Breaking the Intergenerational Drugs-Poverty Cycle

Report by

Kate Camins

Churchill Fellow 2001

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

Report by – Kathryn Janet Camins – 2001 Fellow

The Family and Children's Services Churchill Fellowship to study brief therapy techniques and to network with agencies in USA and United Kingdom, dealing with the issues of parental drug use and the safety of dependent children.

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INTRODUCTION

I was invited to apply for a Churchill Memorial Fellowship by Sue Hudd, of Family and Children's Services, Department for Community Development in Western Australia. I was thrilled and honoured to be selected as a Fellow as it offered me the opportunity to find out more about my particular field of interest; therapeutic work with alcohol or other drug using parents whose children are placed at risk of harm.

The fellowship offered me the opportunity to fill several ambitions. The first was to meet with the originators of brief therapy at the Mental Research Institute in Palo Alto California, and the second was to network with other professional workers committed to working with families where parental drug use has exposed dependent children either to actual or potential risk of harm.

I am indebted to Department for Community Development Family and Children's Services who sponsored my travel as a component of their ten-year commitment to the eradication of poverty. I am also hugely appreciative of my employer, Wesley Mission Perth, who supported and encouraged me in every possible way.

In the body of this report I will use the following abbreviations:

AOD =	Alcohol or other drug use
WMP =	Wesley Mission Perth
DCD =	Department for Community Development, Family and Children's Services (Western Australia)
MRI =	Mental Research Institute (Palo Alto, California)

In the Cabinet War Rooms, London

EXECUTIVE SUMMARY

The trip had two distinct themes; the study of brief therapy intervention in the United States, and the opportunity to examine trends in treatment and to network with agencies in the USA, England and Scotland, who work with a similar client group to those I work with in Perth (AOD using parents whose children are placed at risk of harm because of their AOD use).

I spent two weeks as a resident of the Mental Research Institute in Palo Alto California, where I was able to observe and learn from the experts in the field of brief therapy and strategic therapy. I was also able to consult with Dr Virginia Lewis, who is conducting a long-term study into family recovery from alcohol. A fortunate added opportunity arose to attend a day's workshop about the links between animal abuse and child abuse.

From Palo Alto I went to Buffalo New York, where I gained some insight into the services available to such families, and into the USA justice system.

The remainder of my journey took me to England and Scotland, where I was treated to a "smorgasbord" of services to families with AOD misuse. These included

- 6 office based individual counselling services,
- 6 outreach (home visiting) services which focussed on either the children of AOD using parents or working with the mother on managing her AOD use and protecting her child, and
- 5 residential rehabilitation services for women and their children, where the therapeutic work was done with the whole family.

The impact of this journey was to reinforce my own belief system, which is broadly summarised in the following terms:

1. Therapeutic work is far more likely to be effective when the therapist demonstrates true interest and treats the client with dignity,
2. That change is only likely to happen if the client chooses to make the changes and is enabled to set their own goals,
3. Children are an integral part of the therapeutic process, and their opinions must be sought and heeded.

I returned to Australia with the reassuring knowledge that Australia (and particularly the Hearth Program) is well advanced in offering such services.

The experience also gave me some exciting ideas about how the Hearth Program can expand and develop its services to AOD using parents and their children. In particular, the program would benefit greatly from the services of a specialist children's worker, skilled in offering therapeutic services to children at risk of harm. The second innovation that I would love to see come to fruition is the development of a residential rehabilitation and reunification service for families either separated or at risk of being separated through parental alcohol or other drug use.

Kate Camins

PROJECT DESCRIPTION

The Family and Children's Services WA Churchill Fellowship granted to study effective intervention in breaking the inter-generational drugs–poverty cycle and to gain further knowledge of the connection between parental drug use, economic poverty and child abuse – travelling to USA and UK.

The purpose of my fellowship was to research and network trends in working with AOD using families, particularly focussing on the link between AOD use and the poverty cycle. I particularly wished to look at how to intervene sufficiently early for the children not only to be safe within the family but also for them and their parents to learn other ways of managing their lives apart from the examples they had learned from their respective parents.

The fellowship was very significant for me personally. Somehow I'd convinced others that I was worthy of such an honour when I had never conceived that I was. I owe this confidence in me to Sue Hudd from FCS and from my referees, Dr Barbara Meddin, Danny Ford and Francesca Robinson, and by the Churchill Fellowship selection committee. A big tribute goes to Wesley Mission Perth who developed the Hearth Program. This organisation supported the vision of the program's founders, Francesca Robinson and Doug Robertson. It was my enthusiasm about the Hearth Program that won me the fellowship, and it was Wesley Mission Perth's (in the person of Doug Robertson, Director of Caring Services) encouragement that made the journey as positive as it was.

