent knew three or more risk factors compared to 50 per cent who listed three or more protective factors).

Lastly, in relation to knowledge of services and resources, most clinicians rated their knowledge of services highly (96 per cent saying they are aware of parenting services). Fewer clinicians could actually list the names of two or more services (86 per cent could name two or more). Clinicians reported knowledge of resources was lower than their knowledge of services: 86 per cent of clinicians report being aware of resources, 73 per cent report having given out resources in the past six months, and 40 per cent were able to name two or more parenting resources.

This information is based on data presented at the Addiction Winter School (2005), Brisbane, Qld by Kylie Burke (Victorian Parenting Centre) and Stefan Gruenert (Odyssey House Victoria) and was provided as a personal communication from Kylie Burke to Sally Frye, June 2006).

### 6.9.2 Policy initiatives on child protection

In 2004 the Victorian Department of Human Services (DHS) commenced an overhaul of the child protection system in the State. The reform was officially launched in September 2004 and sought a broad range of stakeholder submissions.

Among the submissions as part of the review process was an outcomes review by the Allen Consulting Group, *Protecting Children: the Child Protection Outcomes Project* (2003). This review found that the Victorian system was highly effective in identifying and responding to immediate and significant risk, particularly where it was of an episodic nature, but that it was less effective in addressing problems of a more chronic nature where there were long-term factors such as parental substance abuse involved (Allen Consulting Group, 2003, p.35).

The review noted an increase in the prevalence of parental substance abuse within Victoria based upon DHS figures, with 25 per cent of cases first investigated in 2001–02 involving parents with substance abuse problems. This increased to 33 per cent of cases substantiated and 42 per cent of cases where the child was first placed in out-of-home care (pp.10–11). The review concluded that the existing child protection legislation was out-of-date by virtue of significant changes in the fourteen years since its introduction, including a substantial increase in substance abuse within the community (p.93).

In response to concerns such as those expressed in the Allen review, the department launched the white paper *Protecting Children: the next steps* in August 2005 and the accompanying legislation, *Children, Youth and Families Act 2005*, scheduled for 2007. The paper reiterated the conclusion, noted in other reports, that substance abuse remains a critical long-term issue for many families involved in the child protection system. Forty-two per cent of Indigenous parents and 22 per cent of non-Indigenous parents were engaged in substance misuse (Victoria Department of Human Services, 2002a, p.29). Substance misuse was also a significant factor in 30 per cent of vulnerable families (Victoria Department of Human Services, 2006). Further, the report noted that ‘family violence and misuse of legal and illicit drugs are expected to have the most significant effect on the number of family and placement services over the next decade’ (Victoria Department of Human Services, 2005, p.116).

### 6.9.2.1 Practice guidelines

The Victorian Department of Human Services provides a range of tools to assist child protection clinicians in assessing child protection matters. In addition to the primary tool of the *Victorian Risk Framework*, version 2 (Victoria Department of Human Services, 1999), the following are also in use: *Parental Substance Abuse: guidelines for protective workers* (Victoria Department of Human Services, 1994a); *Protecting Children*, Vol. 1: *Standards and Procedures for Protective Workers* (Victoria Department of Human Services, 1994b);<sup>6</sup> and *Protocol between Drug Treatment Services and Child Protection for Working with Parents with Alcohol and Drug Issues* (Victoria Department of Human Services, 2002b).

In addition to the more general risk analysis tools noted above, the *Victorian Risk Framework* (Victoria Department of Human Services, 1999) includes a series of specialist assessment guides, including the *Guide for Assessing Parental Substance Use* (Victoria Department of Human Services, 2000).<sup>7</sup> This guide provides a descriptive outline of the linkages between parental substance abuse and child protection matters, stating that drug use has been a 'major factor in over 40 per cent of child protection cases'. The guide notes that 'Drug use by parents may negatively impact on the development of

children' at all stages of their development, and that parents using drugs will 'find it difficult to balance their need for substances with parental responsibilities'. A series of useful questions is then provided to clinicians to assess the nature and risk level of the issue in each case. These questions cover such matters as provision of basic needs, pregnancy history, general development, the home environment, how the parents may procure drugs, and what management efforts the parents may take during periods of hang-over or withdrawal.

This resource provides child protection workers with a useful outline of the critical areas in which to focus questions and potentially direct any subsequent services or care plans, with respect to both the child in need and the parent or caregiver.

<sup>6</sup> *Protecting Children Manual*, Vol. 1: *Standards and Procedures for Protective Workers* is currently being revised and an online web publication is due for release to coincide with the implementation of the new legislation in March 2007.

<sup>7</sup> *The Guide for Assessing Parental Substance Use* (2000) is due to be updated in the near future.



## 6.10 Western Australia

### 6.10.1 Policy initiatives on alcohol and other drugs

The *Western Australian Drug and Alcohol Strategy 2005–2009* identifies children and young people as a priority group that requires targeted attention.

The policy states:

Addressing the needs of children and young people affected by alcohol and other drugs is an important priority. These children may be users themselves or experience family conflict and breakdown because of alcohol and other drug use by parents, siblings or other family members. (Drug and Alcohol Office, 2005, p.6)

In order to address the needs of this priority group, the strategy outlines the government's intention to '*develop family focused strategies to assist parents with alcohol and other drug problems to address their parenting skills in order to prevent their children entering care*' (p.6) and '*ensure family sensitive practice in all alcohol and other drug agencies*' (p.7).

The Western Australian Drug and Alcohol Strategy is complemented by Strong Spirit, Strong Mind (SSSM): Western Australian Aboriginal and Torres Strait Peoples Complementary Action Plan and the Western Australian Alcohol Plan 2006–2009 which has been developed in line with the National Drug Strategy Alcohol Plan. There are a range of family-based initiatives to support the work being done by the Department for Community Development (DCD) through their 'Early Years' and 'Children First' strategies. The plan also includes strategies to develop formal links between alcohol and other drug services and emotional and social wellbeing programs.

To accurately assess the potential risk of harm, the counsellor is encouraged to use structured tools such as the Parent Risk Assessment Tool (<http://www.drugnet.bizland.com/assessment/checklis1.htm>) or the Hearth Child Safety Assessment in Drug Using Environment Tool (the Hearth Tool), which has been designed for use by child protection clinicians or drug and alcohol clinicians to assess the safety of children in families where one or both parents present with issues associated with drug or alcohol use.

Drug and alcohol clinicians in Western Australia also have access to a Family Support Toolkit which aims to assist professionals to better manage issues that arise due to parental substance misuse and includes separate resources for use by professionals, parents and children. The Drug and Alcohol Office has also facilitated an extensive training program for encouraging 'family-inclusive' practice by drug and alcohol clinicians. A series of two-day workshops is provided including an introduction to key practice models and giving participants the opportunity to further practise and develop skills for engaging and working with families through video, role-play and case discussion. The clinical framework for intervention will include Orford's stress-coping health model and other solution-focused interventions.

### 6.10.2 Policy initiatives on child protection

With the introduction of the new *Children and Community Services Act* in March 2006, child protection in Western Australia has undergone a major legislative change and this has initiated a review of all protocols and practice guidelines. The Western Australian Department for Community Development recognised the causal link between parent substance abuse and children entering

government care in its strategic framework of December 2002–June 2005. This recognition supported an earlier study, *Prevalence of Substance Abuse in Care and Protection Applications: a Western Australian study*, conducted in 2000 into parental substance abuse which found alcohol and substance abuse featured in 71 per cent of care and protection applications (Farate, 2001). In its strategic framework, the department further reported that between 1999–2000 and 2001–02 the substantiated cases of neglect resulting in a child entering care increased by 18 per cent and that there was evidence that this increase was the result of increased drug and alcohol abuse by parents. As a result of these conclusions, the department stated that it was necessary to refocus resources on families where drug abuse affects their ability to care for children. In order to minimise the entry of children into out-of-home care, the Western Australian Government therefore proposed closer partnerships between the Department for Community Development, the Drug and Alcohol Office and other agencies in order to develop and implement processes enabling parents with substance abuse problems to gain assistance.

In line with this emphasis, the Western Australian Department of Health has published and disseminated the document *Guidelines for Responding to Child Abuse, Neglect and the Impact of Family and Domestic Violence* (Western Australia Department of Health, 2004) which requires all health clinicians to take an active approach in their concerns about the care and protection of children. The guidelines list a number of parental/family characteristics that may increase the child's level of risk and includes reference to parental substance misuse: 'Parent engages in substance use/misuse, including risky high use alcohol use' (p.21) and identifies substance abuse as a possible barrier to

the ability of the parent to act protectively (p.44). All staff within the Health Department, including drug and alcohol clinicians, have received specialised training on the implementation of these guidelines.

There are a number of treatment services funded across Western Australia designed to impact on substance-misusing families (see Chapter 8 for a brief description and contacts). In addition to these specific services is the targeted home visiting program, Best Beginnings, implemented through the Department for Community Development. This home visiting program, with a focus on developing attachment, targets high-risk families including those with substance misuse. The program appears to be based on home visiting models originally proposed by David Olds, who initiated and trialled the first nurse home-visiting model for at-risk families, and further developed in the Family Care model.

Systematic evaluation of the program's outcome is strongly recommended as the literature reviewed in Chapters 2 and 3 raises some issues in relation to (i) the effectiveness of this home visiting model in families with substance misuse (e.g. Family CARE was not designed for this population; Fraser et al., 2000), and (ii) the relevance of home visiting services based on Olds for contemporary families (i.e. Duggan et al., 2000; Nair et al., 2003). In reviewing the literature on effective interventions (see Chapters 2 and 3), it may be proposed that traditional home visiting programs need to be augmented by services that address a range of risk factors present in families' lives. Ideally, this should be done within the context of a single program.

## 6.11 Summary and recommendations

In this chapter we have provided an overview of the policies and practices of two major arms of government that potentially influence the nature of services provided to families with substance misuse problems: namely, drug and alcohol services and child protection services. While there are many other arms of government where policy and practice will impact on children in substance-misusing families (corrective services is one obvious example), it is beyond the scope of this report to comment on these areas.

In our review of the policies and practice guidelines we have attempted to determine three broad questions for each arm of government. In relation to drug and alcohol services, we have attempted to identify: (i) whether the major policy document underpinning each jurisdiction's approach to drug and alcohol use specifically targets family-inclusive practices as core business within the policy directive; (ii) whether this has led to guidelines for workers on the assessment of risk for children whose parents are clients of drug and alcohol services; and (iii) whether drug and alcohol clinicians have access to treatment interventions that will impact on family functioning in multi-problem families with parental substance misuse.

In relation to child protection services, we have attempted to determine whether: (i) child protection assessments consider the issue of parental substance use at the initial risk assessment; (ii) whether child protection workers have access to treatment interventions that will *impact* on family functioning in multi-problem families with parental substance misuse; and (iii) whether there are interdepartmental guidelines established between child protection services and drug and alcohol services that allow for information sharing and coordinated treatment planning. Table 6.1 provides a summary of the current status of policy and practice by jurisdiction on each of these issues.

Our attempts to identify policies and practice guidelines across jurisdictions highlighted the difficulty in locating current government policies, practice guidelines and accompanying materials such as structured risk assessment instruments across different jurisdictions. Having a single point of contact that allowed access to these documents would have been enormously helpful for the purposes of the current project. This would also, however, assist a range of policy makers and senior managers of non-government organisations by giving a key point of access.

### Key point

A website providing links to current national and State policy initiatives (together with linked websites) for the drug and alcohol sector, in addition to practice guidelines and other resources, is recommended.

It is also apparent that there are some jurisdictions where there has been significant progress made in relation to the development of assessment frameworks, interagency guidelines and models of good practice. It is inefficient for each jurisdiction to take on these tasks in isolation and therefore it seems timely for the development of a nationally consistent approach. As a first step, a series of forums could be held in each jurisdiction to include, but not be limited to, key stakeholders such as representatives from health, child protection, corrections and police. The purpose would be to identify key points of common agreement or near-common agreement on how to respond to this issue at a policy level. This may lead to a set of guiding principles on what constitutes best practice in addressing the needs of children and improving child outcome in multi-problem families with parental substance misuse.

With agreement reached on the form and content of a national set of principles, it would be useful to have a further series of forums to focus on turning policy into practice. While jurisdictions will have different line agencies with differing responsibilities (due to the unique needs of each jurisdiction and to the historical context that has shaped the differing structures of government across jurisdictions), development of a set of national principles describing best practice would be helpful. A further goal of forums could be to identify which jurisdictions could be used as pilot sites to test the implementation of policy and practices and to allow for the development of an evidence base for future reference.

### Key point

Development of a nationally consistent response where points of common or near-common agreement can be identified is recommended; these can be incorporated into policy and practice guidelines with some uniformity across jurisdictions. Pilot testing the principles could be undertaken in selected jurisdictions in order to develop an evidence base for best practice.

In addition to the general recommendations above, we have made a series of specific recommendations which could provide a starting point for each jurisdiction to consider. These recommendations follow from the three broad areas of consideration for drug and alcohol services and child protection services respectively and the conclusions regarding these are summarised in Table 6.1.

The first major issue is the extent to which the key policy document relating to the strategic directions to be followed in alcohol and other drug use within each jurisdiction makes reference to the needs of children and young people affected by parental substance misuse. The New South Wales Drug Treatment Service Plan 2000–2005 refers to the provision of parenting skills to clients on methadone maintenance. It is not clear why those on opioid replacement should be particularly targeted for parenting interventions but this is a good start to providing more family-focused policy at a State level.

South Australia and Western Australia made more extensive provisions for family-based practice. The South Australian Drug Strategy 2005–2010 aims to foster support to parents with drug misuse problems and increased protection for children living in drug-using families. The Western Australian Drug and Alcohol Strategy 2005–2009 has made the needs of children and young people affected by alcohol and other drugs an important priority area. It is notable that both the South Australian and Western Australian policies are very recent and the inclusion of the needs of children and young people may reflect a current national concern about the impact of parental substance use on child outcome. This may be mirrored in future policy statements across other jurisdictions.

#### Key point

State policy on treatment and service delivery should identify the needs of children and young people affected by substance misuse, either by use themselves or by exposure to parental substance misuse, as a priority area.

