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Special situations, settings and groups

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Contraception

OVERVIEW

Choosing when and if to have children is an important decision. In Australia, different ways to prevent pregnancy are available and this is known as ‘contraception’. Each type has advantages and disadvantages. Contraception may also have other health benefits. This section describes different contraception options available in Australia for men and women.

COMBINED ORAL CONTRACEPTIVE PILLS

The tablet is taken by women, and is simply known as ‘the pill’. It contains small amounts of two hormones – progestogen and oestrogen.

How reliable are combined oral contraceptive pills?

Out of every 100 women using the pill, one or two might get pregnant in a year.

Key tips about the pill

- Needs to be taken every day (one tablet)
- Sometimes may cause: irregular bleeding, headache, feeling sick in the stomach (nausea), sore breasts, mood changes and pimples
- Cannot usually be used by women who:
 - Have had liver disease
 - Have high blood pressure
 - Smoke
 - Are over 35 years of age
 - Have had a blood clot or stroke
 - Have had breast cancer
 - Have had diabetes for many years
 - Who take some medicines for epilepsy
 - Have severe migraine with loss of sight
 - Are breastfeeding
- Health benefits include: more regular, lighter and less painful periods.

PROGESTOGEN ONLY PILLS

Progestogen only pills contain only one hormone and are used when women are breastfeeding or for women who are unable to take the combined oral contraceptive pill.

How reliable are progestogen only pills?

Progestogen only pills are not as reliable as the combined oral contraceptive pill. But they are still reliable if taken using the instructions from your doctor. Out of every 100 women using this method, two or three might get pregnant in a year.

Key tips about progestogen only pills

- Needs to be taken every day and at the same time (one tablet)
- Bleeding changes are common
- Safe to use when breastfeeding.

INJECTABLES ('DEPO')

Contraceptives that can be injected contain the progestogen hormone and are known as 'Depo' (Depoprovera). Depo is injected into muscles (most often on the bottom) every 12 weeks.

How reliable are injectables ('Depo')?

Because a woman does not need to remember to take a tablet, Depo is very reliable. Out of 100 women using this method, less than one might get pregnant in a year.

Key tips about Depo

- Injection needs to be made every 12 weeks.
- Bleeding changes are common, especially after the first injection.
- May cause: weight gain, mood changes and headaches. These side effects may take a while to settle down.
- Women may not be able to get pregnant straight away after stopping.

IMPLANTS

Implants contain the progestogen hormone. They are plastic rods about 4cm long that are put under the skin, often in the upper arm. In Australia, 'Implanon' is the available implant. Implants can be felt under the skin and are easily removed by a trained health professional.

How reliable are implants ('Implanon')?

Out of 100 women using this method, less than one will get pregnant in a year.

Key tips about implants

- Last for three years
- Bleeding changes are common
- May cause: weight gain, mood changes and headaches
- Needs to be inserted under the skin by a trained health professional.

INTRAUTERINE DEVICES (IUDS)

Intrauterine devices are placed inside the woman's uterus. There are two types: the copper type that lasts for 5–10 years (depending on the type) and the hormone IUDs that last for 5 years and contain progestogen.

How reliable are intrauterine devices (IUDs)?

They are one of the most effective forms of contraception. Out of 100 women using this method, less than one will get pregnant in a year.

Key tips about IUDs

- Needs to be inserted into the uterus by a specifically trained health professional
- Can last 5–10 years depending on the type
- May cause bleeding problems: copper IUDs can make periods heavier and hormone IUDs can make the periods irregular.

CONDOMS

Male condoms

Male condoms are usually made of latex rubber and stop the sperm from the man meeting the egg in the woman. They also help protect against sexually transmissible infections (STIs) (see STIs, p. 284). Condoms need to be put on the penis before any sexual contact is made. They are cheap and widely available to buy. Some men believe that they have less sensation during sex when using condoms but for most men this is not a problem.

Female condoms

Female condoms are made of plastic and sit inside the vagina. They have a ring at the top, which is placed inside and a ring at the bottom, which holds the condom outside the vagina. They prevent pregnancy by stopping the sperm meeting the egg, and also protect against STIs (see STIs, p. 284). Female condoms are available at chemists, but are more expensive than male condoms and not as easy to use or buy.

How reliable are male and female condoms?

Male and female condoms are not as reliable as pills, implants or IUDs.

Male condoms: out of 100 women, 15 will get pregnant in a year. If this method is used perfectly every time, two women will get pregnant.

Female condoms: out of 100 women, 5–15 will get pregnant in a year.

Key tips about male and female condoms

- Need to be used every time and in the correct way following the instructions
- Need male and/or female partners to work together to use them properly
- Helps to protect against getting STIs, including HIV.

EMERGENCY CONTRACEPTION (THE MORNING AFTER PILL)

If a woman has sex without protection, emergency contraception is available to help prevent pregnancy. Two options are available:

- Taking a pill called ‘Postinor’ – contains a progestogen hormone and can be bought from a chemist
- Getting a copper intrauterine device inserted by a doctor.

How reliable is emergency contraception?

Emergency contraception is not as reliable as using condoms, pills or other methods described above. The morning after pill will prevent about 3 in 4 pregnancies.

Key tips about emergency contraception

- Taken after sex to prevent pregnancy
- Should be taken as soon as possible after sex and within five days
- Copper IUDs need to be inserted by a doctor within five days of sex.

STERILISATION

Female sterilisation

Women who are sure that they do not ever want to get pregnant can be sterilised using a procedure called a 'laparoscopy'. In this procedure, a camera is put into the woman's belly – and then clips are used to block the tubes, which carry the women's egg to her uterus. This prevents the sperm meeting the egg.

Male sterilisation

Men who are sure that they do not ever want to have children can be sterilised using a procedure called a 'vasectomy'. In this procedure, the tube that carries the sperm out of the scrotum is blocked. Vasectomies are usually done under a local anaesthetic. Three months after the operation the man needs to check that no sperm is able to get through the blockage to be sure that the operation has been successful.

Key tips about female and male sterilisation

- They are permanent options – as it is not usually possible to reverse either procedure.
- Both procedures involve surgery but male sterilisation can be done under a local anaesthetic.
- Neither method affects the ability to enjoy sex.
- There are no other side effects.

FURTHER READING

For fact sheets for clients and information for health professionals, see: www.fpnsw.org.au.
For other information see: www.fsrh.org.

Pregnancy, breastfeeding and early childhood

OVERVIEW

It is particularly important to understand substance use in pregnancy, because it can harm the unborn baby. It is even more important to know when to organise medical care to help a woman who is dependent on alcohol, opioids or benzos to stop safely. If the woman goes through withdrawals, this can harm the developing baby. Treatment can prevent withdrawals.

Sometimes if a mother is dependent on alcohol or a drug, the newborn baby may go through withdrawals. This is known as Neonatal Abstinence Syndrome (NAS) and can usually be treated.

It is also important to be able to advise a woman who uses alcohol or drugs on how to reduce the risks to her baby, when she is breastfeeding.

This section also has some tips to support families with young children to bring up strong children.

PREGNANCY

Pregnancy is a time when a woman needs to be encouraged to look at her substance use and make positive changes. During this time, problems can happen with the unborn baby (foetus) because of alcohol or drugs. The harms may be due to:

- The drug itself: different problems happen depending on when and what drugs the woman uses during pregnancy. For example, alcohol or other substance use early in pregnancy may be more likely to result in miscarriage or physical abnormalities, while later in pregnancy the risk may result in slowed growth of the foetus or even death of the unborn baby.
- Other substances mixed in with the drugs: illegal drugs are not chemically pure and may be cut with other unknown and toxic substances. These substances can be dangerous to an unborn baby.
- Withdrawal: the stress of the mother's withdrawal can be harmful to the baby.
- Neglecting care of oneself and from the risks typically seen with a lifestyle of using alcohol or drugs: women who are dependent on a drug may not eat a good diet and may be exposed to risky situations including violence.
- Where the mother is physically dependent on alcohol, or some other drugs (particularly benzos and opioids), the baby may go through withdrawal when born (Neonatal Abstinence Syndrome).

Alcohol and pregnancy

Drinking alcohol during pregnancy can lead to the following problems in the baby:

- Miscarriage, stillbirth, and premature birth
- Foetal Alcohol Spectrum Disorders (FASD), which can include problems with brain development, behaviour and abnormalities of the face (see FASD, p. 364 and p. 206)
- Babies who do not develop as well as others (e.g. slowed growth).

The safest option for pregnant women and women who are planning to have a baby is not to drink at all.

Tobacco and pregnancy

Carbon monoxide in cigarettes reduces the amount of oxygen getting to the baby, and increases the chances of the following problems:

- Miscarriage, stillbirth, and premature birth
- Problems with the placenta getting nutrients and oxygen to the foetus (placental insufficiency)
- Breathing problems and infections in the newborn baby
- Sudden Infant Death Syndrome (SIDS or 'cot death')
- Middle ear infections which can lead to hearing loss (otitis media)
- Babies born too small.

There is no safe level of smoking in pregnancy. The more cigarettes smoked the more likely the chance of problems. Even passive smoking in pregnancy and after birth increases the risk of SIDS (cot death), breathing problems, and chest infections in the baby.

Caffeine and pregnancy

Drinking large amounts of caffeine (600mg or more a day) during pregnancy may lead to the following problems in the baby:

- Miscarriage and stillbirths
- Lower birth weights.

Pregnant women should keep their caffeine down to 200mg daily (i.e. this is no more than one large cup of drip coffee or espresso; and this is the same as two cups of instant coffee, 3–4 cups of tea or cocoa, or three cans of cola).

Cannabis and pregnancy

There is not a lot of information about the effects of cannabis use in pregnancy. However, THC (the active ingredient in cannabis) can cross from the mother to the developing baby.

Cannabis use in pregnancy may lead to the following problems in the baby:

- They grow less well (e.g. weight and length)
- Birth defects
- Sleep problems
- Later problems with short-term memory and concentration.

People often mix cannabis with tobacco, which can further increase the harms. Any smoking can reduce the amount of oxygen and nutrients going to the foetus.

Opioids and pregnancy

Opioids (e.g. heroin, Oxycontin, codeine, morphine, fentanyl) are not linked to birth defects but the ‘highs and lows’ of intoxication and withdrawal can be harmful to the unborn baby. Withdrawal between doses can lead to miscarriage or a premature baby. It is important not to go ‘cold turkey’ in pregnancy. If a pregnant woman is in withdrawal (‘hanging out’), her unborn baby will also be hanging out and will not grow well.

Heroin and other opioid use may lead to the following problems in the baby:

- Miscarriage, stillbirth, and premature birth (particularly if opioid use is stopped suddenly)
- Infections from injecting which can harm the mother and the baby
- Poor growth before birth (i.e. the baby is small for how many weeks it has been growing)
- SIDS.

Methadone is safer for a pregnant woman than heroin because the woman is no longer cycling between intoxication and withdrawal. Her life is more stable and she can eat a proper diet. Also, while the woman is coming to get her methadone, the treatment team can help link her with health care for her pregnancy.

Stimulant use and pregnancy

Cocaine and amphetamines make the heart rate in the mother and foetus go up. The blood vessels in the mother and in the placenta get smaller (constrict), which then reduces the blood supply to the baby. This means that the baby then gets less oxygen and nutrients than are needed for healthy growth and it may be born small. If cocaine causes a blood vessel in the baby's brain to spasm, an area of brain can die, and this can lead to stroke (i.e. like in an adult). Cocaine and amphetamines may cause the placenta to break away from the wall of the womb (placental abruption). This is life threatening for the mother and baby.