HIGHLIGHTS

The places I went and the people I met who were particularly valuable in providing information

UNITED STATES OF AMERICA

1 June 2001: Palo Alto, California – two weeks

- MRI (Mental research Institute), Two weeks intensive program studying the philosophy and implementation of brief therapy techniques. This involved learning from the source, and watching experts operating, being in the presence of legends.
- Attendance at seminar dealing with Mandatory Response to Animal Cruelty.

Highlights

I went first to MRI, where brief therapy was conceived and taught. Visiting MRI offered the opportunity to observe brief therapy in its purest form, to discuss the principles and process of the therapeutic approach with its creators, and to have the privilege of participating in discussions and case presentations. Simply to be in the presence of world famous names, and to get to know these wise and wonderful men was a privilege. The best part of this was to discover that they were also simple and compassionate people.

Dr. Paul Watzlawick signs his book for me at MRI.

Dr Paul Watzlawick, a close colleague of Milton Erickson, has published 17 books on human communication and reality. He had written a paper for the International Erickson Conference (on his old electric typewriter), where he described the following stories:

The first was related to answering the question "what is the truth?":
Every day at noon the colonel would go to the cannon in the village and fire it. The villagers would listen for the shot and would set their watches by it. A stranger came into the town and was interested in this. He asked the colonel how he knew when noon was exactly. The colonel answered that he sent the sergeant

to the watchmaker in the village, where there was a very accurate clock. Each morning the sergeant would set his watch by the clock, the colonel would check his watch by it and the cannon would go off at noon. The stranger, being of an enquiring mind decided to go to see this accurate clock, so he went to the watchmaker's. He asked the watchmaker how he knew the clock was so accurate. He replied that he listened every day for the cannon and checked the clock to ensure that it was noon!

Dr Watzlawick's second story demonstrated the problem solving power of the brief intervention:

A man had 17 camels. Before he died he told his three sons that he wanted one to have half the camels, one to have one third of the camels, and one to have one ninth. He died soon after, and his sons were left wondering how they would meet the terms of their father's will without cutting camels in pieces. A stranger rode into town on his camel, found the men discussing their problem and came up with a strategy. He gave the men his camel. They divided the camels amongst themselves:

Half the camels = 9
One third of the camels = 6
One ninth of the camels = 2
Total camels =17

The stranger took his camel back and rode on!

In its purest form brief therapy is focussed on clearly defining the problem (or the client's definition of the truth), exploring the past attempted solutions, and revisiting these over and over to reinforce their ineffectiveness. The client then develops his/her own solutions, which fit with the agreed definition of the problem. Therapists encourage the client to make the change process slow, warning them again and again that the therapy may fail, and not to expect too much. Dr Dick Fisch ("I'm allowed to be pessimistic; I'm from New York") relates that when a client comes in excitedly saying "Dr Fisch the most wonderful thing has happened…". He responds (straight faced): "Oh no I was hoping you wouldn't say that. Now things can only get worse!".

Presentation of my Certificate on completion of program at MRI, June 2001.
L to R: Myself with mascot puppy, Dr. Dick Fisch, Karin Schlanger.

Brief therapy gives back the responsibility to the client and focuses only on **what the client is able to do.** The key question is: "What will be the first small sign of change?".

Thus the family members feel in control of their own lives and are able to set their own goals as a family. This approach has been effectively adapted to the work done at Hearth over the past seven years, with sustainable changes happening in families we work with.

Brief therapy is not recognised in the USA as a legitimate form of therapy. There is a national requirement that a descriptive analysis is made in all mental health issues, a process which does not fit with the principles of brief therapy. Most interventions in the USA are based on a psychodynamic or cognitive behaviour therapy approach.
The American system of dealing with problematic AOD use is generally based on a 12 Step medical model, where abstinence is the only option, especially in the legal system. Labels are "in", and residential treatment is also "in", especially for children whose behaviour has become unmanageable at home. The one reunification program I visited dealt with teenage children who had been in foster care for years because of their antisocial behaviour. This was a new concept as the alternative future for these (mostly male) children was the detention system or the streets. However in therapy generally, the theme was that if the problem (e.g. the child or the drug) was identified and was removed, it was expected that the family would then be able to function "normally".

Animal abuse and its links to child abuse
These two weeks offered an unexpected bonus. I was able to attend a day seminar regarding the linkages between child abuse and animal abuse. It was hosted by the Marin Humane Society in Marin, California. Key presenters were Randall Lockwood, a world authority on animal abuse, and Lynne Loar, a child protection expert passionate about animal welfare.

