

Assessing the Consequences For Children and Families When a Parent Has A Problem With Substance Use and Abuse: Considerations For Social Workers and Other Helping Professionals

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Dedicated to the memory of Margaret Cork and her forgotten children.

Introduction

“She was a crack ho who did lines on the way to birth me. I am better off where I be than back with her, brud and dad.”¹

The intent of this paper is to contribute to scholarship, knowledge and public policy regarding child maltreatment and parenting capacity within the context of parental substance use and abuse. One goal is to give voice to the children who have moved to, or who are approaching, the threshold for needing a type of protection that is neither governed by the best interest of the parent (even by default) nor by fixation by professionals on an ideology of family preservation—in the face of competing logical possibilities. In their best interest, many children and youth with drug addicted parents, who present repeated risks with known harm, are now more likely to require continuous care and a permanency plan (Brown and Hohman, 2006; Covey, 2007; Hogan, 2007; Schmittroth, 1994).

Among the objectives of this analysis are included:

- to contribute to policy analysis and debate with respect to children’s protection programming and practices within the context of repeated parental substance use or abuse, which pose imminent and highly likely risks and associated valid concerns with parental capacity and child-youth care;
- to apply child risk-need-harm assessment knowledge, gained from the qualitative review of 50 cases from one clinical practice, that integrated assessments of parental capacity and care issues associated with substance use, abuse and/or addictions—cases where expert professional opinion was requested by the court and/or by children’s services;
- to explore the risk-need implications of parent capacity issues associated with co-occurring (concurrent) disorders - addictions and mental health;
- to analyze some program implications of treating parental addiction as a form of child maltreatment and of defining increasing numbers of children as in need of continuous out of home care.

This policy-practice analysis relies on selected literature and on published studies and analyses within some current and emerging contexts. Part of the analysis is informed an analysis of fifty case files, exploring an available sample of expert assessment processes and classifications associated with parental capacity and child-risk need—where parental capacity has been repeatedly compromised by substance use, abuse and addictions. The analysis applied pre-determined broad child-risk-need-harm dimensions, expanded upon within the context of interpretations arising from the case content and findings from the literature, to enable formulation of conclusions regarding how some drug effects, substance use and abuse, and/or drug using lifestyle, interact with parental capacity and child risk-need-harm.

¹ Statement of a young male who found himself “doing better” in continuous care and a 24/7 alternative living arrangement. Quotes have been modified slightly and cases have been merged in order to ensure childrens’ voices are heard and identifying information is not disclosed.

The context of child maltreatment associated with addictions-compromised parenting²

Since the early 1900's social workers and cognate disciplines responsible for the protection of children have been concerned with the impact of parental substance use and abuse: on the safety, well being and development of children and youth; on personal and social functioning of parent[s]; as well as on the social functioning of the family (Richmond, 1917). Of note by the 1960's were the findings that, even when the alcoholic parent became sober, children reported their experiences of parental and family problems and risks had not changed significantly and had sometimes become worse (Cork, 1969, 53-56). By the 1970's treatment policies, programs and practices expanded to enable family therapy supports for children of alcoholics (Aubertin and Berlinguet, 1971; Bepko, 2002).

Following from Cork (1969), by the 1980's, those writing from an adult children of alcoholics perspective often emphasized the long term developmental and transgenerational damage of being raised by a parent or parents who had problems with substance abuse; family, group and self-help supports were offered for some children (Woititz, 1990). Some addictions-related abuse, neglect and developmental damage was sufficiently serious that by the 1990's it was argued that parental alcoholism and/or drug addiction, justifiably, could be judged as being a form of child maltreatment (Briere, 1992; Covey, 2007: 142). As well, some professionals and courts have made a best interest case that repeated patterns of addicted mothers, putting unborn and newborn children at risk (and causing predictable developmental damage, Chapman, Tarter, Kirisci, and Cornelius, 2007) should result in children being apprehended at birth. The counter point is typically advocacy for the mothers and accounting for child risk in terms of structural and situational factors that contribute to the mothers' addiction risks, versus assuming a primary focus on individual parental responsibility and child-centeredness. This author has revisited the issue of repeated parental relapse to substance use, abuse and/or addictions (after personalized, social and economic supports have been offered) as posing sufficient risk and harm, as well as a serious violation of the rights of children to have basic needs met, and concluded that child-centered assessments may be more and more justified in defining substance addictions-compromised parenting as a form of child maltreatment³—independent of any additional compounding risks and harm with respect to sexual, physical, or emotional abuse and exploitation.⁴

While family support and preservation have been themes of child and family practice since the early 1900's, and while there was a major emphasis in the 1980's and 1990's on family preservation as being in a child's best interest, largely based on the impacts of parent-child-parent attachment and separation dynamics on child development (Daniel, Wassell and Gilligan,

² The words addicted and addiction are hereafter applied to refer to substance use, abuse and/or life style patterns consistent with a general addictions paradigm, rather than repeating the complete phrase in the text.

³ It is disturbing to note that DUI laws do not require officers to prove reckless driving but arguments that children's protection social workers must observe acts of endangerment associated with parental addiction may be put forward (Covey, 2007,140).

