familiar needs

working with children and families

A resource folder for alcohol and other drug services in Victoria

vaada

About VAADA

The Victorian Alcohol and Drug Association (VAADA) is the peak body for alcohol and other drug (AOD) services in Victoria. We provide advocacy, leadership, information and representation on AOD issues both within and beyond the AOD sector.

As a state-wide peak organisation, VAADA has a broad constituency. Our membership and stakeholders include 'drug specific' organisations, consumer advocacy organisations, hospitals, community health centres, primary health organisations, disability services, religious services, general youth services, local government and others, as well as interested individuals.

VAADA's purpose is to ensure that the issues for people experiencing the harms associated with alcohol and other drug use, and the organisations that support them, are well represented in policy, program development and public discussion.

About the Sector Development project

VAADA has been funded by the Victorian Department of Health to increase our capacity to support the work of the Victorian AOD sector. The Sector Development project has a specific focus on key areas identified in the Victorian Government's *A new blueprint for alcohol and other drug treatment services 2009-2013* (the Blueprint).

The overarching aims of the project are to enhance the capacity of AOD services and staff to:

1. Strengthen client and family input into service planning and development;
2. Consider family functioning and the wellbeing of dependent children in assessment and treatment planning;
3. Understand their responsibilities within the *Children Youth and Families Act 2005* (CYFA); and
4. Build stronger links between AOD treatment services and pharmacotherapy and harm reduction programs.

VAADA has mapped current practices across these areas and continues to consult and build relationships with individuals and relevant networks.

The *Familiar needs* forums and resource folder are based on consultation with the sector about current needs and challenges in considering families and vulnerable children.

Acknowledgements

To ensure this project was relevant for the Victorian AOD sector, VAADA formed a Reference Group of key experts. We would like to thank these people for their valuable time, support and guidance:

- Stefan Gruenert (Odyssey House)
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- Angela Ireland (Family Drug Help)
- Elena Tauridsky (The Bouverie Centre)
- Tracey Martin (YSAS)
- Ray Beacham (Ballarat Community Health Service)

As part of a series of scoping exercises to inform the project, VAADA also developed a survey to identify current needs and issues for the AOD sector in considering families and the wellbeing of dependent children, and to determine the kind of resources that would promote understanding of the CYFA.

We would like to thank all AOD managers and staff who completed the survey and who provided a range of insightful responses.

We extend our thanks to Domenico Calabro, Robyn Hamilton and Suzanne Bettink from Victoria Legal Aid for their expertise and generous input into the resource material on the CYFA 2005.

Finally, and importantly, we would like to thank all the speakers and presenters that have volunteered their time to support the *Familiar needs* professional development forums.

We also wish to acknowledge the positive response from the Office of the Child Safety Commissioner, Child FIRST and Child Protection, and thank respresentatives of these agencies for their involvement in the forums.

The policy context

Federal and State Governments are increasingly emphasising the need to intervene early across health services, to foster holistic and integrated approaches to service delivery, and to increase the capacity of frontline health services to identify and respond to the needs of children and families.

The Australian National Council on Drugs (ANCD) has identified substance use within the family context as a national priority area, and their 2007 report provides a comprehensive overview of recent national and state-based policy initiatives and practice guidelines relating to substance use, families and children (Dawe et al 2007, Chapter 6) in Australia.

These policy directions broadly inform the Blueprint that provides a framework for provision of AOD treatment services in Victoria. The Blueprint sets out an acknowledgement of the need to consider families and dependent children of clients in service planning and treatment, calling for 'a service system that recognises that children and families of people receiving drug and alcohol services are also clients' (DHS 2008, p1).

It identifies the need to ensure clients and families can access a range of information, advice, support and treatment options; and that client and family involvement in service planning and development is strengthened. Specifically, it also states that

> *Interventions must reduce the harmful impact of alcohol and other drug use on children and families*
>
> The children and families of our clients are also our clients... Treatment services have an important responsibility to identify parents in their services, to collaborate with child and family services to support parents and their children to break the cycle of intergenerational substance abuse and to recognise and respond to a client's family context and prioritise the best interests of the child
>
> (DHS 2008, p10).

In Victoria, the need to consider family functioning in AOD treatment sits alongside the imperative to identify and respond to the needs of vulnerable children legislated in the CYFA.

A key aspect of practice that is sensitive to the needs of families is enhancing the AOD sector's capacity to recognise and respond to the potential vulnerability of a child whose parents come into contact with our services.

Building on what's there

Evidence for the effectiveness of treatment models and approaches that include families is very strong.

There is also a growing body of excellent resources, guidelines and practice wisdom on benefits and 'what works' in involving and supporting children and families in alcohol and other drug treatment services.

Over the last decade, the Victorian AOD sector has initiated some particularly successful programs that have focused on both families and children, and there are numerous sites of strong, innovative practice for and with families currently occurring across the state.

The momentum is growing, with many practitioners and services recognising that family inclusive practices make sense, and contributes to good outcomes for individuals, families and communities.

A survey conducted by VAADA in March 2010 indicated that services are at different points in the way they think about families and that not all services have capacity or resources to engage families in their delivery of funded activities.

The survey also indicated that relationships with child and family service providers, including the Child FIRST and Child Protection service systems, could be strengthened to more effectively meet the needs of children and families of AOD service users.

AOD services and practitioners have valuable, specialised knowledge and expertise on substances, their effects and impacts, and options for treatment, harm reduction and recovery.

Our sector is well placed to promote practices and ways of understanding substance use that reduce stigma and harm. Widening the lens to include families as possible clients in their own right, as well as potential sources of support for individuals with a substance use issue, are among these important practices.

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Contents

This folder was developed to support VAADA's professional development forum series *Familiar needs: working with children and families in Victorian alcohol and other drug services*.

Together, the Familiar needs forums and this **resource folder** aim to:

- Introduce and promote family inclusive practice
- Outline a basic level of understanding of family inclusive practice
- Strengthen confidence and capacity to respond to the needs of dependent children by developing stronger links between AOD and child and family services
- Build understanding of practitioner responsibilities under the Children Youth and Families Act 2005
- Provide opportunities to reflect on organisational enablers and barriers to family inclusive practice
- Collate and provide useful resources in an accessible format to support knowledge and practice, and provide directions and links to further resources

What is this folder?

There are already many excellent resources and sites of significant family inclusive practice across the AOD sector. Rather than reinventing the wheel, the purpose of this resource folder is to:

✓ provide an orientation to key information and issues for family inclusive practice as well as a selection of supporting resources

✓ offer a snapshot of evidence and resources available locally and internationally and links to further information

✓ highlight practice tips to consider in your organisation and everyday work.

Services and resources relevant to family inclusive practice can change with funding and staffing, and as evidence and practice evolve. As such, this kit is not comprehensive, and does not attempt to identify all resources and services available to the Victorian AOD sector.

By signposting some of the key evidence, issues and resources for family inclusive practice, it aims to support services in pursuit of good practice, in the hope that this will mean better outcomes for clients and greater confidence for staff in engaging and responding to families and children of service users.

Using this resource

✓ Take notes and record your thoughts on the forum presentations in Section 1

✓ Add or take out material to suit the needs of you and your agency

✓ Use the folder and plastic pockets to collate relevant service information, agency resources and contacts

✓ Use the practice tips to prompt discussion and action on what is possible within your organisation

Red boxes highlight practice tips

Yellow boxes summarise key themes and information.

Blue boxes provide references and links to more information.

Key facts

How many children and families are affected?

The hidden nature of substance use and its associated stigma, together with inadequate data collection, mean that evidence about the number and characteristics of children and families affected by substance use is patchy and limited.

Studies indicate that:

- every substance user may negatively affect at least two close family members (Velleman 2002)
- for both licit and illicit drug use, it is estimated that over 15 per cent of children under 12 years old (1 in 7 children nationally) are exposed to problem drinking and/or illicit substance use in their household (Dawe et al 2007)

In Victoria:

- 7 per cent of people engaged with the AOD treatment service system in 2006-7 were spouses, parents, siblings, friends or children of a substance user (Department of Human Services 2008)
- the Family Drug Helpline receives over 6000 contacts by concerned family members each year (Department of Human Services 2008).

Having an alcohol or other drug user in the family can have a devastating impact on family life and individual family members, arousing complex emotions, changing family dynamics and weakening relationships.

Individual physical and psychological health, education, housing and employment opportunities, finances, social life, child development and parenting capacity can all be affected.

Adfam 2010

Significant numbers of children and families are affected by a family member's problematic substance use

What are the effects of problematic substance use on the family?

Problematic substance use can affect families in different ways and across different domains. Importantly, not all families will experience a member's substance use as problematic. Some of the family structures and functions that may be disrupted include:

Rituals - the ways families celebrate holidays, birthdays and special occasions

Roles - as one family member develops problems associated with their substance use, others take over their roles, such as finances, disciplining, shopping and cleaning

Routines - when behaviour becomes unpredictable it creates difficulties for the family in planning or committing to routines - Will she remember to collect her son from school? When will he come home, and in what state?

Communication - alcohol and other drugs can have a major effect on the quality of communication between family members

Social life - families tend to become increasingly socially isolated, owing to the difficulty of explaining to friends and neighbours that a family member has a substance use problem, or the social embarrassment or unpredictability associated with drinking and drugs

Finances - a family's finances can be hugely affected by reduction in income (e.g. owing to job loss) and by spending of available income on alcohol or drugs instead of more vital items

Relationships and interactions - for example both the user and their partner may become neglectful of other family members; aggression, violence and other abuse become more likely (Velleman & Templeton 2007).

Substance use, including alcohol, can affect children and families in different ways

Children at risk

The prevalence and effects of parental substance misuse on children is receiving increasing attention. This is particularly in relation to problematic parental alcohol or other drug use as a risk factor for neglect, and/or emotional or physical abuse.

For example, the annual report of the Victorian Child Death Review Committee, which investigates the deaths of children known to Child Protection, found that parental substance misuse and domestic violence were risk factors in 62 per cent of cases in 2008-2009, with family mental illness and homelessness presenting in almost half of the deaths.

Children and young people living with parental substance misuse may be subject to a range of negative experiences, including inconsistency; feeling shame, guilt, fear and anger; having to adopt responsible roles at an early age; and experiencing or witnessing violence, abuse and criminal activity. The possible neurodevelopmental impacts of alcohol and other drugs on a foetus during pregnancy are increasingly recognised (Velleman & Templeton 2007).

There is little doubt that the effects of intoxication and withdrawal influence parenting practices and parenting capacity (Dawe, Harnett and Frye 2008). However, substance misuse and dependence frequently occur with other complex and challenging problems, and it is the combination of these problems that place children at heightened risk and have the greatest negative impact (Dawe, Harnett & Frye 2008; Scott 2009).

AOD professionals are in a position to recognise children and complex families that may be at particular risk, and to have a role in responding to and supporting those children and families.

Use a broad, inclusive and sensitive definition of family

Think about and understand family in broad terms, as people who may be affected by or concerned about the substance use of someone close.

Who are family?

'Family' should be defined and understood broadly. Narrow definitions or understandings can limit and exclude. It is important to conceptualise family in ways that are inclusive and sensitive to diverse cultural, social, sexual and religious backgrounds and orientations.

A broad definition will include parents, partners, children, grandparents, siblings, carers, friends, colleagues and significant others. Orford et al use the term 'concerned and affected others' (2005).

It may also be useful to think about family members in terms of *families of origin* - the family a person comes from including grandparents, parents and siblings, and/or their *families of procreation* - children and grandchildren.

Information and discussion

International

Hidden Harm reports and responses Scotland, 2003-2006

Access and download Hidden Harm publications from www.scotland.gov.uk or www.adfam.org.uk

Australia

Dawe, S., Frye, S., Best, D., Lynch, M., Atkinson, J., Evans, C. & Harnett, P. 2007 *Drug use in the family: Impacts and implications for children, Australian National Council on Drugs*, Canberra

Dawe, S., Harnett, P., and Frye, S. 2008 'Improving outcomes for children living in families with parental substance misuse: What do we know and what should we do', *Child Abuse Prevention Issues*, 29, Australian Institute of Family Studies

Clients are the best judges of who their family is and the extent to which their family should be involved in treatment

Family inclusive practice acknowledges that family includes any significant person in the client's life. Services should value whoever the client chooses to involve in their treatment (Patterson & Clapp 2004, p7).

Common barriers for families

Families affected by someone else's substance use can often struggle to get information and support and may feel their needs are not recognised.

Even where services are available, there may be a series of common barriers families face when trying to access support. These include:

- stigma, shame and fear of being identified by others in the community as having a problem in the family
- isolation due to the nature of illicit drug use and its legal status, potentially exacerbated by having to keep this secret from others (including their own families)
- language – this can relate to the language or jargon used by service providers, as well as to barriers in accessing information and support in migrant and cultural community languages
- cultural views, norms and values
- uncertainties around how confidentiality policies operate and what information will be shared
- narrow and non-inclusive definitions of 'family' used by services that may deter some family members or significant relations from accessing support
- limited choice and flexibility of services, in terms of the type of service offered and/or the opening hours and suitability of the venue (Adfam 2010).

Further reading

Scott, D. 2009 'Think child, think family', *Family Matters,* No.81, Australian Institute of Family Studies, p37-42

See Resource 1 for a copy of this article

Considering a client's family, social networks and wider environment is intuitively good practice.

The AOD treatment sector in Victoria can draw on strong precedents in partnerships, networking and coordinated responses across mental health, housing, legal services and other health and community service systems.

Challenges for services and practitioners

There are many promising models and sites of AOD practice that are child and family inclusive. Alongside this though, the need to continue to provide more integrated responses to families with multiple and complex needs is growing.

Organisational and individual professional factors can influence if and how a service is inclusive of children and families. Individual practitioner attitudes and willingness will be shaped by personal experiences of family, personality, and beliefs about the ideals of service (Scott 2009). Organisational factors might include:

- size of caseloads
- proceduralisation of service delivery and narrow performance indicators
- agency culture, norms and philosophy
- levels of professional autonomy and discretion (Scott 2009).

The legal and policy contexts that shape funding, resourcing and planning also play a powerful role in determining the AOD sector's capacity to work in particular ways. Momentum is growing to address challenges across all of these levels.

Value families for their expertise

Families are often considered to be 'problems' in the lives of people who are experiencing difficulties with substance use. While this may be true for some clients, family members have a lot of knowledge about each other that, if harnessed appropriately, can assist in client work (Patterson & Clapp 2004, p7).

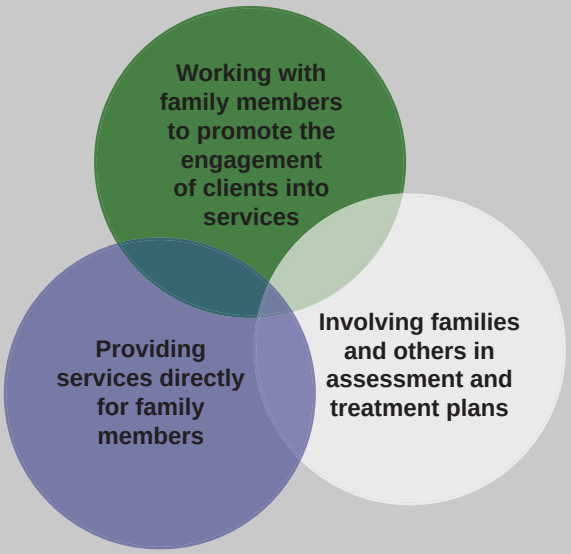
Family inclusive practice

Definitions and principles

Common descriptors for treatment and service delivery models that seek to involve and address the needs of family members include *child and family sensitive practice* and *family-centred* or *child-centred practice*. In Victoria, a current, common and useful term is 'family inclusive practice'.

Whatever the language used, family inclusive practices value families, recognise that families have needs in their own right, and seek to include families in the scope of work even though the main focus of the intervention may be on an individual within a family.

Family inclusive practices can be categorised into three broad types:



(Copello, Velleman & Templeton 2005)

Each of these 'types' has different aims and will bring a distinct focus to engagement with families. There are also obvious overlaps, but it is important for practitioners and services to determine how, why and to what end they are engaging families. The expectations and understandings of clients and family members themselves should also be clarified.

Core assumptions and principles of family inclusive practice in alcohol and other drug services include:

- The impacts and harms of problematic substance use and dependence often extend beyond the individual
- Families, children and carers have needs in their own right, and have a right to have their needs acknowledged
- Involving, educating and supporting families is part of a comprehensive and holistic service and should be considered where possible, as early as possible
- Involving and supporting families contributes to the effectiveness of services
- Openness, respect, empathy and collaboration are essential to engaging and working with families

While varying in language and emphasis, there are some common principles and assumptions that inform family inclusive practice. Versions of these are articulated in various guidelines and resources developed over the last decade. *Core assumptions and principles are outlined above*.

It is important to make a clear distinction between family inclusive practice and **family therapy**. Traditionally, family therapy in the AOD sector has been used as a means of identifying and improving patterns of interaction that are associated with an individual client's AOD use and behaviour. Family therapy requires specialised training. In contrast, practice that is family inclusive does not necessarily require specialist skills or training. It is an **approach** and **way of thinking** that recognises the role of families in clients' lives, and is sensitive to the needs of children and families affected by a relative's substance use.

Evidence and benefits

Strengths, relationships and existing resources within families can be used by services in working with clients

Services working with clients with substance-related issues often focus on what is not working or on what is absent in families. Looking for strengths and resources within families can often open up alternatives for action and change (Patterson & Clapp 2004, p7).

Evidence that supports the importance of family in alcohol and other drug assessment and treatment is growing. Comprehensive reviews of the literature indicate that AOD treatments that include a social component are among the most **effective** (see for example Miller & Wilbourne 2002).

Key researchers in the field, Alex Copello and John Orford, found that an increased emphasis on the role of families and wider social networks in service provision can:

i) assist in getting clients to treatment and maintaining engagement in treatment;

ii) improve both substance-related outcomes and family functioning, and

iii) lead to a reduction of impacts and harm for family members and others affected (Copello & Orford 2002).

There is also a growing recognition of the need to offer support to family members in their own right, regardless of whether the user is in treatment. Evidence shows this can reduce potential harmful impacts on family members, especially children (Copello & Orford 2002), and increase the capacity of family members to cope.

In addition to demonstrating positive outcomes for individual clients and their families, some studies have examined the **long-term cost-effectiveness** of interventions that support and/or involve family members. For example, improved and earlier support for the children of substance-using parents presents an efficiency saving to public health services.

Substance users are more likely to access treatment services, and rehabilitation and recovery are also more likely where there is family support, therefore providing better value for money and leading to additional savings across healthcare and criminal justice systems (Adfam 2010).

There is no single model that can be adopted uniformly. Treatment providers need to strengthen their capacity to deliver a range of interventions in response to the identified needs of each family.

Australian National Council on Drugs 2008

Evidence for the effectiveness of treatment models and approaches that include families is strong.

There is also a growing body of excellent resources, guidelines and practice wisdom on the benefits and 'what works' in involving and supporting children and families in alcohol and other drug treatment and services.

In terms of maximising outcomes for the **individual client**, families can be highly influential in

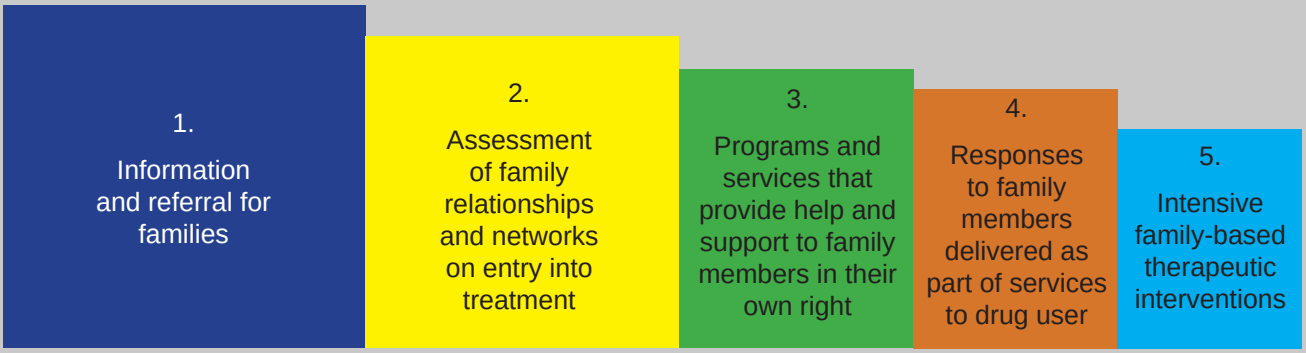
- helping initiate treatment
- affecting the course and outcomes of treatment
- influencing the likelihood of relapse and supporting long-term maintenance of change.

In terms of benefits for **families** affected by a member's substance use, evidence shows support and/or treatment can

- improve family functioning
- improve identification and earlier intervention for parents or children who may be at risk
- reduce the impacts and harm for family members.

(Copello & Orford 2002; Copello et al 2006)

A continuum of practice



(Copello et al 2009)

Ideally, families affected by substance use should have access to a range of support and treatment responses. **Most common is a need for targeted information and referral.** For services, the spectrum of responses that include families can range from being conscious of the presence and role of family in a client's life and strengthening referral pathways, through to provision of direct support for family members as clients of the service.

At its most basic level, considering the needs of families means **making services 'family friendly' environments**; for example, by ensuring that families (including young children) can access the physical space of the service, at suitable times, and that appropriate toys are available.

Widening the lens to consider both the client and their family entails a range of approaches and interventions. The intensity and level of resource commitment and specialised training required across this range varies greatly and capacity and capability to deliver the more intensive interventions will differ across services.

Some interventions require a higher level of training and supervision than may be relevant or achievable for a particular agency. It is important to remember that provision of flexible services of different intensities is necessary to meet the varied and complex needs of families (Copello, Templeton & Powell 2009).

Examples of interventions

Turning Point's *Clinical Treatment Guidelines No.11: Working with families* (Patterson & Clapp 2004) provide examples of 12 types of intervention along a spectrum of family inclusive practices.

There is no one intervention that should be made available to families; rather, as with drug treatment, *a toolbox of interventions and services* should be considered. Brief interventions for family members, self-help approaches, support groups, online materials, treatments involving users, family members and others..., as well as broader family oriented approaches all have their place.

What seems to be clear from the evidence is that *family members need and value the space to talk about their problems and to receive guided support to explore solutions* (Copello et al 2009, p39, emphasis added).

Australian researchers have suggested that ***process* may be equally as important as *content* in effectively treating families** with a substance using member (Dawe, Harnett & Frye 2008). In other words, the particular treatment model adopted may be less important than the process of orienting organisational and clinical practices toward family needs and dynamics.

Conceptualising family inclusive practice as a continuum of possible responses makes improving engagement with families, according to each service's capacity, both practical and feasible.

What is most important is that individual clients are recognised as being part of a family system and social network; that those family members and significant others can be involved in assessment and treatment; and that they may have support needs in their own right.

Family inclusive practice is a way of thinking. It can occur directly or indirectly

Services operating on family inclusive principles may not directly provide services to families but services will consider the client's family when they are working with clients (Patterson & Clapp 2004, p7).

Tips for family inclusive practice

Involving and supporting the families of clients accessing AOD treatment services can be complex and challenging work.

Implementing and enhancing family inclusive practices requires individual and organisational commitment and resources, as well as structural and system-level support.

Many individuals and organisations across the sector already include family in their practice, whether to improve individual client outcomes or to identify and respond to the needs of families and children in the their own right.

It is important to remember there is no expectation that all AOD practitioners become family therapists, nor should all agencies offer programs that are specifically targeted at families.

Given the evidence for the range of benefits of assessment and treatment that includes families however, there is a growing recognition that considering the needs of families is effective practice.

This section provides some pointers for organisations and individual practitioners moving toward implementing family inclusive practices in their programs and services.

Some of the following tips have been adapted from the *Tools for Change: A new way of working with families and carers* toolkit (2009) developed by the Network of Alcohol & Other Drug Agencies (NADA), New South Wales.

Best practice in alcohol and other drug treatment service delivery should include

a) routinely assessing the strengths and needs of the substance user's current family and social networks, and then

b) implementing an intervention that impacts either the substance misuse in the family/social context, or the affected family members

or

referring and collaborating with a service that provides suitable interventions and programs.

(Copello et al 2006)

Educate staff about the role of family involvement

Increase staff confidence and awareness of the role of family involvement in prevention, harm reduction, treatment, recovery and relapse.

Identify what's happening in your organisation

Many individuals and services consider families in their practice already. The terminology and approaches used may differ.

Conducting an audit of your service is one means of determining the ways in which the needs of families and children are addressed, and identifying areas for improvement.

A sample audit that could be adapted to the needs and context of your organisation is available on the CD ROM developed as part of the NADA *Tools for Change: A new way of working with families and carers* toolkit.

NADA 2009 *Tools for change: a new way of working with families and carers*, NSW

Download the audit at www.nada.org.au

Talk about and plan for families and children

Put family inclusive practice on the agenda for team meetings and in strategic planning.

Develop organisational values and policies that support family inclusive practices

A set of organisational 'family values' could affirm that:

- All family members have needs and rights that should be respected
- Family members can be an important resource to each other
- Families go on for ever and services are short-term
- People carry family with them regardless of their level of current contact
- Family members have a high level of knowledge about each other
- Families can change and often want to
- Involving families in treatment services can lead to better outcomes for individual clients

(Patterson & Clapp 2004).

