perfectionist, experiencing confusion over abilities, work overload and excessive competition.

The book ends with a substantial chapter on learning to cope and some directions for the future. The use of optimism, humour and the construction of metaphors emerge as significant contributors to learning to cope with stress. Learning can occur in informal settings and formal programs. Reference is made to two recent major reports, one from each side of the Atlantic, which point collectively to the importance of a wide ranging community response in the light of the 'gradient rise in disorder' evident in the social and economic conditions of the last fifty years, to address needs and engender opportunities for healthy adolescent development. Opportunities to develop coping skills are part of that responsibility (p. 203). Much is known which can aid the process, notwithstanding a clear need for a great deal more research.

Reviewer
Lloyd Owen
Editor, *Children Australia*

Making social policy in Australia

An introduction

Tony Dalton, Mary Draper, Wendy Weeks and John Wiseman

1996, Allen and Unwin, St Leonards, NSW, 252 pages

The pace of change in Australia within the global context accentuates the need for both politicians and practitioners in child and family welfare to develop a better understanding of social policy. This book provides a means to rapidly gain an appreciation of the way ideas and the forces which gather around them translate through the policy process into structures and events which impact on everyday life in a major way. The authors draw on a rich pool of experiences and academic work to present a very readable book which is a must for students in disciplines concerned with human services. It will help others with an interest in the role of governments, the market and the community in human affairs.

In common with most courses on social policy the reader is introduced to a selection of the many attempts made to define social policy. Included is the seminal definition of David Gil 1970 which speaks of systems and courses of action which shape quality of life or well being and determine the nature of relationships within society through governing resources and services, the allocation of status, the distribution of rights, rewards and constraints and the relationships between these things. To this is added a variety of political and theoretical perspectives including some distinctively Australian ones. Considine's 1994 view points to the variety of policy actors who use available public institutions to articulate and express the things they value and to achieve their ends.

The first part of the book develops a framework for understanding and participating in social policy making. One special contribution made by this book is the way it registers two major areas of contest in policy. These are firstly, debates and contest over social goals and, secondly, debates and disputes over policy process. Contest over social goals and purposes follows an historical account of the rise and demise of the essentially Australian form of welfare, the 'wage earner's welfare state', under challenge from economic conditions and the socio-political challenges of feminism, post-colonialism and multiculturalism. Rights and freedoms, self interest and sustainable society are considered against the backgrounds of the libertarian, social liberal, egalitarian and communitarian traditions and schools of thought. Against the backdrop of the rise of economic rationalism through the eighties, the globalisation of the economy, nostalgia, post-modernism and technocracy, the reader is drawn toward the contemporary institutions and organisations in public, non-government and private sectors which contribute to the making of social policy.

Two chapters explore these organisations and some issues attached to working in them. A useful typology of public sector organisations is presented in table form (pp. 60-61) and useful information is presented about the detail of the other sectors. Structural issues are brought to the fore with discussion of bureaucracy, professionals, gender and ethnicity before the next chapter turns to the second major contest, disputes about policy process: governments, citizens and markets. In the short history of the past two and half decades we have seen the ascendancy of prevailing philosophies of government administration give way in turn from democratic participation to managerial administration, rationality and control, then contract administration and an emphasis on market solutions. The point is made however that this is not a simple sequential process and that these elements are not mutually exclusive. The greatest danger perhaps comes from simplistic conceptions. the notion of 'steering not rowing' (p. 103) may not go far enough. The ideas of Offe 1985 attempt to convey some of the tensions and dynamic complexity.

Continued on page 27

Service to parents who abuse substances

Literature to inform a practice-research initiative

Lynda Campbell

Children of parents who abuse substances have become a concern of child protection agencies, family support services, family preservation services and increasingly of drug and alcohol treatment agencies. In the context of a formative evaluation of a specialised intensive family support service designed to address the needs of families at this interface, a literature review has been undertaken. From that review, themes relating to women as substance abusers, the children of substance abusers, and services to enhance parenting in these situations are reported. Implications for intensive home-based practice are identified.

This review is undertaken as part of an ongoing funded evaluation of the Substance Abuse Family Support Program of St Joseph's Child and Family Services, Flemington, Victoria. Enquiries may be directed to Dr Lynda Campbell.

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Over the last decade in Australia, as elsewhere, there has been rising concern over the safety and development of children whose parents abuse substances. Protective workers note a high correlation between parental substance abuse and child abuse and neglect, including fatalities, and health workers must decide whether to refer to protective workers those babies born addicted (Clark 1993; Tomison 1996). Family support agencies report increases in client families struggling with the competing demands of substance use and child rearing, sometimes combined with psychiatric illness or intellectual disability, with all three of these conditions challenging service providers more and more. For brief intensive family services, substance abuse poses a significant dilemma, as extra time is needed for consolidation of change and relapse prevention and management. There is a point at which the target group and child protection, family support and drug and alcohol services intersect, with each set of workers having different barriers to thinking holistically and adopting a family focus (Scott & Campbell 1994), and tensions and confusion arising between them (Clark 1993).

