

'there is no keener revelation of a society's soul than the way in which it treats its children'

Nelson Mandela



FOR KIDS' SAKE:

A workforce development resource for
Family Sensitive Policy and Practice in the
Alcohol and Other Drugs sector



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Australian Centre for Child Protection, University of South Australia

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on behalf of Families SA, Department for Families and Communities, SA

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Australian Centre for Child Protection, University of South Australia

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NCETA's Family Sensitive Practice materials

This resource is part of a suite of workforce development materials produced by NCETA on Family Sensitive Practice.

A Checklist for Family Sensitive Practice for the Alcohol and Other Drug Field

Assessor:

1. Do the treatment/health care assessment procedures you use identify whether the client has a parenting/caregiver role?
2. Do your assessment procedures consider:
 - a. Multiple risk and protective factors for children, parents, families and communities (e.g. intimate violence, mental health, housing issues, employment, substance use, social isolation, etc.)?
 - b. Child care responsibilities and parenting needs?
 - c. The needs for child care while clients attend treatment?
 - d. The parenting role of the client as a potential parent?
 - e. Continuation issues and emergency plans of care?
 - f. Clients' concerns about the children?
 - g. Violence and vehicle measures of family members (including children, often through the support of their parent's drug or alcohol treatment)?
 - h. If there are children who are clients or at risk within service (e.g. statutory child protection, child and family support services, etc.)?
3. Do you often see and speak to your client's children?
4. Do you collaborate with children's services where relevant?
5. Are other family members, including children, offered information and support about their parent's drug or alcohol treatment?
6. Are further resources offered for the identified needs of families?
7. Is a list of parent/carer support services available?
8. The cultural background of families and/or the major influence perception of family and parental roles in relation to parenting support?
9. Are clients involved in care planning? If yes, how? Are other family members, including those with child care responsibilities, involved in care planning?
10. Are client and care givers involved in the planning and design of services and policies, especially those relating to Family Sensitive Policy and Practice?
11. How included are communities in the identification of their own needs and the development of programs and services?
12. How included are families' concerns with organisations?
13. Do you offer support strategies tailored to your client's needs?
14. Are your support strategies culturally sensitive?
15. Are interventions substance and prevention focused?

Multi-agency and cross-sectoral strategy

1. What organisations and processes are in place for engagement with cross-sectoral networks and strategies?
 - a. Child care
 - b. Support accommodation or informal family support
 - c. Material and child health services
 - d. Domestic violence services
 - e. Children's disability services
 - f. Mental health services
 - g. Statutory child protection
2. Have you ever engaged one of the following services to assist a client with parental caregiver roles...?
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 - e. Children's disability services
 - f. Mental health services
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3. Do you have a multi-agency strategy for engagement with cross-sectoral networks and strategies?
4. When working with clients who have parenting/guardianship roles, do you have a strategy for engagement with cross-sectoral networks and strategies?
5. Are staff members supported to take up training and development opportunities on Family Sensitive Policy and Practice?
 - a. Have staff had training in culturally sensitive practice?
 - b. Support accommodation or informal family support
 - c. Material and child health services
 - d. Domestic violence services
 - e. Children's disability services
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6. Are there recognizable organisational structures and monitoring of case load load?
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The cover features a collage of diverse children's faces. The title "for kids' sake:" is prominently displayed. Below the title, it reads "A workforce development resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs sector". Logos for NCETA and Flinders University are at the bottom.

Alan Titmuff
Vivita Dounayk
Anni Roche
Ken Todd

The cover shows a group of children's feet walking on grass. The title "Taking first steps" is written in a large, stylized font. Below the title, it says "What Family Sensitive Practice means for Alcohol and Other Drug Workers: A Survey Report". Logos for NCETA and Australian Centre for Unisa Child Protection are at the bottom.

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Flinders

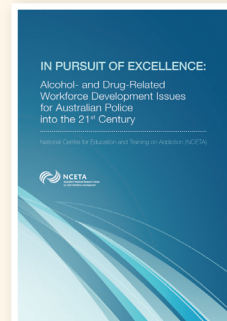
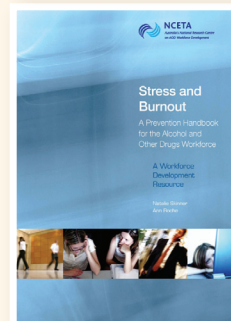
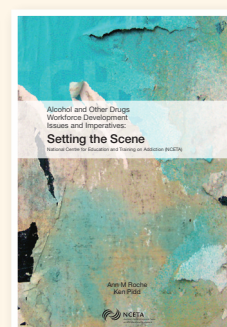
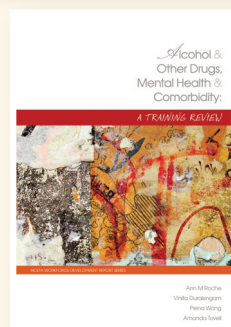
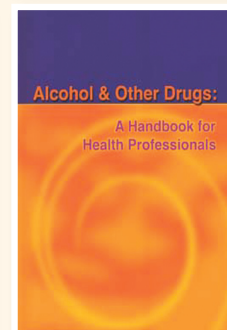
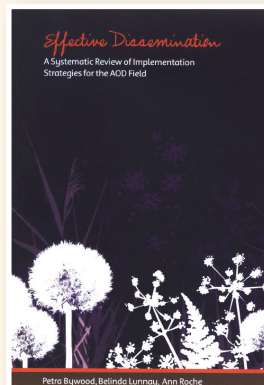
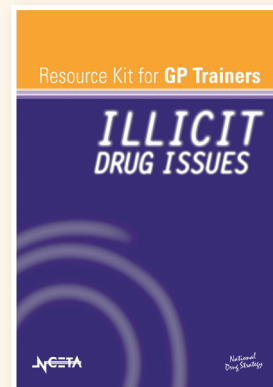
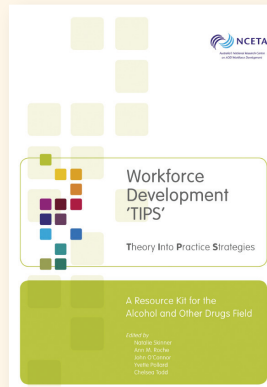
The cover features a collage of children's faces. The title "Family Sensitive Practice in the Alcohol and Other Drugs Field" is at the top. Below the title, it says "Samantha Battams Anni Roche". The text describes the resource as a "workforce development resource for Family Sensitive Policy and Practice". Logos for NCETA and Flinders University are at the bottom.

NCETA's Workforce Development Series

This report is part of a new series from the National Centre for Education and Training on Addiction (NCETA) on workforce development. Various aspects of workforce development are explored in the individual reports in this series.

Reports can be downloaded from the NCETA website www.nceta.flinders.edu.au or hard copies are available on request.

NCETA has produced a diverse array of workforce development-related materials (see the NCETA website for details and downloadable copies) that include the following examples:



Foreword

1

Over the last few years, there has been a growing appreciation in the wider community that someone's problematic use of alcohol or other drugs is likely to have a significant impact on other family members, especially children. During this time, the Family Alcohol and Drug Network (FADNET) has been working to raise awareness of the need for family sensitive practice, to share resources and evidence around effective interventions, and to provide staff with opportunities for professional development.

Most organisations and workers in the alcohol and other drug sector agree that family members welcome some level of support and advice. They know that outcomes for individuals are better when family members are included in treatment and that early intervention and prevention initiatives help to break family cycles of addiction. Many organisations are also realising that they have a great opportunity, and in many cases a duty of care, to ensure that their clients' parenting needs are being supported and that any safety and wellbeing issues for their clients' children are being addressed.

As momentum to respond more effectively to children and families builds among workers across Australia, this new resource from NCETA provides timely information and tools to assist in this task. On behalf of FADNET, I congratulate the authors and feel confident that with adequate and flexible funding models, opportunities for staff training and supervision, and with tools and information such as this, we will see family sensitive practice in the alcohol and other drug sector begin to thrive.

Dr. Stefan Gruenert

Chief Executive Officer,
Odyssey House Victoria
Family Alcohol and Drug Network
(FADNET)

2

For many years the approach adopted by many in drug and alcohol 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.

But times have changed and much of the impetus for this change has come from the front line – the clinical staff themselves expressing concern about the broader social context of their clients’ lives and dissatisfaction with existing options. “We want to do more” is something I have heard repeatedly over the years. What is more? What can be realistically done to alter the trajectory of inter-generational dysfunction that seems to be part of the lives of so many of the clients of drug and alcohol services?

Within this context the current publication provides a critical starting point by giving voice to the issue – let us call it Family Sensitive Policy and Practice. And having given name to this, let us expand and develop the idea to give it shape and form. Family Sensitive Policy and Practice becomes a process whereby the unit of intervention becomes the family – a mother, a father, a child, an aunty – however family needs to be defined - and thus shift the focus of the intervention from individual case management to working out how the family can function better. There is no single correct model of practice:

a key point made throughout this publication. But once having adopted a framework of Family Sensitive Policy and Practice, agencies will be led to a position in which their own current practice is examined and changes made.

It is a big task and one that will require both funding from government and commitment from those in clinical services. I am convinced that there is the latter, and with growing pressure from the field with time believe the former will be forthcoming. I welcome the publication of this set of guidelines and encourage all of us in the sector to maintain the pressure on policy and management to develop family sensitive practices and policies “FOR THE KIDS’ SAKE.”

Professor Sharon Dawe

School of Psychology
Griffith University
Brisbane, Queensland

3

In any effort to achieve integration of services to families where alcohol and drug use problems emerge, the recognition and response to parenting and children's needs is required. This statement is self evident. However, the extent to which this is achieved in alcohol and drug related response services is variable. This resource provides a starting point to any effort to examine and attend to the factors that either facilitate or impede its realisation.

Some services now actively promote and provide a focus on parenting roles and children as a part of their response to drug dependent clients. Others 'squeeze this in' wherever and whenever opportunity, time, access and resources allow. Some probably note the needs but feel and think that they do not have the capacity (either knowledge, skills or other resources including time) or 'permission' (from their clients or services) to get involved.

To ignore the parenting roles and clients responsibilities and involvement with children in our treatment services loses out for the clients now and for their children both now and in to their futures.

It is often difficulties people are having in family roles that directly or indirectly provoke treatment seeking. This does not always mean that this motivation is shared when a client approaches or is 'sent'; through pressure from close others or through legal processes including diversion. Similarly, there is variable experience regarding the extent to which clients 'allow' such a focus. This however does not, in my mind, preclude a family oriented response from us as workers.

We must examine policies, guidelines and tools we can use to check out practice; we must examine contracts and look closely at what is counted in considering outcomes if we are to appropriately and adequately address the needs of our clients and their children, including the preventative interventions for them as well as improved direct drug specific client outcomes. We must take seriously the need for integration and develop sophisticated methods of achieving this in conjunction with other service sectors who are also struggling with these issues. Whether we focus on it or not, we are part of the front line of family services.

Professor Margaret Hamilton

School of Population Health,
University of Melbourne
Executive member: Australian National
Council on Drugs (ANCD)
Member: Prime Minister's Council on
Homelessness

Executive Summary

A Workforce

Development Resource

This resource is designed to provide workforce development/capacity building knowledge and strategies for alcohol and other drug interventions that are sensitive to the needs of, and involve, families and children. The focus is on Family Sensitive Policy and Practice where there are parents and caregivers who misuse alcohol or drugs and who have children and adolescents under 18 years in their care.

A Book plus CD-Rom

The resource comprises three distinct components. One is this hard copy book and the others are the accompanying CD-Rom that contains an e-copy of this resource document together with a range of other electronic resources that are referred to at various places within the document, and a poster containing an assessment and intervention checklist.

The Focus

A significant social harm derived from alcohol and other drug misuse is its impact upon relationships, especially families and children. Family Sensitive Policy and Practice involves raising awareness of the impact of substance abuse upon families, addressing the needs of children and families and seeing them - rather than an individual client - as the unit of intervention. It does not rely on one particular practice model in service delivery, and can be built into existing practices.

Family Sensitive Policy and Practice does not refer to family therapy. It goes well beyond understanding and meeting the 'needs' of families and children/adolescents, as it also involves seeing families as resources and partners in the client-worker relationship. A comprehensive approach entails the adoption of Family Sensitive Policy and Practice within treatment services, along with family friendly organisational cultures and policies, and resources and structures to enhance Family Sensitive Policy and Practice. It also entails the adoption of a preventative approach to child abuse and neglect.

The focus is on *secondary prevention*, or prevention programs targeted to families and communities at risk of alcohol and other drugs misuse and early identification for alcohol and other drugs problems, as well as *tertiary prevention* programs involving Family Sensitive Policy and Practice in treatment and rehabilitation programs which may incorporate joint case management, partnerships and inter-sectoral policy.

The Target Audience

The primary audience for this resource is the alcohol and other drugs sector, including alcohol and other drugs practitioners, nurses, social workers, general practitioners, mental health professionals, psychologists, community health workers, health promotion staff and those in the legal/justice system.

It is also intended for professionals working in the Family and Child Welfare/Child Protection sector. These workforces are broadly defined and include those working across government, non-government organisations (NGOs) and private organisations, in practitioner, manager and policy roles.

The Context

Promoting child wellbeing and preventing child abuse, neglect and foster care placements is important to prevent child and adolescent behavioural problems (Scott, 2009b) and future social problems. Australia, as a signatory to the United Nations Convention on the Rights of the Child, has an obligation to protect children's rights and to support parents in their childrearing responsibilities.

International surveys estimate that around 10% of children are exposed to alcohol and other drug misuse (Dawe et al., 2007), whilst Australian estimates suggest that 10% to 13% of children are affected by parental alcohol or other drug misuse (Jeffreys, Hirte, Rogers, & Wilson, 2008; Nicholas, 2009).

However, parental substance misuse should not automatically be associated with harm to children (Forrester & Harwin, 2004), and should be considered alongside a range of interrelated factors when determining impact. Nonetheless, one Australian report suggested that up to 80% of child notifications involved concerns about parenting being affected by substance misuse (Ainsworth, 2004).

The risks to children from parental alcohol and drug misuse include:

- child neglect
- physical, sexual and emotional abuse (Scott, 2009a)
- witnessing violence (Burke, Schmied, & Montrose, 2006)
- transport accidents (Lenne, Dietze, Rumbold, Redman, & Triggs, 2003)
- and in extreme cases, deaths through transport, co-sleeping and drowning incidents (NSW Ombudsman, 2009).

Early childhood development is a key social determinant of health (CSDH, 2008), and nurturing in the early years is crucial for social, emotional and cognitive development (Mustard, 2007). Effective primary prevention strategies in early childhood can prevent future problems such as alcohol and drug misuse and child abuse (Olds et al., 1997; Olds et al., 1998). Evidence on targeted parenting/early infancy programs suggests that supporting parents in their parenting role works in the interests of both parents and children.

Traditional categories of child abuse, namely; neglect, physical abuse, sexual abuse and emotional abuse don't include coverage of the emerging issue of abusive use of drugs on children.

Alcohol and drug services and parenting programs have considerable untapped potential to play an important role in targeted prevention strategies to prevent child abuse and neglect and future social problems. However, in order to fulfil this role services need to:

- recognise the scope for preventive intervention
- be more responsive to the needs of parents and children (Scott, 2009b)
- and be more cross-sectoral in their approach.

The alcohol and other drugs and family and child welfare sectors are increasingly recognising the relationship between alcohol and drug misuse, childhood and adolescent development, and child wellbeing and protection issues. However, lack of access to resources and strategies, and limited mutual exchange of information, have hindered development of Family Sensitive Policy and Practice. The capacity of the child wellbeing and protection system to respond to cases has also been highlighted as an issue in Australia.

Worker responses to the misuse of different types of drugs is also important. Different types of drugs influence behaviour and impact upon families differently. As Templeton, Zohhadi, Galvani, and Velleman (2006, p.34) highlight:

There are quite strong findings that parents who misuse alcohol are more likely to demonstrate aggression and violent behaviour than are parents who misuse opiates, whose behaviour is more commonly associated with neglect.

There tends to be a focus on illicit drugs rather than alcohol when considering the impact of drug misuse upon families and children. Cases involving illicit drugs tend to be identified by child wellbeing and protection services sooner, even before harm has occurred, while there is a general under-response

to alcohol misuse that has clear implications for policy and practice.

Family Sensitive Policy and Practice can enhance the protective or resilience factors known to reduce alcohol and other drugs misuse and its impact by:

- utilising and building upon social capital resources
- enhancing support to parents
- building upon parents' coping strategies
- developing supportive relationships with children
- establishing links with other services such as schools and domestic violence services.

A UK review of research into what works in supporting parents who misuse drugs and alcohol (Asmussen & Weizel, 2009) offered 10 key recommendations for frontline workers and planners:

1. Address multiple risk and protective factors for children, parents, families and communities.
2. Assess family needs and identify resources necessary. Assessing families can be done through the Common Assessment Framework or similar tool.
3. Services for parents who misuse drugs and alcohol should be a part of local/state government plans for children and young people.
4. Intensive, long term interventions are required for parents who misuse drugs and alcohol.

5. Highly trained professionals are necessary for these interventions.
6. Multi-agency working is necessary for effective interventions that address multi-family problems. Services should consider their strategies for information sharing and referral.
7. Strategies aimed at improving the parent-child relationship and teaching parents about appropriate responses to their children's behaviour (enabling parents to reflect on their behaviour e.g. through video-taping) are necessary for effective interventions.
8. Interventions should be informed by models of therapeutic practice and theories of child development which have been tested and proven.
9. Consider carefully the involvement of extended family members in treatment plans and the alternative care of children, as they may also have substance problems or difficulties with parenting.
10. Monitoring and assessment processes must be in place for effective interventions e.g. monitoring progress in parenting skills.

The Aim and Structure

This resource aims to provide a practical guide to enhancing Family Sensitive Policy and Practice whilst taking a systems approach. It takes a public health perspective on interventions which aim to prevent and reduce the impact of alcohol

and other drugs misuse on families and children. It is presented in four parts:

Part 1. Family Sensitive Policy and Practice in context

Provides a definition of Family Sensitive Policy and Practice and a public health approach, along with a rationale for and background knowledge and evidence on Family Sensitive Policy and Practice. It includes information on key barriers and enablers for Family Sensitive Policy and Practice and highlights the link between alcohol and other drugs interventions, health promotion and child wellbeing and protection.

Part 2. Good Practice in Action

Provides practice examples of Family Sensitive Policy and Practice.

The last two sections of the document provide useful resources and tools for the alcohol and other drugs sector

Part 3. Guidelines for Family Sensitive Policy and Practice

This section aims to help organisations to become more sensitive to the needs of families. It gives suggestions for workforce and organisational development, systems and leadership strategies, government policy and evaluation and monitoring systems to support Family Sensitive Policy and Practice. Links to key resources are included. This section also includes a checklist (see over page and also the separate checklist poster) of questions to consider in order to facilitate alcohol and other drugs policy and practices to become more sensitive to the needs of families with children.

Part 4. Resources for Family Sensitive Policy and Practice

Provides a more extensive list of resources and links to a range of training, development and information resources to enhance Family Sensitive Policy and Practice. This section is supported by the accompanying CD-Rom which includes an electronic version of this resource, along with other electronic resources and links. Part 4 includes:

1. Key reports and journal articles on Family Sensitive Policy and Practice issues
2. Manuals and resources for front line workers
3. Child development and management theories
4. Resources to assist you when planning programs
5. Guidelines for agencies working together for child safety and wellbeing
6. Resources for schools
7. Resources for children, adolescents and families
8. Policy and legislation
9. Evaluations and evidence reviews
10. Peak bodies
11. Clearinghouses and national resource centres.

A Checklist for Family Sensitive Practice

Assessment

1. Do the treatment/intake/client assessment procedures you use identify whether the client has a parenting/caregiver role?
2. Do your assessment procedures consider:
 - a. Multiple risk and protective factors for children, parents, families and communities (e.g. domestic violence, mental health, housing issues, employment, relationships, income/employment, etc)?
 - b. Child care responsibilities and parenting needs?
 - c. The need for child care while clients attend treatment?
 - d. The parenting role of the client as a potential stressor?
 - e. Contraception issues and pregnancy status of female clients?
 - f. Clients concerns about their children?
 - g. Validated and reliable measures of family functioning, parental mental health and child behaviour?
 - h. If clients have children who are clients of a child welfare service (e.g. statutory child protection service, child and family support service, etc)?

- i. The cultural background of families and how this may influence perception of 'family' and potential access to additional parenting supports?

Intervention

When working with clients who have parental/care giver roles:

1. Are interventions tailored to family needs – including the specific needs of CALD or Indigenous families?
2. Are interventions focused on prevention and early intervention strategies?
3. Are families' strengths and resources considered? Are parents' coping strategies identified and supported?
4. Does strengthening parent-child relationships form part of the treatment goal?
5. Do you often see and speak to your clients' children?
6. Do you collaborate with children's services where needed?
7. Are other family members, including children, offered information and support about their parents' drug or alcohol misuse?
8. Are further resources offered for the identified needs of families?

9. Is level of parental/social support identified and developed?
10. Are interventions sustainable and prevention focused?

A partnership and empowerment approach

1. Are clients involved in care planning? Where appropriate, are other family members, including those with child care responsibilities, involved in care planning?
2. Are client and carer groups involved in the planning and design of services and policies, especially those involving Family Sensitive Policy and Practice?
3. How involved are communities in the identification of their own needs and the development of programs and services?
4. How involved are families/carers/peers within organisations?
5. Are peer support strategies utilised?
6. Are the strategies adopted culturally sensitive?

Multi-agency and cross-sectoral working

1. What organisational processes are in place for engagement with cross-sectoral networks and strategies?
2. Have you ever engaged any of the following services to assist a client with parental/caregiver roles:
 - a. Child care
 - b. Supported accommodation or in-home family support
 - c. Maternal and child health nurses
 - d. Domestic violence services
 - e. Children's disability services
 - f. Mental health services
 - g. Statutory child protection.

Workforce development

1. Are workers clear about the goals of the organisation in terms of Family Sensitive Policy and Practice?
2. To what extent do workers see Family Sensitive Policy and Practice as central to their role?
3. Do job descriptions include criteria on knowledge and competencies for Family Sensitive Policy and Practice?
4. When working with clients who have parental/care giver roles do

workers receive regular clinical supervision from someone experienced in Family Sensitive Policy and Practice?

5. Are staff members supported to take up training and development opportunities on Family Sensitive Policy and Practice?
6. Have staff had training in culturally sensitive practice?

Organisational and systems development

1. Are organisational policies and guidelines on Family Sensitive Policy and Practice in place?
2. Does the organisation provide a child friendly environment?
3. Is adequate time allowed to engage in Family Sensitive Policy and Practice?
4. Are there reasonable organisational expectations and monitoring of case load size?
5. Does the organisation provide guidelines for working with other agencies that can assist with the needs of clients who have parental/care giver roles (e.g. child/family welfare, domestic violence, relationships, Centrelink, mental health, disability, etc.)?
6. Are workers' linkages with external agencies resourced and supported?
7. Do workers understand the legal duty of care requirements

concerning child safety/welfare that may apply when working with clients who have parental/caregiver roles?

8. Does the organisation provide training on Family Sensitive Policy and Practice and/or support staff to engage in capacity building/workforce development activities on Family Sensitive Policy and Practice?
9. Are you aware of funding available to assist in meeting the needs of clients' children?

Building leadership and integrated government policy

1. What government strategies are in place to ensure close linkages between alcohol and other drugs and child wellbeing/welfare services?

Accountability and monitoring

1. When you assess the treatment outcomes for clients with parental/caregiver roles do you include 1) changes in parenting competence and 2) changes in the wellbeing and welfare of their children?
2. Is monitoring and evaluation of programs aimed at achieving Family Sensitive Policy and Practice built into the planning stages?
3. Is Family Sensitive Policy and Practice rigorously evaluated so that strategies may be confidently transferred?

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Part 1:

Family Sensitive Policy and Practice in Context

1.1 Introduction

There is growing impetus for a more comprehensive approach in understanding the causes, prevention and treatment of alcohol and other drugs problems across sectors.

A holistic, public health approach is required to prevent the misuse of alcohol and other drugs in society and mitigate the impact of such misuse, especially the impact upon children and adolescents. In particular, the alcohol and other drugs and family and child welfare sectors have increasingly recognised the relationship between alcohol and drug misuse, childhood and adolescent development, and child wellbeing and protection. However, relatively few programs consider the needs and development of children and adolescents, or provide for the care of children, whilst parent/s are in counselling or treatment programs.

In 2007, the Family Alcohol and Drug Network (FADNET) called on the Australian Government to 'recognise and respond to the connection between parental drug and alcohol misuse and child protection as a matter of national urgency' (FADNET, 2007, p. 36).

Whilst there have been additional resources dedicated to this area,¹ many argue that a consistent and coordinated approach is still lacking. There have also been calls for a national policy to be developed to provide a cohesive policy response to the developmental needs of young Australians from birth to adulthood (Australian Research Alliance for Children and Youth (ARACY), 2009). Such approaches are intended to enhance the wellbeing and life chances of children and young people.

This resource is designed to facilitate Family Sensitive Policy and Practice in alcohol and other drugs settings. It follows on from a survey on Family Sensitive Policy and Practice conducted by the National Centre for Education and Training on Addiction at Flinders University and the Australian Centre for Child Protection at the University of South

Australia² that examined awareness and use of Family Sensitive Policy and Practice strategies and barriers to their implementation.

Family Sensitive Policy and Practice is an approach that not only aims to identify and address the needs of families and children within services, but also to create partnerships with families and work with their strengths and resources.

A comprehensive approach entails the adoption of Family Sensitive Policy and Practice within treatment services, along with family friendly organisational cultures and policies, and resources and structures to enhance Family Sensitive Policy and Practice. It also entails the adoption of a preventative approach to child abuse and neglect.

The primary audience for this resource is the alcohol and other drugs sector, including alcohol and other drugs practitioners, nurses, social workers, general practitioners, mental health professionals, psychologists, community health workers, health promotion staff and those in the legal/justice system. It is also intended for professionals working in the Family and Child Welfare/ Child Protection sector.

¹ For example, the Federal government recently announced funding for programs to support drug dependent parents (Oct 27th 2009) <http://www.abc.net.au/news/stories/2009/10/27/2725207.htm>

² Findings from the survey are available at: <http://www.nceta.flinders.edu.au/>

These workforces are broadly defined and include those working across government, non-government organisations (NGOs) and private organisations, in practitioner, manager and policy roles. Family Sensitive Policy and Practice is an approach that may be more familiar to some professional groups and those working within the child and family welfare sector than those in the alcohol and other drugs sector. However, over the past 10 years both sectors have increasingly come to understand the importance of collaboration for the wellbeing of children and families.

The national policy framework context

A snapshot is provided below of the current national policy framework. Please see below for recommendations on policy and legislative frameworks to enhance Family Sensitive Policy and Practice.

Alcohol and other drugs sector

National Drug Strategy (NDS) (2004-2009)
(Ministerial Council on Drug Strategy, 2004)

The NDS provides the national policy framework for the alcohol and other drugs sector along with a complementary action plan for Indigenous Australians. It made little reference to the relationship between alcohol and drug misuse and its impact upon families or working with families to address the needs of children. Dawe et al. state that:

In terms of policy, a review of the Australian Government's National Drug Strategy indicates that there is no reference to the needs of children raised in substance-misusing families..... it raises concerns about the relative importance given to providing services to children affected by parental substance misuse across the political spectrum. (Dawe et al., 2007, p. xi)

The evaluation of the 2004-2009 NDS (Siggins Miller, 2009) made a number of recommendations, including:

- enhancing partnerships across and engagement in the sector
- a greater emphasis on prevention and the social determinants of alcohol and other drugs misuse
- consistency in investment in intervention services
- evidence based policy and programs
- strengthening capacity for policy debate, and
- improved monitoring and evaluation of the NDS.

