

Practice Paper
Parental substance misuse and child protection:
intervention strategies

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1. Introduction

This paper has been developed to assist departmental officers to implement effective, evidence-based interventions, in cases where children have been harmed, or are at risk of harm, by parents who misuse substances.

Refer to the corresponding practice paper, 'Parental substance misuse and child protection: Overview, indicators, impacts, risk and protective factors', in relation to identifying, assessing and monitoring parental substance misuse and its impact on the safety and wellbeing of children.

2. Practice principles for effective substance misuse treatment

The following principles apply to **effective substance misuse treatment** (National Institute on Drug Abuse 2006) and are therefore important to the provision of services to children in circumstances where parental substance misuse is an identified child protection concern, and/or the presence of other evidence-based risk factors indicate the possible presence of parental substance misuse:

- no single treatment is appropriate for all individuals;
- treatment needs to be readily available;
- effective treatment attends to multiple needs;
- treatment needs to be flexible;
- remaining in treatment for an adequate period of time is **critical** for treatment effectiveness;
- individual and/or group counselling and other behavioural therapies are critical components of effective treatment for addiction;
- medications are an important element of treatment for many patients;
- substance misusing individuals with coexisting mental disorders should have both disorders treated in an integrated way;
- medical detoxification is only the first stage of substance misuse treatment;
- treatment does not need to be voluntary to be effective;
- possible substance use during treatment must be continuously monitored;
- treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases; and
- recovery from substance misuse can be a long-term process and frequently requires multiple episodes of treatment.

3. Definitions

Substance – for the purpose of this paper, ‘substance’ refers to alcohol, prescription drugs and illicit drugs.

Drug/s – for the purpose of this paper, ‘drugs’ mean drugs other than alcohol.

ATODS – Alcohol, Tobacco and other Drugs Services.

Co-morbid conditions – this term is frequently mentioned in the literature on substance misuse, and refers to the presence of a **concurrent** psychiatric or psychological condition or disorder in the parent who misuses substances. Examples of co-morbid conditions include depression, anxiety disorder and antisocial personality disorder.

Substance misuse – refers to the use of a substance that is part of, or associated with, problematic or harmful behaviour (Forrester and Harwin 2004).

Physical dependence – refers to the existence of withdrawal symptoms if a substance is not taken. There is a common misconception that physical dependence is all there is to addiction however, physical dependence is only **one** aspect that defines addiction. Others include the pattern of use and psychological feelings associated with not using, such as feeling a craving (Forrester and Harwin 2004).

Illicit drugs – incorporate the following (AIHW 2005):

marijuana/cannabis	pain-killers/ analgesics*	steroids*	tranquillisers/ sleeping pills*
barbiturates*	inhalants	heroin	methadone (non-maintenance)
cocaine	other opiates/ opioids*	meth/amphetamine (speed)	hallucinogens
injected drugs	ketamine	GHB	ecstasy

** for non-medical purposes*

AIHW – Australian Institute of Health and Welfare.

4. The importance of timeframes in providing intensive time-limited reunification services

Practice Tip: To address the competing timeframes and priorities associated with the child protection service system and substance misuse treatment services, departmental officers must work jointly with ATODS (or other relevant substance misuse treatment services) to:

- complete joint assessment, planning, implementation and reviews of case plans;
- ensure collaboration and service delivery coordination as these are “critical to working effectively with substance-abusing parents and providing intensive time-limited reunification services to children and families” (McAlpine, Courts Marshall and Harper Doran 2001:2);
- provide a timely and intensive process when assisting parents to resolve substance misuse issues and address other identified risk factors (eg. parenting skills, support networks) and related harm and/or risk of harm to their children.
- give consideration to, and establish clear case plans for, managing the issue of conflicting timeframes for children and parents, including:
 - setting realistic expectations;
 - making reasonable efforts to obtain prompt access to adequate substance misuse treatment services and associated resources for parents; and
 - coordinating the provision of child protection, substance misuse and other (if applicable) services to children and parents.

If families are to be given real opportunities for recovery and children are to have a chance to grow up in safe family situations, it is important that treatment be made available quickly and include “aggressive outreach as well as a focus on retention and monitoring as integral service components” (McAlpine, Courts Marshall and Harper Doran 2001:4).

“The majority of professionals working in adult services viewed the dependent substance misusing behaviour as a chronic condition which, having taken years to develop, may take years to relinquish, and where relapse, for example, was seen as a stage to recovery. Child welfare workers, on the other hand, were more acutely aware of the damage that could occur to children in terms of development and welfare whilst the adult’s struggle with drugs or alcohol was being tackled...” (Taylor and Kroll 2004:1122).

Given the above perspectives, it is of no surprise that the literature on parental substance misuse and child protection commonly refers to the different timeframes within which workers operate as a **major practice dilemma**. One of the most critical child protection decisions illustrative of the timeframe dilemma is ‘should the child be returned to the family, or should there be alternative long-term care arrangements?’

Decision making, particularly with respect to reunification, is difficult as “the courts prefer to see families reunited quickly, while addiction treatment providers argue for longer timelines so that clients can solidify treatment gains...” (Hohman and Butt 2001:53).

In Queensland, one of the goals of Structured Decision Making™ – an assessment and decision making model to assist in making critical decisions about the safety of children – is to expedite permanency for children (or reduce the time to permanency arrangements for children in out-of-home care).

The implication for practice is that if issues such as parental substance misuse are not resolved in a timely and intensive manner (for example, parents may express a desire to change but not follow through, or not make changes fast enough for the child's protection and care needs), the focus is on stability for the child and moving to long term decisions about the child's care.

The increasing focus on making longer term decisions for the care of children is in acknowledgement that governments are increasingly reluctant to have children drifting in foster care, where children wait for years to see if a parent manages to make the necessary changes in order to resume their children's care.

The metaphor of **four hourglass clocks** provides a useful illustration of the timeframes that significantly impact child protection intervention in cases of parental substance misuse (McAlpine, Courts Marshall and Harper Doran 2001:5), including:

- **child welfare mandates for decisions regarding permanent placements for children who are in out-of-home care** – in Queensland, timeframes specific to the Family Reunification Assessment decision tool are clearly outlined in departmental procedures, with children under 3 years having shorter timeframes for deciding permanency (in recognition of the rapidly changing needs of young children and the importance of attachment and permanent, stable care for these children);
- **the pace of recovery from addiction** – addiction is a complex illness where multiple treatment attempts occur over a period of time before significant improvement occurs, and where relapse is common (particularly in early stages of recovery). Research into substance misuse and relapse rates clearly illustrates that recovery from addiction may require long-term or lifelong intervention, timeframes which conflict with child welfare mandates;
- **children's developmental timelines** – increasingly, the 'early years' (the age range between birth and eight years) for children are recognised as a crucial developmental stage, with the experiences children are exposed to during this time having enormous impacts on their future development. It is argued that children cannot be placed 'on hold' during a parent's addiction and recovery without serious developmental consequences, particularly when considering the attachment needs of infants and young children (in Queensland, departmental procedures require more frequent (3 monthly) reviews of case plans for children under three years, than for children 3 years and over (6 monthly)); and
- **time limits for welfare recipients** – some parents in substance misuse treatment are welfare recipients and may therefore be subject to requirements and time limits associated with such benefits (for example, Centrelink requirements specific to employment benefits). In addition to child welfare and substance misuse treatment timeframes, parents may be subject to time limits that threaten their source of income. As a result, substance misuse treatment programs may need to increasingly accommodate clients' other activities and responsibilities.

5. Assessing and monitoring parental substance misuse

Departmental officers should refer to existing departmental procedures to assist them in fulfilling the requirements associated with assessing, planning, implementing and reviewing the protection and care needs of children. In addition, the frameworks outlined below may assist departmental officers in relation to undertaking the assessment and monitoring of parental substance misuse and the subsequent harm, or risk of harm, to children.

5.1 'Standing Conference on Drug Abuse (SCODA) guidelines'

Practice Tip: While there is no straightforward advice that can be given with respect to effectively assessing and monitoring parental substance misuse, the Standing Conference on Drug Abuse (SCODA) guidelines (Phillips 2004:177-179) may be of assistance to departmental officers in cases of actual, or suspected, parental substance misuse. Refer to **Appendix 1**, for the SCODA Guidelines.

It is important to note however that the SCODA guidelines are intended as a starting point only, to **support** departmental officers in considering and exploring applicable issues of potential relevance to parents and children.

The guidelines are **not** to be used in isolation but rather, will:

- inform the department's Structured Decision Making assessment and decision making model; and
- facilitate the conduct of holistic assessments and interventions consistent with departmental procedures.

In addition to the above guidelines, the key considerations outlined throughout this paper require incorporation into practice at relevant assessment and decision making points. Of particular importance are the risk and protective factors, and impacts of parental substance misuse on children.

5.2 Sources of information assisting the assessment and monitoring of parental substance misuse

Practice Tip: Inquiring about **family history** of addiction is likely to be useful, given that many parents who misuse substances have a history (as a child) of being exposed to their own parents' substance misuse.

Sources of information generally available to departmental officers when assessing and monitoring harm and/or risk of harm to children, associated with parental substance misuse, include the following:

- information directly obtained from interviews and conversations with children and parents;
- observations of the attachment between children and parents;
- observations of parent-child behaviours;
- written and verbal advice requested from mental health professionals and/or ATODS professionals, regarding the presence of mental health disorders including substance misuse and dependence;
- in-home observations of paraphernalia (for example, syringes, charred spoons, pipes, foils, drug storage etc.);
- external sources, particularly the Queensland Police Service and Queensland Corrective Services;
- General Practitioners and other health professionals; and
- family members and significant others may also be interviewed to establish or verify a parent's substance use (having regard to privacy issues).

