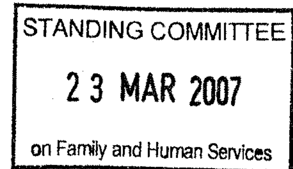

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Submission to the Inquiry into the Impact of Illicit Drug Use on Families 2007.

Parliament of Australia
House of Representatives
House Standing Committee on Family and Human Services

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Submission to the Inquiry into the Impact of Illicit Drug Use on Families 2007.
Parliament of Australia House Standing Committee on Family and Human Services

Submission by: Barnardos Australia.

Acknowledgements:

This submission reflects the work of a group of inspired and inspiring workers in the Illawarra region of NSW who have for the past 5 years worked tirelessly to develop a service for drug addicted pregnant women, their children and families. To those workers Barnardos thanks you.

Most importantly this submission acknowledges the strengths and motivation of those women and men who have turned their lives around to nurture and parent their new babies and growing families.

Executive Summary:

This submission addresses the following terms of reference:

1. the impact of harm minimisation programs on families; and
2. ways to strengthen families who are coping with a member(s) using illicit drugs.

Its focus is on innovative models of work to strengthen parenting of young children by parents who use illicit drugs . This submission highlights in particular a model of collaborative practice between state government health and child protection services and family support non government programs. This collaborative service works with pregnant drug affected women / families antenatally using a family based approach and continues through to the age of 3 years for children.

The submission also highlights the literature on the impact of collaborative approaches with drug affected families expecting a child . These approaches are underpinned by harm minimisation approaches and the international models which demonstrate these approaches to be highly successful.

The submission argues that there needs to be support for evidence based family approaches which clearly support drug affected families to parent their children where this is a safe option for the child. In the event of a lack of safety for the child then permanency planning principles need to ensure clear decisions are made to take the child into long term foster care with the provision for adoption for babies. The literature on the harmful effects of the care system on children will be cited as a precautionary note that a child's biological family is still, in the majority of cases, the best place for them and we need to be supporting families who are able to demonstrate their good enough parenting capacity and who will resolve their illicit drug use and its associated problems.

The evidence is overwhelming in what works for the children born to families who use illicit drugs. The research is clear that strategies targeting pregnant women and their families which are

- multidisciplinary,
- operating across health, child protection and family support aspects of service delivery being across both government and non government services

- delivered early in pregnancy to ensure good outcomes for stabilisation of drug usage and provision of good ante natal health care
- which are also delivered over a sustained number of years for the child
- and not focussed solely on one aspect of the care only eg drug usage or ante natal care

are effective in gaining not only short term benefits for babies but longer term benefits for the children of drug affected families. The literature on attachment, early intervention and crime prevention also supports the message that a harm minimisation approach which works to engage and support families through sustained delivery of service and which address holistically the family needs , will produce longer term benefits for children. This success is reflected in their involvement and success in the education system, reduction in involvement in the criminal justice system and reduced behavioural problems.

The out of home care system and child protection system cannot hope to provide viable alternative care for all children of drug affected families in Australia. These systems should rightfully be utilised for children for whom safety in the family can never be guaranteed. Models which support families to stabilise their drug usage and address the complexities of their lives as well as develop the necessary parenting expertise and capacity must be explored and funded to ensure children receive the best possible start in life.

What we Know:

Obstetric Management of Women using Illicit Drugs:

- *Drug Using women have poor ante natal health care without the provision of services to engage and support them during the pregnancy.*
- *Unstablised drug use during pregnancy causes neonatal harm.*
- *Early engagement of these women gets improved infant outcomes.*

" Obstetric management of substance using women is complicated by a number of factors that may impede adequate care i.e. inadequate ante natal care, homelessness, social isolation, domestic violence, depression, poverty.(Deren, 1986; Hoegerman, Wilson, Thurnomd & Schnoll, 1990; Householder, Hatcher, Burns & Chasnoff, 1982; Kaltenbach and Finnegan, 1989).) Substance using women are prone to removal of children into government care and avoidance of mainstream services (Mikhail & Curry, 1999; Green & Gossop, 1998).

Permanent harm brought to babies of substance using women include the neonatal affects of unstablised drug usage (Neonatal abstinence syndrome) (Thandi, 2002; Green and Gossop, 1998; Field, Scafidi, Pickens, Prodromidis, Pelaez-Nogueras, Torquati, Wilcox, Malphurs, Schanberg & Kuhn, 1998; Connaughton, Reeser, Schut & Finnegan, 1997; Lam To, Duthie & Ma, 1992; Chasnoff, Griffith, Freier, & Murray, 1992; Doberczak, Kandall & Wilets, 1991; Abel & Sokol, 1986; Rosett, Weiner, Lee, Zuckerman, Dooling & Oppenheimer, 1983; Finnegan et al., 1975) in addition to harm associated with a substance using lifestyle (Assi-Lessing & Olsen, 1996; Buka, 1991; Fried & Watkinson, 1990).

Services targeting this group for earlier engagement, increased antenatal care and/or reducing/stabilised drug use have demonstrated improved infant outcomes (Kelly Davis & Henschke, 2000; Green & Gossop, 1998; Daley, Argeriou, and McCarty, 1998; Carroll, Chang, Behr, Clinton & Kosten, 1995; Malpas, Darlow, Lennox,& Horwood, 1995; Freda, Chazotte & Youchah, 1995; Chang, Carroll, Behr & Kosten, 1992; Dawe, Gerada, Strang, 1992; Finnegan, 1991; Jarvis & Schnoll, 1994; Morrison Siney, C., Ruben,

S. M., & Worthington, et al., 1995; McLellan, Arndt, Metzger, Woody & O'Brien, 1993; Suffet & Brotman, 1984).[1]"

Long term Infant Outcomes:[2]

- *Babies born to drug using women are at increased risk of abuse and neglect, health and behavioural problems if not provided with family based support services over longer periods of time.*

"Infants born to substance using women are at increased risk of physical abuse and neglect, asthma, learning disabilities, and behavioural problems (Buka, 1991; Fried & Watkinson, 1990). However, it remains undetermined to what extent these difficulties are due to prenatal drug exposure or to the environmental factors that may accompany substance use (i.e. poverty, homelessness, level of educational attainment, lack of support).

Marijuana in utero disrupts neurodevelopment; it can cause fetal growth retardation and subtle, long lasting neurobehavioral abnormalities through effects in the prefrontal cortical regions of the brain. In neonates, cannabis has been associated with transient irritability tremors, and an exaggerated startle reflex. After this early period, there is little evidence of adverse neurobehavior in children followed up to 3 years. However, in older children (up to 12 yrs), exposure is associated with inattention, hyperactivity increased impulsivity and delinquency and deficits in short-term memory tasks and problem solving.

