



## Responding to the needs of children and parents in families experiencing alcohol and other drug problems

**Dr Stefan Gruenert**, Chief Executive Officer, Odyssey House Victoria

**Dr Menka Tsantefski**, Lecturer, Department of Social Work, School of Health Sciences, The University of Melbourne and consultant to Odyssey House Victoria "Kids in Focus" program, Victoria

The range of harms that an individual may experience from their use of alcohol and other drugs (AOD) has been widely documented. More recently, greater attention has been paid to the way in which problematic AOD use can harm others, including children. As a consequence, there is a growing expectation that health and community services providing AOD treatment and support to individuals also consider and address broader family needs.

This issues paper provides a summary of current research as well as professional opinion relevant to working with families, especially when a parent presents for treatment or support. The paper aims to be a useful resource for both service providers and practitioners, providing tips and advice on family sensitive and family inclusive practice, with a specific focus on supporting children.

Interest in family policy and practice has been growing steadily over the past three decades. While a number of AOD programs have highlighted the benefits of its application, the number of services in Australia that have implemented family inclusive practice remains small. A coordinated approach with minimum standards and some additional resources is required to ensure that a consistent and adequate response occurs across the entire AOD system.

Family-focused interventions within the AOD sector can be categorised into four broad types:

1. Working with family members with the primary aim of motivating someone with problematic AOD use to seek or engage in treatment.
2. Working with the family *and* with the person experiencing AOD problems to gain greater understanding of their problems and to enhance treatment outcomes.
3. Working independently with family members to support their own needs.
4. Working with some family members *and* with the person experiencing AOD problems, with the aim of identifying and addressing all members' needs and facilitating change to the whole family system.<sup>1</sup>

Traditionally, much of the family work in the AOD sector has drawn on family therapy models of practice and

## Definitions

### Family members

*For the purpose of this article, family members may include biological, adopted or step-children, siblings, current or ex-partners, parents, grandparents, and other relatives, as well as close or significant others.*

### Parents

*While the term parent generally refers to biological, adoptive or step-mothers and step-fathers, it may also include any other people acting as carers for children.*

### Child

*A child refers to any person under 18 years of age. However, the focus of this paper is on younger children, recognising that the needs of many older children in their mid to late teens are typically addressed by youth services and that they may also be living independently.*

### Client/consumer/service user

*Traditionally, these terms have been used interchangeably to describe the individuals that a service is funded to work with (generally the person using AOD in problematic ways). However, it is becoming increasingly common to view whole families and communities as clients.*

### Child and family sensitive/inclusive practice

*These terms have been used interchangeably elsewhere. However, in this publication, family sensitive practice occurs when services and support are based on an understanding of family issues and are sensitive to family needs. Family inclusive practice builds on this approach and occurs when family members are also directly involved in the interventions and support that a service provides. Family inclusive practice also aims to work in partnership with families to identify and utilise their strengths.*

included the partners or parents of the person with an AOD problem. This type of work includes providing information about the effects of drugs and different treatment options, as well as providing individual and/or group based family sessions and family therapy. Peer support from other families who have experienced similar difficulties is sometimes included. While some of the more advanced interventions of this type have focused on both the needs of the person experiencing AOD problems and their family members, most have traditionally focused on either one or the other.

More recently, it has been acknowledged that many people seeking help for AOD problems are in fact parents themselves. Consequently, a second type of family work has emerged that aims to address the client's AOD issues, their parenting needs and the needs of their children. This paper is largely focused on this type of work, which draws on parenting, child and family models of support, in addition to child development and child protection considerations.

While the two areas of practice have developed independently and involve a number of different policies, knowledge, and skills, it is recognised that both have an important role to play when addressing intergenerational AOD problems, cultural issues and more complex family care arrangements that involve the broader family system and other community members.

There are several initiatives driving practice change in this area. In Australia, the public health model is the overarching policy direction.<sup>2</sup> The model suggests:

- universal preventative services for all families
- targeted early intervention programs for families with children at risk of maltreatment
- tertiary mandated interventions reserved for children at serious risk of harm, or when abuse and neglect have already occurred.

The recent report of the Protecting Victoria's Vulnerable Children Inquiry recommends supporting specialist adult services to develop family sensitive practices.<sup>3</sup> Alcohol and other drug services have been identified as a priority area because parental AOD use has been recognised as a significant risk factor for child abuse and neglect.<sup>3</sup> The AOD sector has also been identified as playing a critical role in the implementation of a national framework for protecting Australia's children by addressing children's needs when parents access services.<sup>2</sup> Lastly, a number of obligations for AOD services arise out of international conventions including the United Nations Convention on the Rights of the Child.<sup>4</sup> Key principles include:

- the right to live with and be raised by their parents unless their safety and wellbeing is compromised
- the right to express their opinion on matters that concern them
- the right to grow and reach their potential
- the right to be protected from physical or emotional harm.

The first part of this paper outlines the type of issues that children face when their parents have AOD problems. The second part seeks to explain why a new approach is required across all AOD services, while the last part offers practical suggestions on how parents with AOD problems and their children can be better supported.

### Parental substance use

Illicit drug use generally occurs in the critical child-bearing and child-rearing years (ages 15–40 years), while alcohol use may extend well into older age. Alcohol and other drug use itself is not necessarily problematic and it is important to examine the nature of use. Most concern is centred on AOD intoxication or dependency. The hidden nature of most illicit drug use, stigma, and an over reliance on parental self-report make it difficult to determine the extent or type of



use and therefore the actual number of children exposed to problematic use. The two service sectors that most frequently come into contact with problematic parental substance use and children are AOD treatment and child welfare. However, neither routinely or consistently collect data that would give an accurate picture of problematic parental substance use in Australia. Likewise, national surveys of AOD use have traditionally not included a full examination of parental status. Consequently, there can be significant variation in reported estimates of parental AOD use.<sup>5</sup>

Prevalence data must, therefore, be collated from a number of different sources. Drug use in pregnancy is consistently reported at around five per cent in Australia,<sup>6</sup> the United Kingdom (UK)<sup>7</sup> and the United States of America (US).<sup>8</sup> An estimated 2–3 per cent of children in the UK are thought to be living in households where one or both parents have serious AOD problems,<sup>9</sup> although more recent results suggest that these figures may underestimate the number of children living with a substance-misusing parent.<sup>10</sup> An estimated 13 per cent of Australian children under 12 years of age live in households with at least one adult that misuses alcohol, 2.3 per cent with at least one adult using cannabis daily, and 0.8 per cent with an adult who uses methamphetamine in the home at least monthly.<sup>11</sup> Although more Indigenous Australians abstain from alcohol consumption than the general population, those that do drink alcohol report higher levels of problematic use. Consequently, the overall number of Indigenous children exposed to problematic parental alcohol misuse is thought to be similar to that of other Australian children.<sup>12</sup> Data from the most recent Australian National Drug Strategy Household Survey suggest that parents are less likely to engage in risky alcohol consumption than non-parents.<sup>13</sup> Despite this, more than 700,000 Australian children are believed to be living in households in which

substantial quantities of alcohol are consumed by caregivers, with many in single-parent families.<sup>14</sup>

### Impact on children

Problematic parental substance use rarely occurs in isolation and is frequently associated with mental health problems, inappropriate or unstable housing, family violence, under-employment, social isolation and poverty.<sup>12</sup> As a result, it is very difficult to separate the impacts on children from other co-occurring factors.