There were few recommendations made in terms of outcomes for children, but one 'process' suggested was to:

Enhance referral and collaboration between funded NGOs, other alcohol and other drugs treatment services, and support services across sectors e.g. family support, child protection, employment, housing, education, corrections, youth and Indigenous specific services.

(Siggins Miller 2009, p. 37)

Balancing the rights and needs of children and parents

Urging alcohol and other drugs services to be more sensitive to clients' parenting roles and the needs of the children involved is not necessarily straightforward. At times the rights and needs of children, parents/clients and other family caregivers may be perceived to be in conflict. Adult focused alcohol and other drugs services often take on an advocacy role for the parent in child protection situations. This may create inter-agency conflict and result in a reluctance to work collaboratively.

Evidence on targeted parenting/early infancy programs suggests that supporting parents in their parenting role works in the interests of both parents and children (Barry, Canavan, Clarke, Dempsey, & O'Sullivan, 2009; Olds et al., 1997; Olds, Sadler, & Kitzman, 2007; Olds et al., 1998). Hence, seeking out strategies that provide support to parents is recommended as it is in the best interests of both the parent (i.e. the client) and their children.

A more recent alcohol and other drugs policy which takes into account families and children is Victoria's *A new blueprint for alcohol and other drug treatment services 2009-2013* (Victorian Government, 2008). It provides an example of a client-centred, service-focused policy which includes principles and strategies for working with children and families. One intended process outcome under the client-centred principle 'children and families' is 'training to improve workforce skills in working with families' (Victorian Government, p. 21).³

A program called *Strengthening Families* operated from 2005 – 2009 under the *National Illicit Drug Strategy* (Siggins Miller/National Expert Advisory Committee on Illicit Drugs, 2001). It provided family support through various national and state level funded projects (see Part 4). In 2009 this program was re-focused and is now called Family Support Program's Kids in Focus – Family Drug Support. The Kids in Focus program is an early intervention, family focused component of the National Drug Strategy specifically directed towards family support rather than the health, education or criminal aspects of the wider National Drug Strategy.

Child wellbeing and protection sector

The policy, *Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020* (Council of Australian Governments, 2009), acknowledges alcohol and drug misuse (along with other factors) as a risk factor for child abuse and neglect. One intended outcome of the policy is:

Risk factors for child abuse and neglect are addressed

Major parental risk factors that are associated with child abuse and neglect are addressed in individuals and reduced in communities. A particular focus is sustained on key risk factors of mental health, domestic violence and drug and alcohol abuse.

(Council of Australian Governments, 2009, p. 17)

The policy above adopted a public health approach in outlining strategies for the prevention and treatment of child abuse and neglect, recognising the role of families, communities, NGOs, at all levels of government as well as the private sector.

³ For further details see: <http://www.health.vic.gov.au/drugservices/downloads/blueprint09-13.pdf>

In addition, Australia, as a signatory to the United Nations Convention on the Rights of the Child (CROC) (United Nations, 1991), has an obligation to protect children's rights and to support parents in childrearing responsibilities. Through its ratification of the UN Convention on the Rights of the Child Australia acknowledges that children have a special need for protection by the state and recognises their rights to protection (Roche et al., 2008). Further to this, the 'best interests of the child' test is enacted in the Family Law Act (1975)⁴. This test has been assessed as paramount in that the 'protection of the child should be elevated above all other interests, although those interests are not disregarded' ("*Minister for Health v AS & Anor*," 2004). As such, Australian children are afforded special protection.

The International Harm Reduction Association has also recently addressed the issue of the UN Convention on the Rights of the Child from the perspective of youth drug users and has identified the key elements of CROC that apply in regard to the best interests of the child and their right to be heard (Youth RISE & International Harm Reduction Association, 2009).

Prevention strategies

This resource is predicated on the need and untapped role for prevention. Prevention strategies can be implemented at three levels: primary prevention (universal, whole of population strategies to promote health), secondary prevention (strategies targeted to those at risk of disease/conditions or early detection strategies) and *tertiary prevention* (disease/condition management, curative and rehabilitation services).

This resource especially highlights the potential for *secondary prevention*, or prevention programs targeted to families and communities at risk of alcohol and other drugs misuse and early identification of alcohol and other drugs problems, as well as tertiary prevention programs involving Family Sensitive Policy and Practice in treatment and rehabilitation strategies which may incorporate joint case management, partnerships and inter-sectoral policy. From the perspective of

those working with child abuse and neglect, tertiary prevention in the alcohol and other drugs sector that incorporates Family Sensitive Policy and Practice may in fact be secondary prevention for child abuse and neglect.

O'Donnell et al. (2008) endorse the following framework for prevention and interventions in child abuse and neglect and argue that a public health approach is required if we are to prevent child abuse and neglect and out-of-home care (O'Donnell, Scott, & Stanley, 2008). Figure 1 illustrates these levels of primary prevention (universal prevention), secondary prevention (targeted prevention) and tertiary prevention (including child protection responses and treatment for victims and offenders).

This resource identifies ways in which these levels of prevention and intervention responses may be activated in an alcohol and other drugs service delivery context.

Primary prevention	incorporates supportive health promotion, welfare and education services and programs for all families and communities
Secondary prevention	targets families and communities vulnerable to abuse and neglect, including those already misusing and being treated for drug and alcohol problems.
Tertiary prevention	includes responses to child abuse and neglect, including assessment, treatment and placements.

⁴ Family Law Act, Commonwealth of Australia, s60CA (1975).

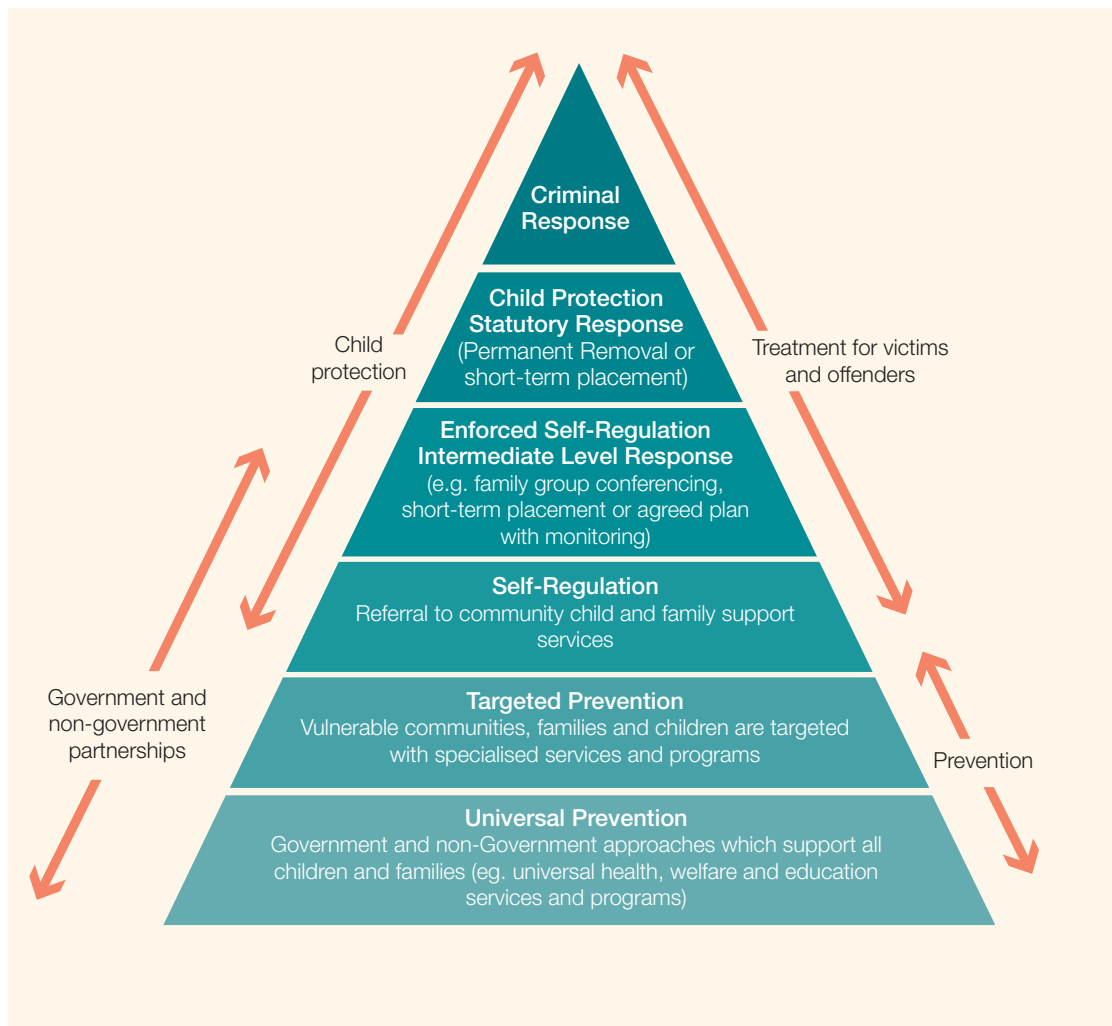


Figure 1. Responsive regulation model of prevention and intervention in child abuse and neglect

(modified from the Allen Consulting Group (2003), based on the model by Ayres and Braithwaite (1992) (O'Donnell et al., 2008, p. 328))

1.2 Defining the parameters of a family sensitive approach

Definitions and principles

Family Sensitive Policy and Practice involves raising awareness of the impact of substance abuse upon families, addressing the needs of families (Addaction, 2009, p. 10) and seeing the family - rather than an individual adult or child - as the unit of intervention. It necessitates identifying and addressing the needs of adult clients as parents, as well as the needs of their children, as part of treatment and intervention processes, in order to ensure that as parents they are supported and child wellbeing and safety is maintained.

Family Sensitive Policy and Practice involves raising awareness of the impact of substance abuse upon families, addressing the needs of families and seeing the family - rather than an individual adult or child - as the unit of intervention.

Family Sensitive Policy and Practice also goes well beyond understanding and meeting the needs of families and children/adolescents, as it entails seeing families as resources and partners in the client-worker relationship.

Family Sensitive Policy and Practice tenets include:

- dignity and respect for clients and families
- open communication
- a 'strengths based approach' to service delivery
- collaboration and information sharing with families (both at a treatment and organisational level)
- understanding the familial and social context of clients and
- consideration of the needs and preferences of families, including the provision of culturally appropriate services (Centre for Addiction and Mental Health, 2004).

Family Sensitive Policy and Practice addresses the needs of adult clients as parents

Rather than focusing on deficits, a strengths based approach is recommended which recognises and builds on the strengths, resilience, assets and resources of individuals, families, organisations and communities.

Family Sensitive Policy and Practice incorporates the following values/principles:

- Self-determination
- Empowerment
- Respect
- Acceptance
- Flexibility
- Teamwork
- Valuing uniqueness (Sandau-Beckler, Salcido, Beckler, Mannes & Beck, 2002, p. 725).

Family Sensitive Policy and Practice does not rely on one particular practice model in service delivery, and can be built into existing practices. It draws from systems theory and utilises ecological, multicultural and empowerment approaches to understand and address health issues. An ecological approach necessitates understanding the various interacting bio-psycho-social-

environmental causation factors in health. In this model, health is seen to be influenced by intrapersonal factors, interpersonal relationships, organisational factors, community relationships and structures and public policies (Campbell, 2001). The concepts of resilience, risk and protective factors also inform public health thinking.

Family Sensitive Policy and Practice does *not* refer to family therapy, which aims to incorporate family dynamics within treatment interventions. In terms of service delivery and clinical care, a distinction is made between approaches that aim to 1) include family members as part of the treatment for an *individual* alcohol and other drugs client and 2) those that focus on multiple needs and interventions, considering

the differing impacts alcohol and other drug use has on each family member. Family members may include significant others and safe supports (e.g. trusted friends or extended family members) that can be identified by clients.

Family Sensitive Policy and Practice spans both individual and family treatment approaches, but it also goes beyond treatment to consider workforce practices, organisational processes and procedures, the wider alcohol and drug service system, as well as strategies that are important for a public health, preventative approach. Thus Family Sensitive Policy and Practice can operate across a number of interacting levels, as shown in Box 1.

Service delivery	e.g. consideration of families and children within treatment and other services, developing the skills and attitudes of workers.
Organisational	e.g. organisational guidelines for Family Sensitive Policy and Practice, culturally appropriate services, processes for interacting with other services, family sensitive physical environments within services.
Systems and Services	e.g. building knowledge and partnerships for Family Sensitive Policy and Practice across services and sectors.
Policy	e.g. prioritisation of Family Sensitive Policy and Practice within policy, facilitating structures and resources, cross-sectoral policy.

Box 1 Levels of Family Sensitive Policy and Practice

Family Sensitive Policy and Practice Terminology

Many different terms are used for approaches that consider families, including 'family centred', 'child and parent centred', 'family focused', 'family inclusive', 'family sensitive', 'parent and child sensitive' and 'child and family aware'. Whilst sometimes these terms are used interchangeably in the literature, they do not always mean the same thing. This resource primarily uses the term 'Family Sensitive Policy and Practice' to refer to the approach outlined above.

Alcohol and other drug misuse

The use of alcohol, (certain) illicit drugs and pharmaceuticals is common in Australian society. The prevalence of alcohol and other drug use and problematic substance use is outlined below. It is also noted that there is comparatively little data collected on the parental status of most people who misuse alcohol and other drugs. Available data indicate that risky alcohol and other drug use is generally most common amongst those aged 20-29. Alcohol and other drug treatment episodes also peak in this age group. This has important implications as over 41% of babies in Australia are born to mothers aged 20-29.

Alcohol

Alcohol is the most commonly used psychoactive substance in Australia. In 2007, approximately 83% of Australians had drunk alcohol in the previous 12 months (AIHW, 2008b). One in 12 Australians (8.1%) drink alcohol on a daily basis and over 40% drink at least weekly. Approximately 7% of Australians are ex-drinkers. The proportion of people drinking on a daily basis increases with age, for instance only 2.3% of those aged 20-29 drink alcohol daily, compared with almost 16% of those aged over 60 (Laws, 2009).

The 2007 National Drug Strategy Household Survey data indicates that approximately 10.3% of Australians put their long-term health at risk due to alcohol consumption through risky

and high-risk levels of alcohol consumption (AIHW, 2008b).⁵ People aged 20-29 were most likely to drink in this way (16.0%). Drinking which places an individual at risk of short term harm (e.g. accidents, injuries, violence etc) is more common, with over 20% of Australians engaging in this drinking pattern at least monthly (AIHW, 2008b).⁶ This was most prevalent among those aged 20-29 (39.6%).

Over the past decade alcohol use has remained stable in terms of overall consumption; however, there has been a noticeable increase in the use of "alco-pops" by young people (AIHW, 2008b) and increased concern about "binge drinking" by young people and especially young women. Heavy episodic drinking by young people is also associated with increased violence and anti-social behaviour (Williams, Toumbourou, Williamson, Hemphill, & Patton, 2009).

A recent report examining the range and magnitude of alcohol's harm to others (Laslett et al., 2010) has also highlighted the importance of comprehending the largely hidden impact of alcohol on children and notes the wide range of harms experienced by children as a result of their parents' drinking. The report also notes that the ways in which children may be affected by their parents' drinking occurs along a continuum with a vast range in the spectrum of severity. Underscoring the extent of this problem is a lack of general awareness by the

⁵ This measure was based on the previous 2001 NHMRC guidelines whereby consumption of 29 or more standard drinks in a week for males, and 15 or more for females was considered risky for long term harm. Also see footnote 7.

⁶ This measure was based on the previous 2001 NHMRC guidelines whereby consumption of 7 or more standard drinks in one day for males, and 5 or more for females was considered risky for short term harm. Also see footnote 7.

community and professionals. The report has highlighted that very little work has been undertaken in regard to how the drinking of others might be impacting on children. Laslett et al.s' (2010) recent data found that 17% of carers indicated that their drinking had negatively affected the children for whom they were responsible and 12% of parents indicated that one or more of their children had been physically hurt, emotionally abused, left unsupervised, or exposed to domestic violence because of alcohol use.

Other drugs

In 2007 approximately one in eight Australians (13.4%) had used any illicit drug in the previous twelve months (AIHW, 2008b). This was most prevalent among those aged 20-29 (27.7%). Cannabis was the most commonly used illicit drug, with 9.1% of Australians using cannabis in the previous twelve months, followed by ecstasy (3.5%), pain-killers/analgesics used for non-medical purposes (2.5%), and amphetamines (2.3%). The use of these substances was most common amongst 20-29 year olds.

Cannabis use fell dramatically in the period 1998-2007 (17.9% to 9.1%), however, the pattern of cannabis use among those who continue to use has not changed. Heroin use has declined over the past decade and use remains low; however, use tends to increase as heroin availability increases. Ecstasy use across the population remains high with 11% of 20-29 year olds using in the last year and 24% having ever used. This is the highest prevalence of any age group. Methamphetamine was used by 7% of 20-29 year olds in the last year and 16% had ever used (AIHW, 2008b).

Table 1. Trends in alcohol and other drug treatment episodes by principal drug of concern 2001-02 to 2007-08

	2001-02a	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
	%	%	%	%	%	%	%
Alcohol	37.0	38.0	37.5	37.2	38.7	42.3	44.5
Amphetamines	10.8	10.7	11.0	10.9	11.0	12.3	11.2
Benzodiazepines	2.4	2.0	2.1	1.9	1.8	1.6	1.7
Cannabis	21.0	22.0	22.0	23.0	24.6	22.8	21.6
Cocaine	0.7	0.3	0.2	0.3	0.3	0.3	0.3
Ecstasy	0.2	0.3	0.4	0.4	0.6	0.7	0.9
Heroin	17.7	18.4	18.0	17.2	13.6	10.6	10.5
Methadone	2.3	1.8	1.9	1.8	1.7	1.6	1.6
Other opioids	2.0	1.8	1.9	2.0	2.0	2.2	2.4
All other drugs ^b	5.2	3.9	4.6	5.3	5.7	5.5	5.4
Not stated	0.7	0.5	0.5	-	-	-	-
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

^a Queensland supplied data for police diversion clients only and South Australia provided client registration data rather than treatment episode data.

^b Includes balance of principal drugs of concern coded according to the Australian Standard Classification of Drugs of Concern.

Source: Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW, 2009d)

The unsanctioned use of pharmaceutical opioids (such as morphine and oxycodone) is an area of growing concern. The number of people presenting for pain management is increasing rapidly. The increase in clients accessing alcohol and other drugs treatment services for misuse of prescription pharmaceuticals is expected to grow exponentially in coming years. Recent USA research highlights the 'malicious use of pharmaceuticals' as an issue of growing concern and an under-recognised form of child abuse (Yin, 2010).

Traditional categories of child abuse, namely; neglect, physical abuse, sexual abuse and emotional abuse don't include coverage of the emerging issue of abusive use of drugs on children.

Some maintain that it should be considered an important form of child abuse and suggest comprehensive drug screening during evaluations of suspected child abuse (Yin, 2010).

Treatment Trends

In Australia, most people presenting for alcohol and other drug treatment have problems with alcohol (AIHW, 2009d). In 2007-08, 44.5% of alcohol and other drug treatment episodes in Australia were principally for alcohol. In addition, in 2007-08 almost 22% of people accessing treatment identified cannabis as the principal drug of concern, while over 11% identified amphetamines and 10.5% identified heroin as the principal drug of concern.

Poly-drug use, or using two or more drugs concurrently, is very common and cannabis and alcohol are often used together (AIHW, 2008a). It is also the norm for injecting drug users to engage in poly-drug use, with cannabis, heroin and methamphetamines frequently used concurrently (Stafford et al., 2009).

Drug misuse should not always be seen as a short-term, transient event in a young persons' life which they eventually 'grow out' of. The experience of drug misuse may be long term and/or sporadic, as people come in and out of drug misuse across their life. In Australia, alcohol and other drug treatment episodes peak amongst the 20-29 and 30-39 age groups, with the median age of those accessing alcohol and other drug treatment services being 32 (AIHW, 2009d). This age range corresponds with the peak child rearing years and most parents with dependent children fall within these age ranges.

Traditional categories of child abuse, namely; neglect, physical abuse, sexual abuse and emotional abuse don't include coverage of the emerging issue of abusive use of drugs on children.

Key trends in alcohol and other drug misuse

There are changing patterns of alcohol and other drugs use and misuse in Australia with drug use extending across the life span and commonly characterised by polydrug use. Whilst alcohol consumption is stable overall there is concern about “binge drinking” and concurrent use of stimulants. Tobacco and illicit drug use is generally on the decline (in 2007, 13.4% of Australians used illicit drugs in the previous 12 months, mostly cannabis) (AIHW, 2008a). However, cocaine (1.6%) and tranquilliser/sleeping pill use (1.4%) has increased (AIHW, 2008a). The use of psycho-stimulants has also increased dramatically (Nicholas, 2009).

The inappropriate use of pharmaceuticals, particularly pharmaceutical opioid misuse leading to overdoses, has emerged as an important issue (Fry, Smith, Raimondo, O’Keefe, & Miller, 2007; Nicholas, 2009), although the use of benzodiazepines has generally declined (Nicholas, 2009). In 2007, 7% of Australians over 14 years old had used pharmaceuticals for non-medical purposes in the previous 12 months, and the 20-29 year age group were most likely (10.3%) to have done this in their lifetime (AIHW, 2008a).

Alcohol and Other Drug Terminology

The term ‘alcohol and other drug misuse’ is used throughout this document. It refers to use of alcohol and other drugs that has harmful effects, including negative impacts on relationships and children. This term is drawn from a psycho-social perspective, focusing on problems created by misuse and social responses to misuse, rather than physical dependence or addiction (Forrester & Harwin, 2004). Whilst ‘alcohol and other drugs’ are often considered together, it is important to acknowledge that different drugs may pose different risks to children and families (see ‘The impact of different drugs and professionals’ responses to them’ on p. 50).

‘Risky’, ‘problem’ and ‘harmful’ drinking are also terms used within the document, as they correspond to terms used within the alcohol and other drugs literature⁷. Drinking which is problematic can impact negatively upon relationships, school, work and social activities, as well as upon how one thinks and feels (Centers for Disease Control and Prevention, 2008). ‘Harmful’ drinking refers to drinking at levels that are likely to cause significant injury or ill health (NHMRC, 2009).

⁷ Recent Australian guidelines have not included terms such as ‘problem’ and ‘risky’ drinking as they are difficult to quantify and are considered pejorative terms (NHMRC, 2009). The NHMRC 2009 guidelines indicate that drinking less than 2 standard alcoholic drinks per day (for both men and women) reduces the lifetime risk of harm from such drinking, whilst drinking less than 4 standard alcoholic drinks on one occasion reduces the risk of alcohol-related injury on that occasion (NHMRC, 2009). Previously, long term ‘risky drinking’ was categorised into ‘low risk’ (up to 28 standard drinks per week for men and up to 14 for women), ‘risky’ (between 28 and 42 standard drinks for men and 15 to 28 for women) and ‘high risk’ drinking (more than 43 standard drinks per week for men and 29 or more for women) (AIHW, 2004, 2008b).

Child wellbeing and protection

Please see section 1.3 below for a description of the relationship between child wellbeing and protection and alcohol and other drugs use.

Child Wellbeing and Protection Terminology

Throughout this resource, the phrase 'child wellbeing and protection' is used to refer to both health promotion and prevention strategies for children and child care and protection strategies. There are various child protection Acts across jurisdictions within Australia (see the National Child Protection Clearinghouse <http://www.aifs.gov.au/nch/> or the Australasian Legal Information Institute www.austlii.edu.au for recent legislation in your jurisdiction). Contact with child wellbeing and protection services, due to concerns about the wellbeing of young people, may lead to a family support assessment and referral or a child protection notification.

In the 'child wellbeing and protection system' common terms and phrases include:

1. 'notifications'
2. 'mandated notifiers'
3. 'investigations'
4. 'substantiations'
5. 'care and protection orders'
6. 'alternative care' or 'out-of-home care.'

These terms are explained further below.

For a number of professions and/or services, it is mandatory under law to notify the child wellbeing and protection system once child neglect or abuse is suspected (hence '**mandatory notifiers**'). This legislative requirement, along with greater awareness of abuse and neglect, has led to increases in **notifications**, although it is believed that various forms of child abuse and neglect have also actually increased (AIHW, 2010a). Emotional abuse and neglect are the most common forms of child maltreatment substantiated following investigation (AIHW, 2010a). The most common mandatory notifiers are police, social workers, medical practitioners and school personnel (AIHW, 2010a).

Notifications of suspected child neglect or abuse are **investigated** by the child wellbeing and protection system if this is deemed to be warranted; in 2008-09, only 47.8% of notifications led to finalised investigations (AIHW, 2010a). Investigations are not always **substantiated**; around 59% of finalised investigations were substantiated in 2007-2008 (Bromfield & Irenyi, 2009), and in 2008-09 this figure was 66% (AIHW, 2010a).

Investigations that are substantiated do not necessarily equate to children being placed on **care and protection orders** or in **alternative/out-of-home care**. Care and protection orders may be short term (with reunification with parent/s anticipated) or longer term. Of children placed in alternative or out-of-home care (OOHC) as a result of substantiation, around half (47%) are living with relatives (usually grandparents) and half (45%) are cared for by foster carers (a sector largely managed by NGOs), whilst around 1.4% are in another type of out-of-home care (AIHW, 2010a).

Figures indicating a gap between notifications, investigations, substantiations and statutory orders should be closely considered to assess whether they refer to the number of notifications or number of children, as many children may be subjected to multiple notifications in a given year. The gap between actual notifications and further investigations, substantiations and statutory orders can be explained by a number of factors, including:

- the gap between the low threshold for making a notification and the high threshold for statutory intervention (e.g. in Tasmania, all police investigating domestic violence cases are required to refer children to the child protection service)
- the emphasis placed on mandatory reporting obligations within professions and training (leading to higher notifications in some states, including where professionals are 'in doubt')
- insufficient evidence to substantiate investigations and insufficient resources to investigate notifications.

Trends in child wellbeing and protection for Australian children

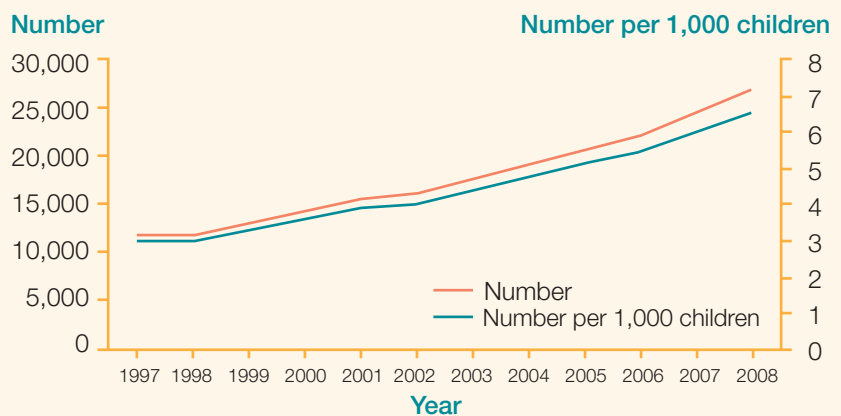
Notifications of suspected child abuse and neglect are very common, with around one fifth of all children born being the subject of notifications. For example, in South Australia, 23% of the cohort of all children born in 1991 were the subject of notifications by 2007, out of which 25% were substantiated (Hirte, Rogers, & Wilson, 2008). In NSW, it has been predicted that one in every five children will be the subject of notifications (NSW Department of Community Services, cited in Higgins & Katz, 2008).

