

Practice Paper

Parental substance misuse and child protection:
Overview, indicators, impacts,
risk and protective factors

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1. Introduction

Substance misuse can be **hidden**. It tends not to occur in the presence of the worker and parents have considerable control over when, where and how much they use. Even when under the influence of drugs or alcohol, behaviour can be moderated to disguise the impact of use, should the parent meet the worker when intoxicated. As a result, parents are often able to hide the presence and impact of substance misuse, and social workers can struggle with assessments in such circumstances" (Forrester 2004).

Refer to the corresponding practice paper, 'Parental substance misuse and child protection: intervention strategies', in relation to evidence-based strategies and practice tips for intervening in cases involving parental substance misuse.

2. Definitions

Substance – for the purpose of this paper, 'substance' refers to alcohol, prescription drugs and illicit drugs.

Drug/s – for the purpose of this paper, 'drugs' mean drugs other than alcohol.

ATODS – Alcohol, Tobacco and other Drugs Services.

Co-morbid conditions – this term is frequently mentioned in the literature on substance misuse, and refers to the presence of a **concurrent** psychiatric or psychological condition or disorder in the parent who misuses substances. Examples of co-morbid conditions include depression, anxiety disorder and antisocial personality disorder.

Substance abuse or misuse – refers to the use of a substance that is part of, or associated with, problematic or harmful behaviour (Forrester and Harwin 2004).

Physical dependence – refers to the existence of withdrawal symptoms if a substance is not taken. There is a common misconception that physical dependence is all there is to *addiction* however, physical dependence is only **one** aspect that defines addiction. Others include the pattern of use and psychological feelings associated with not using, such as feeling a craving (Forrester and Harwin 2004).

Illicit drugs – incorporate the following (AIHW 2005):

marijuana/cannabis	pain-killers/ analgesics*	steroids*	tranquillisers/ sleeping pills*
barbiturates*	inhalants	heroin	methadone (non-maintenance)
cocaine	other opiates/ opioids*	meth/ amphetamine (speed)	hallucinogens
injected drugs	ketamine	GHB	ecstasy

* for non-medical purposes

AIHW – Australian Institute of Health and Welfare.

3. Indicators in parents of substance misuse

Practice Tip: Developing your knowledge about the range of symptoms and consequences associated with various substances will assist in identifying and assessing parental substance misuse, particularly in the face of secrecy and denial (common factors among families who experience parental substance misuse).

The physical and emotional/behavioural presentations of parents are **key visual cues** requiring consideration during the investigation and assessment and ongoing intervention phases of departmental intervention.

Provide other key professionals and agencies (who are working with individual families) with relevant and accurate information about the likely symptoms and consequences of particular substances, or assist in facilitating this process.

3.1 Types of substances, symptoms and possible consequences

* *Recent refers to used in the last 12 months*

Cannabis – Symptoms of cannabis use include (but are not exhaustive of):

- slow reflexes, reduced concentration/self-awareness;
- dilated pupils and blood shot/glassy eyes.

Potential consequences of cannabis incorporate:

- mood swings and mental health problems; and
- the exacerbation of psychotic illness and symptoms of schizophrenia, for example, delusions and hallucinations (Department of Health and Ageing 2006).

Ecstasy – Symptoms of ecstasy use include (but are not exhaustive of):

- sweating;
- anxiety;
- tremors; and
- dilated pupils.

Possible consequences of ecstasy incorporate:

- physical conditions such as weight loss and cracked teeth;
- psychological issues such as decreased emotional control and severe depression;
- a 'hangover effect', or depression that can last for days after using ecstasy; and
- a person's death due to heart failure (Department of Health and Ageing 2006).

Amphetamines – Symptoms of amphetamine use include (but are not exhaustive of):

- teeth grinding;
- sweating;
- dilated pupils;

- nausea and vomiting; and
- excitability and anxiety.

Possible consequences of amphetamines incorporate:

- physical presentations such as cracked teeth, chronic sleep problems and violent behaviour;
- serious psychological issues including hallucinations, and paranoia and severe depression;
- speed psychosis, a particularly common effect of amphetamine overdose, resembling a sudden attack of paranoid schizophrenia.

Practice Tip: Liaise with an ATODS professional (particularly where the parent is currently engaged with a service) to obtain advice regarding what levels of amphetamine use might constitute 'high dosage' for an individual parent.

Amphetamine use is particularly associated with **violent behaviour**, as these drugs raise excitability and muscle tension, which may lead to impulsive behaviour. High dosage users with an aggressive personality are likely to become more aggressive when using amphetamines.

Ensure your safety plans, case plans and interventions with children whose parents misuse amphetamines take into account, adequately respond to, and are closely/frequently monitored, given the increased likelihood of violent behaviour.

Cocaine – Symptoms of cocaine include (but are not limited to):

- dilated pupils;
- euphoria;
- agitation; and
- paranoia.

Potential consequences of using cocaine incorporate:

- violent or erratic behaviour;
- cocaine psychosis; and
- eating or sleeping disorders.

Cocaine use has a high risk of addiction, and taking cocaine while drinking can be particularly dangerous (Department of Health and Ageing 2006).

Depressants – may consist of sleeping pills and minor tranquillisers. Symptoms include (but are not limited to):

- drowsiness;
- slurred speech;
- confusion; and
- a lack of coordination.

Potential consequences incorporate:

- anxiety;
- depression;
- suicide; and
- a high risk of addiction (Department of Health and Ageing 2006).

GHB (Gamma-hydroxybutyrate) – for example, fantasy, liquid ecstasy. GHB use is associated with symptoms that include:

- drowsiness;
- reduced inhibitions;
- dizziness; and
- agitation.

Possible consequences incorporate (but are not exhaustive of):

- extreme drowsiness/grogginess;
- difficulty focusing eyes;
- impaired movement and speech; and
- seizures, coma, amnesia and death after prolonged use due to addiction (Department of Health and Ageing 2006).

Hallucinogens – for example, LSD, PCP.

Hallucinogens are associated with symptoms such as:

- a trance-like state;
- euphoria;
- hallucinations; and
- paranoia.

Possible consequences of hallucinogens incorporate:

- depression;
- unpredictable flashbacks; and
- impaired judgement and coordination, result in greater risk of injury, self-inflicted injury and violent behaviour (Department of Health and Ageing 2006).

Inhalants –Inhalants may consist of solvents, aerosols, glue and petrol. Symptoms include:

- slurred speech;
- impaired coordination; and
- vomiting.

The potential consequences of inhalants incorporate:

- brain damage;
- sores on nose or mouth;

- nosebleeds,
- bizarre or reckless behaviour,
- suffocation; and
- sudden death (Department of Health and Ageing 2006).

Opioids – for example, heroin, morphine, methadone.

The use of opioids may result in symptoms such as:

- lethargy;
- nausea;
- constricted pupils; and
- drowsiness.

Opioid use has a high risk of addiction and potential consequences include:

- mood swings;
- anxiety disorders;
- infection at injection site; and
- death from HIV and overdose (Department of Health and Ageing 2006).

Alcohol – is a depressant and intoxication leads to:

- blurred vision;
- dehydration;
- nausea; and
- slow reflexes.

Alcohol withdrawal symptoms and signs incorporate:

- increased body temperature, pulse rate and respiration rate;
- increased blood pressure;
- nausea and vomiting;
- tremors and sweating;
- agitation and anxiety;
- disturbed sleep;
- tactile disturbances (for example, pins and needles, itching, burning and numbness);
- auditory and/or visual disturbances including hallucinations;
- seizures (which may occur 12 to 48 hours after the last drink is consumed in alcohol dependent persons); and
- delirium (an acute brain syndrome evidenced by agitation, hyperactivity, confusion and disorientation) (Department of Health and Ageing 2006).

Practice Tip: When alcohol abuse is determined to be a risk factor, investigate the likelihood of domestic violence, and physical and sexual abuse. When developing case plans to address domestic violence, physical abuse, and/or sexual abuse include support and interventions related to reducing/abstaining from alcohol use.

Alcohol abuse is strongly associated with violence in the home, and some research studies have also shown that alcohol misuse has been linked to physical and sexual abuse (Tomison 1996).

To access more detailed information about the different substances, including street names and how they are commonly taken, refer to the below websites:

Department of Health and Ageing (Australia)

<http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/information>

DrugInfo Clearinghouse (Australia)

www.druginfo.adf.org.au Home>Articles

NIDA – National Institute on Drug Abuse (United States Department of Health and Human Services)

<http://www.nida.nih.gov/Infofacts/Infofaxindex.html>

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4. Factors potentially impeding safe and responsive parenting

Practice Tip: Explore the possible causes and/or effects of parental substance misuse with parents. Assess such issues in light of the harm or risk of harm to the child, and respond in a holistic manner to the needs of parents who misuse substances. Discuss with parents that they may also need to complete other interventions to ensure the protection of the child and improve their parenting skills.