Clearly, not all children whose parents misuse AOD experience significant problems.<sup>15</sup> Nonetheless, potential adverse outcomes for children such as poor educational achievement, behavioural problems, and the development of their own AOD and mental health problems are well-documented.<sup>12,16,17</sup> Most studies on parenting and substance use have focused on women and their children.<sup>18</sup> Few studies have compared the differences between maternal or paternal AOD use on children.<sup>19</sup> In addition, most research has been conducted in the US or the UK, although experts believe it to be relevant to the Australian context.

Concern for children has generally focused on the direct impact of maternal AOD use during pregnancy, or on the potential for parental AOD use to indirectly affect children through compromised parenting and the quality of the caregiving environment.

### Direct impact on children

Many medically oriented empirical studies have examined the potential negative chemical effects of AOD on the developing foetus, although genetic factors,<sup>20</sup> maternal stress, nutrition, lifestyle and exposure to blood borne viruses during pregnancy confound study findings.<sup>21</sup> Overall, the evidence suggest that infants exposed to AOD *in utero* are more likely to be born prematurely,<sup>22</sup> to be of lower birth weight and small for gestational age, with smaller head circumference.<sup>23,24</sup>

Increased rates of attention-deficit hyperactivity disorder (ADHD) have been reported among older children.<sup>25</sup>

There is limited research comparing differences between drug types on infant outcomes, with many inconsistencies reported.<sup>26</sup> Infant withdrawal or neonatal abstinence syndrome (NAS) may occur from a range of substances including opiates, stimulants, and prescription medication. Short-term effects of cannabis use appear similar to tobacco use, as they are often used together, and include pregnancy complications, respiratory problems and low birth weight. Exposure to alcohol *in utero* has been the subject of much research attention. Foetal alcohol spectrum disorders (FASD) is an umbrella term covering a range of disorders and birth defects with potential for life-long negative consequences for children.<sup>27</sup> While the effects are well-documented, knowledge about the amount of alcohol that may cause FASD, its assessment and its management, remains limited.<sup>28</sup> In the absence of evidence, health messages for pregnant women have taken a conservative approach suggesting that “no alcohol use” is the safest choice. However, it is important that women who have consumed small amounts of alcohol on only few occasions during pregnancy are not made to feel more anxious than necessary.

With the exception of alcohol, and to a smaller extent tobacco, there is inconclusive evidence about the direct long-term impacts of other drug use during pregnancy. This is largely due to the confounding effects of maternal polydrug use and nutrition, domestic violence, quality of pregnancy care, a range of possible toxic additives in illicit street drugs, and almost universal tobacco smoking amongst substance using women.<sup>29</sup> As a result, evidence points to parenting and the quality of the caregiving environment as the critical variables in children’s long-term outcomes.<sup>30</sup>



## Compromised parenting and the caregiving environment

Parental AOD misuse can affect the parent–child relationship and compromise a parent’s ability to meet their child’s safety, developmental and wellbeing needs. Parenting capacity is impacted by problematic substance use in a number of ways. Parenting may be affected by intoxication itself or from withdrawal and the lifestyle associated with an AOD dependency. Problematic or dependent substance use can limit attention and emotional availability, supervision, bonding and attachment behaviours, in addition to limiting the provision of basic needs like food, clothing, shelter, hygiene and safety. Furthermore, it is likely to exacerbate irritability and mood swings and lead to a lack of routine, stability, appropriate boundary setting and enforcement, and increase exposure to unsafe environments and people.<sup>17</sup> Parents affected by problematic substance use have themselves reported yelling more often, being inattentive, being more self-focused, using reactive or

authoritarian parenting, creating an atmosphere of secrecy and allowing children to take on a parenting type role.<sup>31,32</sup>

In addition to increasing the number of risk factors a child is exposed to, problematic parental substance use is likely to reduce the number of protective factors such as educational achievement, strong social connections and community engagement. As a result, children in families affected by problematic substance use are at increased risk of their own problematic substance use<sup>19,20,33</sup> as well as a range of additional problems such as poor social and emotional development,<sup>34</sup> low self-esteem, guilt feelings, loneliness, poorer cognitive development, and emotional and behavioural problems.<sup>20</sup> Outcomes for children are reported to be worse with illicit drug misuse than with alcohol misuse,<sup>35</sup> with more severe parental AOD problems,<sup>20</sup> when both parents have AOD problems,<sup>36</sup> and with co-occurring parental mental health and personality disorders.<sup>11,35</sup> It should also be noted that the cumulative effects of

a compromised caregiving environment may not be obvious in younger children, with symptoms or problems only emerging in adolescence.<sup>20</sup>

Problematic substance use, mental health, and domestic violence feature in notifications of child abuse and neglect in Australia,<sup>37</sup> the US<sup>38</sup> and the UK.<sup>39</sup> Problematic alcohol use is implicated in all forms of child maltreatment<sup>40</sup> and is a significant factor in notification to child protection services across Australian jurisdictions.<sup>41</sup> Between 40 and 80 per cent of families involved with child welfare services across Australia<sup>42</sup> and the US<sup>43</sup> are reported as experiencing problematic substance use. The children of substance using or substance dependent parents enter the out-of-home care system earlier and remain longer.<sup>44,45</sup> Retrospective data from the US suggest that 80 per cent of children in out-of-home care were placed there due to problematic parental substance use.<sup>46</sup> Furthermore, infants are more likely to be in out-of-home care than older children.<sup>47</sup>

## CASE STUDY 1

### UnitingCare Moreland Hall—Supported playgroups

[www.morelandhall.org](http://www.morelandhall.org)

In recognition that parenting issues were rarely addressed when parents accessed AOD treatment, and that many parents were not accessing universal child and family services, Moreland Hall introduced playgroups for children aged 0–6 years. Originally, funding for playgroups was specifically for parents with AOD problems, but the program is now open to all parents with complex needs (e.g. mental health and homelessness). Discussion is focused on the joys and challenges in raising children, rather than family problems. Families requiring additional support are referred to services and programs within, and/or external to, Moreland Hall.