In Australia, over the 12-month period 2008-09, the rate of notifications increased by 6.2%, substantiations of notifications increased by 1.7%, ‘the number of children on care and protection orders increased by 8.5%’ (AIHW, 2010a, vii) and the number of children in out-of-home care increased by 9.3% (AIHW, 2010a). Over the past 5 years, substantiations of notifications decreased by 4%, whilst ‘the number of children on care and protection orders increased by 47%’, with a 44% increase of the

number of children in out-of-home care (AIHW, 2010a, vii). From 1998 to 2008, the number of children on care and protection orders more than doubled (AIHW, 2009b). In addition, from 1997 to 2008, the number of children in out-of-home care doubled (AIHW, 2009a).

Increases in substantiations of child abuse can be explained by a range of factors, including changes to policies and practices in the child protection system (e.g. mandatory reporting, broadening definitions of child abuse and neglect), increased reporting by professionals, increased community awareness

about child abuse and neglect, as well as actual increases in child abuse and neglect or inadequate parenting. It should be noted that the increasing demand for out-of-home care in Victoria has been linked to children being in such care for longer, and fewer children leaving such care, rather than increases in the number of children entering care (Ombudsman Victoria, 2010). This has been attributed to the increasing complexity of parental problems such as substance abuse, domestic violence and mental health problems (Ombudsman Victoria, 2010).



Note: children in out-of-home-care as at June 30
Source: AIHW National Child Protection Data Collection

Figure 2. Children aged 0-14 years in out-of-home care, 1997 to 2008 (AIHW, 2009a, p. 90)

1.3 Why Family Sensitive Policy and Practice is important

Child wellbeing and parental drug and alcohol misuse: A complex relationship

International surveys estimate that around 10% of children are exposed to alcohol and other drug misuse (Dawe et al., 2007), whilst Australian estimates suggest that 10% to 13% of children are affected by parental alcohol or other drug misuse (Jeffreys et al., 2008; Nicholas, 2009). Around 1.5% of children have a parent attending a drug treatment program (Odyssey Institute of Studies, 2004).

The National Aboriginal and Torres Strait Islander Social survey indicates that almost one in six Indigenous children aged 0-14 years (15%) live in a household with a 'risky drinker', compared to 11% of non-Indigenous children. Rates of Indigenous children's exposure to risky drinking also differ according to geographical region (NATSIS, as cited in Pink & Allbon, 2008).

However, parental substance misuse should not automatically be associated with harm to children (Forrester & Harwin, 2004), and should be considered alongside a range of interrelated factors when determining impact. As Dawe and colleagues state:

It is generally difficult to disentangle the effects of parental substance use from broader social and economic factors that contribute to and maintain the misuse of either drugs or alcohol.
(Dawe et al., 2007, p. viii)

Parental substance misuse rarely occurs in isolation from other problems, and families may have a constellation of stressors that all impact on parenting capacity, e.g. mental health problems and severe financial stress (Dawe et al., 2007). Correspondingly, in times of stress it is also known that people tend to partake less in healthy behaviours and may increase risky behaviours such as higher levels of drinking and drug use (Ng & Jeffery, 2003).

... parental substance misuse should not automatically be associated with harm to children.

Case study: Rhonda

Rhonda's mother was an alcoholic and Rhonda was placed in residential reception care in early infancy. She remained there until late toddlerhood, when she returned to her still alcoholic mother.

Her mother ceased drinking when Rhonda was in her mid-teens but became very rejecting, critical, punitive and controlling of Rhonda. Rhonda's stepfather was also an alcoholic, and there was severe domestic violence between Rhonda's parents.

Rhonda entered a life of heavy substance abuse – alcohol and heroin. Her four children have different fathers. There was serious family violence between Rhonda and two of her partners.

Neglect was a feature of Rhonda's life, due to early separation and attachment problems, combined with the effects of her mother's substance use. This precipitated Rhonda into a life of exclusion, exacerbated by heavy substance abuse.

Rhonda's oldest child is in the care of a friend and she has on/off

access with the other two children placed out in care. One child, Joel, whose father died of a drug overdose, is in Rhonda's care.

The referral to Counting the Kids (CTK) was made by Child Protection just prior to reunification with Joel, who had been placed in foster care while his mother attended a residential rehabilitation service. Joel, who was eight years old at the time, was eager to return to his mother's care. CTK initially worked closely with Child Protection to monitor and support the reunification. Rhonda and Joel continued to receive support well after Child Protection was no longer involved with the family.

Although it hasn't always been easy, Rhonda has managed to provide continuous care of Joel over the past few years. Joel is a keen footy player. He is boisterous with most people and affectionate to his mother. Joel has spent considerable time with his eldest sibling and maintains some contact with the others.

Case study: Odyssey House, Counting the Kids program (Contole et al., n.d.)

Parents who misuse alcohol and other drugs may be strongly motivated to be good parents, employ strategies to minimise the impact of their alcohol and other drugs use upon their children (Richter & Bammer, 2000) and recognise when they need help with parenting (Ivec, Braithwaite, & Harris, 2009). In relation to alcohol misuse, Velleman and Orford (1999) concluded that children living with parents who are 'problem drinkers' may experience high levels of stress and are at greater risk for a range of problems, including emotional, behavioural and relationship problems. However, many children of parents who were 'problem drinkers' are in fact resilient, and disharmony per se within a family may contribute more strongly to disadvantage for children than problem drinking itself (Velleman & Orford, 1999).

This notwithstanding, parental substance misuse is increasingly seen as a factor in child wellbeing and protection concerns (NSW Ombudsman, 2009; Ritter & Chalmers, 2009). International research suggests that substance abuse is implicated in at least 50% of families identified by child and protective services (Dawe et al., 2007). One Australian report suggested that up to 80% of child notifications involved concerns about parenting being affected by substance misuse (Ainsworth, 2004). A South Australian report indicated that parental substance misuse was linked to 70% of cases where children entered alternative care (Jeffreys et al., 2008).

The risks to children from parental alcohol and drug misuse include:

- child neglect, physical, sexual and emotional abuse (Scott, 2009a)
- children witnessing violence (Burke et al., 2006)
- transport accidents (Lenne et al., 2003)
- and in extreme cases, deaths through transport, co-sleeping and drowning incidents (NSW Ombudsman, 2009).

In some cases of child deaths in NSW, the family welfare service's assessment of the level of risk to children, and both health and family welfare services' monitoring of alcohol and other drug use, was deemed inadequate (NSW Ombudsman, 2009). The need for adequate screening and assessment of family and alternative carers (i.e. foster, residential carers) has also been emphasised by the Victorian Ombudsman (Ombudsman Victoria, 2010).

These findings strongly support the need for an integrated approach to policies and service provision to support families and children. As the NSW Keep Them Safe principles state, 'child protection is the collective responsibility of whole-of-government and the community' (NSW Government, 2010).

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International research suggests that substance abuse is implicated in at least 50% of families identified by child and protective services (Dawe et al., 2007).

Preventing child abuse and neglect, and minimising out-of-home care

Preventing child abuse and neglect, and minimising foster care placements is important if we are to prevent child and adolescent behavioural problems (Scott, 2009b) and future social problems. Keeping families intact and providing support to parents who are in at risk circumstances is important as out-of-home care strategies do not necessarily lead to better outcomes. In Victoria, only 58% of children in residential foster care attend school, 42% on youth justice orders are in state care and 42% of homeless young people have been in state care (Department of Human Services, as cited in *The Age*, 2010), whilst alternative care arrangements sometimes pose risks to children (Ombudsman Victoria, 2010).

Factors associated with mothers who are drug users not living with their children include:

- mothers' current depression
- previous involvement in prostitution
- a history of homelessness
- co-habitation with a drug user
- a history of incarceration (Gilchrist & Taylor, 2009).

Hence, access to both alcohol and other drugs and mental health treatment services is seen as important to assist women to retain their children (Gilchrist & Taylor 2009).

Alcohol and other drug services and parenting programs have considerable untapped potential to play an important role in targeted prevention strategies to prevent child abuse and neglect and future social problems. However, in order to fulfil this role services need to:

- recognise the scope for preventive intervention
- be more responsive to the needs of parents and children (Scott, 2009b)
- and be more cross-sectoral in their approach.

... out-of-home care strategies do not necessarily lead to better outcomes; in Victoria, only 58% of children in residential foster care attend school, 42% on youth justice orders are in state care and 42% of homeless young people have been in state care (Department of Human Services 2008, cited in *The Age*, 2010), whilst alternative care arrangements sometimes pose risks to children (Ombudsman Victoria, 2010).

Motherhood, stigma and discrimination

To improve access to services it is important to consider the link between stigma and issues such as domestic violence, mental health problems and substance misuse. Stigma and discrimination may pose a problem for families in which there is substance misuse, and cause problems in terms of individuals accessing services.

There is also substantial stigma surrounding substance misuse (Evans-Lacko & Thornicroft, 2010; Jambert-Gray, Lucus, & Hall, 2009; Kipping, 2010; Olszewski, Giraudon, Hedrich, & Montanari, 2009; Powis, Gossop, Bury, Payne, & Griffiths, 2000) and health professionals' attitudes (Skinner, Feather, Freeman, & Roche, 2007).

A range of strategies can be utilised to facilitate an organisational culture that addresses attitudinal barriers and stigma and support professionals' willingness to respond to alcohol and other drugs issues (Skinner, Roche, Freeman, & McKinnon, 2009).

Stigma may be even more pronounced when it comes to women drug and/or alcohol users who are parents (Duncan, 2010). Women, especially, may avoid or delay seeking help for drug and alcohol misuse due to shame and/or the fear of losing one's children (McMahon et al., 2002; Richter & Bammer, 2000). Illicit drug use in particular is often seen to be in conflict with social norms surrounding femininity and motherhood.

Female offenders in the criminal justice system who are drug users may particularly attract stigmatising social labels and be seen as un-maternal as they do not abide by such norms (Loxley & Adams, 2009).

The stigma associated with illicit drug use may also result in excessive monitoring of women who are mothers (Beckett, as cited in Cousins, 2005; Dawe et al., 2007). In one study, women stated that they:

... believed that social services had such a negative image of women drug users that they would deem all to be unfit mothers purely on the basis of their drug use, regardless of their parenting capacities.

(Powis et al., 2000, p. 172)

Drug using mothers who face difficulties encountered by any other mother (e.g. social isolation, low-income, being at home with young children) are more likely to be blamed for their difficulties and receive less social support (including child care and domestic help) than non drug using mothers (Banwell & Bammer, 2006).

Once women enter services, they may be struggling with other problems aside from their alcohol and other drug use, such as overcoming physical, sexual and emotional abuse (Dodd & Saggars, 2006), Post Traumatic Stress Disorder (Pollock, Agllias, & Stublely, 2005/6; Ross et al., 2002) - particularly if from refugee communities (Duncan, 2010) - and other mental health disorders, low-income, social isolation, lack of social support, their children experiencing social exclusion (Banwell & Bammer, 2006) and difficulties at school, as well as problems associated with stigma and discrimination and the criminalisation of drugs.

Opportunities to engage with fathers

Like mothers, fathers are often treated as ‘individuals’ within treatment services and their parenting role is overlooked in both services and research (Alcohol Concern, 2006b; McMahon & Rounsaville, 2002). Given the high proportion of male clients in alcohol and other drugs services, workers have a unique opportunity to engage with men as fathers.

Research has consistently shown the positive benefits to children from involved and supportive fathers, in addition to the benefits to be gained by fathers from being involved in their children’s lives (Alcohol Concern, 2006b).

As with mothers, the parent-child relationship may be one motivator for change for male clients (Alcohol Concern, 2006b). Drug use by fathers (similar to the experience of mothers) may be exacerbated by parenting challenges or guilt. For example, drug use has been shown to compromise responsible fathering, with opioid dependent fathers reporting:

... significant differences in current dimensions of fathering reflecting: (i) constricted personal definitions of the fathering role; (ii) poorer relationships with biological mothers; (iii) less frequent residence with the child; (iv) less frequent provisions of financial support (v) less involvement in positive parenting; (vi) poorer appraisal of self as a father; and (vii) less satisfaction as a father.

(McMahon, Winkel, & Rounsaville, 2008, p. 269)

Addressing these and other father-child relationship factors in treatment is therefore important. However, it is acknowledged that given the gendered nature of domestic violence and its relationship with alcohol and other drugs misuse, it may not always be desirable for men to be involved in their children’s lives (Alcohol Concern, 2006b). McMahon et al. (2008) suggest that, due to a range of factors, intervention services should engage men in discussions about their parenting. Their study demonstrates that whilst some men may have the capacity for ‘positive parenting behaviour’, which should be supported by treatment services, others will engage in ‘negative parenting behaviour’ that needs to be addressed (McMahon et al., 2008).

Case Study: Bill

Bill's father was an alcoholic, and there was family violence between him and Bill's mother. Bill's mother re-partnered, and his stepfather repeatedly physically and sexually abused Bill.

The abuse Bill received was so bad that, in late primary school, he ran away and lived on the streets. He started progressively using a number of drugs until he was heroin dependent. A life of crime paid for his drugs.

His first deliberate overdose occurred in his late teens. He has made attempts on his life on three other occasions. He was incarcerated for violent crime, and has served long prison terms. He remains cut off from his extended family except for minimal contact with one of his father's siblings and his family.

Sophie, the youngest of Bill's three children, was removed from her

mother by Child Protection and placed in foster care while Bill was in prison. She was reunited with her father at Odyssey's Therapeutic Community, where the two formed a strong bond. After exiting the supported environment of the Therapeutic Community, Bill received regular drug and alcohol counselling, parenting education and practical support from the Counting the Kids (CTK) program to ensure the reunification endured and that Sophie's needs would be met while her father continued the long process of rehabilitation. Sophie regularly took part in activities and school-holiday programs with CTK. She has remained in her father's care for several years without further Child Protection involvement.

Case study: Odyssey House, Counting the Kids program (Contole, O'Neill, Mitchell, & Absler, n.d.)

Reducing the impact of alcohol and drug use upon families, children and the wider community

A significant social harm derived from alcohol and other drugs misuse is its impact upon relationships, especially families and children. Social harms from alcohol misuse can affect the quality of life of family members as well as the wellbeing of communities (WHO, 2007) and can manifest in a variety of ways.

There are indicators that violence toward and by young people is increasing in Australia (Australian Institute of Criminology, 2009).

Alcohol is increasingly associated with violence and aggression amongst young people in Australia (ABC, 2010a; Laslett et al, 2010).

There have been growing calls for integrated, whole-of-government responses to address the prevention of violence committed against and by young people including reducing risk factors, such as early uptake and exposure to parental alcohol and other drugs use, and strengthening protective and resilience factors (Australian Research Alliance for Children and Youth (ARACY), 2009).

The links between violence and alcohol are complex, but data indicate that alcohol is implicated in 40-70% of violent crimes, 70-80% of night-time assaults and approximately half of all domestic and sexual assault cases (Dodd and Siggers, 2006). Nearly two thirds of women who report violence by a current partner reported that they had children in their care at some time during the relationship and 38% said that their children had witnessed the violence; 46% of women who had experienced violence from a previous partner said their children witnessed the violence (McLennan, 1996).

Indigenous people are more likely to be victims of assault, and the perpetrator is more likely to be known to them, than for non-Indigenous people (ABS, 2009); assault issues have recently been highlighted and associated with alcohol misuse and poverty in some communities (ABC, 2010b). One study of Indigenous people (who had family members who misused alcohol) in the Northern Territory found that they were often concerned about the impact of their relative's drinking on children, and used a range of strategies to cope with and curb alcohol misuse and its effects (Orford, Templeton, Copello, Velleman, & Bradbury, 2000).

Family Sensitive Policy and Practice strategies have potential to be an important part of reducing the impact of drug use upon children.

Given that parental drug use per se is not necessarily a cause of poor child development, and that out-of-home placement puts children at high risk for adverse outcomes, it is important to explore the full range of familial strategies that potentially reduce harm to children.

(Richter & Bammer, 2000, p. 403)

Encouragingly, Family Sensitive Policy and Practice has been built into some alcohol and other drugs programs including pharmacotherapy maintenance strategies and services. This has led to guidelines that consider the risks to children of 'take away' policies, where medication is taken home for later use (Ritter & Chalmers, 2009). A number of alcohol and other drugs interventions designed to improve family functioning have led to improved parenting skills (Ritter & Chalmers, 2009).

Protective and resilience factors

A range of 'protective' or 'resilience factors' that may reduce the impact of substance misuse upon children has been identified across the lifespan and in relation to parent-child roles (see Box 2) (Velleman & Orford, 1999; Velleman & Templeton, 2007). For example, where families do not experience 'family disruption', children are less likely to experience problems such as emotional and behavioural difficulties (Velleman & Orford, 1999).

A model to assess the impact of parental substance abuse is illustrated in Figure 3. It demonstrates the connections between initial parental alcohol and other drugs use and the potential for subsequent family disruption that may in turn lead to difficulties for the children of those parents.

Ultimately, such early life experiences may lead to later problems for those children when they reach adulthood including development of their own difficulties with alcohol or drugs: thus resulting in patterns of inter-generational use and other problems. Figure 3 also illustrates when and how resilience factors may play a part in modifying this trajectory.

Protective factors and resilience

- The presence of a stable adult figure (usually a non-substance misuser)
- Close positive bond with at least one adult in a caring role (e.g. parents, older siblings, grandparents)
- A good support network
- Little separation from the primary carer in the first year of life
- Parents' positive care style and characteristics
- Being raised in a small family
- Larger age gaps between siblings
- Engagement in a range of activities
- Individual temperament
- Positive opportunities at times of life transition
- Continuing family cohesion and harmony in the face of alcohol and other drugs misuse and its related effects (e.g. domestic violence, mental health problems).

Box 2 Protective factors and resilience

(Velleman & Templeton, 2007, p. 83)

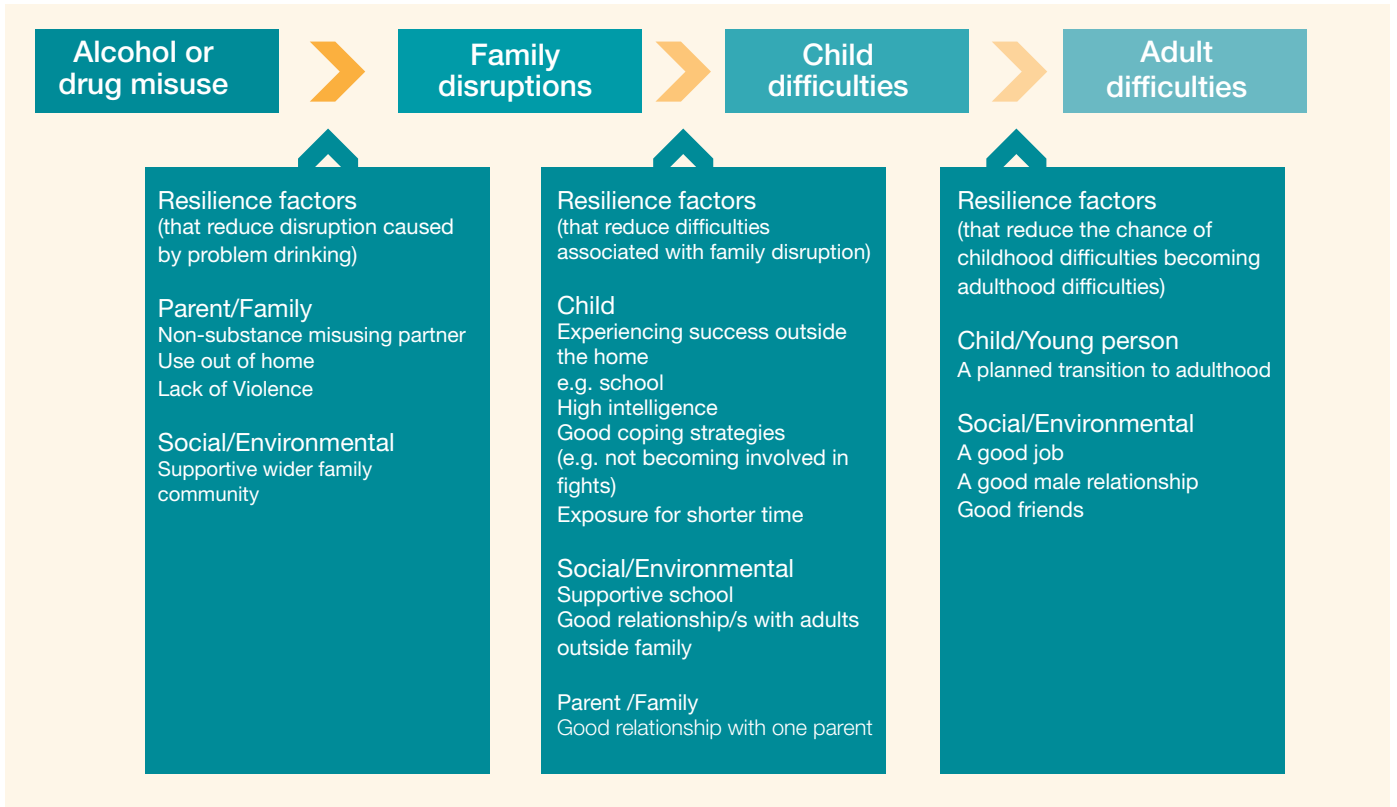


Figure 3. A model for assessing the effect of parental substance misuse
(Forrester 2004, p. 168, based on Velleman and Orford, 1999)

Levels of connectedness among caregivers, school and community are deemed to be central 'protective' factors for children whose parent/s engage in substance misuse (Dawe, Harnett, & Frye, 2008). Social capital, in the form of support and resources, can be a strong factor in building the resilience of individuals, families and communities and enhancing health status (Baum et al., 2007; Pomagalska et al., 2008).

There are two main types of social capital: bonding (bonds with those socially similar to you, typically close family and friends) and bridging social capital (links with people dissimilar e.g. culturally or economically). Bonding social capital is particularly important to mental health (Almedom, 2005).

Family Sensitive Policy and Practice can enhance the protective or resilience factors known to reduce alcohol and other drugs misuse and its impact by:

- utilising and building upon social capital resources
- enhancing support to parents
- building upon parents' coping strategies
- developing supportive relationships with children
- establishing links with other services such as schools and domestic violence services.

Social support has been identified as an important factor in resilience, with its various elements including emotional, esteem, instrumental, informational and appraisal support (Muller, Ward, Winefield, Tsourtos, & Lawn, 2009). Further, social support is held to comprise community support (neighbours, church etc), family support, support from friends and professional support (medical advisors, social workers etc) (Muller et al., 2009).

The impact of drug use upon parenting and child and adolescent health and development

It is important to note that whilst there is a link between parental alcohol misuse, family disruption (e.g. arguments/violence) and childhood and adult problems, most children who have had a parent with an alcohol or drug problem do not have significant problems as adults (Forrester, 2004; Velleman & Orford, 1999). Nevertheless, specific risks to children and adolescents may result from parental/familial alcohol and other drugs misuse.

As mental development starts in the womb (Foresight Mental Capital and Wellbeing Project, 2008), interventions must consider the effect of alcohol and other drugs misuse at the earliest possible stage. Foetal Alcohol Spectrum Disorders (FASD) are increasingly identified as a negative factor in child wellbeing and development. One problem is under-diagnosis and lack of knowledge of FASD, resulting in challenges for prevention, diagnosis and early intervention (Elliott, Payne, Haan, & Bower, 2006; Mutch, Peadon, Elliott, & Bower, 2009).

Learning difficulties in children have been linked to both FASD and 'non stimulating environments' associated with parents engaged with the misuse of alcohol (Foresight Mental Capital and Wellbeing Project, 2008). The social development of children is intrinsically linked to social interaction, emotional availability of parents and attachment in the parent-child relationship (see section 4.2), and aforementioned 'risk and protective' factors. A Queensland longitudinal study has also demonstrated that maternal drinking during pregnancy may increase the risk of alcohol disorders in early adulthood (Alati et al., 2006).

Parental attitudes towards and use of alcohol and drugs can be a strong predictor of adolescent drug use (Johnson et al., 1990; Loxley et al., 2004; Schor, 1996) and problems with inter-generational alcohol and other drugs misuse. In turn, adolescent alcohol and other drug use can affect brain development; attention and memory, learning and other cognitive functions, such as information processing and decision-making (Kirkwood, Bond, May, McKeith, & Teh, 2008).

The transition to adulthood that a young person exposed to parental alcohol and other drugs misuse makes is of great importance. The more planned this transition (e.g. leaving home later, not settling with a partner and children in adolescence or early adulthood, planning a career), the less likely the young person will go on to have difficulties in adulthood (Velleman & Orford, 1999).

The alcohol and other drugs environment at home may also pose specific risks to children's health. Alcohol, analgesics (including methadone) and heroin are amongst the primary agents involved in fatal poisonings of children up to 12 years old in the US (Wilkerson, Northington, & Fisher, 2005). Death in young children (0-4 years) as a result of non-medicinal or medicinal substances is rare in Australia (O'Connor, 2000, 2001); whilst opiates were the most common cause of poisoning death from the ingestion of medicinal substances in pre-schoolers, it is difficult to ascertain if this was from illicit substances, commonly prescribed drugs or prescribed methadone. While take-away prescribing of methadone is part of recommended harm minimisation interventions (see Part 3), they may be a less common source of medicinal overdose than other at-home medications (see Wilkerson et al., 2005). However, take-away use of methadone could sometimes be a factor in the accidental ingestion of methadone by children.

Take-away dosing has also been linked to incidents of accidental oral ingestion of take-away doses by opiate-naive individuals, and in rare cases the death or injury of children.

(Ritter & Chalmers, 2009, p. 36)

In addition, clandestine manufacturing laboratories for amphetamines in private residences create risks for chemical toxicity in children, which can lead to health problems such as 'gastrointestinal problems, chemical burns, brain damage, skin and eye irritations... tachycardia, agitation, irritability and vomiting' (National Drug Research Institute & Australian Institute of Criminology, 2007, p. 54).

Intellectual disability and child wellbeing and protection

Another group with elevated vulnerability is children with an intellectual disability. There is a large number of children with disabilities within the care and protection system. For example, in South Australia in 2007 it was estimated that 39% of children in care had a disability (Department for Education and Children's Services, as cited in Office of the Guardian for Children and Young People, 2010). This figure may relate to the experience of child neglect or abuse e.g. language and communication delays are the most common form of disability identified in South Australia. However, children and adolescents with intellectual disability are especially vulnerable to abuse compared to non-disabled children, and 4-10 times more likely to be abused (Fisher, Hodapp, & Dykens, 2008).

As child neglect by parents with intellectual disabilities can be associated with a lack of support and knowledge (James, 2004), this group of parents may need more support and education regarding child care practices. This is especially important as children of parents with intellectual disabilities can be more vulnerable to child abuse from predatory outsiders who perceive both the person with the intellectual disability and the child to be vulnerable (Booth & Booth, as cited in Lamont & Bromfield, 2009).

