Children of Parents with Mental Illness and/or Addiction (COPMIA):
Addiction workforce development focussed initiatives

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# Contents

Broad messages .......................................................................................................................... 3  
Key messages for Mental Health and Addiction Services ......................................................... 3  
Background ............................................................................................................................... 4  
The COPMIA workforce project ............................................................................................... 5  
The aims and objectives of the scope ..................................................................................... 6  
Key Objective ........................................................................................................................... 6  
Impact of parental addiction on child outcomes ..................................................................... 6  
Problematic parental substance use ....................................................................................... 6  
Parental Problem Gambling ................................................................................................... 8  
Resiliency and protective factors ............................................................................................ 9  
International COPMIA initiatives (addiction focused) ............................................................ 9  
Australia ................................................................................................................................ 9  
The UK experience ................................................................................................................ 11  
The USA .................................................................................................................................. 12  
New Zealand .......................................................................................................................... 12  
  Specialist Addiction Services ................................................................................................. 14  
Hearing from children ............................................................................................................. 14  
Hearing from Practitioners ..................................................................................................... 16  
Changing the way we work .................................................................................................... 18  
Recommendations for workforce development initiatives ..................................................... 18  
  Infrastructure Development ................................................................................................. 19  
  Organisational development ............................................................................................... 19  
  Recruitment and retention ................................................................................................. 19  
  Training and development ................................................................................................. 20  
  Information, research and evaluation ................................................................................ 20  
Conclusions ............................................................................................................................. 20  
References ............................................................................................................................... 22  
Appendix A: Waitemata DHB CADS Pregnancy and Parental Service ................................. 27  
Appendix B: Summary of recommendations for workforce development initiatives .......... 28
Children of Parents with Mental Illness and/or Addiction (COPMIA): Addiction workforce development focussed initiatives

*Protecting children to ensure their safety and wellbeing is everyone’s responsibility* (Medrano and Tabben-Toussaint, 2012: 1)

**Broad messages**

- To realise family and whānau potential Family Inclusive Practice (FIP) and Whānau-centred Best Practice is essential when working with individuals, families and whānau experiencing distress

- A variety of workforces who have contact with individuals, families and whānau have the opportunity to intervene early and realise family and whānau potential

**Key messages for Mental Health and Addiction Services**

- Children of Parents with Mental Illness and/or Addiction (COPMIA) while often resilient and strong are at increased risk from abuse, neglect and developing their own addiction and mental health issues

- Having mental health and addiction related problems is not incompatible with being a good parent, but is likely to affect parenting ability

- There is a clear message from government that we all have responsibilities for protecting and enhancing the health and wellbeing of children

- Families and whānau experiencing mental health and addiction related problems are more likely to live in economic deprivation, be
unemployed, have housing difficulties, and live in isolation. Taking a holistic approach to these complexities is likely to improve outcomes for disenfranchised individuals and whānau.

- Collaboration across systems is imperative
- It’s time to change the way we work in adult mental health and addiction services

Background
The effects of familial mental illness, problematic substance use and/or problem gambling on children are complex and varied. There are however a number of recognised ways in which these issues can potentially impact on the wellbeing of children. There can be harmful effects in relation to poor attachment, family dynamics, neglect and risk of violence as well as an increased likelihood that children may develop their own mental health distress or addiction related problems, as children or in later life. (New South Wales Government, Department of Community Services, 2008; Templeton, Zohhadi, Galvani and Velleman, 2006). Children that are neglected or abused are likely to have poorer physical, intellectual, social and emotional outcomes and are more likely to be placed into care and protection outside of their home (U.S. Department of Health and Human Services, 1999).

Parental mental illness, problematic substance use and/or problem gambling is however not incompatible with being a good parent¹, and many families experiencing these difficulties have great strengths and resiliency. There is however, significant potential for early intervention to build on the strengths and resiliency of children who may experience difficulties as a result of their parent, family or whānau’s circumstances and to intervene before potential problems arise. It is clear that many mental health, emotional and behavioural problems can be prevented before they begin if we are able to intervene early in the lives of children who may be at risk (Beardslee, Chien and Bell, 2011).

A number of priority areas have been identified by the current government in New Zealand that relate to this growing area of concern. *Rising to the Challenge: The National Mental Health and Addiction Service Development Plan 2012-2017* clearly articulates the requirements of services to intervene early in the life course to build resilience, which applies particularly well to children of parents with mental illness and/or addiction (COPMIA) (MoH, 2012: 5). *Rising to the Challenge* also includes a focus on delivering increased access to services for infants, children and youth with high prevalence conditions which also relate to some COPMIA. Other relevant government policies that support work to improve outcomes for COPMIA include but are not limited to Whanau Ora initiatives, the Vulnerable Children’s Bill including the Children’s Action Plan, The Youth Crime Action Plan, the Perinatal and Infant Mental Health Initiative, and the Prime Minster’s Youth Mental Health Project, where the health and wellbeing of children is prioritised.

¹ The term parent is used to include caregivers and family members who have close relationships with children in their care (including grandparents).
Growing evidence about potential harms to COPMIA coupled with recent government priorities culminated in a Ministry of Health (2012b), scoping exercise which highlighted the importance of providing clear national strategy, direction, policy and workforce development initiatives for services who work with COPMIA, their families and whānau. In New Zealand there has historically been a focus on concerns and interventions for children of parents with mental illness (COPMI), primarily due to our close association with Australia where there has been a substantial investment into services, supports and resources in this area. This has meant however that in New Zealand there has been more of a focus on children experiencing potential distress as a result of parental mental illness, and that children experiencing potential distress due to parental substance use or gambling has been less of a focus. The Ministry of Health scope also had an acknowledged mental health focus and clearly articulated the need for more investigation of COPMIA with an addiction focus. Coupled with this the scope also expressed the need for there to be a clear articulation of how COPMIA initiatives might fit with, work with or learn from whānau ora initiatives in this country. Clearly while we can learn from international literature and experience, any COPMIA initiatives will have to be relevant to the New Zealand context.