Playgroups provide age and developmentally appropriate activities for children through play, painting, singing and story-telling. There is a “home-corner” and an outdoor play area in a safe environment. Other groups visit and provide additional input. For example, Sing and

Grow deliver a 10-week music program based on attachment theory. Adults and children share a meal at the end of each group. All food is provided free. Groups run for 2–2.5 hours. Parents and staff organise group excursions once or twice per year.

Playgroups are facilitated by staff members with experience in AOD or child development. A Maternal and Child Health Nurse (MCHN) also joins the group and helps families to access child care and kindergarten. Parents are also able to have individual consultations with the MCHN in a private room.

The playgroups are able to facilitate, but not supervise, access between parents and children not in their care. A key aim of the program is to develop parents’ confidence in accessing “mainstream services”. Some parents have undertaken training with Playgroups Victoria and are able to facilitate groups themselves.

There is minimal literature on the impact of problematic substance use on children from the perspective of parents, and even less reporting children's own experiences and viewpoints.<sup>32,48</sup> The few studies that are available suggest that parents do in fact engage in a range of strategies to protect children and ensure that their basic needs are met.<sup>19,49</sup> Parents report attempting to create a normalising environment for their children and keeping substance use hidden.<sup>50</sup> Some parents acknowledge harm to their children and their tendency to minimise or deny this at times.<sup>50</sup> Parents also report ambivalence or are critical of their parenting practices, acknowledging their need for formal and informal support from service providers and family members,<sup>51</sup> especially grandparents.<sup>31</sup> Although parents often attempt to conceal substance use,<sup>48</sup> recent research confirms that children are usually aware of, and concerned by, parental substance use. The research also confirms that they value family interventions that are helpful.<sup>30,32</sup>

### Family contact with services

Children are a powerful factor in parental motivation to change patterns of AOD use.<sup>31</sup> Despite this, parents face a dilemma when their substance use becomes problematic. Most have a genuine desire for some help with their parenting. Similarly, most are motivated to stop or reduce their substance use so they can provide the best upbringing possible for their children. However, services with expertise in AOD treatment, parenting and child management issues are limited. Family services often fail to understand AOD issues and lack skills in assessing them,<sup>52</sup> while staff members in AOD treatment services rarely have the knowledge, confidence or skills to provide much in the way of parenting or family support. Furthermore, many AOD workers are reluctant to ask clients about their children because they think they will need to make reactive child protection notifications that will jeopardise their working relationship.<sup>53</sup>

Seeking help can therefore raise parental anxiety of being judged and lead to fear about child protection involvement, with the potential for child removal. Interestingly, a US study found that seeking treatment did not increase the risk of children being removed from parental care<sup>54</sup> and that seeking treatment can actually demonstrate parental willingness to address AOD problems.<sup>44</sup>

Many parents experiencing problematic substance use are mandated to receive services and much of the research literature is based on "convenience samples" of parents in treatment or involved with child protection services. In one study examining parental help seeking, most parents receiving detoxification were not prepared to contact child and adolescent mental health or paediatric services if concerned about their child's substance use. While general practitioners were the preferred service provider and some parents were prepared to contact school personnel, almost half reported reluctance to contact an AOD treatment provider.<sup>19</sup> In another study, parents in AOD treatment reported that services which were focused on their children's wellbeing were more helpful than those which focused on changing their parenting behaviour.<sup>32</sup> As a result, while seeking professional treatment or support should bring substantial benefits to a family and lead to improved outcomes for parents and their children, those benefits often limited by parents' reluctance to seek help and then by the skills, knowledge and confidence of those trying to offer support.

Internationally, there are substantial disparities in referral to child protection authorities.<sup>55</sup> Service use in Australia has been found to be higher among women involved with child protection services.<sup>47,56</sup> Indigenous families are over-represented,<sup>57</sup> as are substance using women with a larger number of children, those who are prescribed psychiatric medication, and those who are not in daily contact with their own parents.<sup>47</sup> In contrast, people from culturally and linguistically diverse

communities are under-represented in AOD treatment services, but it is unclear if this is due to fewer problems, better family support, or lack of access to culturally appropriate services.<sup>58</sup>

Children living in some areas are also more likely to be impacted by problematic parental substance use and to be brought to the attention of child welfare authorities. For example, there is a correlation between the supply of alcohol (measured by outlet density and pricing) and other drug use (measured by the number of arrests) and referral to child protection services.<sup>54</sup>

Decision-making processes by child welfare authorities are likely to be different in relation to the children of parents with problematic substance use, when compared with parents who don't use drugs. Child placement in out-of-home care is less likely to be voluntary<sup>18</sup> and parental rights are more likely to be terminated.<sup>30</sup> Evidence from the US suggests that personal biases, values, and stereotyping by authorities often result in the acceptance of cases that would not otherwise reach the threshold for intervention.<sup>59</sup> However, it is unclear whether this also applies in Australia.

### Family interventions

There are many programs that provide family or parenting support to the general population with the aim of improving outcomes for children. However, most of these have excluded parents with substance use problems from evaluations of their effectiveness. Consequently, there are few rigorous studies of family AOD treatment and support of this type. Nevertheless, a number of specific treatment services or programs for families affected by problematic substance use have been proposed or piloted and have shown promising outcomes, including in Indigenous communities.<sup>60</sup> These include residential family programs, family home visiting and support, family therapy, peer support groups, and a range of psycho-education group programs.<sup>46</sup>

## CASE STUDY 2

### Parents Under Pressure (PUP)

[www.pupprogram.net.au](http://www.pupprogram.net.au)

The Parents Under Pressure (PUP) program, developed by Professor Sharon Dawe (Griffith University) and Dr Paul Harnett (University of Queensland), is designed for families with multiple problems, where children are at risk of adverse outcomes.<sup>10</sup> It is an intensive multi-component program comprising 10 modules, delivered in 12 sessions of 1.5 hours duration each. Parents Under Pressure has been used where there is problematic parental substance use and there are concerns about child wellbeing and protection.

