



Alcohol and other drugs (AOD) in child protection Practice Paper

1. Introduction

This practice paper explores how children and young people are impacted when their caregivers (parents, guardians and carers) engage in AOD use. It also considers children and young people in care who engage in AOD use.

AOD use refers to the use of alcohol and/or other drugs that are used illicitly. Substances may be legal or illegal. This includes prescription medication obtained illegally or not used according to medical advice, or substances such as paint, glue, petrol or other inhalants not used in the manner in which they are intended.

Many families who come to the attention of the child protection system have caregivers who experience problems associated with AOD use, in addition to multiple other complex issues such as mental health difficulties, domestic and family violence (DFV) and intergenerational trauma that affects the safety and wellbeing of their children. Caregivers who have experienced trauma can develop a range of coping strategies such as using AOD. Those strategies become maladaptive when they affect a caregiver's functioning and ability to provide safe and responsive care to their children. Children and young people in care who have experienced developmental, complex or intergenerational trauma may have a negative internal working model and are more vulnerable to developing maladaptive coping strategies that put them at increased risk, such as using AOD. The [Trauma Practice Paper](#) provides further information in relation to trauma.

The social and emotional difficulties associated with experiences of colonisation, the Stolen Generations, loss and grief, racism, disconnection from culture, family and community, and the resulting intergenerational trauma that continues to have significant impact on the lives and wellbeing of Aboriginal peoples and communities needs to be considered when conceptualising AOD use for Aboriginal people.

This practice paper uses non-stigmatising language to describe AOD and problems associated with AOD use. Increased stigma may make people who use AOD feel unsafe and deter them from seeking services, which will negatively impact on their health and wellbeing and in turn, the health and wellbeing of their children. For more information on non-stigmatising language, see [The Power of Words](#).

Please note that in this document, the term Aboriginal refers to all people who identify as Aboriginal, Torres Strait Islander or both Aboriginal and Torres Strait Islander. This term is used as the First Nations Peoples of South Australia are predominantly Aboriginal peoples and it is their preferred term. We acknowledge and respect that it is preferable to identify Aboriginal peoples, where possible, by their specific Language group or Nation.

This practice paper should be read in conjunction with the [DCP Assessment framework](#).



2. The impact of AOD use on the brain and the body

AOD are psychoactive substances, meaning they alter the functioning of the central nervous system (the brain and the spinal cord). Consuming AOD alters the body physiologically and the mind psychologically by affecting perception, mood, consciousness, cognition and behaviour.

Psychoactive substances can be categorised in a variety of different ways, including by use (medicinal or recreational) or effect on the body (stimulant or depressant). Psychoactive substances target specific sites of action or receptors in various parts of the central nervous system and regulate how cells (neurons) communicate by affecting how they send, receive or process messages. Psychoactive substances can speed up or slow down our central nervous system and our autonomic functions, such as our blood pressure, heart rate, body temperature and respiration.

Psychoactive substances act on the brain's reward system the dopamine reward pathway (mesolimbic dopamine pathway) and increase dopamine levels that produce feelings of pleasure and mood elevation. Dopamine travels to the prefrontal cortex (mesocortical pathway) and creates a connection between using a drug and feelings of pleasure, which positively reinforces the use of AOD and AOD seeking behaviour.

AOD has both short-term and long-term physical consequences. The impact of AOD use is dependent on the substance used, with different types of drugs affecting the body in different ways. For example, stimulants (such as amphetamines or cocaine) can increase alertness and energy, enlarge pupils, increase sweating due to increases in body temperature and reduce appetite. Depressants (such as alcohol or opioids) will cause drowsiness, slow speech and confusion. The effects of AOD use can vary from person to person and are not necessarily predictable. More information in relation on the impact of AOD use can be found at the [Alcohol and Drug Foundation](#) website.