A useful Framework for COPMIA Activity (Hosman and Van Doesum, 2000) was identified in the Ministry of Health scope. This Framework includes focus on the child, their parents, their networks, and the professionals around them, as well as the inter-relationships between each of these spheres and the wider community. Using this Framework to guide recommendations, the scope identified that in the realm of ‘the professional’ an ideal end state would be that;

*A concerted workforce development initiative ensures clinician’s and other MHA [mental health and addiction] workers have the confidence to facilitate access to information that supports parents, including assisting children to understand their parents’ health problems.*


The current workforce development scoping report focuses primarily on ‘the professional’ sphere in the Framework of COPMIA Activity, with a direct focus on workforce development for specialist adult addiction organisations. It is clear however that workforce development initiatives are also required in mental health services and this scope aims to provide workforce development recommendations that will also fit this requirement.

**The COPMIA workforce project**

‘there is a need for secondary mental health and addiction service providers to appreciate the importance of addressing risks for COPMIA, and come to view this work as core business’ (Ministry of Health, 2012b:34).

The four Mental Health and Addiction Workforce Development Centres (The Werry Centre, Te Pou, Matua Rākī, and Te Rau Matatini) have been charged with the development of the overall COPMIA workforce development project to align with and support national direction, strategy and policy development in this area. The overall aims of the COPMIA project are to increase the capability of health professionals to identify and attend to the needs of children of parents with mental illness and/or addiction in all aspects of service delivery. The project also has a clear de-stigmatisation message for the mental health and addiction sector, that is; while there are risk factors associated
with growing up with a parent who has mental illness or addiction related issues, many parents with these concerns can be, and are good parents. The goal is to balance the rights and needs of children and parents, while giving the safety of children priority.

This scope is one of a suite of deliverables aimed at supporting the mental health and addiction workforces to be better able to work with COMPIA and service users who are parents.

The aims and objectives of the scope
The key aims of this scope are to;

- Undertake a literature review and analysis of the potential harms and risks to children of parents with addiction related concerns (including gambling)
- Undertake a literature review and analysis of the protective factors for children of parents with addiction related concerns
- Undertake a literature review and analysis of what other countries are doing to support children of parents with addiction related problems, which will also meet the needs of adult mental health services.
- Identify workforce development initiatives that can be implemented for specialist adult addiction services to support their service users as parents.
- Undertake a literature review and analysis that will help to articulate the relationship between COPMIA and whanau ora in New Zealand.

Key Objective
To provide clear recommendations for COPMIA workforce development initiatives aimed at adult addiction services in New Zealand that will also meet the needs of adult mental health services.

Impact of parental addiction on child outcomes

Problematic parental substance use
The impacts of parental substance use on children can begin well before the child is born. All psychoactive substances, including medications taken by pregnant women, may have adverse effects on the pregnancy, the unborn child, the newborn and on the on-going development of the child (European Monitoring Centre for Drugs and Drug Addiction, 2012). While the effects of substance use while the mother is pregnant do vary and depend on a number of factors (including substance and amount taken, nutritional status and overall health of the woman), substance use during pregnancy is associated with infant mortality, premature birth, miscarriage, low birth weight and a variety of cognitive and behavioural problems as the child grows older (National Institute on Drug Abuse, 2011; Maternal Substance Abuse and Child Development Project, n.d. cited in Child Welfare Information Gateway, 2009: 3). Fetal Alcohol Spectrum Disorders (FASD) that can result as a consequence of mothers drinking alcohol while pregnant, are among the most well-known of the outcomes of parental substance use. Fetal Alcohol Spectrum Disorder is an umbrella term used to describe a range of adverse effects including Fetal Alcohol Syndrome (FAS), Partial FAS (PFAS), Alcohol-Related Disorders (ARND) or Alcohol Related Birth Defects (ARBD) (Chudley, Conry, Cook, Loock, Rosales and LeBlanc, 2005 cited in Alcohol Healthwatch, 2007). While we do not know the
number of people with FASD in New Zealand it is conservatively estimated based on US data that approximately one in 100 live births are affected by FASD (Alcohol Healthwatch, 2007). We do know however that New Zealanders drink at higher rates during pregnancy than those in the US (Ho and Jacquemard, 2009) and therefore the true rate of FASD in New Zealand could be as high as 5% (Sellman and Connor, 2009).

Parental substance use is consistently reported in the literature has having adverse effects on child outcomes (Ministry of Social Development, 2011). Research has demonstrated that children of parents with problematic substance use are more likely to experience abuse, neglect (Hanson, Self-Brown, Fricker-Elhai, Kilpatrick, Saunders and Resnick, 2006; NSW Government, Department of Community Services, 2008; Templeton, Zohhadi, Galvani and Velleman, 2006) and are at risk of attachment difficulties due to inconsistent caring and nurturing by their parent or caregiver (Tay, 2005). While growing up, children of parents with problematic substance use may also experience a lack of routine and boundaries and are more likely to grow up in chaotic households with a lack of structure and role models (Hornberger, 2008 cited in Child Welfare Information Gateway, 2009). The long term adverse effects on children are thought to be as a result of early exposure to these very stressful situations, which are especially detrimental for children up until the age of 5 (Substance Abuse and Mental Health Services Administration (SAMSHA), 2012). These stressful and difficult experiences can affect the basic foundation of the developing brain, especially when experiences provide little sensory stimulation (neglect), or are over stimulating (trauma) (Hawley, 2000).

While parental problematic substance use is concerning ‘substance misuse is rarely the sole cause of family difficulties. It is usually part of a complex web of co-existing problems’ (The National Treatment Agency for Substance Misuse (NTA), 2012: 3). Families experiencing addiction related problems are also more likely to live in economic deprivation, be unemployed, have housing difficulties, and live in isolation and experience co-existing mental health problems (National Academy for Parenting Practitioners, n.d.; National Center on Addiction and Substance Abuse at Colombia University, 2005; Templeton, et al., 2006). Families often have an assortment of stressors that will also impact on parenting ability and family functioning (Battams and Roche, 2011).