Abstinence, or the reduced/controlled use of substances will not necessarily result in improved or safe parenting **in isolation** from addressing parental factors which potentially impeding safe and responsive parenting. This is because these factors may contribute to, or result from, parental substance misuse.

The research outlines various reasons as to why substance misuse may impede a parent's capacity to ensure their child's safety and wellbeing.

Parents may possess inadequate parenting skills, as they themselves were poorly parented when growing up. The research supports that mothers who misuse substances, as a group, demonstrate increased rates of abuse in their own childhood (Alison 2000). As a result, it is possible that parents have learnt a range of negative parenting practices and in some circumstances, abusive and/or neglectful parenting strategies.

Substance misuse may also provide a reprieve from negative childhood experiences. For example, parents may have experienced abuse or neglect as a child, and/or abuse in adult relationships, and may therefore misuse substances to deal with or minimise a range of negative feelings (trauma, loss, grief) and stress associated with such experiences. In addition, parents may misuse substances to help block feelings of guilt or shame associated with their previous experiences of abuse, and/or to help them feel better about themselves.

Unless the above-mentioned experiences of parents are addressed and parents acquire alternative skills for managing their negative feelings and stresses, they may continue to misuse substances to block their emotional pain, and therefore remain emotionally and psychologically unavailable to their own children.

The nature of substance misuse itself can also directly affect the quality of care provided by parents to their children (Alison 2000). For example, activities associated with financing and procuring substances may take priority for parents, rather than the physical and emotional care needs of their children. In addition, a parent's ability or capacity to respond to the child's needs may be limited while affected by, and during recovery from, substance misuse (particularly when effects include irritability, paranoia and impaired judgment).

Parents' difficulties may further be associated with a range of other existing, **co-morbid conditions**, rather than the substance misuse itself. A range of research indicates that parents who misuse substances commonly experience increased mental health conditions such as depression and anxiety.

While the factors potentially impeding safe and responsive parenting are varied, the research establishes a range of **common findings** in relation to the extent and nature of harm, or risk of harm, subsequently experienced by children.

Sexual, physical, emotional abuse and neglect, have all been associated with substance misuse however, **neglect** is the most commonly experienced harm for children of parents who misuse substances (Alison 2000). Further, children placed in out-of-home care (due to factors associated with parental substance misuse) are **generally younger** than other children in the child welfare system, and more likely to have experienced severe neglect.

Drug misuse in particular, is strongly associated with risk of harm to babies and toddlers. Drug misuse is also an identified risk factor in a significant number of child death inquiries.

For detailed information regarding the relationship between parental substance misuse and child abuse/neglect, including national and international research findings, refer to **Appendix 1**, Parental substance misuse and child abuse/neglect: the experience of Australian and overseas jurisdictions.

5. Risk factors associated with parental substance misuse

Practice Tip: Developing your knowledge of evidence-based risk factors, and applying this knowledge to assessment and intervention frameworks, will assist departmental officers to:

- identify significant risk factors (including less overt indicators) commonly present in the families of substance misusing parents, particularly as the research shows denial and secrecy by children and parents is commonplace in these families;
- identify sources of information to confirm, or lend credence to, the presence of parental substance misuse in families subject to child protection intervention;
- consider the actual, or likely, impact of such factors on the safety and wellbeing of the child; and
- develop evidence-based, effective case plan actions and outcomes.

During all phases of departmental intervention, explore and where appropriate, respond to (through the provision of necessary intervention services), risk factors associated with parental substance misuse.

The research clearly demonstrates that parental substance misuse **rarely** exists in isolation from other risk factors, and an over-reliance (or sole-reliance) on abstinence or controlled/reduced parental substance misuse, is likely to result in other significant harms/risks for children within the family from being overlooked.

Key risk factors commonly associated with parental substance misuse include:

- mental health conditions;
- domestic violence; and
- criminal activity.

6. Impacts and harms associated with parental substance misuse

Practice Tip: Identify the impacts and harms to children as a result of parental substance misuse. Use relevant information to inform the strengths and needs assessment of the child, and ultimately, the development of the child's case plan.

Discuss with children their experiences of growing up in families where parents misuse substances. If children deny the presence of parental substance misuse, discuss the experiences of other children (as per the research findings). Ensure that case plans incorporate interventions to address the likely needs of children.

6.1 Children

Practice Tip: Develop your knowledge of the common experiences and concerns (as informed by the research) of children who grow up in substance misusing families, particularly in light of the likelihood of denial by children.

During contact with children, it will be important to:

- undertake discussions about children's concerns for their own safety and wellbeing, as well as children's concerns about their parents, and possibly siblings. Even if children maintain secrecy and denial with respect to parental substance misuse, the research suggests that a key issue for children is that they still have access to people who are there to help them.;
- focus interactions on the experiences of other children who have grown up in substance misusing families, including what they have said about their experiences, fears and other emotions;
- understand the issues and/or concerns likely to be present for the children;
- acknowledge the presence or likely presence of substance misuse; and
- target interventions at the likely needs of children (for example, lack of peer interaction and limited social and recreational opportunities), even if children deny parental substance misuse however departmental assessments confirm, or strongly indicate, the existence of substance misuse.

As departmental officers demonstrate understanding and knowledge about some of the common experiences and concerns expressed by children who grow up with parents who misuse substances, children may be less likely to maintain the culture of secrecy and denial.

In turn, this may facilitate more effective and open relationships between children and departmental officers with respect to identifying and responding to the protection and care needs of children. The information provided by children will also assist departmental officers in helping parents to understand the impacts of parental substance misuse for their children.

Some of the **most common** research findings on the effects of parental substance misuse on children are discussed in the section below.

6.1.1 High Risk Infants

Practice Tip: Consult with ATODS staff to develop appropriate strategies for assessing substance misusing parents, to ensure the protection and care of infants. Infants are highly vulnerable due to the increased risk associated with the child's age and developmental abilities.

Children are at a much higher risk of harm during **infancy** when one or more of their parents misuse alcohol or drugs (Silver et al 1999:13; Biegel & Blum 1999:58; Osofsky 2004:265; Gessner et al 2004:13; Campbell & Jackson 2002:13; Jackson et al 1999:7).

In Queensland from 1 July 2005 to 30 August 2006 over half of the 48 children known to the

department who died were aged between birth to four years. In the 11 months prior, from 1 August 2004 to 30 June 2005, over half of the 33 children known to the department who died, were aged between birth to four years.

Recent Queensland research approved and supported by the Department of Child Safety (McGlade 2007) indicates that the risk of suffering substantiated harm is estimated to be 17.8 times greater for children whose mothers report using illicit substances compared to children whose mothers did not report illicit substance use. The risk for this group of vulnerable children to enter foster care is estimated to be 12.8 times greater and the risk of not being reunified with a parent is 16.3 times greater. Parental drug use is estimated to be present in up to 80% of referrals to Australian child protection agencies (McGlade 2007).

Research from the United States has proposed that children will be between **four to sixteen** times more likely to experience harm when their parents misuse substances (Hogan, Myers & Elswick 2006:146; Jackson et al 1999:7).

An infant may be at greater risk because:

- the parents' physical and psychological health will be affected by their substance misuse;
- the parents' addiction may result in the use of the family's limited financial resources to purchase alcohol or drugs instead of food and nappies;
- the parents' addiction may expose themselves and their infant to high risk situations (violent or paranoid behaviour) or criminal activity when attempting to procure drugs;
- the parents' capacity to provide constant and consistent care and supervision may be inhibited during periods when they are under the influence of drugs or alcohol;
- the baby may be affected by the alcohol or drugs if the mother is breastfeeding; and
- substance misuse is often exacerbated by a number of concurrent risk factors (Osofsky 2004:265; Biegel & Blum 1999:61; Berrick et al 1998:2; Silver et al 1999:12,13; Ashdown-Lambert 2005:80; Hogan et al 2006:146, 147; Jackson et al 1999:7) including:
 - poverty;
 - young age;
 - poor antenatal care;
 - homelessness/poor housing;
 - incarceration or criminal activity;
 - unemployment;
 - poor physical health;
 - mental illness;
 - stress;
 - low self-esteem;
 - poor parenting skills;
 - low educational status;
 - poor nutrition; and
 - domestic violence

6.1.2 Fatal child abuse

Practice Tip: Consider the likely presence of multiple risk factors, potentially resulting in the serious injury or fatality of a child, during all phases of departmental intervention ie. intake, investigation and assessment and ongoing intervention.

When conducting assessments, providing or facilitating interventions, and reviewing case plans, give adequate consideration to cause and effect issues, and ensure that all risk factors are responded to through the selected interventions.

Of relevance to this paper is the extent to which parental substance misuse is identified as a **common risk factor** within the families subject to child death reviews.

