

Identifying alcohol and other drug use during pregnancy



outcomes for women,
their partners and
their children

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Stephanie Taplin, Giovanna Richmond
and Morag McArthur

Institute of Child Protection Studies,
Australian Catholic University

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Executive summary

Introduction and aims

Recent changes to legislation across Australia have meant that state and territory statutory child protection services now have involvement with pregnant women: these services accept reports on, and are able to work with, pregnant women, with particular attention paid to substance use in pregnancy and the risk this may pose to the child once born. Some jurisdictions are developing intensive support programs for pregnant mothers, to ensure early intervention and planning are provided, which aim to minimise the likelihood that a statutory child protection intervention will be necessary after the birth of the child. An increased emphasis has also been placed by antenatal services on the early identification of substance use in pregnancy by screening for substance use as part of antenatal care. However, some authors and practitioners have expressed concerns about an apparent increasing tendency to make pregnant women's bodies the subject of state surveillance, potentially leading to situations where the rights of the foetus are deemed superior to that of the mother (Meurk, Lucke & Hall, 2014).

Little information, however, is available on the impacts of these new policies and practices or on the outcomes of identifying alcohol and other drug (AOD) use during pregnancy on women, their partners and their children. This report aims to explore these issues and their adoption into policy and practice in Australia. It is focused particularly on the outcomes of this screening activity and the current legislative, policy and practice responses to pregnant women. That is, does screening for AOD use lead to better outcomes for pregnant women, their partners and their children; and, what is the impact of involvement by the child protection system in the identification of AOD use by pregnant women, particularly in relation to bringing infants into statutory care once they are born?

Methods

The methods used to answer the research questions consisted of (i) an online review of the legislation and policies in each Australian jurisdiction related to maternal screening for AOD use in pregnant women and prenatal reporting to child protection services; (ii) telephone or face-to-face semi-structured interviews with policy staff members who work in the prenatal reporting area of statutory child protection services and health departments, in each of the eight states and territories, and a variety of other key stakeholders; and (iii) a review of the published and grey literature, overseen by a project reference group, which provided expert advice on the project.

Findings

Research evidence on the outcomes of maternal screening for AOD use on pregnant women, their partners and their babies as well as on the impact of statutory notification to child protection services

The purpose of screening for substance use in pregnancy is to identify potential substance misuse problems that may affect women and their foetuses. This then enables decisions to be made as to whether further assessment on the frequency and quantity of substance use needs to be undertaken, and to determine appropriate intervention responses. This intervention response may take the form of referral to treatment and may involve reporting to child protection services because of concerns that the pregnant substance-using women may not be able to safely care for their newborns.

Parental substance use can affect children developmentally from the point of conception, after birth and across the lifespan. Pregnancy has been described as the opportune time to address maternal AOD use, but represents a brief window within which to address ‘the multiple intersecting and complex issues that led to substance use initiation and continuation’ (Jones & Kaltenbach, 2013).

Infants and children develop within the context of complex social and environmental conditions, which also influence functional and behavioural capacities, making it difficult to ascertain a drug-specific effect on developmental processes (Bandstra, Morrow, Mansoor & Accornero, 2010).

Parental substance misuse can be associated with child maltreatment and is a common characteristic of families involved with the child protection system. Mothers with an AOD use problem who are involved with the child protection system are more likely to have mental health problems, be younger, have more children, have greater economic problems, have a history of homelessness, and have fewer social supports. The greater the number of adversities, the less likely they are to be caring for their children.

Although the evidence is limited, universal screening for AOD use in pregnancy (including tobacco) is recommended: it reduces the targeted screening of marginalised groups, stigma, and the under-identification of AOD use in pregnancy. Screening should be undertaken by health professionals in a non-judgmental manner at antenatal visits.

There is some evidence that if pregnant women’s partners are encouraged by antenatal services to reduce their substance use, the women are also more likely to reduce their substance use. Other family members may also be an important source of support.

