

Issues for the safety and wellbeing of children in families with multiple and complex problems

The co-occurrence of domestic violence, parental substance misuse, and mental health problems

Leah Bromfield, Alister Lamont, Robyn Parker and Briony Horsfall

Families with multiple and complex problems are no longer a marginal group in service delivery. In fact, they have become the primary client group of modern child protection services. The challenge for child protection services is to respond holistically to address inter-related problems, in order to better support families to make and sustain changes to better meet the needs of children.

Introduction

The factors most commonly associated with the occurrence of child abuse and neglect, and identified in families involved with child protection services, are domestic violence, parental substance abuse and parental mental health problems (Cleaver, Nicholson, Tarr, & Cleaver, 2007; Cleaver, Unell, & Aldgate, 1999; Scott, 2009). The significance of parental substance misuse, mental health problems and domestic violence is made clear in the National Framework for Protecting Australia's Children, which states "A particular focus is sustained on key risk factors of mental health, domestic violence and drug and alcohol abuse" (Council of Australian Governments, 2009, p. 21). Families in which parents present with these problems are often situated within a wider context of exclusion and disadvantage (e.g., housing instability, poverty, low education, social isolation and neighbourhood disadvantage). Parents may also be struggling to come to terms with their own experiences of trauma and victimisation. These types of problems are complex, often inter-related, and chronic in nature and rarely occur in isolation. Where these problems occur within families, the families are described as "families with multiple and complex problems".



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This paper investigates the separate impacts of parental substance misuse, domestic violence and parental mental health problems. It presents evidence regarding the extent to which these problems co-occur and a discussion of the wider context of exclusion and disadvantage, its causes and its consequences. Finally, it provides an overview of research and theory for working with families with multiple and complex problems.

Families with multiple and complex problems are families with multiple, chronic and inter-related problems, the constellation of which can result in children's needs being unmet, and children being at heightened risk of abuse and neglect (Cleaver et al., 2007; Cleaver et al., 1999).

How do drug and alcohol misuse, mental health problems and domestic violence affect parenting?

Substance misuse, mental health problems and domestic violence are commonly associated with child protection involvement and are described as "key risk factors" for child abuse and neglect. There is substantial research documenting the association between these parental problems and poor outcomes for children. Children are particularly vulnerable to cumulative harm in families with multiple and complex problems in which the unremitting daily impact of multiple adverse circumstance and events has a profound and exponential impact on children, and diminishes their sense of safety and wellbeing (Bromfield & Miller, 2007). Despite the strong association between these parental problems and child protection, there is limited guidance for practitioners that sets out exactly *how* these problems affect parenting. The focus of this section is to identify the adverse effects of parental mental health problems, substance misuse and domestic violence on individuals, their parenting behaviours and the consequent immediate risks to children.

This paper does not investigate the subsequent long-term effects of abuse and neglect on children.

For more information on the long-term effects of abuse and neglect for adult survivors, see Lamont (2010).

It is important to note that the severity and longevity of the effects of parental substance misuse, mental health problems and domestic violence on children depend upon the nature, extent and severity of the problem and manner in which it affects the individual. Not all children whose parents experience mental health problems, substance misuse or domestic violence will experience poor outcomes. For example, in a meta-analysis of 118 studies, Kitzmann, Gaylord, Holt, and Kenny (2003) found that 37% of children who had witnessed domestic violence had comparable or better outcomes than children from otherwise similar backgrounds who had not witnessed domestic violence. The extent to which parenting capacity is sustained or diminished and children are at risk of abuse or neglect is also influenced by the presence of protective factors. Responses within families are diverse; some children are able to experience supportive and nurturing environments despite the presence of parental problems. This section draws on research about mental health problems, substance misuse and domestic violence to unpack how these problems can affect individuals, their capacity to parent and, in turn, their child's risk of experiencing abuse or neglect.

Despite the strong association between these parental problems and child protection there is limited guidance for practitioners that sets out exactly *how* these problems affect parenting.

How can parental substance misuse affect parenting?

Individual impacts

- There are many different types of licit and illicit substances. The substances most commonly involved in parenting concerns are alcohol, opiates (heroin, cocaine), amphetamines (ecstasy, speed), psychoactive drugs (marijuana) and the overuse of prescription drugs.
- Substance use affects the brain, impairing the senses (e.g., blurred vision, impaired hearing), perception (e.g., reaction time, balance), motor skills (e.g., impaired coordination, shaking), speech and judgement (e.g., reason, caution, self-restraint, inhibitions). Depending upon the nature of the substance, it may act on the brain as an accelerant (e.g., methamphetamine) or a depressant (e.g., alcohol). Some substances can induce violence (e.g., alcohol) or paranoia (e.g., "ice") in some users. Substance misuse may result in extreme lethargy, tiredness, lack of consciousness or "passing out", coma and death.
- Withdrawing from addictive drugs can also have severe adverse affects such as increased anxiety, irritability, sleeplessness, depression, vomiting and paranoia (NSW Department of Community Services, 2004).
- There are serious long-term health effects for chronic substance misuse (e.g., cancer, liver failure, heart disease), which may themselves impair functioning (Commonwealth of Australia, 2007; NSW Department of Community Services, 2004).
- Maintaining a substance addiction may include involvement in drug dealing (as a buyer or supplier) or criminal behaviour such as shoplifting, burglary or prostitution as individuals attempt to finance their drug habit.

Impacts on parenting behaviour

- Symptoms of intoxication and withdrawal may mean that parents find it difficult to maintain household tasks and routines such as preparing meals, ensuring the child's clothes are clean, supervising children, maintaining regular routines for school attendance and responding to their children's emotional needs (Dawe, Harnett, & Frye, 2008)
- Financial difficulties may arise as parents may ignore buying household essentials such as food, clothes and bills in order to pay for drugs (Dawe et al., 2007).
- Substance misuse influences a parent's mood and can cause inconsistent parenting as a result of fluctuating mood swings, which may result in parents on some occasions using controlling, authoritarian and punitive parenting and, at other times, permissive and neglectful parenting styles (Dawe et al., 2007). Parents themselves have reported yelling more often, being inattentive, being more self-focused, using reactive or authoritarian parenting, creating an atmosphere of secrecy and allowing the child to take on a parenting-type role when affected by substance misuse (Odyssey House Victoria, 2004).

