Government of South Australia
Department for Families and Communities

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Dr Helen Jeffreys, Craig Hirte, Nancy Rogers and Ros Wilson

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Introduction

1.1 Background

In recent years there has been a growing awareness of the potential for an individual's substance use to have implications for other family members and particularly for the welfare and development of children. 'Keeping Them Safe' (2004), the South Australian government's child protection reform agenda, noted for example that substance misuse is one of the underlying and interrelated factors that contribute to an environment where children may be harmed. Accordingly, Children's Protection (Keeping them Safe) Amendment Bill 2005 introduced amendments that make it possible to direct parents to undertake court-ordered assessment, treatment and drug screening for substance misuse problems.

Historically, drug and alcohol services and child protection agencies have developed separately and held different orientations that have made co-ordination and joint service collaboration between the two agencies a challenge (Taylor and Knoll 2004). A major practice dilemma to emerge has been the different timescales within which these two agencies operate. Workers in the substance misuse field view substance dependency as a chronic condition, which having taken years to develop, may take years to relinquish. Relapse is common and often viewed as a stage to recovery. Child protection workers, however, are more focused on children's developmental timelines and believe that children cannot be put 'on hold' whilst adults struggle with their drug and alcohol problems and make the changes required to ensure their children's care and protection needs (QLD Department of Child Safety 2007), particularly infants and young children. Increasingly, however, collaborative relationships between substance abuse treatment providers and child protection agencies are considered a critical factor in achieving optimal outcomes for substance using families given both agencies often serve the same families (Choi and Ryan 2007). Although parental substance use does not inevitably lead to neglectful and abusive parenting; drug and alcohol problems nevertheless feature in a substantial proportion of families where there are child protection concerns and involvement.

Data from a recent report released by the Australian National Council on Drugs found that on best estimates, more than 230,000 Australian children are raised by adults who misuse alcohol or drugs. This figure equates to 13% of Australian children, or almost one in eight – a figure that is higher than international estimates of around 10%. According to this study:

- more than 230,00 children live in households where they are at risk of exposure to a least one adult binge drinker
- more than 40,000 children live in a household where an adult smokes cannabis daily, and
- more than 14,000 children live in a household where an adult uses methamphetamines at least once a month (Dawe, Atikinson, Frye, Evans, Best, Lynch, Moss and Harnett 2007)

The New South Wales Department of Community Services (2002:11) reported that up to 80% of investigated child abuse reports were associated with parental substance abuse. Similarly, the Victorian Department of Human Services (2003:35) reported that 65% of children in foster care presented with backgrounds of drug and alcohol misuse and that 62% of parents with a psychiatric problem were also affected by substance misuse. The (then) Department for Community Development in Western Australia (2004) found that up to 50% of child protection cases involved parental substance misuse concerns.

International studies report similar concerns. MacAlpine, Courts and Harper (2001) proposed that parental substance abuse contributes to at least 50% of all child welfare cases with prevalence rates being as high as 90% in some parts of the United States. According to the Hidden Harm Report (2003:13) a recent review of 290 cases of childcare concerns in London found that 34% involved parental substance misuse and that these cases included many of the most severe cases of abuse and neglect. The Child Protection Review in Scotland found that parental drug or alcohol misuse was involved in 40% of cases.

1.2 Literature review

1.2.1 The impact of substance misuse on families

In a field where difficult decisions are made every day, child protection workers face particular dilemmas when working with families who have complex and multiple problems including substance misuse. A growing body of research insists that parental substance misuse has the potential to impact on virtually all aspects of a child's health and development from conception onwards. The range of risk factors commonly cited includes:

- the adverse effect of pre natal exposure to drugs and alcohol on the developing brain
- compromised parenting practices i.e. physically or psychologically unavailable parents
- increased risk of child maltreatment
- disruption to children's primary care
- neglect where household resources are invested in the pursuit and use of drugs
- exposure to activities related to drug use or drug seeking behaviour including violence within the home and other criminal activity
- risk of infectious diseases
- risk of developing early conduct and behavioural problems
- risk of failing at school
- elevated risk for developing substance use problems themselves[1].

1 See for example, Dawe et al 2007, Ryan 2006, Schiling, Mares and El-Bassel 2004, Hidden Harm 2003, Maluccio and Ainsworth 2003, Tunnard 2002

Children growing up in households with a substance abusing parent have been found to demonstrate more adjustment problems, behavioural, conduct and attention-deficit disorders than other children and generally function less well on many measures of behavioural and emotional functioning (Semidei, Radel and Nolan 2001). Clearly, the more severe the drug problems and the longer the child is exposed to them, the more serious the consequences are likely to be (Hidden Harm 2003:41).

Research indicates that parents who misuse substances often struggle with other complex problems such as poor mental health, domestic violence, economic and housing insecurity and criminal activity (Semidei et al 2001, Department of Health and Human Services, US 1999). Such difficulties combine in the lives of families to produce extremely complex situations and relationships that are challenging to resolve. Mental illness and substance misuse issues, for example, are often intertwined and dual diagnoses have become increasingly more prevalent in recent years, particularly amongst women. Teeson et al (2005) found that over one third of females with problem drug use have experienced a major depressive episode in the past year and 45% experienced at least one of several mental health problems including panic attacks and anxiety disorders.

The co-existence of mental health and substance misuse problems also combines to place families at high risk of homelessness (NSW Dept of Community Services, 2005, and DrugInfo Clearinghouse Fact Sheet 2007). Housing problems impact on both child and family outcomes. Children living in families that are unable to secure safe, affordable and stable housing are at increased risk of a variety of negative outcomes including serious injury and involvement with child protection services (Jones 1998 cited in Ryan 2006:3-6)

The relationship between domestic violence and substance abuse has also been well documented. An Australian study by Swift, Copeland and Hall (1996) found that 52% of substance dependent women reported experiencing sexual or physical assault as adults and 59% had been assaulted by their partners. 24% of these women reported being 'out of it' when the assault happened and 59% indicated that their partner was substance affected at the time the assault happened. Alcohol appears to be a significant factor in episodes of family violence. Miller (1998 cited in Dawe et al 2007:51) suggests for example that women who are alcoholics are more likely to have been beaten than non-alcoholics and they are more likely to have partners who also drink heavily. He also found that women in substance abuse treatment programs report much higher rates of partner violence than women in comparative community samples (up to 4 times higher).

The relationship between crime and substance misuse has also been widely recognised and debated. There is contention regarding the direction of the relationship i.e. whether criminal activity precedes substance misuse or vice versa. Nonetheless, substance misuse is a risk factor for involvement with criminal activity and it is

estimated that approximately 50% of offenders are illicit drug users. Similarly, a high proportion of domestic violence, assault, malicious damage and noise complaints are associated with the misuse of alcohol (Dodd and Saggers 2006).

From a child protection perspective, the presence of such inter-related, multiple and complex problems implies that addressing the substance abuse alone is unlikely to produce the changes in a family that are necessary to ensure a healthy family environment for a child. For instance, even if a substance misusing parent is able to achieve abstinence or use harm minimisation strategies, any other issues present, (eg mental illness, domestic violence, homelessness) may continue to pose safety problems for children. Furthermore, substance misusing parents can become so overwhelmed by their personal issues and problems that addressing their substance misuse is often not perceived as a priority - particularly when considered in relation to other issues such as homelessness, violence or poverty. Often a family's basic needs (food, shelter and safety) are so pressing that they must be addressed before a parent has the ability to focus on their addiction. Many parents may even misuse substances to help them manage other life difficulties. Thus, issues related to co-occurring problems constitute a significant barrier to recovery from substance misuse (Ryan 2006).

Much of the literature suggests that unless the whole of a family's situation is addressed, substance abuse treatment is unlikely to be successful. Semidei et al (2001) argue that unless substance misusing parents have been engaged in a treatment program or are otherwise moving into recovery, the child's prognosis for long-term emotional, social and physical well-being is often poor. Unfortunately, very few substance-abusing parents voluntarily seek or complete treatment and many are resistant to change. Treatment is usually sought as a result of considerable pressure from family, friends or the courts (Inciardi 1988). A family crisis, such as the removal of a child, can be the catalyst to seek treatment. However, research has shown that this resolve may be short-lived and unless timely intervention is provided, the opportunity for intervention may be lost (MacAlpine, Marshall and Doran 2000:137).

Research by Gregoire and Schultz (2001) found that legal coercion positively affected treatment retention, with court-ordered clients more likely to complete treatment. Other research by Atkinson and Butler (1996) suggests, however, that families involved with child protection services have low levels of compliance with court-ordered services even though parents who comply with court-ordered assessments and treatment recommendations are more likely to have their children returned from foster care (Rittner, and Dozier Davenport, 2000). Substance misusing parents in the child welfare system therefore require significant outreach and support throughout the treatment process (Ryan 2006).

Gregoire and Schultz (2001) found that women are less likely to seek substance abuse services, and where they do, they have lower retention rates. Although the problems of limited child care are known to limit access to treatment for women (Ryan 2006),

Dawe et al (2007:76) suggests that substance abusing mothers are less likely to engage with drug treatment services due to anxiety that discovery of their substance misuse may result in the removal of their children. Women drug users who are also mothers typically experience marginalisation and discrimination due to their parenting status. For many substance misusing women, the main form of assistance they receive is scrutiny of their parenting practices and the subsequent removal of their children. As Dawe et al (2007:76) has pointed out, even though children clearly need to be protected, for some drug using women children provide a source of stability and self-worth in their otherwise chaotic lives. Research by Kearney, Murphy and Rosenbaum (1994) found that mother's who have experienced the involuntary removal of their children report more grief and stress than those who have retained some control of their children's living situation and that women's drug use may even increase as a means of coping with the grief and loss associated with the removal of their children which then compounds existing feelings of maternal guilt and inadequacy. According to Magor-Blatch (2007:35) substance using women are more likely to suffer from depression and low self esteem, to combine drugs and alcohol, and to begin their addiction through association with an addicted male.

