

From policy to implementation: child and family sensitive practice

in the alcohol
and other
drugs sector



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National Centre for Education and Training on Addiction

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Contents

Foreword	vi
Acknowledgement	vii
Executive summary	viii
Report structure	viii
Focus	ix
Context	ix
Key findings.....	x
Recommendations	xvi
Part A1. Introduction	1
Part A2. Background	3
Prevalence and nature of parental substance use	3
Substance use and parenting.....	3
Role of alcohol and other drugs treatment services	4
General principles of child and family sensitive practice.....	5
Barriers to implementation	6
Achieving change	7
Part A3. Policy review	8
Policy context	10
International policies	10
National policies	12
State and territory policies.....	14
Policy review summary.....	19
Levers for child and family sensitive policies	20
Policy challenges.....	20
Conclusion.....	26
Part B. Key stakeholder consultations	27
Respondents' demographics.....	27
Understandings of child and family sensitive practice.....	31
Historical context	32
Policy issues.....	33
Government, non-government, Aboriginal and Torres Strait Islander perspectives.....	36

Operational factors 39

Workers' needs and attributes 41

Working across sectors 44

Perceptions of risk 44

Mandatory reporting 45

Change strategies 47

Conclusion 50

Part C. Best practice interventions in child and family sensitive practice 51

Best practice principles 51

Community and public health approaches 54

Types of interventions 56

Relationship with other sectors 57

Additional resources 57

Part D. Recommendations 58

References 60

Appendices 67

Appendix 1: Methodology 67

Appendix 2: Further resources 70

Appendix 3: Current examples of child and family sensitive practice in the
alcohol and other drugs field 72

Appendix 4: Email to potential interviewees 78

Appendix 5: Letter of introduction 79

Appendix 6: Information sheet for interview participants 81

Appendix 7: Consent form 84

Appendix 8: Interview questions 85

Tables

Table 1:	Key issues identified by stakeholders.	xiii
Table 2:	Barriers to child and family sensitive practice	xiv
Table 3:	Facilitators of child and family sensitive practice.	xv
Table 4:	Perceived role definition and adoption of child and family sensitive practice.	7
Table 5:	Key state and territory child and family sensitive policies.	16
Table 6:	Key issues identified by stakeholders.	28
Table 7:	Barriers to child and family sensitive practice	29
Table 8:	Facilitators of child and family sensitive practice.	30
Table 9:	Current examples of the implementation of good child and family sensitive practice principles in the alcohol and other drugs field	72

Figures

Figure 1:	Examples of child and family sensitive policies at the international, national and state/territory levels	11
Figure 2:	WHO Risk Analysis Framework.	24

Foreword

The Australian National Council on Drugs (ANCD) commissioned the National Centre for Education and Training on Addiction (NCETA) to examine policy frameworks that support or restrict the effective implementation of child and family sensitive practices in the alcohol and other drugs sector.

In undertaking this project, NCETA was requested to:

1. Complete a comprehensive audit and analysis of the jurisdictional policy frameworks that support or restrict the effective implementation of child and family sensitive practice in alcohol and other drugs service settings.
2. Consult with key stakeholders in different jurisdictions who are recognised as operating effective child and family sensitive practices in alcohol and other drugs services.
3. Consult with key stakeholders and draw upon completed reviews, research, guidelines and professional opinions, and critically assess the policy frameworks that facilitate, challenge and/or obstruct effective implementation of child and family sensitive practices.
4. Develop a report for the ANCD that includes an executive summary of key findings and discussion of the policy frameworks above, and which would further support and inform its advocacy and advisory role to government on priorities for policy development, emerging issues, and measures by which these can be addressed.

This document comprises the commissioned report and addresses the required tasks.

Acknowledgement

This report was produced by the National Centre for Education and Training on Addiction with funding from the Australian National Council on Drugs.

The National Centre for Education and Training on Addiction

The National Centre for Education and Training on Addiction (NCETA) is an internationally recognised research centre which works as a catalyst for change in the alcohol and other drugs field.

NCETA's mission is to advance the capacity of organisations and workers to respond to alcohol- and drug-related problems. Its core business is the promotion of workforce development principles, research and evaluation of effective practices; investigating the prevalence and effect of alcohol and other drug use in society; and the development and evaluation of prevention and intervention programs, policy and resources for workplaces and organisations.

NCETA is based at Flinders University and is a collaboration between Flinders University and the Australian Government Department of Health.

Visit: <www.nceta.flinders.edu.au>.

Executive summary

The Australian National Council on Drugs (ANCD) commissioned the National Centre for Education and Training on Addiction (NCETA) to develop a comprehensive report on the current policy environment in relation to child and family sensitive practice in Australian alcohol and other drugs settings.

In undertaking this project, NCETA:

1. Completed a comprehensive audit and analysis of the jurisdictional policy frameworks that support or restrict the effective implementation of child and family sensitive practice in alcohol and other drugs service settings.
2. Consulted with key stakeholders in different jurisdictions who are recognised as operating effective child and family sensitive practices in alcohol and other drugs services.
3. Consulted with key stakeholders and drew upon completed reviews, research, guidelines and professional opinions, and critically assessed the policy frameworks that facilitate, challenge and/or obstruct effective implementation of child and family sensitive practices.
4. Developed a report comprising key findings and discussion of policy frameworks that may support and inform advocacy and advice to government on priorities for policy development, emerging issues, and measures by which these can be addressed.

The project involved:

- an audit and analysis of relevant national, state and territory policy frameworks, and an assessment of the extent to which they support or hinder child and family sensitive practice in alcohol and other drugs service settings
- semi-structured interviews with 18 key stakeholders regarding child and family sensitive practice, and their views about barriers and facilitators to its implementation
- examination of reviews, research and practice guidelines to inform an assessment of child and family sensitive practice best practice.

Report structure

The report is divided into four sections. Part A provides the contextual background and a critique of current national and international policy; Part B contains an examination of stakeholder views about policy and systems issues; Part C presents details of evidence-based and consensus views regarding best practice; and Part D provides an overview of the project's recommendations.

Focus

The terms and concepts underpinning child and family sensitive practice can cover a range of issues. In essence, child and family sensitive practice involves service providers addressing the client's parental role and responsibilities and the needs of their children. The concept can also refer to other family members.

Context

In recent years there has been growing interest in the needs of clients' families and children. This reflects a broader international and national focus in relation to support and protection of children. Clearer and more explicit policies have been developed to identify appropriate system and strategic responses. The United Nations Convention on the Rights of the Child provides an imprimatur for signatories (including Australia) to protect children's rights and support parents in their child-rearing responsibilities. At a national level, the National Framework for Protecting Australia's Children encourages national, state and territory jurisdictions to review existing legislation and policies and adopt more child and family sensitive policies, procedures and practices.

The current review was undertaken at a time when a number of other significant examinations of the alcohol and other drugs sector were occurring, including the Victorian Government Service Sector Reform Project (Shergold, 2013) to improve the lives of vulnerable children through community sector reforms. In 2013 the then Australian Government Department of Health and Ageing commissioned a review of alcohol and other drugs sector funding models, and a parallel project to develop quality standards. The Productivity Commission (Productivity Commission, 2010) also recently examined the role and contribution of the not-for-profit sector (including alcohol and other drug agencies) and explored mechanisms to improve its effectiveness and efficiency.

The current review was executed with cognisance of these wider developments. It reflects issues under scrutiny within these parallel review processes that have scope to examine the way the alcohol and other drugs sector may better address the needs of clients' children into the future.

Key findings

Policy audit and analysis

Successful implementation of child and family sensitive practice requires clear policy frameworks, adequate funding and resources, leadership and champions, and intersectoral collaboration. Recent national, state and territory policy initiatives include the development of the National Framework for Protecting Australia's Children, and recognition of the importance of working with children and families within the National Drug Strategy. However, a clear mandate for the alcohol and drugs sector to address the parental roles of their clients and the needs of clients' children is lacking.

A wide and disparate array of policies was identified that have the potential to support child and family sensitive practice in the alcohol and other drugs sector. They ranged from global policies at the international level through to national, state and territory initiatives. Examples of child and family sensitive policy and practice initiatives within the alcohol and other drugs sector were also identified in most Australian states and territories.

All Australian states and territories have child and family sensitive practice-related policies in place. However, there appear to be few mechanisms to guide and inform the implementation and operation of these policies, and many were fragmented, inconsistent and incomplete.

Significant policy gaps identified included a lack of:

- risk frameworks and models that address the risk of harm to children of clients
- explicit assignment of responsibility for providing services to children of clients
- models of care that meet children's needs
- allocation of resources required to support an enhanced systems approach.

The ability of the alcohol and other drugs sector to respond to the needs of clients' children and families is compromised by a lack of consistency in the development and implementation of child and family sensitive policy at both national and state/territory levels.

The diversity of the alcohol and other drugs sector in Australia suggests that *no one size fits all* in relation to the implementation of child and family sensitive practice. It is acknowledged that states and territories, sectors and organisations will have different requirements, particularly in regard to their policy needs, organisational priorities, workers' skills and clients' needs. Hence, while consistency in policy approaches is desirable, flexibility and tailored application at the practice level are also important to achieve optimal results.

Major differences between government and non-government alcohol and other drugs organisations were found in regard to child and family sensitive practice. This was particularly evident in relation to their culture, practice, policy and governance arrangements. These differences have had a significant impact on the development and implementation of child and family sensitive policy and practice in alcohol and other drugs services. For example, government

organisations were more likely to be involved in the development of policy frameworks, contract management and the provision of education and training around child and family sensitive practice. On the other hand, non-government organisations (NGOs) were more likely to be involved in implementing child and family sensitive practice.

Differences identified between the government and non-government sectors are consistent with findings from a previous NCETA study (Trifonoff, Duraisingam, Roche & Pidd, 2010). The differences between the sectors have a number of implications for the implementation of child and family sensitive practice in the alcohol and other drugs field. With non-government workers more likely to respond to the parenting needs of their clients, it is important that these services are provided with appropriate funding and adequate resources, and that the responsiveness and flexibility of the NGO sector to undertake innovative service provision are appropriately recognised.

While some progress has been made to date, a range of barriers need to be addressed if the implementation of child and family sensitive practice in the alcohol and other drugs sector is to be embraced. In particular, the adoption of child and family sensitive practice can be impeded by a range of barriers that operate at:

- policy levels
- sectoral levels, e.g. differing practice frameworks and philosophies
- organisational levels, e.g. lack of structural and/or procedural resources
- individual levels, e.g. client and/or staff reluctance to involve family members in treatment.

Some of these policy and operational barriers included:

- lack of management and organisational support
- inadequate funding
- poor understanding of risk identification and management
- data collection systems not recording information about clients' children
- lack of appropriate child and family sensitive clinical supervision
- lack of appropriate training and professional development for workers
- poor role delineation and assignment of responsibility
- low worker confidence in dealing with child and family sensitive practice issues
- intersectoral barriers, e.g. the alcohol and other drugs and child welfare/child protection sectors working in silos
- mandatory reporting of child protection issues.

Specific barriers were identified in relation to the provision of child and family sensitive services to Aboriginal and Torres Strait Islander people, especially as a focus on children and families is central to Aboriginal cultural practice. Ensuring equitable and appropriate services for Aboriginal and Torres Strait Islanders, their children and families was identified as a priority issue.

Female clients also faced particular barriers in accessing child and family sensitive services. Many residential treatment services did not allow women to bring their children with them into treatment, resulting in forced separation from their families. Some female clients were also reluctant to enter treatment or disclose information about their children for fear of losing custody should child protection services be notified.

A number of facilitators were also identified that could assist alcohol and other drugs services to enhance their child and family sensitive practice. These facilitators included:

- enabling sectoral and organisational policies and procedures
- ongoing organisational commitment and management support
- flexible funding – including the provision of targeted funding for the implementation of child and family sensitive practice
- the provision of appropriate training and professional development to support workers' understanding and implementation of child and family sensitive practice
- skilled staff
- formalised clinical supervision processes focusing on child and family sensitive practice
- identifying and supporting champions to promote child and family sensitive practice.

However, underpinning these potential facilitators and barriers is the requirement for a more comprehensive policy response to the needs of children. Moreover, any such developments in relation to policy must be complemented by a range of governance structures and strategies that reflect commitment and 'buy-in' by funders.

The increasing attention being directed to the identification of children, and in particular the risks children are exposed to, and to assigning responsibility for intervention is likely to have an impact on the alcohol and other drugs service sector. However, responsibility for the children of those attending alcohol and other drug services currently remains ambiguous and this impedes constructive and consistent responses across and within sectors.

Overall, this report identified a high degree of support for the concept of child and family sensitive practice. However, it also identified significant systematic barriers that would need to be addressed before substantial further progress could be achieved.

Key stakeholder feedback

Feedback provided by key stakeholders highlighted a range of policy and governance issues such as policy frameworks, funding, data collection and management, training and professional development, clinical supervision and mandatory reporting requirements. Key stakeholders also identified a range of change management strategies that could be used to enhance the alcohol and other drugs sector’s implementation of child and family sensitive policy and practice. These include:

- management and organisational support
- the use of champions to highlight and support improved policy development
- organisational role modelling of child and family sensitive practice
- the potential co-location of services.

A summary of the key issues, barriers and facilitators identified by stakeholders is presented in Tables 1–3.

Table 1: Key issues identified by stakeholders

Understandings of child and family sensitive practice	Child and family sensitive practice was generally well understood and supported, albeit sometimes under the aegis of alternative terms (e.g. ‘child sensitive practice’, ‘family sensitive practice’, ‘child aware practice’ and ‘family inclusive practice’). The last-mentioned term, however, is distinguished from child and family sensitive practice, as it involves family members directly in the interventions provided by a service (Gruenert & Tsantefski, 2012).
Historical context	While the term ‘child and family sensitive practice’ was relatively new, its underlying principles had been a part of some practices for many years. However, some services continued to adhere to the historical philosophy of solely treating individual clients.
Policy issues	Policies were perceived to play a vital role in guiding the implementation of child and family sensitive practice. However, respondents felt there was a dearth of national policy initiatives that specifically recognised the needs of children within alcohol and other drugs service provision.
Government vs non-government organisations	Government services were seen to be less flexible and more constrained in terms of their ability to change their service delivery models in response to emerging needs and issues.
Aboriginal and Torres Strait Islander service provision	Aboriginal and Torres Strait Islander services often worked in child and family sensitive ways. However, they found it difficult to recruit appropriately trained staff, and there was limited funding to support child and family sensitive practice. As a result, costs were often borne by the services.

Table 2: Barriers to child and family sensitive practice

Management and organisational support	A lack of managerial and organisational support could impede practice change.
Funding issues	Funding was often targeted to specific clients and seldom included costs related to children.
Perceptions of risk	Managers of alcohol and other drugs services were at times reluctant to implement novel practices, as they could entail future risks.
Mandatory reporting	Workers were often hesitant to address issues that could result in a mandatory reporting obligation, for fear of undermining their relationship with the client.
Collecting and managing information about children	Data were often collected in organisational or state and territory systems that were not compatible, so data could not be easily shared. Child-related data did not appear in statistics and, as a consequence, there was a lack of attention directed towards their needs.
Clinical supervision	Relevant clinical supervision was often not available.
Role delineation	Clinicians often felt unclear about who their client was, whether their responsibility extended to other family members, and whether using a client's family as a motivating factor in treatment was good practice.
Worker confidence	Many practitioners felt that they did not have the necessary skills and confidence to implement child and family sensitive practice.
Training	Appropriate, funded, accessible and quality training was not widely available. Newly acquired skills could also be difficult to transfer into practice, and needed to be supported by other initiatives.
Intersectoral barriers	Different values and siloed funding arrangements reduced communication and cooperation between sectors.
Gender issues	Women with children could be reluctant to approach services for fear of losing their children, either by going into residential treatment or through losing custody.
Aboriginal and Torres Strait Islander clients	Services for Aboriginal and Torres Strait Islander clients traditionally focused on the whole family, and many Indigenous alcohol and other drug workers were highly skilled in this area. However, such services for Aboriginal and Torres Strait Islanders with children were limited.

Table 3: Facilitators of child and family sensitive practice

Enabling policies and procedures	Clear policies and procedures were considered necessary to implement child and family sensitive practice, e.g. questions regarding children on intake documents together with collection of data regarding parenting responsibilities.
Flexible funding	Targeted, sufficient and flexible funding was required for organisations to work with children without suffering economic impost.
Training and professional development	Training and professional development were necessary for frontline staff, managers and supervisors, and needed to include intra-agency, inter-agency and cross-sectoral training.
Management support	Organisational support was required from line supervisors, middle managers, senior managers and governing bodies. Knowledge of policies authorising child and family sensitive practice was essential.
Skilled staff	There was wide variation in alcohol and other drug workers' qualification levels. Specialist qualifications or training in child and family sensitive practice may be beneficial for some workers to facilitate the adoption and implementation of child and family sensitive practice across organisations.
Dedicated staff	Staff who were engaged with, and committed to, child and family sensitive practice were essential to embed it within the organisation.
Clinical supervision	Supervision was important to develop and sustain child and family sensitive practice, and to strengthen inter-agency partnerships.
Champions	Champions at sectoral and organisational levels were important in promoting child and family sensitive practice.

Recommendations

Based on the findings from the literature review, audit and analysis of current Australian policy frameworks and intervention strategies, and key stakeholder consultations, the following recommendations are made to guide the ongoing development and implementation of child and family sensitive policy and practice, including capacity building and sustained change in alcohol and other drugs services.

In relation to **policy**, it is recommended that:

1. National policy initiatives and frameworks be developed that explicitly recognise and incorporate the needs of children and families within alcohol and other drugs service provision as core business.
2. National, state and territory alcohol and other drugs policy frameworks be aligned and harmonised in relation to child and family sensitive practice issues.
3. National, state and territory alcohol and other drugs policy frameworks reflect a commitment to enhancing the safety of clients' children.
4. Consideration be given to further reviewing national, state and territory alcohol and other drugs policy frameworks to identify consistencies between these policies and children's rights policies, such as the United Nations Convention on the Rights of the Child.
5. National, state and territory peak bodies in the alcohol and other drugs sector be encouraged to develop and/or endorse child and family sensitive policy and practice frameworks. This work would benefit from consideration of parallel policies in the child protection and child welfare sectors and other adult sectors (e.g. mental health, housing, homelessness, domestic violence).
6. Alcohol and other drugs organisations review and update their existing policies to ensure that they are consistent with the alcohol and other drugs sector and other sectors' national, state and territory policies.
7. Advice and guidance be developed and provided to policy makers at national, state and territory levels as to the importance of including child and family sensitive components in relevant policies.
8. A detailed costing of the unaddressed needs of clients' children be undertaken to help inform policy development and direction.