Parents Under Pressure is delivered by a trained staff member, generally in the family home, and focuses on a range of parental challenges. Beginning with parents' perception of themselves, PUP encourages parents to acknowledge their own strengths and identify and comment on their children's positive behaviours. The program helps parents to identify the various factors

that make parenting difficult and devise strategies to overcome these challenges. This technique differs from the traditional parenting deficit model in that it empowers parents to discover and use their strengths to build positive parent-child relationships, without focusing on a lack of specific parenting skills. Parents Under Pressure includes daily child-focused playtimes and helps parents to improve their mood and use non-punitive methods to control children's behaviour. In addition, the program aims to help families re-connect with their local community, extend social networks and cope with practical family issues, such as child care, school involvement and other social support.

Parents Under Pressure has demonstrated significant reductions in family stress, child abuse potential, problems with others, and improvements in parent and child functioning and parent-child relationships.<sup>11</sup>

## CASE STUDY 3

### Odyssey House Victoria

[www.odyssey.org.au](http://www.odyssey.org.au)

Odyssey House Victoria has implemented a range of family sensitive and inclusive practices since its inception in 1979. Three such programs, which emphasise support to parents and their children, are outlined below.

Odyssey's **Residential Family Program** comprises 30 beds within a larger 85 bed therapeutic community in Melbourne. Parents (mothers/fathers/couples) requiring treatment for their AOD and co-occurring mental health problems are able to access this residential rehabilitation program accompanied by their children (aged 0–12 years). The program is delivered by a variety of professional staff, including psychologists, psychiatrists, general practitioners, nurses, social workers, and those who have recovered from their own problems with substance use. Parenting and family strengthening groups and activities are provided, while children attend either an on-site, therapeutic preschool/children's centre or one of two local primary schools. Other family members can have regular contact/visits, including children no longer in parental care.

Odyssey's **Kids in Focus** program is part of a national Commonwealth-funded, specialist child, parenting and family support service for highly vulnerable families where a parent has an AOD problem. The program includes weekly home visits, therapeutic work based around the Parents Under Pressure model, groups, animal assisted therapy, school holiday camps and other recreational activities.

Odyssey's **Mirror Families** aims to create a positive extended family for vulnerable children and families, and to provide family/social support for life. Anyone with a strong emotional connection to the child or family may be involved, including relatives and current or past counsellors, sports coaches, mentors, and other community members. The model has been shown to be effective and fills a recognised gap for families with parental substance use problems. Odyssey is now planning to move this from its pilot phase into a workforce development and training package to disseminate the model more broadly.



In Australia, some of the most developed examples of child and family inclusive interventions in the AOD sector occur in residential services, although most are only for mothers and their children and do not include fathers. Although evidence for their long-term effectiveness is limited, research suggests that those that focus on strengthening the parent–child relationship and parental reflective functioning are likely to deliver the best outcomes.<sup>61</sup> While residential programs are important, resource limitations mean that other community based programs will need to be the main way in which interventions are delivered.

One community based program developed in Australia has been found to be effective. In fact, in a recent international review of evidence-based programs for parents of younger children, the Parents Under Pressure program (Case Study 2) was considered to be the only one of 238 programs that met the criteria for evidence and demonstrated a positive impact upon parents and children through a rigorous randomised controlled trial.<sup>62</sup> It is hoped that programs like this continue to be rolled out across Australia, while evidence is collected on other types of programs that have shown promising results.

In addition to specific family sensitive interventions, there is evidence that AOD treatment itself can have some positive impact on parenting and on the wellbeing of children. For example, a recent review of over 200 studies on maternal use of pharmacotherapy (mostly methadone) found improved infant outcomes when parents complied with treatment.<sup>63</sup> However, it was also found that differences in the long-term developmental outcomes of children were largely determined by changes in environmental factors, such as poverty, exposure to substance use, and lack of stability, rather than whether a parent was using opiates or not, and even whether they were receiving pharmacotherapy treatment or not. This highlights the need for

AOD treatment services to address a range of factors in addition to AOD use when parents access treatment, and to identify a range of needs of parents and children as part of the assessment process.

With the exception of pharmacotherapy and some residential programs, most of the current AOD treatment programs are of only 6–12 weeks duration. In cases where risk to children has been identified, it is widely accepted that a longer timeframe is needed to ensure the safety and wellbeing of the children.<sup>64</sup> This may be up to one year or longer for some parents, and would suggest that some flexibility in AOD funding is required to provide longer term aftercare and follow-up support.

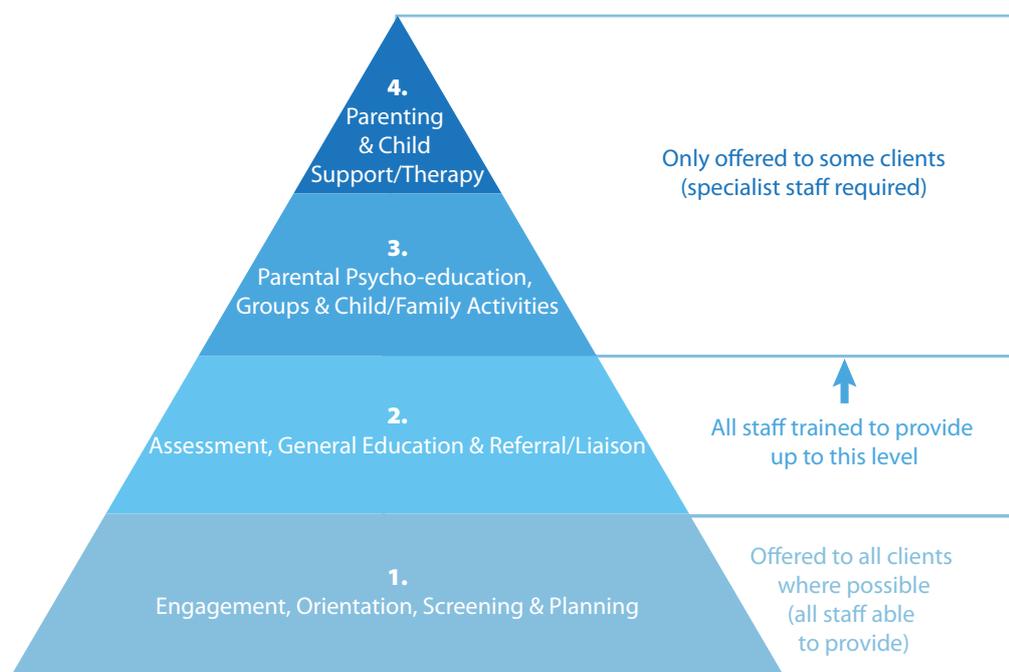
### Determining the levels of support

There are clear opportunities for prevention and early intervention when vulnerable families access AOD treatment.<sup>64,65</sup> Workers can identify and respond to a parent’s need for family support, examine the strength of the parent–child relationship, and ensure children are safe and have

access to educational and recreational opportunities to promote their wellbeing and development. They can address some of these issues directly, or make referrals to other services as appropriate. They can also help parents be aware of and better regulate their emotions so they can be more present to their children.