There are significant connections between animal abuse and neglect and abuse of children. There are also significant links between childhood abuse of animals and adult abuse of children. Some very telling statistics from a study entitled "Incidence of Animal Abuse in Child Abusing Families" by De Vincy, Dickert and Lockwood in 1983 indicated the following:

- 60% had one family member who abused animals
  Of these: children were the animal abusers in 37% of cases
  Children were the sole animal abusers in 14% of cases
- Abusive households had more pets under two years of age and fewer over two years than in the non-abusing control group.
- 22% of abusive households reported that the pet was not well-behaved cf 6% in the non-abusive families.
- 50% of the animal abusers differentiated "good" and "bad" pets.
- 69% of pets had injured family members in abusive households.

These were chilling statistics for me, confirming many of my own guesses. Lynne Loar followed this presentation with strong reasons for child protection workers also to investigate the care of the household pets as an indication of the level of neglect/

violence in the home. She made the statement that **animal abuse is related to attachment disorder.**
Having a pet = attachment
Harming a pet = attachment disorder.

I was able to secure a copy of Randall Lockwood's compilation of significant literature in this field for donation to the DCD library.

2 July 2001: Buffalo, New York

Agencies visited

- Child and Family Services, Buffalo NY (residential care of primary school aged children with behaviour management issues, in home work with reunification of families)
- Family Court, Buffalo NY (new initiative where the Court deals with parental drug issues in child protection cases).
- EPIC Centre, focusing on enhancing children's emotional development and safety
- Child and Family Services mandated family reunification program

Highlights of this visit

Gaining insight into the US philosophies and attitudes to child protection and parental drug use. I was very interested to find that there is little variation in the therapeutic approach and the Court's attitude to AOD users. The approach was consistently a Twelve Step or Minnesota approach to addiction i.e. addiction is a chemical dependency that will stay with the person for life. There was also little tolerance of lapse/relapse, the measure of success for the addicted parent being solely one of abstinence.

Given this basic philosophy, I was not surprised to see external agencies taking responsibility (away from the parents) for the children's behaviour management and character building.

I learned in Buffalo that we in Australia are well advanced in the field of providing the range of therapeutic services for substance users, especially in the context of the family system.

ENGLAND

July 2001: London

Agencies visited

- Marina House. Methadone Clinic, Kings Hospital, Maudsley. Offering counselling and medical attention to users of illicit drugs
- NSPCC. New service offering counselling to children of mothers with alcohol dependency
- Maya Project, Peckham, London; Residential rehabilitation program for women of West Indian origin or partners of West Indian and their children.
- Tower Hamlets Alcohol Service. Counselling/ therapy for children of alcohol using mothers.

- Well Street Family Proceedings Court. Observation of child protection matters.
- Phoenix House, Brighton. Residential rehabilitation for illicit drug using mothers and their children.

Highlights of visits

Networking with new and innovative agencies offering therapeutic services to children of mothers with problematic alcohol use. These programmes offer support and acceptance of stigmatised, marginalised and confused children, who may be expected to be responsible for their parent and/ or siblings, and are carriers of many family secrets.

I met with Wendy Robinson of the NSPCC in London.

Wendy is the author of a number of training programmes for practitioners working with children at risk. She gave me a copy of her book (co-written with Michael Dunne): "Alcohol, Child Care and Parenting: a Handbook for Practitioners".

The key theme of the book is that children are not the cause of alcohol problems, being instead the ones who experience its effects. The findings of Wendy's work with alcohol using families were divided into three categories;

1. How family functioning is affected when a parent drinks too much,
   (e.g. violence, conflict, unpredictable parenting, parentified children etc)
2. How this goes on to affect the children,
   (e.g. taking too much responsibility for things, unable to expect love or to trust adults)
3. How children then respond
   (To survive and cope children will "switch off", have low expectations, avoid becoming attached to people, act out in disruptive ways so as to express how they feel or draw attention to the fact that things aren't OK).

Wendy was a very cooperative and helpful source of both knowledge and contacts in Britain.

SCOTLAND

1 August 2001: Glasgow

- Ms Joy Barlow; Centre for Drug Misuse Research, Glasgow University.
  Joy was predominantly responsible for the development of the Aberlour Trust treatment facilities for women and their children in Scotland. She has recently completed her Masters dissertation entitled "The Nature and Extent of Support for Problem Drug Using Parents and their Children and Implications for Staff Training and Development". Joy is currently contracted by the Scottish Executive to advise and develop a standardised training package in child protection for counsellors working in the alcohol other drugs field.

  Joy appeared to be the cog in the Scottish "parental drug use" wheel. She linked me with so many valuable contacts in Scotland that my feet did not touch the ground for the next two weeks. A wonderful resource; she knows everyone!