In relation to **systems issues**, it is recommended that:

9. Consideration be given to redefining the concept of 'client' in alcohol and other drugs treatment to include children and family members.
10. Consideration be given to the adoption of flexible funding approaches, particularly in relation to alcohol and other drugs service provision, to ensure that child and family sensitive practice is included as an outcome in funding agreements.
11. Funding models recognise the increased demand that working with children and families places on workers and organisations in both time and resource costs.
12. Consideration be given to the development of national minimum data collection standards for information about clients' children as part of their intake and assessment processes by alcohol and other drugs service providers.
13. Alcohol and other drugs data sets be reviewed and, where appropriate, modified to incorporate data on clients' familial relationships, parenting responsibilities and, in the case of clients seeking help for others' drug use, specific data be collected on the nature of their relationship to the user.

In relation to **organisational issues and change**, it is recommended that:

14. Organisations be encouraged to review and, where appropriate, amend their policies to incorporate clear policies and guidelines on working from a child and family sensitive perspective.
15. Alcohol and other drugs organisations and child welfare/protection services develop joint protocols and systems that facilitate information sharing about the wellbeing and safety of clients' children.
16. In the implementation of child and family sensitive practice, consideration be given to the evidence base for good practice, including the exemplars identified as part of this project.
17. When developing and implementing child and family sensitive practice, alcohol and other drugs organisations identify and support champions who can be used to promote the implementation of child and family sensitive practice.
18. Alcohol and other drugs organisations review and update their current training provision in relation to child and family sensitive practice and ensure that staff are provided with appropriate professional development opportunities.
19. Alcohol and other drugs organisations review and update their clinical supervision guidelines to ensure that they include reference to child and family sensitive practice.

Part A1. Introduction

Within the Australian alcohol and other drugs sector, there is growing recognition of the impact that an individual's substance use may have on their family, and in particular their children. As a result, alcohol and other drug workers are increasingly seen to have an ethical and legal obligation to reduce or prevent the potential harm to clients' children. This is commensurate with the growing awareness of the vulnerability and rights of children (Hart, Lee & Wernham, 2011; Solis, Shadur, Burns & Hussong, 2012; Wolfe et al., 2013) and concern for their health and wellbeing needs (Wolfe et al., 2013). A greater focus is required to bring the needs of vulnerable children to the attention of traditional healthcare and human service systems (Wolfe et al., 2013).

The increased focus on the needs of children is underpinned by key policy developments at both the international and national levels. From an international perspective, Australia as a signatory to the United Nations Convention on the Rights of the Child (CROC) has an obligation to protect children's rights and to support parents in their child-rearing responsibilities. Through its ratification of CROC, Australia acknowledges that children have a special need for protection by the state and recognises their rights to protection. This is reflected in two key national policies: the National Drug Strategy 2010–2015; and the Council of Australian Governments' National Framework for Protecting Australia's Children 2009–2020 (*Protecting Children is Everyone's Business*). Both of these policy frameworks highlight the importance of the alcohol and other drugs sector's potential role in addressing the needs of children and other family members.

In recent years there have been increasing efforts to enhance the extent to which services, such as alcohol and other drugs treatment services, implement strategies designed to achieve positive outcomes for both clients and their children. Such strategies may include prevention, early intervention or treatment programs, and may cover a range of activities that operate across policy and service delivery levels. They can involve workforce practices, organisational processes and procedures, and the wider service system. Their common aim is to ensure that vulnerable children of adults with multiple and complex needs receive appropriate support from adult-focused services.

The suite of policies, practices, strategies and philosophies that support clients as well as their families and children are known as 'child and family sensitive practice'.¹ Child and family sensitive practice is defined here as:

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. 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 [are] maintained (Battams, Roche, Duvnjak, Trifonoff & Bywood, 2010).

¹ Many different terms may be used to refer to approaches that consider the families and children of substance misusers, including 'family centred', 'child and parent centred', 'family focused', 'family inclusive', 'family sensitive', 'parent and child sensitive' and 'child and family aware'. While these terms may be used interchangeably, they are not always synonymous. This review uses the term 'child and family sensitive practice' to refer to the approach as defined here.

This project examined the current policy and service provision environment in relation to child and family sensitive practice in the Australian alcohol and other drugs field. The aim was to examine how alcohol and other drugs treatment services may be able to improve client outcomes while accommodating the needs of children and other family members.

A mixed methods approach was used, comprising a review of the literature, an audit and analysis of current Australian policy frameworks and intervention strategies, and key stakeholder consultations. Key policy barriers and facilitators to the implementation of child and family sensitive practice were identified, and recommendations made for enhancing child and family sensitive practice in alcohol and other drugs service provision.

The review was undertaken with cognisance of a number of parallel national and international developments. The focus of the review is on child and family issues, needs and perspectives. However, emphasis has been placed on the needs of children as a first order issue. The broader role and needs of family members (e.g. parents of adult clients, significant others), while acknowledged as very important, are not the primary focus of this report.

Part A2. Background

Prevalence and nature of parental substance use

Reliable estimates of the number of children exposed to parental alcohol and drug use are difficult to ascertain due to the hidden nature of most illicit drug use, associated stigma and reliance on parental self-report (Gruenert & Tsantefski, 2012). Neither the alcohol and other drugs sector nor the child welfare sector collects data on a routine basis that provide an accurate picture of parental alcohol and other drug use in Australia. As a result, variations exist in reported estimates of parental substance use. For example, Australian studies estimate 10–13 per cent of children are affected by parental alcohol and other drug use (Jeffreys, Hirte, Rogers & Wilson, 2009; Nicholas, 2010), and problematic parental use in child protection substantiations vary from 50 to 70 per cent (Dawe et al., 2007; Delfabbro, Borgas, Rogers, Jeffreys & Wilson, 2009; Jeffreys et al., 2009; Zhou & Chilvers, 2010).

Problematic drug use rarely occurs in isolation, and families in which alcohol and other drug misuse occurs are also more likely to experience a range of other problems. These include mental illness, unemployment, social isolation, poverty and domestic violence (Dawe et al., 2007; Galvani, 2009; Hegarty, 2005; Velleman & Templeton, 2007). The range of issues involved can make it difficult to disentangle the effects of parental substance use from broader social, emotional and economic factors (Dawe et al., 2007; Grella, Hser & Huang, 2006; Scannapieco & Connell-Carrick, 2007).

Nevertheless, alcohol and other drug use by one family member can have health and welfare impacts on other family members. It may impact on their mental and physical health, and/or outcomes related to neglect, poverty, social and educational instability, and housing issues (Orford, Velleman, Natera, Templeton & Copello, 2013; Velleman, 2010).

Substance use and parenting

While not all parents who misuse substances will necessarily jeopardise the wellbeing of their children, these children are at greater risk of a range of adverse outcomes. Problematic drug use can substantially increase the risk of poor parenting practices (Barnard & McKeganey, 2004; New South Wales Department of Human Services, 2010). No single client profile defines the parenting style of those with substance misuse problems. However, the children of alcohol and other drug users have consistently been found to be vulnerable to a range of negative outcomes, including abuse and neglect (Dawe et al., 2007; Grella, Needell, Shi & Hser, 2009). Alcohol and other drug use may reduce parents' attention, emotional availability, supervision capacity, bonding and attachment behaviours, and in some cases prevent children from receiving basic requirements such as food, clothing, shelter, hygiene and safety (Gruenert & Tsantefski, 2012). These challenges to effective parenting may be due to parents' intoxication, the lifestyles associated with problematic substance use, or a combination of factors (Gruenert & Tsantefski, 2012).

Specific risks for the children of parents who misuse alcohol and drugs include poor health and wellbeing (Australian Institute of Health and Welfare, 2009), reduced social and cognitive functioning (Peleg-Oren & Teichman, 2006), and developmental and behavioural problems (Ainsworth, 2004; Jeffreys et al., 2009; Scott, 2009; Velleman & Orford, 1999). They are also at greater risk of subsequently developing alcohol and other drug problems themselves (Kuntsche, Rehm & Gmel, 2004; Redelinghuys & Dar, 2008; Solis et al., 2012).

While the potential risks associated with parental alcohol and other drug misuse for children are clear, it is essential to recognise that the outcome for these children is not a foregone conclusion. If a parent has an alcohol or drug problem, this does not automatically imply that their children will be harmed or neglected, and the degree of risk for children of a substance-using parent is highly variable (Barnard & McKeganey, 2004; Solis et al., 2012). Some parents engage in strategies to minimise the impact of alcohol and drug use upon their children (Richter & Bammer, 2000), and are able to provide adequate care for their children without needing intervention from child protection services (Drabble & Poole, 2011).

Role of alcohol and other drugs treatment services

4

Recipients of alcohol and other drug treatment in Australia are concentrated among 20–29 and 30–39 year olds, and the median age of those accessing treatment services is 32 years (Australian Institute of Health and Welfare, 2009). This corresponds with the age of most parents with dependent children. Given the risks for children associated with parental substance use, alcohol and other drugs treatment services have untapped potential for a preventative role in child and adolescent wellbeing (Battams & Roche, 2011). The growing evidence about the impact of family members' substance use on short- and long-term outcomes for their children is a significant driver for the alcohol and other drugs sector to identify these children as clients in their own right, rather than as optional or additional 'clients' who can be supported if and when resources are available. The reconceptualisation of children of parents with a mental illness as clients in the mental health sector demonstrates how a sector can be successfully re-oriented to consider the needs of children (Australian Infant, Child, Adolescent and Family Mental Health Association, 2004).

Furthermore, the drive to be a good or better parent is often a strong motivator for change among people undergoing treatment for substance use (Gruenert, Ratnam & Tsantefski, 2004). It is increasingly recognised that families can play an important role in improving treatment outcomes, and reducing the effects of substance use on other family members (Copello, Templeton & Velleman, 2006). Providing support in relation to parenting and managing drug use within the context of family life can reinforce and enhance the effects of other interventions (Orford et al., 2013).

A recent systematic review by Niccols and colleagues (2012) found that child and family sensitive interventions had positive effects on the development and emotional and behavioural functioning of clients' children. Outcomes were substantially better than for clients' children who received no treatment, and moderately better than for those who received traditional, individual interventions. They concluded that child and family sensitive interventions represented a viable method for reducing negative outcomes associated with parental alcohol and other drug use.

Recognising the importance of the role that family can play has led to calls for child and family sensitive practice to be implemented by alcohol and other drugs service providers (Rhodes, Bernays & Houmoller, 2010). For example, harm reduction services, rather than exclusively focusing on the individual, can place greater emphasis on reducing harm to all family members, including children. Demand reduction services can focus on addressing factors underlying clients' substance use, such as parenting stress (Gruenert & Tsantefski, 2012). Doing so can improve outcomes for the individual undergoing treatment, and can also substantially decrease the risks for their children.

General principles of child and family sensitive practice

One challenge facing service providers is to build the capacity of parents with alcohol and other drug problems to create a home environment that is safe, nurturing and stimulating, and which promotes healthy child development (Dawe, Harnett & Frye, 2008). However, for this to occur, long-term treatment and support for families are required, and lapses during this period are to be expected. Importantly, the wellbeing and safety of children must be ensured throughout the whole process (Gruenert et al., 2004).

Copello and Orford (2002) identified a number of general principles that may assist services to implement child and family sensitive practice. These include:

1. Models of problematic alcohol and other drug use should recognise the social environment as a central factor, which is as important as individual factors.
2. Concepts of treatment should be widened to include the family as a legitimate unit for intervention.
3. Service providers must acknowledge a broader set of positive outcomes beyond reductions in alcohol and other drug use, e.g. reductions in substance-related violence or in utilisation of health and welfare services.

Implementing child and family sensitive practice may require clinicians and service providers to move away from the traditional model whereby professionals are the people who possess expert knowledge. Instead, knowledge exchange and partnership with the client and their family are encouraged (Centre for Addiction and Mental Health, 2004).

It is important for child and family sensitive practice to be developed and implemented with clear principles in mind from the start, as simply adding extra services to programs not designed to deal with families is unlikely to be effective (Dawe et al., 2008).

Barriers to implementation

Despite research demonstrating the benefits of child and family sensitive practice (Niccols et al., 2012), and identifying ways in which it can be implemented successfully (Dawe et al., 2008; Gruenert & Tsantefski, 2012; Scott, 2009), it remains the exception rather than the norm in alcohol and other drugs treatment services (Orford et al., 2013).

There are a range of barriers to incorporating child and family sensitive practice within routine alcohol and other drugs service provision, which may operate at the individual and/or organisational level. Many are also reflected in the policies that shape and direct service delivery. Lack of policy clarity and focus may in part account for the relatively slow uptake of child and family sensitive practice within alcohol and other drugs organisations (Copello et al., 2006).

At the organisational level, alcohol and other drugs services may not have the structural or procedural resources to work with families and children, and may not be equipped to recognise or respond to child welfare issues (Holmila, Itäpuisto & Ilva, 2011). Factors such as assessment processes, confidentiality policies, funding mechanisms and access to resources can be ingrained within an organisation and may represent significant obstacles to change (Battams et al., 2010).

Issues related to the clients themselves may additionally affect the implementation of child and family sensitive practice. Clients may be hesitant to seek help in regard to parenting, for fear of judgement or losing custody of their children (Gruenert & Tsantefski, 2012). Similarly, many alcohol- and other drug-affected individuals have complex and troubled relationships with their families, and the priorities of family members may differ from those of the client, for example total abstinence vs harm minimisation (Springboard Social Planning, 2009). As a result, clients may be reluctant to involve family members in treatment programs.

Staff attitudes can also play a large role in determining the success or failure of child and family sensitive programs. Clinicians may be reluctant to change their current work practices or treatment focus, and may see family issues as falling outside their role (Lee, Christie, Copello & Kellett, 2012). Many have also been trained to work individually with clients, and may feel uncomfortable dealing with more than one person in a single session (Springboard Social Planning, 2009), or accommodating the needs of clients' children. Some alcohol and other drug workers have traditionally refrained from asking clients about their children in order to avoid any perceived potential conflicts of interest or a need to make child protection notifications, which could jeopardise their working relationship with clients. Finally, staff may lack the requisite skills, knowledge or confidence in relation to providing parenting or family support and, as such, may feel unable to respond to parents' needs (Lee et al., 2012).

Scott (2009) suggests that the degree to which a clinician perceives working with families and children as part of their 'core role' (i.e. their role legitimacy) is crucial to their engagement with child and family sensitive practice. Children's needs are often seen as 'other needs' and the extent to which they are addressed depends on whether the clinician is willing or able to define their role as encompassing those other needs. The various ways in which workers' roles may be conceptualised in relation to child and family sensitive practice are shown in Table 4.

Table 4: Perceived role definition and adoption of child and family sensitive practice

Role definition	Practice implication
1. Core role only	<i>'It's not my concern'</i> No engagement with child and family sensitive practice
2. Core role plus assessment of 'other needs'	<i>'It's a concern but someone else's job'</i> Minimal engagement leading to referral
3. 'Other needs' incidental but unavoidable	<i>'Not my core role but I have to do it'</i> Willing to address issues where they impact on client needs
4. 'Other needs' intrinsic part of core role	<i>'It's part and parcel of my job'</i> Engaged with child and family sensitive practice

Adapted from: Scott (2009).

Lee and colleagues (2012) also provide suggestions for reducing resistant attitudes towards child and family sensitive practice among staff. These include broadening narrow perceptions of family-based work to include more flexible interpretations and thereby enhancing role legitimacy and building role adequacy.

Achieving change

In addition to the operational emphasis which centres on workers' roles, skills and perspectives, a closer examination of the roles played by policy, governance and funding is also required. Systems responses aimed at achieving a shift to child and family sensitive practice require close and planned cooperation, and supportive 'family service' oriented policies reinforced by adequate funding (Wolfe et al., 2013).

Successful implementation of child and family sensitive practice is unlikely unless all levels of the organisation are committed to change (Dawe et al., 2008). As such, a formal change management strategy may be required. Broadly, this involves communicating the vision and rationale for the change, combined with appropriate policies, practices and procedures to support the new philosophy and embedding it within the organisational culture (Gruenert & Tsantefski, 2012). In order for this to occur, it is important for organisations to have access to adequate funding and resources. Appropriate policies and procedures that support a culture of child and family sensitive practice need to be developed and implemented, and staff must receive sufficient training and supervision to support their new roles (Dawe et al., 2008).

Research has highlighted the significance of 'leaders and champions' when making significant changes. It can be helpful for particular staff members to model new practices and encourage more resistant workers to participate (Drabble, 2010). This is important to ensure that new policies and procedures are adhered to consistently throughout the entire organisation.

Part A3. Policy review

A desktop environmental audit and analysis were undertaken to identify policies relevant to Australian alcohol and other drugs services. The audit examined the child and family sensitive practice-related policies of government and non-government drug and alcohol services and peak drug and alcohol bodies in each state and territory, as well as nationally and internationally.

The analysis found that although there were numerous child and family sensitive policies in place at the international, national and state/territory levels, consistent and coherent policy support is still lacking. Specific challenges to policy development and implementation relate to funding, costs, information and data collection, information sharing, risk frameworks and responsibility, and unclear conceptualisations.

Historically the alcohol and other drugs sector was developed to address the harms experienced by clients from their alcohol and other drug use. However, a growing awareness of the relationship between substance misuse, parenting and the wellbeing of children has raised concerns regarding the children of alcohol and other drugs service clients, and has increased interest in child and family sensitive policy and practice.

The implementation of child and family sensitive practice necessitates significant sectoral and organisational commitment to change, and can be influenced by a range of factors that operate at:

- policy levels
- sectoral levels, e.g. differing practice frameworks and philosophies
- organisational levels, e.g. lack of structural and/or procedural resources
- individual levels, e.g. client and/or staff reluctance to involve family members in treatment.

To this end, clear policy frameworks are a necessary (although not sufficient) condition for the successful development and implementation of child and family sensitive practice. A coherent policy framework offers an underpinning rationale for effective service provision. Without it, it is unlikely that child and family sensitive practice will be implemented and maintained with any degree of consistency and/or sustainability. In recent years, a number of reforms have been identified and/or implemented which examine this issue, including:

- The Victorian Government Service Sector Reform Project (Shergold, 2013) examined ways to improve the lives of vulnerable children through reforms in the community sector.
- In 2013, the Australian Government Department of Health and Ageing commissioned a review of the funding models that apply in the alcohol and other drugs sector together with a parallel project examining the development of quality standards.
- In 2010, the Productivity Commission (Productivity Commission, 2010) examined the role and contribution of the not-for-profit sector (including alcohol and other drugs agencies) and explored mechanisms to improve its effectiveness and efficiency.

The current policy review was undertaken with cognisance of these wider developments. It reflects issues under scrutiny within these parallel review processes that have scope to examine the way the alcohol and other drugs sector may better address the needs of clients' children into the future.