Risks to children

- There is a high risk of neglect for children whose parents misuse substances. For example, poor supervision may lead to children's needs not being met (having regular healthy meals, clothes being washed, attending school, emotional attention and nurturing) (Dawe et al., 2007).
- Children are at risk of physical and emotional abuse if a parent's response to intoxication or withdrawal symptoms is violent, reactive or punitive (Dawe et al., 2007). They may also be at risk of sexual abuse by a parent if the parent has a predisposition to abuse due to loss of inhibition (Dawe et al., 2007). Children are also at risk of sexual abuse from extra-familial perpetrators, especially when the child is at risk of supervisory neglect. Exposure to drug use, drug overdose, drug dealing and other criminal activity is also possible (Dawe et al., 2007).
- Children may develop pervasive fears: of fights and violence (to parent or themselves); of discovery of family secret and the parent being incarcerated or the child being removed; or for parents' wellbeing and safety. The added emotional stress can harm the development of children's brains and impair cognitive and sensory growth (Perry, 2001). Therefore children are at risk of poor developmental outcomes. Fears may trap children into a position where they cannot discuss their parent's drug problems or ask for help—from their parents, their peers, other family members, family support networks or professionals (Dawe et al., 2007; Odyssey House Victoria, 2004).
- Even before birth, babies in the womb experience the adverse effects of poor diet, drugs and alcohol use, or violence perpetrated on their mother. Maternal stress experienced during pregnancy can cause physiological stress responses in the foetus, which affect the amount of oxygen and nutrition received by the unborn child (Rice, Jones, & Thapar, 2007). Other peri-natal complications may include withdrawal symptoms and premature births (Kroll & Taylor, 2003; Tunnard, 2002).

How can domestic violence affect parenting?

It is vital to consider violence between intimate partners in the context of parenting, as research shows that violence between intimate partners is more likely to occur between couples with children, often commencing during pregnancy (Taft, 2002). Violence between intimate partners is overwhelmingly a gendered issue with the vast majority of incidents involving a female victim and male perpetrator (Australian Bureau of Statistics, 2005). While acknowledging that there are other patterns of violence (Australian Bureau of Statistics, 2005), in this paper we address the issues presented by this dominant pattern of men's violence towards women. This is evident in the way in which parenting impacts are delineated below for mothers as victims and fathers as perpetrators of intimate partner violence.

Individual impacts

- Physical assaults may result in a range of injuries (e.g., bruising, scratches, cuts, burns, bone fractures). Long-term physical assault may result in reduced mobility, long-term adverse health effects, disability, miscarriage and sexual and reproductive health problems. A Victorian study showed that domestic violence is "responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking" (VicHealth, 2004, p. 8).
- There is a well-established relationship between the experience of intimate partner violence and mental health problems (e.g., depression, anxiety, trauma, self-harming and suicide) (Campbell, 2002; Golding, 1999; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; VicHealth, 2004). Although not as strong, there is also an association between the experience of domestic violence and substance misuse (Golding, 1999; see previous and following sections for discussions of substance misuse and mental health problems).
- Domestic violence includes sexual assault by an intimate partner (Heenan, 2005). In a national survey of Australian women, 12% reported experiencing sexual violence perpetrated by a current or former partner. Of women who were sexually assaulted by their partner, 73% were also physically assaulted (Mouzos & Makkai, 2004).
- Domestic violence is linked with homelessness and housing instability for victims fleeing violent partners. Data from the Supported Accommodation Assistance Program (SAAP) for 2007–08 show that the main reason females with children sought support was domestic or family violence (50%) (Australian Bureau of Statistics, 2006). Around 100,000 Australians are homeless, including 7,483 homeless families (10,608 parents and 16,182 children). Of this homeless population, 12% are children under 12 years (most accompanied by a parent) and a further 21% are aged 12–18 years (these children are mainly on their own) (Australian Bureau of Statistics, 2006).
- At its most extreme, domestic violence can result in death. In Australia, approximately 20–25% of all homicides were perpetrated by spouses (Mulroney, 2003).

Characteristics of perpetrators

- Perpetrators of domestic violence have been shown to display the following characteristics towards their partners:
 - control;
 - entitlement;
 - selfishness and self-centredness;
 - superiority;
 - possessiveness;
 - confusion between love and abuse (e.g., claiming they would not become violent with their partner if they did not love the partner so much);
 - manipulation;
 - externalisation of responsibility;
 - denial;
 - minimisation; and
 - victim blaming (Bancroft & Silverman, 2002).
- Service providers are cautioned to avoid making assessments about violent men’s propensity for future violence based on self-reports. Men who are violent towards their partners may make strong anti-violence statements while continuing their violent behaviour (Bancroft & Silverman, 2002). In terms of adverse effects, perpetrators of domestic violence may experience homelessness, housing instability, relationship breakdown, separation from their children, loss of contact with their children and disintegration of father–child relationships, criminal charges, prosecution, and incarceration as a result of their violent behaviour.

Impacts on parenting behaviour

Mothering

- Mothers who have experienced domestic violence are frequently held responsible for “failing to protect” their children (Holt, Buckley, & Whelan, 2008) but research shows that the majority of mothers make considerable efforts to protect their children (Mullender et al., 2002). Women may actually choose to remain with violent partners as they consider it too dangerous to leave. With evidence that violence frequently continues and may actually increase after separation (Holt et al., 2008) such fears cannot be discounted. These findings suggest that a blaming approach with mothers is unlikely to be helpful.
- Effects of violence (e.g., pain, distress, anger, irritability, fear, reduced mobility, hospitalisation) may affect a mother’s parenting capacity, as may mental illness or substance misuse problems that emerge as a consequence of domestic violence (see previous and following sections). Domestic violence may result in mothers being emotionally distant, unavailable or unable to meet their children’s needs (Holt et al., 2008).

