

Review

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Review of Studies Regarding Assessment of Families Where Children Are at Risk of Harm Due to Parental Substance Misuse

[Richard D. Tustin](#) *

Posted Date: 7 March 2025

doi: 10.20944/preprints202503.0541.v1

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Review

Review of Studies Regarding Assessment of Families Where Children Are at Risk of Harm Due to Parental Substance Misuse

Richard D Tustin

Adelaide Psychological Services, Adelaide, Australia; don@psychadelaide.com.au

Abstract: Questions arise about links between use of substances and violence. This topic is important when parents misuse substances and there is potential to expose children to family violence. Background. The state government of South Australia has established a Royal Commission to investigate causes of family violence and to consider implementing a whole of government approach to manage family violence. Method. This paper provides a rapid review of published literature linking parental substance misuse, family violence and parenting capacity, covering both policies and empirical evidence. Results. The main finding is that substance misuse does affect parenting capacity and is associated with family violence. The concept of cumulative risk of harm to vulnerable children is supported by research but not yet implemented in policy. Reports indicate that some parents who misuse substances have multiple complex problems including comorbid mental health issues, domestic violence and difficulty in managing children's behaviour. Early intervention therapies designed to address this cluster of issues are reviewed. Conclusion. There is a need to establish objective assessment instruments that are relevant to the cohort of parents who misuse substances and engage in family violence to ensure vulnerable children and families where parents misuse substances are referred to appropriate therapies.

Keywords: drugs; family violence; psychoactive substances; heavy substance use; health and safety promotion; early intervention therapy; illicit substance; cumulative harm; parental risk factors; risk level; severity of substance use; threshold; parenting capacity; multiple complex needs; parental mental health; coordination of care; objective assessment; transdiagnostic therapy

Introduction

There is growing concern about impacts of domestic and family violence and about causes of family violence. There is concern that high use of psychoactive substances may be linked to violence, especially when aggression occurs in a family home and children are exposed to aggressive behaviour by a parent. The question of how to manage family violence associated with high use of psychoactive substances is viewed as a complex policy topic.

Policy makers in Australia report that children exposed to family violence first come to notice when a notification is made to the child welfare service that a child is at risk of harm from their own parent. However, policy makers are uncertain about how to respond to this scenario.

In 2024 the State Government of South Australia established a Royal Commission into Domestic, Family and Sexual Violence. The terms of reference proposed continuation of a whole of government approach that was introduced following an earlier Royal Commission (Layton, 2003) that focused on how to facilitate delivery of preventive and early intervention services to families where children are vulnerable. The current Royal Commission was established following reports that a woman is killed by an intimate partner in Australia every 11 days; that 39% of Australian women have experienced domestic violence; and 29% of women have experienced violence from a cohabiting partner.

There are further reports that children are at risk of serious harm and death from family violence, including following notification that a child is at risk of harm to the child welfare department. An

annual report to Parliament by a South Australian Child Death and Serious Injury Review Committee stated that in the 16-year period 2005-2020, 473 children had died within three years of being notified to the department for child welfare as being at risk of harm, which averaged 29.6 deaths of children per year in the state (Fuller, 2021). The report considered the life circumstances of parents whose child died, and identified contributing factors to the deaths of children as including; parental violence, parental mental and physical health conditions, and a parent having themselves been raised in out-of-home care. While parental misuse of substances was not identified as a risk factor to children in this report, it is identified as a risk factor in other reports.

A report of the Australian Institute of Criminology into filicide in the 12-year period between 2001 to 2012 found that 84% of children who were killed were killed by a parent, with adult males and females contributing about equally (Brown et al. 2019). Police reports found that parents had consumed substances at the time of the filicide in 23% of cases. Other comorbidities were domestic violence in 30% of cases, parental mental illness in 32% of cases, and criminal convictions in 43% of cases.

One aim of initiatives in Australia is to reduce gaps between policies and clinical practices to ensure that children at risk of harm receive appropriate protection, therapy and support.

Objectives

This paper proposes that the government's aim to provide early intervention therapies for vulnerable children relies on identifying an objective assessment instrument that identifies families where children are at risk of harm, and that distinguishes between families who require early intervention therapy and families where children need to be removed from parental care to protect the child.

This paper distinguishes between policies and practices. The paper considers policy and empirical evidence on the following topics: (a) associations between parental use of psychoactive substances and harm to children; (b) broad government policies; (c) information about risk factors / predictors of harm to children; (d) information about the scale of the problem; (e) information about efficacy of therapies for people who misuse substances; (f) collaboration between health, welfare and legal services; (g) issues of privacy and confidentiality regarding parents who misuse substances; and (h) proposals about how services might be delivered collaboratively when parents are assessed as having complex needs and require input from different providers.

Methods

Review Protocol

A search was conducted of literature about two issues: policy principles about children who are exposed to harm due to parental substance misuse, and empirical evidence about impacts of parental substance use on children.

A rapid review of literature was conducted using the key words; meta-analysis, drugs, family violence, psychoactive substances, heavy substance use, health and safety promotion, early intervention therapy, illicit substance, cumulative harm, risk level, threshold, parenting capacity, multiple complex needs, coordination of care, privacy, and objective assessment.

Literature about policy principles was restricted to policies in Australia. Policy documents included studies that had been conducted to inform government policy and only policies in Australia were considered. International empirical studies were included.

The Australian Commonwealth Government has assigned a role of monitoring efficacy of child welfare practices to in the Australian Institute of Health and Welfare (AIHW) who collects and publishes data annually on a set of indicators. This paper cites data from AIHW on relevant topics.

Results

Information about policy principles and empirical evaluations being discussed together.

a – Associations Between Parental Substance Misuse and Harm to Children

Policy and Educational Practices

Bromfield, Sutherland and Miller (2012) published a document about how the Victorian Department of Human Services views impacts of parental substance use on parenting practices in families with multiple and complex needs. The document proposes that both intoxication and withdrawal impact on a parent's ability to perform basic parenting tasks including maintaining routines, supervising children, and meeting a child's emotional needs as parenting practices become inconsistent when a parent is intoxicated. Predicted impacts on children include a high risk of neglect, risk of physical abuse from a parent, and risk of sexual abuse.

Concerns of child welfare services are based on generally available information about impacts of psychoactive substances including alcohol, cannabis, and illicit substances. Early information sheets provided by child welfare services provide the following views about use of psychoactive substances by parents. High use of psychoactive substances by parents interferes with their thinking processes and their parenting practices and contributes to use of extreme parenting styles as substance use alters the parent's state of consciousness and ability to regulate their emotions. When intoxicated, some parents use more authoritarian parenting styles and expose their child to harsh and unreasonable punishments, and to a parent's high level of emotionality. Other parents use under-involved parenting styles when intoxicated, exposing their child to emotional and physical neglect. Children whose parents use high levels of substances are exposed to inconsistent parenting practices. Many children of substance-abusing parents face a number of adverse childhood events during their formative years of 2-12 years. Extreme parenting styles are associated with an increased prevalence of a range of emotional and behavioural problems in children.

Evidence

A number of empirical studies report research about impacts on children of parental substance misuse.

Chaffin et al. (1996) conducted a two-year follow-up study of more than 7,000 parents with no prior history of child maltreatment, and found that the presence of parental substance misuse increased the odds of child abuse by 2.9 and of child neglect by 3.24.

Gruenert (2004) documented experiences of 48 Australian children whose parents attended treatment for substance dependence. Gruenert found that over half of children had been adversely affected by their parent's substance misuse due to their exposure to family violence, family breakdown, police raids on the home, and children's play areas being searched for drugs. The study found that a third of children had been exposed to experiences of finding their parent unconscious, and being exposed to other dangerous situations. In some cases, children had been neglected. Assessments found that a quarter of children scored in the clinical range for being emotional disturbed. Child welfare services had been involved with 40% of the children. Children who were most severely affected lived in a single parent family. The report described the children as 'nobody's client' as no specific agency provided therapy for affected children. The study made the point that parental misuse of substances can be associated with a range of adverse experiences for children.

Connors et al. (2004) studied 4084 children in USA whose mothers were admitted to publicly funded residential substance abuse treatment programs for pregnant and parenting women, and found their children had increased vulnerability for physical, academic, and social-emotional problems, and that many children required long-term supportive services.

Fergusson, Boden and Horwood (2008) reported a prospective study over 25 years involving the health, development and adjustment of a cohort of 1265 children born in New Zealand. They found that parental use of illicit substances predicted illicit substance use by their children.

Bromfield et al. (2010) analysed families where children were placed in out-of-home care in South Australia, and found that of children who entered care due to parental substance abuse, 69% of parents also experienced domestic violence and 65% of parents had a mental health problem. The

authors identified families who presented with more than one risk factor as having multiple and complex problems, and noted that these families had become the primary client group of the child protection service. Bromfield et al. cited a report by a Special Commission of Inquiry into Child Protection in New South Wales involving 302,977 child protection reports in New South Wales during 2007–08 that found the frequencies of the three most prominent parental risk factors were domestic violence in 31% of cases, drug and alcohol problems in 20% of cases, and mental health conditions in 14% of cases (Wood, 2008, p. 130). Bromfield et al. cited data from Victoria in 2001–2002 showing that the four most frequent concerning characteristics in parents who were investigated were domestic violence in 40% of cases, illicit substance abuse in 25% of cases, alcohol abuse in 21% of cases, and parental psychiatric illness in 15% of cases.

Data summarised by Bromfield et al. indicates that: some notified parents experience only substance misuse; some parents experience dual conditions of substance misuse and a mental illness; and some parents experienced three conditions involving substance misuse, mental illness and family violence.

Jeffreys et al. (2009) reported a study that was commissioned by the South Australian child welfare department. Jeffreys and colleagues studied families where children were placed into out-of-home care in 2006 due to substantiated parental misuse of substances, and this involved 40% of all children in care. The substances most commonly used by parents were alcohol (77% of parents), cannabis (53%), amphetamines (50%), heroin (12%), and prescribed medications (11%). The frequency of use for substances was; alcohol was used daily by 27% of parents, cannabis was used daily by 37% of parents, and amphetamines were used daily by 47% of parent.

The Jeffreys study found that if a parent misused substances, there was an increased likelihood the family experienced other difficulties. The following percentages of families were reported of families experiencing other difficulties: 69% of parents experienced domestic violence, 65% experienced a parental mental health issue, 29% had financial difficulties, 28% had issues of homelessness or transient accommodation, and 25% had issues of parental incarceration. Families who misused substances had a median of 5 problems, with some families having 10 problems. These statistics show that parental substance misuse is associated with multiple complex problems in some families where a notification was made to a child welfare service.

Jeffreys' table 8 shows that the types of abuse experienced by children whose parent misused substances were: 52% of children were exposed to domestic violence, 57% were assessed as being neglected, 54% had unstable living arrangements, and 32% were exposed to drug use and dealing.

The Jeffrey's study also found that 25% of children had been placed into care although no evidence of maltreatment of the child was provided. The study found that a quarter of the children placed into out-of-home care were placed in care while the family received assistance to manage a short-term family crisis, to allow the family time to recover rather than simply to protect children from harm (page 30). The study found that for some parents, placement of their child into care provided a parent with space to 'get their act together' while caseworkers provided support, information, advocacy, referrals and linkages that helped parents to make and sustain positive changes. This was described as a therapeutic approach.

The Jeffreys study also found that some parents were apathetic about their children being returned to their care, were hostile to workers, minimised child protection concerns, and appeared to lack capacity to change. The approach used by caseworkers with children of these parents was described as risk management to protect the child.

The Jeffreys study included a case file review that found child welfare staff referred parents to the following separate support services: substance abuse services in 58% of cases, parenting education in 45% of cases, general counselling in 33% of cases, adult community mental health in 29% of cases, child mental health in 26% of cases, housing in 24% of cases, domestic violence services in 17% of cases, financial counselling in 18% of cases, and child care in 16% of cases. The mean number of services each family was referred to was 5.3.

A case review by Jeffreys found that child welfare services referred only the most serious cases for drug and alcohol intervention. The file analysis found that only 41% of referred cases recorded that parents had received a drug and alcohol intervention, and that 42% of parents had disengaged prematurely from a service.

The Jeffreys study found that most parents with a substance abuse disorder had not contacted a drug and alcohol service provider prior to their child entering care, apart from 30% of parents who were engaged in a methadone maintenance program on referral by their General Practitioner. Jeffreys and colleagues concluded that substance misusing parents are a 'difficult to reach' population.

The Jeffreys study examined whether parents who were referred to a drug and alcohol services received an intervention that was child focused, and concluded that 80% of families who engaged with a rehabilitation service did receive a child focused service.