Cocaine is a human teratogen that causes abnormalities of the heart, limbs, face, bowel and genitourinary tract. Neonatal effects include hypertension and vasoconstriction, causing decreased uterine blood flow and fetal hypoxia. Inkelis, Spierer and Insenberg (1988) reported temporary ocular abnormalities in 40 neonates exposed to cocaine. Premature detachment of the placenta, spontaneous abortion, prematurity, and congenital malformations have all been associated with cocaine (Chasnoff, Burns, Schnoll & Burns, 1985; Cook, Peterson & Moore, 1990). Oro and Dixon (1987) found significant neurological and physiologic alterations in neonates exposed to cocaine and methamphetamine. Abnormal sleep patterns, tremors, poor feeding, hypertonia, vomiting, sneezing, high pitched cry, frantic fist sucking, tachypnea and hyperreflexia were also noted (Oro & Dixon, 1987). Cocaine-exposed neonates have also exhibited an impaired ability to orient and control muscles, which, in 4 month-olds, led to abnormalities of muscle tone, reflexes and volitional movement (Cook, Peterson & Moore, 1990). Low birth weight/size and smaller than normal head circumference (microcephaly) have also been found in cocaine-exposed infants. 15-month old infants with low birth weight and microcephaly have been found to have a higher incidence of abnormal neurologic behaviours (hypotonia, hypertonia, seizures, and hydrocephalus) than low birth-weight babies with normal head sizes (Gross, Oehler & Eckerman, 1983). At five years of age, children with low-birth weight and microcephaly had significantly lower scores on the general cognitive index of the McCarthy Scales of Children's Abilities than low birth weight only children or controls. Differences in brain stem auditory response potentials have been found in multiple drug and cocaine exposed infants compared to non-exposed infants (Shih, Cone-Wesson & Riddix, 1988). It has been suggested this is caused from interference from the myelinization process (Salamy, Eldridge Anderson & Bull, 1990) and would have implications for language acquisition, which depends on auditory input and feedback (Madison, Johnson, Seikel, Arnold, Schulthesis, 1998). Various studies have found evidence of language delays in cocaine and multiple drug exposed infants ranging from 1 to 4 years of age (Johnson, Seikel, Madison, Foose & Rinard, 1997; Von Barr & de Graaff, 1994; Angelilli, Fischer, Delaney-Black,

[1] Hudoba, Michelle: Independent SUPPS Evaluator Illawarra Institute for Mental Health, University of Wollongong. Research summary for Baxter Health Awards submission 2004.
[2] Hudoba Michelle, Substance Use in Pregnancy and Parenting Service [SUPPS] Evaluation [Part 2] Wollongong NSW: University of Wollongong Illawarra Institute for Mental Health. March 2005.

Rubinstein, Ager & Sokol, 1994; Nulman, Rovet, Altman, Bradley, Einarson, & Koren, 1994; Von Baar, 1990). More specifically, Madison et al (1998) have found an increase in the use of and frequency of phonological processes by the drug-exposed infants. These are substitutions and ommisions (eg assimilation, cluster reduction, fronting, syllable or consonant deletion), which contribute to language development delays. As the phonological patterns are delayed rather than disordered, clinicians should rely on remedial approaches and techniques that are effective on all phonologically delayed children (Madison et al, 1998).

Amphetamine-induced malformations have been observed in some animals at high doses. A low risk of birth defects (oral clefts, cardiac defects) have been noted in infants of women taking amphetamines for recreational use, although a causative association has not been established. However, there is much evidence of a significant risk of interuterine growth retardation, decreased head circumference, premature delivery and increased maternal, fetal, and neonatal morbidity, as well as altered growth and neurobehaviour still evident after puberty.

There is little in the literature on the effects of hallucinogens, and results are often confounded by other factors such as the simultaneous ingestion of other drugs. There is no published evidence that LSD causes chromosomal abnormalities, spontaneous abortions or major congenital malformations. PCP has been associated with congenital defects and neonatal neurobehavioral dysfunction (irritability, jitteriness, depression, hypotonia, poor feeding and poor sucking reflex), but these effects have not been observed at age two.

Narcotics (eg heroin, methadone) cross the placenta rapidly and can cause neonatal withdrawal at birth. The neonatal effects of heroin and methadone dosing were reviewed in the previous report (Hudoba et al., 2002). Some studies cast doubt on the long-term, detrimental effects of prenatal heroin exposure on child development. Michailevskaya, Lukasov, Rar-Hamburger and Harel (1996) examined 336 children for developmental delays and behavioural disorders from 6 months old to 6 years. While children born to heroin-addicted parents had a high incidence of hyperactivity, inattention and behavioural problems, the developmental and intellectual capacities were lowest in those children in the low socio-economic status and environmentally deprived control group (Tomison, 1996). Those children born to heroin using mothers that were removed from the home at a young age and adopted, scored as well as the "normal" control groups, while the children raised at home scored significantly lower (Tomison, 1996). Therefore, for children born to heroin using mothers, born without any significant neurological damage, developmental outcome appeared to depend more on home environment than heroin exposure. Werner's (1989) longitudinal study indicated that exposure to adverse social conditions, such as harshness in parenting behaviour, is ten times more likely than perinatal complications to result in poor development.

These findings would suggest that factors such as social support, parenting skills, the parent-child relationship and family resources should be taken into account when making decisions on what is in the child's best interest, and not only substance use (Assi-Lessing & Olsen, 1996). Also, parenting skills should be a focus of postnatal care programs. Effective interagency cooperation between alcohol and drug services, family support services and child protection units is needed to assess and prevent the maltreatment of children in "at risk" families."

Drug Use and Child Abuse:[3]

- *Drug use of parents does not mean as a general rule that drug using parents cannot parent.*

[3] Op cit

- *Some drug using parents will not be able to provide a safe and nurturing environment for their children and good long term foster care or adoption should be provided in these circumstances with a focus on the needs of the child for permanency.*
- *Drug using parents with the appropriate type and intensity of services can stabilise their lifestyles and environment to be able to parent their child/ children.*
- *Drug use of parents and child protection issues are intricately related in a complex web of factors which must be considered when addressing issues of what is in the child's best interest.*

" A UK study that compared 68 infants of pregnant drug users to 127 infants of non-users (matched for social class and gestational age) based on information in the child protection registers and child health surveillance records, found that maternal drug use does not necessarily lead to unacceptable levels of parenting (Street, Harrington, Chiang, Cairns & Ellis 2004). The overall risk of child protection proceedings was 32% for children of drug users, 25% higher than those of non drug users, but most of the excess risk was explained by the small group that was taken into care. For the majority of the 22 children, concerns were short lived and they were subsequently de registered (Street et al 2004)."