The complex factors associated with parental substance misuse pose major challenges for child protection workers. Clients with co-occurring problems are generally recognised to have difficulty achieving positive child welfare outcomes, and substance using families have been found to make even less progress (Marsh, Ryan, Choi and Testa 2006:1074). Parental substance misuse has been associated with longer stays in foster care, non-compliance with case plans and treatment goals, less frequent parental visitation, and a reduced likelihood of reunification (Smith 2003:336, Ryan 2006). Children of substance misusing parents tend to stay in care longer due to the time required to address substance misuse or the failure of parents to address their substance misuse (McAlpine et al 2001 and Courts Marshall and Harper Doran 2000:147). Budde and Harden (2003) found that only 14% of substance exposed infants who entered care in 1994 were reunified after seven years. Schilling et al (2004) found that poly drug use is associated with loss of guardianship.

Caseworkers have reported that substance-abusing families are among the most difficult and frustrating cases to manage. The unpredictability of parental behavior when under the influence of alcohol or illicit drugs and the high likelihood of relapse makes accurate risk assessment a challenge. Harwin and Forrester's (2002) study found that social workers felt they lacked adequate training and support to work with the many issues presented by substance misusing parents including working with denial and maintaining contact with parents who have chaotic lifestyles. Threats and violent behaviour present their own challenges.

1.2.2 Good practice principles

Among the clear lessons to emerge when working with families who have a substance misuse problem is that there are no simple answers - what works for one family may not necessarily work for another. Flexibility and comprehensiveness are essential and intervention needs to be individually tailored and targeted to address the unique needs of each family (Maluccio and Ainsworth 2003 and Department of Health and Human Services, US 1999). Shifting the focus from the substance abusing parent to the total family context, including significant others, has also been found to be effective (Gregoire and Schultz 2001:447).

The need to engage with substance using individuals in a meaningful way so that they are directly involved in the formulation and development of intervention strategies has also been strongly advocated. It is a well established fact that families are more likely to engage with intervention when the process has been collaborative.

- The family should be involved in assessing their needs and the design of services (Dawe et al 2007)
- Assessing needs holistically and in partnership with families and children is integral to the targeting and delivery of services (Fernandez 2007:1389)
- If intervention does not or cannot help the client to address what he or she defines as the family's most significant problem(s), the client is likely to view the program as irrelevant (Dodd and Saggers 2006).

Parents with a substance misuse problem require intervention at a variety of levels. Ideally, effective interventions attend to the multiple needs of the family and not just the use of drugs (Dawe et al 2007:203). Intervention programs need to be contextualised within the family dynamic and acknowledge and respond to the range of social factors that impact on substance misuse (Dodd and Saggers 2006:38). Effective interventions therefore include a comprehensive assessment of the family's functioning across multiple domains and assume a multi-systemic perspective (Dawe et al 2007:203). For example, service interventions need to be multidimensional and include assistance with concrete needs, home visitation, enhancing parenting skills and support, support with accommodation, crisis temporary care, respite care, counselling, respond to domestic violence and abuse, child day care and mentoring. In sum, all major family problems must be addressed to achieve substance abuse treatment success and child safety.

Strong partnerships and collaboration between service providers is critical. With the increased awareness of the effects of substance misuse on families, and the complexity of other structural and health issues, no single agency can provide all the supports these families need, nor does any agency alone have the knowledge or authority upon which to make informed decisions about the strengths and needs of the family as a unit (Department of Health and Human Services, US 1999). Service responses that take

a more 'holistic' or 'joined up' form are necessary for service providers to:

- meet a broader range of family needs
- ensure families are not overwhelmed with requirements
- ensure services do not impose conflicting demands on families (Dodd and Saggers 2006).

Other practice principles seen as important include:

- readily accessible service provision
- continual assessment, monitoring and modification of service intervention to meet changing needs
- service linkage mechanisms that connect clients to services from different systems including adhoc referrals, case management and co-location of services and the cross-training of child protection and substance abuse treatment workers (Maluccio and Ainsworth 2003, Ryan 2006).

Service intervention needs to be sustained, long-term and supportive in order to achieve and maintain change.

- Many famillies will require long-term intervention characterised by intensive periods of support and intervention (Dawe et al 2007:203-204)
- Outcomes for substance abuse treatment are closely linked to clients' length of stay and treatment completion -typically, the longer the client is in treatment, the better the outcomes. Generally, few positive long term outcomes are seen unless the client is in treatment for at least three months (Hubbard et al, 1989, Ryan 2006).

Finally, intervention needs to maintain a strong focus on the health and wellbeing of the child and address the needs of the child within their family context (Dawe et al 2007:202-204).

1.3 The current study

1.3.1 Purpose and research questions

This study was designed to explore a number of key issues relating to problematic parental substance use and the impact on children as well as the child protection and alternative care system. Specifically, the study seeks to answer the following key questions:

- How many children are entering alternative care in South Australia as a result of parental substance misuse?
- What types of substance misuse are associated with children's entry into care?
- Are families receiving targeted interventions that address parental substance misuse and any co-occurring issues and problems?
- What interventions and services are required to reduce risks for children of substance misusing parents?

It is anticipated that the results of the study will:

- identify the numbers of children entering care in South Australia where parental substance misuse is an associated factor
- inform policy and planning relevant to the creation of supportive environments for children of substance misusing parents
- assist practitioners in reducing risk and building and strengthening protective factors within families affected by substance misuse.

1.3.2 Methodology and sampling

In South Australia a total of 467 children entered the alternative care system for the first time between 1 January 2006 and 31 December 2006. An analysis of Families SA 'Client Information System' data was undertaken to ascertain whether parental substance misuse was identified as a factor associated with entry into care. For the purpose of this study, parental substance misuse was considered to be associated with the child's entry into care when:

- the child protection intake preceding the child's entry into care was raised in response to an incident of drug related harm e.g. parent experiencing drug induced psychosis, incident of domestic violence whilst substance affected
- the child protection intake preceding the child's entry into care referred to arrests for possession of substances and/or police reported drug paraphernalia found at the residence, and where
- infants were born substance-exposed and/or dependent.

Further data was then collected from the Families SA 'Client Information System' and case file readings were undertaken for a random sample of children (n=50) where parental substance misuse had been identified as a known factor associated with the child's entry into alternative care. Information in relation to the following areas was collected:

- socio-demographic details
- other family factors contributing to the child's entry into care
- child's current living arrangements
- child's special needs, health and wellbeing
- case planning and decision making
- family and child interventions and service history.

The major objective of the data collection process was to capture the impact of parental substance misuse on children's lives and the interactions between substance using parents and service providers. The intent was to elicit descriptions of practice and service interactions and identify child wellbeing and safety outcomes. Hence, the case file analyses undertook to profile the family's baseline areas of identified need,

problems and child safety concerns as identified and documented through the child protection notification, investigation and assessment processes regarding the child's entry into the care system. These identified areas of need were then compared against further case documentation (ie case plans and notes, court applications and specialist reports) to assess what interventions had been recommended and implemented, and what post intervention change had occurred for these families. Specifically, case file readings examined case planning decisions, service intervention reports, comments and observations, and placement outcomes for children. In cases where case file readings were unclear, caseworkers were also briefly interviewed to ascertain case planning intent and interventions implemented.

Finally, the study included a comparative sample of 50 children for whom parental substance misuse was not identified or seemingly present at the time of the child's entry into care. The children in the comparative sample were also randomly selected from the total of 467 children who had first entered care during the year 1 January 2006 to 31 December 2006.

Few studies directly compare child protection clients with substance misuse problems to other clients in the child protection system. It was anticipated that there would be significant differences between families with substance misuse problems and other families who have child protection involvement, specifically, that families with substance misuse problems will be significantly more troubled; with more complex issues than other families in the child protection system.

The demographic characteristics of the two sample groups are provided in Table 1. Although two samples were drawn (50 where parental substance abuse was an issue; 50 where it was not identified), file analysis revealed parental substance abuse in half of the comparative sample (discussed in Section 2.1.1 below). These children were then reallocated to the first sample. Overall in the samples:

- there was a fairly equal representation of male and females
- 37% of children were Aboriginal and/or Torres Strait Islanders
- the median age at entry into care was 4 years with a range of 0 to 15 years
- almost a quarter of children were less than 12 months of age
- 58% of cases were from metropolitan Adelaide.

Table 1: Demographic characteristics of children in sample groups

Demographic characteristics of children (N=99)	No substance use identified N=24	Parental substance use identified N=75	Total N=99
Gender:			
Female	8 (33%)	39 (52%)	47 (47%)
Male	16 (67%)	36 (48%)	52 (53%)
Age Group:			
<12 months	4 (17%)	19 (25%)	23 (23%)
1-4 years	6 (25%)	22 (29%)	28 (28%)
5-8 years	6 (25%)	13 (17%)	19 (19%)
9-12 years	4 (17%)	13 (17%)	17 (17%)
13-15 years	4 (17%)	8 (11%)	12 (12%)
Ethnicity:			
Aboriginal	0 (0%)	37 (49%)	37 (37%)
Non Aboriginal	24 (100%)	38 (51%)	62 (63%)
Area:			
Metropolitan	14 (58%)	43 (57%)	57 (58%)
Regional	10 (42%)	32 (43%)	42 (42%)

The characteristics of the random samples were generally representative of all children entering care (n=467) in 2006, although Aboriginal children were over represented. Comparisons of categorical demographic variables using Chi-Squared tests showed that the percentage of children who identified as Aboriginal was significantly higher in the sample group where parental substance misuse had been identified compared to the comparison group ($p<.001$)[2]. There were however, no other significant differences between the two sample groups in terms of gender ($p=.111$), age group ($p=.771$), age at entry into care ($p=.254$) and area ($p=.931$).

1.3.3 Research limitations

This has been a small study with the findings based on information available in case files, predominantly worker's written assessments regarding child and family circumstances. Data collected in all fields - including substance misuse, family problems and harm to children – is therefore likely to be incomplete and under-reported: actual rates are likely to be higher. In-depth analysis was based on a relatively small randomly selected sample (75 cases). Further, although the study enabled some comparisons

2 Given that the percentage of Aboriginal children was significantly higher in the parental substance misusing sample, when comparing other outcomes between the two sample groups the influence of cultural background will be controlled for.

between families in which substance misuse was present vs. those where it was not, a larger scale study and larger comparison group is required for greater confidence in results.

