Child Safety Practice Manual

Practice kits

Alcohol and other drugs

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Queensland Government

Table of contents

Alcohol and other drugs

Use this practice kit to learn how to strengthen knowledge, skills and resources to work with parents, children and young people, when there is problematic use of alcohol and other drugs.

The Department of Child Safety Youth and Women acknowledge the generous sharing of resources from the Department of Families and Community Services New South Wales which formed the basis of this Practice kit.

Engagement guidance for

- Overview of alcohol and other drugs
- Working with children
- Working with parents
- Working with expecting and new parents
- Working with young people and alcohol and other drug use
- Working with Aboriginal and Torres Strait Islander communities
- Working with culturally and linguistically diverse communities
- Safety assessment and safety planning
- Risk assessment
- Case planning

Version history

Published on: 28 May 2019 **Last reviewed:** 28 May 2019

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Overview of alcohol and other drugs

Version history

Published on: 20 June 2019 **Last reviewed:** 20 June 2019

Key messages

Alcohol and other drugs are a part of life in Australia.

It is important to remember that not all use of alcohol and other drugs (AOD) is harmful. Many of us start our day with coffee, use painkillers for a headache, or have after-work drinks with friends. But for the families that are reported to Child Safety, alcohol or drug use may have started to negatively affect their lives. They may need help so they can parent their children safely.

Different types of AOD impact on parenting in different ways. The type of substance, how a person uses the substance, and how often they use affects how they parent their children.

People can use AOD in ways that are experimental, recreational, situational, intensive (binge use) or dependent.

Alcohol and other drug use that is causing harm to an individual or others around them can involve more than the immediate effects of the substance. A parent's day-to-day life can be consumed by getting, using, managing the effects or withdrawing from the substance.

Alcohol and other drug use during pregnancy is a key opportunity for change. Working with a mother and father during the pregnancy and motivating them to change can make a positive difference to the health of the baby.

A child needs you to know how they experience all aspects of their parent's problematic use. Asking them about this is an essential part of safety planning and risk assessment.

Children develop ways to cope with and survive the impact of their parents' alcohol and other drug use. Each child will respond in different ways, which may include taking on different roles in their family and trying to stop their parent/s from using.

We need to reduce the labels, shame, stigma and language associated with problematic alcohol and other drug use. They can stop children and parents from talking about what is happening and seeking help.

Problematic alcohol and other drug use often occurs in response to the trauma of domestic violence, sexual abuse, neglect, pain, oppression or mental health issues. Identifying the underlying issues will help to address the problematic use.

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Common drugs and their effects

Drugs are grouped into three basic categories: depressants, stimulants and hallucinogens. This table will help you see how each drug can affect parents and pose risks to children.

Depressants	Stimulants	Hallucinogens
Effects: • slows down the nervous system • in small doses, they make people feel more relaxed • large doses can cause sedation, unconsciousness and death • affect concentration and coordination and lower response times	**Effects:** • speed up the nervous system • increase heart rate, blood pressure and body temperature • increase alertness and confidence • reduce tiredness and hunger • larger doses can cause anxiety or panic	**Effects:** • change perception • can affect all the senses; users may see or hear things that aren't there • some depressants and stimulants (such as cannabis and ecstasy) can have hallucinogenic effects
Common depressants: Alcohol* Benzodiazepines* (Valium, Xanax and Ativan) Buprenorphine* Cannabis	**Common stimulants:** Amphetamines (speed, base) Caffeine* Cocaine Ecstasy	**Common hallucinogens:** Ayahuasca LSD (acid) Magic mushrooms Mescaline (peyote cactus)

Depressants	Stimulants	Hallucinogens
Fentanyl* GHB (fantasy) Heroin Inhalants* Kava Ketamine Medicinal cannabis* Methadone* Oxycodone	Methamphetamine (ice, glass, shard, crystal meth and crystal) Khat Tobacco*	

*Legal drugs with dependence and misuse potential.

Synthetic drugs

Synthetic drugs are substances designed to mimic or produce similar effects to common illegal drugs such as cocaine, ecstasy, LSD, and cannabis. Other commonly used names for synthetic drugs are 'herbal highs' and 'bath salts'.

Psychological effects can include hallucinations, anxiety, acute psychosis and paranoia. The physical effects can be nausea and vomiting, headaches, seizures, overdoses and death.

People who use synthetic drugs are at risk of serious harm, because new versions of these drugs are rarely (or never) tested. Serious harm can occur because of not knowing:

- where they came from
- what chemicals and other compounds are in them even when the packaging appears the same
- what reaction might happen – as they can't assume there won't be a different reaction this time and that it is safe
- how they might react to other substances they've also taken including alcohol or other drugs
- if the experience will be the same (that is, whether the drug will be the same strength or same drug as last time).

Anabolic steroids

Anabolic steroids are drugs with misuse potential, but do not fall into any of the previously stated categories. Other common names for them are roids, gear, and juice.

Prescription drugs and medication

There are three classes of prescription drugs often associated with dependence. They are:

- opioids used to treat pain
- central nervous system (CNS) depressants, such as benzodiazepines (Xanax, Valium and Ativan), used to treat anxiety and sleep disorders
- stimulants, such as amphetamines and Adderall, Concerta, Daytrana, Methylin and Ritalin, used to treat attention deficit disorder and narcolepsy (a sleep disorder)

Further reading

The Alcohol and Drug Foundation's Drug Facts website contain an A to Z list detailing the effects of particular drugs. It includes short- and long-term effects, and the symptoms of withdrawal and overdose.

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Alcohol and drug facts

Statistics about alcohol and other drug use

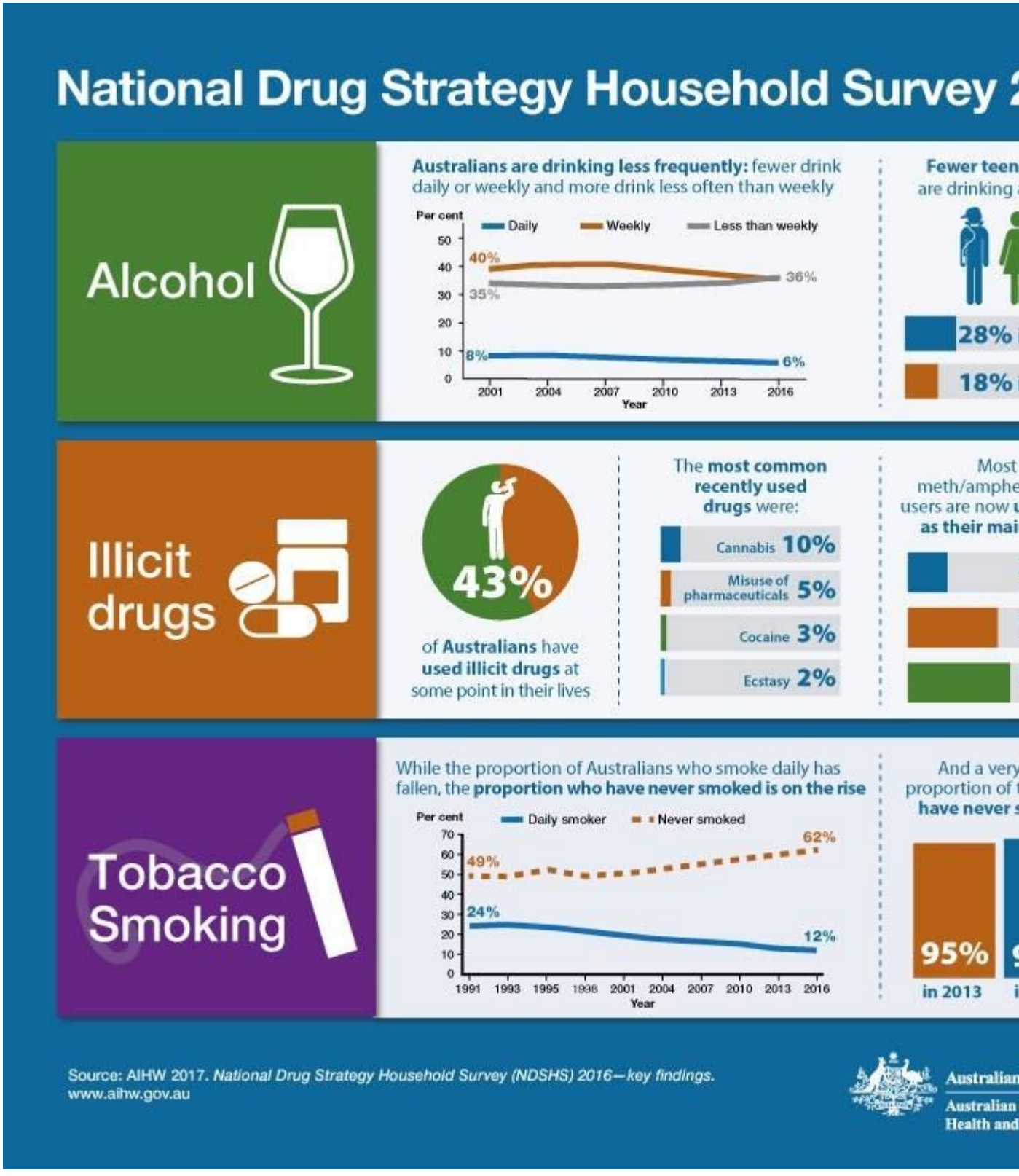

Image caption:

(Highlights of the National Drug Strategy Household Survey 2016)

Tobacco smoking

- 12.2% of people aged 14 or over were daily smokers in 2016. While smoking rates had been on a long-term downward trend, for the first time in over two decades, the daily smoking rate had not significantly declined over the 3-year period from 2013 to 2016.
- There were fewer teenagers smoking. The proportion who had never smoked more than 100 cigarettes significantly increased between 2013 and 2016, from 95% to 98%.
- Younger people continued to delay the take-up of smoking. The average age at which 14–24 year olds smoked their first full cigarette increased from 14.2 years in 1995 to 16.3 in 2016 (a significant increase from 15.9 years in 2013).

Alcohol use

- Compared to 2013, fewer people in Australia drank alcohol in quantities that exceeded the lifetime risk guidelines in 2016 (17.1%, down from 18.2% in 2013). But there was no change in the proportion exceeding the single occasion risk guideline.
- Young adults were drinking less—a significantly lower proportion of 18–24 year olds consumed 5 or more standard drinks on a monthly basis (from 47% in 2013 to 42% in 2016).
- Fewer 12–17 year olds were drinking alcohol and the proportion abstaining from alcohol significantly increased from 2013 to 2016(from 72% to 82%).
- However, more people in their 50s were consuming 11 or more standard drinks in one drinking occasion in 2016 than in 2013.

Illicit use of drugs

- Declines were seen in 2016 in recent use of some illegal drugs including meth/amphetamines (from 2.1% to 1.4%), hallucinogens (1.3% to 1.0%), and synthetic cannabinoids (1.2% to 0.3%).
- About 1 in 20 Australians had misused pharmaceuticals in 2016 (4.8%).
- Crystal/ice continued to be the main form of methamphetamines used in 2016 (57% in 2016; up from 22% in 2010 and 50% in 2013). There was a significant decline in recent meth/amphetamine users who used powder as their main form (from 29% in 2013 to 20% in 2016).

(Australian Institute of Health and Welfare, 2017: National Drug Strategy Household Survey 2016 key findings)

Image caption:
Impacts of alcohol, tobacco and other drug use. Health, social and economic.

Myths about alcohol and other drug use

Despite scientific research that shows dependence on AOD is a chronic brain disorder, individuals experiencing AOD dependence continue to be stigmatised. The general perception is that their use is a choice, they are to blame for their own alcohol and drug problems, and they could give up if they really wanted to.

This is one of many myths about AOD use that allow stereotypes, stigma and shame to continue. They can also influence your assessment of a child's safety. Be aware of them.

Some of the most common are listed in the following table. (Read more about stigma and shame in the Working with parents part.)

Myth	Truth
A person experiencing alcohol or drug dependence can just stop their use.	Alcohol and drug dependence is a chronic condition characterised by compulsive use despite negative consequences. With treatment and support, a parent can make changes

Myth	Truth
	in relation to alcohol and or drug use.
AOD use does not affect children if they are not around their parents when they use.	Children live and breathe the impacts of their parents' AOD use, even when they are not with them. It affects a family's daily life and can harm a child's relationships, learning, and development now and in the future.
A parent experiencing problematic AOD use should plan ahead and get a babysitter when they are using.	Problematic AOD use is different to planning a night out at the pub with friends. Problematic use is characterised by chaos, unpredictability, opportunity, and circumstances. Parents who cannot plan when they use cannot plan ahead for a babysitter. Remember the worry about problematic AOD use is not just about when parents are intoxicated or managing the effects. It is everything in between.
A lack of insight stops parents from acknowledging that their AOD use is a problem.	There are many barriers that stop a parent being able to talk openly with you about their AOD use. Barriers include shame, stigma, the perceived legal consequences, and fear and anxiety about losing their child.
AOD use causes domestic violence. If a man stopped drinking he would not be violent.	AOD use may lower inhibitions that can result in more frequent or severe violence, but it is not the cause of violence. See the practice kit on Domestic and family violence working with fathers, violence is a choicefor more information on the causes.

What happens when a person is experiencing alcohol or drug dependence

A person experiencing alcohol or drug dependence can be in one of the following three states:

- preoccupation or anticipation: They will have constant cravings and an overwhelming urge to use. They can be preoccupied with this despite having other responsibilities in their life. Mood swings, depression, tiredness and being irritable are also part of this stage
- under the influence: They are affected by alcohol or other drug use. They are not in control of themselves or what is happening around them. People can develop a tolerance to the amount of alcohol or drug used if they have used over a long period of time. The results of this can be a need for increased amounts of the substance to experience the desired affects, to feel like they can function, or to manage withdrawal symptoms. People can experience physical pain recovering from episodes, and symptoms can result in them being unable to complete day-to-day tasks
- withdrawal: They experience serious pain and psychological anxiety. They may be unable to sleep or my show signs of paranoia. Possible effects can include agitation, nausea or sweats, tiredness and muscle pain. The addiction cycle continues with the user's main priority becoming avoidance of these painful symptoms—as a result, the preoccupation stage sets in.

(Guiney, 2015)

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Page created

How alcohol and drug use affects a child

Children and young people are affected in three basic ways when their parents and carers are experiencing problematic AOD use:

- in utero, through the pregnant mother's use of alcohol or other drugs. (Find out more in Working with expecting and new parents.)
- in situations at home or in the community
- through their own AOD use (Learn more in the sections on Working with children and Young people and AOD use)

Watch Crystal Oertle tell the story of her dependence on heroin in Heroin addiction, recovery and no shame. Crystal describes taking her young baby with her to score regularly, sometimes more than once a day. Her story highlights the way dependence can take hold of a parent's day-to-day life.

Youtube video URL:
https://www.youtube.com/embed/1fBTTkwb2CU?enablejsapi=1&showinfo=0&rel=0

Video transcript:

00:15

hi so my story is probably pretty

00:21

similar to any of the stories that you

00:24

could read in the newspapers lately the

00:27

only difference is that I have been

00:30

fortunate enough to go through the

00:32

addiction and come out into recovery

00:37

thank you thank you

00:43

um when I was about 20 years old

00:47

somebody offered me a vicodin and I did

00:50

it and I liked it and and that started

00:54

my opiate obsession and addiction right

00:58

there over the next couple of years it

01:02

was every day trying to find a pill

01:04

anywhere that I could and as my

01:08

tolerance grew um so then did my need

01:11

for the stronger kinds of pain

01:13

medications like oxycontin and dilaudid

01:16

um until and that went on for a while

01:20

until one day there there was none I

01:23

couldn't find a pill anywhere and

01:26

someone told me they could get me heroin

01:28

and I was reluctant at first of course

01:32

because at that time when I thought

01:36

about a heroin addict I had a certain

01:39

judgment in my head about what a heroin

01:42

addict looks like what they act like and

01:45

that wasn't me

01:46

so I didn't really want to do it but I

01:50

knew I was physically addicted to the

01:54

pain pills so I was going to be getting

01:56

sick if I didn't get something and the

02:00

withdrawal symptoms are really they're

02:04

really awful um I've gone through it a

02:07

lot of times throughout my over a decade

02:10

of addiction

02:11

and there were days where I just would

02:14

rather have died then feel the pain that

02:18

that is in that sickness so I did the

02:23

heroin that time and the next time it

02:27

was offered to me it was a little bit

02:30

easier until then that was my drug of

02:33

choice

02:34

my obsession every day was getting

02:37

heroin um

02:39

so early on I live a little over an hour

02:43

from Columbus um and when I first got

02:46

addicted to the heroin I would travel to

02:49

Columbus everyday because it wasn't

02:53

everywhere like it is now um now it's in

02:57

my small town but back then it wasn't

03:00

and so I would come to Columbus everyday

03:03

get up in the morning either get my kids

03:08

ready for school my daughter wasn't old

03:11

enough to go to school so I would take

03:13

her with me or if it was summertime

03:15

my son would go to the skate park and we

03:19

would come to Columbus I mean the

03:21

significant other that I was with at

03:23

that time and it was in every day and

03:27

everyday thing and we would would have

03:31

to call ahead of time and let the person

03:34

that we're meeting here in Columbus know

03:35

how much money we had and we'd be there

03:39

in about an hour

03:40

and when we got close then we give them

03:43

a call and they would tell us which exit

03:46

to get off of and where to meet them in

03:50

the neighborhood here in Columbus and we

03:55

would either use here or wait until we

03:58

got back home and get hi there and sell

04:02

what we needed to sell keep what we

04:05

needed to keep and do it all again the

04:09

next day or sometimes later that same

04:12

day um and it was it was craziness

04:18

really looking back on it now it's like

04:20

wow

04:22

things that I did to get that drug my

04:28

daughter like I said was about two at

04:30

the time when I was doing that and I

04:32

brought her with in my mind it was safer

04:37

for her to be with me than to leave her

04:39

with some random person that was waiting

04:42

for us to get back with the drugs when

04:45

we did get pulled over with her in the

04:47

car with us one time that wasn't enough

04:51

to make me quit that didn't scare me

04:53

enough to make me quit my son was about

04:56

13 I think and he would go to the skate

05:00

park when I made these trips and I was

05:04

about 45 minutes away my mom calls and

05:07

says he's at the hospital he'd been

05:10

bitten by a dog a complete stranger

05:13

drove my son at the hospital because I

05:16

was an hour away in another town scoring

05:19

heroin that was enough to make me quit

05:22

um my son got so angry with me one time

05:29

that he went in to my bedroom and found

05:34

the purse that I cut my needles and my

05:37

spoon in and brought it out and gave it

05:41

to my mom just you know like make her

05:44

stop that wasn't enough to make me quit

05:47

this went on for a really long time and

05:51

just recently um my mom wasn't able to

05:55

be here with me today but about seven

06:00

months ago she just looked at me in the

06:04

way she looked at me she wasn't mad um

06:07

she wasn't really even sad she just said

06:11

you've got to stop and she was just so

06:17

serious about it and I could tell by the

06:20

look on her face that I knew I was

06:23

disrupting my life I could feel it I

06:26

could feel the pain that I have felt

06:27

every day

06:28

living an addiction um but I really that

06:32

day realized I was disrupting probably

06:36

every single

06:36

person that I came in contact with but

06:39

really the rest of my family I was

06:42

putting them through hell and so I

06:45

decided to stop and that's how I'm able

06:50

to be standing here today

06:51

so strong in my recovery my family has

06:55

been so supportive through this they

06:58

they never turned their backs on me I'm

07:01

sure there were times where they were

07:02

pretty mad at me for some of the stuff

07:05

that I've done but they never shut me

07:08

out

07:08

um and I'm so lucky I feel so lucky and

07:14

so grateful to have that to have that

07:16

support I can stand here today and not

07:21

feel shame I'm not ashamed

07:24

that I was a heroin addict and my family

07:28

was never ashamed to me and I really

07:32

think that prevents a lot of people from

07:34

getting the help that they need because

07:36

of the stigma that our society has on

07:40

heroin addicts and so that's really what

07:46

my point of coming here and talking

07:49

today and sharing my story with

07:51

everybody if it helps one person realize

07:55

that they don't have to be ashamed go

07:58

and get that help there's someone there

08:00

that's going to have your back if that's

08:03

the one thing that happens today then

08:06

all this nervousness was worth it so

08:10

thank you

08:15

you

In utero

AOD are known to be particularly dangerous to a foetus, as it cannot eliminate drugs as effectively as the mother can.

Drinking during the first 3 months of pregnancy is especially dangerous, as it is the time when important organ development occurs. Consuming alcohol affects the foetus adversely and can result in foetal alcohol syndrome.

At home

A parent with problematic AOD use can struggle to manage their day-to-day lives and to meet the needs of their children. It impacts on their ability to prioritise their child's:

- safety, belonging and wellbeing
- cognitive, emotional and behavioural development
- education.

A child's safety, belonging and wellbeing can be compromised when a parent is experiencing problematic AOD use by:

- not developing a secure attachment to the parent or carer or learning to self-regulate
- not having appropriate supervision, support, and stimulation for their age
- being exposed to unsafe situations, people, and paraphernalia associated with AOD use or criminal activities
- having a higher risk of developing their own problematic AOD use as they grow older
- having an inability to learn, develop relationships and cope with their own emotions
- having their development affected prior to birth and throughout their childhood and adolescent development

A parent with problematic AOD use can:

- struggle to maintain a budget due to spending money on AOD instead of on child or family needs
- engage in theft or other criminal activity to support their AOD use
- be isolated from family, friends and community
- have other co-occurring factors, such as domestic violence or mental health
- experience varied mood swings throughout their use and withdrawal from AOD
- have overly authoritarian or permissive parenting styles and unrealistic expectations of children's abilities
- be inconsistent in showing warmth and affection towards their child

- provide their children with less supervision, and have a lack of judgement and priorities
- lack stability and quality in the care of their children and in parenting.

(Smith and Wilson, 2016)

A child's resilience

Children will develop their own coping and survival strategies in response to their parents' AOD use. A child's resilience will play a role in how they recover, despite the experiences they may have. Many draw upon their inner strengths.

You play an important role in seeing, understanding and responding to each child's lived experience and their ability to cope and move forward. Read more about children's resilience in the Working with children part.

A child or young person's alcohol and other drug use

Many young people you work with will try alcohol and drugs. This may be experimental use or may be in response to their childhood trauma. It is important in your work with young people that you:

- do not label them by their behaviours
- do not blame and shame them because they are using
- are curious about what sits beneath their AOD use
- provide healing and recovery opportunities for childhood trauma, abuse and neglect
- avoid labelling their AOD use as just 'risk-taking behaviours'
- provide information, support and resources to help them be safe and learn the impacts of AOD use.

Watch

In No more anonymous. Eliminate shame and stigma of addiction, Jodee Prouse describes the intergenerational experiences of alcohol dependence in her family and the impact of shame and stigma within families and communities.

Youtube video URL:
https://www.youtube.com/embed/tq6L_hVTBAg?enablejsapi=1&showinfo=0&rel=0

Video transcript:

00:03

my name is Jody proce and I am the

00:06

granddaughter step daughter

00:08

daughter-in-law sister-in-law nice great

00:11

nice aunt cousin and sister to

00:15

alcoholics I have known what the word

00:18

alcoholic meant since I was five years

00:20

old not because anyone told me family

00:24

keeps secrets and mine is no different

00:27

or should I say they think they do but

00:29

you figure things out very quickly by

00:32

six I had already decided that this

00:35

alcohol-fueled life was never going to

00:37

be mine I couldn't have been more wrong

00:40

you see my younger brother was an

00:42

alcoholic I spent over six years

00:45

actively involved desperate and obsessed

00:48

like many family members caught in a

00:51

world we don't understand trying to save

00:53

him so of course I can't speak on the

00:56

percept perspective of the addict in

00:59

recovery instead that of the loving

01:01

family member I am very aware that I am

01:05

not the norm that somehow the word

01:07

controversial follows me when I dare say

01:10

these things about someone that I love

01:12

to some saying someone is an alcoholic

01:15

is a negative disparaging will ruin his

01:19

reputation people will think less of him

01:22

how dare I I saw my brother at his best

01:26

leaving rehab happy and healthy and as

01:30

handsome as any movie star and I am sure

01:34

everyone here can relate I saw him at

01:37

his worst during his 11-year battle with

01:39

addiction and what remained a constant

01:42

then and now that I never not once loved

01:47

him any less nor had any shame for they

01:50

often crazy things that were happening I

01:53

am very aware of the stigma and judgment

01:56

that come not only to those suffering

01:58

with alcohol and drug addiction but the

02:00

family members as well in some small way

02:04

what I hope is to bring change shame

02:08

keeps everyone addicts and the family

02:11

hiding that shame and inability to tell

02:15

the truth to friends

02:16

to family members and most importantly

02:19

to tell the truth to yourself manifests

02:22

itself into denial and with denial there

02:26

will be no recovery I am so honored to

02:30

be a part of this recovery movement a

02:32

face in a voice as everyone has been

02:35

silent for far too long anonymous we all

02:38

know that word I don't want to be

02:41

anonymous in fact quite the opposite my

02:45

outspoken attitude makes some people

02:47

uncomfortable and that's okay

02:49

uncomfortable gets people talking

02:52

uncomfortable challenges people on their

02:54

beliefs we live in a society that says

02:57

it encourages understanding compassion

03:00

empathy non-discrimination and yes that

03:04

addiction is a disease but that is not

03:08

how its treated it just isn't and that's

03:11

the truth we see huge promotional

03:14

campaigns worldwide raising funds and

03:16

awareness for diseases millions walk

03:19

with bright pink bows supporting breast

03:21

cancer buckets of water on Facebook

03:24

supporting ALS research prostate cancer

03:27

and parkinson's everywhere we turn

03:30

there's a cause a rally I can't even go

03:33

to walmart or buy an ice cream at a

03:36

local drive through without being asked

03:38

to donate but until now nothing to bring

03:41

attention to addiction why is that that

03:46

really isn't a question we watchin the

03:50

media's Mayor Rob Ford unravels in

03:52

Toronto doing an addiction and he

03:54

instantly becomes worldwide news and the

03:57

butt of all jokes on late-night

03:58

television would they do that if he has

04:01

Alzheimer's why is this okay how about

04:05

the girl that tells me that addiction is

04:07

simply a choice no one would actively

04:10

choose this life not for themselves and

04:13

certainly not for the ones that they

04:15

love when I calmly asked the question

04:18

back if your mother or grandfather

04:20

smoked for 20 years and got emphysema is

04:23

that what you would say to them I am met

04:27

with an awkward silence

04:28

of course not and that loved one would

04:32

immediately get all the medical

04:34

attention they need for as long as they

04:36

need it for free sharing stories is

04:41

important it makes us feel not so alone

04:45

alone that is what I felt for so long it

04:49

is how I believe my brother felt sharing

04:53

these stories standing tall together to

04:56

a world of judgment it gives us power it

05:00

gives us strength and it gives us hope

05:03

you know someone actually said to me

05:06

your brother was a junkie and he

05:09

deserved to die he had more than enough

05:12

chances I am NOT going to spend my life

05:16

arguing debating letting people break my

05:20

spirit for the truth I know and I

05:22

believe with all my heart it doesn't

05:25

surprise me that we live in a world

05:27

where some people believe this what

05:29

surprises me is that we live in a world

05:32

where it's okay to say that out loud

05:35

what I remind myself when I speak of

05:38

addiction is that this way of thinking

05:41

is not at all about my brother's

05:44

character it is about theirs I can't

05:48

tell you how humbled and proud I am to

05:50

be standing here with all of you

05:52

shedding a bright light on recovery what

05:55

a wonderful gift to our own children and

05:59

our family members that will come after

06:02

us to share openly and honestly about

06:05

this disease in our family tree so this

06:08

does not continue generation after

06:11

generation I don't think we could be

06:15

here today celebrating your recovery if

06:18

we didn't also celebrate the ones that

06:20

lost their battle I think back now to

06:25

when my brother passed away and I wrote

06:27

his obituary it's what I call now the

06:31

died suddenly phenomenon and if I could

06:34

rewind I would proudly tell the truth

06:37

just like the people that write died in

06:40

a motor vehicle accident

06:42

lost their brave battle with cancer or

06:45

passed away peacefully in their sleep at

06:48

90 years young my brother did not die

06:51

suddenly it was slow painful

06:55

excruciating and it has left us all with

06:59

enduring pain but even family members

07:02

won't publish the truth died from

07:04

alcoholism died from a drug overdose

07:07

died from suicide do they believe this

07:11

will ruin their loved ones reputation

07:13

perhaps or maybe it's part of them that

07:17

worries it will ruin their own I know

07:20

how I know all too well how shaman's

07:24

silence where are you down it makes you

07:28

lose hope and that leads to hopelessness

07:31

I do want to make a difference I want to

07:34

change perception I want to proudly be a

07:37

voice on Sunday March 18 2012 after at

07:43

least 18 days of drinking my brother

07:46

would take his own life he was 39 his

07:50

name was Brett Tisdale and he was an

07:54

alcoholic I still do not know all the

07:58

answers but there's one thing I am sure

08:00

of treatment does work people do get

08:05

well and you can live the beautiful life

08:08

you've imagined we are not promised that

08:11

is easy what we are promised is that as

08:14

possible

08:18

you

08:29

you

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Resources

To print

- How can I tell if someone is using drugs? (Positive choices.org.au)
- When you are using international resources, remember the measurements for standard alcoholic drinks will be different. You can access the National guidelines for alcohol consumption for more information.

Services and supports

These self-help services provide support and access to local meetings:

- Alcoholics Anonymous Australia
- Narcotics Anonymous Australia
- SMART Recovery Australia
- Youth, Drugs and Alcohol Advice (YoDDA) This site provides information, tools, advice and news for young people.
- Queensland Government ATODS This site provides information on alcohol, smoking and drugs.
- The National Health and Medical Research Council has produced Australian guidelines to reduce health risks from drinking alcohol.
- The Alcohol and Drug Foundation provides a number of resources about drug facts and effects of specific drugs, and video clips about stigma when working with people affected by AOD use.

These websites provide statistical information about alcohol and other drug use:

- Alcohol and Drug Foundation
- National Drug Strategy Household Survey 2016 report (Australian Institute of Health and Welfare)
- United Nations 2014 World Drug Report
- Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment 2016–17

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References

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Smith, V and Wilson, C, Committee on substance use and prevention (2016) 'Families Affected by Parental Substance use', *American Academy of Paediatrics*. Vol 138 Issue 2.

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Working with children

Use this part to make real connections with children—to find out what life is like living with a parent with problematic alcohol and other drug (AOD) use.

Seeing and understanding

Responding

Version history

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About this part

This part will help you:

- understand how problematic alcohol and other drugs use impacts on a child's safety, belonging and wellbeing
- recognise the ways a child copes with and survives their parent's alcohol and other drugs use
- build a relationship with a child so they can tell you their story
- use age-appropriate conversations and tools to help explain what is happening
- support a child in healing and recovering

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Keeping children at the centre of our practice

A child may experience significant harm when they are abused or neglected because their parent drinks or takes drugs. Practitioners working with families where alcohol and other drug (AOD) use is causing harm can be consumed by the extent of the parent's difficulties, making it harder to keep a focus on the needs of the child. Equally difficult is obtaining a true picture of the realities of the child's day-to-day life because of the parents' secrecy and shame about the extent of the problems.

A child can suffer from chronic and unnoticed emotional and physical neglect and/or abuse.

Practice prompt

Make sure you see and observe the child, speak and listen to them and always keep them at the centre of the assessment and planning process. Tools such as the Three Houses can assist children and young people to outline their worries and 'best hopes' for themselves and their families.

How a parent's problematic alcohol and other drug use can harm children

Because many people with problematic AOD use can behave unpredictably, children who grow up around them may spend a lot of energy trying to work out a parent's mood or guessing what they want. This can affect a child's behaviour, because in an attempt to avoid outbursts from their parent they may not ask for what they need, or may find themselves comforting a parent who promises things will get better.

According to research, having parents with problematic substance use commonly causes difficulties in terms of:

- the family environment (neglect, poverty, hunger and housing)
- exposure to drugs, drug dealing and criminal behaviour
- the emotional wellbeing of the child
- the child's developmental outcomes
- the child's progress at school
- parenting behaviour (aggression, excessive discipline and inconsistency) (CFCA, 2008).

Although problematic AOD use causes similar patterns of harm in many families, each situation is unique. Each child thinks, feels and sees their parent's problematic AOD use in their own way. The way a parent responds to, loves and cares for their child is affected by the substance they use, the way they use, and their level of use.

> ⚠ **Attention**
>
> It is easy to focus on the obvious ways a child is being harmed. But sometimes the most damaging ways a child is harmed are not easily seen. The worry, confusion, fear, stigma, secrecy and shame that children experience can ripple throughout their life. This shapes who they become, how they feel about themselves, the relationships they form and the ways they learn to cope with life's struggles.

From a child's perspective

Young people impacted by their parents' substance use share their experience:

> *We were pretty much too scared to say anything to anyone because we knew there were aggressive consequences if we said pretty much anything to anyone ... We would be told that if we talked to people we wouldn't be allowed out, we wouldn't be allowed to see our friends, see nanna ... [Mum] was very, very intimidating.*
>
> Young man, age 17

> *I had the absolute worse thing happen to me in Year 5. My parents were out with this really wrong crowd and they met these people only for a week because they got introduced by somebody else and [a user] came over to my house one day and they put a needle in my bag and ... I got to school and I was going to put my yugio [Yu-Gi-Oh] cards in and I saw it, and I threw it down and I ran straight back into class.*
>
> Boy, age 11

> *When I was 11 years old I started worrying because [Dad] started not being around when I got home, and he wouldn't tell me where he was going, and 7 o'clock come around and I freak out, and 8 o'clock comes around ... I got scared ... I didn't like being home by myself.*
>
> Girl, age 13

(Moore, Nobel-Carr, McArthur, 2010)

Watch this short video about what a child may experience in relation to a parent's alcohol use.

Youtube video URL:
https://www.youtube.com/embed/Z9xQcHnMsQg?enablejsapi=1&showinfo=0&rel=0

Video Caption:
From a child's perspective (alcohol dependence)

Video transcript:

00:00

[Applause]

00:03

it's nice when your missed ropes my hair

00:06

at bedtime but she doesn't read

00:09

Goodnight stories for me and Emily enemy

00:13

after dad puts us to bed she sometimes

00:16

comes to kisses good night

00:18

she smells a bit funny when she kisses

00:20

us but I like it anyway

00:23

I used to play with us after school but

00:31

now she is tired and needs to elect when

00:33

she gets home from work

00:35

[Music]

00:41

that has to go we're not with this job

00:44

and I have to pick up Emily from daycare

00:47

lot of times now because mom is really

00:49

tired and the other day I can find

00:52

Emma's raincoat when I went to get her

00:54

she got all wet because it's a long way

00:56

her and mom started crying when she saw

00:59

us one day when mom brought me and Amy

01:04

shopping she was driving strange she

01:08

crossed the red light and he had another

01:09

car when we parked

01:12

maybe I should have told him to dead

01:14

because he got really upset with mum he

01:17

told her that he was good to leave me an

01:19

Emmy alone with her and she might do

01:21

things like that again

01:23

[Music]

01:26

mama - friends don't come to our house

01:29

anymore I miss playing with their kids

01:31

especially Jennifer

01:35

last time we went to see her and her

01:37

parents one was really happy she was

01:41

singing and dancing and hugging

01:42

everybody

01:43

[Music]

01:47

but then dad wanted to go home now got

01:51

angry because she didn't want to go and

01:54

they were yelling

01:57

on the way to the car she felt and heard

01:59

her knees I wanted to help her get up

02:04

but she just shocked at me

02:10

mom and dad kept arguing when we got

02:12

home and I couldn't sleep when I got up

02:16

to go to the toilet I heard dad say that

02:20

he might have to take me in MA and move

02:23

away unless mom gets help

02:27

[Music]

02:32

I love money and I don't want to leave

02:36

her I think we should stay here and help

02:40

her

02:46

[Music]

How children cope

Children cope and survive by trying to make things better for themselves and the people they love. A child will learn to read their parent's behaviours and emotions, looking for signs that will become the roadmap of how they think, feel and act.

This comes with a cost for them, and common responses can include:

- withdrawing from others
- blaming others and acting out at school
- being more responsible than normally expected of a child their age
- looking after themselves, their siblings, their mum and dad

- trying to protect their mum, dad, brothers or sisters from being hurt
- trying to be what their parents need and want, even though this changes every day
- looking for ways to have their needs met, such as stealing food, staying with friends, not coming home and lying about what is happening in their life
- looking for other ways to feel loved by seeking love from other adults or friends or feeling relief by drinking and using drugs.

A child tends to have one of two responses as they cope and survive:

- the over-responsible 'take care of everyone' response
- the under-regulated 'emotionally and behaviourally overloaded' response.

Over-responsible: taking care of everyone

Over-responsible children take on household tasks like cooking, cleaning and laundry at an earlier age than their peers. They provide for their siblings in ways a parent should, by:

- making sure they are dressed and fed
- providing personal care (washing, bathing and bedtime routines)
- signing school forms and documents for their siblings
- protecting them from a parent's AOD use, violence, abuse or neglect.

They often take care of their parents as well, by:

- covering up when they are intoxicated
- cleaning up after them
- constantly making sure the parent is alive.

Over-responsible, 'parentified' children miss out on their childhood. They often become adults who are drawn to spouses or partners who have problematic AOD use, and can spend their entire lives in a state of co-dependence.

Emotional dysregulation: emotional and behavioural overload

A child may:

- 'act out' in response to inconsistent parenting
- develop anxiety and depression
- clash with adults
- be aggressive with friends
- get into constant trouble at school.

They tend to:

- cope poorly with frustration

- not know how to calm themselves when frightened or sad
- struggle to form meaningful relationships with others.

They are likely to:

- get poor marks at school
- be identified for special education services
- have a greater chance of dropping out of school or getting involved with the juvenile justice system
- develop their own problematic AOD use.

Children of families where AOD use is causing harm can often adopt the same patterns and problematic behaviours as their parents. These patterns and behaviours can affect them when they become parents. Substance use affects generations.

Understanding children's coping strategies

They can cope and survive their experiences. They may do big and small things to reclaim a life that feels out of control. If they see that their actions make a difference, they gain self-esteem and strength. These responses are their ways of coping and surviving.

When these coping strategies are not understood in the context of their parent's AOD use, the strength and resilience of children can become invisible. Children are instead labelled as a passive victims, as being traumatised, as having negative behaviours and attitudes and as demonstrating risk-taking behaviours.

> *'I was a very angry child, really unhappy, and she [my mum] was too involved in her relationship with the bottle to ever be there. I didn't tell anyone and I don't know why. I saw my dad at weekends, my parents were divorced, but I never talked to him about it. I think children just don't. I lived my life for my mum.'*
>
> - Emma Spiegler

(Mc Veigh,T 2010) Pain and anger are the hidden burden for children with an alcoholic parent

A child's coping strategies and how they can be misinterpreted

The child's coping strategies	How the child's behaviour may be misinterpreted
A child acts out towards the parent because they want to be noticed.	They may be seen as challenging or defiant, with oppositional behaviour.
A child stays close to their parent to make sure they do not	Their behaviour may be seen as evidence of an insecure attachment.

The child's coping strategies	How the child's behaviour may be misinterpreted
overdose and die. A child helps look after their brother or sister because they want to make it easier for their parent.	They may be seen as a 'parentified' child. They may be seen as an easy or helpful child.
A child says they have no friends and does not want to bring friends home because they are ashamed and embarrassed.	They may be seen as a loner, or as having poor social skills.
A child does not speak out about what is happening in an attempt to protect their parent or themselves.	They may be seen as withdrawn.
A child may get support or help a parent to use drugs or alcohol because they know it is worse when their parent is coming down.	They may be seen as colluding, supporting and aiding AOD use.
A young person starts using drugs and alcohol as a way to cope.	This may be seen as teenage experimentation or risk-taking behaviours.

Related forms, templates and resources

The three houses

Resource 18 July 2019

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Helping a child heal and recover

Trauma

Trauma in childhood occurs because of an event or series of events. A child who has experienced trauma often feels helpless and pushed beyond their ability to cope. Children experience trauma differently depending on their age, personality and experiences.

Trauma can have a serious effect on children as young as babies, toddlers and pre-school children. It is incorrect to assume that because of their age they do not notice or remember a traumatic event. Young children are far more vulnerable than adults in experiencing trauma because they are dependent on others for safety and care, and their brains and bodies are still developing.

Age group	Are observed to have	Behavioural responses
Babies—toddlers (birth to around 2 years)	• unusually high levels of distress when separated from their parent or carer • a look of shock, as if they are frozen and very alert • a numb appearance as if they are cut off from what is happening around them • difficulty in soothing and decreased interest in play and interactions with parents and carers • in babies, increased irritability, crying more often and needing to be held and cuddled frequently	• avoidance of eye contact • loss of physical skills such as rolling over, sitting, crawling and walking • fear of going to sleep, especially when alone • nightmares • loss of appetite • making very few sounds • increased crying and general distress • unusual aggression • constantly on the move with no quiet times • sensitivity to noises.

Age group	Are observed to have	Behavioural responses
	• in toddlers, showing uncharacteristic aggression, losing language skills or eating skills.	
Pre-school children (around 3–5 years)	• new or more clingy behaviour such as constantly following a parent, carer or staff around • anxiety when separated from parents or carers • new problems with skills like sleeping, eating, going to the toilet and paying attention • shutting down and withdrawing from everyday experiences • difficulties enjoying activities • being more jumpy or easily frightened • physical complaints with no known cause such as stomach pains and headaches • blaming themselves and thinking the trauma was their fault.	• return of bedwetting • speech difficulties • stomach-aches • under or overactivity • difficulties in paying attention • fear of darkness, animals, monsters and strangers (beyond what would be expected at this age) • loss of appetite or overeating • nightmares • crying • sleeping difficulties • unusual aggression • repeatedly talking about the traumatic experience • nervousness • irritability.

(Beyond Blue, 2019)

A child who has been abused or neglected may be fearful, anxious or sad, may struggle at school, wet the bed, have nightmares, self-harm or express distress and trauma in other ways.

Some children, especially those who suffered early abuse and neglect, may show less obvious yet more damaging signs of trauma, which can include:

- difficulty in making deep attachments to others
- difficulty in feeling empathy for others in distress
- difficulty in expressing or experiencing feelings
- anti-social behaviours and attitudes.

Note

Because these more damaging signs of trauma affect a deeper level of a child's development, it can be harder for them to recover. Healing takes place when a child is in a familial environment and has repetitive, specific, predictable experiences of love, support, comfort, safety, affection, acceptance, understanding and nurturing, especially when they are upset, distressed or fearful.

Watch the following video on links between trauma, the brain and relationships, and on helping children heal from trauma. Think about how we can support a child who has been affected by trauma and neglect.

Youtube video URL:
https://www.youtube.com/embed/RYj7YYHmbQs?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Trauma, Brain and Relationship: Helping Children Heal

Video transcript:

00:00

[Music]

00:10

early childhood trauma changes the

00:14

biology of the brain well early

00:16

childhood support also changes the

00:18

biology of the brain what studies of

00:20

resilience show that even when children

00:23

have insecure attachments in the home if

00:26

they've had at least one secure

00:29

attachment with a daycare provider a

00:31

preschool teacher or another adult in

00:33

their lives then that makes a huge

00:36

difference for them having the seed of

00:39

resilience they may still have

00:41

difficulties but because they've had

00:43

that one secure relationship that

00:45

relationship where they felt that

00:48

another individual the another adult

00:50

knows them and feels what's wrong inside

00:52

of them those kids have the potential to

00:54

do very well in the future we can see

00:56

imaging today of before and after trauma

01:01

and see what happens in the brain and we

01:04

can also see repair that happens in the

01:07

brain when our interventions have been

01:08

successful what makes children get

01:11

better following a trauma is connection

01:14

to other human beings human beings who

01:16

are present who are patient who are kind

01:20

or sensitive and they don't need to be

01:23

necessarily psychologically insightful

01:25

they don't need to know anything about

01:26

trauma all they need to do know is that

01:28

they're right there with this child

01:30

they're trying to be comforting they're

01:32

trying to be supportive to kind of

01:33

encourage those kinds of interactions

01:35

end up being much more therapeutic in

01:38

healing than many of the other things

01:40

that we try to do with kids teachers can

01:43

look more at their children be more

01:46

emotionally present for children touch

01:48

them work on their own nervous system

01:51

and their own regulation if they're

01:54

angry and they're out of control in

01:56

terms of what's going on inside of

01:58

themselves the message that they're

01:59

going to convey to the child is I'm

02:01

angry and I don't like you if you're an

02:03

adult and there are children in your

02:04

life whether you're in law enforcement

02:06

to teacher hair

02:08

foster parent whatever you are and you

02:12

know that a child has been exposed to

02:15

something that's potentially traumatic

02:17

the first thing that you should be aware

02:20

of is that not all traumatic events lead

02:24

to disastrous mental health outcomes in

02:27

fact the vast majority of children that

02:29

are traumatized actually do pretty well

02:31

but they do need your attention they do

02:35

need your kind support and they do need

02:38

your awareness about what our warning

02:40

signs that would tell you to actually

02:43

take the next step and try to get some

02:45

professional help it's up to us we can't

02:48

wait for a day to do this spreading of

02:51

the message that we can do something

02:53

about it that children especially young

02:55

children have the most possibility for

02:58

health and plasticity for overcoming

03:03

these early traumas if we as a community

03:06

a large community support them we have

03:08

permission now to meet children's needs

03:10

we have permission now from neuroscience

03:14

to give children what they need and to

03:17

me that is so exciting if there was one

03:20

place I would like to start with

03:22

individuals as well as our society

03:24

trying to make a difference to really

03:27

stop the cross generational passage of

03:30

trauma and of insecure attachment it

03:33

would be for parents to start the

03:34

process of self understanding it

03:37

basically costs nothing except the time

03:39

and emotion that it takes for parents to

03:42

begin on that process and we all can do

03:45

it and the people who benefit most

03:47

besides ourselves our our children we're

03:51

spending literally ninety five percent

03:52

of our public dollars to change the

03:54

brain because that's what mental health

03:56

is that's what public education is

03:58

that's what juvenile justice

03:59

intervention is all of these are trying

04:01

to change the brain and we're spending

04:02

almost nothing in the first five years

04:04

of life when the brain is easiest to

04:06

modify and it takes the least amount of

04:08

professional input the least amount of

04:10

insight it takes just high quality

04:13

caregiving it's us not they it's it's

04:17

each one of us doing it now not

04:19

later but now

04:21

[Music]

04:48

[Music]

05:06

[Music]

05:13

[Music]

05:23

you

05:25

[Music]

English (auto-generated)

> *'Sometimes it gets a bit hectic so you need to get out of the house. There needs to be a place you can go if you need time out, to get away. A place where parents know you are safe. Not like a refuge 'cause those places are full on, somewhere you can go and*

chill out. Not for a long time but maybe a few days like a week if you need it, or if your parent is in hospital or not doing so well. Some place you can go where you trust them and you can just do the stuff you need to do.'

Young woman, age 16

(Who Cares- Moore, Noble Carr, McArthur 2010)

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Coping with change

As a child's parent goes through the stages of change with their problematic AOD use, the child will need your support to help them cope with the ups and downs. Understanding how the stages affect a child and their parent will give you a clearer idea of how to support the family.

The stages of change as experienced by the parent and child

Parent's stage of change	Child's experience
Relapse	Disappointment, fear, broken promises, What's new? Not again!
Pre-contemplation 'I'm fine'	Familiar, secrecy, fear of disclosure, responsibility, neglect, abuse, lack of support, isolation
Contemplation 'ambivalence'	Things can't go on like this. Hope
Determination 'important, confident, ready'	No more secrets, fear of the unknown, it's been bad, but at least it was familiar
Action 'I'm doing it'	Hope and fear, stress, separation, parents needing more care. Who will look after me?
Maintenance 'I can keep doing this'	Learn to be a child, this is too good to be true, I expect things will go back to how they were
Permanent exit 'I've changed my lifestyle'	A child at last! Now what about all my other problems?

(Harbin, 2006)

The stages of recovery as experienced by the parent and child

Parent's stage of recovery	Child's experience

Parent's stage of recovery	Child's experience
Transition to recovery A parent may be out of control and the family system in chaos. Often a major life event (or many events) may be the trigger for their transition to recovery. Examples of life events: a partner threatens to leave, a parent is arrested or is hospitalised for an overdose, a parent is the victim of a drug-related crime or Child Safety has intervened.	I feel confused because of the changes and the chaos. Mum or Dad are focused on what they need to do for themselves to recover, not me. I am feeling worried, frightened and alone because Mum or Dad is not here with me; they are away somewhere getting help. I don't know what what's going to happen. I just want things to go back to what I know. Have I done something wrong?
Early recovery Parents learn change is possible and begin to build their identity without drinking or using. The household may become more settled and calm. It is new territory for parents and children. Parents will need support to help them implement everything they have learned, to stay sober and to meet their child's needs.	I might act out, go into myself and pull away from others, because I am away from the chaos and am starting to process what has been happening. I like the change, but I'm not sure if I can trust Mum or Dad to stick to it. I feel really worried and try to do whatever I can to make sure Mum or Dad don't go back to their old ways. I don't know what to expect of my mum or dad now that they are different. They've let me down before. I have no control. I want things to be good, I don't know if I like how it feels. I still like to be close to Mum and Dad all the time so I know they are safe and not drinking and using.
Ongoing recovery At this stage, the recovery process becomes internalised for the parent. With prolonged abstinence, the possibility of relapse lessens and the	Now that Mum or Dad is sober they want to tell me all these rules. It was better when I did not have rules. They can't tell me what to do now, when they have broken so many rules themselves.

Parent's stage of recovery	Child's experience
family can begin to rebuild their routines and adopt new family rituals, such as family dinners and outings. Realigning roles in the family and re-establishing rules and boundaries is key. Parents need help to repair their relationships with children alongside their AOD treatment. Unresolved issues with children and lack of skills to deal with these issues can put parents at high risk of relapse. Parents may need help with positive discipline, safe and appropriate boundaries, good role modelling about AOD use, and not overindulging children as a way of making up for the past.	Everything is changing; I used to be the one to look after my brother Max. Now Mum wants to do everything. I don't know what I am supposed to do now. Max doesn't need me anymore. I don't know how to be 'just the kid'. I need Mum and Dad to show me again and again how they will be different so I can learn to trust them again. They need to pick me up from school on time, get breakfast, lunch and dinner for me every day and give us 'special time' together so we can be close. I need Mum and Dad to ask me what I need from them and what I need to see happening so I feel cared for and loved.

(Adapted from Addiction in Family)

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Hearing the voices of children

There are several ways to support the development of positive relationships when working with children impacted by parental AOD use:

- Create an environment in which children trust you and feel comfortable and safe.
- Engage with children in an honest, credible and genuine manner and avoid secrecy.
- Ensure you communicate in a manner appropriate to the child's age and development.
- Offer children choices about the things that affect them and invite them to tell you how they would like to share their story.
- Be objective and curious about their experiences.
- Try to provide children with hope for the future and looks for acts of protection—do not just focus solely on risk.
- Follow up your words with actions. Letting children down can be very damaging to your relationship.

'They talk to the parent ... They'd be more helpful if they listened to what the kids had to say, because this kind of stuff really affects them badly, because they're young and because they don't understand. They pretty much go, "Holy crap, my whole life is falling apart. What do I do?"'

Young man, age 17

(Who Cares- Moore, Noble Carr, McArthur 2010

Techniques to connect with children

Effective techniques to use when working with children whose parents use AOD are as follows:

- Providing opportunities to draw—inviting children to draw a family tree is a good way for them to talk about their family and can be a springboard to discuss their relationship with other family members.
- Using the Three Houses Tool is a good way to help children to talk about what makes them feel safe or unsafe and about their dreams and hopes for the future. Getting a child's permission to share this with their parents can act as a motivator for change. Many children feel unable to express their thoughts and feelings directly to their parents, and this process enables them to put their experience, fears, hopes and dreams into writing. The result can be a confronting but potentially transformative experience for the parent as they hear about their child's experience.

- Using the Safety House Tool is a way for a practitioner to talk with a child about safety and danger and for a child to talk about what needs to happen for them to be safe and the people who can provide the safety. It also identifies the rules that need to be in place so the child feels they are safe in the care of their families.
- Developing family life books—Children whose parents have problematic AOD use often experience very disrupted lives. Family life books, in which mementos such as notes, photos, letters and drawings can be stored, can be an important repository for children's memories. Consider whether kicbox is an option.
- Using safety and support networks, which involves identifying individuals with a connection to the child and helping them to contribute to creating an extended network of support. The group can include extended family members, friends and other adults such as teachers who show a connection with the child. Offer support to develop these networks and to ensure they have the skills to maintain the connection without organisational support.
- Using the Circles of Safety and Support Tool.
- Using family activities (camps and school holiday programs)—Families in which parental AOD use is an issue may not have the financial resources to participate in family activities. Referrals to these sorts of programs can be a way of encouraging positive engagement between children and their parents and can contribute to the vital strengthening of the parent-child relationship.

Related forms, templates and resources

The three houses

Resource 18 July 2019

The safety house

Resource 18 July 2019

Safety and support networks and high intensity responses

Resource 18 July 2019

Circles of safety and support tool

Resource 18 July 2019

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Explaining alcohol and drug use

From a young age, children generally know a lot about their parents' AOD use - more than most adults realise, so it's important to tell them the truth.

Talking to children about this can become the foundation of a relationship based on honesty and trust. Information can help children make sense of the events that have occurred within their family and can prevent them from developing assumptions about their parents' behaviour.

Sharing information with children about their parents' problems may make them feel different to their friends, which may increase the anxiety and worry they already have. Children don't need to know all the details of what is happening, but practitioners should not lie to or mislead them.

When you talk to children about the nature of their parents' AOD use, there are a number of points that can help you to engage with them and not make them feel overwhelmed, fearful and anxious. In particular:

- ask about and listen to what they say about how their parents' AOD use affects their life
- match your explanations about their parents' AOD use to the children's ages and developmental stages
- explain in clear and simple terms that they are not responsible for their parents' AOD use
- communicate that their parents still love them
- connect them to other people if they wish or ask to speak with them
- tell them about their parents' attempts to overcome their problems and change their behaviour, as this may alleviate some of their worries and help them believe change is possible.

Practice prompt

Children as young as 4 can tell the difference between wine and beer based on the shape of the bottle. Children as young as 6 can tell the difference between types of alcohol by smell.

(Alcohol and Drug Foundation, 2019)

Tell children the truth

Explain to the child that their parent has a problem with using alcohol or drugs and that this means their parent finds it hard to avoid and control the amount of alcohol or drugs they take. Let them know that this problem causes the parent to behave differently.

Ask the child:

- Have you noticed this?
- How is your mum or dad different when they drink or take drugs?
- What kinds of things do they do?
- What things do they normally do that they don't do when they drink or use drugs?'

Ask a child how it makes them feel. Many children who have a parent with problematic AOD use feel lonely. They may wish they could have a 'normal' home life like they think their friends have. Let them know Child Safety worka with other children like them and these children feel the same way, too.

Ask the child:

- How does it make you feel when mum or dad drinks or uses drugs?
- What do you think when mum or dad drinks or uses drugs?
- What do you notice about the way mum or dad acts?

Tip

Ask the child what they do when their parent is using alcohol or other drugs. This question reveals the child's strengths, acts of protection and empowers them to see their strength in coping and surviving.

Assure the child that they are not the cause of their parent's AOD use. Children often feel they are to blame for a parent's drinking or drug use. Let them know this is a problem that the parent has, and it's up to the parent to make it better. It is better not to tell them that a parent is sick or has a disease, as this might prompt the child to become a caretaker and misunderstand what is happening. Ask the child if there have been times when they thought or felt it was their fault.

A child is not responsible for getting their parent to stop using. Children need to hear from you and other adults that they are not responsible for getting their parent to stop using drugs or drinking.

Ask the child:

- Have there been times you thought you could make them stop?

- What did you do?

It is important that children hear consistent messages and information. Talk with parents and support networks about who will provide information to the child, so they get clear messages. This may be you, a parent, a carer or another adult in the child's network. As parents recover, they may become more involved in these conversations to support their child.

Include children in the safety planning process, including the development of non-negotiables around safety by:

- giving them something they can take with them.Making a booklet with them or using the Safety House Tool can give a child something concrete to walk away with. They have something to refer to when you or other supportive adults are not there, and it helps other adults give the same messages
- talking about a parent's treatment and recovery. Children and young people will need to know why their parents are seeking treatment and the details of what this will look like, including:
    - what treatment and recovery will mean for them and their parent
    - what the care arrangements will be while their parent is getting treatment
    - how they can stay connected with their parent if they are not seeing them for a while.

A child will also need help to make sense of their parent's treatment and recovery. Check in regularly about how the child's or young person's feeling, worries and needs as they walk alongside their parent's treatment and recovery.

When talking about a parent's relapse, explain to the child what has happened and what it means. Be clear that relapse is common for people recovering from AOD use and it does not mean things have failed. If a child is living with their parent during treatment and recovery, talk to the child about any fears and worries they may have, including any pressure to keep their parent's relapses a secret.

Explaining problematic alcohol and drug use to different age groups

Below are ways to explain a parent's problematic AOD use according to the child's age.

Children aged under 10 years

Children and young people can relate to the question: Have you ever wanted something so bad, no matter how much your brain told you 'no', you still wanted it?. You can show the child the marshmallow test as a conversation starter. It shows that sometimes people make choices they know they are not the best choice to make, but they can't stop themselves.

Youtube video URL:
https://www.youtube.com/embed/d8M7Xzjy_m8?enablejsapi=1&showinfo=0&rel=0

Video Caption:
The marshmallow test: can children learn self control?

After you have watched the clip together, ask the child questions about how hard it was for the child to wait. Even though the better choice is to wait, a person's brain is not always able to make that choice. This example can help a child connect with the struggle their parent has with alcohol and drugs.

You can say to the child: "It is a bit the same way with drugs and alcohol. Even parents have things they want so much they can't seem to say no. Right now, Mum or Dad is dealing with the same thing. Sometimes we make really good choices and sometimes, even when we know better, we don't make the best choice, like in the video".

Resources you can use:

When a parent drinks too much alcohol... what kids want to know is a guide from The Centre for Addiction and Mental Health that may help you when talking to children about their parents' problematic alcohol use. It has suggestions on how to answer questions such as:

- Why does my mum or dad drink so much?
- What does it feel like to drink alcohol? How does it feel to be drunk?
- Why am I so confused about how I feel? Why do I worry so much?
- Why is the alcohol problem a secret?
- Can my mum or dad stop drinking so much? Can people get better?
- Is there anything I can do to make my mum or dad better?
- Why do people drink so much when they know it will hurt them or others?
- When I grow up, will I have an alcohol problem too?
- What can I do so that I do not ever have an alcohol problem?

The Flying DreamThis is a children's book about children who re-enter foster care because of their mother's problems with drugs and mental illness.

Help me understand: A booklet to help children, young people and workers talk about an adult's alcohol and drug treatment. This booklet is suitable for children and young people who are affected by the alcohol or drug use of an adult in their life. It provides useful information to help start conversations with children and young people as well as helpful tools to capture information about the child's thoughts, feelings and needs.

Children aged 9 to 12 years

Children who are in middle childhood are more aware of what's happening around them than younger children. Consider this and give them relevant information. Ask them what they already know and then fill in the gaps. Stick to the facts and what you know is true. Use the child's words when talking with them.

Conversation ideas:

- So you said that Dad drinks beer. I am wondering if you can tell me everything you know about that. Thn I can help you understand things a bit better with what I know.
- Okay, so you said Dad starts drinking in the morning and is still drinking at night. I'm curious what that's like for you. If you did not see Dad drinking beer, how else would you know he has been drinking beer? What do you notice about the times Dad drinks beer from morning to night?
- Some people have had some worries about your dad drinking beer from morning to night. What do you think other people are worried about?
- If we look at all the important people in your life at home and outside of the home, I am wondering what worries they may have. I am also really keen to know if you have any worries.
- You are right, when people drink alcohol the way they think and act can change, depending on how much alcohol they drink. You mentioned that you've asked your dad to stop drinking and he hasn't. What do you think that is about?
- When people have talked about alcohol, have you ever heard someone say 'They are dependent on alcohol'? Is it okay if we talk a bit about this? I think it could really help you understand what is going on with your dad.