The Pyramid of Family Care

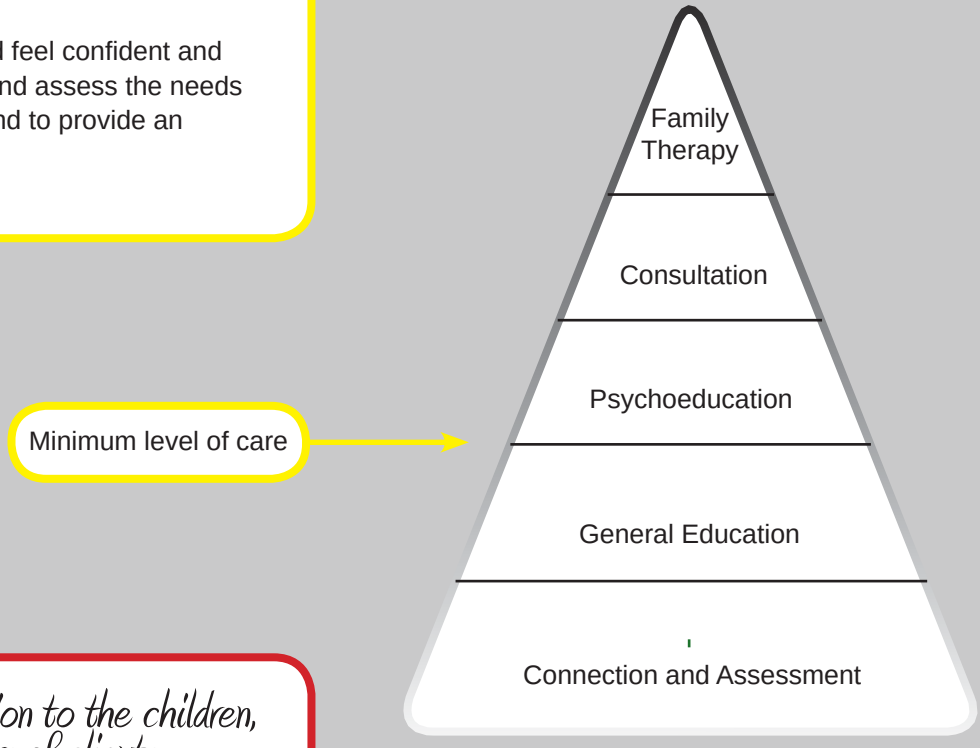
The Pyramid of Family Care illustrates how agencies can work toward a minimum level of care for families.

Based on Maslow's Hierarchy of Needs, this model emphasises the importance of orienting thinking toward families, and making connections.

A minimum level of care focuses on engagement, assessment and education for families, with referral to agencies providing specialised family services as required.

Many staff and agencies already provide this level of care.

Ideally, all staff should feel confident and able to engage with and assess the needs of family members, and to provide an effective referral.



Provide information to the children, families and carers of clients.

Basic information and support is the most common need identified by families affected by a member's substance use.

Connecting with families, and providing relevant information and education represent the first and second tiers in the Pyramid of Family Care.

The Pyramid of Family Care

Mottaghipour, Y. & Bickerton, A. 2005 T*he Pyramid of Family Care: A framework for family involvement with adult mental health services*, Australian e-Journal for the Advancement of Mental Health 4:3, 1-8

Make your service a child and family inclusive space

Think about providing:

- a safe, secure, spacious and flexible waiting area
- user-friendly, durable toys and play materials for a variety of ages
- baby change tables and easy access to toilets
- an outdoor area
- resources and material about families and parenting – posters and pamphlets, an information library, videos, handouts (both adult-focused and child-focused), including father-friendly material.

Have a specific policy for working with children and families

A sample policy is available on the CD ROM developed by NADA as part of the *Tools for Change: A new way of working with families and carers* toolkit.

NADA 2009 *Tools for change: a new way of working with families and carers*, NSW

Download the audit at www.nada.org.au

Understand confidentiality and consent

- Understand your obligations *and*
- Always talk about confidentiality with your client. Any information should be provided only with the agreement of the client.

If the client wants information given to significant others, it can be useful for this to occur in a session with the client present so they know what information is being disclosed.

Confidentiality is discussed further below.

Guidelines for family inclusive practice in the alcohol and other drugs sector

Clinical Treatment Guidelines for Alcohol and Drug Clinicians No 11: Working with Families (2004)

Copies of the Clinical Treatment Guidelines can be ordered from Turning Point Alcohol and Drug Centre. 54-62 Gertrude Street, Fitzroy VIC 3065. Phone 03 8413 8413

www.turningpoint.org.au

Tools for Change: A new way of working with families and carers (2008)

Outlines a range of interventions, practice tips, service models and resources. Includes a CD-Rom containing tools such as template policies, a workplace audit, assessment tools and checklists. Download from www.nada.org.au

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Family Inclusive Practice in the Addictions Field (2004)

Download from www.kinatrust.org.nz

For Kids Sake: A Workforce Development Resource for Family Sensitive Policy and Practice in the Alcohol and Other Drugs Sector (2010)

Developed by the National Centre for Training and Education on Addiction, this resource is designed to provide workforce development and capacity building knowledge and strategies for AOD interventions which are sensitive to the needs of, and involve families and children.

This resource will be available in 2010.

Use the range of available assessment and treatment tools

A widely used tool that has both assessment and therapeutic value is the genogram. Genograms are a visual representation of a family that can help you identify key members, patterns or themes within families.

Many useful tools exist. A selection of clinical tools for assessment and treatment, collated by the Eastern Drug and Alcohol Service (EDAS) into a toolkit for AOD practitioners, is included in this folder. The Parenting Support Toolkit also includes a selection of tools and references.

See Resource 2 - *The Family Focus Toolkit: a resource for family work in the alcohol and other drugs sector*

Ask family members what they need

Often, clients will not want family members involved with them or in their treatment.

Family members can still be provided with information about available services, and may be assisted to find support from other agencies and programs.

Family members are the 'experts' about their families.

The skills and expertise of practitioners can complement the competencies that lie within the family by finding ways to understand problems and issues, and helping to envision how things could be different.

Resources for practice

General

Australian Drug Foundation
www.adf.org.au

Family Drug Help
www.fdh.org.au

Kina Families and Addictions Trust
www.kina.org.nz

Working with parents

The Parenting Support Toolkit for Alcohol and Other Drug Workers
http://www.health.vic.gov.au/drug services/pubs/parenting-support.htm

Working with young people

Jesuit Social Services – Strong Bonds
www.strongbonds.jss.org.au

Working with children

COPMI - Children of Parents with a Mental Illness
www.copmi.net.au

Consider the interests and needs of clients' children

Make yourself and your organisation aware of key child developmental stages and relevant concepts such as the Best Interests principles.

Family inclusive practices recognise children's rights to protection, and to being involved where appropriate.

Staff need to be trained and resourced to work with families

Working with families can involve different activities - from having knowledge about the importance of family through to undertaking complex family therapy. Staff need to be provided with training commensurate with the level of direct family work they are expected to do (Patterson & Clapp 2004,

Work collaboratively

- Have a policy that supports collaboration
- Develop partnerships, joint protocols and memorandums of understanding between relevant services.
- Highlight the need to provide collaborative care in staff position descriptions or statements of duty. For example, state explicitly that staff are expected to:

  "Be responsible for the provision of collaborative care, working collectively with other health professionals involved in the continuum of service delivery with a focus on the best outcomes for the client and their family"
- Collaborate with existing family-specific services providing substance related support in delivering interventions to families.

See Resource 3 for a partnerships analysis tool

Know what services are available locally, statewide and nationally

While there are many local services and programs that can assist you in working with children, families and carers, many clients don't attend a service in their local area. It's important to know what services and support are available for families locally, statewide and nationally.

It may be useful for organisations to hold joint information sessions for staff on local and statewide services.

- Child FIRST in your area may be able to provide you with contacts for a range of local family services.

  See Section 3 for Child FIRST contact and referral numbers by local government area and region.
- Search www.serviceseeker.com.au for relevant services

Allow time

- to engage, connect and consult with families
- to seek information and resources within your agency and community
- to review practice

Understand the core principles of family inclusive practice

Consider including a provision in key selection criteria, staff position descriptions or statements of duty such as

"Understand and apply the principles of family inclusive practice".

Manage expectations

Families and carers should be advised, at the earliest opportunity, about the type, level and nature of the support your service can provide. This may help ensure that everyone understands what is happening, and what they can expect. It can also reduce unreasonable requests on staff for support they cannot, or should not, deliver.

It has been suggested that staff need:

(a) sufficient knowledge of family interventions to discern when a family may benefit from this type of help;

(b) the skill to introduce the idea to families; and

(c) knowledge of available, accessible services, and how to refer to those who will provide the intervention.

This level of competence can be achieved through training, networking and joint professional development opportunities with child and family practitioners, and accessing existing literature and resources.

(Smith & Velleman 2007)

Considering children

A stronger policy and legislative focus on making 'protecting children everyone's business' has meant that AOD services are seen as having a key role to play in identifying and responding to children at risk (Council of Australian Governments 2009).

While problematic substance use by parents is an important risk factor for abuse and neglect, substance use does not always affect parenting capacity and should not be linked automatically to an assumption of abuse or neglect. *Section 3 outlines further information on working with Child FIRST and Child Protection.*

In addition to identifying children at risk through assessment practices that are sensitive to children, agencies should also aim to identify young carers. In some situations, children and young people provide support and take on significant responsibility. These young people may require support themselves, and could be referred to suitable support services.

Children's voices

Children's Voices: Experiences and perceptions of European children on drug and alcohol issues (European Monitoring Centre for Drugs and Drug Addiction 2010)

A European paper that attempts to give meaning and insight into key alcohol and other drug issues that affect children from the perspectives of the children themselves.

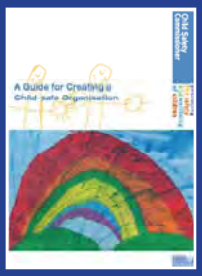
http://www.emcdda.europa.eu/publications/thematic-papers/childrens-voices

Child safety

A Guide for Creating a Child-safe Organisation (2006)

Developed by the Victorian Child Safety Commissioner, this guide includes advice for organisations on how to conduct a child-safe audit, develop a child safety policy and code of conduct.

Available from www.ocsc.vic.gov.au or by phoning the OCSC on 03 8601 5884.



Some basic questions to prompt reflection and assess the different ways your organisation considers the wellbeing of dependent children could include:

Intake

- Is it known and recorded whether clients are responsible for the care of children?
- Are the caregiving needs of parents considered during intake?
- Are the agency waiting room and appointment times child- and parent-friendly?

Assessment

- Are parental roles considered as a potential stressor on clients?
- Are parental roles considered as a possible source of motivation?
- Are parental concerns about their children identified?
- Is parenting capacity assessed?
- Are the needs of clients' children directly considered?

Intervention

- Is intervention individually tailored to family needs?
- Is strengthening parent-child relationships part of the intervention?
- In what ways are children "seen and heard" by the service?
- Is there regular and good collaboration with children's services?

Outcomes

- Do service outcomes include parenting competence?
- Do service outcomes include the safety and wellbeing of children?

(adapted from Scott 2009, p41)

Considering parents

Many clients of alcohol and other drug treatment services are parents, or will become parents in the future.

It's important to think about a client's current circumstances, cultural and social backgrounds, and future plans.

Parenting can be enormously significant for clients attending alcohol and other drug treatment services.

Having children can be a prime motivator for changing alcohol and other drug consumption patterns.

The challenges of parenting can contribute to the maintenance of problematic substance use and can impact upon the likelihood and the severity of any relapse.

Parenting issues can also impact on your client's engagement in treatment. You can minimise the risk of treatment goals not being met by identifying parenting issues and responsibilities early on in your work with clients, and then tailoring your interventions to suit.

You may also need to provide clients with the appropriate information, support, or referrals to other professional services to ensure that clients are in the best position to work on their substance-related problems with you.

(Parenting Support Toolkit 2004, pi)

Toolkit

The Parenting Support Toolkit for Alcohol and Other Drug Workers (2004, updated 2010)

This toolkit can assist AOD workers to understand, identify and respond to the needs of clients in relation to their parenting skills and children's wellbeing.

Relevant to all types and levels of client contact, it provides information and resources to support workers in addressing the crucial role of parenting in their clients' lives.

Sections of the Toolkit are being udpated (2010) to include current resource and service information. The updates will be available in hard copy and for download in 2010.

Access the full Toolkit, and updates as they become available at:

www.health.vic.gov.au

Reading

Working with clients who are parents can raise challenging issues around engagement, confidentiality and assessment. These articles discuss some of the dilemmas in working with clients who are parents:

Cousins, C. 2005 'But the parent is trying', Australian Institute of Family Studies, *National Child Protection Clearinghouse (NCPC) Newsletter*, 13:1, 3-6

Taylor, A., Kroll, B., 2004 'Working with parental substance misuse: dilemmas for practice', *British Journal of Social Work*, 34, 1115-1132

Family inclusive practice is non-blaming

Family inclusive practice acknowledges that relationships and actions between people have effects on them. It does not seek to apportion blame for past events but endeavours to focus on future actions and relationships (Patterson & Clapp 2004, p8).

Including diverse families

Clients are part of multiple and interconnected systems

Family inclusive practice recognises that clients and families operate within wider social and political systems and that these systems impact on them (Patterson & Clapp 2004, p8).

Sensitivity to the social, cultural and economic backgrounds of clients and their families is essential to good practice in AOD services.

The particular histories, contexts and needs of individuals and their family networks require specific attention and sensitivity in relation to individual professional and organisational practices and procedures.

This section provides some basic information and links to resources on developing organisations and practices that are sensitive and inclusive of clients and families from all cultural communities and under-represented groups.

Indigenous Australians, people from non-English speaking or cultural and linguistically diverse (CALD) backgrounds, gay, lesbian, bisexual, transgender and intersex (GLBTI) people and communities are among these groups.

It is essential that recognising a diversity of needs, experiences and choices, and developing real cultural competency are not seen as 'add-ons' to regular service provision. Essential too, is a recognition that individuals and families are influenced by culture, not defined by it.

We all need to have a better understanding of how we can fit in with other services to support families...

It would be beneficial to do some upskilling with other service providers to ensure that we all understand each others' roles.

AOD Service Provider

Indigenous clients and families

Many Indigenous clients access non-indigenous specific AOD and health services. This means that all services need to continue to work toward being responsive to the needs of Indigenous clients and communities. Organisations should foster understanding and sensitivity to the impacts of colonisation and past trauma.

In considering family inclusive practices, it is especially important to recognise that Indigenous definitions of 'family' can be broader and more encompassing that those commonly used by non-Indigenous people.

Links between Indigenous-specific and mainstream treatment providers, inter-agency collaboration, cross-referral and ongoing mentoring and cultural competence training will help to ensure that access to culturally appropriate services and treatment continues to grow.

Local indigenous services and key bodies like the Victorian Aboriginal Child Care Agency (VACCA) are best placed to advise on indigenous family and child wellbeing and development issues.

Indigenous kids and families

Telkaya network of Koori AOD workers

Victorian Aboriginal Child Care Agency
www.vacca.org.au

Victorian Aboriginal Community-Controlled Health Organisation
www.vaccho.org.au

Strategies for engagement

Strategies that apply to **all families** include:

- Providing a range of service options to choose from
- Being active in engagement (following up with phone calls and letters)
- Being persistent and not giving up easily
- Delivering flexible services that are not constrained by targets, funding and geographical areas
- Being flexible about where you see families (for example, homes, a public space or in other service settings)
- Acknowledging family members' expertise in their own lives and working in partnership with them
- Making sure that the family's highest need is the one addressed first
- Being responsive to crisis
- Ensuring that the resource or service offered is what the family wants
- Presenting clear information
- Ensuring that promises and commitments are met
- Promoting conversations and practices that identify and build on existing family strengths and capacities.

(Adapted from Patterson & Clapp 2004, p15)

Tips and guides

Download *tip sheets* on cultural competence from the Centre for Culture, Ethnicity and Health at www.ceh.org.au

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Cultural Diversity Guide: Planning and delivering culturally appropriate human services (DHS 2004)

http://www.dhs.vic.gov.au/multicultural/html/cultdivguide.htm

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Cultural competency in health: A guide for policy, partnerships and participation, Canberra: Commonwealth of Australia (2006)

A resource for health services developed by the National Health and Medical Research Council to build cultural competency and contribute to the evidence base.

http://www.nhmrc.gov.au/publications/synopses/hp25syn.htm

Clients and families from non-english speaking backgrounds

Cultural competence

The Australian Drug Foundation has recently published a series of fact sheets, research and resources, including:

Making treatment and prevention services more accessible for culturally and linguistically diverse communities (June 2010)

Building cultural competency in the AOD sector (June 2010)

A reading and resource list on AOD services and CALD communities.

Download these from www.druginfo.adf.org.au

Our cultural and linguistic backgrounds can form an important part of our identity. Sensitivity to culture, faith and to the language needs of individuals and families from non-English speaking (NESB) underpins effective service delivery.

Culture is often a significant influence on how 'family' is understood, on child-rearing expectations and norms, and how individuals within families relate to each other.

AOD practitioners can increase their cultural awareness by finding out about the languages, practices and experiences of groups in their area. These experiences may include recent migration, grief, loss, refugee experiences, and trauma.

Cultural competency builds on cultural awareness, and demonstrates flexibility, sensitivity, and a fundamental understanding of how our values shape our practice.

Developing partnerships with CALD organisations can be one of the best ways of meeting the needs of local communities. These partnerships may assist with staff training, ensure clear referral pathways and provide information and insight.

Promote generic skills and cultural competence rather than stereotypes.

Information about specific cultural groups and communities should be used to provide a context for interaction, not as a basis for assuming particular behaviours or attitudes.

Gay, lesbian, bisexual, transgender and intersex clients and families

Practical tips and suggestions to develop inclusive and sensitive practice for GLBTI people and their families

- Have an equality and diversity policy with a specific GLBTI strand
- Have a broad definition of family - inclusive of same sex couples, parents and friends - and display it
- Respect and understand GLBTI relationships
- Build partnerships with relevant GLBTI organisations
- Offer information about drugs and alcohol that is relevant to the GLBTI community
- Understand the stereotypes and myths regarding GLBTI people
- Invite GLBTI organisations to come and talk at your monthly staff meetings
- Create an open environment that enables GLBTI disclosure amongst service users, volunteers and staff
- Have an anti-bullying and harassment policy and be prepared to employ it
- Nominate a 'champion' to take forward GLBTI issues
- Do not 'out' a client in front of other colleagues, services users or family members
- Have a robust confidentiality policy and spaces for people to talk openly without being judged

(Adapted from Adfam 2010)

Inclusive, sensitive practice

Adfam is a national umbrella organisation working to improve the quality of life for families affected by AOD use in the UK.

Adfam is a significant voice in UK drugs policy development, and provides resources and advocacy for families and AOD practitioners.

Resources, including recently released good practice guidelines on *Including diverse families* can be accessed and downloaded from the Adfam website at:

www.adfam.org.uk

Confidentiality

Family inclusive practice acknowledges the possible tensions relating to confidentiality

Services working with adults and adolescents with substance-related issues often face the dilemma of breaching client confidentiality. Client confidentiality should only be breached where there is a clear indication that clients pose a safety risk to themselves, others or the community. In family inclusive practice, clients need to give their consent about what information they would like family members to have (Patterson & Clapp 2004, p8).

Family inclusive practice ideally involves family or significant others in assessment, treatment planning and at other times during involvement with a client, for example, to receive or share important information.

Given this, it is important to talk to clients from the outset about the benefits and importance of involving family or significant others, while reassuring them about confidentiality in relation to any contact you may have with family members or significant others.

All organisations should have policies and procedures in place to address client confidentiality. When working with more than one family member, practitioners often face the dilemma of breaching client confidentiality. While families may seek information about a client for a range of reasons, family inclusive practice supports the right of all clients to a confidential service.

It is the right of the client to determine to whom they or others disclose details of their treatment. No information regarding a person's treatment should be given without the client's explicit consent.

Confidentiality should only be breached where there is a clear risk of harm to the client or to others. This may include circumstances where clients are suicidal or where a behaviour is potentially life threatening, where children or young people are at risk of harm, or where there are significant threats to harm others. Decisions to breach confidentiality should be made following consultation with a senior clinician in the service.

Guidance on sharing information with child and family services (Child FIRST) and Child Protection is provided in Section 3.

Organisations should outline their confidentiality policy to all clients attending the service, including information on the limits of confidentiality.

(Patterson & Clapp 2004, p11-12)

Organisations should ensure they:

✓ have prior agreement with the client and informed consent before releasing any information regarding treatment

✓ have a signed release of information form from the client

✓ check after each consultation whether the client continues to agree to have information passed on

✓ clarify with the client the purpose and types of case records and what happens to them

✓ do not disclose to a family member details of a client's treatment without consent. One option is to give family members general information about the types of services offered to clients, without identifying that the client is a user of the service

✓ do not tell family members whether the client is attending the service without prior client consent

✓ establish clear confidentiality guidelines with all parties prior to commencing any joint work with clients and family members.

Further discussion and advice

on confidentiality and duty of care issues can be found in each of the guidelines listed on page 19. Also see

http://www.strongbonds.jss.org.au/workers/professional/confidentiality.pdf

Glossary of common terms

Cumulative harm

refers to harm experienced by a child as a result of a pattern of harmful events and/or experiences that may be ongoing, with the strong possibility of the risk factors being multiple, related and co-existing over critical developmental periods.

Information holder

a person authorised to share information with Child Protection and Child FIRST under certain circumstances. An information holder includes the person in charge of your AOD service (see Service Agency) at the time information is requested.

Mandatory reporter

at the time of writing, the following professions have mandated responsibilities under the CYFA 2005: medical practitioners, nurses (including midwives), teachers, school principals and members of the police force. The legislation also has provisions for a range of other professions, including social, youth and welfare workers that may become gazetted as mandatory reporters in the future. There are no current plans to include any further professions as mandatory reporters.

Protection order

either an interim or final court order that is made when a child is in need of protection. This can range from a simple undertaking through to DHS taking guardianship of the child, depending on the extent of the family's needs. If DHS are to remain involved a Best Interests case plan will be developed, which will incorporate services for the family to promote the child's wellbeing and developmental needs.

Relevant information

information is relevant if it relates directly to concerns about the child. For AOD practitioners, this means that information about a parent's drug use and/or engagement in treatment is only relevant if you believe that it is having an adverse impact on the child's safety, stability and development, or if that is the assessment of Child FIRST or Child Protection. The Child FIRST or Child Protection worker must explain to you the concerns about the child before you share any information, so that you can determine what to disclose.

Referral

a referral can be made to Child FIRST if you have a concern about a child's wellbeing. Usually this would be in relation to issues of concern that have a low to moderate impact on the child and where the immediate safety of the child is not compromised. A referral to Child FIRST may be the best way of connecting children, young people and their families to the services they need, including families who are under pressure due to a family member's problematic substance use.

Report

a report to Child Protection should be made if you have a reasonable belief that a child is in need of protection, where the factors you are concerned about are likely to have a serious impact on the child's immediate safety, stability or development. This includes a situation whereby persistent parental substance misuse is likely to result in significant harm to a child or negatively impact their stability and development.

Service agency

an agency authorised by the CYFA 2005 to share relevant information with Child Protection or Child FIRST to help them determine the most appropriate response to a referral or report they have received. This includes bodies that receive funding from the Secretary under a State contract to provide drug or alcohol treatment services. For example, AOD services are service agencies, in which staff may be information holders but are not mandated to report.

Children, Youth and Families Act 2005

Information and advice for our sector

Practitioners in organisations providing alcohol and other drug services to our community are often in a position to receive information that might impact on the safety and wellbeing of children. While some workers in AOD treatment services are required to report suspicions of child abuse and neglect (**mandatory reporters**) to the Department of Human Services, the majority are not. Organisations should have policies and procedures in place to assist practitioners in responding to perceived risk and suspected neglect or abuse.

This section provides a basic overview of the Victorian child and family service system for AOD practitioners. It summarises information available through the Department of Human Services Children, Youth and Families Division and on the *everychild everychance* website, lists current Child FIRST and Child Protection contact numbers, and provides links to additional information and resources. It includes a glossary and frequently asked questions developed for Victorian AOD workers.

AOD practitioners and services have specialist knowledge about drug use and dependence, including effects and impacts, effective interventions, treatment and strategies to reduce or minimise harms for individuals and communities.

Across the Victorian sector there are many examples of excellent practice, procedures and policy that promote knowledge sharing and effective collaboration between AOD, Child Protection and child and family services. There is a high level of commitment to quality service provision by staff.

Often, the links between services are based on personal relationships and connections, and these connections work to integrate sensitivities around both substance and family issues into case practice. These connections work well where they exist but there are some gaps. One of the core aims of VAADA's *Familiar needs* forums and this resource is to build confidence and strengthen knowledge and relationships with the Child Protection and child and family service systems.

Most of the staff in our organisation are relatively new to the AOD sector.

They understand the basic principles of the Act but will require upskilling.

AOD Service Provider

Legislation and policy

The CYFA is interpreted and applied through a range of policies and guidance for Child Protection, Child FIRST, child and family and related services.

The **Publications** section of the Department of Human Service's *everychild everychance* website provides useful resources including conceptual overviews, case practice models, fact sheets and guidelines. Go to:

www.cyf.vic.gov.au/every-child-every-chance

An electronic version of the legislation can be accessed at:

www.legislation.vic.gov.au

Note

The information provided throughout this section is sourced from information and publications developed by the Department of Human Services and available via:

www.dhs.vic.gov.au, and

www.cyf.vic.gov.au

Fact sheets

and explanatory notes on the CYFA can be accessed and downloaded from:

http://www.cyf.vic.gov.au/every-child-every-chance/library/publications/fact-sheets2

The CYFA legislation is part of the *everychild everychance* reforms underway in Victoria since 2005. The CYFA focuses on principles and systems for protecting and promoting the wellbeing of vulnerable children. The *Child Wellbeing and Safety Act*, also passed by Parliament in 2005, provides an overarching framework for promoting positive outcomes for all children.

Both pieces of legislation align with the *Convention on the Rights of the Child* (1989) that gives precedence to a child's right to safety and healthy development. The legislation is also informed by the idea that while parents are the primary nurturers, the wider community shares responsibility for children's wellbeing and safety.

The enactment of the CYFA marked a shift in Child Protection and child and family services away from responses based on minimal intervention in family life, to assessment, planning and action that is driven by what a child needs to protect and promote their healthy development (DHS 2007).

The CYFA requires:

- a constant focus on the best interests of the child
- that the safety of child, the protection of their rights and promotion of their development must be paramount
- the strengthening of families in culturally appropriate ways
- the inclusion of families and children in decision making process (DHS 2007).

The CYFA recognises that protecting and promoting the wellbeing of all children is dependent on the support of services across the broader health, education and community sectors. **Information sharing** and an understanding of the core concepts of best interests and **cumulative harm** are therefore promoted.

Best Interests

The Best Interests principles underpin all decisions and actions taken in relation to vulnerable children or young people. The CYFA requires that the best interests of the child must be the paramount consideration in any action or decision taken by the Children's Court, Child Protection or Child FIRST/ child and family services.