2 Findings

2.1 Parental substance abuse – extent and patterns

This section summarises results relating to the extent, nature and patterns of parental substance abuse identified in the study.

2.1.1 How many children enter care as a result of parental substance misuse?

Our initial analysis of Families SA's 'Client Information System' regarding all first entries into care for the year 2006 found that parental substance misuse was a known and significant factor associated with children's entry into care in 40% of cases (Table 2).

Table 2: Identified substance misuse associated with children's first entry into care 2006

Any identified substance misuse?	N (%)
No	278 (60%)
Yes	189 (40%)
Total	**467 (100%)**

Two random samples of 50 children were then drawn for further case file analysis:

- a sample of 50 children from the 189 cases where parental substance misuse had been identified as a known factor in entry into care, and
- a comparison sample of 50 children from the 278 cases where parental substance misuse had not been identified[1] .

The purpose of the case file analysis was twofold. Firstly, to collect data so that comparisons between substance misusing families and other families who have contact with the alternative care system could be undertaken. Secondly, to identify those cases where parental substance misuse had not been apparent at the time the child entered care, yet became evident when child protection workers further investigated family circumstances.

The case file analysis soon exposed the hidden extent of parental substance misuse and its association with entry into care, with parental substance misuse present in half of all the cases in the comparison sample (n=25). Given this finding, we estimate that parental substance misuse is associated with children's entry into care in South Australia in approximately 70% of all cases.[2]

This finding is significant as it demonstrates the pervasiveness of substance misuse amongst families when children enter care. At the same time, however, this result

1 One case was later excluded from the sample because the child was found to have first entered care prior to 2006.

2 Given that parental substance misuse was present in half of the cases in the comparison sample, we have estimated that it may also be present in half of the cases from the total population of children where substance misuse had not been immediately identifiable (eg in another 142 cases). Hence, (142+189)/467 x 100 = 70.8%). The 95% confidence interval (CI) of the 70% estimate is (63.3%-78.4%).

undermined the ability of the study to compare families with substance misuse problems to other families whose children enter care. Specifically, our comparison sample was effectively halved.

Consideration was given to further sampling so that rigorous comparative analysis could still be undertaken. However, there was a risk this task may turn into somewhat of a 'fishing expedition' (i.e. we would expect to have to sample at least another 50 cases to identify another 25 cases where parental substance misuse was not present) and time and resource constraints did not make this possible.

Consequently, whilst acknowledging that our capacity to analyse and compare families with a substance misuse problem to other families whose children enter alternative care system has been weakened, our analysis was thus based on a sample of 75 children where parental substance misuse was a factor associated with the child's entry into care, and a sample of 24 children where no parental substance use was identified.

2.1.2 Patterns of substance misuse

Table 3 summarises data describing the relationship of the child to the adult identified as using substances within the household. This was most commonly the mother. This profile roughly reflects the parenting status of children at the point of entry into care, with (33%) parented by a single mother.

Table 3: Substance using adult(s) in household

Substance using adult	Total N=75
Mother only	29 (39%)
Both parents	22 (29%)
Mother and partner	10 (13%)
Father only	8 (11%)
Relative	3 (4%)
Partner only	3 (4%)
Total	**75 (100%)**

As Table 4 shows, the three most common substances being used were alcohol (77%), cannabis (53%) and amphetamines (50%). These results are consistent with the other data relating to patterns of substance use across Australia:

"When all drugs of concern are considered…alcohol and cannabis remained the two most commonly reported drugs of concern in 2005-06… Amphetamines were the third most common reported drug of concern, …"(AIHW 2007:x)

These patterns correspond with the social acceptability, accessibility and cost associated with particular substances – eg alcohol is widely accessible and acceptable in Australian society and relatively cheap.

Table 4: Type of substances used by parents*

Type of substance used	Frequency	Percentage of families
Alcohol	58	77.3%
Cannabis	40	53.3%
Amphetamines	38	50.7%
Heroin	9	12.0%
Prescription	8	10.7%
Intravenous	3	4.0%
Methadone	2	2.7%
Ecstasy	1	1.3%
Inhalents	1	1.3%

* N=75

Further analysis indicated that Aboriginal families were significantly more likely to misuse alcohol, whereas the use of amphetamines tended to be higher in non-Aboriginal families.

Data were collected in relation to the frequency of parental substance misuse (where known and recorded) (Table 5). This information was not always clearly identifiable from case notes, particularly where parents were poly-substance users. Generally, substance abuse labels were loosely applied and case notes lacked detail regarding frequency of use and the nature of administration. For the purposes of analysis, patterns of substance usage were categorised in regards to the substance used most frequently by a parent and defined as followed:

- unknown (not recorded or identified)
- irregular = monthly or less frequent
- at least weekly
- daily = use on all or most days of the week

Table 5: Frequency of substance misuse by alcohol, amphetamine and cannabis use*

Frequency of substance misuse	Used Alcohol (n=58)	Used Amphetamines (n=38)	Used Cannabis (n=40)
Daily	27.6%	47.4%	37.5%
At least weekly	46.6%	31.6%	40.0%
Irregular	10.3%	10.5%	10.0%
Unknown	15.5%	10.5%	12.5%
Total	**100.0%**	**100.0%**	**100.0%**

* Frequency of the misuse of an individual drug may not be known due to multiple drug usage.

This data should be treated with caution given the high rate of combined or poly-substance misuse and the limited details in case files. For example, 47% of the 38 families that used amphetamines used a substance daily but we cannot be certain that they used amphetamines daily. We do know, however, that poly substance use is increasingly becoming the norm for illicit drug users in Australia and taking different substances in combination tends to increase the unpredictability of their effects on the user (Gruenert, Ratnam and Tsantefski 2004).

It should also be noted that daily usage of any substance suggests heavy usage and dependency. It may also indicate that life for the user and their children has become chaotic and unpredictable – centring around obtaining drugs, intoxication and withdrawal.

2.1.3 Do substance abusing families have a more complex profile?

On the basis of previous research (Dawe et al 2007, Hidden Harm 2003, and Semidei et al 2001), it was anticipated that there would be significant differences between the two sample groups (those where substance misuse was a factor vs those where it was not) in terms of the complexity of the issues experienced by families, children's experiences of abuse and neglect, and outcomes for children.

Children in the two sample groups entered care due to a range of connected problems and interplay of issues (Table 6). Analysis indicated, however, that families where substance abuse was a factor tended to have more and more complex, problems. For example:

- the likelihood of families experiencing domestic violence, homelessness, financial difficulties, parental incarceration, transience and criminal activity was significantly higher where parental substance misuse was present
- the likelihood of families experiencing housing instability and where the parent had been abused as a child tended be higher where parental substance misuse was a factor (although these differences did not reach statistical significance)
- by contrast, the likelihood of a child's entry into care being associated with child behaviours, parent / child conflict and parent ex-Guardianship of the Minister was significantly higher where no parental substance misuse was identified.

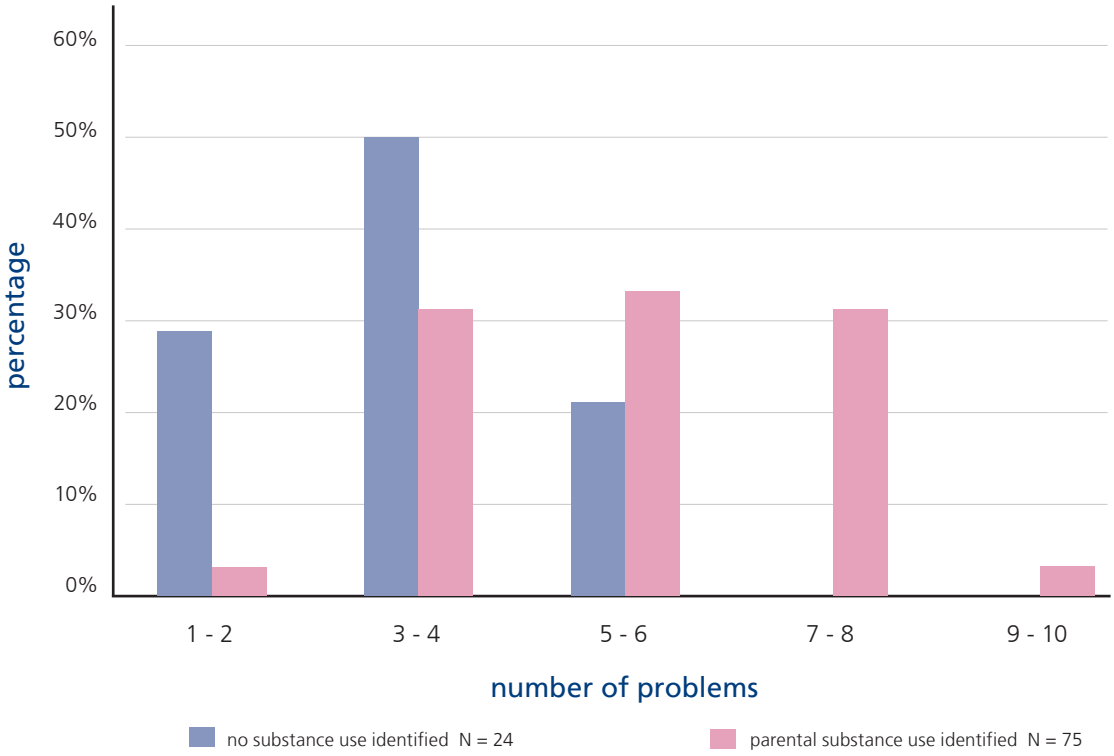
Table 6: Family factors associated with children's entry into care