I didn’t have the same patience with the children when he was there, because I think I was frightened he was going to lose his temper. (Mother in Mullender et al., 2002)

- In their attempts to prevent or manage men's violence, and as a result of living in fear, mothers have reported prioritising their partner's needs over those of their children and denying their children normal childhood experiences (Humphreys, Houghton, & Ellis, 2008; Holt et al., 2008, p. 801). "I was so hooked into placating him that I emotionally neglected the kids" (mother in Mullender et al., 2002).
- Evidence suggests that violence can damage the mother–child relationship. Belittling, undermining, insulting and hitting women in front of their children may affect children's respect for their mother's authority (Bancroft & Silverman, 2002; Humphreys, 2007), and her ability to exercise authority and control over her children (Holt et al., 2008).
- It is worth noting that some research suggests that the effects of domestic violence on mothering may not be permanent. A study in the United States found that women who had experienced intimate partner violence in the past but were no longer victims had significantly better scores on a self-reported measure of parenting skills than women who were currently experiencing violence from an intimate partner. There was no significant difference between women who had experienced intimate partner violence in the past and women who had never experienced intimate partner violence (Casanueva, Martin, Runyan, Barth, & Bradley, 2008). On a similar theme, children who had escaped domestic violence with their mothers predominantly felt that their fathers were to blame and reported wanting to stay with and support their mums (Mullender et al., 2002).

Fathering

- There is limited research regarding the effects of domestic violence on father–child relationships or on men's capacity to father. The fathering practices of men who are violent towards their intimate partners will vary along a continuum of abusive to optimal parenting. It has been argued that men who perpetrate family violence cannot be fully responsible parents, as exposing children to domestic violence is in itself abusive (Bancroft & Silverman, 2002).
- Based on their clinical experience Bancroft and Silverman (2002) identified common parenting characteristics of men who were violent towards their spouses. The characteristics, which are further validated from other empirical evidence, suggest that men who were violent towards their spouses were more likely to:
 - have developmentally inappropriate behavioural expectations of children (Fox & Benson, 2004);
 - generally be under-involved with their children and less physically affectionate but, at times (and unpredictably), to be powerfully present in the child's life, interacting with energy and humour, and spending money freely;
 - be authoritarian and rigid when involved in the disciplining of children, and self-report being more likely to use physical punishment and to "smack hard" (Fox & Benson, 2004);
 - be self-centred and put their own wants above the needs of their children, or even believe that children exist to meet their fathers' needs (Fox & Benson, 2004; Mullender et al., 2002);
 - behave in a manner that suggests they are resentful for their children being the centre of attention (Humphreys et al., 2008; Radford & Hester, 2006);

- undermine (in addition to being violent towards her) their children’s mother by overruling her parenting decisions, ridiculing, belittling and insulting her in children’s presence or to children, and telling children that their mother is a bad or unsafe parent (Humphreys, 2007; Holt et al., 2008; Radford & Hester, 2006);
 - be manipulative with their children: for example, creating confusion about which family members are responsible for violence and encouraging children to blame themselves or their mother (Radford & Hester, 2006); and
 - make statements and express emotions regarding their love and pride for their children and desire to be involved in their children’s life, despite the confusing reality of their underinvolvement (Rothman, Mandel, & Silverman, 2007).
- Children’s reports of the damage or disintegration of the father–child relationship as a result of domestic violence focus on betrayal of trust, loss of respect, seeing their father as a source of fear and terror, loss of love, and hatred for their father (Mullender et al., 2002). “We do not see my dad now and don’t want to see him. I am happy about not seeing him” (8-year-old girl in Mullender et al., 2002).

Risks to children

- The term “witnessing” domestic violence may imply that children are passive observers who see or hear the violence between the adults in their home but research shows that children *experience* domestic violence rather than being passive onlookers.
- In a US study, mothers reported that:
 - 37% of children were accidentally hurt during domestic violence;
 - 26% of children were intentionally hurt during domestic violence;
 - 49% of mothers were hurt protecting children;
 - 47% of perpetrators used the child as pawn to hurt mothers;
 - 39% of perpetrators hurt mothers as punishment for children’s acts;
 - and 23% of perpetrators blamed mothers for perpetrator’s own excessive punishment of children (Fox & Benson, 2004).
- Children are sometimes hurt as a part of the torture and abuse of their mothers. They may be held hostage or threatened. Children may also be forced to watch or perpetrate the abuse of their mother, other siblings or pets (Humphreys et al., 2008; Radford & Hester, 2006).
- The psychological effects of witnessing verbal, physical and sexual assaults perpetrated upon the mother, combined with the effects of living with a father who is frightening, inconsistent, intolerant, and unable to put children’s needs first are abusive.
- The toxic stress and complex trauma caused by living in a perpetual state of alert can damage the developing brain and have profound long-term psychological effects (Perry, 2001).
- Children living with domestic violence display physical, developmental, psychological and behavioural effects, as well as the impact of trauma and developmental regression. Compared to those who don’t witness abuse, children who do have been shown to have significantly poorer outcomes on 21 childhood psycho-social, developmental and behavioural dimensions. Behav-

Journal problems include acting out, violence and aggression towards others. Outcomes for child witnesses were similar to those where children were also directly physically abused (Kitzmann et al., 2003).

- Family violence has different effects on children at different ages. In utero, the mother's physical and emotional distress has a direct impact on the developing foetus (Jordan & Sketchley, 2009). Assault of the mother may result in miscarriage, premature birth, physical injury or disability (Cleaver et al., 1999; McGee, 2000). Infants and younger children are at risk of being harmed while being held in the mother's arms during an assault; older children may be harmed while intervening to defend their mother from assault (Humphreys et al., 2008).
- The presence of domestic violence puts children at high risk of experiencing physical abuse with rates of co-occurrence ranging from 45% to 70% (Holt et al., 2008).
- There is evidence that the presence of domestic violence also increases the risk of child sexual abuse (Holt et al., 2008). If children are sexually abused, they may also be less likely to disclose. Perpetrator manipulation, threats and intimidation, damage to mother-child relationship and a belief that their mother cannot protect them may delay or decrease the likelihood of disclosure.
- The effects of domestic violence on women can result in mothers who are emotionally distant, unavailable or unable to meet their children's needs and therefore increase the risk of children experiencing neglect.

How can parental mental health problems impact parenting?

