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What Family Sensitive Practice Means for Alcohol and Other Drug Workers: A Survey Report

NCETA
Australia's National Research Centre on AOD Workforce Development

University of South Australia
Australian Centre for Child Protection

Taking First Steps

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National Centre for Education and Training on Addiction

(NCETA)

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'there is no keener revelation of a society's soul than the way it treats it's children'
Nelson Mandela

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Finally, NCETA would like to acknowledge the valuable input of all those who responded to the survey.

Foreword

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

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

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

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

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

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

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Introduction

The Australian Government recently released the 'Protecting Children is Everyone's Business: National Framework for Protecting Australia's Children 2009-2020' (Council of Australian Governments, 2009). It identified parental drug and alcohol abuse as a key risk factor for child abuse and neglect (Council of Australian Governments, 2009). Moreover, it highlighted scope for improvements in alcohol and drug services through a greater focus on child and parent-sensitive practice.[1]

> ***Child and parent-sensitive practice defined:***
> *Child and parent-sensitive work practice is defined here as identifying and addressing the needs of adult clients as parents and the needs of their children, as part of the treatment or counselling process. The aim of child and parent-sensitive practice is to improve client outcomes whilst also ensuring the safety and wellbeing of their children.*

A substantial proportion of Australian children have a parent undergoing alcohol and/or drug (AOD) treatment. To-date however, no definitive data are available on the proportion of AOD clients with parental responsibility. Anecdotal sources indicate that the proportion of AOD clients who are parents is substantial and has increased concomitantly with the increasing age and extended drug using careers of clients.

While having a parent with an alcohol and/or drug-related problem does not automatically imply harm to the child, there is a strong body of research that indicates that these children are at higher risk of abuse and neglect, developmental and behavioural problems, or of developing an alcohol and other drug (AOD) problem. It is known that children who live in households where their parents or primary caregivers are problematic substance users are at much greater risk of poor health and

[1] It is important to make a clear distinction between child and parent-sensitive practice and family therapy. Traditionally, the AOD sector has used family therapy to involve the family in treating a client (usually adolescent clients) with AOD problems. The aim of family therapy is to improve client outcomes by identifying and improving patterns of family interaction that are associated with that client's behaviour and AOD problems. In contrast, this project focussed only on child and parent-sensitive practice and did not explicitly examine the role or use of family therapy in the treatment of AOD problems.

wellbeing outcomes in general (AIHW, 2009). Estimates of the extent of problematic parental AOD use in cases of child protection substantiations vary from approximately 50% to 80% of cases within the child protection system in Australia (Jeffreys, Hirte, Rogers & Wilson, 2009) and often coexist with other risk factors such as domestic violence and mental illness.

Caution however needs to be applied in drawing definitive conclusions about the impact of drug and alcohol use on children as: '…it is generally difficult to disentangle the effects of parental substance use from broader social and economic factors that contribute to and maintain the misuse of either drugs or alcohol' (Dawe et al., 2007, p. viii). Further, it is clear that '*[a] correlation does not mean a cause, and substance misuse may just be one factor in a complicated family situation'* (Forrester & Harwin, 2004, p. 118). Dawe et al. (2007) and Dodd and Saggers (2006), among others, have emphasised the need to view parental substance misuse within a cultural, social and political context.

> *…it is acknowledged that problem substance users tend to cluster within areas of social disadvantage that are characterised by social exclusion, unemployment, low educational achievement, poor housing, family stresses and high levels of despair and hopelessness* (Dawe et al., 2007, p. xvi).

Nonetheless, problematic drug use is commonly regarded as being incompatible with effective parenting (Barnard, 2005). The stigma often associated with AOD use is amplified in relation to parents with AOD-related problems and mothers are often the most heavily stigmatised of all AOD users (Barnard, 2005). Stigma and assumptions about the parenting ability of those with AOD problems further compound the challenges of child-sensitive practice.

Such factors notwithstanding, the AOD treatment workforce can play an important role in ensuring the safety and welfare of these children. However, the extent to which Australian AOD treatment agencies employ child and parent-sensitive work practice models is currently unknown and the traditional focus on drug use and the drug user remains the dominant treatment paradigm: '*…it is not uncommon for researchers, social workers and other professionals to become overly focused on the extent of substance misuse, rather than on the impact that it is having on family functioning, relationships within the family and the experience for the child'* (Forrester, 2004, p. 167).

Encouragingly, there is growing awareness among the AOD and child/family welfare sectors of the effects of alcohol and drug use on the individual, their children and ultimately their family and a broader perspective has begun to emerge. This shift in awareness is a relatively recent phenomenon

that is only just beginning to gain traction and to bring about much needed change in both the child welfare and AOD sectors.

Until relatively recently, the need for collaboration among AOD sector and child welfare/protection workers had received comparatively little attention. However, both sectors have come to increasingly recognise the potential value of closer working relations. There has also been a growing awareness that the separate and isolated approaches often taken toward working with children, on the one hand, and parents with drug and/or alcohol problems, on the other, can have major limitations and unintended negative consequences.

A central barrier to inter-sectoral cooperation and collaboration has been the relative isolation of one sector from the other. In addition, workers in both sectors have traditionally had high workloads, community demands and expectations and limited resources, making changes to established practices difficult. A crucial step is to increase the perception of the relevance of each sector and challenge a long held view that: "*each service's main area of expertise and interest is at best of peripheral concern to the others and at worst, thought to be a distraction from 'real work'*" (Kearney & Ibbetson, 1991, p. 107).

In Australia AOD treatment is mainly provided by organisations or agencies that specialise in addressing AOD misuse (Spooner & Dadich, 2009). Over 50% of AOD treatment services are estimated to be administered by non-government organisations (NGOs) (Siggins Miller, 2005). A range of services are provided by treatment agencies within the AOD sector. These broadly include:

- Counselling/therapy
- Residential rehabilitation
- Inpatient/residential withdrawal
- Outpatient withdrawal.

The National Centre for Education and Training on Addiction (NCETA), in collaboration with the Australian Centre for Child Protection, undertook the current project to investigate the role of AOD workers and examine factors that influence child and parent-sensitive work practice within the alcohol and drug treatment field. The project had two objectives:

1. To determine the extent to which drug and alcohol agencies and workers take into account the parenting needs of their clients and the needs of clients' children

2. To identify possible facilitators and inhibitors to introducing child and parent-sensitive practice to the alcohol and other drug sector.

The initial phase of this project involved a survey of the AOD workforce to identify current work practices, individual knowledge and attitudes and organisational policies and support in relation to child and parent-sensitive work practice. This report presents the results of the survey and outlines the implications of these findings.

The report is the first of a range of publications being developed by NCETA to address the issue of child and parent-sensitive practice. One of these includes the development of For Kids' Sake*:* A workforce development resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs Sector. *For Kids' Sake* is a user-friendly resource that has been designed to provide workforce development/capacity building knowledge and strategies for AOD interventions which are sensitive to the needs of, and involve families and children. The resource comprises four parts. The first part sets the scene; the second part provides guidelines for policy and treatment programs; and the third part which is accompanied by a CD-Rom provides links to a range of training, development and information resources.

Methodology

Participants

Survey participants were AOD frontline workers and managers from government, non-government, private and community-owned treatment agencies located in urban and rural areas in each state and territory across Australia.

Questionnaire

An online questionnaire was specifically developed for the project to examine current work practices, individual knowledge and attitudes and organisational policies and support relevant to child and parent-sensitive work practice. The questionnaire was designed in consultation with the Australian Centre for Child Protection. It included questions concerning:

- organisational support for and barriers to child and parent-sensitive work practice;
- organisational policies and practices concerning child and parent-sensitive work practice;
- work practices related to child and parent-sensitive work practice;
- current levels of training and perceived training needs on child and parent-sensitive work practice and child welfare issues; and
- demographic characteristics and employment information such as age, gender, occupation, length of service, agency type, services offered, and work location.

The survey took approximately 15 minutes to complete and participants were assured of their confidentiality and anonymity. A copy of the questionnaire is contained in Appendix 1.

Ethics

Ethics approval for the questionnaire was obtained from the Flinders University and Southern Adelaide Health Service Social and Behavioural Research Ethics Committee. In addition, ethics approval was also obtained from the University of South Australia's Human Research Ethics Committee.

Survey distribution

Using the list of treatment organisations obtained from the Clients of Treatment Services (COTSA) database, an email was sent to each organisation inviting their staff to participate in the study by completing an online questionnaire. Invitation to participate was also advertised on the Alcohol and Drug Council of Australia's (ADCA) update email distribution list and also promoted through other health and human services list serves. Hard copies of the questionnaire were also available to interested participants who preferred this option. The questionnaire was accessible online for a period of four months. Reminders were sent out periodically to increase participation rates.

Data analysis

Descriptive statistics were performed along with comparisons of aggregate responses between different demographic categories such as type of organisation (non-government versus government) and location (state/territory). The descriptive findings are presented below for each question in the survey. Additionally, qualitative comments were compiled and examined for common themes in responses.

Survey Results

Respondent demographics

A total of 271 respondents completed questionnaires that were eligible for analysis. The mean age of respondents was 45 years (SD = 9.64; range 23-67 years; N=251) and the majority of respondents were female (78%; n=197). Respondents had worked in the AOD field for 10 years on average (SD = 6.30; range 1-22 years; N=250).

Almost a third of respondents identified themselves as AOD workers (32%; n=79) whereas a quarter of respondents were nurses by profession (n=62). Respondents who nominated the 'Other' category included counsellors/therapists, researchers, educators, and managers (see Figure 1).

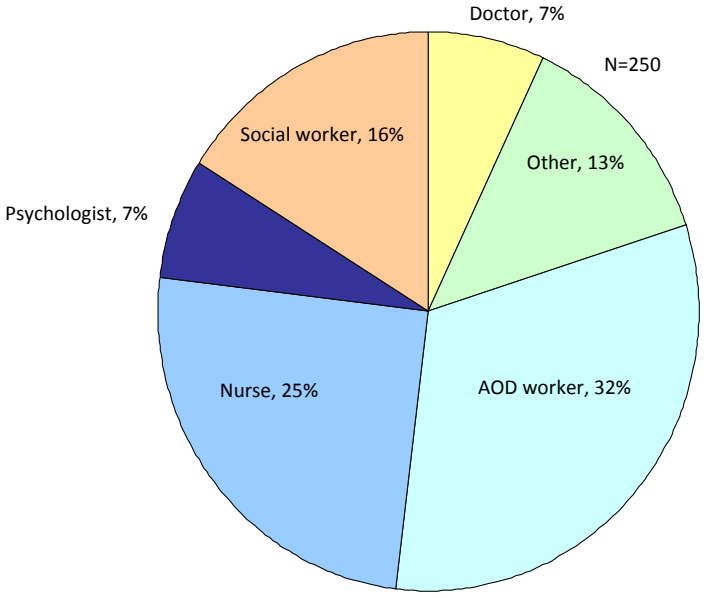

Figure 1. Occupation of respondents

Note: Every respondent did not complete each question.
The number of total respondents thus varied from question to question.

The most frequently listed main work role for respondents was counselling/therapy (45%) (see Figure 2). Other primary work roles included case management (28%) and screening/assessment (26%).

Fewer than 30% of respondents (28%; n=68) indicated that they had ever worked in a child/family welfare service.

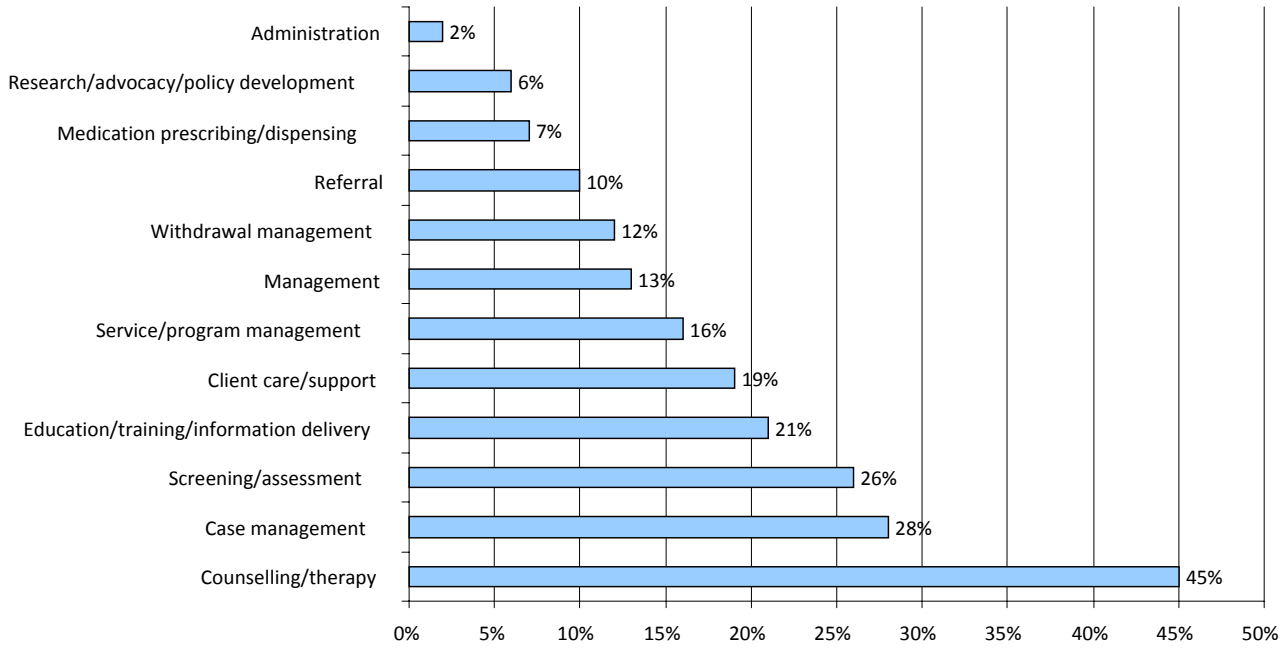

Figure 2. Main work role of respondents

Note: Respondents could select more than one option

As illustrated in Figure 3, the main client group nominated by respondents was the general community (48%), followed by women (23%) and men (21%).