Over the long term, AOD use is associated with numerous health conditions and contributes significantly to the overall burden of disease.¹ Diseases associated with the use of AOD include many cancers, stroke, heart problems, dental issues, lung diseases, infections (for example, HIV or hepatitis), kidney and liver damage. AOD use places additional burden on health systems by contributing significantly to hospital admissions due to intoxication, injuries, overdose or other direct harms associated with AOD use.² While Aboriginal people are more likely to abstain from alcohol use than non-Aboriginal people, some Aboriginal people use AOD in ways that are harmful.³ AOD use significantly affects the health of Aboriginal people, with Aboriginal health being a key target area under the National Agreement on Closing the Gap.

2.1 AOD dependence

¹ Australian Institute of Health and Welfare (AIHW), Alcohol, tobacco & other drugs in Australia, <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts#disease>

² AIHW, <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/impacts/health-impacts>

³ AIHW, Aboriginal and Torres Strait Islander people, <https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/priority-populations/aboriginal-and-torres-strait-islander-people>



Dependence occurs when AOD use continues over time and the body and brain adjusts to use. It is important to note that not everyone who uses AOD has or will go on to develop dependence. AOD dependence can be characterised by a compulsion to seek and take AOD, even when continued use is causing problems or is harmful. Dependence occurs both physically and psychologically. Dependence may lead to include increased tolerance, prompting an increase in the level of AOD consumption to regain the original effects experienced. Other signs and/or symptoms of dependence may include cravings, an inability to limit use, unsuccessful attempts to cut down, control or cease use, giving up social, recreation or occupational activities due to AOD use and continuing use in spite of recurring physical or psychological issues.

3. AOD use and child protection concerns

AOD use becomes a child protection concern when a caregiver's ability to ensure the safety and wellbeing of their children is compromised and it causes harm or it places their children at risk of harm. AOD use can have a range of negative impacts on parenting including when a caregiver is affected by a substance (intoxication), post intoxication (coming down) or during withdrawal.

Problems associated with AOD may include use that affects a caregiver's capacity to provide consistent, responsive and emotionally attuned care. When a caregiver is using AOD, children and young people can experience harm as a result of acts of commission, such as a caregiver becoming aggressive and striking a child, or omission, such as a caregiver being unable to physically respond to a child or young person. Effects of AOD use on caregivers include irritability, aggression, paranoia, impaired judgement, reduced alertness and ability to provide care or unconsciousness.

Caregiver AOD use may affect their ability to meet a child or young person's basic care needs (for example, caregiver's not providing adequate food or clothing) or contribute to unhygienic or unstable housing or homelessness and financial uncertainty, due to caregiver's being unable to maintain employment or diverting financial resources to purchase AOD. Children and young people may also be at risk due to accidental ingestion of or exposure to a substance, needle stick injuries or access to other drug paraphernalia. Children and young people may be exposed to criminal behaviours or activity associated with the purchase or production of AOD that could pose risk of physical and emotional harm. Whilst caregivers are seeking or using AOD, children and young people may be inadequately supervised or left home alone. Children and young people may be vulnerable to harm perpetrated by others when caregivers are intoxicated or coming down.

It is essential that DCP practitioners consider and address AOD use when it is identified as a safety concern when undertaking safety planning with families, including consideration of the impact of AOD use on a carer's capacity to understand safety plans or to provide informed consent. For more information on safety planning, see the [Assess and establish safety](#) key step of the Intake, investigation and assessment chapter of the Manual of Practice.

3.1 AOD use in the antenatal period and for infants

AOD use in pregnancy directly exposes infants to AOD, which can result in a range of adverse outcomes including increased risk of miscarriage, premature or stillbirth and low birth weight. For Aboriginal children, being born healthy and strong is a key target area in the National Agreement on Closing the Gap. AOD use during pregnancy can lead to lifelong difficulties for children and young people such as developmental, health and behavioural issues that may not become apparent until children and young people are older.