⁴ The author notes that intervention with women who have an FASD child is critical because of the likelihood that "successive children with FASD demonstrate even more dramatic effects". For a comprehensive analysis of policy and program issues regarding substance use and abuse during pregnancy see: Basford, Thorpe and Williams (2005)

1999), there was also a recognition that a threshold would be reached where the family preservation goal could no longer be justified as being in the best interest of the child. Within the context of a preference for family preservation, Steinhauer (1991) proposed applying a principle in child placement decisions of “least harm”, but concluded that the family preservation goal may have to be displaced by apprehension, protection, and permanency based on significant known and expected risks and harm. Others have contributed to overcoming attachment difficulties and risks after continuous care has had to be recommended (Archer and Hughes, 2003).

Under conditions where parental use, abuse and/or addiction to substances, and/or related life-styles, create or exacerbate continued risk and harm, and are associated with a significant violation of the child’s rights and related unmet needs, policy, program and practice bias in favor of family preservation, must be challenged. Unfortunately, within the context of repeated and continued addictions-compromised parenting, the best interest with the least harm, and the most developmental benefit, for increasing numbers of children, is permanent out of home care—sometimes with no contact with birth parents. In the current context, the realities of children’s services is that child protection social workers often do not have a choice other than out of home care, with more continuous and permanent placements being needed. From a policy-program point of view protection and least harm options are becoming increasingly limited to placing children—by design or default. (see for example, Barnard, 2007: 157 or Srikanthan, 2005).⁵

Initially, this analysis takes a standpoint that minimizes attention to additional direct concerns of child harm due to assessed or suspected physical abuse, sexual abuse, emotional abuse or exploitation. As well, the recommendation to differentially assess addictions-compromised parenting is put forward to promote child-centered evaluation of parenting capacity that critically analyses the risks and impacts for the child that can be associated with parent capacity concerns related to use, abuse, addiction and “addiction” lifestyle, relatively independent of issues of poverty. Preventable poverty related to substance abuse, but not related to non-addiction disability, illness, or parenting deficits in care and parenting knowledge or skills, is among the main contributors to risk and harm. Within the context of this analysis, the threshold for risk, harm and clinical significance is based on the standpoint of what the parent’s substance use, abuse, addictions and related lifestyle imply if assessments focus on assistance and special care needs and rights of children under the age of eighteen years (United Nations, 1989), versus parental rights.⁶ As one researcher concluded:

“It is perhaps ironic that in all the crowded attention on the parent with the drug problem...there was very little discussion among the practitioners of the

⁵ While the author favors attempting family preservation in many instances, one study (Pidcock and Fischer, 1998) which hypothesized that children of parents in recovery would evidence significantly less addictive behavior than those whose parents were not in recovery, failed to support the hypothesis. Also, addictions-compromised mothers involved with children’s protection were found to be more likely to exhibit unsatisfactory discharges from treatment than were substance abusing mothers not involved with children’s services (Hohman, Shillington and Baxter, 2003).

⁶ Notwithstanding the exclusion of physical abuse, sexual abuse, emotional abuse and child exploitation from the main thrust of the author’s analysis, it is recognized that all of these added risk-harm factors have been found to be more highly correlated with, and exacerbated by, parental addictions and related lifestyles (Briere, 1992; Covey, 2007: 150; Kroll and Taylor, 2003).

children's perspectives. For the most part their needs were assumed, and considered to be best met through supporting the parent. This might be an explicable dynamic, especially where children are very young, but it creates a dangerous invisibility and reinforces their vulnerability." (Barnard, 2007, p.150.)

The position in this analysis is that parental assessments must become more child-centered and the voices of children must assume primacy.

Professionals' assumptions about child care and parenting knowledge and skills deficits may be misapplied when parenting deficits are more associated with addictions-compromised parenting. For example, it may not be uncommon to have addicted parents who have adequate education, adequate resources and/or "good enough" knowledge and skills with respect to child development and child risk-need. Child risk-need issues may not be significantly related to skills and knowledge deficits and problems regarding ability for care and parenting, as they are, for example, related to parental distraction and self-centered motivation -sometimes framed within the context of narcissism associated with addictions (Flores, 2004; Forrest, 1994). Providing parent training services may have little relevance and/or few impacts with respect to risk-harm reduction, or improved well-being for the children of addictions-compromised parents.

The following addictions-compromised parent capacity assessment dimensions may increase effectiveness in estimating child risks and needs:

- the relatively direct impacts of substance use and abuse on parenting and the parent-child-parent relationship (e.g. the increased risks of parental aggression with some drug use patterns);
- the impacts of substance using lifestyle on parenting and the parent-child-parent relationship (e.g. the child having to self-protect from impaired strangers in her home);
- the impacts of parental narcissism that compromises child centered care and parenting (e.g. parental expression of empathy in the interest of manipulating the child); addictions-compromised attachment and bond (e.g. the child receiving repeated double-bind messages such as, "I love you with my life, leave me alone.");
- and parent-centered motivation displacing child centered motivated parenting and care (e.g. an impaired parent playing an adult movie so he/she and the six year old child can have some "quality time" watching a movie together at 1a.m.).

What is important is that parenting capacity issues, directly related to addictions-compromised parenting, must be addressed; these are seldom developed and refined in standardized child or parenting assessments. For example, in the case above, the parent reported staying home with the child and watching movies; without more depth of exploration and analysis, a social worker risks concluding that the parent was being responsibly attentive, was reinforcing attachment and was adequately supervising the child. This example reinforces the necessity for child-centered observations of children and risk, including in interaction with addictions-compromised parents, including independent interviews with the children, to whom addictions-compromised parents have access, or have care and parenting responsibilities.