For example, in Queensland, of the 40 cases resulting in the death of children, the parents of the children misused substances in 13 cases, and multiple risk factors (specifically, family violence, mental illness, criminal history and transience) co-existed in the majority of cases. The most common combination of risk factors included substance misuse and family violence, and family violence and criminal history (Child Death Case Review Committee 2006).

During the previous year, the parents of the children misused substances in 37.5% of cases. The most common combination of risk factors in these cases included substance misuse and family violence, and substance misuse and mental illness (Child Death Case Review Committee 2005).

Refer to Appendix 2, Child fatalities in New South Wales and Victoria.

6.1.3 Foetal Alcohol Syndrome (FAS)

Practice Tip: In collaboration with ATODS staff, identify and implement strategies which aim to prevent, and/or minimise the impact of, FAS in children subject to departmental child protection intervention.

Foetal Alcohol Syndrome is a developmental problem that is caused before birth when a baby is exposed to alcohol, and one of the **most common** harms associated with antenatal substance misuse.

Foetal Alcohol Syndrome is also one of the three most common causes of intellectual impairment (and the only preventable cause of the three), and **adverse effects** on children include the following (Dore, Doris and Wright 1995):

- heart defects;
- hearing and vision problems;
- facial deformities;
- small head circumference;
- decreased height and weight;
- increased risk of stillbirth, miscarriage and infant mortality;
- learning disabilities;

- hyperactivity;
- short attention span; and
- antisocial behaviour.

Many babies with FAS are not identified at birth, partly because many of the women who are misusing alcohol are not identified and doctors do not look for the signs of FAS or other alcohol effects on babies. Children with FAS may not therefore be identified until they grow older and begin to demonstrate behaviour or learning problems, and speech delays, often identified by schools and child care staff.

There are also **secondary effects** of alcohol related developmental disorders which are not present at birth but occur later in the child's development. These include the following:

- an increased risk of mental health problems, including ADD (Attention Deficit Disorder), ADHD (Attention Deficit Disorder with Hyperactivity), conduct disorder, alcohol or drug dependence, depression and psychotic episodes;
- conduct problems in school, children with FAS are more likely than other children to be suspended, expelled or drop out early from school;
- young people with FAS are more likely to commit crime and to be imprisoned, they may have difficulty controlling anger and frustration, and may be violent;
- many people with FAS have problems with alcohol and drugs; and
- adults with FAS may have trouble keeping a job or living independently (Child and Youth Health 2006).

These effects may be preventable if the condition is better understood and if children, adults and families receive appropriate support.

A range of strategies which may be of use to departmental officers, as well as ATODS professionals (Child and Youth Health 2006), include:

- increase the parents' knowledge about the potential short and long-term effects of consuming alcohol during pregnancy. Many women who become pregnant do not know about the serious effects that alcohol can have on an unborn child.;
- ensure that relevant medical professionals are informed of a parents' substance misuse. Early diagnosis will enable children with FAS to access more support for their learning, and their behaviour difficulties can be better understood and managed.;
- involve children in special education through early diagnosis and the development of an individualised education plan;
- facilitate support and community involvement at the early stage of diagnosis. This may enable children to live with their parents or extended family, thereby preventing children from being placed in out-of-home care.;
- consider the effects of alcohol whenever assessing a child for difficult behaviour or developmental delays; and
- carefully monitor a child's developmental milestones and behaviour. This can help prevent or reduce many of the secondary effects of alcohol related developmental disorders.

6.1.4 Neonatal Abstinence Syndrome

Practice Tip: Seek advice from an appropriate service when assessing and intervening with substance misusing pregnant mothers. Consideration and expert knowledge of the significant risk factors will assist in developing a plan to protect the baby from birth and to support the mother to reduce the negative effects on her unborn child.

In view of the multitude of harms potentially associated with newborn babies and pre-natal exposure to substances, the parenting skills of the parent are **particularly important**. In addition to the baby's withdrawal related behaviours (outlined below), babies may present with special needs which place extra, intensive demands on their parents.

Advice to women using drugs during pregnancy is generally to stabilise their drug use (where possible, with prescribed methadone) or to stop the drug use with obstetric assistance.

Neonatal Abstinence Syndrome is a **significant outcome** related to antenatal substance misuse, with newborn babies presenting with the following **symptoms** (Macrory and Harbin 2000):

- general irritability, hyperactivity and poor consolability;
- abnormal sensitivity to touch;
- accelerated cardiac action and an increase in the respiratory rate;
- changes in the sleeping/waking rhythm;
- wild sucking at their fists;
- shrill and excessively long phases of screaming tremors;
- shivering, sneezing, perspiration and fever;
- vomiting and diarrhoea;
- inhibited feeding; and
- in extreme cases, general convulsions.

Some parents may subsequently be ill-equipped to cope with the special needs of these newborn babies. "One study of the parenting of substance abusing mothers found a tendency for **rigidity and over control** in their parenting and little emotional involvement and responsiveness in their interaction with children...Further, the mothers in this study reported **receiving little pleasure** from their interactions with their babies. Other studies support these findings of disturbances in the mother-infant dyad when infants have been prenatally exposed (Dore, Doris and Wright 1995: 534)."

Mother-child attachment problems may also be exacerbated by the tendency to separate infants from their mothers at birth, due to withdrawal, birth defects, prematurity or concerns about the parents' capacity to adequately care for the child (Tomison 1996). In addition to the high demands displayed by babies experiencing withdrawal symptoms and the research findings regarding attachment problems, responsive and safe parenting may be **limited** by the:

- significant amount of time and energy that chemically dependent persons may spend on procuring and misusing substances;
- symptoms and behavioural consequences associated with the varying types of substances misused by parents; and
- parental behaviour and/or moods related to withdrawal and/or coming down from drugs.

6.1.5 Accidents, injuries and exposure to traumatic events

Practice Tip: Advise parents about safe storage of drugs, and the risks posed by the exposure of children to illicit drugs. In conducting investigations and assessments and/or discussing such matters with parents, explore the nature of substances kept in the household and how/where each substance and related drug equipment is stored (in order to keep children safe).

Liaise with ATODS professionals, where involved in the delivery of intervention services, to negotiate roles and responsibilities in relation to:

- providing such advice to a parent; and/or
- ensuring the parent's understanding of the particular risks associated with specific substances.

Children of substance misusing parents may be exposed to an excessive number of **preventable** accidents and/or injuries associated with inadequate parental supervision, including:

- accidental poisoning and drug ingestion due to the accessibility of drugs and/or inadequate parental supervision. Methadone and cocaine are extremely dangerous to children. Parents may also administer substances to their children, to keep their children quiet or to make them sleep; and
- the risk to children of needle stick injuries and subsequently contracting blood borne viruses.

Children may be exposed to **traumatic events**, for example, the arrest of a parent or the death of a parent due to overdose.

6.1.6 Denial, distortion and secrecy – “Elephant? What elephant?”

“To tackle the elephant without exploring what it has left in its wake is to ensure that children of substance misusing parents remain invisible (Kroll 2004:138).”

Kroll examines a number of studies relating to the experiences of children, young people and young adults who grew up in families impacted by parental substance misuse. Kroll refers to children “...for whom a substance is, effectively, a family member – ‘the elephant in the living room’...”, and identifies and discusses a range of emerging themes which have important implications for practice (Kroll 2004:129).

In all the studies, Kroll found that **secrecy and denial** were issues for the children of substance misusing parents. Specific findings incorporate the following (Kroll 2004):

- the dynamic of denial, distortion, confusion and secrecy often resulted in the substance misuse becoming the ‘central organising principle’ of the family;
- children are encouraged from an early age not to speak about parental substance misuse;
- the need for denial and secrecy, and shame and fear of consequences, often cut children off from social networks (such as family, friends), thereby isolating them from possible sources of support; and

- drug misuse in particular (as opposed to alcohol misuse) connected children and parents to a culture in which secrecy was essential, due to the possibility of police raids and the consequences of criminal activity, eg. imprisonment.

Children also spoke of 'locked doors' and other types of suspicious behaviour in their homes, and expressed the feeling of constantly being shut out and excluded. In turn, this contributed to children's sense of being unwanted, rejected and unimportant.

Although children generally worked hard at keeping their secret, they also spoke of feeling aggrieved, because people did not try to discover the 'secret' or make attempts to find out what was wrong.

Kroll asserts that if adults respond as if there is no 'elephant', children develop a distorted view of reality. In addition, if the 'elephant' doesn't exist, children are discouraged from their feelings about the 'elephant' as well as from discussing their feelings, often resulting in disruptive behaviour.

6.1.7 Attachment, separation and loss

Kroll refers to "the pervasive losses children experience and the accompanying, often unresolved, grief", and outlines a range of losses frequently experienced by the children of substance misusing parents (Kroll 2004:133). Typical losses experienced by children whose parents misuse substances, include the loss of:

- a feeling of being loved;
- a reliable, consistent and responsible parent;
- confidence and self-esteem;
- a 'normal' lifestyle in which it was safe to bring friends home or go off to school;
- childhood; and
- opportunities for fun and laughter.