The Jeffreys study assessed whether parents who engaged with rehabilitation received multi-systemic interventions that aimed to address the multiple needs of the family, and concluded that 58% of families did receive a service that was individually tailored to target all of the needs of the family.

The study examined whether efficacy of interventions was individually evaluated and concluded that individualised evaluations and adjustments were made in 58% of cases, and that inter-agency collaboration was achieved in 73% of these cases.

The study noted that the child welfare system can become a gateway to treatment for drug and alcohol issues for families where children were vulnerable, if adequate assessment instruments are used to guide referrals.

Doidge et al. (2017) interviewed adults from a population-based cohort of 2443 Australians about their childhood history, to identify risk factors for maltreatment when they were a child. Their study identified parental substance misuse as being a risk factor for children, along with economic disadvantage, and social instability.

A report by Wright and colleagues (2021) cited Australian research indicating that domestic and family violence often co-occur with parental alcohol and other drug issues and mental health issues when notifications are made regarding child abuse or neglect, and that the co-existence of these three risk factors often precipitates involvement with the child protection service.

Many child welfare services now believe that high parental use of psychoactive substances is a marker for the presence of other risk factors for children (Tomison, 1996; Loxley et al., 2004; Dawe et al. 2007, 2008). There is a belief that parents who use substances heavily experience more difficulty in managing parenting tasks and everyday stressors, especially if a parent experiences socioeconomic disadvantage. Some agencies view all parents who misuse substances as experiencing disability, and propose that all parents who misuse substances be offered a holistic wraparound service that provides a package of many types of support.

However, a meta-analysis of 24 studies where mothers had substance abuse problems by Hatzis et al. (2017) found that the group was not homogeneous. A review of maternal sensitivity to their child's cues and children's responsiveness found significant heterogeneity between mothers, indicating that separate assessments need to be made of maternal substance use and maternal sensitivity to cues.

Overall, empirical research shows that educational practices followed by State child welfare agencies are consistent with empirical research. However, research also finds that parents who use substances are not a homogeneous group, as some parents have a single issue of substance misuse while other parents have a large number of issues and present with multiple and complex problems. There is a role for an objective assessment instrument to clarify the needs of each family where a parent uses substances to support effective delivery of services to this cohort and to meet the individual needs of each family.

Research indicates that the most common concerns regarding parents who misuse substances involve comorbid parental mental health issues, family violence, and difficulty in managing

children's development and behaviour. These families are labelled as having multiple complex problem and as being difficult to reach.

The Jeffreys study found that while the child welfare department is in a position to refer vulnerable families to relevant early intervention services after receiving a notification, the department does not perform this role efficiently, perhaps due to lack of an agreed objective assessment instrument.

b – Broad Government Policies

The Government of the State of South Australia and the Australian Commonwealth Government have implemented a number of policies that are relevant to providing support for parents who use substances.

i – Loxley Review

A review commissioned by the Australian Government about steps to prevent harmful use of substances was reported by Loxley et al. (2004). The review found that government initiatives had previously been focused on educating the general community about risk factors, reviewing legislative measures, and modifying medical interventions.

Based on evidence reviewed, the Loxley group recommended continuing a whole of population approach using universal strategies, while adding further levels of intervention including targeted interventions for cohorts in the population who exhibit moderate levels of risk for harming children.

Parents were identified in the Loxley review as an important group to receive targeted interventions. Parents who used illicit drugs were identified as an important cohort for targeted interventions. The review identified effective interventions for vulnerable families as including education about the adverse impacts of parental drug use on children, and home-based and group skills training for both parents and children, including case management for some families. The review reported that evaluations of moderately intensive family intervention programs had demonstrated positive improvements over one to two years in child behaviour problems. Targeted programs reduced rates of substantiated child abuse and neglect. The review recommended that to maximise effectiveness, intervention strategies should be provided early in the developmental pathway of disorder and aim to enhance protective factors and reduce risk factors.

The review recommended an investment in drug treatment programs for parents to ensure healthy child development.

The review discussed use of cannabis, noting that cannabis was the most widely used illicit drug in Australia with around 10% of adults being regular heavy users of cannabis and being at risk of long-term health consequences including dependence. Acute harms from cannabis use include anxiety, dysphoria, panic and paranoia. Long-term harmful impacts of prolonged cannabis use on mental health include negative impacts on attention, memory and concentration, producing modest impairments in cognitive functioning.

The review found that heavy 'binges' on amphetamine-type drugs were associated with reckless and aggressive behaviour and, when sustained over days, may precipitate a psychosis.

The review found that negative effects of illicit drug use were most clearly predicted by the cumulative number of elevated risk factors, rather than by any specific risk factor.

The review noted that judicial processes have the capacity to divert illicit drug users at an early stage in their drug using career, into effective intervention programs.

Empirical Evidence

Dawe and Harnett (2007) reported an early intervention program called Parent-under Pressure (PUP) that was delivered in one state of Australia. The program is summarised below in sections b and f.

Dawe and Harnett recommended that parents who misuse substances be referred to a therapy program that is provided independently of the child welfare service, and that clinicians provide a treatment report to an authority about the parent's participation in the program.

ii - Nyland Royal Commission 2016

The South Australian Government arranged a Royal Commission to investigate operations of its child protection system, resulting in the Nyland Report (Nyland, 2016). Justice Nyland made findings and made recommendations.

Nyland pointed out that the child protection system was an outmoded model as it focused on recording specific incidents of mistreatment of children, and it didn't identify risks that cumulate over time. Further, tools used by the department to assess risk were of poor quality, had low inter-rate reliability, were not used by many departmental offices, and were not integrated with decision-making about therapy interventions (p. 193-4). Nyland found that some departmental assessors showed excessive optimism that parents could change ingrained practices involving substance use (p. 191-2). Nyland recommended that assessments for court purposes be outsourced to independent expert assessors (p. 16).

Nyland discussed referrals by departmental staff for family-oriented therapy. Nyland found that a high proportion of 61% of notifications were screened out as not requiring any form of investigation or intervention (p. xvi), and this resulted in a large number of allegations being recorded but not substantiated independently of the notifier. The practice of screening out notifications resulted in a large number of children receiving no assistance (p. 196-7), representing missed opportunities for families to be referred for early intervention therapy. Tools used by the department did not identify thresholds to identify families who required a differential response to departmental involvement (p. 162, 195).

Nyland found that departmental staff rarely referred families to external therapists, and there was little evidence of following recommendations of external providers who were involved with a child (p. 193). When a practitioner referred a family to an external therapist, the practitioner often closed a file and did not follow-up progress (p. 193-4).

Nyland noted that a departmental practice of referring families with multiple needs to multiple providers resulted in services to vulnerable families not being coordinated (p. 157).

Nyland recommended that children assessed as at moderate risk of harm be referred for therapy interventions (recommendation 163); that therapy be provided independently of the department (p. xvii); that families be referred to agencies who are capable of providing therapy services that match the needs of individual families especially when a family has multiple complex needs (recommendations 66 & 85); and that assessors use structured assessment instruments (p. 201).

Nyland noted that use of expert assessors who are funded by the department can result in assessments that are partisan and include advocacy, rather than being balanced (p. 201).

Nyland discussed communication between government departments. She noted that departments had been established to address single issues, and this has resulted in a situation where departments operated in isolation from one another with little formalised communication regarding treatment of individual citizens in what she called a "siloe" approach (p. 160). The siloe approach resulted in families with multiple needs being referred to several agencies for services, without any clinical coordinator being appointed to ensure that service delivery was staged and collaborative (p. 160).

Nyland drew attention to the range of government departments that can become involved when a parent misuses substances, involving a Drug and Alcohol department that manages addictions; a Health Department that treats people with physical and mental illnesses; a Child Welfare department that manages children at-risk of harm; and Disability Support services that assist people who have impairments due to an ongoing illness.

No empirical studies were identified that examined implementation of the Nyland recommendations.

iii - National Framework for Protecting Australia's Children 2009

In 2009 Australia adopted a National Framework for Protecting Australia's Children that provides a policy approach to guide delivery of interventions to meet needs of families where children are vulnerable. The framework proposes use of four categories of families and four linked categories of intervention. The four categories are: *competent parents* who are eligible for universal preventive supports that are available without restriction, including preventive education for the whole community; people in *vulnerable families* who are eligible for indicated *early intervention* services with restricted access; *at-risk children* who are eligible for *focused intervention* programs that are restricted to this cohort; and children who are at an unacceptable risk of harm and who are placed into *statutory care* or out-of-home care.

The National Framework was updated and renamed Safe and Supported 2021-2031. Safe and Supported proposes a whole of government approach to improve liaison between departments based on a recognition that some parents who misuse substances have many complex needs. Safe and Supported identified a need to strengthen the interface and integration of services involving drugs and alcohol, domestic and family violence, mental health, disability, education, justice, housing and employment services. The policy seeks to develop multidisciplinary models of care for families who experience multiple and complex needs.

Empirical Evidence

No studies were identified that assessed implementation of the National Framework.

iv - National Children's Mental Health and Wellbeing Strategy 2021

The Australian Government addressed dilemmas around eligibility criteria and promoted access to early intervention therapies by adopting a National Children's Mental Health and Wellbeing Strategy 2021 that introduced a wellbeing continuum. The wellbeing continuum describes a child's mental health on a four-step continuum with steps: *well* where a child experiences positive mental health; *coping* where a child experiences challenges they are equipped to manage; *struggling* where a child experiences challenges they are not managing effectively and they require focused support to manage their challenges; and *unwell* where a child meets criteria for having a mental illness and requires treatment.

The Australian Government encouraged provision of early intervention therapies for families when a child is struggling, without waiting for the child to deteriorate and become unwell.

Empirical Evidence

No studies were identified that evaluated implementation of the National Children's Mental Health and Wellbeing Strategy.

v - National Standards for Out-of-Home Care 2011

The Australian Government introduced National Standards for out-of-home care in 2011 that require state departments to provide information about 13 indicators.

Standard 5 is 'Children and young people have their physical, developmental, psychosocial and mental health needs assessed and attended to in a timely way.'

Standard 10 is 'Children and young people in care are supported to develop their identity, safely and appropriately, through contact with their families, friends, culture, spiritual sources and communities and have their life history recorded as they grow up.'

Empirical Evidence

AIHW (2019-2020) reported that in each year about 3% of all Australian children aged 0-17 years were abused and were assisted by child protection systems. The frequencies of each type of

substantiated abuse of children in child protection systems in 2019-2020 were: emotional abuse in 54% of cases, neglect in 22% of cases, physical abuse in 14% of cases, and sexual abuse in 9% of cases.

AIHW reported that the number of children in out-of-home care in Australia increased by 44 per cent between 1999 and 2009. The proportion of children in out-of-home care differs across jurisdictions, ranging from 4.3 per 1000 in one state to 9.4 per 1000 in another state.

AIHW (2020-2021) reported that the purpose of investigations by child welfare is to determine whether to provide a child with a child welfare service. Of children who did receive a child welfare service, 68% received an investigation of the alleged abuse or neglect, with about 41% of notifications being substantiated and the child receiving a further service of an out-of-home placement. Of notified children, 65% had been the subject of a previous notification.

The AIHW Out-of-Home Care Survey National Dataset (OOH CSND) provides information about the views of children aged 8-17 years in out-of-home (OOH) care, collected by the state/territory departments responsible for child protection and recorded as Indicator 9.3. Indicator 9.3-Family contact refers to the views of young people in OOH care aged 8-17 years about the frequency of contact with family members. Data from a survey of children in 2018 found that 72% of children reported satisfaction with one or more contact types (i.e. visiting, talking or writing) with non-coresident family.

Information about health checks of children in OOH care could not be located when the author searched the AIHW website in February 2025.

AIHW (2023) discussed the circumstances of children described as 'cross-over children' as they became involved in the youth justice system due to an alleged offence, as well as being in the child protection system. Cross-over children were aged 10-17 years. The report found that, while most children referred to the child protection system due to abuse and neglect did not go on to offend, a large proportion of children who did offend had a history of being notified for abuse or neglect. Young people who had experienced an out-of-home placement were more likely to be convicted of a crime than other young people in the general population. One report found that 74% of convicted young people aged 10-17 years had not offended before being placed in out-of-home care, and 61% of young people aged 10-17 who experienced residential care had not offended prior to placement and they committed their first offence either during or after their first residential care placement. The report found that 28% of young people aged 10-17 years under youth justice supervision during 2020-21 had an interaction with the child protection system during 2020-21.

Further studies have examined the cohort of 'crossover children.'

Baidawi and Sheehan (2019) expressed concern about the over-representation of children who had a child protection background and who were in the youth justice system. They conducted a detailed case file audit of 300 children who appeared before the Victorian Children's Court in 2016-17. They found that young people who left the care of child protection were at least nine times more likely than other young people to offend and come under the supervision of youth justice services, and they spoke of a 'care-to-custody pipeline' between the child protection system and youth justice system.