Addiction related problems impact on a parent’s ability to parent for a number of reasons. The literature suggests that some of these reasons include;

- Physical and psychological impairments as a result of substance use
- Domestic violence –which does have a correlation with substance use
- Spending money on substances and gambling instead of household necessities
- Frequent arrests, imprisonments and court dates
- Time spent seeking substances, using, or gambling
- Estrangement from wider family networks and whānau
- Intergenerational family problems including abuse and neglect (Child Welfare Information Gateway, 2009: 2; Templeton et al., 2006).

While estimates of children that may be affected by problematic parental substance use in New Zealand are unknown, figures from the UK suggest that between 780,000 and 1.3 million children are affected by problematic parental alcohol use (Templeton, Velleman, Hardy, and Boon, 2009) and
between 250,000 and 350,000 children are affected by problematic parental drug use (Advisory Council on the Misuse of Drugs (ACMD), 2003). This equates to about one child for every person identified with a substance use problem in the UK. In Australia they estimate that 10% to 13% of children are affected by parental alcohol or other drug use (National Centre for Education and Training on Addiction, 2010), and international studies estimate that 10% of children are exposed to alcohol and other drug ‘misuse’ (Dawe, Atkinson, Frye, Evans, Best and Lynch, 2007). In New Zealand this would equate to over 89,000 children (under 15) according to the 2006 census figures (Statistics New Zealand, 2006)

**Parental Problem Gambling**

Studies show that problem gambling can cause a number of difficulties in family functioning including severe financial problems, emotional and psychological problems and abuse, relationship problems (partner and parent-child) and a negative impact on the psychological development of children (Problem Gambling Foundation of New Zealand (PGF), 2012; Darbyshire, Oster and Carrig, 2001; Abbott, Cramer and Sherrets, 1995). A single persons problem gambling can affect 5 to 10 other people (Ministry of Health, 2010). There is growing concern that children may be more adversely affected as more women are developing gambling problems, especially through the use of ‘pokie machines’ (Darbyshire et al., 2001). This is important to recognise as women are still generally the primary caregivers of children in New Zealand.

*One in six New Zealanders say a family member has gone without something they needed or a bill has gone unpaid due to gambling. This percentage was higher among Māori (38%) and Pacific (28%), and among those in more deprived (deciles 8-10) neighbourhoods* (National Research Bureau Ltd, 2007 cited in PGF, 2012)

Children of parents with gambling problems report feeling: unloved, losing trust in their parents, not having their essential needs met and finding it difficult to concentrate at school. They are more likely to have alcohol and drug use disorders, experience depression or anxiety, eating disorders, have trouble sleeping, asthma, allergies, and gastrointestinal disorders and are at greater risk of developing their own gambling problems later in life (Public Health Association of New Zealand, 2013; Shaw, Forbush, Schlinder, Roseman and Black, 2007; Lesieur and Rothschild, 1989).

Harm in the form of neglect can also come when children are left alone when parents go to gamble. It is not uncommon for children to be left alone in cars in casino carparks while parents are inside gambling. According to PGF (2012) this neglect was reported to the Department of Internal Affairs 59 times in 2011, affecting 101 children. This is likely to be a very small number compared to those actually left alone while parents gamble in a variety of settings, including pubs.

With 54,000 estimated problem or moderate risk gamblers in New Zealand (Ministry of Health, 2009) and an estimate of 0.6 children per person with a gambling problem, we can conservatively estimate that there may be over 32,400 children in New Zealand living with a problem gambler potentially at risk of a variety of negative effects.
**Resiliency and protective factors**

It would be wrong to assume that all of the risk factors associated with growing up as a child whose parent(s) has addiction related concerns will affect all children with these experiences. While they are at greater risk, they will not necessarily develop or experience any of the recognised potential problems or harms. This is because many parents with addiction related problems are good parents and because children and families and whānau are resilient and strong. A literature review (Templeton et al., 2006) which focussed in part on resilience found that a number of studies demonstrated that many children with a parent or parents experiencing addiction related harm will grow up to be resilient, although many will remain at risk. This group of children appears to be very heterogenous and there was no clear pathways to predict negative outcomes. Some studies suggested that children were even able to turn adverse family experiences into positive outcomes, especially where they used their experiences in their chosen careers. For example many children of parents with addiction related problems become therapists, social workers or doctors (Templeton et al., 2006).

A number of protective factors have also been found to protect children from some of the worst outcomes in families where parents experience addiction related problems. The following conditions have been shown to help determine whether parents can parent effectively in stressful situations;

- Concrete resources in times of need, for example do parents have access to food, housing, transportation and employment.
- A support system for the family, for example a network of community supports to reduce isolation.
- Emotional and psychological resilience (of the parent).
- Parenting tips, information and skills courses for the parent
- The child’s socio-emotional and cognitive abilities (SAMSHA, 2012: 34).

The other good news is that very clearly for children of substance using parents, addiction treatment for the parent is a protective factor. Equally having children at home with the parent can be a factor in preventing more serious substance using problems occurring in the first place (NTA, 2012). This evidence about protective factors should underpin the evidence based interventions that are offered to COPMIA and their families and whanau.

**International COPMIA initiatives (addiction focused)**

**Australia**

Australia is our closest neighbour and is also highly evolved in their COMPI national initiative which is run by the Australian Infant, Child, Adolescent & Family Mental Health Association (AICAFMHA). The main focus of this initiative is children of parents with mental illness, and it does not substantially include children of parents with addiction related concerns or co-existing problems. Never the less the initiative and the resources it has created for children, parents, adolescents, families and professionals are comprehensive and of tremendous significance to on-going COPMIA work in New Zealand as we can learn a great deal and borrow from the expertise of the Australian COPMI initiative.
Our information is designed to foster better mental health outcomes for children of parents with a mental illness, reduce stigma associated with parental mental illness and help friends, family and workers in a range of settings identify and respond to the needs of the children and their families where parental mental illness exists. (COPMI, 2013).

