



Human Services
Community Services

Parental drug testing policy

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Parental drug testing to assist in cases of removal and restoration of a child where serious and persistent drug use is suspected

This policy provides evidence-based guidance on the limited circumstances in which drug testing may be helpful or necessary. It explains the preference, in most cases, for urinalysis over hair testing and blood testing and sets out the recommended frequency and duration of random testing.

It describes three main scenarios in which testing is appropriate and specifies the nature and duration of the testing regime:

1. **Prior to removal** - Where serious and persistent drug use is considered to be at least one of the reasons for a child's current risk of harm and this cannot be confirmed by other means, testing is part of a holistic assessment to establish whether removal of a child is warranted.

2. **Prior to restoration (when testing is mandatory)**
 - A. Where a child has been in out of home care primarily due to the serious and persistent drug use of a parent and restoration is now being considered.¹

OR

 - B. Where drug use was not the primary concern in placement of the child in out of home care, but there are current concerns about possible serious and persistent drug use and restoration is being considered. Testing will assist in the assessment about the current situation and whether restoration is a feasible option.

3. **Following restoration** - where a child has been restored, but a further risk of harm report has been made in which drug use is a concern.

The policy sets out the consequences of positive tests and of failure to consent or comply with a testing regime. Guidance is also provided on treatment, waiting times and interaction with Court timeframes and permanency planning.

¹ This applies equally to situations where a parent was drug tested prior to removal to establish serious and persistent use *and* to situations where there were concerns about serious and persistent drug use but testing did not occur as the child was removed due to a combination of other significant issues which testing was not required to support.

1. PURPOSE AND SCOPE OF THE PARENTAL DRUG TESTING POLICY

Parental drug testing is primarily used in Community Services to inform Children's Court decisions on the removal of a child or young person from his or her parent(s) and planning for permanency, including restoration to the family. The safety and wellbeing of children is the primary focus in seeking information about parental drug use.

Drug testing may provide a snapshot or series of snapshots of use or abstinence from a particular drug or drugs but cannot alone provide the information required to determine the impact of use or abstinence on parenting capacity. Holistic assessment of children and young people and their families is therefore a central feature of casework practice in Community Services.

Drug testing is one tool which can be used as part of the holistic risk assessment process, to assist caseworkers in formulating, implementing and reviewing a case plan² for a child and/or young person who may have been or is at risk of being abused and/or neglected because of their parent's serious and persistent drug use (defined below). All risk factors for a child or young person must be considered when completing an assessment and when making case decisions.

This policy does not provide guidance on holistic assessment or on pharmacology and clinical interpretation of test results. The aim of the policy is to provide evidence-based guidance on the limited circumstances in which drug testing may be helpful or necessary. It explains the preference, in most cases, for urinalysis over hair testing and blood testing and sets out the recommended frequency and duration of random testing.

The policy aims to facilitate timely and consistent decision-making in children's best interests by aligning drug testing with permanency planning timeframes (See Appendix). It also covers the important areas of consent to testing and compliance and the consequences of failure to consent or comply with a testing regime.

The policy also provides a rationale for why we seek only to ascertain the nature and pattern of a parent's drug use for removal purposes but require demonstrated abstinence for restoration to proceed.

Relevant legislation that should be considered, where serious and persistent drug use is confirmed, is cited in Appendix, together with a rationale for parental drug testing and a summary of the impact of drug use on the welfare, wellbeing and safety of children.

² In conjunction with the family and relevant interagency partners where appropriate

What drugs does the policy cover?

For the purposes of this policy, the term “drug” includes all illicit drugs and the misuse of prescription drugs (including Methadone, Buprenorphine and powerful opioid pain relievers).

Community Services is not concerned with prescription drugs, such as methadone, provided they are taken in the way and quantity prescribed by a doctor. Prescribed methadone is available through participation in an opioid treatment program which is a common treatment option for individuals struggling with ongoing illicit opioid use³.

Alcohol use is a significant problem for many parents who come to Community Services attention, however, alcohol is not included in the scope of this policy. This is in acknowledgment of a unique set of challenges in relation to alcohol testing which require resolution before appropriate guidance can be developed⁴. It may be that future revisions of this policy will provide guidance on alcohol related testing.