Current policies and practices that promote parent effectiveness training and parent capacity building (e.g. Cipani, 1999), in case of addictions-compromised parenting, may be trying to change the wrong dimensions of parenting capacity such as the less complex area of parenting knowledge and skills. Parent training practices may actually exacerbate the problems and risks for children. An example is the case where a parent is cued to children's protection expectations regarding meals and nutrition and then presents an "illusion of change" that appears as compliance while not acting in the spirit of the child-centered interests. In some cases parents purchased and stored quality nutrition, yet the children did not have regular meals or receive the food with needed regularity. The food may even be found to be well organized for display when a follow up protection assessment is undertaken (one clue is an abundance of out of date food). Goal displacement was common with parents whose patterns of addiction continue. For example, some parents did not reason that obtaining, organizing, placing on the table for possible consumption, and displaying food, was not their primary change goal with respect to child care and the demonstration of improved parent capacity.

As well, from a child-centered perspective, parent training might mean active parent coaching (in real time interaction with their children) from a social worker or behavior management specialist, in order to manage a child who is disruptive and defiant (two of the patterns associated with children's coping with a mentally ill or addicted parent). It should be recognized, though, that from the child's perspective the impact on him or her is that of blaming the child for the parent's failure in recovery; by default, the child is given the responsibility to change his or her behaviour, while the parent may change nothing. In short, typical programs for parent training, as applied to addictions-compromised parenting capacity, are often be misapplied, at best, and may add to risk and harm, at worst.

In the experience of the author, assessing and changing the parent-child-parent relationship in terms of care and parent capacity could require much more complex and extended *in vivo* observation and therapy inputs, observing the real time care and parenting as part of an in-depth biopsychosocial assessment, as well as undertaking parental and family therapy and coaching in real time—much beyond behavior management training for child and parent. For addiction-compromised parents observed *in vivo*⁷ with their children, informed by some independent direct observations and interviews of some of the children, risk control and harm management, as well as demonstrating strengths in meeting the needs of the children, required much effort and commitment by parents to change and sustain change. Unfortunately for the children, half of the assessment observations were made under conditions where parental energy was directed to substances and the related addiction life-styles. Some parents were so impaired cognitively and behaviourally while being observed for assessment and services planning, that alternate care givers had to assume child-care and parenting responsibilities during access. In the experience of the author, confidence levels in the parenting capacity and child risk-need

⁷ In most cases the author and other professionals associated with the parent capacity assessments observed the parent(s) with their children, and some children on their own, for eight to twenty hours over four to seven observation periods. The professionals came to have more confidence in these observations and judgments of problems, risks, harm, strengths and need, than they did from parent interviews in clinic, or from observing and interviewing children in a "less natural" controlled clinical setting.

assessments were increased with multiple direct observations over eight or more hours - preferably over two or more weeks.

Parent's relative lack of sustained success, in parental education and/or counselling-therapy programs, associated with repeated return to parental use of a current range of disabling substances such as cocaine, "crack", methamphetamine, oxycodones, and ecstasy, cannot give justice, policy, program and practice professionals much confidence in the relative likelihood of successful family preservation in the best interest of child safety, meeting children's needs, and supporting normative biopsychosocial development. Even when highly drug involved parents claim, with conviction, that their love for their children is paramount, and when they vociferously "contemplate" child-centered change and promise sustained motivation, and even when they have been given repeated "last chances" by children's protection services and/or the justice system, the likelihood of relapse and return to child risk and harm, most often, is greater than is the likelihood of them sustaining action in the best interest of the child.⁸ After successive broken promises and parental failures, the "forgotten children", then more skeptical of their wish for a "cured" parent, would not have much confidence in effective and sustained parental change; as one twelve year old stated to the learned protection and justice professionals, whom she believed had not protected her and her sister well: "So which last chance is the last chance; I thought the last chance was the last chance." Child-centered parenting capacity assessments could make protection, continuous care and permanency plan thresholds more effective in controlling risk, reducing harm, ameliorating impacts, meeting developmental needs and increasing well-being of children.⁹

For those social workers who are responsible for foster care and adoptions placements, a policy, program and practice movement towards planning for more continuous out of home care, as a permanent plan for children and youth, would likely result in much apprehension and fear.¹⁰ For foster parents and for those adopting highly damaged children and youth, the feeling is often one of being overwhelmed and wishing to do more. Such intense feelings are often associated with professionals being aware that older children, children with developmental deficits (e.g. FASD) due to personal and family history, and those with addicted parents, would be at high risk in terms of both adoption failures and foster family failures. One the other hand, with more resources put in place to control risks (e.g. professionally supervised parental access) or to ameliorate harm (e.g. therapeutic foster care), fostering may provide care and parenting with relatively helpful outcomes (Dozier and Rutter, 2008); similarly, financial and service-supported adoptions, for children at high risk, may be relatively successful. For some children even

⁸ Learning and ability to transfer information from a drugged state to an undrugged state ("dissociation", McKim, 2007, 37) may impair parents' abilities to transfer parent capacity learning from an undrugged state to a drugged state and vice versa.

⁹ Social justice demands that the well-being of children must be framed in such a way that parent-centered expectations for the child's resilience, adaptation and coping do not become a compromising substitute for child-centered well-being.