Recent figures provided by the Dept of Community Services state that in 80% of child abuse reports that drug and alcohol abuse was present. In Victoria two thirds of substantiated cases of abuse and neglect involved drug or alcohol abuse concerns.

Collaborative Models of Practice:

- *Services working together in a collaborative model have been shown to produce superior outcomes for families than other approaches.*

Case or care coordination has become recommended best practice in child welfare and health in general as families may require the help of many disciplines and community services (Laird and Hartman 1985; Pecora, Whittaker & Maluccio, 1992; Voydanoff, 1995). In addition, a lack of care coordination or continuity of care is often identified by many inquires into children dying while services are involved (Reder, Duncan & Grey, 1993). Both viability of a program and its outcomes for its clients are likely to depend on effective resource sharing between organisations (Hasenfield, 1983; Jones and May, 1992).

A consultancy was funded via the Dept of Community Services by Barnardos into Drug and Alcohol Use in Pregnancy: Collaborative Models of Services for Women, Children and their Families [4] in 2006. This consultancy identified 3 models of collaborative practice to achieve outcomes for drug using families and their babies:

> "Women enter a complex care system when they become pregnant. If the woman or partner has drug use issues or presents with other 'problems', 'risks' or 'vulnerabilities', there is potential to interface with a formidable list of care professionals, particularly if you live in Sydney: antenatal hospital staff (nurses and doctors), general practitioner for shared care, hospital social worker, drug and alcohol nurse, child and family health nurses, specialist medical staff for woman and baby, methadone service staff, other drug treatment staff, mental health workers, child protection staff, DoCS early intervention staff, NGOs for early intervention, Tresillion/Karitane. Other services may be enlisted beyond this inner circle and may be contacted on behalf of the woman by

[4] Barnardos Australia, Drug and Alcohol Use in Pregnancy: Collaborative Models of Services for Women, Children and their Families. Report of a project conducted on behalf of Barnardos South Coast by Michelle Wheeler consultancy. Funded by Dept of Community Services March 2006.

a case manager or through referral and liaison. They may include Centrelink, Housing, Aboriginal health services, NGOs offering support to baby/infant/woman or family as a focus.

There will be multiple screens implemented and potentially a number of comprehensive assessments of both health status and functioning in the community across a broad number of domains.

Where the range of interventions indicated by assessment processes are tightly coordinated, the goal of seamless provision around woman, baby and family appears more attainable. This takes considerable effort and resourcing for activities outside direct client contact: planning tasks, identifying needs, advocating for client group, beg/borrow/steal resources, grant applications, development of clinical pathways, protocols, referral processes, assessment regimes, data base development to monitor care and outcomes, case review meetings, care supervision, network meetings, management meetings, discipline accountability.

A number of models exist for coordinating support for substance using women during pregnancy and in the period following birth. Most coordinated services go beyond the immediate perinatal period (6-8 weeks) to infant care (some 0-2 years, some 0-3 years) and some to school starting age of 5. Intensive work however is focussed on the antenatal period, birth, postnatal period in hospital (5-7 days) and discharge planning and supporting early parenting (emphasis on attachment/bonding).

There have been good outcomes documented[5] both in Australia and in the UK, US and Europe for pregnant women with problematic drug or alcohol use and their children who receive early, comprehensive and consistent care. Research studies report benefits along dimensions that include engagement in antenatal care, levels of medical intervention, neonatal and infant outcomes, parental care outcomes, family functioning and measures for various early intervention interventions, particularly home visitation.

In NSW, two services with published evaluations[6], SUPPS Illawarra and the RPAH Perinatal and Family Drug Service, have demonstrated the effectiveness of the multi-disciplinary, multiagency coordinated service focussed on the needs of woman and child, and family (in the case of the RPAH service), from pregnancy well into the early years of the child."

The consultancy demonstrated 3 models of collaboration which were viable and possible in working with this target group:

" The dimension of service that is highly variable is the nature of collaboration. The terms case coordination, case management and coordinated service represent different concepts to different professional disciplines and to different workers.

The consultants classified the services into a number of broad models. These broad descriptors are derived from the sample of services visited, written descriptions of services provided to the project

[5] See for example *Drugs policy and practice in the United Kingdom,* Hilary Klee in Drug Use in Motherhood, Ch20. The chapter summarises developments in the US, Australia and Europe and cites the research base.

[6] University of Wollongong, Illawarra Institute for Mental Health, Centre for Research and Education in Drugs and Alcohol (2002) *Substance Use in Pregnancy and Parenting Service (SUPPS) Evaluation Report.* Wollongong, NSW.
Perinatal and Family Drug Service, Sydney South West Area Health Service. (2005) *Working in Partnership with Hospital and Community Services; Improving Maternal Health and Perinatal Outcomes for Women Affected by Substance Misuse.* Paper prepared for submission to the Baxter Health Awards. NSW Health 2005.

and some overseas literature reviewed. Not all services will fit into one or another of the broad categories, each may have different elements depending on local circumstances.

1 The dedicated service team

The service has all or most of these features:

- funded from a variety of sources but represents a 'single service' to a client
- core team members co-located as far as possible at point of service delivery
- no formal referral required between team members
- comprehensive single assessment
- multiple entry points
- priority access to range of specialised services including methadone program, special care nursery for neonate, mental health
- outcomes specified and monitored and inform continuous improvement
- has a rationale for the timeframe for intervention, well beyond the immediate post natal period – sometimes 0-18mos, 0-2,0-3, 0-5 years (not related to resourcing)
- identified coordinator or leader
- has inbuilt evaluation component (desirable).

2 Service coordination

The service has all or most of these features:
- coordinator is funded, but team members belong and retain accountability to agency, line of supervision
- heavy emphasis on planning and steering committees
- has many elements of effective strategies to 'bind' care together eg case review, identified case manager, protocols for management of birth and neonate
- may have more limited connection with family into the early development years.

3 Care coordination within a single agency supported by multi-agency networking

The service has all or some of these features:

- a single senior manager has corporate responsibility and is supported by steering committee to work at systems level
- there may be local worker meetings/teams that support implementation of the systems of care
- referral networks and care pathways are negotiated, implemented and monitored by this group
- continuity of care is the goal with few identified additional resources."

From the child protection literature Cashmore and Paxman[7] note:

> " *Interagency and interprofessional collaboration and communication* – recognition of the vital role other agencies play in identification, investigation, assessment, treatment,

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[7] Tomison, A M; Stanley, J (2001). Strategic Directions in Child Protection: Informing Policy and Practice. Unpublished report for the South Australian Department of Human Services Brief No. 2 Social welfare framework: System design and service system requirements for a holistic child protection system

support and prevention. Most states have re-newed respect for the role of other agencies, are seeking to engage in partnership throughout assessment and the family support phases of cases. A key aspect of this is cross-sectoral partnerships – vital when working with multi-problem families. Precautionary note: interagency collaboration and communication is exceedingly difficult to undertake successfully, – hence the frequently reported difficulties and case 'mishaps'. To make it successful requires the development of formal and informal structures for information sharing and working together, and importantly, effective case coordination (see Brief no.3). Bottom line – it requires a 'shared understanding' of definitions of child maltreatment and other terminology and the roles and responsibilities of the various 'players'.

