Child Protection and the Methadone Prescribing Physician
Who are we?

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Acknowledgements

Lets talk
Key Messages!

• Duty to report
• Child safety is paramount
• Parents are accountable
• Collective responsibility

WHAT CHILDREN NEED MOST........
LOVE Respect to PLAY
to have fun to be seen
TO BE LISTENED TO
Your presence A hero
A fostered sense of wonder
LOTS OF HUGS To PLAY
The chance to make mistakes
Encouragement to try again
Room to grow DREAMS
To be told YES!
To be trusted Affection
GUIDANCE TO PLAY

Growing A Jeweled Rose.com
Putting All the Pieces Together Before Time Runs Out

Treatment & Stabilization

Legal issues

Multi systemic involvement (complicated)

Legislated time caps

< 6 years = 1 year

> 6 years = 2 years
Myth or Fact

1. The majority of children in CAS care never go home.
2. Most families that experience a child protection investigation loose a child to CAS care.
3. CAS has the power of entry and search without a warrant.
Do Drug Addicted Parents Immediately Represent a Child Protection Threat?

Let's ponder......
Do Drug addicted Parents have a higher likelihood that their addiction related issues will devolve into a child protection concern?
Do Experts Think Substance Abuse = Child Protection Concerns?

Australian study
• 119 infants compared to 238, 4 year follow up
• 52% maltreatment victims
• Only 6% from non substance abuse mothers
• 25% entered foster care as opposed to 2%

Scottish Study
• In reviews of reasons for child protection services, researchers discovered that up to 70% of clients open for protection orders had substance abuse as the primary cause of concern.
Dr. McGlades Conclusions

1. Infants of substance-using mothers have much poorer child protection outcomes than infants of non–substance-using mothers.

2. Association between maternal drug use and child abuse.

3. Greater interagency collaboration is urgently required to reduce this risk.

The Scottish Conclusion

1. Children’s welfare is the most important consideration.

2. Parents with drug problems need professionals to take responsibility for their children’s welfare when they are no longer in a position to care for them adequately.

3. Parents told us that they believed that agencies must do so, though they may well fight against this in practice.

Getting our Priorities Right
Policy and practice guidelines
for working with children and families
affected by problem drug use

When the odds are 50/50 for Child Maltreatment:

• What can one do?
• What can professionals do?
• CAS?
Why the poor child outcomes for Parents with Addictions?
Role of Social determinants of health?

Generational issues

Drug taking for this group could be understood as a symptomatic response to long standing social inequalities and personal difficulties …

(Buchanan and Young 2000; SEU 2002; Buchanan 2004).
What's the Potential Size of the Challenge?

NIDA literature

73% were poly drug users and/or involved in anti-social activities.

Both of which represent a compromised ability to parent. [http://international.drugabuse.gov/about-us](http://international.drugabuse.gov/about-us)
To report or not?

Across the pond…U.K.

The research conclusion: ‘children can experience improvements in their lives and those of their families, when the complexity of ‘Hidden Harm’ is grasped and co-ordinated responses between and across adults' and children's services are developed and put into practice’

Beyond Drug Addiction - It is About Responsible Parenting

A New Brunswick toddler died. The 23-month-old girl died on Wednesday at IWK Health Centre in Halifax, according to an RCMP news release. According to an RCMP statement, paramedics were called to a home in Havelock, N.B., on Jan. 8, where they found the girl. Two people were arrested and later released, but no charges have been laid. RCMP say the death is being considered suspicious and the investigation is continuing. Havelock is about 50 kilometres west of Moncton.

Friday, January 15, 2010
Canwest News Service
The parents of a 2-year-old boy who was given methadone have been arrested in Phoenix on charges of child neglect and child abuse. A friend of the couple's, who was also arrested for supplying the methadone, told police the family had been moving around because Child Protective Services was trying to remove the children from their parents. The 2-year-old became fussy at some point resulting from a unknown cause, the toddler's gums were bleeding and his teeth were rotting. The parents used methadone instead of an over-the-counter treatment for the issue. Court records show the boy had methadone, amphetamine, acetone and nicotine in his system.
Case Study From Ontario Paediatric Death Review Process under the Office of The Chief Coroner

A 9-month-old infant died suddenly and unexpectedly in his crib

There was a long standing history of Child protection intervention in response to allegations of neglect, domestic violence and substance abuse which spanned thirteen (13) years. The Methadone clinic knew of the child welfare concerns but did not report new information.