Other losses sometimes experienced by children included the loss of their parent/s, often due to imprisonment, removal by statutory child protection authorities and abandonment.

6.1.8 Family functioning, breakdown and conflict

All the studies reviewed by Kroll reveal parental conflict, fighting and arguing as a major source of stress and anxiety for children (Kroll 2004).

Kroll identified that in response to high levels of family dysfunction and conflict, the whole family operated around the substance misusing parent and that children effectively disappeared in their own right (as the children's lives were dominated by their parent's needs and emotions).

Children frequently spoke of avoidance strategies, fear, and the denial of their own feelings. Whether or not children had 'good' or 'bad' days was determined by how their parents were feeling and behaving, rather than their own experiences and feelings.

Consequences for children included isolation, loneliness and a feeling there was no one who could be trusted.

Kroll also noted that substance misuse often led to parental separation, with children experiencing additional stresses such as:

- fears about not being wanted by parents;
- concerns about taking on adult responsibilities associated with supporting the parent who was 'left';

- the loss of a sense of family; and
- in some circumstances, changing schools, moving house and losing contact with friends.

6.1.9 Violence, abuse and fear

Practice Tip: Ensure that applicable domestic violence services or professionals are informed of any concerns regarding parental substance misuse and that ATODS professionals are informed of concerns regarding domestic and family violence.

The research overwhelmingly indicates that domestic violence is a **key risk factor** frequently associated with parental substance misuse (Chan 2005; Tunnard 2002).

“What children saw as their **greatest problem** was the violence often associated with substance misuse (particularly alcohol) which frequently caused aggressive behaviour. Attempts to intervene by either child or non-using parent tended to make matters worse and, even when the violence was directed at objects rather than people, the consequences were devastating, with children traumatised or inconsolable for significant periods of time (Kroll 2004:135).”

One of the major consequences for children whose parents misuse substances is **fear**, including fear of arguments, actual physical violence or the threat of it, either to a parent or to themselves and, at times, fear of sexual abuse.

Children referred to assaults and injuries that were inflicted on them, often accompanied by verbal abuse such as derogatory remarks about abilities or appearance, and comments about not being loved or wanted. Children were also significantly impacted by their parents’ attempts to self-harm when under the influence of substances.

Children indicated that the emotional abuse was as painful, if not more so, than the physical injuries or assaults, with taunting, unprovoked humiliation in front of others and other types of emotional abuse identified by children as being common experiences (Kroll 2004). Feelings expressed by children in such circumstances included disbelief, betrayal, vulnerability, not being cared about, and rage and anger towards parents.

The above situations were reported as being difficult to talk about, as children were fearful about what would happen following their disclosures (due to threats by their parents about likely actions if they disclosed).

Additionally, irritability and aggression were **grave sources of concern** for amphetamine users, more so than for those using other drugs. The negative impact on children tended to be about parents using harsh criticism and emotional and verbal abuse.

Parents who misuse substances and are involved in criminal activity (and the extent and nature of this involvement) may have significant implications for the safety of children. Children may be directly involved in, or exposed to, criminal activity by their parents, and they may experience associated trauma (eg. witnessing police raids, arrests of parents and parents’ friends).

Practice Tip: Protect children from involvement in or exposure to criminal activity by parents and ensure children are given adequate support to address any trauma associated with parental involvement in criminal activity.

Research indicates that parental substance misuse has a strong link with parents also participating in criminal activity (Johnson 2004; Tunnard 2002).

When assessing and responding to issues of parental substance misuse, a key consideration with regard to the safety and wellbeing of children is their potential exposure to, and/or involvement in, a parent's criminal activity and/or harms or risks associated with such activity.

Related considerations include the nature of the parent's support and social network (whether these people also misuse substances and/or are involved in criminal activity to fund and/or procure substances) and where, how and from whom, parents procure substances.

Information about a parent's involvement in criminal activity and/or their procurement of substances, may be known to notifiers, extended family members, government and non-government workers. Departmental records (child protection history, client file and SCAN Team records) may also be relevant sources of information.

Further, in specified circumstances, the *Child Protection Act 1999* (section 95) enables the department to request a written report from the Queensland Police Service, regarding a parent's:

- criminal history;
- domestic violence history, including an application for a protection order under the *Domestic and Family Violence Protection Act 1989*; and/or
- records in relation to an offence against the *Drugs Misuse Act 1986*.

6.1.10 Role reversal, role confusion and the child as 'carer'

Kroll found that the extent to which children assumed adult responsibilities within the families of substance misusing parents varied across particular studies, with some children assuming daily responsibilities considered to be of a 'normal' nature and others taking over adult responsibilities such as dealing with debts, managing finances and caring for their siblings (Kroll 2004). Some children spoke of being responsible for meeting their parent's physical care and hygiene needs.

Potential consequences for children who are responsible for meeting their parent's needs, include loss of childhood, loss of recreation and social opportunities, anger and resentment towards parents, poor educational performance and feelings of fear, anxiety and stress.

6.1.11 Health problems and poor developmental outcomes

Neglect of medical needs is common in children of parents who misuse substances, including failure to fully immunise and failure to attend to routine health matters (Alison 2000).

Failure to attend to medical needs may be due to factors such as frequent address changes, changing health care professionals and incomplete health care records that are not appropriately passed on to relevant professionals.

Failure to thrive is also a condition that may be associated with the children of substance misusing parents, and related considerations include the following (Alison 2000):

- a parent's appetite can be suppressed from drug taking, and they may not respond to their child's need for food;
- poverty might contribute to failure to thrive, with resources being spent on drugs instead of food; and
- parents may oversleep as a result of their substance misuse, and therefore not ensure that children receive appropriate meals.

With respect to child **mental health**, studies of children whose parents misuse substances show that children experience the following problems (Dore, Doris and Wright 1995):

- increased incidence of hyperactivity and conduct disorder;
- greater rates of drug and alcohol misuse in adolescence;
- impaired intellectual and academic functioning;
- clinical levels of anxiety and depression; and
- lowered self-esteem and perceived lack of control over the environment.

6.1.12 Education problems

There is some research referring to the likely and actual impact of children's functioning at school. Starting school has been suggested to raise various difficulties for children, including (Tunnard, 2002):

- the conflict for some children between the need to socialise and integrate with their peers and a sense of loyalty to their parents;
- children felt different from their peers due to their exposure to, and knowledge of, drugs;
- children had been directed not to talk about their parents' drug use and were also reluctant to invite other children home; and
- children missed school because they were kept at home to care for parents or siblings, or because they had no clean clothes, or because the children did not wish to attend and parents did not make them.

6.1.13 Social isolation

"Children have described how their friendships were affected because their caring responsibilities at home left them with little time to socialise or because their feelings of shame about their home circumstances kept them apart from other children. This distance from others was sometimes prompted by the children and sometimes forced on them by other children. And the fear of talking about their home life to other adults such as teachers, who might have been able to offer support, was another burden that left children upset and isolated (Tunnard 2002:29)".

Children may feel upset or experience isolation due to their additional roles and responsibilities at home, their unkempt appearances, and rejection by peers (due to their parents' lifestyle and/or unpredictable behaviour).

The children of parents who misuse drugs may also have more difficulties with peer relationships, including (Tunnard 2002):

- having less friends to socialise with and to confide in;
- difficulties with respect to making friends, and lower confidence in this regard;
- being avoided by their peers; and
- peers' parents discouraging friendships with the children of drug using parents.

6.1.14 Additional impacts specific to parental alcohol misuse

The children of parents who misuse alcohol identify fear and anxiety as key issues, particularly with respect to (Tunnard 2002):

- worries about family finances and fear of losing their home;
- fear that one or other parent will leave home because of the tensions caused by alcohol misuse, and they worry about the loneliness of an abandoned parent who seeks solace in alcohol; and
- a sense that nothing will change and that in time, they will behave in the same way as their parent.

Children speak of the shortage of cash, of money used for alcohol (instead of clothes, food, other bills) and of broken promises when money is no longer available for anticipated outings and meals. Children also consistently comment on arguments between parents (Tunnard 2002).

Some children blame themselves for the parental alcohol problem and think that they may have prevented the occurrence of the problem in their parents.

Older children interviewed about their experiences of parental alcohol misuse predominantly identified educational failure as the most significant impact of their parents' behaviour (Tunnard 2002). These children felt they had done less well at school as a result of parental drinking, and spoke about frequently being late to school (or not attending).

6.2 The impact of parental substance misuse on parents

Practice Tip: Discuss with parents the effects of their substance misuse on their children. Ask parents to identify how they would like to parent their children and how the substance misuse is impacting on their ability. Link parents in with appropriate intervention/support services to address their own guilt and anxieties about parenting.

