Submission by:
Queensland Injectors Health Network
(QuIHN) LTD

Queensland Child Protection Commission of Inquiry

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Queensland Injectors Health Network Ltd. (QuIHN) provides a range of services for people who use illicit drugs and those affected by illicit drug use and/or mental health concerns (including families, significant others and community members) across Queensland. QuIHN works from a harm minimisation framework (the basis of Australia's National Drug Strategy since 1985). The core focus of QuIHN's services is to reduce the demands and harms associated with illicit drug use, with a particular focus on dual diagnosis issues (substance use coupled with mental health co morbidity) and blood borne viral infections (e.g. HIV and Hepatitis C). QuIHN provides a comprehensive range of client-focused services to people wanting to manage, reduce or cease their illicit drug use. QuIHN also provides client-focused services to parents, and families affected by mental health concerns and substance use issues via specialised programs. QuIHN has extensive experience in providing services to the very complex dual diagnosis population and engaging such families to provide assistance to parents, their children and significant others or carers through the provision of centre based and outreach services and short to medium term interventions.

Of particular concern to QuIHN are the recent discussions under the guise of the Child Protection Inquiry of the policy of *"parendectomy"*, involving forcing dysfunctional parents to relinquish their rights over their newborn babies. The Forde Inquiry of forced adoptions of the 1960's and 1970's demonstrates the error of a policy challenging basic human rights. Despite such errors being demonstrated

through history and the legacy of systemic damage that spans generations brought about by these types of policies, the discourses of the 'bad' or 'dangerous' parent and professional's failures to prevent a child's death or injuries continue to dominate political discussion, policy and workplace practice often at the detriment of effective systemic reforms. (Lonne, Harries, & Lantz, 2012) Reorientation and rebuilding of the child protection system necessitates establishing policy and practice frameworks where productive staff and client relationships can be developed; whereby a focus is on the involvement of a range of professionals and people in the wider community rather than simply on restructuring current statutory systems that are already suffering 'change fatigue' associated with repetitive organisational restructuring and system reforms. (Lonne, Harries, & Lantz, 2012. & Melton, & Thompson, 2002) QuIHN believe that high risk families, such as those experiencing substance misuse and mental health issues, require intensive interventions targeting multiple dimensions of functioning with a focus on creating and strengthening protective factors. Early intervention with such families is a key to such an approach, as is a reorientation of current child protection practice towards practice priorities that include relationship-based practice. Such an approach works closely with families to recognise potential problems and take action to address inequalities and increase access to appropriate support. Families should not fear or feel threatened with the forced removal of their children when seeking support and assistance with problems. Such an approach must: seek to improve communication between parents and child protection workers; improve referrals for and availability and appropriateness of support services; avoid grouping parents together as they all have different life circumstances and should be viewed with uniqueness; and must avoid punishing victims of domestic violence situations and improve access and appropriateness of resources and support in assisting the victim to break away from such situations. The forced removal of children from such families should remain a last resort option when all possible support interventions have been exhausted and when there is a direct and immediate unacceptable risk of harm to the child.

Establishing the context

Parental drug use has wide ranging impacts on family functioning and the gravity of such issues are well documented in a number of research reports and other reports from government departments and non government agencies. (Hallgrimsdottir, Healy, & Foulds, 2004; AIHW, 2007; AIHW, 2010; Gruenert, Ratnam & Tsantefski, 2004; Ainsworth, 2004. Leek, Seneque & Ward, 2009; & Patton, 2004) A further factor impacting on family functioning, in relation to parental drug use, is mental health diagnoses; as evidence also suggests that mental health problems can have significant and widespread effects for both the individual themselves and their family members. (Copello, Velleman & Templeton, 2005) Furthermore, family members commonly develop problems in their own right, often manifested in high levels of physical and psychological symptoms, particularly where there is a co-occurring substance disorder involved. (Copello, Velleman & Templeton, 2005) It is suggested that these problems may be particularly deleterious for the children of parents who have mental health and drug use problems (dual diagnoses). (Copello, Velleman & Templeton, 2005) Parental drug use also creates issues in relation to family reunification, and the significant rise in the number of children entering substitute care is thought to be due, in part, to abuse and neglect arising from parental drug use among other factors. (Maluccio. & Ainsworth, 2003; Ainsworth, 2004; Leek, Seneque, & Ward, 2009; & Patton, 2004) This complex relationship between drug use, other family risk factors and the high number of children in out of home care is of particular concern. It is important to note that the presence of substance use and/or mental health issues does not directly constitute child abuse, neglect, or maltreatment; however, it is acknowledged that substance use and mental health status do have significant impacts on family functioning and widespread effects for both individuals and their family members, and the harmful use of substances is associated with elevated risks to family members, particularly when combined with mental health problems. (Copello, Velleman & Templeton, 2005 & Hallgrimsdottir, Healy, & Foulds, 2004) Many of these families also