Why does the policy target testing for “serious and persistent” drug use and how is this defined?

This policy provides guidance on the use of parental drug testing and associated casework actions where there is reasonable suspicion of serious and persistent parental drug use. Serious and persistent drug use is defined for the purposes of this policy as drug dependency and/or heavy or binge patterns of use.

Caseworkers are not expected to make clinical judgements about drug dependency but should be aware that patterns of high frequency (daily or near daily) use of any type of illicit drug, are most likely to meet the criteria for drug abuse or dependence and are of most concern in the child protection context⁵. The presumption is that daily or near-daily (regular or dependent) use impedes the care and protection of children due to the parent’s preoccupation with obtaining, using and recovering from drug use.

Binge use, though less frequent, is also of concern in that it is erratic and likely to involve high doses. It can pose particular dangers to children due to increased potential for accidental injuries, violent behaviour and risky sexual behaviour.

³ In NSW, methadone and buprenorphine can only be prescribed by an authorised medical practitioner, who has undertaken an accredited course and then registered with the NSW Department of Health. Opioid treatment therapies involving methadone and buprenorphine are a medically accepted way of treating heroin addiction, effective at retaining people in treatment, suppressing heroin use and associated crime, and reducing the risk of overdose and HIV. The most appropriate opioid treatment medication for a client is a clinical decision made by the prescribing practitioner and will reflect a wide range of factors related to the history of the client’s drug use and treatment and other medical conditions. The effective treatment of opioid dependence is a long-term issue. Any reduction in dose or withdrawal from treatment must be monitored by the prescriber and conducted gradually.

⁴ While there are a variety of tests available to assist health professionals in the diagnosis of hazardous alcohol consumption and related disorders, in general, methods for testing use of alcohol over time are less reliable than methods available for other substances. Further information can be obtained from the article Diagnostic Tests for Alcohol Consumption, Conigrave, Katherine M; Saunders, John B and Whitfield, John B, in Clinical Chemistry, Vol 39, 2266-2270, American Association for Clinical Chemistry, 1993.

⁵ The National Drug and Alcohol Research Centre (NDARC) has noted that the level of drug use which begins to compromise functioning and parental care is a reasonable proxy for the transition from problem use to dependence.

What information can drug testing provide?

Drug testing is used to get accurate information about whether a parent is using drugs, what drugs they are taking and how often. Frequent testing can indicate but not confirm daily, near daily or binge use.

What method of drug testing should be undertaken?

Urinalysis is the preferred method of testing at this point in time⁶. Urinalysis provides information about current use rather than historical information that use occurred in the past. (See Appendix for strengths and weaknesses of testing methods.)

Where a child is still in the home and there is suspicion that serious and persistent drug use may be impacting on parenting and removal is being considered, urinalysis can be used to provide information on a parent's pattern of drug use. This, along with more comprehensive casework assessments, will help to determine whether a child is being adequately cared for and supervised.

If a child has already been removed because of serious and persistent parental drug use, urinalysis can be used to show whether the parent can abstain from drug use, in order for the child to return home.

Hair testing may be appropriate:

- in rural and remote settings, where chain-of-custody is not available for urinalysis, and a parent has undertaken to be abstinent
- as a one-off test to establish/confirm that a parent co-residing with another person, whose serious and persistent drug use is an issue, is abstinent or does not use drugs in a serious and persistent pattern
- for confirmation of continued abstinence where a regime of urinalysis (see Section 5) has informed a decision that restoration is a realistic possibility and there is a gap between the completion of urinalysis, the decision to commence or continue restoration planning, and full restoration – hair testing after a further designated period may be an economical and less intrusive way of determining a parent's capacity for abstinence without the intensive scrutiny of regular urinalysis

⁶ Technological advances in drug testing in future may require review of preferred methods in this policy as the gap between the costs and availability of various methods closes. In 2009, only one Australian laboratory processes hair tests while there are multiple facilities undertaking analysis of urine samples. However, this may alter and Statewide contractual arrangements may yield economies of scale.