Parents also experience a range of impacts as a result of substance misuse however many of these impacts also have follow-on affects for their children. The research indicates that parents often have an awareness of how these impacts affect not only their lives but also the lives of their children, to the extent that some parents feel guilt and sometimes disgust, about the lifestyles they expose their children to.

In assessments and interventions with parents, utilise the research (and particularly the concerns held by parents for their children based on their substance misusing lifestyles) to:

- direct discussions about parents' concerns for their children's personal safety and/or emotional wellbeing;
- discuss key risk factors, including possible impacts of parental substance misuse for children, as well as how parental impacts also have an effect on their children; and
- identify possible motivating factors (for example, child protection concerns held by the department may also be similar to the concerns held by parents) and utilise these factors to develop strengths-based case plans and interventions.

If departmental officers can demonstrate understanding and knowledge about some of the common experiences and concerns of parents who misuse substances and openly discuss these

matters with parents, parents may be less likely to maintain the culture of secrecy and denial. In turn, this may facilitate more effective and open relationships between parents and departmental officers with respect to identifying and responding to the protection and care needs of children.

6.2.1 Living situation

Some studies regarding parental substance misuse have demonstrated that parents' living situations are frequently characterised as follows (Tunnard 2002):

- living conditions are generally poor and household resources are often directed at procuring and using substances, thereby resulting in material deprivation in the home. Poor living conditions are seen as both a cause and effect of parental substance misuse.;
- the strain of finding money for drugs can add to family tensions and leave parents physically and emotionally unavailable for their children;
- some degree of neglect is highly likely where household resources, both financial and emotional, are invested in the pursuit and use of drugs;
- parents generally have a strong awareness of their child care responsibilities however may struggle to provide stable routines (due to the time and energy directed at acquiring and using drugs) and safe homes;
- as a result, there might be little stability for many children around mealtimes and bedtimes, getting up and out for school, being washed and cleanly clothed, having fun and recreation, and getting to appointments on time; and
- **unpredictability** is a key feature of life.

Parents sometimes acknowledge the chaos of people coming and going from their homes at all hours of the day and night, as well as involving children (often late at night) in their attempts to procure substances. Some parents also speak of their homes being a mess, and of their guilt (sometimes disgust) at the lifestyle they have exposed their children to.

6.2.2 Family and social relationships

For many families where parental substance misuse exists, the following issues exist with regard to family and social relationships (Tunnard 2002):

- **separations** are a common occurrence for children and parents, and take many forms, including:
 - one parent leaving the family home;
 - parents being incarcerated due to criminal offences;
 - parents being in residential treatment programs;
 - children frequently being left, sometimes for long periods, with adults other than their parents; and
 - previous removal of children due to child protection concerns;
- some separations are planned by parents, in an attempt to protect their children from the substance misuse and to give children stability (relatives and particularly maternal grandmothers often care for children);
- other relationship difficulties sometimes occur due to traumatic family histories, for example, substance misusing parents having experienced their own abuse or injury as a child;
- friends offer support to substance misusing parents however such adults often pose risks, too, as friends are often made through substance misuse networks, and many misuse substances themselves;

- **isolation** and **social exclusion** are also frequent features of the lives of parents who misuse substances, often due to greater levels of community rejection and limited involvement in social or recreational opportunities; and
- the sense of exclusion is more pronounced for mothers than fathers.

The research also points to **disrupted attachments** as children grow older, associated with the various separations likely to have occurred within the families of substance misusing parents.

Some parents are able to acknowledge and regret the pressure placed on children as a result of parental substance misuse, pressure which often deprives their children of usual childhood experiences. Parents also express fear of rejection by their children, because of their substance misuse, and other parents also fear that their failure to be a positive role model will result in their children adopting parents' negative behaviours.

Lastly, parents and relatives often worry about the **storage of drugs**, that is, how to keep drugs safely out of reach of children and how to protect children from witnessing their parents or other adults using substances at home.

6.2.3 Behaviour

The research clearly establishes the link between parental drug misuse and criminal activity. In addition, the research identifies the following behaviours applicable to substance misusing parents (Tunnard 2002):

- parents implement certain strategies to protect children from disputes about drugs and from the consequences of their drug use, for example, not using drugs when children were present, keeping other drug users away from the home, and keeping equipment in safe places;
- parents' fear that children might copy their drug use, either seeing it as normal behaviour or in order to escape from childhood difficulties and deprivation; and
- inadequate supervision commonly results in children being taken to hospitals for treatment, partly due to unrealistic expectations held by parents about their young children (for example, assuming that a toddler would comply with directions about not touching parents' drugs and expecting children not to copy what they see their parents do).

The research also determines that physical violence in the community is another theme, particularly with respect to recovered heroin users (Tunnard 2002). The studies indicate however that such violence mostly involves other drug users, and is related to issues such as disputes about drug transactions, money lending and the purity of drug supplies.

Stopping the drift into drugs has been identified by parents as an important reason for having an open approach with their children about the consequences of using drugs and the need to avoid copying adult behaviour.

6.2.4 Mental health

Practice Tip: The presence of **mental health conditions** in parents who misuse substances is common, and well supported and documented in the literature regarding parental substance misuse. The concurrent existence of mental illness and parental substance misuse, particularly when associated with violence, is also associated with risk of **serious injury** to children (Forrester 2004).

When assessing and/or intervening in cases involving or alleging parental substance misuse, consider and discuss with the parent and where applicable the relevant ATODS professional, whether parents present with indicators of mental health issues.

In addition, access additional sources of information regarding indicators of mental health issues from notifiers, parents, family members, children, government and non-government workers and departmental records (child protection history, client file and SCAN Team records). For example:

- explore whether parents feel depressed, engage in self-harming or risk taking behaviour and/or have considered and/or attempted suicide; and
- determine whether parents have previously been, or are currently:
 - diagnosed and/or treated by a mental health professional;
 - admitted to a mental health unit within the public health system; and/or
 - medicated for the purpose of treating mental health conditions and if so, whether the medication is recommended or whether the parent is self-medicating.

Ensure that applicable mental health services or professionals are informed of any concerns regarding parental substance misuse and that ATODS professionals are informed of concerns regarding mental health issues.

The **physical health** implications for parents who misuse substances have been previously identified in this paper (refer section 3.1).

6.3 The impact of parental substance misuse on extended family

Practice Tip: The research indicates that parental substance misuse also has a significant impact for extended family members, particularly grandparents who often undertake a caring role for their grandchildren. The research also identifies some of the most common difficulties experienced by extended family members and it is important that departmental officers consider such issues, and respond appropriately, when developing case plans as well as conducting kinship carer assessments.

The adequate identification of, and response to, the needs of extended family members may assist departmental officers in enhancing the safety of children, as the research identifies extended family members as a **key protective factor** in the lives of children whose parents misuse substances. It is therefore important that interventions with families (including kinship carer assessments and out-of-home care placement supports) include understanding and assisting family members in dealing with identified stresses and problems.

The range of impacts upon extended family members are identified below (Salter and Clark):

- finding the user difficult to live with;
- financial difficulties for the family;
- concern for the health and safety of the user;
- concern for the personal safety and emotional wellbeing of children;
- concern for the harmful effects on the whole family;
- experiencing personal anxiety, helplessness and/or depression; and
- restricting the social lives and support networks of extended family members.

7. Protective factors

Practice Tip: Protective factors may influence or reduce the likelihood of future harm to children, and therefore need to be considered in any assessment of likelihood and degree of future harm, at all phases of departmental intervention.

In assessing protective factors, departmental officers should differentiate between those which:

- may provide immediate safety for children but do not decrease the overall and ongoing likelihood of future harm (eg. a child residing with a grandparent temporarily); and
- reduce the overall likelihood of future harm for children and therefore influence the departmental decision about intervention (eg. continued presence of another non-substance misusing adult who is able to assist in the daily care of a child).

Certain protective factors can influence the timing and priority of an intervention or provide strengths or safety nets to be targeted as part of the intervention with children and families.

The **key** to minimising the impact of parental substance misuse on children and to ensuring their personal safety and emotional wellbeing, requires the proactive **identification and strengthening** of evidence-based protective factors (not only for the child but also in relation to the parent and the environment), and the incorporation of such factors in the safety (where applicable) and/or case plan for the child.

Research into child resilience has shown that protective factors can have a **greater impact** on child outcomes than risk factors.