The review involved a desktop audit of alcohol and other drug policy and related frameworks and intervention strategies in Australian states and territories.² It examined the current status of policy coverage of child and family sensitive practice and factors that might impact it, the extent to which child and family sensitive practice is recognised within policy frameworks, and Australian initiatives that have been implemented using a child and family sensitive approach. These policies and initiatives were then analysed to assess their strengths and weaknesses, and the implications for child and family sensitive practice into the future. Policies were considered at international, national and state/territory levels.

Suggestions were made for enhancing policy and systems issues that impact on child and family sensitive practice in alcohol and other drugs service provision. These include policy, structural factors, reconceptualising risk and responsibility frameworks, and models of care and funding. However, it is important to note that policy developments in this area are dynamic and subject to change.³

- 2 This audit focused on higher-level policy documents and intervention strategies. Agency-specific policies have not been included. For further information about agency-specific policy frameworks, refer to the respective alcohol and other drugs departmental/agency websites.
- 3 In undertaking this review, the NCETA project team was aware of a number of projects aimed at enhancing alcohol and other drugs service provision that were being conducted at the same time. These included:
 - mapping and database creation to assist in identifying unmet needs and improving collaboration among primary healthcare, emergency services, carers, consumers and the drug and alcohol sector
 - New South Wales Health's national Drug and Alcohol Clinical Care and Prevention (DA-CCP) Modelling Project, which aims to standardise need estimation across states and territories. This project is being undertaken on behalf of the Intergovernmental Committee on Drugs (IGCD), as a planning tool to estimate need
 - a Quality Framework project which will develop Drug and Alcohol Standards to drive quality improvement in the sector
 - the Patient Pathways Project, which aims to identify health services and systems already in place and identify client pathways that can assist in future modelling.

Policy context

There have been a number of recent national, state and territory initiatives regarding child and family sensitive practice, including the development of the National Framework for Protecting Australia's Children (Council of Australian Governments, 2009) and recognition within the National Drug Strategy of the importance of working with children and families. However, from a policy perspective, there have been limited 'trickle-down' effects (i.e. from top level policy to more on-the-ground alcohol and other drugs policy). Similarly, there has been little upward acknowledgement at the state and territory level of the broader overarching policies. This has resulted in a disjointed policy response at both the national and state/territory levels. The array and hierarchical structure of child and family sensitive policies at the international, national and state/territory levels are displayed in Figure 1.

International policies

The United Nations Convention on the Rights of the Child (CROC) is the core international treaty that sets out a comprehensive framework for the protection of children's rights. In the context of international policy development, Australia is a signatory to CROC and this ratification has the potential to provide a framework for national, state and territory policy in relation to children's rights. As such, Australia has an obligation to protect children's rights and to support parents in their child-rearing responsibilities. Specifically, Australia is required to:

Take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties and to prevent the use of children in the illicit production and trafficking of such substances (United Nations, 1991).

Through its ratification of CROC, Australia acknowledges that children have a special need for protection and recognises their rights to protection by the state. In addition, the 'best interests of the child' test is enacted in the *Family Law Act 1975* and, as such, Australian children are afforded special protection (Battams et al., 2010). The extent to which relevant national, state/territory and organisational policies and practices are consistent with and meet the requirements of CROC therefore warrants consideration.

Unfortunately, there appears to be limited recognition of the Convention in the construction of alcohol and other drugs policies at national, state and territory level. For instance, while a number of Australian alcohol and other drugs policies cite human, client or cultural rights, none of those included in this review specifically mentioned children's rights or CROC.⁴

4 A thorough review of the alignment between Australian alcohol and other drugs policy and the Convention has not been undertaken. However, such a review could provide valuable insights into the level of connectedness between alcohol and other drugs and children's rights policies. The recent appointment of a National Children's Commissioner within the Australian Human Rights Commission may create opportunities for such work to be undertaken.



Figure 1: Examples of child and family sensitive policies at the international, national and state/territory levels

An example of a policy that may not align to CROC is the Northern Territory intervention, which in part specifically addressed alcohol and drug use. The intervention was recently found to have contravened CROC. The United Nations Child Rights Taskforce, in a review of Australian policies, found that:

the Australian Government had contravened children's rights with the Northern Territory Intervention and had generally failed to protect and promote the rights of Indigenous children (Child Rights Taskforce, 2010).

Another specific concern raised by the United Nations Taskforce was the incarceration of 17 children in the adult corrections system in Queensland (many for alcohol- and other drugs-related offences). These examples illustrate how national, state and territory policy and practice implemented without consideration of CROC can conflict with, and impact on, Australia's obligations under the Convention. Improvements in Australia's child and family sensitive policy can be guided by CROC's requirements, philosophy and specifications.

Wolfe and colleagues (2013) noted that, even though CROC provides a useful framework for developing policies that support child health and wellbeing, policy makers are often hesitant about adopting an approach that is consistent with the goals of CROC. They further note that by not enacting policies based on CROC, which support disadvantaged children and their families, opportunities are missed to break the cycle of disadvantage for individuals and populations throughout the life course.

National policies

At a national level, the National Framework for Protecting Australia's Children 2009–2020 is the Australian Government's overarching policy in relation to child wellbeing and safety, which was endorsed by the Council of Australian Governments in April 2009. The Framework outlines a long-term approach to ensuring the safety and wellbeing of Australia's children. It aims to deliver a substantial and sustained reduction in levels of child abuse and neglect and provides guidance to all levels of government and the NGO sector on working together to ensure the safety and wellbeing of Australia's children and young people.

The National Framework encourages national, state and territory jurisdictions to review existing legislation and policies and adopt more child and family sensitive policies, procedures and practices. The Framework provides an indication of the importance that the Council of Australian Governments assigns to child and family sensitive practice across all sectors, including the alcohol and other drugs sector.

Specifically, Strategy 3.1 focuses on enhancing the capacity of alcohol and substance abuse initiatives to provide additional support to families:

3.1 Enhance alcohol and substance abuse initiatives to provide additional support to families (Council of Australian Governments, 2009).

While the Framework and its associated action plans indicate how alcohol and other drugs sector activities and reforms may support the implementation of the Framework, it does not articulate specific strategies or mechanisms for ensuring the alcohol and other drugs sector's adoption of the Framework.

The key national policy for the alcohol and other drugs sector is the National Drug Strategy 2010–2015 (NDS). The NDS specifically addresses the issue of child and family sensitive practice for the first time since its inception and states that:

- Support needs to be available to families, particularly those with children, to help them manage the stresses they may be experiencing from a family member's drug use, and help engage them in managing the individual's drug-related problem. Families can also aid in recovery.
- Services for people with drug-related problems need to recognise the impact of drug use on families and help ensure they are provided or connected with the right support.
- Closer integration with child and family services is needed to more effectively recognise and manage the impacts of alcohol and drug use on families and children and to enhance child and family sensitive practice in alcohol and other drugs treatment services.

The NDS also refers to the term 'child and family sensitive practice' and makes explicit statements about its importance:

Enhance child and family sensitive practice in alcohol and other drug treatment services and build links and integrated approaches with community, family and child welfare services (Ministerial Council on Drug Strategy, 2011).

In doing so, it provides an imprimatur for the implementation of child and family sensitive practice within alcohol and other drugs services. However, while the NDS seeks to articulate a coherent national position, it is nonetheless aspirational. Although it expresses federal government support for child and family sensitive practice, there are no explicit mechanisms stipulated to ensure the consistency of national, state and territory policies and procedures.

Despite this, translation of the policy intent contained within the NDS at the state and territory level is of vital importance. This is because the overarching framework provided by the strategy is in large part intended to inform and guide the development of state and territory policy, as most alcohol and other drugs service delivery is executed at this level.

State and territory policies

Drug and alcohol service provision is largely a state and territory responsibility. Hence, each jurisdiction has developed service systems designed to best meet the needs of the population within that state or territory. An examination of relevant alcohol and other drugs policies in each Australian state and territory was therefore undertaken (see Table 5).

At the most basic level, policies were first scrutinised for their content and coverage related to children. It was noted that, when addressing matters related to the children and/or families of clients, each jurisdiction used different language, terminology and concepts. Currently, many of the state and territory policies in the alcohol and other drugs sector do not use the term ‘child and family sensitive practice’ explicitly. Nor do they refer to ‘child sensitive’ or ‘family sensitive’ practice. New South Wales, the Australian Capital Territory, Western Australia and Tasmania use the term ‘family inclusive’ in a number of their documents.

While inconsistency in terminology is not necessarily problematic, it does raise the spectre of differing interpretations and misinterpretations of what is intended by the concept of child and family sensitive practice. Further, this may translate into inadequate service provision.

Most states and territories identified activities that are consistent with child and family sensitive practice in their alcohol and other drugs strategic plans and policy documents. These plans and policies articulate a commitment at state and territory level to develop or further support the implementation of child and family sensitive practice.

In some states and territories there was a clear and explicit articulation of the role that alcohol and other drugs services, and the alcohol and other drugs sector more broadly, should play in relation to children and families. For example, in 2012, Victoria published *New Directions for Alcohol and Drug Treatment Services: a roadmap*, which represents the future policy directions for Victorian alcohol and other drugs services. This new policy framework articulates a commitment to working within a child and family sensitive framework. It states:

We need to do better at supporting and involving family members in a person’s treatment. We also need to recognise that clients may also be parents and respond appropriately to support and protect their children. As a first step we will educate our workforce on family-inclusive practice and build their skills to involve family members and respond to the needs of children (Victoria Department of Health, 2012).

There are also recent examples of states and territories undertaking work to more closely align their policies with the National Framework for Protecting Australia’s Children. For example, Drug and Alcohol Services South Australia (DASSA) recently commissioned a review to assess the extent to which their policies and procedures are sensitive to the needs of clients’ children and families. That review highlighted a number of opportunities to enhance and better integrate their child and family sensitive policies and practices. There are similar developments in other jurisdictions, most notably New South Wales and Western Australia, where substantive policy changes have been implemented.

However, in a number of states and territories, the policy focus was limited to immediate health issues, including ante- and post-natal health issues for substance-using mothers, and smoking cessation in places where infants and children are present. Very few states or territories had instituted mechanisms to ensure the adoption of child and family sensitive policy and practice. This review found that, without a mechanism requiring or facilitating the adoption of policies and practice consistent with the National Drug Strategy, it may prove difficult to implement child and family sensitive practice at either jurisdictional or service delivery levels.

While every Australian state and territory had some policy content that addressed the needs of alcohol and other drug clients' children, the approach, focus and emphasis appear to vary considerably. Many relevant policies are traditional child and maternal policies which have been in place for some time. Others are more contemporary in nature. In some instances, a number of states and territories had recently revised their child-related policies to extend the scope to approximate a child and family sensitive concept of care. Moreover, it is unclear to what extent the emerging policy focus is appropriate, comprehensive and able to be actioned in alcohol and other drugs services.

Table 5: Key state and territory child and family sensitive policies

State/ territory	Date	Description
Australian Capital Territory	2010– 2014	The Alcohol, Tobacco and Other Drug Strategy 2010–2014 includes several references to clients who may have children. The action plan recognises the special needs of children and young people affected by parental use of alcohol and other drugs as one of its 66 priority actions.
New South Wales	2013	The Protecting Children and Young People Policy Directive states that agencies have a responsibility to protect children and young people and to work collaboratively with other agencies to ensure a coordinated and comprehensive response to their needs. The New South Wales Government endorses an interagency approach to promoting the care and protection of children and young people.
	2011	Network of Alcohol and other Drug Agencies (NADA): Family Inclusive Practice Policy is a policy template available to organisations wishing to incorporate family-inclusive practices in their policies.
	2010	Keep Them Safe Whole-Family Teams were established as part of the New South Wales Government's approach to child wellbeing. The Keep Them Safe Whole-Family Teams are aimed at addressing the needs of families where carers have mental health and/or substance use problems and parenting difficulties.
	2009	Supporting Families Early Package – SAFE START Strategic Policy promotes an integrated approach to the care of women, their infants and families in the perinatal period.
	2009	Supporting Families Early Package – Maternal and Child Health Primary Health Care Policy identifies a model for the provision of universal assessment, coordinated care and home visiting, by NSW Health's maternity and community health services, for all parents expecting or caring for a new baby.
	2006	Child Wellbeing and Child Protection – New South Wales Interagency Guidelines provide practical guidance on interagency cooperation in child protection to assist professionals and agency practitioners to work together across agency boundaries when responding to child protection concerns.
	2006	The Child Protection Issues for Mental Health Services – Risk of Harm policy directive includes a risk assessment tool for workers to identify children who may be at risk of harm due to parental mental health and alcohol and other drugs issues.

State/ territory	Date	Description
Victoria	2012	<i>New Directions for Alcohol and Drug Treatment: a roadmap</i> includes a focus on ensuring that the needs of children of people in alcohol and other drugs treatment become a part of alcohol and other drugs services' core business.
Queensland	2011– 2012	Priority Area 3 (Reducing harm to families) of the Queensland Drug Action Plan aims to improve the provision of services to alcohol and other drugs clients through programs such as Parents Under Pressure (PuP) and Parents, Kids and Drugs (PKD).
Western Australia	2013	The Western Australian Drug and Alcohol Office updated its Working with Families policy which incorporates a set of Family Inclusive Practice (FIP) guidelines for workers.
	2011– 2015	The Drug and Alcohol Interagency Strategic Framework for Western Australia identifies families, including alcohol- and other drug-using parents, as a priority target group.
	2008	The Western Australian Drug and Alcohol Office's Policy Framework for Reducing the Impact of Parental Drug and Alcohol Use on Pregnancy, Newborns and Infants is supported by the Western Australian Government and the Western Australian Network of Alcohol and other Drug Agencies.
South Australia	2011– 2016	One of the priority population groups in the South Australian Drug Strategy are people with alcohol and other drug misuse issues and their dependent children. Priority Action 3 of the Strategy, which highlights the need to develop an interagency strategy to improve coordination of services for children with caregivers who have substance dependence issues, is identified as a key priority.
	2011	Drug and Alcohol Services South Australia's Child Safe Service Development Plan aims to map support services for children of a family member who is affected by alcohol and other drugs.
	2008	South Australia developed Information Sharing Guidelines under the Keeping Them Safe – Child Protection Reform Program. The Guidelines contain a requirement that, for all government contracts in the community services and health sectors, service providers need to have developed information sharing protocols. This requirement overcomes many of the issues relating to confidentiality and disclosure of information to other services, which had previously hampered the sharing of client information.

State/ territory	Date	Description
Tasmania	2008– 2013	The five-year Future Directions plan for alcohol, tobacco and other drugs services aims to strengthen the capacity of the Alcohol and Drug Service to better support Children and Family Services when they encounter alcohol and drug issues that are having a significant impact on families and children.
	2012	Section 5 of the Tasmanian Opioid Pharmacotherapy Program, Policy and Clinical Practice Standards provides guidance to alcohol and other drugs clinicians about recording the client's family history including details about their children.
Northern Territory	2013	The Stronger Communities for Children program guidelines highlight the importance of providing Aboriginal men and women experiencing alcohol and other drug issues with a greater capacity to meet the needs of their families using culturally based family interventions and community development approaches.
	2009– 2012	One of the key focus areas in the Alcohol and Other Drugs Program's Strategic Directions (Priority Action 3: Targeting Smoking, Alcohol and Substance Abuse) is the provision of a range of treatment and rehabilitation services, acute and primary healthcare and family support and child protection services.
	2013	The Northern Territory is introducing mandatory treatment for chronic problem drinkers. Under the Government's model those placed in protective custody three times in two months will be assessed by a clinician to determine whether they are capable of making decisions about their own welfare and could benefit from treatment. The implications for the children and families of people so detained have not been explored in the legislation, government information or submissions to the Legislative Review Committee.

Policy review summary

The policy review identified a disparate array of policies in relation to child and family sensitive practice in the alcohol and other drugs sector. Significant policy developments have occurred in most Australian jurisdictions, including the Australian Capital Territory, Western Australia, Victoria, New South Wales, Queensland and Tasmania. However, while all Australian states and territories have one or more child and family sensitive practice-related policy in place, few mechanisms appear to guide the implementation and operation of these policies. Furthermore, while individual sectors (e.g. alcohol and other drugs, child protection and welfare, family violence, mental health) have developed policy responses, when considered holistically these frameworks lack coherence.

The policy audit and analysis identified scope for the development of greater consistency in policy and practice at both national and state/territory levels, and among and within jurisdictions. While each jurisdiction has developed policies that have specific strengths and are tailored to meet their needs, these policies may be improved through comparison and harmonisation with those from other jurisdictions. This may also benefit service users and workers moving between states and territories, who could be better served by greater consistency.

The policy audit also highlighted that while there were some positive aspects to state and territory child and family sensitive policies as noted above, there were also a number of significant policy gaps, including but not limited to:

- risk frameworks and models that address the risk of harm to children of clients
- the policy responses required to address these risks
- assignment of responsibility for provision of services to children of adult clients
- identification of models of care to meet children's needs
- identifying responsibility for implementing and supporting the model of care
- the resourcing requirements needed to support this enhanced systems approach, e.g. sectoral and intersectoral structures, organisational structures, funding, management and supervision processes, staff skills, knowledge and attitudes.

In sum, the ability of the alcohol and other drugs sector to respond to the needs of children and families of clients is currently compromised by a lack of consistency and significant policy gaps in relation to the development and implementation of child and family sensitive policy at both the national and state/territory levels.

Levers for child and family sensitive policies

Many non-government organisations (NGOs) base their policies and practice on governmental policies. If national, state and territory policies do not contain child and family sensitive practice components, it is less likely that NGO policies will do so. However, a number of NGOs have historically implemented child and family sensitive policy and practice developments in the absence of national, state or territory policy and/or practice frameworks.

Policies are an integral part of implementing child and family sensitive practice and are best served by consistent and harmonious approaches. If they are developed without taking into consideration the policies of other sectors, intersectoral inconsistencies may result. At present, while CROC provides an overarching framework to inform policy development in Australia and is supported by the National Framework for Protecting Australia's Children, many policies within the alcohol and other drugs sector and related sectors (e.g. child protection and wellbeing, family violence, mental health and more general health) appear not to have been developed with consideration of their relationship to other sectors. This is the case for both national and state/territory policies.

The National Framework for Protecting Australia's Children 2009–2020 seeks to address this issue by providing guidance to sectors on intersectoral policy and practice. However, the work of ensuring that policy conflicts do not arise between or within sectors is just beginning. Despite the Framework, new policies continue to be developed and implemented that do not take into account issues that may arise for clients' children or family members supported by other sectors.

While policy is an important mechanism to ensure that services consistently address the needs of alcohol and other drugs clients as parents and their children, good practice is also essential. Practice initiatives are addressed in Part C of this report.