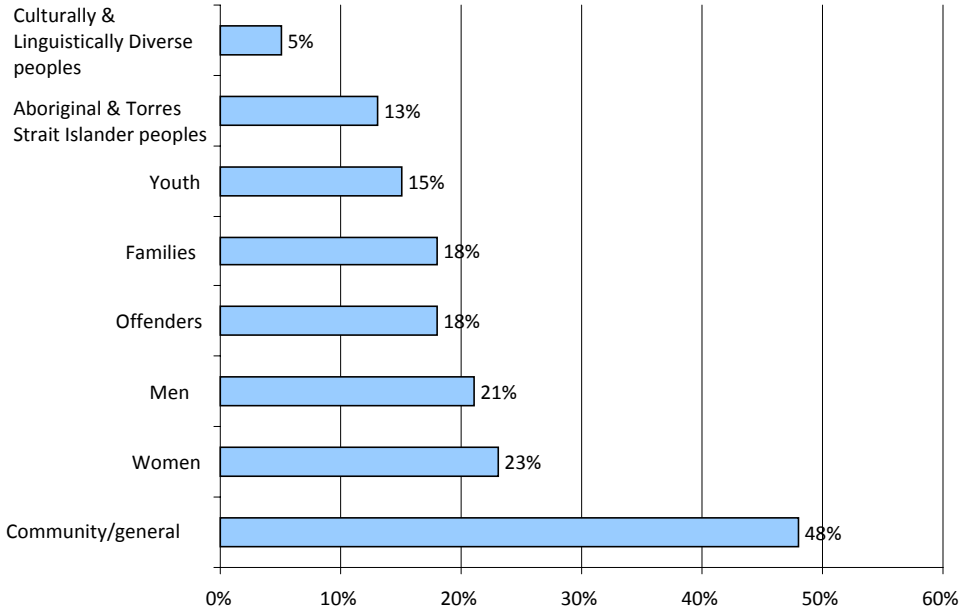

Figure 3. Main client group of respondents

Note: Respondents could select more than one option

More than half the respondents (52%; n=129) worked for government organisations while 44% (n=108) of respondents were employed in non-government organisations (see Figure 4). Separate analyses were undertaken for government versus non-government organisations and these findings are detailed further below.

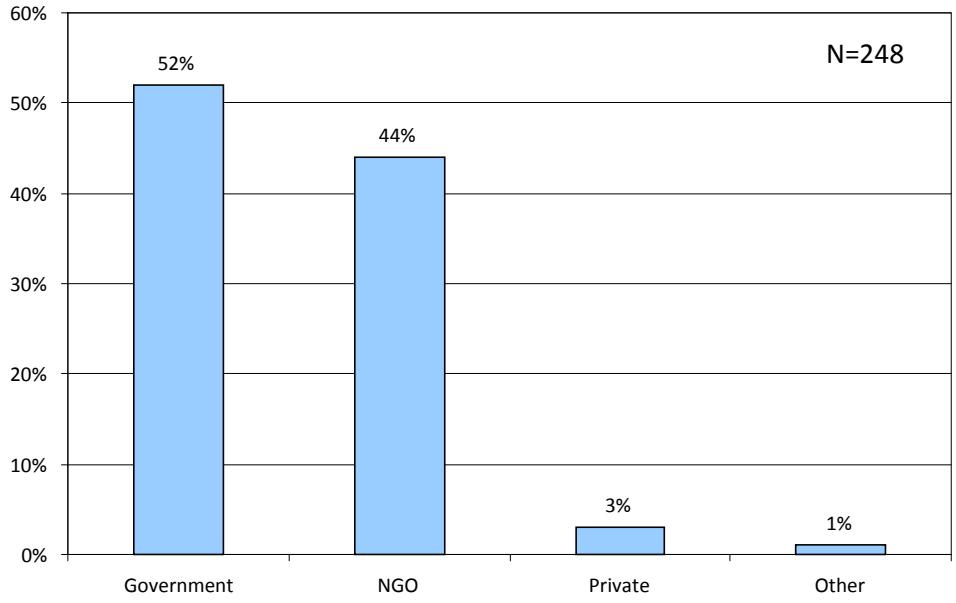

Figure 4. Type of employment organisations

The majority of respondents worked in Victoria (28%; n=70) and New South Wales (25%; n=62). Fewer than 5% of respondents worked in Tasmania and the Northern Territory (see Figure 5).

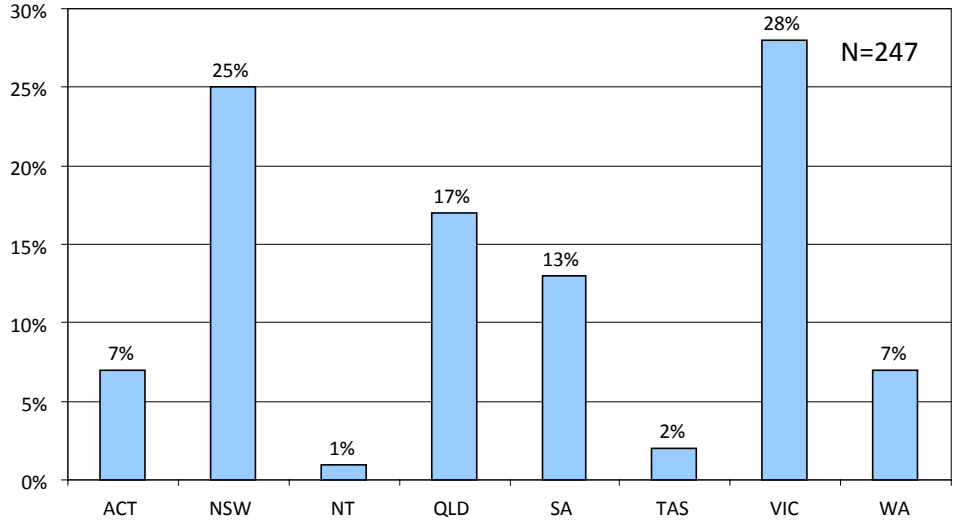

Figure 5. State/Territory of employment

Sixty percent of respondents (n=150) were employed at city/metropolitan locations around the country. Fewer than 20% of respondents worked in rural and remote locations (see Figure 6).

Proportionally, more respondents were based in Victoria than any other state or territory. This may reflect a number of initiatives undertaken over the past few years in relation to addressing child and parent-sensitive practice in the AOD treatment field in that state. An analysis was undertaken to determine if there were any statistically significant differences between Victorian and other respondents. Those analyses revealed no significant differences between respondents from Victoria compared to the sample overall. See Appendix 2.

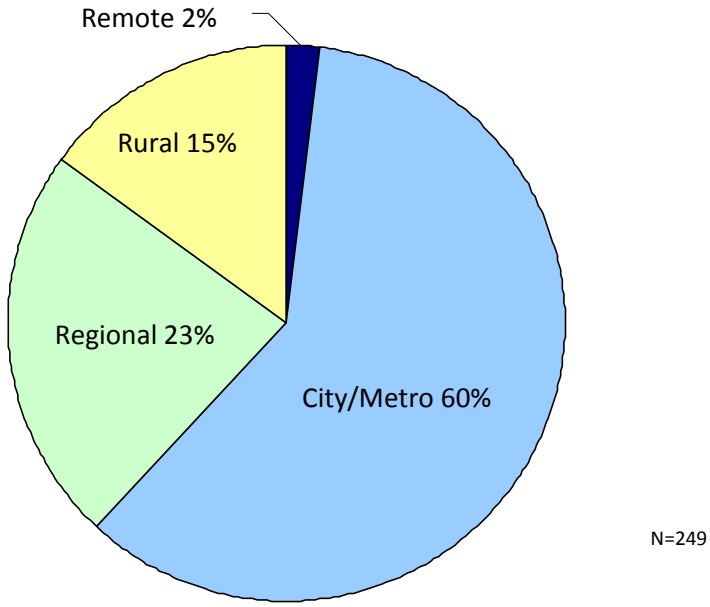

Figure 6. Main work location of respondents

Respondents were asked to nominate the type of service(s) that their work organisation could be categorised as (eg a health promotion, therapeutic community or residential-based organisation). They most frequently identified outpatient (47%) and health promotion (31%) as their organisation's type of service (see Figure 7).

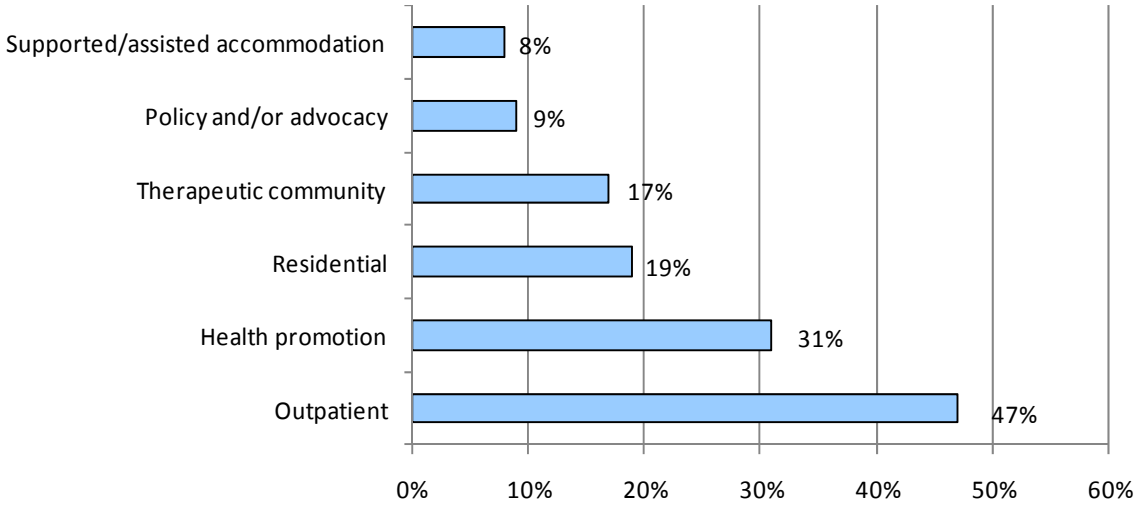

Figure 7. Type of organisations' service

Note: Respondents were able to select all applicable services

Respondents were also asked to identify the main service(s)/program(s) that were offered by their organisation (eg, outpatient withdrawal, inpatient/residential withdrawal and after care programs). Health promotion (41%), services to diversion clients (39%) and outpatient withdrawal (34%) were most frequently selected in response to this question (see Figure 8).

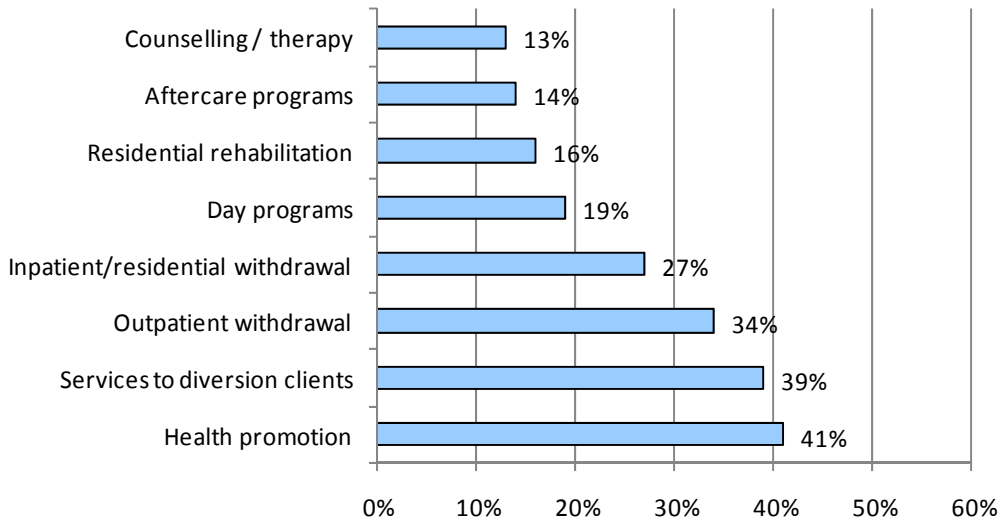

Figure 8. Main services offered by respondents' organisation

Note: Respondents were asked to select all services that apply

Workload

Approximately 60% of respondents (n=165) indicated that they usually supported or worked with between five and 20 clients in a week. Less than 5% of respondents saw over 60 clients in a week and 2% of respondents had no clients (See Figure 9).

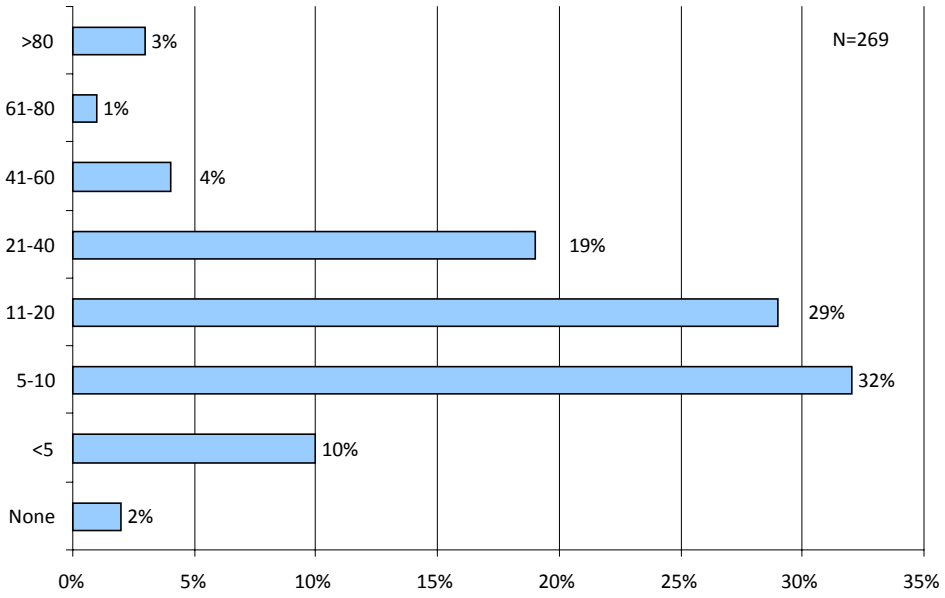

Figure 9. Number of clients reported to be supported / worked with in a week by individual workers (ie does not reflect the overall workload of services)

Knowledge of clients' parenting roles/responsibilities

The majority of respondents (92%; n=244) reported that they generally knew whether or not their clients were parents (Figure 10).

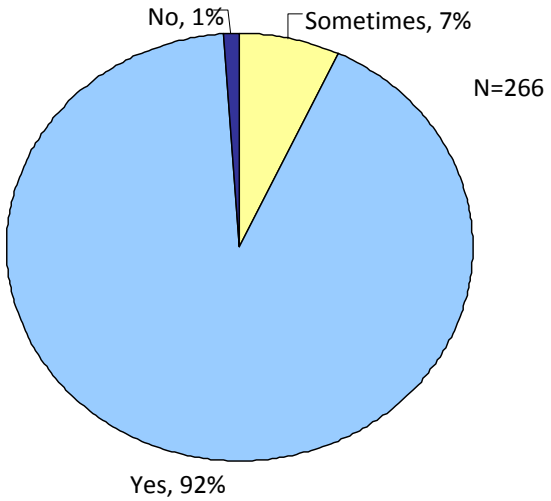

Figure 10. Knowledge of whether clients were parents

Thirty percent of AOD workers indicated that around 50% to 75% of their clients were parents or had carer responsibilities (see Figure 11). A similar proportion of respondents estimated that a quarter to half of their clients had parenting/carer responsibilities.