Individual impacts

- The term "mental illness" is usually used when referring to a specific, diagnosable disorder, such as schizophrenia, while the term "mental health problem" is broader and includes problems that interfere with a person's daily functioning but to a lesser extent than a "mental illness" (Huntsman, 2008).
- The main mental health problems that are likely to affect parenting are depression, bipolar disorder, schizophrenia, borderline personality disorder, post-traumatic stress disorder, and antisocial personality disorder.
- *Depression* is a mood disorder. Symptoms include: depressed mood (sadness, emptiness); sleep disturbances (either not being able to sleep well or sleeping too much); loss of interest, motivation and energy; difficulty in concentrating, in holding a conversation, in paying attention or making decisions that used to be made fairly easily; and suicidal thoughts or intentions (American Psychiatric Association, 1994).
- *Bipolar disorder* is also a mood disorder, in which the individual experiences episodes of mania and depression. Mania is an intense high where the person feels euphoric, may have elevated self-esteem, be talkative, have reduced need for sleep and be easily distracted. The high quickly fades, after which intense depression is often experienced, which can be exacerbated by rash decisions made while manic (e.g., spending too much money, misuse of drugs or alcohol) (American Psychiatric Association, 1994).

- *Schizophrenia* is a psychotic disorder typically emerging in adolescence or early adulthood that may be triggered through stress. Symptoms include: delusions; hallucinations; disorganised behaviour or speech; flattened or inappropriate emotions; and poor social interaction (American Psychiatric Association, 1994).
- *Borderline personality disorder* is most commonly diagnosed in females and often where there is a childhood history of unstable relationships, sexual abuse, family violence or neglect. Major symptoms are unstable relationships, poor or negative sense of self, inconsistent moods, impulsivity and an intense fear of abandonment. Symptoms are constant, enduring and affect most—if not all—aspects of life and typically emerge during adolescence (American Psychiatric Association, 1994).
- *Post-traumatic stress disorder* occurs in response to a traumatic event. Symptoms typically emerge shortly after the event, but may take years to fully manifest. Symptoms can be enduring if untreated and include re-experiencing the trauma through nightmares; obsessive thoughts; flashbacks; avoidance (of situations, people or objects that are reminders of the traumatic event); and increased anxiety (American Psychiatric Association, 1994).
- *Antisocial personality disorder* is sometimes referred to as psychopathy or sociopathy and is characterised by a pervasive disregard for others' rights. It is preceded by a history of conduct disorder through childhood and adolescence, marked by violations of norms relating to aggression towards people and animals, destruction of property, deceitfulness or theft, or serious violation of rules. Other characteristics that may be associated with this disorder include engagement in unlawful behaviour; being arrogant, opinionated and superficially charming; indifference to others' wishes, rights or feelings; being deceitful and manipulative; impulsiveness; aggression and irritability; reckless disregard for their own or others' safety; being irresponsible with respect to work and money; and showing little remorse (American Psychiatric Association, 1994).

Impacts on parenting behaviour

- Research on the effects of mental health problems and their effects on parenting is limited. Research that has been done has mainly concentrated on depression (Huntsman, 2008).
- The symptoms of a mental health issue can influence a parent's perception, cognition and communication (Hegarty, 2005; NSW Department of Community Services, 2004). Problems in parenting associated with mental health conditions have included being emotionally unavailable, withdrawn, unresponsive, overly critical, being disorganised, inconsistent, tense, less happy and active with children (Mowbray et al., 2000).
- Difficulty controlling emotions can cause parents to become unnecessarily angry with their children. A mental health problem may make it difficult for parents to get out of bed in the morning to take their children to school. A loss of motivation can also cause difficulties in performing basic tasks such as doing housework or the shopping (Hegarty, 2005).
- The characteristics of antisocial personality disorder can lead to a lack of responsible parenting in the areas of safety; hygiene; nutrition; responsive nurturing of feelings; dealing adequately with illnesses and physical injuries; and managing money for household goods. Some parents may be fearful of abusing their children and so become withdrawn, or alternatively they may feel an intense need to protect their children and so appear intrusive and anxious (Newman & Stevenson, 2005).

Risks to children

- Children of parents with an uncontrolled mental illness face a high risk of physical neglect. Basic needs may not be met, such as having regular healthy meals and clean clothes (Cowling, 2004). Parents may fail to attend to children's emotional needs, which can instil a sense of isolation and possible mistrust in children. There are risks of physical and psychological abuse by parents, if symptoms of illness contribute to the parent being violent, reactive or punitive (Cowling, 2004).
- Parental mental health problems can also increase the risk of peri-natal complications due to possible side effects of medications, (e.g., antidepressants) during pregnancy and high stress levels in mothers (Cowling, 2004; Huntsman, 2008). Attachment difficulties may arise for babies and infants of mothers with maternal mental health problems such as depression (Cowling, 2004).
- Children may become "parentified" and assume the role of a carer for an ill parent or sibling. This can cause significant emotional stress and disrupt a child's general development (Huntsman, 2008).
- Children of parents with mental health problems have also been found to be at risk of developing mental health problems of their own (Cowling, 2004). Problems in a child's cognitive development may also arise due to the parent's inconsistent and neglectful behaviour (Cleaver et al., 1999).
- The recklessness associated with antisocial personality disorder and the tendency of those suffering from it to minimise the harmful consequences of their actions can put a child at risk of serious or chronic illness, injury and death. In addition, the promiscuity and poor relationship choices made by some adults with antisocial personality disorder may put a child at risk of abuse from others (Newman & Stevenson, 2005).

The co-occurrence of parental mental health problems, substance misuse and domestic violence

The previous section explored how mental health problems, substance misuse and domestic violence individually affect parenting, the effects of which may diminish parenting capacity. This in turn can place children at heightened risk of abuse and neglect. Individually, parental mental health problems, substance misuse and domestic violence represent significant risk factors for child abuse and neglect, but the reality is that parenting problems rarely occur in isolation. Instead, they tend to be part of a complex and inter-related group of problems.