The case file analysis analysed the young people's adverse childhood experiences. Their findings were: 73% had been exposed to family violence; 12% had experienced the death of a sibling or other family member, including from overdoses, suicide and homicide; and 50% had a household family member with a severe mental illness. While exposure to parental substance abuse was reported, incidence figures were not provided. This data shows that crossover children in the sample have multiple needs.

An assessment was made of the number of adverse events crossover children had been exposed to prior to removal from parental care, using a list of ten adverse childhood events. The study found that crossover children were exposed to a mean of 5.4 adverse events, with 68% of children having been exposed to five or more adverse events. The study found that children did not receive intensive support services until their behaviours attracted serious youth justice sanctions.

The Baidawi and Sheehan study found that child protection services had received notifications about most crossover children before the age of 10 years, emphasising the potential for the child welfare system to make referrals for early intervention therapy and support for this cohort of vulnerable children.

The study found that 73% of crossover children had misused drugs and/or alcohol, and there was evidence that 40% had used crystal methamphetamine, other amphetamines, heroin or inhalants.

The Baidawi and Sheehan report recommended greater use of diversionary options for crossover children.

Malvasso and colleagues (2020) were commissioned to review information about the overlap of young people who were registered with both child protection services (CP) and youth justice (YJ) services in South Australia in the period 1991-1998. They reviewed data for 47,377 young people in the child protection system and 3058 young people in the youth justice system. The main findings of the Malvasso study are: (a) 84% of young people supervised by Youth Justice had contact with the CP system; (b) 40% of the YJ group had substantiated maltreatment and 24% had spent time in out-of-home care; and (c) crossover children had experienced many forms of substantiated maltreatment; and (d) 96.3% of crossover children had contact with CP prior to being under YJ supervision.

In conclusion, statistics provided by AIHW and others sources support a case for ensuring that vulnerable children who are referred to child protection services receive adequate assessment using objective screening instruments to identify vulnerabilities that are likely to be responsive to early intervention therapy and practical supports.

vi - Child Protection Legislation

Child protection legislation recognises that two very different types of intervention are required for families where a child is vulnerable due to substance misuse and exposure to family violence, being an approach providing early intervention therapy and support for families motivated to improve their parenting practices, and a child protection approach that safeguards children from an unacceptable risk of harm by removing a child from parental care. The South Australian Government has a stated policy of providing early intervention therapy as a first priority before a child is removed from parental care, so that removal of children from parental care is a step of last resort.

The South Australian child protection legislation (Children and Young People (Safety) Act 2017-CYPS) permits departmental staff to apply to remove a child from parental care initially for 6 months while an investigation is conducted, and then for two further periods of 12 months each while further investigations continue.

Empirical Research

A report of the AIHW titled 'Child Protection 2017-2018' found that: (a) 56% of children across Australia who are subjected to notifications are removed from parental care while allegations are investigated, and then are returned to parental care; (b) 82% of children who are removed from parental care remain in foster care for over a year while investigations are conducted; and (c) of children removed from parental care, 9 per 1000 are aged 1-4 years, and 8.4 per 1000 are aged 5-9 years.

The length of time child welfare staff take to assess risk to children while litigation-oriented investigations are conducted implies the agency does not use efficient methods to assess risk to children. Research summarised by Forslund et al. (2021) shows that long separations of children from a parent the child has developed an attachment bond with introduces risks a child will develop a mental disorder.

When a child is placed in departmental care, the child's contact with their parent is commonly restricted to supervised contact. Departmental staff assess the quality of interactions by observing the parent and child, without the benefit of any structured assessment framework.

vii - Health Practices

The South Australian Children and Young People (Safety) Act 2017 (CYP SA) includes a section that requires health and education professionals to make a mandatory notification to the child protection department if they have a reasonable suspicion that a child is at risk of harm. The mandatory notification requirement passes information in one direction only, as the welfare department is not obliged to communicate information to health or education departments, unless a Freedom of Information form is submitted and approved.

Further, the mandatory notification requirement does not provide any obligation on health professionals who make notifications to provide a health services themselves, or to refer a person to other treatment agencies.

Empirical Evidence

No research was identified about confidentiality issues associated with notifications about suspicions of harm made by health professionals to child welfare authorities.

viii - Law Enforcement Practices

Law enforcement agencies have a role when parents engage in practices that significantly increase risk that a child might be exposed to family violence (Wright et al., 2021). Processes in Australia involve three courts. Allegations can be made to police and be referred to a Magistrate's Court. Allegations made by separated parents can be made to a Family Law Court. Allegations that a child is not safe with a parent are referred to a Child Protection Court.

Under Australian legislation, the Commonwealth Family Law Court and State Child Protection Courts are viewed as civil courts and the standard of proof required to substantiate an allegation is on the 'balance of probabilities' rather than the higher 'beyond reasonable doubt' standard that applies in a criminal court.

Civil courts are authorised by legislation to issue a range of orders including to: restrict access between a parent and child; or require a supervised changeover when care of a child is transferred from one parent to the other; or require a parent to refrain from specific actions such as using a substance before and while a child is in their care; or require a parent to participate in physical testing for substance use; or prohibit contact between a parent and child.

Criteria for Family Assessors

Commonwealth legislation states criteria required for appointment of family assessors who provide reports about functioning of families to family law courts.

Australia follows the Daubert criteria for the admissibility of expert evidence that refer to: (a) whether an assessment procedure can be tested; (b) whether the procedure has been subjected to peer review and publication; (c) the existence and maintenance of standard procedures for administering an assessment; and (d) an instrument's known or potential rate of error in making predictions.

The Australian Supreme Court (*Makita Australia Pty Ltd v Sprowles*, 2001, 52 NSWCA 305) has recognised further criteria for the admissibility of evidence from an expert. The Makita criteria for admissibility of evidence can be summarised: (a) there must be an established field of specialised knowledge; the expert must demonstrate their knowledge of the field based on specified training, study or experience; an expert must establish their opinion is wholly or substantially based on their expert knowledge; a distinction is made between accepted facts and observations; and the scientific or other basis of conclusions must be established. It is the role of a court to decide the weight to give to admitted evidence.

Evaluation of Reports by Family Assessors

Tilbury (2019) interviewed professionals who provide family reports to judicial services in Queensland Australia and found that reports provided by some child protection caseworkers were

not highly regarded by courts. The report identified a need to improve the quality of expert reports by providing guidelines and standards for family assessment experts who work in child protection.

Carson et al. (2018) interviewed 61 young people aged between 10-17 years whose parents had separated, and 47 parents of the children, about their experiences and needs. A majority of young people (62%) had some engagement with mental health professionals and services, and found this helpful. The main concerns of children regarding their parents involved; alcohol or substance abuse (21%), emotional abuse (64%), mental health issues (61%), and violent or dangerous behaviour (32%). The young people stated the following opinions: 76% wanted parents to listen more to their views related to parenting arrangements; young people wanted their views to be taken seriously by family law professionals including family consultants and independent children's lawyers, particularly when they raised safety concerns; and young people asked to be kept informed about aspects of the legal process. The authors recommended greater use of children-inclusive approaches in court proceedings.

van IJzendoorn, Bakermans, Steele and Granqvist (2018) and van IJzendoorn, Steele and Granqvist (2018) emphasised the need for assessors who submit reports to family-oriented courts to ensure the evidence they provide meets both scientific and legal standard of evidence.

Empirical Evaluation of Efficacy of Court Orders

Three studies were found that examined the efficacy of orders made by courts involving parents who misused substance.

De Bortoli et al. (2013) analysed files of 273 cases in the Children's Court of Victoria where children had and hadn't been removed from parental care, to assess level of parental compliance with court orders regarding substance use. They found that parental substance misuse was present in 51% of the sample, and poly-substance abuse was common. Parental substance abuse was associated with lower rates of parental compliance with court orders, and with longer durations between notifications and final decisions by court. The authors concluded that parental substance misuse and non-compliance with court orders were significant factors in delaying stability for a child through the granting of court orders that might involve child removal, indicating that prompt recognition of parental substance misuse and engagement with therapeutic services is required to protect children from delayed decision making.

Carson et al. (2022) noted that police work with Magistrate's Courts that are established under State legislation, meaning that Family Law Courts that are established under Commonwealth legislation have limited capacity to enforce orders they make.

Isobe et al. (2020) reviewed literature involving mothers who misused substances and found that mental health issues and family violence often co-occur with substance misuse in this cohort. They considered that neither agency is enabled to manage the important issue of ensuring that the impacts of one parent's ongoing violence are addressed sufficiently, and they drew attention to the need to strengthen collaboration between the three sectors involving substance misuse, mental health, and family violence.

One potential barrier to collaborative practice is that the agencies of child protection, substance misuse, mental health and law enforcement are staffed by professionals who are trained in different disciplines, introducing a possibility that members of each discipline favour interventions that require involvement of their own discipline, and prioritise the interests of their discipline over the best interests of children (Coates, 2017). A further barrier is that professional codes of ethics and legislation promote the importance of maintaining confidentiality of personal information, leading to professionals being reluctant to share information with people from different disciplines who are employed in different agencies.

Difficulties in achieving multi-disciplinary collaboration between services escalate when a client presents with multiple issues, and reach a height when an adult is designated as having multiple complex needs as they meet criteria to be eligibility for services from several departments. Questions

then arise about how to coordinate service delivery for people with multiple needs who are eligible for several services. The issues of confidentiality and collaboration are discussed below.

Empirical Evaluations of Child Welfare Practices

One policy is that children are removed from parental care as a step of last resort, after early intervention measures have been provided to a family. AIHW data can be used to evaluate whether an adequate threshold is set between providing early intervention therapies for children in vulnerable families and the removal of children from parental care.

There is concern about the length of time taken by welfare personnel to investigate allegations that a child is at risk of harm after a child has been removed from parental care, and about methods of investigation used.

AIHW reports submitted information about indicators on its website under the title 'child protection Australia.' However, length of time to complete assessments is not included as a national standard.

AIHW (2018-2019) reported that agreement on a nationally consistent definition of out-of-home care was reached in 2019. AIHW reported that the number of children placed into out-of-home care and on third party orders had risen consistently from 2015 to 2017.

AIHW (2019-2020) reported that in each year about 3% of all children aged 0–17 years were abused and were assisted by Australia's child protection systems. The frequencies of each type of substantiated abuse of children in 2019-2020 were: emotional abuse in 54% of cases, neglect in 22% of cases, physical abuse in 14% of cases, and sexual abuse in 9% of cases.

AIHW (2023) found that some children who had experienced out-of-home care continued to experience vulnerabilities after discharge, and they were at a higher risk of experiencing poor outcomes in areas including employment, involvement in the criminal justice system and housing.

The statistics provided by AIHW support a case for ensuring that vulnerable children who are referred to child protection services receive adequate assessment using objective screening instruments to identify vulnerabilities that are likely to be responsive to early intervention therapy and practical supports.

Is Out-of-Home Care Over-Used?

Data published by AIHW can be used to assess whether the policy principle of removing children from parental care is a step of last resort, and whether there is an adequate balance between early intervention therapies for vulnerable children and their parents and the removal of children from parental care.

There is concern about the length of time taken by welfare personnel to investigate allegations that a child is at risk of harm after a child has been removed from parental care.

While the Australian Government introduced National Standards for out-of-home care in 2011, length of time to complete assessments is not included as a national standard.

National Standard 5 for out-of-home care requires children's health needs to be assessed and attended to in a timely way. No indicator was found in the AIHW website that provided data on this standard.

c - Assess Severity of Substance Misuse

Studies reviewed above shows that parents who misuse substances are a heterogeneous group as parents have differing needs.

Literature emphasises the importance of assessing levels of severity of substance misuse as interventions vary according to severity (Brophy et al., 2023). For example, ICD -11 distinguishes three levels of severity of substance use: episodic harmful use; substance misuse; and substance dependence or addiction. The National Institute on Drug Abuse (NIDA) views substance misuse as

unhealthy use that produces effects that produces long-term harms. The term addiction describes the most severe end of the spectrum where a condition is a chronic and relapsing disorder.

The World Health Organisation produced a 10-item AUDIT instrument that provides objective assessments of alcohol consumption, drinking behaviours, and alcohol-related problems. A threshold is set to indicate hazardous or harmful alcohol use.

The World Health Organisation also produced an instrument for use in primary health care to facilitate brief interventions or referrals (Humeniuk et al., 2010).

Conway et al (2010) reviewed a number of instruments that had been proposed to assess severity and propensity to use substances. They favoured use of a Severity of Dependence Scale with 5 items that are self-rated on a 4-point Likert scale. Threshold scores are available for different substances.