There is also a high degree of overlap between intellectual and psychiatric disability amongst both young people and adults (AIHW, 2009c), with more than 15% of people with intellectual disability taking two or more psychotropic drugs (Ouellette-Kuntz et al., 2005). Co-ordinated service delivery for families with a member with an intellectual disability is vital.

The overlap between alcohol and other drugs misuse, domestic violence, mental health, incarceration and child wellbeing and protection

Families in which substance misuse occurs are likely to experience a range of problems. In one study of families in welfare services (recruited on the basis of alcohol and/or substance misuse), 92% of the families had other problems aside from substance abuse such as mental health problems, domestic violence and housing problems (Marsh, Ryan, Choi, & Testa, 2006).

Reunification of parents with their children was dependent upon each of these other problems being addressed. Moreover, focusing on substance abuse alone did not lead to progress on either substance abuse or other problems these families faced (Marsh et al., 2006).

Domestic violence

In Australia, the overlap between child abuse and neglect, drug and alcohol misuse (Dawe et al., 2007; Jeffreys et al., 2008; O'Donnell et al., 2008), domestic violence and mental disorders is well recognised (O'Donnell et al., 2008). One Victorian report showed that 52% of child wellbeing and protection cases also involved domestic violence, 33% parental drug abuse, 31% alcohol misuse and 19% psychiatric disability (Scott, 2009b).

Female victims of physical abuse in drug related incidents are most likely to have been abused by their current or former spouse or partner (AIHW, 2008a). In a qualitative study of Australian Indigenous people who had come into contact with child wellbeing and protection services, one third of interviewees spoke about domestic violence and alcohol and drug use (Ivec et al., 2009).

The issues described above may impact upon families and children in different ways. For example, evidence shows that maternal mental health - linked to domestic violence - has a greater impact on outcomes for children than substance use per se (Dawe et al., 2008). Domestic violence is a gendered issue, with around 42% of women experiencing intimate partner violence (IPV) in their lifetime (Rivara et al., 2009). Between 48 to 90% of women with co-occurring mental health and substance abuse problems in the USA have experienced interpersonal abuse (Hora, 2010).

Where drug and alcohol misuse/relapse and domestic violence are issues, child safety is often the focus of services but it is imperative that family and child welfare services also take into account the safety needs of caregivers as well as children (Sandau-Beckler et al., 2002), especially given the relationship between domestic violence, gender and homicide (Dearden & Jones, 2009).

Mental health

Early experience of abuse as a child may lead to increased risk of mental health problems in young adulthood or later adulthood (Fergusson, Boden, & Horwood, 2008; Widom, DuMont, & Czaja, 2007). Conversely, people with mental health problems may be especially vulnerable to abuse, including within health care/treatment environments. The psychological impact of childhood, or later, sexual abuse may include Post Traumatic Stress Disorder (PTSD), where traumatic experiences are relived (e.g. through nightmares, thoughts), leading to avoidance of anything associated with the earlier traumatic event. It has been estimated that around one third of people with substance abuse disorders have PTSD (Mills et al., 2009). Dealing with childhood sexual abuse in alcohol and other drugs treatment can help prevent relapse of alcohol and other drugs problems (Gowling et al., as cited in Tinworth, 2010), however it is crucial that alcohol and other drugs staff are professionally trained to address sexual assault, as a lack of such training may result in more harm than benefit (Swift, as cited in Tinworth, 2010).

There is also a high degree of overlap between mental health and substance misuse problems. For example, Jablensky and colleagues (2000) found that amongst individuals with low prevalence mental disorders, approximately 36% of men and 17% of women experienced alcohol misuse problems, and 38% of men and 16% of women experienced drug misuse problems. An audit of general practice patients in Australia found that 12% of patients had co-occurring mental disorders and substance misuse (Hickie, Koschera, Davenport, Naismith, & Scott, 2001).

The 2007 Australian National Survey of Mental Health and Wellbeing found that approximately 5.1% of Australians experienced a substance use disorder in the previous 12 months, and over 20% of Australians experienced an anxiety or affective disorder in the previous 12 months (Australian Bureau of Statistics, 2008). The survey also found that over 20% of those who drank alcohol every day, and 63% of those who misused drugs every day, also had a mental disorder in the past 12 months. Approximately 8.5% of Australians experienced two or more mental disorders in the previous 12 months. The SPHERE project recommended that screening in general practice should consider co-morbidity as people with co-morbidity have higher rates of disability and are in most need of intervention compared with those who have substance abuse problems alone (Hickie et al., 2001).

The evidence above also supports calls for consideration of the impact of 'dual diagnosis' (co-morbidity/co-occurring disorders) (Dawe et al., 2007; Hegarty, 2004; Stromwall et al., 2008) and domestic violence upon children and families. The Mental Health Council of Australia noted that:

The need for effective treatment for adults as a prevention mechanism for children is particularly evident for people with psychosis, given that 59 per cent of women with psychosis are mothers and 25 per cent of men with psychosis are fathers. (Gilbert and Castle, as cited in Mental Health Council of Australia, 2006, p. 36)

Integrated policy, planning and treatment responses are crucial. In order for treatment programs to address parental mental health issues and their impact upon parenting, training and professional development opportunities for alcohol and other drugs workers and liaison with the mental health system and domestic violence services are required.

Incarceration

There is also a strong link between mental health problems, co-morbidity⁸ and imprisonment. A census of Australian prisoners in 2009 found that over 37% reported a previous diagnosis of mental illness, and 18% were currently taking medication for mental illness (AIHW, 2010a). Over 70% of prison entrants reported using illicit drugs in the 12 months prior to their incarceration, 55% reported injecting drug use at some point in their lifetime, and over half reported drinking alcohol at risky levels for alcohol-related harm. Mental health issues were the third most common reason for accessing prison health services.

International data shows a similar overlap between mental health issues, substance misuse and incarceration. In Europe, up to 80% of women in prison have a mental illness coupled with substance use problems (Olszewski et al., 2009). Around 64% of jail inmates in the US have a mental health problem, 16% in the US criminal justice system have a serious mental illness, and 35% of those in drug courts have a mental disorder (Hora, 2010).

Australian data has also demonstrated a link between female offenders, lifetime experience of physical and sexual abuse, and mental health problems (Johnson, 2006).

Findings from the Drug Use Monitoring in Australia (DUMA) data collection program indicated that amongst police detainees, women, in comparison to men, were more socially and economically disadvantaged (Loxley & Adams, 2009). The DUMA data also showed that 46.5% of women and 30% of male police detainees had dependent children at home (Loxley & Adams, 2009).

Indigenous Australians make up about 2% of the total population, but they are 13 times more likely to be imprisoned than non-Indigenous Australians and they comprise almost 25% of the prison population (NIDAC, 2009). The disproportionately high rates of Indigenous incarceration also have a significant impact on the health and welfare of the individual and their family (NIDAC, 2009). Further, being separated from their family and culture, places many Indigenous offenders at greater risk of harm while they are in prison (NIDAC, 2009).

In its 2009 report entitled *Bridges and Barriers: Addressing Indigenous Incarceration and Health*, the National Indigenous Drug and Alcohol Committee (NIDAC) recommended that federal funding should be provided for each State and Territory to develop and implement appropriate Indigenous-specific programs to assist family members in the return and re-integration of Indigenous offenders into their community and to reduce inter-generational offending and incarceration (NIDAC, 2009).

There is limited information about female Indigenous prisoners and their roles as mothers (Bartels, 2010). Further research is needed to better understand the needs of Indigenous women with infants and young children in prison and also the appropriateness and ease of access to programs which would enable them to keep their children with them (Bartels, 2010). In addition, there is a paucity of information about the experiences and needs of the children of Indigenous women once released from prison with further work needed to better understand this impact (Baldry & McCausland, 2009).

⁸ Co-morbidity, dual diagnosis/co-occurring disorders refers here only to concurrent mental health and alcohol and other drugs problems. Increasingly it is argued that the descriptor 'co-morbidity' needs to extend well beyond that to include a range of other co-occurring problems.

1.4 A public health approach to Family Sensitive Policy and Practice

Social determinants of health

This resource supports a public health approach to addressing Family Sensitive Policy and Practice. Public health is concerned with the health of the whole population and strategies to promote health and prevent, treat and cure/rehabilitate disease and disability. It is based on an understanding of social determinants of health and an awareness that strategies required to address determinants go beyond the health sector (CSDH, 2008). Comprehensive primary health care and health promotion strategies are required to address determinants, including inter-sectoral action, healthy public policy and community empowerment (WHO, 1978, 1986).

Public health evidence has identified early childhood development as a key social determinant of health (CSDH, 2008). Nurturing in the early years is crucial for social, emotional and cognitive development (Mustard, 2007). The right primary and secondary prevention strategies for early childhood can prevent future problems in families such as alcohol and drug misuse and child abuse (Olds et al., 1997; Olds et al., 1998).

However, there are new social risks affecting family and child wellbeing in industrialised countries, which include a lack of family/work balance, increased sole parent and single income families, poverty and social exclusion (Gatenio-Gabel & Kamerman, 2009).

Changing social dynamics

In contemporary Australia, issues affecting families and young people include:

- increasing numbers of women in the workforce
- high divorce rates
- increases in one-parent families (in turn linked to fewer financial resources and poorer outcomes)
- and grandparents raising and supporting children (AIHW, 2007a).

Within this broader context young people are: developing earlier, experiencing the onset of puberty at an earlier age (from 10 years of age onwards) with its associated changes in brain function and development; more technically savvy; wordlier with more money and independence; and more aware of their rights than ever before (Roche et al., 2007). This notwithstanding, while most young people are generally faring well in a physical and material sense they appear to be doing less well in relation to their emotional wellbeing and mental health. Numerous factors are potential contributors to these important changes and some are highlighted below.

Family structure

The structure of families has changed substantially over the last century from large families co-habiting with extended kin at the time of Australian Federation through to the nuclear family with few extended members after the Second World War, to a more diverse range of families today (single-parent, same-sex, blended families, and families with 0-2 children) (Roche et al., 2009). Extended families often live further away from one another and thus are less available for social, financial and emotional support (Roche et al., 2009). The increased geographical mobility of families further contributes to the fractured nature of families and disrupted social support networks. Such loosening of family bonds is also thought to foster young people's closer attachment to peers and greater involvement in activities such as drinking and drug use (Miller, 1997).

The number of single-parent families more than doubled between 1986 and 2006. In 2006, 15.8% of all Australian families reported having only one parent living in the family household (see Figure 4). Fewer extended families result in less support afforded from the traditional extended family structure and associated networks of aunts, uncles and grandparents.

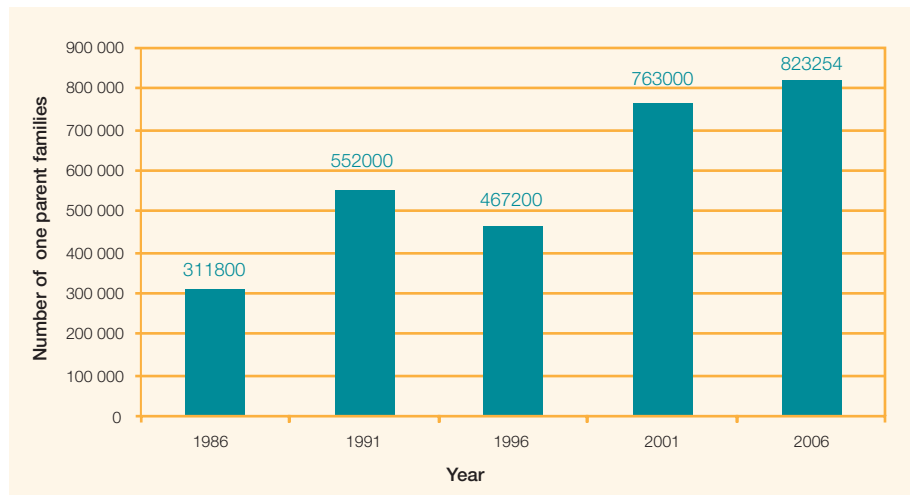


Figure 4. Number of single-parent families in Australia
(Source: Australian Bureau of Statistics, 1997, 2006, 2007)

Children living in single-parent households may be more likely to:

- experience lower levels of social support
- seek peer companionship and engage in risk-taking behaviours
- be vulnerable to developing psychological problems (Duncan, Duncan, & Strycker, 2006; Griffin, Botvin, Scheier, Diaz, & Miller, 2000; Hayes, Smart, Toumbourou, & Sanson, 2004; Ledoux, Miller, Choquet, & Plant, 2002; Miller, 1997; Spruijt & de Goede, 1997).

Violence towards parents has also been reported to be substantially higher in single parent families (Australian Research Alliance for Children and Youth (ARACY), 2009), again highlighting their need for additional support.

Parental influence

Parenting styles are also important. Contemporary parents of young children often reject rigid and authoritarian parenting styles and adopt more lenient approaches to control and discipline (Farouque, 2007). The weakening of traditional parental roles, and the blurring of distinctions between parent and child roles, has important implications for socialisation, modelling and how young people learn self regulation.

Parental support (nurturance, affection, acceptance), parental control (monitoring, permissiveness) and parental modelling (parental drinking) are also associated with adolescents' use of alcohol (Barnes, Hoffman, Welte, Farrell, & Dintcheff, 2006). Low family cohesion is also thought to be a risk factor during adolescence, as being a part of a cohesive family unit acts as a protective buffer and helps young people to cope with stress (AIHW, 2007b). Secure relationships with parents, provision of responsive care and implementation of appropriate limits operate as protective factors against substance misuse (Dawe et al., 2007).

While parental disapproval of adolescent alcohol and other drug use and enforcement of rules has been found to be an effective deterrent (Davey, Davey, & Obst, 2002; Reifman, Barnes, Dintcheff, Farrell, & Uhteg, 1998; van der Vorst, Engels, Meeus, & Dekovic, 2006), overly strict rules and reactive parenting techniques can result in the opposite effect (Guilamo-Ramos, Turrisi, Jaccard, Wood, & Gonzalez, 2004). In contrast, more proactive parenting techniques, such as parental provision of support for their child, involvement in their child's life, establishment of good communication patterns and provision of expressions of warmth and affection, have been found to prevent risky behaviours developing (Guilamo-Ramos et al., 2004).

Parental modelling has also been associated with adolescent drinking patterns. Parental attitudes towards alcohol and parents' own use of alcohol have a significant effect on adolescent drinking behaviour (Bellis et al., 2007; Reifman et al., 1998). If parents support norms favourable to alcohol use, model such behaviours and reinforce attitudes that promote alcohol use, this in turn will encourage children to imitate this behaviour (Fagan & Najman, 2005).

Changing roles of women

The changing role of women in society also has an important impact on parent-child relations and family functioning and dynamics. A higher proportion of women today are represented in the paid workforce (approximately 70% of women aged 25-34 years) compared to previous generations. Similarly, more women complete post-school education. Due to greater access to birth control, fertility rates have declined substantially from 3.5 births per woman in 1961 to 1.75 in 2003 (Australian Bureau of Statistics, 2004b) and the median age of mothers has risen from 28.9 in 1993 to 30.5 in 2003 (Linacre, 2005). Young people delay parenthood for several reasons including tertiary education, career opportunities, establish economic independence and to pursue leisure priorities. These changes, among others, impact significantly on young women's lifestyles, leisure activities, socialising and disposable income.

Spirituality, religious and cultural values

Spirituality and religion can have positive benefits for individuals and communities, in terms of social integration and health. Spirituality has been seen as a potential source of social connectedness and meaning for one's life (Eckersley, 2007). Affiliating with a religion and participating in its group activities is one way in which people develop social networks and connect with communities (Australian Bureau of Statistics, 2004a).

Social connectedness and meaning derived from spiritual practices can help to explain why religiosity and spirituality are seen to have a positive effect on mental health, with religious and spiritual people experiencing less depression, anxiety and alcohol and drug dependence (Williams & Sternthal, 2007). At an individual level, religiosity is also inversely related to adolescents' risky behaviour in terms of substance abuse (Beyers, Toumbourou, Catalano, Arthur, & Hawkins, 2004).

However, since the mid-1970's Australia has experienced a steady decline in levels of affiliation with the denominated forms of religion (Anglican and other Christian denominations) and an increase in

the proportion of the population with no formal religious affiliation (Roche, et al., 2009) (see Figure 5). The cultural and spiritual beliefs and traditions of Indigenous people have also been heavily affected by colonisation.

Conversely, mental health problems are worsening and youth suicide rates are increasing, a trend that has been attributed to:

...a failure of Western societies to provide appropriate sites or sources of social identity and attachment, and, conversely, a tendency to promote unrealistic or inappropriate expectations of individual freedom and autonomy. (Eckersley & Dear, 2002, p. 1891)

In addition, whilst suicide 'was an alien concept in Aboriginal culture' (Tatz, 2005, p. 19) suicide rates for young Indigenous Australians aged 12-24 years are four times higher

than for non-Indigenous young Australians (AIHW, 2008c).

Western cultural values such as materialism/consumerism and individualism also influence the spiritual domain of life and ultimately health and wellbeing (Eckersley 2007). Along with other social determinants of health, these cultural values help to explain why in some highly religious Western societies such as America, social and health indicators are relatively poor. The percentage of people with mental illness has been directly related to the degree of income inequality within a country (Wilkinson & Pickett, 2009). In one study of developing nations, suicide was not attached to religious beliefs but correlated to measures of individualism (Eckersley, 2007).

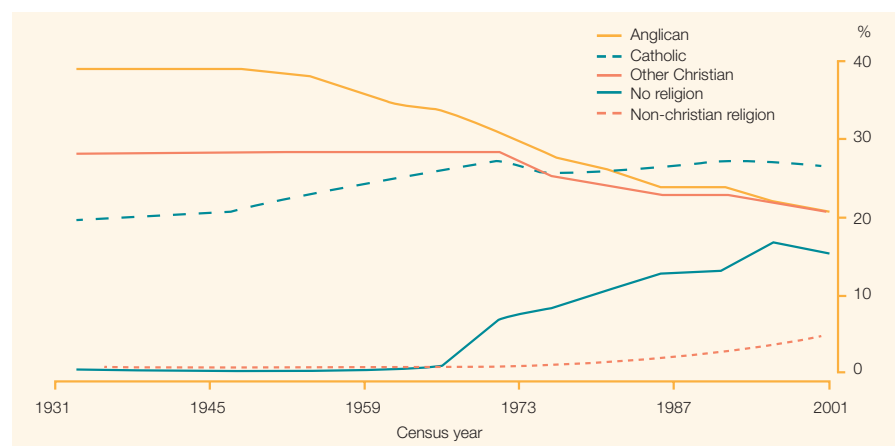


Figure 5. Religious affiliation of Australians of all ages (reproduced from Australian Bureau of Statistics, 2004a)

1.5 The social determinants of health and alcohol and other drugs misuse

Although alcohol and other drugs treatment has traditionally focused upon individual factors, alcohol and drug misuse can be associated with individual, social-structural and environmental factors (Spooner & Hetherington, 2004). Drug and alcohol misuse has been linked to cultural, social-economic and political contexts and experiences such as poverty, social disadvantage, social exclusion, unemployment, low education, poor quality housing and family stressors (Dawe et al., 2007; Dodd & Saggars, 2006; Odyssey Institute of Studies, 2004; Powis et al., 2000; Spooner & Hetherington, 2004).

Socioeconomic status

The relationship between socioeconomic status (SES) and alcohol consumption is complex and evidence is often conflicting. Some studies have found that SES was not a strong predictor of drinking (WHO, 2000; Williams, Sanson, Toumbourou, & Smart, 2000). The following studies reported a positive (but inverse) relationship between SES and drinking:

- lower family and community SES associated with lower rates of heavy episodic drinking in Canada (Breslin & Adlaf, 2005)
- higher disposable income in young New Zealanders was associated with increased purchase of alcohol (Darling, Reeder, McGee, & Williams, 2006).

In Australia the 2007 National Drug Strategy Household Survey (NDSHS) data indicate slightly higher proportions of alcohol consumers and slightly more risky consumption at higher SES levels (see Table 2). A curvilinear relationship appears to exist rather than a linear relationship (as found in British alcohol data (see Figure 8)). There appears to be a strong relationship between remote geographical location and risky/very risky drinking. SEIFA data also show a limited relationship between social gradient and alcohol with the most socially disadvantaged group containing fewer risky drinkers (see Figure 6 and Table 3).

The 2006 Public Health survey data also show a limited relationship between high risk drinking and socioeconomic disadvantage among persons 16 years and older (see Figure 7). In Australia, the relationship between income inequality, alcohol related harm and hospitalisations is complex; increasing rates of alcohol related harm (not deaths) are generally more strongly associated with areas of higher income inequality, but the reverse is true for alcohol related hospitalisations at low levels of income inequality (Dietze et al., 2009).

The relationship between SES and illicit drug use is more straightforward but again not always consistent or strong, as the following Australian data show. Approval of regular use of drugs, but not alcohol, tends to be more common among lower SES groups (see Table 4). While use of illicit drugs is most common among unemployed people, most national survey data show little differentiation by SES (Table 5).

Consumption of drugs and risky drinking by workers' industry and occupational group does however delineate by SES grouping with blue collar workers significantly more likely to drink at risky levels and consume illicit drugs (Berry, Pidd, Roche, & Harrison, 2007; Pidd, Shtangey, & Roche, 2008a, 2008b) and experience alcohol and drug related absenteeism (Roche et al., 2008).

Table 2. Characteristics of persons aged 14 years or older by short- and long-term risk status, 2007 (per cent)

Source: 2007 NDSHS: Detailed results

Characteristic	Short-term risk			Long-term risk	
	Abstainer/ ex-drinker	Low risk	Risky or high risk	Low risk	Risky or high risk
All persons (aged 14+)	17.1	62.5	20.4	72.6	10.3
Education					
With post-school qualification	11.8	57.3	20.9	77.5	10.5
Without post-school qualification	23.1	56.9	20.1	66.9	10.0
Labour force status					
Currently employed	10.2	64.2	25.6	77.7	12.1
Student	31.5	46.4	22.1	61.7	6.8
Unemployed	16.4	54.6	29.0	67.6	16.0
Engaged in home duties	20.1	67.3	12.7	72.1	7.8
Unable to work	31.4	51.9	16.7	57.5	11.2
Retired or on a pension	25.1	67.9	7.0	67.3	7.6
Other	24.4	62.2	13.4	69.8	5.8
Main language spoken at home					
English	14.7	63.8	21.5	74.4	11.0
Other	42.7	51.2	6.0	55.1	2.2
Socioeconomic status					
1st quintile (lowest status)	22.5	57.6	19.9	66.7	10.8
2nd quintile	19.5	60.4	20.1	70.5	9.9
3rd quintile	17.9	62.4	19.7	71.9	10.2
4th quintile	16.5	63.4	20.1	74.4	9.1
5th quintile (highest status)	11.5	66.9	21.6	77.1	11.5
Geography					
Major Cities	17.3	62.9	19.8	72.9	9.8
Inner Regional	17.2	62.1	20.7	72.0	10.9
Outer Regional	16.5	61.8	21.7	71.5	12.0
Remote and Very Remote	12.6	55.3	32.1	72.1	15.3
Marital status					
Never married	20.0	47.1	32.9	66.2	13.9
Divorced/separated/widowed	22.1	63.8	14.0	68.0	9.9
Married/de facto	14.7	69.2	16.0	76.5	8.8
Indigenous status					
Indigenous	23.4	49.2	27.4	64.2	12.5
Other Australians	16.8	63.1	20.1	73.0	10.2

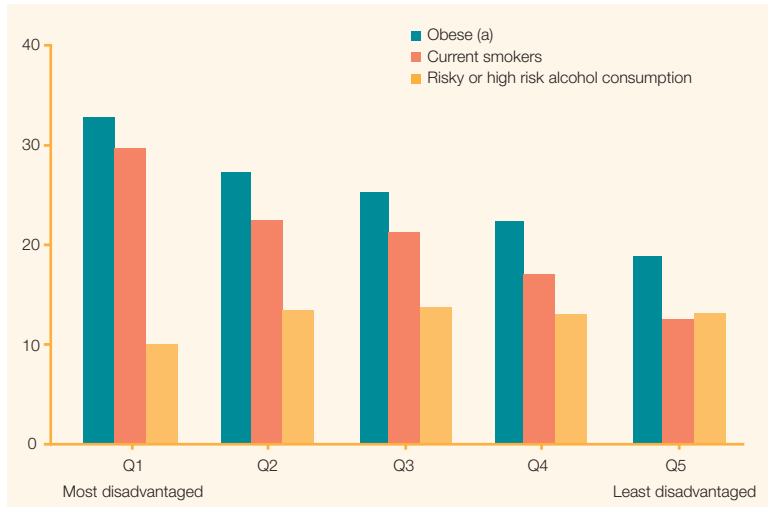


Figure 6. SEIFA (b) quintile of disadvantage⁹
Of total population, aged 15 years and over, living in each quintile.

(a) Proportion of people who are obese of total population who had their BMI score measured, aged 18 years and over, living in each quintile. Source: ABS 2007-08 National Health Survey

(b) Socio-economic Indexes for Areas.

Source: <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features30Mar+2010>

Table 3. Alcohol Consumption by SEIFA IRSD, 16 years and over¹⁰

	Short term harm from alcohol		Long term harm from alcohol	
	%	(95%CI)	%	(95%CI)
Lowest	26.5	(24.6 – 28.4) ↓	5.1	(4.3 – 6.1)
Low	26.9	(25.2 – 28.7) ↓	3.5	(2.8 – 4.3)
Middle	28.5	(26.9 – 30.2)	3.8	(3.2 – 4.6)
High	29.1	(27.4 – 30.9)	3.7	(3.0 – 4.5)
Highest	34.5	(32.8 – 36.2) ↑	4.1	(3.5 – 4.9)
Overall	29.4	(28.6 – 30.1)	4.0	(3.7 – 4.3)

Source: <http://www.health.sa.gov.au/pros/portals/0/BR%202005-28%20SEIFA%20IRSD%20chronic%20conditions%20and%20risk%20factors.pdf>

⁹ The calculations for risk of harm from alcohol in the long and short term based on an Australian Standard Drink and according to the 2001 NHMRC guidelines.

¹⁰ The calculations for risk of harm from alcohol in the long and short term based on an Australian Standard Drink and according to the 2001 NHMRC guidelines.

