Child and Family Focus SA Submission:

South Australian Alcohol and Other Drug Strategy 2024-2030

July 2024

Acknowledgement of Country

We acknowledge the traditional lands of the Kaurna people and acknowledge the Kaurna people as the custodians of the Adelaide region and the Greater Adelaide Plains. We pay our respects to Kaurna Elders past, present and emerging.

We acknowledge the traditional custodians of land beyond Adelaide and the Adelaide Plains, and pay our respects to all Aboriginal Elders past, present and emerging.

We acknowledge and pay our respects to the cultural authority of our Aboriginal and Torres Strait Islander colleagues and are grateful for the cultural expertise that they represent.

The role of Child and Family Focus – SA

CAFFSA is the South Australian peak body and industry association for child safety and child protection, representing the needs of South Australian children, young people, families, and the non-government, not-for-profit organizations who support them.

Background to this submission

This submission responds to the Draft South Australian Alcohol and Other Drug Strategy 2024-2030. This submission focuses on the underlying causal factors associated with drug and alcohol misuse, recognising misuse as a secondary symptom rather than a primary issue. Although there is some mention of determinants throughout the draft strategy, the dominant narrative still presents drug and alcohol use as a 'problem' rather than an attempt by individuals to 'solve other problems' often connected with systemic failures. CAFFSA maintains the stance that trauma, particularly childhood trauma, is a central factor influencing alcohol and drug misuse and that the South Australian strategy should be based on this understanding.

Existing knowledge indicates that childhood maltreatment is linked to various adverse outcomes throughout life, particularly drug and alcohol misuse. Recent findings from the Australian Child Maltreatment Study[1] show that a significant proportion of Australians have experienced child maltreatment, leading to markedly elevated occurrences of health risk behaviours, including cannabis use (6.2 times higher) and weekly binge drinking (1.3 times higher). Notably, sexual abuse and emotional abuse pose the greatest risks. Consequently, there is a need for trauma-informed approaches in responding to people with alcohol and drug misuse. Preventing childhood trauma is also therefore a prevention strategy for drug and alcohol misuse. Given the wide prevalence of child maltreatment, identified by the Australian Child Maltreatment Study at 62% of all Australians, childhood trauma must be appropriately recognised as a significant public health need.

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[1] Lawrence D, et al. (2023). The association between child maltreatment and health risk behaviours and conditions throughout life: The Australian Child Maltreatment Study. *Med J Aust*. 218 (6).

This submission also recognises that drug and alcohol misuse sit within an intergenerational cycle, not only causatively linked to childhood trauma but also affecting an individual's capacity to parent safely. Drug and alcohol misuse is common in families with child protection involvement, often co-occurring with mental ill-health and domestic and family violence.[2] These interconnecting complex issues are found to double the likelihood of a child entering into out-of-home care. In these situations, the whole family is harmed by drug and alcohol misuse across multiple generations.

Finally, this submission recognises drug and alcohol misuse as a health issue and resists any proposed interventions that treat dependency as a criminal issue. While harm minimisation and a health focus are identified, the strategy is not health led and instead builds on the current fragmentation of services intersecting with drug and alcohol use.

Individual, social, and contextual determinants

CAFFSA recognises that drug and alcohol misuse often occur within layers of vulnerability within the community, with CAFFSA member agencies often providing services to people experiencing intersections of multiple vulnerabilities. Although the strategy identified multiple determinants, there is no clear intersection of these factors or clarity on the causal pathways leading to substance misuse. As is shown in the below figures, early childhood development, supported by nurturing parenting, serves as the foundation to pathways of resilience. In South Australia, there are several factors currently impeding the development of this foundation: homelessness, mental health, domestic and family violence, and childhood trauma. These are discussed in more detail.

