Parental substance abuse, parenting capacity and child protection: always a three way tug of war?

Firstly, I acknowledge that we are meeting on the lands of the Ngunnawal people. I offer my respects to them and to their ancestors and hope this forum might contribute, at least in a small way to their present lives.

I thank the Families and Friends for Drug Law Reform for inviting me to speak this Drug Action Week. There is so much we can learn about the realities of substance abuse and its management from listening to these knowledgeable people who are most intimately involved.

I agreed to give this talk because of my longstanding interest in children and their place in our society.

Children experience daily events differently from adults. And the immediate and long-term impacts of these experiences are different too. Unfortunately we seem to be singularly uninterested in the child's perspective and seldom seek it, even when children are intimately involved.

Most of my talk today reflects on what I have learned about children's experiences of their parents' substance abuse.

I will then look at what is currently available for these children and will consider the limitations of current services, both for their support and for protection. Hopefully I will still have time to consider some possibilities for doing things more effectively, with the hope of better experiences for these families.

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I believe we must focus on community involvement and encourage vigorous discussion if we are to make progress and find solutions. This is not an issue to be solved by new laws, increased surveillance and targeted punishments.

What is needed is for the whole of our community to accept that drug use is an expression of human vulnerability and to recognise that we all have a responsibility towards the most vulnerable in our community. These include both drug users and their children. It is this reasoning which will enable some of these troubled people to escape from the dominance of drugs in their lives. These children must be nurtured and kept safe, but this will not be achieved if actions are determined by value judgements.

None of us welcome having our lives dominated and directed by others- even when we know we need help. We need to be able to be fully involved in decision-making. Working with drug abusing people is no different. Unless we look for solutions based on mutual respect, any improvements are likely to be

short-lived. It is seldom straightforward, but this is not an excuse for unilateral decisions to make the process easier for us,

I will be talking about children affected by the use of drugs. Drug users come from families. Drug users were- and in some cases are- children. Drug users have children. Very often the impact of these drugs will determine these children's future lives.

And the families and close friends of drug users continue to care, even in the midst of despair. They mostly cannot- and do not try to- avoid efforts to help their children, and their children's children. All families want their children and grandchildren to stay alive and all hope that they will achieve lives that bring a sizeable measure of enjoyment and contentment. Families with substance abuse have the same hopes.

Now, more than ever before, we have strong evidence for the enormous importance of our early childhood experiences in determining the sort of adults we become. How confident we are, as adults, how caring- and probably more important than anything else-, how we relate to other people and maintain relationships with other people for the rest of our lives has its origins in our earliest experiences.

We all have traumatic experience in our lives, which often shape our lives, but the most pervasively

damaging experiences are those that occur in infancy. For so long we used to think this was the safest time to experience trauma- before we could remember it. But we do remember it- without words. Now we know that it is the time when we are most likely to sustain lifelong emotional damage.

How big a problem is drug use for Australian children?

The Australian National Council on Drugs has recently released a report entitled “Drug use in the family: impacts and implications for children”, which has received some media attention. It considers the impacts and implications for children of growing up in drug using families, specifically alcohol and illicit drug using families.

It studied children between 2 and 12 years of age. A particular limitation of this study, for me, is the exclusion of the first 2 years of life. The first two years of life are increasingly being recognised as crucial in determining how successfully our children grow up and function as adults. The exclusion is probably because infants and toddlers are “more different” from adults than older children, so need to be studied differently- which is not an excuse for excluding them!

Despite these limitations, the study provides useful data related to Australian children.

Approximately 10% of children in Australia are believed to live in households where there is parental alcohol abuse or dependence or illicit drugs.

This means that, based on ABS figures for 2004 and looking at children<12 years, there are about 230,000 children living in households where there is binge drinking, 40,000 living in homes where there is daily cannabis use and 14,000 children in the families which use methamphetamine at least monthly in the home.
All of which means that it is a very significant problem.

There are many other problems associated with parental substance abuse, which have a particularly serious impact on children growing up in these households.