Family factors associated with children's entry into care	No substance use identified N=24	Parental substance use identified N=75	Total children N=99	p-value*
Parental mental health	13 (54.2%)	49 (65.3%)	62 (62.6%)	.325
Domestic Violence	4 (16.7%)	52 (69.3%)	56 (56.6%)	<.001
Homelessness	2 (8.3%)	21 (28%)	23 (23.2%)	.047
Financial difficulties	0 (0%)	22 (29.3%)	22 (22.2%)	.003
Parental incarceration	1 (4.2%)	19 (25.3%)	20 (20.2%)	.025
Housing Instability	2 (8.3%)	18 (24%)	20 (20.2%)	.096
Transience	0 (0%)	17 (22.7%)	17 (17%)	.010
Criminal Activity	0 (0%)	15 (20%)	15 (15.2%)	.017
Abandonment	1 (4.2%)	13 (17.3%)	14 (14.1%)	.107
Social Isolation	5 (20.8%)	9 (12%)	14 (14.1%)	.280
Parent abused as a child	0 (0%)	13 (13.3%)	13 (10.1%)	.059
Family breakdown	3 (12.5%)	10 (13.3%)	13 (13.1%)	.916
Parental intellectual disability	6 (25%)	2 (2.7%)	8 (8.1%)	<.001
Child behaviours	4 (16.7%)	3 (4%)	7 (7.1%)	.035
Parent/child conflict	4 (16.7%)	3 (4%)	7 (7.1%)	.035
Parent hospitalisation	3 (12.5%)	3 (4%)	6 (6.1%)	.151†
Other jurisdiction CP involvement	1 (4.2%)	3 (4%)	4 (4%)	1.00†
Parent ex-GOM	3 (12.5%)	1 (1.3%)	4 (4%)	.043†
Young parents	2 (8.3%)	2 (2.7%)	4 (4%)	.247†
Parental Death	0 (0%)	3 (4%)	3 (3%)	.320
Adolescent at risk	1 (4.2%)	1 (1.3%)	2 (2%)	.428†
New arrivals	1 (4.2%)	1 (1.3%)	2 (2%)	.428†
Support to relative carers	1 (4.2%)	1 (1.3%)	2 (2%)	.428†
Unaccompanied minor, refugee program	2 (8%)	0 (0%)	2 (2%)	1.00†
Child disability	1 (4.2%)	1 (1.3%)	2 (1%)	.428†
Child mental health	0 (0%)	1 (1.3%)	1 (1%)	1.00†
Child intellectual disability	0 (0%)	1 (1%)	1 (1%)	1.00†
Previous CP history (SA)	1 (4.2%)	0 (0%)	1 (1%)	.242†
Recovery Order	1 (4.2%)	0 (0%)	1 (1%)	.242*

* Chi-Squared test used to compare between no substance and substance misusing groups

† Fishers exact test used as assumption of minimum number for expected count in cells for Chi-squared test was not met

Figure 1: Number of problems experienced by families



Families with substance misuse issues also tended to have more total problems (Figure 1): a median of 5 (range 2 to 10), significantly higher than the comparison group median of 3 (range 1 to 5) problems ($p<.001$, Mann-Whitney test).

Figure 1: Number of problems experienced by families

Where substance abuse was present, children were exposed to a dangerous configuration of factors:

- domestic violence was present in 69% of families
- mental health problems were present for 65%
- 29% were experiencing financial difficulties
- 28% were homeless, with a further 24% experiencing housing instability
- 25% had been incarcerated
- 20% were involved in drug dealing or other criminal activity, and
- 13% reported being abused as a child.

The picture that emerges is one of poverty, violence, unpredictability and high risk.

The clustering of such adverse conditions does not bode well for positive child welfare outcomes and suggests a high risk of harm.

The risk profile for children in the comparison sample did not reflect the same concentration or clustering of difficulties. For example:

- only 16% experienced domestic violence
- only 8% were homeless with a further 8% experiencing housing problems
- no families were identified as having financial difficulties
- none had been incarcerated.

Case Study 1

A woman has just given birth. She tells hospital staff she doesn't want to see the baby and has made an agreement with the father that 'he can have it'. Failing that, she wishes it to be placed for adoption. When Families SA workers speak to her she says the father is currently in prison for drug possession, assault and larceny; and that she left him when she was six months pregnant because he was paranoid and they were constantly on the run due to drug debts. Workers make contact with the father who is excited to hear about the child and says he wants to care for it. He believes this will give him the fresh start he needs and a reason to live. Families SA find he has a lengthy history of drug dependency, treatment and relapse, as well as criminal activity and imprisonment. He has been detained under the Mental Health Act several times and will be homeless when released from prison. However, he has apparently withdrawn from substances and re-established connections with his parents since being incarcerated.

Associations were also explored between the type of substance used and other factors associated with entry into care. Given the low numbers for some categories, only family factors experienced by 5 or more children were included. Results indicated that:

- Amphetamine misuse was significantly higher in families where parents experienced poor mental health, were homeless, engaged in criminal activity or were abused as a child
- Cannabis misuse was significantly associated with poor parental mental health, homelessness or housing instability, financial difficulties, and tended to be higher in families where the parent had been abused as child.

Use of illicit substances thus emerged as associated with particular circumstances likely to result in harm to children.

The data was also explored with regard to the known frequency of substance abuse; abuse type and other family problems. No significant associations were

identified between the frequency of substance misuse and the likelihood of any form of abuse. However, daily or at least weekly parental substance misuse was found to be significantly associated with family homelessness and financial difficulties. Homelessness was a factor for:

- 42% of families with daily substance use
- 26% with at least weekly substance use
- 0% with irregular substance use.

Similarly, financial difficulties were a factor for:

- 42% with daily substance use
- 36% with at least weekly substance use
- 0% with irregular substance use.

These results indicate a strong link between the frequency of substance misuse and the experience of homelessness and financial difficulties.

2.2 Children's experience of abuse and harm

2.2.1 Nature of the abuse and relationship to substance misuse

A consistent message from a number of studies is that children of substance misusing parents are at increased risk of emotional abuse and neglect, but not necessarily other forms of abuse (Tunnard 2002:20). Similarly, the Canadian Incidence Study of Reported Child Abuse and Neglect (Trocme et al 2001) found that carer substance misuse was associated with elevated levels of emotional abuse and neglect. Case file analysis was therefore undertaken to examine the types of abuse associated with entry into care and to examine whether there were any differences in terms of the form of abuse experienced by children of substance misusing parents compared to other children entering care (Table 7).

Results indicated that where substance abuse was a factor, children were significantly more likely to experience emotional abuse (33% vs 8%). By contrast, other children tended to be more likely to enter care for reasons associated with sexual abuse (21% vs 8%) or where no abuse was recorded (25% vs 5%).

There was no significant difference between the two samples in terms of the prevalence of neglect, physical abuse, high risk infants or at-risk adolescents.

Table 7: Type of abuse experienced by children

Abuse type	No substance use identified n=24	Substance use identified n=75	Total Children n=99	p-value*
Neglect	10 (41.7%)	39 (52.0%)	49 (49.5%)	.378
Emotional	2 (8.3%)	25 (33.3%)	27 (27.3%)	.017
Physical	3 (12.5%)	20 (26.7%)	23 (23.2%)	.153
Sexual	5 (20.8%)	6 (8.0%)	11 (11.1%)	.082
High risk infant	4 (16.7%)	14 (18.7%)	18 (18.2%)	.825
Adolescent at risk	3 (12.5%)	3 (4.0%)	6 (6.1%)	.129
No abuse recorded	6 (25.0%)	4 (5.3%)	10 (10.1%)	.005

* Chi-Squared test used to compare between the two sample groups

It should be noted that neglect was the most frequently recorded abuse type for children in both sample groups. Results were therefore consistent with other research findings, namely that children of substance misusing parents are at elevated risk of emotional abuse and neglect.

The qualitative data gained through the case file analysis pointed to the need to distinguish between 'intermittent' vs 'chronic' neglect. Intermittent neglect refers to the capacity of parents to provide adequate care in general, with capacity punctuated by episodes of substance misuse, which undermine the quality of care provided and potentially leads to risky situations for children. In contrast, chronic neglect refers to levels of care that are consistently low, where parents fail to meet basic material needs thus exposing children to cumulative risk (Knoll and Taylor 2003:42). The case file analysis suggested that where parental substance misuse was a significant factor in entry into care, children were more likely to experience chronic neglect - generally because these families were more likely to present with a clustering of adverse conditions (domestic violence, homelessness, poor mental health, financial difficulties, parental incarceration, transience and criminal activity).

The case file analysis also suggested that within the context of parental substance misuse, distinguishing between these two forms of neglect may provide some indication as to the chronicity and severity of the substance misuse problem. That is, one would assume that the more severe the problem the more chronic the neglect.

It is sometimes assumed that children must have experienced abuse prior to entry into care. An interesting finding therefore was that 10% of children entered care with no abuse recorded. The likelihood of children having no recorded abuse was significantly higher in the comparison sample. In these cases alternative care was provided:

- to give families 'time out' and a 'cooling off' period where parent/adolescent conflict was an issue
- to support relatives in their care of family children
- to support socially isolated parents requiring emergency surgery and/or hospitalisation due to poor mental health status.

In other words, for a quarter of the children in the comparison sample, placements were provided to assist, support and strengthen families at times of crisis rather than simply protect children from harm.

Analysis was also undertaken to explore any relationship between the form of substance used and the nature of the abuse experienced. The only significant result found was a significant association between alcohol misuse and emotional abuse (after controlling for the impacts of gender and cultural background (Odds Ratio (95% CI) 5.4 (1.1 to 27.3), p=.044). Results thus indicate a strong link between the emotional abuse of children and parental misuse of alcohol.

2.2.2 Harm to children

This section explores available data relating to the harm experienced by children as a consequence of parental substance misuse.

File analysis compared the types of harm identified between the two sample groups (Table 8). Statistical analysis found significant associations between substance misuse and several forms of harm. Thus, when parents misused substances, children were significantly more likely to experience material deprivation and neglect, instability and disruptions to living arrangements, exposure to drugs, drug dealing and criminal behaviour and have poor school attendance (Table 10). They were also more likely to be exposed to domestic violence and to a greater number or combination of harms.

Table 8: % of children with recorded harm

Harm to children	% of children harmed in no substance misuse group (n=24)	% of children with harm in substance misusing group (n=75)
Exposure to domestic violence	25%	52%
Material deprivation and neglect	12.5%	57.3%
Instability and disruptions to living arrangements	4.2%	54.6%
Exposure to drugs, drug dealing and criminal behaviour	0%	32%
Poor school attendance	0.0%	17.3%
Exposure and/or encouraged to engage in adult sex	12.5%	10.7%
None indicated	33.3%	12.0%

Descriptive data collected from the case files painted a grim picture of trauma and loss.