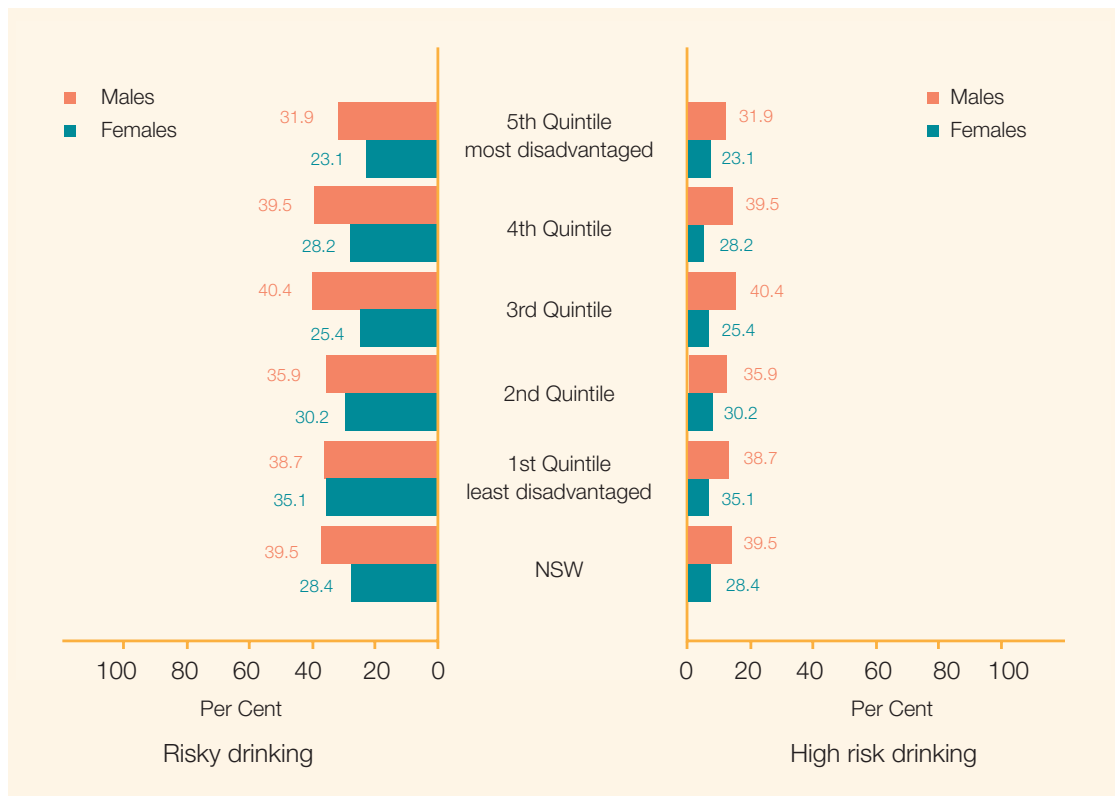


Figure 7. Risky (left) and high risk (right) alcohol drinking by socioeconomic disadvantage, persons aged 16 years and over (NSW, 2006)

Source: http://www.health.nsw.gov.au/PublicHealth/surveys/hsa/06/i_alcohol1/i_alcohol1_barqt.asp

Table 4. Perceptions and attitudes towards drugs, by sex and socioeconomic status, persons aged 14 years or older, 2007 (per cent)

Perceptions and attitudes	Sex		Socioeconomic status (quintile (a))				
	Males	Females	1	2	3	4	5
Drugs associated with a 'drug problem'							
Tobacco	3.3	2.0	3.0	2.8	2.7	2.7	2.0
Alcohol	10.8	10.2	12.1	10.1	10.2	10.0	10.4
Marijuana	25.8	24.6	29.2	28.7	26.4	24.2	19.9
Heroin	29.7	30.9	26.1	28.1	31.4	30.4	34.1
Meth/Amphetamine	16.0	16.8	15.9	15.8	15.3	18.2	16.4
Cocaine	7.2	7.1	6.0	6.0	6.5	7.3	9.0
Ecstasy/designer drugs	3.7	4.7	3.3	4.6	3.8	4.2	4.8
Other	2.4	2.5	3.2	2.7	2.4	1.8	2.5
None/can't think of any	1.0	1.2	1.1	1.2	1.3	1.1	0.9
Most serious concern for the community							
Tobacco smoking	18.2	16.3	17.7	16.1	17.6	17.8	16.9
Excess drinking of alcohol	30.5	34.0	28.3	29.8	31.2	33.2	37.7
Marijuana/cannabis use	5.7	5.8	7.9	7.0	5.9	4.4	3.9
Heroin use	10.8	10.1	11.9	10.3	11.0	9.9	9.5
Meth/amphetamine use	17.2	15.7	15.3	17.7	15.9	17.1	16.2
Cocaine use	8.2	8.3	8.7	8.3	8.7	7.8	8.0
Ecstasy use	6.0	6.0	6.2	6.9	6.1	5.8	5.3
Other	3.0	3.6	3.6	3.7	3.2	3.8	2.2
None of these	0.4	0.3	0.6	0.2	0.4	0.3	0.2
Approval of regular use by an adult							
Tobacco	15.8	12.9	18.6	15.9	13.8	13.4	10.8
Alcohol	51.7	38.9	41.8	40.0	44.3	46.6	51.8
Marijuana	8.7	4.6	8.2	4.8	6.9	6.3	7.0
Heroin	1.3	0.7	1.1	1.1	1.1	1.0	0.8
Pharmaceuticals	13.9	10.7	14.8	12.2	13.4	10.8	10.9
Other	4.4	2.5	3.7	2.8	3.3	3.4	4.0

(a) Socioeconomic quintiles represent levels of relative socioeconomic status. Quintile 1 represents those of lowest socioeconomic status and quintile 5 represents those of highest socioeconomic status.

Source: http://www.health.nsw.gov.au/PublicHealth/surveys/hsa/06/i_alcohol2/i_alcohol2_barqt.asp

Table 5. Characteristics of persons aged 14 years or older by illicit drug use status, 2007 (per cent)

Characteristics	Never used	Ex-users	Recent users
All persons (aged 14+)	61.9	24.8	13.4
Education			
With post-school qualification	56.6	29.5	13.8
Without post-school qualification	68.2	18.0	13.8
Labour force status			
Currently employed	52.7	32.3	15.0
Student	74.8	8.5	16.8
Unemployed	49.6	27.1	23.3
Engaged in home duties	59.0	32.3	8.7
Unable to work	85.3	9.2	5.5
Retired or on a pension	55.3	25.7	19.0
Other	62.2	22.1	15.3
Main language spoken at home			
English	59.7	26.5	13.8
Other	88.3	5.9	5.8
Socioeconomic status			
1st quintile (lowest status)	64.6	21.7	13.7
2nd quintile	64.7	24.0	11.3
3rd quintile	63.5	23.0	13.5
4th quintile	60.0	26.8	13.2
5th quintile (highest status)	50.3	26.9	14.3
Geography			
Major Cities	61.9	24.4	13.6
Inner Regional	63.8	24.5	11.7
Outer Regional	60.3	27.0	12.6
Remote and Very Remote	50.3	28.7	21.0
Marital status			
Never married	59.4	17.3	23.3
Divorced/separated/widowed	66.6	23.0	10.4
Married/de facto	62.1	28.4	9.4
Indigenous status			
Indigenous	46.8	29.0	24.2
Other Australians	62.2	24.8	13.0

Source: 2007 NDSHS detailed results

There is a clearer relationship between young people's academic school performance and predilection for using drugs. Table 6 shows data from the 2007 Australian Secondary Schools Survey on Alcohol and Drugs (ASSAD) (Roche et al., 2008).

Prevalence of drug use over the last year by level of self-reported academic performance was examined (Table 6). Academic performance levels were grouped according to above average performance, average performance and below average performance. Across all illicit drug types there was a statistically significantly higher level of drug use among the below average academic performers compared to average or above average academic performers. Differential levels of drug use were in the order of two to three times greater among below average performers compared to above average students.

Table 6. Percentage of students using each drug in the last year according to self-reported academic performance

Substance (use in last year)	Above average performance (n = 9,047)	Average performance (n = 11, 254)	Below average performance (n = 1,386)	Design-based F1
Cannabis	11.6%	17.2%	31.1%	177.5***
Inhalants	9.8%	13.0%	20.9%	63.3***
Cocaine	1.8%	1.9%	7%	75.9***
Hallucinogens	2.2%	2.3%	7.3%	61.3***
Amphetamines	3.3%	4.6%	11.5%	92.4***
Ecstasy	2.6%	3.1%	8.8%	62.0***
Tranquilisers	7.6%	9.4%	18.0%	71.7***
Opiates	1.2%	1.7%	5.1%	56.5***
Any drug	23.2%	30.8%	45.8%	160.7***

Note.¹ $df_1 = 2$, df_2 ranged from 712 to 741

*** $p < .001$

Source: 2007 Australian Secondary Schools Survey on Alcohol and Drugs (ASSAD)

In other countries, there is an inverse social gradient for alcohol consumption, and more abstinence amongst people of lower socioeconomic status (SES) and women (Wilsnack, Wilsnack, Kristjanson, Vogeltanz-Holm, & Gmel, 2009) and there tends to be more problem drinking behaviour amongst lower SES groups, particularly amongst men (Marmot, 2010; Wilsnack et al., 2009). For example, Figure 8 displays the rate of hospitalisations in England attributed to alcohol by quintile of socioeconomic deprivation for the area of those admitted. This indicates a strong relationship between male gender, level of socioeconomic deprivation of area lived in, and rates of problem drinking leading to hospitalisations.

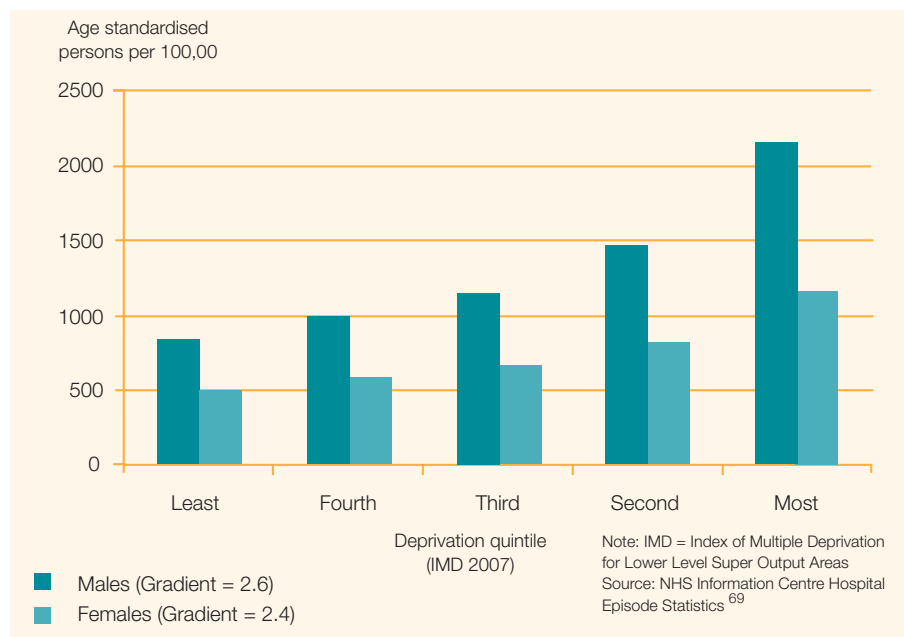


Figure 8. Alcohol-attributable hospital admissions by small area deprivation quintile in England, 2006-2007
(Marmot, 2010, p. 57)

The Marmot Review recommends that public health interventions that aim to reduce alcohol consumption should focus on reducing the 'social gradient' of health (Marmot, 2010). The 'social gradient' refers to the pattern of health status which is linked to socioeconomic status or position in the social hierarchy - increases in health status are directly linked to increments in socioeconomic status (see CSDH, 2008). Thus prevention of alcohol and other drug problems is related to reducing social inequity.

Public health solutions to alcohol (and other drug) misuse also include regulation through policy (CSDH, 2008; Room, Babor, & Rehm, 2005), including policy which impacts on 1) the availability and distribution of alcohol, 2) urban planning and the number and location of alcohol outlets and 3) alcohol affordability (Chikritzhs et al., 2009; Marmot, 2010; Room et al., 2005).

Indigenous families and communities

In the Australian context, the social determinants of Indigenous health are particularly important (Carson, Dunbar, Chenhall, & Bailie, 2007), and includes the inter-generational effects of 1) colonisation, 2) racism (reflected in government policies), and 3) systematised violence.

Amongst the Australian Indigenous population, more people abstain from drinking, but there is more 'risky' drinking (AIHW, 2008a). Substance misusers among Indigenous communities may also be more visible to public alcohol and other drug services, authorities and researchers.¹¹

Aboriginal and Torres Strait Islander children are 8-9 times more likely than non-Indigenous children to be involved in the child wellbeing and protection system (AIHW, 2009a). In addition, the rate of substantiated child wellbeing and protection notifications has increased significantly for Indigenous children: between 2004-05 and 2007-08, there was a 50% increase for Indigenous children compared with a 16% increase for non-Indigenous children (AIHW, 2009a).

Historically, approaches to both child wellbeing and protection and drug and alcohol issues for Indigenous people have been predicated upon racist, paternalist and euro-centric cultural values and norms. Racism has been one factor that has resulted in Indigenous families and children coming into more contact with government and church/social services, e.g. through the 'Stolen Generations'.¹² This creates an additional layer of complexity when considering Indigenous children and child protection and wellbeing issues.

The legacy of the Stolen Generations provides a salutary lesson for well meaning but misplaced policies involving child removal. However, the impact of the Stolen Generations and the perception that a degree of violence is 'cultural' have previously been cited as reasons for reluctance to intervene in child wellbeing and protection matters (Crime and Misconduct Commission, 2004). Currently, the controversial 'Northern Territory Emergency Response (NTER)', the Australian government's response to the '*Little Children are Sacred*' report (NT Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, 2007), has

resulted in increased reporting and confirmation of child abuse in a number of NT communities (FAHCSIA, 2010). In one recent study of Indigenous Australians, workers in the child wellbeing and protection field were seen as 'an extension of the historical authorities responsible for the coercive removal of children.' At the same time, the role of the state in keeping children safe was accepted (Ivec et al., 2009).

Substance misuse has been identified as a coping mechanism for the inter-generational violence experienced by Indigenous communities (Atkinson, as cited in Dawe et al., 2007). An insidious form of violence is 'cultural and spiritual genocide' (Baker, as cited in Dawe et al., 2007), linked to policies supporting the systematic removal of children from families (the 'Stolen Generations').

Drug use in Indigenous communities has also been linked to social exclusion (e.g. social isolation, unemployment). Petrol sniffing and 'chroming' (sniffing paints, solvents and glues) has been associated with isolation, exclusion and boredom experienced by young homeless Indigenous people (Cleary, 2003) but has been marginalised within policy responses (D'Abbs & Brady, 2004).

¹¹ The issue of 'heightened visibility' also applies to other groups such as homeless and those with mental health problems.

¹² The term 'The Stolen Generation' mainly refers to the forced removal of Aboriginal and Torres Strait Islander children from their parents, by governments and missionaries, under state and national government legislation and policies. This occurred between 1869 and 1969, and in some states, up to the 1970s, and resulted in dire social consequences.

Long-term, family sensitive, community-oriented, empowering approaches that establish trust are essential for alcohol and other drugs interventions with Indigenous families. Dodd and Saggars (2006, p. 38) maintain that 'drug and alcohol misuse policy and service responses to Indigenous people should be informed, devised, managed and implemented by Indigenous people.' Including Indigenous families in treatment plans is recommended for the success of alcohol and other drugs interventions (Dodd & Saggars, 2006) recognising that parental responsibilities are taken on by extended family networks, including siblings, aunts/uncles and grandparents (Ivec et al., 2009). Building social support, self-esteem and life skills into schools programs for Indigenous children have also been suggested as preventative strategies (Gray & Saggars, as cited in Dodd & Saggars, 2006).

See Part 3 for 'cultural competence' tools for working with Indigenous Australians.

Culturally and linguistically diverse communities

Research undertaken by the NSW Drug and Alcohol Multicultural Education Centre (DAMEC) has shown less frequent alcohol and other drugs misuse amongst people from Culturally and Linguistically Diverse communities than for other Australians. Culturally and Linguistically Diverse groups also demonstrate low awareness and use of specialist alcohol and other drugs services (Duncan, 2010). Barriers for people from CALD communities engaging with services included 'stigma and shame...unrealistic expectations of treatment; language barriers; and for many, the alien idea of seeking help and counselling outside immediate family or trusted community members' (Duncan, 2010, p. 27). Similarly, trust can be an important factor in engaging clients from Australian Indigenous communities (see below). Part 3 further discusses recommendations on culturally sensitive practice for CALD communities.

1.6 Barriers and enablers to Family Sensitive Policy and Practice

To date, little has been documented about barriers and enablers to Family Sensitive Policy and Practice in the alcohol and other drugs treatment sector. To address this issue, a survey on Family Sensitive Policy and Practice was jointly conducted by the National Centre for Education and Training on Addiction at Flinders University and the Australian Centre for Child Protection at the University of South Australia in 2009. There were 271 respondents from the alcohol and drug workforce, primarily alcohol and other drugs workers from NGOs and government (77), nurses (59) and social workers (38).¹³

An important finding from this survey was that whilst 44% of respondents 'strongly agreed' that their organisation endorsed Family Sensitive Policy and Practice, only 20% 'strongly agreed' that their organisation had guidelines in place for working with clients who were identified as having parental/caregiver roles (Trifonoff, Duraisingam, Roche, & Pidd, 2009). However, it should be noted that the relatively low response rate to the survey suggests the sample may be skewed and represents the views of those with a particular interest in and commitment to Family Sensitive Policy and Practice, and that many organisations may be even less supportive of Family Sensitive Policy and Practice than the survey suggests.

Respondents were asked to rate a series of possible barriers to Family Sensitive Policy and Practice within organisations. The top five 'most substantial' / 'very significant' barriers were:

- lack of access to resources and strategies
- limited mutual exchange of information
- competing priorities
- lack of education/training on child wellbeing/welfare issues and
- lack of linkages between alcohol and other drugs and child/family welfare agencies (Trifonoff et al., 2009).

¹³ To see the full report of the survey, visit www.nceta.flinders.edu.au

Working across sectors and agencies, confidentiality practices and common assessment tools

Factors which may impact upon inter-sectoral collaboration include:

- the stability of a sector and government (extent of reform and turnover in personnel)
- time spent on joint planning
- confidentiality practices
- a lack of common assessment processes
- strength of vertical linkages within a sector
- resources for collaboration
- funding mechanisms
- different discourses and conceptual frameworks shaping perceptions of 'problems' and appropriate 'interventions'
- interagency and cross-government agreements
- joint accountability mechanisms
- the engagement of leaders in cross-sectoral programs and projects, and
- professional and organisational culture (Battams, 2008; Battams & Baum, 2010).

Common frameworks are also important when working across sectors. A medical model of health and illness contrasts with a 'social determinants' model (see section 1.5), and may lead to different policy and interventions. The former model may lead to some services/professionals focusing on the 'individual' user and their physical addiction, rather than addressing their wider social context and the impact of alcohol and drug misuse upon children and extended family members and communities.

A common understanding, language and conceptual framework are helpful when agencies are working together, especially when working across sectors, and interpreting of shared data.

Confidentiality and 'duty of care'

Confidentiality laws and associated practises in health services related to such laws are often associated with the main barriers to Family Sensitive Policy and Practice. This may result in 'limited mutual exchange of information' and 'lack of linkages' between child/family welfare and alcohol and other drugs agencies. Similarly, privacy and confidentiality practices have been a barrier to agencies working together to prevent homelessness (Battams & Baum, 2010), and have been associated with risks to and causes of homelessness (Crane & Warnes, 2000). However, ethical guidelines for a range of professions often stipulate that the practitioner has a duty of care not only to their client but also to 'third parties' (e.g. children of an adult client) and there are constraints on confidentiality when a third party is at risk of harm.

A Common Assessment Framework for a range of agencies has been introduced in the UK which may be useful for Australian agencies to adapt (see Part 3). Resources and guidelines for agencies working together for child wellbeing and protection are provided in Parts 3 and 4.

The impact of service user involvement on service responsiveness, empowerment and health outcomes

Greater user involvement within services can lead to empowerment for individuals, communities and families, and ultimately lead to better health outcomes (National Centre for Health and Clinical Excellence, 2008; Wallerstein, 2006). Empowerment approaches also increase the likelihood that interventions will be sustainable (Wallerstein, 2006). Community engagement processes have helped reduce alcohol misuse (National Centre for Health and Clinical Excellence, 2008). Similarly, youth empowerment processes have been effectively used in alcohol prevention programs (Wallerstein, 2006). Community coalitions and community neighbourhood committees have been used to plan and design interventions to positively impact upon alcohol related behaviours and prevent injuries to children, as well as reduce alcohol impaired driving and crashes (National Centre for Health and Clinical Excellence, 2008).

Time, trust, the contractual environment and management of 'risk'

Conflicts of Interest

Alcohol and drug services where parents are involved require the careful balancing of potentially conflicting needs. Service Providers must establish trust with clients, support families and deal with any problems arising (e.g. with clients' children) (Banwell, Denton, & Bammer, 2002). They must manage conflicting demands and priorities, expectations and roles. For example, where an adolescent is the client, Family Sensitive Policy and Practice may be difficult to achieve in instances where the young person may not want a parent to be involved (or vice versa).

The outcomes-focused, contractual, competitive tendering environment which is increasingly common in both the government and NGO sector may also provide an 'invisible' barrier to workers developing and adopting Family Sensitive Policy and Practice. This environment may lead to short-term contracts, job insecurity, worker turnover, increased pressure to achieve specified 'outcomes', high client caseloads and less time spent with families and children.

In contrast, Family Sensitive Policy and Practice requires more time spent with clients, which is essential to establishing trust, for assessment and the identification of the strengths and risks within families, and for referrals and collaboration with other services. Limited resources (time, staff and services) of NGOs especially, may negatively impact upon their capacity for Family Sensitive Policy and Practice, inter-sectoral collaboration and the workforce development necessary to implement Family Sensitive Policy and Practice.

Competitive tendering may establish risk averse environments and can potentially lead to situations where there is over-monitoring and over-reporting of parenting within contracted organisations. This has the potential to detract from building trustful relationships with families, engaging families within services, and recognising and supporting the strengths and coping mechanisms of families. The competitive tendering environment has also been identified as a barrier to cross-sectoral collaboration (Battams, 2008) and developing the trust important for professional collaboration across services (Walker, 2000).

Role perception

Organisational or policy level factors may also influence workers' perceptions of their roles and functions, potentially creating further barriers to Family Sensitive Policy and Practice. McCaughey et al. (as cited in Scott 2009a) present a model where workers may:

- have a narrow view of their core role and not engage in extra activity
- engage in assessment and referral where activities are not seen as core
- see activities as peripheral to their core role but do them anyway
- see tasks as intrinsic to their job.

Scott (2009a) argues that these roles are influenced by the broader organisational and policy context, and that organisations need to develop workers' values, knowledge and the skills required to enable family centred practice. This could be done through a range of capacity building mechanisms, some of which are discussed further in Part 3. Previous work has also highlighted the pivotal importance of developing workers' sense of role legitimacy and role adequacy to maximise the probability of effective interventions and responses (Roche, Pidd, & Freeman, 2009).

The impact of different drugs and professionals' responses to them

Australians largely associate 'drug problems' with heroin use, although cite alcohol as the drug causing the most concern for the community (AIHW, 2008a). They are also more likely to have been abused by or put in fear by someone using alcohol than illicit drugs (AIHW, 2008a).

The way in which workers respond to the misuse of different types of drugs is important. Different types of drugs influence behaviour and impact upon families differently. As Templeton et al. (2006, p. 34) highlight:

There are quite strong findings that parents who misuse alcohol are more likely to demonstrate aggression and violent behaviour than are parents who misuse opiates, whose behaviour is more commonly associated with neglect.

However, there tends to be a focus on illicit drugs rather than alcohol when considering the impact of drug misuse upon families and children. In the UK, social workers involved with families in the child wellbeing and protection system were less likely to rate alcohol

misuse as great a concern as drug misuse (Forrester, as cited in Forrester & Harwin, 2004). Another study of 100 families affected by alcohol and drug misuse found that social workers' responses to alcohol misuse tend to be over optimistic (Forrester & Harwin, 2004, p. 128):

Children were far more likely to have already experienced harm at the point of allocation if their parents misused alcohol, and, worryingly, the harm was often more serious in nature.
(Forrester & Harwin, 2004, p. 126)

Conversely, cases involving drug misuse tended to be identified by child wellbeing and protection services sooner, before harm had occurred. Forrester and Harwin (2004, p. 128) conclude that there is a general 'under-response to alcohol misuse that has clear implications for policy and practice.'

Also notable are US findings that parents who were heroin users are significantly less likely to complete drug treatment programs than alcohol, cocaine and marijuana users, and that parents involved in the corrections system were more likely to complete treatment than those who were not (Choi & Ryan, 2006). Family Treatment Drug Courts in the US have supported retention in treatment programs and enhanced parents' capacity to support children whilst protecting those at risk (see Family Treatment Drug Courts, section 2.3).

Attitudes and values

The values, attitudes and feelings of professionals towards their clients who misuse substances are also important factors related to client access to services, appropriate treatment, provision of quality care and workers' advocacy on behalf of clients. Health workers' feelings about their clients (i.e. sympathy/concern versus anger/disappointment) have been linked to workers' perceptions of whether the quality of care their clients receive is 'deserved' or not (Skinner et al., 2007).

Workers with conservative values such as conformity, tradition and security (as opposed to those who value change, stimulation and self-direction) are more likely to have negative feelings towards their drug using clients and perceive them as more deserving of poor quality treatment (Skinner et al., 2007). Workforce development strategies thus need to not only provide information and training on Family Sensitive Policy and Practice, but also focus on strategies to enhance workers' values and attitudes towards clients and their children (Skinner et al., 2009).

In the public health field at large in Australia, there is an increased understanding and sophistication of thinking in regard to social determinants of health (Harris & Harris-Roxas, 2010). The current impetus is to identify the values and goals of society and to recognise how they impact on determinants of health and specific issues such as the wellbeing of children and young people.

Part 2: Good Practice in Action

To achieve significant change in practice it is important to be able to identify what constitutes good practice in relation to family friendly alcohol and other drugs practice. This section provides examples of Family Sensitive Policy and Practice programs that demonstrate the application of some of the principles outlined above, and that may also act as exemplars of strategies to overcome the array of potential barriers to Family Sensitive Policy and Practice.

What follows is not a 'review' as such, but rather an eclectic mix of illustrative programs and activities. Elements of programs considered important for 'good practice' (based upon a review) are specified in the next section (Part 3).

Good practice examples have been categorised under the levels of prevention described earlier, namely:

2.1 Secondary prevention, i.e. targeted health promotion programs,

2.2 Tertiary prevention, i.e. alcohol and other drugs treatment programs and services

2.3 'other cross-sectoral strategies', which involve cross-sectoral or multi-disciplinary teams.

Within each of the three sections below, programs targeted towards specific age groups of children or the parenting role are included. Often programs take into account the strengths and needs of parents and children simultaneously.

2.1 Secondary prevention: Targeted health promotion programs for families 'at risk'

- *Early childhood health promotion programs*
- *Primary school aged children and the education sector*

2.2 Tertiary prevention: Family and child friendly treatment programs and services in the alcohol and other drugs sector

- *Parents and younger children*
- *Parents and children in the middle years*
- *Parents, children and teenagers*

2.3 Other cross-sectoral strategies

- *Justice system approaches*
- *Dual diagnosis: mental health and alcohol and other drugs.*

2.1 Secondary prevention: Targeted health promotion programs for families ‘at risk’

Early childhood health promotion programs

Nurse home visitations -
The Elmira Trial (Olds et al.)

Universal (primary prevention) and targeted (secondary prevention) interventions in early childhood can have long-lasting effects.

Early childhood health promotion interventions with families and children have proved successful in preventing later problems, including alcohol and drug misuse. For example, one pre-natal/early infancy project (based on attachment theory) called the Elmira trial (Olds et al., 1997; Olds et al., 2007) was targeted towards low income ‘at risk’¹⁴ women having their first child during pregnancy and for the first 2 years of the child’s life.