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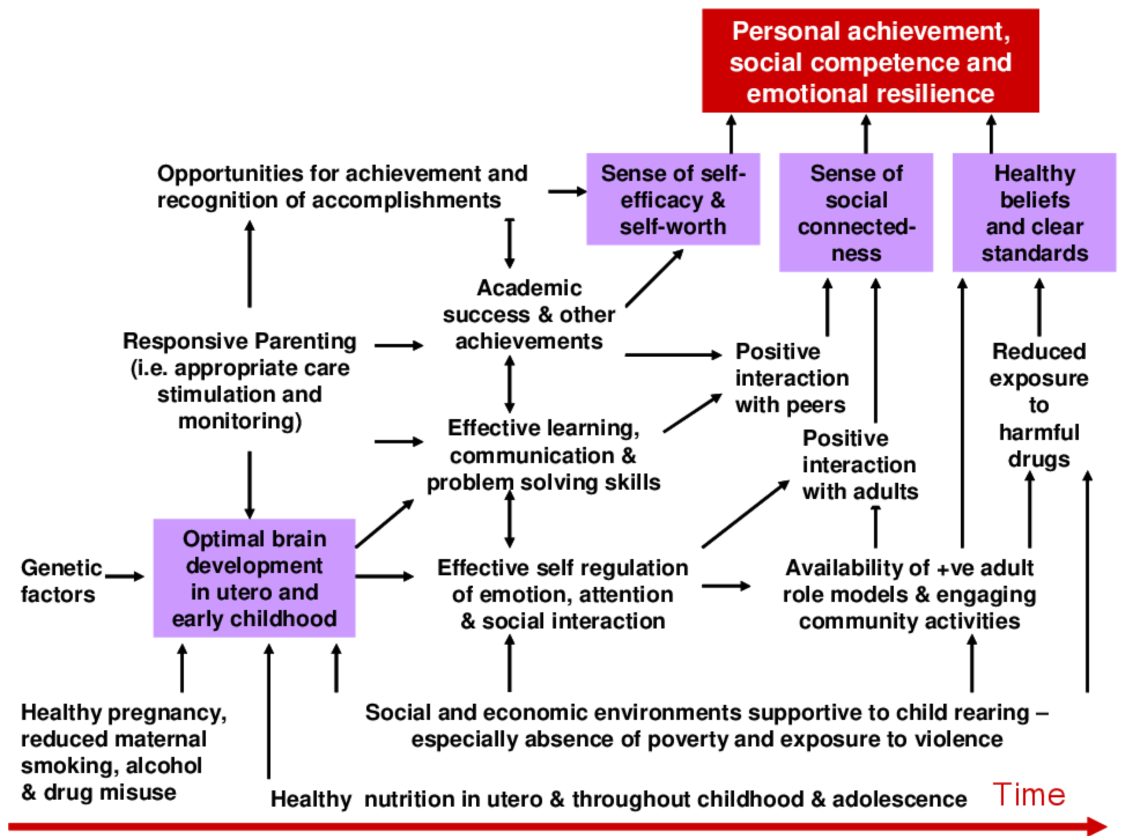
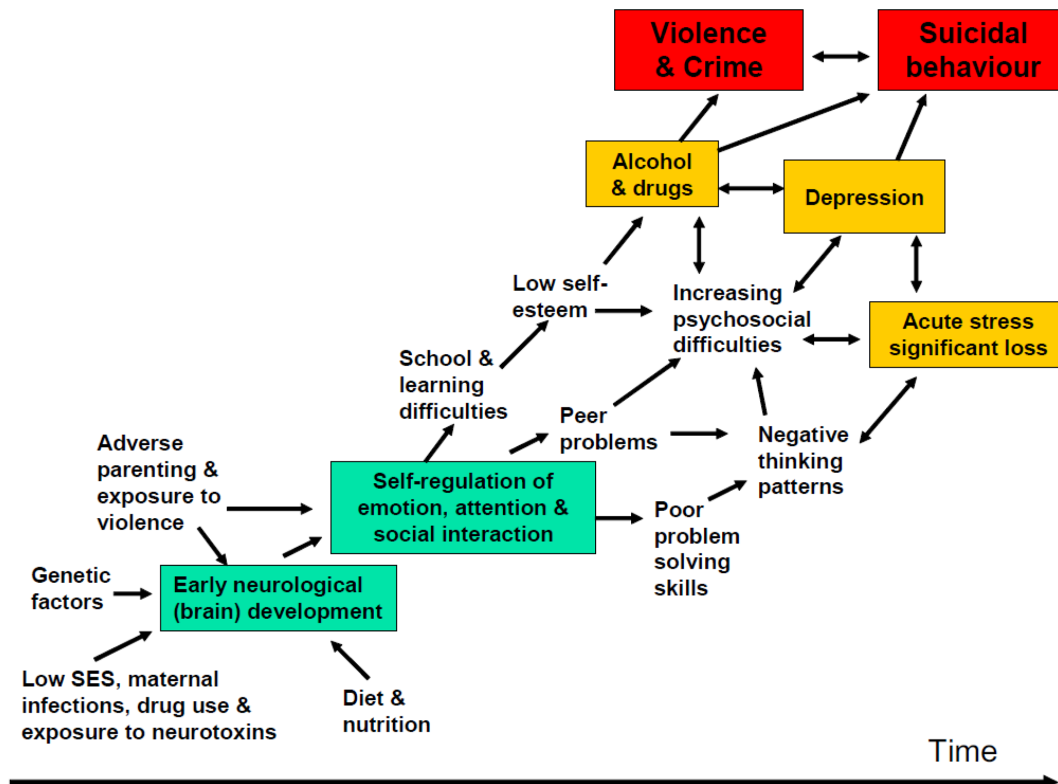
[2] Luu, B., Wright, A. C., Schurer, S., Metcalfe, L., Heward-Belle, S., Collings, S., & Barrett, E. (2024). *Analysis of linked longitudinal administrative data on child protection involvement for NSW families with domestic and family violence, alcohol and other drug issues and mental health issues* (Research report, 01/2024). ANROWS.