experience social isolation, financial difficulties, stigmatisation, and mental health problems. (AIHW, 2010; AIHW, 2007; Patton, 2004; Dawe, Harnett, Staiger et.al, 2000; & Frye, Dawe, Harnett et al, 2008) The capacity of parents to be adaptable, in turn the level of family functioning, is affected by this wide range and complex set of factors, for example but not limited to, substance abuse, marital conflict, stress, mental health problems and learning difficulties. (White, 2005) A range of socio-ecological domains are thought to influence the outcomes of children raised in families with substance abusing parents, who are also subject to a multitude of protective and risk factors across such domains. (Dawe, S., Harnett, P. H., Staiger, P., & Dadds M. R. 2000) It is important to note that despite the large amount of deleterious evidence of the impact of substance use on the outcomes of children, many children demonstrate resilience due to a multitude of factors, such as when; only one parent has problematic substance use, the child is also attached to at least one other adult with whom they can develop a supportive relationship, have good communication skills, access to more resources and mental stimulation, have consistent routines and family rituals, and the extent and quality of external support systems is higher. (Gruenert, Ratnam & Tsantefski, 2004; & Hegarty, M)

The dichotomy of child protection work and family work

Following the CMC Inquiry the role of the child protection worker has become erroneously understood as a policing and administrative role. The majority of casework within the child protection system currently focuses on monitoring and reviewing of families with a core focus on administrative functions, rather than supporting and educating families. (Lonne, Harries, Lantz, 2012; & AASW, 2012) In contrast, family work seeks to provide targeted support and education to vulnerable families to keep families together and functioning. (Holzer, 2007) This draws a distinct difference between family support roles and the role of a Child Safety Officer, with the latter being focused primarily on investigation and assessment functions. (Humphreys. et al 2009) Such narratives draw on a broader dilemma,

arising at times *"through the pathologising of family life and the censure of parents in regard to child rearing practices"*, which a highly statutory framework at times invokes; and the nature of family work and its underlying goal of the creation of a therapeutic alliance with the family – both as strategies to ensure the safety and care of children. (Hansen, & Ainsworth, 2007; & Gillingham, & Bromfield, 2008) Much of the therapeutic and support work with children and families is no longer the direct responsibility of child protection workers and agencies. (Lonne, Harries, Lantz, 2012; & AASW, 2012; & Gupta, & Blewett. 2007) The child protection system has become underpinned by an ideological framework that is punitive and deficit-oriented by a strong shift in focus on the shortcomings and failings of parents or care givers where liability and accountability have become key features. (Lonne, Harries, Lantz, 2012) The number of children under care and protection orders and the number in out of home care in Australia are significantly rising. (AIHW, 2011) The rate of children in out of home care in Australia across all jurisdictions has increased from 4.9 per 1,000 children aged 0 to 17 years in 2005 to 6.7 per 1,000 children aged between 0 to 17 years in 2009. (AIHW, 2010) In 2009 to 2010 there were 35,895 children in out of home care, with the rate per 1,000 children increasing by 43% in the past five years and doubling over the past decade in Australia. (AIHW, 2011; & Lonne, Harries, & Lantz, 2012) This overall increase in the number of children in out of home care has been attributed to a number of complex factors, described as; *"the increasingly complex situations of children associated with parental substance abuse, mental health, and family violence"*, which in turn impact on the duration of time spent in care by children. (AIHW. 2010) With increasing numbers of children being placed into the care of the state there have been increasing questions about the capacity of care systems to meet their needs and out of home care systems frequently failing to provide safe, secure and consistent care to children, with unacceptably high numbers of multiple placements and resultant damage (SCRGSP, Productivity Commission, 2009; Lonne, Harries, & Lantz, 2012; Mendes, 2005; & Osborn, & Delfabbro, 2006) It is arguable that a child protection system preoccupied with risk, social control and proceduralism is