We do not know a lot about the effects of ecstasy (MDMA) use in pregnancy. But because it is a stimulant it may cause harm. Ecstasy tablets also often contain other drugs that are more risky such as methamphetamine.

Stimulant use in pregnancy may lead to the following problems in the baby:

- Miscarriage, premature birth
- Slow growth (small for how many weeks the baby has been growing)
- Stroke or heart failure
- Deformities (heart, face, kidneys, arms, legs)
- Damage to baby's brain.

Benzos and pregnancy

Benzos cross the placenta and are passed from the woman to the developing baby. However, the risk to the baby is thought to be low. There may be a slight increase in the risk of cleft lip or cleft palate. This could depend on the amount of benzos used and at what time during pregnancy they are used. Benzo withdrawal can lead to miscarriage or premature birth, so it is important not to suddenly stop benzo use while pregnant.

Inhalants and pregnancy

Inhalants contain many toxic substances, which are harmful to both mother and baby. It is believed that nearly all inhalants cross the placenta and enter the baby's bloodstream. For this reason, it is important to stop using inhalants during pregnancy.

Inhalants can lead to the following problems in the baby:

- Premature birth
- Problems with brain development and later learning ability
- Breathing problems
- Increased risk of infection
- Neonatal Abstinence Syndrome (NAS).

Vitamins and medicines in pregnancy

Women with alcohol and other drug use issues may have lower levels of some vitamins and minerals. It is good for the woman to have a medical check-up when they find they are pregnant and to have some blood tests.

Vitamin supplements

- Folic acid is recommended before pregnancy and in first three months to prevent serious problems with the brain and spine (e.g. spina bifida). It is okay to take folic acid (also known as folate) throughout pregnancy.
- Other vitamin supplements may be needed if blood tests suggest levels are low (e.g. iron, vitamin D).

A woman should talk to a doctor about any medicines she is taking to check they are safe to take during pregnancy. Sometimes another medicine might be safer.

Tips for discussing substance use with pregnant women

- Shame and stigma might make it difficult for pregnant women to talk about their substance use.
- Avoid focusing on the substance use issues right away – get to know the woman first.
- Be positive when delivering messages about substance use and about any treatment options.
- It is important to look at what is happening in a woman's life and to look at the social or mental health issues related to her substance use.
- Partners and other family members are important to consider – including what alcohol or drugs they might be using.

Some of the following tips may help pregnant women give up or cut down on harmful substance use

- Talk about stressful issues with trusted women (e.g. aunts, sisters, grandmothers).
- Encourage other family members to give up or cut down their substance use.
- Try to 'get in touch' with her unborn child; for example:
 - Talk to the unborn baby and count their kicks.
 - Get copies of the baby's ultrasound images.
- Offer the pregnant woman encouragement for any changes they are able to make.

Antenatal care and child protection services

It is important that a woman see her doctor or midwife (i.e. to book in for antenatal care) as soon as they learn they are pregnant. This can help ensure the baby is as healthy as possible. It is also important that a woman sees her doctor if she has any unexpected symptoms during pregnancy or if she thinks the baby is not moving or not moving as much.

Some women attending drug treatment may worry about seeking regular help for themselves and their unborn baby (antenatal care) because they are afraid that their baby might be taken away by child protection services (see Protecting and supporting families, p. 369). However, if they do not enrol in antenatal care, then child protection services may be involved anyway. Therefore, it is important for mothers to get antenatal care.

HOW TO HELP A PREGNANT CLIENT WHO USES ALCOHOL OR DRUGS

Standard brief intervention and counselling approaches can be used (see Counselling, p. 20).

Treatments for alcohol

- Women who get withdrawals when they stop drinking (e.g. feel sick, get the shakes, feel jittery, sweaty and anxious) may be alcohol dependent. Pregnant women who get withdrawals when they stop drinking should seek medical help to stop drinking. This is especially important if the woman usually has seizures when she stops.
- Sometimes alcohol detox can be undertaken at home or as an outpatient in a clinic. It is better for pregnant women to detox in a hospital or detox centre. This usually takes about a week (see Alcohol withdrawal, p. 87).
- Relapse prevention medicines cannot be used during pregnancy because we do not yet know how safe they are (e.g. Campral, naltrexone, Antabuse).
- Other treatments can still be used, such as counselling and mutual support groups (e.g. Alcoholics Anonymous).

Treatments for smoking

- As well as standard brief intervention and counselling approaches, referral to smoking cessation groups or support options like Quitline (phone: 131 848) may also be helpful.
- Because pregnant women often feel guilty about their smoking, it is important to point out that every cigarette cut down is helping the mother and the baby. Stopping late in pregnancy is better than not stopping at all.

- Smokerlyzers are expensive; however, if available they can help show a woman how much carbon monoxide she has in her body and how much the baby will be getting from her smoking.
- Pregnant women could try going ‘cold turkey’ first, but those with higher levels of dependence can use short-acting NRT like gum, lozenges, microtabs and inhalers. Patches are generally not suitable for pregnant women, although sometimes a specialist may recommend them. If in doubt, you or the woman can ask her obstetrician for advice. Champix and Zyban are not used in pregnancy.

What to do if the woman cannot or will not stop smoking

- Women with babies need to be advised to go outside to smoke, to avoid smoking in cars and avoid smoke-filled places.
- Women with babies can put a jacket on over their clothes when they smoke and remove it before touching the baby.

Treatments for caffeine

Women who drink large amounts of caffeine may have withdrawal symptoms such as severe headaches and irritability if they suddenly stop. They should cut down gradually and can have decaf (decaffeinated) tea or coffee instead. Check with one of the agencies (p. 363) before using herbal teas (apart from chamomile or lemongrass which are fine to drink), because some herbal teas can be harmful during pregnancy.

Treatments for cannabis

- Counselling is the best available treatment for people who are dependent on cannabis. Finding new and healthier ways to deal with stress or boredom is important.
- A supervised medical withdrawal may help some women with withdrawal symptoms such as nausea and vomiting, anxiety, sleep problems and depression. Medicines to relieve these symptoms (e.g. Maxolon to reduce vomiting and diazepam to help with anxiety and sleep) are safe for short-term use in pregnancy (3–7 days).

Treatments for opioids

Pregnant women should not stop opioids (e.g. heroin or methadone) suddenly. Medical supervision is essential for the safety of the growing baby. Methadone is the best treatment for pregnant women who are dependent on opioids.

Methadone treatment

- Sometimes it takes a while for a woman to become stable on methadone and she might use heroin on top of her methadone. If this happens, encourage your client to smoke heroin rather than inject to reduce the risk of infections (e.g. endocarditis, blood infections). These infections are very serious in pregnancy.
- It is possible for women to be admitted to hospital for a few days to stabilise on methadone more quickly. If her partner or others living with her use heroin, they should also be offered methadone or buprenorphine because it is hard to stay clean if others around you are using.
- Some pregnant women worry about methadone treatment because it takes a long time to reduce off. But methadone is considered the safest treatment for opioid dependence in pregnancy.
- Clients may also have heard that pregnant women on methadone are automatically reported to the child protection agency. However, being on methadone does not mean an automatic report to the child protection agency; in fact it can show the agency the client is trying to get her drug use under control. If a woman feels pressured by the child protection agency to stop methadone, she can ask her doctor to ring her child protection caseworker.
- Women on methadone should sip their dose slowly and wait for 20 minutes before leaving the clinic or chemist. This may reduce the chance of vomiting in women with morning sickness. Your client can also get tips from their midwife about dealing with nausea.
- Pregnant women often have to increase their methadone dose because of changes to the body during pregnancy. You can reassure your client that withdrawal in the baby is not related to the mother's methadone dose.

Buprenorphine treatment

Because buprenorphine is a newer medicine, we still do not know a lot about how it affects the developing baby. Because of this, there are warnings about the safety of buprenorphine in pregnancy and some women switch to methadone. But some women stay on buprenorphine without any problems. It is best for the client to make the decision with her prescriber.

Treatments for benzos

Pregnant women should not stop taking benzos suddenly and should get medical advice. Benzo withdrawal in pregnancy needs to happen very gradually to avoid distressing symptoms for the mother and her unborn baby.

Some women can be weaned off benzos while still staying at home (in an outpatient setting) with medical supervision and counselling. But some women need the support and supervision of inpatient withdrawal.

Some women cannot manage to stop benzos completely before the birth; however, it is important to reduce down to the lowest possible dose. The baby's withdrawal is usually less complicated if the mother's benzo use is very low.

NEONATAL ABSTINENCE SYNDROME (NAS)

When a mother is dependent on alcohol or drugs and uses during pregnancy, the baby may go into withdrawal when they are born. This is known as Neonatal Abstinence Syndrome (NAS). NAS happens because the baby is no longer exposed to the substances taken during pregnancy. NAS can cause the baby to be unsettled and can affect feeding.

NAS may occur in babies when the mother has used opioids, benzos, alcohol, tobacco, inhalants, stimulants, and caffeine.

It is hard to predict whether or not a baby will get NAS. Reducing or stopping drugs other than methadone will help reduce the chance of the baby getting NAS and may reduce the severity of withdrawal symptoms in babies who get NAS.

What are the signs of NAS?

- High-pitched cry
- Irritability
- Tremors and jittering
- Sleep problems
- Stuffy nose
- Sneezing (this is a sign of NAS but can also be normal baby behaviour)
- Feeding difficulties (due to sucking problems)
- Tense arms, legs and back
- Poor weight gain
- Vomiting and diarrhoea
- Faster breathing
- Convulsions
- Skin irritation
- Raised temperature, sweating.

Most babies who experience NAS show signs 1–3 days after birth. But sometimes these signs do not appear until 5–7 days after the baby is born. The time it takes for NAS to show depends on the combination of substances used in pregnancy, particularly those used in the last three days before the birth.

NAS can last from one week to six months. The length of withdrawal also depends on the amount and type of drugs the baby has been exposed to.

How is NAS assessed?

Women who use substances during pregnancy, are on methadone or buprenorphine treatment, or are on benzo treatment may need to stay in hospital for 5–7 days after birth so that the baby can be monitored for NAS.

The baby is monitored every four hours and given a score for each symptom (using the Modified Finnegan Score). Babies may also experience these signs for other reasons, so the baby needs to be closely monitored, e.g. to make sure they do not have a fever. The baby is examined after a feed because false high scores can occur if the baby is hungry. Every baby will have an unsettled period each day. We need to keep this in mind so that normal newborn behaviour is not confused with NAS.

How is NAS treated?

If a baby has significant NAS (3 Modified Finnegan Scores of 8 or more in a row in 24 hours) they are given medicine, usually morphine and/or phenobarbitone (phenobarb). These medicines can be used separately or together depending on what substance(s) the baby has been exposed to during pregnancy.

Babies receiving NAS treatment are admitted to a nursery in hospital. Most babies respond quickly to treatment but it can take a few days for the baby to be well enough to be discharged or to be returned to the mother in the hospital ward. The medicine is usually reduced on a weekly basis until the baby is completely weaned off it. This can take quite a few weeks. Many parents are taught how to administer the medicine and how to continue giving it to the baby while at home.

NAS can make the baby very warm, so parents need to try not to use too many blankets or clothes on the baby. If a baby has a temperature over 37.5 degrees, seek medical help.

Medicines for the treatment of NAS

Morphine is an opiate medicine. Morphine is prescribed to treat the baby for opioid withdrawal, for example, if the baby has been exposed to methadone, heroin, morphine, codeine etc.