Ridenour et al (2011) proposed use of a Transmissible Liability Index for young adults.

McNeely et al. (2024) recommended an instrument for use by primary care physicians that rates risk into three categories (low, moderate, high) with aims of improving universal screening of substance misuse, promoting a harm minimisation approach, and minimising child abuse in New York.

This paper proposes that two things are required to provide adequate assessments of parents who misuse substances; first a model that identifies risk factors that need to be assessed, and second an instrument that provides objective assessments of level of severity of each risk factor and associated likelihood of harm to children.

d - Risk Factors for Harm to Children

Van IJzendoorn et al. (2020) reviewed thousands of studies that included almost 1.5 million participants about risk factors for abuse of children. The authors identified six important risk factors for abuse of children that are modifiable by provision of appropriate supports. The identified risk factors are: (a) intimate partner violence; (b) parental experience of maltreatment in their own childhood; (c) aggressive parental personality; (d) low socioeconomic status of the family; (e) parental emotionality as measured from high baseline autonomic nervous system activity; and (f) a dependent parental personality.

A review by the Australian Institute of Family Studies (AIFS, 2017) identified further modifiable risk factors for child abuse, adding: parental substance misuse; parental serious mental illness; parental exposure to multiple stressors; parent being isolated and lacking support; parent finding their child's behaviour difficult to manage; parent having difficulty managing their child's special needs; and parent lacking a suitable parenting template after being raised themselves in an abusive environment including in out-of-home care.

This research supports the proposition that a proportion of parents who misuse substances experience other risk factors, and will be viewed as part of the group who have multiple complex problems.

To date, no Australian State Government appears to have used the research information to formalise a policy about how to assess risk of harm to children due to parental risk factors.

Empirical Evidence About Risks to Children

There is considerable research about harm to children whose parents misuse substances. In part, this research examines children who have been placed in out-of-home care.

Studies that examined the mental health of children in Australia who live in out-of-home care, found that children removed from parental care and placed into out-of-home care have rates of mental disorder that are five times higher than the usual prevalence (Sawyer et al., 2007; Tarren-Sweeney, 2008; Lok & Tzioumi, 2015). A meta-analysis by Dubois-Comtois et al. (2021) analysed 41 studies of children in out-of-home care and matched samples to clarify factors associated with children's mental disorder. The study found an association between placement in foster care and child's psychopathology with an effect size of $d=0.19$, with children in foster care having higher levels of psychopathology. The prevalence of psychopathology in children in foster care was similar to that

of children who remained with their biological families, indicating that simply placing a child into traditional foster care is not a protective factor for children's mental health.

A study by Vargas et al. (2005) reported that children who observe domestic violence are at greater risk for repeating the cycle of violence when they are adult by entering into abusive relationships or becoming abusers themselves. They report that boys who sees their mother being abused are ten times more likely to abuse their female partner when they are adult, and girls who grow up in a home where her father abuses her mother are likely to enter relationships with violent partners and are more than six times as likely to be sexually abused as girls who grow up in a non-abusive home.

Kaspiew et al. (2009) surveyed 10,002 separated parents in Australia and found that 17% of fathers and 26% of mothers reported experiencing physical hurt from their partner. Of the parents who reported experiencing physical violence before separation, 72% of mothers and 63% of fathers reported that their children had witnessed the violence. Similar figures were reported by Kaspiew et al. (2015).

A systematic analysis of research about impacts on children of having been exposed to a caregiver who misused substances was provided by Staton-Tindall et al. (2013). Their review found that researchers had used a wide variety of measures, making it difficult to compare studies. The review found that having a substance-using caregiver was associated with a higher rate of referrals and re-referrals to child welfare services, and a higher rate of substantiated allegations of abuse. The reviewers found that children in households where parents misused substances were exposed to violence, to chaotic lifestyles, and to other risk situations, incurring risk of childhood trauma. There was a higher level of child maltreatment by substance-misusing caregivers, with physical abuse and neglect being the most commonly reported types of child maltreatment associated with caregiver substance misuse.

Caregiver substance use was found by Staton- Tindall et al. to be consistently related to high and clinically significant levels of mental health disturbances in children. The reviewers found that researchers had called for increased provision of evidence-based interventions for families where parents misused substances. However, the reviewers found that few researchers recommended children be referred for their own mental health therapy. The reviewers predicted that advances will be linked to improvements in screening instruments that measure key constructs, where instruments move beyond dichotomous measures. The reviewers noted that most studies report that agencies support either adults or children, with few studies reporting support for families, and this impacts on reunification when children have been removed from parental care for assessment. The review called for provision of therapies that are evidence-based, family oriented, and trauma-specific to address co-occurring traumatic stress conditions such as parental PTSD, acute stress disorder, and a range of substance use disorders.

AIHW (2020, p 338) reported that children who had been exposed to family violence displayed disadvantages on a number of measures including: diminished educational attainment, reduced social participation in early adulthood, physical and psychological disorders, suicidal ideation, behavioural difficulties, homelessness, and future victimisation and/or violent offending.

Orr et al. (2022) analysed health and police records of 16,356 children who had been exposed to family violence in Western Australia between 1987 and 2010 to explore connections between exposure to family violence in childhood and contact with mental health services, compared to children with no involvement in family violence. The study found that children who had been exposed to family violence were almost five times more likely to have used a mental health service by the age of 18, with an increased risk of having been diagnosed with 8 of the 10 mental health disorder diagnoses examined in the study, including double the likelihood of having a substance use disorder.

In summary, research indicates that children exposed to parental substance misuse, parental mental illness and family violence are at increased risk of developing their own mental disorder and forming adverse relationships.

Cumulative Risk

One hypothesis proposes there is an association between number of risk factors that a family demonstrates and risk of cumulative harm to children. This is called a 'cumulative risk hypothesis.'

Meyer et al. (2010) conducted a case file analysis of 60 families who had been referred to a child protection court in Sydney, of whom half of children were placed in foster care and half remained in parental care. Both groups of parents had alcohol and drug abuse issues. Parents whose right to care for their child were terminated had a higher number of risk factors including mental health problems and they had experienced incarceration.

Raviv et al. (2010) studied a sample of 252 maltreated youths aged 9-11 years who were placed in out-of-home care in USA to examine the cumulative risk hypothesis that a youth's exposure to a higher number of risk factors was associated with an increased likelihood that youth would develop mental health symptomatology. They identified seven risk factors as indicators that differentiated youth who did and did not score in the clinical range regarding mental health symptoms, confirming the cumulative risk hypothesis and proposing a potential threshold.

Raman and Sahu (2014) reviewed community health records of 57 children in foster care in Sydney to identify predictors that children were likely to be placed into foster care. They found that, compared to a control group, parental risk factors for a child to be placed into foster care included parental substance use (65%), domestic violence (57%), and parental mental health disorder (33%).

Solomon et al. (2016) further examined the relationship between cumulative risk, parental recidivism, and provision of therapy for parents and children. Their study confirmed a hypothesis that providing therapy for parents that reduced the number of risk factors also reduced parental recidivism. The finding indicates it may be viable for a scale that provides quantified scores to set a threshold that identifies families who warrant early intervention therapy, as well as to set a threshold where risk is excessive.

As discussed above, Baidawi and Sheehan (2019) conducted a case analysis of young people who had been involved with both child protection and youth justice services in Victoria. An assessment of number of adverse events children had been exposed to prior to removal from parental care found that removed children had been exposed to a mean of 5.4 adverse events.

Vial et al. (2021) proposed a system to categorise levels of risk to children based on the number of risk factors that are substantiated in a family. They labelled risk categories as low, medium and high. Families who present with medium-risk might be labelled as vulnerable families who are offered access to therapy services that aim to improve their inadequate parenting practices. Families assessed as presenting with high-risk due to the number and severity of substantiated risk factors might be labelled as high-risk and have their child removed from their care for protective purposes while the parents are given opportunities to engage in rehabilitation.

These studies show that risk factors can cluster. One cluster of parental risk factors that increase risk of harm to children involves parental substance misuse, parental mental health conditions, difficulties in managing children's behaviour, and family violence.

This paper proposes that to facilitate delivery of effective services for vulnerable families, it is essential to adopt a model of risk that is relevant to vulnerable families, and that includes the parental risk factors that cluster.

Assessment Instruments

Cafcass published a SCODA tool to assess risk arising from parental drug use (Cafcass, undated). No research was identified in the rapid review about the ability of SCODA to distinguish families who require early intervention therapy and families where children need to be removed from parental care to protect the child.

The rapid review did not identify any instrument that has been established for the purpose of assessing level of risk to children arising from parental misuse of substances. As noted above, the absence of an agreed objective instrument to assess risk to children contributes to some children being

removed from care of their parents for prolonged periods while assessments are conducted for litigation purposes.

Tustin and Whitcombe-Dobbs (2024) provided a Parenting Capacity Instrument (PCI) that identifies risk factors for maltreatment of children and appears relevant as a model for assessing risk due to parental substance misuse. PCI includes a domain of major parental risk factors with 13 items that identify modifiable parental risk factors, and might serve as a screen. It is proposed that scores on PCI have potential to distinguish between: parents who use adequate parenting practices; parents whose practices are not adequate to meet the needs of their child and who require distinctive types of therapy; and parents whose practices are potentially abusive and where children need to be removed from parental care. However, the scoring system used in PCI might not be adequate when applied to use with parents who misuse substances, and improvements might be made by further research.

This paper proposes that for a government to implement a policy of supporting families where children are vulnerable to harm from parental misuse of substances, it is necessary to adopt a model of risk that identifies specific risk factors and needs of vulnerable families, and to identify an assessment instrument that provides objective assessments to ensure that each family is referred to appropriate services.

This paper proposes the Parenting Capacity Instrument and SCODA be considered as providing a model for assessing risk to children whose parents misuse substances.

e - Scale of Problem

Administrative information is provided in Australia about numbers of children placed into out-of-home care, and related information.

The South Australian Department of Child Protection provides regular statistical reports on its website. Statistics about notifications for the year 2022-2023 are: 114,299 contacts were made to its call centre; there were 92,951 reported notifications; and 39,515 notifications (43% of notifications) were screened in for investigation.

The Commonwealth Government through its Australian Institute of Health and Welfare (AIHW) takes responsibility for monitoring the administration of welfare services that are provided by state governments. AIHW reports statistics annually on topics including use of out-of-home care where a court order is made for a child to be removed from the custody of their parents and is placed in the custody of the child welfare department. Data reported over the years are summarized.

AIHW (2024) reported that the rate of notification of children in Australia was 51 per 1000 in 2022-2023, indicating that 1 child in 32 is notified each year. Ten percent of notifications were made by health or medical personnel. About 33% of notified families were referred to another service by child welfare services. AIHW (2024) reported that the rate of substantiated notifications was 8 with 1000 for children aged under 18, where substantiation means that an investigation concluded the child had been maltreated or was at risk of being maltreated.

f – Efficacy of Therapies

Authorities distinguish between treatments of substance abuse according to the severity of substance abuse, distinguishing between addiction and occasional use (Brophy et al., 2023).

Treatment of Addiction

Reviewers have commented on efficacy of treatments when people are addicted to a substance. Laudet (2008) noted that many treatments for addiction have been short term, and produce benefits that do not endure. Dennis and Scott (2007) reviewed studies of people who required inpatient treatment for heavy substance use and their longitudinal study found that many users required three or four episodes of treatment before they achieved abstinence. They reported that 64% of people admitted to treatment programs in USA were actually re-entering treatment. They identified four

phases that users engaged in they called recovery / relapse / re-enter treatment / incarceration, and they found that users transitioned between each phase about every 90 days.

McLennan and colleagues (2014) proposed that the most severe level of substance use disorder meets criteria for being a chronic disease and needs to be managed using a proactive and ongoing chronic care model of intervention.

Simoneau et al. (2018) reviewed 16 treatment studies and concluded that treatment of addiction requires ongoing long-term intervention rather than episodes of short-term treatment, confirming that addiction is a chronic disorder. Lauder (2008) and McKay (2009) identified requirements for effective interventions for addiction to be; a person's motivation to abstain, coping skills to manage stressors, a source of emotional support, and attendance at a peer support group. A Delphi study of quality indicators for continuing care of people with addictions provided by Bekkering et al. (2016) identified 69 recommendations.

A meta-analysis of general psychosocial interventions for substance abuse disorders by Dutra et al. (2008) found that one third of participants who were addicted dropped out of therapy before treatment was completed.