- to provide information on drug use over a set past period (weeks or months) to inform decisions about the appropriateness of contact following removal where serious and persistent drug use has been an identified issue but there is not capacity for the intensive case management that underpins urinalysis
- to confirm drug use or abstinence over a set past period (weeks or months) if a report is received following restoration and a straightforward historical perspective is what is required.

Which parents are we excluding from drug testing?

This policy is not intended to deal with parents whose drug use is at a low level and where there are no concerns, held by the caseworker, the reporter or another service provider, that drug use is having an adverse effect on parenting capacity.

Who to test?

The focus of the policy is on “serious and persistent” drug use which is placing a child at risk of significant harm. The drug use may involve a constant pattern of use and/or patterns of significant episodic drug use. Generally, the drug use of a child’s primary carer is the focus of concern but if the serious and persistent drug use of both parent/carers is suspected, drug testing and undertakings should apply to both. Where another (non-carer) adult residing in the premises is suspected to be a serious and persistent drug user, the focus should remain on the parent/caregivers.

Drug testing is not intended to be punitive or to be interpreted as an intervention. It is information gathering to inform assessment. Parents may view drug testing as an opportunity to provide evidence of a change in drug using behaviour (either of low level use or abstinence).

2. PARENTAL CONSENT TO DRUG TESTING

Following a decision that drug testing is necessary, the caseworker should discuss this with the parents at the earliest opportunity with the aim of obtaining their formal written consent to drug testing, using the Community Services proforma. The expectations of the parents, requirements for drug testing and review of results by Community Services should be discussed and documented as part of the assessment process.

The discussion with the parent should focus on ensuring that the parent understands that Community Services will review their test results to assist with forming judgements on whether:

- When a child is at home or has been temporarily removed due to safety concerns, there is a serious and persistent pattern of drug use the impact of which (as well as other factors) on parenting warrants the child’s removal and/or the seeking of orders for his/her placement in care

AND/OR

- When a child is already in care, abstinence has been attained and maintained (to inform the decision on whether restoration should be pursued).

What if a parent does not consent to drug testing?

A parent who does not consent to undergo drug testing should be advised that the Court will be informed of their refusal.

Where removal is being considered or supported:

Refusal to undergo testing will be viewed as evidence to support removal. It will be part of the case to be put before the Children's Court that demonstrates that there are sufficient safety concerns for a child to be in need of care and protection under s72 of the *Children and Young Persons (Care and Protection) Act 1998*.

Where restoration is being considered or has occurred:

The parent should be advised that Community Services cannot maintain a restoration case plan goal.

3. WHERE TESTING SHOULD BE CONDUCTED

Specialist pathology facilities should be used, where available, for analysis of samples and, where available, for sample collection as well. These facilities have the appropriate expertise to manage the testing procedure to ensure that tests are not tampered with and results are reliable. However, specialist pathology facilities may not be available throughout the State and in their absence, local GPs may agree to collect samples and send to pathology laboratories. In these instances, pathology laboratories supply the necessary equipment and forms for chain-of-custody.

Where a parent has entered a residential treatment facility and has consented to drug testing, Community Services should liaise with the facility to ascertain the extent to which the facility tests via methods and with the frequency and duration required by Community Services and whether it is willing to share its results with Community Services.

Where possible, Community Services should seek to utilise results obtained during treatment, post stabilisation (see below), to avoid duplication and minimise inconvenience for the parent. However, it is acknowledged that testing without chain-of-custody may occur in some facilities (which may have consequences for their value as evidence before the Children's Court.)

Delayed commencement of testing to allow for stabilisation when parents are in treatment

Advice from NSW Health drug and alcohol experts indicates that where an individual enters treatment they require a minimum of three months to stabilise on replacement therapies and positive tests would generally be expected over this period. This advice applies regardless of whether the treatment is pharmacotherapy or another form of

treatment, and whether it is delivered in a residential facility or via outpatient services. (See appendix for description of forms of treatment) In line with this advice, Community Services would only seek results from tests subsequent to the first three months in treatment.

Where a child is still in the home, it may be necessary to remove them for the duration of the treatment, if sufficient concerns exist for their safety and wellbeing and/or there is no other parent/carer able to provide care (and the treatment facility does not provide a family based service).