Both of the decedent’s parents were on methadone, the mother due to drug addiction and the father as a result of addiction to prescription pain killers stemming from an earlier injury.

The father of the decedent had been prescribed psychotropic medication commonly utilized in the treatment of mood disorders, a diagnosis which was unknown to the Children’s Aid Society.
Recommendation of the Paediatric Death Review Committee (Office of the Chief Coroner)

- The Society should dialogue with the local Methadone Clinic(s) about their Duty to Report obligations under the *Child and Family Services Act*.
- Physicians who see patients with substance abuse disorders should report these clients to a CAS where there is evidence of ongoing substance abuse and the client is in a parenting capacity.

Rationale:
- Submitted documentation indicated that the biological mother repeatedly tested positive for numerous illicit substances yet the Methadone Clinic made no child protection referral.
- Compounding this was the clinic’s knowledge that the Children’s Aid Society was actively involved with the family.
Flow of Information in Ontario’s Child Death Review Process

Death of Child

Investigating Coroner
Conducts investigation

Regional Supervising Coroner
Refers case to expert committee

CAS Involvement
Open case file at time of death; or within 12 months prior to death

Medical Issues or Family Concerns

Paediatric Death Review Committee
Reviews case and issues report

Coroners Role
Why is the Obvious so Challenging?

Key issues are:
1. The wide variations between professions and, in some cases, within professions about what constitutes drug misuse and what constitutes unacceptable risk patterns of behaviour;
2. The conflict in respect of the focus and priority of the different professionals - some aligning themselves with supporting the drug using parent, while others align themselves with protecting the child;
3. The lack of shared training and opportunities for developing shared interprofessional understanding
4. Lack of system leadership and demand for coordinated local community response and case management
What Does the Law Say?
The Child and Family Services Act

Ontario’s Child and Family Services Act (CFSA) provides the mandate and legal framework for the work of Child welfare in Ontario.
Paramount Purpose of the Act

The paramount purpose of the Act is to promote the best interests, protection and well being of children.
The Act recognizes that each of us has a legal and moral responsibility for the welfare of children.
The CFSA states that:

- members of the public, including professionals who work with children, have an obligation to report promptly to a children’s aid society if they suspect that a child is or may be in need of protection.
“Child in Need of Protection”

The Act defines the term “child in need of protection” and sets out what must be reported to a children’s aid society. It includes physical, sexual and emotional abuse, neglect and risk of harm.
Some high Spots to emphasize

• Balance of Probability vs. Beyond a Reasonable Doubt
• Err on the side of caution
• Legislation is both reactive and proactive:
  - Reactive - “the child has suffered ...”
  - Proactive - “There is a risk that child is likely to suffer...”
Examples of things that should be reported

- Physical Abuse
- Sexual Abuse
- Emotional Abuse
- Neglect of basic needs
- Lack of supervision
- Exposure to violence
- Corruption
- Adult conflict
- Failure to protect from harm
Responsibility to report

If a person has reasonable grounds to suspect that a child is or may be in need of protection, the person must promptly report the suspicion and the information upon which it is based to a children’s aid society.
What are “reasonable grounds to suspect”?

You do not need to be sure that a child is or may be in need of protection to make a report to a children’s aid society.
How do I know whether to report or not?

“Reasonable grounds” are what an average person, given his or her training, background and experience, exercising normal and honest judgement, would suspect.
Ongoing Duty to report

The duty to report is an ongoing obligation. If a person has made a previous report about a child, and has additional reasonable ground to suspect that a child is or may be in need of protection, that person must make a further report to a children’s aid society.
Persons must report directly

The person who has the reasonable grounds to suspect that a child is or may be in need of protection **must make the report directly** to a children’s aid society themselves. The person must not rely on anyone else to report on his or her behalf.
Special Responsibilities for Professionals

Professional persons are held to a higher standard under the legislation based on the appreciation of the persons professional training and an assumption that their knowledge is higher than the average person when it comes to recognizing that a child is or may be in need of protection.
Penalty for failure to report

The Act recognizes that persons working closely with children have a special awareness of the signs of child abuse and neglect, and a particular responsibility to report their suspicions, and so makes it an offence to fail to report.
When might you need to report?