Resource you can use:

You are not on your own: a booklet to help children and adults talk about a parent's drinking is aimed at children aged 8 to 12 and has exercises for them to complete. It can also help you when talking to children. (Please note this booklet is from the United Kingdom and contains UK references.)

Young people aged 13 to 17 years

Young people need you to be honest and up-front about their parents' problematic AOD use. If they feel you are not being honest with them or are speaking down to them, they will quickly 'check out'. Glossing over things may lead to distrust. Try starting the conversation with what they know about their parents' substance use or how they have been experienced it.

Conversation ideas:

- Has your mum or dad ever talked to you about their alcohol or drug use? Do you remember you telling me about when dad was so drunk he fell over or when you thought mum was acting weird?
- You may have heard the word 'addict' or 'addiction'? These are not words we like to use, but some people do call it this. We call alcohol or drug dependence a disorder. It is when a person cannot control how much they drink or use, and it hurts them or the people they care about. It can feel like they cannot live without it. They have to have it at all costs.
- Someone who drinks or uses drugs may be more aggressive, or have mood swings. They may act in a way that is embarrassing to them or other people. When your mum or dad drinks or uses, how does it affect them / you / your siblings?
- A person can't cause another person to become dependent on drugs or alcohol, but sometimes it's hard for someone to accept they have a problem and they can blame others. You cannot make someone drink, use or stop. Have you ever felt blame for your mum's or dad's use of alcohol or drugs? Why do you feel so bad about it? What worries you the most about it?

Resource you can use:

- Parenting Positively—Helping teenagers to cope with A Parent's Problem Drug or Alcohol Use is a booklet for parents of teenagers who are affected by a parent's drug or alcohol use.

Useful tools for gathering and mapping historical information include:

- genograms, which provide a visual display of a child's family relationships and medical history
- chronologies, which provide a timeline of important events in a child's life and milestones achieved
- ecomaps, which provide a visual display of important relationships between a child, their family and their social network.

Related forms, templates and resources

The safety house

Resource 18 July 2019

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Resources

Information to help talk to children about their parents' alcohol and other drug use

Help me understand: A booklet to help children, young people and workers talk about an adult's alcohol and drug treatment is a printable booklet for children aged 10 to 14, designed to help you talk to them about their parent's treatment. (Please note this booklet is from the United Kingdom and contains UK references.)

Protection through participation: Involving children in child-safe organisation discusses great ways of talking with children to learn about safety and risk. It is produced by the CFCA (part of the Australian Institute of Family Studies).

You are not on your own: A booklet to help children and adults talk about a parent's drinking. (Please note this booklet is from the United Kingdom and contains UK references.)

Books to read with children or young people

- Centre for Addiction and Mental Health (2011), *Wishes And Worries: Coping with a Parent Who Drinks Too Much,* Tundra Books, Ontario. This book is a way to open a discussion between adult and child about alcoholism and parents.
- Eaton Heegaard, M (1996), *When a Family is in Trouble: Children Can Cope with Grieffrom Drug and Alcohol*, Woodland Press, Minnesota. This book gives parents, counsellors and others an approach to help children 6–12 understand and cope with the problems addicted families face.

- Hastings, JM and Typpo, MH (1984), *An Elephant In The Living Room,* Hazelden Publishing, Minnesota. This is an illustrated story to help children understand and cope with the problem of AOD in the family.

- Higgins PL (1994), *Up And Down The Mountain: Helping Children Cope with Parental Alcoholism,* Small Horizons, USA. This book begins on the day of Jenny's sixth grade graduation and she wonders if her alcoholic father will attend. The book shows children that their parents' alcoholism is not their fault.
- Jones, P (1983), *The Brown Bottle*, Hazelden Publishing, Minnesota. This is an illustrated fable explaining alcohol dependence to young children.

- Tidy, S (2009), *The Flying Dream*,NSW Department of Community Services. This is a children's book about children in foster care because of their mother's problems with drugs and mental illness.

Services and supports

Alateen is a fellowship of young Al-Anon members, usually teenagers, whose lives have been affected by someone else's drinking. Find out more about what helps children and a list of meetings in their local area.

Kids helpline (1800 55 1800) offers phone counselling for children and young people and resources for parents.

Research and further reading

Harry Ferguson, professor of social work at the University of Nottingham in the UK, has written a number of articles about the 'invisible child' in child protection work. These may be useful for group supervision discussions. You will need to sign up for a free account to access the articles.

Long-term foster care for abused and neglected children: How foster parents can help in healing the trauma has ideas about helping a child learn to regulate their feelings, raising self-esteem, helping a child gain a sense of control, and understanding regression.

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Page created

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Page created

Working with parents

Use this part to help you understand a parent's alcohol and other drug use and how it affects their behaviour and ability to keep their children safe, happy and healthy.

Seeing and understanding

Responding

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About this part

This part will help you:

- understand the role alcohol and other drug use plays in a parent's life
- see the way different ways drugs are used, how they affect a person, and the dangers they pose to children
- understand how women and men experience stigma, shame, treatment and recovery differently
- be an ally and give dignity to parents and families
- recognise and witness acts of protection
- meet parents where they are at and to help them move forward
- have balanced and robust conversations about alcohol and other drugs use, and partner with parents to create safety for children
- use solution-focused questions to help parents move towards change and recovery.

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Alcohol and other drug use and parenting

Drinking alcohol or using drugs does not make someone a 'bad' parent. Many Australian parents use alcohol and other drugs (AOD) in a low-risk way. Other parents use alcohol and other drugs more heavily and cope well, doing the best they can in difficult circumstances.

However, many families Child Safety works with can use AOD in a way that negatively affects their ability to parent and in some cases leads to a child being harmed. The effects of problematic AOD use can have immediate or lasting impacts on the child's safety, wellbeing, development and behaviour.

Further reading

Read about the ways a parent's AOD use can harm children in the Working with children section.

To understand the dangers and risk posed by a parent's AOD use, have up-front and frank conversations with parents. This involves looking at more than what and when they drink or use. Practitioners need to consider:

- the parent's story about how AOD has impacted their life
- how they have used AOD to cope and survive
- the triggers and reasons for their drinking or use—in the past and now
- what their current use, behaviours, patterns and lifestyle looks like
- how it impacts on their parenting and bond with their child
- how children feel and see their parent's AOD use
- options for treatment and recovery.

Keeping children at the centre of your work

A child is always at the centre of your relationship and work with a parent. Your ability to be curious will mean listening deeply and asking questions so you can understand a parent's story in more depth.

Note

> A parent's story informs your assessment of what a child needs and guides you to the right healing and recovery options. The more you understand their story, the easier it will be for you to confidently assess what a child needs from their parent and how able the parent will be to meet the child's needs.

Of everything Crystal Oertle remembers from the darkest days of her heroin addiction, the memories that haunt her the most, she says, involve her children. Crystal would leave her son at a skateboard park unattended for hours at a time while she made dope runs. On one of those occasions he was badly bitten by a dog and, bleeding, terrified, and alone, and was rushed to the hospital by a concerned stranger. Often Crystal met with her dealers with her toddler daughter in tow. And she drove high with both kids. 'I put them in danger many times'.

While this is a US-based story it is relevant to the Australian context.

(Crystal Oertle (2015) - *I was a heroin-addicted mom*).

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Page created

Collaborative assessment and planning with parents

In order to make a balanced and robust assessment, partner with parents to explore what is working well and has worked well in the past, and what the worries are in relation to their AOD use.

Understanding a parent's story, past and present, will help you and the parent learn about the cues and contexts that lead them to drink or use, and how these triggers can be addressed through healing and recovery interventions. It will also assist you in developing targeted safety plans so that specific actions can be taken by the parents and the safety and support network to address the situations that trigger a parent's AOD use.

What are we worried about?	What's working well?
Harm We have some worries about how AOD use is impacting on you and your family. Do you have any? Can we talk about that? What do you think Child Safety is most worried about in relation to your AOD use? I wonder what your child/ren might say, if they notice a difference when you are drinking/using drugs and when you're not. What do you think they would say? Sometimes children say they notice their parent is slurring, not able to help with lots of things like breakfast or getting to school, that they are more irritable or angry or tired. Things like that. Do you think your children would notice any of those things?	*Acts of protection* Do you do things to try to help your child/ren be okay when you are drinking/using drugs? When things are okay for you and you're in a good space, what's life like for you and for your children? Are they safer during these times? What makes you think that? When you have been able to better manage your AOD use, what are the positive impacts you see for your children? You have told me that you are more likely to use AOD when (example) is happening. Have there been times when those things have been happening and you could have (gotten smashed) but you didn't? What was that like? How did you do that? *Strengths and resources*

When you are using AOD a lot, and things are not going so well, what is going on for you and for your child/ren? How do your children see/experience your AOD use? *Complicating factors* What are the events/places/people that make you want to drink/use drugs more? How does AOD use impact on your relationship with your children? Do you think your children worry about you? How does AOD use impact on the way you live day to day? What is getting in the way of you making changes to your AOD use? What would be the hardest thing about making changes to you AOD use? What kinds of things get in the way of you managing your AOD use in a way you'd like?	Who or what has ever helped you reduce, stop or better manage your AOD use? Is there anyone who is supportive of you when things are tough and you are more likely to drink, use drugs more? How do they help? Do you have ways of managing AOD use so you feel better and more able to do all you need to, especially as a parent? What are the most positive parts of your relationship with your children? What are you most proud of about yourself as a parent to your children?
Current safety On a scale of 0–10 where 0 means that you are unable to keep your children safe as a result of AOD use and 10 means that your children are completely safe and not affected at all by AOD use, where would you put	**What needs to happen?** What do you think needs to happen to move up the scale? What additional help/support would move things up the scale?

things on the scale for you and your family right now? Where would your children put it? Where do you think Child Safety might put it? What do you think (other network members) might say? What has you scoring so high/low?	What do you think your children would say needs to happen? What do you think Child Safety would say needs to happen? What would be some first small steps? What help do you need to take this action/step? Through our discussion we have identified that AOD use costs a lot of money, makes you feel unwell, gets you into situations you don't like … but it also meets some of your needs. It [*numbs you/ gives you a rest from reality/ whatever parent described*]. Are you sure you are ready to make changes now? [*This is an optional question that acknowledges resistance and fear*].

Talking with a parent to understand the role AOD use has played in their life will help you learn how their use has changed over time. This will assist you in mapping the times when their AOD use has led to harm to their children, and other times when they have been able to create safety and protect their child. It will also help you to understand who and what has been an influence on this journey.

The Family Roadmap and the Future House Tool can assist you partner with parents in these conversations.

Revealing acts of protection, strengths and resources, and exceptions to harm

Understanding the road a parent has travelled, how they have coped and survived oppression, disadvantage, pain and trauma can help reveal other strengths and resources they have.

When you really acknowledge what a parent has been through and how far they have come, you can empower them. This can create an opportunity to talk about other ways they have coped, steps they may have already taken to reduce or stop using, times when they have

created safety for their children, and what and who has helped or hindered them through their life and now. These can be building blocks for creating achievable goals for change.

Related forms, templates and resources

The family roadmap

Resource 18 July 2019

The future house

Resource 18 July 2019

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Page created

Using alcohol and other drugs to cope and survive

Research is clear about the links between childhood trauma, pain, suffering, abuse and violence, and problematic AOD use.

A parent with problematic AOD use has likely experienced pain or suffering from their childhood or are currently experiencing pain from violence, neglect, sexual abuse, mental health, oppression, racism, disadvantage or poverty.

Seeing and understanding the challenges a parent has faced and how their experiences may have led to or maintain their AOD use is important. Helping parents make this connection and sharing this can be a catalyst for change.

When you help parents see their strengths, how they have used AOD to cope and survive, and the times when they have been able to create safety for their children, you give them courage to see themselves as a survivor.

Note

Drugs help numb the feelings, produce positive feelings that override the negative emotions. Some have been abused to such a degree that it is to obliterate having any feelings at all. For some, the secondary trauma of life since then, struggles with relationships and life on the streets, their inability to cope with daily life, is what then perpetuates the using.

(Service worker UNSW, 2010) Use and abuse: Understanding the intersections of childhood abuse, alcohol and drug use and mental health)

Watch

Watch Dr Gabor Mate's short video about the life experiences of people who are dependent on AOD use

Youtube video URL:
https://www.youtube.com/embed/T5sOh4gKPIg?enablejsapi=1&showinfo=0&rel=0

Video Caption:
What is Addiction?

Video transcript:

00:04

all the substances of abuse whether

00:07

they're opiates or cocaine or anything

00:09

else they're actually painkillers

00:11

some of them specifically are

00:12

painkillers but physical pain emotional

00:15

pain the suffering is experienced in the

00:16

same part of the brain so when people

00:19

suffer emotional rejection the same part

00:21

of the brain will light up as if you

00:22

stuck them with a knife

00:23

the neck are told this is very nicely

00:25

that addictions begin with pain and end

00:28

with pain so that all the addictions are

00:30

attempts to soothe the pain so when I

00:34

work with addictions the first question

00:36

is always not why the addiction but why

00:38

the pain and what you find is emotional

00:42

loss or trauma in the case of the severe

00:45

addicts as in the Downtown Eastside er

00:46

they were every single one of them

00:48

traumatized

00:49

there's no women's walk in the streets

00:51

here but not be sexually abused not

00:53

impacted but but but you know whether

00:55

it's a sex addiction or internet or

00:58

relationship or shopping or work

01:01

addiction these are all attempts to get

01:04

away from distress Keith Richards the

01:06

rolling stone guitars said who used to

01:10

have a severe heroin habit as you know

01:12

he said that all the contortions we go

01:16

through just not to be ourselves for a

01:18

few hours or why would somebody not want

01:22

to be themselves because they're in too

01:24

much distress in too much pain so I

01:26

don't care what they tell you about

01:27

genetics or any other choices and that

01:30

nonsense it's always about pain well the

01:33

tibetan book of living and dying it's

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got a wonderful line in it whatever you

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do don't try and escape from your pain

01:40

or be with it was the Reyes the attempt

01:44

to escape from pain is what creates more

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pain that's the reality of an addiction

01:49

but the question is how can people who

01:51

would their pain

01:53

well only if they sense some compassion

01:57

on somebody so as another teacher says

02:01

only when compassion is present well

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people love themselves see the truth so

02:07

I think that people need a compassionate

02:09

present which will permit them to

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experience their pain without having to

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run away from it and all the attempts to

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run away it's like another teacher says

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the surest way to go to hell is to try

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run away from hell

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so you've got to be with that pain you

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just have to be with it but you have to

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have some support and and we live in a

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society that one way or the other is

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always about instant relief quick

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satisfaction distraction in other words

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we live in a culture that is based on

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both economically and psychologically on

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not supporting people to be with

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themselves so it's always the quick

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getaway so it's very difficult to deal

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with the diction's in a society but yeah

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it is a matter of at some point finding

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a way of being with your pain so that

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you can actually get to know what it's

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you

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Living with alcohol and other drug use

A parent may hide, deny or minimise their alcohol and other drug use. They do so, not because they want to be deceitful or malicious, but in response to deep feelings of shame, fear, and worry. A parent may hide, deny or minimise:

- what they are using
- how much they use
- how much they spend to buy what they need
- where they buy drugs or alcohol
- who is with them when they use.

Look deeper to see what is getting in the way when a parent is unable or unwilling to be up-front and open about their AOD use.

Many parents hold some self-denial about their AOD use. This denial is one way to avoid the need to confront how problematic their AOD use has become. For many, the pain of acknowledging this, coupled with the fear of what will happen if they attempt to address their use, is overwhelming. Self-denial helps them keep things the way they are.

A parent may tell themselves:

- Life without alcohol and drugs is boring.
- I want to relive that first high. I know I'll find it again.
- Recovering means I'll be deprived and I'll suffer.
- I failed to stop many times before; this proves I can never stop.
- I have to hit rock bottom before I stop. I'm not at rock bottom yet.
- I am not suffering from drinking or doing drugs. It doesn't hurt me. It may hurt other people but I'm just fine.
- I drink and do drugs because of what I've been through as a child and what I've been through as an adult. I've had rotten luck and met bad people. It's not my fault.
- Everyone else drinks alcohol or uses drugs. I'm normal.

Tip

When working with a parent where AOD is a worry, solution-focused approaches with a parent can help:

create common goals
help them to see a future where their children are safe, and others (including Child Safety) can see the children are safe
can help avoid getting stuck in denial about what has happened in the past.

The way alcohol and other drug use takes control

When a parent has dependent AOD use it can consume every waking thought and feeling. Being intoxicated or managing the effects is only one way AOD permeates a parent's life. Much of their time, effort and emotion goes into having the money to buy what they need; and thinking about how they will get it, where they will use, using, coming down, coping and starting all over again.

Their child is often expected to fit around all of this, and the child's needs can increasingly go unmet by their parents.

The drug-use cycle

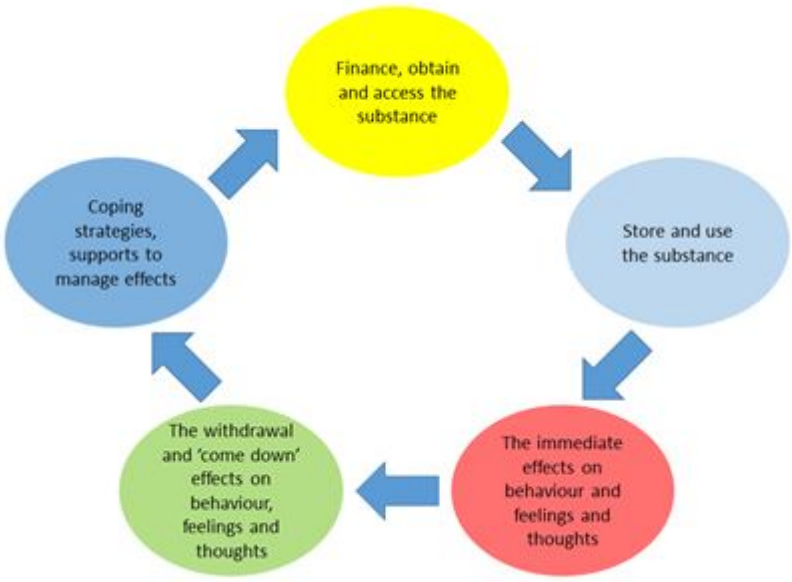

Image caption:
The drug use cycle

Dependence, intoxication and managing the effects

Dependence on AOD can occur over time for some people. Often, people are not concerned that they have increased the amount or frequency of their AOD use. A person who drinks alcohol may start drinking much more at social occasions or in concentrated periods of time ('binge drinking'). They may also start to drink more frequently and larger amounts. In this stage, it may not seem like a problem, but at some point, they need more of the alcohol or substance to get the effect that they are looking for or to feel like they can function.

To help understand a parent's use and dependance on AOD, ask a parent:

- What is it like when you use alcohol or other drugs?
- What is the best part of it?
- What is the worst part of it?
- How do you think your feelings and behaviours change?
- What would others notice?
- What is it like when the effects are diminishing?
- How long does it last?
- How do you cope with the physical and emotional reactions?

Withdrawal, relapse and lapse

Withdrawing from alcohol or drugs can be physically and emotionally painful. Withdrawal can make someone fixated on getting their next dose to alleviate their symptoms, or soothe themselves with prescription or other drug types to mask the effects of withdrawal.

For a parent, focusing on their child's needs might become more difficult. Parenting tasks might feel harder and they may become agitated and irritable and take it out on their child. Sudden withdrawal (completely stopping all AOD use at once) can also be risky for a parent's health, particulalry if they are dependant on a substance.

When parents use alcohol or drugs as a way of coping or surviving, withdrawing can bring deep feelings of pain and suffering back to the surface in a fierce and confronting way that they may not be ready for. This can lead to lapse or relapse or can stop a parent from taking that first step to recovery.

> **Tip**
>
> A relapse is when a person returns to previous levels of use of alcohol and/or drugs. A lapse is a brief return to use of alcohol and / or drugs.

Treatment and recovery can be a lifelong challenge, and lapse and relapse are seen as a normal part of the recovery process. Recovery involves changing the way someone thinks, feel and behaves. A relapse means that a parent may have returned to their unhelpful of ways of thinking, feeling and behaving.

Relapse is most often triggered by stressful or high risk situations or when the person is having trouble using positive coping strategies learned in recovery. Relapse does not mean treatment or recovery has failed, but it may be an indicator that a parent's treatment plan needs to be adjusted. The best ways to minimise relapse are to plan for it with parents, treatment providers and the safety and support network.

Further reading

Read more about relapse: Alcohol and Drug Foundation—What is relapse?

Mixing drugs

Mixing drugs, also known as polydrug or polysusbstance use, is when a parent may do any of the following:

- use two or more drugs at the same time
- use one drug to counteract the effects of another
- use prescription medication and illicit drugs at the same time
- use different drugs at different times over a short period of days or weeks.

A person may mix drugs for different reasons, such as:

- to increase the effect of another drug or to bring on its desired effects
- to try and reduce the negative effects of a drug, usually when coming down from that drug
- to substitute for the drug they were really looking for—the next best thing
- because it seemed like a good idea at the time.

Sometimes people who are trying to cut down their use of one drug find they start to use more of another drug to help manage withdrawal symptoms.

What happens when a parent mixes drugs?

It is not always possible to predict the exact effects of a single drug or a single dose of a drug. Everyone is affected by drugs differently. The same person can even use the same amount of the same drug on different occasions and have different effects each time.

Note

When a person mixes drugs, the impact on the person depends on:

the drug itself—its purity, amount used, frequency of use, how the drug is used, whether the drug has been cut or mixed with another drug or something else
the person who is using the drug—their mood, expectations, personality and individual characteristics
the setting—where the person is and the people they are with.

Combining drugs that have the same physical effects (two or more stimulants or two or more depressants) is especially dangerous. It increases the impact on the normal functioning of the brain and body.

Mixing drugs can:

- affect the body by increasing heart rate, blood pressure and body temperature
- increase the likelihood of increased emotional and mental disturbances, such as panic attacks and paranoia.

When the same drug types are mixed, the risk of accidents, overdose and death significantly increases. In fact, most fatal overdoses occur when there is polydrug use. Read more about polydrug use at the Australian Department of Health's website and at the Australian Indigenous Health Infonet.

What it means for children

Most studies of AOD use focus on the individual person and their use. However, problematic AOD use and dependent AOD use is affected by and affects all family members. Children are particularly vulnerable.

Polydrug use amplifies the child's experience of unpredictable caregiving. For example, when a parent uses amphetamines, a child may experience them being overly attentive, chaotic or excitable. A parent may then use cannabis or benzodiazepines to manage the after-effects of the use or withdrawal symptoms. The child may then experience their parent as drowsy, unmotivated and less attentive.

Prescription shopping

Dependence on prescription drugs is a rising problem in Australia. Child Safety can become worried when a parent develops a dependence on prescription drugs, sells prescription drugs or their parenting ability is impacted by prescription drugs. A person may be prescribed medication by a doctor to address a medical issue and over time, can develop a dependence on the drug.

When a person visits several doctors and chemists with the aim of getting prescription drugs in quantities greater than their therapeutic need, this is called ‘prescription shopping’ or 'doctor shopping'. The drugs may be for personal use or sold to others.

The two classes of prescription drugs most often associated with dependency are benzodiazepines (often used as tranquilisers and sleeping pills) and opioids (often used for pain relief). Other drugs that have potential to be misused include stimulants such as ephedrine, amphetamine and appetite suppressants such as phentermine.

Practice prompt

Ask parents to explain what medication they are taking, for what purpose, and what impact this medication has on them and their role as a parent. If required, seek additional information from their GP or health practitioner in relation to the prescriptions they are using and the illness/conditions for which they are taking them.

Accidental deaths and overdose

An overdose occurs when there is an excessive amount of one or more drugs in the body and it cannot cope. A person can overdose from alcohol (through alcohol poisoning), illicit substances or prescription medications.

An overdose is not always fatal, but deaths by drug overdose claim an extraordinary number of lives in Australia. In 2016, there were 1704 accidental drug-related deaths. Accidental drug-related deaths exceeded the national road toll, which was 1331 in 2016. Such deaths are more likely to occur in regional and rural areas than in capital cities. Western Australia has the highest rates per capita followed by New South Wales, Victoria and Queensland (Pennington Institute, 2018).

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How parents use drugs

Learning more about how a parent uses drugs helps practitioners understand how the child is vulnerable to harm from their parent's problematic substance use. A parent may tell you they smoke or inject heroin; however, practitioners need to really understand how a child sees and experiences this.

Method of drug use:	The child's experience:
Smoking—Parents who smoke drugs inhale the smoke or fumes through a cigarette or pipe, or inhale fumes from a substance that is heated on aluminium foil (such as heroin).	Is the child watching their parent prepare and smoke drugs? What do they smell and breathe in? Is the child sleeping or playing in the same room where parents are smoking?
Snorting—Parents who snort drugs chop the drug into a fine powder first. They may use a razor blade to cut the drug on a mirror or other hard surface. The powder is then divided into 'lines' and snorted using rolled-up paper or a straw.	Are razor blades left in easy reach of the child? Are there drugs or drug residue left on tables and household items?
Injecting—Parents who inject drugs dissolve the drug in water or heat it in a 'cooker' so it is ready to inject. A cooker could be a spoon, a bottle cap or some tin foil. Needles may be reused and shared with others. People inject into veins or just under the skin. To hide needle marks, they may inject between toes or in the groin area. Sometimes people are not able inject themselves and get others to inject them.	Is a child breathing in the fumes when a parent cooks drugs? Are they seeing their parent heating or injecting drugs? Are needles and cookers left within reach of the child or for the child to pick up, stand on or crawl on?
Inhaling—People who use inhalants breathe them in through the mouth (huffing) or through the nose in various ways, such as:	Are children breathing in the fumes or copying their parents by huffing with everyday household products?

Method of drug use:	The child's experience:
• sniffing or snorting fumes from a container or dispenser, such as a glue bottle or a marker pen • spraying aerosols, such as computer cleaning dusters, directly into the nose or mouth • 'huffing' from a chemical-soaked rag in the mouth • sniffing or inhaling fumes from chemicals sprayed or put inside a plastic or paper bag ('bagging') • inhaling from balloons filled with nitrous oxide (often called laughing gas). Although the high that inhalants produce usually lasts just a few minutes, people often try to make it last by inhaling continuously over several hours.	Are aerosol cans, glue bottles or marker pens left within reach of the child?
Manufacturing—Meth labs can be created in a house, garage or outdoors area, or created in smaller area using an esky or trunk. No matter where the lab is set up, it is dangerous. Explosions and fires are common. People can get painful chemical burns if there is an explosion, or blisters on their lungs if they inhale the fumes while meth is cooking. Once cooking is done, there is a lot of toxic waste left over. Some of the odours related to a meth lab have been described as smelling like lighter fluid, ether, ammonia, auto	Is a child living, sleeping or playing near a meth lab that could explode? Are they living, sleeping or playing near harmful fumes? Do they have access to the dangerous chemicals used in meth labs?

Method of drug use:	The child's experience:
parts cleaner and rotten eggs.	

What you need to talk about

Practitioners need to have conversations with parents about the way they use drugs. The following points provide some example questions:

Types of drugs

- What drugs do you usually use? How often do you use each of those substances?
- How do you take the different drugs you use?
- What implements or items do you need to use them like that?

How and where they use

- Where do you usually take drugs? Who is around you?
- Where were you the last time you took drugs? Where were the children?
- When you take them like that, if your child was to walk in, what would they see or smell?
- Are there usually strong smells or fumes in the home?

Storage of alcohol and drugs

- Where do you store your drugs and paraphernalia—at home, in the car, in your bag, or somewhere else?
- What happens after you have taken drugs—would there be any bits left over on the table or elsewhere?
- Would there ever be needles, razor blades, cooking equipment or anything like that left out?
- How do you ensure that the children can't access the drugs or equipment?
- When you have finished with needles, spoons or cookers, how do you get rid of them or where do you throw them out?

Dangers of meth labs

- Do you know the dangers for children being around a meth lab or other dangerous fumes from drug use?

Talk to the parent about any observations you have of their appearance or home that may indicate drug use to further understand what and how they use. For example, physical signs such as track marks or skin sores that may be from drug use, or needles or mirrors with razor blades observed in the home.

Attention

Children living, sleeping or playing near a meth lab are at extremely high risk of poisoning, accidental deaths and burns due to home-based methamphetamine lab fires and explosions. They are also exposed to the highly psychoactive (mind-altering) stimulants and the toxic chemicals that come from methamphetamine production.

Further reading

Read more about the ways people take drugs.

See images of various drug paraphernalia used to sell or take drugs.

Read about the signs and symptoms for different drug types.

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Leaning in as an ally to help parents engage

Alcohol and other drug use affects how parents work with Child Safety and other supports. This leads to people describing or labelling parents by their behaviour, using words like:

- unwilling
- disengaged
- lacking insight
- resistant.

Rather than defining parents in this way, try to look beyond their behaviour and understand why they are responding in this way. Some of the obvious ways AOD may affect a parent's engagement are:

- their intoxication or withdrawal at different times
- whether AOD is experienced alongside domestic violence, mental health concerns or other worries
- stigma, shame, judgement or oppression.

These factors can have a big impact on the parent's ability to:

- talk, behave, feel and think
- understand what is happening
- acknowledge the problem and seek treatment
- remain in treatment and sustain changes.

Attention

Domestic and family violence can exacerbate or contribute to a parent's alcohol and other drug use, and interfere with a parent's recovery efforts. Applying a Safe and Together lens to a family where AOD seems like the biggest worry can bring to light domestic and family violence concerns that were not previously considered.

Talking with a parent about their AOD use and the underlying reasons for it becoming a problem is likely to trigger many emotions for them. Your compassion and curiosity are important.

What gets in the way	What to say

What gets in the way	What to say
Being overwhelmed by the idea of reducing or stopping AOD use. The thought of reducing or stopping their use of AOD can be extremely overwhelming. It can increase their stress, fear and worry, which in turn makes them want to use.	How does the idea of cutting back or stopping your use make you feel or think? What worries you the most? What might be the good things about stopping?
Stigma and shame. The stigma of Child Safety being involved in their life alongside the stigma of being labelled a parent who is a drug user causes shame, which can stop parents from talking with you.	What are your thoughts and feelings about me being here today? How does it add to pressure for you? Some parents have told me it makes them feel like a bad parent or ashamed—can you relate to this?
Own childhood experiences. Because of a parent's own childhood experiences, their ideas, values and beliefs about what is normal AOD use and what is not may differ to yours.	Lots of parents I work with have grown up with AOD use in their lives and this has been 'normal' for them. Some parents find it hard to understand why I'm here talking about their kids, when they grew up in the same way. Can you relate to that?
Different perspectives about child safety and harm. Parents may hold a different perspective about whether or not their AOD use impacts on their parenting or their child.	I think the thing we can agree on is that you love [*child*] and you would never want to intentionally hurt them. Having me here today talking with you about whether [*child*] is safe and how your AOD use might be affecting them must be confronting and frightening. We do not need to agree on everything and it is likely that we won't always. But what we do need to agree on is that the safety of [*child*] will be the number one thing we have to be real about. I'm always up-front with you if there is a problem and if [*child*] is not safe. I need you to be up-front about what

What gets in the way	What to say
	you think and what you are prepared to do. Can we agree on that?

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Alcohol and other drug use, homelessness and family and domestic violence

Alcohol and drug use is frequently linked with domestic and family violence, for perpetrators and victims alike. The Australian Institute of Health and Welfare (AIHW) explored the degree to which AOD and homelessness overlap for people living through family and domestic violence (AIHW, 2018). AIHW identified almost 40,000 clients who used both alcohol and other drug treatment services and specialist homelessness services (SHS). As shown in the following figure, more than 13,000 clients reported experiencing family and domestic violence.

Of these clients, 73% were female and 27% male. One-third (33%) of the female clients and nearly one-third (31%) of the male clients were Indigenous. Nearly two in five (37%) were living alone and only one in fourteen (7%) was employed. (AIHW, 2018).

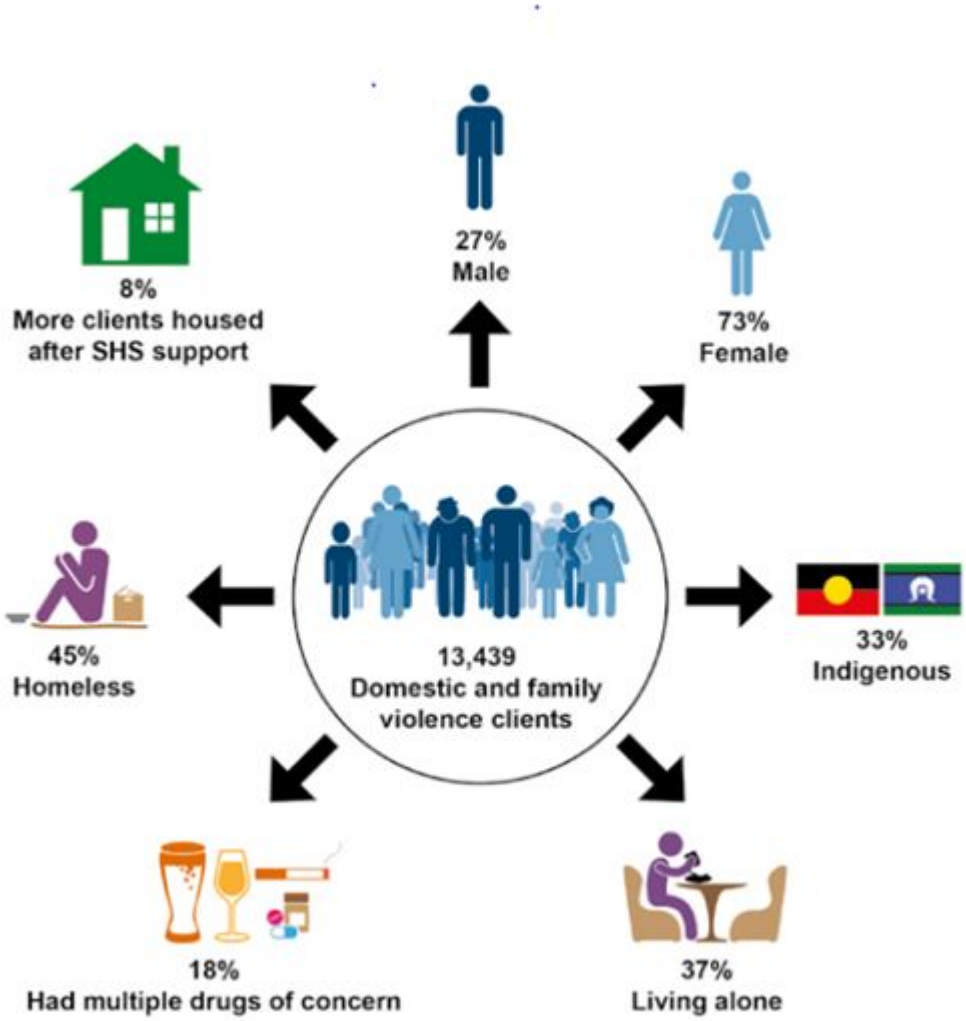

Image caption:

Characteristics of clients who experienced domestic and family violence and used both alcohol and drug treatment and homelessness services, 2011-12 to 2013-14 (AIHW, 2016).

⚠ Attention

Refer to the practice kit Domestic and family violence to broaden your understanding of the Safe and Together model, and to learn how to effectively partner with mothers experiencing domestic and family violence (DFV). Plan to safely talk with mothers about DFV when talking with them about AOD use. While DFV may not seem apparent at first, a mother and her children may be living with DFV which can continue to go unaddressed if all interventions are focused on a mother's AOD use only.

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Gender makes a difference

Gender shapes the different ways women and men access, consume and become dependent on AOD. Gender is also the dominant lens through which problematic AOD use is judged in society. Men and women:

- are initiated to AOD use differently
- often develop a dependence for different reasons
- will be affected by drugs differently and be drawn to different drugs
- experience stigma and shame differently
- have different vulnerabilities and risks related to their dependence.

It is important that you understand the different ways women and men experience AOD use and what it means for your work with each parent.

> *'When we experience being the subject of power, abuses of power, oppression, or attacks on our dignity we accept allies because we need them, not because it is safe or because we have reasons for perfect trust. Ally work requires humility and a resistance to righteousness, alongside the skill and moral courage required to name abuses of power from people within the same groups allies belong to.'*
>
> Reynolds, V (2013).

Working with women

Understanding how AOD dependence influences women, how they are perceived and what it means for them as mothers guides the way practitioners support them in seeking treatment and recovering. Here's what we know about women and problematic AOD use:

Accessing treatment for alcohol and other drugs

- Women access AOD treatment at lower rates than men and are under-represented in the drug and alcohol treatment system.
- Women are more likely than men to face multiple barriers to accessing substance abuse treatment and are less likely to seek treatment.
- A range of issues creates barriers for women's access to AOD services, including social stigma, discrimination, experiences of trauma, childcare and child custody concerns, and financial issues (Taylor, 2010).

Alcohol and other drugs and mental health

- Women who use AOD have a higher prevalence of co-occurring mental health issues such as mood disorders, anxiety, post-traumatic stress and eating disorders than men (Covington, 2008). Affective disorders such as major depression are associated with poorer treatment outcomes and higher rates of relapse.
- Some mental health conditions may go undetected and women may self-medicate rather than seek professional help.
- Women may perceive issues as being related to their mental health rather than AOD use and focus on seeking psychiatric help rather than AOD treatment.
- Women tend to seek care in mental health or primary care settings rather than in specialised treatment programs, which may contribute to poorer treatment outcomes.
- On entering AOD treatment, women present with higher rates of mental health issues, experience of complex trauma as a result of childhood physical and sexual abuse or domestic and family violence, AOD-related risk taking, pregnancy and childcare issues, and greater social and economic disadvantage (Alcohol and Drug Foundation Insights, 2018).

Alcohol and other drugs use and relationships

- Personal relationships and family history appear to be more significant influences on women's initiation, pattern of use, and continuation of problematic alcohol and drug use than they are for men. For example, women with alcohol and drug problems appear more likely than men to have been raised in a family environment of heavy drinking or problematic drug use (Center for Substance Abuse Treatment, 2009).
- Women with problematic AOD use are more likely to have intimate partners who are substance users (Brady & Ashley, 2005) and appear more likely to report that they have family, friends or partners who use drugs or who support their continued substance use (Greenfield et al. 2007).
- Situations and conditions such as having a stressful marriage and being pressured to use drugs by sexual partners have been found to significantly affect women's post-treatment relapse to alcohol use (Grella, 2008).
- Low socio-economic status and income inequality are often linked to poor health and wellbeing and have been associated with serious drug-related harms including foetal alcohol syndrome, alcohol-related deaths and drug overdoses (Spooner & Hetherington, 2004, SAMSHA, 2009).

How women experience stigma and shame

Stigma is a concern for parents and their children, and women with problematic AOD use face significant social stigma and discrimination in relation to pregnancy and parenting.

Along with the barriers posed by family responsibilities or lack of childcare options, if mothers seek treatment, the stigma of being a mother who uses substances and the fear of

losing custody of children are significant obstacles to treatment entry and engagement (Greenfield et al. 2007).

Typical social roles and cultural expectations placed upon women result in very specific stigma and stereotyping about their AOD use. For example, women often assume, or are expected to assume, caregiving roles in their relationships as mother, partner and daughter. Child protection practice has historically reinforced this by expecting mothers to carry the burden of keeping their child safe, even if they are not the person displaying the concerning behaviour. For example, when there is domestic violence, mothers are often expected to protect the child from their partner's violent behaviour.

A mother with problematic AOD use is frequently stereotyped negatively and viewed as a failure. This stigma and shame makes it harder for a mother to seek treatment and stay drug or alcohol free. Women with children, particularly single mothers, who do enter treatment face further stigma or challenges. These include:

- not being able to secure childcare long enough for inpatient stays
- being too worried to leave their child with their partner because of his violence
- transport and childcare difficulties in attending community programs
- the likelihood of their child coming into care either for a short or long period and having reunification dependent upon the mother showing abstinence for a significant period of time.

All of these issues mean women are likely to hide, deny and minimise their dependence and postpone seeking help.

> *'Stigma for women who use any licit or illicit drugs is more severe than for men because of women's 'place' in society.'*
>
> (Shimmin, 2009).

Isolation, dependence and delay in treatment

Many women with problematic AOD use feel they cannot support themselves and their child without relying on a partner. Their AOD use, finances and day-to-day life feel overwhelming on their own. Experiencies of domestic and family violence and mental health complicate this further.

Women with problematic AOD use:

- can be isolated and rely on their partner for physical and emotional support and drug dependence
- are likely to have a limited support network through treatment and early recovery, especially if their partner continues to use substances

- may have a partner sabotage their treatment efforts by threats of abandonment, withdrawal of financial support and manipulation of the woman's feelings—particularly guilt and shame
- face social isolation and financial dependency, which can leave them vulnerable to entering impulsive and self-sabotaging relationships while in treatment and early recovery.

Women with children often report a delay in seeking treatment because they are worried about the social consequences, which are generally more rigid than for men who are parents. For example, it is less socially acceptable for women to leave their children for long periods, and even treatment stays can be perceived as periods of 'abandonment'. Overall, mothers are more likely to have remained intricately involved in their children's lives as primary caregivers, despite their dependence, than fathers who have problematic AOD use have.

The mother and child relationship

Problematic AOD use compromises parenting and parenting tasks; however, it also has major consequences for the parent and child relationship.

Often a mother is the primary carer and the source of attachment for a child. When this is compromised, a child may not feel loved, secure or nurtured by their mother because she:

- may not see, respond to or empathise with the child's cues for attention and care
- may not be emotionally or physically available when her child needs her
- may be erratic and inconsistent in meeting her child's needs and in the way she interacts with them
- may not be able to provide a consistent routine so the child learns predictability and feels secure
- may be the person a child loves but also the person hurting the child.

Some women you work with may develop or be coerced into relationships with men who are not the father of their child. If AOD use is a feature of this partnership, it can quickly dominate their life and priorities.

If a mother's AOD use compromises the bonding and attachment with her child, she will be less likely to see, empathise with and respond to safety concerns that others (such as a new partner) may pose. Read more about bonding and attachment in Risk assessment.

How women use alcohol and other drugs to cope and survive

Women are more likely than men to identify relationship issues as a cause for their problematic AOD use. Women in treatment have much higher rates of domestic violence experience than women in the general community (Greenfield 2010).

Women who have been abused are 15 times more likely to abuse alcohol and 9 times more likely to abuse drugs than women who have not been abused. Problematic AOD use may lead to sexual re-victimisation in adulthood as a result of related and contextual individual, interpersonal, community and social factors (Stathopoulos, 2014).

Practice prompt

AOD may become a woman's way to cope with out-of-control feelings and memories, overwhelming emotions, shame and stigma, and physical pain and injury. If AOD has been a way a woman survives and copes, it is important to recognise, validate and acknowledge her strength and courage in overcoming and surviving as best she can. Be sure to witness strength and resilience when she shares her stories.

The ways alcohol and other drug use and domestic violence become enmeshed for women include the following:

- AOD use:
    - may become a barrier to leave her partner who is violent
    - can influence a woman's assessment of the level of danger posed by her partner
    - may make it harder to recognise the cues a child gives her about their safety
    - may make it harder to follow through on safety plans
    - can be encouraged or forced on a woman as a way in which her partner controls her
    - may exclude her from support services that she desperately needs for refuge, advocacy or other assistance
- her efforts at recovery and abstinence may be sabotaged by her partner
- the compulsion to use and the withdrawal symptoms may make it harder for women to access, seek or stay in a refuge
- she may find that the stress of securing safety for her and her children leads to relapse
- if she has used substances in the past or currently uses, she may fear her experience of violence won't be believed
- she may worry about calling the QPS after a violent incident, possibly due to shame or memory loss
- she may fear the QPS and even her own family won't believe her or take her seriously.

Attention

A woman's alcohol and other drug use never makes her responsible for experiencing domestic and family violence.

Working with men

With regards to men and problematic AOD use, we know:

- Men have higher rates of use or dependence on illicit drugs and alcohol than women do (Traumatic Episode Data Set, 2012).
- Men are three times more likely than women to be frequent drugs users.
- Men are more likely than women to use almost all types of illicit drugs (SAMHSA, 2014), and illicit drug use is more likely to result in emergency department visits or overdose deaths for men than it is for women.
- It is very common for men to try to mask or block out the symptoms of depression or anxiety by using alcohol or other drugs.

'The higher rates of drug use we see among men compound a gender disadvantage we have from birth. We get into accidents more regularly, we have more unhealthy lifestyles, we die earlier, we have less insight into our health and wellbeing. We're generally predisposed to engage in a whole bunch of risky behaviours while being physiologically less equipped to deal with them.'

(Winstock, 2014).

How men experience stigma and shame

Women and men are socialised to have different roles and attributes within the community, home and family. Cultural and Indigenous backgrounds may also influence these roles. Values about men's roles shape:

- the way they are initiated to AOD use
- the reasons they develop problematic AOD use
- their ability and willingness to talk about their AOD use
- their ability and willingness to seek and sustain help and recovery.

Initiation

Men are often initiated into AOD use as a way to prove masculinity and as part of celebrations. For example, reaching adult age is sometimes celebrated through excessive drinking, as are job promotions, becoming a father and sports victories. Drinking can mask the real need for connection and communication between men.

To prove their masculinity, some men engage in reckless behaviours, binge drinking and use of illegal drugs. The desire to take risks and the need to avoid showing weakness can affect men's beliefs and behaviours.

When they have grown up with trauma, abuse or neglect, they may be unlikely to talk about their experiences for fear of being seen as weak. If it is unacceptable to talk about emotions and share experiences without fear of losing masculinity, these emotions can manifest into anger and remain unresolved.

Shame and stigma

Men who are affected by dependence can experience shame and stigma for being ‘weak’. They believe ‘real’ men are supposed to be successful leaders, physically and emotionally strong, and capable of handling everything and anything. These beliefs can stop a man from talking about his AOD use and the reasons that have led to it.

The beliefs may also encourage a man to deny, minimise or hide his AOD use from practitioners and other supports. Men experiencing AOD dependence are likely to say that they can handle the problem on their own—and use this as a reason for not seeking treatment. Seeking treatment itself may seem to be a threat to their masculinity. Men often also have concerns about privacy and may need your added reassurance about confidentiality.

Self-sufficiency

A need to be self-sufficient may also result in a false sense of accomplishment or security in their recovery, which may become an unwillingness to follow through with recovery supports. A man may say, ‘I don’t need it’, ‘I don’t need help,’ ‘I can do it’, or ‘I’ve done it’.

Men may resent being told what to do, which means suggestions may need to be reframed in ways that help men to see the choices they have within what needs to be done. For change to begin, we need to find ways of reducing the stigma and shame of weakness men feel because of their AOD use.

The father and child relationship

Many men you work with may have grown up with authoritarian, or even abusive parenting, with little encouragement to show their emotions because ‘boys who cry are weak’. This style of parenting is what they know. Their AOD use may exacerbate this or they may be shocked you are worried about their parenting.

Even in the midst of chronic substance abuse, a positive father-child relationship can help buffer some effects for children. Often bonding and attachment is focused on the mother and child relationship; however, in your work, you will need to spend time seeing and understanding the child-father relationship, no matter what role the father plays.

Tip

Understand and acknowledge a man's identity and role as a father as a way of engaging him to talk about his hopes, and the things that get in the way of him being the father he wants to be.

Talk with men about what their father was like and their ideas on the father they would like to be - these conversations can be cornerstones for change. Help them connect with their role as a father and partner. Talk with them about:

- the wellbeing of their children
- their role in having a close, responsive relationship with their children
- their emotional and practical support to their partners
- contributing financially to the family's welfare.

Note

Children benefit from a safe, reliable and nurturing relationship with their father. However, there may be times when this type of relationship is not practical or safe for the child. Ongoing AOD use, past or present domestic violence, allegations of child abuse, and ongoing involvement in criminal activity may raise concerns about promoting this relationship if it is harmful to children or women.

Men who use violence

Problematic drug or alcohol use is never an excuse for violence. Although men who use violence may be abusive more often or cause worse injuries to mothers and children when they drink or use drugs, the substances themselves are not the cause of the abuse and violence. Men are responsible for the actions they take.

One in 6 Australian women have been subjected, since the age of 15, to physical and/or sexual violence by a current or previous cohabiting partner. Family, domestic and sexual violence happens repeatedly—more than half (54%) of the women who had experienced current partner violence, experienced more than one violent incident (Australian Bureau of Statistics, 2017b). However, between 2005 and 2016, rates of partner violence against women have remained relatively stable (ABS 2006, 2017b).

In 2014–15, on average, almost 8 women and 2 men were hospitalised each day after being assaulted by their spouse or partner (Australian Institute of Health and Welfare, 2017b).

From 2012–13 to 2013–14, about 1 woman a week and 1 man a month were killed as a result of violence from a current or previous partner (Bryant & Bricknell, 2017; Australian Institute of Health and Welfare, 2018),

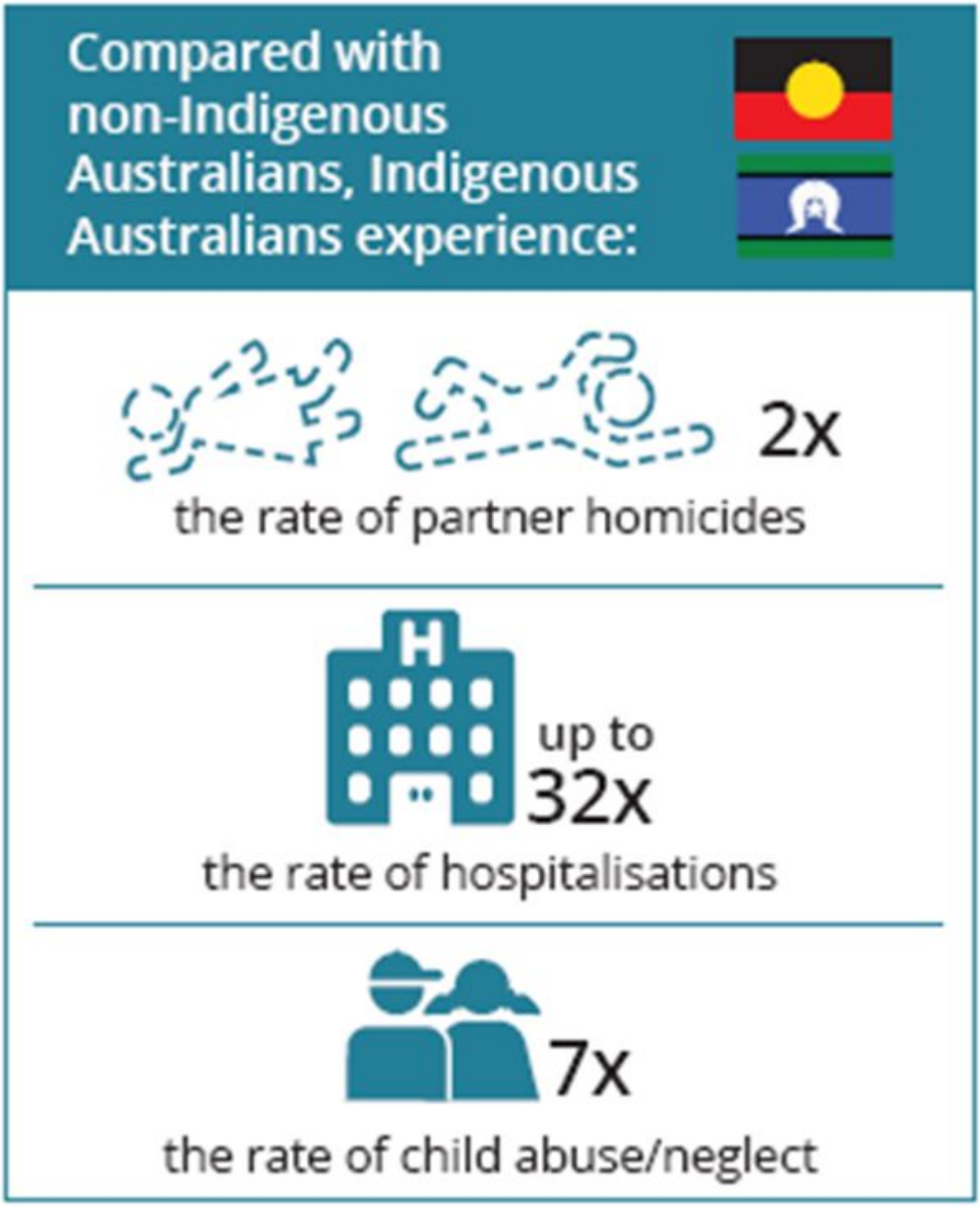

Image caption:

Comparison on rates of partner homicides, hospitalisations and child abuse/neglect between indigenous and non-indigenous Australians.

Source: Family, domestic and sexual violence in Australia, 2018

Men with problematic AOD use who use violence need to access both domestic violence and AOD treatment and supports. When AOD treatment and recovery is occurring can be a risky period where violence may increase. Addressing AOD use on its own will not solve or stop a man using violence towards women and children.

Further reading

Practice kit Domestic and Family Violence

Anger

Anger is a common problem for men with a dependency on AOD, and it can be exacerbated by the stress of the early recovery stage. Because of men's socialisation, anger is often used to cover up other emotions that are uncomfortable to express such as fear, grief and sadness. It is helpful to think about any hostile or aggressive behaviours shown towards you and other professionals as a response to their anxiety or fear.

Attention

Understand the difference between anger management and domestic and family violence in your work with men. Domestic and family violence cannot be addressed by anger management interventions.

How men use alcohol and other drugs to cope and survive

Men who have problematic AOD use may have their own stories of coping and survival. Do not define men by stereotypes of masculinity or deny them the opportunity to tell their story. Ask men:

- how they have coped and survived
- how they have learned the values and skills they have
- about the role AOD use plays for them.

When men do not talk about their feelings, or if they see past abuse, neglect, pain and suffering as a weakness or failure as a man, AOD use can become a way they ‘stay in control’. Help them redefine their ideas of masculinity or ‘failings’ as men by helping them name resistance and survival techniques they have used. For example, you could say 'So, you feel weak because you did not speak about your mum’s boyfriend abusing you. You said you were worried he would kick your family out. That sounds like an incredibly strong young man to me. A young man who, despite being so badly hurt, was trying to protect his mother and sisters and keep a roof over their heads'.

Note

The Acts and stories of resistance video by Murisi Mtsvanga-Moyo tells the stories of resistance from men whose lives have been under the influence of drugs and alcohol. The video seeks to capture and magnify acts of resistance that these men have taken or are constantly taking.

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Respectful and curious engagement

Every parent is a person in their own right. Every parent has things they hold close, value and want for their life.

Social justice, ethical practice and the Framework for Practice principles guide our work with parents with a focus on being fair, curious and respectful. This means seeing and talking with them in ways that make them feel they are more than the negative labels, assumptions and stereotypes. Every parent has their own unique story.

Use respectful and curious engagement, which means:

- taking the time to listen and really hear their story—understanding past or current pain and suffering, and helping them reveal their strengths and resilience
- wanting to know about who they are, how AOD use has taken hold of their life, and how you can help them overcome their problematic use and create safety for their child
- helping them find choices and have self-determination in pathways for treatment and recovery
- making sure everything you ask a parent to do has meaning and purpose (for example, don't ask parents to do drug screens for the sake of it)
- recognising errors in practice, ways that power and/or privilege have been misused or been oppressive, and responding to this, reflecting on it and repairing it
- advocating on their behalf, making sure they are not held back, oppressed, disadvantaged or shamed in your, your colleagues' or other professionals' practice.

Stigma and shame matter

Stigma and shame are some of the biggest barriers for families dealing with problematic AOD use. They can stop a parent and their child from opening up and talking about how AOD affects their lives, and can stop parents who need treatment and support from accessing or staying in treatment and recovery. Helping the parent focus on their health and sobriety, rather than dwelling on feelings of shame, is important.

The stigma and shame a parent feels during recovery can also take its emotional toll. Help them overcome this so it does not take control and derail their recovery. Connect them with support groups of other parents who have walked the same path to recovery. Alcoholics Anonymous Australia, Narcotics Anonymous Australia and SMART Recovery all have excellent resources for parents.

In following video by the New South Wales Users and Aids Association (NUAA), health professionals and people with problematic AOD use discuss how stigma and discrimination impacts on access to health services and day-to-day life.

Youtube video URL:

https://www.youtube.com/embed/SKFUuTzoPv8?enablejsapi=1&showinfo=0&rel=0

Video Caption:

New South Wales Users and Aids Association (NUAA) - Stigma and discrimination against people who use drugs illicitly

Video transcript:

stigma discrimination and paper-lined

00:09

drugs stigma is society's commonly-held

00:13

stereotype when it comes to people who

00:18

inject drugs

00:19

we're like junkies he might be

00:21

aggressive or untrustworthy

00:30

discrimination is the act of treating us

00:33

differently or not treating us at all

00:35

based on being seen as injecting drug

00:37

user whether we are or not a few years

00:41

ago a friend of mine had a dirty hit so

00:44

I decided to take it to the hospital

00:46

when we got there and told the staff

00:49

what was going on they were very

00:51

reluctant to help us in fact they didn't

00:54

give us any help and they left us

00:57

sitting there for hours in the end we

00:59

left went home and she had to get over

01:03

it by herself and I would not go back to

01:07

that hospital again a while ago I went

01:10

into the chemist to buy a foot pack

01:12

I knew exactly how much money I had I

01:14

had 10 bucks when I paid for the fit

01:16

back the guy gave me a change for a $5

01:19

note I said excuse me I gave you a 10 he

01:23

turned around to me and said why should

01:25

I believe you

01:26

look what you've just bought if you want

01:29

to come back tonight I'll check the till

01:30

if I'm over I'll give you your change

01:32

then I couldn't believe his attitude but

01:36

it's hard enough going in to the chemist

01:37

asking for a fit pack you feel pretty

01:39

small I argued with him and I got my

01:41

change but I never went back there again

01:44

to buy food packs recently a friend and

01:47

I went to a rather large Hospital he was

01:48

suffering really badly and in agony with

01:51

back pain and the doctors and nurses

01:53

were all very friendly until I found out

01:55

that it was actually a drug user and

01:57

their attitude to us changed instantly

01:59

they treated us like scum

02:00

they were very just awful

02:04

I'm here with sent away with no pain

02:06

relief at all not even a pen at all I

02:07

would never go back to that hospital

02:09

again I hope so um kind of a feedback

02:14

please sure just can I ask are you

02:19

diabetic no I'm not no I'm sorry we

02:24

don't do those

02:26

that's oranges what yes I'm afraid so

02:34

stigma is cyclical

02:36

we have labels and assumed behaviors to

02:38

go with them based on these we are

02:41

treated differently we may come to

02:43

believe we deserve mistreatment it is

02:45

internalized and we self stigmatize I'd

02:49

always got along really well with my

02:50

family

02:51

very close in fact my brother and two

02:54

sisters and I were very close in age we

02:57

work together socialized together but

03:01

when they became aware of my drug use

03:03

everything changed there was a massive

03:05

rift in the family I have not been to a

03:08

Christmas New Year anniversary

03:10

graduation for many years and I was

03:13

instructed to stay away from my nieces

03:15

and nephews you can imagine how

03:17

difficult that was

03:19

I felt alienated ashamed humiliated a

03:25

pariah I look forward to it maybe one

03:29

day being resolved

03:36

when we come to believe all slights or

03:39

any acts are based on our being and

03:41

injecting drug user we have what's

03:43

called micro aggression these might boil

03:50

over any clue react negatively with the

03:52

feel society's stereotypes of us lateral

04:03

violence occurs when marginalized groups

04:05

feel powerless we pushed these feelings

04:08

sideways and we compare ourselves to

04:10

others lateral violence is prevalent in

04:13

the drug-using community as in other

04:15

groups I've heard heroin users

04:18

describing ice users as scattered

04:21

aggressive ice users describe heroin

04:24

users as junkies when it comes to the

04:28

way you use it the smokers will suggest

04:30

that they above the injectors because

04:35

they even hit rock bottom the injectors

04:38

feel that the smokers are Clayton's

04:39

users because they're not getting the

04:41

most out of their product we're our own

04:45

worst enemy in the druggies in community

04:48

what can we do to challenge stigma and

04:50

discrimination

04:52

as people inject drugs we can be mindful

04:55

of the way we treat other people who use

04:58

drugs whether they inject or not we can

05:02

all think about the stereotypes that we

05:04

hold and the impact that our actions

05:07

have on other people who inject drugs

05:09

newer has a whole programme of ways we

05:12

can challenge stigma and discrimination

05:13

this includes strategies to address

05:15

stigma and discrimination and improve

05:18

people's lives this program is available

05:21

to those working in the healthcare

05:23

sector the general community and to

05:26

people inject drugs themselves visit WWE

05:32

you for more information

05:42

you

Stigma can affect a parent with problematic AOD use, as the parent:

- is less likely to seek help or treatment
- may experience high discrimination and feel abandoned, rejected or ashamed
- is more likely to quit treatment due to stigma and shame.