Australian child protection services do not routinely provide data that report the characteristics of parents involved with child protection. However, where data have been published, the co-occurrence of multiple and complex parenting problems—particularly parental substance misuse, domestic violence and parental mental health problems—are the norm for Australian child protection clients. For example, data published in the report on the Special Commission of Inquiry into Child Protection in New South Wales (Wood, 2008) showed that across 302,977 child protection reports in New South Wales during 2007–08, domestic violence (31%), drug and alcohol problems (20%) and mental health (14%) featured prominently as one of the (up to) three issues

prompting the report (Wood, 2008, p. 130). Earlier data from Victoria show that in 2001–02 the four most frequent “concerning characteristics” of parents in investigated cases were:

- domestic violence (40%);
- substance abuse (25%);
- alcohol abuse (21%); and
- psychiatric illness (15%).

Additionally, the 2001–02 data were compared with data from 5-years earlier (1996–97) and it was found that the number of families presenting to child protection with multiple and complex problems was increasing over time (Allen Consulting Group, 2003).

Research investigating the parental characteristics of children on care and protection orders or in out-of-home care in South Australia shows a similar pattern to the New South Wales and Victorian data. In a study on parental substance abuse and children in out of home care, the South Australian Department for Families and Communities found that of the children entering care due to a parental substance abuse problem, 69% of parents also experienced domestic violence and 65% had mental health problems (Jeffreys, Hirte, Rogers, & Wilson, 2009).

One might look at these data and assume that, as they are based on the characteristics of parents referred to child protection services, the statistics represent “the worst of the worst” and that most parents who experience either mental health problems, substance misuse or domestic violence will not experience multiple problems. But research into domestic violence, substance misuse and mental health as problems in their own right and separate from child protection or parenting issues shows that individuals who experience any one of these problems are likely to also experience other complex problems. For example, substance abuse has been identified as the most common co-morbid condition among people with a severe mental health issue (Hegarty, 2004). Often referred to as “dual diagnosis”, substance abuse and mental health problems have been linked in large representative samples, particularly in clinical settings (Hegarty, 2004; Stromwall et al., 2008). Prevalence estimates of substance abuse issues in mental health service settings consistently report rates of over 25% with estimates of up to 80% (Todd, Sellman, & Robertson, 2002).

Research also consistently indicates strong associations between domestic violence and substance misuse—particularly alcohol abuse (Chan, 2005; Lipsky & Caetano, 2008; Thompson & Kingree, 2006). The Australian Bureau of Statistics Survey on Women’s Safety (1996) indicated that 40% of physical or sexual assaults on women within a 12-month period involved the use of alcohol. A review by Klostermann and Fals-Stewart (2006) also indicated strong relationships between alcohol use and domestic violence in primary health care settings, drug and alcohol treatment programs, family practice clinics and prenatal clinics. It has been argued that drug use and heavy drinking, especially among men, may increase the risk of violence toward an intimate partner due to its inhibiting effects on cognition and perceptions (Chan, 2005). Alcohol and other drugs may also be used by victims of domestic violence to relieve the physical and emotional pain of abuse (Chan, 2005).

Practitioners need to be aware that parents involved with child protection services are likely to be experiencing multiple complex problems and that these problems do not just coincidentally co-occur—they co-occur because they are inter-related.

Social exclusion: The wider context of multiple and complex problems

Families referred to child protection services are also commonly living within a broad context of isolation and disadvantage. Social exclusion manifests through multidimensional and interlinked problems—primarily poverty, but can also include unemployment, poor housing or homelessness, crime, substance addiction, teenage pregnancy, victimisation, poor education or job skills, poor health, lack of social capital and family dysfunction (Social Exclusion Unit, 2001). Bromfield (2005) concluded that the characteristics of “the socially excluded” mirrored many of the common risk factors for child abuse and neglect and that the majority of families involved with child protection services were socially excluded. Furthermore, research has also shown that early childhood trauma contributes to social disadvantage and exclusion (Frederick & Goddard, 2007). Poverty and social exclusion are major causes of the problems that child protection services deal with in practice, yet it is unrealistic to believe that child protection and family services practitioners have the power to end poverty and social exclusion (Beckett, 2003; Munro, 2005).

Systemic responses to social exclusion require attention to be focused upon the causes of structural, relational and distributional disadvantage that contribute to exclusion (Room, 1995). The role for practitioners is to focus upon the conditions and characteristics of the excluded, which require redress through the provision of holistic or “joined up” services (e.g., to tackle homelessness, poverty and isolation). Practitioners need to be supported to think outside their service silos and work with other services to ensure that the unique needs of families are met.

Trauma histories of parents with multiple and complex problems

Frequently, parental substance misuse, domestic violence and mental health problems occur as a precursor to or consequence of previous experiences of trauma and adversity, such as physical or sexual assault or childhood experiences of abuse and neglect. For example, based on data from the Adverse Childhood Experiences Study in the United States researchers found that adults with four or more adverse experiences in childhood were seven times more likely to consider themselves an alcoholic compared to other adults and five times more likely to have used illicit drugs (Felitti et al., 1998). Based on data from the National Co-Morbidity Survey in the United States, adults who had experienced child abuse were two and half times more likely to have major depression compared to adults who had not experienced abuse, and were six times more likely to have post-traumatic stress disorder (Afifi, Boman, Fleisher, & Sareen, 2009). Victims of child abuse or neglect or adult sexual and physical assault may be prone to revictimisation. Widom, Czaja, and Dutton (2008) found that all types of childhood victimisation (physical abuse, sexual abuse and neglect) were associated with increased risks of lifetime revictimisation. Other adverse outcomes associated with past histories of child abuse and neglect include homelessness, physical health problems, revictimisation, unemployment and eating disorders (Gilbert et al., 2009; Johnson, Cohen, Kasen, & Brook, 2002; Kendall-Tackett, 2002).

Responding to families with multiple and complex problems

In summary, parental substance misuse, mental health problems and domestic violence affect parenting and place children at risk of abuse and neglect. Families with multiple and complex problems are also often situated within a wider context of poverty and exclusion. In reviewing the literature it is therefore evident that families with multiple and complex problems have emerged as the primary client group of contemporary child protection services. This has several implications for practice and for the structure and capacity of the child protection system.

Box 1: What is trauma?