A reported professional and ethical tension in risk assessment is between the risk management approach within a child protection framework where the focus is on the safety of children, and the health system which focuses on the health of mothers and development of their foetuses.

Available data on prenatal reporting are limited. In 2012–13, 1427 ‘unborn children’ had substantiated reports of abuse in six Australian jurisdictions, plus another 4356 children under 12 months of age nationally (Australian Institute of Health and Welfare, 2014). Only New South Wales publishes more detailed data. In New South Wales, 2389 ‘unborn children’ were assessed as being at risk of significant harm in 2012–13. Definitional differences and the use of ‘reports’, ‘substantiations’ and ‘entry into out-of-home care’ as proxy measures of child abuse and neglect, rather than outcomes involving child harm or parenting quality, are an issue.

It is estimated that around 10 per cent (range 7.6–15.0%) of the babies of women who use substances in pregnancy have their babies removed from their care around the time of birth (see Section 3.1.8h).

Research evidence on best practice in the management of pregnant women using AOD in relation to child protection risks

One of the strongest messages from research is the need for a coordinated service response in addressing parental substance misuse in a child protection context. The service response should be multidisciplinary, comprehensive and collaborative in scope, use coordinated and evidence-based strategies that incorporate support, and include comprehensive health and social services that are responsive to women’s and children’s needs. There is some evidence that combining family-based interventions with AOD treatment services has positive effects on children of substance users.

Following on from a screening outcome that shows risky or dependent substance use, a brief intervention, referral to pharmacological treatment (where women are dependent on opioids), residential treatment or counselling is recommended.

Case planning, case management and family group conferencing are all strategies aimed at bringing services together with families to discuss decisions and strategies with the aim of working collaboratively to reduce risks to children.

Programs that integrate services, such as antenatal care, parenting programs and child-related services with substance use treatment, address the barriers to accessing care and the unique needs of pregnant women who misuse substances. Meta-analyses of integrated programs show their positive impact on maternal mental health and birth outcomes, but limited improvements in parenting skills.

A recent systematic review found that, although individual studies reported a significant reduction in involvement with child protection services, there was insufficient evidence to recommend the routine use of home visits for pregnant or post-partum women with an AOD problem (Turnbull & Osborn, 2012).

Contingency management approaches have shown effectiveness for improving retention and drug abstinence among substance abusers in treatment, thereby allowing clients to benefit from other components of clinical services.

Residential treatment programs for substance-using pregnant and parenting women that focus on simultaneously treating the substance use and supporting the mother–baby relationship have been shown to be efficacious. Women become more engaged, obtain greater benefit from treatment, and have higher retention when they are permitted to bring their children into the residential treatment setting (Haug, Duffy & McCaul, 2014). Women-only residential treatment services are associated with increased length of stay compared with mixed-gender substance abuse treatment programs, and treatment focused on gender-specific needs results in longer stays and improved continuity of care (Ashley, Marsden & Brady, 2003; Haug et al., 2014).

In Australia, there is little evidence on the extent to which pregnant women gain access to appropriate services in a timely manner.

Policies in Australian jurisdictions relating to the identification of maternal AOD use in pregnancy

Current Australian policy and practice can be characterised as taking a clinical approach to managing AOD use during pregnancy, which emphasises the health of newborns, rather than the enforcement of the laws in relation to substance use.

Six jurisdictions have legislated for the reporting of unborn children to statutory authorities. Only Tasmania has mandated prenatal reporting, meaning that prescribed persons must inform statutory child protection authorities of their belief, suspicion or knowledge that a child once born is reasonably likely to suffer abuse or neglect, or require medical treatment.

Most jurisdictions have developed routine screening and assessment processes for biopsychosocial risks prenatally, including for AOD use. All jurisdictions reported that child protection interventions are generally initiated only when there are multiple risk factors, and that substance use in isolation is not necessarily a trigger for child protection involvement.