Phenobarb is an anti-convulsant and a barbiturate. Phenobarb is prescribed to babies who are withdrawing from substances such as benzos and alcohol.

Parents' feelings when their baby has NAS

It can be very distressing for the parent when their baby has NAS. They can feel a lot of guilt. These feelings are even stronger when parents are separated from their baby. One of your roles as a worker will be to support the parents through the baby's withdrawal.

BREASTFEEDING

General tips: breastfeeding and using alcohol or drugs

- Most substances pass into the breast milk. When a breastfeeding woman is prescribed any medicine it is essential to check that it is safe for use while breastfeeding. Contact the clinic, hospital or one of the agencies below if you are not sure about a particular medicine being taken and its effects on breastfeeding (see Further information, p. 363).
- If a breastfeeding woman uses cannabis, heroin, cocaine, amphetamines or inhalants, her breast milk needs to be expressed into a bottle for 24 hours and thrown away. During this time, the baby can feed on breast milk that has been previously frozen or on formula.
- If your client is intoxicated with alcohol or drugs it is important that they have someone who is not intoxicated to help them care for and feed the baby.
- It is important that someone who is sedated from alcohol or drugs does not sleep with the baby, in case they roll on the baby.
- For more information about breastfeeding, seek advice from a baby nurse or breastfeeding nurse, or from a baby or child health service.

Alcohol and breastfeeding

- The alcohol level in the mother's blood will be about the same as the baby gets in the breast milk.
- Drinking alcohol while breastfeeding can affect the baby's behaviour and development, and can cause problems with the baby's sleep.
- Drinking more than two standard drinks each day during breastfeeding can lead to less milk being produced, so the baby does not get as much milk as it needs.
- The safest option is for the woman to not drink alcohol during breastfeeding. In particular, women should avoid alcohol in the first month after delivery until breastfeeding is well established. If a woman does want to drink, she should:
 - Have no more than two standard drinks a day
 - Avoid drinking immediately before breastfeeding
 - Consider expressing milk before drinking.

Tobacco and breastfeeding

Nicotine can reduce the amount of breast milk that is produced and also change the taste of breast milk. Babies may fuss, struggle or refuse the breast because they do not like the taste. If the mother smokes more than 15 cigarettes a day, the baby can show signs of nicotine toxicity (e.g. vomiting after a feed, 'grey' skin colour, loose stools, increased heart rate and restlessness).

Caffeine and breastfeeding

Breastfeeding mothers who drink a lot of caffeine may report that their baby is jittery, colicky, constipated and generally unsettled. Caffeine may also reduce the milk supply and may contribute to an area of the woman's breasts being inflamed (mastitis). Heavy caffeine use can reduce the amount of iron in breast milk, which can then lead to the baby having a lack of iron and being anaemic.

Methadone or buprenorphine and breastfeeding

Methadone

Women can breastfeed when on methadone. A very small amount of methadone crosses into the milk; but the benefit of breastfeeding is better than a small amount of methadone getting into the breast milk. If the baby is being treated for NAS, the small amount of methadone in breast milk can help relieve the baby's symptoms. If the woman decides to wean suddenly, the baby's NAS medicine dose may need to change. The woman should let the baby's doctor know if she is planning to wean-off feeding the baby by breast.

Buprenorphine

There are warnings about buprenorphine use when breastfeeding; however, many women are breastfeeding on buprenorphine without any problems. The woman can discuss this with her prescriber or the baby's doctor.

Benzos and breastfeeding

Benzos cross into the breast milk; however, women on very low doses of benzos can breastfeed safely. It is important to talk with a baby doctor (paediatrician) about the mother's benzo dose while breastfeeding.

HEP C**Can hep C be passed onto babies from the mother?**

- Babies born to women who have hep C need to have follow-up blood tests when they are four months old and again at 18 months. The mother's antibodies to hep C will disappear from the child's blood by about 18 months; so then an accurate 'antibody test' can be done to find out if the baby has hep C.
- Children who have hep C at 18 months of age are referred to a specialist for follow-up. They may need monitoring or treatment.

Around 1 in 15 babies born to mothers with hep C have hep C passed onto them.

Can women with hep C breastfeed?

Women who have hep C can safely breastfeed. But if the nipples become cracked and bleed it is best to express the milk and discard it until the nipples have healed.

PREPARING FOR GOING HOME WITH A NEW BABY

When a woman and her baby are getting ready to go home, it is important to check that the parents understand:

- How to access family support programs and other community resources
- The importance of the baby's health record
- When to come back to the doctor or go to the early childhood centre
- How to give the baby medicine for NAS (if needed)
- How to register the baby for Medicare, birth certificate and Centrelink
- Safe sleeping for babies
- Emergency contact phone numbers (e.g. hospital, clinic or baby health centre).

EFFECTS OF ALCOHOL AND DRUGS ON PARENTING

Being intoxicated on alcohol or drugs can interfere with parenting. This can be a particular problem with alcohol and benzos, as these substances cause loss of inhibitions, and so loss of temper. Stimulants can also cause problems with anger management. It is not possible to provide safe parenting to children when a parent is intoxicated. If they cannot stop using, it is vital to get someone to care for their children while intoxicated. Withdrawal can also interfere with parenting; for example, causing the parents to be irritable (with alcohol or benzos) or have depression (with stimulants or cannabis). It is important to discuss these issues with the parents.

Safe sleeping for babies and children under the age of two-years

It is important that the newborn baby has a safe place to sleep. Bed sharing with the baby or nursing the baby in the parent's arms while affected by any substance could put the baby at risk of dying from either suffocation or overheating. It is important to have a cot for the baby to sleep in to prevent the risk of Sudden Infant Death Syndrome (SIDS).

To further reduce the risk of SIDS:

- Place the baby on their back to sleep
- Do not smoke around the baby
- Position the baby at the base of the cot
- Put the baby in clothes that may prevent overheating, like cotton
- Do not cover the baby's head.

If your client has any further questions on how to reduce SIDS, suggest that they ask their midwife or doctor or contact the SIDS foundation on 1300 308 307, or from the local clinic in smaller communities. Brochures about SIDS can be found at: www.sidsandkids.org/safe-sleeping/.

Supporting a family to care for a baby or young child

Early in life is when a child's sense of emotional wellbeing is strongly shaped. So supporting families with young children is an important way to help bring up strong children, and end up with young people who are able to cope with the stresses of life. People who have had a supportive and loving home life are less likely to run into problems with alcohol or drugs later in life (see Protecting and supporting families, p. 369).

Further information on drugs in pregnancy and breastfeeding

Australian Capital Territory

ACT Drug Information Service

Canberra Hospital

Ph: 02 6244 3333

New South Wales

Mothersafe

Ph: 9382 6539 (Sydney)

Ph: 1800 647 848 (Rest of NSW)

Northern Territory

NT Department of Children and Families

Web: www.childrenandfamilies.nt.gov.au/Families/

Queensland

Queensland Government Community

Child Health Service

Web: <http://www.health.qld.gov.au/cchs/default.asp>

South Australia

Women's and Children's Hospital

Ph: (08) 8161 7222

Victoria

Royal Women's Hospital

Ph: 03 8345 3190

Monash Medical Centre

Ph: 03 9594 2361

Western Australia

Women's and Children's

Health Services

Ph: 08 9340 2723

All states and territories

NPS Medicines Line

Ph: 1300 MEDICINE (1300 633 424)

FURTHER READING

For resources for health care workers and parents about Foetal Alcohol Spectrum Disorders: www.nofasard.org.

Information about SIDS and kids: www.sidsandkids.org.

Alcohol use in pregnancy and Foetal Alcohol Spectrum Disorders

OVERVIEW

Alcohol is a poison in pregnancy (a 'teratogen') that may damage an unborn child (foetus). It particularly affects the brain. When a woman drinks while pregnant, alcohol moves through her body ('circulates') in the bloodstream, and also enters the baby's bloodstream in the same concentration. So, the more a woman drinks, the higher the chance of damage to the unborn child. The range of clinical problems caused by drinking during pregnancy is described by the term Foetal Alcohol Spectrum Disorders (FASD). We need to do more to prevent FASD and also to support the families who are already caring for individuals with FASD.

How common is alcohol use during pregnancy?

In Australia, more and more women are drinking alcohol at risky levels. During pregnancy, drinking by women is also common – up to 7 in 10 women in some studies. About the same numbers of Indigenous and non-Indigenous women drink during pregnancy, but Indigenous women are more likely to 'binge' (i.e. have five or more drinks in a single drinking occasion). Because up to half of all pregnancies are not planned, many women may expose their unborn child to alcohol even before they realise they are pregnant.

HOW CAN ALCOHOL HARM AN UNBORN CHILD?

When pregnant women drink too much alcohol it can cause:

- Miscarriage, or for the baby to be born early (premature) or stillborn
- Damage to the developing brain of the child. This means that the child may have problems as they grow up with their learning, speech and language, school performance, behaviour and mental health.
- Problems with how well various organs in the body form and grow (including the heart, kidney, eyes and ears). This can cause poor health and problems with hearing and vision.

- Changes in the face: features such as small eyes, thin upper lip and a long, flat area between the upper lip and the bottom of the nose ('philtrum'). Note: birth defects and abnormalities of the face only result from exposure to alcohol during the first 12 weeks (trimester) of pregnancy, when body parts are forming (see FASD, p. 206).
- Damage to the brain – this damage may not be visible to health professionals even on brain scans, but changes to the cells and chemicals in the brain may cause problems with how the brain works.
- Poor growth before and after birth.



Note: the baby's brain grows rapidly throughout pregnancy and may be damaged by being exposed to alcohol any time during pregnancy.

HOW MUCH ALCOHOL IS HARMFUL TO THE UNBORN CHILD?

Not all women who drink alcohol during pregnancy will have an abnormal child. The likely damage depends on:

- The amount of alcohol the mother drinks
- How often she drinks
- The strength of the alcohol
- When the mother drinks during her pregnancy
- Whether the mother drinks throughout her pregnancy.

Damage can occur at any time in pregnancy

Drinking in the first three months of pregnancy can cause birth defects, altered appearance of the face (abnormal facial features) or damage to the developing brain of the unborn child. Although drinking in the last six months of pregnancy will not cause birth defects or alter how the child looks physically (their facial appearance), it may still damage the developing brain and result in problems with development and learning.

Certain factors in the mother determine how high a level of alcohol is reached in her blood, and therefore into the baby's blood. These factors include the mother's:

- Age
- General health
- Body make-up (its composition: fat, muscle)
- Liver function
- Genes (inherited traits can determine how alcohol is broken down in the body).

These factors make it hard to predict the harm that might be caused to the unborn child – so it is impossible to work out a safe level of drinking during pregnancy and we cannot experiment on pregnant women. The best advice is for women to avoid drinking during pregnancy.



Women should not drink alcohol during pregnancy or while breastfeeding – as recommended by the national alcohol guidelines published by the National Health and Medical Research Council of Australia.

WHAT ARE FOETAL ALCOHOL SPECTRUM DISORDERS?

The range of clinical problems that may be caused by drinking during pregnancy can be grouped using the term FASD. This includes three main clusters of problems:

Foetal Alcohol Syndrome (FAS)

Children with Foetal Alcohol Syndrome:

- Have abnormal facial features (small eye openings, thin upper lip and a flat area between the upper lip and the bottom of the nose)
- Are born small and may have poor growth in childhood
- Have a small head or problems with how their brain works (including problems with learning, movement, hearing or vision, behaviour or school performance).