Premature birth and low birth weight increases risks of [sudden unexpected death in infancy \(SUDI\)](#) and [sudden infant death syndrome \(SIDS\)](#). Caregivers using AOD and sleeping on the same surface as an infant (co-sleeping) is not recommended due to caregivers being less aware and able to respond to their baby. DCP practitioners should be aware of safe sleeping practices and can refer to the [Safe Infant Sleeping Policy](#) for more information.

Neonatal abstinence syndrome (NAS) occurs when babies are exposed to certain types of AOD in the womb and undergo withdrawal at birth. Exposure to alcohol in utero can result in [Foetal Alcohol Spectrum Disorder \(FASD\)](#), birth defects and alcohol related neurodevelopmental disorders. More information on FASD can be found at [NOFASD Australia](#) and at the [Alcohol and Other Drugs Knowledge Centre](#). Infants are particularly vulnerable to harm due to caregiver AOD use. Infants and younger children are entirely dependent on caregivers to meet their needs and if a caregiver's ability to meet those needs is impaired, infants are at greater risk of physical or emotional harm and neglect. AOD passes into breast milk and directly exposes breastfeeding infants to AOD. This may cause infants to be drowsy and feed poorly, affect their weight gain, disturb their sleeping patterns and can lead to long term behavioural issues. For more information on working with infants, see the [Working with infants Practice Paper](#).

4. AODs relationship to other risk factors

The co-occurrence of AOD use with other factors, such as mental health difficulties, DFV and unresolved trauma contributes to greater risk of harm for children and young people. Understanding the relationship between AOD use and other risk factors and how parenting capacity can be affected is critical for DCP practitioners undertaking child protection work.

It is important to recognise that AOD use and mental health difficulties often co-occur. People may engage in AOD use to 'self-medicate' and in turn, the AOD use may adversely affect mental health. Certain pre-existing symptoms of mental illness may be exacerbated or AOD use may lead to drug-induced mental illness. For further information in relation to mental health difficulties, see [Understanding mental health difficulties in a child protection context Practice Paper](#).

Where DFV is present, DCP practitioners are required to remain aware of the possible co-occurrence of AOD use and complexities associated with multiple and complex risk factors. Whilst AOD use may be associated with a greater risk of DFV, it does not cause or excuse acts of DFV. People who use DFV may use AOD to control victims by supplying AOD to create dependence or interfere with victims seeking or maintaining treatment for example. For further information regarding DFV, please see [Domestic and family violence Practice Paper](#) and see the [DCP Assessment framework](#) for information and guidance in relation to undertaking assessments that consider multiple and complex risk factors.

For some caregivers, a history of unresolved trauma including childhood harm and intergenerational trauma may lead to the use of AOD as a maladaptive coping strategy to minimise or avoid distress. It is likely that caregivers will continue to engage in AOD use to manage their emotions until they are able to engage with therapeutic support to develop and utilise alternative coping strategies.

5. Assessment considerations for caregivers

DCP practitioners must assess the effect that a caregiver's AOD use has on their ability to safely parent and meet the child or young person's basic and unique needs. It is essential that any assessment also considers the presence of other risk factors such as those detailed above.



Engaging with a caregiver to explore their AOD use is critical to informing a comprehensive assessment of the presenting concerns. DCP practitioners need to develop a relationship with caregivers to support open and honest communication about their AOD use. There are a number of barriers for caregivers being able to talk about AOD use including shame, stigma, fear of possible legal consequences, fear of their children being removed, or not being returned to their care. For Aboriginal families the history of past practices of child removal may significantly affect their ability to trust and engage with DCP practitioners. It is critical that DCP practitioners engage in principles of relationship based practice to build relationships with caregivers and families. For more information on building relationships and relationship-based practice, see [Relationship Based Practice Practice Paper](#).

The [DCP Assessment framework](#) (see [Appendix E](#)) outlines specific considerations to explore with caregiver's when assessing AOD use, these include:



It is necessary for any assessment to consider each caregiver (or other household members) individually, as not all adults may use the same AOD in the same quantities or with the same frequency. It is also essential to consider the caregiver's insight and understanding of their AOD use and how it affects their functioning, parenting and their child/ren. It is vital that DCP practitioners consider a caregiver's readiness, capacity and motivation to change their AOD use, acknowledging change as a process, rather than a single event. Identifying a caregiver's stage of change supports DCP practitioners to make holistic assessments, identify appropriate interventions, undertake case planning and make timely decisions. More information in relation to Change Theory can be found in the [Change theory Practice Paper](#).