¹⁰ Some foster care social workers expressed concern about finding sufficient placements able to help children who brought with them complex issues of addictions-compromised parenting - especially when the child defined the parent as non-abusive. Some adoption social workers were concerned with the added complexities of finding placements for children that were exposed to addictions-compromised parenting - especially when the child may have ingested drugs or have been exposed to hazardous chemicals.

alternate semi-independent, or independent, supported living arrangements provide more hope, less harm, and less risk than do further attempts at family preservation. In applying all of these placement options, the author has come to have confidence in an integrated “therapeutic foster care” or “therapeutically supported adoption” type of model.

The literature suggests that therapeutic foster care has beneficial results in the best interest of the child, albeit while being more costly than traditional foster care (Crosson-Tower, 2008). In the author’s clinical experience, a less costly version of therapeutic foster care, also becomes an option with children at additional risk due to life experiences with, care from, and parenting from, substance using-abusing parents.¹¹ Specifically, part of service planning may put supports in place for traditional foster care families, or traditional adoptive families, that fully integrates long term individual and family therapy, some of which may be undertaken in the home. The policy, program and practice case being made here is for therapeutically supported foster care and adoptive placements with integrated foster parent/adoptive parent development, timely support, psychosocial education and *in vivo* integrated therapy with foster parents and adoptive parents coached in assuming some roles as “surrogate therapists”—thus helping to maintain and enhance strengths and treatment effect. The less ideal option is alternate and semi-independent living arrangements, with multiple child-youth care-givers providing age-stage appropriate and continuous support. Integrated therapy for the child and professional coaching for paraprofessional care givers may simulate a therapeutic foster care model.

Use, Misuse and Addiction—A Child-Centered Perspective

The risks and impacts of substance use, misuse and abuse, and the presence of hazardous materials in living spaces, have serious implications for the safety and developmental needs of children, the personal and social functioning of parents, as well as on the social functioning of their families. The nature of the effects of some drugs and the addicted parent’s lifestyle may increase risks for children and their families. For example, methamphetamine, cocaine and crack cocaine use, and other stimulants such as amphetamine may be associated with irritability, agitation and aggression, and antisocial behavior [McKim, 2007] as well as impaired parental patience, which has posed additional risks for physical and emotional abuse [Barnard, 2007]. Heroin abuse and sedative-hypnotics misuse may be associated with impaired capacity for parental alertness, attention and supervision, but may be followed by irritability; benzodiazapines are associated with confusion. Ecstasy, the love drug (methylenedioxymethamphetamine) is associated with intoxication, increased libido and enhanced sexual pleasure and eroticization [McKim, 2007] and has put children at risk for exposure to explicit sex and eroticization or, at worst, sex abuse and sexual exploitation (see for example Famularo, Kinscherff and Fenton, 1992). The risks of exposure to family violence are exacerbated in families where substance use and abuse is a compounding factor (Potter-Efron, Potter-Efron and Carruth, 1990; Barnard, 2007). In short, each drug, as used in moderate and high levels, and as associated with tolerance,

¹¹ The author distinguishes between care and parenting in that a parent may provide food, shelter, clothing and personal care while not providing adequate supervision, direction, coaching, safety, and optimal age-stage controls. As well, with addicted and mentally disordered parents it is important to differentially assess child care and parenting activities that are acted out in the best interest of the parent - a narcissistic approach to parenting.

withdrawal, and dependence, presents its own risks *vis a vis* addictions-compromised personal and social functioning—including parenting.

The distinction between use, misuse and abuse, or addiction to substances, most often becomes moot when considering risks, impacts and children’s needs for care, parenting and protection. Applying causal theories, such as parental disinhibition due to substance use and abuse, or an expectation effect associated with drug effects (Walsh, MacMillan and Jamieson, 2003; Fromme, D’Amico and Katz, 1999), may help refine assessments, but do not mediate risks and harm to the child. Without attending to risks posed by parents’ friends and acquaintances, a parent might be on a relapse prevention program that supports what is defined as safe controlled use, or may be on a harm reduction program that supports what is defined as use with some known impacts, but with predictably less harm to the parent. The child-centered assessment issue is that even low to moderate levels of substance use may contribute to child risks, harm, unmet needs and developmental damage. For example, even two standard drinks of beverage alcohol (King and Byars, 2004), let alone the single use of a drug like ecstasy, (Jansen and Theron, 2006) may disinhibit parental sexual behavior in the presence of a child; a predictable, imminent and serious risk is premature sexualization and eroticization ¹² A parent may put a child at risk irrespective of the parent not consuming drugs while parenting; for example the child may consume prescription or street drugs left within reach, or the child may be given a drug (often non-prescribed prescription drugs) in the interest of the parents’ needs to control the child or to induce somnolence, or the child may be exposed to other adults or youth who pose risks associated with use and abuse of substances or related life-style issues. As well, a parent’s behavior and cognitive functioning are most likely impacted by drug tolerance, emotional dependence, “hangover” and/or withdrawal; chronic exposure to drug mediated parenting is associated with risks, harm and developmental problems for the child. For the child, parental use, moderate use, misuse, excessive use, dependence and addictions all present avoidable risks in addictions-compromised parents.