5.3 Asking questions of parents who misuse substances and their children

Practice Tip: In circumstances where notified concerns do not directly raise parental substance misuse, it is suggested that general health and well being questions be included in interviews of, or discussions with, parents. As such discussions progress, more specific questions can be asked.

Given that child protection workers are visiting families to investigate and assess concerns of harm or risk, and that such concerns may not necessarily incorporate issues associated with parental substance misuse, it may be difficult to ask questions that do not appear relevant to the nature of the notified concerns.

However given the extent and nature of parental substance misuse within child protection cases, and the serious nature of risk factors and likely harms to children, it is important that departmental officers find a comfortable way of effectively enquiring about the possible existence of parental substance misuse.

For example (Drug and Alcohol Services South Australia 2006):

How is your general health?

What about eating/sleeping/exercise?

Do you smoke?

What about cannabis?

Do you drink alcohol? or Many people drink alcohol – do you drink?

When you drink how much would you have?

The research also highlights the importance of the following when **communicating** with parents and children:

- not making assumptions about the impact of parental substance misuse; and
- not generalising about peoples' circumstances.

A key approach to understanding the child/family's situation is asking them about it. While the information below is specific to parental alcohol misuse, the questions could be modified with respect to discussing drug misuse with parents.

Suggested questions to facilitate discussion with parents, include the following (Tunnard 2002):

- *Have you ever missed taking the children to day care or school because you slept late after drinking the night before?*
- *Have you ever thought the children were missing out because you were under the weather after the previous night's drinking?*
- *Have you ever felt embarrassed about being drunk in front of the children?*
- *Have you ever said hurtful things to your children or hit them when you've had too much to drink?*
- *Have the children ever had to go without because the money has been spent on drink?*
- *Have you ever cried in front of your children when you've had too much to drink?*
- *Have you ever worried that you would not have been able to deal with an emergency because you've had too much to drink?*

Related communication strategies include the following (National Drug and Alcohol Research Centre 2003):

- keep your body language and tone of voice concerned or neutral but not disapproving or judgemental;
- avoid debating the positives and negatives of drinking – talk about your concerns for the person's health and wellbeing and/or encourage them to consider the positives and negatives of their drinking; and
- listen and understand a person's points of view for example, if a person has concerns acknowledge these and find out how the person can be supported if they want to make changes.

Where initial discussions indicate possible problematic use, **explore** the quantity and pattern of use for each drug. For example, ask about the use in the last seven days starting with yesterday and working backwards, then enquire if this is a typical or an unusual week in terms of consumption (if unusual, enquire about a typical week).

In the substance misuse model, **four questions** are explored in turn (Tunnard 2002):

- *an understanding of the place of substance in the life of the parent – questions such as how much, when, with whom, in what circumstances?*

- *an examination of the effects of the substance on the parent – on their availability as parents and on their expression of affection, control and discipline.*
- *an assessment of the effects on the child of this style of parenting – how well is the child's need for basic care, protection, stimulation and love being met?*
- *the fourth question is whether the parent has to provide for all the child's needs – are others available to share this responsibility?*

5.4 Behaviours and attitudes in parents that indicate poor recovery from substance misuse, or recovery

Practice Tip: The following factors are examples identified in the research as **indicators** of a poor recovery, potentially leading to relapse (Hohman and Butt 2001):

- not accepting addiction as a disease;
- continued use of other drugs or alcohol (just not the one the individual is addicted to);
- sporadic attendance at treatment programs and/or support groups;
- isolation from, and distrust of, anyone in treatment programs and/or support groups;
- poor eating and sleeping habits; and
- being easily irritated or annoyed.

Untreated depression or other psychological disorders also place the recovering person at risk for relapse.

“An ongoing concern for child welfare workers involved in family reunification work is deciding how soon to return a child to a parent who has been through addiction or related treatment...Workers often wonder whether a parent is really in recovery and what behaviours and attitudes on the part of the parent would indicate this” (Hohman and Butt 2001:2).

One **developmental model of recovery**, widely used in the addictions field, is based on behavioural change, cognitive change and reconstruction, and “object substitution and replacement”.

The model incorporates **three major processes**, as outlined below (Hohman and Butt 2001):

- **acceptance of the ongoing role of alcohol** (or drugs), meaning that:
 - the substance must maintain a continual organising role in the individual’s life; and
 - while the substance is no longer important in the recovering person’s life, the substance serves as a powerful reminder of the change that has occurred;
- **adjustment to environmental changes**, that is, major life changes and adjustments that an individual must make to sustain recovery, for example:
 - not associating with other persons who misuse substances; and
 - coping with internal reactions to change such as stress and depression; and
- **one’s interpretation of one’s self and others**, which is based on the new identity the individual has chosen and the views of one’s self and others that are constructed and reconstructed.

The model proposes **four stages** in the developmental model of recovery, including (Hohman and Butt 2001):

- **drinking:** marked by the consumption of the substance, combined with increasing loss of control (problems with family, work, other systems due to substance misuse);
- **transition:** at some point, the person reaches a point characterised by despair and recognition of the loss of control (for parents, this may include the removal of children). During the transition stage, the individual embarks upon abstinence;

- **early recovery:** marked by abstinence, and the assumption of the identify of being an alcoholic/addict. Typically, this stage begins when the individual completes treatment and reintegrates into their family, work, social settings. As the early recovery stage is focused on environment interactions, strong supports and structure are necessary. Strong supports and structure include “external recovery rules” such as attending self help or support groups, avoiding drug using friends, creating a sober support network etc. As individuals follow these necessary external behaviours, feedback from the environment (hopefully about how well they are doing) helps them to integrate these changes and begin the process of reinterpreting themselves and others; and
- **ongoing recovery:** tasks associated with this stage include the identification of long-term problems and individuation. Healthy relationships with others become more important, as do the internalised attitudes and behaviours that support the recovering identity and lifestyle. The individual may begin to explore past life events and their meanings, as well as look at those events that may have helped sustain drinking or drug use and hindered recovery.

“...recovery is a fluid process during which the alcoholic/addict shifts back and forth in his or her belief that the addiction can be controlled or is out of control. The alcoholic may return to the earlier drinking stage if he or she believes that the drinking really isn't a problem or can be controlled” (Hohman and Butt 2001:2).

5.5 Critical information requiring immediate action and review by departmental officers

Practice Tip: Given the extent and nature of risk factors associated with a child who is exposed to parental substance misuse, as well as the high likelihood of relapse in parents, certain critical information (which becomes apparent to departmental officers during their intervention with the family) will necessitate **immediate action** to reconsider the safety and wellbeing of the child.

In some circumstances, the receipt of critical information (or direct observations) will result in an **urgent review** of the departmental case plan goal, outcomes and actions.

Departmental officers would take immediate action to review the safety and wellbeing of a child when information becomes apparent to a departmental officer and this information confirms, or leads a departmental officer to reasonably suspect, that a parent has been or is using a substance to an extent, or in a way, that appears inconsistent with the parent's current treatment plan.

Practice Tip: It is **imperative** that liaison occurs with the parent's ATODS professional to obtain and/or clarify information relevant to the parent's current use of the substance/s, having regard to the ATODS treatment plan and the parent's compliance or progress to date (even if the new information does not appear as serious as the information relating to the extent and nature of the parent's original level or type of substance misuse).

It is important, upon and following the reunification of children with their parents, that departmental officers and other agencies involved in the implementation and monitoring of the case plan, identify and respond to parental stressors in a timely manner. Parental stressors are commonly linked to child fatalities, and relapse in parents who misuse (or have misused substances).

Parental stressors include change in family composition, death of a family member, major illness in the family, loss of employment, homelessness, relationship breakdown and change in residence.

6. Collaboration and service delivery coordination

Practice Tip: Even where/if an ATODS or other service expresses the desire to be the primary case coordinator/manager for the family, the departmental officer still remains responsible for implementing relevant case management procedures (this is in addition to the role agreed and undertaken by the other agency), and for regularly and proactively seeking relevant information from the coordinating agency.

Proactively identify and implement a range of strategies to assist in achieving effective collaboration and coordination with ATODS professionals during all phases of departmental intervention, that is, intake, investigation and assessment and ongoing intervention.

Should another agency nominate, or agree to take on, a case coordination/management role with the family subject to departmental intervention, departmental officers continue to be proactive in ensuring that these agencies:

- schedule regular reviews, as well as understand nominated circumstances where additional reviews are required on an urgent basis (for example, where a parent's ATODS' treatment goal is abstinence and it becomes apparent to the agency that a parent has recommenced substance misuse); and
- have prepared contingency plans for responding to new child protection concerns, should they arise, including departmental officers to be contacted, how they are to be contacted and within what timeframes.

The following specific matters require discussion with ATODS staff:

- child protection concerns associated with parents' substance misuse;
- the assessed impact or likely impact of parents' substance misuse on the children involved;
- the identified or suspected risk factors (particularly the possible or actual presence of mental health issues and/or domestic violence);
- protective factors; and
- interventions which can be undertaken by all agencies involved.

Collaboration and coordination across statutory child protection services and government/non-government service providers is critical.

Poor service collaboration and coordination can have **serious implications** for the safety of children, and are frequently mentioned as contributing factors in child death case review inquiries. For example, based on a rigorous qualitative analysis of child death case inquiries reviewed in 2004-2005, the Victorian Child Death Review Committee identified the following difficulties in a large number of cases (VCDRC 2005):

- inadequate participation of relevant professionals in case planning;
- lack of consultation and communication across agencies;
- lack of case conferencing;
- inadequate definition of a lead or coordinating agent;
- poor documentation of task responsibilities; and
- lack of understanding of roles and responsibilities, especially at case closure.