When undertaking assessments, it is imperative that DCP Practitioners consider and critically reflect on their own biases in relation to AOD use. DCP practitioners are strongly encouraged to engage in ongoing case consultation with senior practitioners, supervisors, practice leaders and cultural experts (such as Principal Aboriginal Consultants or [DCP Multicultural Services](#)) to consider information gathered and reflect on bias. For more information in relation to bias, see the [Bias in child protection practice Practice Paper](#).

Where it has been assessed that AOD use is affecting a caregiver's parenting, a referral for a specialist AOD assessment is required. Whilst this will not assess parenting capacity, it can contribute to an overall assessment by providing further information in relation to current and historical AOD use, triggers for use and previous attempts at rehabilitation. Further information in relation to AOD assessment can be found in the 'Alcohol and/or other drug assessment' subsection of the [Conduct additional assessments and interventions relating to parents and caregivers](#) section of the Intake, investigation and assessment chapter of the Manual of Practice.

5.1 AOD testing



AOD testing is a tool that can contribute to the assessment of the impact of a caregiver's AOD use on the safety and wellbeing of a child or young person in their care. AOD testing can provide information on the type of AOD used in a certain time prior to the test occurring. It is important to understand that AOD testing does not provide information on the amount or frequency of use or the extent of a caregiver's dependence on any particular substance. Timeframes for the detection of AOD use can vary and can be short for some substances. Therefore, consideration of other information and assessments is required to determine the extent of AOD use and the impact of AOD use on the child or young person.

Careful consideration should be given to the frequency and duration of testing. For example, a one-off test may be useful to confirm a caregiver's disclosed AOD use. A schedule of testing may be necessary if a caregiver denies current use despite there being indicators that use is continuing (such as CARL notifications, SAPOL reports, DCP case worker observations or drug paraphernalia observed in the home) or are returning positive tests. Random testing is preferred, as this increases the likelihood of AOD detection and decreases opportunities for test manipulation.

Urinalysis is the most common and preferred method of testing due to collection being non-invasive, providing accurate results and being readily available and cost efficient. The Australian Standard (AS/NS 4308) provides a procedure for the collection of urine samples and the detection of a variety of drugs of abuse. Organisations undertaking urinalysis need to be accredited to meet the standard and therefore chain of custody requirements. Urinalysis testing is undertaken using an initial immunoassay-screening test, which indicates whether a certain drug class is detected. If this determines a 'non negative' in a certain drug class, then further testing is undertaken using a GC/MS (gas chromatography and mass spectrometry) method. The GC/MS method is able to confirm the result and to provide detailed information on the specific substance present in the sample.

When collecting a specimen, a number of sample checks are undertaken to ensure the sample is not adulterated. This includes checking the temperature at time of production, the colour of the urine and creatinine levels. Creatinine is a by-product of muscle tissue and is excreted in consistent amounts in urine each day. Checking creatinine can determine whether the urine is human in origin and whether the sample has been adulterated in some way. This may include a person drinking large volumes of water in the hours before the test or having added water to the specimen container in an attempt to reduce the level of substance in the sample. If creatinine levels are lower than expected, this information is provided in the test report.

DCP practitioners should also recognise that AOD testing is facilitated by mainstream health services and organisations. It is essential that DCP practitioners consider the barriers that Aboriginal people may face in accessing these services including a mistrust of mainstream health care.

For more information in relation to AOD testing, see the 'Alcohol and/or other drug testing' subsection in the [Conduct additional assessments and interventions relating to parents and caregivers](#) key step in the Intake, investigation and assessment chapter of the Manual of Practice.