- Exposure to domestic violence:

  Over half of the children were exposed to severe violence between substance-affected parents, and some were physically injured through their efforts to intervene and stop the violence. Children were witness to (most often) their mother being beaten or choked and threatened with death, to police intervention and to parents being arrested and incarcerated due to, at times, mutual assault and/or malicious damage of property.

- Material deprivation and neglect:

  Many children were reported to have sub-optimal diets and hygiene issues (filthy, inappropriate clothing, smelling of urine, malodorous). Medical and dental needs often went unmet (untreated impetigo, perforated ear drum, head lice, rotting teeth). Routine health monitoring, particularly antenatal care, early childhood development checks and immunisations were low. Many children had not had their births registered.

  Some children were reported to be living in squalor - dilapidated caravans (no windows in winter) or 'squats'. Others were reported to have slept on the streets, in cars and on riverbeds.

  Children were also reported to be 'parentified' taking on inappropriate responsibility for parents and siblings. For some children, this included the need to beg or steal to provide food, missing school due to having to care for younger siblings and being left home alone and/or unsupervised for long periods of time.

- Instability and disruptions to living arrangements:

  Over half of the children experienced inconsistent care and disruption to their living arrangements. Relatives - usually grandparents - would often take on the full-time caring responsibility for children. Some children were reported to have been 'abducted' from their grandparents, or unlawfully removed from their placements by intoxicated parents (exposing children to further risk, including parents driving under the influence). At other times, children experienced disruptions in family care due to parental incarceration, or more positively, parental attendance at intensive treatment programs for their substance misuse. Substance misusing parents were often reported to be emotionally unavailable, jeopardising needs for secure attachment and consistency of care. Children were further affected by social instability and the severing of family ties and relationships. Transience, homelessness and housing instability brought frequent moves that prevented children from forming constructive social relationships and exposed them to people and experiences that were unsafe.

- Exposure to and/or encouragement to engage in adult sex

  One tenth of children were exposed to sexually explicit material and/or placed at risk of sexual abuse particularly when their parents were homeless or transient and families stayed at known sex offenders homes or when parents left children in the care of known sex offenders whist drug seeking or drug taking.

- Exposure to drugs, drug dealing and criminal behaviour

  A small proportion (6%) of children were known to have been exposed to maternal substance misuse during pregnancy – heavy maternal alcohol consumption, cannabis and intravenous drug use. Approximately a third were exposed to 'all night parties', to drug paraphernalia (needles and bongs), adults smoking tobacco and cannabis inside the house and strangers coming into the home (particularly when parents were dealing in drugs). Some children were encouraged to engage in substance use and/or breaking and entering to help support their parents' drug habit.

- Poor school attendance

  For approximately a fifth of children, irregular school attendance or late arrival was common. Older children were sometimes required to stay home to look after younger siblings and other children missed school or their performance was affected by anxiety about parents or younger siblings.

The association between the types of harm experienced by children with the type of substance used (alcohol, amphetamines or cannabis) was also explored. This identified that:

- children whose parents misused alcohol were significantly more likely to be exposed to domestic violence
- children whose parents misused amphetamines were significantly more likely to be exposed to drugs, drug dealing and criminal behaviour.

These findings are both consistent with previous research. Parents using illicit drugs typically spend more time and money in procurement and are more likely to engage in illegal activity. Numerous studies have suggested an increased risk of violence in families where alcohol misuse is a problem (Taylor and Knoll 2004 and Tunnard 2002).

2.3 Outcomes for children

2.3.1 Reunification outcomes

Results have already indicated that children entering care from situations of substance misuse are more likely to have been abused and also to come from families with more complex, entrenched and multiple issues which pose serious threats to safe care and development. This section examines outcomes for children in terms of reunification.

Previous research has found parental substance misuse to be associated with longer stays in foster care and a reduced likelihood of reunification (Smith 2003:336 and Ryan 2006). Hence, data was collected in relation to children's current placement status as well as the current case plan intent for children still in care (Table 9)[3].

Overall, 52% of children had already been reunified with their birth family, suggesting that many children who enter care do so only briefly. Statistical analysis showed, however, significant differences in terms of reunification outcomes between the two groups. Thus, children who came from families where substance misuse was a factor tended to be less likely to have been reunified (51% vs 58%), and were significantly more likely to still have their care outcomes (reunified or long term Order) unresolved (27% to 4%). These results suggest a lower likelihood of reunification where substance misuse is a factor, as well as longer and more difficult processes of decision making.

Table 9: Current case plan intent

Current case plan intent	No substance use identified N=24	Parental substance use identified N=75	Total N=99
No further Orders – reunified with family	14 (58.3%)	38 (50.7%)	52 (52.5%)
Long-term Order – G/ship to 18 years	9 (37.5%)	17 (22.7%)	26 (26.3%)
Short term Order – possible reunification	1 (4.2%)	20 (26.6%)	21 (21.2%)
Total	**24 (100%)**	**75 (100%)**	**99 (100%)**

Further, reunification outcomes appeared to be associated with the frequency of substance misuse: those children from families with high frequencies of misuse were more likely to be still in care, with final decisions pending.

2.3.2 Assessment

Case file analysis suggested a number of key factors influencing decision-making processes and reunification outcomes. Firstly and simply, placement outcomes varied according to whether children entered care due to a temporary crisis within the family or due to more serious and persistent problems. As noted earlier, where parental substance misuse was present, the profile of risk for children was generally very high with substance misuse one factor in a whole constellation of adversity and

3 Note that data collection occurred during September to December of 2007 and that children had entered care during 2006. Whilst the time spent in care was not recorded, theoretically, children could have been in care for a minimum of 9 months (had they entered in December 2006) and a maximum of 24 months (had they entered care in January 2006).

risk. Decision-making for children was therefore very much informed by caseworker assessments regarding parenting capacity and/or ability to create and maintain changes in their lives.

In some cases, assessments regarding capacity for change included consideration of prior history of child safety issues. The children where parental substance use was an issue were significantly more likely to have siblings already in care – indicating serious and persistent parenting problems and extensive child protection involvement. Children with other siblings in care were significantly more likely to come from families that experienced domestic violence, financial difficulties, parental incarnation, transience, social isolation and where the parent had been abused as child. These families also had a greater number of problems. Siblings already in care was an extremely strong indicator of reunification outcomes: only 26% of children from households with a substance misusing parent and siblings already in care were reunified, compared to 78% without siblings in care.

Further analysis showed that the likelihood of siblings in care tended to increase with the frequency of parental substance misuse. The correlations between known risk factors, numbers of risk factors, siblings in care and frequency of substance misuse again suggested more chronic and persistent parenting problems and more chaotic and unpredictable environments of risk for children.

2.4 Interventions

Case file analyses were undertaken to assess the nature of intervention provided to families, notably whether they received targeted interventions that addressed both parental substance misuse and any other co-occurring issues and problems. According to Dawe and colleagues (2007:203) parents with a substance misuse problem require intervention at a variety of levels which ideally attend to the multiple needs of the family and not just the use of drugs. The limitations of this section need to be noted, ie the information is based upon documentation available in children's files regarding follow up of referrals and quality and effectiveness of service provision.

2.4.1 What was the service response to families?

Case file readings indicated that Families SA's service response to families varied and was influenced by whether children entered care due to a temporary crisis within the family or because of more serious and persistent parenting problems. Generally, where Families SA had more intensive involvement with families, case file readings suggested the use of two distinct approaches: a 'risk management approach' or a 'therapeutic approach' (Australian Institute of Family Studies and Australian Institute of Health and Welfare 2007), briefly summarised below.

Approaches to child protection (AIFS and AIHW 2007)

Risk Management Approach	Therapeutic Approach
Focus on risks	Focus on needs
Focus on symptoms (child abuse and neglect)	Focus on causes (holistic approach to family)
Short term	Long term
Deficit focus	Strengths focus
Adversarial	Empowerment/supportive
Crisis response (tertiary)	Preventative (secondary)
Documentation	Engagement
Case management	Case work

The 'risk management' approach describes practice that focuses on protecting children from further risk or harm, rather than helping parents address their substance use or other family issues. It is characterized by the use of statutory authority rather than partnership. Generally the file readings suggested that 'risk management' was not used indiscriminately but in circumstances where it was assessed that parents would not benefit from intervention and risk to children was high. For example:

- Families SA had previous involvement with the family and despite attempts to work in partnership repeated abuse had occurred and siblings were already in care
- parents refused or were court-directed to intervention but did not follow up with services
- parents denied the perpetration of abuse or minimised the child protection concerns
- parents were aggressive and hostile towards workers
- parents seemed apathetic regarding the return of their children and there were difficulties maintaining contact
- parents did not have the capacity to achieve change (eg parental intellectual disability).

In the above situations, children remained in care and the onus was usually placed on parents to demonstrate their capacity and readiness for change. The focus and energy of casework was upon the needs of the child in care and there was little evidence of active engagement with parents in a problem solving process.

Case Study 2

A mother of two young children is admitted to hospital experiencing drug induced psychosis and possible head injuries. Her partner has been incarcerated having beaten her severely in front of the children. They have an 'on-again off-again' relationship characterised by mutual violence. Both are heavy drinkers and use amphetamines regularly. The family are homeless and have been staying with drug-using associates or sleeping in their car. The mother doesn't have any family in South Australia and doesn't know the whereabouts of the children's father. The mother can't understand Families SA's concerns over the children and blames her partner for their placement in care. She discharges herself from hospital and Families SA lose contact with her. The children are placed with the maternal grandparents who live interstate. After three months, the mother phones Families SA demanding to see her children. The worker negotiates for the mother to come into the office to discuss the circumstances and possible contact with the children. The mother arrives late and heavily intoxicated. She becomes aggressive and is removed from the office by security. Families SA again lose contact with her but the maternal grandparents report that the mother is back with her partner and they are expecting a baby.