When determining whether a decision or action is in the child's best interests, there are a number of needs that must be considered:

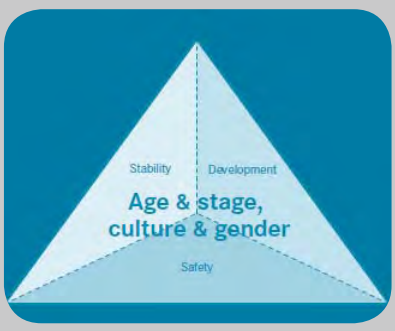
- The need to protect the child from harm
- The need to protect the child's rights
- The need to promote the child's development (taking into account his or her age, stage of development, culture and gender).

In addition, the principles stipulate that the parent-child unit be protected and supported through interventions and assistance; that family relationships be strengthened; that the child's views and wishes be acknowledged; and that a child should only be removed from his or her parents where there is an unacceptable level of risk or harm.

The Best Interests principles include a specific requirement that the cultural and spiritual identity and development of Aboriginal children be promoted and protected.

The Best Interest principles underpin all decisions and actions taken by the Children's Court, Child Protection and Child FIRST/family services.

The need to protect the child from harm, to protect his or her rights, and to promote his or her development will be the priority and foremost consideration in any decision or action in relation to a child and their family.



Child FIRST

Child & Family Information, Referral & Support

Practitioners in organisations providing alcohol and drug services to our community are well placed to receive information that might impact on the safety and wellbeing of children.

Child FIRST sites are central, community-based referral points to a range of family services and supports within sub-regional catchments.

Child FIRST aims to ensure that vulnerable children, young people and their families are linked effectively with relevant services.

This reflects one of the key objectives of the CYFA legislation to create a more integrated Child Protection and child and family service system.

Child development

A series of guides on typical stages of child development are available for download at:

http://www.cyf.vic.gov.au/every-child-every-chance/library/publications/child-development-trauma-guide

The guides offer advice and provide indicators for recognising trauma at specific ages and stages.

Metro Child FIRST Referral

DHS Region	Local Government Area		Child FIRST Referral Number
Eastern Metropolitan	Yarra Ranges Knox	Maroondah	1300 369 146
	Monash Whitehorse	Manningham Boroondara	1300 762 125
North and West Metropolitan	Nillumbik Whittlesea Banyule	Yarra Darebin	9450 0955
	Brimbank	Melton	1300 138 180
	Hume	Moreland	1300 786 433
	Hobson's Bay Maribyrnong Wyndham	Melbourne Moonee Valley	1300 775 160
Southern Metropolitan	Casey Greater Dandenong	Cardinia	9705 3939
	Aboriginal children and families	*Casey Cardinia Greater Dandenong*	*9794 5973*
	Frankston	Mornington Peninsula	1300 721 383
	Kingston Stonnington Port Phillip	Bayside Glen Eira	1300 367 441

Regional Child FIRST Referral

DHS Region	Local Government Area		Child FIRST Referral Number
Barwon South Western	Greater Geelong Queenscliff	Surf Coast	1300 551 948
	Colac-Otway	Corangamite	5232 5500
	Warrnambool Moyne	Glenelg Southern Grampians	1300 889 713
Gippsland	East Gippsland		5152 0052
	Wellington		5144 7777
	La Trobe	Baw Baw	1800 339 100
	South Gippsland	Bass Coast	5662 5150
Grampians	Northern Grampians West Wimmera	Yarriambiak Horsham Hindmarsh	1800 195 114
	Ararat Pyrenees Hepburn	Ballarat Golden Plains Moorabool	1300 783 341
Hume	Wodonga Towong	Indigo	1800 705 211
	Alpine Benalla	Mansfield Wangaratta	1800 705 211
	Greater Shepparton Moira	Strathbogie	1300 854 944
	Mitchell	Murrindindi	1800 663 107
Loddon Mallee	Greater Bendigo Campaspe Central Goldfields	Loddon Macedon Ranges Mount Alexander	1800 230 338
	Buloke Gannawarra	Swan Hill Mildura	1300 325 533 (1300 MALLEE)

A **referral** to Child FIRST

When you make a referral to Child FIRST, a decision is made about what to do with the information you have provided. This may include Child FIRST consulting with other professionals to find out more information about the child.

Some families may be assisted by the provision of information and advice only, however for most families referred to Child FIRST, a cycle of assessment, planning and action will be undertaken.

If Child FIRST decides that the child may benefit from support services, they may arrange appropriate services for the child and their family.

If Child FIRST believes that the child is in need of protection, they must report the case to Child Protection. This is because Child FIRST does not have any statutory powers to protect a child.

When Child FIRST receives a referral and reports it to Child Protection, they will disclose the identity of the referrer to Child Protection, but Child Protection cannot then disclose the referrer's identity to anyone else without the referrer's written consent.

If Child FIRST decides that no offer of service needs to be made, the family will be informed that a referral was made, including the concerns expressed in the referral. Your identity is protected in this instance, unless you consent to it being disclosed.

Although not a legal requirement and keeping in mind that the CYFA 2005 limits the sharing of information, Child FIRST should inform you of the outcome of your referral and in many cases will invite you to be included in the assessment, planning and action to support the child and family.

Child Protection

The Victorian Child Protection Service is specifically targeted to those children and young people at risk of significant harm whose families are unable or unwilling to protect them.

Child Protection workers have statutory powers to intervene to protect a child.

The main functions of Child Protection are to:

- investigate matters where it is alleged that a child is at risk of significant harm
- refer children and families to services that assist in providing the ongoing safety and wellbeing of children
- take matters before the Children's Court if the child's safety cannot be ensured within the family
- supervise children on legal orders granted by the Children's Court
- provide and fund accommodation services, specialist support services, and adoption and permanent care to children and adolescents in need of protection.

Substance use and Child Protection assessments

Child Protection practitioners receive specific guidance on assessing for risk and harm related to parental substance use.

Advice on alcohol and other drug assessments and screening from the Child Protection Practice Manual are included in this folder.

See Resource 4

Metropolitan Child Protection Services

Eastern
1300 360 391

Southern
1300 655 795

Northern & Western
1300 664 977

Regional Child Protection Services

Barwon South Western
1800 075 599

Gippsland
1800 020 202

Grampians
1800 000 551

Hume
1800 650 227

Loddon Mallee
1800 675 598

After Hours

Child Protection Emergency Service
13 12 78

We're aware of the mandatory reporting and notification requirements, but in practice these can be difficult to achieve because of concerns around confidentiality, the rapport between worker and client, and trust among agencies.

AOD Service Provider

Sharing information with Child Protection

When conducting an investigation into alleged concerns about a child or young person, AOD practitioners should be aware that Child Protection workers

- may make wide-ranging enquiries to inform a risk assessment
- gather information through telephone calls, face-to-face visits, case conferences and case planning meetings
- will only provide details of their assessments to other professionals on a 'need to know' basis
- cannot receive information 'off the record', and
- may use any information provided, if it contributes to the child's safety.

A **report** to Child Protection

Upon receipt of a report containing information about factors that may have a serious impact on a child's immediate safety, stability or development, Child Protection will seek further information.

In determining what action to take, Child Protection will also consider any previous concerns that may have been reported about the child or young person. *See the box opposite for a summary of substantiation and risk assignment processes and decisions.*

If Child Protection believes that the child is in need of immediate protection, they can use their statutory powers to protect the child and make an application to the Children's Court.

In most circumstances Child Protection will require consent from the client to disclose outcomes of the investigation to workers. This may be different if you have an ongoing role with the family.

Substantiation and risk assignment decisions

After a protective investigation, where the alleged harm/risk of harm is **not substantiated**, the following actions may be determined:

- *No significant concerns – close*
- *Significant concern for wellbeing – refer to Child FIRST/Family Services and close*

After a protective investigation where alleged harm/risk of harm is **substantiated**, the following actions may be determined:

- *Risk of significant harm – child in need of protection – issue Protection Application*
- *No further risk of significant harm – refer (as necessary) and close*
- *Risk assignment deferred – further protective intervention/assessment - develop Best Interests Plan*

The outcome of a period of further intervention and assessment would be:

- *Risk of significant harm – child in need of protection – issue Protection Application*
- *No further risks of significant harm – refer and close.*

Reports and referrals

How do I know if I should contact Child FIRST or Child Protection?

The following information is based on Department of Human Services information sharing guidelines (DHS 2007), and is intended to provide basic guidance on whether to refer a matter to Child FIRST or make a report to Child Protection.

Referrals and reports are sometimes called 'notifications'.

A referral to Child FIRST

A referral to Child FIRST may be the best way of connecting children, young people and their families to the services they need.

You should consider making a referral where families show any of the following that may impact upon a child's safety, stability or development:

- Significant parenting problems that may be affecting the child's development
- Serious family conflict, including family breakdown
- Families under pressure due to a family member's physical or mental illness, substance use, disability or bereavement
- Young, isolated and/or unsupported families
- Significant social or economic disadvantage that may adversely impact on a child's care or development.

In deciding whether to make a referral to Child FIRST or a report to Child Protection, consider these factors:

- What specifically has happened to the child that has caused your concerns and what is the impact on their safety, stability, health, wellbeing and development?
- How vulnerable is the child?
- Is there a history or pattern of significant concerns with this child or other children in the family?
- Are the parents aware of the concerns, capable and willing to take action to ensure the child's safety and stability, and promote their health, wellbeing, and development?
- Are the parents able and willing to use support services to promote the child's safety, stability, wellbeing and development?

You should consider making a referral to Child FIRST if the factors you are concerned about currently have a **low to moderate impact** on the child, where the immediate safety of the child is not compromised.

You should consider making a report to Child Protection if the factors you are concerned about currently have a **serious impact** on the child's **immediate safety, stability or development**, or are **persistent** and entrenched and likely to have a serious impact on the child's development.

There's a memorandum of understanding between our service and child protection, and staff are encouraged to regularly reflect on their work practices.

AOD Service Provider

Information sharing

Sharing information is a key means of identifying and supporting vulnerable children and families.

A series of **information sharing guides** developed by DHS are available at:

http://www.cyf.vic.gov.au/every-child-every-chance/library/publications/information-sharing-guidelines

You may also wish to contact your local **Victoria Legal Aid** service for further information about your rights and responsibilities in relation to information, privacy and confidentiality.

www.legalaid.vic.gov.au

A report to Child Protection

A report to Child Protection should be made in any of the following circumstances:

- Serious physical abuse of, or non-accidental or unexplained injury to, a child
- A disclosure of sexual abuse by a child or witness, or a combination of factors that suggest the likelihood of sexual abuse – the child showing concerning behaviours, for example, after the child's mother takes on a new partner or where a known or suspected perpetrator has had unsupervised contact with the child
- Serious emotional abuse or ill-treatment of a child impacting on the child's development
- Persistent neglect, poor care or lack of appropriate supervision, where there is likelihood of significant harm to the child or the child's development
- Serious or persistent family violence or parental substance misuse, mental illness or intellectual disability – where there is likelihood of significant harm to the child or the child's development
- Where a child's actions or behaviour may place them at risk of significant harm and the parents are unwilling or unable to protect the child
- Where a child appears to have been abandoned, or where the child's parents are dead or incapacitated, and no other person is caring properly for the child.

Frequently Asked Questions

What am I required to do if I receive a request for information about a client from Child FIRST and/or Child Protection?

The CYFA permits registered Child FIRST/ Family Services and Child Protection staff to consult (seek information and professional opinion) during the intake assessment for the purposes of assessing risk or determining the agency best able to provide assistance. This could include contacting information holders within service agencies to ascertain further details about a particular case.

There are three relevant stages whereby a worker may be required to provide information:

1. At the investigation stage information provision is completely voluntary. This applies whether it is Child FIRST or Child Protection requesting the information.
2. At the court stage there might be a court order that requires parties to authorise the release of information. The content of the report is up to the worker, although deliberate omissions of important information may have a negative impact on the credibility of the worker.
3. At the stage where a protection order is in force there can be a direction under Section 195 of the CYFA 2005 to disclose information.

What recourse do I have under the legislation if I feel that the information shared is being misrepresented or used for purposes not explained to me?

For example, what if information on illicit drug use is provided to police?

When you share information with Child FIRST or Child Protection, you are allowed to disclose any information that you believe is relevant to the safety, stability and development of a child.

Further, the **information sharing** process is a two-way exchange which requires the Child FIRST or Child Protection worker to explain to you the concerns about the child before you share any information, so that you can determine what information is relevant to disclose.

Section 195 of the CYFA 2005 only allows information to be disclosed to the Secretary and used for the protection and development of the child. There are general penalty provisions provided in the legislation, confirming that anything that is disclosed through this process can only be used in Child Protection proceedings. Therefore police are not legally able to use information related to illicit drug use for other purposes.

Information sharing

See Resource 5 for a summary table of information you can share under the CYFA, with whom, and whether you are legally protected.

Under what circumstances would the CYFA or the court require that an authorised persons' identity be disclosed?

Am I able to determine if my details will be disclosed prior to providing information to Child Protection or Child FIRST?

Authorised people who are consulted and provide information to Child Protection or Child FIRST are protected against legal and professional liability.

The identity of authorised people who are consulted and provide information to Child Protection or Child FIRST/Family Services for the purposes of assessing risk or determining the agency best able to provide assistance, will be treated as confidential unless the law or a court order requires the disclosure of their identity, or unless the authorised person consents to their identity being disclosed.

(Note: Confidentiality is, strictly speaking, only given to those who are formal 'reporters' or 'referrers' at the concern stage (Section 41), or at the protection stage (Section 191), or who have sought confidentiality at the formal investigation stage (Section 209)).

Notifiers are protected in all circumstances, however there are many examples whereby a person may be identified due to specific circumstances associated with the case For example, the family subject to the notification may determine that the worker from Service Agency X was the only other person to know about a fact raised in the report.

How do the legal requirements differ with regard to my role as an AOD worker when a Children's Court Protection Order is in place as compared to when no such order exists?

If you choose not to share information with Child Protection when they contact you about a child who is the subject of a Protection Order, as an Information Holder, you can be directed in writing by an officer of the Department of Human Services to provide relevant information about the child. The officer in this instance is personally authorised by the Secretary of the Department of Human Services.

If you fail to disclose information when such a direction is properly made and do not have a reasonable excuse, you may be prosecuted. The information required must be relevant to the protection and development of the child and will be specified in the written direction.

You may be required to provide a verbal or written opinion or information about the child, and/or relevant documents.

Our responsibilities to children are discussed regularly as part of client assessment and clinical review, and issues around child safety are bought to managers for consultation. Development of a playgroup has raised awareness amongst staff.

AOD Service Provider

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This list covers material referenced directly in this resource folder, but also includes articles and publications that may of interest to AOD workers and managers.

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State wide forum presentations

(Note: the presentations delivered by local providers at each forum are not included)

Fadnet: Family Inclusive Practice for the Alcohol & Other Drugs Sector

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Victoria Legal Aid: Children, Youth & Families Act and AOD worker responsibilities

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Parenting Support Toolkit for AOD workers

Familiar Needs

Family Inclusive Practice for the Alcohol & Other Drugs Sector

vaada

What is Fadnet?

- A network of professionals with an interest in family based solutions to drug and alcohol problems.
- Fadnet aims to:
  - ✓ increase & influence awareness of families & their needs, including wellbeing and safety for children
  - ✓ share practice wisdom
  - ✓ promote research on family inclusive policy and practice

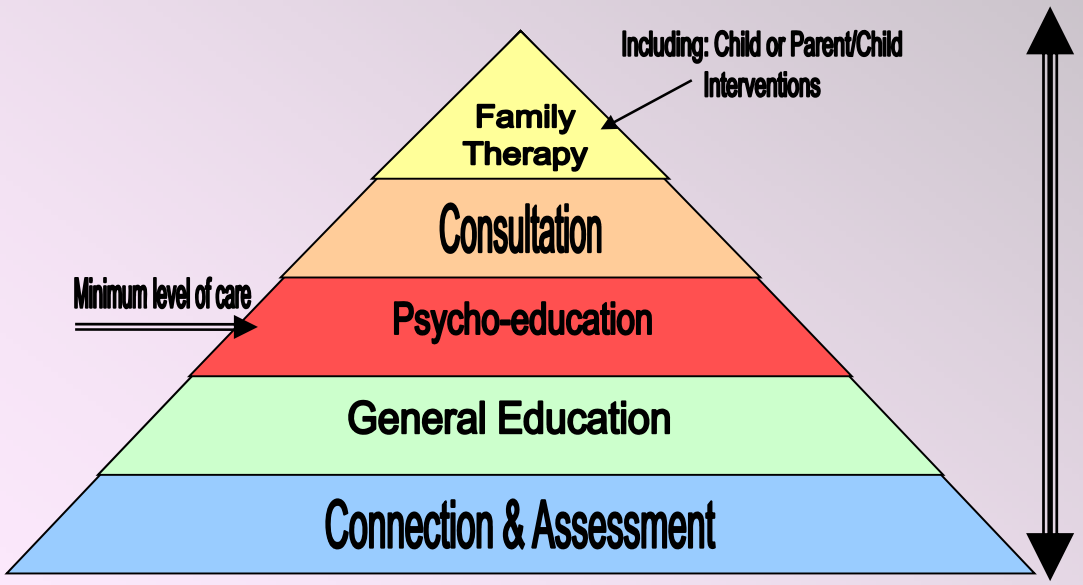
Defining Family Inclusive Practice

- Acknowledges that individuals influence and impact the family
- Recognises that interventions are more effective when family is included
- Considers the family constellation behind the individual
- Continuum of practices that involve families in accordance to needs of both the family & substance user

Copello & Orford, 2002
Mottaghipour & Bickerton, 2005

- *Family-centred* - the family is the focus of the work
- *Family-sensitive* – considers family as a broad concept
- *Family-inclusive* – focussing on the individual and incorporating the family, both directly and indirectly

Family Inclusive Continuum for AOD Workers



Pyramid of Family Care

- Integrated Practice
- Shared Care
- Referral to AOD Family Program
- Primary consultation
- Secondary consultation
- Socratic questions
- Genogram
- Information of services
- Recognition
- Awareness & Openness

Mottaghipour & Bickerton, 2005
EDAS Family Focus Project, 2010

Why does including family matter? The Research…

- Assists with encouraging the substance user into treatment & improves prognosis
- Improves substance-related outcomes & family functioning
- Leads to the reduction & impacts of harm
- Reduces substance use / mental health relapse rates & family distress levels
- Changes in family behaviour/reactions creates opportunities for the substance user to recognise problematic behaviours
- Family approaches are just as effective for co-existing issues
- Enhances children's safety & wellbeing
- Best practice

Copello & Orford, 2002
Copello et al, 2004 & 2006
Mottaghipour & Bickerton, 2005
Smith & Velleman, 2007

Statewide & National Activities… A snapshot

- Kids in Focus
  -early intervention program
- Lighting the Beacon Project
  -workforce development
- COPMI & FAPMI
  -initiatives in mental health
- Think Family
  -from the UK targeted support for parents & families

- AOD and Child Protection partnerships and protocols
- Addressing the need for strategies to bridge gaps between child & family and AOD services
- Australian Centre for Child Protection capacity building funding
  - for Mental Health, Violence and AOD sectors
- Protecting Children is Everyone's Business
  - National Framework

Good Practice Models… another snapshot

- The Bouverie Centre
  - Family Therapy
  - Single Session Therapy
- Counting the Kids & Brokerage Fund
  - Support/resources/opportunities for children of substance users
- EDAS- First Response
  - Information/discussion forum & resource kit for families affected by substance use
- Family Drug Help
  - Help Line
  - Support for families & siblings
- PUP- Parents Under Pressure
  - Home-based 12 module program
- Safe at Home
  - Focus on children's wellbeing and building resilience for positive parenting
- Supported Play Groups

Fadnet's Role

- To support implementation of the Victorian Blueprint for the AOD Sector, particularly:
  - Client-Centred Principle 2: *Interventions must reduce the harmful impact of alcohol and other drug use on children and families*
- To advocate for ongoing government reform:
  - Policy development and strategic planning to ensure accessibility of service
  - New data collection plan – measuring family inclusive practice
  - Increased funding to support innovation and organisational development
- To further family inclusive practice workforce development:
  - Minimum practice standards
  - Further definition & development of the practice continuum

Victoria Legal Aid

Lawyers And Legal Services

VAADA children and families forum

Children, Youth & Families Act and AOD worker responsibilities

Suzanne Bettink - Youth Professional Support Lawyer, VLA

Clear outline of responsibilities

Ha!

- no such thing as ‘clear’

- any attempt at clarity depends on the stage/phase of the case:
  - wellbeing assessment/no court
  - protective investigation/in court
  - final protection order

But first…

Before getting into responsibilities, let's think outside the square…

- AOD knowledge of the average protection worker is not as great as that of an AOD worker (they have to cover a much broader range of issues)
- This might affect their ability to comprehend what you might tell them
- They might have preconceived notions about drug issues that are not based on fact, eg
  - the only way to deal with AOD issues is to stop all AOD use
  - it is not possible to be AOD addicted and care for a child (tell that to doctors who are AOD addicted, including 30 in the UK who were allowed to continue to practice while on legal heroin)
  - a relapse means children must be removed because they must be unsafe
- You have the opportunity to educate them to correct their misconceptions

So, before providing any info to DHS/ChildFirst

Try to make sure that they understand what you are saying:

- don't assume that saying 'they only use once a week so we're only looking at harm minimization issues' means that the worker will accept that this means that they are capable of parenting the child if they are not impaired.

- don't assume that saying 'they are doing really well on methadone/benzos' means that the worker will accept that this means that they are not incapable of caring for their child.

- don't assume that saying 'they only used once on the weekend then contacted me straight away and didn't use again' means that the worker will accept that this is a good thing.

So, back to child protection system involvement…

There are three stages/phases where there may be a request for information that are most relevant to AOD workers:

- wellbeing assessment/no court (by ChildFirst and/or DHS)
- protection investigation/court (by DHS)
- final protection order (by DHS)

Request for information – wellbeing assessment/no court

Whether it is ChildFirst or DHS, the rules are the same

- information may be requested, but the decision about provision is entirely up to each worker
- the client may get a better result if you provide information (if it is helpful, or if there is at least something positive to say with a plan for improvement underway)
- you don't have to obtain the client's permission to disclose information that is provided as a referral or disclosure: protection under sections 37 and 40, BUT
- relationship with client would probably be best served if their authority was obtained and there was discussion about the issues that could be included in the information provided to child protection

Note: this stage may include 3 months, sometimes more, of 'voluntary' involvement with DHS.

Request for information – Protective investigation/Court

If DHS is concerned that a child is need of protection, they may issue a protection application in the Children's Court; there are then two bases for them to request provision of information:

- Section 192 – Secretary may request provision of information relevant to the protection or development of a child.
- NOT compulsory to provide information, but if information is disclosed in good faith it is not a breach of ethics/unprofessional conduct even if you do not have authority from your client.

- Court order – sometimes the court will make an order that a party attend DOA assessment and treatment and that reports (about attendance) be given to DHS.
- If 'about attendance' is included in the order then this simply refers to the fact that the party attended, otherwise the information to be provided is more broad.

Request for information - Final protection order

If a child is in need of protection, the court makes a protection order

- Examples include supervision order, custody to secretary of DHS, guardianship to secretary of DHS
- This does NOT include interim orders (eg Interim Accommodation Order, Interim Protection Order)
- Anyone ‘authorised’ by the Secretary can then give a direction under section 195 to provide information relevant to the protection or development of a child in respect of whom a protection order is in force.
- Under section 196 this can include a direction that you provide oral or written information, documents and ‘reasonable assistance’.
- It is actually an offence to refuse or fail to comply: Section 197
- It is an offence to give false or misleading information: s. 201

Disclosure of the identity of providers of information

Again, there are three stages/phases to be considered in relation to the provision of information by AOD workers:

- wellbeing assessment/no court (by ChildFirst and/or DHS)
- protection investigation/court (by DHS)
- final protection order (by DHS)

Identification of info provider – wellbeing assessment/no court

- Section 37 Disclosers protected (provided acting in good faith)
  - – disclosing information to DHS and ChildFirst is not unprofessional conduct
  - – there can be no liability

- The identity of a person who discloses information is **not** confidential

- Section 40 ‘Reporters’ and ‘referrers’ protected
  - – disclosing concerns about the wellbeing of a child or unborn child is not unprofessional conduct
  - – there can be no liability

- Section 41 Identity of reporter or referrer confidential
  - – if you are a ‘reporter’ (to DHS) or ‘referrer’ (to ChildFirst) about wellbeing concerns, then your identity is protected

Identification of info provider – Protective investigation/in Court

- Section 189 ‘Reporters’ protected
  - a report of protective concerns to DHS is not unprofessional conduct
  - there can be no liability
  - The identity of ‘reporters’ is confidential (section 191), with rare exceptions in court proceedings (section 190)

- Section 193 and 208 ‘Disclosers’ and ‘Givers of Information’ protected
  - disclosing information to DHS is not unprofessional conduct
  - there can be no liability
  - the identity of a person who discloses information is **not** confidential **unless** you specifically state that you are providing the information in confidence: section 209
  - exception to confidentiality: if disclosure is necessary for the safety and well-being of the child

BUT often the family will be able to work out from the allegations (that may be included in written reports) who it was that made the report.

Identification of info provider – Final protection order

Presumably because information provided under section 195-196 has been provided by force, the law does not include protections or confidentiality.

So, if

- a child is on a final protection order
- DHS is of the view that you have information or documents relevant to the development or protection of that child
- DHS gives you a written direction to provide information or documents

Then the family can be told that you provided that information or documents – but you can say you had no choice.

Use of information you provide

This information is only for use by the Secretary

- the information may only be used ‘for the purpose of assessing a risk to a child’ or ‘for a purpose relating to the protection or development of the child’:
  - section 36 re ChildFirst investigation
  - Section 205 (2)(b) re DHS investigation and court
  - Section 196 (3A) re final orders

- The information given or documents produced under s. 196 can not be used in evidence in a legal proceeding other than protection proceedings: Section 202
- This means it can not be given to the police and can not be used in a prosecution of criminal charges.
- BUT there are no similar provisions to section 202 for information provided at the wellbeing assessment or protective investigation/ in court stages/phases.