6. Considerations for Aboriginal people

For Aboriginal families, children, young people and caregivers, the experience of intergenerational trauma, loss and grief, racism, disconnection from culture, family and community has ongoing impacts and can manifest in a range of ways including problems associated with AOD use. Problems associated with AOD use in turn affect the emotional, physical and spiritual wellbeing of Aboriginal people and can further increase



their sense of grief, loss, isolation and disconnection from family, Community and culture. AOD use affects the ways that Aboriginal caregivers are able to fulfil their traditional roles in raising children, so increases the likelihood that Aboriginal children and young people are further disconnected from family, Community and culture.

It is critical that DCP practitioners work in culturally safe ways when working with Aboriginal people. Consultation with a Principal Aboriginal Consultant can support DCP practitioners to develop and maintain relationships with families and/or children and young people and support culturally safe practice. Family led decision making principles should be utilised to engage family participation in all significant decisions relating to Aboriginal children and young people. Working in partnership with Aboriginal families demonstrates that families are the experts in their lives and that they hold valuable information to support the safety of children and young people when caregivers are using AOD. Collaboration and consultation with Aboriginal family members, relevant community members or Aboriginal Community Controlled Organisations (ACCO) supports engagement, assessment, intervention and treatment planning with caregivers or Aboriginal children and young people in care.

Refer to the [Practice Principles – Cultural safety pillar](#), the [Aboriginal and Torres Strait Islander Child Placement Principle Practice Paper](#) and the [Family Led Decision Making for Aboriginal families Framework](#) for further information.

7. Considerations for people from a culturally and linguistically diverse (CALD) background

CALD communities may experience unique challenges that impact on their vulnerability to problems associated with AOD use. Vulnerabilities for families from CALD backgrounds may include racism, loss and grief, isolation and disconnection from family, culture and community, previous trauma experiences, undiagnosed mental health difficulties, disconnection from the dominant culture, stress relating to uncertain visa status, socio economic disadvantage and unemployment. It is important to recognise that there is significant diversity among people from CALD backgrounds and within CALD families, communities and cultural groups. Therefore, it is critical DCP practitioners explore cultural norms and values on an individual basis including health beliefs and beliefs about AOD use. Perceptions of AOD use for some CALD communities can be embedded in stigma and shame, so AOD use may be hidden or kept secret within a family, resulting in family conflict or breakdown. Families may also be fearful of gossip or community backlash that may impact their ability to be transparent about AOD use and its impact. Consultation with DCP [Multicultural Service](#) is recommended when working with people from CALD backgrounds.

For more information on working with CALD communities, see [Working with cultural diversity Practice Paper](#).

8. AOD use by children and young people in care

It is common for young people to experiment with AOD especially during adolescence. Adolescence is a time when young people take risks, explore their identities and relationships, and increase their sense of independence. For young people, the use of AOD in adolescence has been found to increase the risk of developing problems associated with AOD use in later life, including dependence and physical and mental health difficulties.⁴

⁴ <https://www.msmanuals.com/professional/pediatrics/problems-in-adolescents/drug-and-substance-use-in-adolescents>



The pattern and route of administration of AOD for young people may vary from that of adults. Young people may use a variety of language or terms to refer to AOD use or various types of AOD (for example, Aboriginal young people may refer to cannabis as Yarndi or Gunja). The language and terms used to refer to AOD can change over time, so it may be helpful for DCP practitioners to clarify with children and young people the meaning of the language or terms they are using. More information on terminology and slang relevant to AOD can be found at [Dovetail AOD Acronyms and Slang Dictionary](#).

For children and young people in care, the impact of trauma means that emotional, social and cognitive development may be behind that of their same age peers. Experiences of trauma, attachment difficulties and negative internal working models compound the vulnerability of children and young people in care, leaving them at increased risk of AOD use and of physical, sexual and emotional harm associated with that use. Children and young people in care are often operating from a place of feeling unsafe, fearful, disconnected and helpless. AOD use, like other high-risk behaviours, may be a way of communicating underlying unmet needs. Children and young people in care may use AOD to seek connection to peers or others, to help them feel good or to numb negative emotions or memories. For more information, refer to the [Iceberg model fact sheets](#).