Colclough, Parton and Anslow (1999) argue that families need help before they are exposed to the child protection system and that a more holistic view of the needs of vulnerable children and families is needed. They argue for a 'third way' (termed by Pringle 1998) of helping children in addition to child protection investigatory and tertiary-level family support services. As most of the counselling and support services come from non-government agencies, there is a need to be more systematic and coordinated and the role of the community should be far more central to the child protection process, not peripheral, as it is at present."

Outcome of the Care System for Children:

- *National and international studies of children's experiences in care indicate that despite well-meaning intentions, children in care are not receiving good enough care comparable to that received by their peers in the community - outcomes are poor.*

"Young people leaving care experience homelessness, early parenthood, loneliness, depression, poverty, and involvement with the juvenile justice system. "[8] The Longitudinal Study of Wards Leaving Care undertaken by Dr Judy Cashmore and M Paxman[9] 1996 found:

In the interview group:

- 64% were separated from their siblings in care
- 23% finished school below Year 10
- 31.9% completed Year 10, 38.3% completed Year 11
- 6.4% completed the HSC
- 35.5% of wards had attempted suicide; 57.7% had thought about it
- 44% were unemployed a year after discharge
- Nearly one-third of young women had been pregnant or had a baby soon after leaving care

Most young people do not understand why they became wards:

- 36.8% do not recall anyone explaining what was happening to them
- 6.4% had more than 10 District Officers

[8] Mendes Phillip, Graduating from the Child Welfare System .A Case Study of the Leaving Care Debate in Victoria, Australia . Journal of Social Work, Vol. 5, No. 2, 155-171 (2005)

[9] Wards Leaving Care (1996) Cashmore, J. & Paxman, M.
Social Policy Research Centre, UNSW for NSW Department of Community Services

- Average number of placements 8.4

The out of home care system is not a panacea for the problems associated with children living with illicit drug using parents. The damage children experience in out of home care must be carefully weighed in any decision to remove a child from their family.

Harm Minimisation:

- *Barnardos Australia sees daily the benefits of a harm minimisation approach for children and families affected by illicit drug use.*

The consultancy report into Models of Collaborative Practice[10] with drug affected pregnant women confirmed:

> " The harms associated with drug use in pregnancy are well documented.[11] A harm minimisation approach does not condone harmful drug use for pregnant women, but recognizes that a range of strategies are required to reduce and prevent harm associated with both licit and illicit drug use in pregnancy and that a non-stigmatising approach to care that provides positive and practical help will maximize outcomes for both baby and mother
>
> A harm minimisation approach allows for intervention across a range of domains: physical, social, psychological and economic to improve health, social and developmental outcomes for both the mother, child and family. A comprehensive harm minimisation approach takes into account three interacting components: the individuals and their communities; their environment including social, cultural, physical, legal and economic factors; and the drug use itself."

Impact of Family Support Services in Strengthening Families affected by Illicit Drug Use:

The SUPPS Evaluation[12] noted:

> " The involvement of family support services in a comprehensive program for substance using pregnant women has a number of benefits. It allows drug and alcohol and maternal and pediatric staff to focus intensively on their respective specialties, allowing the majority of general case management and social needs (financial, legal, social support, education/employment etc) to be coordinated by family support. This allows larger caseloads, as well as an extended postnatal involvement in the program (up to 3 years), whereas most services are antenatal and discharge clients shortly after the infants' birth with limited follow-up. Family Support services provide a form of non-pharmacological drug treatment, by

[10] Barnardos Australia, Drug and Alcohol Use in Pregnancy: Collaborative Models of Services for Women, Children and their Families. Report of a project conducted on behalf of Barnardos South Coast by Michelle Wheeler consultancy. Funded by Dept of Community Services March 2006.

[11] Ministerial Council on Drug Strategy (2005) *National Clinical Guidelines for the Management of Drug use during Pregnancy, Birth and the Early Developmental Years of the Newborn.* Draft at time of writing.
Klee, H; Jackson, M; Lewis, S.(2002) *Drug Misuse and Motherhood.* Routledge, London.

[12] Hudoba Michelle, Substance Use in Pregnancy and Parenting Service [SUPPS] Evaluation [Part 2] Wollongong NSW: University of Wollongong Illawarra Institute for Mental Health. March 2005.

meeting other needs and stabilizing client's lives. By accepting a referral to family support, immediate attention to basic needs such as food and shelter are provided so that issues of physical survival can be addressed and removed. Thus, larger issues such as homelessness, safety and stability etc can be worked on.

Research suggests that attendance at only two 90-minute support group sessions during pregnancy was associated with improved maternal and infant outcomes compared to no group attendance (Svikis et al., 1998), and longer treatment duration's and consistent attendance result in better maternal and infant outcomes (McCaul and Svikis, 1996; Svikis et al., 1997). Therefore, the involvement of family support can only improve outcomes further."

Cashmore[13] identified :

"The family support approach focuses on the value of working with families and building on their strengths, not just focusing on their problems. It recognises that some parents need additional support and services to meet the needs of their children. Where there are concerns about a child's safety, welfare or wellbeing, families are encouraged to find their own solutions so long as they meet the needs of the child and overcome the concerns. This may involve using alternative dispute resolution processes such as family decision-making conferences to allow families to find solutions that will ensure that the child's needs are met and avoid the need for more intrusive child protection interventions.

Arguably the most significant and substantial development involves the recent and rapid emergence of prevention and early intervention policies and programs. The commonsense notion that prevention is better than cure is now backed by accumulating evidence of the long-term negative impact on children's development of early exposure to violence and inadequate care and nurturing. In addition, it has become clear that child protection services have not been able to handle the demand or meet the needs of families. In particular, the emerging research on the effects on babies' and children's brain development and the long-term consequences and costs has focused attention on the need for early intervention. The aim of intervening early in life and early in the pathway to problems is to promote the health and well-being of children and young people and prevent the development of various behavioural and mental health problems. These include drug and alcohol abuse, juvenile crime, risky sexual behaviour, violent and aggressive behaviour, depression and youth suicide."

[13] Cashmore Judy, "Child Protection in the New Millennium." SPRC Newsletter No 79 May 2001.

What does the International Practice and Research tell us?