Where serious and persistent drug use is suspected and the parent denies it and/ or the need for treatment, consent to commence drug testing should be sought immediately. The decision about whether the child should remain in the home for the duration of the drug testing should be based on a holistic assessment of safety, risk and protective factors. The consent by the parent to drug testing is not a protective factor.

What if parents have to wait for a vacancy in a treatment facility?

If a parent is willing to enter treatment but advice from treatment providers/facilities is that preferred or optimal treatment is not immediately available, the caseworker should confirm the likely waiting period.

If treatment is likely to be available **within the next one to three months:**

- commencement of testing should be delayed
- once the parent enters treatment, the testing should commence after a three month period of stabilisation.

If treatment will not be available for a period **greater than three months:**

- testing must commence immediately unless a parent commences an alternative treatment program during the waiting period. In these cases, testing for Community Services purposes commences after a three month period of stabilisation.

In all these scenarios, the decision about whether a child can remain in the home must be based on the current assessment of safety, risk and protective factors. Willingness to undergo treatment may be a protective factor but has no bearing on the current safety and risk issues experienced by the child. At times, anxiety about treatment and the stress of abstinence and the other demands that come with treatment may further undermine parenting capacity.

4. WHEN SHOULD DRUG TESTING BE USED, WHAT ARE THE APPROPRIATE TESTING REGIMES AND THE CONSEQUENCES OF UNDERGOING TESTING?

Broadly speaking, drug testing may be used in cases to determine whether out of home care is warranted or whether restoration is feasible. The three scenarios outlined below provide more detailed information on the main situations when drug testing should be used:

1. **Prior to removal** ⁷

Where serious and persistent drug use is considered to be at least one of the reasons for a child's current risk of harm and this cannot be confirmed by other means, testing is required to determine the pattern and frequency of drug use. Drug testing will assist in determining the impact this is having on a parent's capacity to provide adequate care as part of a holistic assessment to establish whether removal of a child is warranted.

A demonstrated pattern of serious and persistent drug use supports removal; low or reduced drug use may support the child remaining at home

Drug testing in these cases will help to inform deliberations on what protective action might be required, and specifically whether a placement in out of home care is warranted. Because the focus of this testing is to establish the pattern or nature of use and the type(s) of drugs being used to determine whether serious and persistent, abstinence is not an absolute requirement, although the parent should be aiming to demonstrate abstinence, low level use or reduction in drug use over the testing period.

Positive test results may be expected in the early stages of testing. However, confirmation of serious and persistent drug use (ie daily, near daily use or patterns consistent with binge use) should flag concern about the child's safety and wellbeing at home. Confirmed drug use should always be considered alongside other factors in assessing the overall risk to the child.

2. **Prior to restoration**

Where a child has been in out of home care primarily due to the serious and persistent drug use of a parent and restoration is now being considered⁸

OR

Where drug use was not the primary concern in placement of the child in out of home care, but there are current concerns about possible serious and persistent drug use and restoration is being considered. Testing will assist in the assessment about the current situation and whether restoration is a feasible option.

Demonstrated abstinence (no positive tests) supports restoration; positive tests support a presumption against restoration

Drug testing in these scenarios will assist in determining whether there is likely to be any ongoing risk to a child if they were to return home and will help to establish whether restoration should be the caseplan goal.

Where a child has been in out of home care, abstinence is a requirement from parents in order for restoration to be considered. This is to ensure that the situation which led to removal will not be present if a child is restored. This will reduce the possibility that

⁷ 'Prior to removal' includes circumstances where a child has been temporarily and/or voluntarily removed but no orders have been sought for their placement in out of home care.

⁸ This applies equally to situations where a parent was drug tested prior to removal to establish serious and persistent use *and* to situations where there were concerns about serious and persistent drug use but testing did not occur as the child was removed due to a combination of other significant issues which testing was not required to support

a child will re-enter care, where a cycle of removal and restoration is extremely harmful to their welfare and wellbeing.