A child and family service agency in inner Melbourne, St. Joseph's, has decided to pilot a modified intensive home-based family service of longer duration than the dominant Families First model, which is usually limited to 6-12 weeks. It is targeted to those families at the intersection of these three service systems. This substantial but by no means exhaustive review was undertaken in the early stages of the program as part of a formative evaluation. From searches of literature in the drug and alcohol, child protection, and family welfare fields, this paper seeks to link what is known about the needs of women who misuse substances, their shift to parenthood and issues in effective parenting, and the nature of risks to children posed by parental substance abuse. It concentrates on broad issues and program models, and stops short of the micro detail of therapeutic interventions. The literature has been found to be repetitive and often emotive, but themes and principles of service delivery emerge, with minimal differences according to the substances used. Since much of the writing derives from the USA, where there are large, poor, urban minorities besieged by massive drug problems, including widespread use of crack cocaine, the literature requires cautious translation into the Australian context.

WOMEN AND SUBSTANCE ABUSE

Although the St. Joseph's program has a commitment to working with the men in the families, who are often overlooked in child welfare (Milner 1993), the predominance of female headed client families and the mother-centred nature of the discourse on parental substance abuse make it appropriate to first consider women as substance users. The peak life stage for substance abuse is the years 18-35, the child-bearing years (Lex 1995), and whether alone or with a partner who

often also uses, it is women who chiefly struggle with both child-rearing and substance use demands (Dore, Doris & Wright 1995; Azzi-Lessing & Olsen 1996). Like men, women use a wide range of substances – alone and in combination, both licit and illicit, including tobacco, alcohol, cannabis, opiates, methadone, amphetamines – and more than men they appear to use a wide range of medically prescribed or otherwise obtained anti-depressants, tranquillisers, sleeping pills, and non-narcotic analgesics (Alcohol and Drug Foundation 1992; Robbins 1995). In scanning the literature about women and substance use, we need to bear in mind the caution from Hands, Banwell and Hamilton (1995), whose wide Australian research review suggested a lack of sound descriptive data from the general population in which to ground the research and practice findings that are generated from clinical populations. Yet a number of themes recur, and they articulate with the practice wisdom of the field.

Factors associated with women's substance abuse

In her concise overview of women and substance abuse, Goldberg (1995) used the DSM IV classification to differentiate substance *abuse* – using a substance when expected to perform at work or at home despite awareness of the consequences – from substance *dependence* – abuse augmented by any three of loss of control over use, inability to cut back, substance use taking up time and replacing other important activities, physiological tolerance or withdrawal. Even the lower level classification of abuse signals problems for those with dependent children. For the mother, there is the additional cultural burden that substance abuse is defined as 'worse', more unacceptable, in women (Goldberg 1995; Robbins 1995; Burman & Allen-Meares 1991.) Unravelling complex life histories and determining chains of cause and effect is so fraught with difficulty that there is a general acceptance that substance abuse aetiology in women, as in men, is multi-factorial, but for women there appears to be a higher association with such antecedents as childhood sexual abuse (Goldberg 1995; Robbins 1995; Hands et al 1995; Mumme 1991b; Skorina & Kovach 1986; Kleinman 1984). Women also appear affected by biological/genetic predisposing factors, in that there is, for example, a lower tolerance of alcohol and a 'telescoping' or more rapid move from commencing substance use to experiencing serious physical effects, such as alcoholic liver disease and alcohol-related brain damage (Robbins 1995; Alcohol and Drug Foundation 1992; Goldberg 1995).

For brief intensive family services, substance abuse poses a significant dilemma, as extra time is needed for consolidation of change and relapse prevention and management.

Substance abuse in women is also associated with depression, though the chain of cause and effect is unclear (Robbins 1995). Women often appear to be influenced in their substance use by their partners' usage patterns, by a family history of drinking problems, and by triggering life crisis, including traumatic bereavements and sexual abuse. The connection with substance abusing partners is significant in that this may impede treatment seeking or compliance (Robbins 1995; Waldby 1988), involve the woman in a criminal lifestyle, and doubly expose children to the effects of substance use in parents. Gomberg and Lisansky (1984) suggest viewing the antecedents of women's alcohol abuse from a life course perspective, and reviewing biological and genetic factors, personality and coping mechanisms, sociocultural factors and roles, and family and peer influences on drinking, at each stage of the woman's development: childhood, adolescence and early adulthood.