preventing the provision of quality social care and positive outcomes for children and their families. (Lonne, Harries, Lantz, 2012) Thus, it could be posited that an orientation towards ceasing, rather than restoring family relationships, with punitive and retributive approaches dominating have also contributed to increases in children under care and protection orders and those in out of home care, this is evidenced by children who have multiple placements, inconsistent workers, are not returned home or are returned home too soon, and the increasing number of young people in care who end up in the youth justice system. A greater emphasis within the Child Safety system toward effectively working with families to ensure children are able to remain safely at home is required. In order for this to be achieved within the current child protection system, a reorientation of practice towards relationship based practice is necessary. (Lonne, Harries, Lantz, 2012)

The role of family engagement and the development of a collaborative therapeutic working alliance between the family and worker are thought to be as important as the content of programs targeting multi-problem families. (Dawe, Harnett, & Frye, 2008) It is likely that many families experiencing multiple problems, including substance use and mental health, have had adverse experiences with authorities potentially resulting in a distrust of health and welfare agencies and for these families the creation of a therapeutic alliance is particularly important for child protection and family workers to achieve engagement. (Dawe, Harnett, & Frye, 2008) It has been argued that such meaningful therapeutic working relationships can be established with parents, even when parents are engaged with child protection agencies, when a procedure is outlined in which goals are set that both the parents and child safety authority agree would, if achieved, influence decision making. (Dawe, Harnett, & Frye, 2008) Such goals need to be clinically meaningful while also being manageable targets for change; even without involvement of child protection authorities, defined goals remain critical in ensuring there is a clear focus that the family is able to work towards. (Dawe, Harnett, & Frye, 2008) Parents and care givers consistently report being powerless and disenfranchised from

assessment and decision making processes when involved in the child protection system. Parents and children consistently report wanting more involvement with child protection in the assessment and decision making arena, rather than being simply told what to do. This requires a shift in relationships from unequal and adversarial relationships to one that is built on collaboration and co-operation. What is needed for families are mutually agreed; clear and understandable goals for areas that require improvement to increase family functioning and reduce risks to the children and family members; mutually agreed clear action plans within a basic framework for parents that are simple, understandable and are sensitive to the ecological context of the family that seek to address priority areas that are important for functional child development. Such an approach must recognise the importance of the family, involvement and participation, and the ideals of family empowerment and restoration, in the long term interests and well being of the children involved in the child protection system. (Lonne, Harries, Lantz, 2012. Burford, 2005; & Connolly, 2007, 2009)

Parents affected by significant substance use issues and mental health diagnoses may often avoid seeking out help for parent-child problems for a multitude of reasons, such as general disempowerment and isolation or marginalisation from traditional health services, limited insight into the impact of mental illness or drug use, poor social resources, fear of discrimination and stigmatisation, and poor self esteem and self confidence in relation to parenting. (Dawe, Harnett, Staiger et al, 2000; & Hegarty, 2006) Parents using illicit substances may also fear that their substance use will be exposed, which may lead to intervention by child protection authorities, and parents with a mental illness often may fear that requests for help regarding their children will result in a loss of custody. (Hegarty, 2006; & Hearle et al, 1999) Additionally, substance misuse and/or mental health issues are sometimes subject to 'blaming' processes by professionals who may choose to discount other more constant stressful situations under which some people are forced to live difficult lives. (Hansen, & Ainsworth, 2007; & Gillingham, & Bromfield, 2008) Thus

limiting and further hindering the ability for such families to seek appropriate care and assistance from services. Anecdotally it is reported that the double stigma of substance use and mental health problems generally reduce a families capacity to engage services, there is often a significant fear factor that as soon as families become involved in support services they fear involvement of the child protection system and more so fear the forced removal of their children.