- Ms Marina Barnard; Centre for Drug Misuse Research, Glasgow University.
  Ms Barlow's colleague.
  Co-author of paper researching Scottish response to children at risk of harm through parental drug use.
- Turnaround Project. Manager; Sophia Young.
  A new program for drug using women on the edge of society, either in prison or pending release, or homeless.
  This program is closely linked with a comprehensive range of residential and outreach services for AOD users of both sexes.
- Aberlour Project 1, Glasgow
  Manager; Isabel Dumigan
  Residential detox, rehabilitation and reunification program for women and their children.

Aberlour Project 1, Glasgow.
Setting is an old tobacco baron's mansion.

- Aberlour Outreach Team, Glasgow
  Manager: Gemma McNeil
  Outreach program working in conjunction with Aberlour residential Programs, offering pre-admission assessment and preparation, as well as post-residential adjustment and maintenance of changes.
- Scarrel Road Residential rehabilitation program, Glasgow.
  Manager: Eddie
  Another program of the Aberlour Trust offering residential detox, rehabilitation and reunification for AOD using mothers and their children.

A hamster I met at Scarrel Road, the proud possession of young George, who was living there with his mother and younger sister. His care for his hamster linked with the work I had done recently in the US on animal abuse.

- Neil Squires: Barnados, Glasgow
  Specialising in therapeutic counselling with children whose parents are suffering from HIV/ AIDS

Highlights

Marina Barnard from Glasgow University conducted a literature search of work in this area and has recently published a paper with recommendations the Scottish Executive's policy development. Her findings were summed up in two points. These were

- That any parent's capacity and skill to parent and protect dependent children is diminished with any mood altering substance.
- That children of AOD using parents either need or will benefit greatly from having either a safe person to go to, or a safe, stigma-free service to give them the opportunity to be children and to meet the needs their parents cannot provide. She suggested after-school programmes which offer homework help and counselling.

Turnaround provides counselling and support to homeless women with AOD issues. These women were able to access kitchen facilities with basic foods supplied, a place to sit and meet with their friends. The program is an outreach program, offering visits in prison, and transport home on "Lib(eration) Day". This helped the woman actually get to her address without having to deal with dealers and pimps etc. waiting at the prison gates. The project is located in an old school campus which also houses a range of other programs for drug users, including residential detox and drop-in counselling services.

I was privileged to meet with Neil Squires, of Barnados in Glasgow. Neil works in home (or in the park, or the movie theatre) with children whose parents suffer from AIDS. Neil had a wonderful, gentle manner about him, and a vast knowledge about his field, and his compassion for his clients glowed from him. He was very generous in sharing his resources, many of which I was able to bring back or obtain.

One of my major achievements in my time in Scotland was managing to get to so many exciting programmes in four days, without having an accident or getting lost too many times. The streets of Glasgow are not easily navigable in the rain, and they change name every several hundred metres! It was a testament to my compassionate and welcoming hosts that I was revived on arrival every time.

The residential programs I visited were inspirational. They offered imaginative and individualised therapeutic and practical responses for each woman and her children. Each programme was unique, based on the values of the particular staff and in the local context. I was very aware of the trust and respect between the women and staff. In each program I was also very aware of the "childishness" of the children, who had been given the opportunity to acknowledge the trauma and distress they had suffered, and also to feel safe to experiment with being carefree and secure. In several facilities the children had access to play and art therapies, as well as having a key worker to relate to. This gave the child a safety net without taking primary responsibility away from the parent.

The Aberlour outreach program provided in home support to families linked with the two residential facilities (Scarrel Road and Project 1). Prior to admission a counsellor would engage with the family to help them prepare for the rehabilitation. This would include planning school changes, accommodation, and extended family relationships. When the family returns to the community the outreach worker re-establishes the relationship to ensure the transition is as smooth as it can be, and to maintain the positive changes made.

The Aberlour Trust has a long history in child care in Scotland with a broad range of programs. The programs I visited were impressive in terms of consistency of agency philosophy, overall compassion for the families they work with, and a general optimism about humanity, the outcome of a long tradition of offering caring services to vulnerable children.

2 August 2001: Edinburgh

Agencies Visited

- Brenda House, Edinburgh
  Manager: Louise Long
  The original Aberlour project offering residential detox, rehabilitation and reunification to AOD using mothers and their children.

My favourite place and project of the entire trip. Brenda House, Edinburgh; a custom built facility where families heal and miracles happen.