Lopez et al. (2021) reviewed 50 rigorous studies that examined group treatments for people diagnosed with drug use disorders involving cocaine, methamphetamine, marijuana, opioids, mixed substances, and with co-occurring psychiatric conditions. The review found that efficacy of interventions varied with substances. They found that combined group cognitive behaviour therapy plus pharmacotherapy was more effective in decreasing opioid use than pharmacotherapy alone. Relapse prevention support groups, motivational interviewing, and social support groups were all effective in reducing marijuana use.

Goals of Treatment

Therapists can set different outcomes they aim to achieve from therapy.

Kepple (2018) surveyed families involving 5501 children in USA who were identified as being at high risk of maltreatment and assessed levels of parental drinking in the previous year using four categories of: non-use / moderate drinking / risky use / substance abuse disorder (SUD). The survey found that, compared to non-use, each user category had a heightened incidence of physical abuse being: 148% higher for moderate drinking, 386% higher for risky use, and 562% higher for SUD. However, the study found that the frequency of physical abuse by parents with a previous diagnosis of SUD who had reduced use was not significantly different from that of parents who reported non-use, indicating that changes are possible.

Cannabis Use

One psychoactive substance that causes concern is cannabis. The Australian Department of Health and Aged Care provides advice about safe levels of consumption of alcohol based on a standard drinks approach that provides guidelines for the public and therapists, and that can be adapted for specific population groups including parents. However, it appears that no guidelines have been provided about safe consumption of cannabis, leaving judgments about goals to set in therapy to personal opinions of practitioners.

Some studies have focused on parental use of cannabis.

Donoghue (2015) interviewed 43 parents in Western Australia who used cannabis about strategies parents used to minimise cannabis-related harm to themselves and their children. Most parents did not believe that their children had been adversely affected by their use of cannabis. Strategies used by parents to minimise harm involved: dosage control, managing dependency, awareness of acute risks, addressing long-term harm, monitoring harm to children.

Madras, Han and Wilson (2019) noted that adults of child-bearing and child-rearing ages were in cohorts who consume higher levels of cannabis. They surveyed 24,900 cohabitating parent-child dyads in USA about marijuana use by parents in the past year. They found that 7.6% of mothers and 9.6% of fathers of adolescents have used marijuana in the past year. They found that adolescents

whose parent had used marijuana on 52 or more days in the past year had higher relative risk rates of consuming marihuana than adolescents whose parents had not used marijuana.

Wesemann, Wilson and Riley (2022) surveyed 266 parents of children aged 1-5 to 5 years in three states of USA about use of cannabis in the past 6 months, about parenting practices, exposure to adverse childhood events (ACEs) and children’s emotional/behavioural adjustment. Hierarchical regression analyses were conducted. The study found that 13% of parents reported cannabis use. Parents who endorsed use of cannabis reported significantly more negative parenting, ACEs, anxiety, depression, and child emotional/behavioral problems. Adjusting for the effects of other risk factors, cannabis use significantly predicted more negative parenting practices.

Kokotovic, Psunder and Kirbis (2022) interviewed 839 secondary students in Slovenia aged 14-21 years about their use of cannabis. The study found the strongest predictor of student use of cannabis was parental use of cannabis.

Freisthler, Thurston and Price Wolf (2024) obtained self-report surveys from 77 parents who used cannabis over a 14-day period. They reported that different patterns were followed by groups of parents, and they concluded there were complicated relationships between cannabis use and parenting in their sample. Some parents provided information about use of harm reduction practices to support positive parenting.

Early Intervention Therapies

Loxley et al. (2004) were commissioned by the Australian Government to review evidence about prevention of substance abuse. They supported universal educational programs for the whole community and targeted interventions for cohorts at higher risk. They reported that effective programs for at-risk cohorts provide early interventions that are focused to address specific risk factors in the cohort.

The section below reviews literature about evidence of efficacy of mental health therapies used with parents who misuse substances, including in families where parents have complex presentations.

Interventions are presented using a model proposed to assess level of risk to children arising from different parental risk factors.

Model to Assess Parental Risk to Children

This paper proposes that to facilitate delivery of interventions to families that are appropriate to meet the individual needs of each family, it is necessary first to identify a model of parental risk to children. Establishing a model of risk will enable development of a screening instrument that provides objective assessments of risk to each child and will guide referrals to services that are relevant to each family’s individual needs.

Velleman and Templeton (2016) provide information about protective factors as well as risk factors for children in families where parents consume substances. An effective screening tool will combine both risk factors and protective factors in one scale.

A proposed assessment model is summarised in Table 1. Table 1 describes three components of a model that are; labels for each risk level, eligible family, and types of intervention.

Table 1. Levels of Parental Risk to Children and Recommended Interventions.

Definitions of Levels of Intervention		
Level of Risk	Eligible Family	Type of Focused Intervention
No risk	Competent parent, has no risk factors	Universal educational & support interventions
Low risk	Vulnerable, parent presents a low risk of harm to child	Indicated Group psychoeducation

		Social support group
Moderate risk from one disorder	Vulnerable, parent has a diagnosed disorder and is eligible for indicated therapies provided by a clinician	Indicated / Focused
		Individual therapy for one disorder
		Joint parent-child therapy
		Dual focus therapy
		Trans-diagnostic therapy for co-morbidities
		Clinician-led therapies
Moderate risk of cumulative harm	Vulnerable, parent presents a moderate risk of harm, is willing to participate in voluntary individual therapy that is self-managed	Indicated / Focused
		Therapies as determined by an individual assessment
Moderate risk - Reportable therapy	Vulnerable, parent receives services coordinated by a key clinical who may provide a treatment report to an authority	Targeted
		Services as mandate by a court order, and as identified by an individual assessment
High risk - Multiple complex conditions	Parent presents with many risk factors	Targeted
		Therapy from multi-disciplinary clinic
		Case management
		Intensive family supports
Unacceptable risk	Unsafe, child is removed from parental case and placed into statutory care	Targeted
		Out-of-home care

Seven levels of risk are proposed in the model: (a) *no risk* so families access universal services available to all members of a population; (b) *low risk* where families are eligible for identified services; (c) *moderate risk from a diagnosed disorder* where a family is eligible for focused therapies provided by a clinician; (d) *moderate risk of cumulative harm* where families are eligible for focused services; (e) *moderate risk and reportable therapy* where a person receives focused services that are set by a court order and by assessment; (f) moderate risk due to *multiple complex conditions* where a family receives intensive support services supervised by a case manager and provided by a multi-disciplinary service; and (g) *unacceptable risk* where a child is removed from parental care.

This paper uses the following format to describe administrative interventions. Interventions are distinguished according to the stage of development of a condition: *universal* prevention aims to stop a health condition from developing; *early intervention* services that are indicated and focused aim to teach self-help skills when a health condition is emerging; and *treatment* is used when a health disorder has been diagnosed. *Targeted* health interventions are directed at specific groups in a population. *Indicated* and *focused* interventions are used with people who begin to engage in hazardous activities with an aim of preventing heavy or chronic use of a substance, and aim to develop protective factors and to reduce risk factors. Providers of indicated and focused interventions set priorities between goals when a person exhibits multiple concerning behaviours and engages in several hazardous activities.

Type of intervention refers to administrative arrangements rather than to clinical interventions as similar clinical interventions are provided as part of different administrative interventions.

The proposed model integrates four types of intervention; universal interventions that are available to the general public; interventions that are indicated for certain cohorts in a population where access might be restricted; interventions that are focused and restricted to designated groups; and interventions that are legally mandated.

Types of Therapy Intervention

A rapid review identified a range of evidence based early intervention therapies and supports that have been provided for families where a child is at risk of harm due to parental substance misuse. Therapy interventions and supports are named in the third column of Table 1 and are described below, together with citations of literature.

It is noted that interventions require differing numbers of sessions and require differing qualification of providers, so there are cost aspects to selecting interventions that are not addressed in this article.

The following interventions are discussed: (i) psychoeducation; (ii) social support groups; (iii) therapies for substance use; (iv) joint parent-child therapy; (v) dual focus therapies; (vi) trans-diagnostic therapy for co-morbidities; (vii) clinician-led therapy; (viii) reportable therapy; (ix) integrated multi-disciplinary clinics; (x) continuing case management; (xi) intensive family supports; and (xii) col-located workers.

i - Psycho-Education

Psychoeducation about the impacts of using substances is a commonly used intervention as it can be delivered in a few sessions. Psychoeducation for parents includes information about impacts on children of misuse of substances. Psychoeducation is distinguished from therapy that aims to produce change within a person.

Magill et al. (2021) reviewed literature that provides guidelines about delivering psychoeducation about substance use. They identified 9 principles and 21 practices to encourage clients to engage in discussion and disclosure of their personal issues, rather than to adopt a didactic approach that seeks compliance. Effective groups encourage participants to discuss very personal issues in individual therapy that helps the person to change strongly held beliefs and attitudes, and to manage strong emotions.

The aims of a psychoeducational group are to improve an individual's awareness about the behavioural, medical, and psychological consequences of substance abuse. Psychoeducational groups provide information that is generally relevant to people with a common need, including to develop an understanding of the process of recovery. Groups encourage members to exchange information that is directly relevant to each other's lives, including to identify community resources that can assist clients.

Psychoeducation is more effective when a person is a pre-contemplation stage of changing their activities, and when all members of a group are in a similar stage of change.

A social support peer group has an additional aim of motivating a person to disclose personal information when they feel safe, to make commitments to other members to change, and to reduce anxieties about participating in personal therapy. Rehabilitation groups that provide peer support assist in preventing relapses by providing group support in finding ways to manage current challenges.

Thylstrup et al. (2015) reported a study where psychoeducation about substance misuse was provided to a treatment group but not to a control group. They found that people allocated to the treatment groups attended a median of 2 of 6 scheduled psychoeducation sessions. Attendees showed reduced substance use at a 9-month follow-up. Aggression declined in participants of both groups.

Lyman et al. (2014) conducted a meta-analysis of 30 studies involving randomized controlled trials of consumer psychoeducation about impacts of psychoeducation involving clients with co-morbid severe mental illness and substance misuse. They found that psychoeducation improved

adherence to recommended medication regimes and reduced relapse and hospitalization rates, and was considered to be a powerful intervention. Involvement of supportive family members in psychoeducation reduced burdens on family members who became involved.

Koc et al. (2016) found that psychoeducation was effective in reducing symptoms associated with use of psychoactive substances.

ii - Social Support Groups

Literature about a social support program that operates in Australia called Mirror Family was reported by Tsantefski et al. (2013). The Mirror Family is designed to help mothers affected by alcohol and other drug use. The aim of the program is to introduce a vulnerable family to a social group that will function like an extended family for the life of the child.

The service provides regular home visits from a qualified worker, initially on a weekly basis for two hours, and then reducing in frequency to fortnightly and then monthly. The duration of support for individuals ranged from 7 to 22 months, with a median of 7.5 months and a mean of 14 months. The focus of support is on helping the mother to meet caregiving responsibilities, and to ameliorate the negative effects of parental substance use on the family. The program includes helping parents to reconnect with their community and with family.

One emphasis of the program is to buffer children from the impacts of parental problems by creating an environment of an extended family for life.

The Mirror Family program provides three main types of support. One type of support offers respite care for parents. A second support offers a diversity of supporting roles, including baby-sitting, attending family celebrations, accompanying the child to sporting and other events, mentoring and advocacy. A third type of support offers forms of direct care.

Tsantefski, Humphreys and Jackson (2014) recognised that babies and infants are extremely vulnerable during the first year of life, and they provided a report about a program that followed up 20 substance-dependent mothers from the perinatal period until infants were aged 12 months, using a risk assessment and management approach. Their study identified a sub-group of infants who were at increased risk of harm during this very vulnerable period, and they argue for a differential response to management of risk for this cohort of infants by addressing family-related risk factors when mothers were most open to help.

iii –Therapies for Substance Use

A number of therapies that are derived from different theoretical perspectives have been shown to be effective in treating people with a substance use disorder.

Studies vary in their stated goals. Some studies state a treatment goal to sustained abstinence for a defined time period of time such as a year. Other studies involving alcohol aim to reduce consumption to a recommended number of standard drinks over a 30-day period. Studies vary in the follow-up periods reported.

A study by Forray et al. (2015) involving 152 pregnant women identified likelihood of relapse as a measure of severity of substance misuse. They proposed that number of weeks a person remains abstinent from a substance can be used as a measure of severity of dependence on the substance. They reported the following mean numbers of weeks before relapse by mothers who aimed to abstain postpartum: 16 weeks for cigarettes; 18 weeks for alcohol; 20 weeks for cannabis; and 41 weeks for cocaine.

Forray et al. report that the USA National Institute of Drug Abuse estimates overall relapse rates for substance use disorders was between 40% and 60%, and consider that these relapse rates are comparable to relapse rates for other chronic medical conditions such as hypertension, diabetes, and asthma. Forray et al. proposed that addiction to a substance be viewed as a chronic health disorder.