The analysis below addresses issues associated with children’s protection cases, or cases where children’s protection should have been notified, where there was a high level of parental abuse of street drugs, prescription medications and/or alcohol, and associated lifestyle—with some cases meeting criteria for dual, concurrent, or otherwise labeled as co-occurring mental health and addiction problems - considered to be a high risk and difficult to treat with sustained success (Centre for Addiction and Mental Health, 2001). Many parents meet criteria for being alcohol or drug dependent (American Psychiatric Association (2000) and fit the patterns associated with a general addictions paradigm (Doweiko, 2008); others fit concurrent or dual disorder criteria (Kimberley and Osmond, 2003; Centre for Addiction and Mental Health, 2003).

¹² The author distinguishes between premature adult range sexualized behaviour and actions, which may be expressed by the child without having sexual feelings, sensations, or motives (e.g. when a child is forced to fondle her brother for a porn movie), and premature eroticization, which involves the child having sexual feelings and sensations, sometimes without ostensibly related sexual actions (e.g. observed in children who have observed adult sex movies or live sex acts, at a young age). At another extreme, the author has observed expressions of deviant sexual acts by children such as bestiality, possibly associated with exposure to adult videos, or the fusion of sex acts and physical aggression, by children who have been directly exposed to sexual assault. Such cases have involved addicted or co-morbid parents and/or surrogate care givers.

Either are likely to be high risk clinically, are not likely to sustain personal and child centered change needed to ensure child safety, well being and normative range development.

Notwithstanding the above, from a child-centered perspective, high risk parent's who are now abstinent, parents who are using substances at low levels, parents who abuse, parents who are addicted, or parents who live an addicted lifestyle, may all pose considerable risk and harm for the child. Assuming that parental progress in control of substance use and abuse significantly reduces risk and harm to the child, and/or results in parenting and care that is in the best interest of the child, is a dangerous assumption. Current parental abstinence or low levels of use are not a sufficient rationale for returning children to parental care.

The likelihood is increasing that more children will need to be placed in continuous care, with little hope of family preservation, is becoming a reality. Beyond the social costs, levels of risk and personal and family difficulty are making costs of support, protection and care of great concern. As well, the changing face of families involved with children's protection, it appears, include more persons with (or having had) adequate to significant education and resources—often presenting children's protection with new layers of legal and political complexity.¹³

Assessing risks, needs and harm to children in an addictions context

Within the context of significant and repeated parental abuse of substances, the analysis below is based on selected research and practice related literature and a review of a limited clinical sample of cases in one service which has provided case consultation to children's services and expert opinion to the courts. Parenting capacity, correlated parenting assessment concerns and exemplars of child-risk need issues are integrated into each child assessment dimension, thus supporting a child centered and child relevant parenting assessment and plan.¹⁴

The need to belong

The need to belong to someone or with someone who is a care giver typically does not appear on a list of common human needs [although it is referred to in the United Nations *Convention on the Rights of the Child*, including the right to a name.]. At times the need to belong is enmeshed conceptually with cultural, ethnic, racial, familial and social identity, and personal identity. The author is making the case that even when children have a sense of cultural, ethnic, familial and social identity, they may lack a sense of where they belong and to whom they belong. Children of high risk parents who have a high level of involvement with drugs and the substance abuse lifestyle may be left with various extended family members, friends and neighbors, and have a

¹³ Even those parents who meet the minimal criteria for good enough parenting, but who repeatedly return to repeated high risk, are not likely to sustain their motivation, attention and actions expected with good enough parenting. Some children have reported that their parents "fooled the judge and the counsellors" for a few days, then returned to drug parties within hours of "winning me back" in court. When a newborn half-brother was returned to a drug involved mother, in the interest of mother-infant-mother bonding, the pre-teen, concerned for her new half-brother said: "she couldn't take care of us, what makes them think she can take care of him."

¹⁴ The position taken in this analysis is that parent centered parenting capacity assessment criteria often disadvantage the child(ren). For example, as part of a court order, an addicted parent may be assessed as needing a parenting course; in many cases such courses teach knowledge and skills, often already possessed by the addicted parent. The case plan for, or parental compliance in, completing a parent training program, would result in no verifiable reduction or control in child risk or harm associated with addictions-compromised parenting.

sense that they belong to no one (e.g. A child was left with a neighbor who was a stranger and the parent never returned to claim the child—a form of abandonment; other children have been “forgotten” in shopping malls.).

Even when apprehended and placed, the child’s level of biopsychosocial difficulty may be such that he/she must be placed in 24/7 “alternate living arrangements” that do not model a family care environment. In extreme cases children may be “sold”, sometimes before birth (sometimes to pay for drugs) or given to others in informal “adoption” arrangements. The sense of not belonging with, or to, a parent or care giver is associated with high insecurity, distrust of adults and threats to attachment and bond and a stable and integrated identity. With high risk addictions-compromised parents, children who do not have a sense of belonging may never have this need met; their coping strategies may result in them being relatively independent, adultified, and the “resilience poster child”, but efforts at family preservation, in these cases, may actually exacerbate the risks and long term developmental damage. Repeated failures to protect may contribute to premature school leaving and the child “running”.