- Libra: Women in Alcohol. Coordinator; Noreen Lille
  Offering office based counselling to women voluntarily seeking change.
- West Edinburgh Support Team. Women's workers; Nicole Scherer and Claire Thomas. Offering generic counselling to individuals either referred or seeking counselling voluntarily.
- Simpson House, Church of Scotland. Drug counselling service, offering long term counselling mainly to voluntary clients, and more recently negotiating with authorities to work with "coerced" individuals.
  Team Leader: Maureen Slattery-Marsh
- Helping Young People in Edinburgh (HYPE)
  Manager: Rhona Hunter
  A new initiative offering voluntary counselling to young people between 12 and 18.
- Reporter to the Children's Hearing.
  Seeking information regarding the statutory child protection processes in Scotland.
- Women's Seminar Day, where the writer presented Hearth resources (Family Functioning Profile and Hearth Safety Assessment Tool). Attended by representatives of twelve voluntary agencies in the Edinburgh and Fife areas. Outcomes of this day included the planning of seeking media support for families of AOD using parents.

Highlights

Dundee

- Aberlour Outreach Programme
  Manager: Chris McIlquhan
  A new program offering in home intensive detox, rehabilitation and reunification for families of AOD using mothers and their children.
- Dr Laura Freeman
- Child and Family Centre; one of ten such centres run by the Dundee City Council, offering parenting skills development, respite sessions and networking opportunities to local mothers.

The Aberlour Outreach Program mirrored most the work done at Hearth. The main differences were that the Dundee Project focused almost exclusively on reunification rather than preventative work. Also their approach was less therapeutic and more task-oriented than Hearth's. However this was a day of meeting with like minds, very rewarding for both parties.

Perth

- Hopscotch Project, a project of Barnados
  Manager: Colleen Gibb
  A program offering in home therapy and counselling to children whose parents misuse alcohol.

This project made use of trained volunteer "buddies" for the children, with a long wait list and an active volunteer recruitment and training program. This again was a small but enthusiastic team, locally based, and offering some valuable resources for the children in the community.

THE MAJOR LESSONS I LEARNED AND HOW I PROPOSE TO DISSEMINATE AND IMPLEMENT THEM IN AUSTRALIA

1 Demographic Trends

Drug using patterns varied from country to country and even from town to town. In the northern US States I was told the major drugs of choice were alcohol or crack. In England, heroin was big (although it is apparently not as pure as in Australia) and agencies I met with were unaware of naltrexone as a treatment for managing heroin addiction. Amphetamines are growing in use in London. Methadone withdrawal was a major reason for entering residential rehabilitation in England, while it was both the most significant street drug in Dundee (more so than heroin), and a treatment drug in Edinburgh. In Scotland methadone prescription is not as carefully monitored as in Australia, and it is easy for young people to have regular supplies without a heroin habit and with little or no assessment of its suitability for the situation. However, both projects I visited in Glasgow used methadone successfully as a treatment drug/painkiller as an adjunct for withdrawing from heroin over a four-week period.

2 Residential Services

There were also some elements of the residential rehabilitation programmes that differed from the Australian models;

- Detox and withdrawal were considered to be a social process rather than a medical one, except for in the Hospital Methadone Clinic. While GPs were involved in the prescribing of diazepams etc. for the physical symptoms, the counsellors were the case managers of a withdrawal process planned by the resident with medical support. This is usually over a period of a month.
- The presence of the child was seen as integral in both the parent's recovery, and in meeting both the older child's need to know the truth and the younger child's need to maintain the attachment.
- Where school aged children were involved, there was a range of services available for them, designed to give them the opportunity to deal with their parent's changes, and to experience normal childhood activities and friendships.
- Accommodation ranged from custom built public housing flats, with communal adult and child spaces, to converted mansions or existing public housing.
- The programmes varied in structure and level of intrusion into the women's lives, but all included key elements of emphasising peer interaction, as well as providing the women with key workers and individual counsellors.
- Geographic location varied from relocating the women from one town to another, to remaining in their own areas. It seemed that this second alternative did not hinder the women's rehabilitation but gave them opportunities to deal better with the network issues.

3 Statutory Services

Observations of statutory interventions and response from recipients of these services reflected some of the common complaints of the Australian families I have dealt with. These include:

- Inexperienced staff
- Focus on the gaining of evidence for Court rather than negotiating agreed goal setting
- Frequent staff turnover, necessitating the re-telling of the story
- Reluctance of statutory staff to acknowledge positive change in families
- Rigidity of response to families' requests
- Permanency planning is premature.

4 Services for Children

This is an area I did not intend to pursue. However, the more agencies I visited and was able to consider the family's needs and the community response, I recognised that, if we are to break the abuse cycle, we must be intervening in children's lives as well as in their parents' lives. There are many children whose needs will not be met while their parent is preoccupied with their AOD use. Time is crucial, and the opportunity to work effectively with the child may well be lost.