Trauma theory provides a useful frame for understanding some of the adverse outcomes experienced by adults with past histories of violence, abuse and neglect. Trauma is the overwhelming and uncontrollable feeling of intense fear, helplessness and loss of control in response to terrifying life events (Herman, 1997). Trauma may be experienced as a single traumatic life event such as rape, a near-death experience or witnessing the torture or abuse of another person. Trauma—particularly that which occurs within a domestic context such as domestic violence or child abuse—can also be prolonged and repeated. Herman (1997) equated the experience of prolonged and repeated domestic violence and child abuse with being held hostage. In this situation, Herman argued, victims can become stuck in a present where their initiative is confined to thinking not how they will escape but how they will survive. This narrowing of initiative becomes habitual and must be unlearned to enable the survivor to participate in planning for the future.

Traumatic events induce a wide range of debilitating symptoms that affect all aspects of life for survivors, which can in itself constitute multiple and complex problems. Acknowledging the difficulties that parents may have coming to terms with their own experiences of trauma and victimisation and empathising with their situation does not mean ignoring or excusing abusive or neglectful behaviour directed towards their children. However, understanding parents' past histories may better enable practitioners to determine the underlying causes of parental problems, therefore helping them to engage parents and to assist them to make positive change.

Practice considerations

Child protection practitioners working with families with multiple and complex problems need to recognise the whole experience of parents and children. Practitioners should be supported and prepared to know how to respond to and work with these families as a matter of routine practice.

Assessment

When making assessments of families with complex problems, knowing the types of problems parents are experiencing (e.g., substance addiction and mental health problems) can help to identify issues that may affect parenting (see the sections on impacts). However, it is not enough to simply name such problems—assessments need to examine how such problems affect parental capacity and parent–child relationships. The diagnosis of a mental health or substance abuse problem alone is not sufficient to determine risk (Benjet, Azar, & Kuersten-Hogan, 2003). It does not really matter whether a family is experiencing one or six problems: what matters is how such problems affect parenting and place children at risk of abuse and neglect. An assessment of parenting capacity therefore requires the identification of how the unique constellation of problems and strengths in the family results in children's parenting and safety needs being met or not being met (NSW Department of Community Services, 2005). Assessing parent–child interactions, the quality of the home environment, the parent's perception of child behaviour, the parent's social support networks and his or her ability to solve problems is more important for determining whether a child is at risk of abuse and neglect than simply identifying or diagnosing parental problems such as substance abuse (Mildon, Matthews, & Gavidia-Payne, 2003).

Observing these aspects of a parent–child relationship can enable assessment results to have a direct relationship with intervention planning.

Children’s knowledge and awareness of parent problems

Completing a functional assessment of the impact of parental problems on parenting behaviours is important for identifying the risks for children. Practitioners will also find it worth exploring, as part of the assessment, the extent to which children are aware of these problems. This will inform the assessment, and may also be a powerful motivator for parents to change.

Parents may minimise or underestimate the impact of their problems on their children due to their assumption that children have only a limited awareness of the problem, however, research with children has shown that they know earlier and in greater detail about their parents’ problems than their parents believed (Dawe et al., 2007; Gorin, 2004; Humphreys et al., 2008; Mullender et al., 2002). Based on a review of the research, Gorin (2004) suggested that the average age children became aware of their parents’ problems was between 4 and 5 years. Interviews with children have shown that children were able to put the pieces together to form an accurate picture of what was happening in the household, despite parents’ attempts to shield them (Dawe et al., 2007; Gorin, 2004; Mullender et al., 2002).

I don’t know really—it just kind of crept up on me. All I know is, one day I did know, so it probably happened bit by bit from me not knowing to me knowing. Then I could remember back when things happened when I was younger, but I didn’t think anything of it—like when my mum had bandages and she said she banged herself. But now I realize my dad must have done it, but they hid it from me and I just accepted that at the time. We even made jokes about it—like how clumsy she had been to bash herself ... Mum and Dad, me, we all made those jokes. (15-year-old girl in Mullender et al., 2002)

Parents also reported that, while they tried to conceal their problems from their children, as the problems escalated they became less able to put in place the necessary planning and controls to prevent their child from finding out (Dawe et al., 2007; Mullender et al., 2002). Sadly, there was also evidence that parents’ attempts to control the situation to prevent their children’s discovery of the problem caused their children’s needs to be neglected in other ways (e.g., children feeling rejected and unwanted as parents excluded them while trying to shield them from their substance misuse. Children may be forced to constrain their natural desire for play and exuberance as it was a trigger for violence) (Dawe et al., 2007; Gorin, 2004; Mullender et al., 2002).

In the absence of communication between parents and children about parents’ problems, research has shown that children frequently misattribute the cause of family or parental problems to themselves (Dawe et al., 2007; Mullender et al., 2002).

Planning an intervention strategy

When working with a parent who is dealing with multiple and complex problems, practitioners are likely to have to try to support them on different fronts. Referring the family to a different service or professional for each problem or trying to tackle all problems simultaneously will be overwhelming for the family. An effective intervention is planned and purposeful, based on a comprehensive assessment and staged to meet the family’s needs and capacities over time.

“Maslow’s Hierarchy of Needs” is a theory that can assist in the planning and prioritising of an intervention in practice. Maslow suggested that humans have a natural drive to fulfil their potential but this cannot be achieved unless other, more basic needs are first fulfilled. According to Maslow’s theory, individuals are unlikely to be able to focus on their intimate relationships and connections if their survival and safety needs are not attended to first (McAdams, 2006). Figure 1 is an adaption of Maslow’s hierarchy to indicate how these needs may be met in service provision. Families with multiple and complex problems are often situated within a broader context of poverty and disadvantage. Therefore, parents may derive little benefit from or struggle to benefit from counselling or parenting programs if they are unable to provide their children with appropriate clothing, fix the car, or replace a broken window. Similarly, they may struggle to provide “good enough” parenting if other, more pressing problems such as obtaining food and paying heating bills have not been dealt with.

If families are overwhelmed with multiple and complex problems, a referral to another service that provides material aid may not be optional but a necessary priority. Practitioners may need to then follow through and assist a parent to navigate access to other services. It is only when parents are able to meet the survival and safety and security needs of their family (see Figure 1) that they will be ready to attend any form of parenting intervention.