The program led to long-term benefits (up to 15 years) which included fewer maternal behavioural problems associated with misuse of drugs and alcohol, less child abuse and neglect and fewer criminal arrests, convictions and days of incarceration (Olds et al., 1997). The same trial resulted in fewer arrests and convictions for children/adolescents who had been involved in the program when younger (Olds et al., 1998). This project highlights the importance of early, targeted support provided to families in terms of prevention

of later alcohol and other drugs problems. It emphasises the need for connections between early childhood mental health promotion programs and alcohol and other drugs interventions.

However, it should be noted that the above trial is not ‘tertiary prevention’, i.e. for families where there is existing alcohol and other drugs problems. Research on the Healthy Families America model of home visitation, delivered to ‘parents at risk of abusing or neglecting their children’, has proven the effect of the HFA model on lessening physical aggression and harsh parenting for first time mothers and those considered psychologically vulnerable. It was concluded that the effects of home visiting programs can be explained by who is targeted within such programs, with groups traditionally targeted including first time mothers and those psychologically vulnerable (DuMont et al., 2008).

Other examples:

- **Circle of Security model in Louisiana, US**
www.circleofsecurity.org
A targeted prevention program, based on attachment theory.
- **‘The Incredible Years’** program <http://www.incredibleyears.com/>, which includes parenting competency programs which have been targeted to population groups: <http://www.incredibleyears.com/program/parent.asp>
This is also an attachment theory based program, which includes parenting competency programs: <http://www.incredibleyears.com/program/parent.asp> and programs for children up to 12 years with conduct problems: <http://www.incredibleyears.com/program/child.asp>
Analyses of the program’s effectiveness can be found at <http://www.nice.org.uk/>, including a summary analysis of the cost effectiveness of the program:
<http://www.crd.york.ac.uk/crdweb/ShowRecord.asp?LinkFrom=OAI&ID=22008000676>
- A number of jurisdictions in Australia have implemented home visitation programs for ‘at-risk’ families.

¹⁴ The term ‘at risk’ implies that alcohol and other drugs problems may not currently exist but a greater propensity for the development of problems is indicated.

Primary school aged children and the education sector

Place2Be, UK

www.theplace2be.org.uk

The Place2Be is a charitable organisation which offers a range of services to primary school aged children attending schools within deprived neighbourhoods in the UK, as well as their parents. It is primarily an early intervention resource aimed at addressing the emotional needs of and building resilience in school aged children, and is currently running in 155 schools (and available to 51,000 students). It offers one to one counselling sessions, group sessions, a lunchtime service (both group and individual sessions), supporting year 7 and 8 students in transition, a counselling service for parents and carers, training for schools and the community, and professional qualifications.

Counsellors see a range of children within schools, including children living with parental alcohol and other drug misuse. The organisation has its own Research and Evaluation team and standard instruments are used within its evaluation (the Goodman Strengths and Difficulties Questionnaire for work with children and the Clinical Outcomes in Routine Evaluation Outcome Measure for work with parents), alongside qualitative measures. External evaluations have also been conducted by Ofsted, the Children's Funds and the Scottish Executive.

2.2 Tertiary prevention: Family and child friendly treatment programs and services in the alcohol and other drugs sector

'Tertiary' Prevention Treatment Programs are for people and families with alcohol and other drugs problems and are typically delivered in one of four ways, or using a combination of the following:

1. Home visits: Trained professionals (nurses, social workers, psychologists, alcohol and other drugs workers) or Peer Workers visit clients in their homes to support parents with substance abuse problems in their parenting role.
2. Residential: Programs that accommodate both mothers/parents and children in an alcohol and other drugs residential treatment program, which address some of the barriers that prevent people (especially women) from entering treatment programs.
3. Non-residential: Including community-based ante-natal programs, parenting programs, intensive play groups for children of parents who misuse drugs.
4. Assertive Outreach: Visiting or following up people who misuse substances within the community, wherever they may be (e.g. home/homeless and on the streets/other service environments).

Parents and younger children

Parents under Pressure program (PuP)
(Griffith University/
University of Queensland)
<http://www.pupprogram.net.au/>

The Parents under Pressure (PuP) program was designed by Professor Sharon Dawe (Griffith University) and Dr Paul Harnett (University of Queensland) specifically for families with multiple problems, where children are at risk of adverse outcomes (Dawe & Harnett, 2008). In particular, PuP has been used for families with parental substance abuse and/or concerns about child wellbeing and protection. It is an intensive multi-component program comprising 10 modules delivered across 3-4 months, usually in families' homes.

PuP is delivered by a Family Support Worker in the family home and focuses on a range of parental challenges. Beginning with parents' perception of themselves, PuP encourages parents to acknowledge their own strengths and identify and comment on their child's positive behaviours. The program helps parents to identify the various factors that make parenting difficult and devise strategies to overcome

the challenges. This technique differs from the traditional parenting deficit model in that it empowers parents to discover and use their strengths to build positive parent-child relationships. PuP builds the connection between parent and child with an emphasis on the importance of a nurturing, loving and safe relationship. In addition, the program aims to help families re-connect with their local community, extend social networks and cope with practical family issues, such as child care, school involvement and other social support.

PuP has demonstrated significant reductions in family stress, child abuse potential problems with others; and improvements in parent and child functioning and parent-child relationships (Dawe & Harnett, 2007).

The National Academy of Parenting Practitioners in the UK recently conducted a review of programs aimed at parents who misuse substances and their children. Of 238 studies, PuP was considered to be *the only program which met the criteria for evidence under the review* and demonstrated a positive impact upon parents and children through a rigorous randomised control trial (Asmussen & Weizel, 2009).

The key features of the PuP program (Dawe & Harnett, 2007) are:

1. *Assessment.* Comprehensive individual assessment of family's needs in collaboration with the family
2. *Case formulation.* Identify specific targets for change
3. *Challenging the notion of an ideal parent.* Strengthen parents' view of themselves as competent parents (achievements recorded in a workbook)
4. *How to parent under pressure.* Develop skills to cope with negative emotions by increasing mindful awareness (i.e., parents learn how to cope with negative emotions without avoiding or escaping through use of alcohol and other drugs)
5. *Connecting with your child and encouraging good behaviour.* Develop good parenting skills, such as using praise and reward children for good behaviour and including daily child-centred play where parents increase their emotional availability during play
6. *Mindful child management.* Use of non-punitive child management techniques, such as 'time out', and help parents gain control of their own emotional responses in situations where discipline is necessary (e.g., reduce impulsive, anger-driven punishment)
7. *Coping with lapse and relapse.* Develop skills to prevent relapse and increase mindful awareness of moods and emotional states related to alcohol and other drugs use
8. *Extend social networks.* Encourage parents to identify and extend their social and support networks to reduce social isolation
9. *Life skills.* Practical advice about nutrition, exercise, budgeting, health care and other responsibilities
10. *Relationships.* Improve communication between partners; identify and avoid recurring negative relationship patterns.

Intensive Supported Playgroups

See: <http://www.playgroup.org.au/Programs/FaHCSIA-Supported-Playgroup-Program.aspx>

Funded by FACSIA: <http://www.fahcsia.gov.au/sa/families/progserv/Pages/parenting-playgroups.aspx>

Intensive supported playgroups entail a supported playgroup development worker providing support to families with special needs (including disadvantaged families or those with alcohol and drug misuse problems) who otherwise would not utilise a playgroup. One example is Uniting Care Moreland Hall's (Victoria) Intensive Playgroup, which supports pre-school aged children of clients undergoing alcohol and other drugs treatment or who have other complex needs, and who are socially isolated.

The program delivers a play-based curriculum that supports families with pre-school aged children to connect with others in their local area who otherwise (due to complex needs) would have been socially isolated. Therapeutic program content is delivered via a strengths-based approach and focuses on parent-child attachment through art, music, storytelling, etc. Parents are also provided with support in developing strategies for positive parenting and coping with the challenges for parents with complex needs of their own. The program supports children in overcoming the impacts of their parents' social isolation by encouraging their social, emotional and physical development and facilitating increased family engagement with mainstream services such as kindergarten and Maternal and Child Health. (Steen & Hunt, 2009)

Cyrenian House Saranna Women and Children's Program (WA)

<http://cyrenianhouse.com/>

This service offers a non-residential family program which supports families, including children, and aims to minimise the impact of a family member's drug use. It also provides a residential program - the Saranna Women and Children's Program – which aims to 'enhance the quality of life and wellbeing' of women and children affected by addiction.

NB: A number of other alcohol and other drugs Residential Rehabilitation or Therapeutic Communities around Australia have family programs in which children (usually from birth to age 12 years) are able to accompany their parents into treatment, including Karilika in the ACT, Banyan House in the NT and Odyssey House in both NSW and Victoria.

Point of Engagement Project (2007-2009) (SA)

<http://www.southernjunction.org.au/services/homecommunity/poe.htm>

This pilot project aimed to improve the health and safety of young infants (during the ante and post natal period) whose parents use illicit drugs. It was a collaborative project between Drug and Alcohol Services South Australia (DASSA) and the Southern Junction Community Services in South Australia, funded by the National Illicit Drug Strategy – Community Partnerships Initiative. It supported 16 children through the pilot project. Specific objectives were to provide early intervention and home visiting to maximise opportunities for the engagement of 'high risk' families with services, reduce drug related harm for vulnerable babies and children by promoting attachment experiences and positive home environments and improving interagency service responses. The internal evaluation of the project identified a range of key outcomes including better engagement of families with alcohol and other drugs services and community activities as well as multi-agency collaboration.

Assertive Outreach: The Community Alcohol and Drug Services (CADS) Pregnancy and Parental Service (NZ)

<http://www.cads.org.nz/Pregnancy.asp>

"The Community Alcohol and Drug Services (CADS) Pregnancy and Parental Service (PPS) is a multi disciplinary team which provides long term case management and service coordination to socially marginalised substance using parents with the goal of improving health outcomes and reducing risk to clients and their children. The team uses an assertive outreach treatment model to actively engage clients into treatment. This model works positively for clients who are wary of services due to perceived problems or past treatment experiences. It has also been of value in preventing high risk families from "slipping through the cracks" given the sometimes itinerant nature of this client group. Interventions offered target common risks in this client group including psycho-education about substances during pregnancy and lactation, 'Safe sleep' and Non-accidental injury – 'shaken baby' intervention, tobacco and family violence interventions using a harm reduction framework." (Neild & Athanasos, 2009)

Other assertive outreach services include: The Sheway project in Canada

http://www.niichro.com/fas/fas_9.html

The PCAP project in Seattle <http://depts.washington.edu/fadu/FADU.projects.html#B23P> (also assertive outreach home visiting but with paraprofessional staff rather than nurses).

Parents and children in the middle years

Odyssey House Victoria
<http://www.odyssey.org.au/>

The Nobody's Clients Project
http://www.odyssey.org.au/institute/projects/full_report.pdf

The Nobody's Clients Project was an early intervention program for young children whose parents were affected by alcohol and other drug addiction (Odyssey Institute of Studies, 2004). This collaborative project targeted Children aged 4-13 years whose parents accessed treatment for alcohol and other drugs dependence. The project was developed after it became apparent that services were focussed on the needs of substance-using parents, their infants and adolescents, but less attention was given to children in middle childhood.

The Nobody's Clients project used action research methods to identify and record the experiences of children and their carers. Case workers conducted assessments of the family's needs and then provided support, counselling, parenting skills training and arranged mediation where necessary for up to 12 months. The interventions focussed on:

- Engaging parents in communication about their children
- Engaging children to understand their experiences and needs
- Addressing risk and strengthening protective factors with case management and family support.

The impact of the interventions included:

- Improved household structure and routine
- Reduced parental stress
- Improved linkage to respite services
- Improved behaviour management of children
- Improved resolution of family conflicts
- Improved school communication and attendance
- Reduced child stress
- Increased children's participation in activities (e.g., school camps, sports).

The project made a number of recommendations for practice change in the alcohol and other drugs and allied sectors.

Counting the Kids Program

http://www.odyssey.org.au/publications/reports/CTK_Evaluation.pdf

Counting the Kids (CTK) is a specialist child, parenting and family support program for those most severely affected by parental alcohol and other drug dependence. The program was based on the recommendations of the Odyssey House Victoria's *Nobody's Clients Project*, and since 2005, has been further developed to target children from conception through to 18 years of age. Families involved in the program have multiple and complex issues in addition to alcohol and other drugs problems, including mental health, domestic violence, housing and poverty.

Interventions include:

- Intensive and long-term home visiting and case management
- Parenting skills training with a focus on the parent child relationship
- Children's therapeutic groups and school holiday activities
- Brokerage Funds for children
- Family camps
- Secondary consultation and co-work to other professionals
- Training and presentations to workers and support with program development.

Counting the Kids is also developing a number of resources for workers in the alcohol and other drugs and allied sectors.

Parents, children and teenagers

Strengthening Families Program, Utah, US
<http://strengtheningfamiliesprogram.org/>

The US-based Strengthening Families (SFP) program was developed in the 1980s from a National Institute on Drug Abuse Research grant. This video-based program was developed to help drug-using parents improve their parenting by enhancing the parent-child relationship (Kumpfer, 1998), and to help prevent teen drug use (Messer, 2010).

The original SFP program was developed for high risk families with children aged 6-11 years (SPF 6-11). A shorter 7 session program is available for low risk families with pre-teens and younger teenagers (SPF 10-14). The original program is still available along with a 14 session program for high risk families with young children (SPF3-5) and early teenagers (SPF12-16).

The key features and aims of the SFP are:

- Parent skills training: to increase parenting skills, efficacy and confidence; reduce depression, stress and substance use
- Children skills training: to increase social skills and competencies; reduce conduct disorders, shyness, aggression and substance use
- Family life training: to reduce family conflict; increase organisation; enhance positive communication and family bonding.

The SPF 10-14 program is currently being modified and evaluated, with initial findings indicating that the program led to parents controlling their anger, being less negative and more positive toward their children (Messer, 2010).

Focus on Families/Families Facing the Future

<http://depts.washington.edu/sdrg/FOF.htm>

Focus on Families, now called Families Facing the Future, is an intensive family-focused program for people in methadone treatment who are parents of 3-14 year olds, which combines parent skills training with home-based case management (Catalano, Gainey, Fleming, Haggerty, & Johnson, 1999). The parent skills training component comprise 53 hours of training delivered in small groups (6-10 families). Following an initial five-hour family retreat, parents attend two 90-minute meetings per week for 16 weeks and children are present at 12 of the sessions. The case management component entail home visits and individualised service to set goals and monitor progress for approximately nine months.

Twelve months after the program was delivered to parents in methadone treatment, parents reported improved skills to avoid drug use, more defined household rules, and reduced domestic conflict compared to control families (Catalano et al., 1999). Long-term follow up research on the program demonstrated that there was no difference between intervention and control groups when it came to drug use in those who had been in the program as children. However, males who had been in the program as children were significantly less likely to develop a drug problem than males who had not been in the program (Haggerty, Skinner, Fleming, Gainey, & Catalano, 2008).

Emergency Services Child Abuse Prevention Program (ESCAPP)

http://www.drugnet.bizland.com/assessment/comm_pro.htm#Blau

ESCAPP is a family-centred program that 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” (Campbell, 1997, p 23). It is a 4-week intensive in-home intervention involving a clinician, family support worker and nurse. This is followed by case management and coordination with relevant agencies for up to one year. An outreach program, which involves health care providers, child care, schools, police, child wellbeing and protection services, emergency shelters and other social service providers, is implemented to identify families in need. Stabilisation is established through intensive home-based assessment of needs and implementing intervention. Improving long-term outcomes involves developing links with relevant services, including substance abuse facilities, child care services, and respite care. While program facilitators successfully engaged with families, cooperation of other service providers was more challenging.

Breaking the Cycle (UK)

Breaking the Cycle (BtC), an initiative of Addaction and Zurich Community Trust, aimed to “support and empower families where parents have substance misuse issues to improve their family functioning and family life and to provide an environment where their children can thrive” (Addaction, 2009, p 2). The program involved working with families to reduce parental substance use, improve parenting skills, establish boundaries and structures within the home, put their children’s needs first, manage their finances and undertake training or find employment.

Results from a pilot study reported more than 80% of clients in the program stabilised, reduced or stopped problematic substance use; reduced harmful behaviours, such as domestic violence and crime, and increased their efforts to prioritise their children’s health and development (Addaction, 2009). Clients also reported satisfaction with the approach and level of support provided.

Respite Program: Share Care

Share Care offers overnight respite care for children of substance-dependent parents (Odyssey Institute of Studies, 2004). It is a foster care program that aims to support families and avoid family breakdown.

Other Service examples include:

Opioids in Pregnancy Clinic, The Langton Centre, Sydney

<http://www.sesiahs.health.nsw.gov.au/sydhosp/Services/langton.asp>

Family Alcohol Service/Foundation 66 in Camden, London

<http://www.foundation66.org.uk/pages/familyalcoholservice.html>

- A multi-disciplinary team offering a range of services to help minimise the impact of parental alcohol and other drugs misuse upon children.

2.3 Other cross-sectoral strategies

Justice system approaches

Legislative and justice approaches / Illicit Drug Diversion Initiative

In Australia, the Illicit Drug Diversion Initiative (IDDI) provides a nationally consistent framework through which police and courts may refer eligible drug offenders towards appropriate assessment, education or drug treatment. Offenders can be diverted at different points throughout the justice continuum: police detection and apprehension (e.g. police drug diversion), court-level diversion (e.g. Magistrates Courts Assessment and Referral) and at the specialist courts (e.g. Drug Courts).

Australian Drug Diversion Programs

The illicit drug diversion programs operate at multiple stages of the criminal justice system in Australia and involve the redirection of drug and drug-related offenders away from conventional criminal justice processes into assessment and treatment (Ogilvie & Willis, 2009). Their primary aim is to minimise the levels of contact that offenders have with the formal criminal justice system. Research to date suggests that, in addition to reducing drug use and offending, diversionary programs can also improve the drug user's relationships with significant others including family members (Hughes & Ritter, 2008).

Police drug diversion programs are provided at the front end of the justice continuum. They give offenders the option of being diverted into education and assessment. There are three main types of police drug diversion programs, two of which are aimed at illicit drug use and possession. The third type is focused on providing drug or drug-related offenders with a range of diversionary options (Hughes & Ritter, 2008).

Court diversion programs in Australia are provided at the pre-trial, pre-sentence and post-sentence stages of the court process (Hughes & Ritter, 2008). The use of court diversion for minor drug or drug-related offences provides the courts with the option of referring offenders into assessment, education and or treatment. Most of these programs are usually provided at the pre-plea stage of the process, they are usually 3-4 months in duration and have a strong emphasis on counselling (Hughes & Ritter, 2008). Participation in court diversion programs allows clients to address their drug-related issues via an intense period of treatment and case management (Hughes & Ritter, 2008).

Serious drug and drug-related offenders are dealt with at the pre-sentence and post-sentence stages of the judicial processes through specialist drug courts. These drug courts are intended to be an alternative to imprisonment and usually involve an intensive approach comprising drug treatment, case management, supervision, urine testing, and access to a range of programs including anger management, relapse prevention and life skills (Hughes & Ritter, 2008). As part of the process, drug court participants are given individual program plans and are required to remain drug free and not commit offences for the period of the court order. Drug court programs vary in length from 6-24 months, with the median length usually being 12 months (Hughes & Ritter, 2008).

For a summary of the drug diversion programs operating in Australia, see:

[http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/Monograph+16.pdf/\\$file/Mono+16.pdf](http://www.dpmp.unsw.edu.au/DPMPWeb.nsf/resources/Monograph+16.pdf/$file/Mono+16.pdf)

US Family Treatment Drug Courts, see: <http://www.courts.state.ri.us/family/familytreatment.htm>

Family Treatment Drug Courts are a voluntary alternative to the traditional dependency court processes. These child and family centred courts aim to protect children at risk due to their parents' drug and alcohol or other drug misuse, to enhance parents' capacity to support children and meet their health and development needs, and to reduce costs to the foster care system.

Family Treatment Drug Courts use a non-adversarial, culturally competent and collaborative approach to justice. Importantly, Family Drug Courts have led to better retention in treatment programs and improved child welfare outcomes (Choi & Ryan, 2006). A cost analysis of this program has also demonstrated significant savings due to reduced use of the foster care system (Crumpton, Worcel, & Finigan, 2003).

National Center on Substance Abuse and Child Welfare:

<http://www.ncsacw.samhsa.gov/>

This US centre works in collaboration with child welfare agencies, substance abuse treatment centres and court professionals to develop family centred approaches for families and communities; identifying the needs of children whose parents abuse substances, developing MOUs between agencies and screening and assessment tools to ensure 'family retention', as well as information sharing protocols.

Center for Families, Children and the Courts:

<http://law.ubalt.edu/template.cfm?page=602>

A US national leader of reform to improve the justice system so that it is integrated with the community and adopts family centred approaches.

Dual diagnosis: mental health and alcohol and other drugs

National Illicit Drug Strategy (NIDS) Dual Diagnosis Project

The NIDS Dual Diagnosis Project was developed through a partnership between the NSW Department of Community Services and the Mental Health Co-ordinating Council. This project aimed to improve identification, support and referral services to substance-using parents with mental illness; improve awareness and capacity of service providers to respond to the needs of children in the care of parents with dual diagnosis; and encourage collaboration with relevant services to meet the needs of such families (Hegarty, 2005).

SAMHSA's Co-occurring Center for Excellence

This excellent US website offers a range of resources for treating dual diagnosis (referred to here as co-occurring disorders) and service system strategies:

<http://coce.samhsa.gov/about/>

These include assessment tools:

<http://coce.samhsa.gov/core/screening.aspx>

and a resource on addressing co-morbidity in 'non-traditional' service settings:

http://coce.samhsa.gov/cod_resources/PDF/OP4-SpecialSettings-8-13-07.pdf

Part 3:

Guidelines for Family Sensitive Policy and Practice

Part 3 is comprised of two sections.

Part 3.1 considers *Guidelines for interventions on Family Sensitive Policy and Practice*, based upon recommendations from a UK review of alcohol and other drugs programs targeted towards families (Asmussen & Weizel, 2009). These guidelines are then elaborated upon in relation to 'assessment' and 'intervention', with links to resources currently available.

Part 3.2 considers *Capacity Building for Family Sensitive Policy and Practice*, and examines wider issues such as workforce and organisational development, building leadership and government policy and accountability mechanisms. Throughout Part 3, key questions on Family Sensitive Policy and Practice which may be used as discussion points for agencies are highlighted.

The key issues identified in this section are collated and summarised in a Checklist for Family Sensitive Practice contained at the front of this document. The Checklist is also available as a stand alone document.

Both Parts 3 and 4 offer good illustrations of resources available. Examples provided are not exhaustive. Other practices and resources may exist, some of which are not widely publicised or well known.

3.1 Guidelines for interventions on Family Sensitive Policy and Practice

A review of research into 'what works in supporting parents who misuse drugs and alcohol' by the UK based National Academy for Parenting Practitioners (Asmussen & Weizel, 2009) concludes with 10 overarching recommendations for frontline workers and planners which included:

1. Address multiple risk and protective factors for children, parents, families and communities. Assessing family needs and identifying resources is necessary.
 2. An assessment of families needs can be done through the Common Assessment Framework or similar tool of assessment for families.
 3. Services for parents who misuse drugs and alcohol should be a part of local/state government plans for children and young people.
 4. Intensive, long term interventions are required for parents who misuse drugs and alcohol.
 5. Highly trained professionals are necessary for these interventions. Service plans/systems should consider the availability of appropriately trained staff, ongoing supervision and professional development.
 6. Multi-agency working is necessary for effective interventions that address multi-family problems. Services should consider their strategies for information sharing and referral.
 7. Strategies aimed at improving the parent-child relationship and teaching parents about appropriate responses to their children's behaviour (enabling parents to reflect on their behaviour e.g. through video-taping) are necessary for effective interventions.
 8. Interventions should be informed by models of therapeutic practice and theories of child development which have been tested and are proven.
 9. Consider carefully the involvement of extended family members in treatment plans and the alternative care of children, as they may also have substance problems or difficulties with parenting.
 10. Monitoring and assessment processes must be in place for effective interventions e.g. monitoring progress in parenting skills.
- These points are considered further below in relation to assessment and interventions.

Assessment

Key Discussion Points: Assessment

- Do the treatment/intake/client assessment procedures you use identify whether the client has a parenting/caregiver role?
- Do your assessment procedures consider:
 - » Multiple risk and protective factors for children, parents, families and communities (e.g. domestic violence, mental health, housing issues, employment, relationships, income/employment, etc)?
 - » Child care responsibilities and parenting needs?
 - » The need for child care while clients attend treatment?
 - » The parenting role of the client as a potential stressor?
 - » Contraception issues and pregnancy status of female clients?
 - » Clients' concerns about their children?
 - » Validated and reliable measures of family functioning, parental mental health and child behaviour?
 - » If clients have children who are clients of a child welfare service (e.g. statutory child protection service, child and family support service, etc)?
 - » The cultural background of families and how this may influence perception of 'family' and potential access to additional parenting supports?

Identify and address multiple problems through assessment, care planning and treatment

To address the range of problems experienced by drug using parents who are clients of child and family welfare services, it is important to undertake a comprehensive problem assessment to ensure that the necessary services are provided (Marsh et al., 2006). Positive child welfare outcomes - including increased chances of parents being reunited with their children - are related to multiple problems being simultaneously identified and addressed through treatment (e.g. domestic violence, housing and mental health) (Marsh et al., 2006). Developing specific targets through care planning is also recommended.

In particular, simultaneously offering treatment for both alcohol and other drugs misuse and mental health problems and disorders is recommended for parents with co-morbidity/dual diagnosis. Information on tools for the assessment of co-occurring substance misuse and mental health disorders can be found at: <http://coce.samhsa.gov/core/screening.aspx>

Routinely identify clients with parenting responsibilities

The routine identification of parenting responsibilities upon initial client attendance at professional services, programs or institutions is necessary. Questions to ask in regard to children include their age, current care arrangements and school/child care situation. The organisation 'Children of Parents with a Mental Illness' (COPMI) have developed a range of checklists/questions for professionals to ask of clients/parents/carers, families and young people.

When accessing the COPMI website follow the 'worker resources' side bar at the left of the homepage to locate relevant resources.

<http://www.copmi.net.au/mhw/parent.html>

Assessment and care-planning taking into account child and adolescent support and development issues and the strengths and coping mechanisms of families

Assessment should include:

- » the strengths and coping mechanisms of families and children,
- » the level of support received by families,
- » parental and other carer stress and
- » child and adolescent development issues.
- The Common Assessment Framework is an important resource for *assessing the needs of children and young people* which is widely used in the UK by practitioners working with this group, and can be obtained from: <http://www.cypswansea.co.uk/index.cfm?articleid=24906> A guide for management on the Common Assessment Framework is available at: <http://publications.everychildmatters.gov.uk/eOrderingDownload/CAF.pdf>
- Assessment and interventions should also consider protective factors and the resilience of children. A good reference on this is Velleman and Templeton (2007) *Understanding and modifying the impact of parents' substance misuse on children*, *Advances in Psychiatric Treatment*, vol 13, p79-89.