To this end I returned to Australia convinced that this was an area that Hearth could pursue appropriately, given the growing number of requests for counselling from parents, teachers, other agencies, and from children themselves.

5 Client Feedback

AOD dependent men and women are invariably lacking in confidence and have very poor self-esteem. Many have been abused as children and as adults both in intimate relationships and in the community. Most believe they are worthless. All the AOD dependent women and men I have met in Australia and in my travels are able to assess when a person is genuinely interested in them.

Therefore, the most effective approach to treating drug use is integrally bound up with the use of the therapeutic relationship, which aims at improving the user's sense of self worth sufficiently not to need the drug to deal with the perceived problem.

My greatest lessons learned, as in my work at Hearth, comes from the users of the services. When asked what has worked for them, all the women I interviewed made the following points:

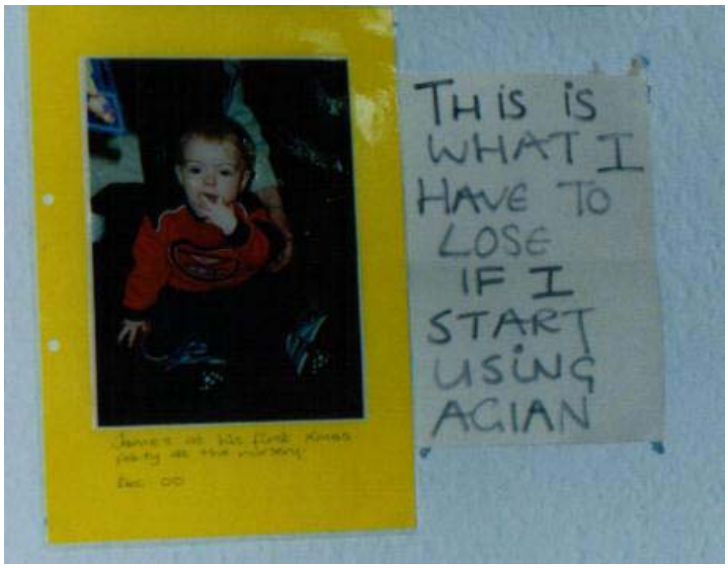
- Each immediately talked of one particular defining moment ("crunch time") which led to their decision to manage their AOD use
- For each this moment included a fortunate (apparently unplanned) meeting with a caring person (in all these cases a professional counsellor)
- Previous attempts to manage drug use had failed as they had felt they were judged and treated without dignity,
- All had lapsed on at least one occasion during the period of rehabilitation, but had not been expelled from the program, which had increased their determination to succeed in meeting their goals,
- All the women had lost one or more of their children to permanent care/ adoption, and were concentrating on staying clean in order to keep their remaining child. Thus the child was always the reason for wanting to make the change, and established the desire to break the cycle,
- Their experiences with statutory authorities were universally negative, where they had felt they were always being investigated, that positive change had not been acknowledged, and that they were not encouraged to maintain what bonds they had with their children.
- Managing the drug use was the easy part, maintaining the change despite exposure to old associates and situations was the hard part, and this took time and commitment.

RECOMMENDATIONS

In developing my ideas for future directions of Hearth, I have built up a vision of how the Western Australian system might offer more effective services for AOD using families with children at risk, which will focus on breaking the inter-generational cycle of addiction and family and child abuse;

- In the immediate term, I believe we are in need of increased therapeutic and safety net services for children of AOD using parents. There has recently been increased funding made available for services around domestic violence; giving children the opportunity to make sense of the confusing messages of violence and abuse around AOD using families can short circuit the abuse cycle. It is the most effective early intervention in breaking the cycle.

- A more integrated range of services is indicated, with greater interagency trust and communication.
- In order to break the cycle of abuse, it is crucial that families establish their own achievable goals, and that that these are respected by the authorities.
- Children living in such environments will often benefit greatly from being offered appropriate therapeutic services, which give them the chance to learn about "normal" feelings, families and relationships.



Inspiration for a mother in residential rehabilitation whose older children were in care and never to be returned to her. This is her last remaining child.

My ideal programme for rehabilitation and reunification is a blend of the above principles and the practices I observed in Scotland as well as utilisation of some of the principles of the excellent services we have here in Perth. The key to these services is honesty and clarity of consequences with the families, and an integration of AOD treatment within the family system, always being aware of the children's needs.