Regarding the extent to which drug and alcohol services have access to guidelines that assist in making decisions about child protection issues and provide drug and alcohol workers with specific parenting resources, it is apparent that this occurs in only three jurisdictions. Notably it has occurred in States where the needs of children and young people have been identified as a priority area — New South Wales, Western Australia and South Australia (under development). It may be deduced that this has been influenced by a State-level policy that promotes family-focused practice.

#### Key point

Provision of guidelines for drug and alcohol workers in the assessment of child protection issues is strongly recommended.

Finally, in relation to drug and alcohol treatment agencies, we strongly endorse the view that services should be provided within drug and alcohol services for substance-misusing families. In order for this to occur, workers need to have access to parenting resources developed specifically for them, such as the Parenting Toolkit developed in Victoria, and rolled out to all youth and child agencies across the State. To our knowledge there is limited provision of family-based treatments provided within the context of a drug and alcohol treatment agency.

#### Key point

Family-based interventions need to be provided to clients of alcohol and drug services. Research evidence points to the importance of interventions that are multi-systemic in nature and that address multiple domains of family functioning. We recommend that these be made available to clients of drug and alcohol treatment agencies.

In relation to the three broad issues for child protection services, almost all jurisdictions (an exception is the Northern Territory) have well-developed guidelines for the consideration of parental substance misuse as part of a risk assessment framework. There is less consistency across jurisdictions regarding the issue of interdepartmental agency guidelines for child protection intervention.

Finally, there are limited options for interventions for multi-problem families with parental substance misuse either from within the child protection services or accessible by child protection services. What is clearly needed is a commitment to providing treatment services that have the greatest chance of reducing the harm associated with living in a multi-problem family with substance misuse. There will clearly be a range of different services. A number of jurisdictions provide residential treatment for women and children. However, in light of the estimates of prevalence (see Chapter 1), it is clear that residential services will be provided only to a minority of at-risk children.

It would appear that child protection services have more contact with substance-misusing families than any other single government department (with perhaps the exception of corrective services) (see Chapter 1). Thus, child protection services are uniquely placed to provide treatment options that may impact on child maltreatment and parental substance misuse. The research literature indicates that many different approaches have been tried. Unfortunately there are many examples of treatment programs targeting substance-misusing families that have been found to be ineffective. The challenge for services is to continue to refine and extend current knowledge on effective strategies in multi-problem families and to develop a methodology for translating such findings into clinical practice.

Despite the many systemic and organisational problems faced by government departments involved in drug and alcohol treatment and child protection, there is a growing awareness that improving the lives of children in families with parental substance misuse is a critical issue. All jurisdictions have taken steps towards addressing this and there are many examples of interagency collaboration resulting in shared practice models of assessment.

The next logical step is to develop complementary treatment models which can be coordinated by case managers across drug and alcohol and child protection agencies. However, these treatments need to be informed by the research evidence. Replicating treatment approaches that have been shown to have limited effectiveness overseas should be avoided at all costs. However, if it were possible to build on existing strengths to allow for the development of a national coordinated response to treatment development, Australia could well become an international leader in this area. Commitment of time and resources from government is essential if the current opportunity is not to be lost.

Table 6.1: Presence (✓), absence (X) or unknown (?) status of key policy documents relating to the needs of children and practice guidelines by jurisdiction

State/Territory initiative	Commonwealth	ACT	NSW
Drug and alcohol strategy specifically targeting family-inclusive practices as core business within a policy directive	X	X	✓
Drug and alcohol clinicians have access to guidelines to inform decision making re child protection issues	N/A	X	✓
Drug and alcohol clinicians have access to treatment interventions that will impact on family functioning in multi-problem families with parental substance misuse	N/A	X	Limited
Child protection practice guidelines assess impact of parental substance misuse	N/A	X	✓
Child protection services have access to treatment interventions that will impact on family functioning in multi-problem families with parental substance misuse	N/A	X	Under development
Interdepartmental guidelines established between child protection and drug and alcohol services	N/A	X	✓

N/A = not applicable



	NT	Qld	SA	Tas	Vic	WA
	×	×	✓	×	×	✓
	×	×	Under development	×	✓	✓
	×	Limited	Under development	×	✓	✓
	?	✓	?	✓	✓	✓
	?	Under development	?	?	Limited	?
	×	×	×	×	✓	✓

## 6.12 References

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# 7. Responses to Hidden Harm in the United Kingdom and beyond

## 7.1 Introduction

*Hidden Harm: responding to the needs of children of problem drug users* is a report commissioned by the Advisory Council on the Misuse of Drugs and published in 2003. *Hidden Harm* arrived at 48 key recommendations of which 42 were endorsed by a later government response (Great Britain Department for Education and Skills, 2005).

The conclusion to the *Hidden Harm* report (Advisory Council on the Misuse of Drugs, 2003) begins with the assertion that 'Whilst there has been huge concern about drug misuse in the UK for many years, the children of problem drug users have largely remained hidden from view' (p.90). The estimated levels of risk from drugs alone, 2–3 per cent of children in England and Wales, and higher in Scotland, are recognised as limited and contingent on overall levels of use and problem use of drugs. This led the authors of the report to acknowledge the importance of three core areas for work – the first concerning improved estimation methods, the second concerning improvements in the child protection system in the United Kingdom, and the third concerning infrastructures supporting drug-using parents and their children, and in the coordination of services.

This chapter will focus on the government response in these three areas – epidemiology, child protection and service development – primarily in the United Kingdom context but also in other countries, to illustrate where progress had been made and where there is still considerable scope for improving conceptual and empirical foundations for intervention. What this will demonstrate is that, while there is a considerable amount of work around service development in the United Kingdom, particularly relating to interventions involving more than one member of the family, relatively little of this has been adequately evaluated or tested and our knowledge of what works is still at a relatively early stage.

In terms of the child protection agenda, there has been a significant restructuring in the United Kingdom in an attempt to improve outcomes for vulnerable young people and to promote the children's agenda. This has been implemented too recently for there to have been clear evidence on effectiveness, but the broad policy framework will be described and the implications discussed.

In the sections below, the responses to *Hidden Harm* are outlined for each of the four home countries, plus research initiatives and policy directives, but they are poorly coordinated and generally poorly assessed and the inconsistent provision of interventions should not be disguised by the examples of good practice outlined below.

## 7.2 Hidden Harm and beyond – the United Kingdom situation

### 7.2.1 Overview to *Hidden Harm*

For the first time, the Advisory Council on the Misuse of Drugs has appointed a follow-up provision to the work of the Prevention Working Group, in the form of an implementation working group. This group has been charged with assessing the impact of the *Hidden Harm* report and identifying examples of good practice in relation to the recommendations made in *Hidden Harm*. Although this group is not due to report until November 2006, there will be a follow-up survey of specialist addiction and maternity services that will attempt to map change in both awareness and practice in specialist addiction services. The survey will assess whether there has been any improvement in the rates of community and residential treatment services providing services for drug users with children, for the children themselves and for pregnant drug users.

However, it is important to acknowledge that the brief for the *Hidden Harm* initiative focused exclusively on drugs (only including alcohol as part of poly-substance use), and that the situation with alcohol in the United Kingdom is different. While there is a larger and longer-established evidence base around the risks to children of alcoholic parents, there is less of a priority around the policy response in this area. As Velleman, Templeton and Copello (2005) pointed out, the recent draft of Models of Care for Alcohol Misusers (National Treatment Agency for Substance Misuse, 2005), the equivalent of a national service framework for alcohol treatment, makes no mention of working with families or of initiatives designed to increase

resilience in children. They went on to argue that recent changes in child protection have not been matched by equivalent developments in substance use policy in the United Kingdom. There is also a suggestion that drug-using mothers may be more socially isolated than their alcohol-using equivalents, and so the support systems provided within the family may vary as a consequence.

### 7.2.2 Response in England to *Hidden Harm*

The formal British government response to *Hidden Harm* was published by the Department for Education and Skills (2005). The report addresses each of the 48 recommendations of *Hidden Harm*. First, the department with lead responsibility for the recommendation was identified; there was then information specifying whether the recommendation had been accepted or declined; and finally a brief statement of action was provided. This is notable in two respects. First, the *Hidden Harm* report has clearly been regarded as a significant and substantive report which warranted a formal government response. Second, of the 48 recommendations made in *Hidden Harm*, 42 were accepted and a clear response and accompanying action were documented.

In addition to addressing the recommendations of the *Hidden Harm* report, the foreword to the government's response emphasises the government initiative *Every Child Matters* as the underlying philosophy for developing a multi-agency framework for protecting all children, supported by the development of Local Safeguarding Children Boards. *Every Child Matters* sets out a shared program of change to improve outcomes for all children and young people. It outlines the national framework for changes underpinned by the *Children Act 2004*. The

overall aim is to reduce levels of educational failure, ill-health, teenage pregnancy, abuse and neglect, crime and anti-social behaviour among young people. It takes forward the government's vision of radical reform for children, young people and families and brings together ways of working towards improved outcomes into a national framework for 150 local authority-led programs. The increased policy emphasis on young people represents a significant opportunity to advance local policy and practice relating to substance use risks in young people and to expand our knowledge base about 'what works' in this area, although the evidence of this has not yet been seen at a consistent implementation level.

Five outcomes have been identified as crucial to wellbeing in childhood and later life: being healthy, staying safe, enjoying and achieving, making a positive contribution, and achieving economic wellbeing. Preventing substance misuse contributes significantly to improving the outcomes for children and young people in *Every Child Matters*. The program aims to improve these outcomes for all children and to close the gap in outcomes between disadvantaged children and their peers. Improved outcomes may depend on the effective integration of universal services with targeted and more specialised help, and on bringing services together around the needs of the child and their family.

Schools are increasingly offering pupils learning that is tailored to meet their specific needs. Children and young people should receive increasingly personalised and child-centred care from health services in line with the standards of the Department of Health's National Service Framework for Children, Young People and Maternity Services. There is currently a research program led by the Department of Health and managed through the Evidence Base Program Group

which is concerned with identifying information needs and key gaps in knowledge for those involved in the delivery of the young people's target within the drug strategy. Collaborating projects and agencies include: the Health Development Agency Collaborating Centre; the Health Development Agency Public Health Review – Drug Prevention; Drug Education and Prevention Information Service (DEPIS); DEPIS Plus (which includes the new evaluation consultancy service); Health Action Zone (HAZ); Drug Prevention Program Evaluation; Mentor UK; Drug Prevention Resource Pack; Parents Work; Turning Point and Addiction. In other words, this initiative involves a combination of policy groups, expert bodies and practitioners whose collective aim is to produce something with practical objectives and methods.

#### *7.2.2.1 The common assessment framework for children and young people*

Central to this notion of improved coherence across systems has been the idea of a consistent method for identification of risks to children across agencies and providers. The Common Assessment Framework (CAF) for Children and Young People is part of the wider *Every Child Matters: Change for Children* programs and will form a nationally standardised approach to conducting an assessment of the needs of a child or young person and deciding how those needs should be met, with a shift in focus from dealing with the consequences of difficulties in children's lives to preventing things from going wrong in the first place. It is currently being implemented in all local authority areas.

The CAF should reduce the number and duration of different assessment processes that children and young people need to undergo, improve the quality and consistency of referrals between agencies by making them more evidence-based, and promote a



common language about the needs of children by promoting appropriate sharing of information. If it is identified that a child or young person requires further input from more than one service, a lead professional will be assigned to the child to:

- provide a single point of contact for the child, young person and families
- ensure that children and families get appropriate interventions which are well planned, regularly reviewed and effectively delivered
- reduce overlap and inconsistency from other practitioners.

All services working with children and young people will be expected to use this framework to ensure the adequate integration of assessment instruments and suitable pathways for referral and management. Thus, in principle there should be more consistency across areas in identification of child harms, improved joint working and less duplication of assessment procedures.

In March 2005, the first Children's Commissioner for England was appointed, to give children and young people a voice in government and in public life. The Commissioner will pay particular attention to gathering and putting forward the views of the most vulnerable children and young people in society, and will promote their involvement in the work of organisations whose decisions and actions affect them.

This initiative has also been accompanied by the replacement of Area Child Protection Committees with Local Safeguarding Children Boards (LSCBs), which will have a statutory duty to assess the effectiveness of arrangements, at a local level, for safeguarding and promoting the wellbeing of children. The core objectives of LSCBs are to protect children from maltreatment; to

prevent impairment to children's health or development; to ensure children grow up in environments consistent with the provision of safe and effective care; and to enable children to have optimum life chances. The intention is that LSCBs will achieve this through promoting interagency cooperation, by monitoring the actions of local agencies, increasing understanding of safeguarding children issues and proactive work including protecting children who are at risk of suffering harm or neglect as a consequence of the impact of substance misuse.

#### *7.2.2.2 Developments within the substance misuse field*

In 2001, the National Treatment Agency for Substance Misuse (NTA) was set up to increase the availability, capacity and effectiveness of drug treatment in England, and to act as a monitoring and oversight body for treatment provision, including specialist treatment provision for young people. A major part of this is to promote practice that is evidence-based, appropriately delivered, outcome-focused, and integrated into a system of coordinated treatment and care. In 2005, the NTA produced *Essential Elements* outlining the basic range of services that should be commissioned for the provision of harm reduction services for young people. The *Essential Elements* guidelines are largely based on integrated care planning, prompt comprehensive assessment, support for families, and the provision of appropriate psychosocial interventions. Where appropriate, these should be supplemented with the provision of pharmacotherapy and, in a minority of cases, with access to inpatient detoxification and residential rehabilitation services. The NTA now has responsibility for substance misuse treatment in young people and this will be reflected in a modified version of the tiered approach that already exists for adult drug services.

Similarly, since January 2005, the Department for Education and Skills (DfES) has overseen coordinated work between Children's Trusts and Drug Action Teams (DATs) at a local level to facilitate the delivery of effective interventions. DfES has recognised the need to increase the amount of drug prevention and early intervention work, to develop specialist drug treatment skills, improve drug education in schools, and strengthen the evidence base.