- Standardised measures of parenting capacity and child behaviour problems are recommended as they enable systematic review of treatment gains. Instruments need to cover parental psychological problems, e.g. depression, anxiety, stress, e.g. the Parenting Stress Index (Adibin) http://www.tjta.com/products/TST_031.htm Depression Anxiety Stress Scale (Lovibond) <http://www2.psy.unsw.edu.au/groups/dass/> and the Strengths and Difficulties Questionnaire (Goodman) <http://vinst.umdj.edu/VAID/TestReport.asp?Code=SEDQT>
- Another measure for the *assessment of adult family members* of those with alcohol and other drugs problems is the *Stress-Strain-Coping-Support model* and associated standardized questionnaires for assessing stress, coping and strain (Alcohol Drugs and the Family Research Group, 2009; Orford, Templeton, Velleman, & Copello, 2005).

The Alcohol, Drugs and the Family Social Support Scale is also an assessment tool to help determine the level of *social support families receive* (Toner, 2010; Toner & Velleman, 2010). For further details see the CD-Rom accompanying this resource.

Provide support and educational resources to children and adolescents on parental substance misuse/co-morbidity

Support and age-appropriate educational resources on alcohol and other drugs issues for children, as well as other family members should be provided where appropriate. See the following free brochure for information about what children might want to know:

- http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/when_parent_drinks.pdf
- Educational books for children aged 5-12 years whose parents have dual diagnosis: <http://www.nscchealth.nsw.gov.au/carersupport/fami/ddkit/003745004.pdf> (Blue Polar Bear, for 5-7 year olds) and <http://www.nscchealth.nsw.gov.au/carersupport/fami/ddkit/003745003.pdf> (The Flying Dream, for 8-12 year olds)
- http://www.camh.net/News_events/News_releases_and_media_advisories_and_backgrounders/wishes_worries_pr0405.html (Canadian book for younger children – not free).

Other resources currently available are listed in Part 4.

Social development theory: learning across the lifetime

A popular theorist in cognitive/language/social development is Vygotsky who believed that learning occurs across the lifespan, not just in early developmental 'stages'. Learning was also seen as a dialectical process between learner/student and parent/child.

Vygotsky's theory of social development (Vygotsky, 1978) emphasises the importance of *social interaction* and social and family culture to social and cognitive development. Social learning was seen as the precursor to cognitive development. One concept he introduced was the 'zone of proximal development' which provides the window for learning: this is where tasks are too difficult for learners and may require assistance from a teacher/peer/parent.

Learning is seen to be best achieved through scaffolding, whereby a parent/teacher/peer with higher level skills adjusts their guidance/assistance with the increasing development of learners. Vygotsky's approach is aligned to social-cultural frameworks which highlight the importance of interpersonal relationships and understanding to child development, along with 'educaring' which relates to the mutual nurturing and educational aspects of early learning environments (Smith, 1996).

Behaviour management

This includes teaching parents about positive reinforcement (i.e. providing rewards when children are being good, rather than focusing on punishment for bad behaviour), steering children away from undesired behaviours (e.g. diverting their focus/changing the subject) and non-punitive punishment techniques for 'bad' behaviours (e.g. time out) (see Miltenberger, 2008).

For more information about child development theories see the Resources section below (Part 4).

Emotional availability has been used to assess and predict attachment and the quality of parent-child relationships as well as child development (Biringen, 2000). For example, emotional availability has been used in programs such as Head Start to assess early childhood development. Emotional availability as a construct includes both parental and child dimensions (Biringen, 2000).

For parental dimensions, features are:

- *parental sensitivity* (i.e. clear perceptions of children's needs and prompt responses to children's signals as well as the negotiation of conflict)
- *parental structuring* (support of learning and exploration that does not impede the child's autonomy, and where there are consistent rules and regulations for interactions)
- *parental non-intrusiveness* (being available without being overwhelming, being patient and allowing children to take risks to build their confidence) and

- *parental non-hostility* (positive, harmonious, patient and calm parenting behaviour).

Child dimensions of emotional availability include:

- *child responsiveness* (a balance between autonomous exploring and connecting and emotionally responding to the parent) and
- *child involvement of the parent* (a balance between independent activity and 'checking in' with the parent via eye contact, showing objects, asking questions, etc) (Biringen, 2000).

Biringen's (2000) operationalisation of the construct of emotional availability integrates both attachment theory and emotional availability perspectives. The Emotional Availability Scale (EAS) provides a well validated and theoretically driven measure of the quality of the parent-child relationship. In moving beyond traditional observation systems in which particular behaviours (e.g. praise) are simply counted, Biringen's (2000) EAS allows for the clinician to describe the quality of the relationship between parent and child.

Personality development (e.g. level of introversion/extraversion), children's developmental stage and the capacity of personality to change (Caspi & Roberts, 2001) should also be taken into account when using attachment theory and emotional availability.

Good enough parenting

The phrase 'good enough parenting' was first introduced by Winnicott (1965) who recognised 'that it is unhelpful and unrealistic to demand perfection of parents, and to do so undermines the efforts of the vast majority of parents who are in, all practical respects, 'good enough' to meet their children's needs' (Hoghughi & Speight, 1998, p. 293).

Components of 'good enough parenting' include meeting basic physical needs (physical care, nutrition) along with emotional needs:

- 1) love, care and commitment
- 2) control/consistent limit setting (e.g. setting and enforcing rules and boundaries to indicate the acceptability of behaviours)
- 3) facilitation of development (i.e. fostering opportunities for physical, emotional and intellectual and moral/spiritual development) (Hoghughi & Speight, 1998).

'Good enough parenting' entails low levels of criticism and high levels of warmth and praise for children, spending time with children engaged in child focused activities, regular communication between parents and children, presenting a 'united front' in parenting, parents and children enjoying each other's company, and setting limits consistently:

(see: http://www.alcoholandfamilies.org.uk/taining_materials/12.3.ppt).

Intervention

Key Discussion Points: Intervention

When working with clients who have parental/care giver roles:

- Are interventions tailored to family needs – including the specific needs of CALD or Indigenous families?
- Are interventions focused on prevention and early intervention strategies?
- Are families' strengths and resources considered? Are parents' coping strategies identified and supported?
- Does strengthening parent-child relationships form part of the treatment goal?
- Do you often see and speak to your clients' children?
- Do you collaborate with children's services where needed?
- Are other family members, including children, offered information and support about their parents' drug or alcohol misuse?
- Are further resources offered for the identified needs of families?
- Is level of parental/social support identified and developed?
- Are interventions sustainable and prevention focused?

Plan for intensive, long term interventions

Motivational interviewing, including within brief interventions, is a common therapeutic technique which has proved to be effective with clients with drug and alcohol problems (Hickie et al., 2001; McCambridge & Strang, 2004). The importance of intensive, long term interventions has also been highlighted in an assessment of the PuP intervention for families where a parent misuses substances (Asmussen & Weizel, 2009).

Intensive services for parents living with drug problems can promote family preservation (Barth, as cited in Campbell, 1997, p 24). Additionally, attachment based interventions can strengthen relationships between parents and children and potentially enhance child development (see below for more information about attachment theory and its use).

Engagement of the substance using parent in treatment can be initially challenging due to fear and mistrust, however it is critical to promote engagement and retention in treatment for the long term in order to ensure optimal outcomes (Poole, 2000).

Engaging GPs

Engaging GPs is especially important particularly for specific population groups such as CALD (above) and rural communities (where specific alcohol and other drugs services may be scarce). However, whilst substance misuse may be common amongst clients of GPs, detection rates are low (Hickie et al., 2001). People with alcohol and other drugs problems may not often present to GPs specifically for help with their alcohol and other drugs issues, and are more likely to present with mental health issues where there is an alcohol and other drugs/mental health co-morbidity.

It is also more likely that GPs will see family members of people with alcohol and other drugs problems - including their children, partners, parents and siblings – who may be aware that their family member has an alcohol and other drugs problem, even if the client lacks this insight. GPs have been advised to consider mental disorders such as depression and anxiety when substance misuse is identified, and to screen for co-morbidity due to the higher rates of disability and need for interventions when co-morbidity does occur (Hickie et al., 2001).

Employ strategies aimed at improving the parent-child relationship and parenting skills, informed by models of therapeutic practice and theories of child development

Effective interventions are required to enable parents to reflect upon their responses to their children and learn better strategies for coping and interacting with their children. Attachment theory is an important component of many parenting skills interventions (Marvin, Cooper, Hoffman, & Powell, 2002), including those for drug-dependent mothers and their young children (Suchman, Pajulo, DeCoste, & Mayes, 2006). Programs such as HeadStart, the PuP program and The Incredible Years are informed by attachment theory and the concept of emotional availability, and hence strengthening parenting competencies are often a feature of programs. Theories of child development and behaviour management are discussed further below.

Attachment theory and the emotional availability construct
Attachment theory sees the importance of a secure base and *emotional development* to overall child development, including parents identifying and sensitively responding to the emotional needs of their children (Bowlby, 1978). It sees the influence of early attachment in the primary care giving relationship to the capacity for and nature of later intimate relationships, including future generation parent-child relationships (see Bowlby, 1977; Schore, 1994), as well as the choice of career (Tillett, 2003). For example,

‘insecure’ attachments in early childhood where the parent/s did not provide care, but instead was ‘cared for’ has been associated with ‘compulsive caregiving’ and the helping professions (Bowlby, 1977; Tillett, 2003).

According to attachment approaches, there are a number of parent-caregiver ‘dyads’ operating, including:

- 1) the ‘ideal’ secure child-autonomous parent
- 2) the insecure child-avoidant-dismissing parent
- 3) the insecure child-ambivalent-preoccupied parent
- 4) disordered patterns of relating (see Marvin et al., 2002).

Stressful life experiences (i.e. death or divorce) can also change one’s level of security and the way of relating – i.e. ‘secure’, ‘dismissing’ or ‘avoidant’ - carried into early adulthood (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Positive attachments between parents and children can act as a protective factor, decreasing the likelihood that young people will engage in drug taking, whilst weaker or unstable attachments can increase the likelihood of drug use (Brook et al., 1993; Hawkins et al., 1992).

Harm minimisation

The links between a harm reduction approach and the welfare of children in the care of parents who misuse alcohol and other drugs are becoming clearer. In one recent Australian study, it was found that ‘infants of mothers using illicit drugs were more likely to suffer substantiated harm and more likely to enter foster care than infants of mothers who were compliant with a methadone program’ (McGlade, Ware, & Crawford, 2009, p. 285). Methadone can provide metabolic stability (fewer highs and lows), slower withdrawal from opioids and more control over one’s life. However, as noted above, the ‘alcohol and other drugs’ environment at home, including ‘take-away’ policies for methadone, may pose specific risks to children’s’ health.

Harm minimisation strategies and services such as “safe houses”, night patrols and sobering-up shelters’ have also been used and recommended when working with some Indigenous communities, (Dawe et al., 2007, p. 98).

For more information about harm minimisation, see:

- http://www.druginfo.adf.org.au/druginfo/fact_sheets/harm_minimisation1/harm_minimisation1.html
- http://www.alcoholsummit.nsw.gov.au/links/Harm_Minimisation
- <http://www.opendoors.com.au/educateD.htm>
- <http://ihra.net>

The GPs’ role in Family Sensitive Policy and Practice for alcohol and other drugs interventions may potentially include:

- providing support for family members and referrals to other services (*although more information about local resources and referral processes may be required*)
- recruiting family members as therapeutic allies, i.e. to assist in care planning and supporting any interventions (*training may be required*)
- reporting when risk is high for dependent children involved in situations where there are alcohol and other drugs problems (*developing skills in risk assessment may be required*)
- planned, targeted preventative interventions
- involvement in case conferencing where child protection issues are at stake.

However, factors such as GP funding models and the predominant bio-medical framework may detract from GPs working in a manner consistent with Family Sensitive Policy and Practice and a systems based approach.

A partnership and empowerment approach

Adopt a partnership and empowerment approach

A partnership and empowering approach is important. This includes client involvement in care planning, the planning and design of interventions and culturally and age appropriate social support/peer support based approaches in interventions (e.g. for parents, young people, grandparents).

Peer support and advocacy approaches have successfully led to tailored programs for children of illicit drug users (Byrne, Bedford, Richter, & Bammer, 2000). An empowering approach may entail the involvement of service users and families in advocacy for and the development of new services as well as participating in existing organisational policy and programs.

Key Discussion Points: A partnership and empowerment approach

- Are clients involved in care planning? Where appropriate, are other family members, including those with child care responsibilities, involved in care planning?
- Are client and carer groups involved in the planning and design of services and policies, especially those involving Family Sensitive Policy and Practice?
- How involved are communities in the identification of their own needs and the development of programs and services?
- How involved are families/carers/peers within organisations?
- Are peer support strategies utilised?
- Are the strategies adopted culturally sensitive?

Adopt a culturally sensitive approach to enhance access by CALD and Indigenous communities

Suggestions for service providers wishing to engage community members from Culturally and Linguistically Diverse Communities (CALD) include:

- developing trust and engaging community leaders (especially for newer communities)
- pro-active and flexible interventions targeted to community needs
- increasing confidence in and awareness of sources of help
- engaging ethnic media and online networks
- engaging community members or 'insiders' for interventions and peer support strategies
- training programs for community members
- engaging GPs in strategies (who may be the primary source of help for alcohol and other drugs issues). (Duncan, 2010)

Collaboration and partnerships with a range of other agencies are important for interventions, especially where there is co-morbidity or multiple problems have been identified. Building collaboration within the alcohol and other drugs sector may thus entail working with other services such as the Child Welfare/Protection/Foster care sector, Family/Nurse visiting schemes, Mental Health services, Domestic Violence Services, Child Care services, Hospitals, etc. Agreements and processes for communication, information sharing and confidentiality issues may formalise processes for working together. Working across settings and sectors may also entail education strategies for prevention, such as the Learner Wellbeing and Drug Strategy (South Australian Department of Education and Children's Services).

The following resources provide guidelines for working across sectors and agencies to promote the wellbeing and protection of children:

- General guidelines on collaboration from the Australian Research Alliance for Children and Youth:
http://www.aracy.org.au/index.cfm?pageName=adv_collaboration_fact_sheets#pdf

Specific guidelines and protocols for working with Child Welfare Services include:

- The South Australian government's protocols for working across agencies: Government of South Australia Information Sharing: Guidelines for promoting the safety and wellbeing of children, young people and their families:
http://www.gcyp.sa.gov.au/documents/Information%20Sharing%20Guidelines/98_Information_Sharing_Guidelines_authorised_version_March09s.pdf

- NSW Child Wellbeing and Child Protection Interagency Guidelines:
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm
- Victoria: Summary Brochure on Information Sharing 'Every child, every chance.'
http://www.cyf.vic.gov.au/__data/assets/pdf_file/0019/44209/drug_and_alcohol_services_guide.pdf
- UK Government Information Sharing: Guidance for Practitioners and Managers:
<http://www.governornet.co.uk/linkAttachments/Information%20sharing%20guidance%20for%20practitioners%20and%20managers.pdf>

The provision of culturally sensitive strategies, information and resources tailored to CALD families may support engagement efforts. Some of the Drug and Alcohol Multicultural Education Centre's (DAMEC) successful projects have included peer support strategies for young people, community outreach programs and translated information resources (Duncan, 2010). See the DAMEC online publications:

<http://www.damec.org.au/>

Multi-cultural Mental Health Australia also provides mental health and suicide prevention resources tailored to the needs of Australians from culturally diverse backgrounds:

<http://www.mmha.org.au/>

Working with Indigenous families and communities

Alcohol and Other Drug interventions for Indigenous communities can be informed by the Iga Warta or similar principles for working with Indigenous communities and families (see below).

Atkinson (in Dawe et al., 2007) recommends the following strategies for working with Indigenous communities on alcohol and other drugs interventions:

- a multi-systemic approach to service provision
- short term supply reduction strategies and harm minimisation services
- 'educaring' (promoting awareness of the links between the historical socio-political context and trauma, violence and substance abuse), and

- long term strategies which tackle the cause of substance misuse.

In addition, NCETA's recommendations for supporting interventions for the Indigenous community and the Indigenous alcohol and other drugs workforce include:

- recognising the resilience of Indigenous people and communities
- ensuring co-ordination of services
- adopting stress management techniques for Indigenous workers
- providing flexible working arrangements
- regular consultation regarding workload management, and
- providing opportunities for learning and ongoing professional development. (Roche et al., 2010)

Resources to develop Aboriginal Cultural Competence include:

- <http://www.cyf.vic.gov.au/indigenous-initiatives/publications2/aboriginal-cultural-competence-framework>
- DOCS. (2009). Working with Aboriginal people and communities: a practice based resource. http://dubbokin.com.au/_literature_41892/Working_with_Aboriginal_People

Iga Warta Principle, South Australia, 1999

<http://www.dh.sa.gov.au/reconciliation/images/IgaWarta.pdf>

- 1. The project must be sustainable** i.e. in funding/ leadership/co-ordination/ continuously evaluated.
- 2. It must have a pro-active/preventative approach** i.e. addresses the need to 'get in early'.
- 3. It must address the environmental determinants of health** i.e. food, water, housing, unemployment, etc.
- 4. It must have an Aboriginal and community and family approach** i.e. it must address the need to empower Aboriginal communities and families and enhance their traditional guiding function over Aboriginal people.
- 5. It must respect Aboriginal time and space** i.e. it should be culturally sensitive.
- 6. It must address the need for co-ordination and continuity between regions and Adelaide** i.e. strategies must be coordinated with other activities in other sectors, e.g. transport, housing, education which offer the potential to strengthen health outcomes.

These principles should be explored to determine their relevance to every intervention to improve Aboriginal health.

Multi-agency working, links to other services and sectors for service delivery and health promotion initiatives

Key Discussion Points: Multi-agency and cross-sectoral working

- What organisational processes are in place for engagement with cross-sectoral networks and strategies?
- Have you ever engaged any of the following services to assist a client with parental/caregiver roles:
 - » Child care
 - » Supported accommodation or in-home family support
 - » Maternal and child health nurses
 - » Domestic violence services
 - » Children's disability services
 - » Mental health services
 - » Statutory child protection.

3.2 Capacity building for Family Sensitive Policy and Practice

Workforce development and investment in staff

Key Discussion Points: Workforce development

- Are workers clear about the goals of the organisation in terms of Family Sensitive Policy and Practice?
- To what extent do workers see Family Sensitive Policy and Practice as central to their role?
- Do job descriptions include criteria on knowledge and competencies for Family Sensitive Policy and Practice?
- When working with clients who have parental/care giver roles do workers receive regular clinical supervision from someone experienced in Family Sensitive Policy and Practice?
- Are staff members supported to take up training and development opportunities on Family Sensitive Policy and Practice?
- Have staff had training in culturally sensitive practice?

Workforce development has been conceived as consisting of three levels, including:

1. A systems perspective, e.g. workforce development policies, the way in which organisational change is managed, resources and partnerships
2. Organisational capacity building, e.g. workforce sustainability: recruitment, motivation, job satisfaction, turnover, career paths and management and supervision (mentoring, management development)
3. Development of a skilled alcohol and other drugs workforce, e.g. information management (evidence-based practice), development of knowledge, skills and abilities, and transfer of training to work practice.

(Roche, 2001; Roche & Pidd, 2010; Skinner, Freeman, Shoobridge, & Roche, 2003)

Family Sensitive Policy and Practice in the alcohol and other drugs sector can thus be facilitated by appropriate infrastructure, organisations, skills, policies and resources. Lessons about successful programs run by the Social Exclusion Initiative in the UK (e.g. SureStart, Family Nurse Partnerships, Predictive Risk Modelling) emphasise the need to invest in staff to ensure there are quality staff who are well trained, motivated and have a clear purpose for their work (Eisenstadt, 2009).

Recruitment and retention policies which enhance the stability of staff may be important for establishing trust with families in long-term interventions. Due to the ageing of the alcohol and other drugs workforce, recruitment and retention strategies have been considered priorities for workforce development in the alcohol and other drugs sector more generally (Roche & Pidd, 2010). Suggested strategies for recruitment and retention include; traineeships or recruitment drives in tertiary education settings to attract younger workers, 're-training redundant workers from shrinking industries' and programs to attract those seeking a career change or re-entering the workforce (Roche & Pidd, 2010).

Workforce development on Family Sensitive Policy and Practice can be further facilitated through:

Organisational factors:

- clinical supervision of staff by those experienced in Family Sensitive Policy and Practice is important to support workers to achieve Family Sensitive Policy and Practice *and* prevent burnout and worker turnover
- on the job learning on Family Sensitive Policy and Practice (closely connected to clinical supervision)
- peer support strategies
- performance management
- management development on Family Sensitive Policy and Practice strategies
- dissemination/implementation of policies and resources on Family Sensitive Policy and Practice
- staffing policies, i.e. position descriptions including Family Sensitive Policy and Practices/competencies/skills in collaboration/communication.

Alcohol and other drugs sector factors:

- supporting training and development opportunities
- offering continuing professional education (across professional groups: targeting peak bodies and professional groups)
- professional support and networks
- mentoring across sector/organisations (e.g. through professional bodies)
- changing attitudes and values through social marketing strategies.

'Other sector' factors:

- Education sector strategies: ensuring Family Sensitive Policy and Practice is in alcohol and other drugs curriculum and considered within course development processes for the Vocational Education and Training (VET) sector and universities.

See the manual and resources for frontline workers on Family Sensitive Policy and Practice detailed in Part 4.

Organisational and systems development

Key Discussion Points: Organisational and systems development

- Are organisational policies and guidelines on Family Sensitive Policy and Practice in place?
- Does the organisation provide a child friendly environment?
- Is adequate time allowed to engage in Family Sensitive Policy and Practice?
- Are there reasonable organisational expectations and monitoring of case load size?
- Does the organisation provide guidelines for working with other agencies that can assist with the needs of clients who have parental/care giver roles (e.g. child/family welfare, domestic violence, relationships, Centrelink, mental health, disability, etc.)?
- Are workers' linkages with external agencies resourced and supported?
- Do workers understand the legal duty of care requirements concerning child safety/welfare that may apply when working with clients who have parental/caregiver roles?
- Does the organisation provide training on Family Sensitive Policy and Practice and/or support staff to engage in capacity building/workforce development activities on Family Sensitive Policy and Practice?
- Are you aware of funding available to assist in meeting the needs of clients' children?

Organisational environments which support Family Sensitive Policy and Practice may include:

- Family friendly environments with a safe and dedicated space for children, toys/books, etc.
- Organisational guidelines, assessment and screening tools for Family Sensitive Policy and Practice in place (e.g. the Common Assessment Framework)
- Communication strategies on Family Sensitive Policy and Practice for the organisation
- Service agreements with other organisations on information sharing
- Strategic plans incorporating Family Sensitive Policy and Practice/and liaison and involvement with other agencies
- Joint strategic plans
- Management support and commitment to Family Sensitive Policy and Practice: adequate time allowed for Family Sensitive Policy and Practice, monitoring of case load size.

For a useful toolkit designed to assist in the planning, development, monitoring and evaluation of family sensitive alcohol and other drugs services click on to the following:
link: <http://www.bath.ac.uk/health/mhrdu/adf/toolkit.html>

Building leadership and integrated government policy

Key Discussion Points: Building leadership and integrated government policy

- What government strategies are in place to ensure close linkages between alcohol and other drugs and child wellbeing/welfare services?

Leadership is closely connected to participation and requires strong support from participants i.e. staff of organisations, members of community groups and within cross-sectoral alliances (Laverack, 2005). The development of capacity building for Family Sensitive Policy and Practice may entail leadership skill development, identification and development of skills/competencies for Family Sensitive Policy and Practice, visioning, planning and processes to adopt Family Sensitive Policy and Practice within and across organisations and sectors and networks and structures. In Australia, workforce development on Family Sensitive Policy and Practice within the alcohol and other drugs sector occurs through the Family Alcohol and Drug Network (FADNET), which has local networks in most states: <http://www.fadnet.org.au/>

Government policy on Family Sensitive Policy and Practice can support and resource workforce development/capacity building leadership and integration initiatives. Given the overlap between issues such as drug use and mental health, it has been recommended that 'policies and strategies on drugs, cannabis, mental health, suicide prevention and co-morbidity be better aligned and integrated and agreed' (Mental Health Council of Australia, 2006).

Given the aforementioned relationship between alcohol and other drugs, mental health, domestic violence and child protection issues, integrated policies and planning in these areas will be important for effective Family Sensitive Policy and Practice and the wellbeing of children.

Asmussen and Weizel (2009) also highlight the importance of local/state government plans including services for parents who misuse drugs and alcohol. Placement of alcohol and other drugs workers/counsellors in local Child Welfare offices has been shown to facilitate early identification of substance use and to improve treatment referral and engagement (Lee, Esaki, & Greene, 2009).

Child welfare workers also reported that the presence of alcohol and other drugs counsellors facilitated processing of cases and provided additional resources, which may contribute to development of better programs. Such collaboration has also led to improved outcomes for both the substance using parent and their children (Marsh et al., 2006).

Successful inter-sectoral collaboration will be important for the development of such strategies. Partnerships and alliances with other organisations and community groups are also important for advocacy activity, support and resources to achieve community and organisational goals (Laverack, 2005).

Factors facilitating collaboration across agencies and sectors are evident at the interpersonal, service, organisational, sectoral and political level. At the interpersonal level, values, attitudes, personal skills and knowledge are necessary to facilitate collaboration (Walker, 2000). In particular, skills in and *processes* of negotiation are beneficial for working together, whilst strategic planning, trust building and interpersonal communication skills are also important for collaborative processes across organisations (Walker, 2000, 2002). In general, when it comes to joint planning, *processes* should be seen as being more important to collaborative work than joint structures (Costongs & Springett, 1997; Gray, 1989), and should include the development of a shared definition of problems, joint ownership of decisions and collective responsibility for managing problems (Gray, 1989).

Planning, accountability, monitoring and evaluation

Key Discussion Points: Accountability and monitoring

- When you assess the treatment outcomes for clients with parental/caregiver roles do you include
 - 1) changes in parenting competence and
 - 2) changes in the wellbeing and welfare of their children?
- Is monitoring and evaluation of programs aimed at achieving Family Sensitive Policy and Practice built into the planning stages?
- Is Family Sensitive Policy and Practice rigorously evaluated so that strategies may be confidently transferred?

Family Sensitive Policy and Practice entails measuring outcomes both in terms of parenting and the wellbeing and welfare of children. Joint accountability mechanisms across services (i.e. alcohol and other drugs/Family and Child Welfare) may help to facilitate Family Sensitive Policy and Practice within and across agencies, and may be embedded within service agreements or memoranda of understandings (MOUs).

Cross-sectoral accountability mechanisms may thus include process measures such as joint training for cross-agency and cross-sectoral workforces, processes for communication between agencies being in place, common assessment tools, as well as common outcome measures for child wellbeing and measures to assess parent-child relationships.

3.3 Summary of Discussion Points

The following is a summary of the discussion points listed throughout Part 3. They can be used as discussion starters when thinking about Family Sensitive Policy and Practice in your organisation or as a checklist¹⁵ to see where your organisation stands when it comes to Family Sensitive Policy and Practice.

Assessment

- Do the treatment/intake/client assessment procedures you use identify whether the client has a parenting/caregiver role?
- Do your assessment procedures consider:
 - » Multiple risk and protective factors for children, parents, families and communities (e.g. domestic violence, mental health, housing issues, employment, relationships, income/employment, etc)?
 - » Child care responsibilities and parenting needs?
 - » The need for child care while clients attend treatment?
- » The parenting role of the client as a potential stressor?
- » Contraception issues and pregnancy status of female clients?
- » Clients' concerns about their children?
- » Validated and reliable measures of family functioning, parental mental health and child behaviour?
- » If clients have children who are clients of a child welfare service (e.g. statutory child protection service, child and family support service, etc)?
- » The cultural background of families and how this may influence perception of 'family' and potential access to additional parenting supports?