For Aboriginal children and young people in care who use AOD, connection to family, Community, Country and culture is essential to support positive outcomes and enhance social and emotional wellbeing. DCP practitioners must make active efforts to adhere to the precursor and five elements of the Aboriginal Child Placement Principle when working with Aboriginal children and young people in care. Please refer to the [Aboriginal and Torres Strait Islander Child Placement Principle Practice Paper](#) for more information.

It is vital that DCP practitioners engage with the child or young person who uses AOD to understand that child or young person's underlying needs. It is crucial that DCP practitioners develop strong and meaningful relationships with children and young people to effect change. This will support ongoing assessment and the development of strategies and interventions as part of the case planning process. For more information on relationship-based practice, see the [Relationship Based Practice Practice Paper](#). For information on engaging with children and young people, refer to the [Seek the views of the child or young person](#) key step in the Supporting children and young people in care chapter of the Manual of Practice and the [Case planning, review and annual review chapter](#) of the Manual of Practice for more information on case planning.

It is important to engage with the child or young person about their use of AOD when they are calm and better able to reflect. When children and young people are intoxicated, it is important to remain calm and focus on their immediate physical and emotional safety and basic care needs, including seeking medical attention if necessary. Children and young people who are intoxicated are unlikely to be able to focus on discussions of the risks and consequences associated with their AOD use. For information on supporting children and young people in DCP Residential Care who use AOD, see the 'Support children and young people with high risk and complex behaviours' subsection of the [Support children and young people in residential care](#) key step of the DCP Residential Care chapter of the Manual of Practice.

Working with children and young people in care who use AOD requires a collaborative and coordinated care team approach. It is vital that the child or young person's carers, whether family based or residential care staff, are actively involved in the care team. Carers provide day-to-day care for children and young people and are able to provide an invaluable understanding of the child or young person's needs, strengths and behaviours, which is central to case planning and decision-making. For further information, refer to the [Supporting and collaborating with carers Practice Paper](#). The [Supporting children and young people in care with high risk and complex behaviours Practice Paper](#) provides further information on working with children and young people in care who engage in high-risk behaviour such as AOD use.



9. AOD interventions and treatment

Harm minimisation has been a nationally agreed approach to AOD intervention and treatment since the 1980s. Harm minimisation concentrates on strategies that reduce harm to both the individual and to society.

AOD treatment services support people who use AOD to meet treatment objectives such as reducing, stabilising or ceasing AOD use, as well as focusing on improving health and wellbeing. Balancing harm minimisation, abstinence, relapse and child safety can present challenges and cause tension. It is critical that DCP practitioners clearly articulate what needs to change to ensure the safety of and reduce the risk of harm to the child or young person. To support this, it is essential that case planning actions and goals in relation to AOD use are transparent and plainly articulated to both caregivers and AOD service providers. This will ensure an alignment of treatment objectives and support a focus on the safety of children and young people as the paramount consideration.

DCP practitioners should support children, young people and caregivers to be aware that there are treatments and interventions available that can support them to make changes to their AOD use. The Alcohol and Drug Information Service (ADIS) run by Drug and Alcohol Services South Australia (DASSA) provides people who use AOD, their families and health professionals with information and referral pathways to support changes to use. For more information on ADIS, see the [Alcohol and Drug Information Service \(ADIS\)](#) web page. Information about treatment and support services can also be obtained through the [Know Your Options](#) website.

It is essential that DCP practitioners understand AOD use through a trauma lens. This requires consideration of the child or young person or caregiver's trauma history. For caregivers or children and young people in care who have experienced multiple and/or complex risk factors, ongoing therapeutic support maybe necessary to address underlying and co-occurring issues alongside their AOD use. For more information in relation to trauma informed and responsive practice, see the [Trauma lens - Practice Paper](#).