Substance abuse and domestic violence

In clinical samples, the influence of partners' substance abuse on the woman's substance use is also connected with women's experience of domestic violence. The substance abuse-domestic violence connection may be approached from a variety of stances, and there appears to be a shift from the potentially victim-blaming 1980s discourse of co-dependency, to an increased emphasis on the accountability of the abuser whose behaviour is regarded as controllable and changeable, the effects of the substances notwithstanding (Baker 1987; Alcohol & Drug Foundation 1992; Bennett 1995). Nevertheless, the alcohol/drug-family violence connection is recognised as having serious service system ramifications, leading to recommendations that, when clients present to either the substance abuse or family violence service sector, they should be explicitly assessed in relation to the other (Rogan 1985/6; Baker 1987; Bennett 1995; Lex 1995). Baker (1987), for example, advocates the use of educational interventions intertwined with assessment, through asking 'presumptive questions' about not whether people have been abused, but how; encouraging women to use a wide range of support services, to increase the visibility of their endangered situation; and establishing personal accountability for one's own abusive behaviour as a community and societal norm, appropriately dealt with by legal sanctions.

Bennett (1995), in a solid review of substance abuse and male violence to women, suggests that for the man, a substance abuse program should precede, or at least accompany, a batterers' program, since substance abuse is a strong predictor of recidivism in family violence, as is the man's (and sometimes the woman's) belief that situational violence to women is justified. He cautions that such strategies as anger management groups can be mistaken by clients as substance abuse treatments, and vice versa, since they confound the issues of substance abuse and violence:

> They may believe that when drinking and drugging stop, the violence will stop. The exact construction of this belief will prove useful in interventions for both problems' (p.766-767).

Yet Bennett warns that substance abuse treatment may, paradoxically, expose the partner to greater risk when, for example, heavy drinking is reduced and no longer inhibits violence. Worker vigilance is stressed. He also suggests that batterers' programs cannot be expected to be successful with a man whose violence is

more generalised in the community, and this may be an issue when the use of illicit drugs is connected with other criminal activity that entails violence. Further, Lex (1995) suggests that:

> ...male substance abusers whose attitudes and actions are independent and detached from family concerns seem to exhibit a pernicious individualism that is associated with a poor outcome in treatment' (p.487).

Thus it is important that assessment involving couples attends to patterns of drinking, of violent behaviour, of family and community participation, and to the myths and meanings attached to both substance use and violence.

Women's services and treatment issues

Despite a changing substance abuse service environment, it appears that women have difficulty finding programs that can adapt to their parenting responsibilities and that can comprehensively address both historical legacies and the complex of current life problems that beset them – housing, financial, child care, health and especially gynaecological health, contraception, and so on (Goldberg 1995; Robbins 1995; Waldby 1988; Mumme 1991b). Both Goldberg's review of primarily US research (1995) and the Alcohol and Drug Foundation's review of Australian studies (1992) identify the fear of loss of children through child protection and criminalising responses as a significant deterrent to seeking treatment. Women who abuse substances also often bring a sense helplessness and powerlessness derived from earlier life experiences, low self esteem, social isolation, and difficulties in trusting others. Services, preferably woman-specific and women staffed, need to address these as intrinsic sources of pain, as factors shaping coping strategies, and as barriers to treatment effectiveness (Mumme 1991a, 1991b; Kleinman 1984; Skorina & Kovach 1986; Burman & Allen-Meares 1991; Braiker 1984). In the early 1980s, Braiker (1984) suggested that a mix of rational/cognitive, behavioural, and psychodynamic intervention methods were appropriate; in 1991, Burman and Allen-Meares narrowed the choice of relevant practice theory to social learning theory, role theory and empowerment. Mumme (1991a) also reflects these approaches, but draws heavily on a Jungian orientation, evoking the image of addiction as a 'descent into chaos' which, like all descents, offers the challenge of a renewing ascent, but is compounded by the difficulty of the women finding 'there is no positive model of wholeness towards which the recovering woman can direct herself'. Mumme further elaborates such a model (1991b) when she suggests criteria for assessing outcomes for treatment of women substance abusers: abstinence or controlled use, a positive and autonomous self concept, autonomous sexuality, a sense of purpose and achievement, financial autonomy, peer support from both women and mixed groups, and resolution of child/family/gynaecological issues. These, she suggests, are the issues to be addressed for women in the context of what is generally suggested to be a good 'aftercare' mix: a continuing care program, ongoing counselling and group work, self-help group participation, crisis intervention as relapse management, family therapy, alongside a substitute positive dependence, external reminders that substance abuse is aversive, increased sources of unambivalently offered social support, and a source of inspiration, hope, and enhanced self-esteem.