Alcohol-Related Neurodevelopmental Disorder (ARND)

Children with alcohol-related neurodevelopmental disorder do not have the facial features described above for Foetal Alcohol Syndrome, but they have:

- Problems with how their brain works (such as problems with: lower intelligence, speech and language, academic achievement, memory, the ability to plan and carry out complex tasks – also known as 'executive functioning', attention deficit or hyperactivity, behaviour and social skills).

Alcohol-related birth defects (ARBD)

Alcohol use in pregnancy can result in problems with the development and growth of one or more of the body's organs (e.g. heart, lungs, kidneys).

What do we know about FASD in Australia?

We do not know how often FASD occurs in Australia because of under-diagnosis and under-reporting. Some Aboriginal workers report that many children are affected in certain communities.

What is the long-term outlook for children with FASD?

The damage caused by alcohol does not go away. Although we can help affected children to reach their potential, long-term studies show that many young people and adults with FASD will have problems with education, employment, drugs and alcohol, and mental health. Early diagnosis and assessment gives affected children the chance to access health and education programs.

HOW TO PREVENT FOETAL ALCOHOL SPECTRUM DISORDERS

What you can do for a pregnant client

When seeing a pregnant woman, health professionals should try to help women become aware of the harms of drinking during pregnancy, to themselves and their unborn child.

- *Ask* about their alcohol use.
- *Assess* and record the amount of alcohol they use .
- *Advise* that no alcohol is the safest choice in pregnancy. This is because we do not know what level of drinking is safe, that risk to the unborn child is hard to predict, and that alcohol may harm the unborn child.
- *Assist* women to stop drinking by offering positive reinforcement of their efforts to stop drinking, offering a brief intervention and advising that alcohol may harm the unborn child.
- *Arrange* further support or treatment if needed.
- *Note:* remember that there may be many reasons why a client drinks during pregnancy. You may be able to help lessen stresses, or help the woman find some other way to cope with them. It is important not to judge the woman because she may already feel shame or guilt about drinking in pregnancy.



Early diagnosis of FASD will enable the right help to be given to the child straight away and lessen the chance of problems later in life. It will also enable the mother to get help and may prevent the birth of another child with FASD.

Working with communities to prevent FASD

FASD does not occur in children whose mothers do not drink in pregnancy. However, it can be hard to start up efforts to get women to not drink during pregnancy. Some remote communities have asked their clubs not to serve alcohol to an obviously pregnant woman. Other communities have lobbied for alcohol restrictions or have become totally 'dry' communities. There are also education programs for teenage girls, older women and men to warn them about the dangers of drinking during pregnancy. Efforts to work with communities to change attitudes to drinking alcohol during pregnancy are needed – as is more education about the potential harms of alcohol to the unborn child.

FURTHER READING

Alcohol and Pregnancy Project (2009). *Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder: A resource for health professionals (1st revision)*. Perth: Telethon Institute for Child Health Research. See: www.ichr.uwa.edu.au/files/user5/2009_Revised_Core_web.pdf.

Protecting and supporting families at risk

OVERVIEW

Alcohol or drug misuse in parents can put children at risk. On the other hand, some parents are careful that their children are well looked after if and when they use alcohol or drugs. As health professionals, we need to be aware of what we can do to support families at risk. We also need to be aware of what the law and our workplace say we need to do to protect children.

In our work with families, we are also responsible for the safety of their children. This includes being alert to the needs of the children, and supporting parents to care for their children, e.g. helping parents work out how their behaviour may affect their children, and what they could do to make sure that their children's physical and emotional needs are met. In more extreme cases we may need to report concerns about a child's safety to the child protection agency. This chapter looks at how we can protect and support families at risk from alcohol or drugs.

TIPS FOR PARENTS ON HOW TO KEEP THEIR CHILDREN SAFE

As health professionals, we should aim to provide help earlier (early intervention) to make sure children are safe and to support families better.

A number of practical ideas can help keep kids safe if their parents use alcohol or drugs.

- Someone to look after the children: suggest that if the client is going to use alcohol or drugs that they ask someone they trust to look after their children.
- Parenting skills: some clients may have been exposed to poor parenting themselves (i.e. when they were children) or they may have been brought up in an institution. Other parents may have trouble looking after children who are more challenging. Try to link the client into a parenting program in your area. Sometimes these are informally offered (e.g. by cultural leaders or other strong parents) or as formal programs (e.g. like the Triple P Parenting Program). Ask your baby health centre or child health service what programs are available.
- If a parent is feeling stressed from looking after their children: they may be able to find a reliable relative or close friend to look after the child for a short time each week. This can stop pressures from building up.
- If the parent is ever in a crisis situation where they feel so stressed (e.g. because of a screaming child) that they feel at risk of hurting the child, they should leave the child in a safe place (e.g. in a cot or with a trusted adult) and step out of the room.

- If you are able to see the client in their own home, it can be easier to discuss practical ideas with parents on ways to look after their children. If you are not confident to do this, then perhaps another person from your team or region may offer this support with the family's consent.
- In some regions, there are services or programs to help couples or families under pressure, e.g. Brighter Futures in NSW, or Relationships Australia. Ask your baby health centre or child health service what programs are available.
- If a lot of the client's money is being spent on alcohol or drugs: help the client make sure that bills are paid automatically, either:
 - Direct from their Centrelink benefits (a free service called 'Centrepay'), or
 - As an automatic deduction from the client's bank account.
- If a lot of the client's money is being spent on alcohol or drugs: you can give them advice on how to budget and manage their money better. If there is a particular risk on payday, you might suggest that they give their key card to someone they trust. Or they could arrange for someone they trust to be with them to make sure money is spent on the family's needs first before being spent on alcohol or drugs.



Where to get help for parents in your area

Work out what supports are available for parents and families in your area. Larger cities may have a dedicated 'drugs in pregnancy' service. Ask your baby health centre or child health service what programs are available.

THE DIFFICULT QUESTION: WHEN TO DISCUSS A CLIENT WITH A CHILD PROTECTION AGENCY

All health workers have a role to play in protecting children from abuse and neglect. This means thinking about how a client's alcohol or drug use may affect their children's wellbeing or safety and it could mean looking out for obvious signs of abuse or neglect in a client's children.

Sometimes if health workers have concerns for a child's welfare, they may need to notify the child protection agency. Many years ago, reporting to a child protection agency was often done in secret without talking to the client. Now, where possible, health workers talk with clients about:

- The effect that the client's behaviour may be having on their children
- Whether the child protection agency needs to be involved.

It is important to remember that you would not talk with the client about your concerns if you thought it would put the child or yourself at risk. In this situation, you may find it helpful to talk first with your manager or supervisor before reporting to the child protection agency.

Child protection and the law

Child protection laws are different in each state and territory. In most states and territories, health workers are compulsory (mandatory) reporters. This means that health workers legally have to report to their local child protection agency if they believe a child is at risk of abuse or neglect. Note that a child usually means a person up to 18 years of age.

It is important to be aware of your legal responsibilities as a health worker. Talk to your manager or supervisor about how to find out what is needed to make a report, or what training is available to learn more about child protection issues. You can also contact your local child protection agency about training (see Contacts, p. 375).

What do I need to report?

Child protection laws generally cover cases about:

- Sexual abuse
- Physical abuse
- Neglect (physical or psychological)
- Emotional or psychological abuse
- Family or domestic violence.

If you have concerns about a pregnant woman and her unborn baby, it may be appropriate to discuss these with the local child protection agency. The aim of making a report would be to get early support and help for the woman to make sure the baby is safe when born. You may wish to talk to your manager or supervisor before making a report about a pregnant woman.

Am I breaking client confidentiality if I make a report to a child protection agency?

Some health workers may worry that they are breaking client confidentiality if they make a report to the child protection agency. However, health workers who report possible child protection issues are not breaking confidentiality, and are protected by the law. It is good to inform clients that you have a mandatory reporting responsibility so they know where they stand.

In some cases, the law says that health workers must share information with the child protection agency to help with their investigations. Talk with your manager or supervisor about what to do if you are asked to provide confidential information about a client in a child protection investigation.



For clients seeking help about alcohol and drug issues, it can sometimes be hard to work out whether you need to make a report to the local child protection agency. Ask your manager or supervisor for advice and more information about when you need to make a report.

DIFFERENT TYPES OF ABUSE

What is child sexual abuse?

Child sexual abuse is any sexual act or sexual threat made to a child or young person that causes them physical or psychological harm, or to be frightened, fearful or upset. It can happen to children of any age and in most cases the offender is known to the child.

There are different types of sexual abuse including those with no physical contact. Victims of child sexual abuse may be physically and/or psychologically pressured into sexual activity. In these situations, the child's young age or dependency on their caregiver or other authority figure is taken advantage of.

What is physical abuse?

Physical abuse is any physical harm made to a child or young person that is not an accident, and is caused by actions of a parent or other caregiver. Physical abuse often results in physical signs or marks. Examples include beating, shaking, biting, kicking, deliberate burning with an object, and attempted strangulation.

What is neglect?

Neglect happens when the parent or caregiver does not look after the child's basic physical needs such as:

- Food
- Clothing
- Keeping them clean and washed
- Having a home to live in
- Safety from harm, including appropriate supervision (e.g. keeping young children safe from roads and other dangers).

Neglect can also happen when a parent or caregiver does not look after a child's emotional needs. For example, the parent or caregiver may not give the attention and stimulation the child needs to thrive; they may not encourage, comfort, reassure, or accept the child. This form of neglect also includes regularly ignoring the child's signals of distress and pleas for help.

Neglect may or may not be done on purpose, but, like abuse, neglect can be serious and can have long-term negative effects on the child as they grow up. It is important to distinguish neglect from simple poverty, when a parent cannot provide for their child, even though they are trying hard to.

What is emotional or psychological abuse?

Serious emotional and psychological harm occurs when the behaviour of the parent or caregiver damages the confidence and self-esteem of a child or young person, resulting in possible trauma, or seriously affecting the child's emotional development. It can include when the only attention a child gets is when they are yelled at, or when the child is totally ignored even if afraid or upset.

This sort of abuse can harm the child's social, emotional, cognitive and intellectual development, as well as how the child relates to other people.

What is family violence?

Family violence (or domestic violence) is when a person uses abusive behaviour to keep control over their partner or other family members (e.g. wife, husband, girlfriend, boyfriend, children). It can include behaviour that makes a person frightened or makes them feel like they have to do something that the person says (intimidating behaviour). Family violence can include physical assault, sexual assault and/or psychological abuse.

Children and young people may experience harm from domestic violence on a number of levels. They may be:

- Direct victims of physical and emotional abuse. Child abuse is common in homes where domestic violence happens.
- Indirect victims (e.g. when trying to protect someone else from family violence or living in the same house where there is domestic violence).

HOW TO RECOGNISE FAMILY VIOLENCE OR ABUSE OF A YOUNG PERSON

Everyone whose work brings them into contact with children, young people and families has an important role to play in child protection. Workers may receive information that a child has been harmed or may be at risk of harm, or may make observations about a child's appearance, behaviour or family circumstances that causes them to be concerned about the child's safety.

Some signs (indicators) of child abuse and neglect may be enough to make workers have concerns, while others might be part of a puzzle that builds a picture of abuse or neglect.

Some general signs of abuse or neglect include:

- A child tells you of their abuse or neglect
- Someone else tells you about the abuse or neglect
- There is a history of abuse or neglect
- Parents appear unable to function well enough to look after their children
- Sometimes a child's behaviour might be unusual – for example, very withdrawn, strangely well behaved, inappropriate sexual talk or behaviour, physical violence towards other children or animals. These behaviours are not always because of abuse or problems in the family, but are a reminder to consider that possibility.