*Every Child Matters: Change for Children, Young People and Drugs* was published by the Department for Education and Skills and the Home Office in 2005. This report sets out how those responsible for the delivery of *Every Child Matters: Change for Children* and the Updated Drugs Strategy cooperate to provide a holistic response. The report has three main objectives:

- reforming delivery and strengthening accountability
- ensuring provision is built around the needs of vulnerable children and young people, including prevention and early intervention work
- building service and workforce capacity.

A number of high-focus geographical areas have been identified where drug misuse problems are prevalent. These areas will be required to develop a best-practice model and make an impact on the delivery of drug services to children and young people. Findings from these areas will be used to help inform the development of an effective practice model. This links to the overall drug strategy by establishing a series of key performance indicators including one for looked-after children and other vulnerable populations of young people.

The resulting treatment target for 2008 was for 9512 young people in England to be receiving treatment interventions, but by the end of December 2005 there were over 14 000 young people in treatment. Following this, the National Treatment Agency was asked to look at the qualitative aspects of young people's views/experiences and publish a treatment effectiveness strategy for young people. This has not yet been published.

### 7.2.2.3 The specific response to Hidden Harm

As a result of this much broader initiative on child welfare and assessment, the recommendations in the *Hidden Harm* report have generally not been addressed. In terms of its specific recommendations, the response to recommendations regarding data collection on children was less positive than had been anticipated. While the government response broadly agreed with the importance of ensuring that treatment agencies routinely ask about parental responsibilities (recommendations 9 & 13), there is currently no system in place that makes this information part of a national minimum data set. There are also no plans to commission research into vertical transmission of hepatitis C or longitudinal research on parental drug use. Thus, in England, there are no immediate plans for measuring, at a national level, the number of children at risk; although this work is being done locally within some Drug Action Team and Community Safety Partnership areas. However, at present, there are no plans to add fields on numbers of dependent children to the national data set (the National Drug Treatment Monitoring System, NDTMS).

The more coherent response has been at a local level. A number of Drug Action Teams have developed *Hidden Harm* implementation groups, but these are primarily focused on

interagency working and on improvements in service delivery. There is no requirement around *Hidden Harm* in local treatment plans, and so local commissioning of services has no targets based on *Hidden Harm*. This means that, without local champions, the issues raised in *Hidden Harm* are often low on the list of priorities for service delivery.

The response was generally regarded as disappointing, particularly in comparison with the response from the Scottish Executive (see below). Nonetheless, the Advisory Council on the Misuse of Drugs took the unusual step of continuing the work of the Hidden Harm Prevention Working Group beyond the initial publication to identify changes resulting from the initial publication and to examine for evidence of local good practice, as discussed above.

### 7.2.3 Response in Scotland to *Hidden Harm*

The *Hidden Harm* report estimated that as many as 41 000–59 000 children in Scotland were affected by parental drug use (around 4–6 per cent of children under 16 years), a rate substantially higher than that estimated for the rest of the United Kingdom. The Scottish Executive published an initial response (Scottish Executive, 2004) outlining actions being taken to ensure that, under the ‘Partnership Agreement’, the most vulnerable children have the protection they need and deserve.

The report outlines how progress (including earlier identification of children of substance-misusing parents, the provision of improved care and support for such children, and the facilitation of more effective communication and joint working across agencies) will be measured. The Scottish Executive is taking forward a range of measures to help support local arrangements for the joint delivery of

services; for example, through the integrated community schools approach, Integrated Early Years Strategy and Community Health Partnerships. As with the English response, the response to *Hidden Harm* is to be understood within the need to improve services for all children in Scotland, not only children of substance-misusing parents. This has resulted in the legal requirement for local authorities to produce Children’s Services Plans as the broad framework of activity in this area.

Specifically, there already existed a stronger database in Scotland with the Scottish Drug Misuse Database (SDMD) gathering information on whether the drug user accessing treatment lives with dependent children and who else lives in the household. As in England, there is no provision for measuring the number of children at risk as a result of the alcohol abuse of parents. Additionally, data will also be collected through the National Arrest Referral Monitoring Framework (measuring substance misuse in police custody populations) and this will provide information relating to children of both drinkers and drug users. This is an opportunistic framework that will enable some estimation of risk in an untreated population that may be experiencing harm from substance misuse.

A more recent development has been the publication of *Hidden Harm: Next Steps – Supporting Children, Working with Parents* (Scottish Executive, 2006). This report extends the work of the original document to cover alcohol issues as well. The document continues the emphasis on delivery including key actions to:

- develop legislation to require information sharing for child protection purposes
- improve contraception and family planning services for substance misusers

- improve joint working between maternity services, addiction services and services for children and families
- place a legislative duty on all agencies to identify the needs of children for whom they have responsibility
- better identification and earlier support for vulnerable children
- provide incentives for medical practices to put protocols in place so that young carers are put in contact with local support services and agencies
- expand the Scottish Drug Misuse Database to ensure that information on dependent children of drug-using parents is collected when clients present for treatment.

The report shows a significant commitment to evidence-based practice, committing funding to pilot projects, and supporting and publishing research evidence on key areas in relation to the unborn child, children in infancy, children in school, children in need of care and protection, children's health, children with parents in the criminal justice system, and children and the wider environment.

The broader policy framework in Scotland is based on *Tackling Drugs in Scotland: action in partnership – Scotland's objectives and action priorities* (Scottish Executive, 1999). This report embraces the four main aims of the United Kingdom Government's drugs strategy, but with specific Scottish objectives and priorities. One of the action priorities resulting from this strategy is: 'Support for children and young people in vulnerable situations, including assessment of needs of children of drug misusers'.

### 7.2.4 Response in Wales to Hidden Harm

The overall context of the Welsh response is based on the Welsh substance misuse strategy *Tackling Substance Misuse in Wales: A Partnership Approach*, which was launched in May 2000. This strategy embraces the four key aims of the United Kingdom anti-drugs strategy *Tackling Drugs to Build a Better Britain*. The main difference is that the Welsh response to substance misuse is more inclusive, involving prescribed drugs, over-the-counter medicines, volatile substances and alcohol.

In Wales, a stakeholder consultation was launched as a response to *Hidden Harm* in June 2003, and the Welsh Assembly's Advisory Panel on Substance Misuse considered the 48 recommendations. This resulted in a Framework of Action developed in December 2004 targeting five themed areas:

1. Family Support Services to ensure the wellbeing of children of substance-using parents
2. Improved health outcomes for substance-misusing women, their families and children
3. Raising awareness and training among the health and social care workforce
4. To ensure that the outcomes for substance misusers in the criminal justice system account for their parenting status
5. To enhance policy development with the relevant quantitative data.

Wales also houses one of the most innovative and well-established providers of services for children and parents with substance use problems. Option 2 involves provision of a service that has been extensively researched and developed for over 15 years in the United States of America and has been implemented in Wales. The service provides an immediate response to crisis on the basis of a referral from a childcare social worker, utilising a short and intense intervention (over the first four to six weeks of crisis). In the first three days an assessment is made of the resources, beliefs and strengths within the family, and a safety plan is developed to overcome the crisis. Initially, practical obstacles are identified, such as unsafe environments or lack of gas and electricity, and these are addressed if at all possible.

The therapeutic component builds on strengths within the family to promote belief in the possibility of change, and the aim of the intervention is to build on these strengths and related values to get clearly defined goals in relation to substance use, family relationships, supporting the physical environment, and promoting routines in the children's lives. Outcome assessments after 12 months indicate that participating families are maintaining 89–90 per cent of their goals. There is also evidence that many families manage to build on the achievements in the initial phase and show greater improvements over the subsequent year.

### 7.2.5 Response in Northern Ireland to *Hidden Harm*

In Northern Ireland, the Drugs and Alcohol Ministerial Strategic Steering Group has been responsible for coordinating the activities of departments and their agencies. The minister-led Drug and Alcohol Implementation Steering Group has been responsible for overseeing the delivery of the drug and alcohol strategies. Six partner working groups created action plans based on their key outputs. In addition, four Drug and Alcohol Implementation Teams cover the four Health and Social Services Board areas ensuring that agencies work together to tackle local issues and needs.

In May 2006, a new strategy for tackling drug- and alcohol-related harm in Northern Ireland was launched entitled *New Strategic Direction for Alcohol and Drugs (2006–2011)*. This proposes to build on the above implementation model and to take forward a five-year plan to reduce the level of alcohol- and drug-related harm in Northern Ireland. Implementation of the *New Strategic Direction* is due to begin in October 2006. A *New Strategic Direction (for Alcohol and Drugs)* Steering Group will be established which will report to the current Ministerial Group on Public Health. Four new advisory groups are also planned:

- Children, Young People and Families
- Treatment and Support
- Law and Criminal Justice
- Binge Drinking.

One of the key strategic targets is around at-risk and vulnerable young people. However, no more specific targets have been set in response to *Hidden Harm*, although the document was considered in the development of the five-year strategy.

### 7.2.6 United Kingdom research evidence

In a recent review article, Velleman and colleagues (2005) concluded that 'there appears to be the start of a shift in policy direction towards initiatives which are more family or child focused and integrative in their approaches to prevention and treatment' (p.103), although the authors do suggest that such initiatives remain divorced from policy changes in the substance misuse field. They argue that different arms of government need to do more to work in concert around this issue, particularly as a result of the Home Office dominance of the substance use policy agenda.

The Scottish Executive response to *Hidden Harm* reported that children of drug-using parents are one of the priority themes identified within the drug misuse research program, supplementing ongoing research on babies born to substance-misusing mothers, and an evaluation of young people projects, including projects for children of drug-using parents.

Scotland has been a major research centre within the United Kingdom on the issue of children at risk, with a research team at Glasgow University, led by Dr Marina Barnard, having produced a significant body of work in this area. In 2003, Barnard and Barlow interviewed 36 young people about the experience of growing up as children of drug-using parents, as well as interviewing 62 drug-using parents. The authors concluded that 'the reluctance of most children and young people to be identified on the basis of their parents' drug problems means that they remain hidden as children in need of services' (Barnard & Barlow, 2002, p.55).

In the same year, McKeganey, Barnard and McIntosh (2002) reported on the impact of drug use on the children of 30 recovering heroin addicts. The main areas identified by the parents related to material deprivation and neglect; exposing the children to drugs, drug dealing and crime; physical abuse; violence; and possible family break-up. The authors recommend that drug services need be much more systematic in recording the status and circumstances of their children; and, in policy terms, there needs to be much closer joint working between adult drug treatment services and children's services. The final recommendation made by the authors was that there needs to be a safe haven for the children of drug-using parents where they are able to spend some time away from the stresses of their home lives.

More recently Barnard and McKeganey (2004) have reviewed the existing literature and argued that, while there is limited evaluation of programs targeting children of drug-using parents, there are four areas in which there are grounds for optimism. The first is around community-based family training for clients drawn from adult drug treatment services, followed by home-based case management that resulted in reductions in drug use, and reductions in domestic conflicts, although no improvements were reported in problem behaviours among the children. Second, interventions provided during residential drug treatment showed inconsistent results, partly as a result of differential attrition rates, although marked improvements were shown in aspects of parenting skills. Third, home visiting for parents with drug problems showed relative modest effects in both mothers and their children, and finally in a program that provided home-based support from birth to the age of three (in Seattle in



the United States) where higher degrees of program engagement were associated with significant gains in rates of parental abstinence and treatment engagement as well as improved ratings of child functioning.

Finally, Barnard (2005) reported on a study of 65 interviews with problem drug users, parents and younger brothers and sisters, supplemented by ten professional interviews, with the focus in this study on drug use by the children rather than by the parents. The report documents the dramatic effect of child substance use and its discovery on family functioning and the potential impact on siblings, a key risk group in examining effects of drug use in the family. Barnard advocates a greater role for family support groups and for mentors in addressing the added risk of exposure to drugs in the family and in managing the stresses placed on families by the drug use of one or more members.

### 7.3 The European situation

There is almost no evidence of systematic monitoring of children at risk from parental substance use across the European Union, and marked variability in legislation or policy response to this issue. As in the United Kingdom, there are many examples of innovative practice and local commitment, but too rarely have these been evaluated systematically. Nonetheless, there is enough activity to suggest an increasing concern about this issue and a need to respond effectively.

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) does not currently conduct any central monitoring around numbers of children of drug-using parents or the number of children at risk, although initiatives addressing parental drug use have been identified as a theme for development in this area.

With regard to alcohol, there is a pan-European website, [www.encare.info](http://www.encare.info), launched in 2004 as part of the 10th anniversary of the United Nations International Year of the Family, providing information on background literature, describing the risks associated with alcohol and the range of possible interventions available.

ENCARE, the European Network for Children Affected by Risky Environments within the family, provides information on risks associated with parental substance use, information on interventions and has national pages for activities in Austria, France, Germany, Ireland and the Netherlands. A text box summarises the web page relating to the number of children at risk.



### ENCARE assessment of children at risk and resilience factors

The summary starts with the assertion that not all children are at risk and describes the resilience factors associated with reduced risk from parental substance use. Protective factors such as high self-esteem and confidence are described, along with an ability to deal with change, good problem-solving skills, and a good support network, including at least one close relationship with an adult. Crucially, the text also discusses protective processes such as reducing the risk, reducing negative chain reactions, and improving resilience.

For this chapter, EDDRA, the EMCDDA's information system on demand reduction (<http://eddra.emcdda.eu.int>), provided valuable support in collating national information for this project. However, not all of the countries contacted responded to the requests for information with the interventions listed below representing only those reported back to the authors.

#### 7.3.1 Austria

Austria contributes to the ENCARE network, providing information and advice to service providers, but there is no specific policy or legislation in this area, nor is there a central mechanism for monitoring the number of children at risk. Nonetheless, children of substance-using parents are mentioned as specific target groups for prevention in most regional drug strategies.

There are, additionally, a number of programs providing support and intervention. In Vienna there is a pilot project with two sub-programs, one for pregnant drug users and one for young children. Across the country

the initiatives have the quality of both preventative work and structural development based on interagency cooperation. Thus, in Graz, there are collaborations between drug counselling centres and youth welfare groups, while in Salzburg a regional coordination unit has been established to target children of drug-using parents. Austria has also hosted awareness raising initiatives including a European as well as national websites and a web-based intervention, Onysos, where young people can access support from an anonymised online facility.