If the needs of children and their families are to be routinely identified and addressed, a minimum standard of family sensitive practice will be required across all services and programs. An ideal service system would also have some capacity to deliver some family inclusive practice for those most in need. However, the way in which family practice is implemented in any given AOD organisation will depend on a range of factors, including the types of treatment and support offered, the nature of the setting and the flexibility in the use of available resources.

A useful framework for family involvement has been proposed within the mental health sector.<sup>66</sup> An adapted version of this pyramid of family care is presented in *Figure 1* and could serve as a useful framework in the AOD sector.<sup>66</sup>



**Figure 1. Pyramid of Family Care/Needs**

Adapted from Mottaghipour Y & Bickerton A 2005 “The Pyramid of Family Care: A framework for family involvement with adult mental health services”, *Advances in Mental Health*, 4:3, pp. 210–217.

## Key informants' top tips for workers

- You do not need to be an expert in family therapy to ask clients about their children or other family members. Be yourself, honest, genuine, open and interested.
- Do not make assumptions. Aim to have some communication with relevant family members and encourage greater communication between family members.
- You probably already have the skills to contact other family members and identify their needs.
- Be aware that trauma and grief may go beyond individuals, and impact families and whole communities.
- Be open and respectful to all you speak with and anticipate some level of anxiety, conflict and shame. The stigma of having an AOD problem while being a parent can be enormous.
- Where possible, family members should be informed about their rights and responsibilities, what information will be shared, and how this will be done.
- Provide families with some information and support to address the effects of trauma and build hope for recovery.
- Take a supportive and strengths based approach rather than a punitive or risk focused approach. This will help engagement with parents and improve the likelihood of real change, not simply compliance.
- Include child and parent focused goals in your treatment plan. Think about what children need to be healthy and happy, in addition to any safety issues. Learn more about child development levels and timeframes, and discuss these in supervision and case reviews.
- Setting and monitoring goals is important. So is having a plan B for the care of children. As lapses are common in the recovery process, a parent's functioning may vary considerably over time.
- Ensure pregnant women get specialist antenatal support and care.
- Consider inviting a trusted family member or significant person to attend a session with your client. This may be especially important for building trust when meeting families for the first time, and within Indigenous and culturally and linguistically diverse communities.
- Help parents to understand or explore the possible impact of their AOD use or treatment on their children. Support parents to access material needs and develop new parenting strategies, especially around limit setting for their children.
- Help parents to strengthen their social network.
- Get to know your local child and family support and child protection workers. Know where the maternal and child health and education services are located. Identify child care options.
- Seek and respect children's opinions, but not at the expense of their safety.
- Help children to understand what is happening to their parents. They may need help to understand that family problems are not their fault, and that their parents love them, even if they are unable to care (or adequately care) for them at present.
- Provide children with opportunities to share their experiences with other children in similar circumstances. Tutoring and recreational activities may help children feel normal.
- Older children and young people may need their own intensive and specific long-term support and follow-up.

It is suggested that where possible, all clients seeking AOD treatment should be offered level 1 interventions, with smaller numbers of clients progressively needing and being offered level 2, 3, and 4 interventions. To achieve this, it is likely that all AOD staff members would need to be trained to be able to deliver both level 1 and 2 interventions, while level 3 and 4 interventions would generally only be provided by specialist or appropriately trained senior staff.

Level 1 interventions include asking about, making contact with, or engaging other family members

(including children) in order to identify any needs. This includes planning responses to these needs and directing family members to the types of services available. Response to any safety or immediate needs should also occur at level 1. Level 2 interventions include conducting any further assessments where necessary and providing general information and support to family members, liaising with other more specialised services such as family support, child protection, maternal and child health, and education where required, and supporting referrals

where necessary. Level 3 responses may include more specific education and support around parenting, child behaviour management, social and community connections, and life skills, as well as specific activities or groups for parents and/or their children. Level 4 interventions would be reserved for those most in need and may include home-based family support, and more specialised child and family therapy.

All services adopting this framework would need to have policies, practices and an appropriately trained workforce in place to screen, identify and address

family needs, either through simple direct responses or through liaison/referral. However, professional opinion suggests that referral may not be particularly successful with complex families, and that workers should build on the engagement already established with a parent and directly provide as much support and psycho-education as possible. Consequently, larger AOD organisations should employ or train one or more dedicated staff who are able to provide level 3 or 4 interventions, and who can also provide guidance and supervision to other AOD staff. Naturally this would require additional resources or more flexible use of funding and performance targets than is currently allowable in most settings.

## Changing organisational culture

It is clear that commitment at all levels of an organisation is required if family sensitive and inclusive practices are to be effectively implemented. Changing the culture of organisations and systems is likely to require a change management strategy. Rather than merely relying on "carrot and stick" strategies to achieve this, modern approaches to change management focus on communicating the vision and the rationale for the change to staff and key stakeholders. This is then followed up with non-threatening opportunities to practice new knowledge and skills.

Culture change is required across all AOD program types. Harm reduction services that have typically focused

on the individual<sup>50</sup> can do more to reduce the harm to others including children, while demand reduction services can do more to address the underlying contributors to AOD problems, including parenting stress. While individual staff may believe that their responsibility remains only to the individual, most are likely to realise that they can't ensure good long-term outcomes for a parent without considering the safety and wellbeing of their children.

Organisations looking to strengthen their family practices may wish to:

- review their available resources and the conditions attached to their use in order to determine the level of support they will be able to offer internally

## CASE STUDY 4

### Yakapna Family Healing Centre

[www.njernda.com.au](http://www.njernda.com.au)

Yakapna is a 14-week residential program based in Echuca that provides a healing journey for Aboriginal families. The program accepts single parents or couples who are experiencing AOD problems and a range of other complex issues such as mental health and domestic violence, together with their children. Funded through the Department of Health and Ageing Office for Aboriginal and Torres Strait Islander Health (OATSIH) and the Victorian Department of Human Services, Yakapna can accommodate two adults and up to five children at any one time.