Trying to work out if a child's safety is at risk can be difficult. It can be important to identify appropriate people who you can talk to about these issues. You may be able to get advice from a senior clinician in your service or you may be able to discuss the case with child protection services or another advisor without mentioning the client's name. It is important that you carefully weigh up the desire for confidentiality against the risks to the child.

HOW TO MAKE A REPORT

Making a report to the child protection agency is different in each state and territory. In some parts of Australia there is one central number to call to make a report. In other places there is a local office to call to make a report.

Contact details for child protection agencies in Australia

Australian Capital Territory

Office for Children, Youth and Family Support

Ph: 1300 556 729

For mandatory reporting,

Ph: 1300 556 728

www.dhcs.act.gov.au/ocyfs

New South Wales

Family and Community Services

Ph: 132 111

For mandatory reporting,

Ph: 133 627

www.community.nsw.gov.au/preventing_child_abuse_and_neglect.html

Northern Territory

Department of Children and Families

Ph: 1800 700 250

www.childrenandfamilies.nt.gov.au

Queensland

Child Safety Queensland

Ph: 1800 811 810

www.communities.qld.gov.au/childsafety

South Australia

Department for Education and Child Development, Families SA Child Abuse Report Line (for mandatory reporting) Ph: 131 478

Ph: (08) 8226 8800

www.dec.d.sa.gov.au/speced2/pages/childprotection/

Tasmania

Department of Health and Human Services – Child Protection Services

Ph: 1300 737 639

www.dhhs.tas.gov.au/children/child_protection_services

Victoria

Department of Human Services – Children, Youth and Families

Ph: 131 278

www.dhs.vic.gov.au/for-individuals/child,-youth-and-family-services/child-protection

Western Australia

Department for Child Protection

Ph: 1800 622 258

For mandatory reporting

Ph: 1800 708 704

www.dcp.wa.gov.au

Tips for making a report to child protection

- Be aware of what you legally have to report in your state or territory.
- Prepare the information required by the child protection agency before you call. For example:
 - The client and child’s personal details
 - Your concerns for the child, and what led you to have these concerns, e.g. this might include signs of potential abuse or neglect you have seen, such as: bruising on the child, signs of the child not getting enough nutrients either from not eating enough or not eating good food, or things the client or the child has said.
 - You will also need to say when you saw the things that concern you.
- When making a report it is important to describe why you are concerned that the child is being placed in an unsafe situation, e.g. because of their parents’ alcohol or drug issues.
- Talk to your manager or supervisor before calling (where possible or appropriate).
- You will usually need to fill out some forms either to send to the agency or for your own records. Make notes about the report in the client’s file.



To find out what information is needed to make a report, contact your local child protection agency or visit the National Child Protection Clearinghouse website which has information sheets for each state and territory (www.aifs.gov.au/nch/pubs/sheets/menu.html).

WHAT HAPPENS AFTER YOU MAKE A NOTIFICATION

The child protection agency will decide whether the matter needs to be investigated. If this happens, the child protection agency may work with the family and other agencies (e.g. schools, health workers) to find out what is happening for the child (or children). Remember that your piece of information may be one piece in a jigsaw puzzle.

The child protection agency may work with the family in order to make the child safe again. The family may also be referred to other agencies for support and help. In extreme situations, children may no longer be able to live with their parents, and alternative caregivers may be found. Ideally these caregivers would be other family members or local community members.

What to do if you do not hear back from the child protection agency

When you make a report to the child protection agency, they may contact you for more information or ask you to attend a case meeting so a plan can be developed with the family to make the children safe. If you do not hear back from the agency, you can call them to ask what progress has been made about your report. If you are concerned about other issues or new incidents that may be affecting the children's safety, it is important to make a new report.

HOW CAN I SUPPORT A CLIENT IF THEY HAVE HAD A CHILD REMOVED?

Sometimes the parents' lifestyle means that they are unable to care for their children into the future and the children need to be placed in the care of someone else on a permanent basis. Where parents have had children removed in the past, in order to get their children back, or to keep looking after a new baby, they may need to demonstrate what is different about their life that means their children will be kept safe.

If a parent wants to have their child or children returned to their care, it is important for them to understand what needs to be different before the child protection agency or court will allow the child to return home. You may be able to help parents work with the child protection agency to get their child returned to them (e.g. by passing on positive information to the agency about things the parents have done to address their children's safety, or by supporting the parents as they seek legal advice or representation in the Children's Court). It is also a good idea to get to know your local child protection agency or workers, so you can work together to protect children and support families.

FURTHER READING

National Child Protection Clearinghouse resource sheets. These provide information about different child protection issues in Australia, as well as for each state and territory. See: www.aifs.gov.au/nch/pubs/sheets/menu.html.

National Association for Prevention of Child Abuse and Neglect (NAPCAN). This website includes brochures that can be downloaded, as well as brochures and other resources that can be ordered for a small fee. See: www.napcan.org.au.

Parentline provides phone counselling, support and parent education at the cost of a local call. See: www.parentline.com.au.

Preventing alcohol or drug issues among young people

OVERVIEW

Prevention typically targets young people who have not yet starting using alcohol or other drugs. Or sometimes it targets groups of young people, where there is a mix of non-users, sometimes users and regular users. Prevention can happen anywhere, in any setting, and is not just provided by health services/staff. It is important to have a range of holistic prevention measures that do not just involve giving facts about alcohol or drugs. Keeping young people, families and communities strong is important. Measures that make alcohol or other drugs less available to young people also have a role.

HOW TO PREVENT SUBSTANCE MISUSE AMONG YOUNG PEOPLE

Prevention can happen in many different settings (e.g. youth groups, youth camps, community), not just in school. Sometimes the young people most at risk of alcohol or drug problems are those who are not attending school or do not like the school setting. Bush camps can provide a setting where young people can receive education about alcohol or drugs in a culturally appropriate setting. Even for young people from cities, the bush provides a peaceful setting, away from distractions. It also provides an opportunity for young people to learn about culture. This can help to give them a stronger sense of who they are and of their belonging. The bush setting also provides the opportunity for relaxed one-on-one talking.

Prevention may not be delivered by alcohol and drug workers or other health workers by themselves, as it is the role of whole communities and a range of services (health, education, law, licensing etc.). Sometimes even punishment and policing can help prevent a person taking up a drug, or can move a 'sometimes' user away from drugs.

Prevention can aim to stop young people ever beginning to use a drug (whether that is tobacco, alcohol or other drugs). It can also aim to stop occasional users ('sometimes mob') becoming regular users ('all-the-time mob'). For young people who already have a substance use problem, any of the measures below may help them shift back to becoming occasional users or non-users.

Prevention can include a range of different approaches

- Education on the harms of alcohol or drugs is useful, but may not always work, especially when education is given on its own. It needs to be part of a holistic approach that also involves other support mechanisms. The value of education also depends on who is providing the education, e.g. how comfortable they are, is there a language barrier, how up-to-date and relevant the information is that is being presented.
 - One of the challenges of education on drugs is to give young people the knowledge they need, but not make them curious about the drug, or ‘glorify’ use. One way to do this is to tailor the education to the needs of different groups of young people. This is easier in a less formal setting like a camp. So, for example, the whole group of young people might receive the basic information. But the ‘all-the-time mob’ that regularly uses alcohol or drugs might receive more detailed education, even one-by-one, away from the main group. The ‘sometimes mob’, who use only occasionally, might receive different information.
 - There are also challenges as to when to start giving education about alcohol or drugs. Because most drugs are illegal, many schools (and some communities) are uncomfortable about starting drug education before the mid-teenage years. However, some young people start using drugs or alcohol at quite a young age. One solution is for education in primary school to focus on general health messages, and to touch on alcohol and smoking. Then, in early secondary school, other substances like inhalants or cannabis can be introduced, in the context of keeping yourself healthy. Then education about other illegal drugs often starts from around Year 9 (about 15 years). Remember that messages need to be regularly reinforced, and be a standard part of the curriculum rather than a one-off add in. Whoever is doing the education (whether teacher or health worker) needs to update their skills and training regularly. If they do not have the required skills or confidence, they may need to seek additional help.
- Families may need education about how to recognise the effects of drugs, and on knowing how to talk to young people about drug use (see What can families do?, p. 62).
 - Keeping kids occupied: the more programs in the community the better to avoid young people getting bored. These could be sport, culture, training, music and art etc. As well as providing an alternative to drug use, these programs help young people feel connected and feel good about themselves (higher self-esteem). However, these programs need to be ongoing – i.e. all through the year, and need to be continued even when the community is doing well.
 - Making families and communities stronger: families and communities need to be involved with keeping young people safe. This might be, for example, taking adults

or senior members of the community on a camp, or it might involve community members in watching or running sport programs or teaching culture. In this way the adults are part of the day-to-day solution to address substance use issues. A holistic approach is needed, so that young people at risk are seen as part of their family or community. So, for example, if a young person is using petrol, their parents or family may need support. On the other hand, if the parents are misusing alcohol or other drugs, their children (and extended family) may need extra support.

- Looking at the mental health needs of young people: some young people may need treatment or extra support because of mental health issues. This may include young people with Foetal Alcohol Syndrome (see FASD, p. 364 and p. 206).
- Trying to keep underage people from accessing tobacco, alcohol, and drugs – if young people have easy access to these substances they are more likely to run into problems.
- Supporting communities' efforts to stamp out alcohol or drug misuse.
- Remember you are a role model.

ENGAGING AND EMPOWERING YOUNG PEOPLE TO PREVENT SUBSTANCE MISUSE

Try to work with the community to get the message to young people to think before they act. These messages might incorporate local Aboriginal concepts and language (if appropriate).

Working with young people with alcohol or drug issues

OVERVIEW

Young people use alcohol and drugs for the same reasons as adults: to have fun, to relax, for an emotional escape, or to block out problems. However, being younger and not having as much life experience can make extra challenges for young people and increase their exposure to alcohol and drugs. Young people are often very influenced by their friends and at a stage where it is normal for them to challenge and be suspicious of adults. This can make them more at risk of falling into alcohol or drug use problems and less aware of the dangers of use. This section describes what is different when working with young people with an alcohol or drug problem, and discusses treatment options available for young people.

How common are alcohol or drug problems among young people?

Many young people in Australia first use alcohol and other drugs during their teenage years. Some young people also grow up in families and communities who often use alcohol or drugs, which makes it more likely that the young person will also use. The earlier a person starts using alcohol or drugs, the more likely they are to use as an adult, and have problems with use. Young people have the added risk that their bodies and brains are still growing, so normal development can be affected by substance use, leading to further problems.



The importance of good relationships

Establishing and maintaining a good relationship with the young person will be key to the help you are able to offer them. Take the time to get to know them and to build rapport before talking about their use of drugs or alcohol.

GENERAL TIPS FOR WORKING WITH YOUNG PEOPLE

- Education on drugs and alcohol should be given as part of a motivational interviewing approach – helping the young person to weigh up the good and not-so-good things about substance use. This can avoid the young person feeling you are telling them what to do. If an adolescent feels they are being ‘pushed around’ they may react by feeling angry or wanting to do the opposite. You can help the young person ‘own’ the decision to change their alcohol or drug use by using open questions, showing you are listening carefully (reflective listening) and by summing up what they have just said to you. This approach can help cut down the young person’s resistance to change and help them find reasons for change.
- Just as working with adults, young people need to feel there is a reason for them to change their behaviour and that they have the necessary skills to attempt this change. Breaking strategies into simple and clear steps will help young people gain confidence. Also reassure them that sometimes it takes many attempts to make change happen.
- You can use a range of approaches such as workbooks, DVDs, group exercises, outings and activities to create an engaging and stimulating opportunity for young people to learn skills to address their drug and alcohol issues.
- Young people who are strongly connected to family and community, who have something to do, such as school or sport, and who have good support networks will be less likely to misuse drugs or alcohol. Feeling good about life is one of the best ways to prevent substance use problems from happening.