Stigma can influence how practitioners and other professionals see the parent with problematic AOD use. Parents may:

- be held in poorer regard compared to other parents
- be seen as not motivated
- not get enough professional or quality time because of avoidance
- have limited opportunity to recover because of the belief they can't change or are hopeless.

'Body language tells me they've already judged me before the session has even started.'

(AOD Provider Collaborative, 2014)

Guilt, remorse and shame are very raw emotions during the early recovery stage and can be gnawing, harmful and all-consuming emotions that creep into every aspect of family life. Once a parent has started to come down and intoxication wears off, they feel the shame, guilt and remorse and the heavy realisation that they are accountable for what has happened. These overwhelming feelings can be a trigger to use again.

This following three part video series produced by the Alcohol and Drug Foundation attempts to reduce the negativity, misunderstanding, stigma and shame surrounding problematic AOD use.

Youtube video URL: https://www.youtube.com/embed/sqME-o2SRcY?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Alcohol and drug foundation- Breaking the ice in our community: Jay Morris' story

Video transcript:

00:00

it's really important I feel that you

00:02

know we look beyond the person that you

00:05

see who's affected by drugs and realize

00:08

that you know I'm a person the person

00:12

that you have in your life that's using

00:14

is a person they have emotions they have

00:17

feelings they need help

00:21

I started using ice when I was 20 years

00:25

old I used it recreationally and formed

00:29

a habit over period of a couple of

00:31

months and it ended up spiralling into to

00:35

something that you know I couldn't

00:36

control and then went through a very

00:37

long and painful recovery period the

00:42

triggers for me that made me realize

00:44

crystal meth was a problem was I felt

00:47

through my addiction that you know I had

00:50

done everything wrong by hurting my

00:52

family like not in a violent way but you

00:56

can hurt people in other ways

00:57

emotionally mentally like lying to my

01:00

family stealing from my family all of

01:04

that stuff then I suppose bottled up

01:06

inside me to make me feel like what I

01:08

was doing which it wasn't wasn't Ryan

01:10

and that feeling of just loneliness

01:13

complete and utter loneliness was not

01:15

not worth it at all from recognizing

01:18

what their the issues were and those

01:20

being triggers it was a few things that

01:22

came together for me to realize I needed

01:24

help I was going out regularly to two

01:27

nightclubs and there was actually a

01:28

security guard who said to me that I

01:30

needed to go to rehab which was amazing

01:32

like it really to this day the fact that

01:35

somebody you know I get emotional with

01:38

it somebody actually put their hands out

01:39

and said you need help was a kick in the

01:41

ass you know like it really pushed me

01:43

along and that was the moment that I

01:45

realized you know yes I need to help yes

01:47

I need to move forward so as soon as I

01:50

got into a rehab facility I had a huge

01:53

impact with stigma and then going out

01:55

into the community it was like a

01:57

waterfall of stigma but it's important

02:00

to be strong enough to know that

02:02

recovery is possible and recovery is a

02:05

better life than then using so my

02:09

message for anybody out there using the

02:11

drug would be the first step is just

02:13

call someone and talk like admit you've

02:16

got a problem my life has changed

02:18

dramatically since recovering from

02:21

crystal meth I'm going to be studying in

02:24

social work giving back to everyone

02:26

who's given to me and my hopes for the

02:28

future is to see that you know the

02:30

stigma around drug addiction

02:32

ceases and that you know as a community

02:34

and as an individual we look at you know

02:37

the people in addiction as human beings

02:40

so it's really important to to recognize

02:43

that and give them support as people and

02:45

to look beyond the drugs my name is Jay

02:48

Morris I'm a recovering addict I'd like

02:51

you to see the person and not just the

02:53

drug

02:57

you

Youtube video URL:
https://www.youtube.com/embed/aVA3Pj6gBGk?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Alcohol and drug foundation- Debbie Warner: A mother struggling with her children's problematic AOD use

Video transcript:

00:00

he comes home and he's got blisters all

00:02

over his feet and he's got dirty clothes

00:05

on and he smells then I still hug him

00:07

and still say love you heaps so I don't

00:10

judge him at all because now

00:12

relationships are very very strong

00:17

I have five adult children and two of

00:20

them such have problems with drugs

00:24

they're all high achievers and one of

00:26

them specifically became sad to have

00:29

problems with crystal meth I think their

00:32

headlines around methamphetamine have

00:34

become out of control and quite negative

00:37

so then it makes it even more difficult

00:39

for people that have got problems using

00:42

the drug because then they become even

00:43

more isolated so you feel the shame the

00:46

stigma you feel you don't want anyone in

00:48

the community to know about it you try

00:50

and hide it away so you become quite

00:53

consumed I became very consumed with it

00:55

I was suffering from anxiety in the end

00:57

most families will feel guilt and shame

01:00

around the young person's drug use

01:03

because of society's views they'll go

01:06

back and look at what they did and think

01:09

this is why it's happening every parent

01:11

doesn't and it's really quite

01:14

destructive to do it because we can't

01:16

control what another person does and you

01:19

know my son's now better take

01:20

responsibility as an adult for his

01:22

decisions but at the same time you know

01:24

I'll continually support him I can

01:26

generally not judge him for his actions

01:29

I think it was important for me to watch

01:31

and understand his cycle because he

01:34

would know to stay awake for three days

01:35

I would put myself in his shoes and go I

01:38

couldn't imagine how bad I would feel

01:40

after three days of not sleeping and if

01:42

anybody asked me a question I would

01:43

probably snap at them as well once I

01:45

understood that it's like I became

01:47

educated around what the drug did I was

01:50

then able to get over my own anxiety and

01:53

because I did the best I called as a mum

01:56

so I started to go to support groups

01:58

what I started to learn was that was

02:01

really really important for me to build

02:03

on my relationship and stay connected

02:05

with him as much as I could the best

02:07

part about that was that I was able to

02:10

speak to someone that could identify

02:12

with what was what I was have been it's

02:14

really important that families straight

02:17

away have access to help because I feel

02:21

that that would be one hurdle that they

02:23

don't need to then overcome once they

02:26

they are ready to get change their

02:28

behavior my message to families

02:30

would be to stay connected with a person

02:32

that is using methamphetamines as much

02:34

as possible because it's the

02:36

relationship that you have with the

02:38

person that is the most important

02:40

families do have a huge influence over

02:42

the person that is using and you know

02:46

there is hope at the other end

02:48

my name is Debbie Warner and I would

02:50

like you to see the person not just the

02:52

drug

Youtube video URL: https://www.youtube.com/embed/ZwvVd-iLv-U?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Alcohol and drug foundation- Dr Suzie Hudson: Clinical Director at the Network of Alcohol and other Drug Agencies (NADA)

Video transcript:

00:00

so crystal methamphetamine itself is a

00:02

central nervous system stimulant and

00:04

when it's smoked which is how it's

00:06

usually used in this country it has a

00:08

very powerful effect it's absolutely a

00:10

drug that does not discriminate

00:14

the drug itself methamphetamine comes in

00:17

three forms the crystalline form is

00:19

obviously what we talk about a lot these

00:20

days

00:21

it really works on receptors dopamine

00:24

serotonin and noradrenaline and actually

00:27

blocks the reuptake if you like of these

00:29

naturally occurring chemicals meaning

00:31

that the body is then flooded leading to

00:34

that sense of euphoria and that's why we

00:36

see some of the behavior we see the drug

00:37

itself including alcohol have been very

00:40

much a part of our culture in Australia

00:42

and what that means is that crystal

00:44

methamphetamine is used by a wide range

00:47

of people in different circumstances I

00:49

spent over 12 months working with women

00:52

on the streets of King's Cross who were

00:55

injecting stimulant drugs including

00:57

crystal methamphetamine and what I saw

00:59

there was not only the impacts and harms

01:01

associated with these drugs but the

01:03

resilience and strength of the people

01:05

using them one of the biggest issues I

01:08

see with crystalline methamphetamine use

01:10

is the huge amount of stigma and

01:12

discrimination that's around this drug

01:14

so what you've been god is an isolation

01:17

of those who are experiencing

01:19

difficulties with this drug which keep

01:21

them away from treatment in fact what we

01:24

know from the statistics that overall in

01:27

terms the Australian population less

01:29

than 2 percent have used this drug in

01:32

the last year of that 2 percent 70% to

01:36

have useless than once a month

01:38

that other 30 percent are using more

01:40

regularly and absolutely it's that group

01:43

that we're looking to provide as much

01:45

treatment and support

01:46

we possibly can well I think the biggest

01:48

concern at the moment is really there's

01:50

no hope or no treatment that can be

01:52

provided which is just not the case what

01:55

we can be confident about is that there

01:57

was a range of extremely effective and

01:59

useful supports and treatments available

02:01

for those experiencing concerns around

02:03

crystal methamphetamine use and I would

02:05

encourage all those people that are

02:07

wanting support whether it's people who

02:09

use crystal methamphetamine all those

02:10

that are supporting them to reach out

02:12

for that persistence what we need to be

02:14

doing as a community is trying to

02:16

increase in confidence around the

02:18

treatment that is available does work is

02:21

effective and what I'd like to see is

02:23

that people are engaging more with the

02:25

human being not the being overwhelmed by

02:28

the drug itself so the real message is

02:31

to recognize that these are just people

02:33

these are our husbands our sisters our

02:36

children and that's why we need as a

02:39

community here to come together to

02:41

provide a solution

02:43

I'm dr. Susie Hudson I'm the clinical

02:45

director at nada and I want you to see

02:48

the person not just the drug

Reducing stigma and shame: Recognise, understand and appreciate difference

The shame and blame parents feel from their family, support networks, community and society can create self-doubt, feelings of defeat and hopelessness about change. Parents are likely to feel like you are also judging them just by the role you hold, even if you are practising with dignity and respect. What should you do?

Acknowledge it. It is helpful to acknowledge and talk with parents about how they feel about your role and that of others working with them, and how you can make things easier. Let parents know that you understand how complex their situation is. This is not condoning the problematic use but acknowledging their feelings, experiences and the struggle.

Use words that reduce it. The language you use when talking about a parent's problematic alcohol or other drug use matters. Seeing a parent simply as a drug user without understanding the context means that your assessment and case planning may miss the issue that needs the most attention.

Reduce it from others. Vulnerable children need you to challenge any negative opinions from family and from professionals about the parent's problematic use and the myths of dependence. This can help the family move forward and give parents hope that change is possible.

You should also:

- recognise that dependence on alcohol or other drugs is a treatable disorder
- learn about the unique story and experience each family has of their struggle with problematic AOD use
- think about the words you use with children, parents, professionals and the community- Are they reducing or perpetuating stigma and shame?
- help others reframe language and views that perpetuate stigma, bias, and assumptions about problematic AOD use

- use any opportunity you have to educate, share information, and help others to understand problematic AOD use
- build your knowledge and expertise about problematic AOD use
- consider how your own beliefs, values and attitudes may contribute to stigma and shame.

Source: AOD Provider Collaborative (2014) Reducing stigma towards AOD service users (Final report), NUAA

Tip

Reflect on the following questions during individual or group supervision with your senior team leader, senior practitioner or peers:

Do you have any negative beliefs, values, and attitudes about AOD use?
What are the outcomes you have had when working with other families with problematic AOD use?
How does this shape the way you see and feel about other families?
How have you seen, felt or observed someone's experience of problematic AOD use in your own life? What does this mean for how you feel and see it now?
What expertise and knowledge do you have about parents with problematic AOD use, treatment and recovery? Is there a gap?
How does your understanding of the complex issues that surround AOD use—such as childhood trauma, domestic and family violence and mental health—influence your practice?

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Language and alcohol and other drug use

The language you choose when you write and talk about problematic alcohol and other drug use matter to parents and their children. Your words are powerful and have consequences. They shape the way you and others feel, see, and think about problematic AOD use, treatment and recovery. Language also influences the attitudes, beliefs, and perceptions of the community and the professionals working with the parent who has problematic AOD use.

Words like 'junkie', 'druggie', and 'alco' and similar words project shame onto a person with problematic AOD use. When parents are described with negative labels, it condones the stereotypes and spreads misinformation. This can trigger a punitive, judgemental, and uncaring response from family, community, and professionals. These and other similar words are not the language that Child Safety uses.

Note

A parent with problematic alcohol and other drug use who does not stop or give up their use for their child triggers the most shame and stigma from community and professionals. Yet the reality is dependence is not a choice. It is a chronic disorder similar to diabetes, heart conditions or arthritis. It needs to be treated with targeted intervention and support.

> *'Names with negative words in them like detox or dependence indicate that something is wrong with the person. They are stuck, diagnosed, helpless, labelled, boxed, dangerous, unpredictable, and incompetent.'*
>
> (AOD Provider Collaborative, 2014).

Talking about alcohol and other drug use

How should you talk about problematic AOD use? Use words and language that do not carry shame and stigma. There are some examples of what to say in the following table.

What not to say (language that supports stigma and shame)	How it impacts	What to say (language that lessens stigma and shame)

What not to say (language that supports stigma and shame)	How it impacts	What to say (language that lessens stigma and shame)
You prioritise your drug use over your child.	This can be seen (and felt) as a failure—this minimises the complexity of drug use and recovery, and limits hope.	'I can see the struggle you're having is real. I have heard and seen ways that you love your child, but at times your alcohol and drug use stops you from being able to look after [*child*] in the way you would like or they need.'
You will need to stop drinking and using so that you can keep your child safe.	This projects unrealistic expectations and simplistic attitudes about healing and recovery, and distances you from the parent's experience. It may also invite false compliance, as parents want to do what you say, but the reality is it's a far greater struggle.	'[*Child*] needs to be safe. Your alcohol and drug use is one of the things that we need to work on to make sure that can happen. I understand that this may be a difficult process and change is not always easy; however, I will be here to support you in accessing the help you need.'
You have an alcohol problem. You have a drug use problem.	This projects shame and stigma, makes it seem that 'you are a problem' and minimises the complexities that surround problematic AOD use.	'There are many reasons why people's alcohol and drug use becomes a problem in their life. Sometimes people have grown up with it, sometimes people have experienced suffering and pain and this is a way they cope. There are many

What not to say (language that supports stigma and shame)	How it impacts	What to say (language that lessens stigma and shame)
		reasons why this happens. You're not alone and I know that alcohol and drugs is just one part of your story. It's not who you are.'
Addict Abuser Junkie User	These terms are demeaning because they label a person solely by their illness or behaviour and imply a permanency of the condition.	Person with problematic substance use Person who uses alcohol or other drugs
Alcoholic	Identifies the person by their problem and defines them by their alcohol use. This limits the ability to see them as anything other than their alcohol use.	A person with problematic alcohol use
Drug problem Drug habit	These terms deny the medical nature of the condition and imply that the solution to the problem is simply a matter of willpower in being able to stop.	Problematic substance use
Drug abuse Drug abuser	'Abuse' has negative connotations and reinforces the idea that the parent has a level of control over the 'abuse' of their substance, that this is something they are doing to	Problematic use Person with problematic substance use

What not to say (language that supports stigma and shame)	How it impacts	What to say (language that lessens stigma and shame)
	the substance. These terms encourage a negative perception of the person.	
Clean Dirty A clean or dirty drug screen	These terms used to describe a positive drug test indicate a level of judgement about the parents' cleanliness. This can make a parent feel that they are either 'clean' or 'dirty' depending on their urine screen. It can imply that others see them as clean or dirty. These terms can be demoralising and shameful for a parent, particularly for people who have experienced sexual abuse.	Person who has recently stopped using drugs/alcohol Testing negative or positive for substance use
Former or reformed addict or alcoholic	These terms reinforce that a person will always be defined by their drug problem, no matter which stage of recovery they are at. This does little to recognise and	Person with lived experience of alcohol or drug dependence Person no longer using drugs or alcohol

What not to say (language that supports stigma and shame)	How it impacts	What to say (language that lessens stigma and shame)
	validate steps forward, and their hope and optimism for the future.	
Opioid replacement Methadone maintenance	These words imply that treatment medications are equal to street drugs and suggest a lateral move from illegal to legal addiction.	Opioid treatment

Further reading

Read Language matters

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Page created

Listening and responding

There are some common things parents with problematic AOD use may say because of denial, hiding, minimisation, fear, worry, stigma or shame. There are also effective ways practitioners can respond:

What a parent might say	How to respond
I don't have a drug problem.	'Okay, so right now you feel your AOD use is not a problem. Tell me a bit about what it does look like?' 'What would make you feel like it had become a problem? How would you know?' 'Would others say it was a problem?' 'Has it ever impacted on your relationships with your partner? Family? Child?' 'Has it ever stopped you doing things you needed to do, like work? Or doing stuff with the kids?'
I use when the kids are asleep or aren't around.	'What makes you use when they are asleep?' 'It sounds like you have tried to take some steps so they don't see you [*drink/use drugs*]. Tell me more about what that looks like.' 'What would they see in the morning when they woke up? What would be different on a morning that you had not used?'
I parent better when I'm using.	'Tell me more about what makes you say that. How does your parenting look when you use and when you don't?'

What a parent might say	How to respond
	'What would [*child*] say was different?' 'What do you think are good qualities to have as a parent? Which of these qualities do you have when you're not using?'
They're safe. They don't see me use and I hide my drugs from them.	'Sounds like you've taken some real steps to try and make sure your kids are safe and they're some good starting steps. Sometimes, when I talk with other parents who use, we talk about a whole heap of other safety things that they may or may not have thought of. I can hear that your kids' safety is important to you. Can we talk about some other safety ideas?'
Other people use more than me. Why are you knocking on my door?	'Although you could compare it to others, what I have learned from talking with families is that every parent and child has a different story, their own experiences and life challenges. And although [notification / worries] has led me to visit you, I really want to understand your story and your [*child's*] story and you're the best one to tell me that.'
It stops my pain.	'I really want to understand more about what it's like for you. Can you tell me about the pain and how the drugs help you?' 'What's your biggest worry about stopping?'
I don't use that often.	'Tell me more about not using that often.' 'So you are not using all of the time. What makes you use some of the time but not all of the time?' 'What other things do you do when you are not using?'

Rolling with resistance

Resistance to change occurs when we expect or push for change when a parent is not ready for that change. There is no way to make a parent ready for change or make them like change. You can, however, help make them feel less threatened by it and help them discover their own motivations for change.

When a parent appears resistant to change, sometimes it is best to akcnowledge where they are at rather than challenge them. Be curious, rather than trying to convince them to change their mind. Let the parent know what supports are available for them when they are ready to make the changes they need to in order to safely parent their child. You can see what is not good about their AOD use and the impact on their child and why they need to stop, but parents are better persuaded by reasons they discover themselves. This is the heart of what's referred to as 'change talk'.

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Page created

Documenting alcohol and other drug use

When you document a child's and parent's experiences, use language that is clear and respectful. Work with the child and parents to develop clear worry and goal statements.

Use words that are relevant to the family and give context, recognise the impacts of problematic alcohol and other drug use, and the actions being taken. Avoid jargon, labels and bureaucratic speak. Be curious. Notice what is happening. Record what you see and what you understand.

Don't document like this.	Try and document like this.
Paula is a drug user.	Paula drinks alcohol and smokes pot as a way of coping with her childhood trauma, which involved sexual abuse when she was 6.
Paula uses drugs when her kids are asleep or at school.	Paula smokes cannabis at night to cope with her pain, loneliness and her anxiety. She is slow to get started in the mornings because of the night before and because she can't stop her mind racing. She is agitated with her kids and reactive towards them as she gets them ready for school. She is thinking about having another smoke and managing how much she has left.
Paula leaves her children at home unsupervised while she and James go out to get ice and get high.	James forces Paula to leave the children at home to get their ice. Although Paula does not want to, she knows if she says no, James will take it out on the kids.
Paula prostitutes herself to support her drug habit.	James controls the money in the household and spends most of the money on heroin. When money is low he will not

Don't document like this.	Try and document like this.
	give Paula money to get food or supplies for the children. Paula reluctantly engages in sex work so that her kids have food and are looked after.

'When you use language that 'conceals the context of violence, resistance, and responsibility', you minimise the impact of these behaviours on families.'

(Coates and Wade, 2007).

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Page created

Working with parents

The cycle of change

The parents you work with will be at varying stages in the cycle of change. Some parents will not realise a problem exists, may not be ready to change, may have thought or not thought about change, may be taking active steps towards change or may have taken steps and lapsed or relapsed. They may shift quickly from feeling they want to stop, to not wanting to stop. They may say they want to stop using, but they do not know how, are unable to, or are not ready.

These are all different stages in the cycle of change. Talking about their readiness to change and what may be stopping them will help you get to the heart of the problem. Always meet a parent where they are at in their world to understand their reluctance, so you can support them with choices in getting help and support.

Watch the below short video, which explains the stages of change in relation to alcohol and other drugs use.

Youtube video URL: https://www.youtube.com/embed/ayjXMix-nMw?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Stages of change

Video transcript:

00:01

the transtheoretical model also known as

00:04

the stages of change represents a

00:06

person's readiness to change there's six

00:09

stages these are pre contemplation

00:12

contemplation preparation action

00:16

maintenance and relapse and lapse today

00:21

we'll look at the model in the context

00:23

of alcohol and other drug use

00:26

identifying where a person might be ad

00:28

in the change process can provide some

00:30

direction as to how they can best be

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supported let's take a closer look pre

00:37

contemplation people in this stage

00:41

aren't worried about their use they're

00:43

not interested in stopping or cutting

00:44

back even though other people might be

00:47

concerned about their use for them the

00:49

benefits far outweigh the consequences

00:52

contemplation people in this stage of

00:57

change still enjoy using however maybe

01:00

they're starting to notice some problems

01:01

from their use they're weighing up what

01:03

changing might mean for them preparation

01:09

this is when the not-so-good things

01:11

about using are starting to outweigh the

01:13

things they enjoy about it and they

01:15

begin preparing to make a change to

01:17

their use action they've started to make

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changes to their alcohol or drug use it

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will depend on the person's goal but

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this might include things like using

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less or stopping maintenance

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they're maintaining this change they've

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been in the action stage for long enough

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that change has become easy they've got

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this they're no longer dealing with

01:43

constant cravings and triggers and have

01:45

maintained their goal for a significant

01:47

period relapse or lapse a relapse is a

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return back to using and elapse is a

01:56

slip-up elapsed does not automatically

02:00

lead to a relapse

02:01

both lapses and relapses provide an

02:04

opportunity for the person to learn more

02:05

about themselves what triggers them or

02:07

challenges them and what promotes

02:09

opportunities for growth it's really

02:12

important to help the person see any

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lapse or relapse as a learning

02:16

opportunity as opposed to a failure

02:18

people learn a lot more from their

02:20

setbacks than from their successes and

02:22

that's the stages of change or as it's

02:25

known as in technical terms the

02:26

transtheoretical model

Source: Insight Queensland (2019)

Connecting parents to their child's experience

When you are working with parents, remember how vital the connection between the child and parent is in providing a catalyst for change.

Practice prompt

When a parent cannot see how their problematic use impacts on their life, their child and the people around them, it can be difficult to motivate them to change. Before a parent can consider what it is like for their child, they need the chance to tell you their own perspective. Take the time to hear about what their life has been like, and what it is like now, so that parents can feel listened to and validated.

Always be curious and when a parent talks to you, relate it back to what it means for their child. A parent may say: 'I parent better when I'm on drugs.' If you take a 'forensic' approach and simply see this as evidence to support their lack of insight, you will miss the opportunity to understand what this means for the child. Taking a 'curious' approach will allow you to explore why they feel this way.

For example, when a parent says 'I parent better when I'm on drugs', ask them:

- 'I am wondering if you can tell me what you think you do better?'
- 'Can you tell me a bit more about that? It sounds like your parenting can change depending on whether you're intoxicated or coming down? Or when you are not able to get alcohol or drugs? I really want to understand what it is like for you.'

Use practice tools like the Three Houses or the Future House to elicit the views and wishes of children about their parents' AOD use. Ask children how you would like them to share these perspectives with their parents. It can be a powerful experience for a parent to hear feedback about their AOD use directly in their child's voice.

Helping parents get their life back

The biggest barrier for the recovery of parents who use AOD as a way to cope and survive is finding new ways to cope without AOD. Overcoming this obstacle cannot be done alone. Parents need a strong safety and support network, and need to know that you and others supporting them believe that they can make changes and keep their children safe.

> **Note**
>
> For many parents, asking them to stop the very thing that has helped them survive until now is like taking a lifeline away. When practitioners meet parents at this stage, they are able to see that their struggle to take their life back is not about choosing AOD over their child, or a lack of insight. Instead, it is asking them to be vulnerable enough and courageous enough to give up what they may see as their life support.

Parents want to be good parents. Parents want to keep their children safe. Starting at this place offers dignity and compassion. This gives you some common ground on which to work with them.

Help parents talk about their fears of giving up AOD and make sure case planning includes healing and recovery work that offers them the opportunity to learn new and positive ways of coping. Ask them:

- What would it be like to get your life back from AOD use?
- What would be the best things about having your life back?
- What would be hard, uncomfortable or scary about letting AOD use go?
- What things are going to make it easier for you to do it?

A safety and support network is vital

Since a safety and support network is vital in safety planning and in reducing long-term risks for children, talk with parents about who is and who could be in their lives. Practitioners may need to ask them questions such as:

- When do you feel supported and strong in your life?
- What makes you feel supported and strong?

- Who has supported you in the past?
- What would it take to talk to this person today?
- What would you need? What would they need?
- What would they think and feel if you told them the extent of your use?
- How can I be most useful to you in talking with [*person*]?

Make sure a parent understands that change can take time, even with the right supports in place. A parent will need a support network and practitioners can start helping them build, repair and connect with people who can help. Developing a safety and support network, safety planning and case planning are perfect opportunities to bring people together to talk about keeping a child safe.

Practice prompt

Use the Circles of Safety and Support Tool when engaging with parents to explore who in their life 'knows nothing, something and everything' about their problematic AOD issues.

Solution-focused questions can help reveal strengths and the times in a parent's life that AOD has not been a problem. These conversations are important for your safety assessment, safety planning and case planning. Some examples are in the table below.

Questions	Conversation ideas
Exception questions Exception questions provide parents with the opportunity to identify times when things have been different for them and AOD use was not problematic for them or their child.	'Tell me about a time when you felt like drinking but you didn't.' 'Tell me about a time where you would have normally taken [*child*] to get drugs but you didn't.' 'Tell me about a time when you reduced or stopped drinking.'
Scaling questions Scaling questions invite parents to look at their AOD use on a continuum. Scaling questions ask parents to consider their position on a scale (usually from 1 to 10, with one being the least desirable situation and 10 being the most	'You said that things are between a 5 and a 6. What would need to happen so that you could say things were between a 6 and a 7?' 'How confident are you that you could have a good day like you did last week, on a scale of 0 to 10, where 0 equals no confidence and 10

Questions	Conversation ideas
desirable). Scaling questions can be a helpful way to track progress towards goals and monitor incremental change.	means you have every confidence?'
Coping questions These questions are powerful reminders that all clients engage in many useful things even in times of overwhelming difficulties. They can be a great way to explore acts of resistance. Coping questions can work well when a parent is struggling to contemplate or stay motivated to change.	'You have been through a lot, tell me about other ways you have coped in your life.' 'Tell me more about the times you have stopped using before. How did you cope?' 'What helps you to keep going even though things are really hard?' 'It is admirable how you have been able to keep on going under such difficult circumstances. How did you do that?' 'How have you coped before when you felt like giving up? What stopped you from giving up before?'
Future-focused questions This type of question helps the parent create a picture of what things could look like or how they would like it to look if they did not use AOD. The key lies in exploring the details of what things would be like for them and those around them, particularly their child. This can be useful in talking about what the first step would be towards the future vision.	'If you were able to be the parent you wanted to be, what would it look like?' 'If AOD were no longer an issue in your life, what would things look like? How would it be different for you? For [*child*]?' 'What would be the first thing you noticed? What would [*child*] notice? How would others tell something had changed?'
Open questions With this type of question, the parent does most of the talking. Questions prompt a narrative to	'I'm wondering how alcohol has become such a big part of your life.' 'I understand you have some concerns about your drinking. I'm

Questions	Conversation ideas
learn more about the parent's thoughts, feelings and behaviours.	curious—tell me about them.' 'Tell me more about that.'
Affirming Affirming statements can take the form of compliments or statements of appreciation and understanding. They help build rapport and validate and support a parent during the process of change. They are most effective when they focus on parents' strengths and efforts for change.	'I just want to acknowledge how hard that must have been making that phone call. That was really brave to do that when you're feeling so flat.' 'I appreciate that it took a lot of courage for you to talk about your drinking today.' 'You appear to have lots of different ways you have coped with these difficulties for the past few years.' 'Thank you for hanging in there with me. I appreciate this is not easy for you to hear.'
Reflecting Reflecting involves rephrasing a statement to capture the implicit meaning and feeling of a parent's statement It encourages continual personal exploration and helps people understand their motivations more fully. It can be used to amplify or reinforce a desire for change.	'You feel that alcohol is what has got you through and it's really hard to stop now.' 'You feel that you have to break away from some of your friends because they make it hard to stop using.' 'You have enjoyed the way alcohol helps you cope with life and you thought you had it under control. But you are starting to worry that you don't. Has having me here today made you question how bad it actually is?'
Summarising Summarising links discussions, checks in with the parent and ensures mutual understanding of the discussion so far. Summarising can point out discrepancies between the person's	'If it is okay with you, just let me check that I understand everything that we've been discussing so far. You have been worrying about how much you've been drinking in recent months but you have not been able to stop and you are worried that you can't stop. How am I doing?'

Questions	Conversation ideas
current situation and future goals. It also demonstrates listening and understanding of the parents' perspective.	
Rolling with resistance Use this approach to explore their resistance to change rather than trying to change their mind for them.	'What is it about your drinking that others may worry about?' 'What would be different for your children if you stopped using?' 'What has using ice stopped you doing?' 'I wonder what makes other people think your drug use is a problem?'

Related forms, templates and resources

The three houses

Resource 18 July 2019

The future house

Resource 18 July 2019

Circles of safety and support tool

Resource 18 July 2019

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Page history

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Page created.

19 November 2019
Page created

Resources

Print out

The stages of change (Prochaska & DiClemente)—Social work tech provides a printable version of the cycle of change to help in your conversations with parents.

For parents

Insight QLD has a range of resources available for parents, family and safety networks about problematic AOD use.

Queensland Aboriginal and Islander Health Council has a number of resources and information sessions for families where problematic AOD use, particularly ICE, is impact families.

Support services

Service finders

Healthdirect—This is a free Australian health advice directory that helps people search for drug and alcohol treatment services in their area.

QNADA—The Queensland Network of Alcohol and other Drug Agencies (QNADA) service provider also helps people locate services in their area.

Services

Alcohol and Drug Information Service (ADIS)—People can call the Alcohol Drug information Service (ADIS) for support, information advice, crisis counselling and referrals to service in Queensland. ADIS is available 24 hours a day, 7 days a week on free call 1800 177 833.

Family Drug Support (FDS)—Parents/carers and family members can call Family Drug Support for information, referral and counselling 24 hours a day, 7 days a week on the national free call number: 1300 368 186.

Institute for Urban Indigenous Health (IUIH) provides an integrated social health model, including primary mental health services, alcohol and other drug treatment services and suicide prevention services.

This is a specialised service for Aboriginal and Torres Strait Islander people of all ages. For information or referral, contact IUIH Connect on 1800 254 354. Self-referrals or professional referrals (GP or other health providers) are accepted.

Locations:

- Caboolture Clinic: 5428 58555—James Street, Caboolture QLD 4510
- Morayfield Clinic: 5429 1000—10–20 Walkers Road, Morayfield QLD 4506
- Strathpine Clinic: 3897 0500—6/199 Gympie Road, Strathpine QLD 4500
- Deception Bay Clinic: 3049 2299—675 Deception Bay Road, Deception Bay QLD 4508
- Northgate Clinic: 3240 8903—313 Melton Road, Northgate QLD 4013

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Working with expecting and new parents

Pregnancy can be a great catalyst for change. It is a time when parents may be more prepared to look at their substance use and make changes with the right support.

Seeing and understanding

Responding

Version history

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About this part

This part will help you understand:

- the ways an unborn baby can be harmed when alcohol and other drugs cross the placenta
- foetal alcohol spectrum disorders (FASD) and neonatal abstinence syndrome (NAS)
- the needs of babies born with FASD and NAS and how to support their parents
- the shame, stigma and barriers to services for women and how you can alleviate them
- how to talk to women about substance use and support needs
- how you can be useful to women and reduce risk during the prenatal period
- the support, information and education a woman may need about alcohol and other drugs use and about breastfeeding and safe-sleeping practices
- how to help men connect with their role as a father and support their partner
- what to consider for a baby to safely go home from hospital.

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Pregnancy and alcohol and other drugs use

Having a dependency on alcohol and other drugs (AOD) is linked to social stresses and physical and mental health.

Many women who use substances during their pregnancy fall into this category experience poverty, social disadvantage, unemployment, are a young parent, have poor health and inadequate antenatal care. Mental health issues are also common when there is AOD dependency, with depression and anxiety the most common diagnoses.

While pregnancy increases many women's motivation to change their substance use, it is important to remember that dependence is an illness, not just a behaviour.

Some women may not be ready to change. If the pregnancy has been unplanned, they may find creating new patterns of behaviour or new ways to manage emotional and physical needs even more challenging. However, no matter where a woman is in the change cycle, her pregnancy is an opportunity. Pregnancy is often the first time a woman will appear before Health and Child Safety, which provides an opportunity to understand the support she needs, when she is ready. This is a crucial time for readying women for change.

Further reading

In recent years, there has been an increase in the proportion of women who abstain from alcohol once they become aware of their pregnancy, but the proportion of women drinking at risky levels has remained stable. Women who find it difficult to stop drinking need extra support.

The National Drug and Alcohol Research Centre's Supporting pregnant women who use alcohol or other drugs guide provides great strategies for reducing harm to women and their babies during pregnancy.

Effects of alcohol on an unborn baby

The use of AOD during pregnancy is linked to many potential risks for a baby. A baby who is affected by AOD crossing the placenta during pregnancy may:

- unexpectedly abort (miscarriage)

- be born early
- have low birth weight
- be stillborn
- be born with physical abnormalities or intellectual disabilities
- be born with foetal alcohol spectrum disorder
- be born with neonatal abstinence syndrome.

If a woman has been drinking heavily shortly before giving birth or has been withdrawing from alcohol during labour, her baby is at risk of acute alcohol withdrawal. The onset of withdrawal for a newborn may begin 24 to 48 hours after delivery, depending on the time of the mother's last drink.

If a woman has been drinking alcohol regularly during her pregnancy, her baby will need to be monitored and assessed for foetal alcohol spectrum disorder by a paediatrician, who will guide the baby's ongoing treatment needs.

Foetal alcohol spectrum disorder

The term 'foetal alcohol spectrum disorder' (FASD) is used to cover the full range of possible effects of foetal exposure to alcohol, while the term foetal alcohol syndrome is used to encompass the severe effects. Refer to Identifying and understanding common disabilities for more information on FASD.

Foetal alcohol syndrome

Foetal alcohol syndrome (FAS) is a continuum of permanent birth defects caused by alcohol crossing the placenta to an unborn baby. It typically includes deformities of the head and face, various defects in vital organs and appendages, and intellectual disability and behaviour problems. Partial FAS is where a child has some, but not all, features reported in FAS.

Alcohol-related neurodevelopmental disorders

Alcohol-related neurodevelopmental disorders refer to problems with learning and behaviour experienced by children as a result of alcohol exposure during their mother's pregnancy.

Alcohol-related birth defects

Alcohol-related birth defects refer to abnormalities in organs (such as the heart or kidneys) related to alcohol exposure.

Watch the following video *Foetal alcohol spectrum disorder impacts you, but you don't know it*.

Youtube video URL:
https://www.youtube.com/embed/ECaLJAWkuDA?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Fetal alcohol spectrum disorder impacts you, but you don't know it

Video transcript:

00:07

fifteen years ago if you had told me

00:09

that I would be the foster mother to

00:11

over a hundred children I would have

00:13

probably laughed you out of my life 15

00:15

years ago we were dealing with the fact

00:17

that we would never parent a child of

00:19

our own

00:20

that's a moment of impact for me that

00:23

led me on a journey that I never ever

00:25

would have pictured and to know that

00:28

years later twelve of those children

00:30

were permanent in our lives was

00:33

something that I never would have

00:34

expected today we're going to talk about

00:36

fetal alcohol spectrum disorder it's a

00:39

hard topic it's a touchy topic

00:41

it often gathers a lot of emotion a lot

00:45

of people really struggle with this for

00:48

me it's definitely an emotional topic a

00:52

moment of impact for me would be sitting

00:55

outside of a hospital room and listening

00:57

to them coding my daughter hearing them

01:01

talking about how long they should

01:02

continue to work on her and whether it

01:04

was really valid to continue to try and

01:06

keep her alive

01:07

hearing them finally say I think it's

01:09

time for mom to come in and say goodbye

01:12

having to hold her feet and tell her

01:15

that it was okay it was okay to be gone

01:18

it was okay to give up it was time to

01:20

stop struggling telling her everything

01:22

that I didn't believe in that moment

01:24

telling her that I understood that she

01:27

was probably very tired and in that

01:29

moment holding her very cold feet and

01:31

realizing that this was my last moment

01:33

with her I finally heard them calling

01:36

out numbers and I couldn't understand

01:38

what those numbers meant and as they're

01:41

doing that I heard nineteen forty 51 I

01:47

have a heartbeat and that's when my

01:50

knees gave out and I realized that she

01:53

was back with us that maybe we had at

01:55

least one more day I'm going to go back

01:58

to when she was born Arianna was born

02:01

thirteen weeks early when she was born

02:05

everyone realized that her life would be

02:07

an interesting struggle and a long

02:10

journey Arianna was born with a blood

02:12

alcohol level she was born with every

02:15

organ in her body affected by alcohol we

02:18

Ariana's life when she was three months

02:20

old and she was ready to be discharged

02:22

from NICU and we got to take her home

02:24

and love her and we were told to love

02:25

her for every day that she had with us

02:27

and we realized that all of those days

02:29

would be gifts because ariana is an

02:32

amazing spirit and while her brain may

02:35

not be what everyone else's brain is or

02:38

we think is typical or normal or

02:40

acceptable her brain is one that gives

02:42

love in ways that I can't even explain

02:44

to you without you meeting her ariana

02:47

spent almost all of her life in the

02:49

hospital she spent well over half of her

02:51

life in the hospital at this stage she's

02:53

been on event seven times she's had 22

02:58

hospitalizations and nine surgeries

03:00

Ariana costs about $60,000 a month to

03:04

just keep her alive

03:05

so when I talk about fetal alcohol

03:07

spectrum disorder I always want people

03:09

to care about about the human cost

03:11

because for me I sit with a human cost

03:14

every day all of our 12 children are

03:16

affected prenatally by drugs and alcohol

03:18

I never imagined that becoming a mother

03:21

would literally change my entire view on

03:23

life and my entire journey and my entire

03:26

crusade but it has because I realized

03:30

that my children can't give voice to

03:32

their needs and so I have to I have to

03:36

become the advocate if you'da told me I

03:37

was going to stand on a stage and talk

03:39

in front of people let alone stand on

03:41

stages and talk to hundreds of people I

03:43

would have seriously run you out of my

03:45

house because I flunked speech I

03:47

couldn't do it I couldn't stand in front

03:49

of people and talk

03:50

I kept stuttering I'd fall apart I'd run

03:52

off the stage that was not me I was not

03:55

that person I was not the person who

03:56

would go on to start a non-profit and go

03:58

around the world and talk about fetal

04:00

alcohol spectrum disorder that was the

04:02

last person that I thought I would be

04:03

but today in our country we have an

04:06

epidemic that we don't talk about we

04:09

talk about the Zika virus your chances

04:10

of getting the Zika virus or point zero

04:13

zero zero one percent or something I

04:15

guess I don't remember exactly but it's

04:16

pretty darn low we talked about autism

04:18

we talked about Down syndrome but when

04:21

people talk about FASD there's a lot of

04:24

stigma first of all everyone wants to

04:26

blame the birth mother when you look at

04:28

this picture you want to lock someone up

04:29

I did it first

04:31

with my first child that I sat by their

04:33

bedside like this I did I wanted to lock

04:35

the mom up but the fact is what I

04:38

learned through my journey is that my

04:42

children's birth moms are affected

04:44

prenatally by alcohol Ariana's mom will

04:47

tell you she drank 20 drinks a day and

04:48

did meth any chance she had but she

04:51

can't equate this with those choices she

04:55

doesn't understand that that's why this

04:57

happened she looks at her and she cries

05:02

I get to share being a mother I share

05:05

being a mother with a woman who honestly

05:07

does not understand that her choices if

05:09

you can call them choices led to this

05:14

the CDC has finally come forward with

05:18

the first active study of FASD in our

05:21

country we used to have numbers one in a

05:23

thousand I'm not scary enough to me one

05:25

in a thousand children being born and

05:27

living the way that my daughter lives

05:29

but those were passive studies those

05:31

were only people who were born and

05:34

diagnosed at birth FST is very hard to

05:37

diagnose at birth and a lot of doctors

05:38

don't really know how to diagnose it so

05:40

we were talking only birth records two

05:43

years ago there was a study and actually

05:44

Sioux Falls South Dakota was one of the

05:46

study sites we were able to go in and

05:48

look at all the first graders in the

05:50

three study sites they had and diagnosed

05:53

everyone in those grade levels and look

05:55

at them and try and see how many

05:57

children actually were impacted by

05:59

prenatal alcohol exposure and what came

06:02

back was the shocking and scary number

06:04

of one in 20 that's five percent of our

06:08

population the CDC actually put a

06:11

warning out and what happened was I

06:13

think hard for me to watch because on

06:16

Facebook and on all sorts of social

06:17

media women were screaming about people

06:20

taking away their choices and it's my

06:22

body and if I want to drink I will and

06:24

you know you're right it is your choice

06:26

absolutely it's your choice I guess I

06:28

challenge people that want to drink

06:30

though you need to really do some great

06:31

brain research and really good research

06:33

on prenatal development because if you

06:35

want to drink and you choose to drink

06:37

knowing that we have no idea safe level

06:40

of alcohol you are choosing the damage

06:42

to your unborn child and you better be

06:45

okay with your

06:45

choices I look at Ariana and to me she's

06:50

a gift

06:51

I love being Ariana's mom but if I could

06:54

take away one moment of her pain

06:56

I absolutely would so people say do I

06:59

accept her I accept her with everything

07:01

she's to me a perfect child but this is

07:05

a child that at five years old lives on

07:07

scheduled pain management

07:08

this is a child who has seizures

07:11

constantly we have to watch her go

07:14

through these seizures and watch what

07:16

they do to her some of her seizures she

07:18

can talk and she'll scream for me

07:19

and I can't stop them I can't do

07:22

anything other than administer the drugs

07:23

that I hope will stop the seizure

07:25

sometimes they work sometimes they don't

07:27

we've had seizures lasting over seven

07:29

hours that the hospital couldn't stop

07:33

there's hope there is hope there's all

07:37

sorts of studies going on for prevention

07:39

I do challenge those studies though

07:41

because the one area we're missing is

07:43

that in the United States today were

07:44

three to five generations into FASD

07:47

which is why we're seeing children that

07:49

are more affected than in the past

07:51

because when you add genetics to faulty

07:53

genetics to faulty genetics you end up

07:56

with a greater outcome the hope that I

07:59

have is that we need to start supporting

08:01

the people who are here who have fetal

08:03

alcohol spectrum disorder like Ariana's

08:05

mom we need to give her the right

08:07

support and the right treatment so she

08:09

doesn't continue to go on and have more

08:11

children that are affected like Ariana

08:12

the fact that she's had two more we have

08:16

to look at ways to recognize that there

08:19

are things that can be done when I first

08:22

had my first children diagnosed I was

08:24

struggling because I said where do I go

08:26

now how do I learn what do I do and I

08:29

was told you're lucky you haven't

08:31

adopted them yet

08:32

go home give them back there's no hope

08:35

and I'm sitting there with a two year

08:38

old a three on a sixth child thinking

08:39

I'm supposed to look at these children

08:41

that I'd loved for over two years and

08:43

say there's nothing for you I'm going to

08:46

give you back give you back to who it's

08:48

not a pair of shoes that I can go take

08:50

to the Salvation Army and get rid of and

08:53

whether they recognize it or not we may

08:56

not have signed the documents yet but

08:58

they were our children

08:59

from the moment they entered our home

09:00

and I loved them and I could not look at

09:04

them and think of the things that were

09:06

said in the olden days they used to say

09:08

the boys get locked up and the girls get

09:10

knocked up

09:10

and that's just the way it is and I know

09:13

we can do better I'm watching us learn

09:15

and recognize these children and I've

09:18

seen great success stories and so I know

09:20

there's hope and that's why I go out to

09:22

educate because to me I don't want

09:25

someone to look at my child and think

09:27

there's no hope for you I know there's

09:29

hope for them I don't want parents to

09:34

sit at bedside like this I don't want

09:37

people to have to say goodbye to their

09:38

children unfortunately life spans with

09:42

FASD are short usually about 35 years

09:45

old if they live that long

09:47

sometimes it's accidental I have a

09:49

friend whose son literally walked out in

09:51

front of a truck and he lives with the

09:53

fact that everyone thinks his son killed

09:54

himself his son did not kill himself he

09:57

forgot to look both ways the fact is

09:59

that as parents were bearing these

10:01

children at a far higher rate than we

10:02

should and that's something that I hope

10:05

will change also with education with

10:07

people putting supports in place I try

10:11

to put a human face on it but I'm going

10:14

to put $1 in cents face on it too

10:16

in 1991 and strikes cthe did a study on

10:21

the cost to society of a person with

10:24

FASD at that time it was 2 million

10:26

dollars over that person's lifetime

10:27

that's pretty pretty scary number

10:31

arianna by 3 which she's three sitting

10:34

here with her grandmother she was

10:36

already at three million dollars pretty

10:39

soon if we allow this to continue we're

10:43

going to have to start knocking on

10:44

people's doors and saying we're going to

10:46

have to tax you extra because how are we

10:48

going to keep paying for this

10:49

Arianna has to have a special formula

10:52

that she eats because she can't eat by

10:53

mouth the formula is 83 dollars a can at

10:57

five she drinks one and a half cans a

10:59

day as she gets older that's going to go

11:01

up her cost of living is intense and yet

11:04

to me it's worth it because I love her

11:06

and I'm not someone who can put a

11:08

dollars and cents sign on her life

11:09

however at some points we do have to

11:12

make

11:12

some hard decisions about that that's a

11:14

lot of money and she's not unique she's

11:17

not all alone this is happening all over

11:22

trying to keep her alive trying to keep

11:24

her breathing trying to help her just

11:26

maneuver through life is that a cost to

11:29

society all of you guys are paying for

11:32

Ariana you are and that's why I

11:36

challenge people if you saw a woman

11:39

drinking it was pregnant how many of you

11:40

would be brave enough to go up and say

11:42

do you know it's not safe to be drinking

11:44

while you're pregnant I have a boy that

11:46

I counseled who's twenty seven and he

11:49

just got arrested for grabbing a drink

11:51

out of a woman's hand and pouring it out

11:53

and he looked at her and he said I have

11:56

permanent brain damage because my mom

11:57

couldn't put drinks down you need to

11:59

stop drinking and he's proud of being

12:02

arrested for that

12:03

he said I'd do it again I don't care if

12:04

they send me to jail he said if I helped

12:06

her baby at all even just at all it was

12:08

worth it

12:10

Ariana will always know love and she'll

12:13

always be accepted unfortunately the

12:15

most unadoptable child out there in the

12:18

foster care system is a child diagnosed

12:20

with FASD a lot of these kids literally

12:24

will never get a home they'll never have

12:26

that structure they'll never have that

12:28

support and so we will run them through

12:30

the system and when they turn 18 they're

12:33

going to go out in the world and they're

12:34

going to make a mistake because they

12:36

don't know any better and then we're

12:37

going to house them in the penal system

12:38

I think we can do better I think as a

12:43

society we can all do better I know we

12:46

can and my moment of impact is standing

12:48

here asking you to remember Ariana to

12:52

think about her when you see someone

12:54

drinking or when you have your

12:56

sister-in-law drinking when she's

12:57

pregnant or whatever or just telling

12:59

someone about fetal alcohol spectrum

13:00

disorder I can't tell you how many times

13:03

people don't know about it and they'll

13:05

tell me well that's just a baby thing

13:07

because fetal alcohol that's unfortunate

13:09

for the name they don't outgrow this

13:11

Ariana will never just outgrow having

13:14

this damage

13:15

there is absolutely no known safe amount

13:19

of alcohol absolutely no known so I

13:22

challenge you if you are going to become

13:23

pregnant if you're thinking of having

13:25

kids or if your

13:27

childbearing age and you're sexually

13:28

active don't drink

13:30

57% of pregnancies are not planned and a

13:33

lot of us drink a lot of us have that

13:35

glass of wine and we don't think about

13:36

it thank you so much for listening today

13:41

and for realizing that fetal alcohol

13:43

spectrum disorder is real and it is a

13:46

hundred percent preventable all you have

13:49

to do is abstain for those times when

13:50

you're pregnant

English (auto-generated)

Watch the following video about *FASD in Australia.*

Youtube video URL:
https://www.youtube.com/embed/T47kOz_B1ig?enablejsapi=1&showinfo=0&rel=0

Video Caption:
FASD in Australia

Video transcript:

00:01

FASD is everybody’s business.

00:03

I've actually found that it's a lonely journey.

00:06

FASD needs to come out of the closet.

00:20

FASD is a diffuse brain injury caused by exposure of the unborn baby's brain to alcohol.

00:30

FASD occurs in all sectors of our society, and in studies internationally it's thought

00:36

that between two and five percent of the general population may be affected by FASD.

00:42

It's probably where ADHD was 20 years ago in Australia.

00:49

Some scepticism, some oh, is it real?

01:00

When I got the diagnosis the first thing that I remember hearing was, "a permanent brain injury"

01:06

um, it could not be fixed.

01:09

I remember hearing that and it's like my whole world fell apart.

01:21

There is no typical child with Fetal Alcohol Spectrum Disorder,

01:25

but if you ask parents and teachers, perhaps the most common problem is behavioural problems.

01:31

You know, the fact of the matter is, 80 percent of these children, if they don't have the

01:36

supports end up either in an institution, in jail, you know living on the streets, with

01:42

health issues.

01:43

They're just unable to live in the community unsupported and so you've got to have that

01:48

knowledge so you can then put the supports in place.

01:54

Health professionals, I've found don't always understand what FASD is.

02:00

It's very important when you find a therapist, like ah, an OT or a speech that they have some

02:06

awareness or understanding, or be willing to learn.

02:09

So that um, the best outcome for your child is achieved.

02:14

"applause"

02:19

FASD at this point in time is sometimes a stigmatising diagnosis, and I think the reason

02:27

for that is because it's only diagnosed rarely.

02:35

There's a lot of guilt and shame that can be experienced by a lot parents as well.

02:39

So it's really important that as health professionals we have a responsibility to

02:43

really let those families know how, how much we appreciate how difficult and challenging

02:50

that process might be.

02:52

Community attitude needs to change 100 percent.

02:54

We've all, we've felt it.

02:57

The negativity and statements that have been made to us because we have two children with FASD.

03:03

Um, at times is just, is just so disheartening

03:09

and you know they're obviously not our children so the stigma doesn't really stick but already

03:15

we've felt it so you can imagine how hard it must be for a parent.

03:19

Indeed most of the children that we see the exposure to alcohol was inadvertent because

03:25

mum didn't realise she was pregnant, wasn't planning to get pregnant, and stopped drinking

03:31

as soon as she found out she was pregnant.

03:37

Understand, that that this is a real condition and it is a challenge for parents not to judge

03:43

the parents on how they are parenting but to support and to learn as much as they can

03:49

about it to be able to support the parents and the child with FASD.

03:54

You know at the end of the day they're still your child.

03:56

They're still perfect to you.

03:58

Ah, they have meltdowns, they have difficulties, they struggle every day, but it doesn't

04:03

stop you loving your kids.

04:05

Our two, are the light of life.

04:08

You know, if they weren't at the school, the school would be a dull and boring place

04:12

without our two.

04:13

They are the centre of attention in the classroom, and not for bad reasons anymore.

04:17

Because they are happy easy going, um very loveable children and most of these kids are

04:23

like that, they just need the support and the structure for them to be able to achieve

04:27

it.

04:28

The caregivers of Australia are the ones who have led this charge.

04:32

It's because carers and advocates have kept their advocacy up for the past 20 years and

04:38

they haven't let go, and clinicians and researchers have followed.

04:42

So we are all in this together and there is great cause for hope.

Further reading

Understanding more about support for families

Webinar: 'Supporting children and families affected by foetal alcohol spectrum disorder' (Australian Institute of Family Studies, 2014).

Opiate use during pregnancy

Studies have found that heroin use in pregnancy is associated with foetal harms such as intrauterine growth restriction (a condition in which a baby does not grow to normal weight during pregnancy), low birth weight and neonatal death. Injecting opioid use is also

associated with harm such as blood-borne viruses, non-viral infections including cellulitis, endocarditis and septicaemia, and overdoses (fatal and non-fatal).

During pregnancy, other possible harmful effects of using opioids include:

- miscarriage
- premature birth
- stillbirth.

For the child, other possible harmful effects of using opioids include:

- withdrawal in the newborn
- reduced growth
- death from sudden infant death syndrome (SIDS).

Keeping women and their babies safe when there is opiate use

A pregnant woman who is using opiate substances should be offered stabilisation by induction onto an opioid substitution treatment, combined with drug and alcohol counselling and psychosocial support.

Stabilisation (through methadone and buprenorphine maintenance programs) can result in improved foetal development, healthier infant birth weight and a reduction in neonatal mortality.

Research indicates that withdrawal from methadone or buprenorphine during pregnancy can put mothers at risk of returning to dependent illicit opioid use. Opioid withdrawal during pregnancy may also place unborn children at heightened risk.

As such, opiate withdrawal is not encouraged or recommended for women during pregnancy under the Queensland clinical guidelines – Perinatal substance use – Maternal.

The management of alcohol and drug use during and after pregnancy should be undertaken by suitable qualified medical professionals.

Neonatal abstinence syndrome

Neonatal abstinence syndrome (NAS) is a withdrawal symptom that occurs because infants are prenatally exposed to opioids, heroin, codeine, oxycodone, methadone or buprenorphine. Babies exposed before birth to these drugs can be become physically dependent on the drugs and be born with withdrawal symptoms.

Other possible effects of amphetamine-type substances for the child may include:

- reduced growth
- stroke or heart failure in newborn

- withdrawal in the newborn
- death
- cognitive problems
- delays in motor development.

Heroin slows foetal growth, causing intrauterine growth retardation and premature birth. If mothers are injecting drugs, there is an increased risk of the transmission of HIV and viral hepatitis.

If women are stable on methadone and using no other substances, the baby will experience withdrawal due to the nature of the prescribed drug. Women will commonly need their dose increased while they are pregnant. Their current prescriber usually reviews this. Reducing the dose after giving birth is currently a common practice. The prescriber will also assess this.

Note

Problematic drug use is associated with low birth weight, premature birth, stillbirth and sudden infant death syndrome (SIDS). But some women who use substances are also cigarette smokers, with poor nutrition and complex social circumstances. This means some of the symptoms may be due to tobacco exposure and other lifestyle factors such a malnutrition and parental anxiety or stress.

Symptoms of NAS in an infant may include:

- blotchy skin colouring (mottling)
- diarrhoea
- excessive crying or high-pitched crying
- excessive sucking
- fever
- hyperactive reflexes
- tight muscle tone
- tense arms, legs and back
- irritability
- poor feeding due to sucking problems
- rapid breathing
- seizures (convulsions)
- sleep problems
- slow weight gain
- stuffy nose and/or sneezing
- sweating
- trembling (tremors and jitters)
- vomiting
- dehydration.

This syndrome usually begins within 72 hours after birth, but may appear up to two weeks after birth.

NAS can be detected when health professionals use the Finnegan Scoring System. Babies who score high on the system may need medical treatment, such as morphine or phenobarbitone, to help them withdraw safely.

What to do if a baby might have neonatal abstinence syndrome

Practitioners need to talk with health staff to understand the testing score and what treatment a newborn baby needs in order to withdraw safely. Ask about what this means for how parents may care for and look after her baby during this time, including settling, feeding and sleeping.

If a baby is discharged within the first two weeks, practitioners need to know the NAS signs to look for and talk with parents, carers and other professionals involved about this possibility.

Supporting parents who have a baby diagnosed with neonatal abstinence syndrome

Caring for a baby with NAS is difficult. Feeding and sleeping in particular are often difficult for the baby, which can make parenting more challenging. Parents may find it difficult to settle their baby, may experience more infrequent and shorter periods of sleep than other new parents, and will likely struggle to develop clear routines.

If AOD use has been a parent's way of coping, the increase in stress may trigger a relapse or escalate their substance use. Carefully consider how to ensure how the needs of a baby with NAS will be met and who can help support the parents. Ensure a robust safety and support network is in place for the family.

Managing neonatal abstinence syndrome

The stress of caring for a baby with NAS may prevent early bonding between mother and baby. Babies may be in a great deal of distress, and this can be difficult for both parents and professionals.

Note

What you see during this period can be confronting, which can have an impact on your attitudes towards the mother and those of other health and service professionals. It is important, however, to reflect on your values, bias and assumptions, and challenge any negative stereotyping you see from other professionals.

A mother is already likely to feel guilty and ashamed for the impact her AOD use has had on her newborn baby, and negative attitudes from professionals are likely to make her feel worse. This can make a woman feel like withdrawing from services, drinking or using drugs as she tries to cope with her remorse. This can also affect the early bonding and attachment behaviours between a mother and her baby.

Babies experiencing withdrawal symptoms

Guilt, shame and stigma can get in the way of a mother bonding with her child. When a newborn baby is in the neonatal unit, as is often the case for a baby with NAS, a mother is able to visit to spend time and be a part of feeding, sleeping and care routines. But this is an unnatural setting, where babies are monitored and ultimately, where parents' interactions are observed.

⚠ Attention

For some parents, being observed in an unnatural setting can feel intrusive and can add to their perception of being judged. Some parents may respond to this by avoiding the negative stigma, which ultimately means they limit their contact with their baby. Help parents to feel comfortable in this setting. Help them see the benefits of this early bonding time and make the most of it.

Some of the actions you can take to support parents when babies have withdrawal symptoms are:

- talking to mothers about what it is like seeing their baby distressed and in withdrawal:
    - How do they feel when they see their baby in distress?
    - What can you do to support them in connecting and bonding with their baby even if they feel guilt or sadness?
- talking to parents about who may be able to support them:
    - Connect mothers to child protection social workers to talk about how they can be helped through this time.
    - Ask if there are friends, family or community members who may be able to help parents cope with the challenges of their new baby and even provide short periods of respite.