- .Children whose parents use illicit drugs are far more likely to experience socioeconomic disadvantage. As for all other children, these children need appropriate housing, health care and schooling, together with the opportunity to participate in community activities with their friends. If they are deprived of these necessities, it will change the trajectory of their lives and perpetuate their disadvantage.

- Violence, including DV, is so commonly associated with drug use. It has made a great impression on me in my work. It is recorded

for about 50% of children attending the Child at Risk Health Unit and I am aware there are more children where the DV and its consequences are concealed. ?Story

- There is so much guilt associated with drug use. Substance using mothers often see themselves as “bad mothers” and this can be a barrier to them seeking “mainstream” help from health, mental health, housing and A&D services. I believe the way we offer these services, with so much “gate keeping”, can be quite daunting.
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Now I want to talk about the impact of parental drug use on children, starting with the implications for pregnancy and in infancy.

Since I started working with these children in 1990, the pattern of illicit drug use has changed, but I do not believe it has diminished

One of the difficulties with the newer drugs is that we are less certain about the effects on the babies. These drugs certainly affect babies, but in less predictable ways than the better-known opiates.

For heroin users, we can care for the babies with greater confidence. There is an established “harm minimisation” approach, using methadone, which enables the baby to grow in the womb in a relatively

stable environment, without the hazards of erratic heroin use. The baby is still born dependent on methadone, but this is far safer for the baby than any attempt to abruptly cease drug use during the pregnancy. Heroin use, on its own, is unlikely to cause birth defects.

Alcohol consumption remains a major issue for pregnancy and there is no doubt about the direct damaging effect of alcohol on unborn babies. In its full blown form the baby can be physically identified as having Foetal Alcohol Syndrome. In many cases the impact is more subtle, with the baby, and later the child, looking normal, but having learning and behaviour difficulties.

Sorting out these problems is made even more complex because high alcohol consumption is so often associated with other drug use and with DV. Any one of these, acting alone, can result in similar developmental and behavioural problems for the baby.

What we <u>have</u> learned in recent years is that each baby's genetic potential is far more affected by the environment during infancy than we had previously imagined.

Even before birth, babies are becoming aware of the outside world- and beginning to recognise daily

patterns, such as the sounds of their mothers, familiar everyday noises- and violence.

Babies are born with a driving need to become attached to close, reliable people who love them. It is a critical requirement. Without it, no baby could survive. All the major senses are involved- hearing, smell and taste, touch and sight. But babies need help, from birth, to see, hear, smell and feel their world, so that they can make sense of the world they have arrived in.

Newborn babies are far more complex and capable than we previously believed.

Almost all babies, including babies in substance abusing households, are eagerly awaited and greeted by loving family. In normal circumstances they learn, within the first few days, that they can signal their needs for food, comfort and reassurance and someone will be there to respond to those signals and meet their needs. Babies can respond to and initiate communication from birth.

These communications are subtle at first, but rapidly become quite complex. Even though the baby might need a lot of help in coming to terms with the world, all babies are born expecting to be helped to do this.

Consider now the situation for a baby born to a drug-using parent – particularly one who is who is unsupported and alone.

When the mother is not drug-affected, her loving interactions with her baby might be very appropriate and enjoyable for both mother and baby.

However, if she is “hanging out” for drugs, she might be cross and distractible and give her baby a very different, even hostile, response.

When she is strongly influenced by drugs, she might lose all awareness of her baby. There is no one for the baby. This is the most dangerous situation of all. How can any baby deal with this? Young infants cannot care for themselves.

They can cry for attention, but might soon learn that this provokes anger, so that is not a good idea. They often learn, very early, that the best way not to be hurt is not to be seen, so many young babies learn to “dissociate”- remain so still and quiet that they are not noticed.

All such babies become extremely vigilant about their surroundings, trying to anticipate what is coming next. All of this hampers their normal development.

When the drug use is in he context of chaos and violence, these babies become the children who are

“unmanageable” even at preschool, with disastrous consequences for their schooling.