On the other hand, where the therapeutic approach was evident, engagement between workers and parents was clear. Purposeful case planning and mutual goal setting often harnessed the support of extended family members and involved inter-agency collaboration and service partnerships. Communication between caseworkers and parents was open, honest and frequent, with parents 'dropping in' to the office to share their progress or actively seeking advice and assistance at times of crisis. For some parents, the removal of their children acted as a catalyst for change. Short-term placements and financial support enabled parents to attend detoxification and rehabilitative programs. For others, the placement of children in care provided parents with the space to 'get their act together' and caseworkers provided support, information, advocacy, referrals and linkages which helped parents make and sustain positive changes.

Case Study 3

Families SA receive a notification regarding the neglect of four children. When workers investigate, they observe 'track marks' on the mother's arm. She admits to amphetamine misuse and says that she wants to get off drugs but can't. She says she is depressed, can't cope and the family are being evicted from their home due to rent arrears. Workers provide her with information and options for assistance. Together they organise for her to attend detoxification and rehabilitation treatment that incorporates a parenting program. Families SA pay for the treatment and the children are placed in short-term care with the mother's consent. While the mother is in treatment, Families SA ensure she has ongoing communication with her children and advocate around her housing issues. Following the completion of the program, the mother engages with a drug and alcohol counsellor and agrees to random drug testing. The children are returned home and Families SA organise for a family support worker to work intensively with the mother to assist with parenting difficulties, budgeting, nutrition and cooking. After six months of consistently clean drug screens, Families SA assess they no longer require these. However, the mother says they are useful in keeping her drug-free so random screens are continued. The mother and children attend therapy at CAMHS and work on addressing the parentified behaviours of the oldest child and the mother's tendency to over-indulge the children as a compensation for her past behaviour. She joins a local playgroup and enrols in TAFE. The two youngest children are enrolled in family day care. Families SA close the case after twelve months.

2.4.2 Service referrals and linkage for families

Generally, families in the study were referred by Families SA workers to a wide range of services and agencies, which would suggest multidimensional interventions aimed at addressing the various needs of families (Table 10). Service referrals were generally reflective of presenting problems and service needs. The higher likelihood of substance misusing families being referred for parenting assessments probably, however, reflects the challenge parental substance misuse poses for child protection workers: decision-making regarding reunification was often guided by psychological assessment.

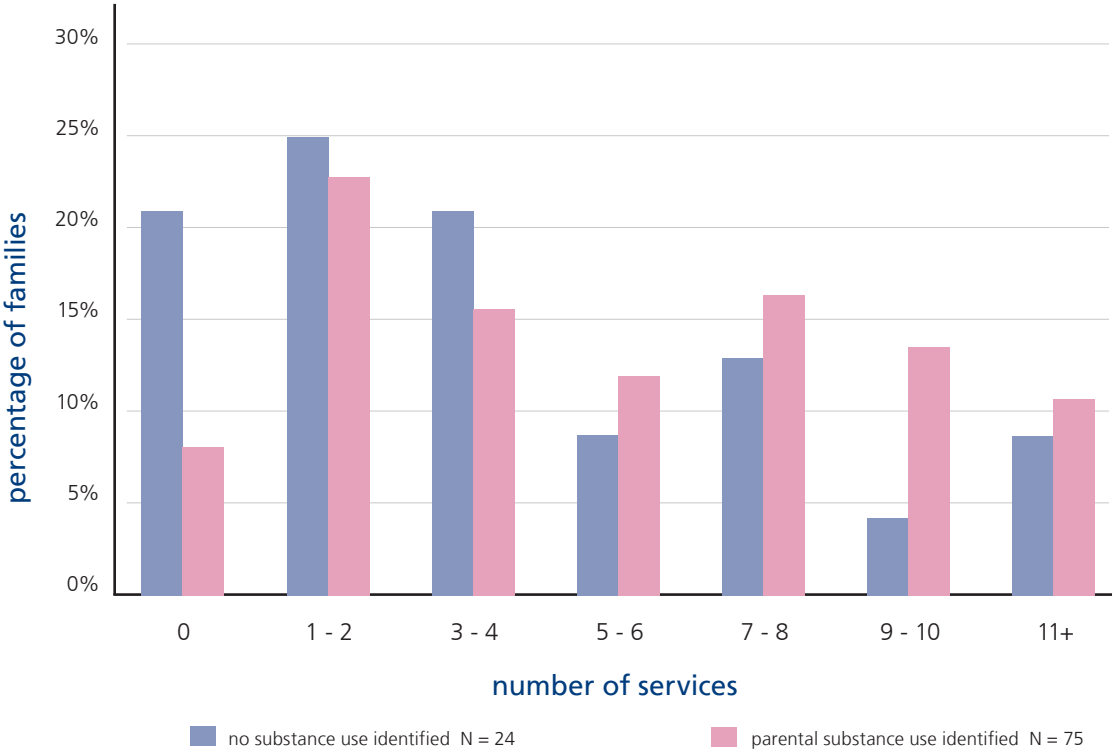
Table 10: Types of services referred to

Types of services families referred to	No substance use identified N=24	Parental substance use identified N=75	Total N=99	p-value*
Drug and alcohol	0 (0.0%)	44 (58.7%)	44 (44.4%)	<.001
Parenting education and support	10 (41.7%)	34 (45.3%)	44 (44.4%)	.753
Parenting assessment	5 (20.8%)	33 (44.0%)	38 (38.4%)	.042
Counselling	10 (41.7%)	25 (33.3%)	35 (35.4%)	.457
Child mental health	7 (29.2%)	20 (26.7%)	27 (27.3%)	.811
Adult community mental health	3 (12.5%)	22 (29.3%)	25 (25.3%)	.099
Housing	6 (25.0%)	18 (24.0%)	24 (24.2%)	.921
Reunification	0 (0.0%)	17 (22.7%)	17 (17.2%)	.010
Domestic violence counselling	3 (12.5%)	13 (17.3%)	16 (16.2%)	.576
Financial counselling	0 (0.0%)	14 (18.7%)	14 (14.1%)	.022
Health	2 (8.3%)	12 (16.0%)	14 (14.1%)	.348
Child health	5 (20.8%)	9 (12.0%)	14 (14.1%)	.280
Psychiatric	4 (16.7%)	9 (12.0%)	13 (13.1%)	.556
Child care	1 (4.2%)	12 (16.0%)	13 (13.1%)	.135
No service	5 (20.8%)	6 (8.0%)	11 (11.1%)	.082
Child educational	0 (0.0%)	8 (10.7%)	8 (8.1%)	.095
Youth	1 (4.2%)	5 (6.7%)	6 (6.1%)	.655
Psychological	0 (0.0%)	6 (8.0%)	6 (6.1%)	.153
Domestic violence crisis	1 (4.2%)	4 (5.3%)	5 (5.1%)	1.00
Disability	3 (12.5%)	2 (2.7%)	5 (5.1%)	.090
Employment	1 (4.2%)	2 (2.7%)	3 (3.0%)	-
Legal	1 (4.2%)	4 (5.3%)	5 (5.3%)	.569
Adult education	1 (4.2%)	1 (1.3%)	2 (2.0%)	-
Mediation	1 (4.2%)	1 (1.3%)	2 (2.0%)	-
Mentoring	0 (0.0%)	1 (1.3%)	1 (1.0%)	-
Correctional	0 (0.0%)	1 (1.3%)	1 (1.0%)	-

* Chi-Squared test used to compare between the two sample groups

The mean (SD) number of services families were referred to tended to be greater for families where parental substance misuse had been identified - 5.3 (4.2) services compared to 4.0 (3.7) (Figure 2), although this difference did not reach statistical significance (p=.182, Mann-Whitney).

Figure 2: Number of services familes referred to



Case files were examined to establish whether families had taken up referrals or if there were any barriers to linking families with services. Problems identified were usually documented in individualised terms, ie as parental resistance or failure to follow through rather than a lack of accessible services or service waiting lists (with the exception of rural and remote families where service accessibility was an issue). The literature consistently reports problems with service engagement for adults with a substance misuse problem due to denial and chaotic lifestyles (Forrester 2002).

2.4.3 Were families connected with drug and alcohol services?

Case files were examined (i) to identify whether families were connected with drug and alcohol services prior to the child's entry into care and, (ii) to determine whether parents had been referred for a drug and alcohol intervention following entry into care.

Most parents (63%) for whom substance misuse had been identified were not known to have been connected with a drug and alcohol service provider prior to their child(ren) entering care (Table 11)[4]. The results are consistent with the literature - namely, that few substance-abusing parents voluntarily seek or complete treatment and treatment is usually sought as a result of considerable pressure from family, friends or the Court (Inciardi 1988). Thus, for many families with a substance misuse problem, contact with the child protection system is likely to be the first initiation of treatment.

Table 11: Number of families connected to drug and/or alcohol services prior to the children entering care.

Prior connection with drug and/or alcohol services?	Total N=75
Yes	20 (27%)
No	47 (63%)
Unknown	8 (11%)
Total	**75 (100%)**

In the cases where parents were already connected with a drug and alcohol service, prior contact was quite limited. Very few had received ongoing case-management or treatment (Table 12).

- 35% of parents had participated in drug and alcohol awareness programs –educational programs whilst incarcerated, or as part of the Drug Diversion Program
- 30% were engaged in a methadone maintenance program through a General Practitioner
- 15% of parents had utilised Drug and Alcohol Services SA for a one-off assessment.

The results suggest substance misusing parents are a 'difficult to reach' population, and are unlikely to have been engaged in sustained treatment or case management prior to the identification of child protection concerns.

4 Families prior connection to drug and/or alcohol services was gauged through reference to reports obtained from drug and alcohol service providers who had eithe-r been requested by the court to provide Families SA with information about services provided to the family, or where families had given consent for Families SA to obtain information about prior service provision.

Table 12: Drug and alcohol services accessed prior to child entering care

Service provider	Total N=20
Correctional Services	7 (35%)
Drug and Alcohol Services SA	3 (15%)
General Practitioner (methadone program)	6 (30%)
Central Australian Aboriginal Alcohol Program	2 (10%)
Youth Health Services	1 (5%)
Interstate service provider (not stated)	1 (5%)
Total	**20 (100%)**

Case files were also examined to identify referrals made to drug and/or alcohol services (Table 13).