Figure 1

Factors and pathways associated with resilience vs poor outcomes





Note. From Spooner, C., & Hetherington, K. (2005). Social determinants of drug use.

Homelessness

One of the most significant vulnerabilities affecting the community at present is that of homelessness. Homelessness intersects with drug and alcohol use in a complex and multifaceted manner.[3] The Journeys Home project (a longitudinal survey of Australians), found that of those people who had experienced housing instability or homelessness, risky use of substances was also reported for alcohol (57%), illicit drug use (39%) and the injection of drugs (14%) in the previous 6 to 12 months.

There are many barriers that prevent homeless individuals, rough sleepers, or those with insecure housing from accessing services. These barriers can be personal or practical, including competing needs, poor health, physical access to health services, difficulty contacting services, medication security, and the cost of health care. Additionally, differences in social status and fears of being judged can create relationship barriers that hinder access to AODS services. Evidence from CAFFSA's member agencies identifies that the cost-of-living crisis and associated housing instability is critically affecting the health and wellbeing of the community.

Homelessness also intersects with the capacity to access residential rehabilitation treatment. Some eligibility criteria for services requires that clients have a stable address. However, accessing residential rehabilitation services can result in the loss of accommodation as clients cannot afford to pay for both rent and treatment. Therefore, in order to access treatment, individuals must maintain stable housing prior to their treatment while simultaneously risking their housing stability during treatment. This creates significant barriers to help seeking.

Domestic and family violence

The strategy does not present a clear understanding of the intersection between DFV and drug and alcohol use. People experiencing DFV, overwhelmingly women, require specific mention. DFV intersects with alcohol and drug use in three ways. First, women may use alcohol or drugs to cope with the physical and psychological impacts of their abuse. Second, men using violence may become more aggressive when under the influence of drugs or alcohol. Finally, women experiencing coercive control may be forced to engage in substance misuse against their will or restricted from engaging with supportive services.