Recent initiatives have had a strong focus on reducing the use of alcohol in pregnancy following the adoption of new guidelines by the National Health and Medical Research Council (2009): *Australian Guidelines to Reduce Health Risks from Drinking Alcohol*. Some lack of understanding and consistency in relation to the identification and advice around alcohol use in pregnancy was reported in the consultations, along with reports of staff's limited understanding of foetal alcohol spectrum disorder (FASD) diagnosis and prevalence.

The AOD screening tools known as ASSIST and AUDIT–C are used and recommended by several jurisdictions. A recurring theme in the consultations was the difficulties that some health practitioners experience in having conversations about AOD use with pregnant women. A tension exists between the need to identify and respond to risk factors, and maintaining engagement of women throughout their pregnancies.

Operation of pathways into AOD treatment services, support services and statutory child protection services for parents and their unborn children in Australia

Identification of any substance use issues at the antenatal visit results in referral to specialist drug use in pregnancy service where further assessments are then undertaken.

No jurisdictional legislation or policies provide for statutory powers to investigate harm or risk of harm until children are born. With the important exception of sharing information about mothers and unborn children across information-sharing entities (such as child protection, welfare and health services), all interventions, including drug testing, require the consent of the mother until the child is born. Policies and guidelines enable the mobilisation of support and treatment services that are not statutory protective interventions.

Stakeholders expressed concerns about AOD-using pregnant women presenting late to antenatal services due to stigma, fear of child protection involvement, lack of access to primary health care, and chaotic lifestyles. Within at least two jurisdictions, prenatal case conferencing was reported as being used as a strategy to plan and implement support for pregnant women. Actively participating in the support services offered (or not) and demonstrating change are key factors in any subsequent child protection interventions at birth.

Early engagement of pregnant substance-using women by antenatal and support services was seen as a critical factor for better outcomes for unborn children, their mothers and families. Early child protection involvement allows more time to support women to address their risk factors.

Stakeholders were concerned that if support is prematurely terminated, outcomes will be poor and increase the possibility that babies will be taken into care at a later date. There are some reports of removals increasing by six months post-birth, supporting the need for longer-term support. Stakeholders expressed concern about the impact on mothers and families of the removal of babies at birth and the resulting distress, which may manifest in increased AOD use.

The need for cross-disciplinary training, education and support of staff, and better collaboration and relationships across sectors and services was identified in the consultations. A lack of comprehensive accessible services for pregnant AOD-using women, particularly residential services, was also identified as an issue.

Key implications for policy and practice

Screening for risk but assessing for need

Although generally supportive, some stakeholders expressed reservations about the focus on a universal screening approach, due to the level of resources required to implement such a strategy and the limited capacity to provide differentiated responses. In some jurisdictions, there is considerable effort expended on identifying AOD use, but with little consistency or commitment to providing a service response. There is only limited evidence that women receive the services they need, and it is thought that increased identification through screening may contribute to the targeting and stigmatising of already-marginalised women, such as those already known to services. Simply put, screening for AOD risk in isolation from service provision appears to be of limited benefit.

Integrated systems of support

Jurisdictional policy and practice, along with the research evidence, point to the need for health and child protection sectors to work together better, in order to support pregnant women, improve outcomes for mothers and babies after birth, and contribute to reducing the number of removals of babies at birth. Women with issues such as AOD misuse, domestic and family violence, and mental health issues are more likely to face other difficulties, such as homelessness and severe financial disadvantage. Such complexity and multifaceted disadvantage require strong intersectoral partnerships, and responsive programs, to provide the intensive sustained support that is required, beginning in early pregnancy.

Engaging women, engaging early and staying engaged

Concerns have been raised in both the published literature and during the consultations with key stakeholders that the consequences of prenatal reporting to child protection services are: (i) disengagement from, or avoidance of, health services by pregnant women; (ii) later presentations at antenatal care; (iii) increased marginalisation; through to (iv) increased involvement with the child protection system.