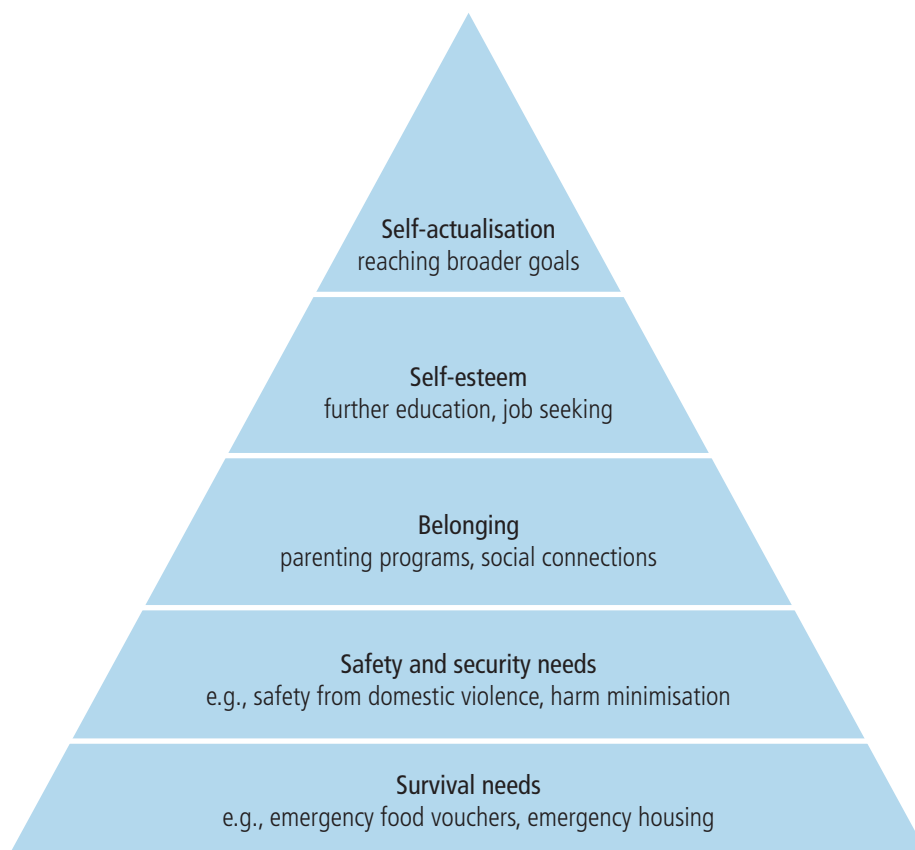


Figure 1. Maslow’s Hierarchy of Needs (McAdams, 2006)

Effective parenting interventions

Once basic needs are met, interventions that deal with relational or self-esteem needs, such as good parenting skills, can begin. Parenting is not necessarily something that one knows how to do intuitively; it is learned (Waylen & Stewart-Brown, 2008). The degree to which each of the tasks of parenting can be achieved is influenced by a range of factors, including:

- the amount and type of material resources available to parents;
- individual characteristics of the parents, including heredity;
- parents' own experiences of being parented and observing the parenting of others, their psychological make-up, relationships; and
- parents' broader circumstances (e.g., employment, health) (Quinton, 2004).

In a meta-analytical review of components associated with parenting intervention effectiveness, Wyatt Kaminski, Valle, Filene and Boyle (2008) found that program components associated with the greatest changes included increasing positive parent–child interactions, encouraging parents to practise new skills, teaching parents to use “time out” and the importance of parenting consistency.

Further research suggests that effective parenting interventions include components that:

- encourage one-on-one learning;
- focus on strengths rather than deficits;
- offer a shared empowerment to families;
- build strong client–practitioner relationships that are predictable and reliable;
- develop positive expectations for change and heightened self-efficacy;
- enhance problem-solving capacity;
- provide information that is clear and concise (not lengthy and complicated); and
- praise parents wherever possible (Berry, 2010; Scott & Dadds, 2009; Wyatt Kaminski et al., 2008).

At times, the effects of parents' other problems may influence their ability to take in and apply knowledge and information, and to read, solve problems or follow complex instructions. It is therefore vital that the factors that may diminish a parent's capacity to learn new skills are attended to so that parents have the best possible chance of developing good parenting skills. (See Box 2 on page 18 for strategies for assisting parents to learn new parenting skills).

Assisting to heal the parent–child relationship

Witnessing or experiencing abuse and neglect in the family not only carries with it direct and indirect injuries to parents and children, but also undermines the parent–child relationships. Redressing this damage takes time and requires that parents have reached a point at which they can acknowledge that their parenting or the home environment has had a negative impact on their child. Parents and children may benefit from specific interventions designed to heal the parent–child relationship (Humphreys, 2007). However, deciding to create the space to support parents and children to talk about their experiences of violence, abuse and neglect may be painful and distressing for parents and children. Practitioners need to carefully prepare and adequately support parents and children to be ready for interventions of this nature to avoid causing further harm (Humphreys & Thiara, 2010).

Box 2: Strategies to assist parents to learn parenting skills

For practitioners working with parents with learning difficulties, the Healthy Start website provides a range of resources and tips. Many of these can also apply to work with parents experiencing other difficulties such as mental health concerns and substance abuse.

- Take an empowering and proactive approach (e.g., structure tasks in ways that success is optimised: i.e., in small, easily achievable steps).
- Use different methods to teach skills (modelling, video demonstration, realistic pictures, etc).
- Try to teach skills in context (i.e., where they will need to be applied—usually the home but perhaps at the supermarket or on a train).
- Play activities can be opportunities for modelling parenting skills, language and safety.
- Be aware that the parents' own negative experiences at school may still affect their attitudes towards learning.
- Materials may need to be adapted to suit the particular family: for example, helping them adapt skills and knowledge to suit the age of their child.
- Provide information in small chunks—avoid long explanations.
- Offer simple explanations (e.g., it is preferable to say: “doing things over and over helps kids learn”, instead of saying: “repeating particular play activities fosters and reinforces the development of neural pathways and builds their cognitive abilities and psychomotor skills”).
- Make room for repetition, reinforcement and practice in different places or with different materials—this helps parents to feel confident in their ability to perform each step.
- Ensure activities fit the space available (i.e., play activities should be appropriate to the type of accommodation).