Despite a changing substance abuse service environment, it appears that women have difficulty finding programs that can adapt to their parenting responsibilities...

PARENTING AND SUBSTANCE ABUSE

Motherhood further complicates these already complex areas of conceptualising and responding to women's substance abuse. Both the children's and the parents' perspectives are needed. There is a large body of literature from the 1980s written from the 'survivor' perspective of adult children of substance abusers (especially alcoholics) and a smaller but a growing body of social work, drug and alcohol practitioner and related literature addressing the needs of substance abusers in their parenting roles. The survivor literature addresses the residual effects on children of exposure to their parents' substance use and of the premature responsibilities they were forced to assume in childhood. It also picks up the residual problems for adult children of alcoholics as they become parents themselves, and feel deprived of viable models for this task. The professional support literature is concerned with interacting demands of parenting and substance use and how parents can be helped to manage these. In addition, there is a third body of literature, often written from a medical or nursing perspective in the wake of the crack problem in the US, that attends to the link between child abuse and neglect and substance abuse.

Children of substance abusers

The self-help/survivor literature incorporates the concept of co-dependency as a 'rallying point' for having family of origin issues addressed (Hazelton 1989). Among the residual effects of exposure to parental substance abuse the literature notes the lack of 'barometers' or implicit ground rules for parenting, such as the difference between control and guidance, or the need to play with the child (O'Gorman & Olivier-Diaz 1987). The adult child of a substance abuser also experiences concern that his or her own future will be marred by substance abuse. Sheridan (1995), analysing data from an incarcerated population of substance users, traces complex relationships between parental substance abuse and child abuse and neglect which, if not moderated by general family competence, contribute to the adult offspring's vulnerability to further abuse and neglect in adulthood (often in the form of partner violence) and potentially to substance abuse, allowing for the transmission of these dynamics to the next generation. Orford and Velleman (1990) caution that these gloomy predictions arise chiefly from the accounts of adult children of alcoholics in such 'clinical' samples, and that they were not borne out in their own community sample. Similarly, Barber and Crisp (1994) refer to this literature as a 'string of unrelated and atheoretical findings' (p. 411) which nevertheless indicate that parental substance abuse creates for

children an experience of 'social and emotional turmoil' (p. 412).

As the numbers of these children in the child welfare system have increased, there are new sources of clinical data on the nature of this turmoil, and Deren (1986), Bays (1990) and Zuckerman (1993) all give good accounts of the growing knowledge about infants exposed to substances *in utero*. Yet the gap in the literature about the effects on the older child (beyond the neonatal and preschool years), noted by Deren in 1986, appears to persist. While Dore et al (1995) suggest that the mental health sequelae of children exposed to parental substance abuse include increased incidence of hyperactivity and conduct disorder, drug and alcohol use in adolescence, impaired intellectual and academic functioning, clinical anxiety and depression, and lowered self-esteem and lowered perceptions of control over the environment, this reviewer has found no evidence comparing the effects of exposure to parental substance abuse at different ages.

Substance abusers as parents

'Social and emotional turmoil' can also describe the experience of the parent. They are reported to feel guilt, anguish, inadequacy as parents, and concern for the futures of their children (Deren 1986; Davis 1990; Kelley 1992). High performance anxiety, attraction to the drug and sometimes to the life that accompanies it, but also pride and pleasure in the child, a desire for normalcy are part of the ambivalence noted by a number of writers, particularly Waldby (1988) in her in-depth study of Australian mothers on a methadone program. These conflicts may be exacerbated by poor social support and equivocal relationships with members of the extended family (Waldby 1988; Deren 1986). While much of the guilt is understandable given the reports of neonatal distress and developmental delay to those children exposed *in utero* to substances, especially alcohol (Deren 1986; La Due 1995; Finnegan et al 1995), Zuckerman (1993) contends that one must balance the picture with emerging findings about the apparent capacity of children to compensate neurologically and developmentally for prenatal harms when given a nurturant post-natal environment.

Hospital observations of pre- and neonatal development and mother-child interaction suggest there is a reality base to mothers' feelings of failure and anxiety. Heroin users in particular have been observed to experience poor prenatal care and obstetric complications with difficult births (Deren 1986; Waldby 1988), and to struggle with babies who are themselves very difficult to care for and to comfort, since infants' neonatal abstinence syndrome brings irritability, susceptibility to infections and respiratory distress (Deren 1986; Bays 1990; Zuckerman 1993; Kelley 1992; Darivakis 1993; Waldby 1988.) The mother may experience these difficulties as rejection by her child, or simply feel inadequate to the task and guilty about causing the child's state, leading to disruptions in the bonding and attachment processes, and a lack of pleasure in the real child (Davis 1990; Dore et al 1995).

