Alcohol and illicit drugs are significant factors in child neglect, abuse, entry to care and the death of children (NSW Ombudsman 2013). Workers are frequently faced with difficult decisions as to which children are at risk of significant harm and which are able to be supported living at home.

Decisions are difficult because of the common use of a wide range of substances in the community and the limited knowledge that workers may have about their impact on children. While decisions may involve addiction to illicit drugs with dramatic impact on children, they more often involve the chronic use of more commonly used substances. The most prevalent of these are alcohol and marijuana (cannabis). Assessment of risk to children because of substance use is also difficult because they often need to be made with limited knowledge of parental substance use. There may also be a general lack of understanding about the impact of substance use on children. Workers must therefore learn as much as possible about the substances misused by parents and observe the impact of substances on parenting behaviour.

All decisions must be focused on the child and the parent’s capacity to care for him or her. Workers should bear in mind that babies and toddlers are particularly vulnerable and that pre-natal damage can be a serious problem. Workers should consider the impact of other problems affecting the household, as well as the supports available to the child. Their judgements must include the likelihood of change in parental behaviour and how this is affected by the help available to parents. Workers should consider the likely success of treatment - within a child’s developmental timeframe.

This paper explores these issues and should be read in conjunction with Permanency Planning Practice Papers 1 Deciding on children’s safety at home, 2 Supporting parents to care for children and 3 Promoting restoration.

Be aware of the risk of significant harm

Substance abuse is a very common issue in making decisions about child protection. In some Australian states almost half of substantiated abuse and neglect situations and Court appearances involve substance misuse (Bortoli, Coles et al. 2012 p.4). Over two-thirds of first time entries to care are substance abuse related (Jeffreys, Hirte et al. 2009). Children’s safety can be put at serious risk. For example, the NSW Ombudsman Reviewable Deaths 2010-11 found that:

*The most commonly identified issue of concern in families where a child died in circumstances of fatal neglect was parental alcohol or drug misuse.* (Abstract)

Substance use may be slow to have an impact on children’s development, or the risks may be immediate. Short-term risks to children include behaviour associated with the mental state and behaviour of the parent, such as lack of responsiveness to the child, irritability and aggression. There may be risks inherent in the child’s environment, such as antisocial behaviour by other adult substance users, especially violence in the home. There may also be less obvious but immediate threats to the child, such as accidents when potentially lethal drugs are left within children’s reach and unsafe sleeping practices. Long-term risks to children can include the effects on the child’s physical development (including neurological development during pregnancy).

Decisions about risk of significant harm must be focused on the child’s developmental needs and safety. The general principles are explored in Management Practice Paper 1. It is important to remember that children affected by parental substance misuse are usually young and at greater risk of recurrent and more severe abuse than older children (Bortoli, Coles et al. 2012). Babies and young children can be particularly vulnerable and workers need to consider the attachment between the child and their carers (particularly for children under three years of age),...
nutrition, physical safety, adequacy of clothing, safe sleeping practices (especially when alcohol is involved), emotional and behavioural development.

Many welfare workers find that there are tensions between adults’ interests and the right of children to safety and the opportunity to develop. The Mirabel Foundation, which supports grandparents caring for children of drug-affected parents, has been highly critical of decisions about child protection:

_Evident in the research is the suggestion that Australia’s child protection services and the Children’s Court have a propensity for focussing on the needs of the adult instead of the best interests of the child. (Mirabel 2003 p15)_

Finally, in assessing risk, it is important to recognise that, because of the illegality and stigma of substance misuse, parents may not be open about the amount and types of substances that they are using. Workers therefore need to be observant and make themselves familiar with patterns of alcohol and drug abuse in the community.

**Understand the impact of substance misuse on parenting**

Workers need to explore current thinking and evidence about the impact of substance use on parents and children. Professional opinion does change and the most recent thinking should be carefully considered. Workers need to be reflective about their own values about substance use.

An example of the conflicting nature of ‘expert opinion’ and the interplay with workers own use of substances is the chronic use of alcohol - a substance widely used in the community, possibly by workers themselves. Some researchers claim that alcohol use by parents may not necessarily be harmful.