In addition to the above, in addictions-compromised parent assessments, direct observations have included parents:

- missing planned and agreed upon access with their child(ren);
- arranging to attend to adults and adult matters during access visits;
- expressing emotional and intended commitment and then not following through;
- playing in parallel activity with a child, when the child is trying to be interactive;
- competing with a child for success in play and/or social tasks;
- competing with the child for the attention of the parent supervisor-coach;
- showing up to access while being under the influence of substances and/or impaired, or evidencing significant withdrawal symptoms;
- falling asleep during access with the child, often associated with addictions and life style choices;
- evidencing very little bond with the child and avoiding the child’s attempts to bond.

Issues of physical, emotional or sexual abuse, maltreatment or exploitation, would compound problems associated with the need to belong. A stable placement with adequate supports (e.g. an *in vivo* therapeutic environment) may give the child a sense of belonging and a sense of continuity as well as more secure structure in her/his life.¹⁵

The need for security and safety

Independent of more general concerns with maltreatment, abuse, exploitation and neglect, while it is not uncommon that children in need of protection experience insecurity and threats to safety, the children of high risk substance abusers may experience a range of risks and harm that are linked to the substance use-abuse and the substance abusing life-style (Covey, 2007; Peleg-Oren and Teichman, 2006). One major problem is children who have been exposed to hazardous

¹⁵ As part of differential assessment, the social worker must consider the logical possibility that a parent’s demonstrated efforts to give the child a sense of belonging may be associated with the child being a source of social assistance income and/or exploitation income, that may be used to support parental addiction.

substances (chemicals of abuse) in the womb and at birth (Schmittroth, 1994)—with special risks for those children experiencing drug effects at birth. Lack of parental attention, care and supervision (Barnard, 2007; Hogan, 2007) can take on new meaning when parents are so impaired that they do not know the whereabouts of their three year old, for four days. Physical environmental threats such as “needles”, broken bottles, and drugs within reach, present clear and imminent dangers. The child’s physical environments may pose a HAZMAT risk for children and safety professionals (e.g. a “crystal meth” lab, see Swetlow, 2003). Additionally, some drugs may compound the risk of physical violence against a child (e.g. “meth”; “coke”; “Oxy’s”) (see for example Covey, 2007: 150) or risks of sexual maltreatment of a child (e.g. ecstasy). Parents’ drug abusing peers may pose many child protection risks. The drug abusing lifestyle may be associated with substances and relationships that expose the children to the immediate threat of being in the presence of violence—let alone the know developmental harm related to such exposure (Potter-Efron , Potter-Efron, and Carruth, B.,1990). With high risk abusers, it is difficult to arrive at a level of confidence in parenting-care change that is child relevant, that would be sustained and control risk.

An additional risk, by default, is that if a child improves in care, the courts may judge that the improved stability and well being of the child is sufficient to give the parent “another chance”. Improvements in a child’s mood or actions in care, or even in the home with 24/7 parent coaching, often have no association with related improvements in the parent with respect to care, parenting, risk reduction or harm amelioration. Besides giving parents multiple “last” chances, children may cue the social workers that the parent has not changed and that risks are still present.¹⁶

Cases and addictions-compromised parenting assessments reviewed, and the literature suggest giving attention to:

- parental impairment, child centered attention and child supervision by the parent, even under conditions where the parent-child contact is being supervised by another adult;
- parental agitation, irritability, threat and/or verbal or physical aggression towards a child, even while being observed;
- parents giving the child an excess of negative attention or punishment based on parental needs, paradoxically at times to impress the parent coach or access supervisor;
- parental sexualization or eroticization of some aspect of activities with the child(ren), sometimes related to active drug use and impairment, independent of other valid concerns about sexual abuse or sexual exploitation;
- parents “accidentally” giving unsafe persons access to the child during the child’s access visit with the parent -even an adult who may have access prohibited;
- parents significantly misjudging the safety of the environment or the level of hazard to which the child is exposed, even while being observed;
- parents exposing the child to physical or verbal violence in adult to adult exchanges, during access or parental supervision;

¹⁶ In one case a thirteen year old child, doing well in foster care, requested to be present at the decision conference to “prove” that her parent had not “really changed”; the parent failed the child’s test and the child got her wish of having her and her sister remain in care.

- parents not complying with children’s protection directions (in case plans or in real time directives) regarding physical, emotional and developmental safety, security and well being, even when the parent has supervised custody.¹⁷

One failure in judicial decision rules for a child protection service plan, that is not in the child’s best interest, is using the child’s progress as a basis to, by default, risk his or her regression in the interest of meeting the parents’ needs for access, under conditions where the parent has not demonstrated adequate child-centered and safety-security relevant progress.

The need for stability and continuity

Children with high risk parents often experience unstable life experiences and significant breaches of continuity associated with substance abuse. One source of rapid and dramatic destabilization is when the child’s parent(s) are sent to prison (e.g. on drug related offenses). (See for example, Srikanthan, 2005) More common instability is associated with long periods in extended and repeated temporary care while a parent is “on a binge”, in withdrawal, or in “rehab”. Terms of parental access may cause further instability and discontinuity when there is a conflict associated with contact and access, or where the parent defaults on a promised “visit.”

One of the decision rules in many protection jurisdictions is to place a child with an approved extended family member or known family friend, as opposed to in a stranger foster home. Relative foster care may reinforce some of the risk dynamics such as permitting a risky parent to have unauthorized and unsupervised access. By the time some children are offered stranger foster care, their biopsychosocial problems are so pervasive (e.g. FASD compounded with PTSD) that risks of foster care failure are increased and risks of adoptive placement failure are increased. There is some evidence that a therapeutic foster care plan, or a therapeutically supported adoption, may enable more amelioration of impact, but such practices may not be supported, broadly and on a sufficiently continuous basis, in policies and programs, as they imply additional costs for a system that is largely reactive.