The COPMI initiative in Australia has been active since the early 2000s and much of the earlier work is based around The Principles and Actions for Services and People Working with Children or Parents with a Mental Illness (AICAFMHA, 2004). These principles guiding the COPMI work include;

- Children’s rights
- Parents’ and families’ rights, responsibilities, roles and diversity
- Rights and responsibilities of people with mental illness
- Promotion, prevention and early intervention
- Collaboration and empowerment
- Quality and effectiveness.

The COPMI initiative initially focused on individual workers and/or teams and also systems responses to the COMPI need. Since this time however the COPMI initiative has grown to include a website, resources, e-learning tools, workforce development (including dedicated workforce development officers), a national secondary schools mental health initiative, a research clearinghouse, publications, workshops, seminars, translations of resources and a number of other activities that support children, families and professionals from a variety of sectors. The resources and workforce development initiatives already developed in Australia could easily be adapted for the New Zealand cultural context with the addition of the addiction aspect of this work which is a focus for this scope.

In 2009 the Australian Government released Protecting Children is Everyone’s Business: National Framework for Protecting Australia’s children (Council of Australian Governments). This document identified parental problem drug and alcohol use as a key risk factor for child abuse and neglect. It also highlighted the need for improvements in alcohol and drug treatment services through a better focus on child and parent-sensitive practice (Trifonoff, Duraisingam, Roche and Pidd, 2010). As a result of this document’s release, alongside the national COPMI initiative (which does not specifically include addiction), Australia’s National Centre for Education and Training on Addiction (NCETA) undertook a survey of addiction practitioners views on child and parent-sensitive practice issues (Trifonoff et al., 2010) and published For Kids Sake: A workforce development resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs sector (2010). This resource was required in Australia for a number of reasons, not least of which was that

..for many years the approach adopted by many alcohol and drug services that treat adult clients has been “Don’t ask about the children”. This has been an implicit directive of policy and management—there is simply not enough time to do anything if one does (Professor Sharon Dawe in NCETA: 2010 vi).

The resource is designed to provide workforce development and capacity building in the Australian adult AOD sector so they can more effectively work with children and families, by way of Family Sensitive Policy and Practice. Enhancing child wellbeing and preventing child abuse, neglect and
foster care placements as an early intervention via adult AOD services is thought to be beneficial for the longer term health outcomes for children (Scott, 2009). This resource provides an extensive overview of and guidelines on Family Sensitive Policy and Practice, an AOD service checklist and recommendations for collaboration and multi-agency working. This resource will be of particular help in establishing the addiction part of COPMIA workforce development initiatives here in New Zealand.

**The UK experience**

*Hidden Harm: Responding to the Needs of Children of Problem Drug Users* (Advisory Council on the Misuse of Drugs (ACMD), 2003), was at the time of its publication a ground breaking document on the subject of parental problem drug use, and alerted health and social service agencies in the UK to the scope of the problem. This document estimated that there were between 250,000 and 350,000 children affected by parental drug use in the UK. While the UK already had child protection legislation and policy that covered this area (The Children’s Act 2004 and *Every Child Matters* (Department for Education and Schools, 2004), or the equivalents in the three devolved governments of England, Scotland and Wales) *Hidden Harm* went on to influence much of the key guidance documents and policy development regarding parental problem drug use in both children and adults services throughout the UK and Ireland. The UK have taken an across systems approach to the potential problems associated with parental drug use, and policy and guidance which identifies the importance of this area is reflected across government and adult and children’s services (education, social services, justice and health). For example the National Treatment Agency (NTA) (now part of the Department of Health) along with the Department for Education have developed guidelines for developing joint local protocols between drug and alcohol partnerships and children and family services (NTA, 2010). This guidance covers:

- Information sharing
- Referrals to Children and Family services
- Referral to drug and alcohol treatment services
- Effective joint working arrangements
- Child protection conferences and core group meetings
- Lower threshold referrals
- Differences of opinion
- Training and supervision

This guidance supports local areas to set up joint protocols together that work for their particular area. This guidance will be of particular use to consider in the New Zealand context to encourage local regions to work more collaboratively across systems (including data systems) to support COPMIA.

While *Hidden Harm* did not identify children who may be affected by parental drinking it is estimated that 780,000 and 1.3 million children are affected by parental problem alcohol use in the UK (Templeton et al., 2009). Alcohol Concern in partnership with The Parenting Fund have developed *The Parenting and Alcohol Project* which provides resources and advice to professionals on multi-agency working, confidentiality and information sharing and protective parenting and children’s resilience. They have also developed a parenting training manual specifically for alcohol
professionals (Alcohol Concern and The Parenting Fund, 2005). These resources will also be useful if they can be adapted to the New Zealand context.

**The USA**

In the USA they estimate that 8.3 million children under the age of 18 live with at least one parent who is dependent on or who abused alcohol or ‘illicit’ drugs in the last year (SAMSHA, 2009). The USA have a proliferation of services, websites and resources for Children of Substance Abusers (COSA) (JBS International and Center for Children and Family Futures, 2008), but do not seem to have had a focus on the role adult mental health and addiction services can play in early intervention with the children of the parents they see.

SAMHSA’s resource *Supporting infants, toddlers and families impacted by caregiver mental health problems, substance abuse and trauma: A community action guide* (2012) will however be a useful reference for use when developing the workforce development resources required by adult mental health and addiction services in New Zealand. This guide focusses on;

- The importance of birth to 5 years old
- Threats to resilience
- Protective factors that promote resilience
- Screening tools
- Assessing the problem
- Strategies for coalition building

It seems that in the USA there is a strategic focus on child welfare services and the community playing a vital role in keeping children safe (SAMHSA, 2012; U.S. Department of Health and Human Services, 2009) with no mention in the literature regarding the role of adult addiction services. Some of the COSA resources may be valuable in the New Zealand context; however many of these resources will best support the development of specific services for COPMIA rather than foster the development of adult services capable of responding to the needs of children and families.