Babies’ brains in the first 3-5 years, but particularly in the first few months, are actually “hard wiring” their nerve pathways for the rest of their lives. They are born with virtually all their nerve cells (neurons) in place and these cells have a dense complex of connections to many other neurons. The final nerve paths are formed by the selective pruning of these connections in response to the messages the babies receive. You can imagine baby brains developing strong, reliable connections, in response to consistent predictable messages from their carers.

If the baby’s world is unpredictable chaos, what happens to the wiring? It becomes chaotic too, attempting to help the baby survive in a highly unpredictable world. The baby might become very “good” and undemanding, or very agitated and distressed.

Add DV to the baby’s world and things become much, much worse. The outside world really is a scary place. Babies have been shown to recognise and respond to violence within weeks of birth.

Mental health problems, so often present in these families, have a very similar, and compounding, influence on the brain development. COPMI is doing excellent work reminding people within mental health

services to remember there are children in the families they see.

If we are used to being with small babies, we learn to recognise, when babies show us, to the best of their ability, that they need help, or have given up and "opted out".

If we don't think very carefully about the baby's environment, and watch the interactions with the parents over a period of time, it can be fairly easy to attribute the baby's trauma messages to the usual causes of infant distress- "colic" and hunger and overtiredness, or maybe feeding difficulties.

Only by working closely with mother and baby can the baby's plight be recognised for what it is. A major problem in recognition, I believe is that we don't want to know how bad things are from the baby's perspective. It is easier to focus on the mother and get caught up in her great needs- particularly if she is grateful for help.

Once the baby's distressed state is noticed, it is first necessary to determine whether the parents can accept that there is a problem and are prepared to seek help. So much then depends on the type of help and how it is offered.

Recognition is harder for all of us when the baby is quiet, and "shut down" rather than agitated.

It is a similar situation later when these children reach school. We insist on action for disruptive and violent children, but fail to notice the quiet, dissociating children, who are failing to learn or make friends at the back of the room. Such dissociating children are at particular risk for both mental health and drug use problems in adolescence. Children with both responses may have experienced similar levels of trauma.

What about the role of Child Protection in relation to parental substance abuse?

Child protection legislation was historically enacted to enable authorities to intervene when children were known to have been physically and sexually abused.

Intervening when abuse has happened remains the first priority for child protection services. These interventions need special skills.

The legislation acknowledges that emotional abuse and neglect are big problems, but reporting is not mandated. These are the issues which so often overwhelm CP services, sometimes to the point of inaction. Children of substance users usually are well represented in this category.

There is recent legislative provision within the ACT to report concerns about the safety of unborn babies.

Any intervention prior to birth has to be voluntary. This means the mother has to choose to accept supports that are offered.

At least it means that we now do have greater capacity to improve the family situation prior to birth. At best we can ensure appropriate antenatal care, suitable housing and contact with services, particularly drug and alcohol, health and mental health services.

However, this provision is, in many ways, a two-edged sword.

Now, contact can be made prior to birth, whereas previously no action could be taken till after birth, either when the baby was shown to be at risk of abuse, or even to have been abused.

Now pregnant women can be contacted, but for many of them this approach is still seen as a threat and is not trusted. Many of these women have had past dealings with a variety of government services and have come to mistrust such services because of these experiences.

Some were in foster care themselves as children. Even if this was very necessary, the resultant feeling of dislocation and abandonment makes it most unlikely that such women will seek. “welfare” help. We still have young people leaving care without the

necessary skills for independent living and with no family to turn to.

Despite best intentions and some excellent, caring workers, the statutory service is mistrusted. Because of the complexity of demands made on the service, it does remain a poor parent in terms of keeping up with the individual needs of children and acknowledging their achievements.

To add to the difficulties, CP is perceived by many parents and grandparents as coercive and authoritarian because of the ways in which it is constrained to act. Whilst acknowledging this, fortunately some people still have the capacity to be empathic and supportive in these situations.

Why are things like this, after so many inquiries have been held across Australia, and with governments and the responsible departments intending to do a better job?

I believe that there are two major obstacles for the CP system.

Firstly their priorities and actions are determined by legislation focused on detection of abuse, not prevention of abuse.