An effective rehabilitation programme would have the following features;

- A woman and her family is referred by the local (statutory) authority, and a collaborative assessment is made over a period of three weeks as to the mutual suitability of the programme to the family and vice versa.
- If both agree that the programme is for her and her family, an outreach worker works with her for a 6-8 week period, planning with the family for the move. This work will include for the woman negotiating with the housing authority, planning financially, working out family issues; and for the children their change of schooling, explaining their absence to friends, understanding the reasons for the move etc.
- When the woman enters the programme, she is responsible for planning her own withdrawal and accompanying medical and personal strategies.
- After the withdrawal period she becomes a contributing member of the community.
- Women are each responsible for their own family's needs.
- Therapy consists of daily peer group meetings and tailored therapeutic and skills development groups.
- Each woman has a key worker and a counsellor, and ideally has a continuing casual relationship with the outreach worker.

- Parallel to this rehabilitation, each child has the opportunity to learn be a child and to experience security.
- Should it be seen as appropriate, the child can be offered play/art/music/ peer group therapy, as well as having a key worker each can talk to individually.
- If the family is separated prior to the woman's admission, reunification is the integral goal of the rehabilitation, occurring within three months of entry, and managed by the programme, both outreach and residential staff.
- On re-entry to the community, the outreach worker again becomes involved, and supports the woman in maintaining the changes over a period of another six months.

The children's play therapy room: Brenda House, Edinburgh.

What other improvements should be made in Australia?

In my travels I was struck by the universality of difficulties faced by both large and small, government and non-government agencies. In order to manage these difficulties there are universal solutions, based on respect for the individual and each person's right to set their own goals. If these values are accepted, a relationship of trust will develop, both at the service delivery level and at the interagency and intra-agency level.

If agencies can trust each other we can develop seamless services to our client families. Ideally this would include the provision of professional assessment and appropriate referral to the agency best suited to the client in terms of service and value base.

To best facilitate this collaborative approach it is important that agencies adopt the attitude that withdrawing from drugs is a social problem, not a medical, and better if it is planned with the user over an agreed period of time.

Residential rehabilitation with the children appears to the most effective long-term solution in order to break the cycle. Women talked about the significance of the peer group to cope with their issues and to learn new strategies. Often this is the first time in their lives that they've had a safe environment in which to test out interactions.
Implications for children include being overlooked, and from visiting outreach services to children of AOD using women, it was impressed on me that while the mother may ultimately be able to meet the child's needs, the interim time is crucial for

the child. Hence further specialised and coordinated services focusing on helping the child make sense of the confusing world they live in are indicated.
Rehabilitation goals would include the fostering of the parental responsibility, and awareness of the child's needs, as well as the opportunity for the child to discuss his/her feelings/ fears with a trusted adult.

CONCLUSIONS

Since my return to Perth, I have reported to and conferred with the Director general of Family and Children's Services, and with the Director of the West Australian Drug Abuse Strategy Office. Both these meeting were had very positive results in terms of the respective departments' openness to my observations and suggestions.

I presented a paper and PowerPoint presentation to guests invited by the WADASO organisers to mark Eradication of Poverty Day on October 17th 2001. I also presented a paper to FCS workers on November 7th 2001.

Wesley Mission Perth has been very supportive of helping me develop my ideas regarding the expansion of current services into the reunification field, and we are planning this for 2002. We have the support (if not the funding) to develop these ideas from Family and Children's Services and I have plans for further consultation with key people in that organisation.

SUMMARY

In brief therapy terms:

1 Define the problem

Our society has a growing number of young children whose parents are dependent on AOD with the associated patterns of poverty and family violence.
The parent's ability to nurture and protect the child will always be diminished by the use of mood altering substances.
A child separated from its parent is less likely to be able to develop healthy emotional attachments and more likely to grow into an adult with an inner well of emptiness, a regular precursor to AOD misuse.

This has resulted in a generational cycle of AOD use as a solution and with children without secure identities and attachments, like their parents.

2 Explore the attempted solutions

In recent years AOD use is increasingly being identified as a major contributing factor to abuse of children and family violence. What solutions have we attempted to deal with this?

First, we have separated the user, the children and the problem, and have tried to deal with the AOD dependency as an independent issue i.e. treat the problem as an individual medical problem. Outcome: an adult whose experience of childhood devaluation has been reinforced by society.

Second, by removing the child from the environment, we have assumed we are protecting him/her. Outcome: a confused child without a sense of self and without family ties and a greater disposition to misuse AOD as an adult.

The attempted solutions have effectively perpetuated the intergenerational cycle of dependency/ poverty/ family violence and child abuse.

3 Develop the strategies
If it doesn't work, try something different

To break the cycle, we focus on identifying and developing strengths, the parent must feel valued, and the child loved and secure.