The Substance Abuse and Mental Health Services Administration's data compiled for the decade 1994-2004 provide information about relapse rates associated with specific substances. Reported

relapse rates were: 78.2% for heroin use; 68.4% for severe alcohol use disorders; 61.9% for cocaine use disorder; and 52.2% for methamphetamine use disorder.

Davis et al. (2015) summarised 10 randomized controlled trials that used psychological interventions for cannabis use disorders. They found that effective interventions were behavioural treatments involving contingency management, relapse prevention, motivational interviewing, and cognitive behavioural therapy (CBT).

Cooper et al. (2015) reviewed 33 random controlled trials of psychological interventions for cannabis use. They found that CBT interventions reduced cannabis use and severity of dependence in 4-14 sessions, with benefits continuing during a follow-up period of 9 months. Evidence-based therapies for cannabis use identified in the review by Cooper et al. are: cognitive behaviour therapy, motivational interviewing and motivational enhancement therapy, supportive expressive dynamic psychotherapy, and social support groups.

Studies reviewed by Cooper that involved brief motivational interviewing with only two sessions produced mixed results. Combining CBT with provision of vouchers for abstinence showed some efficacy. When cannabis users had comorbid mental health diagnoses of bipolar disorder, major depression or psychosis, CBT did not add to efficacy of standard treatment for the mental health disorder.

DiClemente et al. (2017) reviewed efficacy of motivational interviewing for addiction to various substances, and concluded there was evidence of efficacy for alcohol, marijuana and tobacco use.

Kuppens et al. (2020) conducted a meta-analysis on the impacts on children of parental use of alcohol, tobacco and other drugs. They concluded there is an ongoing need for interventions that provide a focus on impacts of parental drug use on children.

Hogue et al. (2021) cited meta-analyses that compared efficacy of therapies that involved family members in treatment of substance users, and reported good efficacy for family-based models of intervention.

A meta-analysis of psychological therapies for substance abuse disorders involving alcohol, cannabis, stimulants, opioids, and benzodiazepines by Dellazizzo et al. (2023) found evidence of efficacy for interventions of brief intervention, cognitive-behavioural therapy, contingency management, voucher-based reinforcement therapy, motivational interviewing, motivational enhancement therapy, involving significant other people in therapy, and cue-exposure therapy.

Nadkarni et al. (2023) reviewed efficacy of different psychological therapies for alcohol use disorders. They found demonstrated efficacy for eight interventions: behavioural couples therapy, cognitive behaviour therapy combined with motivational interviewing, brief interventions, contingency management, psychotherapy plus brief interventions, 12-step programs, family-therapy / family-involved treatment, and community reinforcement. Common components in effective programs were: individual assessment, personalised feedback, motivational interviewing, goal setting, setting and review of homework, promoting problem solving skills, and relapse prevention/management.

Anderson et al. (2023) reported that a 2020 National Survey on Drug Use and Health found that over 22% of American adults reported illicit drug use in 2020, and that 6.8% of adults meet criteria for a drug induced disorder. They conducted a meta-analysis in an effort to identify interventions that are most efficacious for adolescent drug users. Their analysis concluded that interventions involving parents produced small-to-medium positive relations with youth substance use and psychological problems.

Klimas et al. (2014) reviewed four studies where psychological interventions were used with people who consumed both alcohol and illicit drugs. Interventions studied were: CBT coping skills training, 12-step program, motivational interviewing, and brief intervention. Alcohol use was measured using an AUDIT instrument (Babor et al, 2001). Klimas et al. compared efficacy of interventions for specific substances, and aimed to assess relative efficacy of interventions rather than efficacy in meeting stated treatment criteria. The review found that evidence was of low quality, and it was not possible to identify therapies that were superior. Therapies where there was evidence of

efficacy for concurrent alcohol and illicit substance use were cognitive-behavioural coping skills and motivational interviewing.

Haber et al. (2021) provided guidelines for general medical practitioners regarding assessment and treatment of substance misusers. They recommended use of an Alcohol Use Disorders Identification Test (AUDIT, Babor et al., 2001) screen for alcohol use that assesses quantity and frequency of consumption, and impact of consumption on physical health, mental health and social functioning. AUDIT provides information to develop a treatment plan and a relapse prevention plan. The authors identified pharmacotherapy to maintain abstinence, individual therapy and peer support involvement as effective in reducing alcohol use. Engaging family and culture specific agencies were recommended. Harm minimisation by reducing consumption was considered as an alternative goal to abstinence. Neuropsychological assessment was recommended if significant cognitive impairment was suspected.

In conclusion, the literature review identifies a range of specific therapies for substance use. Individuals who misuse substances can be referred to a clinician to treat the condition, leaving selection of suitable treatment modalities to the judgment of the clinician.

iv – Joint Parent-Child Therapy

Some programs focus on improving parenting skills in families where children whose parents misuse substances are at risk of physical violence and provide joint parent-child therapy (Suchman et al., 2006; Runyon et al., 2010).

Schulman et al. (2000) provided an outreach program for children whose parents were in a treatment program for substance abuse, where children were considered to be at risk of developmental delay. The program provided individual assessments of children's skills and found cognitive delays in 69% of children. Children were referred for individualised therapy, resulting in 72% of children receiving services.

Schuler et al. (2002) provided an in-home intervention for post-partum mothers who used drugs that provided weekly visits for 6 months, followed by fortnightly visits for 6 to 18 months. The aim of the intervention was to educate mothers about child development. The program did not aim for mothers to be abstinent.

Dawe and Harnett (2007) reported a Parents Under pressure (PUP) program for 64 mothers who received methadone and whose children are aged 2 to 8 years. PUP is an individualised intensive home visiting program with 12 modules that aims to improve parenting skills by addressing three main issues: psychological functioning of individuals in the family including teaching parents to regulate their emotions; parent-child relationships; and addressing social / contextual factors. The program is implemented by professional clinicians. An evaluation of the program found that parents who completed the program compared to a control group had reduced child abuse potential, experienced less stress from the parenting role, showed improved parental emotional regulation, and children's behaviour improved.

Coates (2017) described a treatment program provided by a multi-disciplinary team of clinicians called Keep Them Safe-Whole Family Team (KTS-WFT) who provided therapy for children whose parents exhibited drug and alcohol and/or mental health issues. Referrals were accepted from child protection services.

Ritzi et al. (2022) reported that no specific intervention for working with parents who misused substances had previously been identified, and they proposed a model of intervention for families where parents misused substances and placed children at risk of violence.

In conclusion, a range of interventions have been reported that provide joint therapy for children and their parent, but there is insufficient evidence to support any specific programs over alternatives.

v – Dual Focus Therapy

Some studies have been designed to treat people with dual diagnoses.

Hides et al. (2019) reviewed evidence from seven random controlled trials about efficacy of four psychological interventions for people who had comorbid depression and substance use disorders, with an aim of identifying more effective interventions. Interventions studied were: Integrated Cognitive Behavioural Therapy (ICBT), Twelve Step Facilitation (TSF), Interpersonal Psychotherapy for Depression (IPT-D), and Brief Supportive Therapy (BST). One of their meta-analyses compared ICBT with TSF and found that while the TSF group had lower depression scores at post-treatment follow-up after 12 months, the difference was not statistically significant. No significant differences were found between groups in proportion of days abstinent, although the ICBT group had a greater proportion of days abstinent at the 12-month follow-up.

A second meta-analysis by Hides et al. compared IPT-D with BST. IPT-D produced immediate significantly lower depression symptoms, but the benefit was not sustained at a 3-month follow-up. Substance use was not reduced by either intervention as interventions did not specifically address substance misuse.

The review by Hides and colleagues found some evidence of efficacy for integrated cognitive behavioural therapy, 12-step facilitation, and interpersonal psychotherapy for depression with clients who had comorbid depression and substance abuse disorders.

vi - Transdiagnostic Therapy for Co-Morbidities

Many studies find that the cognitive behavioural therapy (CBT) approach is effective in treating substance use disorders. The CBT approach encourages clients to review their thinking and emotional reactions to challenges, and to find new coping strategies apart from use of substances. The CBT approach is known for following a scientist-practitioner model, where there is two-way communication between clinicians and scientific researchers, and where clinicians aim to use therapy interventions that are soundly based on principles established in research, and scientists consult with clinicians about topics that require further research.

Commentators note that the CBT approach produces regular advances in knowledge, and that clinical practices derived from the CBT approach progresses through phases. In the first phase, clinicians focused on treating single disorders. In subsequent phases, clinicians have accepted referrals for clients who have been diagnosed with a set of disorders that co-occur in clusters, and clinicians have used a trans-diagnostic approach where they select treatment methods according to each client's presenting issues and needs, rather than being restricted to set procedures that are associated with a single diagnosis (Barlow & Farchione, 2018). Trans-diagnostic therapies focus on mechanisms that contribute to the development and maintenance of psychopathology. Clinicians who use a trans-diagnostic approach are willing to provide interventions that are derived from different theoretical models, if an intervention is shown to be effective. Some therapists focus on interactions between people or on interpersonal dynamics (Garber et al., 2022), while another trans-diagnostic approach for substance misuse examines people's strongly held beliefs using schema therapy (Talbot et al., 2024).

The trans-diagnostic therapy approach is beginning to be applied to the treatment of substance abuse.

Sudhir (2018) discussed one form of trans-diagnostic therapy using relapse prevention strategies based on teaching clients to recognise and manage their signs of cravings. Coping skills used in managing cravings included decreasing the valence of addictive behaviours, teaching coping skills to manage cravings, managing high emotional arousal and negative mood states, assertiveness skills to manage social pressures, family psychoeducation, cognitive strategies to enhance self-efficacy beliefs, and modification of expectations about outcomes of addictive behaviours. Skills used in trans-diagnostic therapies for substance disorders include building distress tolerance skills using mindfulness practices.

Kim and Hodgins (2018) describe a trans-diagnostic model for treating addictions that addressed client's low motivation, deficits in self-control, deficits in social support, and compulsive tendencies.

Narayanan and Naaz (2018) identified a range of trans-diagnostic therapies that are used to treat substance use disorders including Acceptance and Commitment Therapy, Dialectical Behavioural Therapy, Metacognitive Therapy, and Mindfulness-Based Relapse Prevention. They report growing evidence for the efficacy of trans-diagnostic therapies in treating substance misuse disorders.

Neger and Prinz (2015) reviewed 21 studies that provided dual treatment of substance abuse and parenting education, and reported that the dual treatment program generally produced both a reduction in parental substance use and improvements in parenting practices.

Moreland and Mcrae-Clark (2018) reviewed 15 studies of programs that integrated treatment for a parent's substance misuse and a parenting component. The review found a lack of consistency between studies in assessment instruments used. They found the mean retention rate for programs was 72%. Most studies reported a reduction in substance use. The review suggested that the important components to address in a supportive parenting program involve parenting stress, psychosocial adjustment, parental depression, potential for child abuse, parenting practices, and parent-child interactions. The review found that studies that examined parent-child interaction produced improvements following engagement in the program. The review recommended that parenting interventions be routinely included in treatment programs for parents who misuse substances.

In conclusion, a range of trans-diagnostic therapies can now be viewed as been promising and evidence-based and are recommended for parents who misuse substances.

vii - Clinician-Led Therapy

One form of therapy that has been used with clients who present with complex conditions involves delivery of both clinical services and in-home supports, called clinician-led therapy. An example of clinician-led therapy was reported by Tustin (2024a) involving parents with a severe mental health condition who had co-morbidities of substance misuse, exposure to domestic violence, and difficulties in managing their child. The clinician-led program provided each parent with a combination of therapies delivered by one clinician together with in-home parenting education that was provided by a parenting coach who attended the family home and worked collaboratively with the clinician.

viii - Reportable Therapy

Reportable therapy is therapy that has a distinct confidentiality arrangement as the client requests a report about the efficacy of their treatment to be provided to an authority or a court. Reportable therapy is provided by a nominated primary clinician who undertakes to provide a treatment report to the authority at the end of therapy or at agreed times (Tustin, 2024b). Clinicians who provide reportable therapy commonly follow a trans-diagnostic approach as they are required to address a range of presenting issues rather than a single diagnosis.

Clients who receive reportable therapy might be the subject of a court order where they are required to participate in certain mandated activities.

Cashmore (2024) made a call for improvements in the operations of courts in Australia that make orders mandating what parents must do. Cashmore expressed an opinion that the public expects courts to resolve problems such as parental substance abuse that social and health services have not been able to resolve, so applications are made to court to remove children as a protective measure before therapy interventions have been provided.