'Social and emotional turmoil' can also describe the experience of the parent. They are reported to feel guilt, anguish, inadequacy as parents, and concern for the futures of their children.

For practitioners who view substance abuse as disease, the parent's struggles appear more overwhelming: a 'complex and insidious life struggle' which will confront workers with 'a challenge characterised by deception, manipulation and relapse' (Health & Community Services 1994). The parent's primary preoccupation is seen as being the drug itself and substance abuse a significant indicator of the risk of neglect and possible abuse (Deren 1986; Zuckerman 1993).

> Addiction is a chronic, progressive disease with characteristic signs and symptoms. Central to the understanding of addiction is the idea of loss of control over the use of a substance and compulsive preoccupation despite the consequences. All aspects of the self are affected – the physical, the psychological, and the spiritual. With addicted women, their primary relationship is with their drug of choice and not with their child(ren). (Zuckerman, p.40).

For parents who use illicit and expensive drugs, their parental commitments are often played out in hostile environments: time is spent in dealing, prostitution or criminal activity to finance the habit (Bays 1990; Waldby 1988); couple relationships may be marred by violence, criminality and power plays (Bays 1990; Waldby 1988).

How much these factors can be asserted as true for a population in stable treatment is unclear. Both Waldy (1988), from research on methadone maintained mothers, and Klein (1986), from a substance abuse treatment facility, balance the picture by drawing attention to mothers' enormous emotional and practical care commitment to their babies as they seek to strike an accommodation between their use of substances and their child-rearing responsibilities. Carten (1996) suggests that for a small group of mothers graduating from the New York City Family Rehabilitation Program success was associated with '...low severity and chronicity of drug use, identification with the parenting role, availability of environmental supports, and positive future orientation' (Carten 1996, p.222.)

Parental substance abuse and child abuse and neglect: risk assessment

The link between parental substance abuse and child abuse and neglect has been asserted often. Kumpfer and Bays (1995) note the inadequacy of the research base to date, but summarise the following as risk indicators for children:

- modelling physical and sexual abuse and violence in the home
- family violence and conflict
- poor parenting skills
- poverty and stress
- mental disorders including antisocial personality disorder
- physical illness and handicaps
- criminal involvements

While these conditions may well be associated with child abuse and neglect, they also fuel both moral censure of the mothers (fathers are rarely mentioned except as undesirable partners to the women) and pessimism about their

capacity for personal change. From a disease and deviance perspective, Davis (1990), for example, makes sweeping connections between the literature around the antecedents of female substance abuse, the presumed psychological sequelae of these, and the documented low socioeconomic status of many users, to conclude that chemically dependent women 'are basically ineffective in meeting their children's physical, psychological and social needs' (p.229). The picture Davis paints of the impulsive, immature, self-centred woman certainly resonates with much of the child welfare practitioner narrative in this area, but such accounts provide little room for assertive interventions other than child removal and permanent care. Roberts (1993), however, suggests that for risk assessment to be meaningful one must look not only at the risk factors but also at their countervailing strengths (see Table 1).

Table 1 (Adapted from Roberts, 1993)

	RISKS	STRENGTHS
CHILD	• severe withdrawal • prematurity (<36 weeks) • physical handicap	• no apparent medical or physical problems • no known abuse or neglect
PARENTS	• using twice weekly • partner/father using • using mother never in drug treatment • lack of prenatal care and preparation for infant • severe mental or physical handicap • uninterested, evasive, uncooperative • prior/current abuse and neglect of siblings • lack non-drug supporters • unclean, unhealthy home	• in drug treatment • supportive, cooperative, non-using partner • non-criminal • siblings cared for • prenatal care • household members non-drug involved • helpful, committed family and friends • concern about drug effects on child

Underlying any such tentative assessment frameworks is the paucity of sound prospective studies, especially in Australia, establishing the causative patterns between substance abuse and child abuse and neglect (Tomison 1996).

INTERVENTIONS IN SUPPORT OF PARENTING

Given these uncertainties, any intervention models involving wholesale child removal would be fraught with moral, ethical, legal and practical difficulty. Bays (1990) reported that in the US it was estimated that 10 million children were being raised by addicted parents and that each year 675,000 children were being seriously mistreated by an alcoholic or substance abusing caretaker, a figure heightened by sudden and massive increases in births to users of crack cocaine. Such a context helps us understand the US anxieties about rising numbers of children in placement and the interest in prevention. What interventions might improve parenting *in situ* and reduce risks of child abuse and neglect in substance abusing populations? Two models, one from a hospital base and one in-home service from a child welfare base, but both with a strong community presence, are interesting examples of the themes of prevention and early intervention.