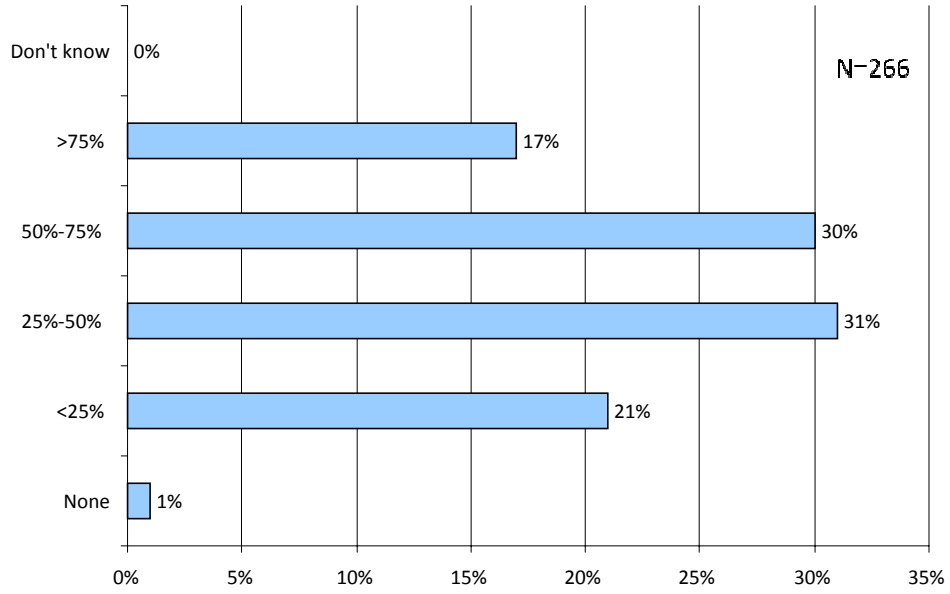

Figure 11. Estimated proportion of clients who have parenting/carer responsibilities

Child and parent-sensitive practice in current work role

Child and parent-sensitive practice was defined in the questionnaire as:

> *identifying and addressing the needs of adult clients as parents and the needs of their children, as part of the treatment/counselling process. The aim is to improve client outcomes and ensure the safety and wellbeing of their children.*

A quarter of respondents (n=68) listed the practice as central to their core role while slightly less than 60% of respondents (n=153) noted that child and parent-sensitive practice was significant but not central to their work roles (Figure 12).

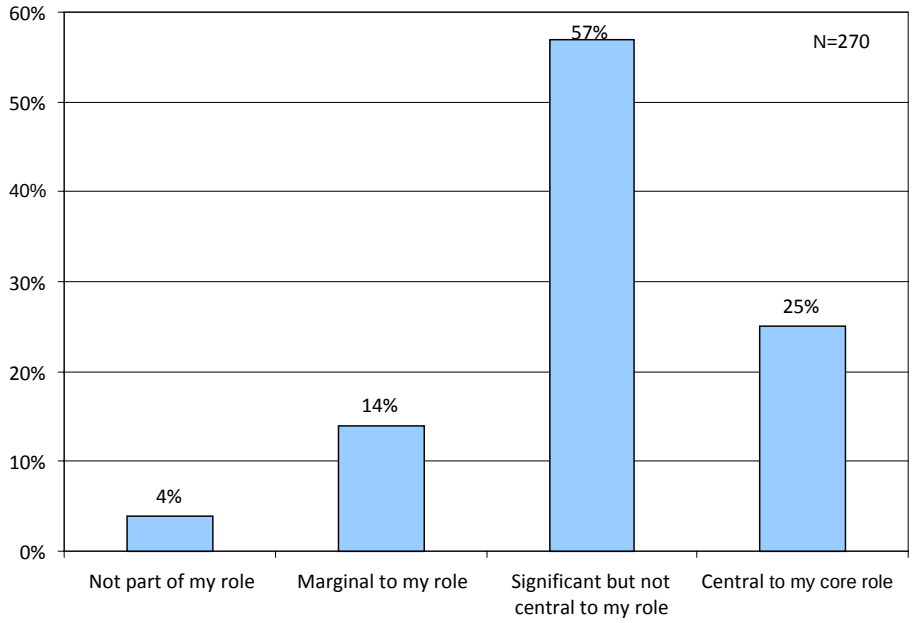

Figure 12. Level of involvement of child and parent-sensitive practice in work role

The vast majority (90%) of respondents indicated that at least some of the parenting clients had children who were being seen by a child welfare service. Almost half the respondents (49%; n=132) indicated that a quarter or less of their clients had children who were being seen by a child welfare service. Twenty eight percent (n=74) estimated that approximately a quarter to a half of their clients had children involved with a child welfare service. That is, more than three quarters of the respondents thought that up to 50% of their parenting clients had children in receipt of child welfare services (Figure 13).

Four percent of respondents did not have parenting clients who had children who were being seen by a child welfare service and 6% did not know if their parenting clients had children who were being seen by a child welfare service.

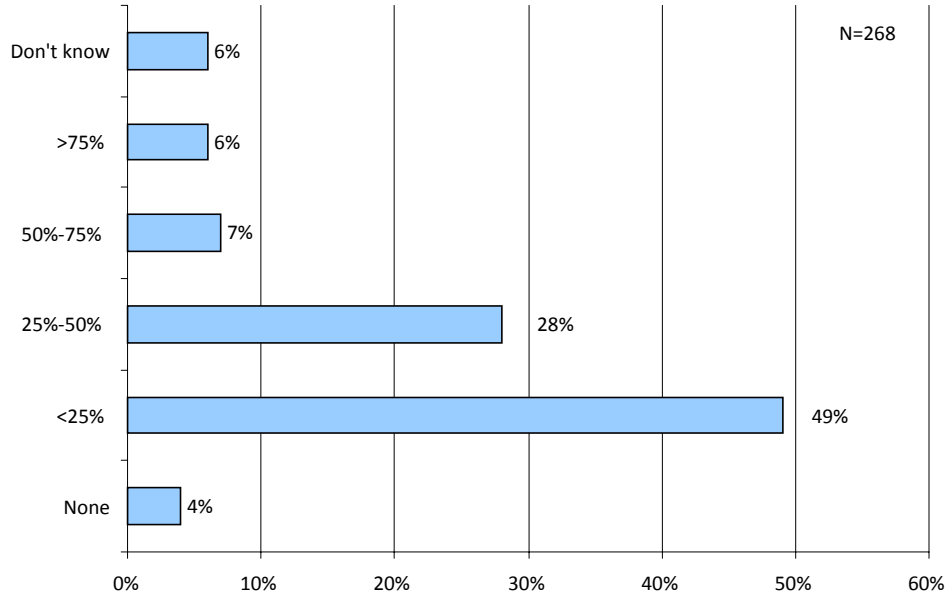

Figure 13. Proportion of parenting clients with children who are clients of a child welfare service

Organisational and individual work practices

Respondents were asked about their organisation's policies in relation to child and parent-sensitive practice (see Table 1). The majority (79%) of respondents agreed/strongly agreed that child and parent-sensitive practice was endorsed by their organisation. Approximately 60% also agreed/strongly agreed that their organisation provided guidelines for working with other agencies (eg, child/family welfare, domestic violence, relationships, Centrelink) that could assist with the needs of clients who have parental or caregiver roles.

Half the respondents confirmed that their organisation had child and parent-sensitive practice guidelines for working with clients who have been identified as parents or caregivers. Most respondents (46%) agreed/strongly agreed that their organisation provided a child-friendly environment (eg, a safe and dedicated space for children, toys) but 37% of respondents indicated

that this was not the case with their organisation. Most organisations (43%) reported that appropriate training was provided to undertake child and parent-sensitive practice, but 35% indicated that this type of training was not available. Approximately half the respondents agreed/strongly agreed that their organisation allows them adequate time to undertake child and parent-sensitive practice. In addition, 58% reported that their organisation had guidelines for working with other agencies that could assist with the needs of clients who were parents/caregivers.

Table 1. Organisational policies regarding child and parent-sensitive practice

The organisation I work for: n (%)	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	N/A	N
Endorses child & parent-sensitive practice	9 (3%)	10 (4%)	36 (13%)	93 (35%)	120 (44%)	2 (1%)	**270**
Has child & parent-sensitive practice guidelines in place for working with clients who are identified as having parental/caregiver roles	14 (5%)	61 (23%)	51 (19%)	82 (31%)	53 (20%)	5 (2%)	**266**
Provides a child-friendly environment	34 (13%)	65 (24%)	32 (11%)	77 (29%)	45 (17%)	17 (6%)	**270**
Provides training to undertake child & parent-sensitive practice	24 (9%)	69 (26%)	54 (20%)	73 (27%)	39 (15%)	8 (3%)	**267**
Allows adequate time to undertake child & parent-sensitive practice	14 (5%)	54 (20%)	56 (21%)	97 (36%)	40 (15%)	8 (3%)	**269**
Provides guidelines for working with other agencies that can assist with the needs of clients who have parental/caregiver roles	10 (4%)	57 (21%)	42 (16%)	108 (40%)	48 (18%)	2 (1%)	**267**

With respect to treatment intake/client assessment procedures that respondents used, 86% (n=232) confirmed that these procedures identified whether the client has a parenting or caregiver role. Twelve percent of respondents (n=32) noted that the procedures they used did not identify their clients' parental or caregiver roles (see Figure 14).

In addition, more than half of the respondents (53%; n=143) noted that their treatment intake/client assessment procedures allowed for an assessment of parenting issues or child wellbeing/welfare issues but 40% of respondents (n=109) noted that there was no provision for such assessment. Seven percent of respondents (n=19) did not know if their intake procedures provided this assessment (see Figure 15).

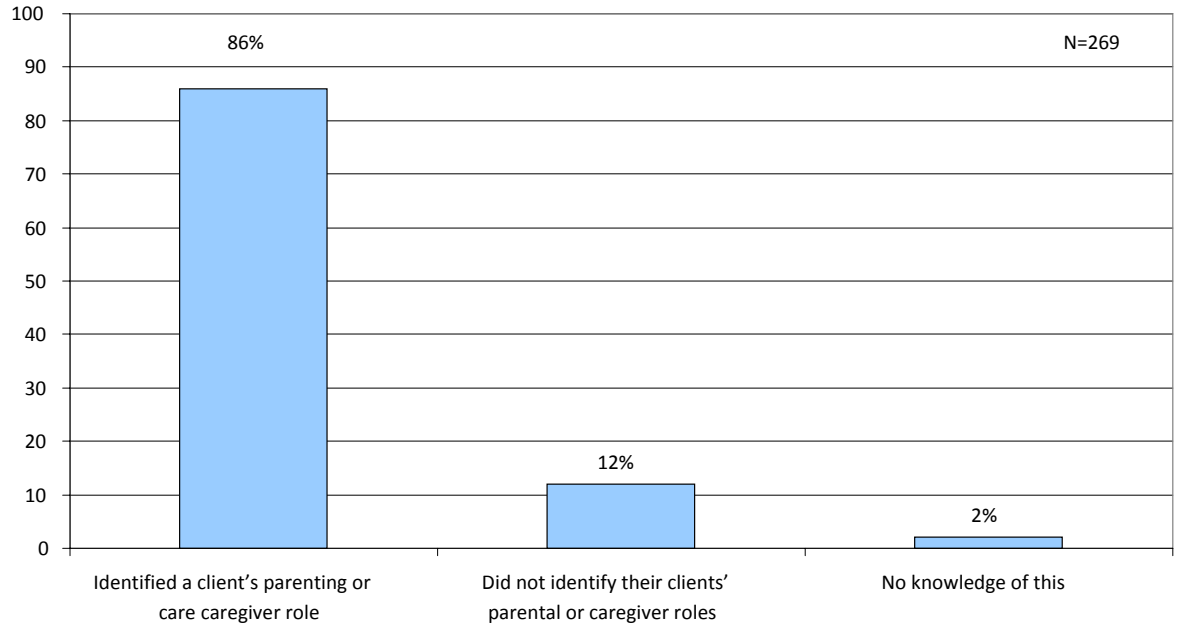

Figure 14. Whether treatment intake/client assessment procedures identify client parenting/caregiver role

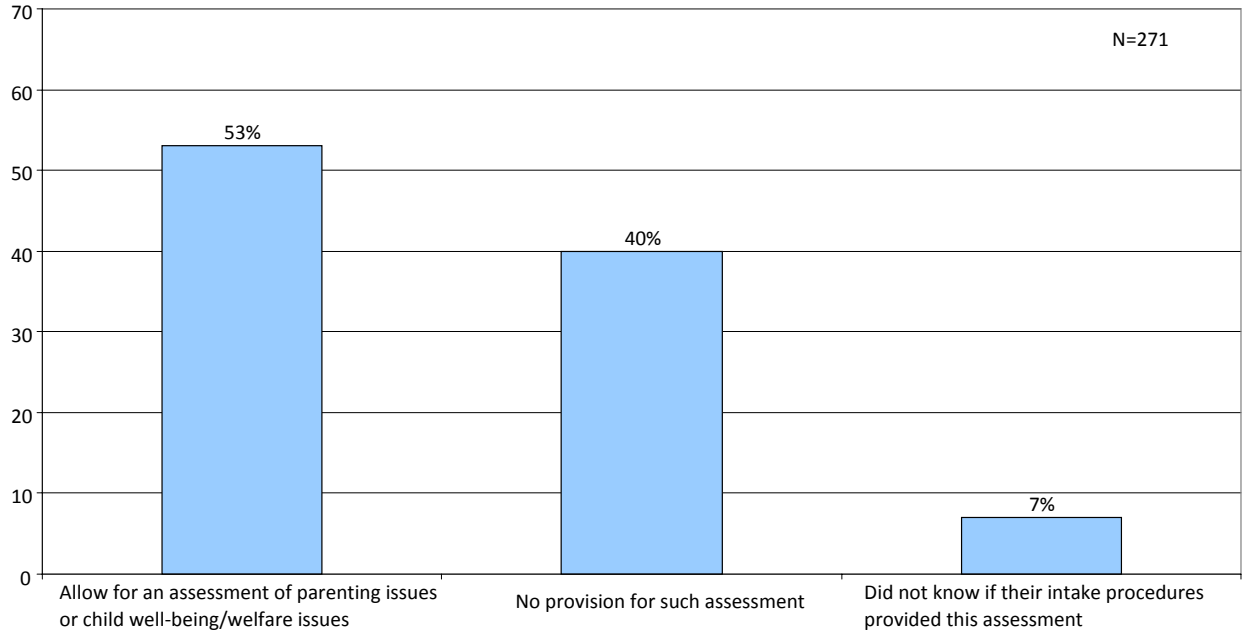

Figure 15. Treatment intake/client assessment procedures

Half of those respondents (n=69) who affirmed that their treatment intake/client assessment procedures allowed for parenting and child wellbeing assessment perceived that such assessments were conducted adequately, while 29% of respondents (n=39) noted that the assessments were somewhat adequate (see Figure 16).