The research indicates that increased, regular collaboration and coordination will assist in achieving the following **outcomes** (Tomison 2004):

- more effective interventions;
- greater efficiency in the use of resources;
- improved service delivery by the avoidance of duplication and overlap between existing services;
- the minimisation of gaps or discontinuity of services;
- clarification of agency or professional roles and responsibilities prior to, and if applicable as a result of, problems arising; and
- comprehensive service provision.

7. Intervening in cases of parental substance misuse

7.1 Personal safety and therapeutic programs for children

Practice Tip: Given the range of impacts of parental substance misuse on children, as well as the documented childhood abuse rates of parents who misuse substances, it is important that children receive appropriate therapeutic interventions. Therapeutic intervention however is only one element of children's case plans – other interventions aimed at responding to the strengths and needs of children are considered, incorporated in the case plan, and implemented in practice, in accordance with existing departmental procedures and legislative requirements.

Personal safety programs are designed to assist children to identify and therefore protect themselves from circumstances potentially leading to sexual abuse. Personal safety programs are important for children of substance misusing parents, given that the research determines the following in relation to parental substance misuse:

- a specific link between:
 - cocaine misuse and the sexual abuse of children; and
 - alcohol misuse and sexual abuse;
- the regular occurrence of people coming and going at all hours, and of children being out late at night with parents looking for drugs, potentially resulting in significant harm such as sexual abuse;
- the common occurrence of sexual problems due to the physical effects of substance misuse, and the possibility that the resultant stress and frustration may lead to the sexual abuse of a child to fulfil adult sexual needs; and
- a parent under the influence of substances may provide a perpetrator with the opportunity to commit sexual offences, due to inadequate care and/or supervision of the child.

Therapeutic programs for children have been developed to address the wide range of social, emotional and personality difficulties associated with their experiences of harm relating to parents who misuse substances. The programs also have an important role in breaking the intergenerational cycle of abuse. The most important aspect of effective therapeutic programs appears to be the inclusion of **cognitive behavioural techniques** (Richardson, Higgins and Bromfield 2005).

Practice Tip: Departmental officers should refer to the range of practice papers and related resources currently available through the Child Safety Practice Manual, to assist them in identifying and responding to the additional protection and care needs of children subject to statutory child protection intervention.

7.2 Intervening with parents who misuse substances

7.2.1 The treatment goal: abstinence or moderation?

Practice Tip: Speak with parents about the differing goals of ATODS treatment and explain that ATODS staff will seek parents' views regarding, and provide professional advice about, the most appropriate treatment goal (based on parents' individual circumstances). Inform parents that many parents aim for, and successfully achieve, reduced or controlled substance use, in an attempt to resolve child protection concerns associated with their substance misuse.

Consult with ATODS professionals to discuss and/or ascertain whether the parent's treatment goal is (or will be):

- controlled use;
- reduced use; and/or
- abstinence.

Ensure that, initial referral information provided to ATODS professionals is sufficient and accurate, as this will:

- assist ATODS during their initial engagement with the parent and/or family; and
- counter the likelihood of denial, distortion and secrecy among substance misusing families.

ATODS professionals require detailed information known to the department about the parent's substance misuse, in order to assist parents in developing the most effective and appropriate treatment goal. Do not solely rely on parents and/or family members to provide this information.

Across Australia, drug and alcohol services are guided by the principle of **harm minimisation**. "Harm minimisation does not condone drug use, rather it refers to policies and programs aimed at reducing drug-related harm,...and encompasses a wide range of approaches, including abstinence-oriented strategies" (Ministerial Council on Drug Strategy 2004:2). The implication for individuals in Queensland, who are seeking ATODS treatment, is that reduced or controlled use of substances is often the treatment goal rather than abstinence.

As a result, abstinence will not always be the **treatment goal** for a parent who misuses substances and is subject to statutory child protection services. In their intervention with parents, ATODS professionals discuss, consider and recommend the most appropriate treatment goal and intervention strategies, based on the parent's individual substance misuse history and their treatment history.

'Reasonable' levels of substance use are not defined within the literature, as there are so many variations with respect to the likely impact for persons who misuse substances. These variations include factors such as risks specific to each category of substance, risks associated with combinations of particular substances, the purity of a substance, and whether the user is dependent.

Practice Tip: Liaise with ATODS to discuss and determine what extent and nature of substance misuse might be considered 'reasonable', based on the individual circumstances of a parent. Ensure that discussions take into account not only 'reasonable' in terms of the parent's health needs but also 'reasonable' in terms of minimising the risk of future harm to children.

7.2.2 Parents who inject substances and/or who may overdose

Practice Tip: Interventions with parents may include allowing them to consider their behaviour and their attitudes towards other persons who inject and to consider aspects of their own injecting (including possible impacts on their child) and ways they might choose to change it. Such strategies may lead to changes in the way a parent acts around their child, possibly reducing risk factors.

Where departmental officers identify that a parent's substance misuse involves injecting, or that parents tend to associate with other persons who inject drugs, it is important that the risks to children are discussed with parents. This may be explored by departmental officers in the first instance, however, also discuss with the parent the option of a referral to ATODS.

Alternatively, where parents are currently engaged with an ATODS professional, contact the professional to discuss whether the parent has previously or is currently injecting, and/or may be at risk of injecting in the future, and whether the parent's treatment plan includes intervention to discuss the risk factors (for children and parents) associated with injecting.

Inform parents about the availability of needle and syringe programs throughout Queensland, and as necessary, provide relevant referrals.

There are multiple risk factors and behaviours associated with predicting drug users who are at greater risk of dying from an **overdose**, and it is important for those working with injecting drug users and the drug users themselves, to be aware of these risk factors and behaviours. Talking to injectors about their past history of overdose may help to identify and reduce risk factors, thereby preventing overdose.

Where risk factors associated with parental overdose are identified by departmental officers, seek advice from ATODS in an attempt to assess the extent to which parents are at risk of overdose. Further, utilise the advice provided by ATODS in making assessments and decisions about possible future harm to children.

In addition to the physical health risks associated with injecting (risk of contracting blood borne viruses) for children and parents, the research shows that parents who misuse substances, regardless of whether they inject, often worry about the following (Tunnard 2002):

- how to store drug using equipment safely and out of reach of children;
- how to protect children from seeing their parents or other adults from using substances at home;
- their children potentially adopting their negative patterns of behaviour, that is, substance misuse; and
- children seeing substance misuse as normal behaviour and/or as a strategy for 'escaping' from difficulties and deprivation.

Practice Tip: Utilise the research findings regarding parents' fears about injecting when discussing the impact of the parent's substance misuse on their children. This approach, in turn, may assist in facilitating an opportunity for referral and/or intervention by ATODS.

Queensland Health's Queensland **Needle and Syringe Program** (QNSP) is the unit responsible for the ordering, purchasing and distribution of injecting equipment or 'Sharp Kits' that include needles, syringes, swabs and a disposal unit (Queensland Health 2003). In Queensland, medical officers, pharmacists and others authorised by the Minister for Health may distribute needles and syringes to injecting drug users, in an attempt to reduce the spread of communicable diseases (eg. HIV/AIDS and Hepatitis B and C).

Practice Tip: Needle and syringe programs are located in various agencies, including Community Health and hospitals (refer **Appendix 2** for information about the range of ATODS currently available across Queensland).

Identified **risk factors** associated with drug users who are at greater risk of dying from an overdose include the following (Hunt, Derricott, Preston and Stillwell 2001):

- injecting heroin;
- history of previous non-fatal overdose;
- longer history of injecting;
- high levels of drug use or intoxication;
- high levels of alcohol use – a history of recent drinking is one of the most consistent predictors of how likely a heroin user is to overdose;
- low tolerance;
- depression, feelings of hopelessness and suicidal thoughts;
- a history of using combinations of drugs including benzodiazepines (depressant) or alcohol;
- higher risk-injecting behaviours, such as sharing or using used equipment;
- not being in a methadone or other treatment program; and
- ending treatment prematurely.

Signs of an overdose include deep snoring, unwakeable, turning blue and not breathing.

7.2.3 Types of treatment/intervention available to parents who misuse substances

Practice Tip: ATODS are voluntary services available to parents who misuse substances and ATODS' professionals have no capacity to make clients participate in, or attend, alcohol or drug assessment and/or intervention services, including substance testing.

Wherever possible, drug and alcohol screening and formal assessment, brief intervention and other treatment options should be provided to parents by ATODS' staff, qualified medical officers or other relevant health care professionals. In some circumstances however, it may be necessary for departmental officers (particularly in rural and remote areas) to undertake some aspects of intervention, for example formal assessment and brief intervention. In such instances, departmental officers should consult with a **senior practitioner**, who will seek advice from the Director of Forensic Medicine, Queensland Health.

Director of Forensic Medicine,
Queensland Health,
(07) 3405 5742.

Refer to **Appendix 2**, for the weblink to information about the range of ATODS currently available across Queensland.

Some of the interventions listed below are specific to the Australian 'Guidelines for the Treatment of Alcohol Problems' and where applicable, will be noted as being specific to 'alcohol' in relevant subheadings. In general however, similar intervention 'types' are likely to be used by drug treatment services, even though they are discussed in a manner specific to alcohol misuse. The identified practice tips apply, regardless of the intervention type and/or the nature of the substance misuse.