**New Zealand**

While it appears New Zealand still has a long way to go to improve services for COPMIA, there are a number of services for COPMIA as well as workforce development initiatives currently underway in New Zealand. Up until recently these have been standalone initiatives developed in an ad hoc way with little or no strategic or policy support from government or funders and planners. According to a Ministry of Health stocktake all DHB’s recognise COPMIA as an important issue that should be embedded in standard practice for all mental health and addiction practitioners, however there are no consistent ways of identifying COMPIA in child or adult mental health and addiction services (2012b: 23). This stocktake discovered that most COPMIA services are usually provided by NGO’s, for example The Bay of Plenty Mental Health Trust (COPMIA service with a mental health focus—although not excluding addiction) and the Familial Trust’s (Christchurch), children’s groups and programmes for children affected by someone else addiction. Some of these services do receive DHB funding but others are self-funded. They appear to have been developed where need has been seen and are often based on an individual worker’s background, training, passion and commitment to COPMIA, rather than any strategic direction. While it is not within the scope of this paper to
identify COPMIA projects currently being offered in New Zealand, this information can be found in another document related to this project (The Werry Centre, in progress). This outlines the services being offered by Stepping Stone/Caroline Reid Family Support Service, Northland DHB, Real Easi, Supporting Families Southland and Tu Tangata Tonu. These COPMIA services will be vital to support any work that adult mental health and addiction services do with COPMIA, and in providing direction and advice to support the development of new COPMIA initiatives.

There are a number of other family focussed services and networks that are provided around the country. For example Strengthening Families in Mental Illness are a service found in many regions in New Zealand and they work to support families affected by a family or whānau members mental health problems. While they do not have a specific focus on addiction many have an awareness of the impact of addiction related problems, for example Supporting Families in Auckland fund and administer Network Mosaic, a network of services and organisations in the northern region to promote best practice when working with children and young people whose families’ maybe experiencing mental illness and/or addiction related problems.

Kina Families and Addiction Trust (Kina Trust), now part of the New Zealand Society on Alcohol and Drug Dependence (NSAD), have (since 2002) provided resources and training to the mental health and addiction sectors with a focus on family inclusive practice. Kina Trust developed some specific resources and training for Matua Raķi in 2010 and Creating Spaces: Working with families experiencing complex and challenging issues, a two day workshop accompanied by a workbook, was rolled out to addiction services across the country in 2010. This training had a specific focus on the impacts of caregiver addiction on children and on fostering family resilience. It was further supported by Family Inclusive Practice Supervision training and resources (Kina Families and Addiction Trust, 2010) developed to support family inclusive practice in organisations. An evaluation of the Creating Spaces work and the Supervisors workshops and guide noted the workshops and resources were very valuable but that sustaining a long term Family Inclusive Practice focus was very difficult when services did not support this work at an organisational level on an on-going basis. The evaluation concluded that there would need to be systemic and organisational changes in the way addiction services worked in order for family inclusive practice to be supported in a sustainable way.

Matua Raķi in partnership with Kina Trust developed the Think Parent Think Family resources in 2011. These resources included a poster for waiting rooms that stated ‘We welcome family, whānau and children here: We invite you to talk about what it’s like to be a parent, any worries you may have about your children and what can help’: a door hanger stating ‘Family/whānau session in progress’ and a brief resource outlining a number of practical ideas for considering children in alcohol and other drug services. This resource also provided services with a family Inclusive practice checklist where practitioners and services could identify what they could to do to make their service more family inclusive. These resources have been very popular with nearly 3000 of the written resource being distributed. However without systemic change and government directives to make this core business it has been up to individual practitioners and organisations to make changes that better support people as parents, as well as their children.

Ruby’s Dad is a children’s book by Frances Rabone (2012) about a little girl (Ruby), her family and their fathers drinking problem. The Ruby’s Dad project was a joint endeavour between the Health Promotion Agency (HPA) and Skylight, with the express objective of providing a resource to support
services and parents to discuss parental problematic substance use with children. *Ruby’s Dad* also includes guidelines and prompts for clinicians and parents using this resource with children, and it has so far been distributed to over 240 services throughout New Zealand. *Ruby’s Dad* will soon be evaluated but appears to be another invaluable tool in supporting adults services (and others) when working with families who have addiction related problems.

The Problem Gambling Foundation have also recently started a targeted response to understanding the impact that parental gambling has on children (PGF, 2012). In August 2013 they held a Children Affected by Problem Gambling symposium in Wellington and, in line with government priorities; this will continue to be a focus for their service.

**Specialist Addiction Services**

Waitemata District Health Board Community Alcohol and Drug Services (CADS) Pregnancy and Parental service provides assessment, information and support for pregnant women and children under 3 years of age. The aim is to improve the life outcomes for unborn babies and children under the age of 3 by working with pregnant women and parents with issues around alcohol and drugs.

This service is a multi-disciplinary team which offers a range of interventions, long term case management and service coordination to socially marginalised substance using parents with the goal of improving health outcomes and reducing risks to parents and their children. This client group typically may be poorly engaged with services for a number of reasons including poverty, poor access to transport, fear of stigma and judgement and subsequent involvement of child welfare agencies. Periods of engagement may vary from consultation and brief intervention to long term intensive case management. Services are provided by a multi-disciplinary team across a number of settings including home visiting, outpatient antenatal clinics, Community Alcohol and Drug Services (CADS) in the community and hospital settings (Cederman, 2013). For a diagrammatic overview of this service please see Appendix A.

Odyssey House also in Auckland provide a Therapeutic Community Family Centre (residential service) for adults with alcohol, drug or gambling problems and their children, under 12. Families live in at the centre and approved childcare and schooling is provided in the weekdays for the children, while their parents attend the addiction treatment programme within Odyssey House.