A Churchill Fellowship was undertaken by Ms Kerry Moore[14] then of Barnardos Australia in 2005 to investigate international models of working in collaborative approaches with pregnant drug addicted women and/or vulnerable families. Services were visited across the UK , Canada and the USA. The Report highlighted several examples of best practice in this area:

> "Two of the services visited in Canada, namely Sheway and Breaking the Cycle (BTC), demonstrated exemplary practice in areas of policy development and practice when working with substance dependent pregnant and parenting women and their families. These practices are recommended widely in international literature and government policy guidance. The recommendations include comprehensive service delivery by a collaborative multidisciplinary team, and a sustained continuum of care from the antenatal period into the early years of childhood. Sheway and BTC are also "one stop shops" of co-located services managed on site by one co-ordinator. This is also a feature of Building Blocks. This trend towards co-location of government and non government services is a growing feature in Canada. Sustained service delivery rather than short term intensive intervention was another critical feature of the services I visited. Certainly provision of sustained comprehensive services to this highly vulnerable group of women and children is recommended widely in the literature. For BTC and Building Blocks "sustained service delivery" meant engaging women early in pregnancy ideally, and working with them and their children until school age. It is instructive at this point to make reference to a Seattle based home visiting service in the United States which has received wide recognition for excellent evidence based practice with this high risk client group. This is the Parent-Child Assistance Program originally known as the Seattle Birth to 3 Program. This is a sustained home visiting program where the home visitors, who are "paraprofessionals", are highly trained on site and intensively supported. This program is subject to ongoing evaluation of its outcomes (Grant TM et al, 1999).
>
> BTC in Toronto has achieved an international reputation for its specific focus on the developmental outcomes of the child born to the substance dependent women. Central to the BTC approach is the highlighting of the critical importance of the attachment relationship between baby and primary carer.
>
> This relationship is assessed and nurtured across many programs in the service. I particularly admired the continuum of joint service delivery between addictions and infant mental health services.
>
> Engaging drug dependent women who are commonly mistrustful of welfare and health services, and who frequently experience serious social disadvantage, early in perinatal service delivery is critical to achieving better outcomes for their health, the birth experience, and the development of the baby. At FIR Square in the Women's Hospital of British Columbia, engaging and maintaining a drug dependent woman in treatment, antenatal care and postnatal follow-up has been achieved. FIR Square's application of a flexible harm reduction approach, the staff's respectful care of the woman and her baby, and the expectation that the woman will be encouraged to room in with

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[14] Moore, Kerry., Substance Use In Pregnancy And Early Parenting: Working Towards Improvements In Developmental Outcomes For The Babies Of Drug & Alcohol Dependent Women. A Report to the Winston Churchill Memorial Trust . October 2005.

her baby and breastfeed (unless medically contra-indicated and if child safety concerns are serious), have encouraged the women to disclose their drug use and seek antenatal care and drug treatment. These approaches have also led to significantly reduced rates of neonatal withdrawal symptoms.”……….

“ The services featured in this section are representative of service models which are popular in the United States. “Best Beginnings” is a model of sustained “paraprofessional” home visiting to vulnerable poor families which, like Early Head Start and other services I visited in California, features child development, the parent/child relationship, and health promotion, prominently in their home visiting curricula. Widely recognised controlled trials of nurse home visiting models conducted by David Olds in the United States have been critical of the outcomes achieved by paraprofessional home visiting models. Certainly an evaluation of Best Beginnings' parent program, Healthy Families New York, has concluded that the model is not achieving significant results in core child development outcomes for families at significant risk, eg where there is substance dependence and mental illness (Mitchell-Herzfeld Set al,2005). However, the Parent-Child Assistance Program, discussed earlier in this report, a paraprofessional home visiting service for families where there is substance dependence, is demonstrating some promising outcomes, at least in the short term, for this high risk group of women(www.hc-sc.ca). Longitudinal studies of this program's outcomes for the children involved are essential.

The PROkids program in Connecticut provides mixed service delivery with the combination of clinic based, home visiting and group services in the community. I was very impressed with PROkids' emphasis on attachment and child development, its commitment to sustained care, and the demonstration by all staff of a genuine empathy for the women and their babies. Finally, the Vulnerable Infants Program (VIP) in Rhode Island, is another example of the unique US Family Drug Treatment Court model. This abstinence based model set within a clinical research program, is achieving significant permanency planning outcomes for the babies of the substance dependent women.”…………….

“ The midwifery and maternity services I visited in England and Scotland are led by visionary and energetic women who have an acute understanding of the wide ranging impacts of severe social disadvantage on pregnancy and early parenting. Dr Mary Hepburn in Glasgow, and Faye Macrory in Manchester who runs the Specialist Midwifery Service, have developed comprehensive maternal health care services within a social disadvantage framework. Essential to this perspective is the recognition that maternal health care for vulnerable pregnant women, must be integrated within a continuum of social service provision and, in the case of substance dependent women, also with addictions services. These models of integrated service delivery to the pregnant woman can be used to inform collaborative early intervention systems which engage vulnerable families during pregnancy. The 2 other services which also particularly impressed me are the Vulnerable Babies Pilot and the Child Care Commissioning Team, both in Manchester.
The VBP is a model of early intervention service case planning and coordination for vulnerable antenatal families, which is well resourced and developed within a collaborative cross government/government service system. The Child Care Commissioning Team is an integral member of this service system which again is well funded and contributes packages of quality child care to children in need. The vital importance of good quality child care and early education provision in the efforts to remediate the impacts of childhood disadvantage, is well demonstrated in the early intervention literature. A final comment here is on the “Framework for the Assessment of Children in Need and their Families” common assessment tool which is used across Great Britain. This common assessment framework is government driven and evidence based. It has been introduced across all local authorities and many NGOs, and is used by a range of service

types such as social services, addictions, housing, health, child care and non government services. Diverse workers are using the same language and are being guided, and in fact expected to provide more comprehensive assessment information which is focussed on the needs of individual children. Although the common assessment framework is being adapted to the needs of particular local authorities and service systems, the core language and design remains consistent throughout."............

The report concluded:

"Perinatal service delivery to substance dependent women, their children, and their partners, can not be confined to maternal care, and drug and alcohol services. This is a well accepted concept in Australian and international government guidelines and the research literature. Multidisciplinary collaboration across health (including maternity, paediatric, drug and alcohol, mental health and early childhood), statutory child protection and social services is being widely recommended by experts in the United States, Canada, the United Kingdom and Australia.