_...There is an extensive body of evidence about the impact of parental alcohol misuse on children and it appears clear that most children with a parent with an alcohol problem go on to live happy and well-

_adjusted adult lives. (Velleman and Orford, 1999)_

However, other researchers claim that the impact of alcohol misuse on children’s welfare is underestimated. They claim that alcohol is a predictor of recurrent abuse and is involved in serious child protection matters (Bortoli, Coles et al. 2012). Evidence shows that, in relation to children referred to child protection authorities because of parental alcohol use, there was a high rate of entry to care over the years:

_We estimated that follow-up at three years would see around two-thirds [of children reported because of their parents’ alcohol use] having moved [into care]. (Forrester and Harwin 2008 p.1528)_

These researchers suggest that workers are leaving children too long in families where alcohol is misused.

Some useful questions to consider in assessing the impact of substance use on a child include:

- What is the protective behaviour of parents if they are planning to use a substance?
- What is the parents’ capacity to identify danger from other people who may come in contact with the child?
- What will the child’s welfare look like in five years?

**Understand the family’s capacity to care for the child**

Workers should consider the overall circumstances of the child when they assess risk of substance use. The family may have strengths in caring for the child, but there may also be significant weaknesses which must be weighed carefully. Workers should be cautious about promises of behaviour change by parents as these may not ultimately affect the family’s care of the child.

Workers must assess the capacity of the household to keep the child safe and meet their developmental needs. Child death statistics show that risk is enhanced where there are at least two factors of the _...toxic trio of family violence, parental substance misuse and_
parental mental illness (Bortoli, Coles et al. 2012). In relation to parents’ use of alcohol, children do most poorly in situations where there is both alcohol and violence in the home (Forrester and Harwin 2008).

Risk to a child appears greater if more than one adult in the house misuses substances. For this reason, workers must make sure that they assess both maternal and other adult substance use in the household (Bortoli, Coles et al. 2012). Workers must also take into account the wide range of associated social problems which accompany substance misuse; these include poverty, housing and health problems.

Family strengths should be carefully considered along with problem behaviour:

Key protective factors include having a parent in the home who does not misuse and that substance abuse is not associated with violence. Resilience factors include experiencing success outside the home and having social supports outside the family. (Forrester and Harwin 2008 p.1520)

In assessing the family’s strengths, workers should understand the ability of wider family networks to support the child. It is commonly found that parents who abuse substances often have poor extended family support because their behaviour has been alienating.

Assessing the family’s capacity to care for the child is often made more complex for workers because of parents’ promises to change their behaviour and seek treatment. Workers need to consider whether such promises are realistic and within a timeframe which will affect the child’s wellbeing. They must be cautious. Research shows that the threat of removing a child from their family is generally not sufficiently motivating for parents to change their behaviour (Bortoli, Coles et al. 2012). Furthermore, substance misuse is often associated with a failure to comply with service guidelines and Court Orders.

Workers also need to be aware that the ability to get parents into treatment varies from area to area, and the success rate of therapy is far from guaranteed. Information on success and relapse rates of drug and alcohol services is difficult to obtain. However, a South Australian study in 2009 showed that only 41% of parents whose children had entered care received drug and alcohol interventions (such as counselling, assessment, detoxification, methadone and drug education). Of these parents, 42% disengaged from the service prematurely. It is clear that services may require a number of attempts to engage parents before substance abuse behaviour changes (Jeffreys, Hirte et al. 2009):

Drug and alcohol addiction is a chronic, relapsing condition that is not quickly or easily overcome. Even those who are successful commonly recount failed attempts at recovery. And the recovered substance abuser must do battle with the dangers of relapse. (Azzi-Lessing and Olsen 1996)

Even when a parent is actively using treatment with a drug or alcohol service, it should not be assumed that the service is aware of issues around children’s wellbeing. Treatment and detoxification programs have traditionally worked in isolation from family services. It does appear that the most effective treatment occurs when drug and alcohol services are integrated with child welfare services (Magura and Laudet 1996). The child welfare service must operate as an advocate for the child at all times.

Furthermore, drug and alcohol services and child welfare decision-making may have very different timelines. The years that it may take to change behavior of an addicted parent will not be timely enough for a young baby whose attachment to a carer may be significantly damaged if restoration to birth family takes place after a long period living with that carer.