A) Screening and assessment – alcohol

* note: 'screening' has a different meaning to 'substance testing'

Practice Tip: In conducting investigations and assessments and child/parental strengths and needs assessments, explore the possible current and/or previous existence of drug and/or alcohol issues within families. This should be achieved in a way which reflects a general conversation and holistic assessment process, rather than in a way that would be considered specific to a certain type of service or ATODS' professional.

Screening and assessment are the **first aspects** of intervention with respect to treatment options. The purpose of screening is to determine whether and if so, to what extent, alcohol issues are a problem. The Australian 'Guidelines for the Treatment of Alcohol Problems' suggest that routine screening should not only be conducted in all health care settings, but also by staff working in general welfare and counselling services.

The Australian 'Guidelines for the Treatment of Alcohol Problems' require that screening is followed by time-limited interventions aimed at reducing consumption for those with risky levels or patterns of drinking.

In-depth assessment and the use of formal screening strategies need to be carefully conducted by appropriately qualified professionals, before intensive and extensive interventions are implemented. The departmental officer would not generally use formal screening strategies (such as a questionnaire used by ATODS staff to determine whether a parent has a psychological disorder as defined by the Diagnostic Statistics Manual-IV (DSM-IV)) which are solely used by specified, qualified professionals such as psychologists and psychiatrists.

On rare occasions however, in the absence of qualified ATODS staff, departmental officers (particularly in rural and remote areas) may use formal screening strategies and conduct in-depth assessments of alcohol and/or drug misuse, in consultation with a **senior practitioner**. Where this occurs, departmental officers are to seek advice and support from an ATODS professional.

Two important functions of assessment, are identified as follows (Department of Health and Ageing 2003):

- assessment assists the client and clinician to develop shared treatment goals and a treatment plan. Any underlying and accompanying problems must be identified and treated, even where the causal relationship is not clear. For example, a person who presents with an alcohol problem may also present with indicators of depression; and

- assessment provides an opportunity for the clinician and client to develop rapport. Assessment could be defined as the beginning of therapy, and sympathetic understanding of the implications of this for the parent and their family is important. In particular, it is important to highlight the parent's perception of the opportunity for change, and this requires the clinician to have a positive and realistic approach.

B) Brief intervention

Brief intervention – as suggested by the name, constitutes a small or limited number of appointments provided by a **health care professional** to assess and discuss a person's extent and nature of drinking.

Brief intervention may involve the completion of a questionnaire (to determine the level of the person's drinking), discussions regarding the impacts of a person's drinking, discussions regarding strategies to reduce and/or cease drinking and the provision of advice and/or referral information with respect to ongoing intervention services.

C) Treatment in a residential facility – alcohol

Practice Tip: ATODS professionals, based on the individual needs and presentation of a parent and their knowledge of relevant research and evidence, are in the best position to identify the most appropriate treatment type for a parent. This highlights the importance of relevant and accurate information provision by departmental officers to ATODS professionals, as well as the need for effective collaboration and coordination.

This type of intervention usually involves clients living at the facility for three to 12 months, where the aim is abstinence and personal growth, aided by the understanding and care of others in the community. Residential care is usually kept for those who are typically worse off in terms of health and drug problems (that is, lack of social support, severe dependence) than those who enter non-residential care.

A distinction is noted between **two types** of residential care – **standard** and the **therapeutic community** (TC) approach. Therapeutic communities emphasise a holistic approach to treatment, and tend to have the following features (Department of Health and Ageing 2003):

- residents participate in the management and operation of the community;
- the community, through self-help and mutual support, is the primary means for promoting behavioural change; and
- there is a focus on social, psychological and behavioural dimensions of substance misuse.

Alternatively, standard residential programs use similar treatment approaches to non-residential services, albeit more intensively.

Therapeutic communities or residential facilities have been shown to be successful at reducing heroin use and crime among those who remain in treatment long enough to benefit (at least three months); however, there is some evidence therapeutic communities may be more effective if they are used in combination with legal coercion or during imprisonment to ensure users are retained in treatment (Department of Health and Ageing 2003).

D) Individualised counselling and cognitive behavioural therapy

Individualised counselling focuses on reducing or stopping the parent's substance misuse, and aims to teach individuals how to control their responses (cognitive behavioural therapy) to their environment through improving social, coping and problem-solving skills. Individualised counselling also addresses the content and structure of the patient's recovery program (National Institute on Drug Abuse 2006).

Through individualised counselling, which has an **emphasis** on short-term behavioural goals, clients are assisted with developing:

- coping and stress management strategies; and
- tools for abstaining from substances, and then maintaining abstinence.

Skills training is also a form of cognitive behavioural therapy and involves teaching people social skills that might help them function without the use of substances (Department of Health and Ageing 2003). Skills training can be used to compensate for skills deficits that have led to the use of substance misuse as a coping strategy and to prevent relapse.

Specific skills which may be taught include problem solving, assertiveness, communication, substance refusal and relaxation training and stress management.

Where necessary, the counsellor makes appropriate referrals for supplementary services, for example, medical, psychiatric and employment services. Individuals are encouraged to attend sessions one or two times per week.

Specific research studies demonstrate that when individualised counselling is combined with other treatment types, clients achieve **improved outcomes** (National Institute on Drug Abuse 2006). The addition of onsite medical, psychiatric, employment and family services further improved outcomes (National Institute on Drug Abuse 2006).

E) Pharmacotherapies

"Pharmacotherapies for opioid dependence (ie. methadone, buprenorphine and naltrexone) are readily available. They are effective methods to manage opiate dependence, being associated with reduced heroin use, improved psychosocial functioning and better physical and psychological health and reduced mortality" (Wood, Mattick, Burns and Shakeshaft 2006:34).

Methadone-maintenance treatment is the most common treatment in Australia for opiate dependence, and it has been demonstrated to be effective by reductions in heroin use, infectious disease transmission, damage to veins and skin infections, criminal activity, psychological problems, and social problems.

The research also indicates that the longer a client stays in methadone-maintenance treatment, the more positive the outcomes. There is however no specific, recommended duration of treatment for methadone-maintenance treatment. "The most appropriate duration of treatment may be several months to years, depending on individual circumstances and client behaviour" (Wood, Mattick, Burns and Shakeshaft 2006:34).

F) Self-Help groups (or 12-Step programs)

The most common self-help groups for parents who misuse substances are Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). These groups are comprised of people who consider they are 'alcoholics' or 'addicts' "with an illness that cannot be cured but only arrested with the ongoing social support of others in the group who have shared similar experiences" (Queensland Health 2003).

The groups follow a 12-Step program that assists individuals to remain **abstinent** one day at a time. Some self-help groups are also available for the families and friends of people with alcohol and/or drug problems.

By providing a social network supportive of abstinence, self-help groups may be an important part of intervention for individuals who are often isolated and excluded, with limited social support.

Practice Tip: It is important to note however that self-help groups are **not** necessarily considered a form of treatment. For example, with respect to AA, "change is not facilitated or mediated by professionals but rather, is the result of the group members' own initiatives and support of each other" (National Drug and Alcohol Research Centre 2003).

Research into the effectiveness of conventional AA meetings suggests the following (National Drug and Alcohol Research Centre 2003):

- it has a place as an adjunct to formal treatment, since participation predicts more positive long term outcomes for many clients;
- AA participation has been shown to predict higher rates of abstinence post-treatment;
- there are poor outcomes for participants who are coerced into AA participation; and
- attendance is useful as an aftercare strategy for relapse prevention, particularly for clients with high network support for drinking.

Given that AA is not viewed as a treatment option, it is **not** considered a sufficient intervention for alcohol problems (National Drug and Alcohol Research Centre 2003). There is also a risk that persons with serious problems that are not dealt with within the self-help group (eg. mental health conditions) will continue to suffer problems that could be addressed through seeking professional assistance.

G) Detoxification

Detoxification "refers to the process by which a drug or alcohol dependent person recovers from intoxication in a supervised manner, so that withdrawal symptoms are minimised" (Wood, Mattick, Burns and Shakeshaft 2006:33).

Detoxification may occur on an inpatient, residential or outpatient basis, however, detoxification facilities have reduced in number and in bed capacity over the past 15 years, with a corresponding increase in outpatient detoxification as a more cost-efficient and effective means of treatment delivery.

Detoxification may be with or without medication, depending on the severity of dependence and/or client choice. Some clients may not wish to detoxify from all substances at once.

7.2.4 Effectiveness of parental substance misuse treatment

Practice Tip: “Research has shown unequivocally that good outcomes are contingent on **adequate** lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years” (National Institute on Drug Abuse 2006:1).

“According to several studies, drug treatment reduces drug use by 40 to 60% and significantly decreases criminal activity during and after treatment” (*National Institute on Drug Abuse 2006*). Individual **treatment outcomes** however are influenced by a range of factors, such as the (*National Institute on Drug Abuse 2006*):

- extent and nature of the patient’s presenting problems;
- appropriateness of the treatment components and related services used to address those problems;
- degree of active engagement of the patient in the treatment process; and
- adequate lengths of treatment.

Because a significant number of persons drop out of drug and/or alcohol treatment prior to receiving all the benefits that programs can provide, attending **multiple treatments** may be necessary for a client to achieve successful outcomes. It is not uncommon for individuals to attend multiple treatments, often with a cumulative impact.

7.2.5 Helping parents to remain in treatment

Practice Tip: Effective outcomes are often associated with the person remaining in treatment long enough to gain the full benefits, and strategies for keeping an individual in treatment are considered **critical**.