#### 7.3.2 Belgium

Parenthood education initiative and reception service for drug-addicted mothers, VAD, runs a project called 'Drug Policy at School' and 'Drugs in the Youth Organisation', and an alcohol-specific initiative called 'Alcohol. Bekijk het eens nuchter' (Alcohol. Look at it sober [www.bekijkheteensnuchter.be](http://www.bekijkheteensnuchter.be)). This campaign focuses on informing the public on alcohol use, specifically the children of drinking parents. However, since this campaign is still quite young, no data are available yet.

#### 7.3.3 Czech Republic

Although there is no direct legislation, a 1999 Act on the social and legal protection of children manages the issue of parents who fail to provide adequate care, including drug-using parents. This is supplemented by an objective within the Czech National Drug Policy Strategy that aims to increase the availability of targeted primary prevention aimed at vulnerable groups and early intervention programs for these groups. Programs targeting such populations receive central funding support for their initiatives. There is no central mechanism in the Czech Republic for monitoring the number of children at

risk from parental substance use. In terms of interventions, there are two agencies, both based in Prague, that offer interventions to children and their parents to reduce the harms resulting from parental drug use, ANIMA (a non-government organisation) and the Department for Youth and Family Treatment (based in the general teaching hospital in Prague).

### 7.3.4 Finland

The overall policy framework is based on strong basic services in municipalities, with social and child welfare services offering a wide range of family interventions, with substance abuse one of the prominent reasons for taking children into care. In terms of specific intervention programs, the A-Clinic Foundation, the largest non-government organisation in Finland, has a project called Fragile Childhood which aims to improve the situation for children in alcohol-abusing families and to decrease the long-term addiction risks in these children.

### 7.3.5 Germany

There are child protection systems in Germany, although there is scope for individual interpretation by social workers, and it is generally regarded that social services will become involved only in long-established and salient cases. However, there are also a range of self-help organisations throughout Germany working with children, particularly the Kreuzbund e.V. and Blaukreuz. There are also interventions available for parents, children or both together. Nearly every region (Bundesland) has at least one dedicated project, including support for families with addiction problems ([www.agd-berlin.de/wigwam](http://www.agd-berlin.de/wigwam)) and a combined youth and addiction prevention centre ([www.kompass-hamburg.de](http://www.kompass-hamburg.de)).

### 7.3.6 Greece

There is no specific legislation in this area, with the General Civil Code applying regardless of substance misuse issues. Drug addiction does not constitute sufficient grounds of itself for children to be taken into care. Greece has no system of child protection specifically targeting this issue, and there is no central measuring mechanism for identifying and enumerating children at risk. Although the research base has been limited, a recent Greek-language PhD thesis has attempted to measure the problems of children of substance-dependent parents.

Specialist interventions are provided only through the mechanism of two special treatment programs for women drug users. One of these is a pioneering program targeting pregnant women and drug-using mothers. The Special Unit for Addicted Mothers was established in 2000 and is part of the non-government organisation KETHEA and the ITHAKI network of services. It is based in Thessaloniki and can house up to ten women. The aim of the unit is to reinforce the mother-child bond and to support mothers in their parenting role. Second, the State Psychiatric Hospital of Attica established a Treatment Program for Dependent Women in 1997 which offers specific services tailored to the needs of addicted mothers. This group also established a 'support network for addicted mothers and their children' in 2001 to bring together agencies dealing with both addicted women and vulnerable children.

### 7.3.7 Republic of Ireland

A member of the ENCARE network. There is a children's project 'to enhance the quality of life for children of parents who use drugs' and the CARP service which responds to the needs of children of opiate-using parents.

### 7.3.8 Italy

There are a number of therapeutic communities that provide facilities for drug-using parents and their children. Italy also has a national-level research study measuring the number of children of drug-using parents, although the findings from this study have not yet been reported. Additionally there is no specific legislation relating to children of drug-using parents and no specific policy initiatives in this area.

### 7.3.9 Netherlands

A member of the ENCARE network. There are many interventions targeting vulnerable young people in the Netherlands but these aim predominantly at children with depression or anxiety disorders (11), eating disorders (7), or behavioural disorders (12). Specific preventative interventions exist that target children of parents with mental disorders or addiction and there are parenting courses for those parents with children who may be beginning to use drugs or are already using drugs (11).

The twelve interventions for parents with mental health or addiction problems are dealing with: public information activities via leaflets etc combined with individual talks; mother–baby interaction patterns via video home techniques and home visits; group contacts for children as well as parents to increase understanding of the situation at home (sometimes combined with skills training); individual psycho-educational family intervention to support communication in the family; parenting training via ‘home parties’ (where motivated and pre-trained mothers are inviting companion-mothers into their living room in order to be engaged in parenting skills, and this is followed up by a snowball selection of other motivated

parents to continue with this initiative); case management and coaching. However, there is no specific policy or legislative activities focusing on drugs or alcohol.

The assistance offered to people or families who found themselves in a difficult situation as a result of drug addiction may take the following forms: financial, social work, specialist counselling, or crisis interventions. There are specialist units operating at a local level which are prepared to offer assistance to families (district centres of family assistance, specialist units for counselling, family therapy and crisis intervention) as well as to children and youth threatened by addiction (social and environmental clubs).

### 7.3.10 Slovakia

The needs of children are addressed under Act 305/2005 which addresses child protection and social care, attempting to address negative influences on child development. Although there is no central monitoring, research evidence would suggest that, between 1995 and 1999, there were 101 newborn children affected by the substance use of their mothers. Additionally, the education system attempts to provide counselling to children with problems, supplemented by non-government organisations and family services.

## 7.4 Summary and conclusions

The response in the United Kingdom has varied markedly across the four countries, with Scotland alone developing ongoing action planning and policy interventions based specifically on the recommendations laid out in the *Hidden Harm* report. Nonetheless, there have been significant changes across the United Kingdom as child protection agendas and legislation have dominated the response in England and Wales, and a new drug strategy (including targets around vulnerable populations and young people) developed in Northern Ireland. Thus, it is reasonable to conclude that, in all four of the home countries, there have been improvements in joint working and in screening and identification of young people at risk. Only in Scotland, however, has there been a commitment to improving the evidence base for quantifying the children at risk as a result of substance-using parents and for developing a legislative framework for supporting drug-using mothers.

The broader international situation reflects the research evidence base in that there are widespread examples of innovative practice, underpinned by high-quality community-based work, but these are generally not adequately evaluated and there is little coherence or consensus around what the core elements for success are. Because of definitional problems, identifying and targeting children at risk can be problematic,

and little systematic work has been done in attempting to measure either of the key variables, the number of children exposed to risky situations or the mediating and moderating variables that will determine acute and chronic harm risks associated with this group. The planned Italian work on measuring numbers of children affected by parental substance misuse may help to develop a method that can be replicated elsewhere.

The most parsimonious method is likely to remain improving the measurement of numbers of dependent children living with treatment-seeking parents who misuse alcohol and drugs, on the one hand, and the number of children identified as being at risk, where the risk originates in parental substance use, on the other hand. The real opportunity will arise when these two databases are sufficiently reliable and consistently formatted that an assessment of overlap (using the principles of capture–recapture) will enable initial prevalence estimates to be made. Once this is in place, additional data sources, such as the Scottish measurement of parenting and substance problems among arrested populations, can be used to further calibrate this initial assessment. However, considerable improvements are needed in basic data collection and information sharing by both addiction services and children's services before this work could be undertaken with any confidence.

Similarly, for provision to be effective and systematically implemented, the needs of the parents, of the child and of the wider community, both immediate and longer-term, need to be mapped and measured, and the full range of interventions assessed through properly evaluated programs. There is clear need for outcome research in this domain, where the effects of interventions on both the children at risk and on the parents are adequately assessed. The patchwork of local evaluation studies provides a crucial foundation for this work, but is not sufficient. The kind of economic costing of long-term savings associated with effective early interventions promoted by Homel and colleagues in *Pathways to Prevention* (National Crime Protection Unit, 1999) are essential to persuade policy makers of the political, as well as the moral, imperative that interventions in this area dictate.

Unfortunately this also requires concerted activity and commitment across government departments within countries that have not yet been evidenced. It is particularly worrying that the increasing focus on criminal justice domination of public policy around substance use, particularly in the United Kingdom, may increasingly divorce this agenda from the child welfare initiatives. The focus on crime

reduction in British drug and alcohol policy has tended to narrow the focus to immediately remedial interventions and reduce the longer-term preventative issues around inter-generational transmission of addictive behaviours and associated social problems, including drug-related criminality.

The increased public policy emphasis in the United Kingdom and elsewhere on protecting children and promoting their developmental potential offers a huge opportunity for integrating the policy concerns for children of substance-using parents within a larger, and more mainstream, initiative. However, to date, this opportunity has not been effectively harnessed and addiction policy remains separate from child protection in the majority of local environments. We have a range of increasingly evidenced interventions, coupled with an increasingly aware and skilled workforce, yet we do not have a clear policy commitment to measure, understand and tackle this problem.

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## 8. Principles of good practice: tackling the needs of children in substance-misusing families

Interventions in drug treatment services have only rarely focused on the needs of children and instead made the assumption that children will receive benefit indirectly through the support offered to the parent. Improving the circumstances and outcomes for children in these families will require a dramatic shift in perspective at an organisational, clinician and treatment level if real gains in child outcome are to be achieved. The following principles of best practice are informed by the research outlined in this document and have application to the work of all service providers who deal directly with substance misusers who are parents.

### 8.1 Principles of good practice

#### 8.1.1 Good practice principles for organisations

1. **Organisations need to recognise the importance of addressing the needs of children within their family context where there is parental substance misuse and regard this as core business.** There is an urgent need for both specialist and non-specialist agencies to acknowledge their responsibility to provide services that address the needs of children affected by parental substance misuse, and for extra resources to be made available. Such services might aim to impact at a variety of levels within the child's ecology including programs aiming to improve parenting capacity of a substance-abusing parent, couple therapy to reduce levels of parental distress and the potential for family violence, individual therapy/support for the child, liaison with schools and community support programs, etc.
2. **Organisations need to give recognition to the importance of this work and provide organisational support for such work to take place.** Clinicians need to be provided with the adequate time, training and resources that are necessary to complete this work. There is longstanding evidence from other areas of research that staff will undertake new and potentially challenging work only if they are both adequately trained and adequately supported in these new roles.
3. **Organisations need to endorse a treatment model that addresses many aspects of families' lives.** Simply providing a 'play group' as an added extra, for example, will not improve child outcome. However, if a play group was part of a range of family-focused interventions that aimed to enhance a parent's social support, and improve parental functioning, this would be a worthwhile endeavour. Clinicians need to be provided with training within a multi-systemic theoretical model that equips them to respond to complexity.

4. **Organisations need to develop inter-agency practice guidelines that facilitate staff working together in a safe, ethical and helpful way.** Parental substance misuse rarely occurs in isolation. The co-existence of parental substance misuse with problems such as parental mental health issues and domestic violence can bring additional challenges for the clinician working with the family. Services need to develop strong links with other service providers and agencies so the different organisations can work together to respond to these complex needs. Training, support and guidance on joint working and information sharing should help this process.
5. **Organisations need to be responsive to the needs of families** and be mindful of the many obstacles that prevent treatment engagement. Practitioners need to think creatively on how to improve treatment accessibility for all families. Client-friendly services might extend beyond standard office hours; provide home visiting services, transport, child care and a flexible response to missed appointments. This, in turn, has implications for staff, in terms of training, contractual obligations and their expectations of their role.

### 8.1.2 Good practice principles for clinicians

1. **Clinicians need to receive training in empirically sound treatment models** for improving outcomes in substance-abusing families.
2. **Clinicians need to be provided with regular supervision to ensure their work with families adheres to a multi-systemic model** and is in accordance with treatment protocols. Supervision also provides a forum to ensure best-practice principles are maintained as well as providing an opportunity for clarifying and elaborating on program content issues.
3. **Clinicians need to be provided with adequate time in their workload** to enable them to meet the often complex and challenging needs of substance-abusing families.

### 8.1.3 Good practice principles for treatment content

1. **No single treatment is appropriate for all families.** Treatments need to be individualised to address the unique needs of each family.
2. **Families need immediate access to treatment programs.** Many families may be reluctant to address issues relating to their children within the treatment setting. It is crucial for clinicians to take advantage of opportunities to address parenting concerns when they arise. Potential opportunities for intervention might be lost if programs are not immediately available or readily accessible.

3. All treatments should include a thorough assessment of the family's functioning across multiple domains. The family should be involved in assessing their needs and the design of services. It is important to talk to children and families about what their needs are and how these can best be met.
4. **Effective programs attend to the multiple needs of the family, not just the parent's use of drugs.** To achieve ongoing change, programs need to address the multiple domains that impact on the parent's ability to provide quality care for their children. There is evidence of the effectiveness of a range of ways of working with families affected by substance misuse. Rather than recommending any one intervention over another, there is a need to consider local need and be creative and flexible and try to offer a range of interventions.
5. **Treatment plans need to be continually assessed, monitored and modified** to ensure that they are meeting the changing needs of each family.
6. **Clinicians need to work actively with all systems that are impacting on families' functioning.** Liaison and intervention with community agencies, schools and other health services are essential.
7. **Family engagement for an adequate period of time is critical to achieve and maintain change.** The length of time required to address the presenting issues of each family will vary in response to the complexity of their needs. Many families will require long-term support characterised by intensive periods of treatment and intermittent booster sessions. For other families the intensity and duration of the intervention may be less. To offset the possibility of families leaving treatment programs prematurely, programs need to include strategies to engage and keep families in treatment.
8. **Clinicians need to work to develop a sound therapeutic alliance with each family.** Recognition must be given to the time it takes for some clients to develop trusting and open relationships with clinicians, and time needs to be provided within the program to address this aspect as required. Encouraging the therapeutic engagement of clients is, however, balanced alongside the need to maintain a strong focus on the health and wellbeing of the child.
9. **Treatment programs need to be evaluated to determine whether they are achieving their aims and objectives.** Evaluation of program outcomes can help to determine whether the program has been effective in meeting desired outcomes and can also help establish best practice in working with families where there is parental substance misuse. Wherever possible, monitoring and evaluation should be built into, and seen as core business in the delivery of, any intervention or service.