My Fellowship visits introduced me to services which worked across a range of fronts with substance dependent women and their families. I met with health services in the UK and Canada where midwifery and maternal care were the core services. However these programs worked in integrated comprehensive teams with social services and addictions services. They recognised the critical importance of the relationship between mother and baby at birth and how this vital relationship can be either nurtured or disrupted by maternal and paediatric hospital practices. I observed in the services I visited in Canada and the UK that statutory child protection services are developing their early intervention role in pregnancy. In Glasgow the role of this service is formalised in assessment and practice guidelines and written documents produced by the local authority. Central features of most of the services I visited in all 3 countries is the parent/child attachment relationship and child development. As I have mentioned above, this was highlighted in the maternity services in Vancouver, Manchester and Glasgow. It is also pivotal to practice in many other health services, residential treatment programs and community based services I visited. From Early Head Start to PROkids, and from Arkansas CARES to Breaking the Cycle, a diverse set of service types recognised that service delivery to substance dependent women and their babies must focus on the attachment relationship and the child's subsequent developmental journey. Babies are not necessarily damaged by foetal exposure to drugs (although we know they can be permanently damaged by exposure to alcohol in pregnancy). However, as Barry Lester at the Vulnerable Infants Program in Rhode Island reminds us, these babies are still vulnerable. A large percentage will be born not only temporarily addicted to such drugs as heroin, methadone, methamphetamine or crack cocaine, but also may leave hospital to live in environments characterised by poverty, violence, chaos, possible homelessness, and other forms of severe social disadvantage. It is hence critical that engagement during pregnancy is achieved to begin the complex and difficult work of assisting parents to not only reduce or cease their drug and alcohol intake, but also to improve their social and living circumstances. The importance of broad based mixed delivery of social, parent/infant mental health, early childhood health, child care and educational services from pregnancy until school age, was commonly stressed across the 3 countries for this high risk client group. To achieve longer term improvements in a child's development, their educational and work potential, and their living circumstances, requires a broad based and sustained effort across diverse services working together. The jury is still out about the long term effectiveness of services for children living in high risk environments such as substance dependence, domestic violence and mental illness. However there are some promising early indicators arising from evaluations of a range of services visited."

The report recommends:

> " That early intervention service delivery in NSW incorporates the following approaches, when seeking to improve the health and developmental outcomes of babies born to substance dependent women:
>
> · Collaborative multi disciplinary continuums of care are delivered across diverse systems of care, including Non-government Family Support as an integral program type
>
> · These collaborative systems of care commence in pregnancy, and are sustained throughout the early years until school entry age
>
> · The parent/child attachment relationship is integral to early intervention programming
>
> · Family Support service delivery incorporates child development assessment and practice models as core program components"

Summary of What Works in Supporting Drug Affected Pregnant Women, their families and their children.

The research is clear that strategies targeting pregnant women and their families which are

- multidisciplinary,
- operating across health, child protection and family support aspects of service delivery being across both government and non government services
- delivered early in pregnancy to ensure good outcomes for stabilisation of drug usage and provision of good ante natal health care
- which are also delivered over a sustained number of years for the child
- which are not focussed solely on one aspect of the care only eg drug usage or ante natal care

are effective in gaining not only short term benefits for babies but longer term benefits for the children of drug affected families. The literature on attachment, early intervention and crime prevention also supports the message that a harm minimisation approach which works to engage and support families through sustained delivery of service which address holistically the family needs will produce longer term benefits for children. These benefits relate to success in the education system, reduction in involvement in the criminal justice system and reduced behavioural problems.

The out of home care system and child protection system cannot hope to provide viable alternative care for all children of drug affected families in Australia. These systems should rightfully be utilised for children for whom safety in the family can never be guaranteed. Models which support families to stabilise their drug usage and address the complexities of their lives as well as develop the necessary parenting expertise and capacity must be explored and funded to ensure children receive the best possible start in life.

A Model of Service to Strengthen Families Affected by Illicit Drug Use: Substance Use in Pregnancy and Parenting Service.{SUPPS}

The consultancy to review models of Collaborative Practice in working with drug addicted pregnant women[15] described SUPPS as:

> "The core elements of the SUPPS model can be categorised as those relating to service delivery and those relating to the processes that support collaborative practice.
>
> The primary clinical pathway for women in the service is an integrated health and non government Family Support core team. Comprehensive assessment and case management are key features of this collaborative team approach. When women are assessed as not requiring the full SUPPS team approach, or when there is no current Family Support capacity, they will always obtain a Health only (medical, midwifery and drug and alcohol) service.
>
> In terms of service delivery the core elements of the SUPPS model are:

- effective screening for drug and alcohol use of the women at first point of contact
- engagement of the women into service provision – this is an ongoing role
- intake through monthly team case review
- a case management model. If there is involvement of an existing case manager from another service then this is retained if appropriate, or for Family Support clients, the Family Support worker becomes the case manager.
- holistic assessment including full drug and alcohol assessment
- involvement of child protection – in particular for risk of harm assessment screening
- priority access to the methadone program for opioid dependent women
- access to safe medically supervised detoxification for opioid dependence if woman chooses (this is discouraged as an option and managed methadone maintenance is preferred)
- weekly case meetings of all workers involved and the co-location of services, even if this co-location only occurs once a week
- monthly case reviews for all workers involved (including DoCS from the local offices) and for the woman
- 34 week 'birthing plan' meeting of all workers involved and of the woman and significant others

[15] Barnardos Australia, Drug and Alcohol Use in Pregnancy: Collaborative Models of Services for Women, Children and their Families. Report of a project conducted on behalf of Barnardos South Coast by Michelle Wheeler consultancy. Funded by Dept of Community Services March 2006.

- discharge planning meeting of all workers involved and of the woman and significant others
- parental capacity assessment using SCARF assessment (Supporting Children and Responding to Families)
- ongoing support with day to day living skills and parenting skills.

In SUPPS, a collaborative model of practice underpins the above service delivery and the family support service underpins the continuity of care from pregnancy through to three years of age. In this collaborative model, the services and workers are seen as partners. The core elements of effective collaborative practice that were identified are:

- shared philosophy about the target group and models of practice

For services involved in SUPPS there was a shared commitment to providing services to the target group, the value of client focused services and a commitment to the philosophy of harm minimisation.

- support by and engagement of service managers in the collaboration

This includes active support of the frontline workers involved in the collaboration and the development of policies, protocols and strategic directions that support the ability of agencies and individual workers to work together. Managers need to be involved in an ongoing manner. In SUPPS this is achieved by Managers from the different participating services meeting regularly as the Steering Committee for the project. Managers also have the responsibility to consult with the frontline workers prior to the meetings and bring any practice issues that need to be resolved to the meeting.

- partnerships between frontline workers

Frontline workers from the different services work together in partnership and there is respect for the skill base that each worker brings to the provision of services to the women.

- designation of a coordinating agency

The coordinating agency acts as a driver for the project, ensures practice issues are adequately dealt with within the collaboration, communication flow and mechanisms are maintained and establishes mechanisms to deal with conflict and tension. In SUPPS Illawarra the coordinating agency is Barnardos South Coast and the overall management is undertaken in a collaborative model through a Steering Committee of partners.