Source: Healthy Start (n.d.). Retrieved from www.healthystart.net.au/developing.php?p=practitioner_resources&r=practice_points.

Responding to adult trauma

Practitioners making assessments should include a thorough family history to identify whether current problems, such as domestic violence, mental health problems and substance misuses, are symptomatic of past traumatic events. Parents may need therapeutic intervention to assist them to process the trauma they have experienced and to explore and develop more adaptive coping strategies that will not impede their parenting capacity.

Box 3 identifies five core empirically derived strategies that have been shown to help adults recover from experiences of trauma.

The structure of the service system: A whole-of-government approach to service delivery

Child protection service systems across Australia are struggling to meet the needs of families with multiple and complex problems (Wood, 2008). This is not only because of a lack of

services for children and families but because the service system is designed as completely separate organisations and agencies or, in effect, “silos” (Bromfield & Holzer, 2008). Services for children and families come from a variety of sources (and not just child protection departments) including other government departments (e.g., health, education, juvenile justice) and the non-government sector, yet most services tend to be focused on one problem. For example, a parent with a dual diagnosis may be referred from child protection to a rehabilitation service for a substance abuse problem, but then referred on to a mental health service without either service providing background information on the family, or either service knowing that their client is a parent. Worse still, a parent may be refused mental health services because of a substance abuse problem. A further example of the difficulties with a “siloesd” system is that families may be unable to claim social welfare benefits due to homelessness or housing instability. Services may be available (albeit often with a substantial waiting list) but families who need them the most may not know how to access them. In many instances, a siloesd service system further compounds disadvantage and exclusion.

Box 3: Effective strategies for responding to trauma in adults

Research on supporting an individual’s recovery from traumatic events has identified five core, empirically derived strategies that have been shown to help:

Build problem-solving skills

Structured problem solving may help when problems appear overwhelming. Working with adults and children in problem solving involves a 6-step process of: defining the problem; identifying possible solutions together; evaluating these solutions; choosing a solution; planning a solution; and reviewing the plan.

Plan and do positive activities

Encouraging adults and children to engage in positive activities may help them to feel more normal. Positive activities may include doing fun things with the kids, continuing family routines, having hope and optimism, helping others, and spending time with friends.

Develop skills for managing distressing reactions

Learning new strategies that may help to manage distressing reactions—for example, calming skills such as controlled breathing.

Develop helpful thinking

Helpful thinking is not the same as positive thinking. Focusing less on unhelpful thoughts and more on helpful ones can help adults and children to move forward. For example, turning a thought such as “absolutely nothing is going well”, into “this is a tough time, but I am doing some things well” may help to re-energise parents.

Develop supportive social connections

Working with adults and children to connect/reconnect with family, friends and others can assist in recovery.

Source: included with the consent of the Parenting Research Centre, which developed this content in association with the Australian Centre for Post-traumatic Mental Health.

Bromfield and Holzer (2008) concluded that, to respond more effectively to families with multiple and complex problems, a whole-of-government approach is needed that facilitates integrated working relationships between child protection and different government agencies and the non-government sector (e.g., adult services, family support services and child care). A systematic, multi-agency approach promotes multilateral departmental initiatives to protecting children, whereby service provision is jointly funded between departments such as health, education, the police and child protection/communities in collaboration with the non-government sector. A holistic approach promotes greater service collaboration and information sharing so that families are provided with the most appropriate support (Wood, 2008). Services that have first contact with a family play a more active referral and linking role. Joining up services may help to reduce situations where families with multiple and complex problems are referred from one service to another where little or no history of the family is known before their first visit.

An example of a whole-of-government cross-departmental approach to protecting children is the Think Family program in the United Kingdom. The aim of the approach, developed in 2008, is to make sure that the support provided by child, adult and family services is coordinated and takes account of how problems affect the whole family. The initiative was designed to build on the capacity of all services to reduce the negative impact on children of parents with multiple and complex problems. The core principles of the initiative have been that:

- there is no wrong door—contact with any service offers an open door to joined-up support;
- services look at the whole family—they take into account family circumstances, and adult services consider clients as parents;
- services build on family strengths—relationship and strength-based engagement; and
- services provide support tailored to need—rather than a “one size fits all” approach (Scott, 2009).

Early intervention and capacity building in an integrated service system

Even with a whole-of-government approach, a key challenge will be to establish a service system that leads to early identification of children and families who may have multiple and complex problems before problems escalate. All services have a role to play in preventing children in such families from being abused or neglected and ultimately referred to tertiary child protection services. Tertiary child protection services are designed to respond to abuse and neglect situations where children have been harmed or are in immediate danger; they have a limited capacity to prevent abuse and neglect. Unfortunately for many families, child protection services are the first point of contact for intervention (Higgins & Katz, 2008). The greatest challenge therefore is to sufficiently resource flexible prevention and early intervention services to help reduce the number of children requiring state intervention (Wood, 2008). In an integrated service system, child protection services are a last-resort response and just one part of the child and family welfare service system where universal services form the foundation.

In order for early intervention in an integrated service system to work, universal and secondary services need to be available to all families (Higgins & Katz, 2008). Secondary services need to be appropriately resourced with a highly skilled workforce to have the capacity to meet demand (Wood, 2008). Building the capacity of adult-focused services (e.g., drug and alcohol services or domestic violence programs) to be child-sensitive, and child-focused services to be more parent-sensitive are also important for developing better responses for families with multiple and

complex problems (Scott, 2009). Ultimately, in an integrated system, adult services would be able to determine first if their clients were parents and then be able to refer the family to further services that meet their needs. An integrated service system, prioritising early intervention and prevention, can ease demand on tertiary child protection services and lead to better outcomes for disadvantaged children and families.

Families characterised as having multiple and complex problems are likely to have experienced either substance misuse problems, mental health problems or domestic violence or a combination of the three. Such families are also likely to be living within a context of isolation and disadvantage, putting children at even greater risk of abuse and neglect. It is therefore no surprise that families with multiple and complex problems are the primary client group in child protection services. To improve service provision for such families, establishing an integrated service system may strengthen the capacity of early intervention and prevention services, which may in turn may ease demand on statutory child protection services.

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