The findings of various studies provide an indication of **strategies** to be utilised for the purpose of encouraging a client to remain in treatment. Various strategies include the following (*National Institute on Drug Abuse 2006*):

- individual factors relating to engagement:
 - motivation to change drug-using behaviour;
 - degree of support from family and friends, eg. personal support, assistance with child care;
 - whether there is pressure to stay in treatment from the criminal justice system, child protection services, employers or the family; and
- program related factors:
 - counsellors establishing a positive, therapeutic relationship;
 - ensuring that a treatment plan is established and followed; and
 - making psychiatric and social services available.

Certain specific problems, including serious mental illness, severe cocaine or crack use, and criminal involvement, **increase the likelihood** of a patient dropping out of treatment. Where these

factors exist, discussions should be held with ATODS professionals as to whether and if intensive treatment, with a range of components, may better assist with retaining such patients in treatment.

Service providers should also **ensure** a transition to continuing service intervention or 'aftercare' following the patient's completion of formal treatment.

8. Drug testing parents who misuse substances

Practice Tip: "The literature on the benefits of drug-testing in the context of parental substance misuse and child protection is small, but suggests its appropriate use is **feasible** and that it can promote **better outcomes** in child-at-risk cases" (Wood, Mattick, Burns and Shakeshaft 2006:37).

8.1 Considerations associated with drug testing

Children of substance misusing parents are at increased risk of abuse and neglect however a range of social and individual factors correlate with poor parenting. Further, given the limitations associated with parental drug testing, negative drug screens **cannot** be taken as a sole indicator of recovery from substance misuse.

It is therefore important to **consider other factors** which may influence behaviour and impact on parenting (such as biological and/or environmental factors, for both children and parents), and ultimately result in the harm of, or risk of harm to, children.

Such factors include indicators of harm or risk of harm in children, protective factors, behavioural and physical health indicators in parents, and behaviours consistent with recovery (or poor recovery) in parents. Negative test results cannot rule out drug use.

The use of parental drug-testing is recommended in the literature (in relation to child protection cases) where the following conditions are met (Wood, Mattick, Burns and Shakeshaft 2006):

- there is reasonable suspicion of substance misuse;
- multiple tests are undertaken over periods ranging between 2 to 6 months or more (depending on level of use);
- confirmation testing is undertaken on all positive results; and
- parents who are seeking treatment or who are found to be drug abusing/dependent are referred immediately to treatment.

Drug testing is a way of determining whether clients are abstaining from substance misuse, and therefore may not be appropriate if the client's treatment goal (as negotiated with their ATODS professional) is reduced or controlled use, rather than abstinence.

Drug testing is not recommended as an alternative to ATODS screening and assessment and counselling. Rather, having regard to the advice of ATODS professionals and the views of parents, it may be a complementary method of assessment and assist departmental officers in assessing **complementary** harm, and/or the risk of harm, to a child.

The appropriate **frequency** for obtaining samples is dependent on the testing method chosen (eg, urinalysis) and specific purpose for testing. Given the half-life (time taken for 50% of the drug to be removed from the body) of most illicit drugs, the detection period for most substances is approximately 2-3 days, with a longer period for THC (up to 10 or more days, depending on frequency and amount of cannabis used) (Wood, Mattick, Burns and Shakeshaft 2006).

The **duration** of drug testing is dependent on the history of substance use. "For chronic dependent users, long-term testing (up to several years) would be appropriate, due to likelihood of relapse. For people who are less dependent, short-term testing of approximately 6 months may suffice" (Wood, Mattick, Burns and Shakeshaft 2006:32).

No set length of time can determine whether the user will not relapse in the future.

8.2 Effectiveness of drug testing

The research indicates that (Wood, Mattick, Burns and Shakeshaft 2006):

- the use of drug-testing does not reliably reduce drug use, especially if the outcome is punitive;
- testing per se does not necessarily lead to a better outcome for the child or the parent. If used in conjunction with supportive staff, appropriate motivating techniques, and **linked to treatment**, drug-testing may be beneficial, as involvement in quality treatment will, on average, reduce drug use problems; and
- drug testing alone seems to have little influence in the long-term as an intervention, but offers a window of opportunity for accessing treatment. Without active pharmacological or psychological intervention with the drug-testing, it seems unlikely that there would be marked benefit from testing alone.

A note of caution to departmental officers

Drug testing is **limited** in its ability to determine dependence and/or impairment in relation to parenting ability. Another key limitation of drug testing is variability in sensitivity and specificity of certain drug-tests (Wood, Mattick, Burns and Shakeshaft 2006).

Urinalysis in particular, has been criticised for being relatively inaccurate, as the possibility of false negatives is quite high (that is, no drug detected when a drug has been used recently) (Wood, Mattick, Burns and Shakeshaft 2006).

Results may be affected by several factors associated with the person tested (ie. metabolism), the drug used and route of its administration, the sample taken (that is, window of detection), the collection procedure and the analytical procedure. As a result, there are four possible results which must be considered, as outlined below (Wood, Mattick, Burns and Shakeshaft 2006):

- a *true positive* result, where a test correctly identifies the presence of a drug;
- a *false positive* result, when a drug is detected by a test when, in fact, that drug is not present in the sample;
- a *true negative* result, where a test correctly identifies the absence of a drug; and
- a *false negative* result, when no drug is detected by a test when, in fact, a drug is present in the sample.

There is also information associated with drug use that **cannot** be determined by drug testing, including the following:

- quantity of drug used (that is, dose administered);
- frequency of use; and
- the extent of physical or psychological dependency.

9. Likelihood of relapse

Practice Tip: The research indicates that the risk of relapse is **high** and that relapse is likely to occur **rapidly** following treatment. Relapse is considered a typical part of the recovery process for persons who misuse substances.

Implement high and consistent levels of monitoring (including by other persons/agencies involved with the family) particularly in the first six months to one year following ATODS treatment and/or the reunification of children with their parents.

The occurrence of relapse in parents who misuse substances should be anticipated and planned for, in consultation with the parent/s, the child (if appropriate) and the ATODS professional. Of particular importance is the development of **safety plans** for children, and departmental officers ensuring that parents, children, relevant professionals (particularly ATODS staff) and where possible, extended family members, are actively involved in relevant discussions and safety planning.

Given the strong likelihood of relapse in the short and longer-term, particularly where parents do not attend ATODS on an ongoing or long-term basis, discuss and plan (with the child, parent/s, ATODS staff, other government/non-government services etcetera), implement, and monitor strategies aimed at preventing relapse.

Liaise with the above-mentioned persons/agencies, on a regular basis (formally and informally) to share information and where appropriate, modify and/or add to the ATODS' relapse prevention plan and/or the departmental case plan for the child.

Regularly check for, and ask about, indicators of possible child protection concerns, and/or indicators of relapse in a parent, rather than relying on such information to be reported to the department.

The research and literature into parental substance misuse confirms the strong likelihood of relapse, and commonly refers to addiction and dependence as a **chronic, relapsing disorder**. Similar to other chronic diseases (for example, asthma and diabetes), recovery from addiction may require long-term or lifelong intervention.

Relapse rates are dependent on various factors, for example, the type of substance/s used, definitions used by different researchers and different methods of detecting relapse. In addition, specific studies tend to focus on, and provide data relating to, a certain category of substance, rather than providing an overall relapse rate for parental substance misuse as a whole.

Further, many studies provide evidence not only about the extent of relapse but also about matters such as possible **contributing factors** and anticipated **timeframes**. Examples of specific findings include the following:

- various studies demonstrate that high relapse rates prevail across classes of substances, for example, one study found that the average time from abstinence to relapse varies from 4 to 32 days for alcohol and opiates (National Institute on Drug Abuse 2006);
- of four studies in which a total of 685 treated alcoholics were followed for two years, 63% were abusing alcohol at the end of the two years (National Institute on Drug Abuse 2006); and

- relapse not only occurs frequently after treatment, it also occurs rapidly after treatment, for example (National Institute on Drug Abuse 2006):
 - in two studies having a combined total of 499 treated alcoholics, only 18% remained abstinent during six months after treatment; and
 - in a different study of the careers of opioid users, researchers found that 70% of 1 653 treatment and correctional interactions over a mean period of 20 years were followed by less than one month of abstinence, and 87% were followed by abstinence of less than six months.

More recent data is available with respect to **alcohol misuse**. For example, a recent Australian review found that (Department of Health and Ageing 2003):

- despite the short-term effectiveness of several treatments for excessive alcohol use, there is little evidence that these treatments are effective in the long term **without** further intervention;
- there is a substantial relapse rate within the first year after treatment, with around 60% of clients returning to problem drinking;
- the conceptual model of relapse prevention views relapse as a natural part of the process of change – lapses and relapses are viewed as opportunities for clients to understand their behaviour and develop new skills to deal with high-risk situations; and
- good treatment should incorporate relapse prevention.

9.1 Relapse prevention as an intervention strategy

Practice Tip: Given that parents who have misused substances remain vulnerable to powerful drug cravings for months or years after establishing abstinence, the occurrence of relapse should be **anticipated** and **planned for** by departmental officers and ATODS professionals.

Liaise with ATODS professionals to discuss (within the context of the intervention goal and treatment plan) the following matters specific to individual clients:

- relapse prevention strategies being explored with, and developed by the parent;
- possible factors identified by ATODS and the parent with regard to the types of stimulus that can trigger intense drug cravings/relapse;
- ways in which the departmental officer, in their intervention with the parent (and if applicable, child), may assist with regard to addressing factors possibly contributing to future relapse; and
- indicators of relapse which may be specific to each client and/or particular substances/ combinations of substances.

Relapse prevention is a **critical** component of ATODS intervention, a key aspect of the ATODS treatment plan, as well as a key risk factor for consideration by departmental officers with regard to harm and/or risk to children.

Relapse prevention helps individuals to learn how to identify and correct problematic behaviours, and encompasses various cognitive-behavioural strategies that facilitate abstinence, as well as provide help for people who experience relapse.