- talking to mothers and fathers about the reaction they have when things are difficult:
    - How do they feel when they hear their baby's high-pitched cry or when it is very difficult settling the baby? Do they feel as if they have failed? Do they feel angry?
    - How do they manage feeding problems?
    - When the child is difficult to feed or settle, are they able to empathise?
    - How do they feel and act towards the professionals working with them?

- talking to the nursing unit manager, or nurses, about what it is like for them:
    - Check in with the nursing team about what it's like for the mother, caring for her baby going through withdrawal and how this makes them feel about the mother.
    - Talk about the impact negativity, blame and shame can have on a mother and how this can stop her from making positive changes and tending to her child's needs.
    - Let nursing staff know how important it is that they also support mothers by not being judgemental about their substance use.

In the following video, Deanna Murphy tells the story of Baby Emily and Mum Michelle and the impact of AOD use.

Youtube video URL:
https://www.youtube.com/embed/l6Tuu7bk2g4?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Hope for Emily

Video transcript:

00:00

[Music]

00:12

[Applause]

00:17

new mom Michelle is 26 years old and

00:21

recently welcomed her precious new

00:23

daughter into the world as she looked

00:26

down into baby Emily's big blue eyes and

00:28

dreamed of all the incredible journeys

00:30

the 7 pounds 2 ounces grow up to

00:33

experience she imagined her girl might

00:35

become a ballerina a paediatrician or a

00:37

teacher tears streaming down her face

00:41

and she felt a sense of joy and

00:43

boundless hope that new moms

00:45

instinctively feel when they see their

00:47

babies fresh full faces but Michelle's

00:51

tears are tinged with guilt and shame

00:55

because she knows that before baby emily

00:57

can grow up to become that pediatrician

00:59

ballerina or teacher she must go through

01:02

the excruciating process of withdrawing

01:04

from heroin the Michelle didn't start

01:08

out using heroin and in fact she might

01:10

not look like how you imagine a junkie

01:12

looking but following a sports injury in

01:16

college a doctor ordered prescription

01:18

pain meds and Michelle was hooked when

01:22

the meds ran out a co-worker offered to

01:25

get her pills for a price and it wasn't

01:28

long before a friend told her about

01:31

heroin it was so much cheaper and would

01:35

make her feel even better than the pills

01:37

well Michelle dropped out of college and

01:40

after going through detox and treatment

01:42

four times Michelle knows the agony of

01:45

withdrawal and it's the last thing she

01:47

wants baby Emily to ever go through

01:49

especially in her first days of life

01:53

Michelle no is that because baby Emily

01:56

is no longer receiving her daily doses

01:57

of heroin she'll soon start to exhibit

01:59

the tell-tale signs of neonatal

02:01

abstinence syndrome as her withdrawal

02:04

sets in baby Emily will begin feeling in

02:07

describable pain causing her to scream a

02:10

telltale recognizable scream that make a

02:13

1/4 hour

02:14

days maybe even weeks or months leaving

02:17

her and her caregivers completely and

02:20

utterly exhausted baby Emily will begin

02:24

shaking in tremoring in describe ibly

02:29

almost unbelievably and I want to show

02:32

you this this is difficult to watch but

02:35

it may look something like this this is

02:40

not sped up or enhanced in any way this

02:42

is the real-time tremor of a baby in

02:44

withdrawal what we're witnessing may go

02:53

on for baby Emily in some fashion for

02:55

months in addition to this tremor baby

03:02

Emily will have a difficult time feeding

03:05

because her nervous system is affected

03:07

by her prenatal drug exposure maybe

03:10

Emily may take a breath when she's

03:13

supposed to be swallowing her formula or

03:15

swallow her formula when she's supposed

03:17

to be breathing much of what she does

03:19

eat she'll likely vomit contributing to

03:22

poor weight gain the drugs and

03:24

medication will leave her body through

03:26

her stool causing diarrhea and horrible

03:29

diaper rash only increasing her

03:31

discomfort baby Emily will begin

03:34

sweating as her body her tiny little

03:37

body deals with the chemical withdrawal

03:39

and as a response to the sudden removal

03:41

of opiates baby Emily will begin to

03:43

sneeze and sneeze and sneeze and not

03:47

those cute little baby sneezes that we

03:49

all find so adorable but repeated

03:52

consistent relentless sneezing in an

03:57

effort to soothe herself baby Emily will

03:59

begin grasping and clawing at her own

04:01

face causing her to leave marks on her

04:03

skin and scratched her precious new

04:06

cheeks which has now begun to model and

04:09

the sign of her withdrawal to alleviate

04:12

her symptoms doctors will admit baby

04:15

emily to the neonatal intensive care

04:16

unit and begin treating her with oral

04:19

doses of methadone or morphine this two

04:23

to three week treatment will relieve

04:25

some of baby Emily's unbearable achy

04:27

an aide in her newborn recovery process

04:29

between periods of caring for babies

04:32

with higher acuity needs the nurses will

04:34

swaddle and hold her whenever they can

04:35

to comfort her and help her to know that

04:38

she's not alone during these frightening

04:39

first days but she often falls to the

04:42

bottom of their priority list because

04:44

while her crying is intense and her

04:46

needs are great they're not immediately

04:48

life-threatening so maybe Emily often

04:52

waits for someone to hold her the

04:54

Michelle wants to be by baby Emily's

04:56

side during this painful first journey

04:59

but she's bought into the lies that her

05:03

disease tells her and she doesn't come

05:05

as often as she wants she Michelle

05:07

believes the lie that she's not worthy

05:10

to be there with baby on the lean

05:13

Michelle believes the lie that she

05:15

wanted to do this to her baby and worst

05:18

of all

05:19

Michelle believes the lie that she must

05:22

not love baby Emily if she allowed this

05:25

to happen to her so her visits become

05:28

fewer and farther between Michelle's

05:32

parents visit baby Emily every day and

05:34

they tell anyone that will listen that

05:36

addiction is a brain disorder that

05:39

Michelle's not some moral failure or

05:41

worthless loser who chose drugs over her

05:43

baby Michelle is as dependent on that

05:48

chemical as baby emily is and she

05:49

deserves the same compassion but they're

05:54

often met with a patronizing head nod or

05:56

an uncomfortable side glance they begin

06:00

to understand why Michelle stays away

06:02

but today today is different today

06:07

Michelle does go to the hospital to bond

06:10

with baby Emily today Michelle chooses

06:13

to believe the truth she is worthy of

06:16

bonding with baby Emily Michelle wants

06:20

baby Emily to grow up healthy and strong

06:24

Michelle loves her baby

06:27

you see Michelle story doesn't have to

06:29

end up on the 6 o'clock news and baby

06:31

Emily doesn't have to grow up fearing

06:33

that her mother might not make it to her

06:35

next birthday party what we know about

06:38

baby Emily and the others like her born

06:40

every

06:40

five minutes in our country is that not

06:44

all their stories and badly mine didn't

06:49

growing up with two addicted parents

06:51

wasn't an easy road for me or for anyone

06:54

in my family but when my father reached

06:57

out to me 17 years ago this very week to

07:01

ask for help the assurance that he

07:04

wasn't alone in his journey is how my

07:06

father's been able to maintain his

07:08

sobriety since that night in October of

07:10

1999 but he couldn't have done it on his

07:13

own and the michelle's of this world

07:15

can't do it on their own either in their

07:18

fight for recovery those who struggle

07:20

with addiction needs support from their

07:22

families their friends and their

07:25

communities the increasing numbers of

07:27

baby Emily's in our society deserve to

07:31

have teachers neighbors clergy and

07:34

lawmakers who understand that addiction

07:36

affects far more than just the addict

07:39

see this is no longer someone else's

07:41

problem we are all affected by this and

07:44

we each have a role to play in the

07:47

solution so today I stand before you as

07:50

a grown-up baby Emily and I ask you to

07:54

search your hearts for the answer to

07:56

this what is your role and more

08:02

importantly are you willing to play it

08:08

[Applause]

08:18

[Music]

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Young women who are pregnant

Supporting young women who are pregnant

Young parents face the challenge of meeting not only their own developmental needs at a time of significant growth, but also the needs of their pregnancy and later their child.

Teenage parenthood can have a significant impact on a young person's life and is associated with a number of adversities. The Australian Institute of Family Studies (AIFS) practice sheet Supporting Young Parents highlights that young parenthood is more likely to happen when there are other adversities already occurring in a person's life such as:

- low socio-economic background
- underachieving in school
- misuse of alcohol or drugs.

Young parents can also face social stigma. Many young mothers report experiences of judgement or even hostility in their dealings with social service institutions, education providers, and health care facilities.

Outcomes for young mothers and their babies

Outcomes across a range of measures are worse for teenage mothers and their babies. Longer-term risks for the mother include depression and rapid repeat pregnancy, and intergenerational teenage parenthood is a risk for the child. Socioeconomic disadvantage is a risk for both.

Younger women are also at greater risk of violence from an intimate partner during pregnancy and in early motherhood (Brownridge et al., 2011; Gartland, Hempill, Hegarty & Brown, 2011; Quinlivan, 2000; and Taft et al., 2004).

> *'The difficulties of teenage parenthood, however, are not the whole story. The challenges of being a young parent are often accompanied by significant personal growth and satisfaction. Many young parents indicate that having a child motivated them to cease risky or antisocial behaviours and lifestyles, and imbued their lives with a newfound sense of purpose, maturity, and responsibility.'*
>
> (Price-Robertson, AIFS, 2010).

Adopt a strengths-based approach

For you to adopt a strengths-based approach, see these young parents not just as people who are at risk, but rather as people who are going through difficult circumstances and, with the right support, can achieve positive, age-appropriate outcomes (Wolin, 1999). Help young parents to reduce existing problems and risk factors for future poor outcomes. Support them in finding their own strengths and in working towards positive personal and interpersonal outcomes consisting of more than simply the absence of risk (Wolin, 1999).

Young women and prenatal care

Many young women who present to services have received little or no prenatal care. While in most cases the pregnancy has been confirmed by a doctor, some may not have attended follow-up appointments.

Some young mothers get poor antenatal care because:

- They avoid follow-up appointments as they don't want to be judged as young mothers.
- They may expect a lower level of care due to their substance use.
- They don't want to deal with the pregnancy.
- They have a lack of knowledge about local services.
- They are unsure of whether to continue the pregnancy or not, and don't engage with services until they have made up their mind.
- They are experiencing domestic and family violence and their partner does not allow them to attend or they do not attend to protect themselves from further abuse.
- They have mental health worries, disabilities or other factors impacting them.

Get to know what young people think about their pregnancy and how this may affect their willingness to go to services and appointments.

> **Tip**
>
> When a young woman does not make it to her appointment, be careful not to rush to judgement. Money, transport, a lack of understanding about what antenatal care is and why it is important may have got in the way, rather than a lack of motivation.

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Keeping men visible

Keeping men visible as partners and fathers

It is always the right of women who are pregnant to make decisions about how involved their partner may be through their pregnancy and birth. Talk to women and help them and others follow through on what they want.

It is also important to recognise the role of men as partners—or at the least as fathers to their children, once born. Fathers can often become invisible in child protection work—especially during pregnancy.

A man can play an important role in supporting a woman during pregnancy, in meeting her goals of reclaiming her life from alcohol and drugs, and in how she seeks and maintains help from family or services. Involving men as partners and fathers in your work early can lead to better outcomes for women and children.

Ignoring men in child protection practice is problematic. It upholds the status quo, where women are entirely responsible for the care and safety of their children.

Parent relationships, substance use and child protection

Relationships between the parents you work with are likely to be complex and diverse. You will need to take the time to understand the relationships and how you can help fathers support their partner and become the father they want to be.

What if the parents are not a couple?

Whether the parents are in a relationship or not—during pregnancy and after the birth—try to keep the man engaged so safe contact can happen and he can be a positive father in his child's life. Your work can also help a man have a better relationship with his child's mother and build a stronger attachment.

Risks of domestic and family violence

Pregnancy is a risky time when violence can increase. Be mindful of and alert to the ways domestic and family violence can exacerbate a woman's AOD use during pregnancy as she copes and resists. You also need to make sure the woman's and her child's safety are at the forefront. Refer to the practice kit Domestic and family violence for ideas on safely partnering with mothers and holding fathers accountable for their behaviour.

If the father also has issues with problematic alcohol and drug use

If a man is struggling with his own problematic AOD use, becoming a father can be a strong motivator for change. Including him in your prenatal and postnatal work can be a catalyst for him to make better choices. If both parents have problematic AOD use, help men engage in healing and recovery work to control, reduce or resolve substance use. Their treatment can assist women who are trying to do the same.

Read more about working with men in the part Working with parents.

Building an identity as fathers and partners

Young men who are navigating adolescence face the challenge of building their identity and role as a man, and also as a father.

A young man may have experienced abuse, neglect, poverty or oppression, and these can greatly influence how he builds his sense of self as a man and what it mean to be a father. Many young men may have no strong positive male role models in their life and have little life experience to draw on. This can make the role of fatherhood daunting and overwhelming.

Connecting men to their roles as fathers and supportive partners can help them connect with their ideas of masculinity in a positive way.

Talk about:

- their childhood
- the father they wish they had
- their feelings when they heard they were going to be a dad. What were they happy about, worried about, and what would they like to be different for them, the mother and their child?
- the kind of dad they would like to be
- where their substance use fits in with their life and experience.

Ask them:

- What would life be like for them, their partner and their child if they took back their life from AOD?
- Who is a father in their community or network who they look up to? What is it about this man they like?
- How could this man provide support and guidance as they become a parent?
- What roles, values and ideas about parenting does that man have?

Further reading

> Engaging fathers: evidence review—a report into practices and knowledge for engaging fathers in child protection work (2014).

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Respectful engagement

Treat women with dignity and respect. They are more than a pregnant woman who drinks or uses drugs. They may be a mother already, a daughter, a sister, an aunt, or a survivor of violence and abuse.

Be interested in who a woman is, what matters to her and what she holds close. Help her talk about the fears and worries she has about working with you and other services.

Explore her fears and acknowledge the obstacles

Ask how she feels about her AOD use and becoming a parent. Name the shame and stigma by talking with her about how she may have experienced this from family, community and professionals, and explore whether this stigma has any impact on her willingness to access support.

Even though she may be very motivated to reduce or cease her AOD use, still acknowledge how difficult it is to stop or get control of problematic AOD use. Let her know you understand that just stopping her use is unlikely and could be dangerous for her or her baby.

Ask her what she knows about AOD use during pregnancy and her treatment options. If she has some information, ask her about who gave her this information and how. Talk about what worries her most about her substance use, for herself and her unborn baby.

Talk about her best hopes for being a mother

Explore what kind of mother she hopes to be. Talk about her thoughts on breastfeeding, co-sleeping and sharing parenthood with her partner.

If she has had a child taken in care previously, never ignore this experience. Acknowledge the pain she must have been through and invite her to tell you what it was like from her perspective, and the perspective of the child's father and her family. Ask her:

- What was happening in her life then?
- What happened that led to her child need to be in care at that time?
- What steps was she trying to take at the time her child went into care and then afterwards?
- How does she reflect on this time now?
- What would she do differently? Is she doing that now? What would she do the same?

- What does she think you could do differently or the same as previous workers to be useful now?

Responding to shame and stigma

It is important to be up-front and address the shame and stigma a pregnant woman may face when she is using alcohol and other drugs. Be clear and honest about why you are there and what you can do to help. Some example questions and statements include:

- I am curious about how you feel about me coming to see you today.
- I wonder what worries you the most.
- I wonder how you feel talking with me today.
- How can I help to ease your worries?
- I am wondering if you can tell me about your worries about your alcohol or drug use now you are pregnant.
- What has worried you or others about your alcohol or drugs use before?
- What worries you about once your baby is born?
- I know this must be really hard having me here today. I just want to reassure you I have worked with lots of parents who have struggled with alcohol or drug use.
- I understand how hard it can be to get control of your use or stop it.

Understanding a woman's fears

While the issues relevant to working with women in general are applicable to working with pregnant women, there are some unique issues you need to consider.

As already mentioned, being pregnant can be an important time for change. It is a time when a woman might be highly motivated to stop or reduce her drinking, come off drugs, or stabilise her drug use in order to have a healthy pregnancy and be the best mum she can be. As such it is important that Child Safety and other professionals working with the family make the most of this unique opportunity.

But pregnancy is also a time of fear for many expectant parents—especially fear that their baby may not be born healthy or may be taken from them. This fear can cause some parents to attempt to hide their AOD use, particularly by avoiding services that may uncover it. This isolates a vulnerable woman further.

Women's attempts to hide from services they fear may take their child can be interpreted negatively—for example, that they're disengaged from services and not wanting help. This fear of services can take the form of a mother who appears to:

- not keep appointments with prenatal services
- not book into hospital until very late in the pregnancy
- not talk about her own or her partner's AOD use

- not want to talk with service professionals who she sees as a threat to her and her baby
- be guarded about what she tells you and only offers the minimum information she has to.

When these things happen, people can make assumptions and women can be labelled as avoidant, neglectful or lacking insight into the impacts of AOD use on their baby. It is important to understand what motivates a mother's action (or perceived inaction) and work with them to overcome the deep fear they hold.

Further reading

Read more about strategies pregnant women use to manage the risk of detection in Pregnant women and substance use: fear, stigma, and barriers to care.

Partnering with women during pregnancy

A woman who is pregnant and fears having her baby taken away needs you to engage with her so she feels safe enough to talk with you and other professionals. This role in particular requires you to be mindful of the power and authority you hold as a Child Safety practitioner and of how families may view you.

Tip

Acknowledge this fear and invite conversations about power and authority. As a practitioner, you cannot step away from your authority, but you can provide opportunities for expectant parents to feel some control and be part of the decision-making process.

If your approach reinforces shame and stigma, fear or worry, the pregnant woman is unlikely to open up and unlikely to be willing to be vulnerable and work with you. The idea of becoming more vulnerable than she already is can be enough to stop her from taking the first steps towards treatment and recovery.

Supporting a pregnant woman

When working with a pregnant woman through an investigation and assessment or a support service case, consider what practical support you can offer to help her achieve her goals. Here are some ideas to start:

- Negotiate longer times for prenatal appointments.
- Negotiate consistent health workers for prenatal appointments if possible.
- Offer practical assistance to get to appointments if possible.
- Use a variety of methods to remind her of upcoming appointments.
- If appointments are missed, stay supportive and curious about why.
- Ask her how you can be of the most use.
- Link her to the hospital social worker.
- Link the woman to cultural or other supports.

Give the woman information about the potential effects problematic substance use can have on her unborn baby, and what to expect when the baby is born, for example:

- what medical care the baby may need
- where they will be cared for.

Help the mother think about and come up with questions for her nurses about the birth and care of her baby once born.

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Reducing risks during pregnancy

Working with parents to reduce risks for their baby

Babies are safer when their parents are getting antenatal care and treatment for their alcohol and other drug use.

What can stop women from getting help?

There are many reasons why a woman who is pregnant and using AOD may be reluctant to get help. These include:

- shame and guilt
- fear of Child Safety involvement
- fear of having a child taken from their care
- feelings of depression and low self-esteem
- belief or hope that they can change without help
- unsupportive, controlling or violent partner
- not having enough information about available services
- difficulties getting into treatment due to limited places and high demand
- lack of services due to geographical location.

Best interventions for a woman who is pregnant

The best interventions for pregnant women are holistic and women-centred. These interventions look at the specific needs of each pregnant woman who uses alcohol or other drugs — both at a practical level such as safe housing and financial assistance to mental health care, and the right treatment for their problematic substance use. Holistic care should encompass a range of health and psychosocial domains and address any practical barriers to the woman getting treatment — such as transport, money, housing, violence.

Treatments can include withdrawal or medical treatments with specific drugs, as appropriate, psychosocial interventions and nutritional support.

After delivery, follow-up and coordination is particularly important, including ongoing alcohol and drug treatment, medical management, health and developmental assessment of the baby, parenting support, contraceptive advice, and referral for additional support services.

Antenatal planning with Queensland Health

Expectant parents need Queensland Health and Child Safety practitioners to work together. Pre-planning is an essential part of casework with expectant parents. Some of the things to explore with service providers and the parents prior to the baby's birth include:

- minimising the shame and stigma parents may feel
- monitoring for neonatal abstinence syndrome
- engaging AOD professionals to support parents during the antenatal period—including getting involved in prenatal care and appointments
- current substance use and what this may mean for the birth, their behavioural and emotional presentation and any worries you have for their baby once born
- supports needed in hospital and once discharged
- where parents are up to in their readiness for change and how professionals can work together with them to motivate and sustain change
- breastfeeding (if this is what the woman wants) and how she might do this safely.

Involve clinical and other health professionals during the hospital planning meeting (via phone or in person) to ensure advice is shared.

Further reading

Read more about working with pregnant women who are using alcohol or other drugs, and about drug types, clinical responses and models of care in the Queensland's Clinical guideline: perinatal substance use.

Readiness for change

Consider how ready an expectant or new parent is to change the way they use substances.

Ask them:

- How do you feel about your AOD use now that you know you are going to be a parent?
- Do you want to change your substance use?
- Have you thought about changing the way you use AOD but not taken action yet?
- Is your alcohol or drug use something you feel does not need to change? Tell me more about that?

The kind of parent they want to be

Encourage parents to talk about their feelings, including their hopes and fears. Ask them:

- How do you feel about becoming a parent?
- What you are most excited about?
- What fears or worries do you have?
- What kind of mum or dad do you want to be?
- What about being a parent are you looking forward to?
- What will be challenging about being a parent?
- Sometimes becoming a parent can make people think about their own childhood. Can you relate to this? What was your childhood like?
- Now that you're about to be a parent, what do you think about your childhood?
- Did you grow up with alcohol or drugs around you? Tell me more about what it was like.
- Compared to your parents, what would you do the same or different for your child?
- Where does your AOD use fit in when you think about the kind of parent you want to be?

Listen out for her ability to make positive change

If AOD use was a worry that has previously contributed to a woman's child being taken into care, ask her what has changed or is different now. Ask what she has done or tried to do since then. Talk about how you can work with her this time. If it is an option, let her know that parenting her unborn child is a possibility.

Listen for indications of change in your conversations, for example, statements such as 'I want to stop' or 'I want to get help'. Ask her if she has tried to stop or take back her life from substance use in the past. Commend her for taking steps and ask her what happened and how it could be useful to her now.

Use an ecomap to talk about the family, friends and community that she is a part of. Use the Circles of Safety and Support Tool to explore who in her life knows nothing, something or everything about her substance use. Ask her about any cultural traditions, perceptions and values about parenting her baby.

Related forms, templates and resources

Circles of safety and support tool

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Assessing and planning for safety for babies

Assessing safety

Working with new and expectant parents requires the continual assessment of safety and an effort to build as much support around the family as possible.

The following tips are for assessing safety—particularly for new parents. Find more information specific to the safety assessment of children where there is parental alcohol or other drug use in the part on Safety assessment and planning.

Assessing safety before a baby goes home

Your work with parents during the antenatal period should give you a good sense of what safety looks like at the time the baby is ready to go home. However, if this is the first time you are meeting with the parents about your concerns, focus your assessment on:

- understanding the specific needs of the baby and any special needs or care required
- how AOD use may affect a parent's willingness, motivation or ability to meet the needs of their baby
- what the parents have done to address their substance use during the pregnancy
- things that may trigger substance use or things about caring for their baby that a parent may find hard (particularly caring for a baby with high needs, foetal alcohol syndrome or neonatal abstinence syndrome)
- the parents' level of dependence, drug type and use and how this affects emotions, behaviours and relationships between the parents and others
- the parents' thoughts, feelings and readiness to address their problematic substance use
- the presentation of both parents at the time of your assessment
- the parents' understanding of the risks of AOD, including co-sleeping
- the parents' intentions about sleeping and feeding arrangements and responses to information about risks of substance use and co-sleeping
- the safety of the home and the availability of safe sleeping surfaces for a baby
- practical assistance that parents may need to help them care for and keep their baby safe
- whether there is a safe adult in the home who understands the worries and who does not drink or use substances
- who in their safety and support network can help them care of their baby

- indicators of bonding and attachment (remember that a parent not taking every opportunity to visit their child in a nursery does not necessarily mean they do not care or are not bonded).

You will need to complete a SDM safety assessment before a baby goes home. Refer to Carry out a safety assessment for procedural guidance on safety assessments.

Name your worries

Be clear with the parents and their safety and support network about what the worries are with both parents.

Some may be immediate concerns such as safe AOD use, co-sleeping and breastfeeding. Others will be things to work towards through case planning goals over time, such as reducing or stopping substance use, and treatment and recovery. Be clear about Child Safety's bottom lines, why Child Safety is worried about their AOD use and how it causes danger or risk to their baby. The following suggestions may help.

I am worried that:

- when your baby is born and you binge drink unexpectedly, you will not be able to feed or care for him or her in the way you need to because you will be intoxicated
- when your baby is born that if you keep topping up your methadone with other drugs you may overdose or it will change the way you think, feel and respond to your baby
- when you are sleep deprived or struggling as many new parents do, you may turn to drugs to cope or you may fall asleep sharing the lounge or bed with your baby after you have used.

I am curious about:

- How you feel hearing that I am worried about your AOD use.
- What you think worries me the most.
- Whether others said they are worried.
- What others have said they are worried about.

What triggers a parent's alcohol and other drug use

Explore what triggers a parent’s alcohol and other drug use. Ask them:

- When I have talked with parents before, they have been able to name the things, people or places that would make them want to drink or use. Can you relate to this?
- What things make you want to drink or use drugs?

- Have you thought about what may trigger you once you have the baby?

Some common triggers include:

- not being able to settle their baby
- lack of sleep
- overnight feeding
- when the baby is irritable.

Safety plans

Using drugs (including prescribed medications) or alcohol may make parents fall into a deep sleep, which can be dangerous for their baby. Tell them that if they are going to use drugs or drink alcohol:

- **They should never** have the baby sleep with them in their bed. They should always put their baby in his or her cot.
- They may not wake for the baby's next feed or if the baby becomes distressed.
- They need to make a 'safety plan' and have a responsible adult to take care of the baby if they decide to use drugs or alcohol.

Help the parents make a list of telephone numbers of people who can help them in times of stress- the family's safety and support network. The list could include:

- family members or friends
- their GP
- their child health nurse
- their drug and alcohol counsellor.

Safe sleeping, breastfeeding and drug storage

Ask parents what they know about the key safety issues of safe sleeping, breastfeeding and drug storage. Gauge their opinions and make an assessment as to how safe that makes them. Ask them about:

Safe sleeping

- Have you read anything or spoken to anyone about the dangers for your baby if you co-sleep when you have been drinking or using drugs?
- What are your thoughts about it?
- Where do you plan on feeding your baby during the day? During the night?
- What things might help or get in the way of you being able to follow through?
- Can I have a look at where (the child) will be sleeping? I might be able to help.

Breastfeeding

- Have you read anything or spoken to anyone about AOD use and breastfeeding?
- What are your thoughts about breastfeeding your baby?
- Would it be helpful if we talk with your nurse or early childhood nurse?

Drug storage

- What have you already thought of and put in place to store your drugs?
- What have you put in place to make sure drug items (paraphernalia) are not left lying around and are thrown away safely? Have you put these plans in place already or are you about to?
- Would it be useful if we talk with your AOD workers about how to make sure you have things in place?
- Can you show me how you are storing and disposing of drugs and the things you use (paraphernalia) or would you be more comfortable showing your AOD worker? I would need your AOD worker to see and let me know what is in place.

As with many aspects of your work, go beyond just words. Follow through on all of the suggestions and questions. Come from a place of trust and non-judgement. All parents deal with the stress of making changes to their home and lifestyle to keep their babies safe. But your role as a change agent means having real conversations about the safe times and the unsafe times. This helps them make their home safer.

Building a safety and support network

Assess what people and services a family already has around them. Think about how to build on that so the child has as much support as possible and is more known and seen in the community.

Get a picture of who knows what about each parent's AOD use. Talk to the parent using questions such as:

- Have you spoken with anyone in your family or professionals about your AOD use before?
- What was it like for you?
- What was helpful?
- What was not?
- Who in your life knows something, everything or nothing about your AOD use?
- What have they seen or heard?
- What would they be most worried about for you/for your baby?
- If they were here, what would they say to you/to me?

Find out who is able to help them and who could potentially make life harder:

- Who do you turn to for support now?
- Who will you turn to for help about being a parent?

- If you were watching your life as a movie, who would you say are the people who help, hurt or hinder you when it comes to taking control of your AOD use?
- What did these people say or do when you said you were having a baby?
- When was the last time you needed to turn to someone? Who was it you turned to and how did they help?
- How do you think they could help you with your substance use and with being the parent you want to be?
- Is there anything that would hold you back from seeking help?

Further reading

Read the Safety and support networks and high intensity responses booklet.

Related forms, templates and resources

Safety and support networks and high intensity responses

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Keeping a baby safely at home

Building ongoing safety and wellbeing at home

Practitioners need to ask themselves, the parents and any other supports around the family (including health and alcohol and drug services) a lot of questions to ensure a child is safe at home.

Baby's needs

- How does this baby need to be cared for?
    - What temperament do they have?
    - Are there any health, medical or special needs?
    - What specific nurturing, care, safety and protection is needed in their home?
    - Are there signs of neonatal abstinence syndrome?
    - What are the sleeping arrangements and are safe sleeping practices occurring?
    - How is the baby feeding, particularly at night?
    - Have there been times co-sleeping or unsafe sleep practices have happened unintentionally?

The parents

- How are the mother and father coping in partnership?
- How are they coping, individually and together, with:
    - parenting tasks?
    - the level of care required?
    - their triggers for AOD use?
    - their actual AOD use?
    - withdrawal or abstinence?
- What role is the mother taking in caring for her child?
- Are there parts of care she is struggling with, not doing or is ambivalent about?
- What could be the reasons for these struggles or avoidance? Have you made assumptions about this?
- How has information and support been provided to her?
- Does it need to be provided differently?
- Does there appear to be a bond and attachment between mother and child?

The mother

- How does the mother feel about:
    - being a mum?
    - her baby?
    - the things that are good about being a mum?
    - the things that are not good?
    - the unexpected things?

- What emotions and thoughts has she been having?
- How does she respond to her baby crying?
- What physical connection and interaction is she having with the child?
- How does her relationship with her child make her feel about drinking or using other drugs?
- How does her AOD use get in the way of her relationship with her child?

The father

- What role is the father playing in caring for his baby and supporting the mother?
- How does he feel about:
    - being a father?
    - his baby?
    - the things that are good about being a father?
    - the thing that are not so good?
    - the unexpected things?

- How does he respond to his baby crying?
- What physical connection and interaction is he having? Does there appear to be a bond and attachment between father and child?
- If you are worried about his connection, what worries you and why?
- How does his relationship or life as a father make him feel about drinking or using other drugs?
- How does his AOD use get in the way of his relationship with his child?
- Has he found his new role in the family?
- Is he resentful of the time the mother puts towards the care of the baby?
- Has the baby affected his sense of freedom, for example, not being able to leave the house when he wants?

Engagement and follow-through with community supports

Have the parents:

- seen health professionals?
- gone to or made appointments for themselves or their baby?
- accessed, attended or participated in drug services, parenting services or supports as agreed?

- progressed in the change cycle—have there been steps backwards or forwards?

Breastfeeding

Women with problematic alcohol or drug use should be encouraged to breastfeed with appropriate support and precautions. Consult with health and AOD staff to explore safe options and to support women.

It may be reasonable to advise some women to express breast milk and discard, if they take a drug that was unplanned (rather than advising that they must not breastfeed at all). However, consideration must be given to the safe care of the infant if the mother has impaired judgement due to drug use.

Encourage the mother to consult with a health practitioner to help her understand the benefits and disadvantages of continued breastfeeding.

Tip

Mothers who use alcohol or other drugs and who breastfeed can be the subject of other people's judgements and bias. Use group supervision or other opportunities for critical reflection to explore your own feelings, particularly if a baby has entered care out-of-home care and the mother wishes to breastfeed.

Planning for safe breastfeeding

Planning to breastfeed starts during pregnancy. Health professionals can work with the parents to make sure the mother breastfeeds safely.

Different substances have different effects on a baby, and every substance including alcohol passes into the breast milk. Use the available fact sheets to talk with mothers, fathers and carers about alcohol, other drugs and breastfeeding.

Further reading

Further reading and information for parents: Queensland Government Health and Wellbeing website—Breastfeeding and drugs.

Suggested conversations with the mother include:

- 'Your local child health nurse can make sure that your baby is in good health and growing well. They can also offer advice on breastfeeding and caring for your baby. It is good to visit regularly.'
- 'There is still a lot we do not know about the effects of drugs on your baby when you are breastfeeding, but it is thought that, even at low levels, taking drugs is likely to:

    - make your baby drowsy, feed poorly and have disturbed sleep patterns and poor weight gain
    - cause behavioural problems.'

A breastfeeding plan

If a mother is still using alcohol, drugs, or both, talk to her about the following:

Alcohol

- When you drink alcohol, it passes into your breast milk.
- There is no known safe level of alcohol consumption while breastfeeding.
- Drinking small amounts of alcohol may reduce your milk supply and may cause your baby to be irritable, feed poorly and have sleeping problems.
- Avoid alcohol in the first month after your baby is born until breastfeeding is well established. However, if you are going to drink alcohol, you should:

    - breastfeed before drinking alcohol, or express and store breast milk before you drink
    - limit alcohol to no more than 2 standard drinks a day
    - avoid drinking immediately before breastfeeding
    - 'pump and dump' breast milk to help keep your supply and for comfort if you are not feeding for an extended time.

- It will take about 2 hours before the alcohol clears one standard drink from your system, 4 hours for 2 drinks, and so on (Source: Western Australia Department of Health).

Drugs

- You should not breastfeed for 24 hours after using amphetamines, ecstasy, cocaine or heroin.
- If you are going to smoke cannabis, breastfeed your baby before you smoke, and smoke outside and away from the baby. Do not have your baby in the same room as the smoke.
- If you have been using benzodiazepines (benzos), your doctor may want to change the type of drug you are taking. Some are better than others for breastfeeding.
- It is not safe to use inhalants while you are breastfeeding.

- It is not safe to breastfeed if you are still injecting drugs.
- If you are sharing or re-using injecting equipment, you can get blood-borne viruses such as HIV. HIV can be passed on to your baby through your breast milk.
- Many drugs such as amphetamines can be cut with substances that can get into your breast milk and harm your baby (Source: Western Australia Department of Health).

Practice prompt

Ensure that parents who are injecting drugs are aware of where they can obtain sterile injecting equipment and storage containers. See Queensland Pharmacy and Needle and Syringe Program.

Further reading

Find out more about using over the counter medications and prescription medications when breastfeeding at the Queensland Health and Wellbeing website—Breastfeeding and drugs.

Safe sleeping

Sudden and unexpected death in infancy (SUDI) is a general term applied when seemingly healthy infants die suddenly and without warning, usually after the infant has been placed to sleep or during sleep. While infants across all socioeconomic groups die in sudden and unexpected circumstances, infants known to child protection services are over-represented in SUDI deaths.

There are several factors that increase the risk and are referred to in research literature as ‘non-modifiable’ and ‘modifiable’ risk factors (American Academy of Pediatrics, 2011).

Non-modifiable risk factors are infant characteristics such as age, gender, premature birth, and low birth weight.

Modifiable risks—those that a parent can control—include:

- sharing a sleep surface with another person, especially when that person is affected by alcohol, drugs or prescribed medication
- sleeping on surfaces other than those designed or recommended for infants (such as a lounge, couch or beanbag)
- placing the infant to sleep on the stomach or side

- having loose or soft objects in the infant's sleep environment such as pillows, doonas and toys
- exposing the infant to cigarette smoke
- overheating.

> **Attention**
>
> Overheating a baby is a particular concern for parents who use substances. Some drugs can cause a change in temperature for a parent, which may lead to them overdressing and unintentionally overheating their baby.

> **Practice prompt**
>
> This Queensland Government website provides a guide on Safe sleeping.
>
> View the Red Nose safe sleeping mobile apps.

Give clear messages about alcohol and other drug use and co-sleeping

Co-sleeping is particularly concerning for parents who use drugs.

> **Attention**
>
> There is no safe way for a person using substances to sleep with their baby.

Be clear that a parent should never sleep with their baby, whether in a bed, on a lounge or other surface, when they have consumed alcohol, drugs, prescribed medications that cause drowsiness, or a combination of these (particularly heroin, methadone and cannabis). These slow down a parent's ability to react and makes them tired and drowsy.

Ensure you see where a baby will sleep and always talk about safe sleeping practices with the parents. Provide parents with well-informed and unambiguous messages about safe sleeping. Use language that is strong, clear and consistent. Support them in finding alternative, safe sleeping arrangements.

Some of this information may seem simple and obvious, such as ways to encourage habits so babies are always put to sleep in their cot. But tired and overburdened parents do not always

make the right choices, and they need the guidance of empathetic and respectful practitioners.

Monitoring progress in the early stages

Assess progress in the early stages of a person's experience as a new parent. Good progress here can set the standard for sustainable change. As mentioned, having a new baby is often a very stressful time for new parents. It's a time filled with anxiety and sleepless nights and a steep learning curve. All of these can be triggers for substance use.

Ask the parents:

- What parts of parenting have you managed well?
- What do you find a challenge?
- What do you enjoy most about being a parent?
- When do you feel sad or bad about parenting?
- How are you coping with night feeding?
- Where is the baby being fed?
- Have there been times you have fallen asleep?
- Have there been times you have felt like or have drank or used?

If the parent tells you they have felt like drinking or using, or have used alcohol or other drugs since the child has come home, ask:

- What was happening that made you feel like drinking or using?
- Who was looking after the baby at this time?
- How was the baby fed?
- Where and when did the baby sleep?
- What was it like before, during and after you used?

Many young fathers want to remain actively involved with their child (Duncan, 2007). Factors most likely to lead to a father's disinterest or non-involvement are financial difficulties or confusion about childcare (Rhein et al., 1997). Finding a service that is suitable for young fathers is important, as they may feel uneasy attending a playgroup where they are the only male parent.

Help young people overcome any lack of understanding by giving them the information they need about both antenatal and drug and alcohol services. Also help them to overcome other obstacles like transport, finances and support.

Find some more information about support for young parents at the Queensland Government Health and Wellbeing website.

What supporting young parents looks like in practice

Young mothers, and fathers, benefit from practitioners helping them:

- link to community-based support and services
- link to peer support programs so they can share their parenting experiences
- engage in weekly playgroup and positive parenting education sessions
- obtain parenting and relationship information and education
- link in with social, education and vocational training skills workshops
- link to life skill programs and/or mentoring
- make connections with other young parents
- develop positive parenting and relationship skills
- access education, employment and/or training.

United Synergies offers a range of programs and services that could assist people aged 12 to 25 years, including a younger parents program.

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Page history

9 December 2019
Page created

19 November 2019
Page created

Resources

'Queensland Clinical guidelines – Perinatal Substance use' provides information in relation to particular drug types, breastfeeding and how best to support mothers. Click this link and type into the search bar 'Perinatal Substance use' to access the guidelines.

For parents

Better Health Victoria information about FASD gives an overview of FASD, including diagnosis, treatment and where to get help.

'Neonatal abstinence syndrome (NAS) information sheet' provides information in relation to commonly asked questions about NAS. Click this link and type into the search bar 'Neonatal abstinence syndrome' to access the information sheet.

Queensland Government —Children's health, parenting and pregnancy This site provides general information about pregnancy, babies and health.

Safe sleeping provides parents with information about safe sleeping practices.

The national organisation for foetal alcohol spectrum disorders provides a number of great fact sheets about FASD: diagnosis and things to know about caring for a child, support groups available in Australia for parents, and useful links and resources in Australia and internationally.

Your Room provides information on AOD, including information specific to pregnancy and breastfeeding.

Queensland Health—Pregnancy and drug use. This is a parent information sheet based on Queensland clinical guidelines.

For Aboriginal and Torres Strait Islander women and families

Australian Indigenous Health*Info*Net provides information, resources (audio, visual and printable) and programs on a range of topics across Australia.

Stay strong and healthy This Facebook page has health information on pregnancy, looking after a new baby, drugs and alcohol and coping with feeling down.

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Page created

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Page created

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Page created

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Working with young people and alcohol and other drug use

Understand why young people use alcohol and other drugs, and support them through change and recovery in partnership with their family and community.

Seeing and understanding

Responding

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Page created.

5 December 2019
Page created

About this part

This part will help you:

- understand why young people use alcohol and other drugs, and how it harms them
- have conversations with young people about their alcohol or other drug use
- work with a young person to minimise harm
- involve parents and carers in casework to support a young person
- know how you can help young people get the support they need to change and recover
- explore your own values, bias and assumptions about young people, alcohol and other drug use.

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Young people's alcohol and other drug use

Understanding alcohol and other drug use by young people

Adolescence is a time of experimentation, curiosity and exploring of identity. For some young people, substance use is seen as a solution rather than a problem. The reasons some young people may drink or use drugs include:

- boredom or curiosity
- because it feels good and it's fun
- to rebel or to take risks
- as pain relief (emotionally and physically)
- because their parents drink or use
- for peer and social acceptance
- to escape or deal with uncomfortable feelings.

According to the Australian Department of Health (2014), the most commonly used substances by young people in order of preference are:

- analgesics (painkillers such as Panadol and Nurofen)
- sedatives (such as sleeping tablets and Valium)
- alcohol
- cannabis
- amphetamine type substances (speed, meth and ice)
- opiates (heroin, morphine and methadone)
- inhalants (glue and paint).

Note

Did you know:

40% of the alcohol consumed by underage drinkers (age 17 or younger) is given to them by parents.
18% of 16 to 24 year olds currently smoke cigarettes.
Daily smokers aged 12 to 17 smoke an average of 47 cigarettes a week.
16 is the average age that 14 to 24 year olds smoked their first full cigarette.
Analgesics are the most commonly used substance, with 95% of students aged 12 to 17 having tried them.

Sources: RaisingChildren.net.au, darta.net.au.

Myths and facts about young people's alcohol and other drug use

Myth	Truth
All drug use by young people will lead to problems later as an adult.	While there are very real risks associated with drug use, most young people who experiment with drugs will not go on to develop major problems in adulthood.
Drinking alcohol is a rite of passage and is safer than taking other drugs.	Although widely perceived as safe and acceptable, drinking alcohol is a risky activity that leads to many more deaths and hospital admissions than illegal drugs.
Most young people use illegal drugs.	The opposite is true. Most young people have never tried illegal drugs, let alone used them on a regular basis.

Source: Alcohol and Drug Foundation (2019).

How alcohol and other drugs cause harm

There is no safe level of alcohol or drug use for young people. Alcohol is the most commonly used and most damaging drug among young people.

The earlier a young person starts drinking, the greater their risk of alcohol-related problems in early adulthood and beyond. Young people who start drinking before they are 15 years old are 4 times more likely to develop alcohol dependence than those who don't start drinking until they are 21.

At extreme levels, alcohol can cause unconsciousness or abnormal breathing, and alcohol poisoning as a result of binge drinking can cause death.

Making decisions

Alcohol and drugs affect a person's ability to think quickly, make judgements, avoid dangerous situations or risky behaviour, and consider consequences. A young person under the influence of alcohol or drugs may be at higher risk of:

- being the victim of sexual, physical or verbal violence
- having unprotected sex
- not being able to deal with unwanted sexual or physical advances
- experiencing hallucinations or delusions that could lead to accidents or injury
- getting alcohol poisoning or losing consciousness
- being injured
- getting into trouble with the police
- losing control or behaving inappropriately
- harming important relationships or damaging their reputation.

Brain development

Adolescence is an important time for brain development, with lots of new nerve connections and pathways being made. Alcohol and drugs can interrupt this process and even cause mild impairment.

In the following video, Amir Levine (psychiatrist and neuroscientist) talks about how a teenager's brain is more susceptible to drug and alcohol dependence.

Youtube video URL:
https://www.youtube.com/embed/UNAbf3J3lR0?enablejsapi=1&showinfo=0&rel=0

Video Caption:
The teenage brain is primed for addiction.

Video transcript:

00:00

I think more and more now people see

00:06

addiction as a developmental disorder we

00:09

think about addiction as something that

00:11

just happens to adults but in truth is

00:13

it really has its root stemmed in

00:16

adolescence that when first that's when

00:18

first people most of the people who

00:20

become addicted try drugs for example if

00:22

you start using an illicit drug before

00:25

you're 18 you're 20 you have a chance of

00:27

we have a 25% chance of becoming

00:29

addicted but if you start using an

00:31

illicit drug after the age of 21 you

00:33

only have a 4% chance of becoming

00:35

addicted so adolescence is a is a

00:39

crucial time for the development of

00:41

addiction and I started to become very

00:44

interested in that because I looked at

00:45

the effect of nicotine on cocaine and I

00:48

found that actually nicotine has a very

00:50

unique ability to basically loosen the

00:53

DNA and Eric was talking about gene

00:56

expression and when that DNA is loosened

00:59

what happens is that when cocaine comes

01:01

along then there's a much more massive

01:02

increase of gene of gene expression

01:05

that's related to addiction and in my

01:08

research I started looking at the effect

01:10

of nicotine specifically on cocaine and

01:13

I found that nicotine has this effect

01:15

that it increases gene expression that's

01:18

related to addiction but what I found

01:20

actually later in adolescence was

01:22

something very different I didn't expect

01:23

that I thought that nicotine would do

01:25

that even more so in adolescence but I

01:27

found something very different because

01:29

when I looked at the adolescent brain at

01:32

baseline I saw that the gene the DNA was

01:35

already loosened up in that particular

01:37

area in the brain in a nucleus accumbens

01:39

so at baseline the adolescent brain is

01:41

much more sensitive to the effect of

01:43

almost any other drug of abuse and so if

01:46

you expose that a lesson brain to any

01:49

any of those drugs you'll get more of

01:51

that growth that Eric described because

01:54

the DNA is more open basically open to

01:56

soaking up new experiences so this is a

01:59

compact DNA that you see that often time

02:02

in adults and what I saw in adolescence

02:05

or something was a very different

02:07

picture it was something more like that

02:08

a much looser DNA so the the gene

02:12

expression so

02:13

jeans that are over there basically can

02:15

get expressed a lot more in that

02:19

particular stance when it's more loose

Alcohol and other drug use, and mental illness

- Around 1 in 35 (2.8%) Australians aged 4 to 17 experience a depressive disorder.
- 1 in 4 (26.4%) Australians aged 16 to 24 currently have a mental health condition.
- A study from the University of Sydney's Brain and Mind Research Institute spoke to 2,122 young people seeking mental healthcare from Headspace centres. It found that 12% of those aged 12 to 17 were drinking alcohol on a weekly basis, and 7% were using cannabis at least once a week.
- Suicide is the biggest killer of young Australians and accounts for the deaths of more young people than car accidents (Youth Beyond Blue (n.d.), Hermens, et. al.).

Mental health and substance use are major challenges for young people. They may drink alcohol or use drugs to cope with undiagnosed mental health conditions or they may develop mental health conditions because of their AOD use.

Alcohol, cannabis, amphetamines, hallucinogens and inhalants affect our brains in different ways. Some act as depressants, while others are stimulants and hallucinogens. Some effects of alcohol and drugs in young people include feeling anxious, agitated, moody, depressed, flat, unmotivated, aggressive or paranoid. These changes can lead people to do things they would not normally do, such as being aggressive and violent, or taking risks.

Note

Some young people seem to be more vulnerable than others. For example, of those who smoke a lot of cannabis, about 2 to 3% will develop psychotic symptoms such as hallucinations, delusions, and confused or disturbed thoughts. Young people with a family history of alcoholism have a much bigger risk of developing problematic alcohol use.

'Things I normally found enjoyable would start to not be so good, I would not want to see friends or talk to people. I would feel really upset like I wanted to cry all the time.'

(Andrew, 18 from beyondblue—Depression.

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Young people and problematic alcohol and other drug use

Problematic alcohol and other drug use for young people is more than just risk-taking behaviour. Understand why AOD use becomes a part of the daily lives of some people, and why their use becomes problematic.

For many, the use of alcohol or drugs is one of the ways they resist, cope and survive. They need your support. Take time to get to know the young person and their whole story, not just their story of AOD use or the problem behaviour you first see.

If a young person says any of the following, it indicates that their AOD use may be risky or problematic for them:

- I drink or use all the time, every day, often and regularly to get through a day or cope.
- I drink or use to 'numb' out or escape from the bad ways that I feel inside.
- I drink or use to forget about the bad things that have happened to me.
- I do not go to school or cannot learn because of the way AOD use affects me.
- I am starting to think and see things that are not real. I am paranoid about other people and what is happening around me.
- I have problems with my friends/ parents/ carers because of my drinking or using drugs.
- I cannot cope when I am not drinking or using.
- I go through signs of withdrawal when I am not drinking or using.
- The way I live each day depends on whether I am drinking or using.
- My time, thoughts and feelings revolve around getting and using alcohol or drugs.
- Sometimes I [*break the law / are sexually exploited*] to get alcohol or drugs.
- When I buy or use I am around people and places that hurt me.
- The only people that I hang around are other young people and adults who drink or use with me.

Further reading

Working with young people with drug or alcohol related problems means practitioners will often be working with young people who have experienced trauma in some form. View information on trauma informed care at the Youth Drugs and Alcohol Advice (YoDAA).

Some young people are more vulnerable

Risk factors for a young person becoming dependent on alcohol and drugs include:

- genetics and family history
- mental health issues
- the age when they started using alcohol or drugs
- family and childhood experiences, including abuse, neglect and trauma
- social environment (cultural and social norms regarding alcohol and drugs)
- the types of drugs they use
- not going to school or not working.

Some groups of young people are at greater risk of using substances, usually due to a lot of stress in their lives. These young people tend to be:

- very young adolescents
- lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ+)
- ethnic and religious minorities
- young or expecting parents
- those in juvenile justice or closed settings
- from war-torn societies
- be refugees
- immigrants
- Aboriginal and Torres Strait Islander
- homeless
- in out-of-home care.

Further reading

See the resources section for information from the organisation 'Open Doors' about working with LGBTIQ+ young people.

See the practice kit Safe care and connection for information on working with Aboriginal and Torres Strait Islander young people.

Alcohol and other drugs use as a way of coping and surviving

A young person's problematic substance use can be a way of coping and surviving—their way of dealing with pain and their way to protest what is happening with them. They may be trying to manage or self-medicate feelings of anxiety, depression, hopelessness and grief.

They may be experiencing violence, sexual abuse, physical abuse, neglect, mental health issues or trauma.

Understanding why a young person drinks alcohol or uses drugs will help you see the underlying issues that need to be addressed to support them to decrease or stop their problematic use.

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Talking with young people

When talking to a young person about their problematic alcohol or other drug use, remember to be strengths-based and safety-oriented. Young people are vulnerable and at risk of harm. Avoid labels, be aware of stigmatising language, and do not blame and shame.

Tips for talking to a young person about using drugs for the first time

In this clip, Youth Drugs and Alcohol Advice (YoDAA) talks about how to plan a conversation when you talk to a young person for the first time about their drug use.

Youtube video URL:
https://www.youtube.com/embed/ecvOAfTVR1M?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Tips for talking to a young person about using drugs for the first time.

Video transcript:

00:06

raise any concerns about drug use with a

00:09

young person who care about love or

00:11

support can be really really hard it's

00:13

not something that's easy to do there

00:15

are actually some of the practical tips

00:17

that can make it easier so some of the

00:22

things that we always recommend our can

00:25

you plan the best time to have that

00:26

conversation the time when you're ready

00:28

for it

00:29

it's likely the young person you care

00:31

about is ready for it when we raise a

00:36

topic of drugs with young people it's

00:39

important that they know that you're

00:40

there to support them and it's not about

00:43

than being in trouble we want them to

00:45

know that you can work with them through

00:47

this and that they're not alone can you

00:52

pick a place or a time or a setting

00:55

where the young person feels really

00:56

comfortable so conversations about drugs

00:58

and alcohol can often make people really

01:01

fearful or feel threatened or feel you

01:05

know they probably either run and hide

01:06

or get very defensive and angry so can

01:09

you choose a place at a time where

01:11

everyone feels really comfortable can

01:16

you do it in a way which is going to

01:17

feel much more like a conversation about

01:19

support and about care and love it's

01:26

really important to be in touch with

01:27

your own emotions about this type of

01:30

subject especially when you're talking

01:31

to a young person the motions can be

01:33

really strong so it's really important

01:35

you're aware of how you're feeling

01:36

especially when you're planning to talk

01:38

to a young person so if you can talk to

01:41

a young person raise your concerns when

01:43

you are feeling calm or when you're

01:47

feeling on top of your emotions so that

01:49

you can be really useful support out of

01:52

that young person

Keeping safe

Talk with young people about what is risky about the way they drink or use, and how they can keep safe or control their use. Risks to talk about include:

- overdosing
- sharing needles
- drinking or using alone
- blackouts
- becoming violent or being a victim of violence
- unsafe sex
- polydrug use (using more than one type of drug)
- accidents or injuries
- driving while intoxicated
- suicide and self-harm
- misuse of prescribed medication.

Motivating change

Simply telling a young person to stop using can have little effect and may even damage the relationship you have with them. Try to discuss changing their harmful behaviour and support them in doing so. For change to occur:

- The young person needs to be motivated to change their AOD use and behaviour—'I want to stop the harm drinking is causing me.'
- The young person needs to have knowledge and understanding of what constitutes risky behaviour in relation to their AOD use—'I know that binge drinking is harming my brain development.'
- The young person needs to be enabled with the opportunity, tools and resources to change their behaviour—'I have a stable place to stay and I have the tools and support I need' (YouthAOD toolbox–Facilitating Behaviour Change).

Being an ally

Conversations with young people need to strike a balance. Be clear about the harms of AOD use and why you would like to see them stop using, while also acknowledging how hard this might be for them. Talk to them about ways to make their current use safer in the short term. Some ideas for this conversation include:

- 'It's safest if you don't drink or use drugs, but I recognise this is a part of your life right now. If you're going to drink or use drugs, let's make sure you have the information you need to keep safe.'
- 'I'm always here to talk to you about your use or the things that might be troubling you. I'm not going to judge you. In fact, I'm proud of you for being able to open up and talk to me.'
- 'You told me that you use alcohol or drugs to numb the pain. I can understand that, but I worry that you might get hurt when you're using. Let's think about ways you can stay safe when you use alcohol or drugs. Later on we might talk about some other things you could do to help with the pain.'

Minimising harm

Encourage the young person never to use drugs alone, and to use when they are with safe people. Drugs and alcohol can cause blackouts, making a person vulnerable to accidents, assaults, and overdoses.

Ask if there is someone they can call for help if they get into trouble, and add their name to the safety plan. The Strong bonds website has some great tips on talking with young people about their lives, where they live, relationships and supports.

What if a young person doesn't want to change their drug use?

Watch the following short clip by Youth Drugs and Alcohol Advice (YoDAA) on why an environment that supports change is just as powerful as someone wanting change.

Youtube video URL:
https://www.youtube.com/embed/h13U61O0shE?enablejsapi=1&showinfo=0&rel=0

Video Caption:
What if a young person I care for doesn't want to change their drug use?

Video transcript:

00:06

young people can sometimes be very

00:08

resistant to change and that can be

00:10

really frustrating disheartening

00:13

especially when we're told that unless

00:15

someone wants a change there's not much

00:16

you can do we actually think there's

00:19

actually quite a bit you can do so you

00:22

can ask yourself is the environment

00:25

around the young person that I care and

00:27

support about one that promotes change

00:33

change with young people is inevitable

00:35

anyway so it's about creating an

00:38

environment where other things for young

00:40

people other than drug use is just as

00:43

appealing so it's about finding things

00:45

that they're interested in that might

00:47

give them a good sense of self or some

00:50

positive reinforcement so it's about

00:52

finding other things in their lives that

00:54

they might get enjoyment or support or

00:56

comfort from so it could be support

00:58

groups it could be things that where

01:00

they're connected with other peers it

01:02

might also be linking them in with

01:03

mental health services

01:07

so change in itself isn't always the

01:10

same for every person so even when a

01:13

young person might not be changing in

01:15

the way that you want so they haven't

01:17

completely given up their drug use or

01:20

alcohol use they can still be making

01:22

changes that could be very positive

01:26

just keep the lines of communication

01:28

open so when they are ready for change

01:31

and when they might want to have some

01:33

support that they know that they can

01:35

come to you for that at that time

01:46

you

Supporting withdrawal, treatment and recovery

Making the decision to decrease or stop using is a big step for young people. Recognise and celebrate their courage by acknowledging and supporting them in this journey. Talk with the young person about what they need from you, from their family and from others.

Remember that withdrawal is a physical, psychological and emotional process. You may need to explain what to expect—how their body might respond and why, and what thoughts and feelings they might experience. Remind them that any negative effects will pass.

Young people need special care and support during withdrawal. Help connect them to the right AOD services and ensure your contact with them is frequent, encouraging, compassionate and supportive.

If they lapse during the recovery process, they will need your support even more. You need to keep them motivated and hopeful. There is no one size fits all approach when it comes to treatment for young people, and the underlying factors leading to their use needs to be addressed at the same time.

Practice prompt

If you have concerns about a young person's wellbeing when they are withdrawing from alcohol and other drug use, seek professional medical advice. All hospital emergency departments have a Drug and Alcohol Brief Intervention team (DABIT) that can assist. Ensure this referral is requested if a young person is attending an emergency department. See more about DABIT in this document.

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Talking with parents and carers

It can be difficult for parents and carers to acknowledge that their child is using AOD. They may need your help to understand what is happening and how they should respond.

Some things to consider when talking with parents and carers:

- What do they know about the child's AOD use?
- What signs, behaviours, emotions and other symptoms have they noticed in the child?
- When did the AOD use start? What was happening? What triggered it? Has the child been through something traumatic recently or in the past?
- What do they think of the child's use and how they are reacting and responding to it?
- Have they talked to the child about their use? If so, what was this conversation like? How did they and the child react to the conversation?
- What are their views on harm minimisation? What are their expectations about AOD use, treatment and recovery?
- What are the risks and safety issues for the young person when (buying AOD, using AOD, they use with others, they are intoxicated and experiencing withdrawal)?

Ideas on what parents and carers can do to build safety:

- Be an active part of the child's life.
- Listen to the child and make time available to do so.
- Be a role model.
- Be honest with them.
- Pick their moment.
- Be calm throughout.
- Avoid conflict.
- Keep talking.
- Set clear boundaries.
- Focus on positives.
- Spend positive time together.
- Help young people learn to be safe.

The following video gives some tips on communicating with young people if there is concern about AOD use.

Youtube video URL:
https://www.youtube.com/embed/_JRfqbFmG5Y?enablejsapi=1&showinfo=0&rel=0

Video Caption:
I found out a young person I care for is taking drugs, now what?

Video transcript:

00:02

if you've just found out that a young

00:04

person that you care about is taking

00:06

drugs or might be taking drugs our very

00:09

first message to you is there is hope

00:12

there are amazing support services

00:14

available that you may not even know

00:15

about yet and there's also information

00:18

and a lot of research being done as to

00:21

what you can do in this moment to best

00:23

support and help them it's really

00:28

important if you find out that a young

00:30

person's using drugs that you don't jump

00:32

to conclusions jumping to conclusions is

00:35

normal but having a knee-jerk reaction

00:38

can be really problematic for the young

00:40

person so it's about supporting them in

00:42

a non-judgmental way

00:46

it's totally normal to feel ashamed to

00:50

feel disappointed to feel angry and feel

00:53

her

00:53

but if you check in with how you feeling

00:55

we can avoid passing on any of these

00:57

feelings to do a person many people who

01:02

are worried about a young person's drug

01:05

use feel they would like to talk to the

01:07

young person but a bit unsure as to how

01:09

to go about that we really recommend

01:11

that you plan that conversation and

01:13

think it through a little bit before you

01:15

go into it and we can support you to do

01:18

that there are also some resources and

01:19

the former videos and articles that

01:21

might help you to consider that

01:23

conversation

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Working with young people

Naming or revealing the problem

Once rapport is built, you can explore the following questions with young people. If they answer yes to any of the following questions, it is a signal that they may have problematic AOD use:

- Do you drink because you have problems or to relax?
- Do you drink when you get mad at other people, including your friends or parents?
- Do you prefer to drink alone rather than with other people?
- Is your work or education suffering as a result of your drinking?
- Have you ever tried to stop drinking or to drink less and found that you can't?
- Do you drink in the morning, before school or work?
- Do you gulp your drinks?
- Do you ever have loss of memory due to your drinking?
- Do you lie about how much or how often you drink?
- Do you ever get into trouble when you're drinking?
- Do you get drunk when you drink, even when you don't mean to?
- Do other people comment about your drinking and think it's a problem?