Women experiencing domestic violence may also be afraid of accessing health care due to stigma and shame.[4] They may feel it is their responsibility to navigate a healthcare system they don't trust and don't fully understand. Trauma makes it harder for them to get the care they need, affecting their understanding of domestic violence, their ability to share information, and their overall awareness. Additionally, they may struggle to remember information given to them and not feel safe enough to talk about their experiences with domestic and family violence. These factors may easily be interpreted as a lack of engagement or motivation to change. Taking a health approach, drug and

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[3] AIHW. (Accessed 2024). *Alcohol, tobacco, & other drugs in Australia.* https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/people-experiencing-homelessness

[4] Hollingdrake, O., Saadi, N., Alban Cruz, A., & Currie, J. (2023). Qualitative study of the perspectives of women with lived experience of domestic and family violence on accessing healthcare. *Journal of advanced nursing*, 79(4), 1353-1366.

alcohol supports should be aligned with women's current avenues of accessing healthcare with a focus on de-stigmatising treatment seeking.

The priority action to 'implement community policing interventions' highlights the role of collaborative initiatives to address DFV, but it is not clear what this will entail. The lead agency identified is SAPOL, taking a criminalizing approach to both DFV and drug and alcohol use. Legal responses, often comprising an Intervention Order, are only effective in certain situations, and have limited effects when the perpetrator has mental ill-health, those with a history of violence and crime, and where the relationship has close ties with fewer opportunities for independence.[5] This action therefore fails to recognize the complexity of families with co-occurring DFV, drug and alcohol use, mental health, and close familial ties – factors which characterize the majority of families provided services by the child protection and family support sector.

Mental health

The acknowledgement of the co-occurrence of mental health and substance misuse is welcomed. Drug and alcohol use is common for individuals with mental ill-health, used in replacement of, or to supplement other pharmacological treatments of psychological distress. CAFFSA members identified that clients of drug and alcohol programs often require mental health and NDIS support more so than AODS support. Agencies have found that clients accessing these services will often struggle with recovery or relapse quickly as they do not have the daily support needed to maintain healthy functioning across their life domains. Therefore, AODS services have also been addressing the unmet mental health and disability needs of clients. This is more pronounced in regional areas where access to other services is more limited.

The priority action to increase and expand co-morbidity services could significantly address the above issues. However, the description of these services in the strategy implies tertiary intervention rather than early intervention and prevention. While it is recognized that increasing mental health services is beyond the remit of this strategy, earlier collaboration between DASSA and mental health services could identify individuals who require concurrent service delivery or priority access to avoid substance misuse.

Childhood trauma

The draft strategy identifies that an experience of trauma can lead to increased substance use as people seek relief from their distressing experiences. Despite this initial framing, however, trauma is not held central throughout the rest of the strategy.

Increasing trauma responsive support could significantly prevent, or intervene early, in cycles where limited distress tolerance could lead to substance misuse. While there is mention of public health programs to provide prevention and early intervention, and that they should be trauma informed, it is unclear what these programs involve and how they respond to trauma. Give that trauma does not appear to be a central theme in the strategy, there is concern that the label 'trauma informed' will not align with recognised forms of trauma-informed and responsive service implementation.

Childhood maltreatment is also identified as a specific type of trauma, but the associations focus on the lack of educational attainment rather than the significant adverse and lifelong effects. While educational attainment is important, engagement with education is also an indicator of health

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[5] Dowling, C., Morgan, A., Hulme, S., Manning, M., & Wong, G. (2018). Protection orders for domestic violence: A systematic review. *Trends and issues in crime and criminal justice*, (551), 1-19.

similarity impacted by trauma. Therefore, the focus should not be on remaining engaged in education but on the causative experiences leading to both educational disconnection and substance misuse. This requires a twofold focus: first, supporting parents to provide safe and nurturing caregiving that is not disrupted by drug and alcohol use. Second, supporting children and young people who have experienced trauma to heal from their experiences, reducing their felt need to self-medicate with drugs and alcohol. These two priority groups will be discussed in more detail later in this submission.