The history of SUPPS outlines a model of service which has evolved from a health only service provider and evolved to take into account the challenges to collaborative practice between government and government practice and government and non government collaboration.

In short[16] this 2005 International paper outlined the history of SUPPS:

> "SUPPS began around 3 years ago as a small Drugs in Pregnancy team consisting of a part time midwife and a part time D & A nurse. The team was based at Wollongong Hospital. These 2 women had lobbied for a number of years for this service because of the rising number of babies withdrawing from opiates in neonatal care. Together these dedicated women performed an invaluable assertive outreach function with a group of women who are notoriously difficult to engage into mainstream health services. The team worked throughout pregnancy and up to approximately 6 weeks post delivery. Critical to the SUPPS approach was their assertive outreach function; their capacity to track the women when they didn't present to the hospital clinic and to engage disparate clinical services such as imaging and blood collection services, psychiatric, methadone, and maternity and neonatal services to respond flexibly to the needs of this high risk group of women. The passion and the plain good sense of the SUPPS work attracted Barnardos into an informal partnership with the original SUPPS team in June 2002. This program is part of Barnardos South Coast, which is a Children's Family Centre, and part of Barnardos Australia, a large non government Childrens Charity. Children's Family Centres are comprised of integrated services all with the goal of preventing child abuse and neglect, and entry of children who are at serious risk of harm, into the out of home care system A successful application by Barnardos and another non government family support program, Northern Illawarra Family Support Service, for government funding meant that a non Health family support service could be added to the original Health team.
>
> This partnership of the Illawarra Health SUPPS team with 2 non government Family Support programs dramatically broadened the early intervention scope of the work with the pregnant substance using women. Family Support workers could provide intensive home visiting support, practical assistance, advice, counselling, referral and advocacy in such areas as housing, domestic violence, social security entitlements, a parenting capacity assessment, parenting preparation and education, budgeting, child protection and out of home care liaison etc. We were also able to greatly enhance the team's capacity to transport the women to their appointments; an essential prerequisite for effective engagement of this client group with antenatal care.
>
> The Family Support component most importantly provides sustained home visiting to families when required; from pregnancy to when the child reaches 3 years of age.
>
> The 2 Family Support agencies provided a dedicated service to the SUPPS team; that is the SUPPS family support workers only accepted referrals from the Illawarra Health SUPPS workers.
>
> As the SUPPS program evolved the team negotiated with local Dept of Community Services (DoCS -statutory child protection department) staff to add designated DoCS case workers to the interagency mix. One of our local DoCS offices agreed to do this which meant that once a prenatal report to DoCS was made, DoCS could allocate a case worker antenatally to work with the team. In this way the resources of the state statutory authority could be harnessed well before the child was born to facilitate planning, provide financial assistance, and proactively work with the woman and her partner, and services, before birth which often includes clarifying and reinforcing safety expectations. Remember in many cases the previous children born to

[16] Moore, Kerry ., Health, community welfare and child protection – a single team: how an Australian cross government/non government collaboration is improving the lives of babies born to substance dependent women." Conference presentation to Bringing Two Worlds Closer Together 6th National Child Welfare Symposium Montreal Canada May 2005.

these women are already in the Department's care The rate of growth and consolidation of our practice model has been extraordinary. The partners, that is, Illawarra Health's Maternal and Paediatric, and Drug and Alcohol services; Barnardos South Coast, Northern Illawarra Family Support Service, and DoCS are now known collectively as SUPPS. We are one multidisciplinary cross sectoral team which works across hospital and community boundaries."

The model is still evolving into a component of a mainstream Perinatal Integrated Care System for women experiencing vulnerable pregnancies and will integrate into 2 systems within child protection the new Early Intervention and Statutory systems within NSW. It has received renewable funding to develop the model further and provide improved capacity to sustain services over a number of years for children.

The outcomes of the initial evaluation of this expanded model showed:

The SUPPS population was described as:

- High risk group in need of various health care and community services in addition to drug and alcohol and maternal and paediatric services
- 79% (n=45) self reported history of domestic violence, 40% (n=23) current
- 66% (n=33) HepC +ve
- 51% (n=28) have a diagnosed mental illness, (19/55 have diagnosed depression, further 15 self report)
- 23% (n=11) are (or were) involved in prostitution

The report concluded that:

[Note: HFS SUPPS was the multidisciplinary cross government non government team / HO SUPPS were those women who only received health services due to resource restrictions or those women who received a SUPPS service prior to family support joining the team]

> "In general, the socio-demographic data indicates that these women are a high risk, high need group, many with little or no social support and other children to care for, most with the additional stress of having previous children removed. Substance use during pregnancy was rarely the only major life problem for these clients. The high number of women with previous children removed also highlights the significance of these women engaging with a service that involves child protection services. This reflects a huge shift in attitudes of the drug using local population, as previously they would have avoided services in fear of losing their baby.
>
> The data also demonstrates that while the HFS SUPPS clients were similar in demographics to the HO SUPPS group, they were particularly in need of housing (21% homeless), and for those that had accommodation, it lacked stability, as 47% were in their current accommodation for less than one year. In addition, 26% had current domestic violence issues, which would affect the safety of the current living arrangements. The majority of HFS SUPPS clients had either physical (84%) and/or mental health issues (74%) to be addressed, 63% had current legal issues, and at least 37% would need to be assisted with transportation to attend appointments as they had minimal or no available transportation."

Their primary drug of concern was:

- Heroin: 22%
- Amphetamines: 17%
- Methadone: 11%
- Cannabis: 44%
- Alcohol: 6%

> "The principal drug trends for the HFS SUPPS group and Non-SUPPS group are similar to each other, with heroin (HFS SUPPS=22%; Non-SUPPS=30%) and cannabis (HFS SUPPS=44%; Non-SUPPS=26%) the most common principal drugs of concern. Also, methadone and amphetamines are the principal drugs of concern for a similar number of clients in both these groups. It should be noted that there is a conscious choice in the SUPPS team to prioritise who receives family support services, not only based on drug use, but for those clients with the most complex vulnerabilities and lowest strengths. Thus, the high number of HFS SUPPS clients with cannabis as their principal drug of concern is a reflection of this. While the pattern of principal drug of concern may be similar between the HFS SUPPS and the Non-SUPPS group, the socio-demographic data indicates that the HFS SUPPS group is at much higher risk given their needs."