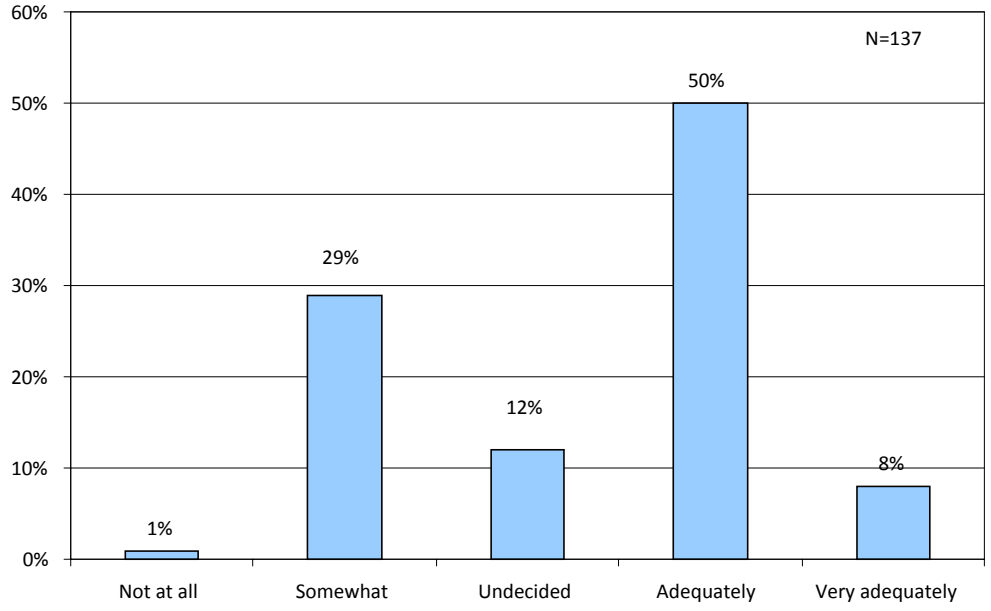

Figure 16. Perceived adequacy of treatment intake/client assessment procedures in assessing parenting or child wellbeing/welfare issues

A significant majority of respondents affirmed that the assessment of parenting issues or child wellbeing/welfare issues included (in descending order of prevalence) examining the involvement of child protection or welfare services (92%), child care responsibilities of the client (85%), the clients' concerns for their children (85%), the role of parenting as a potential motivator in treatment (84%), the pregnancy status of female clients (83%) and the parenting role as a potential stressor for the client (82%) (see Table 2).

However, more than a third of respondents noted that the assessment did not examine the need for child care while clients attend treatment (39%) or the clients' parenting needs in particular (32%).

Table 2. Assessments of parenting or child wellbeing/welfare issues

Type of assessment included: n (%)	Yes	No	Don't know	N
Child care responsibilities of the client	122 (85%)	19 (13%)	2 (2%)	**143**
Client's parenting needs	92 (64%)	46 (32%)	5 (4%)	**143**
Involvement of child protection/welfare services	132 (92%)	7 (5%)	4 (3%)	**143**
Need for child care while clients attend treatment	80 (56%)	56 (39%)	7 (5%)	**143**
Parenting role of the client as a potential stressor for the client	116 (82%)	20 (14%)	6 (4%)	**142**
Pregnancy status of female clients	118 (83%)	19 (13%)	6 (4%)	**143**
Clients' concerns about their children	122 (85%)	17 (12%)	4 (3%)	**143**
Parenting role as a potential motivator in treatment	119 (84%)	18 (13%)	5 (3%)	**142**

More than 70% of respondents stated that they collaborated with children's services as required when working with clients who were parents or caregivers (see Table 3). Around 40% of respondents noted that their interventions were tailored to family needs and that strengthening parent-child relationships formed part of the treatment goal, but 38% of respondents noted that they did not often see and speak to the clients' children themselves.

Table 3. Current work practices when working with clients with parental/caregiver roles

Current work practices: n (%)	Yes	No	Sometimes	Don't know	N
Interventions are tailored to family needs	116 (43%)	35 (13%)	114 (42%)	5 (2%)	**270**
Strengthening parent-child relationships form part of the treatment goal	115 (43%)	44 (16%)	106 (39%)	5 (2%)	**270**
Often see and speak to client's children	65 (24%)	103 (38%)	101 (37%)	1 (1%)	**270**
Collaborate with children's services as needed	194 (72%)	12 (4%)	55 (20%)	10 (4%)	**271**

More than half the respondents (51%; n=135) disagreed/strongly disagreed that they received regular clinical supervision from someone experienced in child and parent-sensitive practice. Approximately 28% of respondents (n=76) agreed/strongly agreed that they regularly received clinical supervision of this kind (see Figure 17).

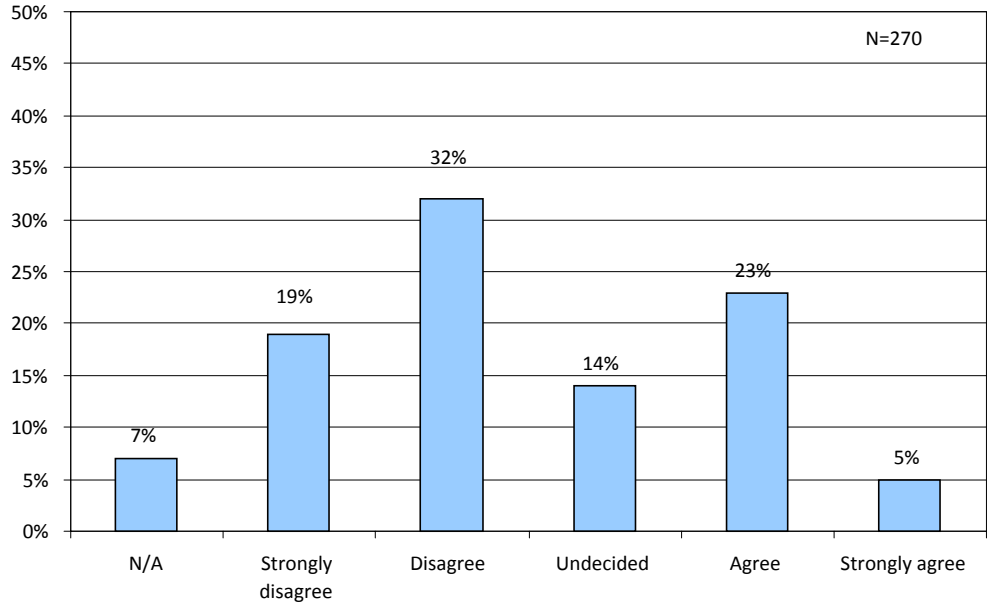

Figure 17. Level of agreement in receiving regular clinical supervision from someone experienced in child & parent-sensitive practice

Nearly 70% of respondents (n=174) stated that they included changes in the wellbeing and welfare of the clients' children when assessing treatment outcomes for clients who were parents or caregivers (see Figure 18). Around 60% of respondents (n=155) affirmed that they also included changes in their clients' parenting competence. However, about a third of respondents (n=84) noted that they did not include such changes in competence when assessing treatment outcomes.

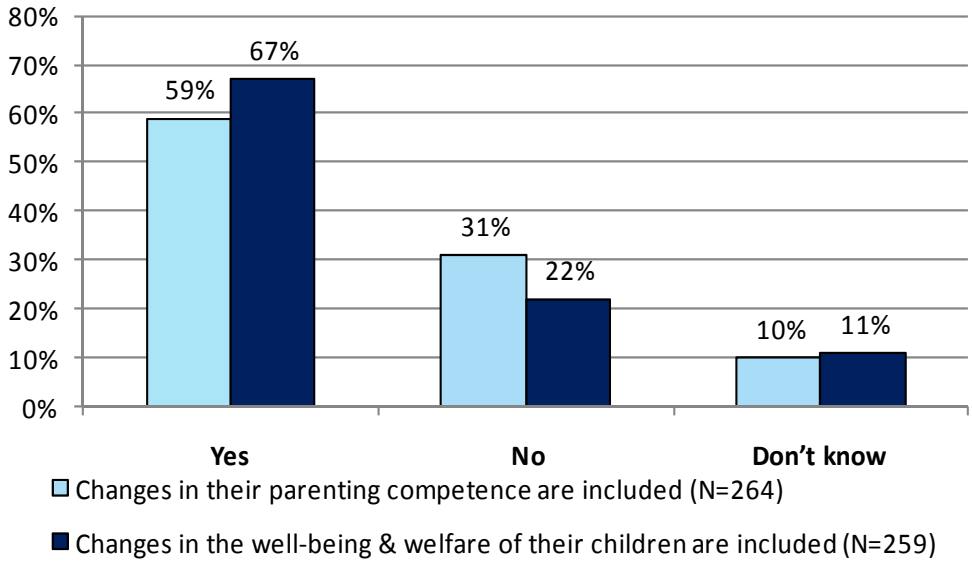

Figure 18. Changes included when assessing treatment outcomes for clients with parental/caregiver roles

Nearly half the respondents (n=129) were not aware of available funding to assist with meeting the needs of clients' children (Figure 19). Only 26% of respondents (n=69) noted that they had sought available funding to assist with meeting the needs of clients' children and 68% (n=183) stated that they had never sought such funding (the remaining 6% selected 'don't know' as a response). The most frequently noted source of funding sought was 'Counting the Kids Brokerage Fund'. Other sources mentioned included funds from Odyssey House (most likely from the Counting the Kids Brokerage Fund), government departments (eg, Department of Community Services, Department of Health Services), Salvation Army and Mission Australia.

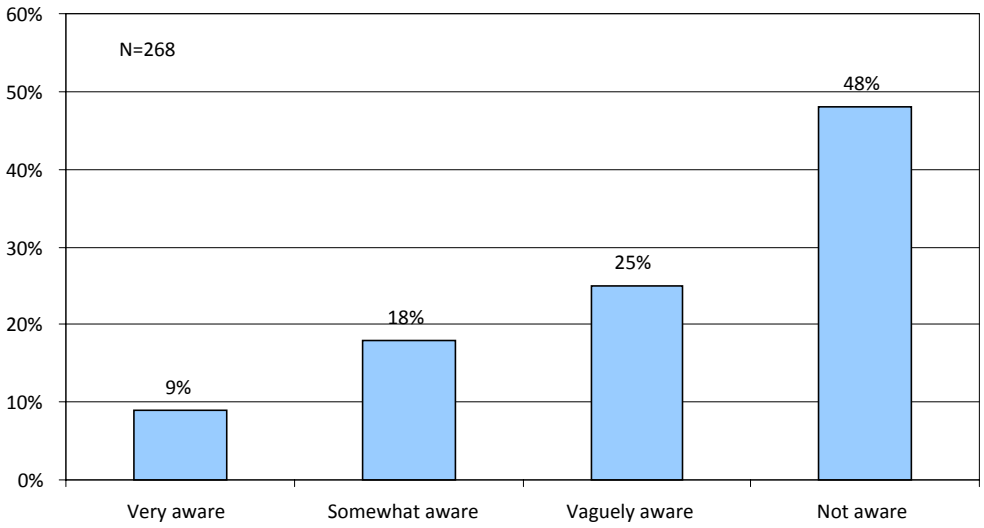

Figure 19. Degree of awareness of available funding to assist with meeting the needs of clients' children

Individual worker perspectives and practices

Nearly 90% of respondents (n=232) stated that they had raised the issue of the wellbeing or welfare of the client's child with them. When these issues had been raised, 28% of respondents (n=65) felt that it was a positive experience whereas 67% of respondents (n=159) stated that the experience was 'mixed' and 5% (n=11) stated that it was a negative experience. When prompted for a reason for their response, many respondents remarked that it very much depended on individual clients and their receptiveness to being asked about their children.

Respondents also indicated that some clients were resistant to discuss such issues because of fear or apprehension of having their children removed, or were defensive about their parenting skills. Some respondents noted that some clients were of the view that AOD workers had no right or responsibility to ask them about the welfare or wellbeing of their children. On the other hand, some clients were reported to be more open and responded positively to discussion about their children. The following are examples of responses provided by workers about their experiences in discussing these issues with their clients:

Respondents with 'mixed' experiences

"Often depends on client's previous experiences with care and protection or welfare services - some clients are happy to discuss welfare and draw on care and protection services as a parenting support resource, while clients with histories of child removal or negative experiences with welfare services tend to be resistant to discussing welfare issues."

"Initially defensive or denied children experienced negative outcomes as a result of substance use but further exploration generally overcomes denial with an understanding that I am a mandated reporter but believe in early intervention work."

"Some clients [are] very scared of consequences of being engaged with Families services. Some clients [are] highly upset when using the service and would see any approach about such a sensitive subject [as] negative. Some think it [is] none of the business of the counsellor. Other clients glad to know where they stand, find the information extra motivation to get well."

Respondents with 'positive' experiences

"Most clients are voluntary and willing to participate in our service. Should parenting be disclosed, we find most people care about and are willing to consider the potential effects of their alcohol use on their children and family relationships."

"Despite their substance related issues, I find majority of parenting clients have best interests of the child as a priority and are open to understanding how their behaviours impact on the child and consider options which may improve the child's experiences in the family."

Respondents with 'negative' experiences

"Clients have stated that they felt their children's issues should not be a topic in AOD counselling, am generally able to reframe as something relevant for them, but they often have a reaction. Also, when I've needed to contact child protection services, this has angered clients, stating that they felt betrayed etc."

The majority of respondents noted that they had engaged statutory child protection (80%) and domestic violence services (76%) to assist a client with their parental/caregiver roles (see Table 4).

Around 60% of respondents had sought assistance from supported accommodation or in-home family support and maternal and child health services. Child care services were engaged for assistance by 47% of respondents.

Table 4. Services engaged to assist a client with parental/caregiver roles

Services: n (%)	Yes	No	Not relevant	N
Child care	120 (47%)	124 (48%)	14 (5%)	**258**
Statutory child protection	209 (80%)	44 (17%)	7 (3%)	**260**
Supported accommodation or in-home family support	152 (58%)	95 (37%)	12 (5%)	**259**
Maternal & child health nurses	151 (58%)	95 (37%)	12 (5%)	**258**
Domestic violence services	199 (76%)	53 (20%)	9 (4%)	**261**
Children's disability services	58 (23%)	175 (69%)	21 (8%)	**254**

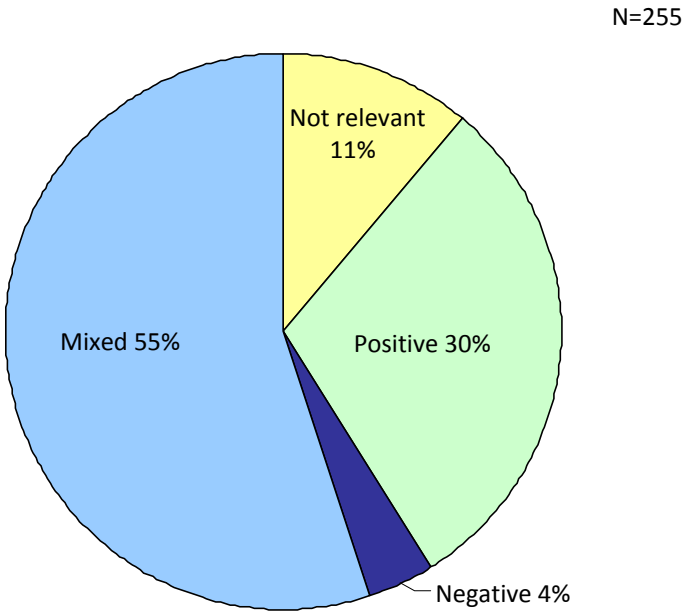

Figure 20. Experience of engaging other services to assist with clients' parental roles

As illustrated in Figure 20, more than half the respondents (55%; n=139) had a mixed experience when engaging other services to assist a client with their parental/caregiver roles. Thirty percent of respondents (n=76) had positive experiences and 4% of respondents (n=11) had negative experiences. Some respondents provided comments to elaborate on their experiences, for example:

"Our service finds child protection can be difficult at times. Much of the problems with services is the judgment that comes from society as a whole around injecting drug users."