HOW TO RECOGNISE WHEN A YOUNG PERSON HAS AN ALCOHOL OR DRUG PROBLEM

Youth is often a time when people experiment with new things, and some young people misuse alcohol or try illegal drugs as part of this process. Talk to the young person and explore their reasons for using and ensure they are aware of the possible harms of their use.

- It is not always easy to recognise if a young person is misusing substances, but engaging with them and talking to them in a non-judgemental way is the best way to find out. Young people expect adults to make judgements about their behaviour but usually respond well to direct questions once a good relationship is established.
- It is important to never assume what the young person is using. If they are willing to engage and to talk about their use, you are best able to try to help them. Some young people will not yet be ready to talk about their alcohol or drug use or to change (see Counselling, p. 22).
- Types of drugs, their names and how they are used change all the time. So if the young person is using names or terms you do not know, ask them – they are a great source of information.

HOW TO HELP YOUNG PEOPLE WITH ALCOHOL OR DRUG PROBLEMS

If a young person is not willing to talk about their alcohol or drug use, you should tell the young person about services that are available if they later decide to make changes. If they are ready to change, support them to change (see Counselling, p. 23) and help them access these services if needed.

Home-based detox

- Some services provide outpatient detox and support where medicine and/or counselling is provided to help the young person at home. This approach suits young people who have less complex issues, and who have good family or other support.
- There are not yet many outpatient detox services available for younger people and you need to check the entry criteria and what type of program it is to see if it suits the young person.

Residential rehabilitation ('rehab')

Rehab programs designed for young people provide drug-free environments where the young person can gain awareness and skills to address their substance misuse. The young person usually leaves their family and community and lives at the rehab centre for 8 to 12 weeks.

- Young people referred to rehab are usually alcohol or drug dependent and need this more intensive treatment.
- Different rehab programs have different treatment approaches. You should be aware of the program's entry criteria and the type of approach it uses before suggesting it to your client (some programs have religious input and this may not suit the client).
- Every young person's needs are different. Matching the young person to the most appropriate service increases the chances of success. The better the program matches the young person's cultural, spiritual and practical needs, the more likely it is to help them.
- Rehabs will conduct a drug and alcohol assessment (usually on the phone and then face to face) before agreeing to take the client. They will also say if detox has to happen before the client enters the rehab centre.

- If the rehab requires the young person to detox before entering their program, detox usually happens at a residential detox unit. There are limited youth detoxes (for under 18 year olds) but some adult detox units accept under 18s in particular situations. Once in detox, the staff will need to be watchful to ensure the young person feels safe and cared for. Staff at rehab and detox programs try to work together so the young person completes their detox and then transfers straight to rehab. However, sometimes this is not possible and a structured support plan should be put in place until they enter rehab. Having a break between detox and rehab usually results in relapse.
- Many rehabs provide outreach support once the young person has finished the program. They will also usually let a young person return if they did not complete the program the first time, as it often takes several attempts to complete. If the rehab does not offer aftercare support, it is important to look at whether you and/or another service can provide aftercare for the young person.
- It can take many weeks or months to access a program, because adolescent detox and rehab services are limited. You can try to help the young person stay safe and sometimes to make small steps in reducing their alcohol or drug use while they wait.
- Sometimes when there is no rehab available, families or communities have been able to create their own safe or healing place for young people. The Mt Theo program is an example of this, which is run by the Warlpiri Youth Development Aboriginal Corporation. It is important to check with a doctor if the young person is safe to detox without medical help. You can help monitor how safe and effective such an approach is.

Prison populations

OVERVIEW

When a person with alcohol or drug issues enters prison it can be a chance for them to 'step back' to decide whether they want to try to stop using. However, it can also be a difficult time because people often come into prison with health issues and many other concerns, and it can be challenging to know what help is available and how to access it. It is also difficult working out how to deal with the drug culture in prison, and how to prepare the person to leave prison and to re-enter the community safely. This is where support from a health worker can be invaluable. Lots of people fail to deal with drug and alcohol issues because they face barriers that could be removed with some helpful guidance.

The criminal justice system can be a confusing place. The easiest way to understand it is that when people are arrested and detained, usually the first place they stay is a watch-house (police cells), and this might be for a few days. If they are detained in custody for a longer period, they go to a prison (it can be called lots of other things, e.g. correctional centre, custodial centre, remand centre). In the case of younger people, it is called a detention centre. However, in this section, we will call everything a prison.

The way that prisons run across Australia varies – the government runs some, while others are private. The types of health services available can also vary. Because of these differences, this chapter offers general advice for working with drug and alcohol clients who are: about to enter prison, currently in prison, and leaving prison to return to their community. Every prison in each state and territory has information about how the prison runs and what services are available. For more information, call the prison or search the internet for more specific information for your client.

WHAT TO DO FOR CLIENTS ABOUT TO ENTER A PRISON

Substance use problems among Indigenous people entering prison are extremely high and may be related to their offending. Programs to avoid being sent to prison once an offence has occurred are available in most states and territories, and may include diversion to rehab services. These are dealt with separately in this book (see Programs to reduce re-offending or avoid prison, p. 325).

Once a client enters prison, the state or territory becomes responsible for their health care. This means that they will have access to health care services and should not lose hope with respect to any progress they have made in addressing their drug and alcohol issues in the community. However, the client will need to adapt to the services that are available in prison and understand what is required to access these.

The following information may help you to prepare your client for entry to prison; it applies equally to men, women and young people.

General advice

- As a health worker you should be able to obtain specific information about the type of health services and drug and alcohol services available in the prison. A good source of information is the Nurse Unit Manager or Nurse in Charge in the prison health centre. This person can usually be contacted on the prison's general phone number.
- Most prisons will also have Indigenous liaison or support officers that may be able to provide information about relevant cultural supports as well as about the health services available inside.
- Check the rules for visiting the prison. Most prisons have particular times and days of the week for personal visits and specific arrangements for professional visits if you, as a worker, want to visit. This information will be very important to your client and their loved ones, as it lets them know what ongoing support and contact they can get.
- Remember, even if visits are not practical, phone calls are available. The usual system is that the inmate must set up an account and provide details of the names and numbers of the people they wish to call. Sometimes this takes a while to set up and can be frustrating, so suggest to your client that they have money ready for their phone account and a list of names and numbers of people they want to contact.
- Prepare the client for some of the realities of prison regarding drug use. Searches for drugs and drug-using equipment, including the use of drug detection dogs, happen regularly, not only for inmates, but also for visitors.
- Being in prison is a stressful time for most people. Your client may be less stressed if they make arrangements for important things before they enter prison (e.g. childcare, finances and care of accommodation and property). Your client may also wish to tell family, friends and employers that they are going to prison, and you may be able to help with this.

Specific advice

For clients with an alcohol or drug issue

- Advise your client that a pre-prison ‘binge’ is likely to cause problems such as: making it more difficult to organise their personal matters before entering prison, facing more charges for things that happen while intoxicated, or facing more alcohol or drug-related harms either while using or when they first enter prison (e.g. going through withdrawal).
- Gradually reducing drug use before entering prison can make withdrawal in prison less difficult. Also, injecting drug use in prison is very risky, so strategies to reduce or stop injecting drug use before entering prison will be helpful.
- At the time of writing, there are no Needle and Syringe Programs (NSPs) in prison to provide clean injecting equipment. In any event, injecting while in prison puts a person at very high risk of health problems.
- For clients with opioid dependence, starting opioid substitution treatment (i.e. methadone or buprenorphine) before custody can avoid withdrawal on entering prison and can reduce problems with access to treatment.
- On arriving in prison, your client will have a health assessment, usually within 24 hours. This is a good time for them to mention any major health issues, including risks of going through alcohol or drug withdrawal. This may be the only chance they get to raise this issue promptly.

For clients with mental health issues

- Most people in prison with a severe substance use issues also have mental health issues. Sometimes this mental health issue is more than just stress, worry, and feeling down and is actually a mental illness such as schizophrenia, bipolar disorder, depression or anxiety disorder.
- If your client has a mental illness, then it is important that the prison health staff know about this when they enter a prison. It is likely that during their initial health screen they will be asked if they have experienced a mental illness, suicidal thoughts or attempts, or any current or past treatment for mental health problems.
- It is very helpful to get a short letter from your client’s doctor or service that states the client’s condition and the required treatment.
- Other things that can provide helpful information to prison health staff include medicine boxes, scripts or discharge summaries. Your client can bring these to prison or you could fax relevant discharge summaries and other relevant information to the prison health centre with your client’s permission.

- Make sure the client has the name and phone number of their doctor, case manager or service written down to provide to prison health staff.
- Taking medicines with them to prison is also a good idea as it alerts health staff to the type and dose of medicine that they need; and it also provides a supply if the health centre does not have the medicine in stock.

WHAT TO DO FOR CLIENTS WHILE THEY ARE IN A PRISON

There are some major differences between approaches taken to drug and alcohol issues in prison compared with services offered in the community. As described above, at the time of writing there are no Needle and Syringe Programs (NSPs) in Australian prisons. There is also likely to be limited access to opioid substitution therapy (methadone or buprenorphine) and to counselling. However, in prison the primary health care services have standard approaches (protocols) to support people going through withdrawal and, there is access to some medicines and/or group programs to help address alcohol and drug problems. What is available will vary by state/territory and prison.

Substance use among adults entering prison

In 2010, one-quarter of all people in prison were Aboriginal Australians. Most Aboriginal people who enter prison smoke tobacco, around two-thirds drink alcohol at risky levels, and more than half have used cannabis. Smaller numbers have used methamphetamine (speed, ice, base), heroin, or ecstasy. One in 10 people will have been on methadone or buprenorphine treatment for opioid dependence. Offending often happens when people are intoxicated.

Substance use among young people entering detention ('juvenile justice centre')

More than half of all young offenders aged 10–17 years are Aboriginal. Young offenders usually start drinking at a young age, and nearly always report getting drunk. Offending often happens when they are drunk. As they may not drink every day, young offenders may not think their alcohol use is harmful, even if it has led them to being in custody. Inhalant use (e.g. petrol, paint, butane) is sometimes reported by young offenders. Young offenders also usually report using cannabis from a young age. Unlike with alcohol, young offenders who use cannabis are usually cannabis dependent. They may smoke cannabis from when they wake up in the morning and use it all day. They may also get stressed if they cannot get any cannabis and may offend to get money to buy cannabis.

General advice

- As mentioned earlier, you can contact the prison (on the general phone number) and speak to the health centre manager to find out which services may be relevant to your client.
- On arriving in prison, your client will have a health assessment, usually within 24 hours. This is a good time for them to mention any major health issues, and whether they expect to go through any alcohol or drug withdrawal. This may be their best chance to get prompt help.
- It may be possible to keep up contact with your client through professional visits if you feel it is needed. Another way to maintain contact is by regular phone calls, and to do this your client needs to add you to their phone list.
- Most clinicians in prison are likely to be non-Indigenous, so if you feel your client will benefit from having an Aboriginal person helping with health assessments, there are usually Indigenous liaison officers or other Indigenous staff who can help. Again, contact the relevant prison to organise this.