The range of protective factors associated with **parental drug misuse**, include (Tunnard 2002):

- entering **treatment** for substance misuse;
- mothers' concerns for their unborn or new child, and their strong motivation to act on their concerns (once concerns are understood);
- attending ante-natal sessions regularly and accepting advice that will minimise problems after birth;
- mothers' partners (if applicable) being supportive of mothers with respect to:
 - mothers coming to terms with the stress of pregnancy and drug use;
 - attempts to achieve abstinence and/or reduced or controlled substance use; and
 - the patience of partners with children and mothers;

- family members, particularly grandparents, available to provide child care help in general and also when parents attend treatment appointments, and to provide support (while disapproving of parents' lifestyles) to both the children and the substance misusing parents; and
- a family's involvement in the community, including religious, neighbourhood and cultural activities, and a sense of inclusion.

With respect to criminal activity, pregnancy acts as a strong incentive to women to change past behaviours and methadone maintenance treatment impacts positively on parents' lifestyles.

In relation to **parental alcohol misuse**, the research identifies protective factors such as (Tunnard 2002):

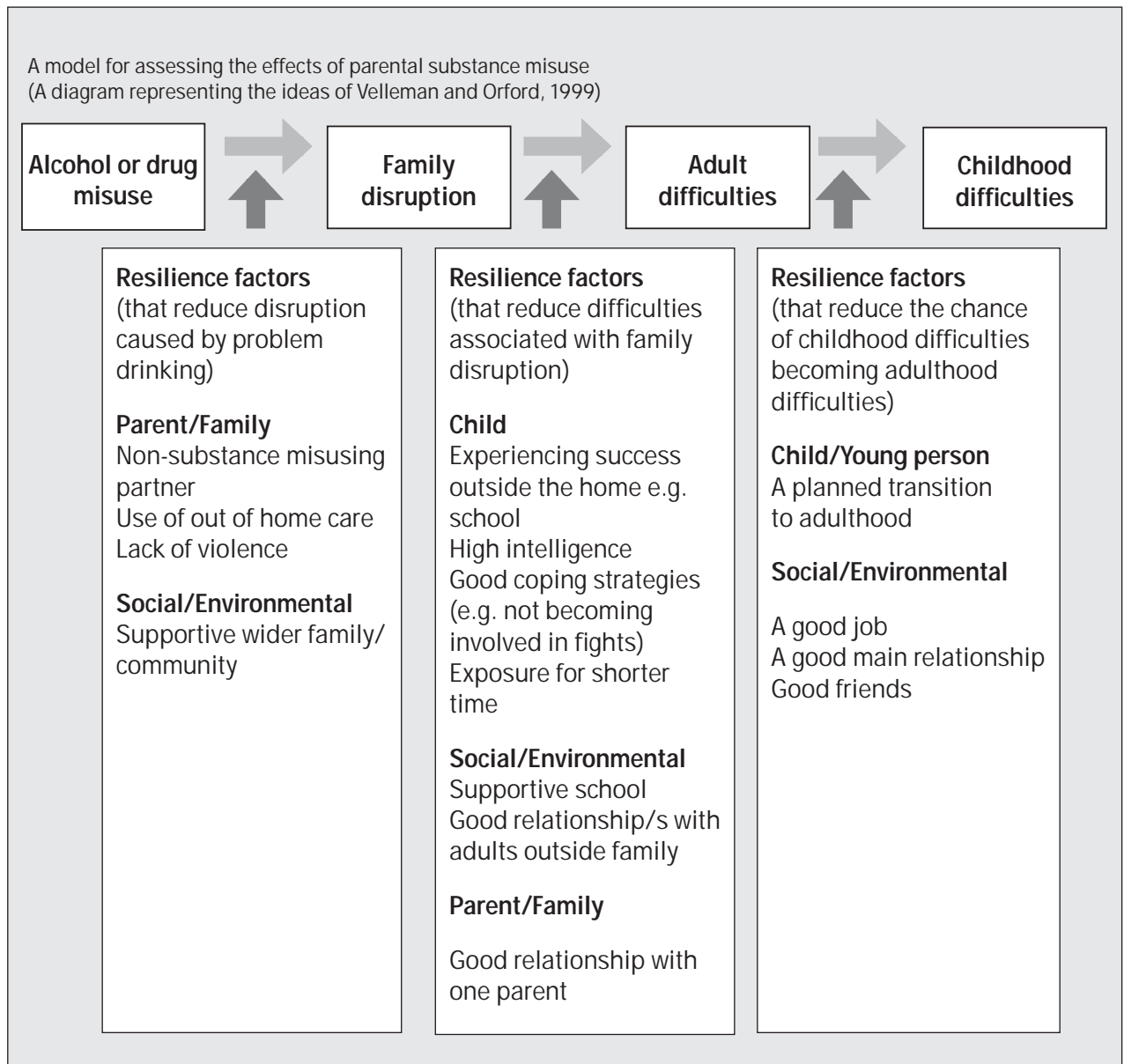
- a stable relationship between a child and a non-drinking parent or other adult;
- nurturing of the child by others within the family;
- the active use of an informal network outside the family for advice and assistance;
- parents providing structure and control, including a united and caring front, family activities, and time and attention;
- positive influences at school; and
- the maintenance of self-esteem and coping skills in the child.

Education is also a significant protective factor for the children of substance misusing parents, and schools often play a significant role in helping to motivate parents and children.

Other research suggests that **young people** who experience parental substance misuse are more likely to overcome difficulties in childhood where they (Forrester 2004):

- leave home at a later age;
- take their time before settling down with a partner;
- avoid becoming parents themselves too early; and
- plan their career or job.

Forrester provides a useful summary of protective factors associated with parental substance misuse, as outlined in the below table (Forrester 2004:168).



8. Conclusion

Responding to parental substance misuse in the context of child protection intervention is complex. Parental substance misuse indicates an increased risk of harm to children, particularly during **infancy** as a result of a multitude of associated factors and co-related risks.

Ensure you:

- coordinate interventions and service responses (particularly with ATODS' professionals but also with other relevant agencies);
- communicate openly and honestly with children and parents;
- proactively create and strengthen protective factors for children;
- provide therapeutic intervention to children and young people who have experienced substance misuse;
- provide ongoing support to children at all phases of departmental intervention (especially following reunification); and
- consider and integrate into the case plan, relapse and prevention strategies and therapeutic intervention for parents.

Consider and where possible, **implement multiple**, concurrent interventions aimed at addressing the range of risk factors. Do not over-rely or solely rely on addressing the parent's substance misuse, as this is likely to result in significant harm or risk to highly vulnerable children, particularly infants.

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10. Appendices

10.1 Appendix 1 – Parental substance misuse and child abuse/neglect: the experience of Australian and overseas jurisdictions

“There is now a convincing amount of evidence which suggests that children living at home with a parent with a serious alcohol or drug problem may encounter a range of barriers to satisfactory development. Clear links have also been found between parental substance misuse and various types of child maltreatment, including neglect and emotional, physical and sexual abuse (Taylor and Kroll 2004:2).”

Australian jurisdictions

“There have been few Australian attempts to determine accurately the extent to which child maltreatment and substance abuse interact (Tomison 1996:5).”

Queensland

Recent* cannabis use in Queensland is most significant among the 20 to 29 year old age group (29%), followed by 14 to 19 year olds (19.4%) and 30 to 39 year olds (15.2%) (AIHW 2005). Cocaine use in Queensland appears to be at a much lower level than the other substances, although a similar pattern applies with respect to applicable age groups. That is, more persons aged 20 to 29 years used cocaine (2.3%) than did persons aged 14 to 19 years (0.9%) and 30 to 39 years (0.5%) (AIHW 2005).

Recent* ecstasy use in Queensland is most prevalent in the 20 to 29 year old age group (11.8%), followed by persons aged 14 to 19 years (5%) and 30 to 39 year olds (3.5%) (AIHW 2005).

Recent* amphetamines - use in Queensland is most significant among the 20-29 year old age group (10.4%), followed by 14 to 19 year olds and 30 to 39 year olds (at approximately 3%) (AIHW 2005).

The recent* use of inhalants is significantly lower than other substances such as cannabis, ecstasy and amphetamines. In the 20 to 29 year old age group, recent use of inhalants constituted 2.0% of persons and for 14 to 19 year olds, 0.9% (AIHW 2005).

Victoria

The Department of Human Services has reported that in 2000-2001, about one third of parents of children entering foster care reported having problems with alcohol abuse and another one third reported having problems with other substances (Wood, Mattick, Burns and Shakeshaft 2005).

Clark (1994) cites an analysis of 75 randomly selected cases from the Department of Human Services, which showed that 41.5% of families sampled had substance abuse concerns recorded as contributing to protective concerns. Further, in cases which involved neglect (the majority of which occurred in single parent families), just under two thirds of cases had a substance abuse concern recorded (Wood, Mattick, Burns and Shakeshaft 2005).

New South Wales

In its 2002 Annual Report, the Department of Community Services estimated that up to 80% of all child abuse reports investigated involved concerns about parental substance misuse (Wood, Mattick, Burns and Shakeshaft 2005).