"Child protection needs and expectations differ to those of our service and they can become quite bullish and overbearing."

"Depends on the quality of the service (esp. the relationship skills of the individual practitioner) being referred to. If they are no good at relationships with vulnerable families then the response is usually negative."

"I have had some wonderful experiences of collaboration with child protection, however I have also has some extremely difficult interactions with child protection workers who have failed to believe in the clients' ability to change.

"Many of these services are NGOs that have limited resources and staff with highly varied training and experience, so the degree to which their response can be tailored to the client's needs can't be readily determined. This said, most services are very open to receiving referrals and providing what they can within their limits."

Table 5. Level of confidence in addressing parenting-related issues with clients

Issues: n (%)	Not at all confident	Not very confident	Somewhat confident	Fairly confident	Very confident	N
Parenting needs	5 (2%)	25 (9%)	69 (27%)	105 (41%)	54 (21%)	**258**
Child wellbeing/welfare concerns raised by clients	4 (2%)	18 (7%)	63 (25%)	111 (43%)	60 (23%)	**256**
Income and housing	6 (2%)	30 (12%)	78 (30%)	92 (36%)	50 (20%)	**256**
Employment and training	11 (4%)	30 (12%)	77 (30%)	96 (37%)	43 (17%)	**257**
Relationships	7 (3%)	17 (6%)	69 (27%)	110 (42%)	56 (22%)	**259**
Referral to other child & family support services	3 (1%)	12 (5%)	42 (16%)	114 (44%)	86 (34%)	**257**

Around 65-70% of respondents were 'somewhat confident' to 'fairly confident' in addressing parenting needs, child wellbeing/welfare concerns raised by clients, income and housing, employment and training and relationship issues with their clients (Table 5). More than a third of respondents were 'very confident' in making referrals to other child and family support services such as child care, domestic violence and housing services.

The majority of respondents (83%; n=216) indicated that it was very important to raise the needs of children when working with clients who have parental/caregiver roles (Table 6). Only 1% of respondents believed that it was 'slightly important'.

Table 6. Perceived importance in raising the needs of children when working with clients who have parental/caregiver roles

Level of importance	Frequency	Percentage
Slightly important	3	1%
Important	40	15%
Very important	216	83%
Undecided	2	1%
Total	**261**	**100%**

Most respondents (90%; n=232) agreed/strongly agreed that assisting a client to manage their parent/caregiver role would contribute to positive treatment outcomes (Figure 21).

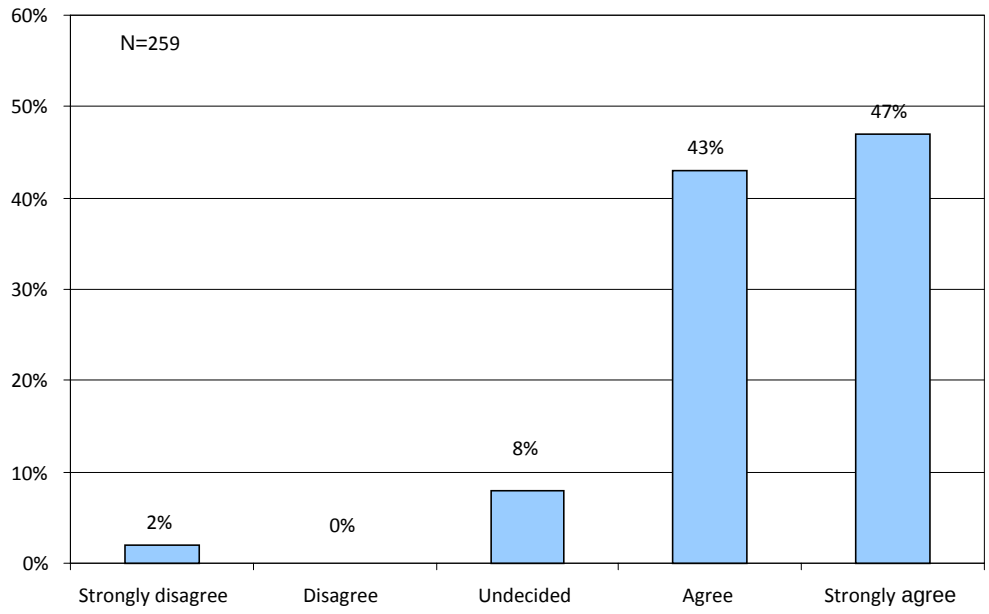

Figure 21. Level of agreement regarding the benefits of assisting clients manage their parent/caregiver roles

More than half the respondents (n=135) believed that it was 'somewhat unlikely' to 'very unlikely' that asking a client about their parenting practices or about their children would lead to involvement with statutory child protection (Figure 22). Conversely, approximately 47% of respondents noted it was 'somewhat likely' to 'very likely' that raising issues related to parenting practices would lead to involvement with a statutory child protection authority.

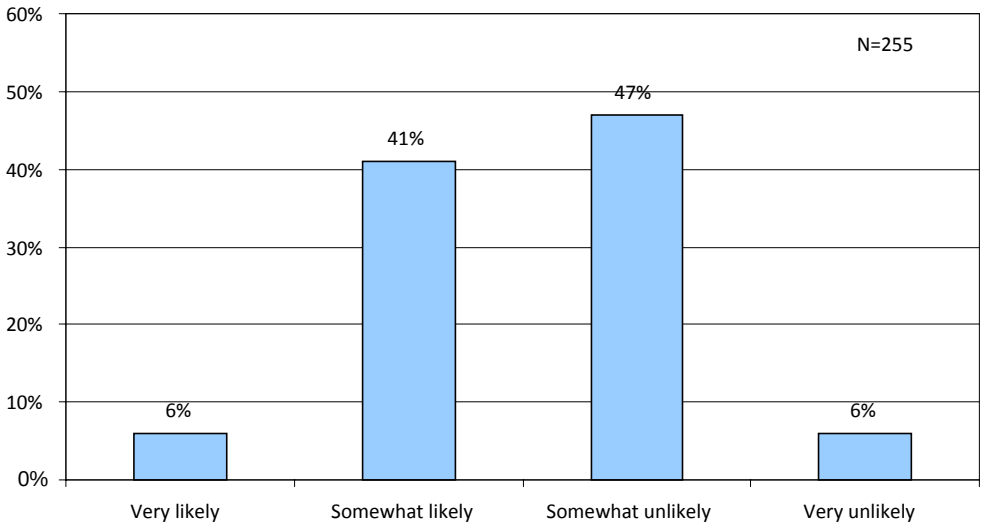

Figure 22. Perceived likelihood that raising issues regarding parenting would lead to involvement with statutory child protection

More than 90% of respondents agreed/strongly agreed that they understood the legal duty of care requirements concerning child safety/welfare that may apply when working with clients who have parental/caregiver roles (Figure 23).

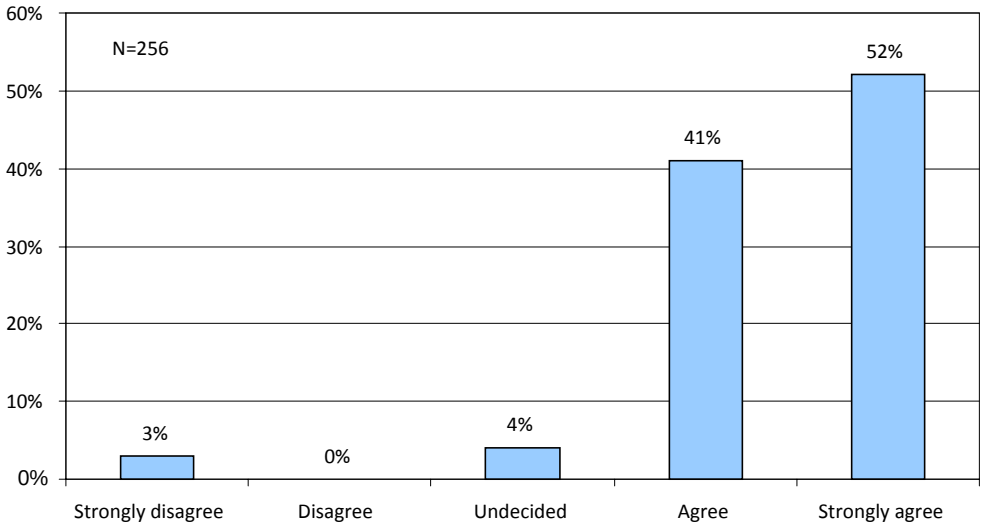

Figure 23. Level of agreement regarding the legal duty of care requirement concerning child safety/welfare

Training received on child and parent-sensitive practice

As can be seen in Figure 24, 56% of respondents (n=142) had received 'a little' to 'a moderate amount' of training on child and parent-sensitive practice. Around 30% of respondents had received 'a fair bit' to 'a lot' of training in this area.

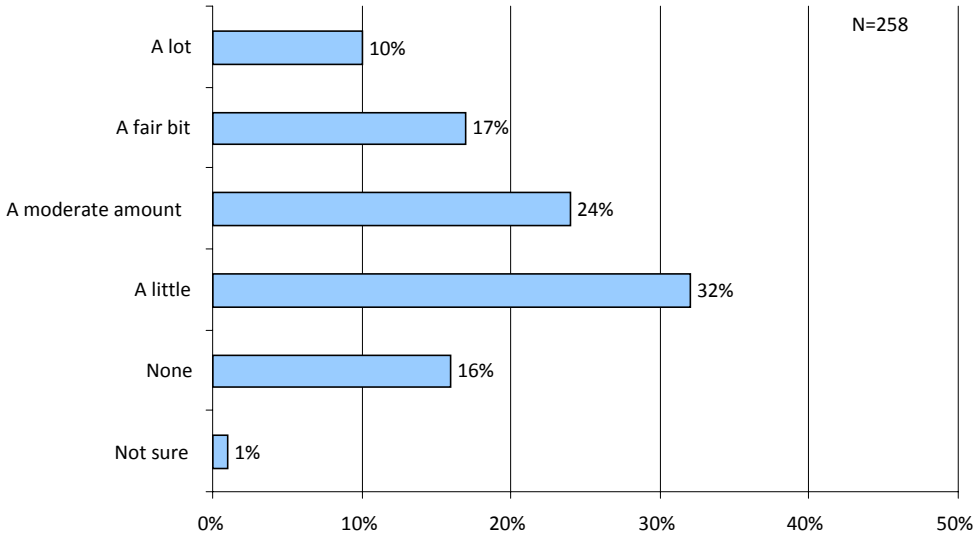

Figure 24. Amount of training received on child and parent-sensitive practice

Nearly 70% of respondents (n=140) stated that the training was effective or very effective in enhancing their skills and knowledge in child and parent-sensitive practice (Figure 25). A quarter of respondents (n=50) perceived the training to be only slightly effective in building their knowledge and skills in this area.

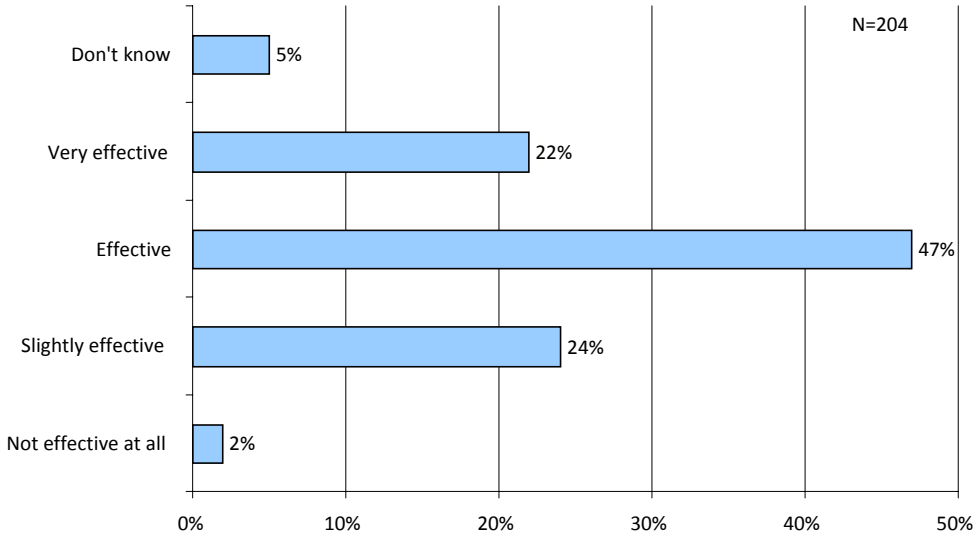

Figure 25. Perceived effectiveness of training received

The following are examples of the comments provided by respondents regarding the training that they had received:

"Enhancing skills and knowledge in this area is an ongoing process and we continue to attend training to ensure we achieve the best possible standards of practice."

"I have undergone specific training in child needs and parental needs within the context of a community-based position working with clients and their families in their homes. I have found training in this area valuable since working in other areas. Child development knowledge has been of much benefit in being able to identify the norm/abnorm."

"My major child-parent sensitive practice actually came from training about supervision for workers."

"Training on its own was ok, but field experience enhanced it greatly."

Barriers to child and parent-sensitive practice

Table 7 presents the respondents' perceptions regarding organisational barriers in relation to child and parent-sensitive practice. The organisational issues that were perceived to be 'substantial' or 'very significant barriers by approximately half the respondents (ie, 45-55%) included:

- lack of access to resources and strategies to assist clients with their parenting/caregiver needs;
- limited mutual exchange of information between child/family welfare agencies and AOD agencies;
- competing priorities (treatment needs of the adult client vs needs of the child);
- lack of education/training on child wellbeing/welfare issues relevant to drug and alcohol using parents; and
- lack of linkages between AOD and child/family welfare agencies.