Source: Signs you might have a drinking problem

Explaining harm from alcohol and cannabis to a young person

The following, highly acclaimed animations discuss adolescent brain development and the effects of alcohol and cannabis on different brain regions and on behaviour. They present complex and up-to-date neurobiological research in a way that is engaging and relevant for teenagers.

Youtube video URL:
https://www.youtube.com/embed/g2gVzVIBc_g?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Under Construction: Alcohol and the Teenage Brain

Video transcript:

00:06

adolescence is the transition from

00:08

childhood to adulthood

00:09

encompassing a period of major physical

00:12

emotional intellectual and social change

00:15

our brains also change considerably

00:18

during this time the developing brain is

00:22

a learning machine and from when we're

00:24

born

00:24

it grows enormous ly as we learn more

00:26

and more about the world

00:28

this means we end up with billions of

00:30

connections in our brains but many of

00:32

these pathways are either too slow or

00:34

not needed it's during the teenage years

00:38

that our brains are renovated whereby

00:40

most of these unnecessary connections

00:42

are removed or pruned away at the same

00:46

time the connections that are kept are

00:48

insulated to allow for faster

00:50

communication across the brain a process

00:52

called myelination pruning and

00:56

myelination occurred gradually over the

00:58

teenage years and are greatly influenced

01:00

by our experiences and interactions with

01:03

the outside world including the alcohol

01:05

and drugs we choose to take let's take a

01:09

closer look inside the brain the frontal

01:13

lobes take the longest to develop by

01:15

about 25 they've become your Center for

01:18

decision making helping you to plan and

01:20

organize focus your attention control

01:22

your mood and behavior and solve

01:24

day-to-day problems the temporal lobes

01:28

are like an information processing

01:30

center that builds your library for

01:32

sounds speech learning and memories the

01:36

cerebellum integrates your senses

01:38

helping you to balance control and

01:40

fine-tune your movements the

01:43

hypothalamus is involved in many

01:45

functions including the release of

01:47

hormones that help regulate your

01:49

temperature hunger thirst and sexual

01:51

development and the brainstem is like

01:55

the final checkpoint for information

01:57

going to the body from the brain and

01:59

vice versa

02:01

alcohol affects the teenage brain

02:04

differently to the adult brain because

02:06

it's still developing and not all areas

02:08

are fully operational how you feel when

02:12

you drink alcohol can be an indication

02:14

of the damage it's doing to different

02:16

areas in your brain alcohol affects the

02:20

frontal lobes first making you feel

02:22

relaxed and reducing your inhibitions

02:23

this means you may talk more freely Axl

02:26

out or rowdy or do foolish things you

02:29

later regret

02:29

as you continue drinking your brain

02:32

starts slowing down reducing your

02:34

ability to concentrate make good

02:36

decisions and control your emotions and

02:38

impulses this means you might do things

02:41

you otherwise wouldn't in the

02:45

hypothalamus alcohol blocks the hormone

02:48

that tells the kidneys to reabsorb water

02:50

this means more water is lost as waste

02:54

reducing the amount of water available

02:56

to the brain makes you dehydrated which

02:59

explains the headaches and body aches

03:01

you may experience the next day

03:02

otherwise known as a hangover alcohols

03:07

effect on your cerebellum is evident

03:09

when you lose your balance and fall over

03:11

or have difficulties with standing and

03:13

walking this is why injuries are so

03:15

common when people are intoxicated

03:18

drinking alcohol particularly affects a

03:21

part of the temporal lobe called the

03:23

hippocampus which enables us to form new

03:25

memories alcohol interferes with the

03:28

transfer of information from short-term

03:30

memory to long-term memory so if you

03:33

drink heavily over a short period you

03:35

may experience a blackout meaning the

03:37

next day you can't remember what you

03:39

said or did drinking at a level that

03:42

causes blackouts means you're also much

03:44

more likely to do something you wouldn't

03:46

usually do and your friends may not be

03:48

aware of how drunk you really are during

03:53

your teenage years you need to look

03:55

after your brain to keep it healthy just

03:57

like other parts of your body our

03:59

scientists are learning more about the

04:01

brain all the time and research has

04:03

shown that the damage alcohol does to

04:04

the developing brain is not only

04:06

short-term but may be permanent

04:10

look after your brain it's the only one

04:13

you've got

Youtube video URL:
https://www.youtube.com/embed/FvszaF4vcNY?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Effects of cannabis on the teenage brain NCPIC + Turning Point

Video transcript:

00:03

during our teenage years how we interact

00:06

with the world changes we seek out new

00:09

interests and experiences take more

00:12

risks and spend more time with our

00:14

friends and less with our family these

00:18

behaviors have developed through

00:19

evolution to make sure we push ourselves

00:22

so that we learn to become independent

00:24

from our parents by putting ourselves in

00:27

new and challenging situations different

00:29

parts of our brain learn to work

00:31

together

00:32

forming brain circuits that can

00:33

communicate with each other rapidly to

00:35

help us respond in different ways

00:38

ensuring that our brain is wide in the

00:41

right way during the teenage years with

00:43

strong and healthy brain circuits is

00:45

critical to our future and how we get

00:47

the most out of life 3 the most

00:49

important circuits that are developing

00:51

during this period are those involved in

00:53

learning and memory motivation and mood

00:59

learning in memory circuits control our

01:02

ability to receive store and recall

01:04

information

01:07

our motivation circuit is supported by

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an inbuilt reward system that helps us

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to decide if something is important and

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whether we should do something to get it

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our mood is shaped by emotional circuits

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that interpret how we experience and

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react to different situations and

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interactions making sure these

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particular circuits wire in the right

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way during our teenage years is the

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brain zone occupational health and

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safety team the endocannabinoid system

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the endocannabinoid system is a complex

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and delicate brain system which helps to

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fine-tune communication within these

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circuits ensuring the wiring is

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assembled correctly damaged cells are

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repaired and the right connections are

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strengthened for the future when looking

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into the effect of cannabis on the brain

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scientists found that we naturally

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produce a brain chemical called an and

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amide that is similar to cannabis

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concentrations of an and amide are

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delicately calibrated for it to

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accomplish its critical role within the

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endocannabinoid system this is why if we

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add cannabis into the brain it causes

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the endocannabinoid system to become

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flooded with cannabis chemicals it's a

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bit like dumping a bucket of salt on

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your chips instead of a pinch or like

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stadium speakers being plugged into your

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iPod constantly disrupting the

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endocannabinoid system with cannabis

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impacts how your brain develops and in

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particular how the mood motivation and

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learning and memory circuits get wired

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short-term memory loss is a common

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characteristic of long-term heavy

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cannabis use because when you use

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cannabis less information gets saved as

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memories this is why it's harder to

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learn and remember new information which

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can lead to significant drops in school

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grades cannabis can reduce your ability

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to focus attention to organize yourself

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and make decisions not just when you're

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using cannabis but for weeks afterwards

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cannabis use can also lead to loss of

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motivation heavy users can feel detached

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and disinterested in things they used to

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like such as sports hobbies and catching

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up with friends it can also lead to low

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self confidence that

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turn affects your mood making it more

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difficult to manage everyday stresses

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worries and frustrations which can

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result in prolonged low mood anxiety and

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depression while these effects are

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commonly experienced by people who use

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cannabis regularly new research suggests

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that these effects are worse and more

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permanent for people who start using

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cannabis while their brain is still

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developing this is because the

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endocannabinoid system plays a central

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role in the development of your neural

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circuitry during the teenage years the

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developing brain has a pretty good

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blueprint to work off but our

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experiences and interactions with the

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outside world also help to shape these

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neural circuits that we will rely on as

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adults your teenage years are an

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adventure that sets you up for life

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enjoy the ride and look up your brain

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it's the only one you've got

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Conversation ideas for talking to young people

Building safety with a young person

Back to top

You need to be a young person's ally without condoning their AOD use. Help them decide the best way to be safe and minimise harm when they drink alcohol or take drugs. Here are some ideas for this type of conversation.

Print out the table below

Short question	Conversation
Short questionWhat kind of alcohol or other drugs do you use?	Conversation I'm wondering or I'm curious about: • When you go out to have a good time with friends, what are you likely to drink or use? How do you decide what you will take? How easy is it to get? • Have there been times where it's hard to get or you can't get it? What did you do? What do others you are with do? • Do you drink or use different things at different times? Have there been times you have mixed alcohol or drugs in one session?
Short questionWhat are the people, places, feelings or things that make you drink or use?	Conversation

Short question	Conversation
	I'm really interested to learn about the times that would make you want to drink or use. People • Do you have certain people you drink or use with? • How do you decide who? Would you say you plan to drink or use or it just comes up, or something else? Places • What places would make you want to drink or use or make it easier for you to? Feelings and emotions • Have there been times you have drunk alcohol or used drugs to cope with tough stuff you are going through or have been through? • When you drink or use, what kind of feeling are you hoping for or what do you hope happens?
Short questionWhen has it become a problem or made you unsafe?	Conversation • Sometimes when people drink or use drugs they are taken advantage of or find themselves in unsafe situations. Can you relate to that?

Short question	Conversation
	• I'm wondering if this has ever happened to you, or have you seen it happen to someone or heard about it? • I'm curious what your thoughts are on keeping safe. • Tell me about times when you may have felt unsafe or worried when drinking or using. • I am curious to know if you have ever felt worried but not able to speak up at the time. • Have you ever woken up, come down and regretted something that has happened? • On a scale of 0 to 10, with 0 being completely unsafe and 10 being completely safe, how safe do you generally feel when you drink or use? Tell me more about that. • On a scale of 0 to 10, what is the least safe you have ever felt when drinking or using? Why? • Has anyone ever talked with you before about your safety or things to think about or plan for?
Short questionWhat are the good and not so good things about it?	Conversation I'm really interested to know more about the things you like about drinking or using. Good things

Short question	Conversation
	• What are the good things about using? • What do you like about the effects? • What would you miss if you weren't using? Not so good things • What are the less good things about using? • What are the things you wouldn't miss if you stopped using? • Do you have any concerns about your substance use? • Do these things worry you? What worries you the most? • If you could wake up tomorrow and things about your alcohol or drug use could be better, what would be different? • What would others notice was different? How would you feel inside? • How would you be spending your time?
Short questionDeveloping a safety plan with young people and finding out about their use	Conversation Things that may make them unsafe when using AOD: • how much they drink or use drugs • how often • the way they take drugs • who they take drugs with

Short question	Conversation
	What things make it risky for them: • how they purchase their AOD • where they use • who they use with Things that can be done right now to make them feel safer or reduce the risks (harm minimisation): Who are safe people they can call on?
Short questionConnecting young people to safe adults	Conversation Who can be a part of their safety plan to keep safe? Who will be available to talk about AOD use, harm minimisation and keeping safe and healthy? Who can check in with the young person or be there if they need them?

Supporting young people

Back to top

Young people may be frightened, worried about your role, and what may happen if they talk about their AOD use. Always be prepared that a young person may:

- be defensive about their AOD use
- not want to talk to you
- be abrupt, aggressive or hostile towards you
- be ashamed, embarrassed and worried.

Take time to get to know the young person and build a relationship with them so that you can learn about their strengths, talents and interests as well as the difficult things that are impacting on their lives.

When you talk with a young person, here are the things you should do:

- Look for different ways to talk with them about their AOD use.
- Try to talk with them often; one conversation is never enough.
- Explore the best and safest place for them to talk with you.
- Explore who should be there or not there during different conversations you have together about AOD.
- Help them have conversations about their AOD use with their parents, carers and other important people.
- Stay neutral if they have a relapse or struggle to make the changes that you hope for.

And these are things you should NOT do:

- Do not lecture, shame, embarrass or blame them for problematic or risky AOD use.
- Do not label them or disengage from them because of what they say or how they act towards you.
- Never blame them for being abused or assaulted when they have been drinking or using.
- Do not minimise or avoid the topic of sexual consent with a young person, their family or professionals if the young person is assaulted while under the influence. Responsibility for the assault needs to remain with the offender, not the young person.

Assessing alcohol and other drugs use

Back to top

Working it out with YoDAA is an online tool to help young people look at their alcohol and drug use. It provides feedback and handy resources, such as the My use diary to monitor their AOD use. The young person may want to use the tool with you, with their parent, with a friend, or by themselves.

We use motivational interviewing with adults who have problematic AOD use. The questions and principles of this practice apply equally to young people. Some motivational interviewing questions you could ask the young person include:

Three Houses / Road Map

Ideal scenario

- How would you like things to be in the future?
- If things were different, what would you be doing?
- If a miracle happened tonight, how would things be in the morning?
- What do you think could happen over time?

Right now

- How would you describe things at the moment?
- Are you where you want to be right now?
- What would you say is the first step you can make right now?

Support for change

- What support do you need from (me, your parents, your carers, services)?
- What things could get in your way?
- How could we plan for that?
- What things in your life would need to change to help you do this? Friends? Places you go?
- How could we support you in making those changes?

Listening and understanding

Back to top

Having 'curious' conversations will encourage the young person to open up, giving you the opportunity to understand how they see things and how you can work together to reduce the risk of harm. Here are some discussion starters:

- I'm really keen to understand what your AOD use means to you.
- I'm wondering how cannabis plays a part of your life.
- I'm curious how you feel 'ice' may be impacting on you.
- I'm wondering what other people may say about your use of alcohol.
- I'm curious to know what worries you have about your drug use.

Stages of change

You need to understand the stages of change in AOD use, know what stage the young person is in, and help them move through the various stages. For ideas on how to work with young people during each of the stages, read these ideas from the YouthAOD Toolbox:

- Ideas for working with young people in the precontemplation stage
- Ideas for working with young people in the contemplation stage
- Ideas for working with young people in the preparing stage
- Ideas for working with young people making changes stage
- Ideas for working with young people in the maintenance stage

> Tip

Watch: Treatment matching for the stages of change (Dovetail, 2019)

Youtube video URL:
https://www.youtube.com/embed/q2hfQeKTaR0?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Treatment matching for the stages of change

Video transcript:

00:01

[Music]

00:03

once you've identified which stage of

00:05

change a young person might be in you

00:07

can match your treatment interventions

00:09

in order to get the best outcomes for

00:12

[Music]

00:14

young people who you assess as being in

00:17

the pre contemplation stage it's

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important to spend time developing a

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trusting therapeutic relationship often

00:25

these young people aren't worried about

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their use and may not care about the

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consequences family or loved ones are

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concerned about so you want to avoid

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lecturing or confrontations instead try

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to explore the issues that the young

00:38

person is worried about it's helpful to

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consider the family household and

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community the young person is coming

00:45

from and explore their capacity to make

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changes in their current environment

00:51

often working with a young person in the

00:53

pre contemplation stage means harm

00:55

reduction advice is going to be a main

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strategy it's saying you're not ready to

01:00

make changes today so what can we do to

01:02

reduce the harms we've made a whole

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video on universal harm reduction advice

01:07

so we won't go into that any more here

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but you can find that on our website or

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YouTube channel young people in the

01:15

contemplation stage are often weighing

01:17

up the pros and cons of changing this

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produces a state of ambivalence or

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associating both positive and negative

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things to their use interventions for

01:27

young people in this stage of change are

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focused on helping the young person

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become aware that change is possible

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a technique that's often employed at

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this stage is motivational interviewing

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motivational interviewing is used to

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explore their ambivalence and to

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encourage a young person's commitment to

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change

01:47

if you're working with a young person in

01:50

the preparation stage interventions

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should be focused on problem-solving and

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building confidence intending to change

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is very different to making changes a

02:02

strong belief in one's ability to change

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increases the likelihood of moving into

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the action stage this is especially

02:09

important for those young people where a

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or des has been ubiquitous in their life

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so for these young people it's helpful

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to identify support people and explore

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how they're going to manage those other

02:23

relationships with people in their

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social network that still use

02:28

interventions for young people in the

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action stage are focused on skill

02:32

development identifying ways to manage

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cravings triggers and high-risk

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situations are all really helpful areas

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to cover young people might also need

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encouragement to explore alternative

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activities because often they've given

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up their past hobbies and interests it's

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also important to help the young person

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understand the function behind their ad

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use and to plan for feelings of loss

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changes in mood or changes in

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relationships for young people who are

03:01

in maintenance interventions are focused

03:03

on relapse prevention planning help the

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young person to identify their triggers

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and their ways to cope

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what are the people places feelings and

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thoughts that the young person

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identifies as high risk for lapse or for

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relapse what strategies can they

03:22

implement to get through a tough time

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[Music]

03:26

while lapse and relapse are not

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guaranteed both are a natural part of

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the change process talking about relapse

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does not lead to relapse if a young

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person experiences a slip up help them

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to view this as an opportunity for

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learning for next time it's not a

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failure

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it doesn't discount all the hard work

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done previously it's important to

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remember that we all learn more from our

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setbacks than from our successes we've

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created a tip sheet which summarizes the

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different techniques and strategies

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mentioned in this video you can download

04:00

a copy in the description box below

04:03

[Music]

English (auto-generated)

Safety and progress

How safe from harm a young person is will depend on their willingness for change. Remember that encouraging harm minimisation is preferable to demanding they stop use completely. Your case planning will need to include building of resilience and reducing of risk factors.

Ways you may assess a young person's progress:

- Has the young person moved forward in their readiness to change?

- Are they turning up to appointments?
- Are they talking with someone about their AOD use?
- Are they actively engaging in a counselling process?
- Are they feeling happier?
- Have they reduced their AOD use?
- Are they using more safely?
- Are there less risks associated with their use?
- Has their circle of friends changed?
- Have they made stronger connections with parents or other adults?
- Are they following through on some, all or none of what they set out to do?

Setting goals with young people

Help young people set goals about their AOD use that they are committed to achieve.

These may include:

- working towards stopping or reducing their substance use
- reducing the harm associated with their substance use
- longer-term behaviour change that reduces their vulnerability such as specialist AOD therapy.
- improving their wellbeing and resilience
- increasing the choices and options they have in their lives
- increasing their own sense of happiness.

Ways young people may express their goals to you:

- I want to cut down.
- My life is going off track because of my alcohol and drug use. I need some help.
- Every time I have a fight with (my parents, friends, at work) I just spin out of control.
- My (friends, parents, carers) have said that I should go and see someone about my alcohol and drug use.
- Unless I see someone, I'm going to get into big trouble with my (parents, girlfriend, boyfriend, teachers, school, co-worker, boss).
- I want to keep using alcohol and drugs but I also want to make sure it doesn't turn into a problem.
- I want to be happier. I don't want to feel like this.

Opportunities for healing and recovery

- Look at more than a young person's AOD use and the way they talk or behave. What are the issues that they are coping with by using?
- Think about how you can be an ally to the young person.

- Think about how you can help others see the young person for more than their AOD use and associated problems.
- Think about the young person and their family and community—what needs attention in the young person's life? How can you build resilience with the young person? (Read more about this in the parts Risk assessment and Working with children)
- What cultural supports can be used to harness safety and protection for the young person? Read more in Working with CALD communities and Working with Aboriginal and Torres Strait Islander People sections.
- Is AOD being used to survive, cope or resist abuse, neglect or violence in the young person's life?
- How will case planning address this alongside their AOD use?
- Are a range of relevant services involved to meet the child's different needs?
- What traditional and cultural methods of healing do you need to consider alongside mainstream AOD services for a young person?

Documenting problematic alcohol and other drugs use

Don't write	Do write
(Young person's name) continues their risk-taking behaviours of drinking alcohol.	(Young person's name) continues to cope with their trauma by drinking alcohol.
(Young person's name) continues to put themselves at risk by drinking.	When they are drinking, (young person's name) is not always able to navigate their own safety. There have been times older men have taken advantage of (young person's name) when they have been drunk.
(Young person's name) disregards their safety and, despite being told not to drink or use, they continue to do so.	(Young person's name) has been provided with information from the following sources ... about their alcohol or drug use. Right now (young person's name) does not believe their drinking is a problem in their life. (Young person's name) and I came up with a plan of how they may be safe when they choose to drink or use.

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Your practice with young people

Values, bias and perspectives

You will need to check your values, bias and assumptions. Ask yourself:

- How do I feel about young people who use AOD?
- What feelings come up for me about working with young people who use?
- What was my own experience as a young person with AOD? How does this influence my thoughts and perceptions now?
- How has AOD impacted on my life?
- What values and beliefs do I have about:
    - legal drugs or illicit drugs?
    - young people who use particular types of drugs?
    - a pregnant young woman who uses alcohol or drugs?
    - a young person who uses AOD and is aggressive or violent?
    - what does this mean for the way I work with certain young people or in certain situations?
- How do I check in about my practice, thinking and decisions?
- How does it make me feel when a young person does not respond to me or refuses to talk with me about their AOD use?
- How do I continue to be an ally when it is hard?
- How do I not give up on a young person when it feels hard?
- What would I do if a young person in my personal life had problematic AOD use?
- How do I link the personal and professional in this area of practice?
- What do I say if a young person asks me if I have used illicit drugs?
- What aspects of discussing AOD issues am I comfortable with? Uncomfortable with?
- Who can I contact when I want to learn more about effectively supporting a young person who uses alcohol and/or drugs.?
- How do I see the problem? How do I express it?
- How do I understand the lived experience of the young person I am working with?
- What needs do I think young people have?
- How would I describe the young people I work with in terms of age, cultural connection, gender and sexual identity, connection to family, education and work?
- How involved do I think young people should be in deciding what interventions to use and how will I promote their participation?

In supervision

Use one of the following activities in supervision to explore how values and perspectives impact on casework and on making decisions for young people who use alcohol or drugs.

Discussing practice values—take one of the following statements and brainstorm how relevant you think it is to youth AOD practice:

- Families should always be involved in treatment.
- Young people become adults at age 18.
- Drugs take away people's ability to make choices for themselves.
- Substance use is always wrong.
- Substance use is usually a sign of an underlying mental health problem.
- The person must want to change, in order to engage in treatment.
- Young people usually know what's best for them.
- People have the right to decide what they do with their own body.
- Drug use is a moral problem.
- Parents are usually responsible for how their children turn out.
- Problematic AOD use is a part of adolescent risk-taking.

Same, same but different:

1. Think of as many terms as you can to describe: 'young people' and then 'people who use drugs'.
2. Consider how many of these terms are positive, negative or neutral.
3. Consider the context of how each term tends to be used, for example, in the media, in health services and elsewhere.
4. Where does the young person or group of young people you work with fit?
5. What does this mean for how they are seen by you and others?
6. What can you do to shift this?

Allocate roles—of the young person, parents, family and caseworker to explore all perspectives about the young person's AOD use:

- What am I thinking, feeling, worried or scared about?
- What is my perception of other people and what is happening?
- What have I found helpful and unhelpful?
- What do I need from others to help me or to support the young person?
- What have others missed about me?
- What would make a difference for me right now?

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Page created

Resources

Support and services—telephone

Lifeline (13 11 14) can be used immediately if a young person needs to talk to someone. This is a useful number to include in the safety plan.

Strong Bonds: Building family connections The Strong Bonds website offers useful information to help you support your young person through hard times, so that you can keep making a difference to their health and well-being. It also, importantly, offers information to help you feel better and cope with the situation.

Alcohol and Drug Information Service (ADIS) (1800 177 833) is a 24-hour support line. It provides information, telephone counselling and referrals for people struggling with AOD use, families and friends of users, and health and welfare professionals.

Counselling Online This is a free, online text-based counselling service for people using AOD, and also their family and friends. Counselling is available 24 hours a day, 7 days a week. You can also get information, support and referrals for more help.

Family Drug Support (1300 368 186) is a 24-hour telephone support line for families affected by drugs and alcohol. It also provides education and referral, and facilitates support groups across Australia.

Youth Beyond Blue (1300 224 636) offers 24-hour phone support, online forums and resources for young people.

Support and services—programs

Alcoholics Anonymous for young people This organisation provides services for young people and can help them work out whether they have a problem with drinking.

Ted Noffs Foundation This organisation provides essential services for young people who are experiencing trauma related to AOD.

Headspace provides information for young people about AOD use and provides mental health services for young people between the ages of 12 and 25 years.

Opendoors offers support for LGBTIQ young people and their families

Support and services—websites

Alcohol and Drug Foundation This organisation develops and distributes free and quality-assured information on alcohol, other drugs and harm prevention through a range of programs, websites and services.

Headspace provides information for young people about AOD use and provides mental health services for young people between the ages of 12 and 25 years.

Dovetail provides clinical advice and professional support to workers, services and communities who engage with young people affected by AOD use.

QNADA provides an overview of the specialist non-governmental youth services providing AOD services in Queensland who are members of the Youth AOD Services Network.

Reachout.com is Australia's leading online mental health organisation for young people. It provides practical support to help them get through life, from everyday issues to tough times. It has articles and online tools, and also has information for parents and carers.

Teenagers talking to parents about drugs has tips for young people on talking to parents about drugs, as well as a list of phone numbers for area health services that offer help for AOD use.

YoDAA is Victoria's Youth Drug and Alcohol Advice service for young people, parents, and youth workers. The website has excellent information and resources, including apps and videos.

Dovetail Support for the youth AOD sector in Queensland provides a range of tools and resources for working with young people and AOD use.

ATSICHS Safe and deadly places offers LGBTQI support Aboriginal and Torres Strait Islander people. The organisation is committed to being a truly inclusive organisation to eliminate isolation, raise the health and wellbeing needs of Brotherboys, Sistergirls and LGBTQI+ mob and for everybody to feel safe, accepted, valued and supported.

Research and further reading

Practice strategies and interventions: youth alcohol and drug good practice guide from Dovetail.org.au has practice tips and interventions for working with young people with alcohol and drug use.

YouthAOD toolbox provides practitioners in the youth AOD field with reliable and current information to help increase their knowledge and enrich their practice. It has a very good trauma-informed care module. Prepared at the Australian Centre for Post Traumatic Mental

Health, this module covers the key aspects of trauma-informed care in practice such as trauma awareness, emphasis on safety, opportunities to build control, strength-based approaches, supporting recovery from trauma, and useful resources and references

Understanding a young person's support needs This article introduces a framework to best understand the needs of young people with AOD-related problems.

Working with young people in the stages of change The stages of change are more than 5 steps on a flow chart. This tool, provided by YoDDA, explores what influences a young person's motivation and offers clear, evidence-based guidelines for care planning.

Perceptions of young people and community stakeholders: LGBT communities and substance use in Queensland, Australia.

Good Practice Guide—Youth work in the family context—working with families and young people with migrant and refugee backgrounds.

You will find ideas and information at the following links:

- Help with tough times, sex friends and drugs—ReachOut.com Australia
- Youth Support + Advocacy Service, Support for Alcohol and Drugs
- Drug Facts—Alcohol & Drug Foundation

YoDAA, Victoria's Youth Drug and Alcohol Advice service for young people, parents, and youth workers, has a lot of resources including:

- Signs and symptoms of trauma
- The 4 top tips for talking about trauma
- Talking about trauma and coping strategies
- talking about withdrawal and dependence
- Young People and AOD use fact sheets
- Use the My use diary to have a conversation with a young person about their AOD use. This will help you explore feelings, thoughts, behaviours and the context of when they use or drink.

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Working with Aboriginal and Torres Strait Islander communities

Where alcohol and other drug use is a worry for Aboriginal and Torres Strait Islander peoples, practitioners must understand historical and past practices which continue to have a devastating effect on Aboriginal and Torres Strait Islander families, communities and cultural continuity.

Cultural Warning: This content contains links to sites that may contain the names and images of Aboriginal and Torres Strait Islander peoples now deceased.

Child Safety acknowledges the impact of historical and past practices through the forced removal of children from their families on Aboriginal and Torres Strait Islander peoples. This continues to have a devastating impact on Aboriginal and Torres Strait Islander families, communities and cultural continuity.

Child Safety endeavours to protect the rights of future generations of Aboriginal and Torres Strait Islander people by reducing the over-representation of Aboriginal and Torres Strait Islander children and young people.

Seeing and understanding

Responding

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About this part

This part will help you:

- understand how alcohol and drug use impacts on Aboriginal and Torres Strait Islander families and communities
- understand how past experiences of racism, cultural trauma and dispossession contribute to current experiences of alcohol and drug use
- ally with Aboriginal and Torres Strait Islander communities in responding to alcohol and drug use.

Version history

Published on: 1 July 2019 **Last reviewed:** 1 July 2019

We acknowledge and are sorry for past policies and practice

The Department of Child Safety, Youth and Women acknowledges the impact of historical and past practices on Aboriginal and Torres Strait Islander peoples through the forced removal of children from their families. This continues to have a devastating impact on Aboriginal and Torres Strait Islander families, communities and cultural continuity.

As the agency responsible for keeping children safe in Queensland, we must not repeat the past. Through our policies and daily work with families, we must always be looking for ways to address the overrepresentation of Aboriginal and Torres Strait Islander children in the system.

We will do this by working in partnership with Aboriginal and Torres Strait Islander families and communities. We will follow families' lead and foster self-determination (control over their own lives) so that Aboriginal and Torres Strait Islander children are safe, connected and have a lived experience of their culture.

Version history

Published on: 1 July 2019 **Last reviewed:** 1 July 2019

Alcohol and other drugs and Aboriginal and Torres Strait Islander cultures

The use of alcohol and other drugs is not a traditional part of Aboriginal or Torres Strait Islander culture. Although people did consume weak alcohol made from various plants, traditional rules controlled how and when it was used. In some communities, traditional beliefs may lead people to think that sickness is not caused by alcohol or drug use but happens because of sorcery and black magic.

Aboriginal and Torres Strait Islander peoples and communities had traditional healers with extensive knowledge and methods, passed from generation to generation. They provided treatments that included bush medicine and spirit balancing to heal pain, suffering, grief, sadness and sorrow. Over time, traditional healing methods have been lost for many communities, and alcohol has become a way to cope, survive and resist.

The ‘poison grog’

The arrival of the British to Australia in 1788 drastically reduced the Aboriginal and Torres Strait Islander population through violence, the introduction of diseases, and prevention of access to land that had provided them with food and resources.

The British also introduced Aboriginal and Torres Strait Islander people to western alcohol. Within weeks of the arrival of the First Fleet, the first pubs opened. That shaped the way Australian society developed over the next few decades.

Many Aboriginal and Torres Strait Islander labourers were paid in alcohol or tobacco (if their wages were not stolen). In the early 1800s, the white settlers in Sydney found it amusing to ply Aboriginal men with alcohol and encourage them to fight each other, often to the death. White settlers also gave alcohol to Aboriginal people to pay for sex.

The problem now

The following video outlines some of the statistics for Aboriginal and Torres Strait Islander use of alcohol.

Youtube video URL: https://www.youtube.com/embed/qEVLja-oe-w?enablejsapi=1&showinfo=0&rel=0

Video Caption:

Review of the harmful use of alcohol among Aboriginal and Torres Strait Islander people

- Aboriginal and Torres Strait Islander peoples are less likely to drink alcohol than non-Indigenous people, but those who do drink are more likely to drink at harmful levels.
- Aboriginal and Torres Strait Islander peoples are 1.2 times more likely to drink at levels of high risk of lifetime harm than non-Indigenous people.
- In 2014–15, 39% of Aboriginal and Torres Strait Islander adults smoke. This is almost 3 times more than the percentage of non-Indigenous Australians who smoke.
- In 2014–15, more than half of Aboriginal and Torres Strait Islander children lived with someone who usually smoked inside the house.
- In 2014–15, 69% of Aboriginal and Torres Strait Islander adults had never used illicit substances.
- The most commonly used drugs for Aboriginal and Torres Strait Islander people are (in order of most used): cannabis, analgesics (painkillers) and sedatives, other drugs (heroin, cocaine, petrol, LSD or kava), and amphetamines (ice).

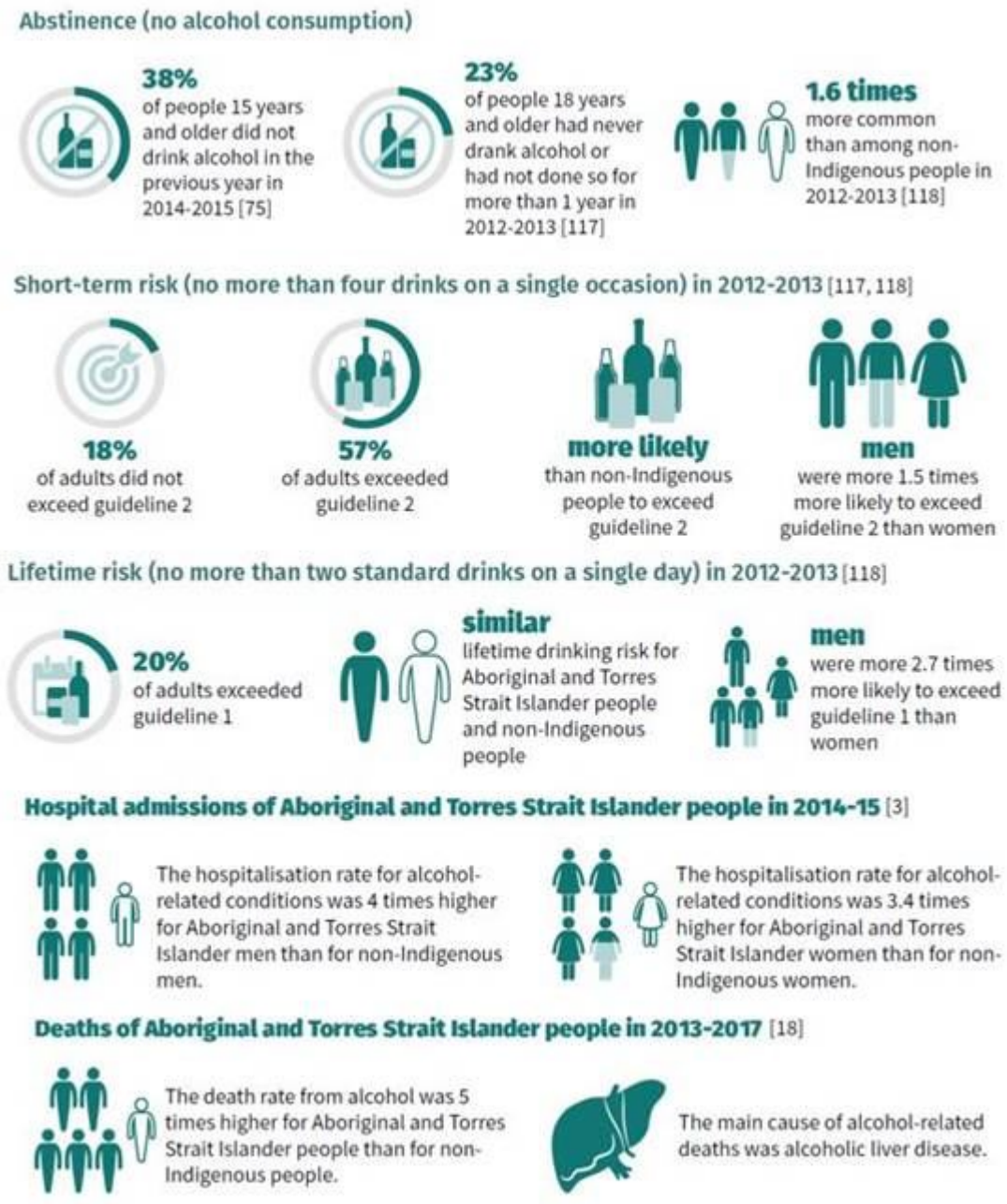


Image caption:

Source: Australian Indigenous Health InfoNet, Summary of Aboriginal and Torres Strait Islander health, 2018

The impact of alcohol and other drugs use

- From 2010–2014, the rate of deaths due to drug use was almost twice as high for Aboriginal and Torres Strait Islander peoples than for non-Indigenous people in New South Wales, Queensland, Western Australia, South Australia and the Northern Territory.
- The most common drug-related conditions that resulted in hospitalisation for Aboriginal and Torres Strait Islander peoples were poisoning and mental and behavioural disorder.
- Hospitalisation for mental and behavioural disorders from the use of amphetamines had the highest rate of hospitalisation due to drug use. The rate of hospitalisation of Aboriginal and Torres Strait Islander peoples for this was more than 3 times higher than for non-Indigenous people.
- Cannabis use was the second highest cause of hospitalisation for mental and behavioural disorders due to drug use, with Aboriginal and Torres Strait Islander peoples almost 4 times more likely to be hospitalised than non-Indigenous people.
- Rates of hospitalisation due to drug use were higher for Aboriginal and Torres Strait Islander peoples living in major cities than in inner and outer regional areas. Remote areas had the lowest rates of hospitalisation due to drug use.
- In 2014–15, hospitalisation rates for poisoning and accidental poisoning from the toxic effects of organic solvents (for example, petrol) were between 3.9 and 5.1 times higher for Aboriginal and Torres Strait Islander peoples than for non-Indigenous people.
- Fewer Indigenous women drink than non-Indigenous women (71% compared with 77% respectively). However, Indigenous women of childbearing age (18–44 years) are more likely to drink at risky levels (11.6% compared with 9.5%).

Fetal alcohol spectrum disorder among Aboriginal and Torres Strait Islander people

Drinking alcohol while pregnant can harm the unborn baby [119]. If a woman drinks while pregnant she risks having a baby with fetal alcohol spectrum disorder (FASD). FASD is a diagnostic term used to describe the range of mental and physical conditions that are caused by drinking alcohol when pregnant.

There good news is that there has been a significant decline in the proportion of mothers of Aboriginal and Torres Strait Islander children that drank throughout their pregnancy, from 20% of mothers in 2008 to 10% in 2014-2015 [75].

Good news

Between 2010 and 2016 there was a significant drop (from 32% to 20%) in the proportion of Aboriginal and Torres Strait Islander people aged 12 years and older who exceeded guideline 1 (no more than two standard drinks on a single day) [115].

Further reading

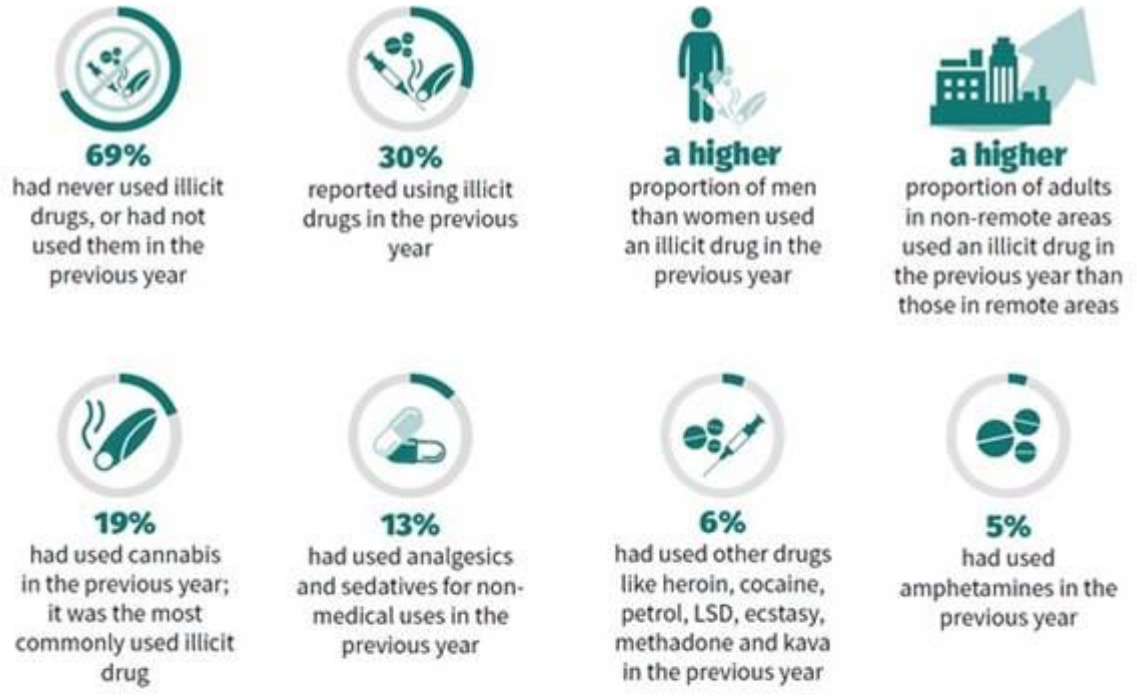
> Plain language review of harmful use of Alcohol among Aboriginal and Torres Strait islander people

Illicit drug use in Aboriginal and Torres Strait Islander communities

Australian Indigenous Health*Info*Net's *Summary of Aboriginal and Torres Strait Islander health, 2018* states that:

Surveys consistently show that most Aboriginal and Torres Strait Islander peoples do not use illicit drugs.

The (following) information … is for adults from the 2014–2015 National Aboriginal and Torres Strait Islander Social Survey (NATSISS). Similar results were found in the 2016 National Drug Strategy Household Survey (NDSHS), but the number of Aboriginal and Torres Strait Islander people in the NDSHS was small, leading to some concerns about the accuracy of the results.



Hospital admissions of Aboriginal and Torres Strait Islander people in 2014-15 [3]

In 2014-15, the most common drug-related conditions that resulted in hospitalisation for Aboriginal and Torres Strait Islander people were 'poisoning' and 'mental and behavioural disorders' [3].

Hospitalisation rates for poisoning due to drug use were 2.3 times higher for Aboriginal and Torres Strait Islander people than for non-Indigenous people.

Hospitalisation rates for mental and behavioural disorders due to drug use were 3.1 times higher for Aboriginal and Torres Strait Islander people than for non-Indigenous people.

Hospitalisation rates from drug use were highest for Aboriginal and Torres Strait Islander people in major cities.

Deaths of Aboriginal and Torres Strait Islander people in 2010-2014 [3]

The rate of drug induced deaths was 1.9 times higher for Aboriginal and Torres Strait Islander people than non-Indigenous people.

SA had the highest rate of drug-induced deaths for Aboriginal and Torres Strait Islander people.

Rates of drug induced deaths were higher for Aboriginal and Torres Strait Islander men than women.

Image caption:

Source: Australian Indigenous HealthInfoNet, Summary of Aboriginal and Torres Strait Islander health, 2018

The following video provides a graphical representation of illicit drug use among Aboriginal and Torres Strait Islander people.

Youtube video URL:
https://www.youtube.com/embed/eSLFIn2_qzI?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Illicit drug use among Aboriginal and Torres Strait Islander people

The impact on children, family and culture

When it occurs in Aboriginal and Torres Strait Islander families, problematic use of AOD:

- affects the spiritual, emotional and physical wellbeing of children, women and men, causing deep pain and disconnection that continues the cycle of AOD use
- influences the way parents are able to fulfil their traditional roles in raising their children and the way young people are initiated in becoming women and men
- models a way of life that becomes the community norm (Aboriginal ethos is based on community and shared living), which will include sharing alcohol and drugs
- can have a negative effect on the whole community.

The impact on women's business

Prior to colonisation, women were responsible for raising children and participated in the spiritual life of their people. This was disrupted by colonisation, when the land was taken away, people were killed and children were taken. Women could no longer fulfil their role, and this has been an enduring pain for children and women for generations across Aboriginal and Torres Strait Islander communities.

AOD use may be one way an Aboriginal and Torres Strait Islander woman choses to cope, resist and survive.

An Aboriginal and Torres Strait Islander woman may experience the impacts of AOD through her own use, through living in a community where alcohol use permeates daily life, and

through the high rates of alcohol-related violence and domestic violence within her family and community.

Things that may make an Aboriginal and Torres Strait Islander woman more vulnerable:

- She may be deprived of support from kin because of social upheaval, dispossession, or early death.
- She may not have AOD workers or services that include all aspects of Aboriginal wellbeing (spiritual, emotional and physical).
- She may not know about the impacts of AOD use on herself or her children.

The impact on men's business

There are a number of ways that Aboriginal and Torres Strait Islander men's roles and values in the family and community have changed since colonisation. Alcohol has had a major impact on this.

> *'Our people would go to the mines and after work they see the whitefella drink beer. A lot of Yolngu men thought that was the way to be. They thought alcohol made them more powerful.'*

Kathy Balngayngu Marika, traditional Elder and artist-in-residence at Bangarra Dance Theatre, SMH October 2011

Other impacts include:

- an inability to carry out their role as men, or mentor young boys, because they have not been taught or traditions have not passed down
- a change of their traditional role as providers of the family. For example, welfare payments see women getting more than men (because of children).

Not being able to carry out their men's business as providers and leaders can lead Aboriginal and Torres Strait Islander men to feel a loss of identity and to feel disempowered, disconnected and devalued.

Alcohol and drugs can become a way of numbing this. Men who are numbed in spirit and identity are unable to show and teach young men that these things are not normal.

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Growing up Aboriginal and Torres Strait Islander children

Disconnection from cultural practices, traditions and roles has caused enduring hurt to Aboriginal and Torres Strait Islander people's identity and sense of belonging to family and community. Problematic alcohol and drug use exacerbates these experiences and can have a direct impact on how Aboriginal and Torres Strait Islander children are raised.

Growing up babies

As reported in The Summary of Aboriginal and Torres Strait Islander Health status 2018, in 2015–2017, babies born to Aboriginal and Torres Strait Islander mothers were twice as likely to die in their first year as those born to non-Indigenous mothers, and were more likely to have a low birth weight than babies of non-Indigenous mothers.

This may be due the age of the mother, lack of knowledge about the risks of cigarettes and AOD use, poverty-like living conditions, and lack of access to prenatal and AOD services.

Improving the health of Aboriginal and Torres Strait Islander mothers, babies and children is crucial in reducing the mortality rates for Aboriginal and Torres Strait Islander children under the age of five.

What can you do?

Do not make assumptions about Aboriginal and Torres Strait Islander women who do not access prenatal or AOD care during their pregnancy. Meeting the woman where she is at is important so you can understand what is getting in her way and how you can help to reduce risks for her baby.

For example, an Aboriginal and Torres Strait Islander woman may:

- hold close traditional ceremonies and beliefs about pregnancy and birthing that go against western practices. This may be a barrier to getting mainstream prenatal care
- not have information about or be able to access Aboriginal antenatal services or health workers, particularly in remote areas
- be unaware of the impact of AOD use on herself or her baby
- be fearful that if she engages with AOD or health services, her baby will be taken from her.

According to the Australian Government's Health Performance Framework 2014 Report, perinatal data shows that in 2011, 99% of Aboriginal and Torres Strait Islander mothers

accessed antenatal care services at least once during their pregnancy—which is similar to the percentage for non-Indigenous mothers.

Watch: Strong Aboriginal women telling their stories of making changes to their AOD use. This video is about Victorian Aboriginal and Torres Strait Islander culture. (While the name for babies in Victoria is 'Boorais', in Queensland it is 'Jarjums'.)

Youtube video URL:
https://www.youtube.com/embed/n_Rvm8C_6OE?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Strong Boorais, Bright Futures - Keeping healthy during pregnancy

Video transcript:

00:21

it's a hard journey being a mum that's

00:24

the most rewarding one and you know to

00:27

be feeling the best that you can you're

00:31

gonna have a better journey I didn't

00:34

find out I was pregnant until I was six

00:35

months pregnant and for four years

00:37

before I found out I was pregnant I was

00:39

a very high ice user I smoked off at

00:43

least a quarter a week and I smoked

00:45

about a deck of series a day I was a

00:48

heavy drinker before I was pregnant yeah

00:50

my body just rejected it because it just

00:53

made me sick the feeling of yeah making

00:55

a baby charged up I smoked with my first

00:59

three children because I didn't realize

01:02

the dangers so my first three children

01:05

were all smaller all had breathing

01:08

difficulties we know that all forms of

01:11

smoking drugs and alcohol can be

01:13

dangerous during pregnancy everything

01:15

that you take in when you're pregnant

01:17

does go through to the baby I just think

01:19

if you're drinking your baby's drinking

01:21

too in same you dragon the same thing

01:25

yeah what you get your baby hits get

01:28

help

01:29

look I think it's almost impossible to

01:32

stop using drugs and alcohol on your own

01:36

there's so many organizations for our

01:39

mob that can go and say you know I think

01:42

I need to try and cut it down or I need

01:44

to quit always go to you your local

01:47

curry

01:48

co-op where you are and ask for a woman

01:51

worker that's for a woman health worker

01:53

or asks for a maternal nurse if they're

01:56

there they will help you and they will

01:57

have a yarn tear and help you the best

01:59

way they can your Aboriginal health work

02:04

is a really good starting point and lots

02:07

of those women I've got really good

02:08

information you can also talk to your

02:11

midwife talking to your GP as well is a

02:14

good source of information and also the

02:16

people at the hospital we're there to be

02:18

culturally respectful for you and make

02:20

sure that everyone at the hospitals are

02:23

respectful for your needs

02:25

the services that really helped me was

02:27

the healthy lifestyle team at VARs but

02:30

really it was the Quitline they have

02:32

good Aboriginal workers that understand

02:35

so they're not really judgmental they're

02:38

just there to support you we are going

02:41

to ask you about your drug and alcohol

02:43

and cigarette use but the reason we ask

02:45

is because if we know what's going on

02:47

and we we can have an open and trusting

02:50

relationship we can really support you

02:52

through your pregnancy they can't help

02:54

you if you're not willing to tell them

02:57

the full story get with positive

02:59

supportive people who are hopeful and I

03:03

think that'll help to get stronger

03:07

within yourself I need to go back home

03:09

and be around my grassroot people and

03:12

that's what strengthens me go home and

03:15

strengthen up go back to land go back to

03:17

the bush people don't realize but it

03:20

helps you heaps like it it heals your

03:23

inside alternative things I did to help

03:26

me reduce and then quit they sleeve

03:29

eating it's get you a bit fat but at

03:33

least you not doing other things but

03:36

then I got real into the exercise I've

03:42

seen a lot of it the girls come in with

03:46

for wear and send them leave a new

03:50

person just got to be strong-willed

03:52

about it yeah that's what how I was

03:54

people knew not to call never charge

03:57

I've won everyone you know get conned up

04:00

not they all just know I don't drink

04:04

when I'm pregnant and that's it I would

04:06

really encourage you to find someone

04:08

that you trust and go and have a yarn to

04:11

them and tell them what's really going

04:12

on and we're there to support you and

04:14

help you the sooner you come into the

04:17

hospital and get your antenatal care and

04:19

go back into community and see the local

04:22

midwives you know you're gonna have it

04:25

you know a beautiful borough at the end

04:27

of it

04:28

you just think about your healthy baby

04:30

the beautiful lies the nice perfectly

04:34

normal arms and legs and chubby little

04:37

face and you just think well that's what

04:42

you're that's what you're giving up for

04:46

that beautiful baby that's going to come

05:36

ah

Further reading

Babies in the Safe care and connection practice kit

Australian Government Department of Health Pregnancy Care Guidelines: 3 Pregnancy care for Aboriginal and Torres Strait Islander Women.

Growing up children

When schoolchildren were asked what the biggest problem was in their community, the most common answers were alcohol use, smoking and violence. When the kids were asked what could be done to make a better community, they said that adults should stop drinking and being violent and look after their kids better (Penman, 2006).

Problematic AOD use harms Aboriginal and Torres Strait Islander children the same way as it does any child. However, there is an additional factor that makes these children more vulnerable to harm. The shorter life span and higher incidence of ill health among Aboriginal people impacts on the vital cultural tradition of parents and grandparents guiding children as they grow up.

Growing up young people

Aboriginal and Torres Strait Islander young people drink and use drugs for the same reasons as any other young person. However, there are some unique factors that can increase their vulnerability:

- Shared cultural grief—they are likely to experience more intense shame, despair, demoralisation and hopelessness, or what is sometimes called 'community depression'. This is a shared cultural grief born from intergenerational trauma and oppression.
- Disconnection and isolation—In the absence of traditional mentoring or guidance from men and women in their community, Aboriginal young people experience disconnection and isolation, which leads them to drinking and taking drugs together as a way to connect.
- Intergenerational patterns of AOD use—Some Aboriginal and Torres Strait Islander young people come from family backgrounds that include significant AOD problems. When children grow up with their parents and other adults openly drinking and excessively using drugs, this becomes the norm. Communal sharing of alcohol and drugs can encourage Aboriginal and Torres Strait Islander young people to partake in the community lifestyle. In this way, older generations influence younger generations in using alcohol and drugs.
- Disruption to family roles and belonging—Young people feel the intergenerational pain and suffering from the centuries of oppression, exclusion, violence and social injustices that their mothers, fathers, aunties, uncles and grandparents have lived and survived. Traditionally, women and men have vital roles in guiding, mentoring and helping Aboriginal and Torres Strait Islander young people in meeting their responsibilities to the land and spirits. Colonisation has meant that many young people are disconnected from family roles, traditions, country and land. This increases their vulnerability to problematic AOD use.
- Aboriginal and Torres Strait Islander identity—Adolescence is the time of discovering yourself. For Aboriginal and Torres Strait Islander young people, this

means building a strong identity, spirit and belonging. Aboriginal and Torres Strait Islander children who have been taken away from their family, kin or country are without the connections they need to support the development of their identity.

Read

Penman (2006): The 'growing up' of Aboriginal and Torres Strait Islander children

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Partnering for safety with families

In Queensland, there are very few Aboriginal or Torres Strait Islander-specific services to address alcohol and other drug use in the family.

Aboriginal Torres Strait Islander people can experience further exclusion and oppression because of:

- programs or services that are built from a white perspective—they have had experiences of racism, of being approached in a culturally insensitive way, of feeling judged, and of having their confidentiality breached
- actions that isolate them from their community and make them feel pressured to do things they are reluctant or are unable to do
- inflexible visiting hours, lack of access to telephone and long waiting lists

These all contribute to further disadvantage and increase the likelihood of Aboriginal or Torres Strait Islander people not completing Alcohol and other drug programs.

Aboriginal and Torres Strait Islander parents need to know that you are an ally for them and their kids in a system that has a history of forced child removal and of failing Aboriginal and Torres Strait Islander communities.

Culturally safe engagement

As a worker for Child Safety, Youth and Women, you are in a position of power and privilege. You need to think about how you use power in a safe way and what you can do to structure safety with Aboriginal and Torres Strait Islander families and communities.

Here are some conversation ideas (print out the table below):

Take collective accountability Take collective accountability for past pain and suffering that has been caused by Child Safety.	I am sorry for the pain and suffering that Aboriginal and Torres Strait Islander peoples have felt because their children were stolen. I understand talking with me today (as a non-Indigenous person or as a worker from Child Safety) must be really hard. I am keen to hear how I can make this any easier.

Find safe spaces to yarn (hold discussions)	Let's talk about who needs to know what and why. Is there anything I need to know about that could stop you from talking with someone about it? Who is appropriate for you to talk about your AOD use with? Would you prefer a man or a woman? I know privacy is important to you. How do we make sure this is respected? Is there anyone you do NOT want to know about this? What worries you about them knowing?
Be aware of lateral violence—community backlash	How might others respond to knowing about the alcohol or drug use? How might other people you've spoken to respond? What will this be like for you? For your child? For your family? How might you respond to that? Who in your community would be helpful? Who can be of help to you? How can I be of most use to you?
Engage Elders and other important people who make decisions	Who are the Elders of your community? How do decisions about children get made? What are the views on harmful alcohol or drugs? What would they say needs to happen? How can you connect with them? How can they help us make good decisions here about what needs to

	happen?
Be guided by Aboriginal and Torres Strait Islander people. Listen deeply to Aboriginal and Torres Strait Islander people as experts	What can you tell me about your culture and traditions and how they may help your AOD treatment? How can you feel the most comfortable through your AOD treatment?

Further reading

Culturally capable behaviours resource.

Self-determination and participation

Principles of self-determination (having control over their own lives) and participation guide our work with families and communities. Do not replicate past oppressive practices in your interactions.

Ask parents where they would like to meet and who can support them.

- What is important to you, so you can feel safe while we talk today?
- How will you let me know if you feel like I am using 'power' over you?
- It is important to me while we talk that I don't offend you or say things that are culturally inappropriate. If this happens, how can you let me know?
- Who can come and support you while we are here?

If alcohol or drug use is making it unsafe for children, talk to parents about who in their family and community could help them. With the parents' agreement, involve these people as a safety and support network and in a Aboriginal and Torres Strait Islander family-led decision making process.

If children cannot stay with their parents because it is unsafe, work with the family to find kin who are willing to be assessed as kinship carers.

Show up for the hard yarns

Aboriginal and Torres Strait Islander parents need to know they can rely on you to be up-front and honest about what is happening. There may be times you need to have

uncomfortable and hard yarns. You need to show up for these conversations with compassion, curiosity and courage.

If you do not, Aboriginal and Torres Strait Islander parents may be left confused and may feel you have lied or been sneaky. This repeats feelings about past injustices and has a flow-on effect within the Aboriginal and Torres Strait Islander community.

Acts of protection

Look for a parent's 'acts of protection' or steps already taken. These may look like:

- distancing themselves from family and kin who are using or drinking
- re-engaging with cultural practices; looking to connect to country and land
- seeking support from a trusted family member, friend or Elder
- limiting their use to only a particular place or time

Try to support a parent's acts of protection and build on their strengths, as it take great strength for an Aboriginal and Torres Strait Islander person to go against what may be the family/community norm.

Related forms, templates and resources

Culturally capable behaviours

Resource 16 September 2019

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Yarning with dignity and respect

Protocols for yarning

There are a variety of ways that yarning may happen and each family or community may have their own rules of engagement and protocols for carrying out and maintaining the conversation. Consulting with the family, Aboriginal and Torres Strait Islander colleagues or local community partners can help you decide on the best yarning approach.

Be aware of the following (print out the table below):

Being culturally respectful	What I can do and say
Be quiet and respectful at all meetings.	Don't over talk or talk over people. Allow all participants in the meeting or discussion to speak.
Honour the autonomy of the family and community. Let them make decisions about what will be talked about and what will be of use.	What are the things that are important for you to talk about today? How would you like to make use of the time we have today? What is most useful, for you and your family, to talk about today? Are there things happening in the community at the moment that you feel would be useful for me to know?
Acknowledge your cultural differences with families. Invite family members to let you know when you say or do things that not okay with them. It would be respectful to let families know your cultural background.	I'm mindful we have different cultural backgrounds, I have [*Practitioners own cultural background*] and there may be things that are discussed between us that I am not aware of or have any understanding of.

Being culturally respectful	What I can do and say
	Do you think when this is happening for me am I able to ask you about it so I can understand? Also if there are things I say that aren't clear or make sense to you, can you please let me know and I'd be happy to talk about it more?
Ask the person how they would be like to be addressed? Don't assume if the person is old that you can call them Aunty or Uncle. In the first instance it would be respectful to call the person Mr or Mrs.	Hi Mr or Mrs… are you ok if I call you that or is there another name you would like me to use?
Continuously ask for permission about when, where, who and what to talk about. The location of meetings and the people involved in discussions may change depending on different circumstance.	Where did you want to meet next time? At our next meeting we will need to discuss [topic], who are the people you think would be most useful for you to have there? If I needed to know more about [topic], who do you think would be the best person to talk with? Who else needs to be involved in that conversation?
Make space for them to say 'no'.	How will I know that you want to say no to something? How would you like me to respond to that? What does saying 'no' say about your ability to decide what's going to happen?
Thinking about tonight, tomorrow and later.	How might you be feeling and thinking about what you have been telling me tomorrow?

Being culturally respectful	What I can do and say
	How will you care for yourself today and tomorrow? Who can be there to help care for you?
Give space for silence.	Aboriginal and Torres Strait Islander peoples will not always respond immediately, there are times where they will quietly reflect and think – allow this to happen.