Table 13: Number of families referred for a drug and/or alcohol intervention

Number of families referred for a drug and alcohol intervention	Substance Using Sample N=75
Yes	47(63%)
No	25 (33%)
Unknown	3 (4%)
Total	**75 (100%)**

Statistical analysis indicated that only the most serious cases were referred for a drug and alcohol intervention. Families where parents were referred to drug and/or alcohol services had significantly higher numbers of factors associated with their children's entry into care (p=001), and were referred to a significantly higher total number of services (p<.001). Their children experienced significantly higher forms of harm, (p=.006) and were significantly more likely to already have siblings in care (p=.001). These families were significantly less likely to be reunified.

Further investigation as to the reasons why parents were not referred for a drug and alcohol service indicated:

- in 10 cases, children had already been reunified with their birth families, and the case closed. Families SA's involvement had been brief and solution focussed. Parental substance misuse was assessed to be 'discrete' and circumstantial and not likely to pose a risk to children
- in 4 cases, families lived in remote and rural areas and service access was an issue

- in the remaining 11 cases, Families SA had not yet been able to effectively engage parents.

Case file analysis also examined how many of the parents referred for a drug and alcohol intervention actually received a service (Table 14). Less than half (41%) were known to have received a drug and alcohol intervention.

Table 14: Number of families who received a drug and/or alcohol intervention

Number of families who received a drug and alcohol intervention	Parental substance use identified N=75
Yes	31 (41%)
No	30 (40%)
Unknown	10 (13%)
N/A	4 (5%)
Total	**75 (100%)**

13 (42%) parents disengaged from the service prematurely (Table 15) - not uncommon for families involved with child welfare services.

Table 15: Number of families who prematurely disengaged from drug and/or alcohol interventions

Number of families who disengaged from drug and alcohol interventions prematurely	Parental substance use identified N=31
No	18 (58%)
Yes	13 (42%)
Total	**31 (100%)**

Details regarding the type of drug and/or alcohol intervention received by the 31 (41%) indicated:

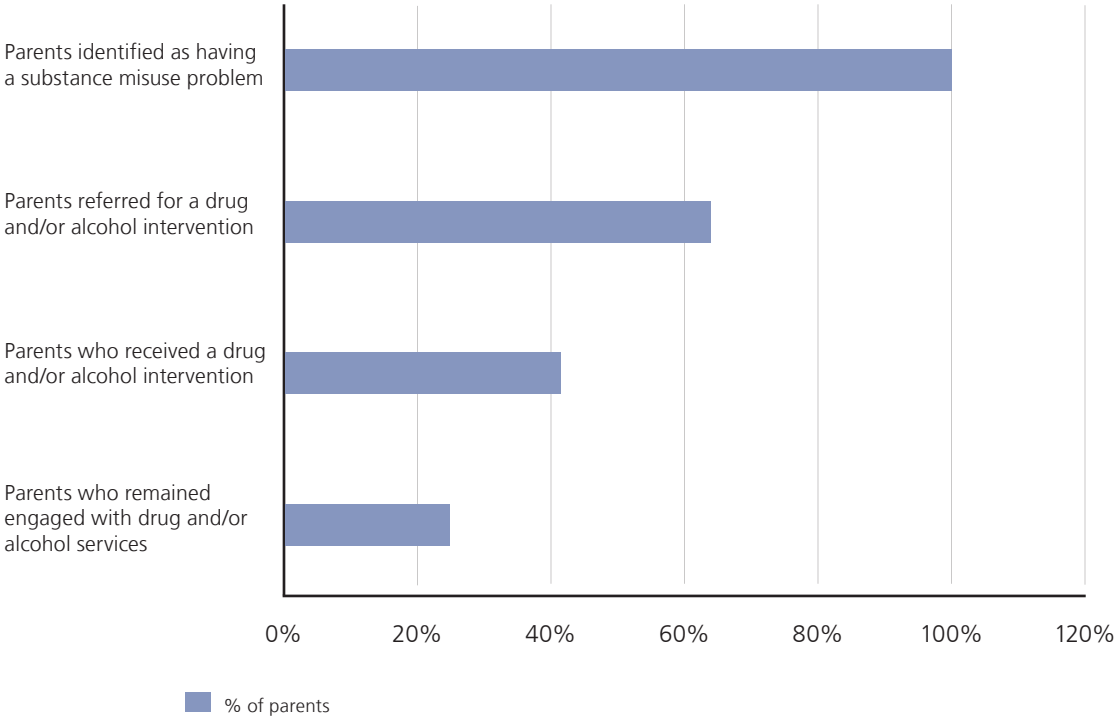
- 13 (42%) attended counselling and/or self help support groups and services
- 8 (26%) attended a one-off drug and/or alcohol assessment session
- 5 (16%) attended a residential detoxification and rehabilitation program
- 3 (10%) engaged in a methadone maintenance program
- 2 (6%) attended a drug education and awareness program.

Even though active engagement with service providers looked poor and the drop out rates were high, analysis showed that where parents had connected with a drug and alcohol service, the results were promising in terms of reunification outcomes.

For example, children from families whose parents had received a drug and alcohol intervention were more likely to be reunified (42%) compared to (20%) for children whose parents did not receive a drug and alcohol intervention.

The uptake of drug and/or alcohol services for parents identified as having a substance misuse problem and whose children had entered alternative care in South Australia during the year 2006 is summarised in Figure 3.

Figure 3: Parental uptake of drug and/or alcohol interventions



2.4.4 Assessment of intervention and practice

Case file analysis was used to assess whether families had received interventions that were evidence informed and incorporated good practice principles. Practice was evaluated through reference to the 'good practice principles devised by the Australian National Council on Drugs (2007:237) and developed as part of their report 'Drug use in the family: impacts and implications for children'. This component of the study required making judgements about practice. Results should be interpreted with caution as they are based on the researcher's interpretation of 'good practice' and lack inter-rater checks. Additionally, assessment was based upon the available documentation in case files and may therefore not be an accurate or complete representation of service provision.

Questions, assessment measures and results are outlined below.

Did the services received address the needs of the child within the family?

A score of yes was given where service interventions focused on the health and wellbeing of children and did not assume that children would benefit indirectly through the support offered to parents. Indicators included: family focused practices that sought to improve the circumstances and outcomes for children, and practice that focused on supporting and strengthening the welfare of children and families rather than 'rescuing' children from abusive parents. Evidence of such practice included: facilitating children's participation in child-care, play groups, school or other community activities; the identification of a support person for the child; home based help to establish routines and boundaries; access to health care and other services; and arranging assessment and treatment of emotional and behavioural problems either through individual or family therapy.

- **A child centred approach was evident in 80% of cases.**

Did the family receive multi-systemic interventions aimed at attending to the multiple needs of the family?

A score of yes was given when interventions acknowledged and responded to the range of factors impacting on family functioning and included (where necessary) assistance with concrete and practical needs.

- **58% of families were assessed as receiving individually tailored and targeted interventions that addressed the whole of the family's situation.**

Did the family form a therapeutic alliance with any service provider?

A score of yes was given where there was good engagement, rapport and empathy and a positive relationship that helped the family move forward to create and sustain long-term change. Evidence included: the provision of advocacy and support; good communication, family (including children) inclusion in decision-making, goal setting and case reviews, a sense that families felt understood and had the trust and confidence to open up to their key worker.

- **In 40% of cases there was evidence a therapeutic alliance had been established.**

Were interventions continually assessed, monitored and modified to meet the change needs of the family?

A score of yes was given where there was evidence of continual monitoring and review of case goals and plans. Indicators included: case reviews and conferences attended by relevant key stakeholders and clear documentation regarding case direction and responsibilities, in particular, evidence that parents knew what obstacles they had to address, timelines and the consequences for not doing so.

- **In 58% of cases there was evidence that interventions were adequately monitored and changed according to family need.**

Was there a collaborative approach between all systems impacting on family functioning?

A score of yes was given where there was evidence of staff across different agencies working together in response to the needs of families. Indicators included: case conferences and reviews attended by all key stakeholders, frequent interagency communication and information sharing between key stakeholders (eg phone, email and meetings).

- **Strong partnerships and collaboration between service providers was evident in 73% of cases.**

Did families receive sustained interventions?

A score of yes was given where there was evidence that families had engaged with services for an adequate period of time to achieve, maintain and demonstrate change. A yes score was also based on the recognition that the length of time required to address the presenting issues of each family varied in response to the complexity of their needs. Indicators included: details of the progress made by parents; evidence of intensive service interventions that had targeted parent's capacity to seek and sustain positive support systems in their family and social networks.

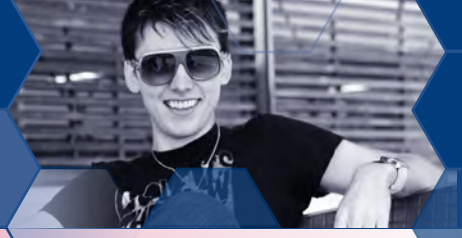
- **There was evidence that 45% of families received supportive interventions likely to sustain and achieve long-term change.**

In summary, in most cases there was evidence that intervention met best practice criteria, particularly in the area of child-centred interventions and collaborations. Less success was achieved in the areas of successful engagement with families and the provision of a sustained intervention.

Table 16: Markers of good practice

Markers of good practice		Total N=99
Did the services received address the needs of the child within the family?	Yes	79 (80%)
	No	13 (13%)
	Unknown	5 (5%)
	N/A*	2 (2%)
Did the family receive multi-systemic interventions aimed at attending to the multiple needs of the family?	Yes	57 (58%)
	No	36 (36%)
	Unknown	4 (4%)
	N/A	2 (2%)
Did the family form a therapeutic alliance with any service provider?	Yes	40 (40%)
	No	28 (28%)
	Unknown	29 (29%)
	N/A	2 (2%)
Were interventions continually assessed, monitored and modified to meet the changing needs of the family?	Yes	57 (58%)
	No	37 (37%)
	Unknown	3 (3%)
	N/A	2 (2%)
Was there a collaborative approach between all systems impacting on family functioning?	Yes	72 (73%)
	No	20 (20%)
	Unknown	5 (5%)
	N/A	2 (2%)
Did families receive sustained interventions?	Yes	45 (45%)
	No	49 (49%)
	Unknown	3 (3%)
	N/A	2 (2%)

*N/A refers to 2 cases where children entered care as unaccompanied Minors through Families SA Refugee Program and not through a child protection pathway.