Often families experience a range of multiple and complex needs and influences that act as barriers to the achievement of goals. The families that QuIHN work with and that come into contact with the statutory child protection system are generally families with multiple and complex needs that go far beyond what people might think of as everyday problems. The ecology of families with multiple and complex needs includes issues such as; substance misuse, mental health, poverty, domestic violence, chronic unemployment, homelessness and vulnerable housing, unsafe and under resourced neighbourhoods and micro communities, isolation, individual and systemic discrimination, racism, and disempowerment. In such ecological circumstances it becomes hard to imagine raising a child in an environment where there are multiple, complex problems that act as serious barriers to *"good"* or *"good enough"* parenting, despite how well committed and good intentioned a parent might be. Yet often the response from child protection authorities is singular and focuses merely on the drug use and/or the mental health status of the parent or parents, with little attention to addressing the complexity of the underlying ecological problems that act as significant barriers (i.e. poverty, domestic violence, chronic unemployment, homelessness and vulnerable housing, unsafe and under resourced neighbourhoods and micro communities, isolation, individual and systemic discrimination, racism, and disempowerment) to *"good"* parenting. It is therefore imperative that care plans between statutory services and families are sensitive to such stressful situations and challenges for families. Finally, families should be viewed as the experts in their own lives; child protection workers whom work with complex and multiple needs families need to be well qualified in an

appropriate and related discipline to child and family issues, critically reflective and respectful of each family's life circumstances. The "Review of the Qualifications and Training Pathways, Department of Child Safety" in 2007 stated that *"the multiple needs of children and young people in the statutory system requires a diversely skilled and qualified workforce which has the ability to respond from a multi-disciplinary perspective and offer particularly vulnerable children and young people the best possible outcomes"*. It is concerning that the Department has subsequently opened its recruitment to a plethora of qualifications. It is questionable what such a plethora of disciplines bring to practice frameworks with some of society's most vulnerable individuals and families? Do such frameworks ensure sufficient attention to areas such as social justice, critical reflection, and anti-oppressive practice?

Early intervention and access to resources required to support child abuse prevention to at risk families

Both the Forde Inquiry and the CMC Inquiry recommended that child protection services require access to resources required to support child abuse prevention to at risk families, specifically, increased access to resources for working with families with children living at home. Despite such recommendations there appears to be problematic access to resources to support at risk children living with their biological families. It is therefore imperative that child protection services have readily accessible and available funding for support services to maintain at risk children in their family home wherever possible. The Forde Inquiry and the CMC Inquiry recommended that child protection services have access to resources required to support child abuse prevention to at risk families, and specifically referred to increased resources towards working with at risk families with children living at home. However, evidence indicates that there is a significant mal-distribution of resources towards investigation and away from early intervention and prevention services. In addition to a greater emphasis within the Child Safety system toward effectively working with families to ensure children are able to

remain safely at home a greater investment is required towards funding for family support and preservation services. High risk families, such as those experiencing substance misuse and mental health issues, require intensive interventions targeting multiple dimensions of functioning with a focus on creating and strengthening protective factors. (Dawe, Harnett, Staiger, et al. 2000) Service responses need to include a mixture of targeted prevention and early intervention, and recreational opportunities for children, while focusing on parents needs; including, family strengthening, mediation and support, parenting and life skills education programs, responsive and flexible respite, and accessible and affordable child care and well supported out of home kinship care. (Gruenert, Ratnam & Tsantefski, 2004) It has been identified that access and navigation of services for people with dual diagnosis is highly complicated and even more difficult for people who have dual diagnosis and who are parents. (Queensland Health, 2008. Staudt, & Cherry, 2009; & Hegarty, 2006) With increasing complexities of multiple needs, such as substance use and mental health issues, it is critical a continuum exists in the form of collaboration between early intervention and statutory services; while ensuring families remain supported in achieving outcomes – whether voluntary, directed, or compulsory in regards to substance use, mental health and child protection issues. (Humphreys, C. et al 2009) This requires a collaborative and inter agency driven approach that is designed to provide comprehensive services that attend to a multitude of issues rather than narrowly focused services that attend to discrete issues. (White, 2005) The requirement for greater collaboration between early intervention and tertiary services is required at the point when parents are identified as high risk with multiple needs; when such families enter into the child protection system the family workers and agencies conducting interventions and home visits need to be more involved in decisions made by statutory authorities. Drug and alcohol services remain an extremely important point of child-family intervention based services. For example, the drive to be a better parent has been cited as a key reason for parents to seek drug treatment and during the course of engagement in such services there is a valuable protracted period of contact with

clinical services providing important opportunities for the provision of child-family intervention services at a time when drug use may be relatively more stable. (Gruenert, Ratnam & Tsantefski, 2004; & Dawe, Harnett, Staiger et al, 2000)