For more about respectful and culturally appropriate ways to talk and communicate with Aboriginal people and communities, read:

- Culturally capable behaviours resource
- Communicating effectively with Aboriginal and Torres Strait Islander people

Yarning with young people

Yarning with young people will take some planning, depending on why you are working with them and their family. You will need to think about what you represent and the purpose of your role. How can you gain credibility with them to have the necessary conversations?

You may need to consult with an Aboriginal and Torres Strait Islander colleague, or someone the young person is connected with, who can help develop the best approach when yarning with a young person, particularly about their AOD use.

Yarning with parents

Yarning is used among Aboriginal and Torres Strait Islander people to share information, stories, knowledge and traditions. It is less structured and less formal than you may be used to. A forensic interview style is unlikely to help an Aboriginal or Torres Strait Islander person tell you their story about AOD use.

In more traditional Aboriginal and Torres Strait Islander areas, it may be best to avoid direct questions at first. A yarning approach can work better. So instead of asking direct questions, you could suggest two alternative scenarios. For example, 'Some people get the shakes when they stop drinking and some people are fine. What is it like for you when you stop?'

You should also be aware that where possible, it is preferable for men to speak with men and women to speak with women, especially when you are not known by the Aboriginal or Torres Strait Islander parent or their community.

Source: Carers Australia, Working with Aboriginal people and communities

Talking about alcohol use and spiritual and emotional wellbeing

When working with Aboriginal and Torres Strait Islander people, you may wish to use the Strong Spirit Strong Mind model. It promotes the uniqueness of Aboriginal culture as a central strength in guiding efforts to manage and reduce AOD-related harm in Aboriginal communities.

The information will help you have meaningful and safe conversations with Aboriginal and Torres Strait Islander people about their alcohol and drug use. Use these bodycards, developed for Aboriginal people, to explain the impacts of alcohol and drugs use on the mind, body and spirit.

However, when working with Torres Strait Islander people you may need to adapt the approaches accordingly.

Talking about the impact of alcohol and other drugs

Read Harmful Drinking from the Alcohol.Think Again website.

The following sites offer great resources to help talk about AOD use with Aboriginal or Torres Strait Islander people:

- Gallang Place
- Cracks in the Ice
- Drug and alcohol research connections

Talking about staying safe

Read Staying Safe from the Alcohol, think again website.

The Australian Indigenous Health*Info*Net Alcohol and Other Drugs Knowledge Centre is about assisting Aboriginal people to reduce the harms caused by alcohol and drugs. All information has been developed for Aboriginal people.

Videos to help your conversations

Ugly drunk—Part of the AERF (alcohol Education and Rehabilitation Foundation) award-winning television campaign, Ugly drunk (YouTube, 1:13 minutes) was created by Broome-based Aboriginal company Goolarri TV. It targets all Australians but uses Aboriginal actors.

Youtube video URL:
https://www.youtube.com/embed/CdjjM0RMoZE?enablejsapi=1&showinfo=0&rel=0

Video Caption:
AERF - Ugly Drunk

The Grog Brain Story—The Grog Brain Story, produced by Menzies Research, is part of a broader multimedia campaign to provide Aboriginal and Torres Strait Islander people with practical information on the damage alcohol causes to the brain. The story is available in English, Kriol and Warlpiri.

Youtube video URL:
https://www.youtube.com/embed/2SxTAH3jq0Y?enablejsapi=1&showinfo=0&rel=0

Video Caption:
The Grog Brain Story

Video transcript:

00:00

let me introduce something very special

00:02

to me this is my brain it might look a

00:06

little funny but it is a very important

00:08

part of who I am how I think act and

00:11

feel without a healthy brain I couldn't

00:14

do any things I was doing but playing

00:16

football hangin with remarks listening

00:19

to music with my family sharing my

00:24

culture this is because the brain has

00:27

many different parts here are some of

00:29

the main ones this part is called the

00:32

limbic system it helps me look after my

00:34

relationships this one is the type of

00:38

load and it helps me make decisions this

00:42

is the cerebellum it controls how I move

00:45

my body this one is the hippocampus it

00:49

actually helps me remember things and

00:51

this one here well this is the pleasure

00:54

center of the brain it helps control how

00:56

happy I am and how good I feel some

01:01

things we do change the brain like

01:05

drinking too much growth this can stop

01:08

the brain working properly but because

01:10

drinking too much grog changes who we

01:12

are at first when I give my brain growl

01:15

it can make me feel good I feel strong

01:19

and really happy after a while I keep

01:23

wanting more and more growth but it

01:26

doesn't make me feel good anything it's

01:29

like I forget how to be happy without

01:31

growth this is part of drug addiction

01:38

when Grogg changes a brain it can be

01:40

hard to walk and talk properly you're

01:44

gonna have trouble making decisions

01:45

because you feel confused your memory

01:49

just doesn't work properly you forget

01:54

things that are important to your

01:55

culture like your stories

01:59

it can make you lose control over your

02:02

feelings sometimes love it's so angry

02:06

that you can hurt the people you love

02:08

the most important part of our brain

02:14

that keeps their heart beating and helps

02:16

us breathe is called the brainstem

02:18

drinking too much growth changes the

02:20

brain stem this can kill you but it

02:27

doesn't have to get this bad the brain

02:30

is very powerful it's important it makes

02:34

us who we are and keeps us alive you

02:38

need to protect it if you make the

02:40

decision that completely then the brain

02:43

can actually hear it thank you it's not

02:46

easy to give up rocks and it can take a

02:49

long time to get better after you start

02:53

there are people and programs that can

02:55

help you if you want to stop drinking

02:59

that's for help at your local health

03:01

center it might not be easy the good

03:05

thing is that you feel like yourself

03:07

again now keeping your brain body and

03:11

Country Strong is worth it be strong do

03:15

it for yourself

03:31

you

Related forms, templates and resources

Culturally capable behaviours

Resource 16 September 2019

Version history

Published on: 19 November 2019 **Last reviewed:** 19 November 2019

Page history

19 November 2019
Page created

Harnessing Aboriginal and Torres Strait Islander culture as a protection and strength

Strengths

The strengths of Aboriginal and Torres Strait Islander cultural practices in family life and child rearing include:

A collective community focus—The concept of 'one community, many eyes' helps children to build trust and confidence in themselves and in others, access support when they face challenges, and be safe.

Autonomous play—Having the freedom to explore the world can empower children to build independence, learn responsibility, make sound decisions.

Respect for the elderly—Elderly family and community members help children to learn their responsibilities, understand who they are and where they come from, and keep the spirit of Aboriginal and Torres Strait Islander culture alive.

Spirituality—Helps children to cope with life by connecting with others, instilling positive values, such as caring and sharing, improving physical, mental and spiritual wellbeing, and providing opportunities to heal from trauma.

Source: CFCA, Strengths of Australian Aboriginal cultural practices in family life and child rearing infographic

Note

> Healing gives us back to ourselves. Not to hide or fight anymore. But to sit still, calm our minds, listen to the universe and allow our spirits to dance on the wind … [and] drift into our dreamtime. Healing ultimately gives us back to our country. To stand once again in our rightful place, eternal and generational. Healing is not just about recovering what has been lost or repairing what has been broken. It is about embracing our life force to create a new and vibrant fabric that keeps us grounded and connected.
>
> Associate Professor Helen Milroy, Aboriginal Child Psychiatrist and Australia's first Aboriginal doctor (MJA, Volume 190 Number 10, 18 May 2009)

Professor Chris Sarra talks about changing the low expectations for Aboriginal and Torres Strait Islander children and young people.

Youtube video URL:
https://www.youtube.com/embed/rPOFPgIpGdY?enablejsapi=1&showinfo=0&rel=0

Video Caption:
TEDx Brisbane: All you need is... TO DREAM

Video transcript:

00:00

last speaker for session three an

00:02

amazing man Chris Sarah he's had an

00:06

extensive career in education

00:08

his passion has been the pursuit of more

00:10

positive and productive emotional

00:12

outcomes for indigenous children chris

00:15

is now the executive director of the

00:17

stronger smarter Institute which is

00:19

making an impact in indigenous education

00:21

through engagement with principals

00:23

teachers community leaders and

00:26

government please welcome to the TEDx

00:28

Brisbane stage Chris Sarah

00:42

thank you nice to see you nice to be

00:45

with you

00:46

let me start by acknowledging the

00:48

traditional owners and custodians of the

00:50

land all you need is to dream

00:56

if only it truly were that simple but

01:02

then maybe it is that simple James Allen

01:07

said that dreams are the seedlings of

01:09

realities and of course they must be and

01:13

my desk at work like a lot of people I

01:15

keep short quotes and I keep one of

01:16

James Ellen's quotes to remind me never

01:19

to give up and never ever to think small

01:24

the greatest achievement was at first

01:26

and for a time a dream the oak sleeps in

01:31

the Acorn the bird waits in the egg and

01:35

in the highest vision of the soul a

01:38

waking angel stirs dreams are the

01:43

seedlings of realities

01:45

James Ellen if I was to round up all of

01:50

the world's high achievers in whatever

01:53

field they would no doubt have all types

01:57

of great stories not as great as you

02:01

would see on an Australian story but

02:05

great stories and it is most likely that

02:10

all that all will have one thing common

02:14

in their stories all will say at some

02:18

stage prior to achieving respective

02:22

great things that they actually had to

02:26

believe that it could be done they

02:30

actually had to dream about this all are

02:34

most likely to say this there's one

02:38

other

02:39

however that most are also likely to say

02:44

that is perhaps less talked about but I

02:48

want to talk about this today all again

02:53

are most likely to say that at some

02:56

point in their lives somebody gave them

03:00

a reason to start believing in their

03:02

dreams what I'm saying here is that it

03:08

is one thing to have dreams but for

03:14

those dreams to become realities someone

03:18

must furnish them some of you will know

03:24

me as an educator in other roles in my

03:28

life I'm a father and at work I'm the

03:34

boss and I have an exceptional team of

03:38

people around me as an educator as a

03:44

father and as the boss an important part

03:50

of my role is to furnish the dreams of

03:54

the people around me together we need to

04:00

achieve some extraordinary things and so

04:04

I need and we need people who can dream

04:08

remarkable things and we also need

04:12

people who can furnish remarkable dreams

04:16

at the stronger smarter Institute that I

04:19

run we've been determined to change the

04:23

tide of low expectation of indigenous

04:27

children in Australian schools and I

04:30

reckon we've done that but things like

04:33

that don't just happen this is the

04:38

result of long-held dreams and the

04:42

dreams of others around me for my part

04:46

let me explain

04:48

I grew up in Bundaberg not far

04:53

here I was the youngest of ten born of a

04:58

very proud and hardworking Italian

05:00

father and a very strong and very proud

05:06

Aboriginal mother at school in Bundaberg

05:12

I had a great time

05:13

I enjoyed the social life of it all but

05:19

in retrospect I don't think that I would

05:23

ever seriously looked upon as a high

05:25

achiever I went okay at rugby league

05:29

greatest game of all and I think that

05:34

was appreciated but nobody seriously

05:40

furnished any dreams of me being a high

05:43

flyer or a high achiever and to be fair

05:47

I don't know that I really had any

05:51

high-flying dreams to furnish at the

05:53

time like too many young people I think

06:01

it's high school with no idea about what

06:03

I wanted to do I had this universe

06:07

University Entrance school that was not

06:10

worth much but thankfully I had a lucky

06:14

break and was offered special entry into

06:16

Teachers College at Kelvin Grove which

06:19

is now QUT the university that I work

06:24

for and because I was a special entry

06:27

student they made my course longer the

06:32

normal course was three years but mine

06:34

was going to be four years or however

06:36

long it needed and because of that I

06:40

started off on a lighter workload 60%

06:43

just so that I could get the feel for it

06:45

I got the hang of it pretty quickly you

06:49

know and in the second semester I moved

06:53

from a 60% workload to a 90% workload

06:57

and it was going okay a big part of

07:02

being in Teachers College is reflecting

07:05

on school processes

07:07

which got me reflecting on my own school

07:10

experiences and on reflection I didn't

07:16

really like what I saw on reflection I

07:22

remembered the primary school principal

07:25

at Bundaberg East State School on the

07:27

Burnet River coming to the door with all

07:30

the results from the diagnostic test

07:32

thing with a degree of surprise in his

07:34

voice Chris Arabic the highest score in

07:37

the school

07:38

I remembered the year 11 maths teacher

07:43

handing back the math teacher saying far

07:45

about 75% must have been an easy test

07:49

and of course it was only joking of

07:53

course I laughed with him at the time

07:56

but subsequently I realized that he was

08:01

sending a message to me without even

08:05

knowing that he was sending it and he

08:08

wasn't being malicious and I was

08:12

receiving a message from him without

08:15

even knowing that I was receiving a

08:16

message from him it was a message that

08:21

certainly wasn't designed to furnish

08:24

dreams of greater heights it was a

08:29

message thing I didn't really expect

08:32

this from you

08:40

realized that I had been selling myself

08:42

short I realized that I had been sold

08:49

short I was sold short because all of us

08:54

at the time

08:55

myself included had colluded with the

08:59

notion that I was only ever an average

09:02

student I never dreamt of great heights

09:06

there was one teacher my year 9 history

09:10

teacher mr. Ramon who tried to get me to

09:14

see that I was academically bright and

09:19

at the time I thought he was crazy at

09:21

the time I thought why are you hounding

09:23

me like this and clearly his lone voice

09:28

would never be enough to furnish within

09:31

me any dreams of greatness which was a

09:36

pity upon this revolution of collusion

09:43

with low expectations it is fair to say

09:45

that I became a little bit angry I guess

09:48

and more importantly I became deeply

09:51

determined to catch up on the work that

09:53

I missed at the start of my teacher

09:55

court teacher training course and I

09:58

wanted to walk out of there in the same

10:01

time as everybody else three years and

10:03

so that meant I had to catch up so for

10:08

my last two years at college I had to

10:10

work a 110 120 % work Road in order to

10:14

catch up and finish at the same time as

10:18

my peers I worked hard I worked really

10:24

hard and I passed and I walked out of

10:30

their normal not special but I walked

10:35

out with everyone else and one would

10:39

think that I would have been happy to

10:42

finish college in many ways I was the

10:46

truth is I became angrier no I was angry

10:51

because

10:53

I was angry because I was wondering how

10:58

the hell could I have dramatically

11:00

misjudged my abilities back then and if

11:05

I had sold myself short in that kind of

11:07

way

11:08

and I had been sold short in this kind

11:12

of way and how many other Aboriginal

11:15

children how many other children were

11:19

being sold short in our schools in the

11:22

same way from there I was determined to

11:30

get other children Aboriginal children

11:33

in particular to see the things that I

11:37

didn't see when I was in school I was

11:41

also determined to get my colleagues

11:44

other educators see Aboriginal children

11:48

differently as potential high-caliber

11:51

learners to see them more for the truth

11:55

about who they are as young students

12:00

bright and capable with just as much

12:04

right to big dreams as any other child

12:11

so as an educator I take my role very

12:18

seriously I am serious about the need to

12:22

make schools and classrooms a place

12:26

where all children have to do is to

12:30

dream and by now you probably get this

12:37

you probably get why I take this so

12:40

seriously

12:42

I'm serious about this because this is

12:46

personal for me I'm a father now and I

12:52

don't ever want to see the dreams of my

12:55

children stifled by people around them

12:58

just because they don't believe in them

13:01

enough to furnish their big dreams

13:03

whilst many of you are here are not

13:06

original many of you I'm sure can relate

13:10

quite strongly to what I'm talking about

13:14

if you were the kid from a single-parent

13:17

family or the one with the secondhand

13:21

uniforms one that never had the nice

13:26

flash lunches of you as a smelly kid in

13:29

the class I think you'll have a good

13:32

sense of what I'm talking about and

13:35

while some of you may not relate so

13:39

strongly to what I'm saying here I know

13:41

that all of you will understand what I

13:43

mean when I say that the role of a

13:46

teacher and her or his influence can be

13:50

crucial I'm quite certain that all of

13:55

you in the room here and all of you

13:56

watching on can remember right now a

14:00

teacher that you had way back in school

14:03

and you can remember whether that

14:06

teacher furnished your dream or whether

14:09

that teacher cycled them I am certain

14:13

that all of you can remember right now a

14:16

teacher in your life who either said to

14:19

you hey you can do this or you had a

14:26

teacher that said you won't amount to

14:30

much and I suspect that you can probably

14:33

see that teacher in your mind right now

14:37

you see this is the power and the magic

14:43

of teaching this is why we have to take

14:50

this seriously the ability to be a

14:54

teacher is truly a gift and it is a gift

15:00

that comes with power and magic that can

15:04

never ever be underestimated

15:08

with the power that we have as an

15:12

educator and the power that we have as

15:15

adults and as parents and as bigger

15:17

brothers or sisters we must

15:20

absolutely said about furnishing the

15:23

dreams of our children and creating

15:26

environments in which all they need is

15:29

to dream amazing things can happen when

15:35

you do this you know one of the

15:39

highlights of my career as an educator

15:40

has been the principle of shurberg

15:42

school an Aboriginal community 250

15:46

children an Aboriginal community school

15:48

of two hundred and fifty children

15:50

tragically it was for too long a school

15:52

going through the usual motions with all

15:55

involved colluding with the notion that

15:58

Aboriginal children were chronic non

15:59

attenders chronic under chair

16:02

underachievers and in many ways

16:04

delinquent under my leadership this was

16:09

always done to change because I knew

16:11

very well the toxic dangers of watered

16:14

down expectations and I knew very well

16:17

the truths about being Aboriginal and I

16:21

wanted children to act like Aborigines

16:23

not like delinquents I wanted children

16:27

to act like Aborigines not like

16:30

delinquents I wanted them to act strong

16:33

I wanted them to act smart the strong

16:38

and smart philosophy in our school I

16:39

have seen the amazing things that

16:42

started the ripple which changed the

16:45

tide of low expectation of indigenous

16:48

kids right across Australia when I was

16:51

principal at sugar school I saw what

16:54

happens when you furnish the dreams of

16:56

young children

16:57

I saw unexplained absences reduced by

17:01

94% within 18 months I saw real

17:05

attendance at school go from 63% in 1998

17:09

to 94% in 2004 I saw a girl named

17:13

talisha year 4 I bring her mum to say

17:16

mum I read a book today and that was the

17:20

first book she'd read in all of her

17:22

years of school and by Easter of the

17:24

following year I'd seen that she had

17:26

read more than 30 books I've seen a girl

17:29

called Marilyn miss almost half of the

17:31

first three years of her schooling

17:33

missing 87

17:34

of year six and only missed seven days

17:37

and year seven we didn't touch her

17:40

parents welfare payments to make her go

17:42

to school we just meet made the school

17:45

her school a place where it was okay to

17:49

dream big dreams so she went on to be

17:52

the top three in her high school

17:54

completed year 12 and is now working for

17:56

the sugar Council with aspirations to

17:58

study business I've seen year to

18:01

literacy improved by 62% within two

18:04

years I've seen year seven literacy go

18:07

from a point where all children were at

18:09

rock bottom on statewide literacy tests

18:11

to a point where eighty-one percent were

18:13

within the state average band in 2004

18:16

and you know something that was no dream

18:23

this was the reality of furnishing the

18:27

dreams of young Aboriginal children this

18:31

was the reality of giving children a

18:34

reason to dream big dreams and an

18:38

environment in which it was okay to

18:39

dream big dreams

18:40

I hope this story makes you think about

18:44

a stronger a smarter approach to

18:46

relationships with children around you

18:49

these are responsibilities that we all

18:52

must take very seriously these are the

18:57

things that we must get personal about

18:59

and when it is personal for us the

19:04

questions change from what do we do is

19:07

these children to what would I want done

19:10

if this was my child or my little

19:12

brother or my little sister and as we do

19:16

that part of it means we must

19:19

acknowledge the humanity of others and

19:21

I'll ask you to think about this for a

19:24

moment within the context of Aboriginal

19:26

Australians it requires us to

19:29

acknowledge the humanity of others and

19:31

when we acknowledge the humanity of

19:34

others we do two things we acknowledge

19:37

that those around us are worthy and have

19:41

capacity capacity to lift themselves and

19:45

worthy of having their dreams been firm

19:50

let's embrace our responsibilities as

19:53

adults and let's be determined to

19:57

furnish the dreams of our children

19:59

let's make Australia truly this place

20:02

which is a land of opportunity and a

20:05

place where we can say confidently to

20:07

our children all you need is to dream

20:10

then

Embracing the Aboriginal inner spirit model for healing

There is a word in many different language groups that describes inner spirit and many Aboriginal people share this belief.

Our Inner Spirit is the centre of our being and emotions.

When our spirit feels strong our mind feels strong.

When our spirit feels tangled our mind feels tangled.

Strong Inner Spirit is what keeps people healthy and keeps them connected together.

Strong Inner Spirit keeps our family strong, our community strong and our country alive.

(From Aboriginal Inner spirit model)

Some healing ways to build strong spirit and identity may include:

- ceremonies
- men and women's business and healing circles
- stories, song, art and dance
- going back to country and taking on responsibilities handed down for care and protection

Youtube video URL:
https://www.youtube.com/embed/zp_vYfEiuGU?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Songlines: Aboriginal Art and Storytelling explains more about this way of Aboriginal healing

Video transcript:

00:02

you

00:07

it actually documents our history our

00:10

culture the things that happen in the

00:12

personal surf of the future and people

00:14

think well how could art be a written

00:16

language do comparisons we're all human

00:18

beings all over the world

00:20

you have the Egyptian hieroglyphics and

00:22

the word hieroglyphics from the Greek

00:24

erotically Pharaoh's sacred carvings and

00:26

they're only being deciphered now still

00:29

being decided that they document the

00:31

Egyptian history all the way through

00:33

it's a written language in art

00:34

similarity to that is South America the

00:37

Inca the Aztec and the Mayan culture

00:39

there's also an art form of

00:41

hieroglyphics which documents a history

00:42

which is still being translated a little

00:45

bit closer to us in Australia we have

00:47

the South Pacific

00:48

for instance the Polynesian structure of

00:50

the Maori especially their carvings the

00:53

tattoos we call Morkel on the face and

00:55

on the arms on the body they are also

00:57

documenting their Eyrie or their clan

01:00

groups the whole structure who they are

01:02

and where they come from so art is a

01:04

written language depending on the person

01:06

who understands that as a written

01:08

language also art documents are

01:11

belonging our belonging to the land the

01:13

importance of the land because in

01:15

Aboriginal culture it's not just the

01:17

land it's what's on the land and in the

01:19

land we become as one with the land so

01:21

we understand the animals but the plants

01:24

the birds the fish we have to know the

01:27

whole structure we know how they breed

01:28

how they migrate where they live time to

01:31

hunt so everything is a part of that

01:33

whole structure that we have to

01:34

understand and so art helps document

01:38

that whole history

01:45

songlines can be very complicated the

01:47

word songlines comes from the english

01:49

translation of islets in english song

01:51

lines in our culture we understood the

01:54

whole area where we lived but also the

01:57

structure of Trade and ceremony so you'd

01:59

move from one piece of your where you

02:01

belong to to another clan group and so

02:04

you'd have to move through the land so

02:06

song lines are actually maps of the land

02:08

to give you an idea you got a group of

02:12

say a hundred people men women and

02:13

children they're living in an area

02:15

they're camping there they go out

02:17

hunting the men go out looking for the

02:18

emia the wallaby the kangaroo and the

02:20

fish and so forth the women go out

02:22

looking for the the seeds and the wild

02:25

fruits and things that they will use for

02:26

cooking and so what happens as you're

02:29

going out to hunt over a period of time

02:31

you have to go a little bit further the

02:33

animals get a little bit scare sir our

02:35

culture you do not destroy so what would

02:37

happen then the Warriors would report

02:40

back the women would report back it was

02:42

getting scare sir and further to go to

02:43

hunt and to gather their food source the

02:46

elders would come together they'd have a

02:48

meeting and then they would decide it's

02:49

now time to leave that area you don't

02:52

destroy it because it has to regenerate

02:54

and regrow again so we move on before we

02:57

destroy it and so they will sing of the

02:59

land they're moving into they'll sing of

03:01

the rivers the bend in the river the

03:03

rock formation the trees the food source

03:04

that's found there and the people

03:06

knowing the land intimately they know

03:08

exactly where they're going and as

03:10

they're going along these tracks or song

03:12

lines or maps of the land they'd be

03:14

singing of the earth because sacred

03:16

areas sacred places things that have

03:17

happened in the past so they're singing

03:19

and chanting all the way along and

03:21

giving thanks to the earth to the mother

03:23

the English see that and they seen our

03:25

people and they call them song lines

03:26

because we moved around the land to

03:28

protect it we were natural greenies and

03:30

ecologist

English (auto-generated)

Being culturally responsive

You do not need to be an expert in culture. You *do* need to understand that:

- AOD treatment alone will not meet the spiritual, emotional and physical wellbeing needs, unless it is an Aboriginal and Torres Strait Islander-specific AOD treatment service that incorporates Aboriginal and Torres Strait Islander ways of healing.
- Aboriginal and Torres Strait Islander women and men have cultural ways of healing that can support their AOD treatment.
- Aboriginal and Torres Strait Islander women talk about women's business with women, not men.
- Aboriginal and Torres Strait Islander men talk about men's business with men, not women.
- Aboriginal and Torres Strait Islander people and communities are the experts in what they need and want. Be guided by them.

You need to take action by:

- inviting a conversation about Aboriginal and Torres Strait Islander healing ways when developing case plans
- consulting with Aboriginal and Torres Strait Islander healing services to learn more about how you can support men, women, young people and children in healing
- consulting with your Aboriginal and Torres Strait Islander colleagues about Aboriginal and Torres Strait Islander healers in your district or in other areas who you may be able to talk with
- helping parents, young people and children to connect with Aboriginal and Torres Strait Islander healers, healing places and other Aboriginal and Torres Strait Islander people who can guide them, if this is what they want
- learning about the traditional sites of healing in your area and how men and women connect with their land and country differently.

Note

This movie explores the chasm between an Indigenous man's western upbringing and his traditional culture. As he goes on a series of journeys to his family's country, he grows from rebellious young man to become a leader.

Set against the backdrop of the long fight to reclaim their traditional lands, Putuparri and the Rainmaker is a story of love, hope and the survival of Aboriginal law and culture against all odds.

The film spans 20 transformative years in Putuparri's life as he navigates the deep chasm between his western upbringing and his traditional culture. He and Spider go on a series of epic journeys to their family's country. Each trip marks a different stage in his passage from rebellious young man to inspirational leader.

Note

> Our stories since colonisation have been dangerous and subversive remembrances. Even remembering our law, our dreaming stories, was a subversive practice, let alone our tales of massacres, resistance, dispossession, living on the mission and the 'welfare' coming to take away our children. Unlike Hollywood, we tell stories to survive, not just to entertain or sell products. We have lost some of our stories because of the brutality of colonisation but we are finding them again and learning new stories, modern stories of surviving the policies of assimilation and establishing our own organisations in law, health, education, child care and child and family services.
>
> SNAICC (2010)

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Page created

Cultural healing to support alcohol and other drugs treatment

Aboriginal and Torres Strait Islander children, young people and their parents need their culture to give them strength to heal and recover.

Healing with children and young people

During a 2016 practice conference, Professor Chris Sarra, founder of the Stronger Smarter Institute and a Gurang and Tarilbilang Bunda man from Bundaberg, described a meeting with a group of teachers who talked about the problematic behaviour of a young Aboriginal boy who was grappling with alcohol abuse, transience and leaving school early. They had lost hope and optimism for this young man. He was destined for a path of destruction and destined for juvenile justice.

Professor Sarra asked: 'What would the Aboriginal elders say this boy needs?'

The teachers answered: 'They would say his spirit has been broken and he needs to find his way home.'

Professor Sarra said, 'Who can help him find his way home? Can we bring them together around a table to talk?'

The teachers answered, 'Yes, we can.'

The shift in conversation was simple yet powerful. It not only gave dignity to the role cultural healing has, but it put it firmly on the table. Asking Aboriginal and Torres Strait Islander people what it is that Aboriginal and Torres Strait Islander children and young people need and how culture can be harnessed to support healing is self-determination in practice. This is cultural healing for young people.

The resilience of Aboriginal and Torres Strait Islander children and young people can be strengthened by harnessing their culture. This will help to reduce their vulnerability to problematic AOD use.

Your support in helping them gain knowledge about who they are, their land and country, and the role they have in their community is an important part of your work.

You can support Aboriginal and Torres Strait Islander children, young people and parents in:

- learning about their connections and belonging

- finding positive Aboriginal and Torres Strait Islander mentors, both men and women
- finding a positive Aboriginal and Torres Strait Islander woman to talk to about women's business
- finding a positive Aboriginal and Torres Strait Islander man to talk to about men's business
- having the opportunity to participate in men's and women's activities to connect to country and enact the important roles they have been given

You will need to consult with Aboriginal and Torres Strait Islander communities, Elders and professionals to understand the best way to connect children and young people to their culture and community.

Note

TEDxCanberra—Sam Perry—Mentoring indigenous youth features Sam Perry, who reflects on his work with the Australian Indigenous Mentoring Experience and how he, a privileged white person, completely changed his life to become a part of the work he now does.

Ice: Recovering Indigenous addicts share their stories is produced by ABC News. It's the story of Aboriginal men who have reclaimed their life, culture and identity from alcohol and drugs.

Healing from ice use in Victorian Aboriginal communities, produced by Onemda Koori Health, is a short film about how Indigenous people have managed to stop or reduce ice use. The film includes interviews with a worker and ex-ice user, and provides contact details for alcohol and drug services across Victoria.

Healing and recovery with parents

Whether treatment is provided by an Aboriginal and Torres Strait Islander community-controlled service or a mainstream service, the following nine guiding principles from the Australian Government's *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples Mental Health and Social and Emotional Wellbeing 2017–2023* provide general guidance about what is needed for effective treatment:

There are nine guiding principles:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context that encompasses mental health and physical, cultural and spiritual health. Land (and Water) is central to wellbeing. Crucially, it must be understood that while the

harmony of these interrelations is disrupted, Aboriginal and Torres Strait Islander ill health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular.
4. It must be recognised that the experiences of trauma and loss, present since European invasion, are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continue to have intergenerational effects.
5. The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health (as against mental ill health). Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.
7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in urbanised, traditional or other lifestyles, and frequently move between these ways of living.
9. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017–2023.

Practice prompt

Ensuring that young people and families are referred to culturally safe and responsive AOD services will assist them and their families to reach their goals in relation to AOD use

Ask yourself:

- What does an AOD assessment tell me this parent needs? How can we connect their cultural healing alongside this? What cultural healing options are best suited

for the type of AOD treatment I am considering? How will the parent's cultural needs be met in the treatment?

- What is the range of options available? How does this match a parent's needs? Who have I consulted with about Aboriginal and Torres Strait Islander healing ways to support their AOD treatment?
- How can the parent engage treatment and aftercare support, particularly in remote areas? What support can I arrange to make access easier and more sustainable? How can kin or the Aboriginal and Torres Strait Islander community assist?
- Where is the parent in the change cycle? (see following diagram) How will I talk about the impacts of AOD use on their spiritual, emotional and physical wellbeing? What does a parent need from me, their kin or community to help them connect with their own reasons for change?
- Have I used resources developed for Aboriginal and Torres Strait Islander people to have conversations about AOD use? Who else can I talk with to give parents the best opportunity possible to connect with their own desire to change? How could connection to country or land support parents here?

Source: Family Relationships Quarterly No. 17

Tip

Use this resource to assist to identify a parent's stage of change

The strength of the community

In spite of the level of disadvantage, Aboriginal and Torres Strait Islander communities are vibrant and are actively seeking to address issues that they face. The importance of strong cultural connections is fundamental in increasing resilience in the community.

How can you support Aboriginal and Torres Strait Islander people and communities to reduce the risks?

- Develop a strong partnership with Aboriginal and Torres Strait Islander alcohol and drug workers and services in your district.
- Show a genuine respect and give dignity to the experiences of Aboriginal and Torres Strait Islander people when talking about their AOD use.
- Consult with Aboriginal and Torres Strait Islander Elders, professionals and your colleagues about real ways to talk about alcohol and drug problems with families and communities.
- Look for Aboriginal and Torres Strait Islander solutions in participation with Aboriginal and Torres Strait Islander families and communities.

- Support Aboriginal and Torres Strait Islander young people, women and men in engaging in genuine opportunities to connect with their country, land and roles within their community.
- Provide information and education about the impacts of AOD on health and parenting in a way that is meaningful and culturally appropriate for Aboriginal and Torres Strait Islander people.
- Embrace Aboriginal and Torres Strait Islander beliefs about spiritual, emotional and physical wellbeing to guide AOD interventions.
- Look for opportunities to involve and connect Aboriginal and Torres Strait Islander young people with Aboriginal and Torres Strait Islander mentors.
- Look for opportunities to engage Aboriginal and Torres Strait Islander elders or professionals in your conversations with parents, family, kin and community to help communicate the worries and develop a solution.
- Find out about men's and women's business, and how AOD use should be discussed with parents.
- Find out about traditional healing methods that may be important. If a parent does not know, help them learn about it or connect them with someone who can support them on their journey.

Indigenous solutions for alcohol and other drugs treatment

Greg Phillips, the chair of the interim board of the Aboriginal and Torres Strait Islander Healing Foundation, described healing as 'a spiritual process that includes addictions recovery, therapeutic change and cultural renewal', and involving reclamation of identity (Phillips, 2008, 2007).

Remember that:

- interventions need to be delivered in culturally meaningful ways
- traditional healing practices should be used
- respect for cultural differences is important.(Draguns in Smith et al., 2011)

Consider how an Aboriginal and Torres Strait Islander community may assist your service centre or region to respond to alcohol and other drugs issues with Aboriginal parents in your community. Ask for ideas on the best way to talk about the impacts on wellbeing and the safety of children. Consider ways Aboriginal and Torres Strait Islander elders or respected community leaders can support conversations or be involved.

Introduce yourself, say where you are from, a bit about yourself and who invited you, and ask permission to talk about the AOD use and how you may go about sharing information and getting ideas, or how to plan an event on drug and alcohol issues. They will tell you what you can talk about and what you cannot, and will also advise on any other cultural barriers you may face.

Read more about working with Aboriginal and Torres Strait Islander families in the Safe care and connection section

How you can do this

Print the below table

Aboriginal and Torres Strait Islander identity and connection to culture Always talk with an Aboriginal and Torres Strait Islander person about whether they identify as Aboriginal and Torres Strait Islander and whether they hold close to their culture and traditional healing ways	How are you connected with your traditional culture? What would healing be like in your culture? How do you see this playing a part in your AOD treatment? How is traditional culture and healing important for you in our work together? Is this something you want to embrace now to support your healing from AOD? What opportunities have you had to connect with Aboriginal and Torres Strait Islander healing ways before? Could traditional healing be useful to you now?
Yarn about problems Aboriginal and Torres Strait Islander may not like talking about family or community problems within groups or over the phone.	What would it be like for you talking about this in a group? What do you need to make this safe enough for you to talk in a group? What would work best for you, talking in a group or one to one with someone?
The best fit of mainstream and Aboriginal and Torres Strait Islander AOD services	It is really important that you feel comfortable and safe with any services, and that treatment

Aboriginal and Torres Strait Islander people may be worried that they know someone in a Aboriginal and Torres Strait Islander service or an AOD support worker. For some, they will worry about confidentiality and information about them going back to their family of community, adding to their shame and possible backlash. Always ask Aboriginal and Torres Strait Islander people what services they would prefer and how you can address any concerns they may have. Never make assumptions.	embraces your Aboriginal and Torres Strait Islander culture and healing ways, if that is what you want. How do you feel about working with Aboriginal and Torres Strait Islander AOD services or workers? Are there any issues we would need to work out with them so you feel good about confidentiality? How do you want Aboriginal and Torres Strait Islander services or workers to support your treatment and healing? You prefer to work with a non-Aboriginal and Torres Strait Islander service. How can we make sure your cultural needs and healing ways are met, if this is what you want?
Look for cultural healing ways to support treatment	How can I support cultural healing with AOD treatment? How can I find out what culturally appropriate supports are available for the parent? Who can I consult with to learn more about this? If there is not a specific Aboriginal and Torres Strait Islander AOD program, how can I get creative to support the parent? Are there programs out of my area that I can talk to for ideas? Who can I talk to in the Aboriginal community to get ideas about how best to support the young person or parent's cultural healing?

Further reading

Culturally capable behaviours

Traditional healing and alcohol and other drugs treatment

To help parents with problematic AOD use access treatment that is culturally responsive, you will need to know how the parent would prefer Aboriginal and Torres Strait Islander healing to be incorporated into their AOD treatment plan. You will need to know what options are available for them.

Find out what Aboriginal and Torres Strait Islander AOD services are available. Services that include restoring spirit will be the most effective for Aboriginal and Torres Strait Islander parents and will benefit their child and their community.

For example:

Gallang Place in Brisbane is an independent Aboriginal Community Controlled Organisation and provides Indigenous counselling for families with a focus on enhancing the health and wellbeing of Aboriginal and Torres Strait Islander people.

If a parent does not want a specific Aboriginal and Torres Strait Islander service or there is not one available to access, you will need to find out what AOD local services are available and how they can meet the cultural needs of Aboriginal and Torres Strait Islander people.

Learn about how men's programs and women's programs differ in meeting traditional healing ways within AOD recovery. If you do not have a local service, consider consulting with others from other regions to explore options and how they may be able to support your work with Aboriginal and Torres Strait Islander parents and young people.

Partnering with Aboriginal and Torres Strait Islander alcohol and other drugs services

You will need to build ongoing relationships and partnerships to meet the needs of Aboriginal and Torres Strait Islander children and families.

There may be some barriers that you will need to consider for you, your Aboriginal and Torres Strait Islander colleagues and Aboriginal and/or Torres Strait Islander community partners.

Be aware that there are cultural reasons why some professionals may not be able to work with other professionals. A person may not be able to talk to particular people because of family relationships (kinship), for example, they cannot talk to their cousin or father-in-law because of cultural reasons. Do not assume that the worker is not doing their job, as there may be other reasons why they appear to not want to talk to a particular community member.

You can read more about questions to ask in a consultation about an Aboriginal and Torres Strait Islander family, community, cultural roles and traditions in the Safe care and connection section.

Here are some things to keep in mind when working with Aboriginal and Torres Strait Islander alcohol and other drug services.

Strong partnerships, strong solutions	How I can do it
Include all services working with the family in all meetings. Do not exclude services. One in all in. Develop a shared understanding of confidentiality.	Establish regular phone contact and regular face to face meetings with AOD and Aboriginal and Torres Strait Islander services Understand how partner agencies record information and how they discuss child protection concerns with family and community members. What information is shared and who with? Be clear about mandatory reporting responsibilities, but acknowledge the difficulties for Aboriginal and Torres Strait Islander workers doing this. Ask what will help or support them.
Talk to Aboriginal and Torres Strait Islander services, such as AOD-specific services or lands councils. Learn the local knowledge about problematic substance use in the community.	Consider the following questions: How do they respond when they hear about family substance use on the grapevine? Are they aware of certain children or families where parental substance use is a concern? Are they aware of certain geographical areas where use and

Strong partnerships, strong solutions	How I can do it
	dealing is occurring? How do they believe the community is responding to the concerns? What are the barriers to reporting that need to be addressed in this community?

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Page created

Your practice

Aboriginal and Torres Strait Islander consultations should help you learn about and respond to the needs of Aboriginal and Torres Strait Islander children, family and communities.

They should be purposeful and have meaning to your practice with families. Consultation can be far and wide. Consider how you may sensitively and confidentially consult with Aboriginal and Torres Strait Islander elders, communities and professionals.

The following questions will help you plan your consultation about AOD use:

- What is the history of alcohol or drug use in this community? Family?
- What pain and suffering has the community or family recently experienced? (Think about children who may have recently been taken from the community, Aboriginal and Torres Strait Islander children who may have been placed off land and country or in non-Indigenous placements, or other government intervention.)
- What are the traditional ways of healing and recovery that may be important to this Aboriginal and Torres Strait Islander family and community? How can I support that here with their AOD recovery?
- How do I talk about AOD use with women, men and children? What are the rules I need to know about? What words should I call alcohol or drugs? Should I use the same names Aboriginal and Torres Strait Islander people use or would this be offensive?
- How should I explain the way AOD use is hurting them and their child?
- How can I be most useful to this family in helping them reduce risks from AOD use and increase safety for children?
- How can Elders, leaders and community help this family?
- What Aboriginal and Torres Strait Islander AOD services, workers and treatment programs are available? What can they tell us about engaging and working with this family? How can they help the parents and family heal and recover? What steps would need to be taken to connect the family with them? What is the best way to talk with the family about this option?

Check your biases and assumptions

Check your bias and assumptions about AOD use among Aboriginal and Torres Strait Islander people.

Areas of bias or assumption	Reflect on
Cultural differences	How would you describe your own culture and traditions?

Areas of bias or assumption	Reflect on
	What points of connection and difference do you have between your own culture and the Aboriginal and Torres Strait Islander cultures? What does this mean for how you understand the life of Aboriginal and Torres Strait Islander people in the past and today? How can you be open in your own mind when hearing things that don't easily fit with your own worldview about parenting, AOD use or healing and recovery options? How can you support Aboriginal and Torres Strait Islander people through your work with them about AOD use?
Aboriginal and Torres Strait Islander people and communities who use alcohol or drugs	What have you seen in the media about alcohol and drug use amongst Aboriginal and Torres Strait Islander people and communities? How did this make you think and feel? What are your thoughts on controlled and prohibited alcohol use in some Aboriginal and Torres Strait Islander communities? What are your perceptions of the level of alcohol and drug use among Aboriginal and Torres Strait Islander people and communities?
AOD use as a response to oppression, violence and social injustice	What do you think about intergenerational trauma and the way it impacts on Aboriginal and Torres Strait Islander families and communities today? Why do you think Aboriginal and Torres Strait Islander people use AOD

Areas of bias or assumption	Reflect on
	in a harmful way? What do you think and feel about when someone says AOD use is a response to Aboriginal and Torres Strait Islander peoples' past and ongoing pain and suffering? How do these thoughts and feelings help or hinder your work to reduce risks of problematic AOD use with Aboriginal and Torres Strait Islander families? How does knowing Aboriginal and Torres Strait Islander history influence your work?

Note

AOD practice kit: Working with parents and Working with young people sections

Culturally capable behaviours

Working with and across difference part of the Safe Care and Connection kit

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Page created

Resources

Resources to support Indigenous healing

Yarning place The Australian Indigenous welfare net provides yarning places—electronic networks enabling people with an interest in Aboriginal and Torres Strait Islander health to share information, knowledge and experience, even when they live in different states, territories and regions, come from different sectors (such as health, education and justice) and work for different organisations.

Marumali Healing Program This is delivered throughout Australia. The program aims to support Indigenous people who have experienced trauma as a result of past removal policies. The program is available for service providers, Aboriginal and Torres Strait Islander men, women and youth, and aims to support the healing journey through recovery and renewal of identity.

The Aboriginal and Torres Strait Islander Healing portal this is an online hub for people working in healing, health, justice, education, employment, child protection and family violence. The portal is designed to encourage information sharing and collaboration across sectors and locations. It brings together information about what is working in Indigenous healing and includes examples of best practice healing initiatives, the latest research from around Australia and tools people can use to develop healing opportunities in their communities.

Between two worlds: a guide to understanding the Stolen Generations This was written to educate non-Indigenous service providers about the challenges faced by members of the stolen generations. It contains information on the history of the stolen generations and advice on the correct practice for working with members of the stolen generations. The topics include important issues such as ‘acting white, feeling black' and 'Facing the challenges'. This may also be useful in your conversations with non-Indigenous carers.

Health Direct—Pregnancy, Birth and Baby service is a support service for Aboriginal and Torres Strait Islander Families.

Australian Government Department of Health Pregnancy Care Guidelines

Alcohol and other drugs support groups

Mutual support groups are made up of people who share their experiences about how their lives have been affected by AOD. They may share their progress, success and hopes for the future. Volunteers typically run these groups to help members support each other. The

groups are recovery focused, and provide social and emotional support and other information. They include:

Alcoholics Anonymous

Narcotics Anonymous

Family and Friends (Al Anon, Alateen)

Smart Recovery Australia

Alcohol and other drugs support services and information

Alcohol and Drug Foundation—AOD resources and information

AOD Knowledge Centre—This provides evidence-based resources to reduce harmful AOD use in Aboriginal and Torres Strait Islander communities.

ATSICHS Brisbane provides a range of health and wellbeing services and programs throughout the greater Brisbane and Logan areas.

Breakthrough for families provides ice education and support services.

Dovetail provides Youth AOD resources and tools.

Family drug support offers 24-hour telephone support, online and face to face support for family members/significant others affected by a loved one's AOD use.

Insight QLD provides Indigenous AOD resources and toolkits.

Queensland Network of Alcohol and other Drug Agencies provides a service finder for AOD services across Queensland.

Queensland Aboriginal & Islander Corp Alcohol and Drug Dependence Services (Jessie Bubing Healing Centre) offers education, counselling and support.

The Townsville Aboriginal and Islanders Health Services (TAIHS) provides Health and Wellness Services.

Lives Lived Well—Shanty Creek rehabilitation centre, located in Mareeba, provides residential rehabilitation to Aboriginal peoples and Torres Strait Islander peoples aged 18 years and over.

Wunjuada Rehabilitation Centre offers a place to stay for Aboriginal peoples and Torres Strait Islander peoples in a substance use rehab program in Cherbourg.

Further reading

Aboriginal and Torres Strait Islander cultural capability—communicating effectively with Aboriginal and Torres Strait Islander people

Carers Australia—Working with Aboriginal people and communities

Learning From Each Other: Working with Aboriginal and Torres Strait Islander Young People 04 youth alcohol and drug good practice guide Dovetail

SNAICC has developed: Growing up our way about Aboriginal and Torres Strait Islander child rearing practices

SNAICC also published Working and Walking Together to support family relationships services in working with Aboriginal and Torres Strait Islander families and organisations.

Creative spirits have created this glossary to help you understand more about important Aboriginal words and terms about life and parenting. An alternative to this is the Department of Child Safety, Youth and Women's Respectful language guide.

Alcohol and other drug treatment for Aboriginal and Torres Strait Islander Peoples was developed by the National Indigenous Drug and Alcohol Committee (NIDAC) in response to a perception that effective AOD treatment is not available for Aboriginal and Torres Strait Islander peoples.

For more about alcohol and drug use and its impacts among Aboriginal and Torres Strait Islander peoples and communities:

- Review of the harmful use of alcohol amongst Indigenous Australians
- Review of illicit drugs use among Aboriginal and Torres Strait Islander people
- Review of the misuse of kava among Indigenous Australians
- Australian Indigenous Health*Info*Net

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Page created

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Page created

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Working with culturally and linguistically diverse communities

Use this part of the practice kit to better understand how to create more safety for children through culturally responsive practice and by seeing the child, family and community in terms of who they are, how they live, what their beliefs are and what they value.

Seeing and understanding

Responding

Version history

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About this part

In this part you will:

- explore how alcohol and other drug use and its treatment is perceived in culturally diverse families and communities
- learn how to harness culture to build resilience, strengths and protection
- reflect on how you have or will acknowledge and harness culture for safety and protection
- gain ideas to help you respond to the needs of culturally diverse families
- learn to build relationships in a cultural community
- find resources to support culturally diverse families facing problematic alcohol and other drug use

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Alcohol and other drugs use in culturally and linguistically diverse families and communities

Australia has a large culturally and linguistically diverse (CALD) population. In 2016, 26% of Australia's population was born overseas. There were over 300 separately identified languages spoken in Australian homes and 21% of Australians spoke a language other than English.

Ethnic background is not a risk factor for problematic alcohol and other drug (AOD) use. Many cultural values, norms and ways of being can act as protective factors against problematic AOD use. However, CALD communities do experience some unique challenges that can impact on their vulnerability.

Vulnerabilities for culturally and linguistically diverse families

These include:

- grief and loss
- racism and discrimination
- religious bigotry
- torture and trauma as refugees or asylum seekers
- undiagnosed mental health problems
- isolation, disconnection from culture and community
- exposure to AOD not previously experienced
- living somewhere where AOD use is the social norm
- difficulty with a new language
- difficulty finding their place in a new community
- conflict between their first country's culture and the Australian culture
- money problems
- unemployment or underemployment because qualifications are not recognised in Australia
- stigma and shame associated with AOD use in some cultures

Protective factors for culturally and linguistically diverse families

However, the protective factors can include:

- strong support networks in the community
- close relationships with friends and family
- open communication between children and parents
- feeling of belonging to a community
- spiritual or religious practice
- friends who don't drink alcohol or use drugs
- good role models within their community
- a culture or religion that discourages alcohol and drug use.

Data on alcohol and other drugs use

Pharmaceuticals for non-medical use are the drugs most commonly used among people from CALD backgrounds (3.4%). People from this group are:

- less likely to consume AOD compared to people whose primary language spoken at home is English
- more likely to report never smoking (82.6%), compared with those whose primary language spoken at home is English (59.5%)
- more likely than those whose primary language spoken at home is English to not consume alcohol (49.4% compared to 18.9%) or illicit drugs (54.2% compared to 82.3%).

Limited data is available on alcohol and other drug use in the CALD population in Australia.

(Source: Australian Institute of Health and Welfare, 2018)

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Harnessing culture as a protection and strength

The intrinsic way that culture can influence an individual, family and community is at the heart of your work in building safety for children in CALD families.

You need to see culture as a strength. It can strengthen resilience, connection and meaning to a person's way of life and the things they value. Being willing to explore culture and being confident in your curiosity to ask and talk about it with parents is vital.

Understanding a parent's 'cultural base' (Houseman, 2003) will help you understand how they might interpret or feel about their problematic AOD use, treatment or supports. Explore their values, perceptions, roles and experiences. Understanding these will enable you to reveal strengths and build protection with parents, families and communities for children.

Talking about the cultural base

In finding out about the context of the migration of the parent and family, use these sorts of questions:

- What made you leave your country?
- What were things like in your country before you left?
- Did you feel like you had a choice in leaving?
- How did you get to Australia?
- What was it like to come here?
- Are you an Australian resident?
- What were your hopes in coming to Australia?

Belonging to a subgroup

Consider other groups that the child, parent or family may also be a part of that may influence their vulnerabilities or protection from problematic AOD use. Consider their:

- ethnicity
- gender
- sexual orientation
- current area and suburb
- status as refugees or migrants
- religion.

Degree to which their culture influences them

Consider how the child, parent and family hold traditional values and beliefs in Australia. You may find this is different for each member or generation of the family.

- Traditional—do they completely follow the beliefs, values and behaviours of their country of origin?
- Bicultural—do they hold a mix of new and old beliefs, values and behaviours?
- Acculturated—have they modified their old beliefs, values and behaviours in an attempt to adjust the new ones?
- Assimilated—have they completely given up their old beliefs, values and behaviours and adopted those of the new country?

Younger generations are more likely to acculturate or assimilate than their parents and grandparents. This can cause conflict and confusion within families, particularly if a young person from a CALD background experiments with or develops their own problematic AOD use. Read more about this in the Working with young people and AOD use section

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Cultural roles, perceptions and experiences

You will find it easier to talk to a parent from a diverse cultural background if you know about the differences in roles between men and women, whether there was oppression in their country of origin, and whether they value just their family or their whole cultural group.

Experience of trauma, loss and oppression

People from culturally diverse backgrounds have their own, unique stories. Some have immigrated to Australia by choice and bring financial resources. Others may have fled their war-torn country of origin with nothing more than the clothes on their backs. Refugee populations in particular will likely have experienced trauma, loss, difficulties adjusting to the new culture, and disadvantage (Sowey, 2005).

Helping a parent to place their AOD problems in the context of their survival and resistance can help to reduce any shame and increase self-compassion.

Further reading

Read more about ways to work with CALD people and communities at the Ethnic Communities Council of Queensland.

The role of women and men

The impact of migration, oppression, social isolation, economic disadvantage and acculturation can greatly influence and change the roles within families. This can add to the risk factors for AOD use. You will need to understand the cultural roles within each family as this may affect who you should speak to and how you should talk with them.

Sometimes it may only be appropriate for women to talk with women and men with men. Age can also be a factor in who you should talk to. Recognising the gender roles and status within the family and community is important in your work with CALD families. You may also need to explore how free and open a parent can be in talking about AOD use with you and health and service professionals.

Individual or collective perspective

People from culturally diverse backgrounds may place a very high value on extended family if they have a collective rather than individual perspective.

Individualism refers to the tendency of people in some cultures to value individual identity, rights and achievements over those of the group. An individual is expected to look after themselves and their immediate family.

Collectivism refers to the tendency of people in some cultures to value group identity and concerns over individual concerns. They prefer to be integrated into strong, cohesive groups that provide protection and loyalty (Hofstede 2011).

Knowing what perspective a parent has can help you understand how to talk about AOD use and the level of engagement a family may or may not have throughout treatment and recovery.

Further reading

Read more about Individualism and collectivism and how this can shape peoples' thinking and identity at: QCISS Community Door eTraining (2018).

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Cultural views about alcohol and other drugs use and treatment

AOD use is understood in different ways across cultures.

You can support a parent's positive change towards treatment and recovery by understanding their cultural views on drugs, pleasure and dependence.

Negative views of AOD treatment are quite common among CALD communities. In fact, many do not believe services can make a difference to their situation, or feel that what is available is not effective.

There can also be confusion and misconception surrounding drug treatment. These misconceptions vary widely, but more so among ethnic communities (groups that are minorities within a larger cultural group).

One the misconceptions concerns AOD dependence and the view that a fast detox is possible and a long-term solution unnecessary. This often results in repeated relapses. Substitution therapy, such as methadone maintenance therapy, is viewed negatively and shamefully by some communities despite it being the most effective treatment for heroin dependency.

The reality is that many ethnic communities do not understand drug treatment, what is involved, or what to expect for the individual over a long period of time. As a result, they do not always get what they expect from drug treatment services and struggle with long-term recovery. This means culturally appropriate communication and education is needed for CALD parents, families, communities and service providers.

Avoid making assumptions about treatment options and what may be getting in the way for families. Be curious. Ask questions to help you understand what they understand about treatment and recovery, and explore any ambiguity or reluctance to engage with services.

Never assume that a parent or family who is connected to their CALD community will receive treatment and recovery support. Many people with problematic AOD use are shunned or lose titles and roles in their community. In some instances, these may never be regained.

Be mindful of the additional stigma and shame that your role may bring to the family and what this may mean after you leave. How will family members and the community react? Will they minimise or try to hide the AOD problem so that shame isn't brought to their family or community?

CALD families may also have heard about or had negative experiences in getting treatment for AOD use. These issues are likely to make parents and families respond in a way that seems reluctant, resistant or ignorant. You will need to explore these issues with parents

without stigma and labels if you are to build safety and protection. Read more in the Working with parents part of this practice kit.

Further reading

Alcohol and other drug use, attitudes and knowledge amongst six CALD communities in Sydney (2008)

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Barriers to alcohol and other drugs treatment

In Australia, culturally and linguistically diverse people represent a small portion of those accessing drug and alcohol treatment services. When families do attempt to seek treatment it's usually because of a medical or legal crisis.

Often families will try their own traditional medicines or healing methods first. It is important that you recognise and value traditional healing methods important to CALD families and how these may be supported alongside mainstream medical services.

Some barriers for CALD families accessing treatment are:

- language difficulties and lack of availability of translation services and material
- lack of awareness of treatment options and available services
- lack of culturally appropriate treatment options or trained workers
- cultural stigma and shame
- lack of family and community support
- insecure living conditions
- immigration statuses that impact on eligibility for many social and health supports
- cultural perceptions and spiritual and religious beliefs about health, drugs and alcohol use that may be different to western models of health and harm reduction approaches.

Stigma and shame about alcohol and other drugs use

Perceptions of alcohol and drug use in many CALD communities living in Australia can be rooted in stigma and shame, which has profound consequences at both an individual and community level. The result of this is that families attempt to hide the drug use of a family member while trying to deal with it on their own for as long as possible. Keeping this secret within the family can result in family conflict, family breakdown, turmoil and angst.

In many CALD communities in Australia there is a self-reliant approach when dealing with personal or family problems and challenges, for fear of blame by others in the wider community.

Also—particularly among communities that are small in number—there is a reluctance to tell anyone in the community for fear of community gossip and backlash. These challenges drive issues of use and dependency further underground, outside of community acknowledgement.

Limited service awareness

Often, CALD parents will seek information from friends or relatives rather than health professionals. General practitioners may also be a source for families looking for information about alcohol and drugs; however, this is often a last resort.

Not knowing or understanding the treatment options available isolates CALD parents and families further. Having different spiritual and cultural beliefs about healing and recovery will also guide the types of services looked for or accessed by families.

It is important that you know what services are available when you talk with families so you can be clear about what is involved and expected. You will need to help parents, families and communities access information that will build their knowledge and understanding about problematic AOD use, treatment and recovery.

Communication barriers

Although AOD information is available for CALD communities and translated into one or more community languages, this may not always be the best option. Many communities prefer the sharing of information through face to face conversation.

To ensure CALD families have and perceive choice, it is important to ask them if they would prefer a service provider or practitioner who is of the same cultural background as themselves; their choice should not be assumed for them, simply based on their cultural background. (Sawrikar, Katz, 2009)

Read more about barriers to participation at:

Further reading

Community Door: Barriers to participation

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Practice reflections

Take some time to think and reflect about the child, parents and family you are working with.

- What do you know and what do you assume about the CALD background, community and AOD use with the family you are working with?
- How have you explored the barriers, stigma and shame experienced within this community? And by the parents and family?
- How have you tried to support and alleviate this?
- How do you understand roles and relationships and how they influence AOD use, treatment and recovery?
- How well do you understand the cultural perspective about AOD use, treatment and recovery?
- If a parent has not completed treatment in the past, what assumptions have you made about this? How have you talked with them about this? What are other possibilities?
- What are the parents' and family's expectations and understanding about treatment, timeframes and recovery?
- How have you provided information to the parents and family?
- What do you understand about the issues underlying their AOD use?
- How can you harness culture to build protection and safety?
- What is your understanding of the trauma, oppression, discrimination and racism the family has experienced?

Watch the following video for tips on communicating with cultural awareness.