For example, patients learn to confront the consequences of their drug use, recognise the

environmental cues and potentially stressful situations that trigger strong drug cravings, and develop strategies to steer clear or respond without relapsing.

In addition, a range of science-based **medical treatments** (pharmacotherapies) are available to buffer patients against the craving that leads to relapse.

The research identifies three types of stimulus that can trigger intense drug craving, **leading to relapse** (National Institute on Drug Abuse 2006):

- priming: just one exposure to the formerly abused substance (be it a cigarette, a drink, or an illegal drug) can precipitate rapid resumption of abuse at previously established or greater levels;
- environmental cues: these cues may incorporate people, places or things associated with past substance misuse; and
- stress: acute and chronic stress can contribute to the establishment, maintenance, and resumption of substance misuse. Patients and treatment providers cite stress as the most common cause of relapse.

10. How family members can support parents who misuse substances and children

Practice Tip: There are a range of ways in which family members can provide support to both parents who misuse substances, and their children. The support provided by family members is important, particularly given the evidence with respect to protective factors for children. Proactively explore and discuss strategies with the child, their parents and applicable family members, and where appropriate, incorporate them in the case plan for the child.

Discuss the family member's needs for information and/or support and where requested/required, facilitate relevant referrals. The research generally indicates that family members find education (about substance misuse) and support groups, to be of **most** assistance.

To **assist** in supporting the parent who misuses substances and their children, family members (Child and Youth Health 2006):

- will be better able to help if they are well informed hence it is important for them to learn about the substance and its effects, be honest about their feelings and seek expert advice;
- provide support to children – often parents who misuse substances do not keep arrangements made with children and leave them feeling disappointed and angry;
- make and implement arrangements to assist in meeting the needs of children – some of these may be basic care arrangements whereas others may be arrangements associated with children participating in social activities;
- encourage free choice – assist with the chosen treatment but be careful not to try to force the parent into a treatment. Alternatively, it is not helpful to try and protect the parent from the consequences of their actions;
- avoid being judgemental or critical – it is often more effective to offer support and sympathy, rather than advice. A person who misuses substances is likely to already feel

vulnerable and defensive, and criticism may make things worse and mean that the parent will not trust relatives with respect to obtaining support.

- keep communication channels open – listen as well as talk and don't force the issue as this causes people to shut down. Helpful questions may be 'What is stopping you from change?', 'What makes you keep using?' and 'What support/information would help you?'
- avoid providing cash – partners and family members should not give the parent money but alternatively, could help by paying bills for treatment (where applicable) by providing non-negotiable cheques, providing groceries or transport; and
- offer practical help – particularly if the parent decides to go into rehabilitation, ask parents what help is needed.

Concerned adults may also help the child cope by (NAPCAN 2003):

- being honest, consistent, trustworthy and available for the child to talk to;
- sharing simple, relaxing and pleasant family time;
- offering supportive child care when children or parents need a break;
- explaining to children that they can ask for help;
- encouraging children to set goals for themselves;
- helping children to write a diary or draw about how they feel;
- helping the child to identify and learn to use a network of adults they can feel safe with (these should be people that the child can ring or contact for help when they find themselves unsupported, afraid or alone);
- learning strategies to keep themselves safe, including emergency contact numbers to use in the event of an overdose;
- ensuring that there is a reliable person available at short notice to care for the child if the parent is unwell or experiencing significant symptoms/effects; and
- helping to ensure that dangerous substances and equipment are safely out of a child's reach.

11. Services acceptable to families and messages from practice

11.1 What the children of substance misusing parents say they need

Practice Tip: It is particularly important, given the high likelihood of relapse in parents, that the child continues to receive ongoing, intensive support (in and out-of-home), following their reunification with parents. For a child who is too young to receive individual therapeutic and/or behavioural support, other forms of support are to be offered, for example parent aides and Child Safety Support Officers. While these supports are primarily directed at the parent, they are likely to have an indirect impact on meeting the needs of very young children.

Addressing a parent's substance misuse and related parental needs, in isolation from identifying and responding to the needs of the child, is likely to have significant negative consequences – not only for the child but also for the overall effectiveness of the departmental case plan goal and outcomes.

In her examination of a number of studies that focus on the experiences of children, Kroll identifies the 'hurt on the inside' as the element requiring the **most pressing** response (Kroll 2004:9). This emotional pain had a significant impact on the children of substance misusing parents, particularly in relation to their self-esteem. Isolation and lack of support were considered to be contributing factors to their sense of hurt.

Another key issue identified by children is "It seemed important for professionals to be patient and **simply notice** that something was wrong" (Kroll 2004:9). Children commonly referred to their sense of loyalty to their parents, their awareness of people's opinions about drinkers and 'druggies' and their concerns about the possible consequences of parental substance misuse, should they acknowledge the presence of the issue within their families.

The studies also revealed that while children were still living at home, it was a real issue to tell anyone what was occurring within their families. Kroll therefore noted the importance of professionals being clear with children with respect to managing issues associated with **confidentiality** (so children understand what would happen to information which they disclose). Of no great surprise is the expressed fears of children with respect to being taken away and separated from their families.

Other critical issues identified by children, include the following (Kroll 2004):

- the need to feel safe, wanted and important;
- protection from violence and conflict (witnessing and managing violence were persistent worries and the impact of family disharmony was often seen by children as more of a problem, than parental substance misuse itself);
- ensuring that their needs are not left unattended and/or seen as secondary to the needs of their parents;

Kroll's review further identifies valuable ways of **supporting** children who are under great stress due to the experience of parental substance misuse. Children specifically refer to the following important factors (Kroll 2004):

- freeing children from guilt about parents' substance misuse;
- helping them to regain some sense of control over their environment;
- enabling them to be, and to behave as, children (where due to the substance misuse, they took on adult responsibilities); and
- reassuring children that people can 'get better'.

The literature and research into substance misuse and child protection widely indicates a tendency for professionals to assume that since it is the substance misuse that causes problems for children, once this is 'treated' or parents are helped to manage their substance use, the problems will go away and all will be well.

What became apparent to Kroll however is that "children needed **continued support**, even after treatment, due to unresolved feelings, adjustments to new roles, rules and behaviours, new fears and anxieties. Although their parent may receive help, they frequently do not'. Children, as a consequence, could feel abandoned once again" (Kroll 2004:137).

11.2 What substance misusing parents say they need

Practice Tip: Parents commonly referred to their **lifestyles and child care** commitments as factors impacting on their use of, or failure to use, intervention services. Issues associated with lifestyle related to the priority parents afforded to finding money, and obtaining, drugs. Many parents identified a reluctance to take children along to drug services and some missed appointments rather than 'dragging children along'.

It is important that **discussions** occur with parents regarding their needs and possible barriers associated with treatment, and that appropriate strategies are implemented to overcome barriers. The possible role of extended **family members** in providing child care for the duration of parents' appointments should also be considered and where appropriate, incorporated in the departmental case plan.

When liaising with ATODS professionals, it is also important to discuss the needs of parents and possible barriers to parents' consistently attending appointments. Parents will not necessarily raise such issues with ATODS and other related services.

Other issues were identified with respect to parents' fears and the subsequent perceived need for secrecy and/or denial. The most common concern articulated by parents was that their children would be removed and this, in turn, affected the parents' relationships with key workers and in some circumstances, prevented parents from seeking assistance in the first instance.

In addition, parents felt the need to 'cover their backs' with generic service providers, and there remained a strong belief that "their status as drug users would override any fair consideration of their parenting abilities" (Harbin and Murphy:32).

Parents spoke about a range of **barriers to service use**, including the following (Harbin and Murphy):

- respondents reported that they were put off approaching or going back to services by what they considered to be overly strict rules and regulations (regular testing of urine samples was particularly criticised in this respect and was specified as a reason for giving up treatment services, and for not seeking formal assistance at all);
- concerns that staff would be judgmental or would treat them differently as drug using parents;
- being in treatment risked public revelation that they were drug users, something they resisted not only because of the impact on their own lives (how they would be viewed by relatives, neighbours, family doctors etc.) but also because of the perceived 'secondary' effects on their families (for example, fear that children would be teased or bullied in school or forbidden by other parents from playing with neighbouring children);
- some parents expressed fear of being rejected by their own children, if their drug use was found out;
- barriers specific to their status as drug users (rather than parents), included:
 - long waiting periods between an initial approach to a service and the first appointment;
 - concerns about developing a 'dual habit' (if they were given a methadone script);
 - inaccessible and/or inappropriate service sites; and
 - in some instances, an impression that some workers lacked the training and experience to fully understand parent's concerns and problems.

In relation to the **needs** of drug using parents, the following factors were identified (Harbin and Murphy):

- concerns about exposing children to drug services, and as a result, to other drug users;
- the need for services to provide more home visits and/or for key workers to meet parents at child friendly sites such as health centres, a doctor's surgery etcetera;
- the need for sites/services to provide play areas and activities so parents could talk without interruption and without worrying if their children were safe; and
- service sites considered by parents to be more 'normal' and anonymous settings.

Other parents however indicated they were happy to take their children to appointments although the provision of child care for the duration of appointments would have been useful. Also, for parents looking after school aged children, ensuring that appointments were made in school hours would have been useful.

Lastly, it was considered very important that service providers were seen to acknowledge the wider implications that expulsion from services could have for the entire family, and not just for the drug user.

11.3 Messages from practice

The following practice tips are taken directly from 'Parental drug misuse – a review of impact and intervention studies' and 'Parental problem drinking and its impact on children', both published in the United Kingdom in 2002. They are based on reviews of the evidence pertaining to substance misuse, and are aimed at assisting departmental officers in achieving effective practice in cases of parental substance misuse.