Table 7. Barriers to child and parent-sensitive practice within the organisation

Barriers: n (%)	Not at all a barrier	A slight barrier	A substantial /very significant barrier	N/A	N
Heavy workloads	43 (17%)	92 (37%)	101 (41%)	12 (5%)	**248**
Lack of professional autonomy & discretion	125 (51%)	64 (26%)	37 (15%)	18 (8%)	**244**
Lack of child & parent-sensitive practice guidelines	56 (22%)	89 (36%)	85 (35%)	18 (7%)	**248**
Lack of govt. policies mandating child & parent-sensitive practice	87 (36%)	62 (25%)	73 (30%)	23 (9%)	**245**
Lack of management support for child & parent-sensitive practice	93 (38%)	73 (29%)	66 (27%)	16 (6%)	**248**
Lack of clinical supervision relevant to child & parent-sensitive practice	60 (25%)	81 (33%)	91 (37%)	13 (5%)	**245**
Lack of linkages between AOD & child/family welfare agencies	50 (20%)	80 (32%)	110 (45%)	7 (3%)	**247**
Limited mutual exchange of information between child/family welfare agencies and AOD agencies	31 (13%)	85 (35%)	121 (49%)	8 (3%)	**245**
Lack of access to resources and strategies to assist clients with their parent/caregiver needs	36 (15%)	72 (29%)	133 (54%)	6 (2%)	**247**
Lack of education/training on child	44 (18%)	86 (35%)	109 (45%)	6 (2%)	**245**

wellbeing/welfare issues relevant to drug and alcohol using parents					
Limited ability to identify less visible/obvious forms of potential harm to children	71 (29%)	81 (33%)	87 (36%)	5 (2%)	**244**
Competing priorities (treatment needs of the adult client vs needs of the child)	29 (12%)	89 (36%)	119 (49%)	8 (3%)	**245**
Lack of treatment plans/goals that involve parental/caregiver needs	57 (24%)	76 (31%)	98 (40%)	13 (5%)	**244**

In addition, heavy workloads and the lack of treatment plans/goals that involve parental/caregiver needs were considered to be substantial or very significant barriers by around 40% of respondents. On the other hand, lack of professional autonomy and discretion was perceived *not* to be a barrier by just over half the respondents.

Comparison of government and non-government respondents

The following section provides a summary of the comparison between respondents who reported that they were employed either by a government or non-government organisation. While there were a number of significant differences, particularly in relation to issues such as length of service in the AOD field, there were proportionally more government-employed respondents from Queensland, South Australia and New South Wales than Victoria and Western Australia; there were more nurses employed in the government sector than the non-government sector; and there were proportionally more non-government-employed respondents who had previously worked in a child/family welfare service.

The average age of respondents employed in government organisations was higher than those employed in non-government organisations (NGOs). On average, government-employed respondents were aged 46.7 years compared to NGO-employed respondents who were 43.5 years (p=.01) (Table 8).

Respondents from government organisations had, on average, worked for a longer duration in the AOD field compared to those from NGOs (ie, 10.7 years vs 8.8 years; p = .018).

Table 8. Average age and length of service of NGO and government respondents

Demographic		N	Mean	Std. Deviation	Std. Error Mean
Age	NGO	107	43.51	8.844	.855
	Govt	128	46.72	10.186	.900
Length of service in AOD field	NGO	108	8.78	5.643	.543
	Govt	127	10.70	6.682	.593

There were proportionally more nurses among government-employed respondents compared to their counterparts from NGOs (40% vs 6%). In contrast, 45% of NGO respondents were AOD workers compared to 22% of respondents from government organisations. There were no doctors among the NGO respondents, whereas 12% of respondents from government organisations were doctors (Table 9).

There were proportionally more government-employed respondents from Queensland, South Australia and New South Wales whereas there were more NGO-employed respondents from Victoria and Western Australia (Table 10).

Table 9. Occupation of NGO and government respondents

Occupation n (%)	Other	AOD worker	Nurse	Psychologist	Social worker	Doctor	Total
NGO	28 (26%)	49 (45%)	6 (6%)	7 (6%)	18 (17%)	0 (0%)	**108 (100%)**
Govt	5 (4%)	28 (22%)	51 (40%)	9 (7%)	20 (15%)	15 (12%)	**128 (100%)**
Total	**33 (14%)**	**77 (33%)**	**57 (24%)**	**16 (7%)**	**38 (16%)**	**15 (6%)**	**236 (100%)**

Table 10. State/Territory of employment

n (%)	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
NGO	6 (6%)	18 (17%)	3 (3%)	7 (6%)	9 (8%)	3 (3%)	51 (47%)	11 (10%)	**108 (100%)**
Govt	9 (7%)	37 (29%)	0 (0%)	34 (27%)	22 (18%)	2 (2%)	18 (14%)	4 (3%)	**126 (100%)**

Total	**15 (6%)**	**55 (24%)**	**3 (1%)**	**41 (18%)**	**31 (13%)**	**5 (2%)**	**69 (30%)**	**15 (6%)**	**234 (100%)**

There was a greater proportion of respondents from government organisations who were located in rural (27%) and regional (19%) areas compared to respondents from NGOs, who were mostly located in metropolitan areas (Table 11). Proportionally more NGO-employed respondents had previously worked in a child/family welfare service compared to government-employed respondents (34% vs 21%) (Table 12).

Table 11. Main work location of NGO and government respondents

n (%)	City/Metropolitan	Regional	Rural	Remote	Total
NGO	76 (70%)	19 (18%)	11 (10%)	2 (2%)	**108 (100%)**
Govt	67 (52%)	34 (27%)	25 (19%)	2 (2%)	**128 (100%)**
Total	**143 (61%)**	**53 (22%)**	**36 (15%)**	**4 (2%)**	**236 (100%)**

Table 12. Had respondents worked in a child/family welfare service

Response: n (%)	Yes	No	Total
NGO	37 (34%)	71 (66%)	**108 (100%)**
Govt	27 (21%)	99 (79%)	**126 (100%)**
Total	**64 (27%)**	**170 (73%)**	**234 (100%)**

Table 13 indicates that proportionally more respondents employed in non-government organisations had more than 25% of clients with children who were clients of a child welfare service, compared to respondents employed in government organisations 49% vs 32%.

Relative to their government-employed counterparts, proportionally more NGO-employed respondents tended to agree that their organisation allowed adequate time to undertake child and parent-sensitive practice (62% vs 42%) (Table 14).

Table 13. Proportion of clients with children who are clients of a child welfare service

% of clients n (%)	Don't know	None	< 25%	25% - 50%	50% - 75%	> 75%	Total
NGO	7 (7%)	6 (6%)	40 (38%)	32 (30%)	11 (10%)	10 (9%)	**106 (100%)**
Govt.	6 (5%)	3 (2%)	79 (61%)	30 (23%)	7 (6%)	4 (3%)	**129 (100%)**
Total	**13 (5%)**	**9 (4%)**	**119 (51%)**	**62 (26%)**	**18 (8%)**	**14 (6%)**	**235 (100%)**

Table 14. Level of agreement regarding the organisation's allowance of adequate time to undertake child and parent-sensitive practice

Level of agreement n (%)	N/A	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Total
NGO	3 (3%)	5 (5%)	15 (14%)	17 (16%)	45 (42%)	21 (20%)	**106 (100%)**
Govt	1 (1%)	6 (5%)	35 (27%)	33 (25%)	42 (33%)	12 (9%)	**129 (100%)**
Total	**4 (2%)**	**11 (5%)**	**50 (21%)**	**50 (21%)**	**87 (37%)**	**33 (14%)**	**235 (100%)**

Approximately twice as many respondents from NGOs compared to those from government organisations indicated that their treatment intake or client assessment procedures did not identify whether the client had a parenting/caregiver role (16% vs 7%). However, this proportion was still a substantial minority (Table 15).

Table 15. Treatment intake/client assessment procedures identification of clients' parenting/caregiver role

Response: n (%)	Yes	No	Don't know	Total
NGO	86 (81%)	17 (16%)	3 (3%)	**106 (100%)**
Govt	119 (92%)	9 (7%)	1 (1%)	**129 (100%)**
Total	**205 (87%)**	**26 (11%)**	**4 (2%)**	**235 (100%)**

As indicated in Table 15a below, a higher proportion of government-employed respondents compared to their NGO counterparts noted that their treatment intake/client assessment procedures did not allow for an assessment of the client's parenting needs (46% vs 24%).

While almost three quarters of respondents from NGOs affirmed that the treatment intake/client assessment procedures used were able to assess the need for child care while clients attended treatment, only 37% of respondents from government organisations indicated the same (Table 15b).

A greater proportion of government-employed respondents indicated that their treatment intake/client assessment procedures were not able to assess client concerns about their children. In comparison, 96% of respondents from NGOs stated that their treatment intake/client assessment procedures allowed for such an assessment (Table 15c).

Table 15a. Treatment intake/client assessment procedures to assess clients' parenting needs

Response: n (%)	Yes	No	Don't know	Total
NGO	41 (71%)	14 (24%)	3 (5%)	**58 (100%)**
Govt	36 (51%)	32 (46%)	2 (3%)	**70 (100%)**
Total	**77 (60%)**	**46 (36%)**	**5 (4%)**	**128 (100%)**

Table 15b. Treatment intake/client assessment procedures ability to assess the need for child care while clients attend treatment

Response: n (%)	Yes	No	Don't know	Total
NGO	43 (74%)	13 (23%)	2 (3%)	**58 (100%)**
Govt	26 (37%)	40 (57%)	4 (6%)	**70 (100%)**
Total	**69 (54%)**	**53 (41%)**	**6 (5%)**	**128 (100%)**

Table 15c. Treatment intake/client assessment procedures to assess clients' concerns about their children

Response: n (%)	Yes	No	Don't know	Total
NGO	56 (96%)	1 (2%)	1 (2%)	**58 (100%)**
Govt	52 (74%)	15 (22%)	3 (4%)	**70 (100%)**
Total	**108 (84%)**	**16 (13%)**	**4 (3%)**	**128 (100%)**

As Table 16 shows, more NGO-employed respondents than government-employed respondents affirmed that they often saw and spoke to the clients' children when working with clients who have parental/caregiver roles (33% vs 13%).

Table 16. Regularity of seeing and speaking to clients' children

Response: n (%)	Yes	No	Sometimes	Don't know	Total
NGO	36 (33%)	40 (37%)	31 (29%)	1 (1%)	**108 (100%)**
Govt	16 (13%)	55 (43%)	57 (44%)	0 (0%)	**128 (100%)**
Total	**52 (22%)**	**95 (40%)**	**88 (37%)**	**1 (1%)**	**236 (100%)**

Substantially more respondents from government organisations compared to NGO respondents disagreed/strongly disagreed that they received regular clinical supervision from someone experienced in child and parent-sensitive practice (62% vs 36%) (Table 17).

Table 17. Level of agreement regarding regular clinical supervision from someone experienced in child & parent-sensitive practice

Level of agreement n (%)	N/A	Strongly disagree	Disagree	Undecided	Agree	Strongly agree	Total
NGO	11 (10%)	14 (13%)	25 (23%)	13 (12%)	36 (34%)	9 (8%)	**108 (100%)**
Govt	6 (5%)	28 (22%)	52 (40%)	19 (15%)	22 (17%)	1 (1%)	**128 (100%)**
Total	**17 (7%)**	**42 (18%)**	**77 (32%)**	**32 (14%)**	**58 (25%)**	**10 (4%)**	**236 (100%)**

Almost 60% of government-employed respondents compared to 31% of NGO-employed respondents were not aware of available funding to assist in meeting the needs of clients' children (Table 18).

Table 18. Extent of awareness regarding available funding to assist meeting the needs of clients' children

Degree of awareness n (%)	Very aware	Somewhat aware	Vaguely aware	Not aware	Total
NGO	16 (15%)	25 (23%)	33 (31%)	34 (31%)	**108 (100%)**
Govt	6 (5%)	18 (14%)	29 (22%)	76 (59%)	**129 (100%)**
Total	**22 (9%)**	**43 (18%)**	**62 (26%)**	**110 (47%)**	**237 (100%)**

Proportionally more respondents from NGOs compared to their counterparts from government organisations noted that they had not raised the wellbeing or welfare of a client's child (13% vs 4%). However, the vast majority of respondents from both organisations affirmed that they had raised the issue of their child's wellbeing/welfare with a client (Table 19).

Table 19. Whether respondents had raised the wellbeing or welfare of a client's child

Response: n (%)	Yes	No	Don't know	Total
NGO	89 (84%)	14 (13%)	3 (3%)	**106 (100%)**
Govt	120 (95%)	5 (4%)	1 (1%)	**126 (100%)**
Total	**209 (90%)**	**19 (8%)**	**4 (2%)**	**232 (100%)**

A quarter of NGO-employed respondents, compared to 12% of government-employed respondents, stated that they had not engaged statutory child protection services to assist a client with parental/caregiver roles (Table 20).

Table 20. Whether respondents had engaged statutory child protection services to assist a client with parental/caregiver roles

Response: n (%)	Yes	No	Not relevant	Total
NGO	75 (70%)	27 (25%)	5 (5%)	**107 (100%)**
Govt	112 (88%)	15 (12%)	0 (0%)	**127 (100%)**
Total	**187 (80%)**	**42 (18%)**	**5 (2%)**	**234 (100%)**

As Table 21 shows, a greater proportion of respondents from government organisations compared to NGOs were not very confident in addressing employment and training issues with their clients (18% vs 5%).

Table 21. Level of confidence in addressing employment and training with clients

Level of confidence n (%)	Not at all confident	Not very confident	Somewhat confident	Fairly confident	Very confident	Total
NGO	4 (4%)	5 (5%)	32 (31%)	44 (42%)	19 (18%)	**104 (100%)**
Govt	6 (5%)	23 (18%)	40 (31)	44 (34%)	16 (12%)	**129 (100%)**
Total	**10 (4%)**	**28 (12%)**	**72 (31%)**	**88 (38%)**	**35 (15%)**	**233 (100%)**

More government-employed respondents compared to those from NGOs indicated that a lack of access to resources and strategies to assist clients with their parenting/caregiver needs was a substantial or very significant barrier to child and parent-sensitive practice in their organisation (62% versus 43%) (Table 22).

Table 22. Lack of access to resources and strategies to assist clients with parenting/caregiver needs as a barrier to child and parent-sensitive practice

n (%)	Not at all a barrier	A slight barrier	A substantial barrier	A very significant barrier	N/A	Total
NGO	22 (22%)	33 (32%)	24 (23%)	20 (20%)	3 (3%)	**102 (100%)**
Govt	13 (10%)	33 (26%)	45 (35%)	35 (27%)	2 (2%)	**128 (100%)**
Total	**35 (15%)**	**66 (29%)**	**69 (30%)**	**55 (24%)**	**5 (2%)**	**230 (100%)**

The results of the comparison of the Victorian sample to other states and territories is included at the end of this report as Appendix 2.

Additional comments from respondents

Respondents were invited to provide any additional comments at the end of the survey regarding child and parent-sensitive practice in relation to the AOD field. The following are a few comments provided by some respondents:

"Cultures need to be created in AOD agencies so that this is seen as a significant part of the work and important to the wellbeing of clients. In order for this to occur, however, funding also needs to be linked to this as it would involve more complex work which would require more resources such as clinical supervision and training."