There should be a presumption against restoration where serious and persistent parental drug misuse was a primary factor in removal of the child and there is an ongoing risk of drug use which adversely impacts on parenting capacity. This presumption can only be displaced by a parental drug testing regime that confirms that the parent is not using drugs. In this sense drug testing is mandatory in these types of restoration scenarios.

Drug testing requirements leading up to restoration, e.g. (to inform the Court about contact and provide evidence of abstinence) need to be negotiated with a manager casework and the Drug & Alcohol expert who can help determine the appropriate mode and frequency of testing.

3. Following restoration

Where a child has been restored, but a further risk of harm report has been made in which drug use is a concern.

Drug testing (most often a one-off hairtest) will be used in the risk assessment process to determine whether a parent is using drugs again.

Drug use in this scenario is assessed in the same way as drug use prior to restoration. Abstinence is a requirement to ensure the previous risk is not present for the child. Apart from considerations of current safety and risk, any decisions about the future placement of the child should take into account the impact on the wellbeing of the child of a cycle of removal and restoration.

5. TIMING AND FREQUENCY OF DRUG TESTING

To support removal/placement in out of home care

As a general rule, where regular, ongoing use or binge use is suspected, the testing regime should be:

- Urinalysis conducted and spread over a period of no less than two months (eight weeks) and in that period, testing should be:
 - three times per week
 - in at least four weeks out of the eight weeks.

This may mean alternating or random weeks, provided that four blocks (weeks) of thrice-weekly tests occur within the eight weeks. The blocks (weeks) do not have to always reflect the general Sunday – Saturday week. However, if testing is available on weekends, Saturdays or Sundays may be included.

Two months is the minimum period over which a pattern of use, including binge use, would become evident.

Prior to a decision about whether a restoration goal can be pursued

Note: See Section 3 for details of timing of commencement of the testing regime for restoration if a parent is waiting or in treatment.

Ideally, testing should occur before it is agreed that a Final Order for restoration will be sought. In some instances, the Court will require Final Orders to be sought before the testing regime can be commenced or concluded. In all instances, the testing regime should be undertaken as set out below:

- Urinalysis conducted and spread over a period of no less than three months (12 weeks) and in that period, testing should be:
 - three times per week
 - in at least six weeks out of the 12 weeks.

This may mean alternating or random weeks provided that six blocks (weeks) of thrice-weekly tests occur within the 12 weeks. The blocks (weeks) do not have to always reflect the general Sunday – Saturday week.

Accepting that drug dependence is a chronic, relapsing condition and the decision to permanently remove children from their parents has life-altering consequences for both children and parents, it is acknowledged that three months is a short time in which to demonstrate abstinence (following three months stabilisation). However, it represents a compromise struck between giving a parent a reasonable chance of success and their children's need for stability and permanency.

Interaction with Court timeframes

Where the Court requires Final Orders to be sought prior to the commencement or conclusion of the testing regime, the Court should be informed of the intention to test on the understanding that if test results suggest a different outcome than anticipated (e.g. that restoration is no longer a realistic possibility or that restoration can now be pursued) a s90 Rescission Order should be sought at the appropriate time, supported by test results and evidence/information about impact on parenting capacity.

Following a decision to seek Final Orders but before order is granted

Where it is decided that restoration is a realistic possibility, drug testing should continue until Restoration occurs. During this phase, the number of blocks of time for testing would be reduced and the advice of the manager casework and appropriate Drug & Alcohol expert should guide a decision on whether hair testing or urinalysis may be used and how often this should occur.

Where a decision is made that restoration is not realistic

When restoration is not a realistic possibility, a case meeting with the parents should include an explanation of this decision and the reasons for it. Drug testing, for Community Services purposes, ceases if restoration is not a realistic possibility.

6. POSITIVE TESTS

What happens if a parent returns a positive result?

Pre removal/where a child is still in the home:

- Where drug use is suspected and positive results ensue, the focus should be on the interpretation of the pattern of drug use and its likely impact on parenting capacity. Consideration may be given to seeking specialist expert advice to interpret the results if there is doubt about whether the pattern of use is serious and persistent and advice is required about the specific aspects of the pattern of use upon parenting. This will assist in making decisions about the placement of a child.