Finally, Aboriginal peoples further experience the impacts of trauma from colonisation, the Stolen Generations, and systemic racism. This intergenerational experience should also be explicitly recognised in treatment for Aboriginal peoples.

Insufficient access to services

Alongside the above determinants, systemic factors influence the pathways to both substance misuse and recovery. These factors are the extensive waitlists for accessing support, a lack of family focused rehabilitation and detox facilities, including those that explicitly focus on women with newborns, infants or young children and inadequate funding for prevention and early intervention initiatives.

Waitlists

Many of the families supported by CAFFSA members' agencies have difficulty accessing services. Members specifically identified mental health counselling, NDIS support, housing, and financial support as required *prior* to addressing drug and alcohol misuse. Therefore, successful treatment is predicated on addressing these other needs to create a stable foundation for therapeutic traction. When individuals have multiple needs, with multiple waitlists, the instability makes addressing any of these needs difficult. Frequently, clients report using drugs and alcohol to cope with the stress of unmet needs, with waitlists therefore serving not only as a barrier to treatment, but an additional stressor.

Waitlists are most significant in regional areas, where specialists may only be available periodically. CAFFSA members identified that referral processes often have multiple gatekeepers that protract the experience. For example, it may take several weeks to gain an appointment with a GP to provide a mental health referral, followed by another several weeks to access a psychologist, at which point a DASSA referral may be made.

The strategy identifies priority access for families accessing Intensive Family Support Services, an important consideration that could have significant benefit. However, this priority access should also be extended to families undergoing investigation and assessment and reunification, ensuring that they can address substance misuse within both legislative timeframes and a socially just framework.

The impact of limited access to services cannot be overstated – some parents may permanently lose the care of their children as they cannot access the needed services within legislative timeframes. In other situations, parents may regain the care of their children but lack the ongoing supports to continue to parent safely and maintain their own recovery. Thus, it could be argued that parents are losing access to their children, or not being reunified with their children, because of a failure of the state to provide the health services required to assist them to address their condition.

Rehabilitation and detox

Families do not have access to appropriate rehabilitation and detox services, with the strategy only identifying an increase in beds rather than new approaches. The strategy states it will develop 'integrated and enhanced alcohol and other drug treatment models' but it is unclear what this entails and whether it will reconsider residential models. Current rehabilitation models do not recognize the role of parents, with many services requiring parents be separated from their children for long periods of time. In some cases, children may be removed and placed in care and are impacted by disruptions to their relationships and attachment. CAFFSA is aware of interstate models that support the whole family.[6] [7] [8] Having greater detox and rehabilitation options, outside of adult only residential services, would significantly improve access. One successful family-oriented service in South Australia is Aboriginal Community Connect and there would be benefit from expansion of this type of service.

Another challenge facing individuals using residential rehabilitation is that their housing may be threatened as a result. Many disadvantaged clients who are unable to afford their rent during their stay may exit rehabilitation into homelessness, greatly reducing the likelihood of maintaining their recovery. This fear also serves as a barrier to individuals accessing rehabilitation services in the first place, particularly with the recognition that children are unlikely to be reunified with parents who do not have stable housing. Given the lengthy wait for public housing and the lack of affordable housing in the private sector, families must often make the heartbreaking choice between treatment and homelessness.

Lack of funding for prevention initiatives

CAFFSA's member agencies identified important community building initiatives, aligned with the draft strategy's focus on Engaging Communities as vital. These initiatives are not funded and are provided through the goodwill of agencies due to recognition of the needs of families. Not-for-profit organisations in the child protection and family support sector are currently facing financial unsustainability with numerous issues having been raised with government.[9] It is further recognised that early intervention and prevention funding is typically insufficient, contributing to intergenerational disadvantage.[10] The NFP sector cannot, and should not be asked to continue these efforts unfunded or under-funded.

Priority populations

Children and young people, and parents who use alcohol and drugs were both identified as priority populations. However, the strategy did not recognise the key issues related to these priority populations.