Late presentations at antenatal services, as well as carrying significant obstetric risks, mean there is a very short window in which pregnant substance-using women can demonstrate the change that child protection services require, to assess them as able to safely care for their newborns. There is some evidence that early engagement in services and strategies such as case conferencing provides promising mechanisms to develop sustainable plans to support women to safely care for their newborns at home.

Unless support is continued for longer periods of time, there is evidence that women may have their babies removed later as supports fall away. There are good examples of antenatal services and specialist services within Australia that aim to link and maintain women to services and programs within the community on a longer-term basis.

Lack of data on prenatal reports and removals at birth

Limited data are available on the number of pregnant women and their families, who are screened or identified for AOD use in pregnancy, and/or are affected by prenatal reporting. Furthermore, data are limited on the number of newborns removed by the child protection system and on their longer-term outcomes. In the absence of such data, and without longitudinal research on the impacts of prenatal reporting and removals of newborns, we were unable to make assessments about the impacts of these policies and practices.

What will be the future prenatal legislation, policies and practices?

Currently, Australian legislation and policies around prenatal reporting are focused on the early identification of risk in pregnancy, and the provision of appropriate services and supports. The extent to which this is realised in practice is unclear. There are emerging indications of a weakening of this supportive focus in some Australian jurisdictions and a leaning towards adopting the more punitive responses currently evident in some states in the United States of America, where the rights of the foetus can be deemed superior to that of the mother, and the state's assumed authority to protect the foetus overrules the interests of the mother (Meurk et al., 2014). What is clear, is that the rights and needs of both pregnant women and their foetuses are critically important, and ethical and legal positions need to be considered in addition to their health needs.

1. Introduction

In recent years, increasing attention has been paid to the use of alcohol and other drugs (AOD) by women during pregnancy, and the effects of such AOD use on their foetuses and on the ability of the mothers to care for themselves and their infants.

There is evidence that substance use during pregnancy can affect the developing foetus. An association between maternal substance use and negative foetal outcomes, including foetal respiratory distress, pre-term delivery, small-for-gestational-age birth, and higher infant mortality in the first year of life, has been found (Burns, Conroy, Moore, Hutchinson & Haber, 2011). However, few longer-term effects have been found, except for alcohol use in pregnancy, and other causes of adverse pregnancy outcomes are likely to also exist within substance-using populations.

Adding to the complexity are issues related to parenting and child maltreatment once the baby is born. Although not all AOD users abuse or neglect their children, a large body of research has found that parental AOD misuse is associated with high rates of child maltreatment and involvement with the child protection system (Dawe, Frye, Best et al., 2006; Grella, Hser & Huang, 2006; Scannapieco & Connell-Carrick, 2007; Taplin & Mattick, 2013).

Recent changes to legislation across Australia have meant that state and territory statutory child protection services now have involvement with pregnant women: these services accept reports on, and are able to work with, pregnant women, with particular attention paid to substance use in pregnancy and the risk this may pose to the child once born. Some jurisdictions are developing intensive support programs for pregnant women, to ensure early intervention and planning are provided, aiming to minimise the likelihood that a statutory child protection intervention will be necessary after the birth of the child. An increased emphasis has also been placed on the early identification of substance use in pregnancy, by screening for substance use as part of routine antenatal care. However, some commentators and practitioners have expressed concerns about an apparent increasing tendency to make pregnant women's bodies the subject of state surveillance, potentially leading to situations where the rights of the foetus are deemed superior to those of the mother (Meurk et al., 2014).

Little information, however, is available on the impacts of these new policies and practices, or on the outcomes of identifying AOD use during pregnancy on women, their partners and their children. This report aims to explore these issues and their adoption into policy and practice in Australia. It is focused particularly on the outcomes of this screening activity and the current legislative, policy and practice responses to pregnant women. That is, does screening for AOD use lead to better outcomes for pregnant women, their partners and their children; and, what is the impact of the involvement by the child protection system in the identification of AOD use by pregnant women, particularly in relation to removals of babies?