For restoration cases:

- Abstinence is a requirement where restoration is being considered and the parent's use has previously been established as serious and persistent. After the agreed period of stabilisation in treatment, a positive test result at any time during the testing period means that, as a general principle, restoration should no longer be considered as an option. This principle is the core of the policy. (See Appendix for detailed rationale)

Exceptions

- If the caseworker and manager casework believe that restoration should continue to be explored even though a positive test has been returned, the decision should be supported by specialist advice that the drug use is not indicative of serious and persistent use. A specialist should review the case, taking into account:
 - the impact of the parent's drug related behaviours on the child/ren
 - their current and ongoing capacity to parent
 - the steps the parent has taken to reduce drug use (volume or frequency) and whether there is a reasonable prospect that the parent will be able to become abstinent, within a timeframe that takes into account the needs of the child/ren

In restoration, the initial three month testing period may need to be extended where there are early positive tests but specialist advice indicates that extension is warranted.

Where there is a pattern of positive tests, the Director Child and Family should become involved. The aim is to prevent unlimited testing and lack of timely decision-making. The Director Child and Family should review the advice of the specialist expert and all other details of the case that are held by Community Services, to determine what is in the best interests of the child.

The presumption is that positive results will mean the seeking of reallocation of parental responsibility, unless there is a formal specialist expert report which proposes

an alternative course of action. If the Director Child and Family agrees that the specialist report should override the presumption, the proposed case plan should include an agreed cycle of case review undertaken by the Director Child and Family.

7. NON COMPLIANCE BY PARENTS

What if a parent fails to comply with the undertakings to participate in drug testing?

Where a parent consents to drug testing, every test contributes to the overall results and decision by Community Services in relation to a child's case plan. Where a parent fails to appear for a test, this should be counted as a positive result in the testing process and a probable indication of serious and persistent drug use.

Would there be any exceptional circumstances which would alter this view on non compliance?

The manager casework may deem particular situations as exceptional in contributing to a parent being unable to attend a test.

This may include:

- an appointment with a specialist, which if changed would mean an extensive delay in securing an alternative time.

This would not include:

- a parent saying they are unwell and are attending a doctor.

8. SPECIALIST EXPERTISE AND ADVICE

Caseworkers should consult with Drug and Alcohol experts to assist in reading test results. Those who can assist in reading results are:

- the laboratory undertaking the test
- treatment centre a parent is involved with
- Drug and Alcohol Expertise Unit, Head Office

The Clinical Issues Unit in Community Services has a special role in supporting caseworkers in exceptional circumstances as outlined above where judgments are required, e.g. when a caseworker wants to continue restoration in spite of a positive test. Their advice may be sought on:

- the impact of drug treatment on drug test results, ie whether treatment is assisting the parent to attain and sustain abstinence,
- whether there are any relevant factors that should overturn the presumption against restoration when there are three positive tests,
- assessment of cases where there is a further risk of harm report in circumstances where restoration has been previously supported and ordered;
- frequency and duration of testing that is appropriate to the case, particularly where the primary drug is cannabis.

Appendix

i. The evidence base

In 2005 the then Department of Community Services commissioned the National Drug and Alcohol Research Centre (NDARC), at the University of New South Wales, to undertake a comprehensive review of the research evidence related to the efficacy of parental drug testing in child protection, relative to alternative approaches and tools.

NDARC's Report told us that drug testing may be used alone or in combination with approaches such as [guided] client self-assessment, clinical observation, compilation of information from interested others and from other agencies. These alternative approaches may also be successfully used in combination with, instead of, or in preference to drug testing in some circumstances. This is why drug testing should not be an automatic part of all casework but a tool to be deployed according to the guidance set out in the Parental Drug Testing Policy.

The report covered the costs and distinctive features of different drug testing methods and helped us determine which methods best suit different casework scenarios.

The report noted that drug use itself does not automatically equate to risk of harm to a child. The misuse of drugs and alcohol by a parent does not necessarily mean a child is at risk. Parenting capacities can vary as widely in substance misusing parents as in non-using parents. However, at its worst, life with a parent or carer who abuses drugs or alcohol can involve physical violence, neglect and sexual or psychological abuse. Testing for the patterns of drug use can assist in assessing the degree to which parental capacity is being compromised by drug use.