While the strategy identifies children and young people as a priority group regarding their use of drugs and alcohol, there is less recognition of their vulnerability when caregivers may be misusing drugs and alcohol. Similarly, the initial evidence presented focused on parents providing alcohol or drugs to young people but not on the impact of parental substance misuse on parenting capacity.

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[6] https://windana.org.au/services/detox-at-home/

[7] https://ro.uow.edu.au/cgi/viewcontent.cgi?article=5803&context=smhpapers

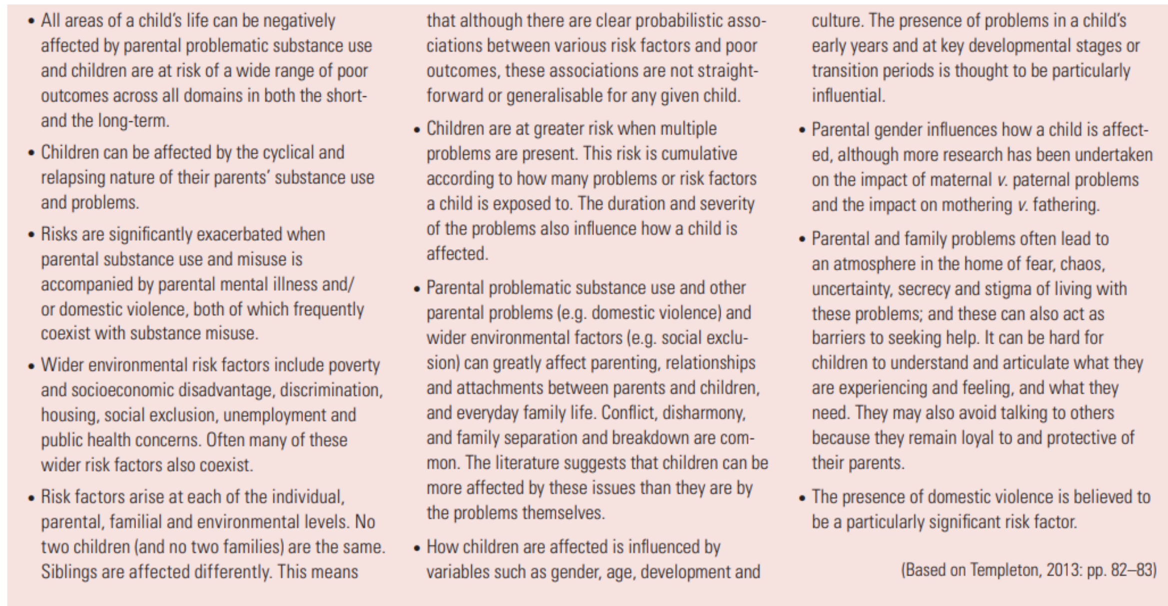
[8] https://www.odysseyhouse.com.au/what-we-do/family-support-programs/parents-childrens-program/

[9] Child and Family Focus SA. (2024). *Submission to A Common Goal – The South Australian Not for Profit Funding Policy Review*. https://www.childandfamily-sa.org.au/policy-and-advocacy/reports-and-submissions/#ras

[10] Child and Family Focus SA. (2024) *Submission to the Economic and Finance Committee on Home Care*. https://www.childandfamily-sa.org.au/policy-and-advocacy/reports-and-submissions/#ras

The impacts of drug and alcohol misuse on the whole family must be recognized, particularly regarding the role of caregivers. This evidence is summarized in Figure 2.