Policy challenges

Alcohol and other drugs services have long been aware of clients' complex issues, as evidenced by the significant work undertaken on comorbidity (Roche & Pollard, 2006) and the emerging work on multi-morbidities (Barnett et al., 2012). However, much of this work has focused on the individual client with relatively little attention paid to clients' children or families. Service responses remain largely focused on the needs of individual clients, albeit with a broadened focus of what these needs might comprise. In addition, most collaboration between the alcohol and other drugs sector and other sectors has focused on other adult services (e.g. mental health, housing and homelessness services, justice and corrections).

The prospect of introducing child and family sensitive practice into an already complex treatment landscape may be challenging. A greater focus on clients' children and increased interaction between sectors may place greater demands on organisations and workers. This may require an increase in the resources and time required to adequately address this broadened focus. The implementation of sound child and family sensitive policies can also be undermined by numerous practical and operational factors. These factors are discussed in more detail below.

Funding

A crucial element in the implementation and operation of any policy is funding. In the first instance, issues need to be identified as core policy areas. They then need to be explicitly prioritised and resourced accordingly. Unless the allocation of appropriate resources accompanies any policy initiative, it will remain ineffective.

The alcohol and other drugs sector, at both the federal and state/territory levels, has traditionally been funded on the basis of service provision to individual clients. Both input- and output-based funding have been allocated to services or episodes of care provided primarily to individuals. However, child and family sensitive practice, with its focus on the provision of services to not only the individual but also their partner, children and extended family, requires organisations to expend resources on 'non-clients'. Many agencies are unable to support services for family members through existing funding models. This effectively requires agencies to self-fund any child and family sensitive service components.

For agencies to be able to provide effective child and family sensitive services, a reframing of funding policy and practice is required so that children and family members can be counted as episodes of service or care for funding purposes. This may require changes in standards for data collection, redefinition of the notion of the client and consideration of how the sector is funded.

Some work is also being undertaken to explore and develop intersectoral collaborations as an additional means by which to meet these needs (White, 2011). Where intersectoral collaboration occurs, sectors can benefit from the capacities brought by the other sectors (including expertise, knowledge, skills and perspectives) to achieve better outcomes for shared clients and their children. It is important, however, to recognise the complexity involved in making this work. There are time, funding and resource implications involved in developing such collaborations. In constrained funding environments, service provision becomes increasingly focused on 'core' clients and child and family sensitive policies may not be successfully implemented and practice may subsequently atrophy.

Child and family sensitive practice spans all aspects of alcohol and other drugs practice. However, there is little specific funding identified that supports the development of child and family sensitive policy or practice in the alcohol and other drugs sector. While a number of programs incorporate some support for the alcohol and other drugs sector to become more child and family sensitive, many of these programs are not funded from within the alcohol and other drugs sector but from other sectors or philanthropic resources, e.g. Building Capacity, Building Bridges (White, 2011).

To enhance the capacity of adult specialist services, and particularly the alcohol and other drugs sector, to identify and respond to vulnerable children and young people, governments at national, state and territory levels need to provide funding to support these services to develop child and family sensitive practices. The first step in this direction involves an audit of practices that identify and respond to the needs of clients' children (Cummins, Scott & Scales, 2012, Recommendation 15).

Costs of unaddressed needs of clients' children

It is estimated that the costs of alcohol and other drug problems associated with family members are both enormous and largely overlooked (Laslett et al., 2010; Orford et al., 2013). A detailed costing of the unaddressed needs of clients' children would help inform policy development and direction. In addition, it would provide an important component of the complex funding equation that underpins resource allocations to the sector.

Information and data collection

An important component of national, state and territory policy agendas is the need for a systematic mechanism to address the provision of appropriate information.

To develop evidence-based interventions, accurate data are essential. At the broader system, sectoral and organisational levels, there are limited data collected on the children of clients with alcohol and other drug issues. Where collected, data are often at the client level and are not aggregated at organisational or sectoral level. Strategies are required to improve data collation and synthesis.

For effective policy development it is also necessary to measure the impact of harmful alcohol consumption on families and children. As such, relevant population surveys that monitor drug use and drug trends across Australia, and collect information on the parental status or childcare responsibilities of drinkers, are vital.

Information sharing

One pivotal factor with the potential to undermine child and family sensitive practice is information sharing and disclosure. Several states and territories have sought to improve their information-sharing processes, including the sharing of information between alcohol and other drugs services and other health and human service providers. For example, the South Australian Government's Child Protection Reform Program developed the Information Sharing Guidelines for Promoting Safety and Wellbeing (ISG). The Guidelines provide a mechanism for information sharing, empowering agencies and organisations to share information about children, young people and adults they work with who are at risk of harm. This sharing of information enables workers to assess whether their work with other services is complementary, sufficient and protective of the client, other family members and the community (South Australia Department for Education and Child Development, 2008). Information about the ISG has been included in a range of training programs provided to adult specialist services in South Australia (including alcohol and other drugs services).

Similar initiatives have been undertaken in Victoria. The Victorian Child Protection Information Sharing Guidelines provide a policy and practice framework for government and non-government agencies interacting with parents and children to share information in the interests of child safety, better service coordination and early intervention (White, Roche, Nicholas, Long, Gruenert & Battams, 2013).

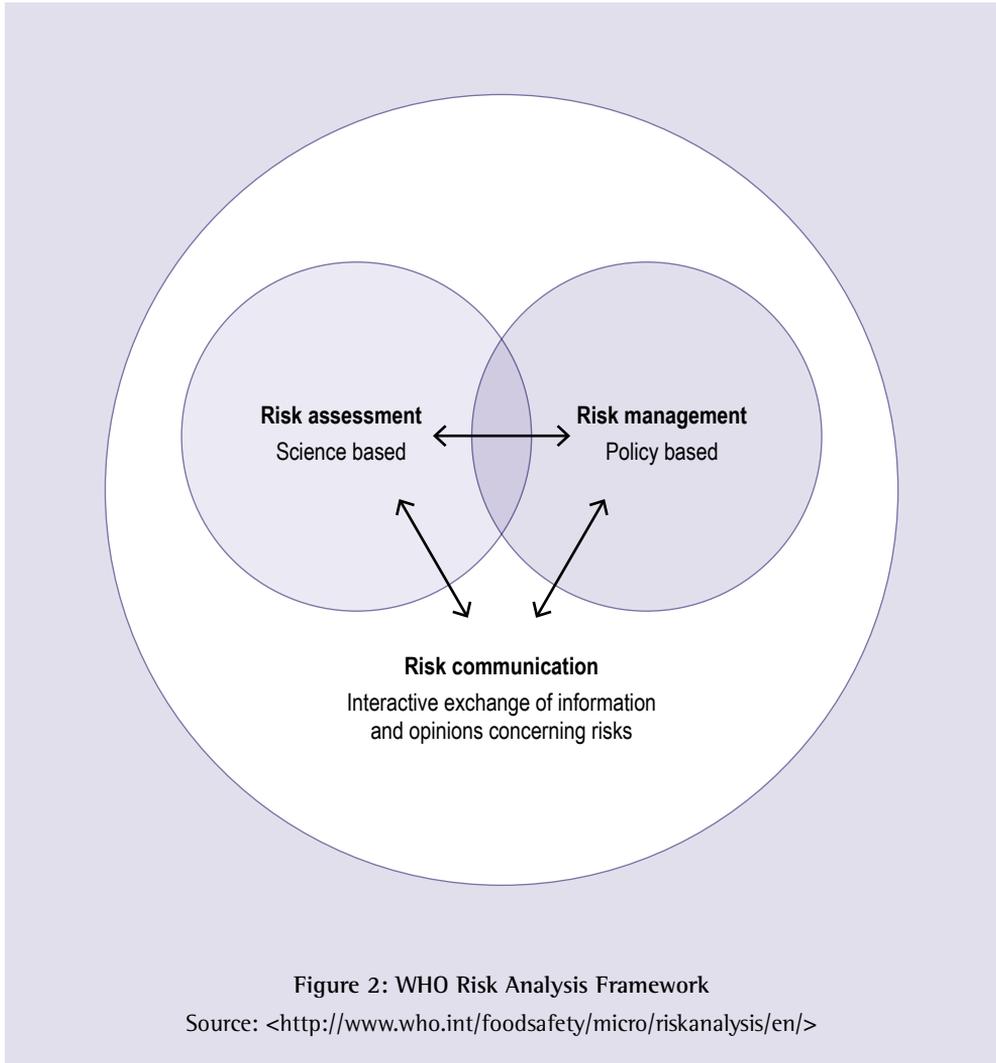
The Information Sharing Protocol between the Commonwealth and Child Protection Agencies (the Protocol), an initiative under the National Framework for Protecting Australia's Children 2009–2020, was approved by the Community and Disability Services Ministers' Conference and implemented in 2009. The implementation of this protocol has been generally well received; however, there are some inconsistencies in its use. While an analysis of its procedural implementation has been undertaken, no assessment of its impact on outcomes for children and families has been undertaken (Allen Consulting Group, 2011). Further work in this area would assist in the implementation of child and family sensitive practice in the alcohol and other drugs sector.

Risk frameworks and responsibility

An overarching concern, which drives and informs policy and responses in health, and the alcohol and other drugs sector specifically, is the concept of risk. In relation to the children of substance misusers, risk assessment entails consideration of the various risks to which they may be exposed. The evidence base in regard to children's risks is growing. It is increasingly understood that the children of alcohol and other drugs clients are at elevated levels of direct and indirect potential harms associated with their carer's use of alcohol or drugs. However, a clearer articulation of the risks and negative outcomes encountered by clients' children will help inform the empirical base required to develop appropriate policy and practice.

Models of risk have been developed in other sectors, which have potential application to improved understanding of the needs of clients' children. For instance, the model of risk shown in Figure 2 indicates the relationship and intersection between empirical assessment of risk and policy responses. To date, however, the case establishing risks to clients' children is only just beginning to be made strongly enough to influence policy and practice at a meaningful level. Without better articulation of the risk to children, the short- and long-term manifestations of this risk, and evidence of effective or innovative strategies to address it, further progress will be severely hampered.

A related element is risk to the healthcare system which holds responsibility for the client and potentially any harm to others that may be incurred by the client. The concept of harm to others has been considered in a legal and criminal sense for some decades (see, for example, the work of Feinberg, 1984). A more sophisticated and nuanced understanding of risk and a clearer assignment of responsibility are required through comprehensive risk analyses to advance policy and practice in the area of child and family sensitive practice.



Risk assessment

Undertaking evidence-based risk assessments in relation to parents with alcohol and other drug problems has primarily been the concern of the child protection sector. More recently, other adult specialist services, such as domestic violence and homelessness service sectors, have included children in their risk management processes. While the alcohol and other drugs sector utilises highly developed risk management processes, these do not generally include measures of the risks to children of clients.

Responsibility

A risk analysis helps to identify response strategies but also indicates the actors/agencies with responsibility for addressing identified problems. Responsibility in relation to alcohol and other drug clients' children has not yet been fully assigned. Without clear designation, acknowledgement and acceptance of responsibility, it is unlikely that a comprehensive response strategy will eventuate.

While the National Framework for Protecting Australia's Children and the National Drug Strategy both make explicit the responsibility of the alcohol and other drugs sector to consider children, further work needs to be undertaken in the risk communication area to ensure that alcohol and other drugs services (both government and NGO) are clear about their responsibilities for children of clients.

It is also of note that risk management has sometimes been used to disable the provision of services to children of clients. Key informants (see Part B) identified instances of risk management processes resulting in the reduction of services to children of clients.⁵ For effective risk management to be undertaken, there needs to be good evidence about the nature of risks and the potential to ameliorate them through changes to policy and practice.

Clearer conceptualisation

In our review of child and family sensitive practice there were indications that a number of services have begun to effectively address the needs of children. However, these programs were limited in scope, they tended to have been developed despite policy and funding guidelines rather than because of them, and while of value in themselves and as exemplars, they are not sufficient to meet the requirements of clients' children.

Orford and colleagues (2013) have recently highlighted the lack of attention, indeed 'silence', that has characterised the alcohol and other drugs sector's response to the families of alcohol and other drugs clients, including their children. This was evident in a simple word count of the number of times the terms 'child', 'family', 'children' or 'parents' are used in key policy documents and research reports, which generally showed few or no references.

There is generally a lack of research and poor conceptualisation about child and family sensitive policy and practice and also a propensity to categorise clients' family members. Models of treatment within alcohol and other drugs services largely exclude family members and clients' children. Orford et al.'s (2013) stress-strain-coping-support model highlights the social and economic stressors faced by clients' family members, including a lack of information and social support, dilemmas about how to cope, and a resultant risk of negative health outcomes. These factors need to be addressed through appropriate policy responses, and more inclusive alternative models of treatment are required in order to fully and comprehensively incorporate the needs of clients' family and children.

⁵ An example given was the withdrawal of funding for a crèche on-site at a treatment centre, as it was perceived that there were risks to children who may be exposed to alcohol and other drugs clients. The effect was to disengage those clients who were parents and required childcare (predominately mothers of young children). Without access to a proximate childcare facility they could not attend treatment.

Conclusion

There is an increasing awareness within the alcohol and other drugs sector of the need to protect and support clients' children, and involve them in the therapeutic process. This awareness is underpinned by several recent positive policy developments at national, state and territory levels, which recognise and endorse child and family sensitive practice. The imprimatur of the United Nations Convention on the Rights of the Child, the existence of an overarching National Framework for Protecting Australia's Children, and a range of national, state and territory policies in relation to alcohol and other drugs and child and family welfare create a sound foundation for further policy developments in the alcohol and other drugs sector. Recognition within the National Drug Strategy of the importance of working with children and families, and examples of child and family sensitive policy and practice initiatives identified in most states and territories, highlight an increasing acknowledgement by the alcohol and other drugs sector that children at risk are their responsibility.

There is an emerging policy framework in relation to child and family sensitive practice. Encouragingly, a number of child and family sensitive practice initiatives have been implemented throughout the alcohol and other drugs sector in Australia, particularly in non-government organisations. In contrast, government organisations were found to be more likely to be involved in developing policy frameworks and providing education and training around child and family sensitive practice.

However, this review found that scope exists to develop more consistent child and family sensitive policy and practice between jurisdictions. Despite the progress made in this area, significant barriers were identified in relation to the implementation of child and family sensitive practice in the alcohol and other drugs sector. The development and implementation of child and family sensitive policy and practice were noted as requiring appropriate attention and resourcing at the level of the organisation, workers and clients.

Further work is also required to improve engagement with child and family sensitive practice. The audit identified a lack of consistency in relation to the development and implementation of child and family sensitive policy and practice at both national and state/territory levels. It identified greater scope for the development of consistent policy and practice at a national level and between and within states and territories.

The increasing attention being directed to the identification of children, and in particular the risks children are exposed to, and to assigning responsibility for intervention is likely to impact on the alcohol and other drugs service sector. However, responsibility for the children of those attending alcohol and other drug services currently remains ambiguous, and this impedes constructive and consistent responses across and within sectors.

The next section of the report presents the findings from key stakeholder consultations, including barriers to and facilitators of implementing child and family sensitive practice.

Part B. Key stakeholder consultations

A series of consultations were undertaken with key stakeholders throughout Australia. The aim of the consultations was to gauge views about child and family sensitive practice and what it means in terms of policy and practice in the alcohol and other drugs field.

Semi-structured interviews were held with 18 stakeholders from across Australia. Participants were recruited from service providers in the alcohol and other drugs sector that delivered child and family sensitive informed programs and initiatives, and key stakeholders in the alcohol and other drugs and child welfare policy arenas.

Most key informants were supportive of child and family sensitive practice and emphasised the need for this practice to be culturally sensitive and appropriate. A range of organisational and worker-related issues that affected the implementation of child and family sensitive practice were identified, such as funding, data collection and management, role delineation/legitimacy, staff skills, training and professional development, clinical supervision, and mandatory reporting requirements. Differences between government and NGO services in relation to the provision of child and family sensitive practice were noted.

Key informants highlighted a number of change strategies, such as management and organisational support, champions and co-location of services that could be used to enhance the implementation of child and family sensitive practice within the alcohol and other drugs sector.

Respondents' demographics

A total of 18 key stakeholders from the alcohol and other drugs sector and child protection/child welfare sectors were interviewed as part of the consultation process.

The majority of participants were female (67%; n=12), aged 50+ years (61%; n=11) with 33 per cent aged 40–49 years. Most (78%; n=14) were from the alcohol and other drugs field and the remainder (22%; n=4) were from the child welfare/child protection sectors. The median number of years of service was 12 years (range: 0–40 years). For those respondents who worked in the alcohol and other drugs field (n=14) the median years of service was 21 (range: 7–40 years). The most common work roles were clinical and managerial. The majority of participants (83%; n=15) had worked in the non-government sector. Half (n=9) had worked in both the government and non-government sectors.

The main themes that emerged from the key stakeholder consultations are summarised in the following tables. The themes focused on: perceptions of national, state/territory and organisational policy contexts; awareness of child and family sensitive practice; its historical context; and government/non-government perspectives.

Table 6: Key issues identified by stakeholders

Understandings of child and family sensitive practice	Child and family sensitive practice was generally well understood and supported, albeit sometimes under the aegis of alternative terms (e.g. 'child sensitive practice', 'family sensitive practice', 'child aware practice' and 'family inclusive practice'). The last-mentioned term, however, is distinguished from child and family sensitive practice, as it involves family members directly in the interventions provided by a service (Gruenert & Tsantefski, 2012).
Historical context	While the term 'child and family sensitive practice' was relatively new, its underlying principles had been a part of some practices for many years. However, some services continue to adhere to the historical philosophy of solely treating individual clients.
Policy issues	Policies were perceived to play a vital role in guiding the implementation of child and family sensitive practice. However, respondents felt there was a dearth of national policy initiatives that specifically recognised the needs of children and families within alcohol and other drugs service provision, including a lack of clarity about identifying and responding to child protection and related matters. There was also limited understanding of how these policies could be implemented in practice.
Government vs non-government organisations	Government services were seen to be less flexible and more constrained in terms of their ability to change their service delivery models in response to emerging needs and issues.
Aboriginal and Torres Strait Islander service provision	Aboriginal and Torres Strait Islander services often worked in child and family sensitive ways, but found it difficult to recruit appropriately trained staff. There was limited funding to support child and family sensitive practice and costs were borne by the services.