Related addictions-compromised parenting assessments observed suggest giving attention to:

- parent functional capacity to sustain stable actions and patterns associated with optimal child care and child centered parenting;¹⁸
- parent functional capacity for good judgement and actions to create child-centered stability and continuity that is in the child’s best interest, as opposed to a narcissistic agenda by the parent;
- parent risks in explicitly or surreptitiously misbehaving or destabilizing out of home placements, or the daycare or school environment;

¹⁷ One differential assessment dynamic that is important to consider is a parent making parentified demands of an age-stage inappropriate child, such as sending the nine year old to get the baby some milk at 1 a.m., based on parental reasoning that the parentified child has proved able in the past. The link between parentification and addiction and mental health-compromised parenting is strong.

¹⁸ One differential assessment consideration is in situations where the parent is creating stability and security because the parent needs the child in her his life for social support and/or economic gain.

- not succumbing to parent agendas in breaking continuity for the child when out of home placements are so child centered that they do not permit the birth parent much opportunity for manipulation and control masquerading as “inclusive care.”

One case on which the author consulted was particularly dramatic. The child had stabilized and progressed and in foster care, benefitting from continuous care from the ages six to eight at the time of observation. The foster mother had the task of monitoring telephone contact between the child and either birth parent. The telephone contact was encouraged, even when the child was “not in the mood”, theoretically in the interest of attachment and bond, identity formation and family inclusion. After one such telephone contact the child became very unstable—emotionally and behaviourally. The foster mother was confused because she had heard nothing in the telephone exchange that would make her suspicious. What was discovered in assessment was that the parent had strategically targeted the foster home for disruption, likely hoping to get the child to declare that she wished to return to her birth home. It appeared that the birth parent strategically “caused” the destabilization by telling the child that he was petting a family pet—the named pet had died years earlier. The foster parent was guided in taking ameliorative and supportive action that would reinforce treatment effect for the child (a modified treatment foster care model).

In short, in the face of repeated addictions-compromised parenting, the child’s need for stability and continuity in a child-centered manner must take precedence over the parent’s need to continue as parent.

The need for attachment and bond

The assumption made by most children’s protection, justice, addictions and mental health professionals is that one of the foundations of healthy and normative biopsychosocial development is an adequate attachment and bond to serve the mental health and developmental needs of the child (Davies, 2004). There is considerable indication that parents with addiction and mental health problems have deficits in enabling an infant or young child to attach and bond sufficiently to meet the developmental needs of the child (Flores, 2004). When parents are heavily into substance use and abuse and/or an addictions lifestyle, there is likely very little energy put into enabling and retaining healthy attachment and bond that is child centered. At later stages of the parents’ development of dependence and addictions, often interacting with the parentification of the child, there may be an unhealthy trauma bond that is developed between the parent and the child. The children need to have a healthy social bond supported, hopefully one that has sufficient continuity to enable more normative development.

In considering parent capacity, assessments should examine the following. Some children report a double bind message from the parent that is reflected in the following depiction: “Mom/Dad wants to be closer to you; go away and stop bothering me”. In observing access, care and parenting it is important to look for indications that the parent has problems with attachment and with enabling the child to attach and sustain attachment. In assessments it is important to distinguish those times when a parent is enabling attachment because a child needs a social bond, care, security, versus the narcissistic counterpoint (Forrest, 1994) that the parent needs the

feeling of bond with her/his child and expects the child to be there for him or her. The risk of significant developmental problems, including reactive attachment disorder, for the children of high risk parents, is evident in some of the patterns of attachment, detachment or failure to attach that are observed and reported. There is some evidence that attachment problems may be overcome through enabling the child to attach to an alternate effective caregiver such as a foster parent (Howes, 1999). The position of this author is that therapeutically integrated foster care or supported adoption increases the chance of the child achieving and sustaining more optimal growth and development, including attachment - with due consideration to the child's potential.¹⁹

Need for positive and instructive attention and affection

There are indications that children respond to parental direction when balanced with affection and positive attention (Suchman, Rounsaville, DeCoste and Luthar, 2007). Children brought into care often experience much negative attention and directives (coaching); parenting may not be associated with child-centered affection. It is not uncommon for the addicted parent, as observed in assessments, to express or look for affection when it is the parent needs such expression.

Associated with the issues of the quality of attention and affection, the high risk parent often has pervasive problems with respect to self-control and then complains that they can't parent, as expected by children's protection, because their child is "out of control", "never cooperates" and "was always that way". The parent then feels vindicated (often supported by default in court decisions) when his/her child is placed in a youth corrections facility or is referred to a children's mental health center²⁰. Addicted parents, often, have much first-hand experience with social exchange based relationships and may barter affection and positive attention needed by their child, on a conditional basis. Foster parents, adoptive parents and therapists, who are trying to successfully integrate the child into a more promising social unit, often must address issues such as: instructive attention being defined as negative attention and the child wishing to "escape" structure and control; the child not knowing how to receive positive attention and affection and to process their meanings in a healthy fashion; the child interpreting being spoken to by an adult as an indication that the child has failed in some fashion.