Youtube video URL:
https://www.youtube.com/embed/ZDvLk7e2Irc?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Cultural Diversity - Tips for communicating with cultural awareness

Video transcript:

00:07

and cultural diversity is about how two

00:11

people would be communicating

00:13

and the way they would be communicating

00:15

would be based on their cultural

00:17

differences so for instance in some

00:20

cultures that communicate by not giving

00:23

eye contact and that's considered as a

00:26

sign of respect in other cultures to

00:29

give eye contact means you're giving

00:31

attention so it's just acknowledging

00:33

that people do communicate in a

00:35

different way

00:43

cultural diversity covers a number of

00:46

differences when we're talking about

00:48

differences in relation to behavior

00:51

attitude differences in relation to

00:54

values to beliefs gender differences

00:59

status differences so there are a number

01:02

of differences that would then come

01:03

under the umbrella of cultural diversity

01:13

there are four tips that you could

01:16

consider when you're interacting with

01:18

somebody who is from a different

01:20

cultural background to you so the first

01:22

tip I would suggest is using your

01:25

observation skills observe how they're

01:28

behaving observe how they're interacting

01:30

with you observe their body language and

01:32

as far as possible

01:34

try and mirror and match the body

01:36

language so in some cultures people like

01:40

to sit and lean forward when they're

01:43

interacting and if you lean back you're

01:46

giving a message that you're not

01:47

interested which they would consider as

01:49

an insult

01:50

so if you match how the other person is

01:53

behaving then the wrap hole will be

01:55

building and then you can then move on

01:58

to the common areas that are therefore

02:00

the points of discussion so that's tip

02:02

number one the second tip is appreciate

02:04

differences some cultures do behave very

02:08

very differently which in other cultures

02:11

will be considered as derogatory or

02:14

insulting so for instance if you go to

02:17

India timekeeping is not so important

02:21

there people are fairly laid-back and

02:23

they don't are not as bothered about

02:26

timekeeping if you go to Switzerland as

02:29

an example if you're if you're a minute

02:32

late it's considered as a real insult so

02:35

just be aware that there are differences

02:38

in what's expected and in turn styles of

02:41

communication so appreciate differences

02:43

another example I can give to you is in

02:46

Northern Europe people would communicate

02:49

by giving facts in Italy people would

02:53

communicate by sharing a lot of emotions

02:55

in Japan people communicate by building

02:58

harmony and in India people would

03:00

communicate by asking about families

03:02

okay so when you're talking about

03:05

differences in culture is about being

03:06

adaptable too so if I if I was

03:09

interacting with somebody from Northern

03:11

Europe I would think oh well they're

03:13

just going to ask me about facts and

03:14

figures rather than asking me about

03:16

personal life and I would then adapt

03:18

myself to accommodate what their needs

03:20

are the third tip which is really

03:24

important is don't assume

03:27

that because that person represents that

03:29

country that he or she is going to

03:32

behave like everybody else

03:33

it's about respecting the individual

03:36

concerned so they would be behaving and

03:39

interacting with you which is about

03:42

their personal values and beliefs so

03:45

it's about respecting the individual

03:47

concerned and the last tip is about

03:52

patience fundamentally I was interacting

03:56

with somebody from southern India in

03:59

English and when I said to him how are

04:02

you a very simple question in UK the

04:05

response would be I'm fine how are you

04:06

whereas in some parts of the world

04:09

they'll give you 20 sentences to explain

04:11

how they are which in UK that would be

04:15

covered in two sentences so cultural

04:18

diversity is also about being patient

04:20

that their style of communicating may

04:23

take longer than what you're used to and

04:25

is just about persevering through those

04:27

patience

04:36

yes cultural diversity fundamentally is

04:39

about acknowledging differences and it's

04:43

about respecting those differences their

04:47

behavior that the values that believes

04:49

is done in a different way to you it's

04:52

not meant in a disrespectful way is just

04:55

how different people behave in different

04:57

circumstances

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Cultural considerations

Here are some suggestions about what to ask yourself (and others) when considering the culture of a family you are working with:

- Does the CALD community have an individual or collective perspective? What will this mean for the way I work with the family and talk about AOD use and worries?
- How should information be shared? What will help parents validate what I am saying about AOD use?
- How would the family likely be dealing with their AOD issues? Who would they talk with about it? What treatments and solutions are they likely to try?
- Who in the community could assist with giving messages about AOD use in a culturally appropriate way?
- What shame and stigma could be associated with AOD use?
- What are the traditional or cultural views about AOD use?
- What are the migration, oppression and trauma experiences of this cultural group within Australia?
- What gender issues do I need to be aware of? What conversations do I need to have and who should I have them with?
- What language is appropriate to use when talking about AOD use?
- What is the best way to name the worries?
- What are potential responses to our worries about AOD use?
- What are the roles within the family and community for this CALD group?

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Talking to parents

Here are some helpful questions and information for talking to parents.

- ask parents to share their story about where they came from, ethnicity and languages spoken, religious affiliation, and practices
- what it is like living in Australia—the best things, the hardest things
- what challenges they have faced and overcome, and how did they do this
- what challenges they face today
- how they feel about living in their community and who are they connected with in the community
- beliefs, moral values and norms of conduct. For example, cultural notions of a 'good family' mean that personal problems are never discussed outside of the family, or in some cultures talking about certain subjects with a member of the opposite sex or a younger person may be inappropriate
- their perceptions of problematic AOD use, the cause of and ways such problems should be managed. For example, in religious or cultural communities that prohibit the use of alcohol, low-risk drinking messages may be seen as inappropriate.

Talk with parents about

- their expectations and cultural norms about treatment and recovery
- what services are available to them
- who they can connect with to make sure their cultural needs are met
- the fact that problematic AOD use is seen as a health issue, not a moral or legal issue
- what they need to attend AOD treatment. Do they need staff support or spiritual support?
- their rights. Explain that they can request an interpreter at any time and ask how they want information to be provided
- confidentiality between them and AOD services (to alleviate worries and to be clear about what will be shared and with whom)
- how they feel about others knowing about their AOD use and treatment
- how they feel about using a mainstream health service. Are they worried about it?

Watch the following brief video on tips and advice for communicating with diverse communities.

Youtube video URL: https://www.youtube.com/embed/V-bNbJRlpHo?enablejsapi=1&showinfo=0&rel=0

Video Caption:
Working with culturally and linguistically diverse CALD communities - Tips and Advice

Video transcript:

00:07

I think the fundamental values are all there

00:09

you know, you will be listening and reading the body language

00:14

and asking questions which you would do with anyone really,

00:17

and pay respect, but I guess there

00:20

are cultural factors that are different

00:22

for each community and we do need to be aware of them.

00:25

That doesn't mean you will have to know everything about their culture,

00:28

but I guess there is room to educate ourselves.

00:33

I think it is about welcoming environments and that's

00:35

about including those people from those

00:37

cultures to create those environments.

00:40

We also make sure that we go to relevant

00:43

meetings that are happening in Hobart

00:44

about who you know what what cultures

00:46

are newly arrived so that we can, I guess

00:49

have a little bit of that background

00:51

knowledge of what the groups that we've

00:53

got coming might be experiencing.

00:55

If the person is coming to the service for the first time

00:58

making sure that you understand their culture first.

01:02

It's just warm welcome

01:04

have a seat, have a chat, a bit of chat

01:07

like warm up.

01:08

If I go to access a service then I meet someone who's

01:12

trying to do things according to how we are used to

01:16

I'm used to then I'll feel more

01:18

comfortable - Oh so this person knows me,

01:21

knows how things work, you know it's

01:24

I think this is very good.

01:26

First of all is very important to

01:30

understand the client context, you know

01:33

historical information about

01:36

their family background, what other

01:38

issues, cultural sensitive issues

01:41

that are more likely to compromise

01:44

their care and their treatment.

01:47

Getting more information about it, even going to

01:49

the website or the internet before

01:52

they see the person, Google and

01:56

read more about that particular culture.

02:00

We normally ask a general question as a

02:02

health professional I mean I suppose

02:04

that's how we

02:05

are trained, to ask questions

02:07

to get information, it is very important that we

02:10

step little bit out of the box that we

02:13

normally ask questions and really try to

02:16

understand what sort of question we

02:19

might be able to re-frame.

02:21

We've also ensured that we've had people come and

02:23

do training with staff, so even if it's

02:26

people who have all done cultural

02:28

responsive training it's not something

02:30

that people do once.

English

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Page created

Talking to alcohol and other drugs services

You will need to explore how alcohol and other drug services can meet the needs of a culturally diverse family. In doing so, you need to:

- Find out whether the AOD service currently has formal policies, practices or strategies to support people from CALD communities in accessing or participating in treatment.
- Find out what CALD services are available to support AOD work with the family.
- Consider how CALD counsellors and AOD services can work together.
- Talk with AOD services about how they will meet the parent's religious, cultural and spirituality needs throughout treatment.
- Be aware of the potential need to include family members in treatment and recovery plans. (Be guided by parents about this).
- Refer to culturally specific services where possible if the parent wants this. Never assume they do; always check what will help them the most.
- Have a conversation with parents about the way the parents experience stigma and shame from family or community.

Further reading

Read more about best practice approaches: talking about AOD use and talking with parents and family from culturally diverse backgrounds

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Page created

Using interpreters

Always ask parents if they would like an interpreter. Never make assumptions about this.

Be aware of the potential problems in using an interpreter, such as

- concerns about confidentiality
- the interpreter coming from within their community or being known to them
- reluctance to talk about certain things in front of an interpreter
- difficulty in translating some languages accurately, which means some of the meaning of what is said may be lost

You will need to:

- talk to parents before and after an interpreter is used
- explain confidentiality to parents and reaffirm this with the interpreter
- use very clear and simple language when using an interpreter to avoid misunderstandings.

Further reading

https://www.tisnational.gov.au/

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Building partnerships with the community

Knowing the local CALD community will help you understand how you can best help the family. Get to know the cultural and linguistic diversity in your local communities.

- What CALD groups live here?
- Are there patterns or trends within particular communities?
- What risk factors are present?
- How can each community reduce these?
- What CALD and AOD services are available?
- What relationships have you, your service centre or region established?
- How do you share expertise with other services to meet CALD family needs?
- How have you engaged community Elders or cultural leaders to talk about problematic AOD use within their community and ideas about cultural solutions?

Further reading

Helping asylum seeker and refugee background communities with problematic alcohol and other drug use, Insight Queensland.

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Page created

Resources

Alcohol and Drug Foundation has fact sheets about ice (crystal methamphetamine) in English, Arabic and Vietnamese.

Carers Queensland offers a range of supports for the CALD community

Comorbidity Guidelines—Specific population groups provides information relating to mental health and AOD use.

Mind + Drug Interpreter App is a smartphone app that provides information about the effects of alcohol and other substances on mental health in Vietnamese, Arabic, Chinese, Turkish and English.

My community directory provides cultural and migrant service information.

The Queensland network of alcohol and drug agencies (QNADA) is the peak organisation for the non-government drug and alcohol sector in the state and provides AOD service information.

Queensland Multicultural Resource Directory is a Queensland Government site providing information about community, non-government and government organisations and agencies.

Supporting multicultural communities is a Queensland Government site providing a range of resources, cultural events, interpreter services etc.

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Page created

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Page created

Safety assessment and safety planning

This part focuses on specific guidance about safety assessment and planning when there is alcohol or other drug use by a parent or household member.

For practice guidance on safety assessment and planning in general see:

- the practice guide: Safety assessment and planning
- the *Structured decision making policy and procedures manual*

Seeing and understanding

Responding

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About this part

This part will help you:

- plan for your first conversation with a child and their parents
- understand what you need to consider in assessing the child's immediate safety
- be clear about what to do when a parent's alcohol and other drugs (AOD) use is a danger for a child
- have an honest discussion with parents about their AOD use
- understand the do's and don'ts of safety planning when you are worried about AOD use
- work with the family to build a safety and support network that can keep the child safe

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Safety, belonging and wellbeing

Safety, belonging and wellbeing are at the heart of your work with families

Imagine not being fed when you are hungry. Imagine walking the streets because no one is watching you. Being in a car that's going too fast and not being buckled in safely. Going to hospital because you drank your mum's methadone. Having to move used needles to get to your toothbrush and toys. Not knowing where you will sleep each night or who will be at your house when you wake up. Not being able to wake your Mum up because she drank too much. Being left alone in the house because your Dad is out seeking drugs to use.

These are just some of the things that children living with parents with problematic alcohol and other drugs (AOD) use might experience.

You will need to gain an understanding of how a parent's AOD use impacts on their child. While your focus at this point needs to be on assessing immediate safety, this is only one of many opportunities to understand the child's lived experience. Take time to build relationships, as they offer you the best chance of gaining a true understanding of how safe the child is.

Parents need your help to understand how their child experiences their AOD use. Work in partnership with them to create safety for their child. Be curious about what their AOD use means for them—what they like and do not like about using and how easy or hard it will be for them to change their patterns of use.

Remember, a person's AOD use can be a way of coping or surviving. Take the time to listen to their story while observing their behaviour and holding back judgement.

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Assessing safety

A respectful and curious approach

Questions to ask yourself?

- Have I read the file?
- What has Child Safety tried in the past?
- What message has Child Safety given the family about the child's safety?
- What has the family's experience of Child Safety been before now?
- What do I already know about the Mum's and Dad's substance use? What substances they use, their patterns of use and when they use?
- How can I let the parents know that my aim today is to help them find safer ways to use to keep children safe, not to stop their use right now?
- What do I know about the Mum's and Dad's histories? Could their use be a way of coping, resisting or surviving oppression, pain or suffering?
- How do I let the Mum and Dad know that I appreciate it will be scary for them to talk to me about their possibly illegal drug use (and that I'm not condoning their use)?
- Will I be able to tell if the parents have just used a drug or if they are coming down?
- What approach should I take if the parents are intoxicated or substance-affected when I see them; and will they even be able to talk to me?
- How knowledgeable am I about alcohol and other drugs' (AOD) immediate effects, signs of current use and signs of withdrawal?
- How will I help the child feel safe and comfortable enough to talk?
- What words will I use to explore my worries with Mum, Dad and the child?
- What can I do to alleviate the parent's worries, fears, stigma or shame so that we can have an honest discussion?

Looking for harm, acts of protection, strengths and resources

- Is there at least one parent who has acted to protect the child from the immediate harm? What specific action have they taken?
- Who knows about the parents' use and is available to support them and their child?
- What do the professionals working with the family say about what is happening?
- Is the parents' AOD use unpredictable, escalating or becoming more harmful?
- Do the parents have their own plan for keeping their child safe when they are using or coming down?
- Are there indicators their plan has worked?

- If there were periods when the child has not been notified to Child Safety, what was happening at those times and how is that different to what is happening now?
- Is there a history of direct harm to the child when Mum or Dad has been using?
- What 'triggers' might exist for parents to use and how do the triggers increase danger?
- What other dangers might exist, and how will I keep my eyes open to these?

Structured decision making safety assessment: Alcohol and other drugs

The purpose of the safety assessment is to ensure that practitioners consider a wide range of family and environmental circumstances that affect a child's safety and to effectively plan interventions to protect the child. A parent's use of AOD is one factor to be considered.

When completing the structured decision making (SDM) safety assessment, practitioners (that is, CSOs) should gather information from a wide variety of sources. Practitioners engage with families, children, young people and communities whose culture, ethnicity, economic status, age, gender, spirituality and sexual orientation may differ greatly from their own.

We can all be influenced by our personal experiences and therefore biased when assessing others where difference exists. This is why information should be gathered not just from the family but also the extended family, the network and cultural Elders or advisors to ensure the practitioner is able to make a rigorous and balanced assessment.

Immediate harm indicator 6, from the Safety Assessment is defined as:

Parent misuses alcohol or drugs to the extent that the child's immediate protection and care needs are currently unmet. See SDM Manual for definitions.

Being ready for the hard conversations

Read *Talking about alcohol and other drugs use* in the *Working with parents* section to help you think about the words and phrases you can use to reduce shame and stigma for parents.

Read about common drugs and the effects in the *Overview* section so you are familiar with the signs of AOD use and the impacts on parental capacity and behaviours.

Take information and fact sheets relevant to your worries with you, for example:

- information on safe sleeping and breastfeeding (from the section on *Working with expecting and new parents*)
- facts about AOD (from the https://adf.org.au/drug-facts/)

- information about safer use of injectable drugs (from the Queensland Needle and Syringe Program).

Related forms, templates and resources

SDM Policy and procedures manual

Resource 16 August 2019

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Talking with children

Talking with children and young people to assess safety

Children whose parents have problematic alcohol and other drugs (AOD) use are in danger of direct and indirect harm.

The following table shows three topics that can be used to help you think about the different harm and worries that may exist, and what you may need to explore with the child.

Topic	Question ideas
Parenting	Is the child: • in the car when Mum or Dad is driving under the influence? • sharing the same bed with Mum or Dad after they drink alcohol or use drugs? • being physically hurt by anyone when Mum or Dad are affected by alcohol or drugs? • being left unsupervised? • being protected from people and things that might hurt them?
Practices and paraphernalia	Is the child: • able to access, play with and use drug paraphernalia in the home? • seeing drugs being cooked, injected, snorted or smoked? • seeing, smelling or a part of drug manufacturing or drug dealing?
Places and people	Is the child: • around people who drink or use drugs? • looked after by people affected by AOD when Mum or Dad are using?

Topic	Question ideas
	• around people who may hurt them? • going to unsafe places with Mum and Dad to buy drugs? • going to unsafe places with Mum and Dad so they can make money to buy drugs (for example, sex work or criminal activity)? • doing unsafe and illegal things with Mum and Dad so they can make money for drugs (such as criminal activity)?

Why it is hard for children to talk

Most children want their parents to stop drinking and using drugs. And even though you are trying to help them, children may feel scared, worried or apprehensive about talking to you because they:

- don't want their parents to get in trouble for talking to you
- don't want to betray their family by letting others know what is going on
- are worried of getting in trouble
- are worried about bigger things and don't see AOD as the main problem
- are worried they are the reason their parent drinks or uses, and that you will blame them too
- may be scared you are going to take them away from their parents and from all of the things that are familiar to them.

When a child does not tell you or open up about their parent's AOD use, it does not mean it is not happening. Naming what you are worried about may help the child understand that you know some of what is happening. This may make it easier for them to tell you more.

Do not shy away from naming your worry out of fear of leading the interview or contaminating evidence. Your role first and foremost is to assess the child's safety and understand the ways AOD can make a child unsafe.

Conversation ideas

Whether it is the first time you are meeting a family or you are reviewing an immediate safety plan, the following conversation ideas may be helpful.

Topic/question	Conversation ideas
Naming the worry	• Some people are worried about your Mum or Dad drinking too much alcohol —what can you tell me about that? • I'm wondering what you know about alcohol and drugs. • Who do you know who uses drugs or alcohol, and what have you seen them do? • I was told that sometimes you are left home alone at night. When was the last time that happened? Tell me more about that.
Gaining an understanding of what it is like for the child	When Mum or Dad is using, what do you do? • What do you see? • Who else is there? • What have you seen, smelled or felt at these times? • What do you do when it is happening?
Who is looking after you:	• when this is happening? • when they buy it? • when they use it?
How does it make you feel when Mum or Dad uses drugs?	• What worries you most about it? • On a scale of 0 to 10, how safe do you feel? • What makes you feel safe? • What makes you feel unsafe? • Tell me more about this.

Topic/question	Conversation ideas
What do you notice about Mum or Dad when they drink and when they're not drinking?	• What do you do when these things happen? • How do you know when Mum or Dad has used? • What do you expect will happen? • What do you do?
Indirect questions	• Tell me about your day. What happens when you wake up? • What happens at breakfast time? • Where's Mum when you're having breakfast? And Dad? • Tell me about getting ready for school. • What do you have for lunch at school? • When do you do your homework? • Do you sometimes bring friends home after school?
Other worries	• Who do you go to when you need comfort or help? • Who do you go to when you need protection? • What makes you scared? • When do you feel afraid? • How do you help your little brother and sister? • What would you like to change? • What would you like to stay the same? • What are your hopes?

Further reading

For more information, go to the Raising Children Australian website—Parenting and problematic alcohol and other drug use.

Reassuring children

Remember that your role is much greater than simply gathering information from a child to determine their safety. Every interaction you have with them is an opportunity for healing. You can also help ease the burden, fear and sense of responsibility that many children experience by growing up in homes where their parent's AOD use is problematic.

During your time with a child:

- Let them know that it is not their job to control or stop their parent from using.
- Assure them that they are not to blame for their parent's use.
- Give them information that helps them understand their parent's dependence, behaviours and thoughts.
- Be clear about what is okay and what is not okay about their safety and what they can do.

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Talking with parents

Talking with parents to assess safety

Before speaking to a parent about their problematic alcohol and other drugs (AOD) use, take time to think about how they may be feeling about it and the anxiety, fear and shame it may bring up. Read more about this in the *Working with parents* section.

Be aware that your safety assessment may trigger many emotions and responses for parents that you may need to help them manage. Be prepared, empathetic and clear about what you need to speak about on the first visit. Overwhelming a parent on the first meeting may hinder your relationship and ultimately your ability to understand the dangers that might be present.

Why it's hard for parents to talk

There are many reasons why a parent may hesitate to talk to you.

It may be because they:

- are worried about being arrested or put in prison if they open up about their illegal drug use
- worry that you will remove their child if they admit they drink or use
- feel you will judge them and look down on them
- are angry that someone 'dobbed' them in
- do not think you will understand what it is like, do not care about their story, and will only see them in a stigmatised way (as a junkie or alcoholic)
- feel embarrassed, stigmatised or ashamed
- are scared you will see evidence of their AOD use if you are inside the home
- are intoxicated or experiencing withdrawal.

How parents might respond

Be aware of the different ways parents might respond to your presence and your questions about their problematic AOD use.

A Mum or Dad may:

- be hostile, angry and not want to talk to you
- deny or minimise their use or the incident that triggered a report
- say they don't use in front of their child so their child is not harmed by it

- say they are a better parent when they use
- not want you to come inside the home or refuse you entry
- be overly willing and quick to agree to everything so you leave, but without any intention to carry through. (This is false compliance.)

Conversation ideas

Here are some conversation ideas that may be helpful when inviting parents to talk:

- I know you're probably worried about what the consequences are if we talk, but if we don't talk, I won't understand what it's like for you or your child. I'll only be able to go on the information we have and I don't want to do that, I'm keen to hear what this is really like for you and what it means for how safe [child's name] is.
- I know that your AOD use is just one part of your life and there are many other things that go alongside it. We don't have to talk about everything today. Today is about how we can make sure [child's name] is safe while we work together over time.
- I have some things about your AOD use that I need to talk about today, so I know that [child's name] will be safe. I know that you love [child's name] and that you're doing the best you can, and you're probably really worried about me being here. I'm not interested in just your AOD use; I want to hear about all the ways you care and love [child's name], as well as what her/his needs are. What's the best way for us to talk today?
- I'm keen to work with you to make sure we both really understand what it is like for [child's name] and how I can help you be the parent you want to be.
- Sometimes parents hold back from talking about their AOD use. Sometimes they're worried about what might happen if they are up-front about it. I understand that. Can you relate to that? What would hold you back from talking with me today?
- I'm interested to learn more about your story, how you got here and if there are things that you would like help to change.
- Have you tried talking with anyone about this before? What was that like? How did it make you feel?

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Helping parents

Helping parents understand safety

Most parents do not want to cause harm to their children.

Parents with problematic alcohol and other drugs (AOD) use often do not connect their AOD use with direct harm to their child. You need to help them connect their problematic use to the behaviour that makes you worried for their child's safety.

Conversation ideas

Here are some conversation ideas to use when helping a parent connect their AOD use with your worries about their child's safety:

- You say that it calms you down and makes your mind stop. A lot of parents have also told me it makes them really drowsy. Do you ever feel like that?
- I'm worried that when you get drowsy you might fall asleep while you're feeding [child's name]. When this happens, babies can fall between sheets, be smothered and suffocate. Benzos [benzodiazepines, such as Valium, Serepax, Xanax and Temazepam] can make you feel so drowsy and heavy you may fall into a deep sleep unexpectedly. Do you ever worry about that?
- When you take [child's name] with you to score, it means that they are around other people that use. Some people were worried that they have picked up and played with needles at these times. Tell me about the last time they went with you. What did they see and hear?
- I'm worried for [child's name] when you drink, particularly the times you have passed out. People have seen them by themselves outside the house at these times. What are the things that could happen to them while they are out there?

Giving clear messages about AOD use

You have to be very clear with parents about what behaviours are negotiable and non-negotiable. This helps them understand what you are most worried about regarding their child's safety. Some non-negotiable rules in a safety plan can include the following:

- Under no circumstances should a parent sleep with their baby when they have consumed alcohol, drugs, prescription medications that cause drowsiness, or a combination of these substances (particularly heroin, methadone and cannabis). These slow down a parent's ability to react and can make them tired and drowsy. Make sure you see where a baby will sleep and talk about safe sleeping practices.

Learn more about safe sleeping in the section on *Working with expecting and new parents*.

- Methadone doses must be stored safely and must never be used to settle or sedate a child. Ask parents where it is stored and how they settle and soothe their baby when they are distressed. Ask them what they do when their normal soothing techniques do not work.
- Children should not be under the supervision or care of other people with problematic AOD use.
- Needles and drugs need to be disposed of safely so children are not around them. Ask parents if they know where the local needle exchange is. (Find out before you go.) Ask what drug equipment they use, where they keep this and how they dispose of it after use.

Acknowledging but not condoning alcohol and other drugs use

When you are talking with a Mum or Dad during the safety assessment, you will need to discuss ways they can keep their child safe. Recognise that recovering from problematic AOD use takes time. It is unlikely that the parent will stop AOD use then and there because of your visit and your worries about their child.

Good safety plans are based on honest conversations that acknowledge:

- the ways AOD use may be causing a danger for their child
- the likelihood that AOD use will continue (while you work with the parent to explore longer-term treatment and recovery options)
- lapse (a temporary departure from a person's AOD goals followed by a return to their original goal) and relapse (when a person stops maintaining their goals of reducing or avoiding AOD use and returns to previous levels of AOD use) are a normal part of recovery
- children are to be kept safe during this period.

Talking about ways parents can keep their child safe while they continue to use drugs or alcohol can feel like you are condoning their use.

Here are some examples of conversations that acknowledge but do not condone AOD use:

- I understand that the way you use and how long you've been using means it will be really hard for you to just stop using today. I need to be clear that, although we will talk about ways to keep [child's name] safe and look at what steps you can take today, I am not saying it is okay to keep using. Our work together will be focused on what you need to do to stop using. Today, we are looking at what we can do to keep [child's name] safe right now.
- I understand what you have been through and why it feels like AOD use has been the only way to cope. We need to work together to find better ways to help you

cope in the future so that [child's name] is always safe. Right now, we need to look at how to make [child's name] safe today. This may mean we need to create an immediate safety plan for how they will be safe over the next few days.

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What you may see

What you may or may not see

It is important that you consider not only what you see directly before you when you visit a family's home, but also consider the things you do not directly see.

Drug use, dealing or manufacturing

These are some of the signs of drug use, drug dealing or drug manufacturing:

- drugs or empty alcohol bottles in the home
- pipes, bongs, foil, spoons, lighters, scissors, alcohol swabs, plastic bags, syringes, fit cases or fit packs for needles (compact anonymous container to hold a clean supply of hypodermic syringes and to lock away used needles)
- the home smells like drugs or alcohol, strong ammonia or bleach (methamphetamine labs)
- other people who use drugs coming, staying or living in the home
- lots of people or cars coming and going at different times.

Image caption:
Intravenous drug paraphernalia and an ice pipe

Current use, intoxication or withdrawal

These are some of the signs parents may be showing if they are currently using or experiencing withdrawal:

- smelling of alcohol or drugs
- feeling really hot or cold; dressing themselves or their child in a way that does not suit the temperature
- sweating or shaking excessively
- having glassy, glazed, pinned (small) pupils or dilated (wide open) pupils
- talking fast, nodding off, being paranoid, agitated, drowsy, aggressive or talking about things that are not real or possible or having delusions (psychosis).

Read more about alcohol and drugs:

- National Drug and Alcohol Research Centre (2017), A Quick guide to Drugs & Alcohol
- Health Direct (2019) Drug abuse and (2017) How alcohol affects your health
- Alcohol and Drug Foundation
- The Australian Institute of Health and Welfare has information on alcohol and drugs
- Queensland Health's ADIS 24/7 Alcohol and drug support and information.
- Alcohol and Drug Foundation—Fact sheets
- QAIHC breakthrough Our Way for practice kits has information about ICE use, a useful resource when working with Aboriginal and Torres Strait Islander families.

Looking and listening for problematic alcohol and other drugs use

Remember that dangers for children can be obvious or can be well-hidden and subtle.

Here are some of the worries about problematic AOD use for you to consider in your safety assessment. The table below can be printed.

Your worry for the child	What to look and listen for
Current presentation	• Do the parents appear intoxicated or experiencing the after-effects of AOD use? Are they able to look after and supervise their child? • Does the way they act and talk suggest they may not be able to consent to or participate in developing an immediate safety plan?

Your worry for the child	What to look and listen for
Attention span and memory	• Does AOD use impact on the parent's ability to focus on the conversations and recall any agreements you might make with them?
General health	• Is the parent's AOD use impacting on their physical or mental health and in turn their ability to parent?
History of drug or alcohol use	• What does the parent's history of AOD use mean for their ability to stop using or plan ahead? • What is their history of drug use? • Are things escalating? • Has polydrug use (the use of more than one drug) been a problem in the past?
Current drug use treatment	• Is their current use part of a lapse or relapse or ongoing? • Has it been triggered by something traumatic? • What drugs are being used? • How are they being used? • How are they stored? • Is polydrug use a current concern? • Is the parent in AOD treatment or do they have supports?
Parenting, bonding and attachment	• How does AOD use (intoxication, withdrawal, buying and using drugs) impact on parenting tasks?

Your worry for the child	What to look and listen for

	• What becomes harder for parents?
	• How do their behaviour and feelings towards their child change?
	• How do they feel about being a parent at different times?
	• Is the parent:
	  ○ co-sleeping with a young child while under the influence of AOD?
	  ○ driving under the influence of AOD with a child or young person in the car?
	  ○ able to help a child or young person in an emergency while under the influence of AOD?
	• What level of supervision does the child need and what is being provided?
	• How is AOD use affecting this?

Relatively stable or chaotic drug use	• Is the parent drinking or using more than they usually do? • Are they spending more money on alcohol or other drugs? • Do they have enough money for essentials such as food and electricity?
Drug use planning	• Do the parents plan their substance use?

Your worry for the child	What to look and listen for
	• What arrangements are made for the children when they use? • Is their level of care different when they are not using?
Supervision	• Is there a parent or other adult who do not use drugs in the home? • Is this person responsible and capable of supervising the child or young person? • At what times is the child unsupervised or supervised by others? • Who is looking after the child if the parent is not able to? • Are these safe options?
Accommodation	• Is the home safe and appropriate for a child or young person? • Is there any evidence of drug paraphernalia around the home that could cause harm to children or young people? • Are there other people who use AOD sharing the home? • Is the parent aware of safe sleeping practices? • Are there sufficient safe sleeping options in the home? • Have you observed these directly?
Transience	• Is AOD use impacting on stability?

Your worry for the child	What to look and listen for
	• Is the family 'transient' or homeless?
Financial commitments	• Do parents have money right now to buy what their child needs? • How is AOD use affecting their finances?
Provision of basic necessities	• Is there food, clothing and bedding for the child? • Who cooks the meals, gets the child dressed and puts them to bed? • Are there nappies and formula for babies? • Is the child attending childcare or school regularly?
Procurement of drugs	• Is the child being left alone while their parents get drugs? • Is the child present when their parents buy drugs? • Is the child being used to sell or buy drugs?
Criminal activity	• Is the parent dealing drugs? • Are they dealing drugs from home? • Do they engage in sex work or crime to support their AOD use and, if so, is the child or young person with them when they do this?
Injecting/smoking drug use	• Is the parent an intravenous drug user? • If so, how are the needles

Your worry for the child	What to look and listen for
	disposed of and are they sharing syringes? • Can you see needles, syringes, other drug equipment and cigarette lighters around the home that could be a source of harm to a child?
Take-away methadone or buprenorphine	• Is the parent receiving takeaway methadone or buprenorphine? • If so, can they show you where they store it? *Methadone must be stored in a locked box that is not easily accessible and not in the fridge. All medication should be kept out of reach of children.
Family social network	• Does the family's social network revolve around other people who use? • Is there violence or a high degree of criminality in the social network? • Are family, friends or relatives aware of the substance use and do they support or condone it? • Could they provide support to the child or young person? • Have they historically done this?
Willingness to accept support	• Will the parent accept help from their support network or other agencies? • Can they contact people in their safety and support network or service now and ask for support?

Your worry for the child	What to look and listen for
Perception of the situation	• What worries does the parent associate with their substance use? • Do they consider their substance use to be harmful to their child? • Do they understand why you are talking with them today? • How do they feel about the worries you have identified?
Vulnerabilities	• Are there any reasons a child or young person may be more at risk, such as age, health, medical, behavioural or developmental needs? • How is AOD use affecting a parent's ability to meet these?

Protective factors

You will need to determine whether a parent is capable of protecting their child and can follow the safety plan. There are ways you can assess their protective abilities. These are explored in the following paragraphs:

Listening for change talk

Knowing which stage a parent is at in the change cycle can be useful in understanding how ready they are to make changes for recovery. Listen to parents to see how willing (ready), motivated (their intention) and able they are to do what is needed to keep their child safe.

Read more about Prochaska and Diclemente's stages of change to see what you can do help parents change and move forward

The safety and support network

The Circles of safety and support tool is designed to help families identify people who could be included in their safety and support network.

This tool also helps practitioners to engage with and have conversations with family members about why a safety and support network is necessary, about the harms and worries, and about the role a network can play in keeping the child safe.

Problem-solving abilities

Does the parent understand they have an AOD problem that affects the safety of their child?

Have a discussion with them about:

- the times in their life when AOD use was not a problem
- times of the week or day that AOD use in not a problem now
- who they have called on to help
- who their child could call on
- whether the parent has sought treatment or worked with AOD services before.

Related forms, templates and resources

Circles of safety and support tool

Resource 18 July 2019

Safety and support networks and high intensity responses

Resource 18 July 2019

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Safety assessment

For practice guidance on safety assessment and planning in general see:

- the practice guide: *Safety assessment and planning*
- the *Structured decision making (SDM) policy and procedures manual*.

Related forms, templates and resources

Safety assessment and planning

Resource 18 September 2019

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SDM Policy and procedures manual

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Immediate safety plans

Immediate safety plans are developed when an immediate harm indicator has been identified when completing the SDM safety assessment tool.

It is important to also assess acts of protection, strengths and resources, if applicable, to help determine whether an immediate safety plan may be possible.

Work with the family and their safety and support network to attempt to create a plan that will provide safety for the child in the short term. Immediate safety plans are to be reviewed at least every 7 days, but monitoring these plans may sometimes be a daily occurrence. Network members can be called on to assist in the monitoring of the plan.

If the family does not have a safety and support network, this is the time to help them identify who may be able to help them. Network members can be extended family, friends and neighbours who care about the child and are able to work both with the family and Child Safety.

Tools such as genograms, eco-maps and Circles of safety and support can assist practitioners to identify network members.

Related forms, templates and resources

Circles of safety and support tool

Resource 18 July 2019

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Long-term safety and support plans

Long-term safety and support plans are to be developed with the children, family and their safety and support network. The network is made up of a range of people, and could include family members, professionals, carers, and community members. These network members will support parents, children and young people in developing and maintaining safety through case planning and safety planning.

The use of safety and support networks in the child safety context aims to build on and strengthen the natural networks of a child or young person and their family. Safety and support plans provide clarity to all network members about their purpose, the known worries, goals and action steps as well as the non-negotiables and 'what ifs' everyone should plan and have contingencies for.

Long-term safety and support plans can support safe and effective reunification, family contact within a more natural setting and the maintenance of connections with family, community and culture.

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Safety planning

Developing an immediate safety plan when there is alcohol and other drugs use

Some things to remember when you are assessing safety with a family and developing an immediate safety plan for a child are:

- Be realistic—Think about the parent's level of problematic alcohol and other drugs (AOD) use and the nature of their use. Parents who come to the attention of Child Safety are more likely to have chaotic, reactive, opportunistic and persistent use. You need to consider this when developing your safety plan.
- Do not use alcohol or drug testing as a safety plan action. Testing only lets you know what substance a parent is using. It does not create safety for a child. Alcohol and other drugs testing is best used in case planning when you are working with the parents to create lasting change.
- Be purposeful and transparent in safety plan actions to keep a child safe. For example, require parents to:
    - have a strategy for storing drugs safely and cleaning up paraphernalia
    - stop other AOD users attending the home
    - not take their children with them when buying drugs
    - nominate specific safe adults who can care for children when they are using or coming down
    - carry out safe sleeping practices
    - develop strategies for breastfeeding and feeding a baby to minimise the risk of co-sleeping
    - have a safe adult stay with the family.

Related forms, templates and resources

Alcohol and other drug testing

Resource 18 September 2019

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Partnering with children

Children often become invisible once a safety plan is developed with their parents.

You need to make sure that children are kept connected and involved. Help them to understand what to expect of others, the rules that their parents and others should follow, and any changes to the way things are.

Involving children in safety planning can help reduce their worries and confusion. It is also important they understand what is happening around them.

This process involves naming:

- who is worried and what about
- why it matters to the child
- what is being done about it
- who is helping
- what the important rules are
- who the child's safety and support network is and who will have a copy of their plan.

The Safety House tool is a good way to find out what children need in order to feel and be safe. You will also need to know who children see as supports and how they can talk to them about worries. A child's ideas can be transferred to the safety plan.

The Three Houses tool can be used to explore the behaviours that frighten and worry the child; as well as what worries they have for others. It can help explore protective factors that can shape safety planning and case planning and create a picture of what needs to change for the child to feel safe and happy.

The Future House is a visual tool that helps practitioners explore with families their vision for the future. The tool focuses on eliciting and understanding the parent's and the family members' visions for the future safety, belonging and wellbeing of the child, and then developing action steps towards that future.

Strengths-based questions for children

Discussing their parent's alcohol and substance use can be very stressful for children. Ensure they have the opportunity to have a safe person with them and good care after the speaking with caseworkers.

Topic	Conversation ideas

Topic	Conversation ideas
Ask about their experiences	• Where are you when your mother is using heroin? • Who is looking after you at those times? • What is it like when your parents have been drinking? • What is it like when they are not drinking?
Indirect questions (which might reveal more)	• Tell me about your day. What happens when you wake up? • What happens at breakfast time? • Where's Mum when you're having breakfast? And Dad? • Tell me about getting ready for school. • What do you have for lunch at school? • When do you do your homework? • Do you sometimes bring friends home after school?
Coping and future hope questions	• Who do you go to when you need comfort or help? • Who do you go to when you need protection? • What makes you scared? • When do you feel afraid? • How do you help your little brother and sister? • What would you like to change? • What would you like to stay the same? • What are your hopes?
Scaling questions	On a scale from 0 to 10, where 0 means that life at home is as bad as it could be and 10 means that life at home is as good as it could be, what number would

Topic	Conversation ideas
	you give to how your life is at home these days? If your life at home was really good, what things would have changed?

Related forms, templates and resources

The safety house

Resource 18 July 2019

The three houses

Resource 18 July 2019

The future house

Resource 18 July 2019

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Partnering with parents

Partnering with parents and safety and support networks

Parents need to take the responsibility for the ways in which they will keep their child safe. They also need to be clear about the specific behaviours or ways their child may be seriously hurt or injured from their parent's alcohol and other drugs (AOD) use.

The safety plan needs to make sense to parents and their networks and use language they understand.

Explaining safety to parents

Talk about the 'what if's' for the period of the safety plan: What if things change? What if you can't follow through? What do you need to make this work?

Help parents and their supports name specific actions they will take to prevent a child being seriously hurt or injured.

Parents and their safety and support networks need to know that:

- you understand that stopping AOD use does not happen overnight, and you will work with them and support them in keeping their child safe while they work towards this
- bringing together a safety network to support the parent and child is what will help keep the child safe
- their child will have a copy of the safety plan
- the safety plan is voluntary and is not a court order or legal document
- signing a safety plan means they have received a copy of it
- they are entitled to seek legal advice
- if they are unable to follow through on the safety plan, they should contact you for help to look at ways their child can still be safe.

Talking with parents about their alcohol and other drugs use

- Respectfully challenge and explore if parents seem hesitant in talking about their AOD use. Try to understand what is holding them back and how you can help them.
- Acknowledge different perspectives, but keep it about the safety of their child.
- Be clear about safety and what it is you are worried about.
- Involve parents and ask for their ideas on what to do.

- Talk about what information needs to be shared with others to keep their child safe. Talk about the best way for this to be shared.
- Bring the parents and their network together to talk about your worries and come up with ideas. Do not just ring and tell someone what they need to do.
- Make sure safety networks know what they need to do to carry out the safety plan.

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When a child is unsafe

Assessing immediate harm either at the investigation and assessment phase or when ongoing intervention is occurring will not always result in an immediate safety plan.

There will be times when an immediate safety plan will not sufficiently mitigate or reduce the risk to the child. When the outcome of the structured decision making (SDM) safety assessment is 'unsafe', it means the child cannot remain in the home. See the SDM manual for placement intervention options.

Key messages to tell parents

The decision made today does not mean their child will never come back home. Let them know you will be there to support them in getting the services and supports they need; however, it will be up to them to make the step towards treatment and recovery.

It is important that children hear the right messages about the parent's AOD use. Talk to parents about how they would like their child to be told and explain to parents what their child will be told. Let parents know when they can see their child next. Speak with them about ways they can stay connected. Talk with them about family options and who may be able to care for the child or help in other ways.

Parents will probably need you to repeat information many times and in different ways. Have patience. Never assume parents have understood everything you have said or that is going on. Your explanations can help them take the steps they need in order to change.

Parents may need someone with them for support to help understand what has happened and needs to happen. You should revisit this conversation with parents regularly, because how they see and feel things is likely to be up and down. Parents will also need your help on how to talk with their child and answer their questions about AOD use.

Explaining the outcome

Finding the words to tell a parent that their child is unsafe is one of the most difficult parts of your role and it never gets easier. There is no easy way to tell a parent the words they do not want to hear. This is one conversation you need to practice.

Being able to emotionally support a parent while being the one who is causing their distress is difficult. Being able to explain to parents the outcome of your safety assessment relies on you having already explained the purpose of your safety assessment, why you are there and the decision that needed to be made.

Explaining this well up-front can help you later. Let them know that this is not the end, and you are going to work with them to have their child returned to them.

Be respectful and show empathy for parents. Here are some conversation examples:

- Acknowledge any difference in perspective but find a common goal about child safety. I know you have said that your AOD use is not a problem for you or [child's name], and I get that there are lots of things that could get in the way of us seeing things the same way. But the most important thing right now is that [child's name] is safe and looked after while we sort through what needs to happen. I know you love [child's name] and want what's best for them too.
- Name the specific way AOD use is making the child unsafe:
    - Right now I can see you have used something and it means that you can't look after [child's name] and we can't have the conversations we need to make sure they are safe.
    - Right now I'm worried you are using every day, you're not able to plan when you use and there is no one to care for [child's name] when you use and they cannot care for themselves.
    - Right now I'm worried that you are leaving [child's name] with other people that use drugs and they are not being supervised by safe people.
    - Right now I'm worried about [child's name] when other people are in your home using drugs. [Child's name] has said they don't like it and don't like [name of visitor] coming into their room. I know you said it's nothing to worry, about but I am worried about it.

- Highlight the seriousness of the worries, but maintain hope: Right now our worries about your AOD use mean that [child's name] is not safe right now. I know that is not what you want to hear. This doesn't mean we don't want to work with you or we don't think they can be safe again and come back home soon. What it means is that they can't stay with you right now but we are going to work with you to help make it safe enough for them to come home.

How parents might respond

If a child is separated from their parent, a parent might:

- increase their AOD use to cope—This does not mean they cannot change. Talk with parents about what supports and services they can get to cope in positive ways
- feel even more ashamed, judged and stigmatised—These feelings are real and can stop parents from talking with you or getting the help they need. Acknowledge their feelings and do not judge them. Talk about the concrete things you are worried about. Instil hope by letting them know that you believe change is possible and that you are there to help them make this change

- ask for AOD testing to prove it is not a problem—A parent may want to prove to you they are not using and ask for AOD testing or ask their doctor to do urine screens. Let them know that talking to their local drug and alcohol counselling services might be a better next step
- ask what they need to do to get their child back—They may say they are willing to stop right now and do whatever you need them to do. It is important that parents understand that it is not just their AOD use that needs to be addressed; it is understanding the reasons why they use, other complicating factors and the best ways to address these (alongside their AOD use).

Strengths-based questions for parents

When working with parents, use strengths-based questions to understand their problematic substance use, the safety of their children, and their capacity for change.

The following table provides examples of questions that may allow you and the parent to identify and build on strengths.

Topic	Conversation ideas
Exception questions	You said earlier that you don't drink every day. Tell me more about the days when you don't drink.
Coping questions	How do you manage each day and not let yourself start using drugs completely?
Expanding questions	You were able not to drink alcohol yesterday so you could attend your child's sports day. • How did you do that? • What did you do that was different? • How did that make a difference? • How do you think that was different for your child? • How important to you is it that you do these things for your child?
Scaling questions	• On a scale from 0 to 10, where 0 means that there is no hope of you keeping your child safe from the risks of your drinking and 10 means that you are sure you can put plans in place to keep the child safe, where are you now?

Topic	Conversation ideas
	• What needs to happen for you to move up the scale and feel more confident that you can keep the child safe from the risks of your drinking?
Ambivalence questions Ambivalence (having mixed feelings) is normal and it is the key to change ('I want to, but ...'	• Tell me about using (drug). For example, tell me about using amphetamines. What do you like about it? What else? (Keep asking to fully understand their appreciation of the drug.) • And what's not so good about using (drug)? What else? (Keep asking to fully understand the problems with the drug.) • What are the difficulties or hassles with using (drug)? • What are your concerns about this? (Raise concerns about the child to trigger discussion and thought about the child.) • Why does this concern you? • What do you think will happen if you don't change anything? • What would be the good things about changing your use of (drug)? • What changes would you need to make to keep your child safe? • How might things be better for you? • How might things be better for your child?
Future hope questions These questions are very relevant to our work with parents. They help parents to consider their drug use and how it affects their child now and in the future.	• What are you hoping for, in your future? • How would you like your life to be, five years from now? • What do you want for your child? • How do you picture your child's life in the future? (Raise the point and discuss with the parent that research shows children whose parents abuse drugs are more likely to abuse drugs themselves. Drug abuse problems can

Topic	Conversation ideas
	affect families from generation to generation.) Unpack with the parent their childhood and experiences growing up: • Did your parents, carers, family, sibling(s) abuse drugs and alcohol? • How do you recall your childhood? • How did you feel when your parents used drugs? • Did you picture things differently for your child? • What do you want different for your child? What hopes do they have for their child? • If you could change things about your child's life now, what would you change? • How does (drug) impact on your hopes and wishes for your child? • How do you want your relationship with your partner to be? • How would you like things to be different from how they are now?
Ideal self-questions	• How would you (or your friends or family) describe the best things about you? • How would your child describe the best things about you? (If the child is too young to talk—how would they like their child to describe them?) • And how would you describe yourself at the moment? • How would you describe yourself as a parent? Is this different to how you hoped to parent?
Confidence	• What obstacles do you foresee, and how might you deal with them?

Topic	Conversation ideas
	• If that obstacle were removed, then how might you go about making this change? • What encourages you that you can change if you want to? • When else in your life have you made a significant change? How did you do it? • What personal strengths do you have that will help you succeed? • Who could offer you helpful support in making this change? • What do you think would work for you, if you decided to change?
Importance	• What are you thinking about your use of (drug) at this point? • What are you thinking at this point about your child's risk of harm because of your drug use? • Never mind 'how' for now—what do you *want* to have happen? • How important is this for you? How much do you want this?

Related forms, templates and resources

SDM Policy and procedures manual

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Monitoring safety

Review the immediate safety plan

The immediate safety plan is to be reviewed within 7 days. However, monitoring should be occurring on a more frequent basis, depending on the level of risk. Checking in with children, parents and the safety and support network is an important part of reviewing the safety plan.

Checking in with parents

Always check in with parents first and give them the opportunity to talk to you about how things have been, what has worked and what has not. Ask parents if they are worried about anything or worried about you talking to their safety network.

Checking in with children

Children need to stay visible. Talk directly to them and ask how things are going. Tools such as the Safety House can be used to talk about safety and gather information about how the safety plan is working.

Ask children:

- how they are feeling
- if they have any new worries
- what happened after your visit
- what has been said to them
- what they overheard
- if safety and support network members have been visiting and providing help according to the plan.

The safety and support network

During the immediate safety plan period, make contact with the family's safety and support network to see:

- what has been happening
- what they have seen
- if anything has changed in the home
- if they are more or less worried than they were a few days ago.

While we know that services do not equate to safety (behaviour change leads to safety), part of reviewing the safety plan means checking with services and other professionals who are also working with the family. It is essential to share information in relation to the worries, progress and successes.

Checking on specific tasks

If the immediate safety plan had specific tasks that needed to be done—such as cleaning the home, putting drugs in locked storage and disposing of needles—you will need to physically check that these have been completed.

Related forms, templates and resources

The safety house

Resource 18 July 2019

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Resources

Refer to this procedure (Undertake substance testing of a parent) when considering the need to test a parent for alcohol or other drug use

The Australian Institute of Health and Welfare has information on alcohol and drugs

Health Direct (2019) Drug abuse and (2017) How alcohol affects your health

Insight QLD This site provides a range of resources and printable tools

The Stages of change is helpful in recognising where the family you are working with is at and working out the next steps to take.

National Drug and Alcohol Research Centre (2017), A Quick guide to Drugs & Alcohol

Raising Children Australian website—Parenting and problematic alcohol and other drug use.

Stages of change to use with Aboriginal and Torres Strait islander families.

Services and supports

Queensland Health's ADIS 24/7 Alcohol and drug support (1800177 833) offers support for Queenslanders with alcohol and other drug concerns.

The Queensland Network of Alcohol and other Drug Agencies (QNADA) service provider helps people locate services in their area.

Queensland Health's Queensland Needle and Syringe Program has information on the safer use of injectable drugs.

To print

Alcohol and Drug Foundation This site has printable brochures on specific drugs and their effects.

Australian Department of Health This site has printable brochures and information.

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Risk assessment

A parent's alcohol and other drug use does not always mean the child is at risk. Focus your assessment on how the parent's behaviour impacts on the child.

This section focuses on specific guidance about risk assessment when there is alcohol or other drug use by a parent or household member.

For practice guidance on assessing harm and risk of harm in general see:

- the practice guide: *Assessment of harm and risk of harm*.
- the*Structured decision making policy and procedures manual*.

Seeing and understanding

Responding

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About this part

In this part you will:

- develop your understanding of the direct and indirect ways alcohol and other drugs (AOD) use affects a child and puts them at risk
- know what to look for when assessing risk related to a parent's problematic AOD use
- learn what questions to ask and how to talk with children and parents to assess risk
- develop your understanding of a child's resilience and a family's strengths, resources and acts of protection and how to include this in your risk assessment.

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The child's experience

Seeing risk through the eyes, heart and mind of a child

Understanding the needs of each child and the different ways they see, feel and respond to their parent's problematic alcohol and other drug (AOD) use is vital. By building a relationship with each child, you will get a clearer sense of how they are affected and of the strengths, resilience and courage they possess.

Here are some examples:

How my parent's alcohol and other drug use shapes my life

The way I live:

- There are no routines: 'I don't have a bedtime. No one wakes me for school. Sometimes we eat, sometimes we don't. Every day is different.'
- My parent's behaviour changes daily: 'One minute you love me, the next you hate me and ignore me. One day you don't care what I do, the next you punish me for going to the shops, because it is unsafe.'
- I rely on myself: 'I get myself ready for school, I sign my own notes. I don't go to my Mum or Dad for help.'
- I worry and take care of my parents: 'I think about this every day. I worry about you and me every day. I'm scared you will die. I will make sure you are okay.'

How I think and feel:

- Embarrassed: 'I wish you did not turn up at school drunk.'
- Ashamed: 'I cannot bring my friends home because you might be drunk.'
- Worried: 'I'm worried you will die from using drugs.'
- guilty and responsible: 'If I was better behaved/did better at school, was a better child you would not need to drink or use drugs.'
- Mum and Dad will stop if I make them happy: 'I will make sure you are happy. I will be better. I will do whatever you need so you stop. I can fix this for you.'
- I love and hate my Mum, my Dad: 'I love you. I want you to stop. I hate you because you don't.'
- lonely and alone: 'I don't have friends. No one wants to come to my house. No one is allowed to come. I sit by myself at school.'

What I might do:

- keep it a family secret: ‘I know this is something we do not talk about. It's the unspoken rule.’
- be the parent when my parents cannot: ‘I will get my own dinner. I will get my little brother to school.’
- be the very best I can be so they love me enough to stop: ‘I will get good grades. I will not get in trouble so it is not harder for you.’
- act out: ‘I cannot control myself. I need you to see me. I need you to stop. I need someone to help me.’
- use alcohol or drugs to cope: ‘I feel hopeless, lost, sad, lonely. Drinking is a good way to deaden the pain.’

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Risk assessment

The process of assessing risk starts at intake and continues until intervention is finalised. Risk assessment is a critical part of child protection work. It includes gathering sufficient information in relation to harm, risk factors, complicating factors and acts of protection, strengths and resources. We analyse the information to provide a rigorous and balanced assessment that can guide decision making and case plan direction.

Assessing risks to a child

A safety assessment requires you to look at the immediate and imminent dangers to the child. A risk assessment asks you to:

- look broadly at the child's lived experience
- consider the short- and long-term impacts their parent's behaviour is having on the child
- be clear on the different risks to which a child is exposed

What you need to assess	Why it matters for children
Effects of alcohol and other drugs (AOD) use on behaviour, parenting and relationships	Each drug has characteristic effects, but each person can react differently to a drug's effects. You need to understand the impacts of each on parental behaviour and how this is seen and understood by the child.
The role AOD use has in the parent's life	Seeing AOD use as a coping strategy for coexisting factors—such as past trauma, domestic violence and mental health issues—rather than a problem itself will help you understand what life is like for a parent, and what coexisting factors need to be addressed for sustained AOD change.
Episodes of AOD use	An episode is the period of time from the start of intoxication until the effects of AOD subside. Understanding what episodes of AOD use may look like is important in order for you to build a picture of how risk may be increasing and what a child may be

What you need to assess	Why it matters for children
	seeing, hearing and feeling during each episode. This is particularly important to understand when episodes include behaviours that are out of control, violent or increase risk for a child.
The pattern and severity of the AOD use	Knowing the amount and how often a parent uses AOD will help build a picture of the extent of the problem, how it affects their parenting, if they are able to stop or reduce their use, and what treatment they will need.
The stages of a parent's AOD use	The risks to a child go beyond the times that their parent is intoxicated. The way a parent buys, stores and uses drugs as well as the impacts of intoxication and withdrawal can potentially expose a child to harm.
Social and family networks that enable or help to stop AOD use	A parent will have people in their life who enable their use and people who want them to stop their use. To help the parent reduce, stop their use and seek treatment, you will need to know who can support them. You will also need to look for ways to strengthen the supports they need.

Assessing how parental AOD impacts the child

When you understand how problematic AOD use affects a parent's daily life, you are more able to see how it impacts on their child.

Use the following practice reflections to understand the particular ways a child may be more vulnerable as risk increases.

People and places the child is around

- Is the child around other people who use AOD?
- Is the child living in a community where excessive AOD is the norm?

- What does this mean for the child?
- Is the child being cared for and supervised by other people who use AOD?
- Is the child going to risky places with their parents to buy or use AOD?
- What risky or unsafe places are associated with the AOD use?

What a child sees and has access to

- Is the child seeing actual drug use?
- What does this mean for what they see, hear and learn?
- Does the child have easy access to AOD around them?
- Has the child been hurt before from taking AOD or from paraphernalia in the home?
- Are you worried that drug manufacturing may be occurring?

What the child sees, thinks and feels during their parent's 'episode'

- What is the child seeing, feeling and hearing during an episode?
- What behaviours or mood swings put the child at risk of being hurt physically and/or emotionally?
- Is the parent's behaviour towards the child and others becoming more worrying?

What the parent's AOD use looks like

- What has the parent's pattern of use been in the past?
- What has their recent (last 12 months) pattern been?
- What AOD is being used, how often, how is it being used and what are the reasons for using?
- Has something triggered a change? (for example, recent trauma, mental health or an increase in stress)
- Are things escalating? What does this mean for safety and risk?

The child's resilience is a factor

A child's resilience can help them thrive and survive despite adversity in their life. Understanding the six domains of a child's resilience will help you know more about what may help buffer the impact of their parent's problematic AOD use. It will also help you find ways to build on these through case planning.

Domain	Exploring a child's resiliency
1. Secure base	How does parental AOD use impact on a child developing a secure base? How does a parent recognise and respond to emotional cues from the child?

Domain	Exploring a child's resiliency
	Who does the child show an attachment to? What type of attachment? How does AOD use influence the type of attachment?
2. Social competencies	How does the child show and manage their emotions, thinking and feeling behaviours? How does the child socialise with other children? With adults? How does parental AOD use affect a child's social competencies? How does the child show empathy?
3. Positive values	How does parental AOD use impact on the child learning positive values about themselves and others? How does the child feel about themselves? How is their confidence and self-esteem? How does parental AOD use impact on this?
4. Education	How does parental AOD use impact on a how a child is learning at school? How does it affect school attendance? How does it impact on a child learning about their world and life at home?
5. Friends	How does parental AOD use impact on a child being able to have social interactions and form friendships with other children their age? Does the child have at least one friendship?
6. Talents and interests	How does parental AOD use impact on a child learning about the things they are interested in or participating in activities that can build their sense of self and efficacy?

Source: Benevolent Society (2014) *A Resilience practice framework.*

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Recognising alcohol and other drugs use

How to recognise problematic alcohol and other drugs use

Parents who have a problematic level of substance use will most likely fall into one or both of the following categories:

Intensive use or 'bingeing'—intentionally consuming a large amount of alcohol or other drugs (AOD) over a short period of time (may be hours or days)

Dependency—becoming dependent on a substance after prolonged or heavy use. They feel compelled to regularly use to feel normal or to avoid withdrawal symptoms. Substances can include illicit drugs, legal drugs (for example, alcohol or tobacco) or prescription medications.

Signs of dependence

A parent may show signs of dependence if they:

- use alcohol or other drugs more often or in larger amounts because they have developed a tolerance to them. (Tolerance means a person needs more of the substance to get the same effect.)
- can't seem to stop even though they have tried
- constantly crave or need alcohol or other drugs
- give up time or other things to get alcohol or other drugs
- experience withdrawal when they do stop.

Read more about what is happening for a parent with dependent AOD use in the *Overview* section.

Signs that AOD use is harming a child

Completing a risk assessment involves more than knowing what a parent uses, how much they use and how often.

As mentioned in the previous section, you also need to understand how the child experiences their parent's AOD use—how it hurts them, how it impacts on the different aspects of their daily life and their development, and the actions the child and parent have taken in an attempt to minimise these harms.

Alcohol

When a parent drinks alcohol to excess they may:

- prioritise money for alcohol over rent, food, bills and clothing
- experience mood swings, increased anger and irritability
- become more verbally or physically abusive
- have more extreme episodes of violence if domestic and family violence is present
- become forgetful
- become chronically ill
- experience blackouts
- drive under the influence.

What it may mean for their child:

- neglect
- increased risk of verbal or physical abuse
- lack of consistency in parenting
- a chaotic home that is characterised by a lack of routine
- older children caring for younger siblings (parentification)
- poor supervision
- less affection from parents
- lack of bedtime routines (including co-sleeping)
- access and consumption of AOD if they are not disposed of properly.

Stimulants

When a parent uses stimulants (such as amphetamines, methamphetamines, ice, speed, cocaine and ecstasy) it can affect their behaviour in the following ways:

- increased mood swings
- focus on obtaining the drug
- reduced patience and a shorter fuse
- over-reactive behaviours
- difficulty concentrating on one subject
- increased aggression
- increased risk of domestic and family violence, if this already exists in a relationship
- increased stress
- poor self-control
- reduced capacity to plan
- poor memory and perception
- lack of appetite
- decreased need for sleep or long periods of sleep when withdrawing.

What this may mean for their child:

- neglect
- poor supervision
- lack of routine
- increased stress
- inconsistent parenting
- chaotic environment
- strangers coming to the home to use or deal drugs
- experiencing increased domestic and family violence
- older children caring for younger siblings (parentification)
- inconsistent mealtimes and bedtimes as parents are not sleeping or eating
- exposure to second-hand smoke and/or injecting equipment and paraphernalia.

Cannabis

When a parent uses cannabis in high doses, they:

- can be inattentive to self and others
- may have an increased need for sleep or deep sleep that decreases their ability to wake to potential dangers
- may be irritable and stressed if the drug is unavailable
- may have poor memory and perception.

What it may mean for their child:

- reduced daily activities
- poor stimulation of child
- lack of supervision
- poor attention to the child's individual needs
- lack of routines
- material deprivation
- older children caring for younger siblings (parentification)
- exposure to second-hand smoke.

Opiates

When a parent uses opiates (such as methadone, heroin, morphine, codeine, oxycodone (that is marketed as endone or oxycontin) it can affect their behaviour in the following ways:

- they may forget to store methadone properly
- mood changes
- poor oral hygiene
- changes in body temperature
- anxiety
- insomnia.