There are many barriers to successful treatment such as difficulty in finding stable housing, employment and childcare (Thompson, Roper et al. 2013).

Consider pregnancy and neonates

Welfare workers are faced with very difficult decisions when working with pregnant women who are addicted. Decisions about the safety of an unborn baby need to be individual, but based on evidence. Once again,
knowledge in this area is often contested and ideas change (Bortoli, Coles et al. 2012).

There is some reason to believe that young mothers may use their pregnancy to change behaviour because the rate of substance use is lower amongst breastfeeding mothers than non-pregnant women (6% vs 17%) (Bortoli, Coles et al. 2012).

Some information is known about the impact of substances in pregnancy, but this should be regularly reviewed by workers.

Workers should be vigilant about substance misuse leading up to the birth as this may affect the parent’s ability to plan for care of the child. The Benevolent Society Early Intervention Program concluded that pregnant women with substance abuse issues often access antenatal care later than other mothers. They do not inform health workers of their substance use, are anxious, have a sense of powerlessness and/or have mood or phobic disorders and feel guilt and shame about hurting the foetus.

Knowledge of the impact of low levels of alcohol consumption in pregnancy has only developed in recent years but is increasingly taken seriously.

In addition to recognized dangers of low level alcohol consumption, binge drinking and heavy alcohol use in pregnancy are of great concern. Foetal Alcohol Syndrome can result in growth retardation, characteristic facial features and central nervous system anomalies, including irreversible intellectual impairment.

*There appears little doubt that the expression of full FAS is found in children whose mothers had a history of chronic heavy alcohol use or frequent heavy intermittent alcohol use during pregnancy.* (National Drug Strategy 2002)

While cannabis use during pregnancy is harmful to babies, it is not associated with birth abnormalities. The effects of cannabis on pregnancy are similar to those of tobacco smoking. Reduced oxygen and nutrition to the baby via the placenta may occur and result in reduced growth and development of the baby during pregnancy. Regular cannabis use during pregnancy may increase the effects that other drugs and alcohol have on the developing baby. Because cannabis use is often combined with tobacco use, there is also increased risk to the developing baby due to the effects of tobacco smoke and nicotine. Smoking during pregnancy has been associated with an increased risk of Sudden Infant Death Syndrome (SIDS) and the development of asthma and breathing conditions in children. Cannabis use during pregnancy is associated with learning and behavioural difficulties in some pre-school and young school age children. THC (Delta-9 tetrahydrocannabinol) is the active chemical in cannabis. If mothers are using cannabis, it will pass freely into breast milk and the THC levels can build up. THC attaches to fatty tissue and can remain in a baby’s body for several weeks. For this reason, breastfeeding while using cannabis is discouraged. (www.thewomens.org.au/Cannabis)

Amphetamines, heroin and methadone can move across the placenta and therefore affect a baby. Injection can result in exposure to HIV and other blood borne viruses and lifestyle can create problems. Heroin and methadone babies can experience withdrawal after birth. Polydrug use can increase risk associated with individual drug use. There can be cumulative effects from the different drugs; use of multiple drugs may complicate withdrawal symptoms. Cocaine (not considered to be widely used in Australia) has severe implications for babies as it can cause bleeding, stillbirth, miscarriage, abnormalities and severe withdrawal symptoms. A useful website for assessing drug use in pregnancy is www.adf.org.au

A worker’s ability to anticipate change in substance use after the baby is born is similarly difficult. The babies themselves may make the parenting task particularly difficult:

*Babies born to drug dependent women bring with them their own extra issues that make them more difficult to manage. As well, they have higher rates of sudden infant death, infection, developmental delays, speech pathologies and behaviour disorders related to problems of their nervous system, such as hypersensitivity to environmental stimuli (Benevolent Society).*

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The capacity of the parent to care for a newborn needs careful consideration. Recent research into the wellbeing of babies referred to child protection authorities in the UK shows that, generally, if change is to occur in the behaviour of parents, it occurs in the first six months after birth (Ward, Brown et al. 2012).

**Conclusion**

Working with children and families in contemporary Australia requires knowledge of the available evidence on drug and alcohol use, as well as assessment of individual circumstances. Professional judgment must be focused on the child and the difficult and complex decisions should be made with supervisors.

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