You need only have a worry. If you are slightly concerned that is generally enough to prompt you to make a referral to a children’s aid society.
Protection from Liability

Any person who has made a report will be protected against civil action, unless he or she acted maliciously or without reasonable grounds for his or her suspicion.
What will the Children’s Aid Society do when you make a report?
Determining Eligibility
Supporting families while protecting children

Child Protection workers work with families to try to build on the strengths within the family while lowering any risks that threaten the safety of the children.
A children’s aid society worker may, as part of the investigation and plan to protect the child, involve the police, other community agencies and extended family members of the child.
Excerpts from A Child Welfare Training Approach

The main emphasis of this Training is to make explicit the nature of the connection between substance abuse and the reason for the child protection intervention. While a corollary strategy may include reducing or stopping substance use, the primary focus should be on child safety. Secondly, reducing the negative impact of substance use on the child(ren) and the larger family system. The priorities of intervention where children may be at risk are to:

1. Err on the side of caution - While engaged in assessment and treatment support, staff need to be focussed on their primary responsibility. In situations where the substance user is a current caregiver or a parent, then the safety of the child/ren must be paramount. This means safety planning for the child(ren) comes before assessing the parents substance abuse patterns and the development of intervention or service plan goals.

2. After safety is assured the service plan can focus on strategies to enhance the protection and care for the children with a particular emphasis on improving parenting skills, reducing addiction-related problems and developing other psycho-social, health enhancing behaviours and skills in the parent.
10 Steps in Intervention

**Assessment**
- Step 1: Establish a Relationship of honesty with the person
- Step 2: Establish a connection between alcohol & other drug use & parenting
- Step 3: Signs of safety- Strength based/child focused approach to develop any necessary safety plans
- Step 4: Third Party corroboration
- Step 5: If a child protection issue exists, Identify your bottom-line & non-negotiable expectations

**Intervention**
- Step 6: Plan short-term achievable goals
- Step 7: Explore external counselling or support required for abuser & any other family members?
- Step 8: Identify any external, environmental factors requiring your advocacy, The Bumps ahead approach
- Step 9: Monitor progress with constant re-assessment and concurrent planning
- Step 10: Plan to Close case, post intervention support to maintain safety and sobriety
Harm Reduction-Can it work?

Often part of the negotiation of a service plan in child protection will involve strategies that are frequently referred to under the umbrella heading of Harm Reduction. The steps of identifying and reducing specific substance abuse-related harms (harm reduction strategies) in child protection should be undertaken by:

1. exploring the possibility of reducing or stopping drug use, how likely is it that the substance abusing person can control their consumption and comply with a harm reduction model as well as
2. identifying and reducing drug-related harm to self and others. This is the “non-negotiable” part of service planning. Weigh up the costs and benefits of these strategies along with careful review of the impact on the child(ren) – Is harm reduction sufficient to reduce child protection concerns in the long term?

3. Harm reduction is not limited to substance use. It must cover all aspects of effective parenting, finances, supervision and safety, psycho social, emotional impacts on the child(ren) and so on.

NB: The overall aim is to ensure that the key harms, particularly those that are related to child protection are reduced sufficiently in a durable plan over time.
Manage the Risks

First Rule of Intervening **Do no more Harm**

Harm maximisation can result from imposed cessation of substance use as well as strategies which may seem like harm reduction.

Do not promote or agree to a Harm Reduction intervention strategy unless you are sure it will **Do no more Harm**
The Role of Toxicology Screening
Toxicology Screening is an Exercise of Absolute Power

Toxicology screening is a frequently used method of determining if a substance abuser is or has been using. Beyond the chemistry it can be a de-humanizing and oppressive intervention strategy that demonstrates a real power imbalance between the client and those attempting to support their recovery. This elephant needs to be taken out of the room.
Toxicology Screening can be a Useful Tool in Working with Substance Abusers

Abstinence Interventions frequently rely on random screens as a component of the intervention. Screening during a Harm Reduction intervention can serve to demonstrate frequency and intensity of use and provide a measure of compliance with the Harm Reduction plan. Screening can become a crutch to the assessor replacing more comprehensive investigations that focus on linking misbehaviour to impact.
Screening is Only One Aspect of Assessment

Historically, we have tended to place undue emphasis on drug or alcohol test results in our assessment of the problem. Identification of drug or alcohol use itself is but one piece of an assessment that requires a broader context. It is the connection between substance abuse and behaviour; including lifestyle choices that more likely place a child at risk. This must be the primary focus of our assessment.
The Bottom Line

If necessary Toxicology screening should be considered at best a component in the overall assessment of parenting and consequent risk to a child. A comprehensive assessment means that you have completed an overall assessment of the parent’s behavior and functioning, in and outside of the home. Whether the parent is using or not is immaterial if they are still maltreating the children in other ways.