Lief (1985) reported positively on the first decade of an assertive outreach program for Pregnant Addicts Addicted Mothers (the PAAM program, chiefly for minority group women). When pregnancy was identified at this Harlem hospital, women were immediately recruited into medical, counselling, social and psychiatric follow-up services, and into three years of parenting classes. With the immediate goal being a living child, the program replaced illicit drugs with cautious use of methadone, and focussed on housing and other practical needs. Framed as a health rather than a child protection program, it worked in a comprehensive way with all members of the household and their needs, and worked educatively with the mothers on the developmental needs of the children. Similarly, Zuckerman (1993) has described the Women and Infants Clinic at the Boston City Hospital, which comprises one-stop, whole family focussed service, with primary health care, relapse prevention and a mother-child group.

Blau and colleagues (1994) have given a useful description of the Emergency Services Child Abuse Prevention Program (ESCAPP) in New London, Connecticut. Sharing with the PAAM program an interest in an holistic, family-centred approach, this program is slanted more heavily to cross-agency linkages in response to what the authors perceive to be 'the continued failure of professionals within specialty fields to extend themselves beyond the limits of their specialty' (p.84). Rejecting the notion of the 'quick fix', the program aimed to identify families, to stabilise their current situation, and to improve the likelihood of positive long-term functioning by linking to ongoing services and supports. It gave four weeks of intensive in-home, voluntary service from a master's level clinician, a family support worker and a nurse, followed by case management and interagency coordination for up to one year. The *identification* function involved assertive outreach to health providers, child care, schools, police, protective services, emergency shelters, peer support programs, and other social service providers. The *stabilisation* function involved intensive risk/need/resources home-based assessment and intervention, focusing on the family unit – including the father and the mother's partner/s – and its relationship to the community. *Improving long term outcomes* involved building links with other service providers across the service spectrum. Families had 24 hour access to workers, and the program subcontracted with an outpatient substance abuse facility to guarantee access within 48 hours, and with a child care facility to provide respite care and longer term child care. The authors noted that, from the first year of service, they had learned that while workers could

successfully engage with the families, their referrals to other programs were less successful; that the cooperation of other agencies was crucial; the importance of including the nurse, without whom many families would go without primary health care and undiagnosed conditions would remain untreated; and that child care was a crucial asset in enabling parents to comply with substance abuse and mental health treatments and to participate in job training and education. They extended the initial four week limit to allow for subsequent crisis intervention and service access problems, and for ongoing treatment needs.

PRINCIPLES FOR SERVICES TO PARENTS AND CHILDREN

These programs fit well with Kelley's (1992) call for 'greater access, on demand, to comprehensive drug treatment programs' and other early intervention services (p.327). They regard pregnancy and childbirth as a crisis or potential turning point for the substance abusing parent, and an opportunity to offer support for both child and parent (Barth 1991; Lief 1986; Waldby 1988; Klein 1986; Bays 1990; Zuckerman 1993; Azzi-lessing & Olsen 1996; Dore, Doris & Wright 1995; Carten 1996). While a disease model of substance abuse is heavily represented in the American literature reviewed, Dore et al (1995) modify this with an appreciation of the role of interventions other than medical, and suggest child welfare practitioners undertake assertive assessment and case planning strategies in relation to substance abuse, to 'help parents recognise that chemical dependency is always inconsistent with adequate parenting' (p.538), and to 'provide the structure and direction that they cannot' (p.539), using their consistent presence and legal sanctions to get access to closed family systems and to get parents into treatment. Understandably, the Victorian guidelines for protective workers (Health & Community Services 1994) similarly emphasise this social control function, placing the safety of the child as the first task, with attention to the parents' issues, including substance abuse, coming second.

While there is face validity in the primacy of the interests of the more vulnerable child, Barth (1991) cautions against assuming that this means only that drug treatment must be the precondition for successful parenting, and suggests that 'it may equally be true that knowledge about parenting and developing more effective ways of reducing stress may lead to becoming drug-free' (p.210) Such a position is consistent with that of the Australian practitioner Klein (1986) who suggests that when substance abusing parents face censure of their parenting efforts, this is a time for values clarification with the parents, and for focussing on their role as decision makers in the management of family affairs. Similarly rejecting the assumption that all substance abusing parents are out of control, Barth discusses the demonisation of crack using parents in the American media, and urges that their diversity be recognised and that social learning principles be adopted to modify the disease models of substance abuse which pose a major barrier to cooperation between family preservation and substance abuse treatment services.