In the 1994-95 national child maltreatment statistics, Angus and Hall (1996) indicated that 22% of all substantiated emotional abuse cases in New South Wales were reported to result from a parent's substance misuse problem. No specific category was provided for other types of abuse (eg. physical abuse or neglect) related to parental substance misuse.

Western Australia

Research conducted by the Department for Community Development in 2001 showed that drug and alcohol use was a contributing factor to the care and protection application in 71% of cases in the year 2000 (Leek, Seneque and Ward 2003).

The 2004 replication of the above study (based on 2003 care and protection applications) revealed that drug and alcohol use was found to be a contributing factor in 57% of the 175 cases. In addition, 44% of the 191 respondents to the applications were found to be drug and alcohol users.

With respect to Aboriginal and Torres Strait Islander people within the study, Aboriginal and Torres Strait Islanders were more likely to have drug and alcohol use as a reason for the care and protection application than people of other origins and alcohol consumption was higher among Aboriginal and Torres Strait Islanders (while opioid use was higher among respondents of other origin).

Overseas jurisdictions

United States

Studies undertaken in the United States, which has been struggling with a significant substance abuse problem, reveal the following outcomes with respect to parental substance misuse and child abuse/neglect (Ainsworth 2004):

- a survey of United States voluntary child welfare services found that 57% of client children were affected by parental substance abuse;
- in 1986, a survey of children who were made Wards of the State in the United States indicated that over half came from chemically-dependent families;
- for one-third to two-thirds of children in out-of-home care, parental substance abuse is a contributing factor to their placement;
- children of parents who misuse substances and who are placed in out-of-home care are:
 - younger (under five years) than other children in the child welfare system; and
 - more likely to have experienced severe and chronic neglect; and
- children from these families are more likely to be placed in out-of-home care, as opposed to receiving in-home intervention by services located in the community.

Specific to alcohol abuse, one particular study (early 1980s) determined that (Tomison 1996):

- up to 66% of children raised by alcoholic parents were physically abused or witnessed family violence;
- 26% of the children had been sexually abused; and
- physical or sexual abuse was reported to occur regularly in one-third of alcohol homes.

Further, "depending upon the study, the reported rates of alcohol abuse in maltreating families in the United States have varied from 25 to 84% (Tomison 1996:4)".

Canada

Results from the first Canadian study (1995) which examined the incidence and characteristics of reported child maltreatment found that alcohol abuse was identified as occurring in 13% of investigations and in 38% of substantiated cases. Drug abuse was reported to occur in only 7% of investigated cases, but 31% of substantiated cases (Tomison 1996).

Sweden

A small but important study conducted in Sweden highlights the potential, serious consequences for children who are raised by parents with substance abuse problems. Billing et al. (1994) conducted a prospective study in which 65 Swedish children born to women who used amphetamines during pregnancy were followed up until the age of eight years.

“Of an original sample of 71, six children died before two months of age. Of the surviving sample, 26 children were taken into custody within their first year of life. After eight years, 44 children (68%) had been adopted or were living in foster homes (Tomison 1996:12).”

Further, the study determined that the extent (amount and duration) of foetal amphetamine exposure was significantly correlated with children’s behavioural problems at eight years of age, particularly problems such as aggressiveness and poor peer relations.

United Kingdom

It is estimated that about a million children in the United Kingdom may be living with parents with problematic drinking patterns, and that between 250 000 and 350 000 are in the care of problem drug users (Kroll 2004). There is also evidence that substance misuse appears to be most common in the more serious cases such as children on the child protection register and/or in court proceedings (Hayden 2004).

It is noted that although child protection registers and social services records are used to gain a sense of the extent of parental substance misuse, such data only relates to children and families who come to the attention of statutory services, and is therefore likely to be underestimated.

“Dependent drug use escalated in the 1980s with the increasing availability of heroin from the Middle East, against the social backdrop of the rise in long-term unemployment...Drug use has continued to expand in the 1990s, with more recent figures indicating an increasing number of women users and a far younger population of drug users as a whole. With the majority of women users being of a childbearing age, it can be assumed that the links between drug use and parenting will continue to increase (Harbin and Murphy 2000:7).”

Each of the categories of abuse, sexual, physical, emotional and neglect, have been associated with substance misuse, with research indicating that neglect is the most commonly experienced harm for children (Alison 2000). As indicated by child death review data and findings specific to the impact of pre-natal substance misuse on children, it is of no surprise that the research highlights newborns and toddlers as being especially vulnerable.

Neglect may incorporate various aspects of parenting, including medical neglect, failure to thrive, inadequate supervision and protection, and failure to provide adequate food, clothing and accommodation etc. Researchers have determined that medical neglect such as failure to fully immunise and failure to attend to routine health monitoring and screening, is more common in children of substance misusers (Alison 2000).

One study conducted in England considered all children allocated a social worker in four London authorities over an average 12 months. A case was included in the substance misuse sample if any professional expressed concern about parental substance use.

The study identified a clear relationship between the types of substances misused and the pattern of child protection concerns, as follows (Phillips 2004):

- whatever substance was misused, children appeared to be at risk of neglect;
- alcohol misuse was strongly associated with violence in the home, with parental intoxication while in charge of children and with concerns about the emotional welfare of children;
- drug misuse was strongly associated with potential harm to new born babies; and
- in a small number of cases, children had suffered serious harm (eg. life-threatening assaults). Alcohol misuse was a feature in all of these cases, and domestic violence and non-cooperation with social workers were common.

In a study of 200 families with an alcohol or opiate addicted parent, Black and Mayer (1980) found the following (Alison 2000):

- some degree of neglect had occurred in all; and
- serious neglect had occurred in around one third of families.

The following research findings apply with respect to the link between substance abuse and sexual harm (Tomison 1996):

- substance abuse was one of a number of risk factors which may increase the likelihood of sexual offending;
- a child who is inadequately cared for or supervised by a parent under the influence of substances may provide a perpetrator with the opportunity to commit sexual offences;
- the use of alcohol, or alcoholism, is the most frequently reported and well established method employed to lower inhibitions associated with sexual offending;
- many studies have shown that alcohol involvement accompanies sexual abuse, that is, involved an offender who was alcoholic and/or drinking at the time of the offence;
- incest offenders appear to have the most extensive histories of alcohol involvement of all sex offenders; and
- there is a common occurrence of sexual problems due to the physical effects of substance abuse, and the resultant stress and frustration may manifest itself as the sexual abuse of a child to fulfil adult sexual needs.

The following research findings apply with respect to the link between substance abuse and physical harm (Tomison 1996):

- recent prospective studies of parental characteristics have identified antisocial behaviour such as aggressiveness or substance abuse as part of a set of parental personality traits that are frequently associated with physically abusive parents;
- a history of mental illness or substance abuse was one of 13 risk factors identified in the United Kingdom to be associated with physical abuse cases in infants;
- partners of substance misusers may also be prone to violence (that is, a non-addicted partner may lash out at children in a misdirected response to stress);

- the potential for physical and verbal violence may also be heightened by the stress and tension which results when a child, whose physical and/or emotional needs are not being met within the family, demands attention or engages in power struggles with the parents;
- amphetamine use is particularly associated with violent behaviour, as these drugs raise excitability and muscle tension, which may lead to impulsive behaviour; and
- high dosage users with an aggressive personality are likely to become more aggressive when using the drug.

For example, in a study of 200 families with an alcohol or opiate addicted parent, Black and Mayer (1980) found that physical or sexual abuse had occurred in over one fifth of the families (Alison 2000).

10.2 Appendix 2 – Child fatalities in New South Wales and Victoria

New South Wales

In New South Wales (NSW) between July 1999 and June 2002, 75 child deaths attributed to fatal child abuse were reviewed by the Child Death Review Team. Of these 75 children, the highest number of deaths occurred among children aged 1 to 4 years (46.7%), followed by infants under 1 year (21.3%).

The 68 families in which these 75 deaths occurred were found to be characterised by multiple carer problems, including health and well-being (alcohol and drug abuse, intellectual disability, mental health problems, suicide attempts), violence (abuse or neglect as a child, domestic violence as a victim or as a perpetrator), criminal behaviour (offending as a juvenile or as an adult) and social or economic issues (financial difficulties, accommodation difficulties and stressful events). Stressful events include “change in family composition, death of family member, major illness in family, carer’s loss of job, homelessness, relationship breakdown, and change in residence” (NSW Child Death Review Team 2003:28).

Specific to parental substance misuse, drug or alcohol abuse was present in 41.2% of the 68 families. In addition, the 68 families subject to child death reviews were characterised by the following factors (not an exhaustive list) (NSW Child Death Review Team 2003):

- victim of abuse or neglect as a child (29.4% of families);
- victim of domestic violence (50%);
- perpetrator of domestic violence (54.4%);
- offending as an adult (51.5%);
- financial difficulties (26.5%); and
- stressful events (58.8%).