For Aboriginal people, treatment and recovery may need to encompass a holistic approach to spiritual, emotional, physical wellbeing and healing rather than AOD treatment alone. For Aboriginal people, healing is supported by connection to family, kin, Community and culture. It is essential that DCP practitioners engage in family led decision making when considering treatment, interventions and case planning with Aboriginal families. Consultation with Principal Aboriginal Consultants is recommended to support culturally safe practice. In collaboration with families, exploring referral to culturally appropriate and responsive AOD services can assist to support long-term recovery and healing. However, some Aboriginal people may not wish to engage with certain Aboriginal AOD services due to having connections within that service and being concerned about confidentiality. For Aboriginal people, treatment and recovery may also include traditional healing practices as well as cultural traditions (such as returning to country or storytelling and narrative therapies). For more information on family led decision making with Aboriginal families, see the [Family Led Decision Making for Aboriginal families Framework](#).

9.1 Withdrawal management

Withdrawal occurs when a dependence on AOD has developed and use has decreased or ceased. Withdrawal symptoms present as the central nervous system and the body adjust to functioning without AOD. Symptoms may be mild or severe and in some circumstances may lead to seizures, delusions and hallucinations with potential for fatality.

Factors that influence the severity of withdrawal include:



- duration and frequency of use
- type of drug and whether other AOD are also being used (polydrug use)
- physical and mental health (comorbidity with medical and psychiatric conditions)
- the way cessation occurs (gradually or abruptly).

Withdrawal management (or detoxification treatment) supports people dependent on AOD to manage the symptoms of withdrawal, to prevent complications and to plan ongoing treatment to avoid relapse. Withdrawal management can occur in both clinical and community settings depending on individual circumstances, health risks and the likely severity of withdrawal. Home based withdrawal can occur where mild to moderate symptoms are likely and withdrawal is unlikely to be complicated and can be managed without admission to a clinical setting. Support can be provided by medical professionals such as a GP and a nurse and would include support from a family member or friend where a safe and supportive home environment is available. Specialist withdrawal services provide care when symptoms are likely to be more severe or complex. Specialist withdrawal services require an inpatient stay of a minimum of five days and have medical professionals available on site. Hospital based withdrawal may be recommended when there are significant medical or mental health difficulties which co-occur with AOD use and the risk of withdrawal is severe and likely to be complicated. Consultation with medical professionals or AOD specialist services is important to ensure that withdrawal treatment is managed appropriately and meets the person's needs. For more information, see SA Health web page [Substance withdrawal management](#).

9.2 Pharmacotherapy

Pharmacotherapy is the use of prescribed medication as an intervention or treatment for AOD dependence. Pharmacotherapies are used to manage withdrawal symptoms and cravings to maintain abstinence and therefore decrease the likelihood of relapse. For example, opioid replacement therapy (ORT) may be used to replace heroin, codeine or other opioid-based drugs with a prescribed alternative. Pharmacotherapy options include methadone, buprenorphine or buprenorphine/naloxone (known as Suboxone). Pharmacotherapy is also available for the treatment of alcohol dependence. Pharmacotherapy is used under medical supervision and alongside other treatments such as counselling.

9.3 Psychosocial interventions

Engagement in individual counselling can support caregivers and young people who use AOD to modify behaviour, expand coping strategies, improve social functioning, enhance connection and identify strategies to manage the risk of returning to AOD use and the problems that are associated with that use. ADIS can support caregivers and DCP practitioners to identify appropriate referral pathways, such as DASSA services, other non-government AOD service providers, culturally specific services or AOD services provided by ACCOs.

Peer based self-help approaches such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and Self-Management and Recovery Training (SMART) are aimed at supporting continued abstinence and can be helpful in sustaining a longer-term recovery program.

Residential rehabilitation programs are long-term, structured programs that can last from 1 to 24 months. Programs are aimed at developing attitudes and skills to support long-term change and recovery. Residents engage in a variety of programs that can include education and employment skills, life skills, counselling, group work and relapse prevention.