What it may mean for their child:

- neglect
- if methadone and other drugs are not stored safely, there is a danger the child can access and consume them
- co-sleeping (which has potential dangers)
- accidental or deliberate poisoning
- unpredictable parenting
- older children caring for younger siblings (parentification)
- lack of supervision
- material deprivation
- unsafe people coming to the home
- witnessing of criminal activities and people
- exposure to second-hand smoke and injecting equipment and paraphernalia.

Benzodiazepines

When a parent uses benzodiazepines (such as Valium, Serepax, Xanax and Temazepam), it can affect their behaviour in the following ways:

- high risk for developing dependence
- excessive sleeping, which can contribute to lack of supervision of children
- co-sleeping (which has potential dangers)
- may use in combination of other drugs (this is common)
- tolerance develops, leading to higher levels of use.

What it may mean for their child

- neglect
- lack of supervision
- co-sleeping
- these drugs may be given to children to sedate them
- older children caring for younger siblings (parentification)
- lack of routines
- access and consumption if not stored safely.

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Page created

Additional risks and factors

When a child's life becomes riskier

Having a parent with problematic substance use has a huge impact on a child. Having a parent who also has a co-occurring condition (see following paragraphs) puts a child's safety at even more risk.

Alcohol, other drugs and mental health issues

You will work with families where problematic alcohol and other drugs (AOD) use and mental health coexist. This is called a co-occurring condition (previously known as dual diagnosis or comorbidity).

You may find it hard to distinguish whether a parent's behaviour relates to a mental health condition or their problematic AOD use. Your role is to assess how the co-existing conditions impact on parenting and the child's safety.

'The realisation that mental illness and substance abuse can be linked is quite recent, so research is scant.' Victorian Better Health Channel (2019), *Substance misuse and mental illness—dual diagnosis.*

The influence of alcohol and other drugs on a parent's mental health

Some patterns of AOD use can cause mental health problems or exacerbate existing ones. For example:

- Problematic use of psychostimulants (such as amphetamines and methamphetamines) increases the risk of psychosis.
- Cannabis use can trigger psychotic symptoms, especially in people vulnerable to mental health issues.
- Heavy use of alcohol can worsen pre-existing anxiety disorders and depression and increase the occurrence of agoraphobia and social phobias.
- Increase in AOD use to cope with trauma-related mental health can interfere with the brain's natural processing of trauma. An attempt to reduce substance use may cause trauma symptoms to worsen, creating a cycle of using drugs and alcohol which manages yet exacerbates symptoms.
- Using alcohol and other drugs for self-medication can lead to psychological dependence.

Drug-induced psychosis

Drugs like methamphetamine, speed, cannabis and hallucinogens can result in psychotic symptoms if taken frequently for long periods of time, even if there is no pre-existing illness. This is commonly known as drug-induced psychosis.

Early symptoms of psychosis are gradual and progress as the drug use continues. Aside from delusions (a false fixed belief) and hallucinations (seeing something that isn't there), here are some symptoms to look for:

- changes in emotion; no emotional response
- difficulty expressing feelings; a 'flat' appearance or no emotional expression
- increased paranoia, such as a belief people are following them or hearing voices in the walls
- social withdrawal
- incoherence in thought and actions; disorganised speech
- erratic, violent, unpredictable behaviour.

The symptoms of a drug-induced psychosis will usually subside once the person stops using; however, some parents may require medications or mental health support.

Further reading

Comorbidity guidelines.

Alcohol, other drugs and domestic violence

You will find many children belonging to families where both problematic substance use and domestic violence are present. It is important you are aware that AOD may exist alongside, and possibly in response to, domestic violence, even if violence was not the reason for the intake.

Always be curious about potential acts of protection and responses by children and women. Your conversations about domestic and family violence matter.

Read more about a woman's and man's experience of alcohol and other drugs in the *Working with parents* section.

Attention

It is important that you give clear messages that men who use violence in the home are responsible for choosing to use violence. Their AOD use is never to blame.

Further reading

In this kit: Part 2: Working with children

Practice kit: Domestic and family violence

Issues for the safety and wellbeing of children and families with multiple and complex problems (2010), Australian Institute of Family Studies

Alcohol, other drugs and sexual abuse and exploitation

Having a parent who has problematic AOD use can increase the risks to a child of sexual abuse and exploitation in the following ways:

- Children may be at risk of sexual abuse by a parent if the parent has a predisposition to abuse due to loss of inhibition (Dawe et al., 2007). Children are also at risk of sexual abuse from extra-familial perpetrators, especially when the child is at risk of supervisory neglect.
- Sexual abuse offenders often target children whose families are under stress.
- Stressors such as problematic AOD use have been shown to increase the risk of child sexual abuse, particularly abuse that is perpetrated by someone outside the immediate family. Researchers believe this is because parents who are distracted, consumed and overwhelmed by their AOD use may provide less supervision and be less alert to risk.
- Parents who are under stress may also be in greater need of support (both financial and practical), and this makes them more susceptible to manipulation and coercion or more willing to allow a suspected offender into their lives and the lives of their children.

Supplying or using AOD can become the backdrop that enables sexual abuse.

- An offender may encourage, supply and facilitate a mother's substance use to create opportunities to sexually abuse her child while she is intoxicated or drug affected.
- AOD may contribute to the secrecy and dependence between a mother and her partner.
- AOD may be used to manipulate and coerce young people for sexual abuse or sexual exploitation.

Read more about Child sexual abuse in the practice kit: Child sexual abuse.

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Page created

Listening deeply to a child's voice

> **Attention**
>
> Children are vulnerable when they are not visible.

Although babies and very young children will be unable to share their story with you, a child's experience can be understood in different ways—no matter what age they are.

Be curious and help children tell their story at their pace. Talk to them often, in multiple settings and with different people, to assess risk. You will not be able to understand how a child experiences life and their parent's alcohol and other drugs (AOD) use from just one interview.

Talk to children about all parts of their life, not just their parent's AOD use. Get to know them—what they like and don't like and what special talents they have.

Get to know a child:

- through observation
- through play, using engagement tools such as the Three Houses
- by taking them out for a milkshake or going to somewhere they like, such as a skateboard park
- by talking to them at a regular place and time.

Related forms, templates and resources

The three houses

Resource 18 July 2019

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Risk assessment and structured decision making

There are several tools to aid and guide practitioners when assessing risk and identifying risk levels. They can help guide decision making in terms of intervention.

Family risk evaluation

The structured decision making (SDM) family risk evaluation (FRE) helps to identify families that have high, moderate or low probabilities of abusing or neglecting their children in the future. The final risk level can be used to guide decisions about whether to open an ongoing intervention case for a child.

The FRE considers parental problematic substance misuse on both the abuse and neglect index. The tool guides practitioners in considering alcohol and other drugs (AOD) use as

- not a past or current problem
- a past or current drug or alcohol problem
    - during the last 12 months and/or
    - at any other time prior to that

The abuse index differentiates between the primary parent's and secondary parent's use.

Family risk re-evaluation

The SDM family risk re-evaluation (FRRE) for in-home cases is used in all ongoing intervention cases in which the children remain in the home. This applies to intervention with parental agreement cases and supervision orders.

In terms of problematic AOD use, the FRRE considers whether there has been/is use (or no use) in the past or currently. It also considers current use that is/is not being addressed.

Family reunification assessment

The SDM family reunification assessment (FRA) is used to guide practitioners when they are making decisions about whether to return a child to the parent/s and to assist in reaching a permanency recommendation.

The FRA specifically considers AOD use in terms of immediate harm indicators, parental behaviour, and progress with case plan goals and actions.

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Talking with children to assess risk

Here are conversation ideas to use when talking to children—to assess risk.

Topic	Conversation ideas
How are you hurting?	• How do you know if you have done something to upset your parents? • What kinds of things would upset them? • What kinds of things would get you in trouble? • What kinds of ways do you get in trouble? • Are there times you feel Mum or Dad get you in more trouble than others? • Have there been times you have been scared or worried about being hurt? • Have there been times you have been hurt in your heart? What about on your body?

What is day-to-day life like?	• Can we make a book together called 'A day in the life of me'?
	• Start the day when you wake up and go all the way through until going to bed and waking up the next morning.
	• [Ask the child to draw pictures to describe each part of their day. Prompt questions along the way:
	  ○ Who would be here in this part of your day?
	  ○ What would they be doing?
	  ○ What would you be thinking and feeling and what would you do when that is happening?]

Topic	Conversation ideas
How safe, nurtured and cared for do you feel?	• When do you feel happiest and most loved? • Have there been times you have felt lonely, sad or invisible? • What has made you feel like that? • What do you do in these times? • On a scale of 0–10, how safe do you feel? • On a scale of 0–10, how loved do you feel by Mum, Dad, brothers/sisters, relatives? • If you need a cuddle or want to feel loved, who do you go to? How do they show you that they love you?
Who are you close to? Who do you trust?	• Who in your family or home do you feel closest to? • Who do you feel is always there for you? • Who would you say always has your back? • When things are tough at home, who do you call on?
What sense do you make of your parent's AOD use?	• Have you heard of people who drink or use drugs? • What do you know about it? • Have you ever seen anything like this in your life or in your family? • How does it make you feel? • What happens? • What do you and others do? • Have you ever spoken to your Mum or Dad about their alcohol or other drugs (AOD) use? • Would you like to speak to them? • Have you ever spoken to anyone else about your parent's AOD use?
What do you hope for?	• What things would be different or what would you change for your life to feel better? • What would you want your parents

Topic	Conversation ideas
	to do? • What would you do? • What would others do? • What things do you want your parents to know about? • What feelings do you want them to know about? • What things do you want them to do or change?

Read about ideas on how to talk, play and observe children of different ages in the *Working with children* section.

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Page created

Talking with parents to assess risk

Practice prompt

Assessing risk means talking with parents on a regular basis about their alcohol and other drugs (AOD) use, the stressors in their life and ways you can work together to get the best outcome for their child.

- Parents are experts about their children, so ask them about their child. Are they able to relate to others, play, concentrate, participate and belong?
- Are there challenges that make it hard for the parent to meet the child's needs? (medical, special or behaviour needs?)
- How does AOD use affect this?
- How do parents experience their AOD use and how does their child experience this?

Read more about ideas on talking with parents about their history, the role AOD use plays in their life and their current use in the *Working with parents* section.

Questions about alcohol and other drugs use

What you need to find out	What to ask the parent
How a parent pays for alcohol or other drugs	• We all have to balance our money. I'm wondering how much of your income is spent on alcohol or drugs. • Would you say you pay your essential living costs before or after you purchase alcohol or drugs? • Are there days, like pay days, where you would buy more drugs or alcohol than on other days? • What does this mean for your use when you just get paid and when you won't get paid for another few days or another week? • How do you manage to make

What you need to find out	What to ask the parent
	ends meet? • What are some of the other ways you make money to buy alcohol or drugs? • Have there been times you have felt sad or guilty that your child has missed out on something because money has been spent on alcohol or drugs? • If you did not spend money on alcohol or drugs, what would you be spending it on? • How would this make a difference for your child? • What about things like after-school activities? If you had the extra money, what other things could your child get to do? Sport, dance or other activities? • Have there been times that AOD has taken such control that it has stopped you buying food, paying rent, paying for school excursions or other things?
How a parent is using alcohol and other drugs	• Can you tell me what you are using and how often you use? • Who is with you when you use? • Does this person use too? • Where are you when you use? • Where is your child? • Has your child ever seen you drink, smoke or inject? • How did they respond? • How did you respond? • Did you talk about this after? • How do you manage withdrawal? • Have there been times you have coped with it by having

What you need to find out	What to ask the parent
	another drink or taking more drugs? Or do you experience the after-effects and withdrawal before you drink or use drugs again? • What is like for you? • How do you feel when you have used alcohol or other drugs, after the effects wear off or you are withdrawing? • When do you eat and sleep? • Is this the same for your child? • How predictable is your routine?
What AOD use patterns look like	• If you think of the last few times that you drank alcohol or used drugs, what did that look like? • What has it been like for you? For your child? • Have there been times when things have gotten out of control or violent? • Have there ever been times someone has been hurt? How? Has anyone hurt you? Who? • What was the impact on you and your child?
How a parent experiences intoxication, comedown and withdrawal	• Walk me through what it is like for you when you are substance-affected, when you are coming down and when you're going through withdrawal. • What do you have control of at these times? • What things do you lose control of? • Do you think your behaviour changes?

What you need to find out	What to ask the parent
	• Do you think it changes how you parent? • What would others say? • What do you think it is like for your child when they see you intoxicated? Going through withdrawal? • Has your child ever told you how it makes them feel? • What do you think it might be like for [child's name]?
How a parent behaves when they are thinking about using AOD	• I'm curious about how your AOD use affects your daily life. How much thinking space and energy does it take from your life? • Is it something you think about all the time or is it always in the back of your mind, and does it get in the way of doing other things? • What is like for you if you do not or cannot use alcohol or drugs? • How do you think these thoughts and feelings deprive your child? • Has it ever taken over so much that you have regretted doing something, like you were so driven to get alcohol or drugs that you left your child at home alone or took them with you to a place that you know isn't safe? • What do you think that was like for [child's name]?
How AOD has taken control and what needs to change	• How do you think your AOD use impacts on your life? • How would you say it hurts you physically and

What you need to find out	What to ask the parent
	emotionally? • How does it hurt your child physically and emotionally? • What troubles you the most for you? for your child? • What do you think troubles your child the most? • What do others say troubles them? • If things do not change, what could or is likely to happen? • What do you think your child would ask you to change if they could find the words? • What else is going on in your life that makes this hard? • How do violence or mental health issues impact on your AOD use? • What do you think needs to change in your life for you to get back in control?

Questions about parenting

What you need to find out	What to ask the parent
Feelings about being a parent	• How do you feel about being a parent when you are intoxicated, experiencing the after-effects, going through withdrawal, and when you can't obtain drugs or alcohol? • What do you enjoy about parenting? • What things do you wish could be different? • How does being a parent affect your AOD

What you need to find out	What to ask the parent
	use? • What things do you like most about being a parent? • What things do you like least about it? • How does this change when you are intoxicated, experiencing the after-effects or withdrawing?
Disciplining children	• What are the rules of the house? • What things does your child get in trouble for? • What do they get praised for? • What happens when they get in trouble? • How does being intoxicated, experiencing the after-effects, and going through withdrawal change the way you discipline your child? • Sometimes parents have told me they tend to be harsher at different times. Can you relate to that? What would your child say?
What is easy and hard about parenting	• What are the things you find easiest to get done and keep on top of? • What are the things that are harder to keep on top of? • How does having people stay here or use with you help or make it

What you need to find out	What to ask the parent
	harder or easier? • Tell me about looking after [your child]. What's the easiest thing about looking after them? • What's the hardest thing? • When things are hard, how do you cope? • Do the hard parts of parenting ever mean you want to drink or use drugs? • What other things do you do to deal with the hard parts?

Questions about care and supervision

What you need to find out	What to ask the parent
Supervision of the child	• How does AOD use, intoxication and withdrawal change the way you look after and supervise your child? • What level of supervision does [your child] need? • Do you think you are able to meet their needs all of the time? • Who helps supervise [your child] when you are using, experiencing the after-effects or experiencing withdrawal? • Are there times when [your child] watches over their brothers and sisters? • What do you think some of the worries are if your child is not supervised properly? • Could they get out on the road?

What you need to find out	What to ask the parent
	• Could they go for a swim without you knowing? • Does your child make their own meals? • Do you ever worry that they could get burnt? • Would they know what to do if something was on fire?
Day-to-day care of the child	• How do intoxication, the after-effects, withdrawal and planning to obtain alcohol or drugs get in the way of day-to-day life and caring for the child? • Has your use of AOD changed the people you spend your time with and hang out with? • Do you have any worries about these people being around your child? • What things do you think your child can do for themselves • What is okay for them to do? • What is not okay? • When you cannot look after the child or do what they need, who looks after them? • Are there times [your child] looks after you or the younger kids? Would you say this is part of their responsibilities?
Routines for the child	• What does a typical day look like for you? What about your child? • Where does drinking or using drugs fit into the day-to-day routines? • Would you say things just happen from day to day, or do you have a set routine you follow? • How do your kids know what needs to be done, what they need to do and what you will do for them? • Does your AOD use impact on

What you need to find out	What to ask the parent
	when you go to bed, when you wake up, and when you feel hungry? • What does this mean for your child's bedtime, wake up time and eating times?
The degree of predictability in the child's daily life	• Do you think your kids know what to expect each day? What do you think it might be like for them when they can't predict when they will get fed, when you will put them to bed and when you wake them up? • What are the things that are unpredictable in their life? • What have they learnt to expect from you and other adults about how their needs will be met? • What chaos do you think exists in their lives?

Questions about bonding and attachment

What you need to find out	What to ask the parent
The bond between parent and child	• When do you feel closest to your child? • How does AOD use change how close and connected you feel? • What things about each of your children make you feel close to them? • What things about them push you away? • How do you feel about them when you are trying to score, use, come down or going through

What you need to find out	What to ask the parent
	withdrawal and they are demanding your attention? • How do you manage these times? • When do you think your child feels the safest and loved by you? • When do you think they may not? • Do you think they have ever been scared of you?
A child's attachment to their parent	• How does your child tell you they need you? • How would they show you they want your attention? • What happens if you are preoccupied by alcohol or drug use at that time? • Tell me about the last time your child was upset or hurt themselves. Who did they go to for help or for a cuddle? • Would you say your child can count on you every time they need you, sometimes, or none of the time? • What makes you say this? • How does your use impact on being able to respond to your child the way you want to?

Questions about safety and protection

What you need to find out	What to ask the parent
People, places, practices and	• What places and people is your

What you need to find out	What to ask the parent
paraphernalia	child around? • How confident are you that your child feels safe? • Are there things you wish your child had not seen or been a part of?
Intoxication and withdrawal	• What does your child see when you drink or use drugs? • Do they see you or others use? • How do you make sure they don't see you at these times? • What you do think it might be like for your child to see you intoxicated, experiencing the after-effects or going through withdrawal? • How do you think they make sense of this? What are they doing at these different times? • What are other people in the house doing? • Do you think there are times when they are more worried about you? Less worried about you? • Do you ever talk about your drug use with your child? • What do you think it would be like for them to talk to me about this? • What do you think they might say? • Are there things you are worried they might say?
Keeping a child safe from harm	• How aware are you of any dangers or risks that might exist in or outside your home? • What times of your AOD use, like buying, intoxication or coming down, do you think could be risky for your child?

What you need to find out	What to ask the parent
	• How could your AOD use impact on how you respond to your child if they needed you? Has there been a time you wished you had been able to respond but could not? Have there been times your child has hurt themselves? • Would you be quicker or slower to react? Would you be alert enough to see these dangers? • What is sleep like for you? • Do you go into a heavy sleep after using AOD? • Would your child be able to wake you if they needed you or were worried about something? • Would you be able to wake if you hear them crying?

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Page created

Building a picture of risk

You need to know what is happening to the child and their family, and the particular ways a child's safety, belonging and wellbeing are affected by their parent's alcohol and other drugs (AOD) use.

Once you have built a picture of what the child needs, you have to make sense of what it all means.

What you need to know	What to ask yourself
About the child	• How does this child need to be cared for? • What is their temperament and development? • What things are easy and more challenging in life for this child? • How is the child being hurt by their parent's AOD use? • If things stay the same, what is the likely trajectory for the child? • What needs to be different to make things better and safer in the child's life? • What things should stay the same in the child's life? • What things do we need to build on in the child's life?
About the parent and AOD use	• How does AOD use affect the parent meeting each child's needs? • What is the parent doing or not doing for the child because of their AOD use? • What places, people and AOD practices are making their child more at risk? • What have you learnt about AOD use in their life? • What is the parent's perspective about risks to their child and

What you need to know	What to ask yourself
	what needs to happen about their AOD use? • Given the patterns of past and current use and the seriousness of episodes, what level of intervention and support is likely for healing and recovery?
About strengths, resources and acts of protection	• What are the things that work well in the family? • What things does the parent do well? • Who is connected to the child and parents? • Who can help? • What acts of protection have you learnt about? • How do these things reduce risk or buffer the impacts for the child?

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Resources

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Page created

Case planning

Case plans are a vehicle for change. They tell you what needs to happen and how.

Seeing and understanding

Responding

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About this part

This part will help you:

- be clear and up-front about what needs to change and why
- motivate and support parents in achieving change
- develop partnerships with alcohol and other drug services to support case planning
- develop meaningful case plans for children and with children
- know what to do and what to avoid when case planning
- monitor and review to assess change

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Keep children front and centre

When problematic substance use is an issue, it can be easy for a child's needs to be overshadowed by the work you do with his or her parents. But a case plan is first and foremost an opportunity to create change for the child.

Involve children in case planning. Talk with them about their life, include them in decisions and partner with others who will advocate on their behalf. Hear what a child wants and needs to change in their lives.

Note

'Kids should be asked about stuff that's got to do with them… They can tell you stuff you'd never think of—cos you're not a kid.'

6-year-old girl, Keep me in the loop—Kids Central Toolkit

What you should know before you start case planning

A picture of the child's life should have emerged during your assessment.

You should know:

- how a parent's past and current alcohol or drug (AOD) use influences their ability to make changes in a way that meets their child's needs
- what level of change is needed
- what parenting practices are affected by AOD use
- how intoxication and withdrawal affect the child's safety and wellbeing
- how bonding and attachment is affected
- any other risks within the family.

Tip

Tools such as the Three Houses and Future House can help to better engage children and young people and help them express their worries, hopes and dreams.

Child-centred case plans

Focus your case plan on changes that will have a significant impact on a child's life. Your case plan will be guided by your assessment of what is working and what the worries are. The parental and child strengths and needs will also need to be included in the case plan.

Ask yourself what needs to be done to:

- help the parents and their network create safety and demonstrate safety over time
- improve parenting practices
- strengthen the bond between child and parent
- reduce the risk of abuse or neglect
- address co-existing risk factors.

Be clear about how these changes will impact a child's everyday life.

Related forms, templates and resources

The three houses

Resource 18 July 2019

The future house

Resource 18 July 2019

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What needs to change

When working with families to develop meaningful case plans it can be useful to use the collaborative assessment and planning (CAP) tool. The CAP tool is best used in partnership with children, families and their safety and support network to organise information into:

- harm
- complicating factors
- acts of protection and belonging
- strengths and resources.

The scaling question can be used to allow participants to express their opinion or perspective on issues such as safety and progress with case plan goals.

Using the CAP framework tool also provides an opportunity for children, family and their safety and support network to develop or have significant input into developing worry statements (which identify risk), goals statements (which is what everyone is hoping to achieve) and action steps (how everyone will reach the goals).

Related forms, templates and resources

Collaborative assessment and planning framework booklet

Resource 18 July 2019

This is a secure resource. Only authenticated users may access this content.

Collaborative assessment and planning framework - worry statements

Resource 19 September 2019

Collaborative assessment and planning framework - goal statements

Resource 19 September 2019

Collaborative assessment and planning framework - action steps and non-negotiables

Resource 19 September 2019

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Page created

What needs to change for children

Case planning is your opportunity to focus parents on the goals and action steps and keep the safety and support network aware of the harms and worries relating to the safety of the children.

Be clear about what must change

When working with parents, be clear about the ways their alcohol and other drugs (AOD) use harms a child—both now and in the future. Tell them what you are worried about and what must change for a child to be safe. Motivate parents by expressing how these changes will change a child's life for the better.

Step into a child's shoes

When setting goals, remember to try to see the world from a child's perspective.

Ask yourself:

- What does the child need to be safe at home today and in the future?
- What cumulative harm is the child exposed to?
- What is the child's relationship and attachment to each of their parents like?
- How is the child being harmed by their parent's problematic AOD use?
- What does the child need to have happen within the next 3–6 months?

Educate and collaborate with parents

Educate parents about what it is about their AOD use that makes their child vulnerable, what risks they face and how these risks can impact on them now and in the future.

If you have worked with the children and used tools such as the Three Houses or the Future House, ask the children if you can share these with the parents. Hearing how their AOD use is affecting their child or children can be a powerful motivator.

You also need to be clear about what will be done and by when and who is responsible. Collaborate with parents and the safety and support network to discover the best ways to make change happen.

Set goals with parents

Parents need to participate in the development of the case plan to increase their sense of ownership. That means setting goals with them, not for them. Collaboration and clarity are vital—parents must know what needs to be done, why and how they will do it.

Be confident about the goals you set. Do not 'change the goalposts' as this can confuse and demotivate parents.

Before you begin setting goals with parents, ask yourself:

How clear am I about what needs to change in the case plan? If I am unclear, how will the parent understand what needs to be done?

- Are my goals realistic regarding what can change within this case plan period?
- Are they realistic for parents and within the timeframe the child needs?
- If childhood trauma, mental health or domestic and family violence is connected with a parent's AOD use, how do I break this down for case planning?
- If a parent is not ready to work through past childhood trauma, what does this mean for developing goals and actions steps in case planning?
- Who do I need to consult with so I am clear before talking with a parent?

Case planning can be challenging for parents, especially when their AOD use is linked to confronting, painful and traumatic experiences.

Not all parents will be able to take the steps to change in the time needed to make a child safe.

Related forms, templates and resources

The three houses

Resource 18 July 2019

The future house

Resource 18 July 2019

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Assess a parent's readiness for change

A parent's feelings about making changes to their life will differ over time. They may also be more open to some changes than others. But children need you to support parents through this challenging journey.

Change is a process not an event

Prochaska and Diclemente's stages of change describes readiness to change as a dynamic process.

Parents might feel stuck with conflicting feelings: on one hand they want to change but on the other, they may be worried or scared. How they feel may change as you continue to work with them.

Keep the conversation about change alive through your case work by using motivational interviewing techniques.

Help parents find their own motivation to make changes and stay on track for change. Regularly check in, monitor and respond to where the parent is at.

Before you start building a case plan with parents, it is important to summarise and be clear with them about what needs to change and why.

- Explain to them the way you have made sense of their alcohol and other drugs (AOD) use and what it means for their child. (This is the outcome of your safety and risk assessments).
- Ask if there is anything you have got wrong or misunderstood.
- Ask for feedback on what they do or do not agree with and let them know it's okay if they do not agree with everything.
- Acknowledge areas of difference and look for common ground for the future.
- Remember that change takes time.

Help parents feel connected

Be curious about their thoughts, feelings and ambitions. Put hope and optimism into every conversation. Helping them staying connected to their child and the goal of keeping them safe can assist parents in their darkest times.

Do not assume that parents will agree with you about all of your worries or all of the things that you think need to change.

If you jump straight into case planning without a clear agreement of what behaviours or patterns need to be different, you can miss the opportunity to understand and see how ready and able a parent is to take action.

Further reading

'Resistance to change is not something inherent in the person with the problem, but in the relationship where the intervention is not tailored to their readiness.'

Women's Council (2009), Supporting women with complex needs—The relationship between substance use and domestic and family violence.

Tips for assessing a parent's readiness for change

A parent's ability to make the changes they need through a case plan relies on their commitment to keeping their child safe, their willingness to do what needs to be done and their ability to follow through.

The following tips can help you think about what you have heard parents say, what you have seen and what you understand from your assessment about how ready they are to make the changes their child needs now.

A commitment to change

Does the parent know things need to change?

- Does the parent understand how their substance misuse affects the child?
- Are they clear about what needs to change and how they can do it?
- Does the family have a different perspective about what needs to change? If so, are you able to acknowledge these differences and overcome them together?

Are they ready to change?

- What was the parent's readiness for change at the time you first spoke about your worries? How has this changed over time or not?
- Where is the parent in the change cycle now? What is happening that leads you to make this assessment?

- What 'change talk' have you heard? (Change talk is when a parent expresses their desire, need, ability or reasons to change their current behaviour, as in: 'I want to change my life. I want things to be better.')

Are they not yet ready to change?

- What tells you they are not ready? Where do they sit in the change cycle?
- Are they using 'sustain talk'? (Sustain talk is when a parent expresses their ambivalence to change. They may express defeat—'I've tried that before', 'I can't do that', 'It is not a problem that needs to be fixed.')
- Are they talking to you about their reasons for not changing? For example, 'I have been drinking for so long I can't stop now, I would have to move away and cut people out of my life to stop. I don't want to have to deal with my past.'

A willingness to change

- How willing is the parent to work with you and AOD services towards change?
- How willing is the parent to open up and talk about what needs to change, how, and who can help them?
- How willing is the parent to take steps that will support change, such as letting go of people who may enable their AOD use, reconnecting with people who can help them, letting people help them, or seeking treatment
- What ideas have they talked about for their healing and treatment?

An ability to change

- Has the parent started working with services already?
- If not, what is getting in the way for them and how can you support them?
- If there is a barrier, what is it and what can you do to support them in overcoming it?
- What services and supports are available for the parent to access?
- What support network does the parent have to help them and their child?

> **Tip**
>
> Watch this short video to help understand where a parent may be in relation to their stage of change

Youtube video URL: https://www.youtube.com/embed/ayjXMix-nMw?enablejsapi=1&showinfo=0&rel=0

Video Caption:
The Stages of Change Model

Video transcript:

00:01

the transtheoretical model also known as

00:04

the stages of change represents a

00:06

person's readiness to change there's six

00:09

stages these are pre contemplation

00:12

contemplation preparation action

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maintenance and relapse and lapse today

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we'll look at the model in the context

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of alcohol and other drug use

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identifying where a person might be ad

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in the change process can provide some

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direction as to how they can best be

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supported let's take a closer look pre

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contemplation people in this stage

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aren't worried about their use they're

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not interested in stopping or cutting

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back even though other people might be

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concerned about their use for them the

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benefits far outweigh the consequences

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contemplation people in this stage of

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change still enjoy using however maybe

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they're starting to notice some problems

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from their use they're weighing up what

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changing might mean for them preparation

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this is when the not-so-good things

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about using are starting to outweigh the

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things they enjoy about it and they

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begin preparing to make a change to

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their use action they've started to make

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changes to their alcohol or drug use it

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will depend on the person's goal but

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this might include things like using

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less or stopping maintenance

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they're maintaining this change they've

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been in the action stage for long enough

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that change has become easy they've got

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this they're no longer dealing with

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constant cravings and triggers and have

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maintained their goal for a significant

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period relapse or lapse a relapse is a

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return back to using and elapse is a

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slip-up elapsed does not automatically

02:00

lead to a relapse

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both lapses and relapses provide an

02:04

opportunity for the person to learn more

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about themselves what triggers them or

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challenges them and what promotes

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opportunities for growth it's really

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important to help the person see any

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lapse or relapse as a learning

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opportunity as opposed to a failure

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people learn a lot more from their

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setbacks than from their successes and

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that's the stages of change or as it's

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known as in technical terms the

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transtheoretical model

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Building positive relationships for family

No matter where a child lives, you will need to ensure that both the child and parents have the opportunity to build, connect and repair relationships to promote a robust safety and support network.

Relationships and strong community or family connections are the cornerstone to child safety. So it is essential that a safety and support network be developed or maintained.

Safety and support networks

A safety and support network is a team of family, friends, community members, carers and professionals who are willing to meet with the child or young person, the family, and Child Safety and work together to keep the child or young person safe.

Network members are not 'add-ons' to the case work but are integral to case and safety planning. In this integrated practice approach, network members are essential to enhancing safety as they keep in regular contact with the child or young person and their families, take specific actions when situations become fragile or dangerous, and listen and respond to the child or young person and their worries.

An important difference between a safety and support network and a more general 'group of concerned people' is that safety and support network members know the harms that have already been experienced and the worries and goals for the future.

They know the risks of future harm to the child or young person should nothing change in the family or if new issues emerge. The key premise for any safety and support network is that network members are:

- informed
- willing to help
- clear about what they must do to respond.

Use the following list of questions with parents to help identify or develop a safety and support network with the children and parents.

Who is currently in your life?

- What role or connection do they have with your alcohol and other drugs (AOD) use now or in the past?
- Are they a positive or negative influence?

- What do they think, say or do about your AOD use?
- Who could be in your life but is not?
- What is stopping them from being in your life now?
- What do you think their wish for you and your child is?

Who is helpful?

- Who is in your life now who would support you in making the changes you want?
- Who has been in your life before who could help you if they were still in your life?
- Who could be in your life to support you in being the parent you want to be?

Who makes it harder?

- Who is in your life now who gets in the way of you making the changes you want?
- Who has been in your life before who has got in the way or made it harder for you to change?

Looking at relationships connected to alcohol or other drug use

Talk to parents about how the various people in their lives:

- influence their AOD use
- feel about the parent making positive changes
- feel about treatment and recovery.

These conversations are often complex, as AOD can play a significant part in the social lives and relationships of people with problematic AOD use.

These relationships may be important and meaningful. If a parent senses you are asking them to cut ties with certain friends or groups, they may feel challenged and upset.

It is not your role to tell parents who they can and cannot spend time with when they are not looking after their child (such as when the child is at school or being looked after by someone else).

In your conversations, help a parent explore how the relationships in their life impact on their substance use and parenting. Your conversations should help a parent come to their own conclusions about who is a positive influence in helping them seek treatment and recover.

If you think a parent's friend, partner or anyone else in their life is a potential risk to a child, you will need to:

- have up-front and frank conversations about this with parents
- develop safety plans that help keep their child safe and

- be clear about what is required (and expected) to keep their child safe.

For example: A parent may see and spend time with people who drink or use drugs and it may take time for them to let go of these relationships. This will be their choice as they move through treatment and recovery. However, you will need to be clear that although they maintain these relationships, their child should not be spending time with anyone who causes a risk.

Further reading

Read more about having conversations about AOD use with parents in the Working with parents section

TED talk: Everything you think you know about addiction is wrong

This TED talk with Johann Hari challenges the way we look at AOD dependence and the powerful role that 'connection' plays when working with parents who struggle with their AOD use.

TED video url:
https://embed.ted.com/talks/johann_hari_everything_you_think_you_know_about_addiction_is_wrong

Video Caption:
Johann Hari: Everything you think you know about addiction is wrong

Video transcript:

00:10

One of my earliest memories is of trying to wake up one of my relatives and not being able to. And I was just a little kid, so I didn't really understand why, but as I got older, I realized we had drug addiction in my family, including later cocaine addiction.

00:23

I'd been thinking about it a lot lately, partly because it's now exactly 100 years since drugs were first banned in the United States and Britain, and we then imposed that on the rest of the world. It's a century since we made this really fateful decision to take addicts and punish them and make them suffer, because we believed that would deter them; it would give them an incentive to stop.

00:45

And a few years ago, I was looking at some of the addicts in my life who I love, and trying to figure out if there was some way to help them. And I realized there were loads of incredibly basic questions I just didn't know the answer to, like, what really causes addiction? Why do we carry on with this approach that doesn't seem to be working, and is there a better way out there that we could try instead?

01:08

So I read loads of stuff about it, and I couldn't really find the answers I was looking for, so I thought, okay, I'll go and sit with different people around the world who lived this and studied this and talk to them and see if I could learn from them. And I didn't realize I would end up going over 30,000 miles at the start, but I ended up going and meeting loads of different people, from a transgender crack dealer in Brownsville, Brooklyn, to a scientist who spends a lot of time feeding hallucinogens to mongooses to see if they like them -- it turns out they do, but only in very specific circumstances -- to the only country that's ever decriminalized all drugs, from cannabis to crack, Portugal. And the thing I realized that really blew my mind is, almost everything we think we know about addiction is wrong, and if we start to absorb the new evidence about addiction, I think we're going to have to change a lot more than our drug policies.

01:55

But let's start with what we think we know, what I thought I knew. Let's think about this middle row here. Imagine all of you, for 20 days now, went off and used heroin three times a day. Some of you look a little more enthusiastic than others at this prospect. (Laughter) Don't worry, it's just a thought experiment. Imagine you did that, right? What would happen? Now, we have a story about what would happen that we've been told for a century. We think, because there are chemical hooks in heroin, as you took it for a while, your body would become dependent on those hooks, you'd start to physically need them, and at the end of those 20 days, you'd all be heroin addicts. Right? That's what I thought.

02:32

First thing that alerted me to the fact that something's not right with this story is when it was explained to me. If I step out of this TED Talk today and I get hit by a car and I break my hip, I'll be taken to hospital and I'll be given loads of diamorphine. Diamorphine is heroin. It's actually much better heroin than you're going to buy on the streets, because the stuff you buy from a drug dealer is contaminated. Actually, very little of it is heroin, whereas the stuff you get from the doctor is medically pure. And you'll be given it for quite a long period of time. There are loads of people in this room, you may not realize it, you've taken quite a lot of heroin. And anyone who is watching this anywhere in the world, this is happening. And if what we believe about addiction is right -- those people are exposed to all those chemical hooks -- What should happen? They should become addicts. This has been studied really

carefully. It doesn't happen; you will have noticed if your grandmother had a hip replacement, she didn't come out as a junkie. (Laughter)

03:23

And when I learned this, it seemed so weird to me, so contrary to everything I'd been told, everything I thought I knew, I just thought it couldn't be right, until I met a man called Bruce Alexander. He's a professor of psychology in Vancouver who carried out an incredible experiment I think really helps us to understand this issue. Professor Alexander explained to me, the idea of addiction we've all got in our heads, that story, comes partly from a series of experiments that were done earlier in the 20th century. They're really simple. You can do them tonight at home if you feel a little sadistic. You get a rat and you put it in a cage, and you give it two water bottles: One is just water, and the other is water laced with either heroin or cocaine. If you do that, the rat will almost always prefer the drug water and almost always kill itself quite quickly. So there you go, right? That's how we think it works. In the '70s, Professor Alexander comes along and he looks at this experiment and he noticed something. He said ah, we're putting the rat in an empty cage. It's got nothing to do except use these drugs. Let's try something different. So Professor Alexander built a cage that he called "Rat Park," which is basically heaven for rats. They've got loads of cheese, they've got loads of colored balls, they've got loads of tunnels. Crucially, they've got loads of friends. They can have loads of sex. And they've got both the water bottles, the normal water and the drugged water. But here's the fascinating thing: In Rat Park, they don't like the drug water. They almost never use it. None of them ever use it compulsively. None of them ever overdose. You go from almost 100 percent overdose when they're isolated to zero percent overdose when they have happy and connected lives.

04:57

Now, when he first saw this, Professor Alexander thought, maybe this is just a thing about rats, they're quite different to us. Maybe not as different as we'd like, but, you know -- But fortunately, there was a human experiment into the exact same principle happening at the exact same time. It was called the Vietnam War. In Vietnam, 20 percent of all American troops were using loads of heroin, and if you look at the news reports from the time, they were really worried, because they thought, my God, we're going to have hundreds of thousands of junkies on the streets of the United States when the war ends; it made total sense. Now, those soldiers who were using loads of heroin were followed home. The Archives of General Psychiatry did a really detailed study, and what happened to them? It turns out they didn't go to rehab. They didn't go into withdrawal. Ninety-five percent of them just stopped. Now, if you believe the story about chemical hooks, that makes absolutely no sense, but Professor Alexander began to think there might be a different story about addiction. He said, what if addiction isn't about your chemical hooks? What if addiction is about your cage? What if addiction is an adaptation to your environment?

06:01

Looking at this, there was another professor called Peter Cohen in the Netherlands who said, maybe we shouldn't even call it addiction. Maybe we should call it bonding. Human beings have a natural and innate need to bond, and when we're happy and healthy, we'll bond and connect with each other, but if you can't do that, because you're traumatized or isolated or beaten down by life, you will bond with something that will give you some sense of relief. Now, that might be gambling, that might be pornography, that might be cocaine, that might be cannabis, but you will bond and connect with something because that's our nature. That's what we want as human beings.

06:37

And at first, I found this quite a difficult thing to get my head around, but one way that helped me to think about it is, I can see, I've got over by my seat a bottle of water, right? I'm looking at lots of you, and lots of you have bottles of water with you. Forget the drugs. Forget the drug war. Totally legally, all of those bottles of water could be bottles of vodka, right? We could all be getting drunk -- I might after this -- (Laughter) -- but we're not. Now, because you've been able to afford the approximately gazillion pounds that it costs to get into a TED Talk, I'm guessing you guys could afford to be drinking vodka for the next six months. You wouldn't end up homeless. You're not going to do that, and the reason you're not going to do that is not because anyone's stopping you. It's because you've got bonds and connections that you want to be present for. You've got work you love. You've got people you love. You've got healthy relationships. And a core part of addiction, I came to think, and I believe the evidence suggests, is about not being able to bear to be present in your life.

07:36

Now, this has really significant implications. The most obvious implications are for the War on Drugs. In Arizona, I went out with a group of women who were made to wear t-shirts saying, "I was a drug addict," and go out on chain gangs and dig graves while members of the public jeer at them, and when those women get out of prison, they're going to have criminal records that mean they'll never work in the legal economy again. Now, that's a very extreme example, obviously, in the case of the chain gang, but actually almost everywhere in the world we treat addicts to some degree like that. We punish them. We shame them. We give them criminal records. We put barriers between them reconnecting. There was a doctor in Canada, Dr. Gabor Maté, an amazing man, who said to me, if you wanted to design a system that would make addiction worse, you would design that system.

08:22

Now, there's a place that decided to do the exact opposite, and I went there to see how it worked. In the year 2000, Portugal had one of the worst drug problems in Europe. One percent of the population was addicted to heroin, which is kind of mind-blowing, and every year, they tried the American way more and more. They punished people and stigmatized them and shamed them more, and every year, the problem got worse. And one day, the Prime Minister and the leader of the opposition got together, and basically said, look, we can't go on with a country where we're having ever more people becoming heroin

addicts. Let's set up a panel of scientists and doctors to figure out what would genuinely solve the problem. And they set up a panel led by an amazing man called Dr. João Goulão, to look at all this new evidence, and they came back and they said, "Decriminalize all drugs from cannabis to crack, but" -- and this is the crucial next step -- "take all the money we used to spend on cutting addicts off, on disconnecting them, and spend it instead on reconnecting them with society." And that's not really what we think of as drug treatment in the United States and Britain. So they do do residential rehab, they do psychological therapy, that does have some value. But the biggest thing they did was the complete opposite of what we do: a massive program of job creation for addicts, and microloans for addicts to set up small businesses. So say you used to be a mechanic. When you're ready, they'll go to a garage, and they'll say, if you employ this guy for a year, we'll pay half his wages. The goal was to make sure that every addict in Portugal had something to get out of bed for in the morning. And when I went and met the addicts in Portugal, what they said is, as they rediscovered purpose, they rediscovered bonds and relationships with the wider society.

09:58

It'll be 15 years this year since that experiment began, and the results are in: injecting drug use is down in Portugal, according to the British Journal of Criminology, by 50 percent, five-zero percent. Overdose is massively down, HIV is massively down among addicts. Addiction in every study is significantly down. One of the ways you know it's worked so well is that almost nobody in Portugal wants to go back to the old system.

10:21

Now, that's the political implications. I actually think there's a layer of implications to all this research below that. We live in a culture where people feel really increasingly vulnerable to all sorts of addictions, whether it's to their smartphones or to shopping or to eating. Before these talks began -- you guys know this -- we were told we weren't allowed to have our smartphones on, and I have to say, a lot of you looked an awful lot like addicts who were told their dealer was going to be unavailable for the next couple of hours. (Laughter) A lot of us feel like that, and it might sound weird to say, I've been talking about how disconnection is a major driver of addiction and weird to say it's growing, because you think we're the most connected society that's ever been, surely. But I increasingly began to think that the connections we have or think we have, are like a kind of parody of human connection. If you have a crisis in your life, you'll notice something. It won't be your Twitter followers who come to sit with you. It won't be your Facebook friends who help you turn it round. It'll be your flesh and blood friends who you have deep and nuanced and textured, face-to-face relationships with, and there's a study I learned about from Bill McKibben, the environmental writer, that I think tells us a lot about this. It looked at the number of close friends the average American believes they can call on in a crisis. That number has been declining steadily since the 1950s. The amount of floor space an individual has in their home has been steadily increasing, and I think that's like a metaphor for the choice we've made as a culture. We've traded floorspace for friends, we've traded stuff for connections, and the result is we are one of the loneliest societies there has ever been. And Bruce Alexander, the guy who did the Rat Park experiment, says, we talk all the time in addiction about individual

recovery, and it's right to talk about that, but we need to talk much more about social recovery. Something's gone wrong with us, not just with individuals but as a group, and we've created a society where, for a lot of us, life looks a whole lot more like that isolated cage and a whole lot less like Rat Park.

12:14

If I'm honest, this isn't why I went into it. I didn't go in to the discover the political stuff, the social stuff. I wanted to know how to help the people I love. And when I came back from this long journey and I'd learned all this, I looked at the addicts in my life, and if you're really candid, it's hard loving an addict, and there's going to be lots of people who know in this room. You are angry a lot of the time, and I think one of the reasons why this debate is so charged is because it runs through the heart of each of us, right? Everyone has a bit of them that looks at an addict and thinks, I wish someone would just stop you. And the kind of scripts we're told for how to deal with the addicts in our lives is typified by, I think, the reality show "Intervention," if you guys have ever seen it. I think everything in our lives is defined by reality TV, but that's another TED Talk. If you've ever seen the show "Intervention," it's a pretty simple premise. Get an addict, all the people in their life, gather them together, confront them with what they're doing, and they say, if you don't shape up, we're going to cut you off. So what they do is they take the connection to the addict, and they threaten it, they make it contingent on the addict behaving the way they want. And I began to think, I began to see why that approach doesn't work, and I began to think that's almost like the importing of the logic of the Drug War into our private lives.

13:31

So I was thinking, how could I be Portuguese? And what I've tried to do now, and I can't tell you I do it consistently and I can't tell you it's easy, is to say to the addicts in my life that I want to deepen the connection with them, to say to them, I love you whether you're using or you're not. I love you, whatever state you're in, and if you need me, I'll come and sit with you because I love you and I don't want you to be alone or to feel alone.

13:59

And I think the core of that message -- you're not alone, we love you -- has to be at every level of how we respond to addicts, socially, politically and individually. For 100 years now, we've been singing war songs about addicts. I think all along we should have been singing love songs to them, because the opposite of addiction is not sobriety. The opposite of addiction is connection.

14:26

Thank you.

14:28

(Applause)

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Treatment options

Treatment must be tailored to the needs and abilities of an individual. Effective treatment depends on the substances the person is using, their level of dependence, their readiness to change and their past experiences with services.

Helping a parent to understand that there is support available to them to assist with making changes to their alcohol and other drugs (AOD) use is important. It may mean talking through past experiences with services: What worked well? What was difficult? What would help now?

Providing parents with information about the types of services that are available and offering to assist them with referrals can be the first step.

If parents have not engaged with AOD services before, it can be useful to explain that when a parent contacts an AOD service:

- an initial assessment may occur over the phone or face to face and
- the service will provide support and treatment to assist with the parent's goals about the changes to their AOD use.

Common treatment options

- Pharmacotherapy services: These are in each district in both public and private settings. Prescribed medications such as methadone and buprenorphine can help people stop using non-prescribed medicines.
- Inpatient detox: This is usually short term and medication-assisted. A person is admitted as an inpatient.
- Long-term inpatient rehabilitation: Rehabilitation often includes intensive and structured treatments. These programs can run anywhere from 3 to 12 months.
- Drug and alcohol counselling: These services provide outpatient counselling on a regular basis. Counselling can be short term (6–10 weeks), but some services provide long-term support.
- Outpatient groups: These may be weekly outpatient services or may be groups that require 2–3 days attendance per week.
- Stimulant treatment programs: These programs are designed to support clients who use stimulants (methamphetamine, cocaine and other amphetamine-type substances) and who wish to develop safer ways of using or to quit.
- Self-help groups: A number of self-help groups exist in different districts. These include Alcoholics Anonymous, Narcotics Anonymous and SMART Recovery.

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Alcohol and other drugs services

Working with alcohol and other drug services

Alcohol and other drug (AOD) services that support parents through treatment and recovery will have the opportunity to see progress and monitor changes. This includes being able to see risks and protective factors for children.

It is useful to make and maintain contact with the AOD services as they provide help for the parents.

Help alcohol and other drug professionals understand both the parent's and child's perspectives

- Talk about a family-centred approach and how you can partner together for the child and family.
- Help alcohol and drug professionals understand the specific ways a child is being hurt and how a collaborative approach can help children and parents.
- Help other professionals connect with a parent's role. Let them know how they can support parents in their relationships with their children and why it is important.

Helping other professionals see risks for children

When speaking with alcohol and other drug providers:

- Be clear about the harm and the worries you have for the child.
- Explain how to recognise these and what should be done.

Talk with AOD services to understand their experience with identifying risks for children that stem from problematic substance use.

A parent's problematic substance use can affect a child or create risks that are both immediately visible or appear over time. Give service providers access to guides on supporting parents and identifying developmental trauma such as the *Child Development and Trauma Guide*.

Tips for working with other service professionals

- Be clear about everyone's role and responsibilities.

- Collaborate and be clear about what information needs to be shared, who it needs to be shared with, how it will be shared and when by. Remember to ask for the parent's consent prior to sharing information.
- Make sure professionals you involve in case planning have the capacity and resources to do what you need from them. Do not assume that, because a service is involved, they will be able to do what you need.
- Ensure parents know what kind of information or conversations will be shared between a service and you. This is integral to developing and keeping their trust and making them feel safe.
- Look for opportunities to talk with parents and their families together with other service providers.
- Be clear with services about how risks for children will be monitored.
- Consult and draw on the expertise that AOD professionals can offer. This can build an understanding about suitable treatment options and what supports parents need.

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Building a partnership with alcohol and drug services

Collaboration between child protection and drug and alcohol services is crucial for good outcomes. These are complementary services, but they also have their differences.

Your primary job is as an advocate for children and their safety. Children are always your primary client. While their whole family and AOD professionals must be spoken with and worked with, the needs of the child always come first.

For most alcohol and other drug (AOD) treatment programs, the user of the alcohol or drug is the primary client. Service is designed to suit their needs. While family life may be part of their assessment, the person's relationship with substances is more likely to be the main focus of intervention.

Recovery can be a long process, but a child's safety must be addressed immediately. This balance is only possible with the support of families and their network, which could include community and AOD service providers.

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Promoting recovery

Relapse prevention is a strategy for how a person can manage their 'triggers' for substance use. These can be anything from stress to social outings to certain friends or family. The more support you can provide, the more likely it is a parent will be able to maintain their goals and keep their children safe.

Check in on parents once they have finished their program. Learn from them and their service providers what is recommended and how you can best support recovery.

Tips for supporting recovery

Being active in the community and using peer support groups and activities are important predictors of recovery.

Alcoholics Anonymous, Narcotics Anonymous or SMART Recovery are self-help groups that represent the most accessible form of peer and community support and are often available even in areas where other treatment options are lacking.

To find local meetings in your area go to:

- Alcoholics Anonymous
- SMART Recovery Australia
- Welcome to Narcotics Anonymous Australia.

Relapse is an opportunity—not the end

Problematic alcohol and other drug (AOD) use is a chronic and relapsing condition and it may take some attempts before a parent is able to maintain their goal of recovery.

A lapse can be useful for a parent if they are able to learn from the situation and then put preventative strategies in place to reduce the chances of it happening again. If a person lapses and re-commences problematic use, then this is a relapse.

Your role will always be to keep connected with what lapse and relapse means for a child, to look at ways to make sure the child is safe, and to determine what steps need to be taken.

For more detail about responding to relapse, go to: Alcohol and Drug Foundation—What is relapse?

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How to involve children in case planning

Give children the opportunity to share their ideas on what needs to change.

Give children and young people the information they need to understand the case plan and why certain decisions have been made. Children should participate directly, but if they are unable to (such as in the case of infants) you must still approach case planning from the child's perspective. Always advocate on their behalf and ensure their voice is clearly heard.

Note

"It is not necessary that the child has comprehensive knowledge of all aspects of the matter affecting her or him, but that she or he has sufficient understanding to be capable of appropriately forming her or his own views on the matter."

Committee on the Rights of the Child, 2009

When case planning with children

- Help children understand what is happening. The simple formula of who is worried, what they are worried about and why is a good place to start.
- Let children know what is happening, what decisions have been made and why.
- As much as possible, include children in decisions that affect their lives.
- Speak about parents in a positive way while being honest and real.
- Help children understand 'dependence', so they can make sense of why their parent needs help. Read more about this in the *Working with children* section.

Ask each child in a family:

- what they want to know
- what worries them the most
- what they need from you, parents and others to feel okay about what is happening.

Practice prompt

> Use tools such as the Three Houses and the Future House to help children express themselves.

Related forms, templates and resources

The three houses

Resource 18 July 2019

The future house

Resource 18 July 2019

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Talk with parents about treatment

Help parents make the referral. Be as proactive in this as you need to be.

Before you speak with a parent, make sure you know:

- what services and treatments are available
- potential waiting times
- any obstacles—such as how easy it is to get to an outpatient rehab by different forms of transport.

Have information about the services on hand and be ready to speak about the advantages of different treatment types—especially how they relate to the individual's own circumstances.

Conversation ideas

Talk with a parent about their treatment options and any previous treatment they may have had. Use the following types of questions:

- What ways have you tried to stop or reduce your alcohol or other drug (AOD) use before now?
- Have you had treatment before?
- What sort of treatment was it? How long ago? How long for?
- What did you find helpful or unhelpful?
- Tell me about how you finished. If you left before finishing, tell me more about that.
- Tell me about any time you've had without drinking or using.
- Was there any relapse prevention work done?
- Can you call on previous treatment strategies you learnt to help you now?

Refer to the *Working with parents* section to look at more ways of talking with parents using strengths-based techniques.

Practice prompt

Use tools such as the Three Houses and the Future House.

How to work with parents to set goals for change

Working with parents to set achievable change goals is an important part of your work towards the safety of the child.

A person's ability to commit to change is dependent on where they are in the change cycle. You can prepare parents for positive change by breaking down the process and motivating them.

Keep an eye on the stages of change

The stages of change model suggests that individuals attempting to change behaviour move through a sequence of stages:

1. Pre-contemplation—A parent in the precontemplation stage is not thinking about changing their AOD use. Parents in the pre-contemplation stage should be provided with harm reduction information and, where possible, persuaded/negotiated into safer methods of using.
2. Contemplation—At this stage, a parent is starting to think about changing their behaviour. Motivational interviewing is useful for clients in this stage.
3. Preparation—At this stage, a parent has made a decision to change and is now thinking about putting it into effect. Goal setting, planning, identifying triggers for relapse and problem solving are useful for parents in this stage.
4. Action—A parent in this stage is changing their behaviour. A counsellor can assist with relapse prevention and management and with reinforcing positive changes.
5. Maintenance—At this stage, a parent is focused on maintaining the positive changes. Continue to reinforce the positive changes that have been made and encourage them to begin working towards their longer-term lifestyle goals.

Related forms, templates and resources

The three houses

Resource 18 July 2019

The future house

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Case plan with purpose

Remember to be SMART about your case plans:

Specific—the family knows exactly what has to be done.

Measurable—goals are measurable, clear and understandable, so everyone knows when they have been achieved.

Achievable—the family is able to accomplish the goal in a designated time period given their available resources.

Realistic—the family has had input into and agreed on the development of feasible goals.

Time-limited—time frames for goal accomplishment are determined based on understanding the family's risks, strengths, ability and motivation to change, and availability of resources.

Source: De Panfilis (2006, p. 65)

Goals and outcomes

A goal should be specific and achievable and should focus on how outcomes are reached. In this case, an outcome is what needs to occur to provide safety. Therefore 'stop using alcohol or drugs' needs to be seen as the outcome rather than the goal.

Listen to the parent's perspective

Be guided by parents about what has and has not worked for them before. If they are worried about using a particular service you have suggested, ask why and explore what they think will work for them. Ask for feedback and other's perspectives (from supports and professionals) to help parents identify the best road forward.

Make sure case plans are culturally appropriate

Ask yourself:

- Is this case plan goal and intervention culturally appropriate?
- Can this service provide a culturally appropriate intervention or service to the child and family?
- How have you considered and consulted about this?

Make sure parents can access the supports they need

- Can the child and parents get to the service they're accessing?
- Do appointments fit around school and other family commitments?
- How can family support children and parents?

Family stress

- Is the family experiencing unnecessary stress because of the services and interventions that have been included in the case plan?
- What benefit are the services providing?
- How can you alleviate stress?

Consult

- Have you consulted with the family and the safety and support network? How have you bought people together?
- Are they committed to doing what the child needs from them?
- Have you consulted with alcohol and other drug services?

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Reviewing the case plan

Your ability to track progress relies on how well you defined case plan goals—what needed to be done, by whom and when.

Progress through each case plan period will look different for each parent.

Lives evolve and change rapidly, and you will need to monitor what is happening while being flexible and responsive to barriers and obstacles. At times, you will need to go backwards so you can keep moving forward.

Strengths-based approaches will help you build your relationships and support a parent's change.

However, you need to be the voice of the child, and you need to be up-front and frank when things are not going well or if the safety and risks for a child increase.

Review more than alcohol and drug use

Your case plan should cover the many elements of life and home that make a child safe. This means creating plans that go beyond the scope of just treatment and recovery.

Your plan should cover parent and child relationships, parenting practices and any coexisting factors that may be part of the child and family experience.

Your review will focus on all these factors too. You should be clear about what progress looks like and how it will be measured.

The following paragraphs provide examples of how to monitor progress.

A parent's progress with treatment and recovery may look like:

- reducing alcohol or other drug use
- reducing overdose risk and blood-borne disease risk behaviours
- improving social functioning
- improving physical health
- improving psychological adjustment
- reducing criminal behaviour
- engaging in treatment and completing treatment
- putting into practice what they learnt during treatment
- connecting with community resources to support relapse prevention and recovery
- disconnecting from people and places that influence their alcohol and other drug (AOD) use

Developing their parenting practices may look like:

- engaging with and completing parenting skills programs
- applying new skills learnt
- improving parenting practices (that can be shown over time)
- putting in place safety strategies and protecting children from people or places that may hurt them
- not exposing children to their alcohol or drug use
- changing discipline strategies.

Repairing their relationship and bonding with their child may look like:

- engaging with and completing of parenting and attachment-based programs
- applying new skills learnt
- showing increased empathy and understanding for their child
- demonstrating increased ability to respond to cues and emotional cues from their child.

Responding to relapse

It is important for the parent to be working with someone well versed in relapse prevention work. It will be the role of AOD professionals to work with parents through this.

Practice prompt

Do not judge parents. Be aware of language and how the words you use may be interpreted or reflect bias. Acknowledge that relapse can be a common experience in recovery.

Example:

I understand that overcoming your alcohol use is not an easy road and relapse can be a part of recovery.

I can only imagine how hard it was for you to tell me this has happened. Tell me what you're thinking and feeling about it.

Practice prompt

Make sure everyone knows why you are there. Reinforce to both parents and AOD professionals that your role is to keep children safe. When doing this, be up-front about your assessment of the child's safety and what it means for the family.

Example:

The great thing about having the right services involved means that we all have a job to do to help you make changes and to make sure [the child] is safe while it happens. We all need to be really clear about what we are doing and need to do—to make sure we do it.

I am worried that if you can't make changes to your current AOD use, it may not be safe for them to stay with you.

Practice prompt

Re-motivate and continue to help motivation grow. Discuss with the parent (at a time that feels right for them) the need to revisit the pros and cons for maintaining change.

Example:

We talked about what making changes would be like for you, both the positives and the challenges. I am wondering if we can have another look at these and what you would like to do to help get you back on track so [your child] is safe

Tip

Tools and worksheets to assist with motivation are available at the Smart Recovery Australia website.

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Page history

19 November 2019
Page created

Resources

Support services

Service finders

healthdirect is a free Australian health advice directory that helps people search for drug and alcohol treatment services in their area.

The Queensland Network of Alcohol and other Drug Agencies (QNADA) service provider helps people locate services in their area.

Queensland Health's ADIS 24/7 Alcohol and drug support (1800177 833) offers support, information, advice, crisis counselling and referral to services in Queensland.

Queensland Health Alcohol, Tobacco and other drugs offers support and resources.

These self-help services provide support and access to local meetings:

- Alcoholics Anonymous Australia
- Narcotics Anonymous Australia
- SMART Recovery.

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Page created

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Page history

19 November 2019
Page created