## 8.2 The Australian context: examples of good practice

Although there is evidence of the effectiveness of a range of ways of working with families affected by substance misuse, further work is needed to consolidate what works best within Australian treatment settings (Barnard & McKeganey, 2004; Copello & Orford, 2002). Services and interventions currently in use across Australia tend not to be evaluated, thus it is difficult to ascertain when a service or treatment intervention is making a difference. Finally, as family-focused interventions are resource-intensive, it is reasonable to determine whether there are families for whom a briefer intervention may be appropriate.

General approaches employed by Australian projects include:

- case management and coordination with a range of other agencies
- family support including the provision of parent training
- individual counselling
- therapeutic group work with children. These groups typically comprise children grouped together by ages with content focused on exploration of feelings and experiences relating to parental substance misuse
- supported childcare placements and play-groups. This approach aims to strengthen the parent–child relationship and address attachment issues through the provision of guided play experiences and direct instruction

- support at the child's school to increase levels of educational and emotional development. This type of intervention aims to improve the interface between home and school and improve levels of connectiveness
- school holiday programs to provide supervised activities
- brokerage funding to access additional services/assistance for children, e.g. school uniforms, dental treatment, access to specialist services.

Table 8.1 contains some examples of Australian services and programs that have been designed to specifically address the needs of children who have been exposed to parental substance misuse. It is important to acknowledge that this list is not exhaustive, but rather designed to provide an overview of the types of services available within the Australian context.

In the following section we have identified a small number of programs that offer treatment to families with substance misuse problems within a multi-systemic framework. These are provided as examples of good practice and have been evaluated according to the guidelines proposed above; they may not be the only examples currently operating in Australia. Time and resources did not allow for a complete audit of all treatments to be undertaken. We have included a description of a comprehensive assessment model (the Hearth Tool), two examples of multi-systemic programs that operate with families and young children (Counting the Kids project: Odyssey House; Parents Under Pressure: Cairns ATODS), and one Indigenous program (The Jalaris Aboriginal Corporation: Derby).

### 8.2.1 Hearth Child Safety Assessment in Drug-Using Environment Tool (Hearth Tool: Wesley Mission, Perth)

The Hearth Tool is an assessment tool designed for use by drug and alcohol workers or child protection workers to assess the safety of children in families where one or more parent presents with issues associated with drug or alcohol use (Dale & Marsh, 2000). It provides a systematic assessment of the parent's capacity to provide a protective and nurturing environment, given the extent of drug use, and also identifies family strengths and provides a framework for dialogue around the carer's capacity to meet the child's needs and to create a nurturing environment.

Hearth suggests that, when assessing risk, counsellors need to consider the age of the child and the potential short- and long-term consequences of parental substance use. Short-term consequences involve safety issues and the parent's ability to respond to the physical needs of the child. Long-term consequences arise from the parent's ability to provide comfort and consistency, and to be emotionally available. The nature of intervention with a substance-using parent is related to the risk assessment as well as a balance between the priorities of intervention. Indeed, Hearth suggests that intervention choice is based on the balance between protection issues for the child and the parent's ability to work towards improving.

The Hearth Tool provides a snapshot assessment of family functioning which can be used repeatedly over time as a measure of change. The assessment consists of two matrices: one maps the impact of drug use on the carer's capacity to function throughout the drug use cycle; and the second

matrix explores childcare arrangements. At the end of the assessment, which takes about 30–40 minutes, a statement is constructed from the response to three questions: The typical impact of drug use is .....; the child is aged .....; and the arrangements for the child's wellbeing during the drug use cycle are .....

The Hearth Tool provides an opportunity for parents to engage in and work to enhance the safety and wellbeing of their child. It also provides parents with an experience of collaboration to identify deficits and strengths in family functioning.

The Hearth Tool is supported by a training package including an accreditation process, a training manual, a DVD, background reading, mechanisms for tracking drug use and its effects over a period of time, and material concerning drug use during pregnancy and lactation, and on parental smoking.

This tool has not yet been evaluated as an accurate indicator of the risk of drug use on children, although it has been trialled with caseworkers by the New South Wales Department of Community Services. Feedback reports from workers who have used it are positive, suggesting that it 'strengthened their decision making and accountability whilst at the same time increasing the level of connection with clients, who all achieved better insights into the impact of their drug use on their children. Attainment of shared understandings, safety plans and goals far exceeded expectations of staff and casework managers' (Robinson, 2005, p.13). Staff state that the Hearth Tool is 'a well-constructed tool and achieved engagement, collaboration and assessment of risks' (ibid., p.13).

### 8.2.2 Counting the Kids project (Odyssey House, Victoria)

This is a specialist child, parenting and family support service in metropolitan Melbourne for families where a parent has a drug or alcohol dependency. The project provides home-based support, tailored to the needs of individual family members, with a primary focus on those families with children aged 0–12 years. The Counting the Kids project also provides support and professional development to staff from alcohol and other drug services, as well as allied sectors.

The program draws on a multi-systemic model and addresses need across multiple domains including the individual parent and/or child, the family context and the wider community, through to policy by knowledge creation and dissemination. Services to families are delivered within a case-management framework with formal eligibility criteria and documented procedures for screening, assessment, planning, implementation, monitoring, case review and case closure. Additional families receive indirect assistance through secondary consultation and co-work with referring agency staff. The aim is capacity building within the drug and alcohol and child and family welfare sectors by embedding knowledge in the referring agency, rather than by always providing direct service provision.

Recognition of the complexity of issues confronting substance-abusing families has meant that the project engages in long-term work with the majority of families, with most receiving in-home support. Following referral, a three-month contract is negotiated with each family. Project staff attempt to engage with and include as many members of the family as possible. Weekly home visits are negotiated with flexibility to become more or less intensive depending on family needs and circumstances. The program has some capacity to respond to crises outside of business hours and for daily contact over the short term. The three-month contract is structured in three phases. Weeks 1–4 comprise the engagement, assessment and goal-setting phase in which baseline data are collected and a service plan is developed. Weeks 5–11 comprise the implementation phase in which progress towards goals is measured. This phase includes a developmental assessment of all children at approximately week 6. Week 12 is the case review phase and includes the collection of follow-up data (repeat measures), leading either to case closure or to negotiation of a further three-month contract, and so on.

The program also provides services directly to children to promote the development of competence and to facilitate community connectedness as an early intervention/prevention measure. The project provides therapeutic groups and school holiday programs to children through collaboration with other child, family and drug treatment service providers.

Recreational activities are provided to parents and children to promote parent–child interaction, addressing the sense of deprivation often experienced by the children of substance-using parents, and assisting children and parents to develop social skills, to model appropriate parenting practices, and to provide normative experiences.

The Counting the Kids program also focuses on areas of capacity building, research and evaluation. Training/forums and secondary consultations are regularly held with the child, family and drug treatment sectors on service provision to families affected by parental substance dependence. Baseline and follow-up data are collected and used for program evaluation and for continuing research into the lives of children affected by parental substance dependence. There has as yet, however, been no systematic empirical analysis completed on the effectiveness of the Counting the Kids project. Although this program incorporates many key elements of good practice at an organisational, clinician and treatment level, until outcomes have been formally evaluated it remains uncertain whether the program is effective in meeting its aims and objectives.

### 8.2.3 Parents Under Pressure program (Cairns ATODS)

In an effort to improve child outcomes in substance-abusing families, the Cairns Alcohol, Tobacco and Other Drugs Service (ATODS) participated in a 2005 Queensland Health initiative to disseminate the Parents Under Pressure (PUP) program in ATODS agencies across Queensland.

The PUP program, developed by Dawe, Harnett and Rendalls, is an empirically validated parenting intervention designed to improve family functioning and child outcomes in substance-misusing families. The program takes a multi-systemic approach, addressing risk factors, both within the family and in the broader social systems. The individualised treatment focus enables the program to directly address the specific needs of each presenting family. Although primarily a parenting program, designed to strengthen family relationships and teach effective child management techniques, the program emphasises the importance of the parent's management of their own emotional state as a precursor to effective parenting.

The PUP program begins with a comprehensive assessment of the family which is used therapeutically to help parents consider the multiple influences across ecological domains impacting on their ability to parent. Traditional behavioural parent training techniques are used to address problematic child functioning. Emotional regulation skills, including mindfulness-based techniques, are taught to reduce parental psychological distress and as a means of developing cognitive control in disciplinary situations to reduce impulsive, emotion-driven punishment.



The concept of mindful child-centered play is introduced to the parent in order to strengthen the quality of the parent–child relationship. A problem-solving approach is adopted so that any crisis in the family that emerges over the course of the intervention can be treated as a therapeutic opportunity to employ newly acquired parenting skills to maintain the stability of the family in the face of adversity. Mindful acceptance is encouraged for problems that cannot be easily resolved through problem solving.

Cairns ATODS has shown ongoing commitment to delivery of the PUP program. Although staffing and timetabling issues have meant that not all of the five initial therapists trained have gone on to become accredited PUP therapists, organisational commitment is such that a second round of therapist training has now been completed and one therapist has commenced training as a PUP supervisor. Time has been made available for therapists to receive supervision in their practice of the PUP program and there is a growing appreciation within the organisation of the importance of delivering evidence-based practice. PUP has now become an established program within ATODS and referrals are received from a number of sources, both internally through the drug and alcohol treatment services and externally from the Queensland Department of Child Safety. Although therapists still report some tension with regard to time pressure of incorporating PUP work into broader work commitments, it is hoped that with the ongoing success of the program will bring pressure on the agency to increase the time allocation of staff to engage in this type of intensive but time-limited intervention.

#### 8.2.4 The Jalaris Aboriginal Corporation

Located in Derby, Western Australia, the Jalaris Aboriginal Corporation has taken a coordinated and holistic approach to addressing major issues affecting family strength and health. The local Indigenous community has a long frontier history of trauma, with massacres occurring into the 1930s. As a consequence, symptoms arising from dispossession and poverty have had a profound impact. The community is said to experience one of the highest levels of alcoholism and drug abuse in Australia, unemployment in excess of 80 per cent, as well as accompanying problems of domestic violence, crime, suicide and poor nutrition (Pillsbury, Lienert & Haviland, 2004). The cumulative exposure to multiple risk factors places tremendous disadvantage on the trajectory of children. The Building Strong and Healthy Families program in Derby, operated by the Jalaris Aboriginal Corporation, is designed to address the needs of Indigenous children in the region with specific focus on core problems of health, nutrition and school attendance.

The program draws on a range of innovative strategies to engage families within the local community. The local Aboriginal kinship system is used to identify and begin working with families experiencing problems. Jalaris members, being kin, visit local families where they work together to identify problems affecting the children and parents. Family support workers, including Aboriginal elders and health workers, provide support to help address these issues. The program has a multi-systemic approach, providing support programs in a range of areas that

impact on child outcome. Initial assistance is usually directed toward meeting the fundamental needs of families in areas such as nutrition, hygiene and housing. Once they are achieved, support moves to other areas including parenting skills and relationship building.

One of the most significant long-term goals of the program is to help families get truanting children back to school. On school days a trainee nutrition worker teaches children to make their own nutritious meal at the Drop In Centre operated by the program. This strategy is designed to attract truanting children to the centre where staff work to encourage them back to school. School-aged children are taken on bush trips during school holidays where elders introduce local bush tucker and bush medicine. Jalaris also operates as a resource centre and has a drop-in centre for children aged 0–12 years and for young mothers. In addition, the introduction of a women's room equipped with computer, fridge, microwave, sewing machines and television/video provides a focal point for women to join together and build new skills. Outreach work is undertaken through use of a nutrition and health caravan, which visits surrounding communities.

The project provides training for family support staff on ways to build self-esteem in children. Jalaris has established an Aboriginal short course negotiated with TAFE which provides additional training for program staff and other interested community members. Links have been established with a range of support agencies that operate within Derby to enable access to more specialised support in addressing family and child issues as required.

In an evaluation of the Jalaris Aboriginal Corporation project, it was noted that one of the strengths of the program is that it uses an Aboriginal model of organisation.

Jalaris is operating within an Aboriginal structure and [in a] way that the expectations are Aboriginal. This is really important 'cause it gives credence to this way, shows that this way can work, that you can achieve stuff without following white fella structure. (Pillsbury & Haviland, 2003, p.17)

As yet, there has been no formal and systematic evaluation of outcomes from this program. Although the concept of evaluation sits within a very ethnocentric approach to intervention, recent work completed by Foster and colleagues (2006) provides a culturally appropriate model for conducting research with Indigenous people which may help to improve the quality of research and in turn the quality of services within Indigenous communities.

### 8.3 Conclusion

As the preceding discussion indicates, the delivery of intensive interventions to substance-abusing families has produced some very positive outcomes. Such programs recognise the importance of intervening at different levels of the family's ecology and address a range of factors that directly impinge on the child outcomes. It is unfortunate that so few programs engage directly in formal and rigorous evaluation both pre- and post-intervention, as this not only limits our understanding of client change over time but also hinders the development of a secure knowledge base of effective interventions.

A more fundamental issue raised by Barnard and McKeganey (2004) concerns the capacity of localised interventions to reach only a small proportion of those families affected by problematic substance misuse. Although not all families will require assistance, the sheer size of the problem suggests that the demand for services will far exceed capabilities. Whether it is possible to incorporate such intervention programs across a range of mainstream services is uncertain. However, it is an approach that might require further consideration as our knowledge of effective interventions grows and our commitment to improving child outcomes strengthens.