A Parenting Support Toolkit for ATOD workers

VAADA Children and Families Forums October 2010

Anne Parkes
Dr. Stefan Gruenert
Odyssey House Victoria

The Parenting Support Toolkit - background

- Victorian DHS (now DH) identified the need
- In 2005 DHS funded the development of the toolkit and some sector orientation to it
- Victorian Parenting Centre (now Parenting Research Centre) & Odyssey House Victoria partnership
- Consultations with the AOD sector & parents

Why include parenting in AOD work

- Enhance clients' commitment to change
- Extend harm minimisation beyond the client
- Increase child wellbeing
- Provide an opportunity to 'break the cycle'
- Work in a holistic and family inclusive way
- Improve service integration

Drug Use & Parenting

- Parenting is:
  - an important aspect of clients' lives
  - a motivating factor and a barrier to treatment
  - both rewarding and stressful by nature
- Parenting and drug use often interact
- Some parenting = good drug treatment

Issues for AOD workers

- Raising parenting issues (when it is not the primary/referral issue)
- Finding the resources (time, funding & skills)
- Involving other sectors and agencies/workers with different perspectives/approaches
- Confronting worker values and beliefs
- Notifying child protection and balancing the needs of all family members

Worker Survey in 2005

- 105 Victorian AOD workers
- Average 7 years in AOD sector
- 85% strongly agree or agree they always know whether their clients are parents
- Difference between stated and actual knowledge.

Rank	**Importance** of Issue	**Frequency** addressed	**Confidence** in assisting
1	Relationships	Relationships	Health
2	Housing	Health	Relationships
3	Health / **Parenting**	Housing	Housing
4	Health / **Parenting**	**Parenting**	**Parenting**
5	Training / Employment	Training / Employment	Training / Employment

What is the Toolkit?

➢ The Parenting Support Toolkit:

- helps AOD workers identify the needs of parents and their children when parents attend drug treatment
- provides workers with resources and strategies to effectively respond to clients' parenting needs
- contains 3 Booklets and a Quick Reference Card

Content of the Toolkit

- Booklet 1: Exploring Parenting Issues
  - how parenting is relevant to AOD work
  - the impact of drug use on children
  - a collaborative, strength-based approach to working with parents
  - a self reflection guide

Content of the Toolkit

- Booklet 2: Information & Tools
  - background information, strategies, measures and guidelines on assessment and interventions with parents
    - eg. Questionnaires and screening tools, sample interview questions, parent-child observation guidelines, Ecomaps, Genograms, Treatment plans etc.

Content of the Toolkit

- Booklet 3: Service & Resource Guide
  - a Service Guide
    - eg. Victorian child and parenting services, child care options, specialist AOD family programs, family benefits and entitlements
  - a Resource Bibliography
    - eg. Tip sheets, websites, booklets, information links about parenting and children

Content of the Toolkit

- Quick Reference Card:
  - 2 sided laminated card
  - summary of the self reflection guide about including parenting in AOD treatment
  - details of key referral service phone numbers and resources

Further Information

- The updated Toolkit is available on the DH website

- Odyssey House Victoria
  - www.odyssey.org.au
- Parenting Research Centre
  - www.parentingrc.org.au

Small Group Exercise

- In groups of three (client; worker; observer)
- Worker is to practice incorporating the client's parenting role and their children's needs into a discussion with the client about a relapse prevention plan

Discussion: Using the Toolkit

- How can the Toolkit be incorporated into your AOD work?
- What barriers (agency, client or personal) might prevent you from using the Toolkit?
- How can these barriers be overcome?

Think child, think family

1

Scott, D. 2009 'Think child, think family',
Family Matters, No.81, Australian Institute of Family Studies, p37-42

The Family Focus Toolkit

2

The Family Focus Toolkit 2010
Eastern Drug and Alcohol Service, Victoria

Also available for download from www.edas.org.au

VicHealth Partnerships Analysis Tool

3

McLeod, J. 2004 *The Partnerships Analysis Tool*
VicHealth, Melbourne

Also available for download from www.vichealth.vic.gov.au

Child Protection Practice advice

4

1. Drug and alcohol assessments (Advice no.1117)
2. Use of drug screens in Child Protection assessments (Advice no.1504)

Department of Human Services (DHS) 2007 *Protecting Victoria's Children – Child Protection Practice Manual,* Victorian Government Department of Human Services, Melbourne

Also available from www.cyf.vic.gov.au

Summary of information sharing guidelines and how they apply to you

5

Department of Human Services (DHS) 2004 *Providing support to vulnerable children and families: an information sharing guide for authorised Information Holders or professionals employed by Service Agencies in Victoria*, Victorian Government Department of Human Services, Melbourne

Also available for download from www.cyf.vic.gov.au

"Think child, think family"

How adult specialist services can support children at risk of abuse and neglect

DOROTHY SCOTT

Child abuse and neglect inflicts immediate suffering on large numbers of children and has serious long-term effects on physical and mental health in adulthood (Middlebrooks & Audage, 2007). Child maltreatment is strongly associated with a number of other serious problems among children and adolescents, including low birth weight, school failure, conduct disorder, poor mental health, substance abuse and teenage pregnancy (Durlak, 1998).

A large number of Australian children are involved in the statutory child protection system. In some jurisdictions in Australia, as in some parts of the United States, at least one in five children has been the subject of a child protection notification by the age of 18 years (Department of Community Services, 2007; Hirte, Rogers, & Wilson, 2008; Sabol, Coulton, & Polousky, 2004). In 2006–07, there were 58,563 substantiated cases of child abuse and neglect in Australia, a 45% increase from 2002–03 (Australian Institute of Health and Welfare [AIHW], 2008). In approximately two-thirds of substantiated child protection cases, the primary problem is neglect or emotional abuse, with physical or sexual abuse comprising the remainder (AIHW, 2008).

On 30 June 2008, there were 31,166 children in state care in Australia, which is almost double the number a decade ago, and the rate of Aboriginal and Torres Strait Islander children in out-of-home care is eight times that of other children (AIHW, 2009). Bringing children into state care may provide short-term safety, but it carries the risk of longer term psychological harm associated with foster placement instability. Such instability is now endemic in out-of-home care systems, with two-thirds of Victorian children in state care on 30 June 2001 having experienced four or more previous placements (Department of Human Services, 2002).

Recent US research suggests that multiple foster placements in the first 18 months after a child enters state care led to an increase in behavioural problems, regardless of whether a child had behavioural problems on entering care (Rubin, O'Reilly, Luan, & Localio, 2007). A massive data linkage study by the National Bureau of Economic Research, involving 45,000 children in Illinois, found that children on the margins of placement who were placed in foster care had higher arrest rates as adults than those at similar levels of risk who remained with their parents (Doyle, 2007).

With the trajectory of numbers of children in state care increasing and the continuing problem of recruiting and retaining foster carers, out-of-home care systems in Australia are unsustainable. While demographic differences between jurisdictions make direct comparisons difficult, the very large gap in the proportions of children in state care across Australia, ranging from 4.2 per 1,000 children in Victoria to 8.4 per 1,000 in New South Wales (AIHW, 2009), suggests that a lot more can be done to prevent children entering state care.

Parental substance dependence, mental illness and domestic violence

Analyses of substantiated child protection cases show very high levels of parental drug and alcohol abuse, mental health problems and domestic violence in this population, and that such problems are closely interrelated. In an analysis of Victorian substantiated child protection cases (Department of Human Services, 2002), 52% were found to involve domestic violence, 33% drug abuse, 31% alcohol abuse and 19% psychiatric disability. In other states, a similar pattern exists (Department of Community Services, 2007).

Families struggling with problems such as substance dependence, mental health and domestic violence are not only concentrated in statutory child protection services but are much more likely to be involved in correctional services and emergency accommodation services. A picture thus emerges of families with complex and compounding problems. For example, maternal depression and substance abuse are closely correlated and it is the combination of these that has the greatest negative impact on children (Dawe, Harnett, & Frye, 2008).

Children in the child protection system are the tip of the iceberg of a much larger number of "at-risk" children in the wider community. For example, in relation to alcohol abuse, Dawe et al. (2008) estimated that approximately 13% of Australian children live in a household with at least one adult who is regularly binge drinking. While not all of these children will suffer from abuse and neglect, parental alcohol misuse greatly increases the risk of:

- *emotional abuse*, for example, by witnessing domestic violence;
- *neglect*, for example, from having inadequate food, clothing and medical care; and
- *physical and sexual abuse*, both directly as a result of the disinhibiting effects of alcohol on the perpetrator, and indirectly due to the reduced capacity of intoxicated parents to protect children from abuse by others.

The scale of the problem of parental alcohol abuse alone is such that it cannot be solved solely by services. It requires population-based measures, such as taxing liquor according to its alcohol content, restricting alcohol advertising and providing evidence-based social marketing campaigns.

A public health approach to child protection includes such population-level interventions, as well as reforming service systems so that primary, secondary and tertiary interventions are better integrated and more effective (O'Donnell, Scott, & Stanley, 2008).

Building the capacity of children's services to be parent–child centred

Increasing attention is being given to the prevention of child abuse and neglect and other poor developmental outcomes for children through universal maternal and child health services, early childhood education and care services, and schools. Universal children's services are seen as unstigmatised platforms from which to reach vulnerable families in holistic ways and reduce risk factors such as poor parent–child attachment and social isolation.

"Joining up" such services so that they provide a more integrated response to families with multiple and complex needs is also receiving greater emphasis. A leading example of this policy direction is the UK Sure Start initiative, which began in 1999, and which brings together early childhood education and care, health and family support services, with a focus on outreach and community development. It is offered to families with children under four years of age living in areas of

social disadvantage. There is great diversity in Sure Start Local Programmes, but the following principles are common:

- involving parents as well as children;
- using non-stigmatising approaches;
- transcending "education", "health" or "parenting" through multifaceted interventions;
- being locally driven and based on consultation with parents and communities; and
- being culturally appropriate and sensitive to the needs of children and parents.

Recent evaluations of Sure Start have raised concerns that the most disadvantaged families are not accessing these services. A variation between the outcomes for different services was also found and the possible reasons for this explored (Anning & National Evaluation of Sure Start Team, 2007).

One of the key challenges in such integration strategies is how to shift the orientation of a child-focused workforce

towards the parent–child relationship being the primary unit of attention. The author was involved in a successful Australian example of this in the late 1970s and 1980s. Victorian maternal and child health nurses (then called infant welfare sisters) were concerned about the problem of post-natal depression, a problem for which their professional education and the traditional paediatric surveillance orientation of their service did not equip them to respond.

A study was undertaken on the conditions under which the nurses' traditional child health focused role (weighing, measuring, immunising and monitoring infant health) could be broadened to encompass "maternal emotional and social well-being" (Scott, 1992). Findings from this study suggested that there were several factors that facilitated broader service provider roles. These included:

- a low level of competition between the new role and existing roles;
- low levels of inter-professional conflict in relation to adopting the new role;
- possessing the professional knowledge and skills to perform a broader role;
- time to perform a broader role; and
- consumer acceptance of the service provider performing a broader role.

By incorporating new content in qualifying and post-qualifying professional educational programs, broadening service objectives and developing performance indicators to reflect a psycho-social orientation, the role of the maternal and child health service in Victoria became more family-centred. The change in the name of this service reflected this shift.

Building the capacity of adult services to be "child and parent sensitive"

Far less attention has been paid to building the capacity of adult-focused services working with families with multiple and complex needs to be "child and parent sensitive", yet there are encouraging signs in most of the key sectors that this is possible. One field in which significant work has been done is adult mental health. Broadening the unit of attention to the parent–child relationship initially emerged in the 1970s in relation to women with serious post-partum psychiatric disorders, following the introduction of joint admission of mother and infant. This facilitated a shift from an exclusive focus on maternal mental state to one that also encompassed the mother–infant dyad (Main, 1968; Scott, 2008).

Over the past decade, a few Australian mental health practitioner–researchers and advocates have made major contributions to enhancing the capacity of adult mental health services to be more responsive to the needs of the children of adult mental health consumers (Cowling, 2004). This has resulted in the Australian Government-funded initiative, Children of Parents with a Mental Illness (COPMI), which is aimed at strengthening the capacity of adult mental health services to address the parental roles of their adult clients and to respond to the needs of their children (www.copmi.net.au). In South Australia, a pilot program involving placing a mental health liaison nurse in a statutory child protection service has shown encouraging results in engaging parents with a mental illness, and improving inter-professional and inter-sectoral collaboration (Arney, Zufferey, & Lange, 2006).

In the field of drug and alcohol treatment services, there are several impressive Australian initiatives, including the Parents Under Pressure program in Queensland (Dawe & Harnett, 2007) and the Nobody's Clients Project in Victoria (Odyssey Institute of Studies, 2004). Dawe et al. (2008) have recently argued, however, that such examples will remain isolated and ad hoc unless the needs of children are given salience in national drug and alcohol policies and that this leads to appropriate funding models.

In fields such as domestic violence, there has also been increasing focus on the needs of children and the impact of domestic violence on the mother–child relationship (Humphreys, 2006). In the corrections field, the Victorian Association for the Care and Resettlement of Offenders (VACRO) has recently published a report that examines the unmet needs of children across the criminal justice continuum: when a parent is arrested, when a decision is made to grant bail, when a custodial sentence is given, while a parent is in prison, during pre-release planning, and post-release (Victorian Association for the Care and Resettlement of Offenders & Hannon, 2007). Their recommendations could provide a useful audit tool by which existing policies and practices can be assessed. There are few such tools of this nature in adult-focused sectors.

One of the key challenges in such integration strategies is how to shift the orientation of a child-focused workforce towards the parent–child relationship being the primary unit of attention.

Recent UK policy: Think Family

Stimulated largely by a crime prevention agenda, in the UK a new emphasis is being placed on building the capacity of all services to reduce the negative impact on children of parents with problems such as substance misuse, anti-social behaviour, mental health problems and non-participation in the workforce. The Social Exclusion Taskforce in Cabinet Office led a cross-Whitehall review on families at risk in 2007 and early 2008, which culminated in an initiative called Think Family (Social Exclusion Task Force, 2008a).

Through the Family Pathfinder programme launched in May 2008, fifteen local government areas are testing innovative ways of supporting vulnerable families. The Think Family initiative builds on the foundations of other major policy initiatives, such as Sure Start and Every Child Matters (the government's response to the inquiry by Lord Laming into the child abuse death of Victoria Climbié), and has the following core principles:

- *there is no "wrong door"*—contact with any service offers an open door to joined-up support;
- *look at the whole family*—services take into account family circumstances, and adult services consider clients as parents;
- *build on family strengths*—relationship and strength-based engagement; and
- *provide support tailored to need*—no "one size fits all".

Propositions relating to broadening roles

If the potential of traditional child- and adult-focused services to become parent–child centred is to be enhanced, capacity-building strategies need to be based on the experience of those who have succeeded in achieving this, sound organisational change principles, and empirical evidence. Given the paucity of evidence in this area, the Australian Centre for Child Protection has identified this as a priority area, with initial emphasis on two fields: emergency housing and drug and alcohol services.

While there are promising models in a range of adult specialist services sectors, as described above, there is no clear conceptual framework for such capacity-building initiatives, nor sound empirical data on the conditions under which such changes can be achieved and sustained. In relation to possible adoption or adaptation of such models by other organisations, the body of knowledge on the diffusion of innovations may provide a useful framework (Salveron, Arney, & Scott, 2006).

It can be hypothesised that the factors facilitating or inhibiting embedding "parent- and child-sensitive practice" exist at several interrelated levels: the individual practitioner, the organisational setting, and the wider policy context.

If audit tools could be developed at each of these levels for key sectors, this would provide baseline measures for assessing change strategies.

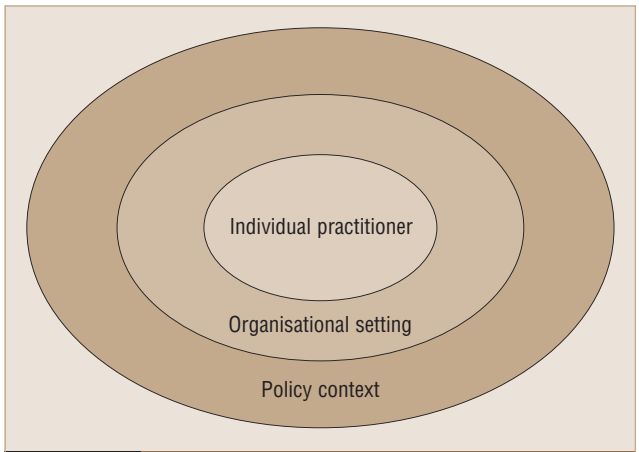


Figure 1 Levels of analysis for service provider role enhancement

Children in the child protection system are the tip of the iceberg of a much larger number of "at-risk" children in the wider community.

Individual practitioner

It is possible to analyse service provider roles in terms of their "core" and "marginal" functions:

> Core responsibilities are defined by society's central institutions, and these institutions possess powerful sanctions to ensure that they are fulfilled … beyond the core are marginal areas in which much more variation is possible. The occupant of the role may … limit his work to his core responsibilities or extend his involvement with clients to include other aspects of their situation. (McCaughey et al., 1977, p. 166)

Factors relating to the individual service provider that may pre-dispose a practitioner to perform "marginal" role functions related to client wellbeing include their personality and beliefs regarding the ideals of service (McCaughey et al., 1977). Role definition is also a function of occupational identity:

> As an occupational group seeks to establish itself as a profession, it focuses its role around the specialised areas for which its members have training and expertise; in the process marginal tasks are excluded as inappropriate. (McCaughey et al., 1977, p. 166)

In response to technological advances and emerging community needs, professional roles evolve and it can be hypothesised that tasks perceived as "higher status" marginal roles will be more likely to be adopted than tasks perceived as "lower status" marginal roles. Roles also differ in the degree to which they are "normally diffuse" (McCaughey et al., 1977, p. 196).

Individual service providers within a particular occupational group or a service sector can probably be placed along a spectrum of role performance from narrow to broad, similar to that suggested by McCaughey et al. (1977):

1. *Narrow*—core role only. ("It's not my concern.")
2. *Somewhat narrow*—core role and assessment of "other needs", leading to referral for the latter. ("It's a concern but someone else's job—refer on.")
3. *Somewhat broad*—clients' "other needs" are incidental but unavoidable. ("Not my core role but I have to do it.")
4. *Broad*—"other needs" are an intrinsic part of core role. ("It's part and parcel of my job.")

Further research at this level of analysis could help to identify effective strategies to shift a critical mass of an occupational group along the spectrum from narrow to broad roles.

Organisational setting

In addition to individual practitioner factors affecting role performance, there are likely to be strong situational factors operating within the organisational context. These may not be uniform across an organisation, as there may be subcultures within a team or program that influence whether broader roles are performed. Situational factors such as pressure of work may fluctuate and so the

breadth of role enactment may also vary markedly in the same setting.

It can be hypothesised that the following organisational factors shape the degree to which the service delivered is more broadly "family-centred".

- Size of caseload—higher pressure for "throughput" will reduce capacity for broader roles.
- Holistic agency norms and philosophy will support broader roles.
- Proceduralisation of service delivery will inhibit individually tailored services.
- Narrow performance indicators will limit broadened roles.
- Risk-averse agency cultures will lead to "risk shifting" and avoidance of complex cases.
- Higher levels of professional autonomy and discretion can support broader roles.
- Positive organisational culture and climate will enhance organisational change and facilitate broader role performance.

It may be helpful for organisations seeking to provide a more family-centred service to develop audit tools that enable them to assess current functioning and measure changes. For example, in the more clinically oriented adult services in fields such as mental health or drug and alcohol treatment services, the following questions may be useful:

Intake

- Is it known and recorded whether clients are responsible for the care of children?
- Are the caregiving needs of parents considered during intake?
- Are the agency waiting room and appointment times etc. child- and parent-friendly?

Assessment

- Are parenting roles considered as a potential stressor on clients?
- Are parental roles considered as a possible source of motivation?
- Are parental concerns about their children identified?
- Is parenting capacity assessed?
- Are the needs of clients' children directly considered?

Intervention

- Is intervention individually tailored to family needs?
- Is strengthening parent–child relationships part of the intervention?
- In what ways are children "seen and heard" by service providers?
- Is there regular and good collaboration with children's services?

Outcomes

- Do service outcomes include parenting competence?
- Do service outcomes include the safety and wellbeing of children?

Policy context

The legal and policy context and the wider sociopolitical milieu in which an organisation exists can powerfully shape the degree to which a service is "child- and family-sensitive". If a "whole-of-government" ethos is strong in a particular political and public sector environment, then it will be easier to promote more "joined-up" service delivery.

For example, the potential to link the National Framework for Protecting Australia's Children with other current Australian Government priorities—such as those in early childhood education and care, Indigenous health and welfare, and homelessness—will be enhanced if they are well integrated under a coherent "social inclusion" structure.

There are other contextual factors that may influence an organisation's capacity to provide a more family-centred service for vulnerable families:

- legal requirements such as mandatory reporting of suspected child maltreatment that may inhibit a service provider from getting "too involved" in children's needs for fear of endangering a fragile therapeutic relationship with the parent;
- privacy constraints on information sharing between organisations that may inhibit a holistic understanding of family needs;
- "single input services" based on categorical funding models that limit comprehensive responses to families with multiple and complex needs;
- greater competition for scarce resources that may lead to increased "gate-keeping" in relation to resource-intensive cases;
- strong centralised reform drivers in government and budget pooling across sectors and portfolios that will support broader, family-centred service delivery; and
- good cost-effectiveness data demonstrating the value of providing a broader service that will support such initiatives.

Factors such as these could be developed into an audit tool for "joined-up" policy. The obstacles to "joined-up" policy and service delivery are significant but not insurmountable. Graycar (2006) proposes that: jurisdiction/domain

disputes need to be addressed by elevating the ownership of the problem; unrealistic time scales for reform need to be adjusted so that there are interim performance measures; and "silo budget processes" need to be replaced with multilateral budget bids, budget pooling, and outcome rather than output measures.

To build the capacity of adult services to respond to the needs of vulnerable parents and their children will require strong and coherent policy frameworks, appropriate funding models and effective workforce development strategies. It would be unwise to "scale up" promising models until they have been rigorously evaluated in terms of reducing risk factors associated with child abuse and neglect, and *improving outcomes for children*.

Key questions to be addressed include:

- Is it effective?
- How is it effective?
- Is it cost-effective?
- Is it sustainable?
- Is it transferable?

It may not be possible, or desirable, to replicate or "adopt" programs in their "pure" form across different contexts, but it may be possible to transfer the principles of successful programs to other contexts, with careful assessment of the effect of adapting original elements.

Conclusion

Child abuse and neglect is a major problem, with serious and long-term consequences for Australian society as well as potentially devastating consequences for individual children and families. Building the capacity of *adult*-focused services to be "child- and parent-sensitive" is as important as building the capacity of *child*-focused services to be "child- and parent-sensitive". Both are essential strategies in a national approach to protecting and enhancing the wellbeing of Australia's most vulnerable children.

Organisational history, professional boundaries, workforce skill limitations, and narrow "performance indicators" and funding models are among the factors that constrain the ability of adult services to respond to the needs of parents and their children. Despite this, a few organisations across a wide range of sectors have been able to pioneer family-centred approaches.

To "scale up" promising models, there needs to be high level, centralised government commitment, as the range of adult services affecting children is large, cuts across all levels of government, and spans different portfolios and service sectors. This is not easy to do, but not to do so will be even harder, as Australian society will carry the human and financial burdens of child abuse and neglect for generations to come. What a wise and good parent would wish for their own child, a wise and good nation must strive to achieve for all of its children.

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The Family Focus Toolkit

A Resource Kit for Family Work in the Alcohol & Other Drug Sector

eDAS

Australian Government
Department of Health and Ageing

The Family Focus Toolkit has been developed by Eastern Drug & Alcohol Service (EDAS) as part of the Family Focus Project. This multi-faceted project has a number of objectives including:

- ✓ Increasing treatment opportunities and resources for families affected by alcohol and other drug issues
- ✓ Providing resources for Family Workers within the Alcohol & Other Drug (AOD) Sector
- ✓ Increasing knowledge of family inclusive practice within the AOD sector through resources and professional development
- ✓ Providing drug education to non-AOD Family & Youth Workers.

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- Angela Ireland - Family Drug Help
- Anne Iversen – Family Drug Help
- Naomi Rottem - The Bouverie Centre
- Tom Stylli - *each* Social & Community Health.

ABOUT EDAS

Eastern Drug & Alcohol Service (EDAS) provides alcohol and other drug counselling and support to adults, young people, families and people with acquired brain injuries in the Eastern Metropolitan Region of Melbourne.

The EDAS Family Program offers support to families, parents, grandparents, siblings, children, carers, friends and significant others of problematic substance users.

eDAS Eastern Drug and Alcohol Service

Australian Government
Department of Health and Ageing

THE TOOLKIT

The Toolkit for AOD Family Work is a collection of selected resources including screening tools, questionnaires, worksheets, and utility practice tools gathered from the sector, research and professional bodies.

Each tool was chosen by the Family Focus Project Team for its relevance to both clinicians and clients of the EDAS Family Service.

How to use the Toolkit

The Toolkit is divided into five areas:

- ☐ Family work framework and assessment
- ☐ Families where there is problematic parental substance use
- ☐ Coping Assessment
- ☐ Concurrent Disorders
- ☐ Family Violence

Each tool has a prefacing page outlining the following:

- ✓ Author/s and references
- ✓ Origin of the tool / original developer
- ✓ Suggestions for use of the tool.

A list of additional resources and references are found on the final pages of the Toolkit.

eDAS Eastern Drug and Alcohol Service

Australian Government
Department of Health and Ageing

CONTENTS

FAMILY WORK FRAMEWORK & ASSESSMENT

A SIMPLE GUIDE AND STANDARD SYMBOLS FOR GENOGRAMS

Network of Alcohol & other Drugs Agencies, (2009), *Tools for Change: A new way of working with families and carers,* Department of Health, NSW
http://www.nada.org.au/index.php?option=com_content&task=view&id=96&Itemid=25

These resources were accessed from the *Tools for Change* toolkit developed by the Network of Alcohol and other Drugs Agencies (NADA) as part of the Mental Health and Drug and Alcohol Family and Carer Project.