The program aims to prevent the removal of children from home because of safety concerns; or enables the safe return of children to the care of their family following placement in out of home care. Implementing culturally specific and holistic practices, Yakapna enhances cultural, family and community connections, provides preventative education for the future, and links families into a range of culturally sound treatment and support services to make real and lasting changes. This ensures that all children and their parents receive full health examinations and have access to AOD treatment, mental health, medical, dental, parenting, behaviour change, anger management support, and specialist consultants as necessary. Preschool children attend Njernda's

Aboriginal Children's Centre, while older children attend the local school next door. Family visits are encouraged on Sundays and all significant family and community members are included wherever possible.

Inspired by cultural strength and knowledge, the model of care is based on self healing through trust, honesty, communication and accountability. It assists residents to learn a range of important skills and strategies that enable families to identify and draw on their own strengths. The program employs up to three Aboriginal Elders (both male and female as appropriate) with significant life experiences to provide care coordination and support on a 24 hour, 7 days a week basis.

Although families can self refer, most referrals come from the Department of Human Services. Demand is very high and access is managed by a steering committee that meets regularly. The program takes a non-judgemental approach to fully support families on their healing journey, while emphasising the safety and wellbeing of children.

Yakapna is operated by Njernda Aboriginal Corporation, formerly the Echuca Aboriginal Cooperative Pty Ltd which was established in 1974. Echuca is located on the Murray River in Northern Victoria and is within the traditional lands of the Yorta Yorta Nation.

- examine current relationships and identify new ones that may need to be developed to provide secondary consultation and referral pathways for clients
- consult with service users and other relevant organisations
- amend workplace policies and procedures where necessary to ensure they are family sensitive
- identify any changes to workplace culture, physical environment, staff attitudes, supervision and management support that will be necessary
- audit staff competencies to determine the type and degree of staff training required
- alter staff position descriptions to incorporate responsibilities for identifying and addressing parents' and children's needs.

Organisations may also wish to remove obvious barriers to treatment for parents by considering the timing of appointments and by assisting with child care.<sup>67</sup> Furthermore, as children are more likely to be living with their mothers,<sup>36</sup> organisations must consider the specific needs of women and their access to treatment in services that may be "male dominated".<sup>64</sup>

A service should be welcoming, safe and appropriate to both genders. Adopting a family sensitive or inclusive approach shouldn't inadvertently alienate men, especially those without children. Recent guidelines on gender sensitivity and safety can assist with this.<sup>68</sup> As domestic violence frequently co-occurs with substance use and has significant impacts on both parental and child wellbeing and safety, AOD services should also consider screening for family violence. This remains a key challenge as it represents a new area for most AOD services.

Screening and assessment tools should be as broad and as comprehensive of child and family needs as possible to ensure they do not make assumptions about parental motivation<sup>69</sup> or children's safety and wellbeing. Ideally, they

will include family background and culture, social support and connections, parental and child mental health and wellbeing, relationship support and conflict, and care giving and education arrangements.

AOD services in Australia would be well aware of the "no wrong door" approach as it applies to people accessing AOD treatment with co-occurring mental health issues. In a similar way, a recent UK initiative called Think Family also encourages services to adopt a "no wrong door" approach to working with families.<sup>70</sup> The approach supports a consideration of the whole family, regardless of which service they access first, and builds on their strengths as well as tailors support to their needs.

Taking a strengths based approach is thought to be most effective in maintaining engagement with families and achieving sustainable outcomes. Organisations should be mindful of this when developing family sensitive policies and practices and avoid merely implementing risk management or deficit-assessing strategies without considering their therapeutic value.

A number of workforce development resources have been created to help organisations become more family sensitive. Most recently, the National Centre for Education and Training on Addiction (NCETA) has developed a comprehensive suite of tools including a practical checklist and descriptions of useful publications and websites.<sup>53</sup> Links to a range of other practical resources, such as the *Parenting Support Toolkit for AOD Workers*,<sup>71</sup> can be found at the end of this paper.

The success of any change to the AOD sector will depend on how well other relevant sectors are able to support this change. Consequently, it will be necessary to build capacity in, and shift the orientation of, children's services to better consider the parent-child relationship and to gain a greater understanding of parental health and wellbeing issues.<sup>65</sup> While child protection training protocols have improved their emphasis on

problematic substance use, domestic violence and mental health, they may also need to include outcome-based evaluation measures to examine actual changes in staff behaviours and practices.<sup>38</sup>

## Building stronger partnerships

The AOD and child welfare sectors have largely operated in isolation,<sup>46</sup> driven by the nature of funding arrangements and service delivery targets. This approach is understandable given that both sectors experience high demand and limited resources, along with staff that have substantially different knowledge, experience and skills. However, while this approach may be reasonable for families with single and isolated problems, it is doomed to fail with vulnerable families who have multiple and complex needs.<sup>65</sup>

There are three developmental levels of collaboration between services:

- cooperation
- coordination
- integration.<sup>72</sup>

Cooperation involves limited shared efforts, conducted on a case-by-case basis, with an absence of formal arrangements between agencies. Coordination requires greater organisational involvement to enhance service access among mutual clients, while integration is more formal and involves shared administrative systems and governance, joint planning, collective resources, and joint training.

While partnerships can be established at a personal level, sustainable partnerships are likely to require formalisation at the agency-agency level where possible, with clear aims and objectives, inter-agency protocols and information sharing, supported by policies, procedures, and documented referral pathways.<sup>19,38</sup> It is acknowledged that good partnerships take time and effort to develop. Resources that can help organisations in this task are listed at the end of this paper.

## Key informants' top tips for organisations

- Ensure workers are screening clients for parental status, caregiving responsibilities, and the need for parenting support.
- Services should also screen for family violence to ensure the immediate safety needs of clients and their children are not being compromised. Guidelines should be in place to ensure an appropriate response occurs when family violence is identified.
- Consider how you can make your services welcoming and safe for men, women and children. Have some clean books and toys available in waiting areas.
- Develop links with local child and family services. Start at worker-worker level and formalise where possible. Attend their staff meetings and invite staff to yours to maintain the relationship.
- Take time out to reflect on your organisation's champions or enablers and any barriers to family sensitive practice. Embed ideas in policies and processes, and in professional development training plans.
- Ensure staff members are aware of your organisation's commitment to child and family sensitive and inclusive practice and orient them to your policies and procedures.
- Promote children's right to happy, healthy, loving and engaged lives and your staff members' role in breaking intergenerational patterns of abuse, neglect, trauma and problematic AOD use.
- Monitor case loads and expectations to ensure time for family inclusive practice is available.
- Ensure practice is goal-focused so that workers stay on track. Use interventions that are based on evidence of what works, and keep a look out for practice that is only informed by individual worker beliefs or morals.
- Provide staff with ongoing opportunities for professional development and relevant supervision.
- Ensure tip sheets and resources are available for staff and clients, especially on strategies for boundary setting and positive behaviour management of children.
- Ask a few staff to imagine they are children accessing your service and view it through a child's eyes. Ask any children who attend what they think.
- Ensure posters in your services include family images from a diverse range of cultural backgrounds. Put up signs that acknowledge Aboriginal and Torres Strait Islander people as the traditional custodians of the land and welcome them to your service.
- Ensure staff members have the appropriate checks before they have contact with children. Seek resources to provide brokerage funds to families so that children can be linked into social and recreational experiences like sport.
- Provide access to child care if this is a barrier.
- Examine change management strategies to assist with implementation, including ways of overcoming workplace/individual barriers.
- Examine what worked when enhancing your staff members' ability to identify and respond to mental health issues. Apply these lessons to build their capacity for family inclusive practice.