**Hearing from children**

There have been a number of studies that have sought to hear the voice of the children who experience distress as a result of their parents’ problems (domestic violence, parental substance misuse or health problems). Although children’s experiences are very different, the Bancroft, Wilson, Cunningham-Burley, Backett-Milburn and Masters (2004) discovered some common themes that arose when children talk about their experiences. This review found that:

- Children are often more aware of problems than parents realise, but they don’t always understand what is happening and why.
- Children whose parents have experienced domestic violence, substance misuse and to a lesser extent, mental health problems report witnessing or experiencing violence themselves.
• Children worry about their parents more than may be recognised, particularly if they fear for their parents safety
• Some children, particularly boys, will not talk to anyone about their problems
• Children mainly use informal support, and are most likely to talk to parents (more often mothers) or friends, siblings, extended family or pets
• Children do not know where to go to get formal help and rarely seek help of professionals initially.
• Experience of contact with professionals is mixed. Children’s concerns include professionals not believing them, not talking directly to them and not acting to help them when asked.
• Children say they want someone to talk to, who they trust, who will listen to them and provide re-assurance and confidentiality.
• Children’s most persistent plea is for more age appropriate information to help them understand what is going on in their family (Joseph Rowntree Foundation (JRF), 2004: 1)

This review also discovered that children are pre-occupied with their family being safe. Children can feel deeply scared as well as intensely close to parents and have a loyalty that is strong and enduring despite the difficulties they are facing. Children also feel sadness and isolation as well as the stigma that is often associated with the problems their parents experience (JRF, 2004). This review has some very important messages for interventions for children and for workforce development in adult services.

_Grownups think they should hide it and shouldn’t tell us, but we want to know. We want to be involved and we want our mums to talk to us about what they are going to do—we could help make decisions_ (Mullender, Hague, Umme, Kelly, Malos and Regan, 2002 cited in JRF, 2004: 3).

_People tend to protect children and young people. For me, this translated into ignoring my need to be informed and involved. My life was affected anyway and if I had guidance it might have made the experience more positive. I needed good, age-specific information about my mother’s condition and its consequences. And I needed someone to talk to who would listen in confidence and help me express and explore my complex feelings and situations I was dealing with_ (Marlowe, 1996 cited in JRF, 2004: 4).

The London School of Hygiene and Tropical Medicine (LSHTM, 2011) also interviewed children (50) whose parents experienced problematic substance use and provided some insight into how children think. Some key findings included;

• Children feel frustrated by not knowing what, for certain, is going on. When they do find out they don’t want to tell anyone else about it.
• Parents tend to deny or remain silent about their alcohol and drug use, even when their children try to confront them.
• Children think that parents should talk to children about alcohol and drug use and not hide it from them.
• Parental substance use has a big effect on the lives of children.
- Children believed that being in a family involves parents and children loving one another no matter what. This love is expected to be unquestioned and unconditional.

*Young people wanted to continue to love their parents and over time many of them found ways to do so. This involved understanding more about the nature of being addicted to a substance and that it wasn’t necessarily about choosing drugs or alcohol over them (LSHTM, 2011: 14)*

- Children often become carers for their parents as well as their siblings
- Children feel worried about talking to adults about their parents substance use, because they feel they are being disloyal and fear what might happen to them.
- Young people valued being able to get to know and trust someone (adults) over time (LSHTM, 2001)

These views were also echoed in a study by Templeton, Novak and Wall (2011) in which children who had been a part of specific services for children whose parents have problematic substance use were interviewed. This study concluded that children benefit from talking to others who have been through similar circumstances and do require specific support.

*It helped me realise all the stuff that had happened and why it happened. I learnt what it was about, what addiction can do and to keep myself happy and prepared for other times* (p175).

The research and the comments of the children involved support the current content of resources available in New Zealand, which clearly acknowledge the need to talk to children about what is going on, and not trying to hide things to protect them (Matua Rāki. 2011). This understanding will underpin the workforce development initiatives recommended for both adult mental health and addiction services.

**Hearing from Practitioners**

Very little is known about how addiction services in New Zealand currently work or perceive work with COPMIA, or even if they identify whether the people they see have a parenting or caring role. Anecdotally while addiction practitioners may be aware that the people they work with have children, it is thought that there is often no question asked about parenting or caring in addiction service assessments, and that this data is not collated anywhere. It is also thought that services often actively discourage people bringing their children with them for appointments or groups related to their addiction treatment. It is thought however that kaupapa Māori adult addiction services work differently and are more likely to take a whānau ora approach to working with the whole family including children. It is clear that in New Zealand we need a better way of collecting data and information about the children of the people seen in mental health and addiction services so they cease to be invisible.

More is known internationally about how the addiction sector current works and perceives working with children and families. In an Australian study (Trifonoff, Duraisingham, Roche and Pidd, 2010)
which surveyed 271 alcohol and drug practitioners, it acknowledged that 92% of the respondents generally knew whether their clients were parents. Thirty percent of respondents estimated that 50 to 75% of their clients had caring responsibilities (for children), and another 30% estimated that 25% to 50% of their clients had caring responsibilities. Twenty-five percent of respondents suggested child-parent sensitive practice was central to their role, while 57% suggested it was significant but not central to their role. Nearly 20% believed this practice was either marginal to or not part of their role.

It appeared that the use of child-parent sensitive practice was ad hoc across the respondent’s services, with 53% saying that their organisation allowed an assessment of parenting or child wellbeing/ welfare issues as part of their assessment, however 40% indicated there was no such service provision in their organisation.

More than 70% or respondents stated that they collaborated with children’s services as required when working with clients who were parents or caregivers...but 28% of respondents noted that they did not often see and speak to the clients’ children themselves (Trifonoff et al., 2010: 20)

In this Australian survey organisational issues were seen as substantial barriers to the implementation of child-parent sensitive practice. These organisational barriers included;

- lack of access to resources and strategies to assist clients with their parenting/caregiver needs
- limited mutual exchange of information between child/family welfare agencies and AOD agencies
- competing priorities (treatment needs of adults versus needs of the child)
- lack of education/training on child wellbeing/welfare issues relevant to substance using parents
- lack of linkages between AOD and child/family welfare agencies (Trifonoff et al., 2010: 32).

Identifying and understanding the relevance and applicability of these types of barriers to New Zealand will be important when developing the workforce development strategy and for the implementation of workforce development initiatives that are identified.