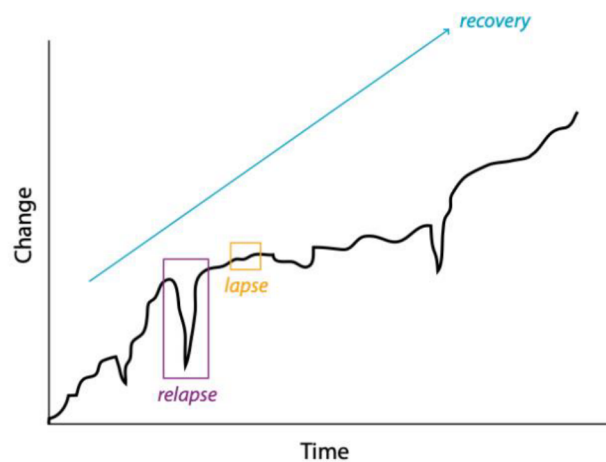
In South Australia, DASSA offers residential rehabilitation within a therapeutic community at the Woolshed. A video of residents experience at the [DASSA Woolshed](#) can be found by following the link.

10. Promoting recovery

It may take a number of attempts before a caregiver is able to maintain recovery. Recovery may be a long-term process and a caregiver's timeline for recovery may not be consistent with the child or young person's need for permanency. Permanency planning requires timely decision making consistent with the *Child and Young People (Safety) Act (2017)*. For more information in relation to permanency planning, see the [Permanency Planning Practice Paper](#).

10.1 Relapse prevention

Relapse prevention strategies are used to manage 'triggers' for AOD use and to build capacity to maintain change. Relapse prevention strategies support and promote recovery. The process of recovery is often not linear and setbacks can occur temporarily (a lapse) or for longer periods (a relapse). A lapse refers to a one-time step back on the recovery pathway. A relapse refers to a return to AOD use at previous levels or patterns of use and the re-experiencing of problems associated with that use. Experiences of lapses or relapses are common.



(Image taken from turningpoint.org.au)

There are a range of circumstances that may cause a lapse or relapse in AOD use. These include (but are not limited to) situations with people and in places where AOD was previously used, past trauma or circumstances that trigger AOD use as a coping mechanism, pre-existing mental health difficulties and physical health issues.

Relapses are an opportunity for learning and strengthening a commitment to change and adjusting prevention strategies to maintain long-term goals.



11. Reflecting on AOD use in practice

DCP practitioners are better able to develop skills when they engage in reflective practice as an individual as well as with their leaders and team. All DCP practitioners are encouraged to seek feedback in relation to their practice when working with children and young people or caregivers who use AOD, and to reflect on and discuss their progress in supervision.

In supervision or a team meeting, discuss one of your cases and consider the following (where relevant):

- What impact is the caregiver's AOD use having on the child or young person?
- What is the history of this family and what does it tell me about their AOD use?
- How have I engaged with this caregiver to understand and further my assessment of their AOD use? What questions have I asked?
- How can I show that I have collaborated with the caregiver to develop goals and actions for intervention and case planning?
- How have I expressed safety concerns and expectations? What has occurred to ensure these align to treatment plans?
- Have I consulted and how did that support my AOD practice?
- What is the history of the child or young person and what is their AOD use communicating to me?
- How can I attempt to safeguard the child or young person using AOD?
- What can I do to encourage the child or young person to develop different coping strategies?

12. Resource list

[Alcohol and Drug Foundation](#) - AOD resources and information

[Positive choices](#) - AOD information with specific information for parents and families, young people, Aboriginal people and people from CALD backgrounds.

[Cracks in the Ice](#) – information and resources about methamphetamines. Includes culturally specific information for Aboriginal people.

[Alcohol and other drugs knowledge centre](#) – provides culturally appropriate content in relation to AOD use among Aboriginal people.

[Dovetail](#) – provides advice and support to workers and services who engage with young people affected by AOD.

Document control

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