11.3.1 Parental drug misuse

Practice Tips (Tunnard 2002):

- Children need opportunities to both understand and escape from the stresses they experience. Help may be needed to cope with the losses they experience.
- Another aspect of direct work with children is help to cope with the changes at home that are consequent on parents benefiting from drug and parenting programs. Parent training programs can succeed in having an impact on the behaviour of very young children however, they are less effective with older children who may resist parents' attempts to impose new rules and boundaries.
- Explore and use family strengths, particularly grandparents, when planning for children. It is an important protective factor to build on. Avoid the assumption that relatives can cope alone. Specific information, counselling or other emotional support may be needed in helping family members generate solutions to problems.
- Relatives may also need to help the children cope with difficult situations, and some may welcome practical help with parenting issues, particularly if it has been some time since they have cared for young relatives, or if children present with behavioural or emotional difficulties.
- The research highlights the extent to which parents use drugs to help them feel more able to cope with life's difficulties. They needed to reduce those stresses, or find other ways of coping, before they could succeed in reducing their problem drug use.
- Parents want help to sort out life's problems. They valued having someone to talk to, someone to help lighten the load, someone to suggest practical ways of dealing with problems, to point them in the right direction.
- Women, in particular, were at risk of social isolation. What was wanted was an opportunity to get involved in neighbourhood, cultural, religious or other activities that might open the door to new social networks.
- Extra reassurance and practical support will be especially helpful for mothers with babies born with drug withdrawal symptoms, so that strong attachments can be nurtured with these babies whose irritability can make it so difficult to care for them.
- Drug reduction or control may achieve stability for families who might otherwise not make progress if the goal were to stop using drugs altogether.
- Timing is important. Delays in getting help can mean that opportunities to build on motivation are lost. Timing is also crucial in helping keep people engaged with services.
- Parents want services that would take account of their child care responsibilities and their busy lifestyle, in part the result of having to visit so many agencies that it felt like a full time job. Safety was an issue, too, with parents worrying about having to take children with them to meetings.
- Fathers need to be proactively involved in assessment and intervention processes, and professionals should help convey to fathers that their involvement in child rearing is both necessary and desirable.

- A similarly proactive stance needs to be taken in relation to working with men whose relationship with their partner is violent or conflictual.
- A sensitive response by workers will include an acknowledgement of their strengths as parents, a focus on the issues they want to work on, and a willingness to provide a flexible solution that takes account of their particular life style, experience and drug use. A real understanding of the dilemmas faced by parents is important.

11.3.2 Parental alcohol misuse

Practice Tips (Tunnard 2002):

- Find ways of making it more possible to talk openly about the problems that exist, to acknowledge that they are common to many families, and to boost the support already offered to children.
- Linked to the above is the need to improve communication and problem-solving in the family, as well as discussion between professionals and the family.
- Children want information about alcohol misuse by parents that gives a clear standard against which to gauge their own experiences, to help them identify the behaviour and circumstances that are problems rather than something to be regarded as ordinary. They want someone else, besides themselves, to identify the problems, partly to validate their own feelings, and partly as a way of getting outside help.
- Opportunities for talking about home life, either singularly or in groups, are also valued by children. The focus is on changing hopelessness into hope. This is about not taking responsibility for parental behaviour and avoiding confronting or protecting parents. It is about finding ways of putting structure and routine into their life, and working on their own strengths and aspirations. Support programs highlight the importance of developing strategies for coping with the hard times and using family members and outside support people as and when necessary.
- Everyone, including the parent with the alcohol problem, is likely to have needs that should be addressed. Their specific needs, some of which may have led to the difficulties, require attention also.
- Partners, relatives and close friends of the parent will also be under stress. They will usually want the parent to behave differently and they may be able to play a crucial role in influencing the treatment outcome. Their supportive presence can also be an important protective factor for children. It is therefore important that help is provided to partners, relatives and close friends of the drinker.
- Some of the key aspects of support seem to be about listening to what friends and relatives say about the family's life and circumstances and responding in a non-judgemental and reassuring way, providing information about alcohol problems and how change can be achieved, and exploring alternative ways of managing stressful events and times in the family. When relatives and partners are engaged, the outcomes are better and quicker.
- Alcohol misuse should not be viewed and treated in isolation. Work with adults must recognise their needs as parents, too, and work with children in need should acknowledge the possible contribution of parental alcohol misuse to family difficulties.

12. Conclusion

It can be seen from the research and practice considerations outlined in this paper that parental substance misuse is a complex and challenging issue increasingly facing departmental officers who are responsible for the protection of children.

In addition to variables such as the extent and nature of a parent's substance misuse, the symptoms and potential consequences of certain substances (and combinations of specific substances), and the needs and vulnerabilities of individual children, the research identifies many challenges likely to make the task of assessing and deciding harm or risk of harm to children even more difficult.

Key points covered in this practice paper include:

- the importance of timeframes in providing intensive time-limited reunification services;
- the critical need for collaboration and service delivery coordination, particularly with staff from Alcohol, Tobacco and other Drugs Services (ATODS);
- the importance of counselling for children;
- treatment options available to parents who misuse substances, including the effectiveness of options;
- the issue of abstinence versus reduced or controlled substance misuse;
- barriers to, and factors contributing to the effectiveness of, the treatment of parents who misuse substances;
- the likelihood of relapse in parents and the critical need for relapse prevention planning;
- suggested frameworks for assessing and monitoring parental substance misuse and the subsequent harm and/or risk of harm to children, including possible sources of information informing assessment and monitoring activities;
- indicators of recovery, or poor recovery, in parents who misuse substances;
- practice strategies and/or interventions considered to be of importance to children and parents;
- strategies to enhance worker safety; and
- a summary of useful drug and alcohol resources and literature, including a weblink to an overview of alcohol and other drug treatment services in Queensland.

This paper has been developed in response to the multiple challenges commonly facing departmental officers who work with parents who misuse substances, and their children, to assist in implementing effective, evidence-based interventions and practice strategies. Specifically, it is envisaged that departmental officers will utilise the research and evidence outlined in this paper, to inform their responses to, and interventions with, relevant children and families.

Key challenges indicated within the literature on parental substance misuse and child protection include the:

- culture of secrecy and denial in families where parents misuse substances;
- common existence of multiple risk factors for these families, particularly mental health conditions and domestic violence;
- health, safety, educational, emotional and psychological problems frequently faced by children whose parents misuse substances;
- general isolation and social exclusion often facing children and families where parents misuse substances;

- childhood histories of parents who misuse substances, including their own abuse as a child and exposure to substance misuse by their own parents; and
- high likelihood of relapse in parents who misuse substances.

This paper has been developed in response to the multiple challenges commonly facing departmental officers who work with parents who misuse substances, and their children, to assist in implementing effective, evidence-based interventions and practice strategies. Specifically, it is envisaged that departmental officers will utilise the research and evidence outlined in this paper, to inform their responses to, and interventions with, relevant children and families.

The research overwhelmingly indicates that effective child protection intervention with parents who misuse substances, and their children, incorporates:

- assessing, strengthening and creating immediate and ongoing protective factors specific to children, parents and the environment;
- personal safety and therapeutic intervention for children;
- identifying possible mental health conditions in parents and where possible, facilitating related assessments and interventions;
- identifying possible domestic violence related to substance misuse and where possible, making appropriate referrals for intervention;
- effective and consistent collaboration and coordinated service delivery;
- addressing barriers to parents seeking ATODS intervention;
- creating, providing and/or utilising supports aimed at assisting parents to remain in treatment on an ongoing basis;
- relapse prevention planning; and
- open and direct communication with children and parents and in particular, discussions about the common feelings, experiences and views of other parents who misuse substances and their children (as per the research findings).

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14. Appendices

14.1 Appendix 1 – Standing Conference on Drug Abuse (SCODA): Guidelines for professionals assessing risk when working with drug-using parents (Phillips 2004:177-179)

(SCODA is now DrugScope)

Parental drug use

1. Is there a drug-free parent, supportive partner or relative?
2. Is the drug use by the parent: Experimental? Recreational? Chaotic? Dependent?
3. Does the user move between categories at different times? Does the drug use also involve alcohol?
4. Are levels of child care different when a parent is using drugs and when not using?
5. Is there 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?

Accommodation and the home environment

6. Is the accommodation adequate for children?
7. Are the parents ensuring that the rent and bills are paid?
8. Does the family remain in one area or move frequently; if the latter, why?
9. Are other drug users sharing the accommodation? If they are, are relationships with them harmonious, or is there conflict?
10. Is the family living in a drug-using community?
11. If parents are using drugs, do children witness the taking of the drugs, or other substances?
12. 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)?

Provision of basic needs

13. Is there adequate food, clothing and warmth for the children?
14. Are the children attending school regularly?
15. Are children engaged in age-appropriate activities?
16. Are the children's emotional needs being adequately met?
17. 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.)?

Procurement of drugs

18. Are the children left alone while their parents are procuring drugs?
19. Because of their parents drug use, are the children being taken to places where they could be 'at risk'?
20. How much are the drugs costing?
21. How is the money obtained?
22. Is this causing financial problems?
23. Are the premises being used to sell drugs?
24. Are the parents allowing their premises to be used by other drug users?