Table 7: Barriers to child and family sensitive practice

Management and organisational support	A lack of managerial and organisational support could impede practice change.
Funding	Funding was often targeted to specific clients and seldom included costs related to children.
Perceptions of risk	Managers of alcohol and other drugs services were at times reluctant to implement novel practices, as they may entail future risks.
Mandatory reporting	Workers were often hesitant to address issues that could result in a mandatory reporting obligation, for fear of undermining their relationship with the client.
Data collection and management	Data were often collected in organisational or jurisdictional systems that were not compatible, so data could not be easily shared. Child-related data did not appear in statistics and as a consequence there was a lack of attention directed towards their needs.
Clinical supervision	Relevant clinical supervision was often not available.
Role delineation	Clinicians often felt unclear about who their client was, whether their responsibility extended to other family members, and whether using a client's family as a motivating factor in treatment was good practice.
Worker confidence	Many practitioners felt that they did not have the necessary skills and confidence to implement child and family sensitive practice.
Training	Appropriate, funded, accessible and quality training was not widely available. Newly acquired skills could also be difficult to transfer into practice, and needed to be supported by other initiatives.
Intersectoral barriers	Different values and siloed funding arrangements reduced communication and cooperation between sectors.
Gender issues	Women with children may be reluctant to approach services for fear of losing their children, either by going into residential treatment or through losing custody.
Aboriginal and Torres Strait Islander clients	Services for Aboriginal and Torres Strait Islander clients traditionally focused on the whole family, and many Indigenous alcohol and other drug workers were highly skilled in this area. However, such services for Aboriginal and Torres Strait Islanders with children were limited.

Table 8: Facilitators of child and family sensitive practice

Flexible funding	Targeted, sufficient and flexible funding was required for organisations to work with children without suffering economic impost.
Enabling policies and procedures	Clear policies and procedures were considered necessary to implement child and family sensitive practice, e.g. questions regarding children on intake documents together with collection of data regarding parenting responsibilities.
Training and professional development	Training and professional development were necessary for frontline staff, managers and supervisors, and needed to include intra-agency, inter-agency and cross-sectoral training.
Management support	Organisational support was required from line supervisors, middle managers, senior managers and governing bodies. Knowledge of policies authorising child and family sensitive practice was essential.
Skilled staff	There was wide variation in alcohol and other drug workers' qualification levels. Specialist qualifications or training in child and family sensitive practice may be beneficial for some workers to facilitate the adoption and implementation of child and family sensitive practice across organisations.
Staff dedication	Staff who were engaged with, and committed to, child and family sensitive practice were essential to embed it within the organisation.
Clinical supervision	Supervision was important to develop and sustain child and family sensitive practice, and to strengthen inter-agency partnerships.
Champions	Champions at sectoral and organisational levels were important in promoting child and family sensitive practice.

The following sections explore in more detail the issues identified by key informants in relation to child and family sensitive practice in the alcohol and other drugs sector. Key themes include:

- understandings of child and family sensitive practice
- historical context
- policy issues
- government, non-government and Aboriginal and Torres Strait Islander perspectives
- operational challenges, e.g. funding issues, data collection and management
- workers' needs and attributes, e.g. role delineation/legitimacy, worker confidence, staff skills, training and professional development
- working across sectors, e.g. mandatory reporting, perceptions of risk
- change strategies that organisations and workers could employ to enhance child and family sensitive practice in their service provision, e.g. management and organisational support, champions, examples of best practice.

Understandings of child and family sensitive practice

There was a wide range of perspectives and understandings in relation to the term 'child and family sensitive practice', ranging from simple to very sophisticated interpretations.

A number of respondents emphasised the distinction between child and family sensitive practice and 'family inclusive practice'. Perspectives on child and family sensitive practice ranged from 'being aware of the legislation and mandatory reporting requirements', to 'understanding the family dynamic or the relationships between the alcohol and other drugs client and others within the family'. Most respondents saw child and family sensitive practice as ensuring that all work undertaken was responsive not only to the needs of clients, but also to their needs as parents and to the needs of their children. Conversely, 'family inclusive practice' was defined as providing therapeutic interventions to family members affected by the client's behaviour or involving family members in family therapy interventions with the client. This perspective was distinctly and qualitatively different from child and family sensitive practice.

Overall, the key components of child and family sensitive practice identified by respondents included:

- being essentially different from family therapy or family inclusive practice
- understanding the family dynamic and the relationships between the alcohol and other drugs client and other family members
- being aware of children and their relationships with ‘significant others’
- understanding influences upon the family itself, e.g. social–environmental influences
- going beyond treating the individual and ensuring that all family members had their needs met
- highly relevant to practice in therapeutic communities and Aboriginal and Torres Strait Islander treatment services
- more prevalent in services that treat female clients
- comprising policy and procedures, practice guidelines and treatment interventions
- operating at both formal and informal levels in organisations.

Generally, the concept of child and family sensitive practice was well understood, although some respondents used different terms to describe the same concept. The majority of participants supported the premise that clients’ children and other family members needed to be identified as part of the assessment process and included in alcohol and other drugs service provision where appropriate.

Historical context

While the term ‘child and family sensitive practice’ may be relatively new to the alcohol and other drugs field, some participants stressed that the principles of supporting clients as parents and ensuring the safety of their children have been an underlying part of practice for a number of years. This was particularly evident in the non-government sector and in therapeutic community settings.

Key informants also reported that a number of alcohol and other drugs services had been established in response to the alcohol- or drug-related death of a family member. Participants further noted that such services were generally provided by not-for-profit organisations with a strong philosophical, policy and operational focus on the needs of the family and children. In contrast, other respondents indicated that historically alcohol services were established to deal with males only and often did not have the capacity to deal with children or other family members.

While there has been a significant philosophical shift among alcohol and other drugs service providers in the past 20 years, many key informants noted that there was still a strong underlying focus on treating the individual client, rather than the individual in the context of their family.

From a service delivery perspective, a number of participants indicated that some alcohol and other drugs organisations had previously provided child and family inclusive services, which had subsequently ceased. In some cases, this was due to financial constraints. In other instances, it was due to concerns about the children's safety and increased awareness of child protection issues:

Felt that it put the children at risk being around adult clients (R16).

Key informants also reported that some alcohol and other drugs services had reoriented their focus to assist their clients with parent/child reunification processes where children had been placed in care:

Now we work with women who have had their children removed so our resources are now dedicated to family support work, working with mothers, the guardian and the children (R16).

A number of issues relating to clients' gender were identified by interviewees. Several indicated that their service did not treat many women with children. This was perceived to be due to women fearing that if they entered treatment they would lose their children. Loss of children related to two main issues:

1. Some treatment services' policies prevented female clients from bringing their children into residential treatment, resulting in periods of forced separation from their children and the negative issues that this entailed.
2. Many alcohol and other drug workers and/or their organisations were mandated to report child abuse and neglect. There was a perception among workers and female clients that, by bringing children into treatment, parents risked coming to the attention of child protection services.

Some respondents noted that a fear of losing their children made it difficult for services to encourage female clients to enter treatment and, when they did, they were unlikely to disclose information about their children.

Policy issues

Respondents were generally aware of broad policies and frameworks that highlighted the importance of adult services working with families and children. Most participants acknowledged the key national child protection policy frameworks, such as the National Framework for Protecting Australia's Children. This Framework was seen to send a clear message about the importance of child and family sensitive practice:

Nationally, under COAG under the National Framework for Protecting Australia's Children, the importance of adult services in enhancing child wellbeing is clearly understood (R10).

However, some key informants also noted that, while there was a general awareness of these national policies, there was little understanding of how these policies could be implemented in practice.

Most respondents noted that there was a dearth of national policy initiatives/frameworks that specifically recognised and incorporated the role and needs of the family and children within alcohol and other drugs service provision, including a lack of clarity about identifying and responding to child protection and related matters. Some participants reported that the current National Drug Strategy (2010–2015) was more inclusive of child and family sensitive practice than previous iterations.

Nevertheless, there was general consensus that, while there had been significant policy developments in the child protection sector, this was not the case for the alcohol and other drugs sector:

I am aware of some regulatory frameworks in the area of child protection ... there is very little in Australia within the alcohol and other drugs field (R14).

Participants were also aware of policy developments in the alcohol and other drugs and child protection sectors at the state or territory level. Recent developments in New South Wales, Victoria and Western Australia were noted as potential catalysts for practice change. Some respondents reported direct involvement in informing policy reviews and development, and in redrafting existing policy to ensure greater emphasis on child and family sensitive practice. Some key informants also reported that being involved in policy reviews and development had encouraged them to advocate for the implementation of child and family sensitive practice in alcohol and other drugs service provision.

For some respondents, policies and procedures were seen to have an important role in providing overarching guidance and in changing practice:

Policies are absolutely critical. They set the agenda which can then flow onto services. If we don't have [policies] that explicitly address child and family issues in alcohol and other drugs service provision, it becomes an ad hoc organisation-by-organisation approach. Need to have something embedded in policy that will in turn lead to specific funding, dedicated job titles and specific job focus (R2).

Policies are critical in formalising what an organisation will do by providing a framework and guidance. They inform practice and provide an overarching view of what is expected of people when supporting families and children (R8).

Policies are a framework to guide thinking, planning, directions, consideration for services, development and partnerships ... they are pertinent to cross-sector, lifespan, coordinated care issues and requirements ... they are effective if developed in consultation (R13).

These policies are good at reorienting day-to-day practice to take into account key people supporting the child ... helping to create a solution (R3).

Several respondents indicated the need for a clearer policy commitment at the national level which could be translated into direct service provision within states and territories. In addition, some participants suggested that alcohol and other drugs policy initiatives focusing on child and family sensitive practice needed to be consistent within the alcohol and other drugs sector, as well as across sectors, particularly the child protection sector. A number of

interviewees indicated that while significant policy review work was underway, much of it had not addressed key issues, such as information exchange, that arose between the alcohol and other drugs and child protection sectors. Hence, there was a view that more needed to be done in developing appropriate policies.

Despite recent policy reviews in a number of states and territories, child and family sensitive practice was noted to generally lack priority. For example, one key informant indicated that a recent review of policy in one jurisdiction had failed to incorporate child and family sensitive practice despite its importance being highlighted in associated consultations:

I just don't understand how it was missed. It is a classic gap. Some of us raised child and family sensitive practice as an issue. If they are not going to put it in a common assessment and screening tool for alcohol and other drugs services, then how are they going to change practice? (R1)

It was also indicated that policies and procedures could be used to identify mechanisms for early intervention. A number of respondents felt that while child and family sensitive policy was implemented when children were seen to be at imminent risk (requiring notification), this missed the opportunity to intervene earlier and provide support before the situation became critical:

There are a number of services that have policies to screen for significant risk in intake/assessment, but those policies don't look at intervening early in the lives of adults and children. So they are at the pointy end of risk and looking at statutory reporting mechanisms rather than how do we prevent families from getting to the point of being at risk (R9).

Some respondents identified the need for clear policies and procedures and suggested a number of changes to existing policies. These suggestions included:

- the inclusion of key performance indicators for child and family sensitive practice in agency data sets and outcome measurement tools
- the inclusion of questions about parenting status/role and children in organisations' intake and assessment documentation
- the inclusion of child and family sensitive practice in organisational policy and procedure documents such as:
 - strategic plans
 - position/job descriptions
 - information brochures, flyers and posters
 - organisational websites.

Government, non-government, Aboriginal and Torres Strait Islander perspectives

Role of government and non-government services in policy development and implementation

The majority of participants had experience in non-government organisations (NGOs). Respondents highlighted major differences in culture, practice, policy and governance arrangements between government and NGO services. NGO services were considered to be more responsive to emerging trends and issues with greater capacity and flexibility to readily incorporate child and family sensitive practice into their service provision:

We have to react to what is walking in our front door; we can't turn people away because we don't have a policy to deal with them (R16).

Government services were seen to be better at setting policy frameworks but less flexible and more constrained in terms of their ability to change their service delivery models in response to emerging needs and issues:

There is a lot of lag in the government bureaucracy (R16).

I can't think of any government services providing these services; most are non-government (R16).

Some key informants noted the complementary role of government and NGO services where government bodies often established policy (an area where NGO services were seen to have less scope) while NGO services were better at on-the-ground implementation and innovation. It was suggested by one NGO respondent that while government organisations set the policy context, NGOs could assist in the implementation of the policy, particularly in relation to program design and delivery:

NGOs are very good at delivering services, but not so good at developing the policies (R16).

At least one interviewee from an NGO which adopted child and family sensitive practice emphasised that they were driving the implementation of child and family sensitive practice, rather than it resulting from government policy, and that their organisation had advocated to ensure that clients were asked if they had children within assessment processes in local area health services:

We drive it [child and family sensitive practice], not government or regional level services (R11).

Many respondents indicated that there had been a shift by government departments to out-source alcohol and other drugs service provision to NGOs, which placed contractual requirements on frontline NGO service providers to include a focus on child and family sensitive practice. Some NGO respondents suggested that while they were supportive of taking on an expanded role in providing child and family sensitive practice, they were also adamant that it needed to be accompanied by:

- appropriate funding from government organisations
- adequate resources to support working across government organisations and NGO services, and for NGO services to develop and implement child and family sensitive practice
- capacity-building initiatives for staff employed by NGO services
- relevant governance arrangements, including providing NGO services with reporting templates.

Some participants wanted to see child and family sensitive practice prioritised in the contractual arrangements between government funders and NGO service providers. Further, it was stressed that this needed to be supported by capacity-building initiatives and appropriate funding:

The desired outcomes focusing on child and family sensitive practice and need conflicts with the funding environment. There is no mention of child and family sensitive practice in current contractual arrangements with NGOs ... NGOs are tightly bound to providing services according to existing contracts (R5).

One key informant noted that it was important for funding contracts between government organisations and NGOs to stipulate that service providers enter into formal arrangements with child protection/child welfare agencies as part of a comprehensive approach to child and family sensitive practice:

The ... which funds NGOs ... requires that [the NGO services] have formal memoranda of understanding with the local child protection departmental office (R18).

Respondents highlighted the important role that peak NGO alcohol and other drugs bodies played in working with and supporting their member organisations to undertake child and family sensitive practice:

Peak bodies such as ... play an important role in providing a network which facilitates service provision consistency and opportunities for agencies and workers to clarify policy and direction in relation to child and family sensitive practice (R13).

Key informants also highlighted the importance of networking, particularly among NGO service providers, to support each other to undertake child and family sensitive practice. Networking was noted to:

- facilitate service provision consistency across agencies
- provide opportunities for agencies and workers to clarify policy directions
- enable sharing of information and best practice strategies.

Indigenous alcohol and other drugs services

Key informants noted that child and family sensitive practice was central to Aboriginal and Torres Strait Islander alcohol and other drugs services. Several respondents indicated that Aboriginal and Torres Strait Islander service provision has traditionally focused on the whole or extended family. Clients were not seen as separate from their community and their immediate and extended family which were integral to the treatment models.

Nonetheless, there were limited services for Aboriginal clients with children. This often meant clients were unable or unwilling to fully engage in treatment and, when they did, it often resulted in poor client retention. Where children were not included in service provision, clients would often leave the service to check up on their children and partners:

Sometimes if the family weren't involved, the client wouldn't be there (R6).

One participant believed that, due to the history of the Stolen Generation, child protection services were more hesitant or reluctant to monitor child protection agreements and intervene than they would be with non-Indigenous children. This Indigenous respondent also suggested that other family members such as grandparents had similar concerns to alcohol and other drugs workers regarding a perceived lack of intervention by child protection services.

Respondents also noted that Aboriginal and Torres Strait Islander services were more likely to receive funding for child and family sensitive practice models. This was supported by flexible funding that took account of children as clients, and recognised the resource needs of services that supported children (brokerage funds, emergency travel, food, transport, child care requirements, etc). Conversely, where funding was not flexible or did not accommodate child and family sensitive initiatives, then Indigenous services struggled to meet the needs of their communities in a culturally sensitive and appropriate manner. A respondent cited the example of a lack of residential Indigenous alcohol and other drugs services that also took in children.

The adoption of child and family sensitive practice models in mainstream practice was described as validating Aboriginal and Torres Strait Islander cultural practice. The movement in mainstream services towards working with the wider family acknowledged many of the underpinning Aboriginal and Torres Strait Islander values. Many Aboriginal and Torres Strait Islander alcohol and other drugs workers were seen to have high-level skills in working from a child and family sensitive perspective.

Operational factors

Funding issues

Lack of appropriate funding was cited by nearly all respondents as a significant barrier to the adoption and implementation of child and family sensitive practice. Of key concern was funding for the exclusive provision of services to adult clients, while other family members and children were not addressed. This meant that funds could not be used to address the needs of clients' children. As a consequence, where organisations chose to work within a child and family sensitive practice framework, the children were not counted as clients in terms of service outputs.

Hence, working with children could lead to a subsequent reduction in funding, conflict with the funding provider or declining to take women who needed to bring children with them:

Current funding structures do not allow a more holistic approach – funding is based on block funding or episodes of care (R7).

NGO respondents indicated that a lack of adequate and flexible funding required them to find other funding sources to support interventions that involved clients' children. For instance, some respondents noted that school-aged children often needed lunches, excursion expenses, sports fees, payment for out of school hours' care, and other extracurricular activities. In many instances, service providers had to obtain funds to meet these needs from philanthropic or other funding sources.

Other funding issues related to state- or territory-based pilot programs not receiving ongoing or sustainable funding after the completion of the pilot. An example was the roll-out of two projects in Victoria: Parents Under Pressure (Dawe et al., 2008) and the Beacon Project. Both projects achieved considerable practice improvements in the short term, but neither was funded on an ongoing basis and initial practice improvements were subsequently lost.

Funding doesn't always follow the program and [you] don't get continuity of service delivery (R3).

Respondents indicated that these discouraging experiences, involving innovative projects with limited funding and time-specific duration, prevented efforts to embed child and family sensitive practice into routine alcohol and other drugs service provision. It also made it difficult for advocates of child and family sensitive practice to maintain their momentum.

The provision of sufficient targeted funding was seen as crucial by many respondents. Funding requirements were seen to range from episodic or seed funding, through to long-term grants. Seed funding was a useful mechanism to get new initiatives started. This often took the form of training subsidies or funding to employ a project officer dedicated to developing child and family sensitive practice:

Where a lot of these programs have worked and certainly at ... it has helped to have some seed funding not only for professional development but often for a worker to be employed for whom this is a core focus of their role. Then they didn't get side-tracked (R1).

Several participants noted that recent funding cuts had also had a significant impact on how workers and organisations addressed issues outside of their ‘core’ work roles.

Also seeing with funding cuts the ability to network is retreating, as people are pulling back to core business (R10).

A number of interviewees also suggested that, for some organisations to incorporate child and family sensitive service provision as a component of funded service delivery, it may need to be stipulated as a funding deliverable, particularly if those organisations were hesitant to work in a child and family sensitive way:

It may be necessary for government funders to insist on the incorporation of child and family sensitive practice into the funding of alcohol and other drugs treatment programs (R14).

Should be written into the funding agreement (R17).

Two respondents who indicated the importance of embedding child and family sensitive practice within funding agreements also suggested the need for regular monitoring of child and family sensitive practice outcomes in those agreements. They indicated that this would be one way to ensure greater accountability for the implementation of child and family sensitive practice.