In the absence of widespread holistic and generalist services, effective partnerships and linkages between specialist services are critical to support integrated care and better outcomes for vulnerable families. Such outcomes will also be improved through stronger partnerships between AOD services and schools and early childhood services, child and adolescent health and specialist pregnancy services, and local governments, among others.

The particular challenges that adult-focused and child welfare services face when collaborating have been documented over many years, both internationally and in Australia.<sup>72</sup> Better integration of these sectors is critical.

This integration will also help the monitoring, supervision, consultation and ongoing support of staff in areas outside of their expertise. High case loads in both sectors and limited outreach capacity by most AOD workers means that travelling to meetings held off-site may be unrealistic under present funding arrangements. However, technology-enabled contact between these sectors is an underutilised resource. Where possible, staff rotations and discussion groups for staff who have recently received training are also effective ways of utilising and sustaining partnerships, and giving staff opportunities to integrate new knowledge.

## Workforce development and capacity building

Assisting vulnerable families with multiple and complex needs, wherever they access support, is likely to require a more generalist workforce at the frontline of service delivery than is currently available. Significant investment in workforce development will be required to achieve this. Specific cultural sensitivity training relevant to geographic location will also enable access to service delivery for Aboriginal and Torres Strait Islander families and for those from a range of culturally and linguistically diverse backgrounds. Furthermore, the workforce will need to be supported and supervised by

## Key informants' top tips for government and other funders

- Ensure AOD workforce development strategies include capacity building on family sensitive and inclusive practice. Build on what worked to enhance dual diagnosis workforce capacity.
- Provide flexible funding that allows for and provides incentives for AOD services to do family work.
- Ensure services have sufficient capacity to capitalise on a parent's motivation to seek help.
- Develop or adapt data and client management systems that allow AOD services to document their work with children and families.
- Develop clinical standards that incorporate some minimum level of screening and response for parents with AOD problems and their children.
- Facilitate integration between AOD, parenting and child welfare services. This is likely to take time and resources to fully develop. Develop and promote tools to assist this.
- Consider clarifying privacy legislation and facilitate information sharing protocols between sectors so that this does not become an excuse or barrier to service coordination.
- Family carers such as grandparents need to have their role acknowledged and to be able to access services that understand their specific needs. They also welcome the opportunity to share experiences with others in the same situation.
- Consider alternative models for mediation and decision-making where there is problematic AOD use by parents such as Family Drug Courts.

specialist staff from a wide range of backgrounds and expertise. Program evaluations examining the extent to which workers are able to apply skills, engage effectively across service sectors, and influence outcomes for parents and children are more likely to bring about sustainable changes.<sup>38</sup>

### AOD workforce

Before delivering training to staff, an examination of worker beliefs, knowledge and attitudes is necessary. It appears that some AOD workers don't view child and family practice as a core part of their role.<sup>53</sup> Surveys of Australian AOD workers have found that most know if their clients have children, and that most believe identifying and addressing child and parenting needs are important.<sup>71,73</sup> However, only a minority of workers report having received any training in this area and consequently, most lack the confidence to actually assess or address these needs. Furthermore, when tested, workers' actual knowledge about parenting services and resources is less accurate than they believe it to be.<sup>71</sup>

At a basic level, AOD workforce training should focus on:

- helping workers to understand the important role that parenting can play in their client's lives

- providing information on how AOD use may compromise parenting and impact on children, and how the rewards and stress of parenting and child behavioural difficulties may in turn influence AOD use or relapse
- providing workers with the confidence to ask about family goals, children's wellbeing, and parenting strengths and support needs
- providing strategies to prioritise competing demands
- demonstrating the use of screening and assessment tools and frameworks
- incorporating identified goals or needs into treatment plans, in partnership with family members
- providing examples of appropriate resources, evidence-based intervention programs and local services designed to support parents and/or their children
- establishing relationships and communicating with relevant services such as education, child welfare and child protection workers
- providing opportunities for workers to observe and practice new skills in low stress situations before applying these to their own clients.

Self reflection guides,<sup>71</sup> specialist clinical guidelines<sup>74</sup> and supervision

may also help workers identify their own areas of strength and weakness in implementing family sensitive or inclusive practice. A short course in family inclusive practice, specifically designed for the AOD workforce, has also recently been developed and accredited.<sup>75</sup> With sufficient resourcing to roll out courses such as these, substantial progress could be made in developing child and family sensitive practice across the whole AOD sector.

### Child and family welfare workforce

In the US, and anecdotally in Australia and elsewhere, many child welfare workers lack knowledge in assessment of AOD problems,<sup>52</sup> the nature and effectiveness of various AOD treatment modalities including pharmacotherapy, and the outcomes for children when parents receive medication-assisted treatments.<sup>63</sup> As with AOD staff, training of child welfare staff needs to go beyond developing awareness of internal policies and procedures and AOD effects, and should include examination of personal biases that influence decision-making.<sup>59</sup> Assessment needs to distinguish functional from dysfunctional substance use and to consider how substance use actually impacts on parenting and influences risk to children.<sup>59</sup>

There is evidence from the US that suggests that training in AOD positively impacts child welfare workers' knowledge, skills and practices.<sup>52</sup> Furthermore, a two-day workshop on motivational interviewing for child welfare staff working with parents who use alcohol showed promising results.<sup>39</sup> Participants reported increased knowledge of alcohol use, more confidence in addressing issues with parents, reduced role stress, engaging in less confrontational practices, more active listening and increased job satisfaction. While simulated case scenarios demonstrated that workers had not yet acquired competence in motivational interviewing, the findings revealed that workers had gained alternative strategies for engaging parents.<sup>39</sup> Such research also highlights the need for ongoing professional development when delivering interventions in complex family systems.<sup>38</sup>

## Conclusion

There is clear evidence that problematic parental substance use poses a significant risk to the safety and wellbeing of children. In addition, many clients accessing AOD services have significant parenting support needs that are not routinely met. Although there appears to be a strong commitment to address these issues, there is currently a lack of workforce capacity to do so. Consequently, there is a growing impetus for the widespread implementation of a family sensitive approach to AOD treatment and support. Some structural changes and financial resources will be required to ensure a minimum and consistent level of practice is developed and maintained in all areas. However, there are many useful tools and guides to assist individual organisations and workers to make immediate changes that would contribute to the prevention of child abuse and neglect, and the likelihood that all members in vulnerable families reach their full potential.