### 8.4 References

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**Table 8.1: Examples of Australian services and programs that currently target substance-misusing families**

Service	Target group	Type of service
Aboriginal Kinship program (Adelaide)	Aboriginal people who wish to reduce or cease substance abuse, and families of people who use illicit drugs or misuse other substances.	Intensive case management
Alcohol and Other Drugs Parenting Support Service (AODPSS) (Victoria)	Families who reside in alcohol and other drugs supported accommodation	Specialist child/family support
Benevolent Society (Redfern, Sydney)	Children 0–8 of drug-using parents	Child-focused intervention
Counting the Kids Odyssey House (Melbourne)	Families who are experiencing difficulties due to parental substance misuse	Specialist family support Primary care and intervention

	Program content	Contact
	<ul style="list-style-type: none"> <li>• Case management</li> <li>• Brokerage funds</li> <li>• Provision of group programs</li> </ul>	Central Northern Adelaide Health Services Inc. ph: 08 8243 5590 Nasir.Rus3@saugov.sa.gov.au
	<ul style="list-style-type: none"> <li>• Case management support via engagement, assessment and the development of a parenting plan</li> <li>• Provision of information and advice</li> <li>• Group parenting programs</li> <li>• Financial counselling</li> <li>• Referral to other support services</li> </ul>	Connections Child Youth and Family Services operate the AODPSS enquiries@connections.org.au www.connections.org.au  Kildonan Child & Family Services also operate the AODPSS www.kildonan.unitingcare.org.au
	<ul style="list-style-type: none"> <li>• Therapeutic groups for children</li> <li>• Supported playgroups for parents and children</li> <li>• Brokerage funds</li> <li>• Liaison with schools</li> <li>• Linkage to community support</li> </ul>	The Benevolent Society ph: 02 9310 3788 henriettaf@bensoc.org.au
	<ul style="list-style-type: none"> <li>• In-home family support</li> <li>• Therapeutic group work for children</li> <li>• Access to school holiday programs</li> <li>• Consultation and training to other sectors on aspects of service delivery</li> <li>• Family preservation service focusing on increasing parenting capacity and strengthening family resilience</li> <li>• Brokerage funds</li> <li>• Postnatal follow-up and support</li> </ul>	Dr Stefan Gruenert Odyssey House sgruenert@odyssey.org.au

Service	Target group	Type of service
Cyrenian House (Perth)	Women with alcohol and other drug problems and their children	Residential family support program
Glastonbury Family Services SKATE (Geelong, Vic)	Children (0–18) with parents who misuse a substance. The key focus of the program is on primary school-aged children	Specialist child/family support
Grandparents Raising Grandchildren (GRG)	Grandparents and other kinship carers raising children of drug-using people	Family support services

	Program content	Contact
	<ul style="list-style-type: none"> <li>• Accommodation for women and children in self-contained cottages</li> <li>• Provision of a safe and caring environment for children</li> <li>• Parent skills training</li> <li>• On-site creche for children</li> <li>• Play therapy for children</li> <li>• Organise activities and outings for children during school holidays</li> <li>• Supported re-entry into the community</li> </ul>	<p>Cyrenian House (WA) 318 Fitzgerald St, Perth WA ph: 08 9328 9200 www.cyrenianhouse.com</p>
	<ul style="list-style-type: none"> <li>• Group work for children</li> <li>• Support groups for family members</li> <li>• Assertive outreach to children whose families disengage from support services</li> <li>• Brokerage funding</li> <li>• Linkage to other service providers</li> <li>• Secondary consultation/education to service sector</li> </ul>	<p>Glastonbury Child and Family Services Geelong Victoria ph: 03 5222 6911 abaker@glastonbury.org.au</p>
	<ul style="list-style-type: none"> <li>• Support and counselling</li> <li>• Case management</li> <li>• Brokerage</li> <li>• Advocacy</li> <li>• Information and skill development for grandparents</li> <li>• Referral</li> </ul>	<p>GRG has support groups operating across Australia</p> <p>Marie Frodsham Grandparents Raising Grandchildren (GRG) coordgrg@netspace.net.au</p>



Service	Target group	Type of service
Jalaris Aboriginal Corporation (Derby, WA)	Indigenous families living in Derby and outlying communities	Holistic and child-centred approach to strengthen family wellbeing
Karralika Family Program (ACT)	Parents who either live at Karralika therapeutic community or reside in one of the halfway houses	Childcare centre providing family support services
Mirabel Foundation	Children (0–17) and their kinship carers who have been affected by substance misuse	Specialist family support
Odyssey House (Victoria)	Parents accessing treatment services from Odyssey House (Victoria)	Residential family support in which children 0–12 reside with mothers/fathers

	Program content	Contact
	<ul style="list-style-type: none"> <li>• Aboriginal kinship system</li> <li>• Outreach health education caravan</li> <li>• Provision of a drop-in centre for children aged 0–12 and young mothers</li> <li>• Provision of a women’s room to encourage women to join together and learn new skills</li> <li>• Parenting groups</li> <li>• School-aged children are taken on bush trips with elders during school holidays</li> </ul>	<p>Jalaris Aboriginal Corporation PO Box 610, Derby WA ph: 08 9193 2200 jalaris@westnet.com.au</p>
	<ul style="list-style-type: none"> <li>• Child and family psychologist works closely with staff, children and families</li> </ul>	<p>ADFACT Karralika Child Care Centre ph: 02 6292 2733 adfact@adfact.org www.adfact.org</p>
	<ul style="list-style-type: none"> <li>• Advocacy</li> <li>• Individualised assessment</li> <li>• Intensive crisis intervention</li> <li>• Recreational, respite and educational programs</li> <li>• Family/grief therapy</li> <li>• Family camps and holidays</li> <li>• Contingency fund</li> <li>• Telephone support counselling</li> <li>• Referral and advice</li> <li>• Community awareness</li> </ul>	<p>The Mirabel Foundation Inc. PO Box 1320, St Kilda South, Victoria 3182 mirabel@mirabelfoundation.org.au ph: 03 9527 9422 www.mirabelfoundation.com</p>
	<ul style="list-style-type: none"> <li>• Parenting programs and skills development, provision of a children’s centre</li> <li>• Provision of psychological assessment and treatment</li> <li>• Life skills development</li> </ul>	<p>Odyssey House (Victoria) Admissions: 03 9420 7610 www.odyssey.org.au</p>

Service	Target group	Type of service
Odyssey House (NSW)	Parents accessing treatment services form Odyssey House (NSW)	Residential family support for clients and their children while in treatment program  Option of ongoing support while in after-care program
Parent YES Program Brisbane Youth Service (Brisbane)	Parents under age of 25 years with issues relating to homelessness, substance use, health, income support, child safety and isolation	Parenting support and life skills development
Pregnancy, Early Parenting and Illicit Substance Use project Perth Women's Service (Perth)	Women who use while pregnant, or use and have young children	Support, information, treatment and referrals
Taskforce Alcohol & Drug Services (Melbourne)	Mothers undertaking pharmacotherapy	Parenting support group
Teenlink (Sydney)	Children aged 8–16 years with parents on Western Sydney Methadone Program or related programs	Health service delivered by psychologist and paediatrician
The New Hope Project Mary of the Cross Centre (Melbourne)	Vietnamese families with drug and alcohol problems	In-home support for Vietnamese mothers

	Program content	Contact
	<ul style="list-style-type: none"> <li>• Co-location in self-contained cottages</li> <li>• Parent educational groups</li> <li>• Coordination of outings and holiday programs for parents and children</li> <li>• Liaison with specialist paediatric, psychiatric, psychological and medical services</li> </ul>	Odyssey House (NSW) Admissions: 02 9281 5144 www.odysseyhouse.com.au
	<ul style="list-style-type: none"> <li>• Intensive outreach support</li> <li>• Centre-based support</li> <li>• Weekly group work</li> <li>• Peer-based interventions</li> <li>• Monthly community barbecues</li> </ul>	Brisbane Youth Service Parents YES Program New Farm QLD 4005 yesyouth@bigpond.net.au
	<ul style="list-style-type: none"> <li>• Support groups for new mothers and babies</li> <li>• Children's art therapy</li> <li>• Recreational physical activity program</li> <li>• Training program for service providers</li> </ul>	Perth Women's Centre, Northbridge WA ph: 08 9227 9032 / 08 9227 5762 pepisu@iinet.net.au
	<ul style="list-style-type: none"> <li>• Offers emotional support</li> <li>• Enhancement of parenting skills</li> <li>• Facilitation of events to improve social networks</li> <li>• Parenting groups</li> </ul>	Taskforce Alcohol & Drug Services 421 South Road, Moorabbin Vic 3189 www.taskforce.org.au
	<ul style="list-style-type: none"> <li>• Family therapy</li> <li>• Medical assessments</li> <li>• Individual counselling (delivered in schools)</li> <li>• Parenting skills training</li> <li>• Liaison with other sectors, e.g. DoCS, Housing etc</li> </ul>	Teenlink Department of Adolescent Medicine The Children's Hospital Westmead ph: 02 9845 244 'Popi Zappia' <PopiZ@chw.edu.au>
	<ul style="list-style-type: none"> <li>• Counselling and support</li> <li>• Education and community development</li> <li>• Supportive playgroups</li> </ul>	AMarmion@melbourne. catholic.org.au

Service	Target group	Type of service
Uniting Care Moreland Hall (Melbourne)	Mothers (who have alcohol and other drug problems) and their children	Weekly therapeutic playgroup
Wesley Hearth Wesley Mission (Perth)	Parents with children aged 0–18 years  Children affected by parental drug use	In-home counselling program
Windana SAFE at Home family support service (Melbourne)	Parent accessing services from WINDANA therapeutic community	Home visiting family support programs

	Program content	Contact
	<ul style="list-style-type: none"> <li>• Provision of developmentally appropriate play activities</li> <li>• Parents encouraged to engage in activities</li> <li>• Social support for mothers</li> </ul>	Uniting Care Moreland Hall 26 Jessie Street, Moreland Vic 3058 ph: 03 9386 2876
	<ul style="list-style-type: none"> <li>• Assessment of child safety</li> <li>• Development of case plans</li> <li>• Child counselling</li> <li>• Parent supportive counselling and skill development</li> </ul>	Wesley Centre ph: 08 9212 1966 <a href="mailto:wesleyhearth@wmp.org.au">wesleyhearth@wmp.org.au</a>
	<ul style="list-style-type: none"> <li>• Specialist drug and alcohol support</li> <li>• Parenting skill development</li> <li>• Direct support for children as required</li> <li>• Supported accommodation program for 1–12 months</li> </ul>	PO Box 372 St Kilda Vic 3182 ph: 03 3 9529 7955 <a href="http://www.windana.org.au">www.windana.org.au</a>

# 9. Summary and recommendations

## 9.1 Summary

This report aims to provide a balanced and reflective review of the evidence from research examining the impact of parental substance misuse on child outcome. The report builds on two prior important documents. The first of these is the *Role of Families in the Development, Identification, Prevention and Treatment of Illicit Drug Problems* (Mitchell et al., 2001), commissioned by the National Health and Medical Research Council. This document sets the scene by providing a broad review of the area.

The second key document is *Hidden Harm: responding to the needs of children of problem drug users*, commissioned by the Advisory Council on the Misuse of Drugs (UK). *Hidden Harm* has had far-reaching effects in the United Kingdom. It was the first attempt to derive estimates of the number of children living with parental substance abuse; it reviewed the effects of such use on children's lives, provided an overview of the legal framework protecting children and accompanying government strategies, policies and programs, and looked at those services that played a role in protecting and supporting the children of problem drug users. The report arrived at 48 key recommendations, 42 of which were endorsed by a later government response (Great Britain Department for Education and Skills, *Government Response to Hidden Harm*).

While parental substance misuse can affect many aspects of a child's life, it is generally difficult to disentangle the effects of parental substance use from the social and economic factors that contribute to and maintain the misuse of either drugs or alcohol. In Chapters 2 and 3, the extant literature is reviewed to ascertain the contribution of other factors in addition to parental substance misuse that influence child outcome. A separate chapter has been especially written for this report on the effects of parental substance misuse on Indigenous children (Chapter 4). Whilst many of the risk and protective factors are similar across cultures, it is our view that the unique historical context resulting from colonialisation and subsequent social and cultural devastation in Indigenous communities brings an additional set of considerations when looking at the impact of parental substance abuse on Indigenous children.

Understanding legislative framework and current policy initiatives is essential in determining how best to engage families in which there is risk of poor child outcome. Thus, this report provides a legislative overview (Chapter 5), a description of current Australian policies (Chapter 6) and a review of significant international initiatives, in particular those following the publication of the *Hidden Harm* report (Chapter 7). This leads to the generation of a set of 'Principles of Good Practice' and we have provided examples of such from current clinical initiatives in Australia today (Chapter 8). Each chapter and recommendations are briefly reviewed below.



### 9.1.1 Chapter 1: Estimating the prevalence of substance misuse in Australian parents

As in the *Hidden Harm* report, the current report begins by reviewing what is currently known about the number of children living in families with parental substance misuse. There was a surprising paucity of information on the numbers of children living in households with parental substance misuse. National data sets are limited by the nature of the questions as (i) parental status of respondents may not be established, or (ii) questions do not include details on children in care. An attempt to derive estimates of the number of children living in families with parental substance misuse was undertaken with considerable caveats in place. The use of alcohol and other drugs in households with dependent children was analysed using the National Drug Strategy Household Survey (NDSHS) data. A risk rate was calculated for each parent group stratified by the number of children living in the household under the age of 12 years. There was a high rate of exposure to binge drinking, with an estimated 102 children per 1000 exposed to male binge drinking and 58 children per 1000 exposed to female binge drinking in couple households. The rate of exposure to daily cannabis use was estimated to be 24 children per 1000 and the rate of exposure to monthly methamphetamine use where use occurred in the home was 8 children per 1000.

Analysis of the National Health Survey (NHS) focused on alcohol use. Approximately 6 per cent of men living in households with children but no other adults reported at least one alcohol binge in the last week. Rates of binge drinking were higher (11%) when men reported living in a couple household

with children. In relation to female binge drinking, we found that nearly 12 per cent of women living in single-parent households with children reported binge drinking. However, unlike men, this figure was much lower (6%) when women lived in couple households with children.