A Simple Guide to Genograms

A genogram or family tree is a useful tool to gather information about a client's family. (The 'client' is defined as the person in counselling. This could be the substance user and/or family members.) This visual representation of a family can help to identify patterns or themes within families that may be influencing or driving the client's current behaviour.

Many clients enjoy the opportunity to talk about their family history, and this can work as a good tool to build trust and rapport in a working relationship. However some clients may find seeing a visual representation/illustration of their relationships confronting, particularly if the majority of relationships in their life at present are conflictual or distant. Sensitive use of this tool will be useful to help promote healthy change and the development of more positive relationships in the client's life.

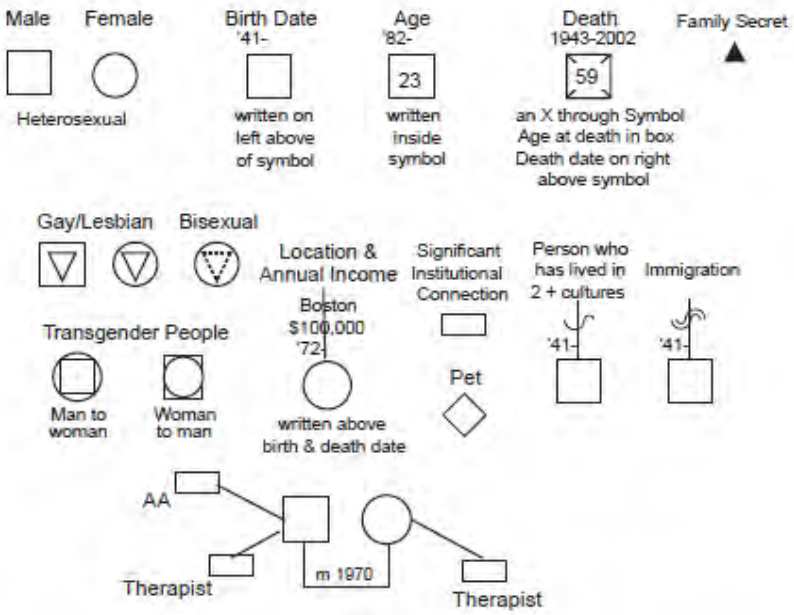
This process is also used to identify key family members who can be included in recovery plans, particularly those who are seen to be supportive. Also, family members who have displayed resilience in the face of addiction can be identified and acknowledged. (Kina Family and Addictions Trust, 2005)

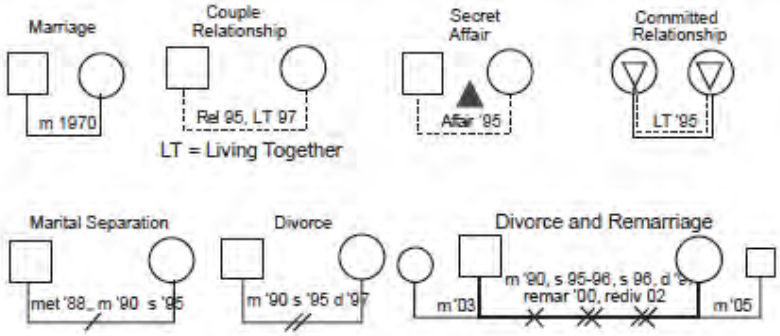
With the client

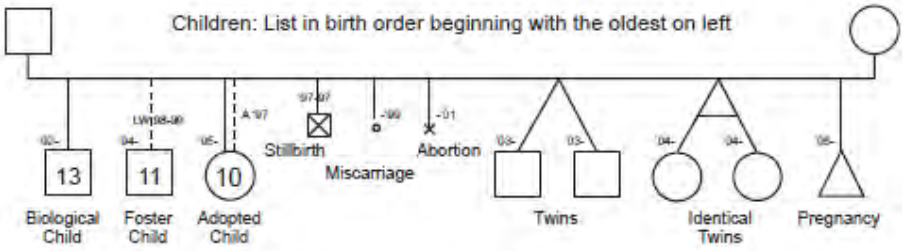
- Aim to gather information about three generations: the client's generation, the parent, and the grandparents.
- Include significant others who lived with or cared for the family.
- Start with drawing the family structure; who is in the family; in which generations; how they are connected (birth, marriage, deaths etc).
- Ask them to tell you a bit about each person.
- As the client talks about family members and relationships, make a note alongside the name.
- Ask about relationships between family members
    - Who are you closest to?
    - What is/was your relationship like with...?
    - How often do you see...?
    - Where does...live now?
    - Is there any one here that you really don't get along with?
    - Is there anyone else who is very close in the family? Or who really don't get along?
- Ask about characteristics or habits of family members: health issues, drug and alcohol use, physical and mental health, violence, crime/trouble with the law, employment, and education. These are then added to the diagram. The effect of this is to emphasise the pervasive impact of addiction and can stimulate a desire to halt the family cycle of drug and alcohol problems (Kina Family and Addictions Trust, 2005). It is important, however, not to assume that there are drug and alcohol and mental health problems within the family history.
- Ask about family values, beliefs and traditions.
- Try to explore patterns and themes.
    - Who are you most like?
    - What is...like? Who else is like them?

The Multicultural Family Institute

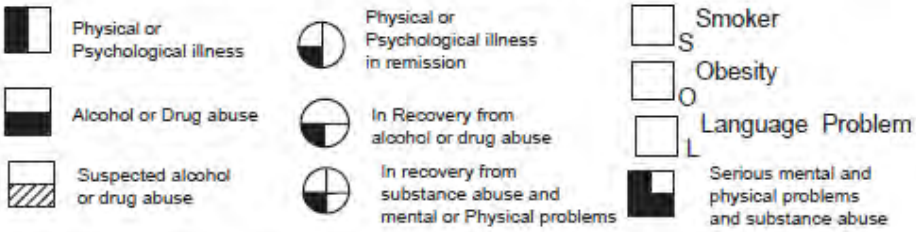
Standard Symbols for Genograms



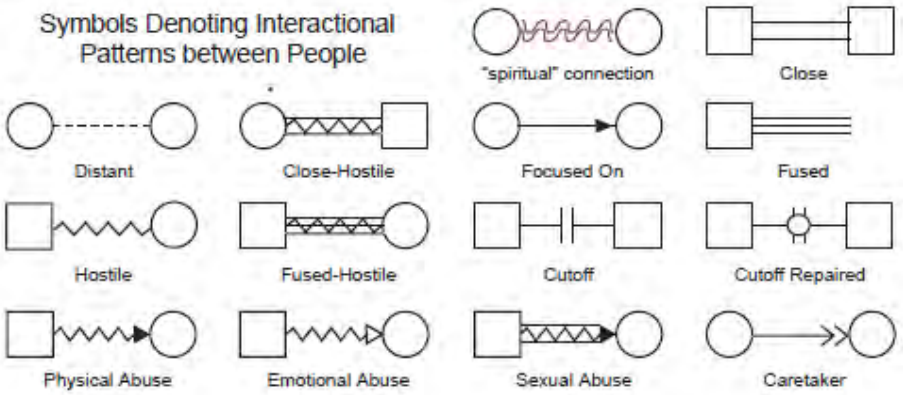




Symbols Denoting Addiction, and Physical or Mental Illness



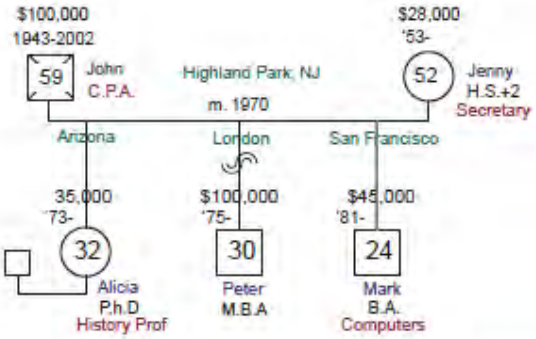
Symbols Denoting Interactional Patterns between People



Annual income is written just above the birth & death date.

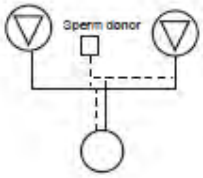
Typically you would include the person's occupation and education near the name and the person's whereabouts at the top of the line connecting to the symbol.

Symbol for Immigration =

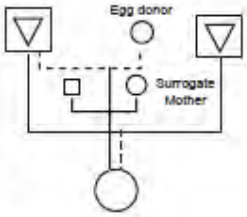


Artificial Insemination

Lesbian couple whose daughter was conceived with egg of one partner and sperm donor.

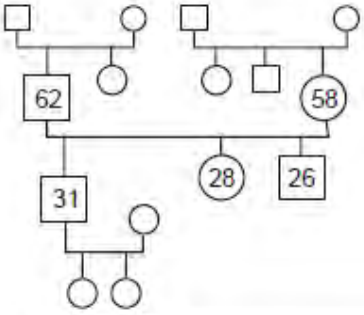


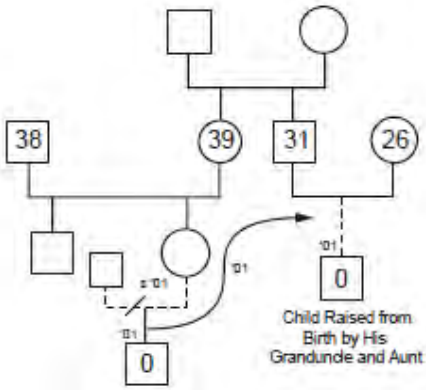
Gay Couple whose daughter was conceived with sperm of John and an egg donor, and carried by surrogate mother till birth.



Foster Children

Siblings of Primary Genogram Members are written smaller and higher. Spouses are written smaller and lower:

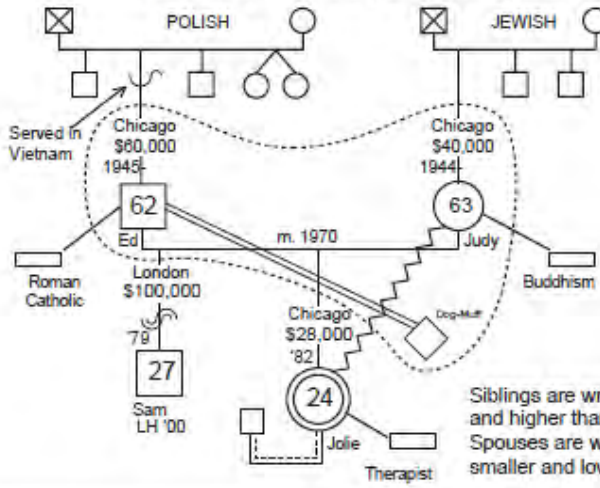




Use an arrow to show family into which child moved

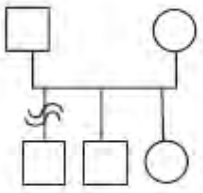
Household

Household shown by encircling members living together
(Couple living with their dog after launching Children)

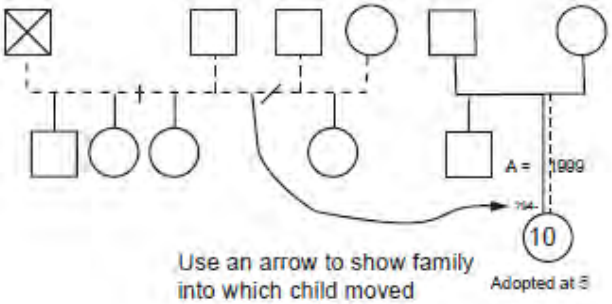


Siblings are written smaller and higher than IP. Spouses are written smaller and lower.

Symbol for Immigration



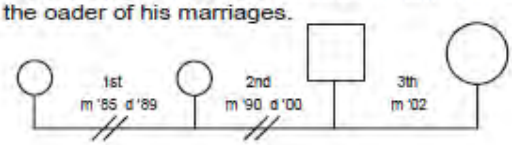
Adopted Child



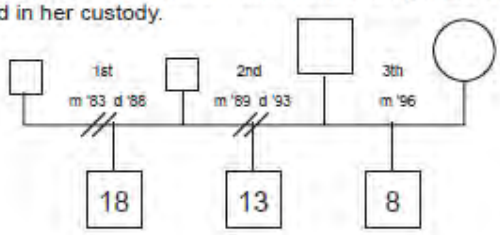
Use an arrow to show family into which child moved

Adopted at 5

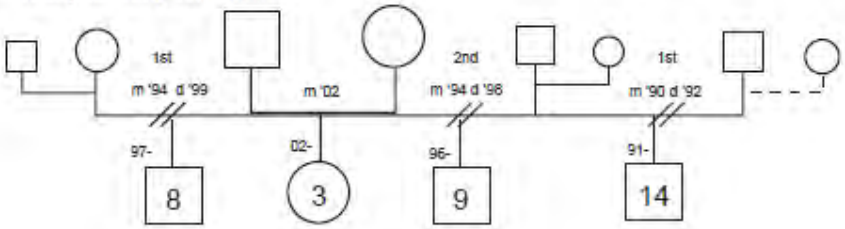
1 Husband, His Current Wife and his Ex-Wives (who are shown lower and smaller). Husband's wives may go on left to be closest to him. Indicators "1st," "2nd" etc. make clear the oader of his marriages.



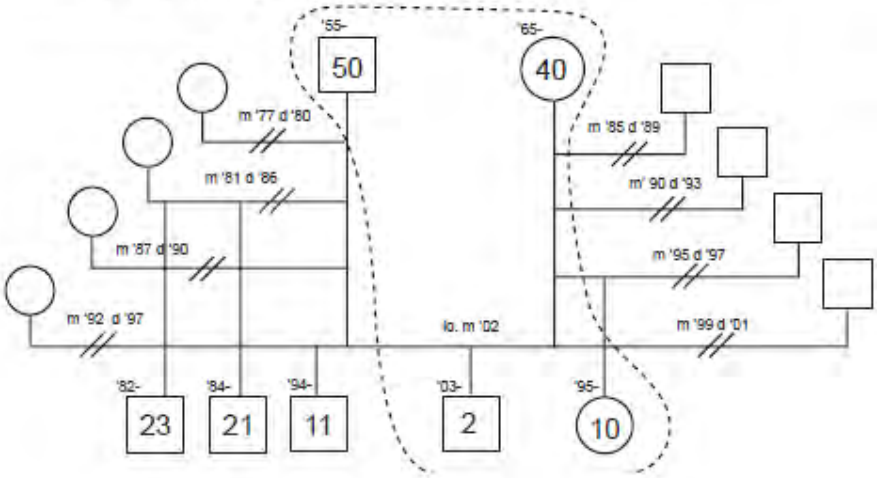
2 Wife, Her Current Husband and her Ex-Husbands (who are shown lower and smaller). Wife's previous relationships are shown on left to keep children in birth order, since they remained in her custody.



3 Couple with 3 year old, showing their previous spouses (smaller) and those spouses' new partners (even smaller)



4 Couple living with their joint child and her child from a previous relationship. The other spouses of the partners are shown smaller and lower on either side of the present household, indicated by a dotted line.



A SIMPLE FRAMEWORK FOR WORKING WITH FAMILIES

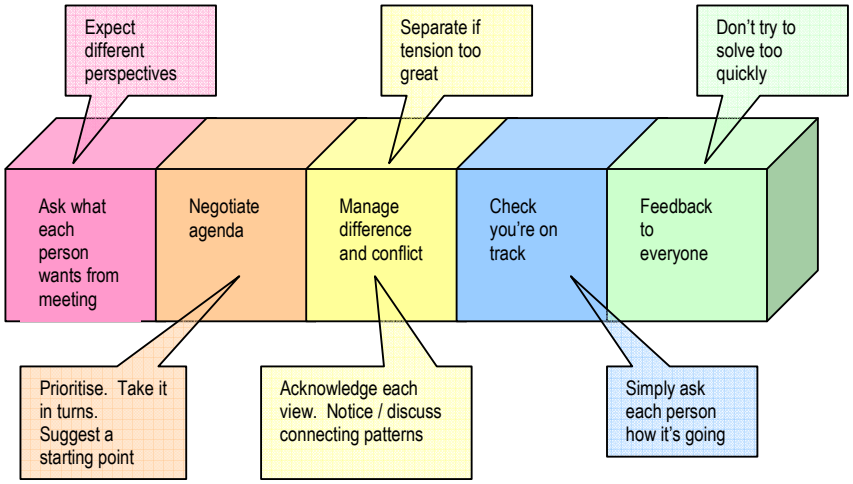
Proctor, K., Young, J. & Weir, S., (2006), *Focus on Families: Building confidence to work with families and significant others,* The Bouverie Centre

The following three resources were accessed from The Bouverie Centre's *Focus on Families* continuing education course workbook and are part of a two-day training program. The resources are reproduced with the permission of Shane Weir, Community Services Team Manager.

1. First Session Framework for Working with Families

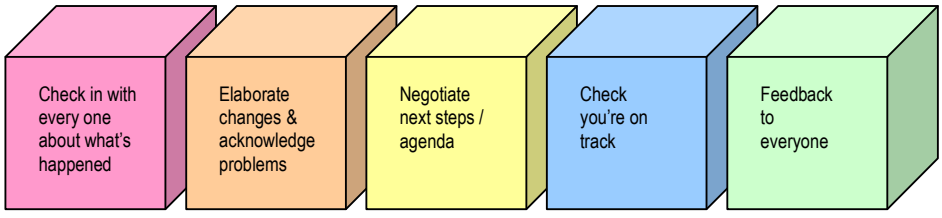
This framework follows the practice principles of Single Session Work and shows the broad stages of this work with families. The framework is helpful with preparing and managing the different stages of the family session. A family session can follow the structure of a meeting:

- The worker sets their agenda for the meeting.
- Time is then taken to make all the family members feel comfortable.
- Each family member is asked what they would like to discuss.
- The worker regularly checks in to ensure the agreed agenda is on target.
- Each family member is assisted to relate directly and respectfully to each other throughout the meeting.



2. Managing Subsequent Sessions: Ongoing Framework for Working with Families

This framework again follows the Single Session Work and outlines the stages of subsequent family meetings.



3. Conducting a Family Session Checklist

The Family Session Checklist

Welcome

- ☐ Welcome and thank the family for attending.
- ☐ State or re-state your agenda for the meeting.
- ☐ Invite other agenda items
- ☐ Identify any limitations – time, scope of possible outcomes.

Make Comfortable

- ☐ Communicate assumption that family members are doing the best they can.
- ☐ Acknowledge their difficult situation.
- ☐ Normalise their reactions and concerns.
- ☐ Encourage each person to contribute.
- ☐ Acknowledge family strengths.

Be Curious

- ☐ Approach the family with an open mind.
- ☐ Maintain a position of 'not knowing', i.e. be curious.
- ☐ Try to understand the unique perspective of each person present (step into each person's shoes)

Tolerate Difference / Predict Difference

- ☐ Expect that each person will have a different point of view.
- ☐ Accept each point of view rather than feel you have to decide the correct view.
- ☐ Articulate and share different points of view. This simple action can be very helpful.
- ☐ Facilitate productive interaction / interconnectedness.
- ☐ Explore how different points of view inter-relate.
- ☐ Point out similar concerns.
- ☐ Identify unhelpful patterns (vicious cycles).

Check In

- ☐ Check in to see if you are on course.
- ☐ Ask if meeting is being helpful.
- ☐ Ask if there is anything you should have asked about but haven't.

Clarify Progress and Next Step

- ☐ Clarify what is resolved and what is not.
- ☐ State plans to address unresolved issues.
- ☐ Emphasise positive outcomes.
- ☐ Provide tentative advice and clear feedback.
- ☐ Thanks family for attending and clarify next steps.

SINGLE SESSION WORK (SSW) – PRE & POST-SSW CLIENT QUESTIONNAIRES

Young, J., Rycroft, P. & Weir, S., (2006), *Single Session Work*, The Bouverie Centre

The following two questionnaires were accessed from The Bouverie Centre's *Single Session Work* continuing education course workbook and are part of a two-day training program. The resources are reproduced with the permission of Shane Weir, Community Services Team Manager.

The Pre-Single Session Work (SSW) and Post-SSW Client Questionnaires are part of the Single Session Framework which follows a set process:

i. Initial Letter to Client
ii. Pre-SSW Client Questionnaire
iii. Letter to Referrer
iv. Take Aways
v. SSW Summary
vi. Post-SSW Client Questionnaire
vii. SSW Phone Follow-Up Form
viii. SSW Evaluation Letter
ix. SSW Evaluation Form
x. SSW Worker Questionnaire

These questionnaires are useful tools to assist clients to focus on identifying goals they would like to explore / achieve in the session and to evaluate the efficacy of the work.

Ideally the client fills out the Pre-SSW Client Questionnaire before the first session.

The Post-SSW Client Questionnaire within the SSW Framework is completed during a follow-up phone consultation.

Outside the Single Session Framework, the questionnaires are useful guides to address and review treatment goals during the course of therapy.

Pre-SSW Client Questionnaire

Welcome. To assist us to maximise the effectiveness of the consultation, please complete the following questionnaire and bring it with you to your session.

There are different ways to fill out the questionnaire; some families call a family meeting to fill it out, some families photocopy it and everyone fills out their own questionnaire and sometimes only the person who requested the consultation fills it out. Do what suits your family.

Name of person(s) filling out the questionnaire:

……

What are the main issues that bring you to this service?
(a) Greatest problem:

……

(b) Second greatest problem:

……

How upset / worried are you about these problems? (Place a cross on the line)

(1) Not at all — As worried as I could possibly be (10)

How often do these problems happen?

(1) Not at all — All the time (10)

Are there other difficulties you are coping with now? Please outline below.

……

How much is the problem (or problems) interfering in your life?

(1) Not at all — It is dominating my life completely (10)

What made you decide that now was the right time to seek help?

……

……

……

Pre-SSW Client Questionnaire cont.

How confident do you feel in dealing with the problem(s)?

(1) Not at all								Extremely (10)

If casework / counselling was successful, what would you / you and your family be doing differently?

……

……

……

……

Since you first contacted the centre, what have you noticed happening to you (and your relationships with others) that you would like to keep happening in the future?

……

……

……

……

Often when people are in a stressful situation it is easy to forget to ask all of the questions you want to ask. Therefore we suggest you list the major questions you would like addressed below.

……

……

……

……

Post-SSW Client Questionnaire

To be filled out at follow-up or review. (In the SSW Framework, this questionnaire would be filled out during a phone follow-up consultation, in association with the Follow-Up Form – not included here.)

Name of person(s) responding to this questionnaire:

……

You nominated:

……

……

……

as the main problem which brought you to counselling, and

……

……

……

as your second greatest problem.

♣ How upset / worried are you about this problem (or these problems) at the present time? (Place a cross on the line)

(1) Not at all — As worried as I could possibly be (10)

☆ How often do these problems happen?

(1) Not at all — All the time (10)

☸ How much is the problem (or problems) interfering in your life?

(1) Not at all — It is dominating my life completely (10)

In what ways?

……

……

◎ How confident do you feel in dealing with the problem(s)?

(1) Not at all								Extremely confident(10)

You nominated the following questions as those you would like addressed within the Single Session:

……

……

……

To what extent do you feel these questions were addressed?

……

……

……

Office use only:

	Pre-session	Post-session	Difference
♣ How upset / worried:			
☆ Problem frequency:			
☸ Life interference:			
◎ Confidence:			

☐ Client willing to be sent Client Satisfaction Survey (tick if applicable)

FAMILIES WHERE THERE IS PROBLEMATIC PARENTAL SUBSTANCE USE

eDAS
Eastern Drug and Alcohol Service

THE FAMILY CAGE: AN ALCOHOLISM SCREENING TEST

Price, A.W., & Emshoff, J.G., (1997), *Breaking the Cycle of Addiction: Prevention and intervention with children of alcoholics,* Alcohol Health & Research World Vol.21, No.3, pp241-246.

This tool was accessed from the Deakin University Library and is embedded in a research article by Price and Emshoff as referenced above.

The original CAGE screening tool is a set of four questions regarding the substance user's concern about their own drinking behaviour. The Family CAGE follows the same principles but is specifically designed to screen for concerns about the drinking habits of a parent.

The tool is useful particularly when working with children of substance users to gauge initial reflections, concerns and thoughts about parental substance use. It is a screening tool only and if the results are positive, it is recommended further assessment of the family situation occurs to assist with treatment planning.

The Family **CAGE**

1. Do you think your parent needs to **C**UT down on his/her drinking?
2. Does your parent get **A**NNOYED at comments about his/her drinking?
3. Does your parent ever feel **G**UILTY about his/her drinking?
4. Does your parent ever take a drink early in the morning as an **E**YE opener?

THE CIRCLES OF HARM AND SAFETY

Department of Human Services, (2006), *Parenting Support Toolkit for Alcohol and Other Drug Workers*, Victorian Government Publishing Service. Available at: http://www.health.vic.gov.au/drugservices/pubs/parenting-support.htm

The '*Circles of Harm and Safety'* template was accessed from the Parenting Support Toolkit for Alcohol and Other Drug Workers as referenced above.

This tool can be used with parents who want to explore ways to minimise the potential impact of their substance use on their children. It can be used to highlight and document a parent's strengths and the things they are already doing to ensure this. The tool may be used in additional ways including:

- As part of motivational interviewing
- As a whiteboard exercise
- As a homework activity.

THE FAMILY PROBLEM COMMUNICATION INDEX

Department of Human Services, (2006), *Parenting Support Toolkit for Alcohol and Other Drug Workers*, Victorian Government Publishing Service. Available at: http://www.health.vic.gov.au/drugservices/pubs/parenting-support.htm

McCubbin, H. I., Thompson, A. I., & McCubbin, M. A., (1996), *Family problem-solving communication (FPSC), in Family Assessment: Resiliency, Coping and Adaptation*, Inventories for Research and Practice., 639-684, Edited by McCubbin HI, Thompson AI, McCubbin MA. Madison, University of Wisconsin Press.

The *Family Problem Communication Index* was accessed from the Parenting Support Toolkit for Alcohol and Other Drug Workers as above.