Collecting and managing information about children

The importance of data was a recurrent theme. Typically, lack of data about clients’ children and lack of capacity to collect relevant data were reported. Some respondents indicated that existing organisational data systems did not collect information on children in the care of clients, the needs of those children, notifications to child protection services, living arrangements or presence in residential treatment or other services.

An example was cited from one state where the client data management system did not record data in relation to clients’ children:

This was despite the fact that there was substantial support in that jurisdiction’s policies for child and family sensitive practice (R1).

Other respondents indicated that not collecting data on clients’ families meant that there were no lines of accountability, targets or funding associated with including families in the treatment process. A number of interviewees noted that this meant that the work they did with children and other family members was not always reflected in their organisations’ data or reports. For some respondents, this lack of data made it challenging to implement child and family sensitive policy and practice within their organisation.

State and territory alcohol and other drugs client data were also frequently collected in different, incompatible formats or held in databases that were not accessible by other services. This often resulted in children not appearing in statistics, rendering them invisible to policy makers, planners, and funders.

Workers' needs and attributes

Worker confidence

Workers' lack of skills and confidence were identified by a number of interviewees as pivotal in relation to adopting a child and family sensitive-based approach. This included fundamental skills such as asking clients about their children and other family members. Some respondents also noted that many workers did not feel confident in working with children at the most basic level.

One respondent involved in delivering training to the adult alcohol and other drugs sector suggested that this could be addressed by alcohol and other drugs service providers supporting workers to enhance their professional practice skills in terms of relating to clients' children.

Staff skills

The wide variation in staff qualifications was highlighted. One key informant indicated that because the majority of their staff had only a Certificate or Diploma, their organisation had developed child and family sensitive-related policies that reflected the qualifications and skill sets of their staff:

We have a lot of staff with Cert IV, some with Diploma, so we are not a highly qualified workforce. We have to have relevant policies for this workforce, recognising that they don't have the same skills as social workers and psychologists (R16).

It was indicated by some respondents that working within a child and family sensitive framework required specialist qualifications or training. There was a suggestion that this training and skill enhancement could be taken up by the vocational education and training (VET) sector:

In the accredited space there is increasing child and family welfare awareness being built in to the training being delivered, and I think that in the not too distant future it is likely that child and family sensitive practice will be built into all alcohol and other drugs qualifications in the VET sector (R12).

Training and professional development

Training and professional development were seen as critical to enhancing an organisation's capacity to deliver child and family sensitive practice. Respondents cited the lack of appropriate, funded, accessible quality training as a barrier to implementing child and family sensitive practice. Even where training was provided, difficulty in transferring new skills into practice was noted:

There was some training offered around parenting using the Parenting Under Pressure program. This occurred around ... but this training is very small because this is much more onerous and much more demanding (R1).

One respondent indicated that workforce development and training, along with assistance in implementing policies, were required as:

There are different skills necessary in working with families than working with individuals only (R13).

Training-related challenges identified by key stakeholders included:

- the limitations of ad hoc brief training sessions
- a lack of associated resources and materials
- a lack of reciprocal training provided to both the alcohol and other drugs and child welfare/child protection sectors to increase intersectoral awareness.

One organisation included child and family sensitive practice as a key component of their staff induction package.

Staff induction package – reinforcing to new staff the importance of working in a child and family inclusive manner ... All staff in the organisation have completed Family Sensitive Practice [now referred to as Family Inclusive Practice] conducted by [the Drug and Alcohol Office] – the organisation has this as part of their mandatory training for staff (R18).

42

This respondent also indicated that they had achieved very good engagement in training by providing financial incentives to staff and autonomy in developing individually structured professional development programs:

Good allowances [financial incentives] for staff to complete education and training – individual packages available to staff to spend at least \$400 every six months on training that is specifically related to their area of work (R18).

Some respondents highlighted the importance of engaging external training providers. Others suggested that inter-organisational training should be offered that involved workers from both the alcohol and other drugs sector and the child protection sector attending joint training sessions:

It is easy for us to just become an advocate for a parent retaining custody, and sometimes it is important that people have an understanding of children's needs and child development. That is why it is important to have opportunities for staff to attend training. Needs to be that kind of cross-sectoral stuff (R15).

It was also acknowledged that inter-organisational training was more difficult to achieve because of funding barriers, staff release and subsequent implementation of new practices.

Differing views were expressed about the impact of training on changing child and family sensitive practice. While training was highlighted as an important component in implementing child and family sensitive practice in alcohol and other drugs services, it needed to be supported by a range of other initiatives:

Training alone will not get us to where we need to be. There must be an emphasis on embedding child and family sensitive practice into agency-based best practice (R14).

Sustained training (including cross-training placements) in the workplace across sectors is needed to ensure sustained changes in practice (R8).

Ongoing professional development that included intra-organisational, inter-organisational and intersectoral opportunities for learning was identified as a key facilitator of child and family sensitive practice.

Clinical supervision

Lack of appropriate clinical supervision was identified as a barrier by a number of respondents. For some, the lack of adequately trained supervisors constrained or hampered child and family sensitive practice. Some respondents felt that, given the emergent nature of child and family sensitive practice, appropriate clinical supervision was essential when adopting new initiatives/practices:

People often need opportunities to practice new skills and new ways of behaving in a safe environment (R1).

Clinical supervision was noted by a number of interviewees to be integral to the development and sustainability of child and family sensitive practice. One service (a therapeutic community) had engaged in such supervision: *'over a long period of time'* (R11). Other services highlighted its importance:

Need well-qualified staff, with regular clinical supervision and review (R17).

One person suggested that clinical supervision was particularly important for new or junior staff and their managers. This respondent indicated that clinical supervision could be used to inform junior caseworkers about how to incorporate child and family sensitive practice into their treatment repertoire:

Clinical supervision of junior caseworkers and their immediate managers to inculcate: how the work should be done; who the key partners are; and how they should work with those partners (R3).

Working across sectors

Differing values and world views were seen as potential barriers to the implementation of child and family sensitive practice. One participant noted that the presence of siloed government policy and its inherent assumption that a service or sector exclusively dealt with an individual could create barriers for intersectoral collaboration across services.

Professional discourses were also linked to a lack of intersectoral practice. As one key informant noted:

A key barrier to cross-sectoral practice is that the health sector focuses on the sick individual and does not always see the bigger picture (R11).

Cross-sectoral collaboration was seen by some participants as essential to working, particularly in rural and remote areas, and could act as a catalyst for the implementation of child and family sensitive practice in those areas. As one participant noted:

Collaboration can be built on the basis of the small pool of practitioners who move between organisations who live in the community and work in it. They generally have a high developed understanding of the community needs and the way of working in different local organisations (R9).

While there was interest and a willingness to participate in networks, it was often difficult to create networks that crossed sectoral barriers. It was also noted that recent funding cuts had made it more difficult for individuals and organisations to participate in networks:

While we continue to see siloed funding it's very easy for partnerships to fall over Having different sectors having different priorities and different funding means agencies first and foremost have to be driven by their funding and so partnerships can come second (R12).

Perceptions of risk

Interviewees indicated that risk management could constrain child and family sensitive practice by preventing the implementation of new or novel practices. Respondents also noted that if organisations and workers were overly focused on risk, this may impede the implementation of child and family sensitive practice regardless of whether there was a supportive policy framework:

People get afraid of the risk and you get an intensification of the conflict. This is always going to be a difficult space (R10).

Risk management requirements were also seen to inhibit child and family sensitive practice, even after a program had commenced. Some interviewees provided examples of promising programs that had been terminated because they were seen to put clients' children at risk:

[Talking about] a therapeutic playgroup for young children of parents on methadone treatment. Very early example started maybe 15 years ago. Sadly ceased when state department got worried about the risks of having children at an alcohol and other drugs treatment site and so shut it down. A classic example of how a policy can override a really great initiative (R10).

Key informants also identified confusion about whether it was good or safe practice to use a client's family and/or children as a motivator in treatment. Similarly, when children were identified as clients of the service in their own right, this also raised issues in relation to risk and reporting.

Mandatory reporting

Mandatory reporting requirements were cited as a barrier to alcohol and other drug workers undertaking child and family sensitive practice. In a number of states and territories alcohol and other drug workers were mandated to notify child protection services if they believed that children in the care of their clients were at risk of imminent harm. Key informants also noted that many organisations had their own internal policies and procedures in relation to notification of children perceived to be at risk.

A number of respondents indicated that they were aware that alcohol and other drug workers were often reluctant to address issues associated with the children of clients due to the potential impact this may have on their relationship with their client. Issues of concern included:

- loss of client trust if child protection services/workers approached the client
- lack of clarity over who was the client – the adult or the child
- lack of clarity over which service a client 'belonged' to and who was responsible for the notification
- frustration when children of clients were notified to child protection, but were not investigated and no feedback was provided. Alcohol and other drug workers were often aware of risks to children but frustrated that other workers did not address these risks.

In general, a diversity of views was expressed about the issue of mandatory reporting in relation to 'at-risk' children and families. Some respondents were concerned about the perceived reluctance of child protection/child welfare services to intervene when a report had been made by an alcohol and other drug worker. One informant indicated that, despite the fact that parents may be drinking or using drugs at levels that could result in serious harm, child protection would not necessarily intervene:

This is the lost generation – I thought children should go to school til they're 16 otherwise someone would intervene – this is not happening (R6).

On the other hand, a few participants noted that the involvement of child protection/child welfare services was perceived by some alcohol and other drug workers as unhelpful, and as having a negative impact on their relationship with the client. A respondent noted that, for alcohol and other drug workers, this often resulted in frustration with child protection services, and in some instances disengagement between the two service providers.

Thresholds for reporting child protection issues

A number of respondents suggested that reporting thresholds were inhibitors to child and family sensitive practice, e.g. when a child was not seen to be at sufficiently high risk to warrant a notification. Interviewees suggested that in some instances the identification of a child considered to be at risk of neglect/abuse did not automatically act as a trigger for early intervention. Rather the situation was sometimes left until it either resolved itself or deteriorated and required a notification:

Child protection still has that connotation; it is about high risk rather than protecting and nurturing all children. We respond to the significant events for children rather than to the little things that happen regularly but that cause harm over time, e.g. parental drug use, meaning children don't get encouraged or able to go out and play, interact socially. What do those cumulative impacts mean for children? Not just the significant harms like noticing bruising etc. (R9).

There are a number of services that have policies to screen for significant risk at intake and assessment but those policies don't look at intervening early in the lives of adults and children, so they are at the pointy end of risk and look at statutory reporting mechanisms rather than how do we prevent families from getting to the point of being at risk (R9).

Some key informants also indicated that the identification of at-risk children could be compromised by alcohol and other drug workers exclusively focusing on an individual client's strengths and resilience without addressing the potential for risk of harm to other family members:

The other thing is that we have gone into such strength-based frameworks so much we have forgotten to bring in what are the risks, impacts of clients' behaviours on children. We are focused on the strength of the individual and we don't look at the effect on the whole family (R9).

Change strategies

Management and organisational support

Lack of organisational support and preparedness for the implementation of child and family sensitive practice was a major issue identified by key informants. This included a lack of acknowledgement of child and family sensitive practice in organisational plans and/or a lack of organisational funds allocated to support its implementation.

Some managers were reported to be unsupportive of child and family sensitive practice for a number of reasons including:

- lack of funding
- concerns about time taken to work with families
- child and family work could impact on achieving service targets, e.g. children not being counted as 'clients'
- risks to children coming into alcohol and other drugs services, e.g. exposure to harm from other clients, witnessing conflict, proximity to substance-affected adults, removal from school or other social supports (R10)
- ambivalence among managers even when evidence was presented to them about the importance of child and family sensitive practice: *'Is this really our job?'* (R8).

Lack of managerial support was seen to affect not only practice at the individual client level but also engagement with other services, impacting on intersectoral referral and collaboration:

Where interaction happens at practitioner level, sometimes there can be a lack of organisational collaboration and then there is no authorisation to work together (R9).

Hence, organisational commitment and support of child and family sensitive practice were seen as important facilitators. It was noted that support was required from line supervisors, middle managers, senior managers and governing bodies. Support needed to be more than *'lip service'* (R17). It was important that *'staff feel supported to see it as good practice'* (R9). One respondent who worked with a range of services reported a recent shift:

In the last nine months there has been a significant shift to wanting to understand child and family sensitive practice, how [alcohol and other drugs services] can develop the workforce around that, what it means for service delivery, for intake and assessment and what does it mean for supporting staff (R9).

The participant above suggested that, in order for management to support child and family sensitive practice, they needed to be aware of the national and state or territory policies that sanctioned it.

Organisational perceptions were seen to have a significant impact on worker practice. For example, some interviewees indicated that workers were more likely to consider the needs of children if the organisation viewed children as clients. There were strong views held by some in regard to the status of a client's child:

Services need to understand that the child is there as a client in their own right, not as an appendage to the adult (R15).

Respondents suggested that this type of organisational acknowledgement acted as a substantial incentive for workers to incorporate child and family sensitive practice into their service provision. They also suggested that workers could be encouraged to engage in child and family sensitive practice by highlighting that this was both consistent with and supportive of treatment outcomes:

The alcohol and other drugs worker needs to see that taking into account the parenting needs of alcohol and other drugs clients and the needs of their children is not working against their main goals but is helping them to work to achieve the clients' goals (R10).

Several respondents indicated that child and family sensitive practice was led by highly committed clinicians and workers. It was noted to be important that they were supported by their organisation, managers and supervisors. Where staff were engaged in child and family sensitive practice, this was seen to provide high levels of protection for children through provision of information and parenting education:

Important to recognise that the greatest protective factor for a child with a parent with alcohol and other drugs issues may be the trust that the parent has in their alcohol and other drugs worker (R10).

Champions

A number of respondents highlighted the essential role played by champions. Champions were seen to be important at the sectoral level to highlight and support improved policy development. They could be a senior person, well known to the sector, who promoted child and family sensitive policy and practice in a range of forums, including conference presentations, advisory groups, intersectoral events and leadership in their own organisation.

Respondents noted that organisational champions could emerge informally, especially where people had developed expertise and practice wisdom. Alternatively, some champions were employed where projects included dedicated funds to support child and family sensitive practice:

When we look at what child and family sensitive practice looks like, what we see is that there is a local champion who has passion and is a key motivator (R12).

However, there was concern that champions could also inhibit practice if they became the person identified as the 'go-to' worker for child and family sensitive practice:

I would reinforce that champions are excellent and absolutely required but need to not become the default go-to person (R12).

One respondent indicated that champions not only needed to promote child and family sensitive practice but also needed a range of other skills including change management:

Identification of change champions and staff with referent expertise to provide supervision and oversee agency-wide implementation (R14).

Sometimes champions were self-identified or nominated by their organisation because of their particular skills and interests. Respondents noted that, to be able to function effectively, champions also required management support:

Often there is a champion or someone who is passionate in an agency. It always has to have the support of management at some level, often from the top or at least middle management level (R1).

A number of government-funded programs were noted to employ child and family sensitive practice 'champions' whose role included supporting change across the wider service system. Examples included:

- Australia's first dedicated National Children's Commissioner, who focuses solely on the protection of the rights of children
- children's commissioners who operate in every Australian state and territory and focus on reducing the risk of harm to children
- the Australian Centre for Child Protection's 'Building Capacity, Building Bridges' project which employs a number of project staff who operate as intersectoral champions to support the implementation of child and family sensitive practice across adult services.

Organisational role modelling

One interviewee indicated that, by creating a family-friendly workplace, the organisation was able to raise awareness of child and family sensitive practice and that this in turn enabled workers to engage effectively with clients who were parents:

There is a high level of awareness amongst staff about family inclusive practice ... a large number of staff are parents themselves. We practise family sensitive practice with our own staff to ensure that we are a child-friendly organisation (R18).

Co-location

Structural arrangements of services were identified as important in facilitating different ways of working. Co-location of alcohol and other drugs and child protection services and integrated service provision were seen by interviewees to result in increased confidence, competence, greater networking and stronger relationships between clinicians/workers and organisations. One interviewee who had been working across a number of sites highlighted the positive impact on alcohol and other drugs practice of co-locating services:

It's fantastic if you can walk down the corridor and chat to someone in another service. Co-location can be extraordinarily helpful in building relationships (R8).

Key informants noted that co-location of alcohol and other drugs and other services occurred in a number of sites. This was seen to be a more direct approach to interagency child and family sensitive practice than networks.

Conclusion

Most key informants were supportive of child and family sensitive practice. They acknowledged that there were differences between government and NGO services in relation to the provision of child and family sensitive practice and that this practice needed to be culturally sensitive and appropriate. Interviewees also identified a range of organisational and worker-related issues that affected the implementation of child and family sensitive practice, such as policy frameworks, funding, data collection and management, role delineation/legitimacy, staff skills, training and professional development, clinical supervision, and mandatory reporting requirements. Ultimately, key informants highlighted a number of change strategies, such as management and organisational support, champions and co-location of services, which could enhance the alcohol and other drugs sector's implementation of child and family sensitive practice.

The next section of the report examines the issue of best practice in child and family sensitive practice in the alcohol and other drugs field.

Part C. Best practice interventions in child and family sensitive practice

Best practice principles regarding child and family sensitive practice in the alcohol and other drugs field were identified from the literature review, policy audit and stakeholder consultations. Although no single recognised program or model currently represents best practice, it is generally accepted that child and family sensitive practice should be holistic, bespoke, collaborative and evidence-based. Research regarding implementing child and family sensitive practice and changing practitioner behaviour accordingly is presented.

Best practice principles

On the basis of the literature review, policy and practice audit, and key stakeholder consultations, best practice principles in child and family sensitive practice were identified.

Key stakeholders identified best practice in child and family sensitive practice as being:

- reflected in all aspects of an organisation's work, its vision, values and mission statements, policy and procedures, job descriptions and marketing materials
- supported at all levels of the organisation including governance, management and practice arrangements
- tailored to the needs of the client, their children and family
- considerate of the needs of clients and the best interests of their children, and working to ensure that each gets support from other appropriate services as needed
- evidence-informed
- enhanced by effective collaboration at individual, organisational and sectoral levels. (While collaboration at one level, e.g. between individual workers or organisations, was often beneficial, best practice benefited from systemic collaboration.)

Practical strategies cited to achieve best practice in child and family sensitive practice included:

- changing hours of operation to school hours, in order to accommodate women with children at school
- when planning the location of services, ensuring that they are accessible via public transport
- child-friendly waiting rooms, e.g. provision of toys, supervision
- providing treatment options for mothers and children including a focus on parenting and, where appropriate, employing childcare workers with experience in counselling

- utilising ‘Circle of Security’⁶ models and philosophies within the service
- building better relationships between staff and clients’ children
- outreach services offering childcare.