A UK study (Families, Drugs and Alcohol (ADFAM), 2013) which held focus groups, an online survey and in depth interviews sought the views of alcohol and drug practitioners about their role in meeting the needs of the children of the people they worked with. This study found that;

- workers appreciated protocols and guidance accompanied by managerial support and multi-agency training in their work with people and their children
- partnership working is essential and is dependent on a number of considerations (for example mutual awareness and understanding, good training provision and management support).
- information sharing is an on-going process and one weak link can break the whole chain
- parental substance misuse must be owned as an agenda from as high a local level as possible.
- there must be clear leadership of cases
- a full working knowledge of local service provision is essential
• a mutual understanding of thresholds and criteria for inter-agency referral
• physical meetings between frontline workers facilitate effective partnership
• there is great demand for training from practitioners
• hearing the voice of the child will improve services
• support structures in the wider family must be engaged (ADFAM, 2013: 4-7).

Given that addiction services in the UK have been working with the recommendations of *Hidden Harm* (Advisory Council on the Misuse of Drugs (ACMD), 2003) for some time it will be informative to learn from these practitioners’ experiences.

**Changing the way we work**

While there is still further direction to come from the Ministry of Health in terms on New Zealand’s COPMIA work, it is clear that it has never been more clearly articulated by government that we are all responsible for looking after the health and wellbeing of New Zealand children. While *Rising to the Challenge: The Mental Health and Addiction Service Development Plan* (Ministry of Health, 2012) clearly articulates the need for early intervention in the lives of children and families experiencing distress, the Vulnerable Children’s Bill (which will result in The Vulnerable Children’s Act and the Child Harm Prevention Orders Act, the Children’s Action Plan and also make amendments to the Children, Young Person’s and Their Families Act 1989) clearly conveys the likely roles and responsibilities that all services have in safeguarding the health and wellbeing of children and their families.

While historically ICAMHS/AOD services have seen the welfare of children and families as core business, adult mental health and addiction services have primarily focussed on individualised treatment for tangata whaiora and have often felt restrained and hampered by contracts, funding and privacy legislation, from working with families and children in a more holistic way. The mental health and addiction sectors now have the mandate and indeed the responsibility to better serve families and COPMIA in their care. Now is the time to change the way we work by putting the safety and health and wellbeing of the children of the families we see at the heart of the work we do.

This will require a shift in the way most adult mental health and addiction services have worked for a long time. This shift will take time and will require a number of different workforce development initiatives at a number of different levels (systems/policy level, organisational and professional/individual) if COPMIA is to be a key consideration in organisational models of care and for the change to be permanent and sustained over time.

**Recommendations for workforce development initiatives**

There is likely to be a range of workforce development initiatives required to implement and embed changes to the way we work to better serve COPMIA and their families. These initiatives will be set out under the COPMIA Workforce Development Strategy yet to be developed by the four workforce centres and key stakeholders (Advisory and Reference Groups). It is clear from this scope however that these initiatives will be required at a number of different levels. Some of the interventions will require the Ministry of Health to lead direction and policy development, but many of the
developments will be the responsibility of the four mental health and addiction workforce development centres.

This section utilises the Ministry of Health’s five strategic imperatives to mental health workforce development (Ministry of Health, 2002) to outline some of the workforce development initiatives that are recommended as a result of this scope. A summary of this section can be seen in Appendix B.

**Infrastructure Development**
The Ministry of Health will primarily lead the overall direction and strategy of this work with an equal focus on children whose parents experience mental illness and/or addiction problems. While it has been clear for some time that evidence exists that children of parents with mental illness require further acknowledgement by adult mental health services, it is also clear from this report that the same is also required for those children whose parents present at addiction services (including problem gambling services). Adult mental health and addiction services are in an excellent position to intervene early with the children of the people they see.

The direction given by the Ministry of Health will underpin the rest of the work led by the four workforce development centres. The four workforce centres will support the development of the COPMIA workforce strategy by convening and maintaining both a COPMIA advisory and reference group. These groups will also support the rest of the workforce development initiatives that will be required to sustain the COPMIA vision.

**Organisational development**
There needs to be a fundamental shift in the way services view the people they see. Rather than seeing them as individuals in social isolation, organisations must be family inclusive and whānau ora focussed to realise family and whānau potential.

Leaders and managers in the adult mental health and addiction sector are likely to require resources and/or workshops/seminars about the following in relation to COPMIA:

- Legislative and Policy implications (for example Vulnerable Children’s Bill and then the associated Acts, Children’s Action Plan, Children’s teams, Rising to the Challenge)
- How their organisation operates now and where it needs to be
- Models of Care
- Policy and Procedure development for safeguarding children-for example changes to assessments to include a question about parenting and caring responsibilities.
- Development of joint local protocols between adult and child services in their areas
- How to lead collaboration and working in partnership
- An organisational checklist for Family Inclusive Practice, including supervision for FIP
- Leading through organisational change

**Recruitment and retention**
The mental health and addiction workforce will require a higher level of knowledge and skills for working with children and families prior to their recruitment into the sector. Some of the
organisational and training and development initiatives mentioned here will also help with recruitment and retention however other areas of focus might also include;

- Advocating for a fundamental shift in the way services view the people they see. Skills and knowledge for working with families and children in mental health and addiction qualifications must be given priority.
- Supporting services to actively advertise for practitioners with skills in working with children and families in their recruitment processes.
- Ensuring access to on-going in-service and external training for working with children and families.

**Training and development**

Practitioners and supervisors are likely to require resources (a toolkit) and/or training/workshops or seminars on the following;

- Recognising tangata whaiora as parents
- Recognising child abuse and neglect
- Understanding their role and responsibilities in relation to legislation and policy
- Family Inclusive Practice
- Parenting
- Keeping children safe-safety plans
- Talking to children about the difficulties in their families
- Referral pathways to child services and knowledge of local joint protocols (including information sharing)
- Understanding the role of Children’s Teams
- Working in partnership and collaboration. Interagency, interprofessional and transdisciplinary working
- FASD and other in utero substance effects on foetal development and later behaviours
- Building Resilience

**Information, research and evaluation**

All COMPIA workforce development initiatives must be evaluated to ascertain how they influence COPMIA work in the long term. Evaluation will underpin the review of existing initiatives and identify gaps in workforce development provision.