Figure 2
Impacts of parental substance misuse on children



- All areas of a child's life can be negatively affected by parental problematic substance use and children are at risk of a wide range of poor outcomes across all domains in both the short- and the long-term.
- Children can be affected by the cyclical and relapsing nature of their parents' substance use and problems.
- Risks are significantly exacerbated when parental substance use and misuse is accompanied by parental mental illness and/ or domestic violence, both of which frequently coexist with substance misuse.
- Wider environmental risk factors include poverty and socioeconomic disadvantage, discrimination, housing, social exclusion, unemployment and public health concerns. Often many of these wider risk factors also coexist.
- Risk factors arise at each of the individual, parental, familial and environmental levels. No two children (and no two families) are the same. Siblings are affected differently. This means that although there are clear probabilistic associations between various risk factors and poor outcomes, these associations are not straightforward or generalisable for any given child.
- Children are at greater risk when multiple problems are present. This risk is cumulative according to how many problems or risk factors a child is exposed to. The duration and severity of the problems also influence how a child is affected.
- Parental problematic substance use and other parental problems (e.g. domestic violence) and wider environmental factors (e.g. social exclusion) can greatly affect parenting, relationships and attachments between parents and children, and everyday family life. Conflict, disharmony, and family separation and breakdown are common. The literature suggests that children can be more affected by these issues than they are by the problems themselves.
- How children are affected is influenced by variables such as gender, age, development and culture. The presence of problems in a child's early years and at key developmental stages or transition periods is thought to be particularly influential.
- Parental gender influences how a child is affected, although more research has been undertaken on the impact of maternal *v.* paternal problems and the impact on mothering *v.* fathering.
- Parental and family problems often lead to an atmosphere in the home of fear, chaos, uncertainty, secrecy and stigma of living with these problems; and these can also act as barriers to seeking help. It can be hard for children to understand and articulate what they are experiencing and feeling, and what they need. They may also avoid talking to others because they remain loyal to and protective of their parents.
- The presence of domestic violence is believed to be a particularly significant risk factor.

(Based on Templeton, 2013: pp. 82–83)

Note. From Velleman, R., & Templeton, L. J. (2016). Impact of parents' substance misuse on children: an update. *BJPsych Advances*, 22(2), 108-117.

It is acknowledged that one of the priority actions under early and targeted intervention is to "*Implement a framework for working with parents and children in contact with the child protection system, prioritising access to alcohol and other drug support for families eligible for Intensive Family Services, so that alcohol and other drug services form part of an integrated, intensive case management response to address multiple risk factors.*" While this priority is welcomed, it is not underpinned by referencing this group earlier in the document and seems to be disconnected from the rest of the strategy which rarely acknowledges the impact of substance misuse on parenting.

The supporting activity to '*work collaboratively across government to better integrate referral pathways to support children and young people whose parents use alcohol and/ or other drugs*' is supported. This is an important action that could provide early intervention and recognition of children at risk of maltreatment prior to child protection involvement. However, improvements in referral pathways do not equate to the receipt of appropriate services, as evidenced by the waitlists in South Australia. It is therefore unclear how or if this activity will result in any tangible change in service delivery to children and young people.

There is also concern regarding a shared understanding of how drugs and alcohol impacts parenting and the threshold at which 'good enough' parenting is no longer being reached. CAFFSA members report inconsistencies regarding DCP office responses to drug use. For example, one office will require complete abstinence from cannabis use before children will be returned to the care of their parents, while another office will not require full abstinence from methamphetamines provided there is evidence that the use does not interfere with parenting. These inconsistencies are thought

to be based on cultural bias and values that dominate decision-making in the absence of clear guidelines for best practice. This bias was felt by CAFFSA members to be stronger in regional areas and when family members are Aboriginal, where there were more likely to be zero tolerance approaches to any drug or alcohol use even in the absence of negative impacts to caregiving. While it is acknowledged that DCP has a practice paper that outlines that the focus of assessment should be on the impacts of alcohol and drug use on caregiving, this does not appear to be uniformly guiding practice. It is recommended that DASSA, DCP, CAFFSA and the new peak for Aboriginal children and families, Wakwakurna Kanyini collaborate to clearly define the evidence base regarding drug and alcohol use and misuse, the impact on caregiving, and how these factors should influence decision making.