Best practice principles identified within the extant literature followed similar principles to those identified by key stakeholders. Orford and colleagues (2013) have described three different approaches to supporting families:

- family members participate in joint therapy
- the family is engaged to support the treatment process, e.g. community reinforcement
- responses to the needs of family members in their own right.

In relation to children of clients, the latter approach has salience, but as Orford and colleagues (2013) note, very few initiatives fall into this response category. An appropriate treatment and intervention model has yet to be developed for the children of clients. This is identified as a principal next step in tackling this important but much neglected area.

Copello and colleagues (2006) argue that no single intervention or program represents best practice for child and family sensitive practice. Instead, best practice comprises routinely:

- (a) assess[ing] the strengths and needs of substance misusers’ current familial and social networks and
- (b) implement[ing] one or more of the range of evidence-based approaches which impact either the substance misuser in their familial/social context or the affected family members (Copello et al., 2006).

This should be undertaken in conjunction with clear policies and guidelines, appropriate training and adequate supervision (Copello et al., 2006).

Dawe and colleagues (2008) identified numerous factors that are important to embed within child and family sensitive interventions. These include:

- engaging the family
- developing trust
- identifying and maintaining a focus on goals
- using a flexible, individualised and strengths-based approach.

⁶ The Circle of Security is a relationship-based early intervention program designed to enhance attachment security between parents and children. Information about the Circle of Security is available from the following website: <<http://circleofsecurity.net/>>.

Similarly, Gruenert and colleagues (2004) have developed the following list of needs, which can help inform the implementation of child and family sensitive practice:

Needs of children:

- Protection from harm
- Age-appropriate levels of responsibility
- Counselling and play-therapy services
- Peer support and mentoring programs
- Stability and routines
- Opportunities for positive socialisation and community connectedness
- Advocates
- Direct provision of material aid
- Educational support

Needs of parents:

- Parenting education
- Family counselling
- A coordinated service response
- Housing
- Personal support
- Family-sensitive drug treatment services

However, it has been noted that many child and family sensitive interventions face low rates of uptake and high rates of attrition (Watson, 2005). To address this, a review conducted by Watson (2005) suggests:

- prompt follow-ups and frequent contact with families
- offering services during times of transition, e.g. the antenatal period
- building a strong caseworker–family relationship
- financial incentives (this is dependent on context and the type of incentive)
- providing transport to centre-based treatment
- obtaining multiple contact points through whom the family can be reached
- manageable caseloads for workers.

Behaviour change

Implementation of child and family sensitive practice can require substantial modifications to current methods of operating, and may be met with staff resistance (Lee et al., 2012). As such, it is important to fully understand which behaviours and procedures need to change, the barriers to change, and evidence-based methods for encouraging change (Bywood, Lunnay & Roche, 2008). Doing so can result in better outcomes for both alcohol and other drugs clients and their children.

French and colleagues (2012) suggest that theory, evidence and practical issues should inform the process of changing health professionals' behaviour. Theory can assist in understanding the factors that influence relevant behaviours; evidence can inform which behaviours should be changed and the appropriate methods to do so; and practical issues determine which behaviour change techniques are feasible. Four questions can be used to guide this process:

1. Who needs to do what, differently? (Identifying the problem)
2. Which barriers and enablers need to be addressed? (Assessing the problem)
3. Which intervention components could overcome the modifiable barriers and enhance the enablers? (Forming possible solutions)
4. How can behaviour change be measured and understood? (Evaluating the intervention) (French et al., 2012).

The Theoretical Domains Framework, developed in 2005 (Michie et al., 2005) and refined in 2012 (Cane, O'Connor & Michie, 2012), specifies 14 domains that can influence practitioners' behaviour. These can be used in conjunction with the above questions to understand the barriers and enablers influencing behaviour. The domains are:

- Knowledge
- Skills
- Social/professional role and identity
- Beliefs about capabilities
- Optimism
- Beliefs about consequences
- Reinforcement
- Goals
- Memory, attention and decision processes
- Environmental context and resources
- Social influences
- Emotions
- Behavioural regulation
- Intentions

These all have applicability to any initiatives designed to facilitate the adoption of child and family sensitive practice within the alcohol and other drugs sector.

Ultimately, however, the implementation of new policies or procedures is often based on organisational and fiscal pressures, rather than scientific evidence of effectiveness (Bywood et al., 2008).

Community and public health approaches

A potential strategy for enhancing child and family sensitive alcohol and other drugs policy at a systems level is the application of a public health approach. This approach seeks to provide a framework for providing support to children and families in a range of health and community service settings, from universal support services (e.g. early childhood services, education, universal health services) through to statutory interventions.

A comprehensive public health approach to reducing the harms associated with alcohol and other drug use (including child abuse and neglect, injuries, violence and public order) also includes community-level responses aimed at minimising harm. As with clinical interventions, these interventions need to be supported by evidence of feasibility, efficacy and cost-effectiveness (Ministerial Council on Drug Strategy, 2011).

Responding to the needs of parents and children in families with alcohol and other drug issues from a public health perspective is consistent with the findings of recent child death reviews, academic reviews and practice-based research (Australian Institute of Health and Welfare, 2012; Arney, Lewig, Bromfield & Holzer, 2010; O'Donnell, Scott & Stanley, 2008; Scott, 2009; Gruenert & Tsantefski, 2012; Battams et al., 2010; Trifonoff et al., 2010; Nicholas, White, Roche, Gruenert & Lee, 2012; Roche, Francis & White, 2012).

A public health approach to child and family sensitive practice may comprise:

- designing and delivering activities in alcohol and other drugs services that ensure that clients' children receive appropriate support
- adopting both individual and family-oriented treatment approaches
- redesigning alcohol and other drugs workforce practices, organisational processes and procedures to ensure they support services to children and families across all levels of intervention
- engaging the alcohol and other drugs sector in working with the wider service system to implement a public health preventative approach.

Public health approaches which alcohol and other drugs services may adopt include:

- universal initiatives, e.g. informing and educating parents about the impact of alcohol and drugs on parenting and child health and wellbeing during pre-conception and pre- and ante-natal periods. It could include supply and demand reduction strategies targeted at families with children (e.g. the reduction or elimination of consumption in schools, at public events where children are present, or a minimum floor price)
- early intervention, e.g. the provision of counselling and support to parents at risk of using alcohol and other drugs in ways that impact on their children
- targeted support, e.g. more intensive support (during treatment, counselling, residential care)
- statutory level support, e.g. as part of the treatment process, assisting parents to reunite with their children who have been placed into care.

This model does not propose that alcohol and other drugs services become responsible for addressing all risks to children. If alcohol and other drugs organisations consider moving towards a child and family sensitive public health-informed system, changes need to be made at service delivery, organisational, systems, sectoral and policy levels. Opportunities exist within the context of current jurisdictional reviews to consider the adoption of a wide array of child and family sensitive practice strategies in the alcohol and other drugs sector.

Types of interventions

There are several child and family sensitive interventions with robust evidence bases. These include Behavioural Couples Therapy (BCT) and the Community Reinforcement Approach (CRA) (Copello et al., 2006). Studies have also investigated the merits of programs including home visiting, intensive interventions and parenting education. While in many cases preliminary evaluations are promising, further research is required to establish their long-term effectiveness.

Home visiting

Evaluations of home visiting interventions have found inconsistent results. Some studies have reported positive outcomes (Armstrong, Fraser, Dadds & Morris, 1999; Olds, Henderson, Tatelbaum & Chamberlin, 1988), while others have found little or no effect (Fraser, Armstrong, Morris & Dadds, 2000; Gessner, 2008; Schuler, Nair & Black, 2002). A recent systematic review (Segal, Opie & Dalziel, 2012) found that the extent to which there is consistency between (a) the theory of change underpinning the program, (b) the target population and their specific needs, (c) the program components, and (d) the program objectives, can have an impact on the success of home visiting interventions. The overall efficacy of home visiting is therefore still in question, and further research is required (Turnbull & Osborn, 2012).

Intensive interventions

Several evaluations of intensive programs such as Focus on Families, Relational Psychotherapy Mothers' Group, and Parents Under Pressure (PuP) have found promising results (Catalano, Gainey, Fleming, Haggerty & Johnson, 1999; Dawe & Harnett, 2007; Luthar & Suchman, 2000). In particular, PuP has had very positive outcomes. In a recent international review of programs for the parents of young children, PuP was found to be the only one that met all criteria (Asmussen & Weizel, 2009). Studies have found that parents and families who undertook the PuP program showed reductions in parenting stress, child abuse potential and rigid parenting behaviours, and increases in child pro-social behaviour (Dawe & Harnett, 2007). However, the follow-up periods in these evaluations were fairly short, and results should therefore be interpreted with caution (Dawe et al., 2008).

Parental education

Parental education generally involves four components: (a) assessing parenting problems; (b) teaching parents new skills; (c) applying skills with their children; and (d) providing feedback (Barth et al., 2005). Barth and colleagues (2005) have identified four leading evidence-based parenting programs with promising results: The Incredible Years; Multisystemic Therapy; Parent Management Training; and Parent Child Interaction Therapy. However, variability in format, duration and intensity makes further research advisable before conclusions regarding long-term effectiveness are drawn (New South Wales Department of Human Services, 2010).

Relationship with other sectors

Collaboration

Adopting a child and family sensitive approach requires greater collaboration with other organisations and sectors, particularly child welfare. This can represent a significant shift in practice for sectors that have traditionally worked in relative isolation (Gruenert & Tsantefski, 2012). McArthur and Winkworth (2010) propose a developmental model of collaboration that involves three levels: networking; coordination; and integration. The level chosen depends on the purpose of the collaboration. *Networking* refers to the process of building stronger ties with other individuals and organisations, gaining information and building trust. *Coordination* involves changing service design, for example by improving referral/linking processes. *Integration* involves addressing high-risk issues through a ‘no wrong door’ approach, and including community partners. However, while effective partnerships can be developed between individuals, sustainable collaboration is likely to require formalised relationships between agencies, supported by shared aims, policies and procedures. As such, they may take considerable time and resources to develop (Gruenert & Tsantefski, 2012).

Maternal and child health

Nurses and midwives play a key role in providing universal maternal, child and family health services in Australia. However, the federal model has resulted in different policy frameworks across various jurisdictions and fragmented services (Schmied et al., 2011). For maternal and child health nurses to support families with alcohol and other drug issues it is necessary for them to be trained in appropriate screening and assessment techniques and to be able to access support from relevant alcohol and other drugs services (Office of Healthy Communities, 2012; White, 2011).

General practice

General practitioners (GPs) are increasingly expected to be more involved in the diagnosis and management of drug and alcohol problems (Royal Australian College of General Practitioners, 2011). At the same time there are increased expectations of their role in relation to child abuse and neglect and family violence (Royal Australian College of General Practitioners, 2008). These presentations commonly co-occur. In order for a GP to manage patients’ co-occurring drug and alcohol and child protection risks, they must work in conjunction with other medical and social service agencies (Royal Australian College of General Practitioners, 2011).

Additional resources

A list of additional resources detailing programs and research relevant to child and family sensitive practice, and examples of best practice in child and family sensitive programs, can be found in Appendices 2 and 3, respectively.

Part D. Recommendations

Based on the findings from the literature review, audit and analysis of current Australian policy frameworks and intervention strategies, and key stakeholder consultations, the following recommendations are made to guide the ongoing development and implementation of child and family sensitive policy and practice, including capacity building and sustained change in alcohol and other drugs services.

In relation to **policy**, it is recommended that:

1. National policy initiatives and frameworks be developed that explicitly recognise and incorporate the needs of children and families within alcohol and other drugs service provision as core business.
2. National, state and territory alcohol and other drugs policy frameworks be aligned and harmonised in relation to child and family sensitive practice issues.
3. National, state and territory alcohol and other drugs policy frameworks reflect a commitment to enhancing the safety of clients' children.
4. Consideration be given to further reviewing national, state and territory alcohol and other drugs policy frameworks to identify consistencies between these policies and children's rights policies, such as the United Nations Convention on the Rights of the Child.
5. National, state and territory peak bodies in the alcohol and other drugs sector be encouraged to develop and/or endorse child and family sensitive policy and practice frameworks. This work would benefit from consideration of parallel policies in the child protection and child welfare sectors and other adult sectors (e.g. mental health, housing, homelessness, domestic violence).
6. Alcohol and other drugs organisations review and update their existing policies to ensure that they are consistent with the alcohol and other drugs sector and other sectors' national, state and territory policies.
7. Advice and guidance be developed and provided to policy makers at national, state and territory level as to the importance of including child and family sensitive components in relevant policies.
8. A detailed costing of the unaddressed needs of clients' children be undertaken to help inform policy development and direction.

In relation to **systems issues**, it is recommended that:

9. Consideration be given to redefining the concept of 'client' in alcohol and other drugs treatment to include children and family members.
10. Consideration be given to the adoption of flexible funding approaches, particularly in relation to alcohol and other drugs service provision, to ensure that child and family sensitive practice is included as an outcome in funding agreements.

11. Funding models recognise the increased demand that working with children and families places on workers and organisations in both time and resource costs.
12. Consideration be given to the development of national minimum data collection standards for information about clients' children as part of their intake and assessment processes by alcohol and other drugs service providers.
13. Alcohol and other drugs data sets be reviewed and, where appropriate, modified to incorporate data on clients' familial relationships, parenting responsibilities and, in the case of clients seeking help for others' drug use, specific data be collected on the nature of their relationship to the user.

In relation to **organisational issues and change**, it is recommended that:

14. Organisations be encouraged to review and, where appropriate, amend their policies to incorporate clear policies and guidelines on working from a child and family sensitive perspective.
15. Alcohol and other drugs organisations and child welfare/protection services develop joint protocols and systems that facilitate information sharing about the wellbeing and safety of clients' children.
16. In the implementation of child and family sensitive practice, consideration be given to the evidence base for good practice, including the exemplars of good practice identified as part of this project.
17. When developing and implementing child and family sensitive practice, alcohol and other drugs organisations identify and support champions who can be used to promote the implementation of child and family sensitive practice.
18. Alcohol and other drugs organisations review and update their current training provision in relation to child and family sensitive practice and ensure that staff are provided with appropriate professional development opportunities.
19. Alcohol and other drugs organisations review and update their clinical supervision guidelines to ensure that they include reference to child and family sensitive practice.

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Appendices

Appendix 1: Methodology

This project used a mixed methods approach. To achieve the project aim, a desktop review of academic and grey literature was undertaken in relation to child and family sensitive policy and practice in the alcohol and other drugs sector. Key stakeholders were interviewed and their responses analysed to identify key themes. The methodology is further detailed below.

Project aim

The aim of this project was to undertake a comprehensive review of the current policy environment in relation to child and family sensitive practice in alcohol and other drugs settings in Australia.

The project included:

- a comprehensive audit and analysis of the jurisdictional policy frameworks that support or restrict effective implementation of child and family sensitive practice in alcohol and other drugs service settings
- consultations with key stakeholders in different jurisdictions who are recognised as operating effective child and family sensitive practices in alcohol and other drugs services.

Audit of Australian policy frameworks and intervention strategies

A desktop environmental scan was undertaken to identify relevant prevention and early intervention strategies currently in place within Australian drug and alcohol services. The scan examined the child and family sensitive policies and practices of government and non-government drug and alcohol services and peak drug and alcohol bodies in each state and territory, nationally and internationally.

The Australian Drug Information Network database was used to initially identify relevant documents. National and state/territory-based initiatives were examined further by scrutinising the websites of Australian government alcohol and other drugs services and peak non-government bodies. These initiatives were assessed to determine the extent to which they supported or hindered child and family sensitive practice in alcohol and other drugs service settings.

Key policy documents were also identified through the stakeholder consultation component of the project.

Key stakeholder consultations

Key informant consultations were undertaken through semi-structured interviews. Interviewees responded to 16 open-ended questions. Responses were recorded. Three researchers undertook analyses of the audio recordings. Key themes were identified. Themes were also examined from the perspective of their function as a barrier and subsequently as a facilitator to the implementation of child and family sensitive practice.

Sample

A purposive sampling technique was used to identify potential participants. This included: utilising NCETA's existing relationships and networks with government and non-government alcohol and other drugs organisations undertaking child and family sensitive practice; suggestions from ANCD members; and suggestions from participants.

Participants were recruited from:

- service providers, managers and policy makers in the alcohol and other drugs sector involved in funding or delivering child and family sensitive informed programs and initiatives
- key stakeholders in the alcohol and other drugs and child welfare policy arenas.

Ethics

Ethics approval was obtained from the Flinders University Social and Behavioural Research Committee.

Procedure

NCETA, in consultation with the ANCD, identified a list of potential participants who were sent an email invitation and provided with information about the project. Interviewees also identified additional key stakeholders as potential participants. Those who agreed to participate in the study were sent a follow-up email asking them to nominate a date and time for an interview. The follow-up email also included a Letter of Introduction, Project Information Sheet, a semi-structured interview protocol, and a Consent Form (see Appendices 5–8).

A semi-structured interview protocol was provided to participants prior to the interview. Participants were asked about: their understanding of and involvement in child and family sensitive policy and practice development and implementation in Australian alcohol and other drugs services; barriers and facilitators to the implementation of policy and practice; and exemplars of best practice.

Written consent was obtained from all participants prior to the commencement of the interview.

Participants

This study involved 18 participants. Seventeen telephone interviews and one face-to-face interview were held with participants from across Australia. Interviews were conducted between March and May 2013.

Data analysis and management

Audio files

Interviews were recorded on a digital voice recorder and these files were uploaded onto a secure location on the NCETA computer network.

Data management

Each participant was assigned a unique code and their demographic information was recorded onto an Excel spreadsheet.

Data analysis

The researchers listened to the audio recordings, identified main issues and recorded their findings on a Word document. The qualitative responses were categorised according to recurring words, phrases or ideas in response to individual questions. The researchers cross-validated the responses and further analysis identified key themes arising from those responses.

Appendix 2: Further resources

The following is a list of papers and reports detailing programs and research relevant to child and family sensitive practice.

- Banwell, C., Denton, B. & Bammer, G. (2002). Programmes for the children of illicit drug-using parents: issues and dilemmas. *Drug and Alcohol Review*, 21(4): 381–386.
- Brotherhood of St Laurence (2009). *Frankston North Communities for Children Local Evaluation: final report*. Fitzroy, Victoria: Brotherhood of St Laurence.
- Centre for Community Child Health, Royal Children’s Hospital Melbourne, in partnership with Hume Early Years Partnership (2010). *Communities for Children in Broadmeadows, Victoria: final local evaluation report*. Broadmeadows, Victoria: Broadmeadows UnitingCare.
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Appendix 3: Current examples of child and family sensitive practice in the alcohol and other drugs field

The following examples of the implementation of good child and family sensitive practice principles in the alcohol and other drugs field were identified through the literature review, policy framework audit and analysis, and consultations with key stakeholders. This list is not intended to be exhaustive but is designed to highlight examples of the types of activities that agencies/services can undertake as part of their service delivery.