Parents who misuse alcohol and other drugs often have other multiple and complex problems which impact on their capacity to care for and protect their children. They tend to possess fewer protective and coping strategies and this increases the risk of harm to children and young people. In addition, the parental pre-occupation with obtaining and using drugs, intoxication and recovery from the effects of drugs or alcohol, are likely to impact seriously on parenting ability.

ii. Impact of drug use on the welfare, wellbeing and safety of children

The evidence base clearly illustrates that the safety, development, attachment, stability and security of children are compromised by living in households where there is serious and persistent drug use and equally by return to homes where substance use is ongoing or characterised by periods of abstinence and relapse.

A repeated pattern of removal and restoration (coinciding with periods of parental abstinence and relapse) is inherently harmful for children of any age, but particularly for babies and infants. This should be a key consideration in case assessment, planning and review processes with families and in discussions with any agencies that are essential to the implementation of the case plan.

Long timeframes for treatment and unpredictable outcomes for adult recovery (which may involve cycles of relapse and engagement and disengagement with treatment) pose risks to the safety, welfare and wellbeing of children. The safety, welfare and wellbeing of babies and infants in particular will be poorly served by remaining long term in chaotic households where drug use predominates, even if there are intimations of recovery for the primary carer(s) some time in the future.

Similarly, child protection interventions which remove and restore children in response to a parent's treatment cycle of use, abstinence and relapse, are prejudicial to a child's attachment and development, particularly where that child is a baby or an infant.

iii. Abstinence

Research evidence suggests that abstinence is often but not always an appropriate treatment goal for parents whose children's safety and wellbeing has been compromised by their drug use.

NDARC has advised that the level of drug use which begins to compromise functioning and parental care is a reasonable proxy for the transition from problem use to dependence. The October 2003 Child Welfare Practice Update is devoted to the issue of substance abuse, dependence and recovery in the context of child protection. Their expert view is that:

- abstinence is generally an expected outcome of treatment for individuals who meet the diagnostic criteria for substance dependence;
- abstinence is generally not required for individuals who meet the diagnostic criteria for substance abuse, although temporary or long term abstinence may be required, "particularly for adults involved in the child welfare system, wanting to maintain parental rights.

In either case, treatment goals need to be appropriate to the diagnosis (dependence versus abuse) and should be developed by the individual in treatment, the treatment service provider/professional and other service providers involved in supporting change. Clearly, for dependent users suffering "a multitude of negative consequences, e.g. job loss, arrest, illness, which compromise the care of their children, abstinence is an appropriate treatment goal."

iv. Link with the Permanency Planning policy

There is a strong link between the key requirements of the Drug Testing policy and the Permanency Planning policy. Under the Permanency Planning policy a decision about whether restoration is a realistic possibility is expected to take:

- no longer than six months for children under two years of age, and
- no longer than twelve months for all other children and young persons.

Taking these timeframes into account, drug testing must be conducted in a manner to allow for decisions about permanency to be made. As testing for restoration requires a minimum period of 12 weeks (three months) of testing, this will mean that for:

- Parents of children under two should commence drug testing no later than the three month point from the date of entry into care. This will enable a decision on restoration to be made with confidence at the six month point.
- Parents of children over two should commence drug testing no later than nine months after removal if restoration is under consideration.

For parents of children over two years, the above does not mean that testing cannot be commenced earlier i.e. immediately after they have been in treatment for three months or at any time before this if they have declined to enter treatment.

The aim of testing at the earliest point within the parameters of the policy is to prevent children “drifting in care”.

v. Drug testing – what it can and cannot do – strengths and limitations of urinalysis and hair testing

Drug testing cannot confirm substance abuse or dependence. However, frequent testing can confirm suspicion about frequency of use and this can be used as a proxy measure for dependence. While frequency of use does not equate to abuse or dependence, confirmation of frequent use, coupled with other observations, can reliably suggest abuse or dependence.