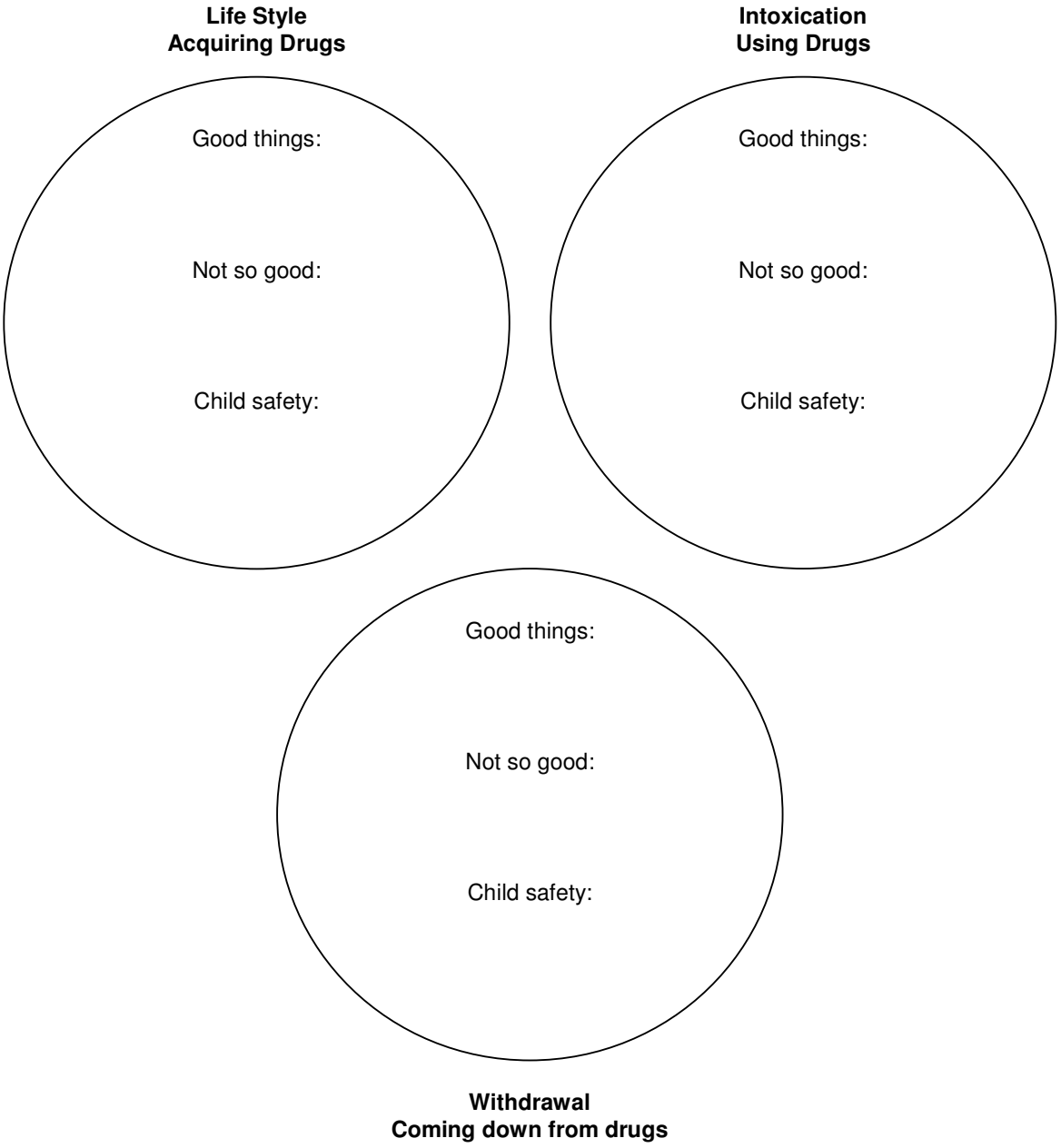
The Family Problem Solving Communication Index is a 10-item measure of family communication patterns. The measure explores two types of communication patterns:

- inflammatory (incendiary) communications that exacerbate family stress; and
- affirming communications that convey caring and support that exert a calming influence.

This measure takes less than 5 minutes to complete and is a useful exploration of communication exchanges between parents and their children.

Circles of Harm and Safety

In each circle: list 1 or 2 good things that you currently do to minimise the harm that your drug use has on your kids; list 1 or 2 things you currently do that are not-so-good for the well-being of your kids, and then list 1 or 2 things that you could do to make things safer for your kids. Remember to describe specific things that someone else could see you doing.



Family Problem Solving Communication Index

When our family struggles with problems or conflicts which upset us, I would describe my family in the following way:

		False	Mostly False	Mostly True	True
1.	We yell and scream at each other.	0	1	2	3
2.	We are respectful of each others' feelings.	0	1	2	3
3.	We talk things through till we reach a solution.	0	1	2	3
4.	We work hard to be sure family members were not hurt, emotionally or physically.	0	1	2	3
5.	We walk away from conflicts without much satisfaction.	0	1	2	3
6.	We share with each other how much we care for one another.	0	1	2	3
7.	We make matters more difficult by fighting and bringing up old matters.	0	1	2	3
8.	We take the time to hear what each other has to say or feel.	0	1	2	3
9.	We work to be calm and talk things through.	0	1	2	3
10.	We get upset, but we try to end our conflicts on a positive note.	0	1	2	3

McCubbin, Thompson & McCubbin, (1996)

To score this scale:
Reverse score items 3 & 9.
For Affirming Communication: sum items 2, 4, and 6,8,10.
For Incendiary Communication: sum items 1, 3,5,7,9.

THE PARENT/CARE-GIVER DRUG ISSUES CHECKLIST - RISK ASSESSMENT WITH PARENTAL DRUG USE

DrugNet (1997), *Risk Assessment with Parental Drug Use,* DrugNet Professional Drug Management for Clinicians & Educators

This tool was accessed from the internet:
http://www.drugnet.bizland.com/assessment/checklis1.htm

The Parent/Care-Giver Drug Issues Checklist outlines seven key domains which can be used as part of a risk assessment with parental substance use. These domains were developed by the Standing Conference on Drug Abuse (SCODA) and the Local Government Drugs Forum (LGDF) for use by non-specialist professionals in England, Scotland and Wales.

The four scoring categories developed for the DrugNet site aim to broaden a 'yes/no' response and to identify evidence of positive parenting as well as potential child safety issues. The numerical system is a general guide only. Higher scores indicate increased risk and concern. Standardised or validated assessment of the sum totals of this checklist has NOT been developed. The comments section should be used to summarise the assessment from each of the domains.

This tool can be used as a guide towards exploring risk in the therapeutic conversation, where problematic parental substance use is a potential issue for the family.

Parent / Care-Giver Drug Issues Checklist

Key to scoring

Numbers are only intended to discriminate between protective factors, concerns and more serious issues which require immediate intervention.

-1 = Positive (positive – congratulate)
1 = Transitional (somewhat an issues)
2 = Problematic (requires immediate attention)
? = Unsure (further information required or not applicable)

The Pattern of Parental Drug Use

Is there a drug-free parent, supportive partner or relative?	-1	1	2	?
Is the drug use by the parent: Experimental? Recreational? Chaotic? Dependent?	-1	1	2	?
Does the user move between categories at different times? Does the drug use also involve alcohol *or a combination of drugs?*	-1	1	2	?
Are the levels of care different from when the parent is/was a non-user?	-1	1	2	?
Is there any evidence of co-existence of mental health problems alongside the drug use? If there is, do the drugs cause these problems, or have these problems led to the drug use?	-1	1	2	?

Comments:

Accommodation and Home Environment

Is the accommodation adequate for children?	-1	1	2	?
Are parents ensuring that rent and bills are paid?	-1	1	2	?
Does the family remain in one area or move frequently? If the latter, why?	-1	1	2	?
Are other drug users sharing the accommodation? If they are, are relationships with them harmonious, or is there conflict?	-1	1	2	?
Is the family living in a drug using community?	-1	1	2	?
If parents are using drugs, do children witness the taking of the drugs, or other substances?	-1	1	2	?
Could other aspects of the drug use constitute a risk to children (eg. conflict with or between dealers, exposure to criminal activities related to drug use)?	-1	1	2	?
Does the alcohol or other drug use contribute to any domestic violence issues?	-1	1	2	?

Comments:

Provision of Basic Necessities

Is there adequate food, clothing and warmth for the children?	-1	1	2	?
Are the children attending school regularly?	-1	1	2	?
Are children engaged in age-appropriate activities?	-1	1	2	?
Are the children's emotional needs being adequately met?	-1	1	2	?

Are there any indications that any of the children are taking on a parenting role within the family (eg. caring for other children, excessive household responsibilities, etc.)?	-1	1	2	?
Comments:				
Procurement of Drugs				
Are the children being left alone while their parents are procuring drugs?	-1	1	2	?
Because of their parent's drug use, are the children being taken to places where they could be "at risk"?	-1	1	2	?
How much are the drugs costing?	-1	1	2	?
How is the money obtained?	-1	1	2	?
Is this causing financial problems?	-1	1	2	?
Are the premises being used to sell drugs?	-1	1	2	?
Are the parents allowing their premises to be used by other drug users?	-1	1	2	?
Comments:				
Health Risks				
If drugs and/or injecting equipment are kept on the premises, are they kept securely?	-1	1	2	?
Are the children aware of where the drugs are kept?	-1	1	2	?
If the parents are intravenous drug users: * Do they share injecting equipment? * Do they use a needle exchange scheme? * How do they dispose of syringes? * Are parents aware of the health risks of injecting or using drugs?	-1	1	2	?
If parents are on a substitute prescribing program, such as methadone: * Are parents aware of the dangers of children accessing this medication? * Do they take adequate precautions to ensure this does not happen?	-1	1	2	?
Are parents aware of, and in touch with, local specialist agencies that can advise on issues such as needle exchanges, substitute prescribing programs, detox and rehabilitation facilities? If they are in touch with agencies, how regular is the contact?	-1	1	2	?
Comments:				
Family's social networks & support systems				
Do parents and children associate primarily with: * Other drug users? * Non-users * Both?	-1	1	2	?
Are relatives aware of the drug use? Are they supportive?	-1	1	2	?

Will the parents accept help from the relatives?	-1	1	2	?
Will the parents accept help from statutory/non-statutory agencies?	-1	1	2	?
The degree of social isolation should be considered particularly for those parents living in remote areas where resources may not be available and they may experience social stigmatisation.				
Comments:				

The parents' perception of the situation				
Do the parents see their drug use as harmful to themselves or to their children?	-1	1	2	?
Do the parents place their own needs before the needs of their children?	-1	1	2	?
Are the parents aware of the legislative and procedural context applying to their circumstances, (eg. child protection procedures, statutory powers, other legal issues)?	-1	1	2	?
Comments:				

Other child safety issues	**Other positive parenting issues**
Overall summary of findings:	
Negotiated recommendations and goals:	
Source (Parent/Care-Giver, neighbour): Case Worker	Dated: Review Date:

COPING ASSESSMENT

THE COPING QUESTIONNAIRE – 30 ITEM FORM

Orford, J., Templeton, L., Velleman, R. & Copello, A., (2005), *Family Members of Relatives with Alcohol, Drug and Gambling Problems: A set of standardised questionnaires for assessing stress, coping and strain,* Addiction, 100 (11), pp 1611-1624.

The Coping Questionnaire is used to obtain information about how a family member is coping with their relative's alcohol or other drug use. The questionnaire has also been adapted for families where problem gambling is an issue. The questionnaire comes in two versions – relating to a male substance user and the other to a female. (The latter is the version found in this toolkit.)

The Coping Questionnaire explores three main ways of coping:

1. Engaged Coping – standing up to the problem
2. Tolerant Inactive Coping – putting up with the problem
3. Withdrawal Coping – withdrawing from the problem and gaining independence.

This questionnaire is useful as a tool within a semi-structured family session and draws out:

- areas for treatment planning;
- information towards developing creative solutions to current issues; and
- self-care goals.

The Coping Questionnaire

Have you recently (in the last 3 months)		Please circle one answer			
1	Refused to lend her money or to help her out financial in other ways?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
2	Put the interests of other members of the family before hers?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
3	Put yourself out for her, for example by getting her to bed or by clearing up mess after her after she had been drinking?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
4	Given her money even when you thought it would be spent on drink?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
5	Sat down together with her and talked frankly about what could be done about her drinking?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
6	Started an argument with her about her drinking?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
7	Pleaded with her about her consumption of alcohol?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
8	When she was under the influence of drink, left her alone to look after herself or kept out of her way?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
9	Made it quite clear to her that her drinking was causing you upset and that it had got to change?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
10	Felt too frightened to do anything?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
11	Tried to limit her drinking by making some rule about it, for example forbidding drinking in the house, or stopping her bringing drinking friends home?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
12	Pursued your own interests or looked for new interests or occupation for yourself, or got more involved in a political, church, sports or other organisation?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
13	Encouraged her to take an oath or promise not to drink?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
14	Felt too hopeless to do anything?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
15	Avoided her as much as possible because of her drinking?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
16	Got moody or emotional with her?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
17	Watched her every move or checked up on her or kept a close eye on her?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
18	Got on with your own things or acted as if she wasn't there?	NO	ONCE OR TWICE	SOMETIMES	OFTEN

Have you recently (in the last 3 months)

Please circle one answer

19	Made it clear that you won't accept her reasons for drinking, or cover up for her?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
20	Made threats that you didn't really mean to carry out?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
21	Made clear to her your expectations of what she should do to contribute to the family?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
22	Stuck up for her or stood by her when others were criticising her?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
23	Got in a state where you didn't or couldn't make any decision?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
24	Accepted the situation as a part of life that couldn't be changed?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
25	Accused her of not loving you, or of letting you down?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
26	Sat down with her to help her sort out the financial situation?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
27	When things have happened as a result of her drinking, made excuses for her, covered up for her, or taken the blame yourself?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
28	Searched for her drink or hidden or disposed of it yourself?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
29	Sometimes put yourself first by looking after yourself or giving yourself treats?	NO	ONCE OR TWICE	SOMETIMES	OFTEN
30	Tried to keep things looking normal, pretended all was well when it wasn't or hidden the extent of her drinking?	NO	ONCE OR TWICE	SOMETIMES	OFTEN

Scoring Key

Score each item	NO = 0	ONCE OR TWICE = 1	SOMETIMES = 2	OFTEN = 3
FOR TOTAL (CQ-TOT) COPING, sum all 30 items				
FOR ENGAGED COPING SUB-SCALE (CQ-E), sum score for items: 1, 5, 6, 7, 9, 11, 13, 16, 17, 19, 21, 25, 26, 28				
FOR TOLERANT COPING SUB-SCALE (CQ-T), sum scores for items: 3, 4, 10, 14, 20, 23, 24, 27, 30				
FOR WITHDRAWAL COPING SUB-SCLAE (CQ-W) sum scores for items: 2, 8, 12, 15, 18, 29 and subtract scores for items 5 and 22: and then add 6 (to ensure all values for CQ-W are positive)				
(N.B. – Item 5 contributes positively to CQ-TOT and CQ-E, but negatively to CQ-W)				

CONCURRENT DISORDERS

HOW CONCURRENT DISORDERS AFFECT FAMILY LIFE

O'Grady, C.P. & Skinner, W.J., (2007), *A Family Guide to Concurrent Disorders,* Centre for Addiction and Mental Health

Additional references: Kashner TM, Rader LE, Rodell DE, et al, (1991), *Family characteristics, substance abuse, and hospitalization patterns of patients with schizophrenia*, Hospital and Community Psychiatry 42:195-196.

The tools were accessed from the *Family Guide to Concurrent Disorders* resource manual as referenced above.

The following three tools assist families to gauge the impact of concurrent disorders of substance abuse and mental illness on the family. The tools can be self-administered within session or as homework tasks, or can be used as a method of exploration and discussion in session.

1. **The Personal Impact Log** assists with exploring the effects of concurrent disorders on the family's physical, emotional, social and spiritual health. The log helps to break down the overall impact of the family member's life into smaller and more manageable areas of concern. This log is particularly useful when creating a self-care plan for family members.

2. **The Preoccupation and Impact Scale** assists with exploring thoughts, fears and worries about the family member with the concurrent disorder. This scale has not been tested and therefore the score should not be interpreted. Rather it should be used as a tool to elicit how much the preoccupation effect has infiltrated the family's life. The scale can also elicit the family member's move from a constant state of preoccupation to an emotionally healthier, calmer and more balanced lifestyle.

3. **The Family Concurrent Index of Concerns Quiz** assists with exploring and pinpointing areas of concern. The quiz may also help to:
    - Identify personal areas of concern over which the family client may have little control;
    - Consider how the family client might learn to accept what they cannot change; and
    - Identify opportunities for change.

1. The Personal Impact Log

On the personal impact log, write down ways your life has been affected in the areas that apply to you. You may find that you fill in only some of the areas. You will use this information to help you to develop a self-care plan.

An example of a personal impact log:

PERSONAL IMPACT LOG	
Physical Health	Emotional Health
• Chest pain has returned – too worries about my son • No time to go to my own doctor anymore • No longer exercising • Always tired • Can't sleep without talking sleeping medication (never used to need anything to sleep) • Joint stiffness and neck pain • Eat high-sugar foods, don't care about my diet anymore	• Constant worrying about my son • Worrying about everything now • Bad anxiety and sadness • I'm always angry or frustrated or depressed these days • I snap at my other children and then feel guilty • I'm angry with my husband – he gets to leave for work all day and leaves me to deal with all of our problems
Social Life	Spiritual Life
• Never go out with husband or close friends anymore • Never have guests over for dinner • Can't concentrate on reading • Spend all of our time in emergency rooms or visiting our son on psychiatric wards	• Don't know what this is anymore! • Don't go to church • No time for my daily meditation readings • Don't feel like doing my yoga sessions anymore • Bitter and resentful about my son's illness – why my family?

PERSONAL IMPACT LOG	
Physical Health	Emotional Health
Social Life	Spiritual Life

2. The Preoccupation and Impact Scale

How strongly do you agree or disagree with these statements?	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know
I can't stop worrying about my family member's illness.	1	2	3	4	9
I am able to maintain a healthy balance in my life.	1	2	3	4	9
I have trouble thinking about anything other than my family member's mental illness and substance use problems.	1	2	3	4	9
I feel that I'm completely preoccupied with my family member's mental illness and substance use problems.	1	2	3	4	9
My daily routine completely centres on my family member's illness.	1	2	3	4	9
I find myself a lot more anxious these days.	1	2	3	4	9
I make sure I find time to do things for myself and to have fun.	1	2	3	4	9
I never feel that I am doing enough for my ill family member.	1	2	3	4	9
Sometimes I feel that I am drowning in my family member's illness.	1	2	3	4	9
I focus so my on my ill relative's problems that I have difficulty finding time to spend on other members of my family.	1	2	3	4	9
I have very little time and energy to socialise with my friends.	1	2	3	4	9
My physical health (eg. nutrition, sleep and rest) has been negatively affected since I've been dealing with my family member's mental health and substance use problems.	1	2	3	4	9
I have had a hard time gaining a sense of emotional well-being since my family member developed mental illness and substance use problems.	1	2	3	4	9
I am able to cope with my loved one's mental illness and substance use problems.	1	2	3	4	9
I think it is OK for family members to feel angry with, or resentful of, their ill loved one.	1	2	3	4	9

3. The Family Concurrent Disorders Index of Concerns Quiz

For each item, circle the number that best corresponds with *how you are feeling right now.* Once you have completed all of the questions, add them up. The higher your total score, the more uneasy, worried or alarmed you are overall about your situation and the more you need to focus on your own emotional, social and physical health and wellbeing.

How concerned am I about...											
	Not Concerned ←										→ **Very Concerned**
The immediate overall health and wellbeing of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
The immediate overall health and wellbeing of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
My own immediate overall health and wellbeing?	0	1	2	3	4	5	6	7	8	9	10
The long term overall health and wellbeing of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
The long term overall health and wellbeing of other members of my family?	0	1	2	3	4	5	6	7	8	9	10
My own long term overall health and wellbeing?	0	1	2	3	4	5	6	7	8	9	10
How much my ill family member is suffering?	0	1	2	3	4	5	6	7	8	9	10
How much the other members of my family are suffering?	0	1	2	3	4	5	6	7	8	9	10
How much I am suffering?	0	1	2	3	4	5	6	7	8	9	10
My ill family member's ability to get through this?	0	1	2	3	4	5	6	7	8	9	10
The ability of my other family members to get through this?	0	1	2	3	4	5	6	7	8	9	10
My own ability to get through this?	0	1	2	3	4	5	6	7	8	9	10
The emotional health of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
The emotional health of other members of my family?	0	1	2	3	4	5	6	7	8	9	10
My own emotional health?	0	1	2	3	4	5	6	7	8	9	10
Whether my ill family member is getting enough social support?	0	1	2	3	4	5	6	7	8	9	10
Whether the other members of my family are getting enough social support?	0	1	2	3	4	5	6	7	8	9	10
Whether I am getting enough social support?	0	1	2	3	4	5	6	7	8	9	10
My ill family member's physical health?	0	1	2	3	4	5	6	7	8	9	10
The physical health of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
My own physical health?	0	1	2	3	4	5	6	7	8	9	10
The spiritual health of my ill family member?	0	1	2	3	4	5	6	7	8	9	10
The spiritual health of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
My own spiritual health?	0	1	2	3	4	5	6	7	8	9	10
My ill family member's financial situation?	0	1	2	3	4	5	6	7	8	9	10
The financial situation of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
My own financial situation?	0	1	2	3	4	5	6	7	8	9	10
My ill family member's journey of recovery?	0	1	2	3	4	5	6	7	8	9	10
The recovery journey of the other members of my family?	0	1	2	3	4	5	6	7	8	9	10
My own journey of recovery?	0	1	2	3	4	5	6	7	8	9	10

FAMILY VIOLENCE

FAMILY VIOLENCE – PRELIMINARY ASSESSMENT

Victorian Government, (2007), *Family Violence: Risk Assessment and Risk Management*, Melbourne: Department of Victorian Communities. Available at: http://www.cyf.vic.gov.au/__data/assets/pdf_file/0018/69102/ifvs_risk_assessment_and_risk_management_framework.pdf

The Preliminary Assessment Tool has been accessed from the *Family Violence, Risk Assessment and Risk Management* Manual as referenced above and is part of a one-day training program.

Family violence is a complex area that is often not properly / adequately addressed in family work in the alcohol and other drug sector by virtue of a lack of understanding or knowledge of how to screen or assess for this issue.

This complexity is also due to the fact that there are several forms of abuse, which can occur in a wide variety of family settings.

Risk assessment for family violence should be holistic and take into account safety of all family members – both 'perpetrator' and 'victim'.

The Preliminary Assessment Tool is a tool for professionals who work with victims of family violence but also for whom it is not their core business.

This tool is a useful guide around areas of concern regarding family violence. The risk or vulnerability factor checklist should be explored through the course of the counselling conversation and not used as data collection. The tool has been developed specifically for women and children affected by violence.

Family Violence – Preliminary Assessment

Memory Aide

Note: these risk and vulnerability factors should be explored through the course of a conversation. Risk indicators are not intended to be asked as part of a data collection process and should not be used as such.

Risk or vulnerability factor	Presence of factor	
	Yes	No
Victim		
Pregnancy/new birth*	☐	☐
Depression/ mental health issue	☐	☐
Drug and/or alcohol misuse/abuse	☐	☐
Has ever verbalised or had suicidal ideas or tried to commit suicide	☐	☐
Isolation	☐	☐
Perpetrator		
Use of weapon in most recent event*	☐	☐
Access to weapons*	☐	☐
Has ever harmed or threatened to harm victim	☐	☐
Has ever tried to choke the victim*	☐	☐
Has ever threatened to kill victim*	☐	☐
Has ever harmed or threatened to harm or kill children*	☐	☐
Has ever harmed or threatened to harm or kill other family members	☐	☐
Has ever harmed or threatened to harm or kill pets or other animals*	☐	☐
Has ever threatened or tried to commit suicide*	☐	☐
Stalking of victim*	☐	☐
Sexual assault of victim*	☐	☐
Previous or current breach of intervention order	☐	☐
Drug and/or alcohol misuse/abuse*	☐	☐
Obsession/jealous behaviour toward victim*	☐	☐
Controlling behaviour*	☐	☐
Unemployed*	☐	☐
Depression/mental health issue#	☐	☐
History of violent behaviour (not family violence)	☐	☐
Relationship		
Recent separation*	☐	☐
Escalation – increase in severity and/or frequency of violence*	☐	☐
Financial difficulties	☐	☐

* May indicate an increased risk of the victim being killed or almost killed.
# Mental health issues such as depression and paranoid psychosis, which focuses on the victim as hostile, are high risk factors when they are present in conjunction with other risk factors, particularly a previous history of violence. The presence of a mental health issue must be carefully considered in relation to the co-occurrence of other risk factors.

Preliminary Assessment cont.

Victim's own assessment of safety

Has a crime been committed?

Criminal offences include physical abuse, sexual assault, threats, pet abuse, property damage, stalking and breaching intervention orders. (See Classification Code Table for reference).

☐ No ☐ Yes If yes, provide details

CASE CLASSIFCATION CODE TABLE *

Instructions: Describe the most serious feature of the current case, and use this code number in the box above.

CRIMINAL ABUSE

ASSAULTS				PROPERTY		STALKING		BREACHING I/O	
1	Serious (Physical)	4	Threats (non-physical)	7	Serious (Damage)	10	Less than 2 weeks	13	Only
2	Minor (Physical)	5	Pet Abuse	8	Minor (Damage)	11	Between 2 & 4 weeks	14	Plus Other Charges
3	Sexual	6	Other types of assault	9	Theft	12	Greater than 4 weeks		

NON-CRIMINAL ABUSE

15	Emotional	Manipulative or controlling behaviour, humiliating or intimidating behaviour, subjecting victim to reckless driving, continual criticism, threatening to take children away or undermining the relationship between victim and children. Threatening to commit suicide.
16	Verbal	Swearing or making derogatory insults to the victim.
17	Social	Keeping victim away from family and friends, not letting victim leave the house, insulting victim in public.
18	Financial	Keeping victim totally dependent, not giving victim enough money to buy things for the household or for basic needs, threatening that victim will lose all victim's property if the relationship ends.
19	Spiritual	Ridiculing or insulting victim's most valued beliefs about religion, ethnicity, socio-economic background or sexual preferences.

NON-ABUSIVE AND NON-CRIMINAL BEHAVIOUR

20	Conflict	Non-violent, non-abusive, non-criminal dispute between family members characterised by the absence of controlling or coercive behaviour

* This is consistent with the Classification Table used by the Victoria Police in the Family Violence Risk Assessment and Management Report (the L17).