3 Summary: key results

This study has estimated that substance misuse is a significant factor in 70% of first-time entries into alternative care in South Australia. Alcohol has emerged as the most commonly misused substance (in 77% of cases), but with high rates also recorded for illicit drugs (cannabis – 53% and amphetamines – 50%).

The analysis has found that children who enter care from families where substance misuse is present are likely to have been exposed to more, and more complex problems than other children in the out of home care system, including abuse and neglect, domestic violence, homelessness, housing instability, transience, severe financial problems, parental involvement with criminal activities and incarceration. Substance misuse is thus associated with situations which pose extremely high risk to children; and also with complex family issues which are unlikely to be resolved quickly or easily. Serious harms identified for children commonly included exposure to domestic violence, material deprivation and neglect, instability and disrupted living arrangements.

Neglect was the most common form of abuse experienced by both samples of children; however emotional abuse was significantly more prevalent where substance misuse was a factor, and was strongly associated with alcohol misuse (probably due to its relationship with family violence). Children from families that used illicit substances were significantly more likely to have experienced family homelessness and parental mental health problems. A strong link was also found between the frequency of substance misuse and the likelihood of families (and children) experiencing homelessness and severe financial difficulties.

Consistent with previous research, substance misuse was found to be associated with longer stays in care, longer periods of decision making and reduced likelihood of reunification.

Both a 'risk management' and 'therapeutic' approach were evident in the service response provided to families. These two styles appeared to be adopted in response to the level of risk to the child and the perceived attitude and engagement of parents. Families were generally referred to a wide range of services – more than other families in the child protection system – with referrals largely reflecting presenting problems and needs.

Significantly, most parents had had no sustained drug and alcohol treatment prior to the involvement of child protective services: the intervention was thus for many the first gateway to treatment. Drug and alcohol services referrals were not automatic, however, and were generally dependent on the severity of the problem and parental attitude and engagement. A relatively low rate of drug and alcohol treatment was observed (24%), with considerable numbers of parents not following through with referrals or dropping out of services. Thus, consistent with the literature, substantial difficulty was indicated in achieving sustained drug and alcohol interventions.

An assessment of the intervention provided indicated that most cases met best practice criteria, particularly relating to child-centred interventions and collaborations. Less success was achieved in the areas of successful engagement with families and the provision of a sustained intervention.

4 Implications and future directions

This study has explored a number of key issues relating to problematic parental substance use and its impact on children as well as the child protection and alternative care systems. Key opportunities for policy and practice are identified below.

Prevalence

Drug and alcohol misuse is not a peripheral issue but a core component in a substantial majority of situations where children enter care.

This finding has major implications for both the child welfare and drug and alcohol fields. Policy, practice and service delivery in child welfare should be predicated on the assumption that substance misuse issues are the norm, rather than the exception, and drug and alcohol interventions are clearly situated as a key family/child welfare intervention. Implications for specific sectors include the following:

- **Child protection workforce: practice and competency**

  Child protection practitioners are often uncomfortable in the area of substance misuse and view assessment and treatment as a specialist activity to be undertaken by drug and alcohol workers. This approach may limit the potential effectiveness of the child protection intervention. The child protection workforce needs the confidence, skills, knowledge and competencies to work in this difficult terrain – not as specialist drug and alcohol workers, but simply in order to do their job. A well-equipped and supported child protection workforce creates opportunities in a wide range of areas. For example, a more detailed assessment by caseworkers of the types of substances used, the quantity and pattern of usage would assist in building a deeper and more accurate understanding of the place of substances in the life of the parent; its effect on the adult and their parenting capacity and interventions which may be required.

  Child protection workers also need intervention strategies and skills. This may precede, lead to or complement specialist intervention, or in some instances be all that is required. Additionally, many of the skills and techniques used by drug and alcohol workers are not unique and are already in use in the child protection setting (eg generic social work skills and roles such as empathetic listener, enabler, educator, resource, advocate, broker, motivational interviewing and assessment skills). Perhaps what is required is to break down some of the 'mystique' of drug and alcohol interventions – that only specialists can do it – and rather equip a broader range of workers to work more effectively and confidently – at least to some level - with the growing number of people for whom drug and alcohol misuse is an issue.

- Drug and alcohol specialist services and strategies

  Reducing harm to children should be a major objective of drug and alcohol strategies and services; and safeguarding and promoting the wellbeing of children a core component of drug and alcohol intervention. This requires effective multi-agency and collaborative strategies; assessment and treatment approaches which take into account the user as a parent and the impacts on children, and a workforce whose core competencies include knowledge of child protection and family systems issues. The drug and alcohol workforce should be equipped and supported in this role (with skills, knowledge, processes, treatment and collaborative models).

- Family support and intervention services

  Dealing with drug and alcohol issues will be central to the work of family support and intervention services in the non-government sector, particularly reunification and intensive family preservation services, with resulting implications for service models, staff competencies, intervention strategies; and training and development.

- A holistic approach

  Child protection and drug and alcohol services have developed separately and traditionally held different orientations. They often operate under different mandates, priorities, timelines and definitions of the primary client and have different goals and definitions of success. These differences fundamentally impact upon how agencies work together and present barriers to collaboration. Families in which substance abuse is an issue, however, need a holistic service. Strategies to develop robust collaboration between child protection and drug and alcohol services are now imperative. Collaborative practice needs to be the norm and not the exception, and a focus should be placed on building models and systems which support this.

Prevention and early intervention

This study is one of a growing number which provides evidence that parental alcohol and substance misuse is demonstrably associated with child abuse and neglect, and rising levels of misuse will thus increase harm to children. Or, as argued in Hidden Harm (2003), "harm to children is only likely to decrease when the numbers of problem substance users decreases". This has implications for child abuse prevention and early intervention strategies: reducing levels of alcohol and substance misuse becomes a critical and powerful element. Similarly, drug and alcohol strategies should be constructed with an awareness of the impact on child and family welfare, with strategies clearly focused on this area.

Child protection as a gateway to treatment

Most parents had not received treatment for their drug and alcohol issues prior to the involvement of child protection services. Child protection processes are therefore an important gateway to treatment.

People with problem drug and alcohol use are often a 'hidden' population, not voluntarily disclosing their misuse or seeking help. Parents may be especially guarded and reluctant, fearing legal intervention and the removal of their children.

This study has identified that child protection issues may be the catalyst that bring drug and alcohol issues to light and may also provide the motivation to change. In addition, it has highlighted what is possible: child protection practitioners can successfully engage families and support the move into treatment.

Child protection interventions therefore should be conceptualised and understood as a key – and perhaps unique – opportunity to engage people in treatment. The relationship between child protection and drug and alcohol services is essential to ensuring this gateway works effectively; and child protection workers have a crucial role in supporting the pathway to treatment.

Complexity, cause and effect

Substance abuse rarely occurs in isolation but typically coexists in combination with a constellation of issues which create high levels of risk to children. These families tend to be amongst the most difficult in the child protection system, with outcomes more problematic.

Children growing up in families where parents are abusing alcohol or substances are highly likely to be exposed to a multitude of harms and potentially high-risk situations. These families are amongst the most challenging in the child protection system, with problems particularly difficult to resolve; and children are often more damaged due to the cumulative impacts of harm.

Drug and alcohol misuse would thus appear to be driving not only more, but also more difficult, cases. This creates workload challenges for the child protection, out of home care, family support and treatment systems. It also creates challenges in relation to intervention approaches and models (including for out of home care) and the need to develop approaches and systems that will be effective (the 'old' approaches may not be enough). For example, increased numbers of entries into care place pressure on an over-stretched foster care system; and children who have been significantly harmed will have different care needs which may or may not be met in family-based care.

Holistic and interagency work is also fundamental. Services can no longer deal with family problems separately or in isolation but need to work as a collaborative team. Research shows that people react more positively to drug and alcohol treatments

when services respond constructively to their range of needs rather than focusing solely on the drug use (NHS 2004, Dawe et al 2007 and Department of Human Services 1999). Collaborative practice also improves the abilities of service providers to make good decisions and increases the efficiency of service delivery (Green et al 2008).

Substance type

Alcohol was found to be the substance most commonly misused, either in combination with illicit drugs or by itself. Alcohol misuse was associated with particular risks and harms, including family violence.

Drinking to intoxication is increasingly a normalised activity for many Australians but is often not recognised as a 'drinking problem' (National Alcohol Strategy 2006 – 2009). Alcohol misuse may go 'under the radar' because of different perceptions around alcohol compared to drugs: alcohol is a legal substance, widely available, its use broadly sanctioned, and often valued as an important feature of family and social life. General community perceptions around illicit drugs are much different and more negative. This study has suggested, however, the prominent role alcohol misuse has in causing harm to children. These risks should not be overlooked or under-estimated, and deserve broader attention in community debate, research and policy. It is also important to note, however, that alcohol and drug misuse are not discrete issues and that many – and probably increasing - numbers are poly substance users.

Building the evidence base

This study is a small contribution to the growing literature on the impact of problematic drug and alcohol use on parenting and child wellbeing, and in particular substance misuse as a 'driver' for children's entry into care. There is still limited Australian research literature on this topic, and the area deserves and needs stronger research attention.

A range of issues have emerged in the study which are worthy of further research, with the most pressing including prevalence; the impact of different substance types on parental behaviour and harm; intervention approaches; collaborative models; early intervention and prevention strategies; the care and treatment needs of children; and the associations between the clustering of problems related to drug and alcohol misuse. These significant issues call for larger-scale, robust and sophisticated studies, and particularly for collaborations between child welfare and drug and alcohol researchers. Such studies could make a major contribution building an evidence base for policy, practice and intervention, both at individual and community levels, in order to reduce harm to children.

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