As rehabilitation goals and strategies will only be effective if they are individually formed to fit with the client's value system, we need to have available a range of programmes offering differing intensities and interventions.

The logical strategy is to develop more integrated services, which aim to provide an environment safe for both parent and child, as described above, within which they can take the risk to try something different.

4 Evaluate

While it is a costly procedure in terms of intensity of service and resources, it is little in comparison with the long-term cost of perpetuating the poverty cycle for generations.

In the light of the current world despondency and growing AOD use and associated crime, violence and poverty, we as a society must be prepared to try anything different to turn the cycle around.

APPENDIX 1

DETAILS OF PEOPLE MET AND PLACES VISITED

USA
Mental Research Institute
555 Middlefield Road
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USA
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Child & Family Services
Kevin Burke, Director
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Kevin Burke 882-0555, ext. 204

LONDON
Addictions Resource Centre
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Maya Project
Project Manager; Beverley Polson
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NSPCC Family Alcohol Project
Manager: Wendy Robinson
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Telephone 020 7383 3817
www.nspcc.org.uk
mailto:
WROBINSON@NSPCC.org.uk

Tower Hamlets Alcohol Services
Children and Young People's Service
Director Sue Clements
Unit 218, Bow House Business Centre
153-159 Bow Rd,
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Fiona Harbin
Bolton Social Services
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Civic Centre
Bolton BL1 1SA
Great Britain
tel: 01204 337475
Fiona Harbin Fiona.Harbin@bolton.gov.uk

Phoenix House
Service Manager; Chris
Brighton Family Service
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SCOTLAND
Marina Barnard and Joy Barlow
Glasgow University *Department for Substance Misuse*
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Abelour
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No. 1 Project, 1 Lancaster Crescent
Glasgow G12 0RR
Tel: 0141 337 6637
Project Manager: Isobel Dumigan
lancastercres@abelour.org.uk

Aberlour Outreach Service
Block 6, Unit D3, Templeton Business Centre
62 Templeton Street
Glasgow G40 1DA
Tel: 0141 554 5055
Project Manager: Gemma McNeill

Scarrel Road Project
5 Scarrel Road
Castlemilk
Glasgow
G45 0DR
Tel: 0141 631 1504
Project Manager: Eddie *(unfortunately I have misplaced his surname)*

Dundee Outreach Team
10 Constitution Road
Dundee DD1 1LL
Tel: 01382 305724
Project Manager: Chris McIlquham

Turning Point,
Turnaround Programme
Programme Manager: Sophia Young
The Glasgow Drugs Crisis Centre
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turnaround@btconnect.com
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Barnados
Therapist: Neil Squires
Positive Accommodation Team Granite House, 1st Floor
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Simpson House
Team Leader: Maureen Slattery-Marsh
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West Edinburgh Support Team
Women's Worker; Claire Thomas
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APPENDIX 11

BOOKS ACQUIRED

Fisch, Richard, and Schlanger, Karin: *Brief Therapy with Intimidating Cases: Changing the Unchangeable*. Jossey-Bass Publishers: San Francisco, 1999

Harbin, Fiona and Murphy, Michael: *Substance Misuse and Childcare: How to understand and intervene when drugs affect parenting*. Russell House Publishing: 2001.

Heegaard, Marge: *When a Family is in Trouble: Children Can Cope with Grief from Drug and Alcohol Addiction.* Woodland Press: Minneapolis MN., 1993

Jackson, Don D. (ed.); *Communication, family and marriage: Human Communication Vol 1*. Science and Behavior Books Inc.: Palo Alto, Ca., 1968

Jackson, Don D. (ed.); *Therapy, Communication, and Change: Human Communication Vol. 2.* Science and Behavior Books, Inc.: Palo Alto Ca., 1967

Johnstone, Cath: *Being a Parent: Parent Network.* Hawthorn Press: London, 1999

Lockwood, Randall, and Ascione, Frank R. (eds.): *Cruelty to Animals and Interpersonal Violence*. Reading in Research and Application. Purdue University Press: Indiana, 1998.
(N.B. A copy of this publication has also been donated to the Family and Children's Services Library, Royal Street, Perth)

Robinson, Wendy and Dunne, Michael: *Alcohol, Child Care and Parenting. A handbook for Practitioners.* NSPCC: London, 2000

Robinson, Wendy and Hassle, Jenny: *Alcohol Problems and the Family: From Stigma to Solution*. NSPCC: London, 1999

Watzlawick, Paul: *The Language of Change; Elements of Therapeutic Communication*. Norton 1978

White, Michael and Epstein, David. *Narrative Means to Therapeutic Ends*. W.W. Norton and Co.: 1990