Data provided by the Longitudinal Study on Women's Health also indicated that women with children were reporting both binge drinking and use of other drugs. In relation to binge drinking, 11 per cent of women with children aged 6–12 years reported a binge of once or more per week. It is somewhat lower (6%) for women with children aged 1–5 years. There were high rates of illicit drug use, with approximately 8 per cent of women with older children (6–12 years) and 5 per cent of women with younger children (1–5 years) reporting current cannabis use. Current multiple/other drug use was reported by 16 per cent of women with older children (6–12 years) and 10 per cent of women with younger children (1–5 years).

Finally, data on parents' alcohol use were analysed from the Longitudinal Study of Australian Children. This study is a longitudinal study of over 10 000 children and their families recruited in 2004. The data provided for this ANCD report were derived from a preliminary analysis of Wave 1 data for both infants and 4–5 year-old children, and report on alcohol use by parents. As with both the NDSHS and the NHS data, single mothers report the highest rates of binge drinking. Thirteen per cent of mothers with babies and 19 per cent of women with children aged 4–5 years report binge drinking 2–3 times per month compared to women in couple households (6.5% and 10% respectively). It is unfortunate that illicit drug use is not recorded given the high rates of use found in the Longitudinal Study on Women's Health.

Two further data sets were analysed. These data could be viewed as data from high-risk populations. The first is from a data set referred to as 'Life experiences of people serving community corrections orders (Qld)'. There were very high rates of alcohol and other substance use – nearly 60 per cent reported drinking 7 or more standard drinks on a typical drinking occasion. For those living with children, 25 per cent reported that they would typically drink 10 or more standard drinks on each drinking occasion. There was also a high rate of drug use. Seventy per cent reported using daily, almost daily or weekly of any drug. Of these, 17 per cent of daily or almost daily cannabis users had children living with them and 21 (4.3%) of daily or almost daily amphetamine users had children living with them. The second database analysed was a study of 690 individuals reporting amphetamine use. Two hundred and seven (30.2%) reported that they had children, averaging 1.7 children each. Of these, 115 (56.1%) were women. There were significantly more days of amphetamine use in those who were parents.

In summary, it is clear that the use of alcohol and other drugs in households with dependent children is high. The national databases all point to high rates of binge drinking. While rates vary across each of the studies, there is a clear pattern showing that the highest rates of binge drinking amongst those with children are single mothers and the lowest rates are amongst women in couple households. Analyses from the Longitudinal Study on Women's Health also found high rates of illicit drug use amongst women with children. Evidence for a 'cumulative parenting disadvantage' is clear from both the community crime and amphetamines surveys.

Elevated levels of substance use are linked to other significant lifestyle and functioning deficits including exposure to violence, mental health problems, and elevated levels of criminality, which are occurring both in adults living with children and in those with children who are financially dependent upon them.

### Key points

1. International household surveys and other population estimates suggest that approximately 10 per cent of children live in households where there is parental alcohol abuse or dependence and/or substance dependence.
2. International research indicates 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.
3. Based on the number of children aged 12 years or less living in Australia (1 755 343 males and 1 666 031 females in this age group, totalling 3 421 374 children, Australian Bureau of Statistics, 2004), we estimated that 13.2 per cent of children are at risk of exposure to binge drinking in the household by at least one adult. Another 2.3 per cent or 78 691 live in a household containing at least one daily cannabis user. Finally, 0.8 per cent or 27 370 live in a household with an adult who uses methamphetamine at least monthly and reports doing so in their home.

### 9.1.2 Chapter 2: Impact of parental substance misuse on children

Although parental use of alcohol or illicit drugs is clearly a risk factor for adverse child outcomes, it does not in itself equate with maladaptive child outcomes. Specific risk factors tend to coincide and it is the cumulative exposure to multiple risk factors that creates the greatest vulnerability in children. Parental substance misuse is often linked with a constellation of other chronic life conditions associated with a drug-using lifestyle such as parental psychopathology, socioeconomic disadvantage, social isolation and violence. The concentration and co-occurrence of these kinds of adversities make it difficult to establish their independent influence on child outcomes. The nature of the substance used will also significantly impact on child outcome, as the lifestyle associated with illicit drug use requires engagement in a range of criminal activities. The relative impact of specific illicit substances is not known, although the growing use of amphetamine and associated mental illness raise particular concern about the influence of this drug on parental capacity.

Yet clearly not all children from substance-abusing families experience a maladaptive and negative trajectory. Studies of childhood resilience document that many children are able to avoid negative outcomes, despite exposure to multiple risk factors. Resilient children are seen to have the capacity to cope effectively with and overcome adversity, to bounce back and move on to lead productive lives. Such resilience is not seen as a stable characteristic of individual children or families, but as an ongoing transactional process between individuals and the environment. Various protective factors have been defined, which operate to buffer or mitigate the negative effects of risk exposure, in turn facilitating positive outcomes. The more protective factors that are present in a child's life, the more they are likely to display resilience. The two most important of these protective factors appear to be: (i) children who experience secure relationships with their parents through sensitive and responsive care and appropriate limits; and (ii) children who are engaged in school and other community activities.

### Key points

4. While there is a good literature documenting the negative impact of parental substance misuse, combined with other life problems, on child outcome, there is no specific comparison between substance classes. For example, it is not possible to determine whether parental amphetamine abuse poses a greater risk to adverse child outcome compared to a substance such as heroin. Australian research into this area needs to be encouraged.
5. Parental substance misuse might be seen as a possible marker of co-morbid parental psychopathology, which may in itself contribute to greater impairments to child outcomes than substance use alone. To improve child outcomes in substance-abusing families, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role.
6. To improve child outcome in substance-abusing families, treatment programs need to attend to the management of parental mental health issues and their corresponding impact on the parenting role. In practice, this might translate into both improved training opportunities for alcohol and other drug (AOD) workers to help better address mental health issues, and improved liaison with mental health services. It appears likely that employing experienced mental health workers in AOD services will increase the use of such treatment options within substance-using families.
7. Treatment services need to help families with parental substance misuse to better manage the daily stresses associated with socioeconomic disadvantage in order to reduce the impact of this risk factor on child outcomes. Tackling drug use in isolation is unlikely to be effective without addressing the key context issues of unemployment and poor housing which in many cases sustain drug lifestyles.
8. Effective interventions for substance-abusing families need to target the parent's capacity to seek and sustain support systems in their family and social networks. Therapeutic interventions that directly address the parent's access to social services and community supports can effectively reduce child maltreatment risk and also foster adaptive parenting behaviour.
9. Substance abuse problems and partner violence often co-occur for women. Treatment services need to routinely screen for the occurrence of family violence and provide services for these problems. Likewise, services to help address alcohol and other drug problems need to be provided in women's shelters and 'safe houses'.
10. Women with substance abuse problems are also at high risk of being assaulted. This in turn increases the risk of subsequent substance dependence and heavy use. These women need to be targeted to receive self-protection or crime protection training in an attempt to break the vicious cycle that links victimisation, post-traumatic stress disorder and substance abuse in women.

11. The inclusion of couples-based interventions that assist parents to manage their anger and levels of verbal/violent behaviours more effectively within drug and alcohol treatment services is recommended. This can improve psychosocial outcomes in children by reducing family hostility, tension and exposure to conflict.

12. A significant protective factor in a child's life is the experience of a secure relationship with his/her parents through the provision of sensitive and responsive care and appropriate limits. All attempts should be made to enhance this relationship through support of the parent(s) while engaged in treatment.

### 9.1.3 Chapter 3: Impact of problematic drug and alcohol use on parenting capacity

Our current understanding of parenting issues in substance-misusing families draws heavily on the perspectives of mothers. This ignores the experiences of many substance-misusing men who also fulfil significant parenting roles as well as other carers such as grandparents who have assumed full-time parental responsibilities as a consequence of parental substance misuse. Women who are mothers and who also have substance misuse problems experience stigmatisation and discrimination. They are labelled 'bad mothers' and have often internalised a pervasively negative view of their parenting capacity. Making change in parenting practices is made even more difficult if women begin with a view that they are inherently incapable of being a 'good enough' mother. The views and experiences of children exposed to parental substance misuse are also important; giving these children the opportunity to give voice to their experiences and to help develop an understanding of their parent's substance misuse problem is critical.

There is much evidence of variation in the way drug use impacts on parenting capacity. Levels of parental availability and sensitivity appear to change over time in response to frequency and intensity of drug use and levels of engagement in treatment. It is noteworthy that comment has also been made of the parenting strengths displayed by some substance-misusing parents. Although the impact of parental substance misuse varies according to the developmental age of the child, most research has focused on the impact during the early childhood years and there are only a small number of studies addressing the middle childhood years and even fewer examining the impact of parental substance use in adolescent years. The lack of systematic longitudinal research investigating substance misuse and parenting capacity across critical developmental periods is a significant limitation in our current knowledge base.

**Key points**

13. Women drug users who are also mothers typically experience marginalisation and discrimination due to their parenting status. This dynamic needs to be acknowledged. Attention should be directed to the development of realistic methods to appraise and support both the parenting strengths and the difficulties experienced by these women, in particular the internalised view of self as a 'hopeless' parent.
14. Many men who have childcare responsibilities are accessing treatment services, yet the experience of substance-misusing fathers has been largely ignored in the research literature and treatment setting. The alcohol and other drugs sector has a unique opportunity to work with fathers on parenting issues, particularly as more men than women access treatment services.
15. Grandparents are increasingly taking on full-time caring responsibilities in response to concerns for the welfare of their grandchildren due to their own children's substance misuse. The support needs of these grandparent carers are many and at present are only erratically addressed. Australian research is urgently needed to determine best-practice models for supporting grandparent carers.
16. The perspective of the child living in a substance-abusing family is important. Giving children an opportunity to express their views and to help them understand the nature of their parents' substance misuse needs to be facilitated. This needs to take into consideration a child's developmental level.
17. To accurately describe how substance misuse affects parenting capacity, further research is required, especially within an Australian context.

#### 9.1.4 Chapter 4: Parental substance misuse in Indigenous communities: a social ecology perspective

Educational, health, mental health, social services, welfare and criminal justice strategies imposed on Indigenous communities to date have failed to have a significant impact on improving outcomes for Indigenous children, their families and communities. Indigenous children are sometimes immersed in families and communities that have been fractured across generations as a result of colonising agendas. High levels of alcohol

and other drug misuse in families, and the resultant impact and implications for children, are an indicator of that fracturing.

Substance misuse is the final outcome of societal and personal alienation, the dynamics of which are complex and cannot be resolved by dealing with the substance misuse alone. This must come first as it has its own dynamic force but it is intertwined with so many other aspects of Indigenous experience that it cannot be resolved without looking at the broader socio-historical context that impacts on the daily experience

of Indigenous people. Of necessity is a focus on children and families, so pivotal in Indigenous culture. Treatment centres must be adapted to house families in order to create places of healing for future generations.

Only when communities are strong, have identity and purpose, and are actively engaged in energetic and vibrant pursuits, which are nurturing to the spirit, will Indigenous people be able to successfully address individual drug and alcohol problems. The huge task is to address the wellbeing of the entire community whilst at the same time addressing the needs of the individual who is abusing a substance.

Indigenous programs need to address the following areas:

- enhanced capacity for Indigenous people, both individually and as a community, to address current and future issues of substance abuse to promote their own health and wellbeing
- a whole-of-government approach to implement, evaluate and improve community-based strategies to reduce drug-related harm
- a range of services, programs and interventions to be introduced that address substance abuse from a holistic framework
- workforce initiatives to be introduced to enhance the capacity of Indigenous community-controlled and mainstream organisations to provide quality services. There needs to be increased ownership and sustainable partnerships of research, monitoring and evaluation and dissemination of information between Indigenous and non-Indigenous people
- substance abuse policies, interventions and treatment services to focus on implementing and instilling Indigenous values, principles and procedures in all spheres of prevention, education and treatment of substance abuse with Indigenous people
- support ethno-cultural responsiveness in the development and delivery of services, in order to meet the needs of Indigenous people in terms of substance abuse treatments
- training in cultural competence, designed to respectfully challenge misconceptions, is essential. Cultural safety is an essential and non-negotiable element in working with all Indigenous people, especially those who are seeking assistance with substance abuse problems
- regaining identities is an important element of treatment and sensitivity and responsiveness in the provision of culturally competent services that ensure access to treatment and prevention initiatives
- most importantly, the recognition of the right of Indigenous people to promote, develop and maintain their own institutional structures, distinctive traditions, customs and practices and procedures; pathways to empowerment and self-determination will be pivotal.



**Key points**

18. Supply reduction strategies are critical to ensure the safety of women and children exposed to violence associated with drunkenness and other substance intoxication. It is stressed, however, that these are short-term emergency measures that have an immediate, albeit partial, impact on the physical safety of the community. Failing to address the fundamental causes of the problems will not ameliorate the long-term effects of substance misuse within Indigenous communities
19. The provision of harm minimisation services such as 'safe houses', night patrols and sobering-up shelters plays a valuable role in reducing levels of harm that arise as a consequence of substance misuse. These services, however, are akin to bomb shelters in a war. They will in no way serve as a solution to the conflict (substance misuse) or resolve the underlying issues to prevent another war (a new generation of people with substance abuse problems). No one with any credibility would deny the usefulness and necessity of a bomb shelter in a war, nor would the same mind consider a bomb shelter a solution to war.
20. A major emphasis of 'educaring' is promoting understanding of the relationship between historical and socio-political influences that result in social trauma and violent behaviour – in particular, how trauma and violence are transmitted – and consequently it has inter- and trans-generational effects across societies and populations. In this, the presence of alcohol and other drug misuse, together with conflicted parenting, are seen within the broader context of its emergence across generations.

### 9.1.5 Chapter 5: Parental substance misuse: the legal framework

This chapter aims to provide a clear sense of how different jurisdictions, both nationally and internationally, have sought to manage the issue of parental substance misuse within regulatory frameworks intended to protect the wellbeing of children.