...the Victorian guidelines for protective workers ... emphasise this social control function, placing the safety of the child as the first task, with attention to the parents' issues, including substance abuse, coming second.

In a later comprehensive and informative attempt to bridge the gap between health and welfare sectors, Barth (1993) frames the issue as primarily one of public health, and only secondarily one of child protection services. Combining aspects of the mainstream disease model and social-ecological and learning models of substance abuse, and rejecting a criminal justice approach, Barth et al (1993) propose a set of nine guiding principles for the development and reform of social and health services to families living with drugs and HIV:

1. Perinatal alcohol and substance abuse are a health problem.
2. Drug use is more than an individual failing.
3. Family-focused recovery services must be available.
4. Services must be provided voluntarily and without loss of integrity.
5. Intensive services to parents can promote family preservation.
6. Allied services must be provided.
7. Children have the right to receive treatment.
8. Prevention programs should have a community focus.
9. A multi-disciplinary coordinated continuum of care is needed.

These principles speak to a system of services with a sound foothold in the community, concerted efforts by diverse professional groupings, the dissolution of rigid field of practice boundaries, and a retreat from notions of protective intervention by the state as the primary response to parental substance abuse. They are, however, generated from an examination of programs and research related primarily to infants, and while they offer some hope that well-served families will expose their children to less risk as they develop, the specific needs of school-aged children receive less attention. For these children, the child welfare field increasingly draws attention to the need for well-functioning and supportive extended families and competency affirming membership in community activities. For the child whose parents' social networks are saturated with fellow substance abusers, functional role models may be few, and there may be many conflicts to be resolved between family needs and loyalties and the demands of the child's other social settings, such as the schoolroom and schoolyard. Garbarino (1982) would describe this as a situation of sociocultural risk at the level of the mesosystem – the interaction between face to face settings.

PRACTICE IMPLICATIONS FOR INTENSIVE FAMILY SERVICES AT THE INTERFACE

While special access to knowledge about the effects and culture of drug and alcohol use may be needed, intensive service to families with parents who abuse substances calls for the skills and roles

generic to social work and other helping professions – empathic listener, teacher/ therapist, consultant, resource, enabler, mobiliser, mediator, advocate (St. Claire 1993) – and for balanced attention to the internal and external aspects of family functioning. In the latter realm, service coordination efforts may be joined by lifestyle changes, restructuring social networks from drug-saturated to relatively drug-free (Nunes-Dinis 1993), and empowering people within those networks to support the family – not a straightforward task, as both Orford (1994) and Toumbourou (1994) have made clear.

For the child whose parents' social networks are saturated with fellow substance abusers, functional role models may be few, and there may be many conflicts to be resolved between family needs and loyalties and the demands of the child's other social settings...

While the 'hard scientific' research at the interface of substance abuse and child well-being has often been described as sparse, this literature review has yielded multiple strands of relevant writings derived from both practice and research in the different fields of practice. There are several messages for the intensive family services practitioner:

Assertive outreach: assume that the worker and the service must reach out to the target population, who will have many reasons for being wary of professional intervention;

Gender awareness: attend to the mother's experiences of abuse, violence, self-abnegation, and ill-health; to the themes and goals at the heart of her socialisation; and to the real and present interplay between the sexes in this home and social environment;

Cautious optimism: attend to early parenting as an opportunity for growth and change, while acknowledging the extreme vulnerability of the infant who is subject to the vagaries of the chemically dependent parent's lifestyle and personal functioning;

Service coordination: be conscious of the many different systems of service that may be relevant to the situation, and consciously remove obstacles and build bridges between services, and from the services to the family;

Future planning: balance attention to current risks with attention to future normative life transitions and to developmental opportunities that will enhance the future life chances of parents and children alike; and

Modesty: recognise that your own efforts are one part of a complex set of social interactions in which the family is embedded, so that you cannot readily know what is working against your efforts, nor what effect you might be having on players who are invisible to you.

It is clear from the literature that such work is envisaged as complex, challenging and specialised. From an ecosystemic reading, this literature suggests that each program begins not with answers but with a number of hypotheses to be tested. Such expectations include:

Microsystem

- expect to be working primarily with sole mothers who have histories of subjugation and abuse, high anxiety about parenting, and stressful relationships with their children, BUT who also have a desire to be an adequate, even good, parent to this child, and skills in learning and survival that can be brought to bear on the current tasks;

Mesosystem

- expect deficits and conflicts within extended family BUT do not assume their intractability nor whether these are cause or effect of the parent's substance use;
- expect there to be players in the social network whose demands are inimical to the task of child rearing BUT look for others who can counteract these forces;

Exosystem

- expect gaps, overlaps and incongruities between services, linked with the family's problems of finances, child care, housing and health, BUT acknowledge that complex and multiple needs trigger eligibility for varied forms of assistance and predispose workers to acknowledge the need for collaboration;

Macrosystem

- expect poverty, alienation, and social themes of shame, exposure, badness, unworthiness attached to the target group, BUT enlist the positive valuing of family life and child rearing function and the growing social acceptance of needs and rights of substance using population.