## Further information

### Websites

- Australian Indigenous Health/InfoNet ([www.healthinfonet.ecu.edu.au](http://www.healthinfonet.ecu.edu.au))
  - Children
    - Children of Parents with a Mental Illness (COPMI; [www.copmi.net.au](http://www.copmi.net.au))
    - The Mirabel Foundation ([www.mirabelfoundation.org.au](http://www.mirabelfoundation.org.au))
  - Culturally and linguistically diverse communities
    - Australian Institute of Family Studies ([www.aifs.gov.au/cfca/topics/webresources/caldfamilies](http://www.aifs.gov.au/cfca/topics/webresources/caldfamilies))
  - Domestic Violence
    - Domestic Violence Resource Centre Victoria ([www.dvrcv.org.au](http://www.dvrcv.org.au))
  - Early parenting services
    - QEC ([www.qec.org.au](http://www.qec.org.au))
    - Tweddle ([www.tweddle.org.au](http://www.tweddle.org.au))
  - Family Alcohol and Drug Network (fadnet) ([www.fadnet.org.au](http://www.fadnet.org.au))
  - Parenting and families
    - Alcohol Concern ([www.alcoholandfamilies.org.uk](http://www.alcoholandfamilies.org.uk))
    - Centre for Excellence in Child and Family Welfare Inc ([www.cfecfw.asn.au](http://www.cfecfw.asn.au))
    - Parenting Research Centre ([www.parentingrc.org.au](http://www.parentingrc.org.au))
    - Raising Children Network ([www.raisingchildren.net.au](http://www.raisingchildren.net.au))
  - Partnership tools
    - Mental Health Coordinating Council ([www.mhcc.org.au/sector-development/promoting-partnerships.aspx](http://www.mhcc.org.au/sector-development/promoting-partnerships.aspx))
    - No Wrong Door ([www.nowrongdoor.org.au](http://www.nowrongdoor.org.au))
  - Substance use and pregnancy services
    - Women's Alcohol and Drug Service (WADS; [www.thewomens.org.au/alcoholdrugservice](http://www.thewomens.org.au/alcoholdrugservice))
  - The Bouverie Centre ([www.bouverie.org.au](http://www.bouverie.org.au))
  - Young Parents Program ([www.ysas.org.au/specialist-programs/young-parents-program](http://www.ysas.org.au/specialist-programs/young-parents-program))
- Online resources/publications*
- Alcohol, pregnancy and foetal alcohol spectrum disorders (FASD) ([alcoholpregnancy.childhealthresearch.org.au](http://alcoholpregnancy.childhealthresearch.org.au))
  - Drug use in the family: impacts and implications for children ([www.ancd.org.au/images/PDF/Researchpapers/rp13\\_drug\\_use\\_in\\_family.pdf?phpMyAdmin=rGQ2XkO0sKjMp24r2sFwuVc5ibb](http://www.ancd.org.au/images/PDF/Researchpapers/rp13_drug_use_in_family.pdf?phpMyAdmin=rGQ2XkO0sKjMp24r2sFwuVc5ibb)) (PDF: 1MB)
  - 2006 conference: Working with families ([www.vaada.org.au/resources/detail.html?filename\\_num=69020](http://www.vaada.org.au/resources/detail.html?filename_num=69020))
  - Family Focus Toolkit ([www.edas.org.au/family\\_resources](http://www.edas.org.au/family_resources))
  - For Kids Sake: A workforce development resource ([nceta.flinders.edu.au/download\\_file/view/563/](http://nceta.flinders.edu.au/download_file/view/563/))
  - Impact of drug and alcohol misuse on children and families ([www.aracy.org.au/publicationDocuments/ TOP\\_The\\_impact\\_of\\_drug\\_and\\_alcohol\\_misuse\\_on\\_children\\_and\\_families\\_2006.pdf](http://www.aracy.org.au/publicationDocuments/TOP_The_impact_of_drug_and_alcohol_misuse_on_children_and_families_2006.pdf)) (PDF: 808KB)
  - National Drug and Alcohol Research Centre (NDARC) Child protection and mothers in substance abuse treatment ([www.ndarc.med.unsw.edu.au/resource/child-protection-and-mothers-substance-abuse-treatment](http://www.ndarc.med.unsw.edu.au/resource/child-protection-and-mothers-substance-abuse-treatment))
  - Nobody's Clients Project & Counting the Kids reports ([www.odyssey.org.au](http://www.odyssey.org.au))
  - Parental Substance Misuse and Child Protection ([www.communities.qld.gov.au/resources/childsafety/practice-manual/prac-paper-substance-misuse-factors.pdf](http://www.communities.qld.gov.au/resources/childsafety/practice-manual/prac-paper-substance-misuse-factors.pdf)) (PDF: 225KB)
  - Parenting Support Toolkit ([www.health.vic.gov.au/aod/pubs/#parenting](http://www.health.vic.gov.au/aod/pubs/#parenting))
  - Tools for Change: A new way of working with families and carers ([www.nada.org.au/resources/nadapublications/resourcestoolkits/familycarer toolkit/](http://www.nada.org.au/resources/nadapublications/resourcestoolkits/familycarer toolkit/))
  - Victorian Child Protection Practice Manual ([www.dhs.vic.gov.au/cpmanual](http://www.dhs.vic.gov.au/cpmanual))
  - Working With Families: Clinical Treatment Guidelines (available for sale through [www.turningpoint.org.au](http://www.turningpoint.org.au))

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Any enquiries or comments on this publication should be directed to the Program Manager (Information Services), at Australian Drug Foundation  
PO Box 818 North Melbourne, Victoria 3051, Australia  
Tel. 1300 85 85 84  
Email [druginfo@adf.org.au](mailto:druginfo@adf.org.au)

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