In Australia, parental substance misuse is not a factor that under any legislation will necessarily trigger child protection action. This is not, however, to say that parental substance misuse will never trigger child protection action. In at least two jurisdictions (New South Wales and the Northern Territory) it is open on the face of the legislation

to include parental substance misuse as a potential behaviour or social factor that causes harm or risk of harm to a child. In both cases, however, taking the matter further would be a judgement made on behalf of the child protection agency. In all jurisdictions parental substance misuse may be a secondary factor that causes harmful action by a parent or otherwise causes harm to a child. In these cases the question of parental substance misuse will be most important not in triggering child protection action, but in forming one of the factors that child protection agencies will consider in making a determination as to what type of child protection action to undertake.

### Key points

21. While drug use *alone* is not sufficient to trigger child protection mechanisms within Australia as a primary factor, it may be a contributing cause of neglect, harm or other abuse of a child, which could trigger such a response as a secondary factor.
22. Australian jurisdictions have, by and large, established satisfactory legislative frameworks for tackling adverse impacts upon children associated with parental substance misuse.

All child protection regimes in Australia are based upon a system of community reporting. Allegations or suspicions of child abuse or neglect are reported to the relevant child protection agency which then assesses the report and takes appropriate action. By and large, the reporting of child protection matters is broad and voluntary, meaning that any person can report to the agency on child protection matters within that jurisdiction. The range of behaviour that may be reported and then acted upon is limited only by the legislative definition of a child in need of protection. Parental substance misuse may be reported through the voluntary reporting mechanisms, but child protection action would be possible only where the report was consistent with the statutory definitions.

In addition to a voluntary reporting capacity for child protection matters, all Australian jurisdictions also include some form of mandatory reporting requirements. These mandatory reporting requirements are rarely general and are normally required only of certain classes of person. In relation to parental substance abuse, there is no mandatory reporting in Australia of parental substance misuse simpliciter. Only in circumstances where parental drug abuse resulted in a sufficient level of risk or harm to a child would mandatory reporting be required, and even then, only with respect to the *consequence* of harm to the child, not the *reason* (i.e. parental drug misuse) such harm may have come about.

On balance it is clear that parental substance misuse alone is not sufficient to trigger a child protection response. However, in all jurisdictions parental substance abuse can provide leverage if required for the triggering of a child protection action. Arguably what this all means is that jurisdictions have, by and large, established satisfactory legislative frameworks for tackling adverse impacts upon children associated with parental substance misuse. The challenge, therefore, is not so much the development of new regulatory frameworks of one sort or another, but rather the enhancing of the system's capacity to appropriately respond to the human services needs of both parents and children within the existing frameworks.

### 9.1.6 Chapter 6: Policy initiatives and practice guidelines relating to service provision for children living with parental substance misuse

The policy initiatives and practice guidelines from drug and alcohol services and child protection services were reviewed to identify where policy and practice will impact on children in substance-misusing families.

The following three broad questions were considered in relation to drug and alcohol services: (i) whether the major policy document underpinning each jurisdiction's approach to drug and alcohol use specifically targets family-inclusive practices as core business within the policy directive; (ii) whether this has led to guidelines for workers on the assessment of risk for children whose parents are clients of drug and alcohol services; and (iii) whether drug and alcohol clinicians have access to treatment interventions that will impact on family functioning in multi-problem families with parental substance misuse.

In relation to child protection services, we have attempted to determine: (i) whether child protection assessments consider the issue of parental substance use at the initial risk assessment; (ii) whether child protection workers have access to treatment interventions that will impact on family functioning in multi-problem families with parental substance misuse; and (iii) whether there are interdepartmental guidelines between child protection services and drug and alcohol services that allow for information sharing and coordinated treatment planning.

Our attempts to identify policies and practice guidelines across jurisdictions highlighted the difficulty in locating current government policies, practice guidelines and accompanying materials such as structured risk assessment instruments. Having a single point of contact that allowed access to these documents would have been enormously helpful for the purposes of the current project. This would also, however, assist a range of policy makers and senior managers of non-government organisations by giving a key point of access.

### Key points

23. A website providing links to current national and State policy initiatives (together with the linked websites) for the drug and alcohol sector, in addition to practice guidelines and other resources, is recommended.
24. In terms of policy, a review of the Australian Government's National Drug Strategy indicates that there is no reference to the needs of children raised in substance-misusing families. As this strategy may be viewed as a cooperative venture between the federal and State/Territory governments and non-government sectors, it raises concerns about the relative importance given to providing services to children affected by parental substance misuse across the political spectrum.
25. A National Strategy for the Prevention of Child Abuse and Neglect is currently under development. This is a critical opportunity to develop a policy that would directly impact on children in multi-problem families with parental substance misuse. The Community and Disability Services Ministers' Advisory Council could also consider the establishment of a working group directly addressing this issue.
26. State policy on treatment and service delivery should identify the needs of children and young people affected by substance misuse, either by use themselves or by exposure to parental substance misuse, as a priority area.
27. Provision of guidelines for drug and alcohol workers in the assessment of child protection issues is strongly recommended.
28. Family-based interventions need to be provided to clients of alcohol and drug services. Research evidence points to the importance of interventions where such services address many aspects of families' lives rather than focus on single issues. We recommend that these be made available to clients of drug and alcohol treatment agencies.

It is also apparent that there are some jurisdictions where there has been significant progress made in relation to the development of assessment frameworks, interagency guidelines and models of good practice. It seems inefficient for each jurisdiction to take on these tasks in isolation and, therefore, it seems timely for a nationally consistent approach to develop. As a first step, a series of forums could be held in each jurisdiction to include, but not be limited to, key

stakeholders such as representatives from health, child protection, corrections and police. The purpose would be to identify key points of common agreement or near-common agreement on how to respond to this issue at a policy level. This may lead to a set of guiding principles on what constitutes best practice in addressing the needs of children and improving child outcome in multi-problem families with parental substance misuse.

With agreement reached on the form and content of a national set of principles, it would be useful to have a further series of forums to focus on turning policy into practice. While jurisdictions will have different line agencies with differing responsibilities (due to the unique needs of each jurisdiction and to the historical context that has shaped the differing structures of government across jurisdictions), development of a set of national principles describing best practice would be helpful. A further goal of forums would be to identify whether there are jurisdictions that can be used as pilot sites to test the implementation of policy and practices and to allow for the development of an evidence base for future reference.

In addition to the key points above, we have made a series of specific recommendations that could provide a starting point for each jurisdiction to consider. These recommendations follow from the three broad areas of consideration for drug and alcohol services and child protection services respectively and the conclusions regarding them, as summarised in Chapter 6.

The first major issue is the extent to which the key policy document relating to the strategic directions in alcohol and other drug use to be taken within the jurisdiction makes reference to the needs of children and young people affected by parental substance misuse.

In looking at the extent to which drug and alcohol services have access to guidelines that assist in making decisions about child protections issues and provide drug and alcohol workers with specific parenting resources, it is apparent that this occurs across three jurisdictions. Notably this has occurred in States where the needs of children and young people have been identified as a priority area: New South Wales, Western Australia and South Australia (under development). It may be deduced that this has been influenced by a State-level policy that promotes family-focused practice.

Finally, in relation to drug and alcohol treatment agencies, we strongly endorse the view that services should be provided within drug and alcohol services for substance-misusing families. In order for this to occur, workers need to have access to parenting resources developed specifically for this population. To our knowledge there is limited provision of family-based treatments provided within the context of a drug and alcohol treatment agency.

In relation to the three broad issues for child protection services, almost all States have well-developed guidelines for the consideration of parental substance misuse as part of a risk assessment framework. There seems to be less consistency across jurisdictions regarding the issue of interdepartmental agency guidelines for child protection intervention. Finally, there are limited options for interventions for multi-problem families with parental substance misuse either from within the child protection services or accessible by child protection.

### 9.1.7 Chapter 7: Responses to *Hidden Harm* in the United Kingdom and beyond

The response to the *Hidden Harm* report in the United Kingdom has varied markedly across the four countries, with Scotland alone developing ongoing action planning and policy interventions based specifically on the recommendations laid out in the report. Nonetheless, there have been significant changes across the United Kingdom as child protection agendas and legislation have dominated the response in England and Wales, with a new drug strategy (including targets around vulnerable populations and young people) developed in Northern Ireland. Thus, it is reasonable to conclude that, in all four of the home countries, there have been improvements in joint working and in screening and identification of young people at risk. Only in Scotland, however, has there been a commitment to improving the evidence base for quantifying the children at risk as a result of substance-using parents and for developing a legislative framework for supporting drug-using mothers.

The broader international situation reflects the research evidence base in that there are widespread examples of innovative practice, underpinned by high-quality community-based work, but these are generally not adequately evaluated and there is little coherence or consensus on what the core elements for success are. Because of definitional problems, identifying and targeting children at risk is problematic, and little systematic work has been done in attempting to measure either of the key variables, the number of children exposed to risky situations or the mediating and moderating variables that will determine acute and chronic harm risks associated with this group.

### 9.1.8 Chapter 8: Principles of good practice: tackling the needs of children in substance-misusing families

Interventions in drug treatment services have only rarely focused on the needs of children and instead have made the assumption that children will receive benefit indirectly through the support offered to the parent. Improving the circumstances and outcomes for children in these families will require a dramatic shift in perspective at an organisational, clinician and treatment level if real gains in child outcome are to be achieved. The following principles of best practice are informed by the research outlined in this document and have application to the work of all service providers who deal directly with substance misusers who are parents.

#### *9.1.8.1 Good practice principles for organisations*

1. Organisations need to recognise the importance of addressing the needs of children of substance misusers and regard this as core business.
2. Organisations need to give recognition to the importance of this work and accept that this work is time-consuming and intensive.
3. Clinicians need to be provided with training within a multi-systemic theoretical model.
4. Organisations need to develop inter-agency practice guidelines that facilitate staff across different agencies working together in a safe, ethical and helpful way.
5. Organisations need to be responsive to the needs of families to ensure treatment engagement.

#### *9.1.8.2 Good practice principles for clinicians*

1. Clinicians need to receive training in empirically sound treatment models for improving outcomes in substance-abusing families.
2. Clinicians need to be provided with regular supervision.
3. Clinicians need to be provided with adequate time to provide intensive family-focused interventions.

#### *9.1.8.3 Good practice principles for treatment content*

1. No single treatment is appropriate for all families.
2. Families need immediate access to treatment programs.
3. All treatments should include a thorough assessment of the family's functioning across multiple domains. The family should be involved in assessing their needs and the design of services.
4. Effective programs attend to the multiple needs of the family, not just the parent's use of drugs.
5. Treatment plans need to be continually assessed, monitored and modified to ensure that they are meeting the changing needs of each family.
6. Clinicians need to work actively with all systems that are impacting on families' functioning.
7. Family engagement for an adequate period of time is critical to achieve and maintain change.
8. Clinicians need to work to develop a sound therapeutic alliance with each family.
9. Treatment programs need to be evaluated to determine whether they are achieving their aims and objectives.



## 9.2 Recommendations

On the basis of the key points and literature reviewed we have derived a series of recommendations for consideration. These have been grouped as follows:

### 9.2.1 Recommendations for determining prevalence estimates of children living in families with parental substance misuse

**Recommendation 1:** All national surveys of substance use should collect minimum basic data on number of biological children, number of dependent children, and number of children living in the households of adults.

**Recommendation 2:** Surveys of particular high-risk populations should also collect data on number of biological children, number of dependent children, and number of children living in the households of adults. Additional information on whether children are currently or have ever been taken into social services' care should, ideally, also be collected. This could be done as part of the National Minimum Data Set to allow comparisons to be made across jurisdictions.

**Recommendation 3:** Data collected on harms to children and children taken into care should include clear information on the referral and decision-making mechanisms and, where multiple reasons are given, the primacy of parental substance use should be stated along with the type of substance use involved. Similarly, the relationship between the type of harm (e.g. neglect or abuse) should be cross-tabulated against the profile of parental risk factors.

**Recommendation 4:** Future research needs to be conducted to ascertain whether different substances carry particular levels of risk or harm to children living with parental drug use. The interplay between parental drug use, mental health and child outcome should be a particular focus of this research.

### 9.2.2 Recommendations regarding the content of treatment programs to meet the needs of children living in families with substance misuse

**Recommendation 5:** Parental alcohol and drug misuse is only one of many problems affecting children in multi-problem families. Treatments need to focus on the multiple domains affecting children's lives if child outcome is to be improved. Thus, treatment models need to adopt a multi-systemic perspective.

**Recommendation 6:** There is no single treatment program that is right for all families. However, a set of agreed principles of good practice will provide a benchmark for determining program content. The Practice Guidelines developed as part of this report should be used as a starting point in the development of an agreed set of National Guidelines.

### 9.2.3 Recommendations for Indigenous communities

**Recommendation 7:** Supply reduction strategies appear critical in order to improve levels of safety experienced by children and women exposed to violence associated with drunkenness and other substance intoxication. However, further research is required to determine which strategies are most helpful in protecting children and women.

**Recommendation 8:** The provision of harm minimisation services such as ‘safe houses’, night patrols and sobering-up shelters plays a valuable role in reducing levels of harm that arise as a consequence of substance misuse. Existing services should retain their funding. Further development of harm minimisation strategies should be undertaken – as a minimum, each community should have a ‘safe house’.

**Recommendation 9:** An approach of ‘educaring’ has been proposed as a model that promotes understanding of the relationship between historical and socio-political influences that result in social trauma and violent behaviour in Indigenous communities. Alcohol and other drug misuse, together with conflicted parenting, are seen within the broader context of the emergence across generations. Approaches that allow for consultation within communities and across a number of different arms of government are strongly endorsed.

### 9.2.4 Recommendations regarding policy and practice guidelines for government

**Recommendation 10:** State policy on treatment and service delivery should identify the needs of children and young people affected by substance misuse, either by use themselves or by exposure to parental substance misuse, as a priority area.

**Recommendation 11:** Provision of guidelines for drug and alcohol workers for the assessment of child protection issues is strongly recommended.

**Recommendation 12:** Research evidence points to the importance of having interventions that are multi-systemic in nature and address multiple domains of family functioning. We recommend that staff within the alcohol and other drug services deliver these interventions.

**Recommendation 13:** Staff involved in the delivery of intensive family-focused interventions need to be supported by the provision of adequate models of practice, supervision and sufficient time to ensure that treatments have a realistic chance of improving outcome in children of problem substance users.