Cashmore noted that involving courts in decisions about the functioning of a family is traumatic for all members of a family. Both parents and children become defensive, and they are susceptible to ideas they are being treated unfairly. Parents who feel anxious and helpless are likely to become argumentative and combative, and to reduce their cooperation with child welfare authorities. On the other hand, families who consider they are being treated fairly are more likely to engage in recommended therapy interventions.

Cashmore identified a range of steps that can be taken to foster a more collaborative and a less adversarial approach between welfare and therapy services. She hypothesised that improved collaboration could lead to implementation of more effective interventions, to improved child safety and to better outcomes for families and to a reduced need to remove children from their homes while extended investigations occur.

Cashmore also proposed that, when a parent views decision-making processes as fair, the parent is more likely to accept their own responsibility for outcomes that have occurred to a child.

Cashmore called for three improvements in the court process. The first call was for improvement in the quality of evidence provided to courts by expert assessors. A second topic for improvement involves feedback from courts to report writers, and feedback to courts about the outcomes of their decisions regarding placements and introduction of restrictive practices. Cashmore recommended that courts routinely provide feedback to assessors about the quality of their report, and whether the court found their report helpful when making a decision.

A third call by Cashmore sought publication of de-identified decisions by courts. Cashmore noted there has been little published research about the effectiveness of interventions ordered by courts, and about the long-term outcomes of recommendations by caseworkers. Cashmore noted that courts could receive feedback about the impacts of orders on the welfare of individual children, suggesting this would help judicial officers to weigh the potential benefits and harm to children of the various alternative orders that a judicial officer can make.

Cashmore noted that legal decision making is opaque rather than transparent due to an emphasis on privacy, as courts are closed and many judgments are not published. Transcripts are accessible only if a party appeals a judgment, and few parents are in a position to appeal decisions.

Cashmore stated there are good arguments for Children's Courts and other courts, including the Supreme Court that deals with adoption matters, to make a standard practice of publishing de-identified final judgments with their reasons.

ix - Integrated Multi-Disciplinary Clinics

One approach for treating people who misuse substances and who have multiple issues involves providing services from a multi-disciplinary team of clinicians who are co-located in an integrated clinic and who operate from the same premises.

Gwynne et al. (2009) reported that three modes of early intervention had been shown to produce sustained improvements in children's health, education and well-being. They described a program that is provided in Australia called a Spilstead Model that delivers integrated care over a 12-month period through a community centre that delivers the three approaches. Their evaluation found that the intervention produced changes in parent/child interaction by; reducing parent stress; improving parental satisfaction, parent confidence, parenting capacity, family interactions, child well-being, and total family functioning. The study found that 71% of children who had presented with developmental delay in initial screens functioned in the normal range on post-testing. Parents reported improvements in externalising behaviours with a large effect size of $d = 1.46$.

Vidair et al. (2011) reported an administrative arrangement that provided family-oriented services for families as parents were routinely screened when they brought their child to the clinic. The study found that 18.80% of mothers and 18.42% of fathers of distressed children themselves reported elevated internalizing symptoms. A similar result was reported by Middeldorp et al. (2016).

A systematic review of studies that aimed to address the three issues of parental symptoms, child symptoms and parenting practices was provided by Everett et al. (2021). The review identified 25 psychotherapeutic interventions that directly intervened on parenting practices and that reported improvements in all three outcomes, but few interventions improved all three outcomes in samples where parents, children or both met clinical-level thresholds of psychopathology.

x – Continuing Case Management

Commentators have noted that addiction is a chronic disease where relapses occur frequently, and recommend that people who are addicted to substances need to be viewed as having a chronic disease that requires continuing case management (Morgenstern et al., 2016; McKay 2009, 2014, 2021).

Morgenstern et al. (2016) evaluated the efficacy of providing an intensive case management (ICM) service to coordinate long-term care for 302 substance dependent women who were recruited from welfare offices that included referral to a substance abuse service. Follow-up occurred for 15 months. They reported the ICM clients received a significantly higher level of service for their substance misuse, and they achieved higher rates of abstinence.

However, due to the risks to children associated with frequent relapses when a person has an addiction, it appears wise that children not remain in the care of a parent who is diagnosed with a relapsing addiction.

An alternative approach is to authorise supervision of a parent who is assessed as having a substance misuse, while their child remains in the care of the parent. Legislation in some states authorises courts to issue supervision orders, but these orders are rarely issued in Australia as child welfare departments rarely apply for a supervision order and courts lack mechanisms to monitor supervision orders (Nyland, 2016, p. 209).

xi - Intensive Family Supports

Use of intensive family support services to prevent removal of children from parental care and to aid reunification has long been promoted (Scott, 1994).

The Australian Government introduced a voluntary Intensive Family Support Service (IFSS) program in 2016 for parents and caregivers of children aged 0-12 years where child neglect is a concern (Department of Social Services, 2016). IFSS providers are expected to develop and maintain strong and productive working relationships with the local child protection authority, who retains statutory responsibility for the ongoing case management, risk assessment and risk management of the child. IFSS providers do not deliver specialist, clinical or therapeutic interventions such as family counselling, financial counselling, or alcohol and drug treatment services. The scheme includes a referral process, a list of eligible funded activities, a needs assessment process, a support plan, an exit plan, and a workforce development strategy. Outcomes are to be measured, including using a Child Neglect Index. Services are delivered by small teams who are locally employed professional and paraprofessional family support workers who work under close professional supervision. The intensity of IFSS service provision commences at 20 hours per week and is scaled back as progress is made with each individual family. A caseload per worker of between 5-8 families across a year is proposed. An extension of service provision over 12 months can be negotiated.

AIHW (2021) subsequently defined a family support service as intensive if a family receives a service for an average of 4 hours per week for a specified period usually less than 180 days, and the purpose of the service is to prevent separation or to reunify families.

Forrester et al. (2008) reported an evaluation of an intensive family support service that was provided to 279 children, and compared outcomes to a control group. They found that 40% of children in both groups entered care, but children from families who received intensive family support took longer to enter care, spent less time in care, and were more likely to be at home on follow-up, and this option produced significant cost savings. Permanent changes were achieved for some families. Significant changes were not sustained for families who were assessed as having complex and long-standing problems, including sustained substance misuse.

Forrester et al (2008) reported an evaluation of an intensive family support service that aimed to preserve a family and prevent children from being placed in out-of-home care. The study compared outcomes for children who did and didn't receive the service. Their evaluation found that 40% of children did enter care, but they stayed in care for less time before returning to their family. Change was not sustained for families who presented with complex and long-standing problems.

Milligan et al. (2010) studied the efficacy of programs to support mothers with substance abuse that were integrated between service delivery systems, were non-integrated, or where no intervention was provided. They found that outcome measures of urine toxicology and percent of mothers using substances significantly favoured integrated programs over no treatment. However, integrated programs were not significantly more effective than non-integrated programs.

Niccols et al. (2012) reviewed studies of impacts on children whose mothers' misused substances from interventions that were or were not integrated between health and welfare services. They found that infants obtained higher scores on developmental tasks when their mothers participated in integrated programs than when their mothers did not engage in treatment. Studies that compared integrated and non-integrated programs found small effect sizes favouring integrated programs.

Al et al. (2012) conducted a meta-analysis of efficacy of brief, in-home intensive family preservation (IFS) programs to prevent out-of-home placement and improve family functioning, based on data from 20 studies including 31,369 participants. They found that, while IFS programs had a medium positive effect on family functioning for families with multiple problems ($d = 0.486$), the programs were generally not effective in preventing out-of-home placements.

Macvean and colleagues (2015) were commissioned by the child welfare department of the State of New South Wales in Australia to review services funded by the child welfare department and provided by non-government agencies to assist families where children were vulnerable as their parents had been notified to the department, leading to a report by Macvean et al. (2015). The purpose of the review was to identify interventions that were effective in improving outcomes for families with a range of identified vulnerabilities, and to inform reformation of service delivery.

The authors reviewed information about efficacy of interventions provided by four authoritative international clearinghouses, and rated 45 efficacy of interventions using four categories of: well supported, supported, promising, and emerging.

The review group separated interventions according to risk factors addressed into four categories of: community, family, parent, and child. Exposure to family violence was identified as a family risk factor. Parental substance misuse was categorised as a parent risk factor.

The Macvean group found that services funded by the child welfare department focused primarily on families in crisis where children were at risk of significant and immediate harm, rather than on providing early preventive intervention.

The group found that families in crisis commonly displayed many issues, and that addressing one issue such as improving parenting skills often produced improvements for other outcomes such as maternal substance use and depression. The authors noted that absence of agreed measures of outcomes made it difficult to draw clear conclusions.

Macvean and colleagues discussed applicability of interventions for families in specific circumstances.

The Macvean group in their Table 6 identify interventions for parental substance misuse. Their Table 6 identifies one intervention as supported (Healthy Families America home visiting), one intervention as promising (Adult-Focused Family Behavior Therapy), and four interventions as emerging (Early Start, Families Facing the Future, Family Connections, and Parents Under Pressure). Their Table 1 identified 5 interventions for domestic violence, with one rated as promising and four rated as emerging.

Effective interventions are discussed briefly by Macvean et al., including statements about qualifications required of providers. Interventions might be delivered by an individual qualified clinician, by a multi-disciplinary team, or by worker with brief qualifications who is supervised. Some services are made available for 24 hours of the day.

The group noted that interventions commonly include many components. Macvean and colleagues analysed components that were shared between all programs as including parenting education, and a focus on parent-child relationships. Common procedural steps were: assessment instruments might be used; interventions were delivered in homes and were adjusted for individual needs; interventions involved weekly contact and continued for periods of up to 6 months; many

interventions were delivered by trained staff; and efficacy was assessed after 6 months of intervention.

The group identified gaps in services provided by the non-government agencies including: few interventions for families where domestic violence occurred; and few interventions for families with co-existing substance misuse and mental health issues. Some interventions were available only for parents or only for children, rather than for parent-child pairs.

Macvean et al. reported the use of intensive case management which they defined as providing intensive support by a case coordinator to people with high needs, with an aim of reducing high-risk behaviour and increasing stability for a child. Intensive case management provides extended hours of service availability, and after-hours crisis support and outreach intervention, and is managed by Intensive Family Support and Intensive Family Preservation services who provide 24-hour support for clients for 12 weeks for families in crisis where children are at high or imminent risk of removal and placement in out-of-home care.

The Macvean review did not find that local service delivery agencies used any of the evidence-based interventions identified in their review. Nor did the Macvean review find that the funding agency required use of evidence-based interventions.

One policy approach that has been used in Australia is for child welfare departments to allocate funding to non-government services to provide parenting education for families who experience multiple issues, where the non-government agency operates independently of therapy services. One Minister of the Australian Government described this type of disability support service as being an economic reform that provides work for unemployed people. Care is needed to ensure that workers who provide disability support to citizens are trained for the work they provide, or act in liaison with clinicians.

Bezczky et al. (2019) conducted a review of intensive family preservation services and concluded there is a need for an objective assessment instrument to distinguish families where parents can and cannot be rehabilitated, as the aim of preventing all out-of-home placements is not always appropriate as there are family circumstances where children are better off being removed from parental care.

To assist evaluation of intensive family support services, the South Australian Department of Human Services issued a list of instruments that can be used to evaluate programs, including 35 generic instruments for all population groups and 8 instruments designed for use with the Aboriginal population (DHS).

Advice for agencies on how to select a suitable to evaluate a program is provided by Goldsworthy and Robinson (2016).

One proposition is that members of the workforce who provide intensive family services are qualified about the needs of their client.

xiii – Co-Locate Workers

A further initiative was reported by Zufferey et al. (2006). To improve collaboration between services to support parents with comorbidities of substance misuse, mental health issues, and interpersonal violence, the South Australian Government supported a Mental Health Liaison Project where a senior mental health nurse was relocated into a child welfare office to promote collaboration between departments that had traditionally adopted either a child-focus or an adult-focus, rather than a family-focus. The roles of the mental health nurse were to educate welfare workers and to facilitate referrals to appropriate specialist services.

An evaluation by Zufferey involved interviewing workers and parents. The evaluation found that placing a mental health nurse in a child welfare department enhanced the parent's perception of the empathy and respect shown by welfare officers. Parents had previously perceived the child welfare service as a surveillance system and they viewed the system as being less stigmatising once the liaison project commenced. The project recommended that the liaison project be extended.

Conclusions

This section identified a wide range of therapy interventions and practices to assist families where children are at risk of harm due to parental substance misuse. Interventions were categorised as suitable for families where children are at different levels of risk.