No method of testing, except blood testing (which is prohibitively expensive and invasive at this point in time), can reliably determine the level (dose) of drugs taken by an individual. However, the absolute level of drug taking is not as important as frequency and patterns of use when the issue is the impact on the care and protection of children.

Drug testing can provide reliable information about which drugs have been used in the past months and which drugs are currently being used.

Different methods of testing are required to determine current use and past use.

The windows of detection (the amount of time that drugs remain detectable in a person’s system through testing) vary for different drugs.

Hair testing and urine testing can both determine that use has occurred and the type of drug or drugs ingested. Both urine and hair testing offer good reliability and validity under optimum conditions.

Hair testing cannot detect use within the previous seven days but allows reliable, retrospective analysis as the drug metabolites are kept in a stable manner and are not excreted. It is useful for determining whether a person has used over the past several months and the range of drugs they have used.

Urine testing detects recent use as the detection window is one to three days for most drugs before the drug metabolite is no longer detectable. It shows the person's current usage and the range of drugs (but not how much) they have used over the last few days.

Testing schedules need to be determined in accordance with the detection windows for particular drugs and must be regular but random and monitored.

Urine testing detection windows for recent use (based on half-life of drugs) are:

- Amphetamines, 2-4 days
- Cocaine, 2-3 days
- Opiates, 2-3 days
- Cannabis - casual use, 2 -10 days
- Cannabis - heavy use, 30 days, though some laboratories guarantee results up to 60 days
- Benzodiazepines, 2 days to 2 weeks

Polydrug use affects detection periods. The frequency required for urine testing to effectively detect drug use varies according to the type of drug and nature of the use.

However, if the range of drugs used is not known, urine testing would need to take place 2-3 times a week.

In view of the above information, if testing establishes that the drug of concern is cannabis, expert advice should be sought in regard to varying the testing regime as 2-3 times per week may be unnecessary and inappropriate.

vi. Treatment and rehabilitation

While Community Services focus in undertaking drug testing is timely decision making for children, supportive efforts should be made to facilitate access to treatment and rehabilitation. The main forms of treatment available are:

- detoxification, which aims to achieve safe and humane withdrawal from a drug of dependence but is not an independent treatment for drug dependence
- pharmacotherapies, (where medicines ie methadone, buprenorphine, with a similar effect to the drug of dependence, are used for replacement or withdrawal) which are methods of managing opiate dependence, reducing heroin use and improving psychosocial functioning

- residential care, which involves between three to twelve months living in a therapeutic community with the aim of abstinence and personal growth;
- outpatient counselling, day programs and cognitive-behaviour therapy, which are appropriate for cannabis and psychostimulant problems but less effective for entrenched dependent opioid use,
- self-help or 12 step programs, which involve attendance at groups such as Narcotics Anonymous, whose effectiveness has not been researched but which may be an integral part of treatment for individuals lacking support and valuing a social network of supportive abstinence.

Specialist Drug and Alcohol Services can best evaluate the particular needs of an individual. The Alcohol and Drug Information Service (ADIS) provides 24 hour, 7 days per week, confidential advice, information and referral. Information about referral and the availability of treatment services can be found on the Community Services Drugnet site or at www.health.nsw.gov.au.

vii. Legislation to be considered in terms of a child's safety, welfare and wellbeing

Under Section 8(a) of the *Children and Young Persons (Care and Protection) Act 1998*, children and young people need to receive such care and protection as is necessary for their safety, welfare and wellbeing, having regard to the capacity of their parents or other persons responsible for them. Particularly where restoration is being considered, acceptance of extended periods of parental drug abuse is inconsistent with fulfilling this duty.

Where serious and persistent parental drug use is confirmed, the following principles in the *Children and Young Persons (Care and Protection) Act 1998* are also relevant and should be considered in decision making:

- Section 9(a) - that the safety, welfare and wellbeing of a child or young person who has been removed from his or her parents must be the paramount consideration
- Section 9(f) - if a child or young person is placed in out-of-home care, arrangements should be made, in a timely manner, to ensure the provision of a safe, nurturing, stable and secure environment, recognising the child or young person's circumstances and that, the younger the age of the child, the greater the need for early decisions to be made in relation to a permanent placement.