To add to that, both our current C&YP Act, and the proposals in the current revised legislation vest all

responsibility and authority for decision making within the statutory authority.

C&P have the primary filtering role for all reports of suspected abuse and neglect. This is a huge responsibility and discourages the development of community skills to protect children. In many cases the referrers have far better skills in assessment of children.

Another difficulty is that there is no requirement within current legislation for all involved government departments who work with families and children, to work together for these families.

This cooperation is being pursued informally, but my lengthy experience here has taught me that such informal arrangements do not last and have limited power to change practice.

So the people with specific skills in intervening for abuse and implementing the legislation also have the ultimate control and decision making for final case plans for complex and damaged children. They have to undertake this role without contemporary knowledge of appropriate ways to help these children, or the very important understanding of child development, which should underpin any plan.

Because of the consistently overwhelming workload, 3 months is generally considered to be an acceptable

intervention time frame within C&P. However, these children need to be monitored throughout their childhoods, at least as long as they remain in a substance-using environment.

Supervision could be better continued within the community, but only if there remained the capability of intervening promptly and effectively if things go wrong. It all comes down to confident communication.

The legislation is currently in a lengthy process of revision. There is still time to consider these matters.

In my thinking about this dilemma, I have become interested in different approaches used in other countries. I am particularly attracted to a model which has been in place in Scotland since the 1970s and which still seems to be working, with ongoing modifications.

At risk children, who are not in need of court intervention, are managed by a Children's Hearing System. This is a community run system, connected to, but independent from the court CP system (arising from the Kilbrandon report. In particular, no lawyers are involved. The focus is re-integration into the community. Interventions emphasise parental responsibility, organising community services and strengthening the family. In this process, the welfare of the child is the paramount concern.

Children are referred by a Children's Reporter, who is contacted initially by individuals and services, who have concerns. The hearings are convened and run by trained individuals from the community. There is an impressive level of transparency of process- so often absent in the "traditional" child protection system.

Another obstacle to the current management of these families and their problems is the current provision of health services. Often their health needs are quite complex. Complying with many different appointments (and booking processes) can be an overwhelming challenge for these families, even when their intentions are good.

There are particular difficulties in the ACT connecting all the services substance abusing families need in relation to the birth of a baby- ante-natal, birth and post-natal services- and alcohol and drug services and mental health services too. Once the baby is born there are also MACH services to fit in.

ACT Health and C&P are currently developing an initiative for such families, but whilst it remains as a targeted service, and not closely linked to universal services, there will be suspicion and reluctance to become involved.

If a chosen person from community health could take responsibility for the management of the pregnancy at the outset and be the mother's primary contact point, a comprehensive involvement could be arranged from early pregnancy until the baby was well integrated into the MACH service.

Unfortunately ACT does not yet have a universal home visiting service for new babies, let alone one which can provide intensive sustained support for families experiencing difficulties.

Most other states have already developed such services, in recognition of the emerging importance of the early years.

Even with all services "locked in" for the family, most only function from 9 till 5 Monday to Friday. Most of the time when a crisis happens there is no-one to contact- in the middle of the night, or at weekends.

Add on the Centalink regulations and you have a very stressed family, who might give up on their good intentions.

Research with isolated young people had shown that providing a 24-hour mobile phone number for contact is a great help. It is almost never used indiscriminately, only when help is needed.

If each of these very vulnerable families were offered similar support, with an acceptable contact person, who has responsibility for coordinating services and relaying information to the regular worker, we would have the basis of a trusted framework to give the best chance of success.

If a credible intervention such as this did not succeed in ensuring the baby's safety and the baby needed to be removed, at least the need for statutory intervention would be well established and more defensible.

I will finish with two Aboriginal pictures, painted for NAPCAN by Tex Skuthorpe a Noonguburra man, who uses traditional art to tell child protection stories.

The first has the theme of Mutual Respect and discusses the mutual obligations between generations.

The second is entitled "Every Child is Sacred" and emphasises that the safety of every child is the responsibility of everyone associated with the child's life and no one person is to blame.

I believe these are two excellent principles to guide the development of more effective services for children of substance abusing families.