Finally, intergenerational cycles show that parental substance misuse and childhood maltreatment are associated with similar patterns of behaviour in the next generation. Children and young people who have experienced maltreatment required trauma-informed responses. Trauma can impair self-regulation processes, making it difficult for individuals to manage their emotions and behaviours. This can lead to increased vulnerability to substance use as a means of coping with overwhelming feelings or memories related to the trauma. Addressing substance misuse, without providing support for the underlying trauma, can be harmful for children and young people who may seek other coping strategies such as high risk behaviours, self-harm, or suicide.

Workforce development

There are significant workforce issues across many of the human services sectors, including homelessness, drug and alcohol, mental health, child protection, family support, and DFV.

CAFFSA advocates for a shared knowledge based to be held across adjacent sectors and has provided recommendations to enhance the sector.[11] Rather than having information sit in silos, many families are clients of multiple services across multiple sectors, requiring the workforce to have a shared understanding. This does not mean that expertise in all areas is required - rather that the shared expertise should be better utilised. For example, AODS staff hold expertise about recovery and the impacts of different substances. Family support and child protection staff hold expertise about the safety needs of children and are often in the home, providing them with greater insight into the lives of parents receiving AODS treatment. Greater collaboration would support both sectors to enhance service delivery and CAFFSA is well positioned to work in partnership with government and other peak bodies to deliver cross sector workforce development.

Measurement

There is significant opportunity to measure the impact of substance misuse as it relates to parenting capacity via DCP notification data. Longitudinal analysis can better demonstrate the effectiveness (or lack thereof) of current interventions and the disruption of intergenerational abuse related to substance misuse.

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[11] CAFFSA (2024). *Final Report on the Out of Home Care Workforce Mapping Project.* https://www.childandfamily-sa.org.au/wp-content/uploads/2024/06/Final-Workforce-Development-Report.pdf

Methamphetamine use

CAFFSA members continue to report that methamphetamine use remains the most harmful drug used in the community in relation to impacts on children, young people and families. It was surprising that methamphetamines were not specifically mentioned in the strategy, given that they are one of the most used in Australia.[12] CAFFSA members stated that methamphetamine detoxification is more complex than other substances, and that there has been pressure from Drug and Alcohol Services SA (DASSA) to develop in-house rehabilitation programs. Members attributed this pressure to anecdotal reports that DASSA now only services clients with high-level alcohol use because of high waitlists. While agencies acknowledged some funding provided for methamphetamine treatment, this was identified as insufficient to meet demand.

The number of child deaths associated with methamphetamines has increased in the last ten years, and almost half of deceased children were not a 'child protection client' at the time of their death.[13] The estimated social costs of methylamphetamine use is $5023.8 million nationally, including legal costs, premature deaths, and workplace costs.[14]

Concluding remarks

CAFFSA welcomes the recognition of trauma, child protection, and parenting within the strategy. Greater focus on these areas serves as an important preventive strategy for drug and alcohol misuse, particularly within intergenerational cycles. We would warmly welcome the opportunity to work with all relevant government and non-government agencies to play our part in driving the new strategy in the multi-sector approach that will be required to achieve the success that is so urgently required.

Thank you for the opportunity to comment.

SUBMISSION ENDS

[12] Australian Criminal Intelligence Commission. (2024). *Report 22 of the National Wastewater Drug Monitoring Program*. https://www.acic.gov.au/publications/national-wastewater-drug-monitoring-program-reports/report-22-national-wastewater-drug-monitoring-program

[13] Mantinieks, D., Parsons, S., Schumann, J., Drummer, O. H., Crump, K., Baber, Y., ... & Gerostamoulos, D. (2024). A retrospective review of methylamphetamine detected in child deaths reported to the Victorian Coroner, Australia. *Forensic Science, Medicine and Pathology*, 1-7.

[14] Tait, R. J., Whetton, S., Shanahan, M., Cartwright, K., Ferrante, A., Gray, D., ... & Allsop, S. (2018). Quantifying the societal cost of methamphetamine use to Australia. *International Journal of Drug Policy*, 62, 30-36.