"DHS need to have a better understanding of what family services mean in the AOD sector. It is so broad and needs a coordinated implementation of programs. To do this those who have worked with families in the AOD field for a long time need to be liaised with as they know what is needed, both from a service and client perspective. I've been asking DHS for clear guidelines on client files for 10 years and still haven't had any response!!! There are a number of these issues that need addressing."

"I have had the privilege of working within an organisation which supports child and parent-sensitive practice. The interest in supporting children living with parental substance use is growing because drug treatment is slowly shifting in other organisations to ask the hard questions. I feel the obstacle is workers feeling responsible to do something when children are involved if the only option is involving Child Protective Services. There are few AOD services that employ Child Development workers to support AOD workers to support them to develop treatment plans addressing the needs of children. It is difficult to practice in a holistic family-sensitive way if AOD clinicians only conduct treatment in an office based capacity- children respond better when they see their parents trust workers in their homes, they are more likely to disclose how they feel if their parent makes it understood that they can speak out. Children equally fear being removed from their parents."

"I think we often fail to recognise the impact that children and parenting have on our alcohol and drug using clients. It is important to recognise that these experiences may be both positive and negative but all are valid for these clients."

"In this setting there are conflicting views about responsibilities regarding these areas. The detox from AOD is the primary focus which so it often feels like the child-focused practice is missed. It sometimes feels like this practice is not supported/encouraged as there is a fear that it will stop clients from using the service."

Discussion

The national survey reported here is the first of its kind undertaken to examine views of Australian AOD workers in relation to child and parent-sensitive practice issues. It was conducted by the National Centre for Education and Training on Addiction (NCETA) in collaboration with the Australian Centre for Child Protection.

This survey population indicated that a large proportion of their AOD clients are parents with dependent children, with approximately 60% of workers indicating that about a third of their clients are parents. The majority of respondents also thought that up to 50% of their parenting clients had children in receipt of child welfare services. While this survey sample is relatively small, they appear demographically similar to the wider AOD field in many respects. Hence the findings reported here are cautiously assumed to be applicable to the AOD field in general, but further research is required to confirm this. These findings are therefore interpreted to be indicative rather than conclusive at this point in time.

Most respondents acknowledged that from a clinical/counselling perspective it was important to address the needs of clients' children and that this would also be a significant contributor to positive treatment outcomes for the client. One in four AOD workers indicated that they perceived child and parent-sensitive practice to be central to their core work role, while about two thirds indicted that it was significant but not central to their work role.

Child-sensitive policies

It was encouraging to find that most respondents (79%) noted that their organisation endorsed child and parent-sensitive practice and about two thirds also indicated that their organisation provided guidelines for working with other agencies to assist with the needs of clients who are identified as having parental/caregiver roles. But in terms of provision of guidelines for actually working with clients who are parents/caregivers, only about half the respondents indicated that their organisation had such guidelines in place and about the same proportion indicated that their organisation allowed adequate time to undertake child and parent-sensitive practice. These findings indicate the scope for improvement in the provision of essential policies to ensure that child-sensitive practice is able to be conducted in AOD workplaces.

In contrast to the generally supportive endorsement of child-sensitive practice, less than half of the respondents indicated that their organisation provided a child-friendly environment. So while there

appears to be a general acknowledgement of the importance of this issue, when it comes to actual implementation there was considerable deficit. Again, scope exists here to review existing workplace arrangements. Such a review might include undertaking an audit of the physical layout and set-up of an agency, through to reviewing and revising policies and procedures at reception and check-in. Enhancing the 'child-friendly' nature of AOD agencies and services is highlighted here as an imperative. This is a goal that can readily achieved in nearly all AOD organisations with minimum resources required to achieved significant improvement in this regard.

While not all strategies to improve the child-friendly nature of an AOD organisation require substantial resources, some strategies will. In view of this, increasing sources of funds have been made available for this purpose. However, nearly half the respondents were unaware of funding available to assist them to meet the needs of clients with children. This finding suggests that better promotion is required within the AOD field, particularly in the government sector, in regard to brokerage funds such as 'Counting the Kids' – information about this fund can be found here: (http://www.odyssey.org.au/brokerage/content/index.asp).

Assessment procedures

While the majority of services appeared to incorporate a determination of whether the client had a parenting or caregiver role within their intake/assessment procedures, a substantial minority of around 40% of respondents indicated that there was no provision in their service's treatment and intake procedures to allow for an assessment of parenting or child wellbeing and welfare issues. Moreover, only half of the respondents indicated that they thought the assessment processes were adequate in this regard. This was particularly the case for government-employed respondents, especially with respect to assessment of child care and clients' concerns about their children. These results suggest that improvements in treatment intake/client assessment procedures, particularly in the government sector, are needed. Such improvements could be achieved with relatively little effort and moderate resourcing.

Importantly, of all the issues covered as part of these assessments the area that was reported to receive least attention was an assessment of the need for child care while the client attended treatment. Given that previous research has established the pivotal importance of the provision of child care for clients with children in ensuring that they receive and remain in treatment, it is notably remiss that AOD services do not include this as a standard component of best practice and quality care.

Other areas where AOD workers indicated appropriately child-sensitive practices included monitoring changes in the wellbeing and welfare of clients' children when assessing the client's treatment outcomes; which was reported to be undertaken by more than two thirds of respondents. Around two thirds of respondents also indicated that they included changes in their clients' parenting competence when assessing treatment outcomes. However, as about a third of respondents reported that they did not include such changes there is clear scope for improved practice in these areas.

Professional development and clinical supervision

Approximately a third of respondents indicated that there was no appropriate training in this area provided through their organisation. Just over half the respondents indicated that they had received a little or a moderate amount of training and among those that had received such training, most considered it to be effective in enhancing their skills and knowledge in child and parent-sensitive practice. A key finding of this study is therefore that to achieve improvements, AOD organisations need to place greater emphasis on worker training and support in this area.

More than half the respondents (and especially the government-employed respondents) did not receive regular clinical supervision from someone experienced in child and parent-sensitive practice. Given the high proportion of AOD clients who have parental roles, lack of provision of this type of clinical supervision by appropriately skilled and experienced supervisors is identified as a significant deficit in the AOD treatment system and one which warrants immediate attention and remediation.

In light of the challenges identified in relation to AOD clients with children, the need for clinical supervision is seen as paramount. This is required to both ensure the ongoing professional development of workers and to offer appropriate skill development and support for complex and multiple needs clients.

Experiences of AOD workers in dealing with child welfare services

A large proportion of respondents noted that they had mixed experiences when engaging with other services to assist with their clients' children's needs and welfare and only a minority (less than a third) reported positive experiences in these interactions. In addition, a substantial proportion of respondents (nearly half) thought that asking the client about their parenting role and children would likely lead to the involvement of a statutory child protection authority. This is not surprising

given that the majority of workers indicated that at least some of their clients had children who were being seen by a child welfare service.

Most of the negative experiences reported by AOD workers in regard to dealing with child protection/welfare services stemmed from the stigma and cynicism that surrounds AOD users. Hence, there is a clear need to develop strategies designed to de-stigmatise AOD users and to better inform other workers so that improved cooperation and communication can be fostered between AOD services and child welfare services. Such cooperation and communication would be of value not only to AOD clients and their children but also to AOD and child/family welfare workers.

Differences between government and non-government AOD agencies

A key finding from this study was that non-government workers appeared to be better equipped to address child and parent-sensitive issues in a treatment setting. To some extent, this may reflect the different backgrounds, experience and professions of the government vs NGO workers. NGO workers, compared to government workers, were more likely to come from backgrounds that involved child welfare work, as the government workers were predominantly from tertiary trained professional groups. However, it may also indicate a different orientation between the government and NGO service sectors in relation to child-friendly practice issues. If this is the case, there is considerable scope for government services to review and improve their approach and orientation toward child-friendly practices. Government-based workers and organisations may require targeted assistance, support and resources to develop child and parent-sensitive practice.

Barriers

Respondents noted a number of significant barriers to be overcome to achieve the implementation of child and parent-sensitive practice within an AOD organisation. It was further noted that these barriers need to be addressed in order to achieve improved standards of practice.

Merely endorsing child and parent-sensitive practice in isolation from practice change strategies is insufficient. Without putting in place actual measures that will enable practices to change it is unlikely to ensure that treatment approaches and paradigms will shift from their traditional orientation. Practical measures that could be implemented by organisations include: improved access to child-friendly resources and strategies; developing strategies to assist workers to manage competing priorities between adult clients' needs and the needs of their children; better knowledge

sharing and the establishment of pathways and linkages between AOD agencies and child/family welfare services.

This survey sample was smaller than anticipated (N=271) and smaller than similar workforce surveys undertaken by NCETA. The sample appears typical of the AOD workforce in many respects and comparable in relation to gender, age, geographical location and type of organisation within which they were employed (Duraisingam, Pidd, Roche, & O'Connor, 2006). This sample differed in relation to length of service, with an average length of service of 10 years compared to 5-6 years in previous surveys.

Based on NCETA's work in AOD workforce development, overall, while this sample appears typical and reasonably representative of the Australian AOD workforce (Roche & Pidd, 2010) it is noted that a social desirability response bias may have contributed to the relatively strong endorsement of child and parent-sensitive practice. Further research is therefore required to gain a more precise understanding of the views of workers and the practices that typify responses to this issue in the AOD field.

Key findings and recommendations

This study has highlighted that while AOD workers are generally disposed towards child and parent-sensitive practice, more steps need to taken to improve organisational policies and practice in relation to child and parent-sensitive practice.

Key findings and recommendations to emerge from this study include the following:

1. develop an organisational checklist in regard to child-friendly practices to ensure that each organisation has child-friendly policies and procedures in place;
2. expand the provision of education and training aimed at building the capacity of the AOD workforce to undertake child and parent-sensitive practice;
3. ensure that appropriate clinical supervision is available for all staff and services where clients have children;
4. undertake an audit of one's organisation to assess the level of child-friendly practice in place;
5. include questions regarding clients' parenting roles and responsibilities as part of a routine assessment; and
6. regularly review procedures related to working with child welfare services (eg DOCS).

The findings of this study have the potential to inform improvements to the work practices of the alcohol and drug treatment workforce, the safety and welfare of the children of alcohol and drug treatment agency clients, the parental practices of AOD treatment agency clients who have parental or child care roles and treatment outcomes for AOD treatment agency clients who have children. The wider adoption of child and parent-sensitive work practice models is not only likely to positively impact the safety and welfare of clients' children, but may also improve clients' parenting practices as well as their treatment outcomes.

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Appendices

Appendix 1

Comparison of Victorian respondents to other States and Territories

	Frequency	Percent	Valid Percent
Other	177	65.3	**71.7**
VIC	70	25.8	**28.3**
Total	247	91.1	**100.0**
Missing	**24**	**8.9**	

Q4. Child and parent-sensitive practice is part of work role

			Other	VIC	Total
Child and parent-sensitive practice is part of work role	Not part of my role	Count	5	4	**9**
		%	2.8%	5.7%	**3.7%**
	Marginal to my role	Count	23	11	**34**
		%	13.1%	15.7%	**13.8%**
	Significant but not central to my role	Count	101	40	**141**
		%	57.4%	57.1%	**57.3%**
	Central to my core role	Count	47	15	**62**
		%	26.7%	21.4%	**25.2%**
Total		Count	176	70	**246**
		%	**100.0%**	**100.0%**	**100.0%**

		N	Mean	Std. Deviation	Std. Error Mean
Child and parent-sensitive practice is part of work role	VIC	70	2.94	.778	**.093**
	Other	**176**	**3.08**	**.713**	**.054**

t = -1.32; *p* = .187 (not significant)

Question 7

		N	Mean	Std. Deviation	Std. Error Mean
Endorses child & parent practice	VIC	69	4.09	1.108	**.133**
	Other	177	4.24	.977	**.073**
Has child & parent-sensitive practice guidelines in place for working with clients who are identified as having parental/caregiver roles	VIC	69	3.29	1.189	**.143**
	Other	173	3.56	1.240	**.094**
Provides a child-friendly environment	VIC	69	3.46	1.357	**.163**
	Other	177	3.24	1.489	**.112**
Provides training to undertake child & parent-sensitive practice	VIC	67	3.19	1.222	**.149**
	Other	176	3.21	1.321	**.100**
Allow adequate time to undertake child & parent-sensitive practice	VIC	69	3.59	1.089	**.131**
	Other	176	3.36	1.206	**.091**
Provides guidelines for working with other agencies that can assist with the needs of clients who have parental/caregiver roles	VIC	67	3.25	1.092	**.133**
	Other	**176**	**3.59**	**1.153**	**.087**

Note: None significantly different

Q7a. Endorses child & parent practice

			Other	VIC	Total
Endorses child & parent practice	SD	Count	4	4	**8**
		%	2.3%	5.8%	**3.3%**
	D	Count	7	2	**9**
		%	4.0%	2.9%	**3.7%**
	NAND	Count	21	9	**30**
		%	11.9%	13.0%	**12.2%**
	A	Count	58	23	**81**
		%	32.8%	33.3%	**32.9%**
	SA	Count	85	31	**116**
		%	48.0%	44.9%	**47.2%**
	N/A	Count	2	0	**2**
		%	1.1%	.0%	**.8%**
Total		Count	177	69	**246**
		%	**100.0%**	**100.0%**	**100.0%**

Q7b Has child & parent-sensitive practice guidelines in place for working with clients who are identified as having parental/caregiver roles

			Other	VIC	Total
Has child & parent-sensitive practice guidelines in place for working with clients who are identified as having parental/caregiver roles	SD	Count	6	4	**10**
		%	3.5%	5.8%	**4.1%**
	D	Count	39	16	**55**
		%	22.5%	23.2%	**22.7%**
	NAND	Count	29	18	**47**
		%	16.8%	26.1%	**19.4%**
	A	Count	55	18	**73**
		%	31.8%	26.1%	**30.2%**
	SA	Count	39	13	**52**
		%	22.5%	18.8%	**21.5%**
	N/A	Count	5	0	**5**
		%	2.9%	.0%	**2.1%**
Total		Count	173	69	**242**
		%	**100.0%**	**100.0%**	**100.0%**

Q7d Provides training to undertake child & parent-sensitive practice

			Other	VIC	Total
Provides training to undertake child & parent-sensitive practice	SD	Count	17	4	**21**
		%	9.7%	6.0%	**8.6%**
	D	Count	46	19	**65**
		%	26.1%	28.4%	**26.7%**
	NAND	Count	31	17	**48**
		%	17.6%	25.4%	**19.8%**
	A	Count	53	14	**67**
		%	30.1%	20.9%	**27.6%**
	SA	Count	23	13	**36**
		%	13.1%	19.4%	**14.8%**
	N/A	Count	6	0	**6**
		%	3.4%	.0%	**2.5%**
Total		Count	176	67	**243**
		%	**100.0%**	**100.0%**	**100.0%**

Q9. Treatment intake / client assessment procedures allow for an assessment of parenting issues or child wellbeing / welfare issues

		N	Mean	Std. Deviation	Std. Error Mean
Treatment intake / client assessment procedures allow for an assessment of parenting issues or child wellbeing / welfare issues	Vic	70	1.60	.668	**.080**
	Other	**177**	**1.47**	**.594**	**.045**

Note: Means not significantly different

Q12b Strengthening parent-child relationships form part of the treatment goal

			Other	Vic	Total
Strengthening parent-child relationships form part of the treatment goal	Yes	Count	77	26	**103**
		%	43.5%	37.7%	**41.9%**
	No	Count	35	6	**41**
		%	19.8%	8.7%	**16.7%**
	Sometimes	Count	62	35	**97**
		%	35.0%	50.7%	**39.4%**
	Don't know	Count	3	2	**5**
		%	1.7%	2.9%	**2.0%**
Total		Count	177	69	**246**
		%	**100.0%**	**100.0%**	**100.0%**

Appendix 2

Child parent-sensitive practice survey

Child and Parent Sensitive Practice

Introduction to the survey...