We also recommend that data is collected, kept and utilised by the Ministry of Health and adult mental health and addiction services that identifies COPMIA in the first instance, but that can also identify referral pathways and collaborative working in the future to better inform future policy and direction.

**Conclusions**

There can be no doubt that while parents, children, families and whānau are strong and resilient in the face of adversity, many can and do experience distress as a result of a multitude of co-existing
problems including mental health and addiction problems. While the responsibility to realise family and whānau potential is everybody’s business, it is evident that there is clear direction and mandate from government to change the way adult mental health and addiction services work with parents, children, family and whānau throughout New Zealand. While we can learn from family inclusive practice and COPMIA initiatives internationally and throughout New Zealand, we must also learn from whānau ora initiatives based on Māori philosophy and principles.

In partnership with the Ministry of Health the four mental health and addiction workforce development centres have a key role to play in supporting a fundamental shift in the way mental health and addiction services work with people and their families. This shift away from individualised working in silos, towards the inclusion of wider family and whānau networks and collaboration across systems will require a variety of infrastructure, policy, educational and workforce development initiatives at a variety of levels.
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The Werry Centre (In progress) *COPMIA Service Delivery: A Focus on Initiatives.* Auckland: The Werry Centre.


Appendix A: Waitemata DHB CADS Pregnancy and Parental Service

- The harm associated with the client’s substance use is reduced
- Client is able to utilise relapse-prevention strategies and skills
- Client and family can identify the substance supports they need and can access these
- Client expresses insight on the impact that substance use has on their life
- Client takes responsibility for their physical well-being
- Client has timely access to medical and nursing assessment treatment and advice
- Client has the ability to meet the ongoing nutritional needs for themselves and their family
- Client is educated regarding the effects of substance use in pregnancy
- Harm to the unborn baby is lessened by abstinence/reduction in substance use
- Women access and engage with an appropriate lead maternity carer
- Client has a network of people whom they can call upon for support
- Client is connected to services to meet needs identified by them and have PPS advocacy with these services
- On discharge from PPS, clients are able to independently access community resources

KEY:
- In the centre – PPS’ principles of practice
- Encoding the principles – Key approaches
- Ovals – Key areas addressed
- Outer text – Expected outcomes

- Client’s child(ren) receive ongoing health and development assessments and appropriate interventions
- Client is able to recognising child developmental and emotional needs and the support to meet these needs safely
- Clients are able to recognise when children require medical assessment and access treatment
- Client receives education regarding parenting skills and resources
- Client is able to parent in a safe and nurturing way
- Client involves family and significant others to support them in parenting safely
- Client engages with parenting interventions
- Client is educated about BBVs, STIs and family planning in order to make an informed choice about treatment options
- Client accesses appropriate interventions
- Client is supported in taking an active role in decisions about parenting, custody and access issues
- Client is educated and is able to access legal services to support them in resolving custody, access to children and other legal issues
- PPS provides advocacy and education to other services in regard to the impact of substance use on parenting to ensure safe and realistic plans and outcomes occur
- Client’s children live in a safe and protective environment

- Client finds and is able to keep safe, suitable housing
- Client knows about, and are able to access, community supports and services for assistance with housing and finance needs
- Family / whanau are actively included in PPS interventions and are able to access further treatment and support
- Family / whanau is proactive in client’s recovery

- Client receives services that are comprehensive, compatible and co-operative so they attain the best possible outcome for themselves and their family
- PPS provides education to other services to reduce the stigma associated with substance use
- Other services provide a nonjudgmental service to the clients of PPS

1. Pregnancy
2. Developing sustainable networks
3. Child health
4. Physical Health
5. Substance use
6. Consumer participation
7. Mental health
8. Co-ordination of services
9. Inclusive practice
10. Advocacy
11. Reducing barriers
12. Assertive outreach
13. Risk Management
14. Brief Intervention
15. Relapse prevention
16. Custody, care and protection and other legal issues
17. Family / whanau involvement and support
18. Housing and financial issues
19. Safe relationships
20. Parenting
21. Sexual health, family planning & blood-borne viruses
22. Assertive outreach
23. Nonjudgmental
24. Empowerment and recovery
25. Prevention strategies and skills
26. Relapse

- Client receives education on the impact of family violence
- Client has a safety plan for themselves and their child(ren)
- Client and significant others are connected to and engage with family violence prevention services
- Client develops and experiences safe relationships
- Client is able to utilise relapse
- On discharge from PPS
- Client develops and experiences safe relationships
Appendix B: Summary of recommendations for workforce development initiatives

<table>
<thead>
<tr>
<th>Area of workforce Development</th>
<th>Type of Workforce Development</th>
<th>Audience</th>
<th>Focus</th>
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• Seminars  
• Advocacy  
• Organisational support | • Leaders and managers | • Organisational checklists  
• Topics addressed in organisational development and training and development  
• Advocacy for Family and child sensitive practice in education  
• Support to recruit practitioners | • Four workforce development centres |
|---------------------------|---------------------------------------------------|--------------------------|---------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| Training and Development  | • Workshops  
• Seminars  
• Resources/Toolkit | • Practitioners  
• Supervisors  
• Leaders and managers | • Whanau Ora  
• Parenting  
• Child abuse and neglect  
• Legislation and policy  
• Family work  
• Risk and Safety  
• Talking to children  
• Referral pathways  
• Children’s Action Plan and Children’s Teams  
• Resilience  
• Partnership and collaboration | • Four workforce development centres |
| Information, Research and Evaluation | • Evaluation  
• Data collection | • Ministry of Health  
• Workforce Centres  
• Leaders and Managers | • Review of initiatives  
• Gaps analysis  
• Data Collection | • Four workforce development centres  
• Ministry of Health | • FASD etc |