Preliminary assessment cont.

Protective factors

Risk Level

Is risk present?	☐ No	☐ Yes
Is action required?	☐ No	☐ Yes

Agencies already involved

Name of organisation	Contact person and number	Type of involvement

Safety plan

Preliminary assessment cont.

Referrals made

Type of organisation	Name of organisation	Name of contact person	Date of referral
Police			
Child protection			
Child FIRST			
24-hour state-wide crisis service			
Regional family violence service			
Counselling service			
Housing service			
Community Legal Centre/Legal Aid			
Centrelink			
Mental Health Service			
Drug and Alcohol Service			
Sexual Assault Service			

Consent

I, _____

consent for this practitioner to share the information I have provided in this assessment with other agencies to which I am being referred

Signature: _____

Date: _____ / _____ / _____

Verbal consent obtained: ☐ Yes ☐ No

RESOURCES & REFERENCES

RESOURCES

Department of Human Services, (2006), *Parenting Support Toolkit for Alcohol and Other Drug Workers*, Victorian Government Publishing Service
http://www.health.vic.gov.au/drugservices/pubs/parenting-support.htm
This resource kit is for all Victorian Alcohol and Other Drug Workers and helps to identify parenting needs by including parenting issues in the assessment process. The Toolkit helps workers respond to the identified parenting needs. It is divided into three books including:

- Exploring Parenting
- Information and Tools
- Services and Resource Guide

Victorian Government, (2007), *Family Violence: Risk Assessment and Risk Management*, Melbourne: Department of Victorian Communities
http://www.cyf.vic.gov.au/__data/assets/pdf_file/0018/69102/ifvs_risk_assessment_and_risk_management_framework.pdf
This resource kit forms part of a one-day training module and offers a framework for working with family violence issues. The framework has seven components including:

- Shared understanding of risk and family violence
- Standardised risk assessment
- Referral pathways and information sharing
- Risk management strategies
- Data collection and analysis
- Quality assurance

Network of Alcohol & other Drugs Agencies, (2009), *Tools for Change: A new way of working with families and carers,* Department of Health, NSW
http://www.nada.org.au/index.php?option=com_content&task=view&id=96&Itemid=25
The toolkit contains a range of interventions, practice tips, service models, resources and training organisations to assist services in working with families. A CD-Rom is also included which contains useful tools such as template policies for working with families, a family inclusive practice workplace audit tool, assessment tools, checklists and a list of family and carer support services.

O'Grady, C.P. & Skinner, W.J., (2007), *A Family Guide to Concurrent Disorders,* Centre for Addiction and Mental Health
http://www.camh.net/publications/resources_for_professionals/partnering_with_families/partnering_families_famguide.pdf
This manual has been developed specifically for families as a self-help resource. It offers an overall understanding of the challenges and opportunities that are present when dealing with a family member who has concurrent disorders. The manual is divided into four parts including:

- What are concurrent disorders?
- The impact on families
- Treatment
- Recovery

The Bouverie Centre Handbook 2010
http://www.bouverie.org.au/handbook
This handbook outlines a number of new initiatives as well as academic teaching, training and consultation options and specialist professional development workshops. The handbook is useful for professionals looking for opportunities to further their skills and education in family work. It is divided into five sections including:

- Welcome and general information
- Therapeutic and training resources
- Continuing education
- Academic award courses
- Clinical information

REFERENCES

Department of Human Services, (2006), *Parenting Support Toolkit for Alcohol and Other Drug Workers*, Victorian Government Publishing Service

DrugNet (1997), *Risk Assessment with Parental Drug Use,* DrugNet Professional Drug Management for Clinicians & Educators

Kashner, T.M. et al (1991), *Family Characteristics, Substance Abuse and Hospitalisation,* Hospital and Community, pp195-197

Kina Families and Addictions Trust, (2005), *Family Inclusive Practice in the Addiction Field – A Guide for Practitioners Working with Couples and Families,* Whanau, New Zealand.

McCubbin, H. I., Thompson, A. I., & McCubbin, M. A., (1996), *Family Problem-Solving Communication (FPSC) in Family Assessment: Resiliency, Coping and Adaptation*, Inventories for Research and Practice., 639-684, Edited by McCubbin HI, Thompson AI, McCubbin MA. Madison, University of Wisconsin Press.

Network of Alcohol & other Drugs Agencies, (2009), *Tools for Change, A new way of working with families and carers,* Department of Health, NSW

O'Grady, C.P. & Skinner, W.J. (2007), *A Family Guide to Concurrent Disorders,* Centre for Addiction and Mental Health

Orford, J., Templeton, L., Velleman, R. & Copello, A., (2005), *Family Members of Relatives with Alcohol, Drug and Gambling Problems: A set of standardised questionnaires for assessing stress, coping and strain,* Addiction, 100 (11), pp 1611-1624, Society for the Study of Addiction

Price, A.W., & Emshoff, J.G., (1997), *Breaking the Cycle of Addiction: Prevention and intervention with children of alcoholics,* Alcohol Health & Research World Vol.21, No.3, pp241-246

Proctor, K., Young, J. & Weir, S., (2006), *Focus on Families: Building confidence to work with families and significant others,* The Bouverie Centre

Victorian Government, (2007), *Family Violence: Risk Assessment and Risk Management*, Melbourne: Department of Victorian Communities.

Young, J., Rycroft, P. & Weir, S., (2006), *Single Session Work*, The Bouverie Centre

eDAS
Eastern Drug and Alcohol Service

The partnerships analysis tool

For partners in health promotion

Supporting partnerships

Based on the evaluation of a range of initiatives undertaken to promote mental health and wellbeing, John McLeod, on behalf of VicHealth, produced ***The Partnerships Analysis Tool*** to facilitate partnerships across sectors. It is a resource which (a) assists organisations to develop a clearer understanding of the range of purposes of collaborations, (b) reflects on the partnerships they have established and, (c) focuses on ways to strengthen new and existing partnerships by engaging in discussion about issues and ways forward.

Contents

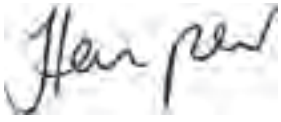
A resource for establishing, developing and maintaining productive partnerships

The Victorian Health Promotion Foundation considers partnerships an important mechanism for building and sustaining capacity in mental health promotion. This emphasis is particularly relevant when working across diverse sectors and with a range of organisations.

Partnerships are an important vehicle for bringing together a diversity of skills and resources for more effective health promotion outcomes. Partnerships can increase the efficiency of the health and community service system by making the best use of different but complementary resources. Collaborations, joint advocacy and action can also potentially make a bigger impact on policy-makers and government.

If partnerships are to be successful, however, they must have a clear purpose, add value to the work of the partners and be carefully planned and monitored.

The Partnerships Analysis Tool provides a tool for organisations entering into or working with a partnership to assess, monitor and maximise its ongoing effectiveness. VicHealth is pleased to offer this resource and welcomes your comments and feedback.



Todd Harper
Chief Executive Officer
VicHealth

Activity 1

Assessing the purpose of the partnership

Activity 1: How to assess the purpose of the partnership

Activity 1 is designed to explore and clarify the purpose of the partnership. In order to complete it we suggest you adopt the following approach:

1. Have each participant write five answers to each of the following questions on a piece of paper and rank them in order of importance:
   – Why is the partnership necessary in this particular project?
   – What value is it trying to add to the project?
2. Compare individual lists by starting with the reasons that are most important and following through to those that are least important.
3. Look for the points of consensus, but also be aware of any differences.
4. Do organisations have a clear understanding of what each one can contribute to the partnership?

How to use the tool

The tool is designed to provide a focus for discussion between agencies. Wherever possible, the activities should be completed by participating partners as a group. The discussion involved in working through the activities will help to strengthen the partnership by clarifying ideas and different perspectives. In some cases, it may indicate that the partnership is not working as intended.

Where a lead agency has initiated or is coordinating the partnership they would normally assume responsibility for facilitating the three activities.

Completing the activities will take a number of hours because there will be a variety of perspectives among the partners and different evidence will be cited as a way of substantiating the views people hold. The various stakeholders need time to reflect on the partnership and how it is working. The discussion that occurs around completing the tasks will contribute to the partnership because ideas, expectations and any tensions can be aired and clarified.

The tool can be used at different times in the partnership. Early on, it will provide some information on how the partnership has been established and identify areas in which there is a need for further work. A year or so into the partnership, it provides a basis for structured reflection on how the partnership is developing and how inter-partner relationships are forming. With longer-term partnerships, it may be worth revisiting the tool every 12 or 18 months as a method of continuing to monitor progress and the ways in which relationships are evolving.

The tool may also be useful to a lead agency as a tool for reflection when forming and planning partnerships.

What is the aim of the tool?

The aim of this tool is to help organisations involved in health promotion projects to reflect on the partnerships they have established and monitor their effectiveness.

The tool is divided into **three activities:**

Activity 1 explores the reason for the partnership. Why is the partnership necessary in this particular project?
What value does the partnership add to the project?

Activity 2 involves designing a map which visually represents the nature of the relationships between agencies in the partnership.

Activity 3 involves completing a checklist which defines the key features of a successful interdepartmental, interagency or intersectoral partnership. The checklist is designed to provide feedback on the current status of the partnership and to suggest areas that need further support and work.

Activity 2

A map of the partnership

Background

The concept of partnerships used in this tool implies a level of mutuality and equality between agencies. There are different types of partnerships in health promotion, ranging on a continuum from networking through to collaboration (see below).

A continuum of partnerships in health promotion

A distinction can be made between the purposes and nature of partnerships. Partnerships in health promotion may usefully be seen to range on a continuum from networking through to collaboration.

- **Networking** involves the exchange of information for mutual benefit. This requires little time and trust between partners. For example, youth services within a local government area may meet monthly to provide an update on their work and discuss issues that affect young people.
- **Coordinating** involves exchanging information and altering activities for a common purpose. For example, the youth services may meet and plan a coordinated campaign to lobby the council for more youth-specific services.
- **Cooperating** involves exchanging information, altering activities and sharing resources. It requires a significant amount of time, high level of trust between partners and sharing the turf between agencies. For example, a group of secondary schools may pool some resources with a youth welfare agency to run a 'Diversity Week' as a way of combating violence and discrimination.
- **Collaborating.** In addition to the other activities described, collaboration includes enhancing the capacity of the other partner for mutual benefit and a common purpose. Collaborating requires the partner to give up a part of their turf to another agency to create a better or more seamless service system. For example, a group of schools may fund a youth agency to establish a full-time position to coordinate a Diversity Week, provide professional development for teachers and train student peer mediators in conflict resolution.

Adapted from: Himmelman A 2001, 'on coalitions and the transformation of power relations: Collaborative betterment and collaborative empowerment', American Journal of Community Psychology, vol. 29, no. 2.

Not all partnerships will or should move to collaboration. In some cases, networking is the appropriate response. The nature of the partnership will depend on the need, purpose and willingness of participating agencies to engage in the partnership.

As a partnership moves towards collaboration, the more embedded it will need to become in the core work of the agencies involved. This has resource and structural implications. In particular, collaborative partnerships require the support and involvement of senior agency personnel, since project workers may be relatively junior or on short-term contracts. This can affect their capacity to mobilise the agency resources required for collaboration.

Working at partnerships

Working collaboratively is not always easy. Rae Walker, in her review on collaboration and alliances,[1] acknowledges the challenges and tensions created by working collaboratively as well as the importance of deciding when partnership is not an appropriate or effective strategy. Walker also describes the critical factors for successful collaboration including the need for partners to establish a process ensuring that organisations develop a shared vision and objectives. Ongoing monitoring and shared reflection of how the partnership is working is critical to strengthening and sustaining relationships between organisations and achieving effective outcomes.

Available at
www.vichealth.vic.gov.au

1 Walker R Sep 2000 Collaboration & Alliances: A Review for VicHealth.

Activity 2

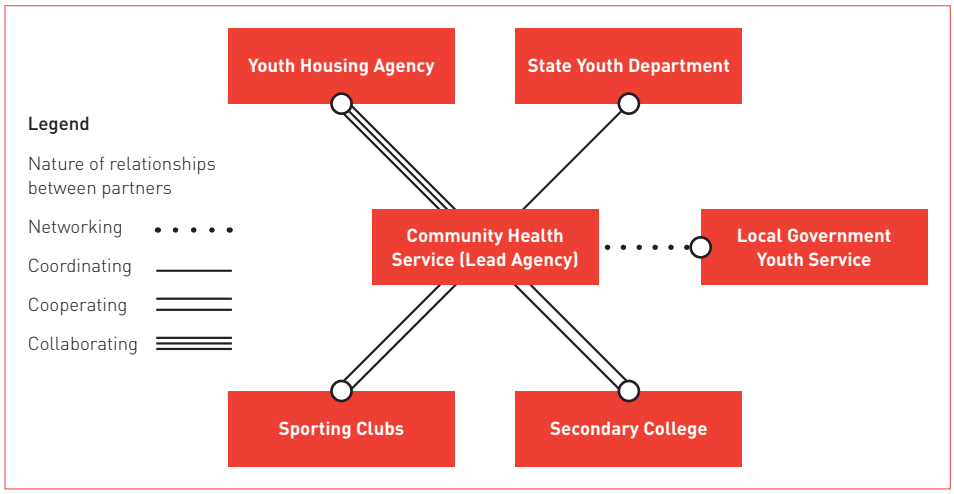
A map of the partnership

Activity 2: Completing the mapping exercise

1. Look at the examples below then follow this suggested approach to complete the mapping exercise:
2. List all the agencies involved in the partnership. The lead agency (if there is one) can be placed in the centre.
3. Using the legend below, link the agencies in terms of the nature of the relationship between them. The lead agency is likely to have a relationship with all of the others; however, there may also be important links between partners that do not rely on the lead agency.
4. The strength of the links between partners should be based on evidence of how the partnership actually works rather than how people might like it to work or how it may work in the future. Where possible cite concrete examples as evidence of the strength of the coalition.

Mapping example

A project to increase participation for young people at risk.



Nature of relationships

Community Health Service	→ is the lead agency, coordinates funds and project steering group.
State Youth Department	→ provides funds for the project and requires report at completion of funding.
Sporting Clubs	→ provides sports facilities, equipment and a coach.
Youth Housing Agency	→ provides office for project workers, coordinates and provides transport for young people to travel from school to the club.
	→ provides training for volunteers, sports coaches and generalist workers about youth issues, in particular it promotes this project.
Secondary College	→ refers young people to project.
Local Government Youth Service	→ member of steering committee.

The mapping exercise

This mapping exercise is designed to place all of the partners in relation to each other. Lines are drawn between them to show the strength and nature of the relationship. Mapping the relationship is a way of clarifying roles and the level of commitment to the partnership. This is important as partners may have different understandings or expectations of what their involvement means. If done collectively, this exercise can help to strengthen a partnership because people are able to raise issues of concern. This provides an opportunity to address areas in which there is a lack of consensus.

It is interesting to note patterns in the relationships and how these change over time. Many partnerships are strong on networking and coordinating but considerably weaker on collaborating. Completing the map provides an opportunity to look at ways in which relationships can be strengthened and made more effective.

Activity 3

A checklist for partnership in health promotion

Activity 3: Providing feedback using a checklist

In this activity, partners rank themselves against each of the items in a checklist (pages 6-7) describing the key features of a successful partnership. The checklist is designed to provide feedback on the current status of the partnership and suggest areas that need further support and work.

The questions address the major issues of forming and sustaining meaningful partnerships.

There are three ways to complete the checklist:

- The lead agency can fill in the checklist and present the results to a meeting of the partnership. Canvassing the various partners' views at a meeting is a way of testing out the accuracy of the lead agency's perceptions.
- Each partner can be given a copy to complete independently. They can compare and discuss the results at a meeting. This approach ensures the views of every partner are given equal weight.
- The checklist can be completed as a group activity. This approach will tend to emphasise consensus among members.

The checklist is a global measure that accepts there will be different perceptions. Consequently, there is some value in citing different examples that either confirm or test the global result. For example, most partners may be working well but one or two may be seen to be less cooperative. The 'outliers' need to be considered but they should not skew the dominant response. Similarly, a partnership may rate well against some of the key features and not in others.

To use the checklist on the following two pages follow the suggested approach:

1. Make copies of the checklist and, working as a group, consider each of the statements in relation to the partnership as a whole.
2. For each statement, rate the partnership on a scale, with a rating of one indicating strong disagreement with the statement and a rating of four indicating strong agreement.
3. Look at the scores in each section as this will show trends and illustrate areas of good practice as well as helping to identify aspects of the partnership in which further work needs to be done.
4. Consider aggregating the scores across the sections and using the accompanying key to establish an indication of the overall strength of the partnership. This will also provide a basis for monitoring aspects of the partnership over time. Aggregations are a gross measure; but can be good starting points for discussions about the project and the partnership.

What use is a checklist?

Checklists act as summaries of complex actions and interactions between various stakeholders. They are valuable because they synthesise the factors that contribute to a successful partnership and direct attention to the range of issues to be considered in assessing effectiveness. They point out the things to look for and consider. They can also guide future action as well as providing a focus for reflecting on the current state of affairs.

The checklist

Rate your level of agreement with each of the statements below, with 0 indicating strong disagreement and 4 indicating a strong agreement.

Rating	0 Strongly disagree	1 Disagree	2 Not sure	3 Agree	4 Strongly agree	
1. Determining the need for the partnership						
There is a perceived need for the partnership in terms of areas of common interest and complementary capacity.						
There is a clear goal for the partnership.						
There is a shared understanding of, and commitment to, this goal among all potential partners.						
The partners are willing to share some of their ideas, resources, influence and power to fulfil the goal.						
The perceived benefits of the partnership outweigh the perceived costs.						**TOTAL**
TOTAL						

2. Choosing partners						
The partners share common ideologies, interests and approaches.						
The partners see their core business as partially interdependent.						
There is a history of good relations between the partners.						
The coalition brings added prestige to the partners individually as well as collectively.						
There is enough variety among members to have a comprehensive understanding of the issues being addressed.						**TOTAL**
TOTAL						

3. Making sure partnerships work						
The managers in each organisation support the partnership.						
Partners have the necessary skills for collaborative action.						
There are strategies to enhance the skills of the partnership through increasing the membership or workforce development.						
The roles, responsibilities and expectations of partners are clearly defined and understood by all other partners.						
The administrative, communication and decision-making structure of the partnership is as simple as possible.						**TOTAL**
TOTAL						

4. Planning collaborative action						
All partners are involved in planning and setting priorities for collaborative action.						
Partners have the task of communicating and promoting the coalition in their own organisations.						
Some staff have roles that cross the traditional boundaries that exist between agencies in the partnership.						
The lines of communication, roles and expectations of partners are clear.						
There is a participatory decision-making system that is accountable, responsive and inclusive.						**TOTAL**
TOTAL						

Rating	0 Strongly disagree	1 Disagree	2 Not sure	3 Agree	4 Strongly agree	
5. Implementing collaborative action						
Processes that are common across agencies such as referral protocols, service standards, data collection and reporting mechanisms have been standardised.						
There is an investment in the partnership of time, personnel, materials or facilities.						
Collaborative action by staff and reciprocity between agencies is rewarded by management.						
The action is adding value (rather than duplicating services) for the community, clients or the agencies involved in the partnership.						
There are regular opportunities for informal and voluntary contact between staff from the different agencies and other members of the partnership.						**TOTAL**
TOTAL						

6. Minimising the barriers to partnerships						
Differences in organisational priorities, goals and tasks have been addressed.						
There is a core group of skilled and committed (in terms of the partnership) staff that has continued over the life of the partnership.						
There are formal structures for sharing information and resolving demarcation disputes.						
There are informal ways of achieving this.						
There are strategies to ensure alternative views are expressed within the partnership.						**TOTAL**
TOTAL						

7. Reflecting on and continuing the partnership						
There are processes for recognising and celebrating collective achievements and/or individual contributions.						
The partnership can demonstrate or document the outcomes of its collective work.						
There is a clear need and commitment to continuing the collaboration in the medium term.						
There are resources available from either internal or external sources to continue the partnership.						
There is a way of reviewing the range of partners and bringing in new members or removing some.						**TOTAL**
TOTAL						

Aggregate score	**TOTAL**
Determining the need for a partnership	
Choosing partners	
Making sure partnerships work	
Planning collaborative action	
Implementing collaborative action	
Minimising the barriers to partnerships	
Reflecting on and continuing the partnership	
TOTAL	

Checklist score

0–49 The whole idea of a partnership should be rigorously questioned.

50–91 The partnership is moving in the right direction but it will need more attention if it is going to be really successful.

92–140 A partnership based on genuine collaboration has been established. The challenge is to maintain its impetus and build on the current success.

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Drug and alcohol assessments

Date of Advice: **23 April 2007**

Advice no: **1117**

This Advice is current **only** if the date of Advice in this document matches the date of Advice in the online version. Check the date of Advice online before relying on this printed copy.

This Advice is endorsed by: Director, Child Protection and Family Services Branch.

Introduction and purpose

This Advice describes the purpose of parental drug and alcohol assessments and how they are utilised in Child Protection assessments and best interests plans. It outlines:

- the definition of substances, substance use and abuse
- the prevalence of substance use in Child Protection
- identifying the need for, and requesting, parental drug and alcohol assessment
- utilising the drug and alcohol assessment to develop and achieve the goals of best interest plans
- neonatal abstinence syndrome
- drug and alcohol assessments of young people.

The impact of parental substance abuse on a child requires thorough assessment. A stable and nurturing environment is crucial in the development of a healthy and emotionally secure child. Parents using substances continuously or daily will have significant difficulties caring for their children and their commitment and ability to provide care and protection will be significantly compromised by the effects of the substance abuse on mental health, physical health, lifestyle and functioning. Children rely on their parents to meet their physical, emotional, social, developmental and economic needs. When a parent is dependent on substances their primary commitment is to the substance, not to their children. A parent may find it difficult to prioritise the child's needs. The lifestyle associated with substance abuse precludes rational and long term decision making. Day to day decisions are oriented towards maintaining an addiction. Consequently, a parent's capacity to respond appropriately to their child's needs is limited, even though the parent may express the desire to care for their child.

Department of Human Services data indicates that parental substance abuse as a factor in Child Protection cases is a major trend over the past decade, with a 52 per cent increase in the five year period 1996-97 to 2000-01. Research indicates that substance abuse as a parental characteristic increases the likelihood of abuse and neglect of a child and therefore there is an increased likelihood of the removal of that child. In their case practice, Child Protection practitioners are required to assess possible substance abuse by the parent or child. Intervention strategies vary in both nature and timing, with the protection of the child requiring immediate attention and action, whereas parental acknowledgement, treatment and the maintenance of a substance free lifestyle will only be achieved over time. Therefore, Child Protection practitioners need to develop a knowledge base about substance abuse in order to make informed decisions and implement interventions, which can be supported with research findings and theory in court reports and utilised in best interests planning.

Definitions

Drug / substance

A drug is a substance which is psychoactive, that is it produces a mind altering affect on an individual.

The term 'substance' refers to all drugs, licit and illicit, including alcohol.

Examples of substances include, though are not limited to:

> *amphetamines* (speed, crystal meth, ice), *opioids* (heroin, morphine, methadone, pethidine, opium), *alcohol*, *cannabis*, *cocaine*, *hallucinogens* (LSD, PCP), *inhalants* (glue, petrol, aerosol, paint), *benzodiazepines* (valium, librium, mogadon, serapax, temazipan, normison), other prescribed medications.

(1) Legislation

Note:

Use the Legislation link on toolbar to access full text versions of the legislation.

Any sections of an Act noted in this Advice are partial references only and should not be relied on. Practitioners should refer to the Act for full details.

Children, Youth and Families Act

Children, Youth and Families Act 2005 (CYFA)

- s. 10 Best interests principles
- s. 11 Decision-making principles
- s. 205(3) Investigation by protective intervener

Information Privacy Act

Information Privacy Act 2000

Health Records Act

Health Records Act 2001

(2) Standards and procedures

Determining the need for a drug and alcohol assessment

It is part of the Child Protection practitioner's role to assess the impact of parental substance abuse by the parent and potential or actual harm to the child. Therefore, the Child Protection practitioner is required to ask questions relating to substance use, including past, current and the effects of substance use on the persons' physical and emotional wellbeing and level of functioning. The parent may not provide complete or accurate details of their substance use. It is vital that information about a parents' possible substance abuse is gathered from other family members as well as any professionals involved with the parent or family.

The Child Protection practitioner will need to be aware of physical indicators of possible substance abuse. The following list is illustrative and not exhaustive of physical indicators of possible substance abuse:

> disoriented, loss of inhibition, relaxation, dizziness, poor coordination, slower reaction time, blurred vision, slurred speech, aggressive disposition, feeling depressed, dilated pupils, pin-point pupils, increased or decreased appetite, paranoia or hallucinations, anxiety or panic attacks, confusion, restlessness/irritability, weight gain or loss, sweating, sleepy, feeling nauseous and vomiting.

It should be noted that the above are only indicators of possible substance abuse and that there may be another plausible explanation for the parents' presentation, which should be explored and considered.

When symptoms listed above are evident and there is a possibility that the parent may be using substances, a drug and alcohol assessment is required.

The most effective way to understand a parent's drug and alcohol use is by a drug and alcohol assessment. A drug and alcohol assessment may be helpful when:

- there is a known history of drug and alcohol use by the parent
- there is information to indicate current drug and alcohol use by the parent
- the parent has disclosed current drug and alcohol abuse
- you require a comprehensive assessment and understanding of the parents' use of substances and impact on their parenting capacity
- you require information about support services necessary for the parent to address their substance abuse
- there is a need to identify the most appropriate treatment for the parents' substance abuse.

What a drug and alcohol assessment involves

A drug and alcohol assessment is an interview process designed to gather information about the parents' history of substance use, current substance use, triggers for use, impact on level of functioning, treatments undertaken and to ascertain the most suitable treatment for the parent. A drug and alcohol assessment is undertaken by a drug and alcohol clinician.

In situations where a parents' drug and alcohol abuse may meet the criteria for substance dependency under the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), this assessment must be undertaken by a psychologist with relevant experience in this area.