Dear Colleague

The National Centre for Education and Training on Addiction (NCETA), in conjunction with the Australian Centre for Child Protection, is conducting a survey concerning child and parent sensitive work practice in the alcohol and other drug (AOD) field.

Child and parent sensitive work practice involves identifying and addressing the needs of adult clients as parents, and the needs of their children as a part of the treatment/counselling process. The aim of child and parent sensitive work practice is to improve client outcomes and ensure the safety and well-being of their children.

We think it is important to hear your views and experiences of child and parent sensitive work practice in the AOD treatment setting. To achieve this, we have developed an online questionnaire for you to share your thoughts and work practices concerning this issue.

It should take approximately 15 minutes to complete the survey. Participation is completely voluntary, and you are free to not answer particular questions. Be assured that your responses are anonymous and confidential, and you are not required to provide your name or the name of your organisation. However, you should note that online material is not a secure medium.

If you have any questions or would like more information on the project then please contact me on 08 8201 7535 or e-mail at ann.roche@flinders.edu.au.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. The Secretary of this Committee can be contacted on 08 8201 5962, fax 08 8201 2035, or e-mail andrea.jacobs@flinders.edu.au.

Thank you in advance for your time and consideration.

Yours sincerely

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

Child and Parent Sensitive Practice

Definitions

The focus of this survey is on child and parent sensitive practice. Child and parent sensitive practice is distinct from family therapy, as outlined below:

Family therapy – involvement of family in the treatment of a client's (usually adolescent) drug use problems. The aim is to improve client outcomes by identifying and improving patterns of family interaction that are associated with the client's behaviour problems.

Child and parent sensitive practice – identifying and addressing the needs of adult clients as parents, and the needs of their children, as a part of the treatment/counselling process. The aim is to improve client outcomes and ensure the safety and well-being of their children.

Child and Parent Sensitive Practice

Background Statistics

1. How many clients do you usually support / work with in a week?

- ◯ None
- ◯ Less than 5
- ◯ 5-10
- ◯ 11-20
- ◯ 21-40
- ◯ 41-60
- ◯ 61-80
- ◯ More than 80

2. Do you generally know whether your clients are parents?

◯ Yes ◯ No ◯ Sometimes

Background Information

3. Please estimate the percentage of your clients who have parenting / carer responsibilities:

- ◯ None
- ◯ Less than 25%
- ◯ Between 25% and 50%
- ◯ Between 50% and 75%
- ◯ More than 75%
- ◯ Don’t know

Child and Parent Sensitive Practice

Background Information

4. Child and parent sensitive practice is identifying and addressing the needs of adult clients as parents, and the needs of their children, as a part of the treatment / counselling process. The aim is to improve client outcomes and ensure the safety and well-being of their children.

Please indicate if child and parent sensitive practice, as defined above, is...
(Please tick one)

- ◯ Not part of my role
- ◯ Marginal to my role
- ◯ Significant but not central to my role
- ◯ Central to my core role

5. To your knowledge do any of your current clients have children who are clients of a child welfare service (e.g. statutory child protection service, child & family support service, etc)?

◯ Yes ◯ No ◯ Don't know

Background Statistics

6. Approximately what percentage of your clients have children who are clients of a child welfare service?

- ◯ None
- ◯ Less than 25%
- ◯ Between 25% and 50%
- ◯ Between 50% and 75%
- ◯ More than 75%
- ◯ Don’t know

Work Organisation

7. Please indicate your level of agreement with each of the following statements.

The organisation I work for:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Not applicable
Endorses child and parent sensitive practice.	◯	◯	◯	◯	◯	◯
Has child and parent sensitive practice guidelines in place for working with clients who are identified as having parental/care giver roles.	◯	◯	◯	◯	◯	◯
Provides a child friendly environment (e.g., a safe and dedicated space for children, toys, etc).	◯	◯	◯	◯	◯	◯
Provides training to undertake child and parent sensitive practice.	◯	◯	◯	◯	◯	◯
Allows adequate time to undertake child and parent sensitive practice.	◯	◯	◯	◯	◯	◯
Provides guidelines for working with other agencies (e.g., child/family welfare, domestic violence, relationships, Centrelink, etc.) that can assist with the needs of clients who have parental/care giver roles.	◯	◯	◯	◯	◯	◯

Current Work Practices

8. Do the treatment intake / client assessment procedures you use identify whether the client has a parenting / care giver role?

◯ Yes ◯ No ◯ Don't know

9. If the client has a parental / care giver role, do the treatment intake / client assessment procedures you use allow for an assessment of parenting issues or child well-being / welfare issues?

◯ Yes ◯ No ◯ Don't know

Current Work Practices

10. To what extent do you think your treatment intake / client assessment procedures adequately assess parenting issues or child well-being / welfare issues?

◯ Not at all ◯ Somewhat ◯ Undecided ◯ Adequately ◯ Very adequately

11. If the treatment intake / client assessment procedures you use allow for an assessment of parenting issues or child well-being / welfare issues, do they assess:

	Yes	No	Don't know
Child care responsibilities of the client?	◯	◯	◯
Client's parenting needs?	◯	◯	◯
Involvement of child protection / welfare services?	◯	◯	◯
The need for child care while clients attend treatment?	◯	◯	◯
The parenting role of the client as a potential stressor for the client?	◯	◯	◯
Pregnancy status of female clients?	◯	◯	◯
Clients' concerns about their children?	◯	◯	◯
The parenting role as a potential motivator in treatment?	◯	◯	◯

Other (please specify)

Child and Parent Sensitive Practice

Current Work Practices

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

	Yes	No	Sometimes	Don't know
Are interventions tailored to family needs?	◯	◯	◯	◯
Does strengthening parent-child relationships form part of the treatment goal?	◯	◯	◯	◯
Do you often see and speak to your clients' children?	◯	◯	◯	◯
Do you collaborate with children's services where needed?	◯	◯	◯	◯

Other (please specify)

13. To what extent do you agree with the following statement:

When I work with clients who have parenting / care giver roles I receive regular clinical supervision from someone experienced in child and parent sensitive practice.

◯ Not applicable ◯ Strongly disagree ◯ Disagree ◯ Undecided ◯ Agree ◯ Strongly agree

Current Work Practice

14. When you assess the treatment outcomes for clients with parental / care giver roles do you include:

	Yes	No	Don't know
Any changes in their parenting competence?	◯	◯	◯
Any changes in the well-being and welfare of their children?	◯	◯	◯

15. How aware are you of funding that is available to assist with meeting the needs of clients' child(ren) (e.g., Counting the Kids Brokerage Fund)?

◯ Very aware ◯ Somewhat aware ◯ Vaguely aware ◯ Not aware

16. Have you ever sought funding that is available to assist with meeting the needs of clients' child(ren)?

◯ Yes ◯ No ◯ Don't know

Current Work Practice

17. Please name the source(s) of the funding.

5

6

Individual Worker

18. Have you ever raised the well-being or welfare of a client's child(ren) with them?

- ◯ Yes
- ◯ No
- ◯ Don't Know

Individual Worker

19. When you have raised issues about child well-being / welfare issues with clients please tell us if these experiences were:

- ◯ Positive
- ◯ Negative
- ◯ Mixed

Please tell us why you chose this option

Individual Worker

20. Have you ever engaged any of the following services to assist a client with parental / care giver roles
(Select all that apply)?

	Yes	No	Not relevant
Child care	◯	◯	◯
Statutory child protection	◯	◯	◯
Supported accommodation or in-home family support	◯	◯	◯
Maternal and child health nurses	◯	◯	◯
Domestic violence services	◯	◯	◯
Children's disability services	◯	◯	◯

Other (please specify)

21. If you have ever engaged other services to assist a client with their parental / care giver roles please tell us if your experiences were:

◯ Positive ◯ Negative ◯ Mixed ◯ Not relevant

Please tell us why you chose this option

22. Please rate your level of confidence in addressing the following issues with your clients:

	Not at all confident	Not very confident	Somewhat confident	Fairly confident	Very confident
Parenting needs	◯	◯	◯	◯	◯
Child well-being/welfare concerns raised by clients	◯	◯	◯	◯	◯
Income and housing	◯	◯	◯	◯	◯
Employment and training	◯	◯	◯	◯	◯
Relationships	◯	◯	◯	◯	◯
Referral to other child & family support services (e.g., child care, domestic violence, relationships, housing, etc)	◯	◯	◯	◯	◯

23. How important do you believe it is to raise the needs of children when working with clients who have parental / care giver roles?

◯ Not important at all ◯ Slightly important ◯ Important ◯ Very important ◯ Undecided

24. Do you think that assisting a client manage their parent / care giver role will contribute to positive treatment outcomes?

◯ Strongly disagree ◯ Disagree ◯ Undecided ◯ Agree ◯ Strongly agree

Individual Worker

25. How likely do you think it is that asking a client about their parenting practices or about their children will lead to involvement with statutory child protection?

◯ Very likely ◯ Somewhat likely ◯ Somewhat unlikely ◯ Very unlikely

26. To what extent do you agree with the following statement?

I understand the legal duty of care requirements concerning child safety / welfare that may apply when working with clients who have parental / care giver roles.

◯ Strongly disagree ◯ Disagree ◯ Undecided ◯ Agree ◯ Strongly agree

27. How much training concerning child and parent sensitive practice have you received?

◯ Not sure

◯ None

◯ A little

◯ A moderate amount

◯ A fair bit

◯ A lot

Child and Parent Sensitive Practice

Individual Worker

28. If you have received child and parent sensitive practice training, how effective was it in enhancing your skills and knowledge in this area?

◯ Not effective at all ◯ Slightly effective ◯ Effective ◯ Very effective ◯ Don't know

Comments

Individual Worker

29. To what extent do each of the following issues present a barrier to child and parent sensitive practice in your organisation?

	Not at all a barrier	A slight barrier	A substantial barrier	A very significant barrier	Not applicable
Heavy workloads	◯	◯	◯	◯	◯
Lack of professional autonomy and discretion	◯	◯	◯	◯	◯
Lack of child and parent sensitive practice guidelines	◯	◯	◯	◯	◯
Lack of government policies mandating child and parent sensitive practice	◯	◯	◯	◯	◯
Lack of management support for child and parent sensitive practice	◯	◯	◯	◯	◯
Lack of clinical supervision relevant to child and parent sensitive practice	◯	◯	◯	◯	◯
Lack of linkages between AOD and child/family welfare agencies	◯	◯	◯	◯	◯
Limited mutual exchange of information between child/family welfare agencies and AOD agencies	◯	◯	◯	◯	◯
Lack of access to resources and strategies to assist clients with their parenting/care giver needs	◯	◯	◯	◯	◯
Lack of education/training on child wellbeing/welfare issues relevant to drug and alcohol using parents	◯	◯	◯	◯	◯
Limited ability to identify less visible/obvious forms of potential harm to children (e.g., neglect, emotional abuse, exposure to domestic violence)	◯	◯	◯	◯	◯
Competing priorities (treatment needs of the adult client vs needs of the child)	◯	◯	◯	◯	◯
Lack of treatment plans/goals that involve parental/care giver needs	◯	◯	◯	◯	◯

Other (please specify)

Child and Parent Sensitive Practice

Demographics

30. What is your age in years?

Age

31. What is your gender?

◯ Male ◯ Female

32. How long have you worked in the AOD field? (please select one)

	Years
Number of years	

Demographics

33. What is your occupation? (please tick one):

- ◯ AOD worker
- ◯ Nurse
- ◯ Psychologist
- ◯ Social worker
- ◯ Doctor
- ◯ Other (please specify)

34. What is your main work role? (if you have multiple work roles, select no more than three that best describe your main roles)

- ☐ Referral
- ☐ Screening/assessment
- ☐ Counselling/therapy
- ☐ Withdrawal management
- ☐ Service/program management
- ☐ Client care/support
- ☐ Case management
- ☐ Education/training/information delivery
- ☐ Medication prescribing/dispensing
- ☐ Management
- ☐ Administration
- ☐ Research/advocacy/policy development
- ☐ Other (please specify)

35. Who are your main client group?

- [ ] Community/General
- [ ] Men
- [ ] Women
- [ ] Youth
- [ ] Families
- [ ] Aboriginal and Torres Strait Islander (ATSI) peoples
- [ ] Culturally and Linguistically Diverse (CALD) peoples
- [ ] Offenders
- [ ] Other (please specify)

Demographics

36. What type of organisation do you work for? (please tick one)

- ◯ Government
- ◯ Non-Government
- ◯ Private
- ◯ Other (please specify)

37. What state or territory do you work in? (please tick one)

- ◯ Australian Capital Territory
- ◯ New South Wales
- ◯ Northern Territory
- ◯ Queensland
- ◯ South Australia
- ◯ Tasmania
- ◯ Victoria
- ◯ Western Australia

38. Where is your main work location? (please tick one)

- ◯ City/Metropolitan
- ◯ Regional
- ◯ Rural
- ◯ Remote

Child and Parent Sensitive Practice

What Type of Service

39. What type of service is your work organisation? (select all that apply)

- [ ] Health promotion
- [ ] Therapeutic community
- [ ] Outpatient
- [ ] Supported/assisted accommodation
- [ ] Residential
- [ ] Policy and/or advocacy
- [ ] Other (please specify)

40. What are the main services your organisation offers? (select all that apply)

- [ ] Outpatient withdrawal
- [ ] Day programs
- [ ] Inpatient/residential withdrawal
- [ ] After care programs
- [ ] Residential rehabilitation
- [ ] Health promotion
- [ ] Services to diversion clients
- [ ] Other (please specify)

41. Have you ever worked in a child / family welfare service?

- ◯ Yes
- ◯ No
- ◯ Don't know

Any Final Comments ...Thank you

42. Is there anything else you would like to tell us about child and parent sensitive practice in relation to the AOD field?

This is the end of the survey.

Thank you very much for your time.

If you have any queries about this survey please feel free to contact either:

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Or:

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