Table 9: Current examples of the implementation of good child and family sensitive practice principles in the alcohol and other drugs field

Program name	Description	Jurisdiction	Contact details/website
ARACY Common Approach to Assessment, Referral and Support	<p>The Common Approach to Assessment, Referral and Support (CAARS or the Common Approach) is a practical and flexible way of improving the wellbeing of children, youth and families. The Common Approach has been independently evaluated and shown to be an appropriate approach to help reduce child abuse and neglect.</p> <p>The Common Approach has been used by practitioners in the early childhood, family support, mental health, family relationships, health and education sectors. The approach is beneficial in assisting practitioners to:</p> <ul style="list-style-type: none"> • identify and verify early signs that a child or family needs support • increase awareness of their role in the prevention of abuse and neglect • think holistically about the strengths and needs of the child and family • provide support to children and families, before problems escalate into crises. 	National	

Program name	Description	Jurisdiction	Contact details/website
Parents Under Pressure (PuP)	The PuP program, designed by Professor Sharon Dawe (Griffith University) and Dr Paul Harnett (University of Queensland), is a home-based program designed for families experiencing problems such as depression and anxiety, substance misuse, family conflict and severe financial stress. The aim of the program is to help parents facing adversity develop positive and secure relationships with their children.	Queensland-based but is also provided in a number of other states and territories	www.pupprogram.net.au
Odyssey House: Kids in Focus program	A specialist child, parenting and family support service, operated by Odyssey House Victoria, for highly vulnerable families where a parent has an alcohol and other drug problem. It provides a family-centred approach that emphasises the safety and wellbeing of children in addition to parenting and family support.	Victoria	www.odyssey.org.au/index.php?option=com_content&view=article&id=125&Itemid=69
Odyssey House Victoria: Counting the Kids	A specialist child, parenting and family support program for families with multiple and complex needs including alcohol and other drug issues.		
NSW NADA: Tools for Change – A New Way of Working with Families and Carers	This program seeks to improve the support offered to the families and carers of clients with mental illness who access non-government drug and alcohol services in New South Wales.		

Program name	Description	Jurisdiction	Contact details/website
Drug and Alcohol Services SA (DASSA): Child Safe Service Development Plan	The plan aims to map support services for children of a family member who is affected by alcohol and other drugs. In addition, in late 2012/early 2013 DASSA commissioned an internal audit of its policies and procedures with a view to enhancing the implementation of child and family sensitive practice within the organisation.		
UnitingCare ReGen: Intensive Playgroup	<p>This program is aimed at families who are affected by alcohol and other drug use and provides an opportunity for parents and or carers of preschool-aged children (0–5 years) to participate in a playgroup.</p> <p>Intensive Playgroup is a program specifically designed to support families with complex needs including substance use, social isolation and family violence. It is facilitated by staff trained in alcohol and other drugs and/or childcare.</p>	Victoria	www.regen.org.au/playgroup
Australian Centre for Child Protection – Protecting and Nurturing Children: Building Capacity, Building Bridges'	<p>This program aims to:</p> <ul style="list-style-type: none"> • build the capacity of practitioners in adult-focused services to better support their adult clients to meet the immediate needs of children in their care • strengthen the collaboration between adult-focused and child- and family-focused services to change the way clients with multiple needs experience the service system. <p>It is a national trial being conducted in 12 specified Communities for Children or Communities for Children Plus geographic areas across Australia.</p>	National	w3.unisa.edu.au/childprotection/projects/bcbb/

Program name	Description	Jurisdiction	Contact details/website
Cyrenian House: Family Program	This program is offered to families (including children) and significant others (i.e. individuals affected by another's drug misuse). The aim of this program is to promote awareness, improve communication, and encourage positive relationships to reduce the harm caused by a significant other's alcohol or drug use.	Western Australia	www.cyrenianhouse.com/non+residential
Cyrenian House: Saranna Women and Children's Program	The Saranna Women and Children's Program allows mothers with young dependent children in their care to access a residential service within a therapeutic community setting. It facilitates family re-unification and is the only alcohol and other drugs residential program in Western Australia for Indigenous and non-Indigenous women and children impacted by alcohol and drug use.	Western Australia	www.cyrenianhouse.com/therapeutic
Kamira alcohol and other drugs Residential Rehabilitation Family and Significant Others (FASOs) Program	The FASOs residential program (6–12 months in duration) is available to alcohol- and/or other drug-dependent women with or without children who live in New South Wales. It can accommodate 16 women and 6 children. Children up to the age of 8 years can be accommodated permanently with their mothers during treatment. The program comprises child and parent assessments; family information groups; family therapy; and family support groups.	New South Wales	www.kamira.com.au/assets/Kamira_FamilyandSignificantDOC.pdf

Program name	Description	Jurisdiction	Contact details/website
Karralika Therapeutic Community: Child and Family Services Program	The Child and Family Services Program at Karralika Programs Inc. provides opportunities for young children to reside with their parents while they are undertaking the program. Children participate in an early childhood development program either through full-time day care or in after-school care or holiday programs. Parents take part in counselling and parenting programs and cognitive behavioural therapies which seek to develop positive parent/child/family relationships.	Australian Capital Territory	karralika.org.au/services/karralika-child-and-family-services-program/
New South Wales: Safe Start and Supporting Families Early	Brings together initiatives from NSW Health's Primary Health and Community Partnerships Branch and Mental Health and Drug & Alcohol Office. It promotes an integrated approach to the care of women, their infants and families in the perinatal period.	New South Wales	
Australian Capital Territory: Impact Program	A coordination service for pregnant women, their partners and their young children (less than two years of age) who are clients of Mental Health ACT and/or are receiving opioid replacement therapy and require assistance to manage their involvement with multiple services.	Australian Capital Territory	
Council for Aboriginal Alcohol Program Services Inc. (CAAPS)	CAAPS is the largest not-for-profit family-focused residential alcohol and other drug rehabilitation centre in Northern Australia. CAAPS Healthy Families Department provides a range of services to individuals and families who are affected by substance misuse issues, under the umbrella of the Healthy Families Program.	Northern Territory	

Program name	Description	Jurisdiction	Contact details/website
Kids In Focus: Women's Health & Family Services WA	<p>Women's Health and Family Services works in partnership with Cyrenian House and CLAN WA to provide the free Kids in Focus service in Western Australia. Kids in Focus WA (KIFWA) offers a comprehensive array of services to children affected by parental alcohol and/or other drug use, and to their families. KIFWA services offered through WHFS include:</p> <ul style="list-style-type: none"> • child and family counselling • art, play and sand tray therapies • group work • parenting training and support • social and recreational activities. 	Western Australia	

Appendix 4: Email to potential interviewees

Dear

My name is Professor Ann Roche. I am the Director of the National Centre for Education and Training at Flinders University. I am writing to you in regard to a research project that NCETA has been funded to undertake on behalf of the Australian National Council on Drugs. This research is looking at how policy frameworks (national, jurisdictional and organisational) influence the delivery of child and family sensitive services in the alcohol and other drugs sector. As part of the research NCETA is seeking to interview a number of key practitioners and policy officers from government and non-government organisations involved in the planning and/or delivery of alcohol and other drugs services in Australia.

You have been identified as a person who could make a valuable contribution to our knowledge about the issues involved. We are contacting you to ask if you would be prepared to participate in an interview of approximately 20–30 minutes in duration, answering questions related to child and family sensitive practice in Australian alcohol and drugs services.

If you indicate that you are prepared to take part, I will email you a letter of introduction to the project, a consent form for you to sign (that includes consent to being audio recorded) and a copy of the questions that will be addressed in the interview.

Your participation is completely voluntary and you may withdraw from the research at any time, without prejudice. Your involvement will be completely confidential. Any information you provide will be kept in a de-identified database and locked storage facility, and not be attributed to you in the final report.

If you do not wish to or are unable to participate, could you please indicate if there is anyone in your organisation/network that we could approach in relation to this matter.

Please respond by return email indicating if you wish to be involved/do not wish to be involved or can refer us to a more appropriate person in your organisation/network.

Thank you for your consideration of this matter.

Yours sincerely

Prof Ann Roche

Appendix 5: Letter of introduction

Dear ,

I am writing to you in regard to a research project that the National Centre for Education and Training on Addiction (NCETA) at Flinders University is undertaking funded by the Australian National Council on Drugs. This research will examine how policy frameworks (national, jurisdictional and organisational) influence the delivery of child and family sensitive services in the alcohol and other drugs sector. Further information is provided in the attached project Information Sheet for Interview Participants.

As part of the research NCETA is seeking to interview a number of key practitioners and policy officers from government and non-government organisations involved in the planning and/or delivery of alcohol and other drug services in Australia. We invite you to be involved in this project via participation in an interview of approximately 20–30 minutes duration. Please find attached a copy of the sorts of questions that would be asked in an interview.

Any information provided in interviews will be treated in the strictest confidence and participants will not be individually identifiable in the final report. Participation in this project is completely voluntary and participants are entirely free to discontinue participation at any time or to decline to answer particular questions. There are no negative consequences for declining to participate in this project.

If you agree to be involved in this project, please confirm that you are prepared to take part in an interview by signing and returning the attached consent form. If you do not wish to take part, we would appreciate you indicating this by return email. There are no negative consequences for declining to participate in this project.

If you agree to participate, we will contact you shortly to arrange a telephone interview.

Please be assured that any information you provide will be treated in the strictest confidence and that participants will not be individually identifiable in the final report.

Please note that the interview will be audio recorded. I therefore seek your consent, on the attached form, to use the transcription of the interview to prepare the final report, on condition that your name or identity is not revealed. I also seek your consent to make the recording available to other researchers working on this project on the same conditions. It may be necessary to provide the recording to secretarial assistants for transcription purposes and should this occur, they will be advised that your name or identity must not be revealed and that the confidentiality of the material must be respected and maintained at all times.

If you do not wish to, or are unable to, participate could you please indicate if there is anyone else in your organisation that we could approach in relation to this matter.

If you have any questions please do not hesitate to contact me on 08 82017535 at ann.roche@flinders.edu.au or Michael White on 08 8201 7537 at michael.white@flinders.edu.au.

Yours sincerely

Professor Ann Roche
Director
National Centre for Education and Training on Addiction
Flinders University
GPO Box 2100
Adelaide SA 5001
www.nceta.flinders.edu.au

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 5941). For more information regarding ethical approval of the project, the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email at human.researchethics@flinders.edu.au.

Appendix 6: Information sheet for interview participants

Exploring ways of supporting child and family sensitive practices in alcohol and other drug services

1. Aims

The aim of this project is to develop a comprehensive report on the current policy environment in relation to child and family sensitive practice in alcohol and other drugs settings in Australia. The report will identify:

- current national and jurisdictional policy
- emerging issues in relation to child and family sensitive practice
- measures to address these issues including potential priorities for future policy development.

These aims will be achieved by:

1. Undertaking an audit and analysis of the extent to which jurisdictional policy frameworks support or hinder child and family sensitive practice.
2. Consulting with key stakeholders recognised as providing effective child and family sensitive practice in alcohol and other drugs services and those involved in policy and practice development and research.
3. Documenting findings in a comprehensive report.

2. Background and rationale

The alcohol and other drugs sector has a vital role to play in promoting child wellbeing and preventing child maltreatment. However, to date there has been little research undertaken to examine the jurisdictional policy frameworks which may be conducive to or hinder child and family sensitive practice.

Parents who misuse drugs and alcohol may be strongly motivated to be good parents and to try and protect their children from the effects of alcohol misuse (Richter & Bammer, 2000). Conversely, it is recognised that parental alcohol and drug misuse may negatively affect child wellbeing, and that children whose parent/s misuse alcohol and drugs are at greater risk for exposure to neglect and/or abuse (Battams et al., 2010; Dawe et al., 2007).

In 2007, the ANCD resource *Drug Use in the Family: impacts and implications for children* (Dawe et al., 2007) examined the extent to which each Australian state and territory had key policy documents relating to the needs of children and practice guidelines. The ANCD's assessment found policy initiatives to support child and family sensitive practice were patchy across states and territories and almost non-existent at the federal level.

Consequently, there have been a number of significant policy developments at national and jurisdictional levels in recent years to address child and family sensitive practice including the following:

- the National Drug Strategy 2010–2015, which includes as a key objective ‘reducing harms to families’ and a number of actions on family sensitive policy and practice. It highlights that ‘closer integration with child and family services is needed to more effectively recognise and manage the impacts of drug use on families and children’ (Ministerial Council on Drug Strategy, 2011)
- the National Framework for Protecting Australia’s Children 2009–2020 (the National Framework), endorsed by the Council of Australian Governments in April 2009, which includes action plans for developing improved service integration between the child and family welfare and the alcohol and other drug and other adult specialist services sectors (Council of Australian Governments, 2009).

There has also been an increased focus on ‘primary prevention’ in the health and welfare sectors, including the child protection sector. Of relevance to child and family sensitive practice in the alcohol and other drugs sector are policies and practices developed across the three levels of ‘prevention’ that have been developed in the wider community services and health context. These include:

1. primary prevention (universal) strategies including health promotion, welfare and education services to support all families
2. secondary prevention strategies (targeting families and communities vulnerable to abuse and neglect, including where members misuse drugs and alcohol) and
3. tertiary prevention strategies (including responses to child abuse and neglect, assessment, treatment and placements) (Battams, Roche, Duvnjak, Trifonoff & Bywood, 2010).

As substance abuse often co-occurs with multiple problems or disadvantage such as mental health problems, a number of jurisdictions have responded by developing resources for families with multiple and complex needs (e.g. dual diagnosis, complex health needs, disabilities, multiple disadvantage). These resources have a high degree of relevance to the alcohol and other drugs sector and will be used to further inform this project (Bromfield, Sutherland & Parker, 2012).

A range of international, national and jurisdictional activities (research, resource development and projects) have recently been undertaken to support the implementation of child and family sensitive practices which focus on frontline workers and organisational systems in the alcohol and other drugs field. These will be drawn on to inform this project. This project will also build on previous work on child and family sensitive policy and practice in the alcohol and other drugs and associated sectors in Australia and internationally, with a particular focus on policy.

3. Method

This project will explore policy frameworks in related sectors, strategies and links across departments and service settings, 'family service orientation' of services, and emerging policy themes and issues related to child and family sensitive policy and practice. It will do this via the following:

1. a brief literature review building on existing reviews undertaken by NCETA and published by other research institutes
2. an audit and analysis of national and jurisdictional policy frameworks
3. stakeholder interviews with: providers in the alcohol and other drugs sector delivering child and family sensitive informed services; relevant child and family welfare services; and stakeholders in the policy arena.

Appendix 7: Consent form

Dear ,

The National Centre for Education and Training on Addiction is conducting a project to examine how policy frameworks (national, jurisdictional and organisational) influence the delivery of child and family sensitive services in the alcohol and other drugs sector. As part of the research NCETA is seeking to interview a number of key practitioners and policy officers from government and non-government organisations involved in the planning and/or delivery of alcohol and other drug services in Australia.

As part of our compliance with ethical research requirements I am requesting that you indicate that you are authorised to allow and that you consent for this research to be undertaken in your organisation.

I, _____, as (insert position title) _____ am an appropriate person to authorise this research and on behalf of (insert organisation name) _____ I consent/do not consent (strike out as appropriate) to it being undertaken.

Signed _____ Date _____

Please email or fax the complete response to Michael White at your earliest convenience.

A copy of the Letter of Introduction and the survey interview questions are attached for your information. If you have any questions or would like some more information about the project then please contact Michael White on (08) 8201 7537, michael.white@flinders.edu.au.

Thank you for your time.

Yours sincerely,



Professor Ann Roche
Director
National Centre for Education and Training on Addiction (NCETA)
Flinders University

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee (Project Number 5941). For more information regarding ethical approval of the project, the Executive Officer of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email at human.researchethics@flinders.edu.au.

Appendix 8: Interview questions

NCETA is undertaking a project to explore:

1. some of the difficulties and complexities facing organisations working in the alcohol and other drugs sector when responding to children whose parents have experienced alcohol and other drug problems
2. how alcohol and other drugs treatment services might include parental roles and responsibilities in their management/treatment plans to address the needs of at-risk children
3. the jurisdictional policy frameworks that support or restrict the effective implementation of child and family sensitive practice in alcohol and other drugs service settings with a view to inform government policy and services.

As part of this research you have been approached and have consented to be interviewed. This interview will be recorded and transcribed. However, your contribution will be treated confidentially and you will not be identified in any report or documentation arising from this project. All records of interviews will be de-identified. Originals will be stored in a secure location at NCETA, Flinders University.

All respondents:

1. Demographic data:

Age Range: 18–29, 30–39, 40–49, 50–59, 60–69

Gender:

2. How long have you worked in the alcohol and other drugs field?
3. What has been your main work role/s? (Select more than one if appropriate)
 - Clinical
 - Managerial
 - Researcher
 - Policy/Administration
 - Other (please specify)
4. Have you worked in? (Select more than one if appropriate)
 - Government
 - Non-government

5. What sectors have you worked in? (Select more than one if appropriate)

- Alcohol and other drugs
- Child protection/child welfare
- Human services
- Other

We are interested in ‘child and family sensitive policy and practice’ and what it means in terms of policy and practice in the alcohol and other drugs field.

6. What do you understand by the term ‘child and family sensitive practice’?

Policies and strategies

7. Are you **aware of policies** to support child and family sensitive practice at workplace, state or national levels?

a. What roles do these policies play?

8. Have you been involved in the **development of any policies** to support child and family sensitive practice? If yes, please give examples.

9. Can you identify some initiatives, either at the policy or service delivery levels that are good exemplars of child and family sensitive practice?

a. What are some of the key factors that supported the development and implementation of these initiatives?

10. What strategies (research, consultations, reviews, etc.) are you aware of that have enhanced the adoption of child and family sensitive practice in the alcohol and other drugs sector?

11. What additional government strategies are in place or could be implemented to support closer linkages and/or information exchange between alcohol and other drugs and child wellbeing/welfare services?

12. Do you think there are any **gaps in organisational or government policy** which need to be addressed to support the implementation of child and family sensitive practices in the alcohol and other drugs field?

13. Please describe any barriers to the implementation of **cross-sectoral** child and family sensitive policies that you are aware of?

Practice barriers

14. What do you think are some of the key barriers to workers implementing child and family sensitive policy or practice in the **alcohol and other drugs sector** at the individual worker, organisational and sectoral levels?

Facilitators

15. What factors do you think operate as **facilitators** to the current or future implementation of child and family sensitive policy and practice in the alcohol and other drugs sector?
 - a. For example, the presence of a champion, managerial support, appropriate policies, staff development, clinical supervision.

Anything else

16. Are there any other comments you would like to make about child and family sensitive practice in relation to the alcohol and other drugs field?