Five therapy interventions are identified as being indicated and focused interventions that are suitable as early intervention therapies for families where hazardous practices are emerging or well established. The five early intervention therapies are; therapy for one disorder, joint parent-child therapy, dual focus therapy, trans-diagnostic therapy, and clinician-led therapy. These therapies can be provided by a skilled clinician with supports, for clients who display a moderate level of each risk factor.

Reportable therapy is identified as a targeted intervention as it applies to a distinct cohort of people who are mandated by court to participate in interventions.

Therapies for families that are provided by a multi-disciplinary team are classified as targeted interventions if they are required by an authority. Three interventions that require funded input from many practitioners are classified as targeted, being services from a multi-disciplinary team, case management, and intensive family supports.

The rapid review did not find evidence of efficacy for two interventions that are currently used. One intervention involves referring citizens with multiple issues to multiple independent therapists who each treat one issue in an uncoordinated manner. A second intervention that lacks evidence of efficacy occurs when a child welfare worker has a dual role of being a counsellor one week and then being a prosecutor who prepares a case for court the next week. As noted by Justice Nyland, clients often lack trust in a practitioner who tries to combine the dual roles of being a therapist and a prosecutor (Nyland p. 196).

g – Privacy and Confidentiality

As discussed above the child protection legislation CYPsA includes a mandatory notification clause requiring health professionals to inform the child welfare department of any reasonable suspicion that a child might be maltreated. The mandatory notification impinges ??of confidentiality of family information, as people usually have a right to privacy of their personal information. The topic of confidentiality is also emphasised in codes of ethics of professional bodies. Health professionals are usually bound by strict confidentiality where they are prohibited from disclosing any personal information to third parties unless the disclosure is specifically authorised by the client involved or by legislation.

The topic of confidentiality is especially important when there is an assessed of increased potential for family violence.

Clinicians who provide therapy to parents and children often ask the parent to sign a distinct restricted confidentiality contract that permits the clinicians to disclose information to both clients.

If a person receives treatment from a multi-disciplinary team of clinicians, then it is conventional for one member of the team to be identified as a coordinator, and for the coordinator to prepare a treatment plan that lists inputs agreed for each team member, and to distribute the treatment plan to all members of the treating team and to the client.

A system might be envisaged where a government introduces a whole of government approach to manage family violence, that requires exchange of some information between participating parties. This would require a distinct confidentiality arrangement.

The following proposal is made if a whole of government approach is introduced to manage family violence. Strict confidentiality applies when one provider delivers indicated or focused services to a voluntary client. If reportable therapy is requested, then a referrer provides the clinician with relevant information, and a treatment report is provided to identified agencies, giving a restricted confidentiality contract. Members of a treating team who work with targeted groups are authorised to exchange information with each other about inputs they provide, progress made, and

need for their service being ongoing. If a person with multiple complex problems receives services from a range of providers, then a case manager is appointed who is responsible for maintaining suitable confidentiality.

The Australian Family Law Act defines the authority of parents to include a parent making decisions regarding children aged under 18 years about major topics that have long term impacts on children, called parental responsibility. Section 60CC of the Act discusses equal shared parental responsibility (where both parents have the same right to make decisions regarding their child) and sole parental responsibility (where authority to make certain decisions is granted by a court order to one parent).

Family Courts in Australia use distinct procedures when they ask community clinicians to provide therapy for vulnerable families, through a Lighthouse project. The Lighthouse project manages cases that involve risk relating to parental drug and alcohol misuse, family violence, mental health issues, and child abuse and neglect, using a Family DOORS screen. Cases with the highest levels of risk are referred to an Evatt List where the case is managed by a specialist court process. If a case is allocated to the Evatt list, then information is gathered from state courts, child welfare authorities, police and other relevant bodies.

Section 150(5) of the South Australian Children and Young People (Safety) Act 2017 authorises departmental staff to require clinicians who provide therapy for a parent whose child has been placed in departmental care to provide a written report to the department answering specific questions, under a threat of punishment including imprisonment for a year for non-compliance. Information provided by the clinician to the department may be used in the department's case in court proceedings.

In conclusion, this paper recognises that distinct confidentiality arrangements are required if a government introduces a whole of government approach to manage family violence associated with parental substance misuse.

A proposal was made about how confidentiality arrangements might be made arranged.

h – Coordination of Services

This paper cited studies finding that many parents who misuse substances display other risk factors for harming their children. Some parents display so many risk factors they are labelled as having multiple complex needs. Writers recommend that families who present with multiple complex needs be provided with distinct forms of therapy and support before consideration is given to removing their children from their care.

Questions arise about how to coordinate support for families that have multiple complex needs.

This paper noted the emergence of clinicians who are able to provide joint parent-child therapy, dual focus therapy, trans-disciplinary therapy, and clinician-led therapy. As each of these therapies is provided by a single clinician who takes responsibility for the therapy, it is proposed that the clinician can be responsible for coordination of services.

The situation is more involved when a family is assessed as presenting with multiple complex needs that require input from a range of separate professionals or agencies. Questions arise about how input from several providers might best be coordinated to meet the best interests of children while ensuring that children remain safe.

The topic of how to coordinate care for citizens with multiple needs arises with other cohorts including aged people. Discussions of coordination of care have been provided by several writers. Schultz et al. (2013) discussed coordination of health care. Hillis et al. (2016) discussed coordination for children with complex needs. Seckler et al. (2020) discussed coordination in aged care. Olson et al. (2021) discussed coordination of services for children and adolescents with serious emotional disorders who received wrap-around services. Khatri et al. (2023) reviewed 56 studies regarding coordination of a range of client health cohorts.

This paper envisages clinicians taking on a role of case coordination. A case coordinator has several roles that can be summarised: (a) make or arrange objective assessments of the client's abilities

and needs; (b) either deliver necessary services or identify a suitable provider for each need; (c) prepare a written treatment plan that records the client's needs, providers, and goals, and distribute the plan to all involved personnel; (d) motivate a client to engage in relevant services; (e) prepare a relapse management plan if a person's condition is in remission; and (f) encourage a client to develop a supportive community based network where relevant.

Some agencies use an administrative case management model where coordination of services is provided by a person who doesn't provide any direct welfare services so is independent of service delivery and perhaps is impartial. An administrative case manager might act as a navigator who refers families to services providers, or an administrative case manager might manage the budget that funds providers especially if a client has been assessed as having a cognitive disability and is incapable of managing the task of coordinating services.

Literature reviewed shows that a skilled clinician who follows a trans-diagnostic approach is potentially able to provide interventions that target each of the four issues in the cluster (substance misuse, parental mental health, family violence, and difficulty in managing a child's behaviour), when each issue occurs at a moderate level. Further issues such as difficulty in managing finances and managing tensions with extended family might be best referred to an independent service. In this scenario, a skilled clinician who is the primary provider might be asked to take on the additional role of being a case coordinator.

Whitcombe-Dobbs and Tarren-Sweeney (2019) reviewed nine studies of programs that delivered intensive parenting supports for maltreating parents. Their review concluded that maltreating parents are not homogeneous, and they found that no program they reviewed demonstrated efficacy in reducing all risk issues and all types of child maltreatment.

A report by Kaspiw et al. (2022) involving cases managed by Australia's Family Courts recommended there is a need for both: (a) specialised screening and assessment approaches when family violence and/or child abuse are identified; and (b) specific case management procedures to ensure that litigation is managed quickly, cost-effectively and in a way that is consistent with the best interests of the child. This paper concludes there is a similar need for an assessment screen that identifies specific needs of a family where maltreatment of children occurs, and that facilitates efficient coordination of services that are offered to each family.

This section summarises coordination practices that can be used for each level of risk.

The following proposals are made, referring back to Table 1. A parent who is assessed as posing no-risk and low-risk can self-manage services by accepting responsibility for decisions about receiving services. A parent who is assessed as presenting a moderate risk can also be viewed as being capable of self-management of services as a voluntary client, and be held accountable for their decisions to accept or decline recommended services. Parents who are assessed as posing a high risk and/or who require multiple services can have service delivery coordinated by a designated case manager.

If a child has been placed into statutory care, then involvement of services is coordinated by a case manager employed by a relevant government department.

Discussion

This paper reviewed information about parents who use substances and found these parents are not a homogeneous group as they present with different risk issues and needs. Research indicates that some parents have a single issue of misusing substances, while other parents display additional risk issues. Research indicates that a significant proportion of parents who misuse substances display a cluster of risk issues including mental health issues, difficulties in managing their child's behaviour, and domestic violence.

The paper proposes there is a need to identify a model of risk factors that is relevant for families where parents misuse substances. Once a model has been identified, there is a need to develop an assessment instrument that objectively and reliably identifies specific early intervention services

required by each family, as well as identifying families where risk factors are too severe and expose children to an unacceptable risk of harm.

A suitable screening instrument will meet legal standards regarding the quality of evidence submitted by an expert witness to a court. The paper proposes that a suitable screen will facilitate communication with legal services, and will assist assessors who provide reports to courts.

It is proposed that introduction of a suitable screening instrument will significantly enhance delivery of early intervention services to families where children are vulnerable to developing mental disorders and are at risk of being placed in out-of-home care.

The review identified a range of early intervention therapies that can be provided by skilled clinicians who deliver indicated and focused interventions.

The review discussed mechanisms to coordinate services for parents who have multiple complex needs, and proposed that a suitable screening instrument might contribute both to identifying parents with multiple complex needs, and might contribute to decision-making about coordination of services for these families.

Overall Conclusion

The paper draws attention to topics under discussion in one Australian State where the government has expressed concern that children at risk of harm from parental substance use, first attract attention when a notification is made to the child welfare service. The child welfare service has a statutory obligation to protect children at an unacceptable risk of harm by removing the child from parental care. But the child welfare service has not been able to ensure that children who are vulnerable as their parents misuse substances, are referred for early intervention therapy.

This paper proposes there is a need for an assessment model that identifies parental risk factors that predict an increased likelihood of a child being harmed by their parents. An evidence-based model of assessment is presented.

The paper recommends use of a model of risk and intervention that distinguishes between administrative categories and clinical categories of intervention. Four administrative categories are used to describe interventions: universal / indicated / focused / targeted. The paper recognises that specific clinical therapies might fall within several administrative categories.

The paper proposes there is a need for a screening instrument for administrative purposes that provides objective assessments of level of risk to children and that differentiates between three categories of parenting: competent parenting / parenting where children are vulnerable and require early intervention therapies / parenting where children are at an unacceptable risk of harm.

Future Directions

A number of important topics are addressed in this paper, and it can be argued that each topic requires additional research.

The paper found that parents who misuse substances are not homogeneous and they have varying needs and they present varying levels of risk of harm to their children.

The paper reported studies from Australia that found some parents who misused substances had comorbidities of mental illness, exposure to family violence, and difficulty in managing their child's behaviour. Parents with comorbidities were viewed as having multiple complex problems and as being difficult to treat. Researchers might investigate whether the phenomenon of multiple complex problems occurs in countries other than Australia.

The paper proposes that the cluster of parental issues involving substance misuse, mental illness, exposure to family violence and difficulty in managing children's behaviour can be managed by skilled clinicians who take an interest in this cohort and who use a transdiagnostic approach in therapy. This hypothesis warrants further research, including to identify components of effective transdiagnostic therapy.

Further questions arise about whether clinicians are adequately trained in transdiagnostic therapy for this cohort of parents, and whether clinicians are trained to present objective reports to family-oriented courts.

The paper proposes that risk factors cluster together in families with multiple complex problems and encourages recognition of a model of risk factors that is relevant to this cohort. Research is warranted on whether existing instruments suitably summarise risk factors for this cohort of parents.

It is recommended that an assessment screen be introduced based on a model of risk to facilitate referral of families where children are vulnerable to appropriate services, that include early intervention therapy and removal of children from parental care when risks are unacceptably high. Further research is required to clarify whether this ambition is achievable. Research is warranted on whether existing instrument that assess severity of substance use are helpful with parents who misuse substances.

The paper proposes that if a whole of government approach is to be introduced to manage cohorts of parents who misuse substances, then legal issues of confidentiality of confidentiality will need to be addressed, and that confidentiality arrangement might need to vary according to risk categories. Topics around confidentiality need to be researched.

Finally, the paper addresses questions about how to coordinate service delivery for parents who are assessed as posing different levels of risk of harming their children. The paper proposes a hierarchy where some parents self-manage service delivery, a skilled clinician is responsible for coordinating delivery of services as risk and complexity increases, and that a case manager be appointed in some circumstances. The viability of this administrative arrangement needs to be researched.

The most important proposal made in this paper involves a need for an instrument that facilitates objective assessments of risk levels to children when their parents use substances, where the instrument distinguishes levels of predictable harm to children and assists in decision making about referral to appropriate services.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study.

Conflicts of Interest: The authors declare no conflicts of interest.

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