More than half (54.4%) of the 68 families experienced three or more factors.

Three children aged between 3 and 6 years died as a result of negligent driving associated with parental substance misuse - that is, two children died during a motor vehicle accident in which their mother was driving with a blood alcohol level of 0.153g/100ml. The third child was killed in a motor vehicle accident in which her father was driving while affected by cannabis and amphetamines (NSW Child Death Review Team 2003).

Victoria

In 2004-2005, the Victorian Child Death Review Committee (VCDRC) considered and analysed 18 child death inquiries which related to a proportion of the deaths that occurred in 2002, 2003 and 2004. Again, there was a high infant representation in these child death reviews (13 of 18 cases). Four cases involved infants younger than 6 months of age, 5 were children aged 6 to 12 months and 4 cases involved toddlers aged 13 months to 3 years (VCDRC 2005).

In 14 of the 18 cases reviewed, the VCDRC was able to ascertain information relating to parental characteristics. Again, parental substance misuse featured strongly with 85% of families presenting with “longstanding issues of substance use.” (VCDRC 2005:31) Other parental characteristics identified during the analysis included family violence (50%), transience (50%) and mental illness (42%).

Similar to Victoria, a significant finding was the co-existence of multiple parental characteristics. Eight of the 14 families presented with more than one parental characteristic, “most commonly drug use and mental illness, drug use and family violence or drug use and transience” (VCDRC 2005:31).

10.3 Appendix 3 – Summary of practice tips

3

Practice Tip: Developing your knowledge about the range of symptoms and consequences associated with various substances will assist in identifying and assessing parental substance misuse, particularly in the face of secrecy and denial (common factors among families who experience parental substance misuse).

The physical and emotional/behavioural presentations of parents are **key visual cues** requiring consideration during the investigation and assessment and ongoing intervention phases of departmental intervention.

Provide other key professionals and agencies (who are working with individual families) with relevant and accurate information about the likely symptoms and consequences of particular substances, or assist in facilitating this process.

3.1

Practice Tip: Liaise with an ATODS professional (particularly where the parent is currently engaged with a service) to obtain advice regarding what levels of amphetamine use might constitute 'high dosage' for an individual parent.

Amphetamine use is particularly associated with violent behaviour, as these drugs raise excitability and muscle tension, which may lead to impulsive behaviour. High dosage users with an aggressive personality are likely to become more aggressive when using amphetamines.

Ensure your safety plans, case plans and interventions with children whose parents misuse amphetamines take into account, adequately respond to, and are closely/frequently monitored, given the increased likelihood of violent behaviour.

Practice Tip: When alcohol abuse is determined to be a risk factor, investigate the likelihood of domestic violence, and physical and sexual abuse. When developing case plans to address domestic violence, physical abuse, and/or sexual abuse include support and interventions related to reducing/abstaining from alcohol use.

Alcohol abuse is strongly associated with violence in the home, and some research studies have also shown that alcohol misuse has been linked to physical and sexual abuse (Tomison 1996).

4

Practice Tip: Explore the possible causes and/or effects of parental substance misuse with parents. Assess such issues in light of the harm or risk of harm to the child, and respond in a holistic manner to the needs of parents who misuse substances. Discuss with parents that they may also need to complete other interventions to ensure the protection of the child and improve their parenting skills.

Abstinence, or the reduced/controlled use of substances will not necessarily result in improved or safe parenting **in isolation** from addressing parental factors which potentially impeding safe and responsive parenting. This is because these factors may contribute to, or result from, parental substance misuse.

5

Practice Tip: Developing your knowledge of evidence-based risk factors, and applying this knowledge to assessment and intervention frameworks, will assist departmental officers to:

- identify significant risk factors (including less overt indicators) commonly present in the families of substance misusing parents, particularly as the research shows denial and secrecy by children and parents is commonplace in these families;
- identify sources of information to confirm, or lend credence to, the presence of parental substance misuse in families subject to child protection intervention;
- consider the actual, or likely, impact of such factors on the safety and wellbeing of the child; and
- develop evidence-based, effective case plan outcomes and actions.

During all phases of departmental intervention, explore and where appropriate, respond to (through the provision of necessary intervention services), risk factors associated with parental substance misuse.

6

Practice Tip: Identify the impacts and harms to children as a result of parental substance misuse. Use relevant information to inform the strengths and needs assessment of the child, and ultimately, the development of the child's case plan.

Discuss with children their experiences of growing up in families where parents misuse substances. If children deny the presence of parental substance misuse, discuss the experiences of other children (as per the research findings). Ensure that case plans incorporate interventions to address the likely needs of children.

6.1

Practice Tip: Develop your knowledge of the common experiences and concerns (as informed by the research) of children who grow up in substance misusing families, particularly in light of the likelihood of denial by children.

6.1.1

Practice Tip: Consult with ATODS staff to develop appropriate strategies for assessing substance misusing parents, to ensure the protection and care of infants. Infants are highly vulnerable due to the increased risk associated with the child's age and developmental abilities.

6.1.2

Practice Tip: Consider the likely presence of **multiple** risk factors, potentially resulting in the serious injury or fatality of a child, during all phases of departmental intervention ie. intake, investigation and assessment and ongoing intervention.

When conducting assessments, providing or facilitating interventions, and reviewing case plans, give adequate consideration to cause and effect issues, and ensure that all risk factors are responded to through the selected interventions.

6.1.3

Practice Tip: In collaboration with ATODS staff, identify and implement strategies which aim to prevent, and/or minimise the impact of, FAS in children subject to departmental child protection intervention.

6.1.4

Practice Tip: Seek advice from an appropriate service when assessing and intervening with substance misusing pregnant mothers. Consideration and expert knowledge of the significant risk factors will assist in developing a plan to protect the baby from birth and to support the mother to reduce the negative effects on her unborn child.

In view of the multitude of harms potentially associated with newborn babies and pre-natal exposure to substances, the parenting skills of the parent are **particularly important**. In addition to the baby's withdrawal related behaviours (outlined below), babies may present with special needs which place extra, intensive demands on their parents.

Advice to women using drugs during pregnancy is generally to stabilise their drug use (where possible, with prescribed methadone) or to stop the drug use with obstetric assistance.

6.1.5

Practice Tip: Advise parents about safe storage of drugs, and the risks posed by the exposure of children to illicit drugs. In conducting investigations and assessments and/or discussing such matters with parents, explore the nature of substances kept in the household and how/where each substance and related drug equipment is stored (in order to keep children safe).

Liaise with ATODS professionals, where involved in the delivery of intervention services, to negotiate roles and responsibilities in relation to:

- providing such advice to a parent; and/or
- ensuring the parent's understanding of the particular risks associated with specific substances.

6.1.9

Practice Tip: Ensure that applicable domestic violence services or professionals are informed of any concerns regarding parental substance misuse and that ATODS professionals are informed of concerns regarding domestic and family violence.

Practice Tip: Protect children from involvement in or exposure to criminal activity by parents and ensure children are given adequate support to address any trauma associated with parental involvement in criminal activity.

6.2

Practice Tip: Discuss with parents the effects of their substance misuse on their children. Ask parents to identify how they would like to parent their children and how the substance misuse is impacting on their ability. Link parents in with appropriate intervention/support services to address their own guilt and anxieties about parenting.

Parents also experience a range of impacts as a result of substance misuse however many of these impacts also have follow-on effects for their children. The research indicates that parents often have an awareness of how these impacts effect not only their lives but also the lives of their children, to the extent that some parents feel guilt and sometimes disgust, about the lifestyles they expose their children to.

6.2.4

Practice Tip: The presence of **mental health conditions** in parents who misuse substances is common, and well supported and documented in the literature regarding parental substance misuse. The concurrent existence of mental illness and parental substance misuse, particularly when associated with violence, is also associated with risk of **serious injury** to children (Forrester 2004).

6.3

Practice Tip: The research indicates that parental substance misuse also has a significant impact for extended family members, particularly grandparents who often undertake a caring role for their grandchildren. The research also identifies some of the most common difficulties experienced by extended family members and it is important that departmental officers consider such issues, and respond appropriately, when developing case plans as well as conducting kinship carer assessments.

7

Practice Tip: Protective factors may influence or reduce the likelihood of future harm to children, and therefore need to be considered in any assessment of likelihood and degree of future harm, at all phases of departmental intervention.

In assessing protective factors, departmental officers should differentiate between those which:

- may provide immediate safety for children but do not decrease the overall and ongoing likelihood of future harm (eg. a child residing with a grandparent temporarily); and
- reduce the overall likelihood of future harm for children and therefore influence the departmental decision about intervention (eg. continued presence of another non-substance misusing adult who is able to assist in the daily care of a child).

Certain protective factors can influence the timing and priority of an intervention or provide strengths or safety nets to be targeted as part of the intervention with children and families.