The conclusions of the Evaluation demonstrated that:

> "Data from this follow-up report continues to provide evidence that SUPPS has led to significantly earlier engagement of substance using pregnant women and increased compliance with antenatal care. 57%-100% of clients had ceased or reduced their alcohol, heroin, amphetamine or benzodiazepine use 6 weeks after pregnancy. Infant outcomes have remained the same or slightly better for the two SUPPS groups; despite greater drug use compared the Non-SUPPS group. A greater percentage of Non-SUPPS infants continue to exhibit withdrawal. The length of stay in the Neonatal Unit and hospital is one day shorter on average for the two SUPPS groups combined, which still represents significant cost savings for the hospital. The data from the clients that went on to receive family support services (HFS SUPPS) suggests that the main needs involve drug and alcohol issues, housing and child protection involvement, either with the current pregnancy or involving previous children. The most common goals or tasks involved maternal health (physical or antenatal care), income or material aid, and housing and stability. The number of contacts and time spent per client is considerable. By far the most time was spent on home visits, support and transport, phone calls on behalf of the client (i.e. advocacy), and seeing the client at the centre or hospital. 49% of the goals were achieved, and a further 7% were partly achieved. As the majority of these clients are still active (only 6 had been discharged at the time of this report), the majority of the 43% of goals not achieved can still be re-visited at a later point when more progress might be made. The outcomes will be evaluated again once more of these clients have been discharged."

Since this evaluation was completed the SUPPS service has continued to develop its post natal work with a SUPPS playgroup forming an additional hub of post natal support and capacity building complimenting the sustained home visiting of family support which reaches long after the drug and alcohol and maternity service interventions cease.

The Evaluation[17] however provides us with a useful overview of what family support looks like for these women:

"Family Support Outcomes

Out of the 134 SUPPS clients, 74 were referred to Family Support services, and 38 (51%) accepted this referral. At the time of this report, 3 clients were on the waiting list for Family Support Services. 45 clients were not referred because at the time they were seen by HO SUPPS (prior to June 2002), Family Support Services were not involved in the SUPPS collaboration, and for a further 4 clients referral was not appropriate for because they moved out of area, miscarried, postnatal, etc. Nine clients were not referred (so far) because it was determined they didn't need the referral due to low drug use and not many other problems, one had too many mental health problems to be referred, and one had already had her baby removed so referral was inappropriate.

While no baseline data was available from DoCs on removal rates of infants of substance using mothers prior to the establishment of SUPPS, we were able to compare health only (HO) SUPPS outcomes (prior to June 2003, the SUPPS service did not include Family Support Services) to the removal rates after Family Support services became involved. Prior to Family Support Services being involved in the SUPPS collaboration, there was a 22% removal rate (16/71 removed, 6 outcome unknown and 4 N/A because miscarried). Since June 2003, there has been only 7 infants removed (7/49=14%), and of those, only 1 was a client that had accepted Family Support referral (HSF SUPPS).

Of those 38 clients that accepted a referral to Family Support, 19 have consented so far to participate in the evaluation. The following data refers to those 19 clients.

Figure 9: Needs Identified to be Assisted with by Family Support
(n=19)

Need	%
D&A Use	100%
Housing	74%
Child Protection	72%
Legal	56%
Transportation	56%
Health & Well-Being	50%
Social Integration	47%
Family History & Functioning	44%
Family Members/relationships	42%
Income	39%
Community Resources	26%
Disability	11%

[17] Hudoba Michelle, Substance Use in Pregnancy and Parenting Service [SUPPS] Evaluation [Part 2] Wollongong NSW: University of Wollongong Illawarra Institute for Mental Health. March 2005.

Figure 10: Family Support Goals/Tasks in Care Plan
(n=19)

Goal/Task	#
Maternal Health	17
Income/Financial/Material Aid	15
Housing/Stability	15
Basic care, health and well being of children	11
D&A Issues	10
Legal Issues	8
Development, stimulation and education	8
Child protection from DV	6
Advocacy re:DCS involvement/restoration	5
Mental Health	3
Family Counselling	3
Community resources, social relationships/integration	3
Parental Capacity/Safety	2

Figure 11: Type, Number and Duration of Family Support Contracts

Type of Contact	# Contacts	Total Time (hrs)	Av.Time (min/Contact)
Home Visit	334	314	56.4
Follow-up Phone call to family	428	73	10.2
Phone call on behalf of family	454	106	14.0
Transport only	18	8	26.7
Support and transport	189	220	69.8
Advocate in person	88	74	50.5
Court support	2	5	150.0
Seeing client at centre/hospital	102	102	60.0
Multiple activities in one day	8	25	187.5
TOTAL	**1623**	**927 hrs**	**69.46 min/contact**

"Figure 9 shows the percentage of clients that had each of the needs listed identified as an area needing assistance. The top three include their drug and alcohol issues, housing and child protection involvement, either with the current pregnancy or involving previous children (eg restoration or increased contact), or both. Figure 10 shows the goals and tasks laid out in the care plans involving the identified needs. The 3 most common goals or tasks involved maternal health (physical or antenatal care), income or material aid, and housing and stability. Family support workers would often liaise with or refer to mainstream D&A services regarding ongoing drug and alcohol treatment (i.e. to further reduce or relapse prevention).

Figure 11 shows the type, number and duration of contacts that were associated with the goals or tasks in the care plans. By far the most time was spent on home visits, support and transport, phone calls on behalf of the client (i.e. advocacy), and seeing the client at the centre or hospital. However, the longest average time per contact was spent in court support."

In Conclusion:

The Inquiry is urged to ensure that a harm minimisation approach is retained in services targeting children of drug affected parents. The evidence is overwhelming that these children need sustained services which commence intervention early during pregnancy and assist parents to ensure:

- Secure attachment is achieved between the primary carer and the child and the court system and statutory system does not unnecessarily disrupt this process.
- Where they cannot ensure the safety of their children, babies are provided with clear permanency plans for their entry into out of home care. Adoption should be a consideration in this planning.
- Good ante natal health care is achieved
- Drug stablisation occurs during pregnancy
- Stabilisation of mental health problems is achieved
- Family Support services facilitate parents to address the complex issues they are dealing with including homelessness, domestic violence, legal and financial issues, parenting skill development and capacity, sustained reduction in drug and alcohol use and continued child development education and support.
- Sustained change over a number of years
- Access supports and networks which assist their family development
- Parents remain child focussed in the early years of their child's life

The evidence is clear that no single agency can achieve this service delivery and collaborative models must be embraced and resourced well to achieve a holistic family approach to children's development in families affected by illicit drugs.

The Commonwealth has an opportunity to utilise the wealth of evidence in early intervention, brain development research, attachment theory, perinatal integrated care practice models and international experience in working with these highly vulnerable families. The Commonwealth has strong models already for the resourcing of collaborative approaches through its Stronger Families and Communities Strategy. These models should be assessed in their implications for working with children and families affected by licit and illicit drugs.