Similarly, such services are well placed to continue to deliver behavioural family interventions. Research generally supports the short and long term effectiveness of intensive behavioural family interventions in improving parent-child relations. (Dawe, Harnett, Staiger et al, 2000; & Dawe, Harnett, & Frye, 2008) It is critical that behavioural family intervention services also include additional individualised plans to address such multiple level needs, for example; life-skills training such as self management, concurrent marital therapy and mediation, anger management, training in selection and arrangement of activities for children in high risk situations, social support training, and development of strategies for better home-school liaison, among other areas. (Dawe, Harnett, Staiger et al, 2000) The importance of individualised plans reflects the reality that any combination of problems may be hindering the achievement of goals for change in the family. (Dawe, Harnett, Staiger et al, 2000) Behavioural family interventions should encourage parents to identify goals for change and parents should then be encouraged to identify the range of influences that act as barriers to the achievement of such goals, thus providing a clear basis for intervention to improve the wider ecology of the family. (Dawe, Harnett, Staiger et al, 2000) Areas of family life that are not identified as potential problems can be thought of as potentially facilitating factors and acknowledging such areas can be helpful for families. (Dawe, Harnett, & Frye, 2008) For example, parents faced with multiple level problems may often face reduced emotional resources to cope with their children's needs, however if a support network is available parents may turn to these people for assistance with such needs. (Dawe, Harnett, & Frye, 2008) Additional to professional support raised and accessed via community and other services, social support (including support received from family members and friends) is extremely important. Social support, particularly in the case of substance use and mental health, is a critical

factor in the ability of parents' to cope with the pressures of parenting, and other than formal links to services it may frequently include more informal support provided by family members and friends. (Gruenert, Ratnam & Tsantefski, 2004) The role of connectedness to family and to the wider community is thought to play a key role in the emotional wellbeing of children, and to protect against some of the negative impacts of parental substance misuse. (Dawe, Harnett, Staiger et al, 2000) Outcomes are arguably generally better for families when there is a level of both professional support from services and support from family and friends, however that access to and level of support received is strongly influenced by a range of factors. Accessing support from family and friends may be complicated and hindered by substance use and/or mental health diagnoses; therefore it is imperative such support is made readily available to complex and multiple needs families via the brokering of various support services. This is particularly so as research on the various modalities and access to social support in Australia indicates that many people turn to their families for assistance with tangible needs; however such assistance is generally not available to those families who have experienced long term drug or alcohol problems. (Gruenert, Ratnam & Tsantefski, 2004) In order to increase social support opportunities among families affected by substance use and/or mental health, the provision of home visits from appropriately trained professionals delivered through a brokered system may be required. For example, research indicates that women with substance misuse problems often feel unable to attend a range of community activities and parents who have limited social support and live socially isolated are at greater risk for poorer parenting practices. (Dawe, Harnett, & Frye, 2008) The provision of tailored and individualised behavioural parent training, counselling, interpersonal problem solving and other interventions delivered in the home may be particularly important for parents who are significantly affected by social isolation. Within intervention programs targeting families with multiple problems, such as substance use and mental health, there exists a need for individualised approaches delivered in a multitude of settings, including the home. This may be particularly important

for this population, as the provision of home based services may assist in the creation of a non threatening environment and may decrease the potential for loss of engagement in intervention programs, while assisting the family support worker to identify potential facilitating factors and other difficulties in coping, thus allowing greater opportunity for learning alternative coping skills to assist with multiple life stressors. The nature of mental health and/or substance use often may also lead to situations of personal and family crisis, it is therefore particularly important that families are assisted in developing crisis management plans for dealing with such situations if and when they arise.