Interventions

- When working with clients who have parental/care giver roles:
 - » Are interventions tailored to family needs?
 - » Are interventions focused on prevention and early intervention strategies?
 - » Are families' strengths and resources considered? Are parents' coping strategies identified and supported?
 - » Does strengthening parent-child relationships form part of the treatment goal?
 - » Do you often see and speak to your clients' children?
 - » Do you collaborate with children's services where needed?
 - » Are other family members, including children, offered information and support about their parents' drug or alcohol misuse?
 - » Are further resources offered for the identified needs of families?
 - » Is level of parental/social support identified and developed?
 - » Are interventions sustainable and prevention focused?

¹⁵ A checklist of these issues is provided at the end of the Executive Summary as well as a separate Checklist poster.

A partnership and empowerment approach

- Are clients involved in care planning? Where appropriate, are other family members, including those with child care responsibilities, involved in care planning?
- Are client and carer groups involved in the planning and design of services and policies, especially those on Family Sensitive Policy and Practice?
- How involved are communities in the identification of their own needs and the development of programs and services?
- How involved are families/ carers/peers within organisations?
- Are peer support strategies utilised?
- Are the strategies adopted culturally sensitive?

Multi-agency and cross-sectoral working

- What government strategies are in place to ensure close linkages between alcohol and other drugs and child wellbeing/welfare services?
- What organisational processes are in place for engagement with cross-sectoral networks and strategies?
- Have you ever engaged any of the following services to assist a client with parental/caregiver roles:
 - » Child care
 - » Supported accommodation or in-home family support
 - » Maternal and child health nurses
 - » Domestic violence services
 - » Children's disability services
 - » Mental health services
 - » Statutory child protection.

Workforce development

Are workers clear about the goals of the organisation in terms of Family Sensitive Policy and Practice?

- To what extent do workers see Family Sensitive Policy and Practice as central to their role?
- Do job descriptions include criteria on knowledge and competencies for Family Sensitive Policy and Practice?
- When working with clients who have parental/care giver roles do workers receive regular clinical supervision from someone experienced in Family Sensitive Policy and Practice?
- Are staff members supported to uptake training and development opportunities on Family Sensitive Policy and Practice?
- Have staff had training in culturally sensitive practice?

Organisational and systems development

- Are organisational policies and guidelines in place on Family Sensitive Policy and Practice?
- Does the organisation provide a child friendly environment?
- Is adequate time allowed to engage in Family Sensitive Policy and Practice?
- Are there reasonable organisational expectations and monitoring of case load size?
- Does the organisation provide guidelines for working with other agencies that can assist with the needs of clients who have parental/care giver roles (e.g. child/family welfare, domestic violence, relationships, Centrelink, mental health, disability, etc.)?
- Are workers' linkages with external agencies resourced and supported?
- Do workers understand the legal duty of care requirements concerning child safety/welfare that may apply when working with clients who have parental/caregiver roles?
- Does the organisation provide training on Family Sensitive Policy and Practice and/or support staff to engage in capacity building/workforce development activities on Family Sensitive Policy and Practice?
- Are you aware of funding available to assist in meeting the needs of clients' children?

Building leadership and integrated government policy

- What government strategies are in place to ensure close linkages between alcohol and other drugs and child wellbeing/welfare services?

Accountability and monitoring

- When you assess the treatment outcomes for clients with parental/caregiver roles do you include 1) changes in parenting competence and 2) changes in the wellbeing and welfare of their children?
- Is the monitoring and evaluation of programs aiming for Family Sensitive Policy and Practice built into the planning stages?
- Is Family Sensitive Policy and Practice rigorously evaluated so that strategies may be confidently transferred?

Part 4:

Resources for Family Sensitive Policy and Practice

This final part provides a more extensive list of resources, programs and services to support families and children, and information and resources to assist in the development of Family Sensitive Policy and Practice in your organisation. It includes tools for alcohol and other drugs workers, organisations, clients, adult family members, children and adolescents. You can directly link to these resources via the URLs in the electronic version of this resource on the CD-Rom.

Part 4 includes the following sections:

1. Key reports and journal articles on Family Sensitive Policy and Practice issues
2. Manuals and resources for front line workers
3. Child development and management theories
4. Resources to assist you when planning programs
5. Guidelines for agencies working together for child safety and wellbeing
6. Resources for schools
7. Resources for children, adolescents and families
8. Policy and legislation
9. Evaluations and evidence reviews
10. Peak bodies
11. Clearinghouses and national resource centres.

4.1 Key reports and journal articles

Dawe, S., Atkinson, J., Frye, S., Evans, C., Best, D., Lynch, M., et al. (2007). *Drug use in the family: impacts and implications for children*. Canberra: Australian National Council on Drugs.

http://www.ancd.org.au/assets/pdf/rp13_drug_use_in_family.pdf

- A key Australian resource which considers the impact of alcohol and other drug misuse on children between 2-12 years.

Frye, S., Dawe, S., Hartnett, P., Kowalenko, S., & Harlen, M. (2008). *Supporting the families of young people with problematic drug use*. Canberra: Australian National Council on Drugs.

http://www.ancd.org.au/images/PDF/Researchpapers/rp15_supporting_families.pdf

- Focuses on support and treatment options for young people who misuse alcohol and other drugs.

Velleman, R., and Templeton, L. (2007). 'Understanding and modifying the impact of parents' substance misuse on children', *Advances in Psychiatric Treatment*, vol 13, p79-89.

- Discusses risk and protective factors and what makes children of alcohol and other drugs misusers more resilient.

Orford, J., Templeton, L., Copello, A., Velleman, R., Ibanga, A., Binnie, C. (2009). 'Increasing the involvement of family members in alcohol and drug treatment services: The results of an action research project in two specialist agencies', *Drugs: Education, Prevention and Policy*, October 2009; 16 (5): 379-408.

- The paper discusses an action research project which focused on developing two alcohol and other drugs services to become more family sensitive.

4.2 Manuals and resources for frontline workers

Guidelines on prevention programs

United Nations Office on Drugs and Crime. (2010). *Guide to implementing family skills training programs for drug abuse prevention*. (United Nations Office on Drugs and Crime, 2010): http://www.unodc.org/pdf/youthnet/family%20based/FINAL_ENGLISH_version%20for%20PRINTING%20received%20120209.pdf

Resources for workers on working with families and caregivers

Children of Parents with a Mental Illness (COPMI) online worker education resource:

<http://www.copmi.net.au/worked/index.html>

- Contains a comprehensive list of resources and links useful for those who work with families where the parent has mental illness and/or for those people who care for them.

(NADA, 2009) *Tools for change: A new way of working with families and carers*. Sydney: Network of Alcohol and Drug Agencies.

http://www.nada.org.au/index.php?option=com_content&task=view&id=96&Itemid=64

- Resource developed by the Network of Alcohol and Drug Agencies, with a focus on working with adult carers.

Parenting Support Toolkit for Alcohol and Other Drug Workers (Victorian Department of Human Services). www.health.vic.gov.au/drugservices/pubs/parenting-support.htm

Youth Substance Abuse Service. (2006). *Working with Young Parents Who Are Substance Users – A Practical Casework Guide* (see CD-Rom).

The Parenting Fund/Alcohol Concern Resources http://www.alcoholandfamilies.org.uk/training_materials.htm

These resources include:

- *Parenting Training for Alcohol Professionals: Trainer's Manual* http://www.alcoholandfamilies.org.uk/taining_materials/12.6.pdf

and accompanying presentation:

Alcohol Awareness Training for Parenting Professionals http://www.alcoholandfamilies.org.uk/taining_materials/12.7.ppt

- See also the Good Enough Parenting presentation: http://www.alcoholandfamilies.org.uk/taining_materials/12.3.ppt

Alcohol, Drugs and the Family Research Group, UK:

Working with the Children and Families of Problem Drinkers: a Toolkit

Available from

<http://www.bath.ac.uk/health/mhrdu/adf/toolkit.html> and

[http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0014\(toolkit\).pdf](http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0014(toolkit).pdf)

Alcohol, Drugs and the Family Research Group. (2006). *Responding to Alcohol and Drug Problems in the Family: A guide for workers in drug and alcohol services using a five step approach*.

For more information about the above resource, contact:

The Alcohol, Drugs and the Family Research Group
Professor Alex Copello, PhD
Professor of Addiction Research
School of Psychology, The University of Birmingham & Consultant Clinical Psychologist, Addictions Program
Birmingham and Solihull Mental Health Foundation Trust
School of Psychology, Edgbaston, Birmingham B15 2TT UK
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4.3 Child development and management theories

Biringen, Z. (2000). Emotional availability: Conceptualisation and research findings. *American Journal of Orthopsychiatry*, 70(1), 104-114.

Hoghugh, M., & Speight, A. (1998). Good enough parenting for all children - a strategy for a healthier society. *Archives of Disease in Childhood*, 78, 293-296.

- Also see resource on 'good enough parenting' tailored to the alcohol and other drugs sector: http://www.alcoholandfamilies.org.uk/training_materials/12.3.ppt

Marvin, R., Cooper, G., Hoffman, K., Powell, B. (2002). The circle of security project: Attachment-based intervention with caregiver-preschool child dyads. *Attachment and Human Development*, 4 (1), 107-124.

Miltenberger, R. (2008). Behaviour modification: principles and procedures. Belmont, California: Thomson Wadsworth.

Suchman, N., Pajulo, M., DeCoste, C., & Mayes, L. (2006). Parenting interventions for drug-dependent mothers and their young children: the case for an attachment-based approach. *Family Relations*, 55, 211-226.

4.4 Resources to assist planning programs

Planning programs

Working with the Children and Families of Problem Drinkers: a Toolkit is available from <http://www.bath.ac.uk/health/mhrdu/adf/toolkit.html> and

[http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0014\(toolkit\).pdf](http://www.aerc.org.uk/documents/pdfs/finalReports/AERC_FinalReport_0014(toolkit).pdf)

- This toolkit is an online ‘how to’ resource to assist in the planning and development of services for children and families where parents misuse alcohol and other drugs. It has been designed to provide guidance on developing and delivering services to children and families who are affected by substance misuse. It contains information on getting started, getting up and running, and maintaining the service, along with numerous examples from services in England, and a resources section.

Assessment and questions to ask parents and carers

The Common Assessment Framework for Children and Young People: A practitioners Guide: London: Department for Education and Skills.
<http://www.cypswansea.co.uk/index.cfm?articleid=24906>

Children of Parents with a Mental Illness (COPMI) provides a range of checklists/questions for professionals to ask of clients/parents/carers, families and young people. Follow the ‘worker resources’ side bar at the left of the homepage
<http://www.copmi.net.au/mhw/parent.html>

Standardised measures of parenting capacity and child behaviour problems:

The Parenting Stress Index (Adibin)
http://www.tjta.com/products/TST_031.htm
Depression Anxiety Stress Scale (Lovibond) <http://www2.psy.unsw.edu.au/groups/dass/> and the Strengths and Difficulties Questionnaire (Goodman)
<http://vinst.umdj.edu/VAID/TestReport.asp?Code=SEDQT>

Also see the CD-Rom for these resources from the Alcohol, Drugs and Family Research Group:

- *The Stress-Strain-Coping-Support model and the development of the 5-step brief intervention to support adult family members of those with alcohol and other drugs problems* (Professor Velleman’s handout of presentation delivered at the Western Australian Drug and Alcohol Conference, 2010)
- *A set of standardised questionnaires to assess stress, coping and strain, for completion by family members of relatives with alcohol, drug and gambling problems* (Alcohol, Drugs and the Family Research Group)
 - » Also see (Orford et al., 2005) *Family members of relatives with alcohol, drug and gambling problems: a set of standardised questionnaires for assessing stress, coping and strain, Addiction*, 2005. (not on CD-Rom)
- *Alcohol, Drugs and the Family Social Support Scale* (Toner, 2010; Toner & Velleman, 2010).

Child welfare workers

The following three resources are manuals for child welfare professionals working with those who misuse substances:

- (Gibbs, Dwyer, & Vivekananda, 2009) *Leading Practice: A resource guide for Child Protection frontline and middle managers*, Department of Human Services, Victoria. <http://www.cyf.vic.gov.au/child-protection-family-services/home/take-the-lead>
- (Children's Bureau, 2009) *Protecting Children in Families Affected by Substance Use Disorders*, ICF International. <http://www.childwelfare.gov/pubs/usermanuals/substanceuse/>
- (Breshears, Yeh, & Young, 2004) *Understanding Substance Abuse and Facilitating Recovery: A Guide for Child Welfare Workers*. <http://www.ncsacw.samhsa.gov/files/UnderstandingSAGuide.pdf>

The following is a project aimed at developing common processes for assessment, referral and support for the wellbeing, safety and protection of children:

http://www.aracy.org.au/index.cfm?pageName=the_CAARS_taskforce

Dual diagnosis

Children of Parents with a Mental Illness (COPMI) online worker education resource:

<http://www.copmi.net.au/worked/index.html>

Contains a comprehensive list of resources and links useful for those who work with families where the parent has a mental illness and/or for those people who care for them.

Being Seen and Heard training package and video

<http://www.rcpsych.ac.uk/campaigns/partnersincare/beingseenandheard.aspx>

Developed by the Royal College of Psychiatrists for staff working with children who are affected by their parents' mental health problems. The training package includes a video of interviews with children.

See SAMHSA's Co-occurring Centre for Excellence Resources: http://coce.samhsa.gov/links/cod_women.aspx

Dual Diagnosis Support Kit 2006

The Dual Diagnosis Support Kit includes information for workers, foster carers, and parents with dual diagnosis - as well as two storybooks for children aged 5 -7 years and 8 -12 years, plus a handy wallet-sized information card for adolescents.

The kit is downloadable from the DoCS website and available through the website free of charge. Web:

<http://www.nscchealth.nsw.gov.au/carersupport/fami/ddkit/default.shtml>

The Effective Family program from Finland aims to provide the service delivery system with working methods for supporting families and children when a parent has mental health problems, a severe somatic illness or other such factors that make it more difficult to cope with parenthood. Articles about this program/approach are available from

<http://www.parentalmentalillness.org/Finland.html>

Cultural competence resources

Aboriginal Cultural Competence:

<http://www.cyf.vic.gov.au/indigenous-initiatives/publications2/aboriginal-cultural-competence-framework>

Department of Community Services. (2009). *Working with Aboriginal people and communities: a practice based resource*.

http://dubbokin.com.au/_literature_41892/Working_with_Aboriginal_People

4.5 Guidelines for agencies working together for child safety and wellbeing

The Parenting Fund/Alcohol Concern. *Multi-agency working: guidance for professionals working with problem drinking parents* (Alcohol Concern, 2006a)
<http://www.alcoholandfamilies.org.uk/briefings/13.14.pdf>

Young, N. K., Nakashian, M., Yeh, S., & Amatetti, S. (2007). *Screening and Assessment for Family Engagement, Retention, and Recovery* (SAFERR). DHHS Pub. No. (SMA) 07-4261. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2007. (Young, Nakashian, Yeh, & Amatetti, 2007)
<http://www.ncsacw.samhsa.gov/files/SAFERR.pdf>

Goldman, J., Salus, M. K., Wolcott, D., Kennedy, K. Y. (2003). A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice, Office on Child Abuse and Neglect, Washington D.C. (Goldman, Salus, Wolcott, & Kennedy, 2003).
<http://www.childwelfare.gov/pubs/usermanuals/foundation/>

The South Australian government's protocols for working across agencies: Government of South Australia *Information Sharing: Guidelines for promoting the safety and wellbeing of children, young people and their families*
http://www.gcyp.sa.gov.au/documents/Information%20Sharing%20Guidelines/98_Information_Sharing_Guidelines_authorized_version_March09s.pdf

Government of South Australia *Decision steps for information sharing (flowchart)*
http://www.gcyp.sa.gov.au/documents/Information%20Sharing%20Guidelines/92_Decision%20making%20steps%20and%20practice%20guide.pdf

NSW Child Wellbeing and Child Protection Interagency Guidelines
http://www.community.nsw.gov.au/kts/guidelines/info_exchange/introduction.htm

UK Government Information Sharing: Guidance for Practitioners and Managers
<http://www.governornet.co.uk/linkAttachments/Information%20sharing%20guidance%20for%20practitioners%20and%20managers.pdf>

The Aboriginal Child Placement Principle (Victoria):
http://www.cyf.vic.gov.au/indigenous-initiatives/publications2/child_placement_principle_guide
http://www.vacca.org/03_about_us/the_aboriginal_child_placement_principle.html

Also see: Green, B. L., Rockhill, A., & Burrus, S. (2008). The role of interagency collaboration for substance-abusing families involved with child welfare. *Child Welfare*, 87(1), 29-61.

4.6 Resources for schools

Australian Government, Resilience and Drug Education Website (REDI)
www.redi.gov.au

South Australian Department for Education and Children's Services:
<http://www.decs.sa.gov.au/drugstrategy/>

Inyahead Press
www.inyahead.com.au

- *Walking in Other's Shoes: Empathy and Deep Understanding for Middle and Senior Primary Students*
- A resource to help primary teachers explore different children's experiences, especially parental alcohol and other drug misuse
- *A Day in the Life of Raindrop*
- A story book about a child whose mother is on a methadone program.

4.7 Resources for children, adolescents and families

Support for family members

See the range of projects listed under the National Illicit Drug Strategy

<http://www.fahcsia.gov.au/sa/gamblingdrugs/proserv/nids/Pages/StrengthenFamiliesProjects.aspx>

Family Drug Support, Bridging the Divide

<http://www.fds.org.au/bridgingthedivide.html>

- Support services funded by the National Illicit Drug Strategy, with online links to a range of other information resources and guidelines.

Family Drug Support Helpline:
1300 368 186

Stepping Stones project

<http://www.fds.org.au/services.html>

How to Drugproof Your Kids program

<http://dpyk.families.org.au/Default.aspx?go=article&aid=32&tid=6&anum=0>

Alcohol, Drugs, the Family and YOU: A Self-Help Manual for Family Members (2007) The Alcohol, Drugs and the Family Research Group

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Centre for Addiction and Mental Health (2001) *Take action! Alcohol, other drug problems and your family.*

http://www.camh.net/Publications/CAMH_Publications/take_action.html (Pamphlet, 25pg)

Information for parents about adolescent drug use:

<http://www.dassa.sa.gov.au/site/page.cfm?u=199>

Centre for Addiction and Mental Health (2009) *Raising Resilient Children and Youth* (Brochure)

http://www.camh.net/About_Addiction_Mental_Health/Mental_Health_Information/3663resiliencePIM_EN.pdf

Centre for Addiction and Mental Health (2005) *When a parent drinks too much alcohol: What a Child Wants to Know* (Brochure)

http://www.camh.net/About_Addiction_Mental_Health/Drug_and_Addiction_Information/when_parent_drinks.pdf

Supporting those with co-morbidity

1) see the *Dual Diagnosis Support Kit* (above)

<http://www.nscchealth.nsw.gov.au/carersupport/fami/ddkit/default.shtml>

2) COPMI *online resources*
www.copmi.net.au

3) *Book: (Nicholson, Henry, Clayfield, & Phillips, 2001) Parenting well when you're depressed: A complete resource for maintaining a healthy family, New Harbinger Publications*

Support for grandparents

Information about supporting grandparents who are carers:

<http://www.aifs.gov.au/institute/pubs/fm2007/fm76/eb.pdf>

<http://www.health.act.gov.au/c/health?a=sendfile&ft=p&fid=1157353958&sid=>

Support for children and teenagers

Free Australian resources:

From the Dual Diagnosis Support Kit, NSW

Tidy, S. & Forss, I. (2005). *The Blue Polar Bear*

Developed as part of the Dual Diagnosis Support Kit produced by the NSW Department of Community Services, this book for children 5-7 years aims to assist workers, carers and parents to introduce the issues of parental dual diagnosis (mental illness and substance misuse), explore concerns and encourage positive coping and help-seeking behaviours. Available at:

<http://www.nscchealth.nsw.gov.au/carersupport/fami/ddkit/003745004.pdf>

Tidy, S. (2005). *The Flying Dream*

The book has a similar aim to the above, with the target audience being children 8-12 years old.

<http://www.nscchealth.nsw.gov.au/carersupport/fami/ddkit/003745003.pdf>

A Day in the Life of Raindrop, Inyahead Press

Story book about a child whose mother is on a methadone program.

www.inyahead.com.au

Better ways to better days

http://www.copmi.net.au/jsp/resources/files/bet_way_bet_day.pdf

This is an Australian Resource for teenagers whose parent or carer is affected by alcohol and other drugs or mental health problems.

Overseas resources:

Centre for Addiction and Mental Health (2005) *Wishes and worries: A story to help children understand a parent who drinks too much alcohol* http://www.camh.net/News_events/News_releases_and_media_advisories_and_backgrounders/wishes_worries_pr0405.html (cost)

This is a storybook resource for children aged 5 to 10 years. It follows the story of a little girl, Maggie, and her struggle to understand her father's addiction to alcohol.

4.8 Policy and legislation

National Policy

National drug strategy

Ministerial Council on Drug Strategy. (2004). *The National Drug Strategy: Australia's integrated framework 2004-2009*. Retrieved from

[http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/5EAED77A78166EB5CA2575B4001353A4/\\$File/framework0409.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/5EAED77A78166EB5CA2575B4001353A4/$File/framework0409.pdf).

Complementary Action Plan
for ATSI people

[http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/545C92F95DF8C76ACA257162000DA780/\\$File/indigenous-summary.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/545C92F95DF8C76ACA257162000DA780/$File/indigenous-summary.pdf)

*National Illicit Drug Strategy a
Strengthening Families Program !
National Illicit Drug Strategy*

<http://www.fahcsia.gov.au/sa/gamblingdrugs/progserv/nids/Pages/StrengthenFamiliesProjects.aspx>

Dodd, J., & Saggars, S. (2006). Current policies and practices addressing the impact of drug and alcohol misuse on children and families. *Australian Research Alliance for Children & Youth*, (Dec).

http://www.aracy.org.au/publicationDocuments/TOP_Current_Policies_and_Practices_addressing_the_Impact_of_Drug_and_Alcohol_Misuse_on_Children_and_Families_2006.pdf

- A review of policy and practice in Australia, with recommendations.

Legislation

Child Protection Acts - see the National Child Protection Clearinghouse:

<http://www.aifs.gov.au/nch/>

4.9 Evaluations and evidence reviews

Children of Parents with a Mental Illness (COPMI)

GEMS (Gateway to Evidence that MatterS) - a summary of recent Australian and international research concerning children (aged 0-18 years) of parents with a mental illness, their parents and families.

<http://www.copmi.net.au/gems/index.html>

Evidence and Evaluation section

http://www.copmi.net.au/ee/evaluate_interventions.html

(or access it via = the 'Evidence and Evaluation' tab on the left menu on the home page).

This section of the COPMI website:

- provides a strong evidence base for practice
- helps practitioners to inform and shape their practice through quality evaluation
- offers support regarding best practice approaches and methods for evaluating practice
- informs planners and policy makers regard best practice programs.

It includes audio-visual presentations, a wealth of useful information and links to other resources.

UK: Evaluating the evidence

Asmussen, K., & Weizel, K. (2009). *Evaluating the evidence: what works in supporting parents who misuse drugs and alcohol*. London: National Academy for Parenting Practitioners.

UK Think Family: the Families at Risk Review

http://www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/think_families/think_families.pdf

4.10 Peak bodies

Alcohol and other Drugs Council of Australia: <http://www.adca.org.au/>

Australian Drug Foundation:
<http://www.adf.org.au/>

Network of Alcohol and Drug Agencies (NADA) NSW:
<http://www.nada.org.au/>

Queensland Network of Alcohol and Other Drug Agencies (QNADA):
<http://www.qnada.org.au/>

South Australian Network of Drug and Alcohol Services (SANDAS):
<http://www.sandas.org.au/>

Victorian Alcohol and Drug Association (VAADA):
<http://www.vaada.org.au/>

Western Australian Network of Alcohol and other Drugs Agencies:
<http://www.wanada.org.au/>

Alcohol, Tobacco and Other Drug Association ACT (ATODA)
http://www.atoda.org.au

Alcohol, Tobacco and Other Drug Council TAS (ATDA)
<http://www.atdc.org.au>

4.11 Clearinghouses and national resource centres

Australian

Australian Centre for Child Protection

<http://www.unisa.edu.au/childprotection/>

Australian Institute of Family Studies

- Australian Family Relationships Clearinghouse:
<http://www.aifs.gov.au/afrc/>
- Indigenous Resources:
<http://www.aifs.gov.au/afrc/links/indigenous.html>
<http://www.aifs.gov.au/cafca/resources/indigenous/indigenous.html>

Australian Domestic Violence Clearinghouse

<http://www.austdvclearinghouse.unsw.edu.au/>

- Indigenous resources:
http://www.adfvc.unsw.edu.au/indigenous_res.html

Alcohol Drug Information Network:

http://www.adin.com.au/content.asp?Document_ID=1

Australian Research Alliance for Children and Youth:

http://www.aracy.org.au/index.cfm?pageName=Home_Page

- See their 'Protecting Children' collaborative project which includes the development of a common assessment framework: http://www.aracy.org.au/index.cfm?pageName=protecting_children

Children of Parents with a Mental Illness (COPMI)

- 'Resources' section of the website includes comprehensive listing of age or worker appropriate resources. http://www.copmi.net.au/jsp/resources/resource_index.jsp
- Online Bibliography - a searchable reference database that contains over 2,500 citations of published works of 'COPMI' (children of parents with a mental illness) - related literature. This regularly updated reference collection includes journal articles, books, book chapters, government and agency reports, working papers and other resources. See http://www.copmi.net.au/jsp/resources/resource_index.jsp

Drug Information Clearinghouse:

<http://www.druginfo.adf.org.au/>

National Centre for Education and Training on Addiction

<http://www.nceta.flinders.edu.au/>

National Child Protection Clearinghouse

<http://www.aifs.gov.au/nch/>

The Australian Centre for Social Innovation: <http://tacsi.org.au/>

- There is currently a mapping project on child protection: <http://tacsi.org.au/mapping/>

VicHealth

- See a review of selected preventative, targeted programs for child wellbeing and protection at: <http://www.education.vic.gov.au/>

healthwellbeing/childyouth/catalogue/sections/childprotection-ind1.htm (Note that the Healthy Start program and Healthy Families program failed to reduce child abuse/neglect (Duggan et al., 2007; Duggan et al., 2004; DuMont et al., 2008; Gessner, 2008).

National Drug and Alcohol Research Centre

<http://ndarc.med.unsw.edu.au/>

NAPCAN www.napcan.org.au

International

Centre for Addiction and Mental Health <http://www.camh.net/>

- Has a section on child, youth and family resources at: http://www.camh.net/About_Addiction_Mental_Health/Child_Youth_Family_Resources/index.html

Child Welfare Information Gateway
<http://www.childwelfare.gov/famcentered/>

National Center on Substance Abuse and Child Welfare
<http://www.ncsacw.samhsa.gov/>

Useful Organisations
Adfam <http://www.adfam.org.uk/>

Alcohol Concern
<http://www.alcoholconcern.org.uk/doc/966>

and their Embrace Initiative:
<http://www.alcoholconcern.org.uk/alcohol-concern-in-action/projects/embrace>

Encare <http://www.encare.info/>

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