Specific advice

For clients with a alcohol or drug issue

- Prisons generally use standard withdrawal management protocols (guidelines) that include medicines. If your client has severe dependence or has had a past complication of withdrawal, like seizures, and you think their treatment needs may not be met, try to discuss this with the prison health centre. Most prisons have doctors who can adapt treatment to your client's needs.
- Young people entering custody are less likely than adults to experience withdrawal symptoms. However, if you believe a young person may experience significant withdrawal symptoms, it is important to tell the health staff as soon as possible.
- It is common for people to be offered drugs while in prison. Using drugs in prison can result in greater legal, physical, emotional and health problems than in the outside world. The drug trade inside prison, like outside, is associated with violence and standover tactics.
- Most large prisons have drug-free units and your client may not be aware of this. They may be able to request to transfer to one of these units.

For clients with a mental health issue

- Entering prison and being separated from family and community can be very stressful; it may increase feelings of hopelessness and helplessness. If your client has a mental illness, it is important that the health service in prison is aware of this so they can continue treatment.
- You can help with coordination and communication in your client's ongoing health care. Sending in letters from their doctor or health service will help their mental health care in prison.
- Sometimes inmates will not mention thoughts about suicide or self-harm to prison staff because they are worried they will be isolated and placed under observation. Encourage them to tell the health staff why they are thinking about suicide (i.e. the context), and also about any factors that would keep them safe (e.g. if they would not hurt themselves because of their children). In that way mental health staff can better assess their risks and find the best way to keep them safe.
- Where prisoners are placed in prison is usually decided based on security concerns, and it may not be flexible. However, prisons will usually try to find ways to help distressed individuals. For example, they may be prepared to place a person in a unit with family and friends from the same community to help keep them safer. This can also help a person find out about the types of services available in prisons.
- Some prisons will have Indigenous-specific programs and activities such as elder visits and art groups. Make sure your client is aware of these (if available) as these may help your client feel less isolated from family and community.
- If you become aware that your client is not coping in prison, or something is affecting their mental wellbeing, contact the prison health service, usually the nurse unit manager, and let them know about your concerns.
- The prison may have Aboriginal staff in counselling or health positions that your client can see.

Substance withdrawal in prison*Alcohol*

Alcohol withdrawal is serious and can be life-threatening but prison health staff are usually experienced in identifying the risk of alcohol withdrawal. It is very important that your client lets staff know if they have an alcohol problem, particularly if they have a history of complicated withdrawals (DTs, seizures) or liver disease. Alcohol withdrawal treatment usually includes Valium (diazepam), thiamine and other medicines to relieve symptoms. Most prisons (that receive people straight from the community) will have a health centre with beds set aside for detox for people who need closer observation (see Alcohol withdrawal, p. 86).

Tobacco

Helping people to stop smoking in prison is not easy. Tobacco is usually sold to inmates, and most smokers say it is harder to quit in prison than outside. NRT is available in prisons in all states and territories for inmates who want to stop smoking. Some prisons are smoke-free, so smokers entering these prisons can be given NRT to help with cravings.

The cost of NRT in prison varies; for example:

- *Qld and SA prisons*: free to prisoners who take part in smoking cessation programs
- *In Tasmania*: half price to clients who take part in smoking cessation programs
- *In NT, ACT and NSW*: at cost price (i.e. a little cheaper than the cost outside prison).

Champix (Varenicline)

- Champix (varenicline) is available for free in prisons in ACT, Qld and SA.

For young offenders, smoking is usually not allowed. NRT is sometimes given to young offenders to manage nicotine withdrawal. For more information about helping people quit smoking, see Tobacco, p. 115.

Cannabis and stimulants

There are no standard medicines used for cannabis withdrawal or stimulant withdrawal in prisons. Your client can talk to the nursing staff in the prison if they are having difficulty coping with cannabis or stimulant withdrawal, including if their mental health is becoming worse during withdrawal (see Cannabis, p. 135; Stimulants, p. 168).

Opioids

Withdrawal from opioids (e.g. heroin, morphine) can be very unpleasant; also if the person uses illegal drugs in prison to cope with withdrawal, this puts them at a major health risk. Most prisons have guidelines to manage withdrawal symptoms and the approach varies depending on what medicines are available, including methadone.

Being on opioid substitution treatment (OST) in prison can relieve withdrawal, and it can also reduce the risk of getting infected with hep C or HIV from sharing needles, syringes and other injecting equipment. OST can also reduce the risk of returning to heroin use, and of overdosing, when an opioid dependent person leaves prison.

The availability of methadone and buprenorphine in prison varies in each state and territory and also within each prison.

- Some prisons only offer methadone to pregnant women who are opioid dependent or to those who were already on treatment before entering prison. Some prisons only offer reducing methadone regimes (to manage withdrawal symptoms), and not maintenance treatment.
- Some prisons do not offer buprenorphine at all because of fears it will be diverted. Suboxone film (which contains buprenorphine combined with naloxone) has recently become available outside prisons. It dissolves very quickly in the mouth and is less likely to be diverted. It is possible it may become approved for use in some prisons.

Which prisons in Australia offer methadone and buprenorphine treatment?

	Methadone		Buprenorphine (with or without naloxone)	
	On a program before prison	Not on a program before prison	On a program before prison	Not on a program before prison
<i>ACT</i>	✓	✓	✗	✗
<i>NSW</i>	✓	✓	✓	✓
<i>NT</i>	✓	✗	✗	✗
<i>Qld</i>	✓	✗	✗	✗
<i>SA</i>	✓	✓	✓	✓
<i>Tas</i>	✓	✗	✗	✗
<i>Vic</i>	✓	✓	✓	✗
<i>WA</i>	✓	✓	✓	✗

Adapted from: AIHW (2011). The health of Australia's prisoners 2010

Note: this information was accurate at the time of writing



Extra note on OST in prisons

- In NT, Qld and Tas, methadone and buprenorphine are only available if the person was already on a program before entering prison.
- In some states (e.g. WA) buprenorphine is only available with naloxone (i.e. as Suboxone), and this is to reduce the risk of ‘medicine diversion’.

Benzos

Benzo withdrawal can be very serious if not identified and treated properly. Make sure your client knows to tell health staff about their benzo use, so that treatment can be provided. Detox usually involves a benzo like diazepam prescribed in gradually reducing doses over time (see *Benzos*, p. 180).

Injecting drug use in prisons

- Injecting in prisons can be very dangerous as it is difficult to get new or sterile needles, syringes and other injecting equipment. At the time of writing, there are no NSPs in Australian prisons, so injecting equipment used for illegal drugs (‘picks’, ‘fixes’, ‘kits’) is usually makeshift.
- There is a very high chance that needles and syringes used in prison have been used by other people, e.g. one study found that prison needles were shared by up to 100 people. Because of this, injecting in prison carries a very high risk of becoming infected with blood-borne viruses like hep C and hep B, and getting other infections.
- Injecting contaminated drugs (e.g. drugs stored in someone’s mouth or other body cavity) is very risky and can result in life-threatening (or limb-threatening) infections or blood vessel damage.
- Inmates may not know what drug they are getting.
- Some drugs should not be injected. For example, injecting benzos or psychiatric medicines can cause very significant health risks including death; and injecting Suboxone can cause acute withdrawal because it contains naloxone (Narcan).

Medicine diversion in prison

- Medicine diversion is when a client removes (or tries to remove) their medicines (e.g. benzos, methadone, buprenorphine or mental health medicines) from the clinic so they can take it later, or so they can sell it or give it to someone else.
- Medicine diversion does occur in prison, and because of this people may not receive their prescribed treatment.
- There are significant penalties for diverting medicine.
- Sometimes people are pressured by other inmates to divert their medicine, and this can be extremely unpleasant. One way to deal with this is to request a transfer to another unit. If a person is on buprenorphine, they can consider requesting transfer to Suboxone (if available) or methadone, which are harder to divert.

WHAT TO DO FOR CLIENTS ABOUT TO BE RELEASED FROM A PRISON

Supporting people who are about to be released from prison is important because:

- Transition from prison to the community is a high-risk period; drug-related death and suicide in the first few weeks following release is very common.
- People often lose tolerance to drugs while in prison. This means that if they start using the same amount they used before entering prison, they are more likely to overdose (especially if they use opioids or benzos).
- Often people return to the same stressful environment they were in when they entered prison (i.e. limited supports and finances, no accommodation and exposure to drug-using peers).
- The risk of re-offending is high in people who have already been in prison, especially if inmates are not reconnected with their families and communities.

General advice

- The most critical thing about release is preparing for it, so it is important to be aware of a client's release date.
- Some prisons have transitional programs that can help smooth a client's return back to their community. These programs help clients to prepare for release by helping them organise accommodation, finances, social supports, return to work and sometimes health care needs.
- Most people will not have had access to transitional programs and the biggest initial challenges can be accessing finances, gaining accommodation, and accessing continuous health care.
- People who have been in custody for some time may need to get new identification. Assisting your client with these matters can also help them to successfully transition to being out in the community.

- Some people who are in prison get released unexpectedly by a court. This can be extremely challenging. In most states there are non-government organisations that provide short-term assistance to your client (e.g. the Court Network or Salvation Army) while they get organised.
- When a release is planned, clients will usually be given a summary letter about their general health care and several days of prescribed medicine. It is important that they engage with a relevant doctor (or other health care provider) as soon as possible to be sure their treatment continues in the community.
- While many clients will be excited about being released, some people may feel anxious about leaving prison. They might fear returning to old circumstances and habits. This is why it is critical to work with your client to identify challenges they may face and to find realistic short-term goals and plans. The pre-release period is a time for your client to get prepared.
- After release, it is important to find out what health care programs your client has received while in custody, so you can find out if any similar programs are available in their community.
- The Aboriginal staff (either in the prison or other health services) may be aware of particular issues a client could face when returning to their community. Talk with these staff to get their ideas on what can be organised to support your client's transition back to their community.

Specific advice

For clients with a alcohol or drug issue

- It is possible that your client will have accessed an alcohol or drug program or OST (e.g. methadone or buprenorphine) while in prison. Being clear about any treatment they have had in prison will help with planning ongoing care.
- Link your client with the local drug and alcohol services.
- Ensure follow-up plans are made as soon as you become aware your client may be released – as risk of overdose is high if your client is not prepared and supported.
- While most prisons will have either alcohol or drug clinicians or health clinicians with knowledge in this area to help your client prepare, there are often not enough of these staff members and there is a huge demand on their services. Therefore you can play an important role in linking your client to a relevant drug and alcohol (or other) service in the community or with a rehab.

- Transferring methadone and buprenorphine treatment from prison can be difficult because most clients will need daily dosing at a clinic in the community from the day they leave prison. Release dates are not always predictable, and this means that arrangements sometimes have to be made at the last moment. Talk with the prison health staff to support this process. Generally in prison the nurses find a local dosing point as soon as they know a prisoner will be released. The details of the prisoner's last dose, any other identifying documents and a script is then faxed to the new dosing point. But sometimes things do not go to plan, especially approaching weekends. Be sure your client knows where to go to collect their dose.
- Rehab may be good for your client, or it could be part of their parole conditions or release planning. Your knowledge of services that may help your client will be useful in planning for their release.