Health risks

25. If drugs and/or injecting equipment are kept on the premises, are they kept securely?
26. Are the children aware of where the drugs are kept?
27. If parents are intravenous drug users:
 - do they share injecting equipment?
 - do they use a needle exchange scheme?
 - how do they dispose of the syringes?
 - are parents aware of the health risks of injecting or using drugs?
28. If parents are on a substitute prescribing programme, 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?
29. Are parents aware of, and in touch with, local specialist agencies who can advise on such issues as needle exchanges, substitute prescribing programmes, detox **and** rehabilitation facilities? If they are in touch with agencies, how regular is the contact?

Family social network and support systems

30. Do parents and children associated primarily with:
 - other drug users?
 - non-users?
 - both?
31. Are relatives aware of the drug use? Are they supportive?
32. Will parents accept help from the relatives and other professional or non-statutory agencies?
33. 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.

Parents' perception of the situation

34. Do the parents see their drug use as harmful to themselves or to their children?
35. Do the parents place their own needs before the needs of the children?
36. Are the parents aware of the legislative and procedural context applying to their circumstances (eg. child protection procedures, statutory powers)?

14.2 Appendix 2 – Drug and alcohol resources and literature

14.2.1 Resources

1. ATODS – Alcohol, Tobacco and Other Drug Services (Public Health Services, Queensland Health)

<http://www.health.qld.gov.au/atods/documents/22063.pdf>

The above link relates to the document titled 'Alcohol, tobacco & other drug services in Queensland 2003 Inventory of specialist treatment agencies', which provides an overview of alcohol and other drug **treatment services in Queensland**.

The document includes details of residential/hospital withdrawal programs; treatment, rehabilitation and aftercare centres; counselling services; opioid pharmacotherapy, and needle and syringe programs.

2. ADIS – Alcohol and Drug Information Service (Queensland)

ADIS is a free, 24 hour **telephone counselling** service which provides advice and counselling to people concerned about their own or a relative/friend's drug use. Brochures and other resources are also available.

Contact: (07) 3236 2414 (all hours); or
Areas outside Brisbane:
FREECALL 1800 177 833

Interstate services:

<http://www.health.qld.gov.au/atods/helplines.asp>

3. Department of Health and Ageing (Australia)

<http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/information>

The above website provides the reader with information about the different types of substances, their street names, and their symptoms and potential consequences.

<http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf>

The above website provides a link to the document titled 'Treatment Options for Heroin and Other Opioid Dependence A Guide for Frontline Workers'.

The document provides information about opioid dependence and the treatment options, including substitution (eg. methadone) and abstinence-based treatments.

4. NIDA – National Institute on Drug Abuse (United States Department of Health and Human Services)

<http://www.nida.nih.gov/Infofacts/Infofaxindex.html>

The above website provides InfoFacts (fact sheets), regarding the different types of substances and their health effects. There is no copyright on any of the materials available through NIDA InfoFacts, and all can be reproduced for further distribution.

14.2.2 Literature

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14.3 Appendix 3 – Summary of practice tips

4

Practice Tip: To address the competing timeframes and priorities associated with the child protection service system and substance misuse treatment services, departmental officers must work jointly with ATODS (or other relevant substance misuse treatment services) to:

- complete joint assessment, planning, implementation and reviews of case plans;
- ensure collaboration and service delivery coordination as these are “critical to working effectively with substance-abusing parents and providing intensive time-limited reunification services to children and families” (McAlpine, Courts Marshall and Harper Doran 2001:2);
- provide a timely and intensive process when assisting parents to resolve substance misuse issues and address other identified risk factors (eg. parenting skills, support networks) and related harm and/or risk of harm to their children.
- give consideration to, and establish clear case plans for, managing the issue of conflicting timeframes for children and parents, including:
 - setting realistic expectations;
 - making reasonable efforts to obtain prompt access to adequate substance misuse treatment services and associated resources for parents; and
 - coordinating the provision of child protection, substance misuse and other (if applicable) services to children and parents.

Practice Tip: While there is no straightforward advice that can be given with respect to effectively assessing and monitoring parental substance misuse, the Standing Conference on Drug Abuse (SCODA) guidelines (Phillips 2004:177-179) may be of assistance to departmental officers in cases of actual, or suspected, parental substance misuse. Refer to **Appendix 1**, for the SCODA Guidelines.

It is important to note however that the SCODA guidelines are intended as a starting point only, to **support** departmental officers in considering and exploring applicable issues of potential relevance to parents and children.

5.2

Practice Tip: Inquiring about **family history** of addiction is likely to be useful, given that many parents who misuse substances have a history (as a child) of being exposed to their own parents' substance misuse.

5.3

Practice Tip: In circumstances where notified concerns do not directly raise parental substance misuse, it is suggested that general health and well being questions be included in interviews of, or discussions with, parents. As such discussions progress, more specific questions can be asked.

5.4

Practice Tip: The following factors are examples identified in the research as **indicators** of a poor recovery, potentially leading to relapse (Hohman and Butt 2001):

- not accepting addiction as a disease;
- continued use of other drugs or alcohol (just not the one the individual is addicted to);
- sporadic attendance at treatment programs and/or support groups;
- isolation from, and distrust of, anyone in treatment programs and/or support groups;
- poor eating and sleeping habits; and
- being easily irritated or annoyed.

Untreated depression or other psychological disorders also place the recovering person at risk for relapse.

5.5

Practice Tip: Given the extent and nature of risk factors associated with a child who is exposed to parental substance misuse, as well as the high likelihood of relapse in parents, certain critical information (which becomes apparent to departmental officers during their intervention with the family) will necessitate **immediate action** to reconsider the safety and wellbeing of the child.

Practice Tip: It is **imperative** that liaison occurs with the parent's ATODS professional to obtain and/or clarify information relevant to the parent's current use of the substance/s, having regard to the ATODS treatment plan and the parent's compliance or progress to date (even if the new information does not appear as serious as the information relating to the extent and nature of the parent's original level or type of substance misuse).

It is important, upon and following the reunification of children with their parents, that departmental officers and other agencies involved in the implementation and monitoring of the case plan, identify and respond to parental stressors in a timely manner. Parental stressors are commonly linked to child fatalities, and relapse in parents who misuse (or have misused substances).

Parental stressors include change in family composition, death of a family member, major illness in the family, loss of employment, homelessness, relationship breakdown and change in residence.

6

Practice Tip: Even where/if an ATODS or other service expresses the desire to be the primary case coordinator/manager for the family, the departmental officer still remains responsible for implementing relevant case management procedures (this is in addition to the role agreed and undertaken by the other agency), and for regularly and proactively seeking relevant information from the coordinating agency.

7.1

Practice Tip: Given the range of impacts of parental substance misuse on children, as well as the documented childhood abuse rates of parents who misuse substances, it is important that children receive appropriate therapeutic interventions. Therapeutic intervention however is only one element of children's case plans – other interventions aimed at responding to the strengths and needs of children are considered, incorporated in the case plan, and implemented in practice, in accordance with existing departmental procedures and legislative requirements.

Practice Tip: Departmental officers should refer to the range of practice papers and related resources currently available through the Child Safety Practice Manual, to assist them in identifying and responding to the additional protection and care needs of children subject to statutory child protection intervention.

7.2.1

Practice Tip: Speak with parents about the differing goals of ATODS treatment and explain that ATODS staff will seek parents' views regarding, and provide professional advice about, the most appropriate treatment goal (based on parents' individual circumstances). Inform parents that many parents aim for, and successfully achieve, reduced or controlled substance use, in an attempt to resolve child protection concerns associated with their substance misuse.

Practice Tip: Liaise with ATODS to discuss and determine what extent and nature of substance misuse might be considered 'reasonable', based on the individual circumstances of a parent. Ensure that discussions take into account not only 'reasonable' in terms of the parent's health needs but also 'reasonable' in terms of minimising the risk of future harm to children.

7.2.2

Practice Tip: Interventions with parents may include allowing them to consider their behaviour and their attitudes towards other persons who inject and to consider aspects of their own injecting (including possible impacts on their child) and ways they might choose to change it. Such strategies may lead to changes in the way a parent acts around their child, possibly reducing risk factors.

Practice Tip: Utilise the research findings regarding parents' fears about injecting when discussing the impact of the parent's substance misuse on their children. This approach, in turn, may assist in facilitating an opportunity for referral and/or intervention by ATODS.

Practice Tip: Needle and syringe programs are located in various agencies, including Community Health and hospitals (refer **Appendix 2** for information about the range of ATODS currently available across Queensland).

7.2.3

Practice Tip: ATODS are voluntary services available to parents who misuse substances and ATODS' professionals have no capacity to make clients participate in, or attend, alcohol or drug assessment and/or intervention services, including substance testing.

Practice Tip: In conducting investigations and assessments and child/parental strengths and needs assessments, explore the possible current and/or previous existence of drug and/or alcohol issues within families. This should be achieved in a way which reflects a general conversation and holistic assessment process, rather than in a way that would be considered specific to a certain type of service or ATODS' professional.

Practice Tip: ATODS professionals, based on the individual needs and presentation of a parent and their knowledge of relevant research and evidence, are in the best position to identify the most appropriate treatment type for a parent. This highlights the importance of relevant and accurate information provision by departmental officers to ATODS professionals, as well as the need for effective collaboration and coordination.

Practice Tip: It is important to note however that self-help groups are **not** necessarily considered a form of treatment. For example, with respect to AA, "change is not facilitated or mediated by professionals but rather, is the result of the group members' own initiatives and support of each other" (National Drug and Alcohol Research Centre 2003).

7.2.4

Practice Tip: "Research has shown unequivocally that good outcomes are contingent on **adequate** lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years" (National Institute on Drug Abuse 2006:1).

7.2.5

Practice Tip: Effective outcomes are often associated with the person remaining in treatment long enough to gain the full benefits, and strategies for keeping an individual in treatment are considered **critical**.