The Child Protection practitioner may need to consider the possibility that the parent may have an alcohol related brain injury (ARBI). In these situations, a parents' cognitive ability may be compromised due to excessive alcohol consumption and this may impact on their ability to learn new information, memory capacity and coping and adapting to change. Consequently, this would have significant implications on a parents' ability to care for and protect their child or engage in a plan to address specific concerns. The most effective way to diagnose ARBI is by a neuropsychological assessment. This can only be conducted by a neuropsychologist who has completed specialised training in acquired brain injury. The neuropsychologist will diagnose brain injury and make recommendations about rehabilitation and management needs.

Requesting a purposeful drug and alcohol assessment

The purpose for which the drug and alcohol assessment is required and the specific circumstances of the case will dictate what information is required. It is important for the Child Protection practitioner to clearly identify what assessment information is required to the drug and alcohol clinician. The following are some likely areas to be covered:

- the age of the parent when the substance abuse began, including experimentation with substances
- the frequency, pattern and extent of substance abuse, including periods of abstinence and relapse
- reasons for initial substance abuse and the reasons for continued use
- types of substances used, including licit and illicit, and whether the parent engages in poly-substance use and substitute substance use (using another substance when the preferred substance is not available)
- the impact of different substances used concurrently on the parent's level of functioning
- triggers for substance use and ascertaining high risk situations in which a parent is more likely to use

- the effect of substance abuse on the parents' level of functioning, including physical health, emotional wellbeing, cognitive capacity
- source of licit or illicit substances – including lifestyle factors, parents association with other substance uses or sellers, the children's exposure to the drug culture
- observations of the impact of the parents' substance abuse on their parenting capacity and ability to care for and protect the child (it is not appropriate to expect a parenting capacity assessment. A drug and alcohol assessment will usually not include this aspect, unless the agency provides a specific service that addresses parenting and substance use issues with the parent)
- to identify the stage the parent is at in the 'model of change' and therefore their prognosis and likelihood of the successful completion of treatment
- recommendation of most appropriate treatment plan for the parent, that is, residential detoxification, home detoxification, counselling.

Utilising the drug and alcohol assessment

A drug and alcohol assessment has the potential to provide the Child Protection practitioner with a comprehensive understanding of the parents' drug and alcohol abuse, inform risk and needs assessment for the child and provides a framework for planning interventions when working with families where one or both parents are abusing substances and decision-making to protect the child.

Immediate risk

The Child Protection practitioner's first priority should always be the protection of the child. Therefore if issues of immediacy and risk to the child are identified in the drug and alcohol assessment, this must be dealt with initially. Once the safety of the child is assured then other issues such as substance abuse, treatment and parenting can be addressed.

Risk and needs assessment

The drug and alcohol assessment is a valuable source of information that can be utilised by the Child Protection practitioner in articulating a risk and needs assessment for the child, particularly for the purposes of a court report and best interests planning. The information used in conjunction with observations of the parents' behaviour by the Child Protection practitioner, family members, child and other professionals can highlight the type and level of risk to the child. For example, if the effect of the parents' substance abuse is that the parent falls asleep or becomes aggressive and this has been observed to occur by a family member, then the child (particularly an infant) is assessed to be at an increased risk of significant harm.

Best interests planning

The drug and alcohol assessment will assist the Child Protection practitioner when developing goals and tasks in the best interests plan. The Child Protection practitioner will be able to clearly identify the tasks or actions that the parent must undertake to ensure that this protective concern is adequately addressed. The Child Protection practitioner should consider strategic planning to the goals and the timely introduction of tasks should be tightly managed to avoid overwhelming the parent.

The prognosis of a parents' ability to address their substance abuse and where they are at on the 'model for change' will enable the practitioner to assess the viability of reunification, if the child is placed out of the parents' care. Substance abuse is a complex life struggle for those individuals consumed by dependence and addiction. Addressing substance abuse is a challenge characterised by deception, manipulation and relapse. A parent displaying frequent and unpredictable relapses into substance abusing behaviour is not uncommon, despite acknowledgement and an articulated commitment to change. The Child Protection practitioner must always make decisions in the best interests of the child's age and stage of development. Therefore if a parent has not been able to adequately address their substance abuse within an appropriate timeframe, a review of the goals and timelines of the best interests plan and a review of the overall plan for the child is required. The possibility of reunification may not be an option and the Child Protection practitioner is required to make a decision for the child's long term stability and care.

Parenting capacity

The drug and alcohol assessment can be used to assess parenting capacity and the parent's ability to ensure the child's safety and meet their developmental needs. The Child Protection practitioner can utilise the information regarding the parents' use and the impact of this on their level of functioning to articulate possible parenting capacity. The Child Protection practitioner should be conscious of the age and stage of development of the child when assessing parenting ability. For example, the parenting ability required of a parent with the care of an infant is very different from the capacity required to care for an older child.

Referral to support services

A drug and alcohol assessment identifies and enables early response so that parents are offered support in their parenting role and treatment for their drug and alcohol issues. The Child Protection practitioner can refer the parents to appropriate drug and alcohol support services so that the parents can undergo relevant treatment to address their substance use.

Neonatal Abstinence Syndrome

If the mother is known to be using substances during pregnancy, the Child Protection practitioner should discuss with the hospital whether the neonate is exhibiting signs of Neonatal Abstinence Syndrome (NAS). Statistics from the Women's Alcohol and Drug Services, Royal Women's Hospital, indicate that more than 66 per cent of infants born to substance dependent mothers exhibit some signs of NAS. Twenty-five percent of infants exposed to narcotics (primarily heroin and methadone) require medication for symptomatic narcotic withdrawal.

The Neonatal Abstinence Scoring System (NASS) is used when scoring newborns to determine if treatment for NAS is required. The two types of treatment include:

1. non-pharmocological (holding, rocking, demand feeding, reduced lighting and noise levels), and
2. morphine therapy, which the process of withdrawal management may take approximately four weeks.

Knowledge as to whether an infant was born with symptoms of NAS is critical when planning for the infant's discharge from hospital and for their short to medium term care requirements, as subacute withdrawal (irritability, sleep problems, hyperactivity, feeding problems) may last four to six months and there is an increased risk of Sudden Infant Death Syndrome (SIDS). This information is useful when assessing whether an infant can be placed in the care of the parent and whether the parent will be able to meet the infant's special physical and emotional needs.

The practitioner should consult with the high risk infant (HRI) manager or specialist infant protective practitioner (SIPW) in order to determine the level of risk to the neonate, undertake best interests planning and identify relevant support services that may benefit the neonate and the mother.

Drug and alcohol assessments of young people

The Child Protection practitioner may have responsibility for a young person who is using substances, often cannabis or inhalants (chroming). Therefore it may be necessary to refer the young person to a youth drug and alcohol service for an assessment, treatment and support. The purpose of a drug and alcohol assessment of a young person is to:

- identify the frequency and type of use
- ascertain the impact on their level of functioning
- identify treatment options for the young person
- provide education to the young person regarding the effect of substance abuse on their development.

Whilst a young person cannot be forced to undergo a drug and alcohol assessment or treatment, the Child Protection practitioner has a duty of care to act in the young person's best interests and strongly encourage the young person to do so and develop a safety plan which ensures that they do not place themselves at significant risk of harm. This may include, accessing secondary consultations with a youth drug and alcohol service, referral to an outreach youth drug and alcohol service for assertive engagement, secure welfare.

The practitioner should consult with the high risk adolescent (HRA) manager in order to determine the level of risk to the young person, undertake best interests planing and identify relevant support services that may benefit the young person. Prochaska and DiClemente, *The transtheoretical approach: crossing traditional boundaries of therapy,* Homewood Illinois, 1984.

(3) Considerations for good practice

Note:

Use the Practice Research link on the toolbar to access further Practice Guidance and Research.

Secondary consultations

At any point during Child Protection involvement, the Child Protection practitioner may require advice from a range of professionals to assist with developing an intervention to address the child's safety, stability and development issues.

When assessing substance abuse issues of a parent or young person, the Child Protection practitioner may contact a drug and alcohol service for information and advice. The Child Protection practitioner may seek to gather information on the range of treatment options available or seek the expertise of the drug and alcohol clinician about the particular alcohol and other drug use issues without making a referral to that service.

Poly-substance use and abuse of prescribed medication

When assessing drug and alcohol issues for a parent or young person, the Child Protection practitioner should be conscious of the possibility that the parent may be using more than one substance at any given time. Poly-substance use is when an individual uses more than once substance concurrently and not when a parent has used different substances at different periods of time. For example, a parent may smoke cannabis and consume alcohol at the same time, may smoke cannabis after taking prescribed medication, a young person may consume alcohol and inhale solvents at the same time.

On occasions the parent may use excuses or rationalise that they are not abusing substances because what they are consuming may be prescribed medication. The Child Protection practitioner must be aware that the parent may be consuming large amounts of the prescribed medication in order to have the desired effect, may have substituted prescribed medication for illicit substances, or may be attending different doctors ('doctor-shopping') to obtain various prescribed medications. All of the above may not be known to the regular general practitioner. These issues are highly concerning when assessing risk to a child and if identified by the Child Protection practitioner, then a drug and alcohol assessment is highly recommended to obtain a comprehensive assessment of the parents' substance abuse, impact on level of functioning, the effects and consequences of poly-substance use and appropriate treatment.

Dual diagnosis

There is a high incidence of dual diagnosis of substance abuse and mental illness. Adults with this dual diagnosis are more difficult to treat, and their treatment outcomes are poorer, than for adults who are either abusing substances or have a mental illness.

The Child Protection practitioner may need to explore the possibility that the parent may be 'self-medicating'. For example, a parent diagnosed with anxiety, personality disorder or schizophrenia may smoke cannabis, use amphetamines or take valium in order to feel calm and relaxed or just able to function, as opposed to taking the required medication for their mental illness.

Therefore, it is important for the Child Protection practitioner to consider if the parent has a mental illness or shows evidence of a mental/emotional disorder. If so, then there should be consideration for a mental health assessment as well. In these situations, dual treatment and regular liaison with both specialist services is imperative.

Associated risk factors

The emerging trend of multiple risk factors in Child Protection cases is concerning and something that the Child Protection practitioner must consider. The presence of family violence in the parent's relationship where one or both are abusing substances significantly increases the risk of abuse to the child. For example, alcohol abuse is common in physical abuse cases and is usually associated with violence in the home.

The Child Protection practitioner must explore family violence, mental health and substance abuse issues when investigating Child Protection cases. Any combination of these risk factors should be carefully assessed, as there is an increased likelihood of significant harm and neglect to the child and serious impact on a child's development and emotional wellbeing.

(4) Contact for further procedural advice

- Team leader
- Unit manager
- HRI manager
- HRA manager
- Specialist infant protective practitioner
- Policy and Practice Unit, Child Protection and Family Services branch
- Drug and alcohol services

(5) Related policy documents and procedures

Note:

Advice, Protocols and Policy Documents directly related to this Advice are listed below. To access the full range of Protocols and Policy documents use the Protocol and Policy links on the Home Page.

Related Practice Advice:

- Advice no. 1074 - Drug and alcohol assessment and treatment services
- Advice no. 1246 – Use of conditions on court orders
- Advice no. 1483 - Mental health assessments and treatment
- Advice no. 1504 - Use of drug screen in Child Protection assessment

Related Protocols:

- Protocol between drug treatment services and child protection for working with parents with alcohol and other drug issues (2002)
- Protocols with local drug and alcohol services

Other related procedural documents:

- For this Advice, there are no specific related procedural documents.

Related policy documents:

- Parental Substance Abuse – Guidelines for Protective Workers (1994)

(6) Checklist of required standards

Note:

A checklist of the required standards follows. It can be utilised as a reference point for practitioners and supervisors or printed and utilised in supervision to assist in ensuring required tasks are undertaken.

- For this Advice, there are no specific standards.

Use of drug screen in Child Protection assessment

Date of Advice: **23 April 2007**

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This Advice is current **only** if the date of Advice in this document matches the date of Advice in the online version. Check the date of Advice online before relying on this printed copy.

This Advice is endorsed by: Director, Child Protection and Family Services Branch.

Introduction and purpose

This Advice describes the purpose of drug and alcohol screens and how they are utilised in Child Protection assessment. It outlines:

- what is a drug and alcohol screen
- when is a drug and alcohol screen requested
- issues to consider when requesting drug and alcohol screens
- utilising drug and alcohol screens in best interests plans and risk and needs assessment.

Child Protection practitioners are sometimes required to assess the effects of substance abuse by a parent on their parenting capacity. A drug and alcohol screen is one tool that can be used to assess drug and alcohol usage and should not be used in isolation. Drug and alcohol screens should be utilised in conjunction with a drug and alcohol assessment, feedback regarding the parents' drug and alcohol treatment and observations during contact between the Child Protection practitioner and the parent.

Child Protection practitioners should consult with specialist Koori drug and alcohol services when working with parents of an Aboriginal background who need to address drug and alcohol issues. See Advice number 1074, 'Drug and alcohol assessment and treatment services' and Advice number 1117, 'Drug and alcohol assessments' – refer section (5) for links.

Regular monitoring through drug and alcohol screens is an indicator used to assess a parent's level and type of substance use and their commitment and capacity to change. The Child Protection practitioner should exercise caution when relying solely on drug and alcohol testing as it does not detect all drugs and the testing process may be manipulated by the parent.

What is a drug and alcohol screen?

Drug and alcohol screens are a form of testing for monitoring substance use. There are three types of screens used when testing for drugs and alcohol:

- urine screen
- blood test
- breathalyser test.

For the detection of drugs a urine drug screen is usually requested. For the detection of alcohol, whilst a urine screen can be requested it only detects alcohol up to 24 hours. A more useful test of alcohol consumption is a blood test, however this is an intrusive measure. In some areas an agency may offer the possibility of the parent attending and undergoing a breathalyser test.

Drug and alcohol screens can be completed either at a local medical centre or a pathology clinic. The drug and alcohol screen will usually be supervised by the general practitioner or the nurse at the pathology clinic, if this is required. The Child Protection practitioner will need to negotiate directly with the general practitioner or the pathology clinic when organising urine drug screens for a parent, to ensure that the results are sent to the practitioner. It is important that the practitioner is familiar with the process of requesting drug and alcohol screens in their region, that is, requesting that a parent attend the local medical centre or a particular pathology, as costs may be associated.

(1) Legislation

Note:

Use the Legislation link on toolbar to access full text versions of the legislation.

Any sections of an Act noted in this Advice are partial references only and should not be relied on. Practitioners should refer to the Act for full details.

Children, Youth and Families Act

Children, Youth and Families Act 2005 (CYFA)

- s. 10 Best interests principles
- s. 11 Decision-making principles
- s. 281 Supervision order may impose conditions
- s. 167 Preparation of case plan
- s. 168 Review of case plan
- s. 205 Investigation by protective intervener
- s. 263(2)(7)(8) Conditions of interim accommodation order
- s. 283(1)(e) Conditions of custody to secretary order
- s. 284(1)(e) Conditions of supervised custody order
- s. 291(3)(f) Conditions of interim protection order

(2) Standards and procedures

Determining the need for drug and alcohol screens

The requirement of drug and alcohol screens needs to be viewed as one component of a broader understanding of the parent's substance use and their ability to parent the child adequately. Drug and alcohol screens are required when there is a need for a clear assessment of the parent's drug and alcohol use and the impact on their parenting capacity. Drug and alcohol screens may identify drug and alcohol use, however they do not provide information regarding a parent's motivating factors, triggers, obstacles. Therefore, it is important for the Child Protection practitioner to consult with drug and alcohol agencies in order to gain a clear understanding of the effects of particular substances, the impact on a parent's level of functioning and to be guided in determining an appropriate plan for the parent to address their substance use.

The purpose and aim of drug and alcohol screens needs to be considered when determining the necessity for these. For example, is the aim for the parent to achieve abstinence or to identify a degree of use where it may be possible to safely use and continue to parent the child? It may be that a safety plan is developed in consultation with a drug and alcohol clinician and negotiated with a parent, that when substance use occurs recreationally, that the parent does not have the sole care of the child and an extended family member may provide care and supervision of the child. A parent's substance use becomes a significant risk factor when it impacts on their level of functioning and ability to parent the child.

Practitioners should consider the need for drug and alcohol screens to be provided by parents when:

- the parent is currently using substances
- there is a reasonable belief that the parent may be using substances
- to determine frequency and level of substance use by the parent
- to determine the type(s) of substance that are being used by the parent
- to monitor compliance of the parent on the methadone program.

If it is determined that drug and alcohol screens are required as part of the Child Protection assessment, then these can be requested of the parent directly during protective intervention involvement (as this involvement is voluntary, the parent does not have to comply) or via a court order.

The Child Protection practitioner has a number of options when requesting drug and alcohol screens of parents:

- random versus set days
- frequency (one day per week or three days per week)
- supervised versus unsupervised urine drug screens.

The Child Protection practitioner can consider any combination of these, however must have a clear rationale for this. When considering each of these options, the Child Protection practitioner would need to take into account the following:

- level and frequency of suspected substance use by the parent
- is the child in the parents' care, is the child having access with the parent or is reunification imminent
- the type of substance used by the parent and an understanding of the lifespan of the substance in one's system
- parental history of compliance with drug and alcohol testing
- any parental history of attempts to manipulate drug and alcohol testing (for example, using another person's specimen, not attending on requested days).

For example, if the child is in the care of the parent or reunification is imminent, then it is more likely that frequent, supervised and random drug and alcohol screens would be required to ensure that the child is not at risk of possible harm and neglect, that the child is not exposed to parental substance abuse and that the parent has not relapsed.

If the condition of the court order stipulates 'random' drug and alcohol testing, then requesting the parent to provide drug and alcohol screens on set days (that is, Monday, Wednesday and Friday) is not considered to be random. Random drug and alcohol testing reduces the possibility of manipulation of the results by the parent. For example, if the parent is dependent on substances, it is probable that the parent could plan their substance use around the set days and ensure that substances are not detected in the urine sample. However, random drug and alcohol testing makes it more difficult for a parent to plan and manipulate the results.

Having an understanding of the lifespan of the substance in one's system allows the Child Protection practitioner to articulate a strong rationale for the frequency of drug and alcohol testing. For example, if the parent uses heroin or amphetamines, then a urine drug screen would be required every two days. If the parent uses cannabis or benzodiazepines then one to two times per week may suffice. It is recommended that the Child Protection practitioner consults with a drug and alcohol clinician in identifying the most appropriate drug and alcohol screen regime.

Child Protection practitioners request urine drug screens three times per week in court orders, without considering whether this is required. The Child Protection practitioner should be prepared to negotiate this with the parent and be able to articulate the rationale for requesting drug and alcohol testing and the frequency of this at court.

Utilising drug and alcohol screens

Drug and alcohol screens are only useful when they are utilised constructively and monitored effectively.

Best interests plans

The purpose and frequency of the drug and alcohol screens should be incorporated into best interests plans, clearly outlining the expectations of the parents. For example, the parents should be informed of the process of how they will be requested to provide drug and alcohol screens, that is, contacted on the day via telephone or provided with set dates that they must provide the screens.

The Child Protection practitioner, in consultation with the team leader and unit manager, should develop bottom lines for a parent when there is a requirement to provide drug and alcohol screens. The practitioner must inform the parent of the implications if drug and alcohol screens are not provided or return with positive results and contingency plans must be developed if a parent cannot complete a drug and alcohol screen in an emergency.

Risk assessment

The Child Protection practitioner needs to be vigilant in ensuring that the results of drug and alcohol screens are received in a timely manner. This will enable assessment of the risk to the child and appropriate and timely action to be undertaken, if this is required. The Child Protection practitioner will need to assess the level of risk to the child when results of the parents' drug and alcohol screens are positive. For example, if the parent provides a number of consecutive positive drug and alcohol screens and the child is residing in the care of the parent, then consideration needs to be given as to the risk to the child, as it would be apparent that the child may be exposed to the parent's substance use or the parent is affected by substances when caring for the child.

Likewise, if the parent provides consistently negative results, then unsupervised access or reunification may be considered, if this is in the best interests of the child. The provision of negative drug and alcohol screens over a period of time may lead to a review of the frequency of requested drug and alcohol screens.

Summary of important points

- Drug and alcohol screens are to be requested of a parent where there is known or suspected substance use of a level which impairs parenting ability.
- Consult with the team leader regarding the appropriateness of a drug and alcohol assessment of the parent.
- Consult with a drug and alcohol agency regarding the type and use of drug and alcohol screening that is appropriate for the parent, the need for a drug and alcohol assessment and what complimentary measures could be utilised with the drug and alcohol screens to monitor a parents' substance use, for example, drug and alcohol counselling.
- Consult with the unit manager with regard to case planning issues, for example, scheduling drug and alcohol screens either prior to or after access, have identified a clear plan of action if the drug and alcohol screens are not completed or return with a positive result and when this action will be implemented.

- The implications of drug and alcohol screens not being completed or if the results return positive must be explained clearly to the parent and prior to any process that may commence as a result of this.

(3) Considerations for good practice

Note:

Use the Practice Research link on the toolbar to access further Practice Guidance and Research.

Preferred practice dictates that a parent be informed of Child Protection expectations. With regard to drug and alcohol screens, the following may be considered:

- If the parent is to provide random drug and alcohol screens that they be contacted via telephone on the day that the screen is required. Practitioners need to consider the practical realities of this request, for example, transport for the parent, proximity of the parent to the medical centre or pathology clinic, time provided to allow the parent to comply with the request (that is, the parent should be advised of the need to provide a drug and alcohol screen in the morning to allow him/her adequate time to attend at the clinic).
- That the parent be informed that if the drug and alcohol screen is not provided on the day requested it will be considered as a 'positive' screen.
- Minimal flexibility is to be exercised when negotiating with a parent if they are unable to provide a drug and alcohol screen on a particular day. It may be that they must provide one the following day. The reason for this is to reduce the possibility of a parent manipulating the results of a drug and alcohol screen, in an attempt to ensure that the result is negative.
- If the parent presents as substance affected during a home visit the practitioner should request that the parent provide a drug and alcohol screen.
- How many 'positive' screens will be accepted by Child Protection before action is taken. Consideration needs to be given to the impact of substance use on the parent's level of functioning, the child's exposure to the parent's substance use and the age of the child.

Supporting parents

Substance dependence and parenting are very difficult for parents to manage concurrently. The Child Protection practitioner needs to emphasise to the parents the importance of the relationship with their child and their parenting responsibilities over their substance use. The parent should be informed of the impact of their substance use on their parenting and on the child. For example, if access is suspended or cancelled as a result of the parent being substance affected, the child experiences trauma at not seeing the parent.

Treatment of substance dependence is a long process and relapse is likely. However committed or willing a parent is to address their substance abuse, it is very difficult for a parent to cease and is dependent on the level of addiction, type of substance used and motivation. It is the role of the Child Protection practitioner to support and encourage a parent to address the substance use and not to punish the parent. Notwithstanding, it is critically important that practitioner's focus on the risks and safety for the child and to make decisions as to what is in the best interests of the child.

Drug and alcohol screens and access

Drug and alcohol screens are often used in determining the need for supervised or unsupervised access between a parent and the child and whether reunification occurs. The Child Protection practitioner should articulate clear bottom lines of what is acceptable and what would compromise access with the child and reunification of the child to the parent. For example, if a parent has supervised access with the child however is providing positive drug and alcohol screens, consideration needs to be given as to whether this places the child at risk of harm and an assessment of the impact of substance use on the parent's functioning may be required. It may be that access is suspended or cancelled, pending further assessment. Similarly, if a parent presents as substance affected during access, then good practice suggests that the Child Protection practitioner requests a drug and alcohol screen of the parent to determine possible substance use.

(4) Contact for further procedural advice

- Team leader
- Unit manager
- HRI manager
- Policy and Practice Unit, Child Protection and Family Services Branch
- Drug and alcohol services
- Pathology services

(5) Related policy documents and procedures

Note:

Advice, Protocols and Policy Documents directly related to this Advice are listed below. To access the full range of Protocols and Policy documents use the Protocol and Policy links on the Home Page.

Related Practice Advice:

- Advice no. 1044 - Duty of care
- Advice no. 1074 - Drug and alcohol assessment and treatment services
- Advice no. 1090 - Information sharing in Child Protection practice
- Advice no. 1117 - Drug and alcohol assessments
- Advice no. 1246 - Use of conditions on court orders

Related Protocols:

- Regional protocols with local pathology clinics
- Protocol between drug treatment services and Child Protection for working with parents with alcohol and drug issues

Other related procedural documents:

- For this Advice, there are no specific related procedural documents.

Related policy documents:

- For this Advice, there are no specific related policy documents.

(6) Checklist of required standards

Note:

A checklist of the required standards follows. It can be utilised as a reference point for practitioners and supervisors or printed and utilised in supervision to assist in ensuring required tasks are undertaken.

- For this Advice, there are no specific standards.

Summary of information sharing guidelines and how they apply to you

Action	Is this required by law? (where not required by law, it may be good practice to do so voluntarily)	Is this authorised by the *Children, Youth and Families Act 2005*?	Is my identity protected by the *Children, Youth and Families Act 2005*?*	Am I protected from negative legal and professional consequences by the *Children, Youth and Families Act 2005*?
Making a referral to Child FIRST	NO	YES	YES	YES
Making a report to Child Protection	NO	YES	YES	YES
Sharing information when you are consulted by Child FIRST or Child Protection	NO	YES	NO, but it will be held in confidence upon request	YES
Sharing information with family services when they are providing services to a family	NO	NO	NO	NO
Sharing information with Child Protection during an investigation#	NO	YES	YES	YES
For information holders only				
Sharing information with Child Protection to support ongoing case planning after an investigation	NO	YES	NO, but it will be held in confidence upon request	YES
Sharing information with Child Protection on request when a child is subject to a Children's Court Protection Order	NO	YES	NO, but it will be held in confidence upon request	YES
Sharing information with Child Protection when a child is subject to a Children's Court Protection Order and when you are directed by an officer authorised by the Secretary of the Department of Human Services	YES	YES	NO, but it will be held in confidence upon request	YES

* You are encouraged to allow your identity to be disclosed, even where it is protected by law (i.e. when making a referral or report, or assisting an investigation). Your identity will be treated in confidence, if that is your wish, except where disclosure is required by law (for example, if directed by a court).

\# Service Agency professionals who are not authorised Information Holders must be specifically authorised by a Child Protection worker. Information Holders are automatically authorised.