For clients with a mental health problem

- It is important to arrange ongoing mental health care after your client is released from prison. This can be done, for example, through counselling services, general health services or mental health services.
- Some people may have mental health care as a condition of their release, or be on an involuntary community treatment order. You should be able to find out this information from the client.
- Clients who need to attend community mental health services will usually have arrangements for follow-up made through the specialist mental health services in prison. Your client can get a summary letter from the mental health service in prison, indicating their medicines and doses, to ensure that treatment continues when back in the community.
- As there can be long waiting lists for mental health appointments it is important to book these appointments before release.
- Many families and communities may not have a good understanding of your client's mental health problems and other needs on release. Work with the family, and in some cases the community, to enhance the person's support networks once they are released.
- Some people will be returning to remote areas, so make sure you have an understanding of the local services, as well as the visiting mental health services and the timing of these visits to help coordinate appointments.

WHAT TO DO FOR CLIENTS AFTER RELEASE FROM A PRISON

If your client has been released unexpectedly, or has not had an opportunity to prepare for release, many of the points above may not have been addressed. You may need to help work through all these issues and in particular to arrange aftercare for their drug and alcohol issues, mental health, general health, as well as the practical problems (like lack of identity documents). You may also have an important role in supporting the client and in helping their family come to terms with their release.

If your client is on methadone or buprenorphine and does not know where to collect their dose, you can phone for advice from either the prison health service or a local OST unit. This can be challenging to solve over a weekend, but sometimes you or the local OST can call the on-call doctor at the prison. If a solution is not possible, your client may face an uncomfortable weekend, waiting for a solution on the Monday.

Considering practical issues like establishing contact with a regular GP will be important to ensure regular health and medicines reviews as well as specific issues such as restarting contraception.

In some states and territories there are services to support clients after release from prison (e.g. Connections in NSW, the Catholic Prison Ministry in Queensland); however, there are many different groups and the organisations vary significantly between states and territories, so an internet search of what is available in your state or territory is the best place to start.

FURTHER READING

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Aggressive clients

OVERVIEW

When working in the drug and alcohol field, you often see people who are in an aggressive mood. They may look tense and angry. They may pace around, speak loudly, or even shout. They may throw things or attack people or property.

The first thing to do in any aggressive situation is to keep yourself safe. Next, try to keep others safe. And then, as much as possible try to make sure that the aggressive person is safe as well. But you come first. If you are not safe, you will not be able to help anyone else.

Aggression can have a damaging effect on health workers, causing unhappiness, fear, bad sleep, sick leave, stress leave, or quitting work.

WHY DO PEOPLE GET AGGRESSIVE?

It is important to understand why some clients are behaving in an aggressive way so you can deal with it properly.

Some causes of aggression include:

- Alcohol and other drug use. For example, if a client is:
 - Going through withdrawal from alcohol, inhalants or cannabis
 - Currently intoxicated with alcohol, methamphetamines (ice) or other stimulants, e.g. cocaine, MDMA, 'speed'
 - Heavy use of anabolic steroids
 - Experiencing psychosis because of their drug use (drug-induced psychosis). This can be caused by cannabis, psychostimulants or hallucinogens.
 - Experiencing psychosis because they are withdrawing from alcohol or benzos (e.g. diazepam, oxazepam, alprazolam).
- Mental illness. For example, if a client:
 - has not taken their medicines
 - is having a psychotic episode.

- Other reasons
 - People may be become angry or aggressive if they feel stressed or anxious or are going through other hard times (e.g. worrying about family or friends, having money problems, or grieving for the death of a loved one).
 - Physical problems (including pain) may make people less able to deal with stress and to ‘snap’ more easily.
 - Damage to the brain caused by injuries, lack of oxygen, infections, and epilepsy (after a seizure) may cause aggressive behaviour.
 - Aggression can be a side effect of some medicines, e.g. anti-psychotics, anti-depressants, benzos, Champix (varenicline) and anti-seizure medicines.

HOW CAN AGGRESSION BE PREVENTED?

What can clinicians do?

There are many things that clinicians can do to prevent ‘cranky’ or irritable behaviour from becoming aggression:

- Develop a good relationship with the client from the first time they come to see you for help. The rapport and trust developed with this client will be very helpful if you need to deal with an aggressive situation that they are involved in at a later time.
- Look out for the warning signs of aggression like: raised voices and ‘agitated’ behaviour that is out of the ordinary for that client.
- Listen to the client’s concerns before the problem gets worse:
 - For example, are they upset about waiting? For clients on methadone or buprenorphine, are the dosing queues too long?
 - Consider any changes that could be made to address the client’s concerns and to improve the system. For example, if there are delays that cannot be helped, keep the client up-to-date on how long the wait will be.
- Make sure the client is aware of their treatment choices and is involved in deciding what the best treatment is for them. Where appropriate and with the client’s consent, family members of significant people in the client’s life may also be involved in considering treatment choices.

What can your workplace do?

There are many things that your workplace can do to prevent aggression or to manage it better. This includes:

- Trying to make your service comfortable and welcoming to help prevent clients from getting bored and irritated. For example: having pictures on the walls, toys for the kids, a television and reading material (e.g. magazines, leaflets) in the waiting room.
- Making sure appropriate security measures are in place
- For clients who might be aggressive, try not to see them alone or in an isolated area. Let another staff member know where you will be seeing this client.
 - Carry a security alarm (duress alarm) if your workplace has them.
 - If possible, counselling rooms should have two doors so that clinicians can easily leave the room and clients do not feel trapped. Make sure that there are no objects in the room or on the clinician that could be used as a weapon.
 - If a client is aggressive or has a severe mental illness, try not to see them when they are having a hot drink because it could be thrown at you.
- Attending training on how to cope with aggressive behaviour (if available).
- Reading your workplace's policy on how to manage aggression (if available). Talk to your manager if you have any questions.

HOW TO CALM THINGS DOWN ('DE-ESCALATION TECHNIQUES')

If a client is getting angry, there are things you can do to calm the situation down and stop it from getting worse. For example:

- Talk to the client in a calm voice.
- Ask any extra staff and clients who may be present to leave, as sometimes a situation can get worse if there are a lot of people around and many people are talking all at once.
- If there is someone around who is very familiar with the client (e.g. a relative, friend or other staff member), ask this person to talk to the client.
- Stay calm, introduce yourself (if the client does not know you), be respectful and polite and offer the client a drink or some food (if available).
- Keep things simple when talking with the client: use short sentences, explain things clearly, and make sure the client understands what is being said.

- If a clinician or service has made a mistake, apologise to the client.
- Focus on the current problem and try work out with the client what could be done to help make things a little better now (instead of focusing on the bigger issues that may take more time to organise).
- Do not challenge the person or get caught up in an argument. If you start to feel angry and do not think you can control your reactions, try to get out of the situation as soon as you can. You could ask another staff member for help.
- Try not to take what is happening personally.

WHAT TO DO IF A CLIENT IS BEING AGGRESSIVE

- Do not get too close to the person as this will keep you out of hitting and kicking range. Try not to turn your back to the client.
- If you are inside, try to stay near an exit. But do not block the person from leaving or make them feel like they cannot leave.
- Stand in front and slightly to the side of the person, and try to avoid folding your arms or staring at them (as this could appear like you are trying to intimidate them).
- If the person has a weapon, leave the area as soon as you can and tell other staff or clients who might be present so they do not enter the area. If this happens, inform security or the police.
- If you cannot manage the situation on your own, ask staff (or even call security or the police) for immediate help.
- Sometimes, to protect the person as well as other people, clients may need to be treated against their will ('scheduled'). This is usually organised by a doctor or psychiatrist. Nurses or police may organise this in smaller communities.

WHAT TO DO AFTER A CLIENT HAS BEEN AGGRESSIVE

- Seek help straight away for anyone who has been injured or is feeling upset as a result of the aggressive incident. An ambulance, nurse or doctor may need to be called.
- The staff member should be given the opportunity to sit down with their manager or another staff member to talk about what has happened (this is called *debriefing*).
- If anyone needs more help (e.g. counselling), ask your manager what kind of support is available.
- The manager and team should then discuss how to prevent further aggressive situations from happening with this client. This could involve giving the client a warning or changing the conditions of their visit to the service (e.g. for someone on methadone treatment, this could involve reduced takeaway doses).
 - In cities or towns it may be possible to stop the client's treatment (discharge) or transfer their care to another service for a period of time.
 - In rural or remote regions this may not be possible and, instead, a plan to prevent or manage aggression could be developed with the client. This plan could also involve their family and in some cases the police. Sometimes a client may be asked to always bring a nominated family member with them when attending the service. In more severe cases legal action may be required.
- Talk to your manager to find out what needs to happen after an incident so that it is properly reported (and follow the procedure written in your workplace's aggression policy, if available). Following these procedures is important because it tells management how serious the problem was and can help to work out a plan to prevent incidents from happening again. It also warns other workers about what happened so that they can be careful in similar situations, or when they are dealing with that client in the future.

Torres Strait Islanders

For people living in the Torres Strait there are some particular issues to think about in relation to substance use. This includes where people are living, their history and closeness to Papua New Guinea (PNG), and how these factors relate to alcohol and drug use.

GEOGRAPHY AND HISTORY

The Torres Strait consists of 18 islands and two Northern Peninsula Area communities. The islands are scattered over an area of 48,000 square km, from the tip of Cape York, up north towards the borders of Papua New Guinea (PNG) and west to Indonesia. PNG is a short boat trip away from some of the outer islands and each year thousands of PNG citizens cross the border under the 'free movement' provisions of the Torres Strait Treaty. There are also links in heritage between the Torres Strait, Indonesia, PNG and other Pacific Island communities.

Some issues to consider

- *HIV*: there are many people living with HIV in PNG (nearly 1 in every 100 adults). There is a real chance of the spread of HIV into the Torres Strait, because PNG citizens are able to freely move between PNG and the Torres Strait. Because of this, men and women from PNG and the Torres Strait Islands can form relationships. Substance use, like alcohol, can increase the chance of unprotected sex, and this may increase the spread of HIV (see HIV/AIDS, p. 311).
- *Supply of alcohol*: like other parts of Australia, there are several alcohol outlets in the Torres Straits. We know that the more alcohol outlets you have for a population, the greater the chance of harms from alcohol (see Alcohol harms, p. 71; Preventing and limiting drinking problems, p. 337).
- *Tuberculosis (TB)*: TB is a common disease in PNG and people with HIV have an increased chance of contracting it. TB is also the fourth most common cause of deaths in hospitals in PNG. When left undetected, a person with TB can spread the infection, especially in social settings. The movement of people between PNG and the Torres Strait can spread TB. Alcohol misuse can further increase the spread by interfering with the body's ability to fight off infections (the immune system). Also, a person with an alcohol problem is more likely to drop out of treatment for their TB.

- *Injecting drug use*: if injecting drug use were to become more common in the Torres Straits, this could lead to further spread of HIV (and of other blood-borne viruses like hep C and B). There is also no Needle and Syringe Program in the Torres Straits, so there would be a risk of needle sharing (see NSPs, p. 298; Harms from injecting and safer injecting, p. 289; Hep C and B, p. 302).
- *Cannabis*: cannabis is one of the most commonly used illegal drugs in PNG (see Cannabis, p. 127). It was originally introduced to PNG during the Second World War. Cannabis can also contribute to spread of infectious diseases like TB through sharing of smoking equipment (e.g. bongs, joints).
- *Betel nut*: substances used in PNG like betel nut can be sold, traded or shared with people living in the Torres Strait (see Betel nut, p. 232).

FURTHER READING

ABC (2011). *Island life*. Australian Broadcasting Cooperation. See: www.abc.net.au/nature/island/ep4/default.htm.

The Torres Strait Regional Authority (2007). *The Torres Strait community profile*. Australian Government. See: www.tsra.gov.au/the-torres-strait/community-profiles.aspx.