In short, it is important to understand care and parenting based on the child's experience in life as lived, not life as reported by the parent. With younger children, direct observation of them and interacting with the child in play may be a source of hypotheses regarding the quality

¹⁹ In differential assessment, aside from the issues of trauma bond, it is important to the assessor to be sensitive to illusions of healthy attachment based on a parent's actions to get the child to meet the parent's need for bond. One marker that the author has found useful in assessment, is when the parent becomes angry with the child because mom/dad "needs a hug/kiss/cuddle", and the child has not responded or complied; yet when the child is trying to attach, based on child-centered initiative, the parent may be unattentive, unaware or rejecting - sometimes compounded by substance induced impairment. Another dimension that is important to differentiate is parental use of what this author has labeled "strategic empathy" for parent centered purposes, with a child who needs positive attention.

²⁰ This author has seen cases where a parent has insisted that her/his child see one mental health professional after another until a diagnosis is discovered and confirmed, not within the sense of Munchausen's Syndrome, but in the sense that if the child has a now "proven" mental disorder, then a thesis of parental deficits may be replaced with the cognitive script that: "I knew this all along; I am a good parent with an impossible child".

of parental attention the child has experienced. Within this context, the child's interpretation of the quality and quantity of parental attention must be factored into the assessments.

Need for freedom from preventable maltreatment and trauma

While the author has focussed on impacts of parental addictions independent of other forms of child maltreatment, abuse, exploitation and related trauma, the literature and research has many examples of findings that parental use and abuse of substances, addictions and related life styles are associated with a child's increased risk of death, sex abuse, physical abuse, neglect and various levels of exploitation from parentification to sexual exploitation. Children may be faced with a double disadvantage and sets of risks in that they experience the direct effects of parental addictions as well as associated risks of other forms of maltreatment (see for example Wolock and Magura, 1996). While family preservation theory was built largely on the assumption that neglected children would have less harm if they did not go into continuous care and thus benefitted from family preservation plans, children who are repeatedly abused and/or put at repeated risk for maltreatment, may be sacrificed on the alter of family preservation.

Need to not be increasingly resilient in the interest of parents

Application of resilience theory is often paradoxical in that children and youth, who have suffered maltreatment and developmental damage associated with a life with addictions-compromised parenting, often demonstrate much ability to adjust, adapt and cope (Ungar, 2005). Their strengths are often framed being associated with resilience. Yet, in their silent awareness, or shared thoughts in confidence with counselors, many do not define themselves as resilient; they define themselves as fragile. The metaphor used by some is that of the tough outer shell but with anxiety provoking cracks. The paradox is that the children's apparent strength may be used by "the system" to justify giving their parents yet another chance. When the child's resilience finally fails and the child ends up in mental health services, addictions services or youth detention, accounts seldom point to the system's responsibility or to parental responsibility but to the child (now a youth) taking responsibility for his/her actions, attitudes and feelings. As one child queried, "How come I am responsible for what I did but mom and dad were never responsible for what they did to me, it was always blamed on the booze or the drugs". When another youth (aged 14) was complimented by professionals on her strength and resilience, the wise teen retorted, "My resilience runs thin". In assessments it is important to explore the child's paradoxical perspective on strengths and resilience as the voice of the child often expresses nuances of anxiety and fragility that imply risk, need and harm that requires amelioration. In short, the great strength of resilience may be experienced as a troubling weakness and be self-defined, by the child, as a fraudulent presentation of self.

Conclusion

As parental use, abuse, addictions and substance abuse lifestyles become more intractable, and have more repeated and lasting damage on children and youth, society must come to define parental addictions that are chronic and/or repeated as a form of child maltreatment. As parenting capacity is increasingly compromised by parental addictions and/or related life-style, and as

developmental risks increase, addictions and children's services, as well as the justice, education and mental health systems, are faced with the growing reality of parents defaulting on care and parenting responsibilities. Child centered risk-need and parenting assessments, which include significant *in vivo* observations, must address how the effects of the chemicals themselves, addictions-compromised parenting and and/ or²¹ addictions lifestyle, independent of any other child maltreatment and developmental issues, should be addressed in policy, program and practices in the best interest of children²². Variations of *in vivo* therapeutic foster care, even within 24/7 alternate care or adoptions, present one avenue for amelioration of harm, control of risk, and support for more normative child-youth development. As one male child in an alternative living arrangement offered: "I tried it again back there. I'm doing better with my four mothers; they all take care of me" . But, his statement is not as poignant as the plea of a six year old in a letter to the judge:

"Dear Judge, please don't send me and my sister back to mommy and daddy. They can fool you. They don't change."

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²¹ The reason "and/or" is used in relation to life-style assessment is that even if a parent is in a "sober" period, life as lived on a daily basis still may exhibit parental lifestyle patterns, some associated with "the drug scene", that pose continued and unacceptable risks for children and youth.

²² One significant developmental issue is how addiction compromised parenting impacts the child's participation in and performance in day care, school and, later, part-time employment. One need category that could be further developed is the child's *need for support for optimal growth and development within the context of optimizing her/ his potential*. This frame for assessment would remove the challenge of having unreasonable parent capacity expectations of addiction-compromised parents, yet attend to the developmental needs of the child. See for example Suchman et al. 2007. For a summary of issues associated with parental problems and disorders, parenting capacity and children's needs see Cleaver, Unell and Aldgate, 1999)

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