A shift in policy and approaches to dealing with problematic families has begun occurring, resulting in more emphasis on early interventions to support children and families, particularly those considered to be high risk. (Humphreys, Harries, Healy, et al 2009; & COAG, 2009) The evidence of the effectiveness of early interventions has continued to grow and rather than weighting investment into statutory interventions there is good reason to supporting families and children through universal and specialist services. (Humphreys, Harries, Healy, et al 2009) However, surges in demand have continued to create competing demands to simultaneous fund the statutory system at the expense of earlier interventions. (Humphreys, Harries, Healy, et al 2009) Previous commentary on the funding of early interventions and the child protection system provide reference to the challenges of resourcing universal early intervention systems, while still maintaining the funding needed for such a system to provide statutory responses. (Humphreys, C. et al 2009). This challenge is further complicated by the increasingly complex and multiple needs of families, such as those of families affected by dual diagnosis, which requires a highly collaborative and efficient system well connected to community based services and other resources. Such challenges are complicated and the increasing recognition that families have multiple level and complex needs, including substance use issues and mental health, leads to a requirement for the development of multi level responses.

There is good reason to supporting families and children through universal and specialist services and alcohol and drug services remain an extremely important point of child-family intervention based services. (Dawe, Harnett, Staiger et al, 2000) However the challenge remains in resourcing early interventions in order to effectively provide targeted prevention and support to vulnerable families while reducing the demand on the statutory system. (Humphreys, et al. 2009) This challenge is further complicated by the increasingly complex needs of families, such as those experiencing issues associated with dual diagnosis and there is increasing recognition that families have multiple level needs leading to a requirement for multi level responses. It is critical that a continuum exists in the form of collaboration between and within early intervention and statutory services to ensure families remain supported in achieving outcomes. (Humphreys, et al. 2009) Community services require resourcing in order for such services to be able to re focus from primarily dealing with adult problems to be better placed to address the 'whole' family affected by dual diagnosis and to provide family facilities. High risk families require a mixture of intensive interventions and other less intensive interventions targeting multiple dimensions of functioning with a focus on creating and strengthening protective factors. (Dawe, Harnett, Staiger, et al. 2000) Further research is needed in relation to both the long term effectiveness of such intensive interventions and the role of home visits among vulnerable families experiencing dual diagnosis issues. (Dawe, Harnett, & Frye, 2008. & Holzer, et al, 2006) The role of family engagement and the development of a collaborative therapeutic working alliance remains a critical element in the delivery of such interventions. (Dawe, Harnett, & Frye, 2008) Families with multiple needs require clear and understandable goals to work towards that are both clinically meaningful and agreed on by parents and services. (Dawe, Harnett, & Frye, 2008) It is critical that child protection and behavioural family intervention services seek to improve the wider ecology of the family by the inclusion of individualised action plans for families with multiple needs which encourage parents to identify goals for change

and the range of influences that act as barriers to the achievement of goals. (Dawe, Harnett, Staiger et al, 2000) Families with multi level needs require the ability to access and receive assistance from social support networks, and given the difficulty observed for many in obtaining social support, intervention programs should focus on strengths based practice that seeks to identify and create such support networks. Given the complexity of issues and the requirement for family support work to be tailored to families needs and intensive but time limited, it is essential for the effective treatment of multi problem families that staff have small case loads. (Dawe, Harnett, & Frye, 2008) Service responses need to include a mixture of targeted prevention and early intervention, and recreational opportunities for children, while focusing on parents needs; including, family strengthening, mediation and support, parenting and life skills education programs, responsive and flexible respite, and accessible and affordable child care and well supported out of home kinship care. (Gruenert, Ratnam & Tsantefski, 2004) The role of drug use and mental health in the causes of family dysfunction and risk is highly complex as is the ability to seek care for family problems among people affected by substance misuse and mental health. (Hegarty, M, 2006) Gaps in consumer access and barriers to the ability to navigate services among people with dual diagnosis requires further attention and effort to ensure services are accessible and responsive to access issues. Finally, there is a requirement for the child protection system to give due attention to a reorientation to a more public health driven model, whilst mindful of the imperative to safeguard vulnerable children, this requires a shift away from forensically oriented and punitive approaches to those that focus on universal services, prevention of harm and the promotion of safety and well being. (Lonne, Harries, Lantz, 2012) Such an approach requires the involvement of a range of professionals and people in the wider community and must seek to tackle the underlying causal and contributory factors related to child abuse from a 'whole of government' perspective that crosses various demarcations such as housing, education, health, and child welfare and seeks to draw in various sectors such as housing, alcohol and drug, and employment, to name only a few. Such an approach

may provide greater multi faceted strategies that seek to address the underlying risk and protective factors.

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