...intensive service to families with parents who abuse substances calls for the skills and roles generic to social work and other helping professions ... and for balanced attention to the internal and external aspects of family functioning.

LOOKING FORWARD

In its very small experimental Substance Abuse Family Support Service, comprising one multi-skilled worker and a supervisor, St. Joseph's Child and Family Services has gathered together a set of goals and service principles that appear to be consistent with the suggestions arising from this literature review. The in-home model has five defined areas of activity with the family:

- *dealing with the parent's substance abuse* directly and in concert with other agencies with a view to minimising the harm to both children and adults;
- enhancing the parent's *knowledge and implementation of parenting skills* to enhance the safety and development of the child;

- providing *concrete and practical help* to ensure adequate care;
- assisting the parent with *personal change and developmental goals*; and
- enhancing the functioning of *the informal social network and the formal service network* around the family.

The service begins intensively, offering multiple home visits per week and full on-call availability, and is anticipated to reduce in intensity over a period of 3-4 months per family, by which time it is intended that links with ongoing forms of support will be consolidated. Still in its very early days, the program is guided by a reference group with representatives from both the drug and alcohol and child welfare service systems, and is actively seeking referrals from a variety of sources, to begin to test out the appropriate niche for such a program in the local service ecology. The model is regarded as essentially a set of hypotheses about what will help these parents and children. It remains to be seen how these practice research hypotheses flesh out and shape up with real service users, and where they best fit in the spectrum of services. The author would welcome comment and advice from readers. □

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Note: Those articles this reviewer judged as most comprehensive and/or informative are bolded. Australian papers are noted.

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> ...there are competing and contradictory principles of administration governments have to observe. They need to be fair and just and be seen to be so, to observe rules and due process, such as legislation and public tendering processes and to be accountable and transparent through parliament and parliamentary committees such as public accounts committees. At the same time they have to get things done in an efficient and purposeful way, such as caring for people's health, providing for those with disabilities and attracting capital investment to the country or state. And simultaneously, they have to generate and develop consensus, support and cooperative relations with varied interest groups and service users (p.103).

Chapter seven summarises the policy process as power and contest. Policy is created by people associated with organisations, ideas and debates: '...policy is a negotiated process (p. 105)'. Examples are given of the way certain social movements have shaped the policy agenda of the state. The role of research and the more rational approaches to policy making are considered as well as roles and sites from which participation springs or can be engineered. Strategic phone calls, meals, media releases and leaks supplement meetings of regular and irregular kind. Peak bodies, advocates, lobby groups and activists influence the agenda and often contribute to the language used in defining problems. Use of up-to-date language may be important in getting an idea accepted as a policy option to enter the decision making process. Mixtures of reason and logic, politics and pragmatism play varied roles through both the decision making stage (the adoption of a particular policy) and its implementation. Just as ministries and cabinet play an important role in determining the social policy of the country, many others, including 'street level bureaucrats', play a part in formulation and implementation. Greater consciousness of the roles of players and processes has the potential to empower anyone to exercise influence. The policy process includes the notion of evaluation. If those on the receiving end of social policy can have a voice, better policy may follow.

Part II of the book consists of an interesting set of seven case studies. They bring the policy process alive – real people grappling with real issues and negotiating social policy outcomes. Winning and losing are facets of contest but hopefully losses resulting from bad policy will not be the norm in our community. The case studies are introduced with ten propositions about social policy and a framework to apply to the case studies which in itself provides a formula for policy analysis (pp. 125-128). These will raise awareness.

The case studies further illustrate their significance and the reader is treated to a journey through some very substantial social issues of our time. Eleanor Burke traces the struggle of aboriginal Australians to gain access to tertiary education. Wendy Weeks and Kate Gilmore discuss how violence against women became an issue on the national policy agenda. Hurriyet Babacan describes the mobilising efforts involved in establishing a collective Kurdish identity in Victoria. Low-start mortgages provide fuel for Tony Dalton's observations about housing policy. Jan Williams describes a comprehensive policy and planning process adopted in Queensland to introduce a collaborative government/non-government approach to community service development and delivery. Mary Draper and Alan Owen report on community reactions and outcomes to hospital privatisation at Port Macquarie. John Wiseman observes on the changes to Victorian education policy under the Kennett government.

Reviewer

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