1.1 Aim and research questions

The principal aim of this project was to examine the outcomes of identifying AOD use during pregnancy on women, their partners and their children. The specific research questions were:

- What is the research evidence on the outcomes of maternal screening for AOD use on pregnant mothers, their partners and their babies as well as on the impact of statutory notification to child protection services?
- What is the research evidence on best practice in the management of pregnant women using AOD in relation to child protection risks?
- What are the existing policies, in Australian states and territories, relating to the identification of maternal AOD use in pregnancy?
- How do pathways into AOD treatment services, support services and statutory child protection services operate for the parents in these jurisdictions?

2. Methods

The methods used to answer the research questions consisted of four separate components.

2.1 Online review of jurisdictional policies and legislation

In late 2013 and early 2014, the legislation and policies in each Australian state and territory that covered maternal screening for AOD use in pregnant women and prenatal reporting to child protection services were searched online and summarised. Relevant legislation was obtained using the Australasian Legal Information Institute's (AustLII) databases. Both child protection/welfare and health legislation and policies were included. The summaries for each jurisdiction were then provided to each jurisdiction for verification of their completeness and currency (see Appendix A for details).

2.2 Key stakeholder interviews

Telephone or face-to-face interviews were undertaken with policy staff members who work in the prenatal reporting area from statutory child protection services and health departments, in each of the eight states and territories.¹ In some jurisdictions, several interviews were conducted. In total, 24 interviews were conducted with departmental policy makers.

Nine interviews were also undertaken with a variety of other key stakeholders who were representatives of: a substance users group (n=1); residential drug treatment service providers (n=1); family support services (n=2); general practitioners (n=1); substance use in pregnancy services (n=3); and a pilot perinatal family conferencing service for at-risk newborns (n=1). Interviewees were identified in consultation with the Project Reference Group (see Appendix B for key stakeholder interview list).

The main issues covered in these semi-structured interviews were current practices relating to identifying substance use in pregnancy; the impacts and outcomes of identifying AOD use during pregnancy; their views of current legislation and policies nationally, and AOD screening practices; and any information on evaluations or exemplary programs.

¹ In one jurisdiction, a health response was not obtained, and in a second jurisdiction no child protection/welfare response was obtained, despite multiple attempts to contact the nominated departmental interviewees.

2.3 Literature review

The literature review draws mainly on academic sources of national and international literature, including research articles, monographs, systematic reviews and reports from 2003 to May 2014. Databases used in the literature review included Medline, PsychINFO, Sociological, Family Studies and Family & Society Abstracts, Google Scholar, Maternity & Infant Care, ProQuest, BMJ Best Practice, Web of Science Core Collection and Health Collection. Additionally, publications were sourced from relevant websites including the Australian Institute of Family Studies, the Australian Institute of Health and Welfare, the Australian Research Alliance for Children and Youth, Chapin Hall at the University of Chicago, the Cochrane and Campbell Collaboration websites, and Western Australia's Telethon Kids Institute.

Search terms used included: prenatal; antenatal; pregnant; mother; unborn; substance/drug; screen(ing). Some assessments were made of the quality of the evidence in this narrative review, placing greater reliance on larger-scale studies and bodies of research, previous systematic literature reviews and meta-analyses.

Relevant and publicly available data have also been used, predominantly from the Australian Institute of Health and Welfare and individual jurisdictions, particularly New South Wales Department of Family and Community Services.

2.4 Project Reference Group

The Project Reference Group, established to provide specialist advice on the project, comprised relevant experts in maternal AOD use and child protection. Members are listed in Appendix C. The Project Reference Group provided advice throughout the project and contributed to formulating policy recommendations from the work.

2.5 Defining the terms

2.5.1 Substance use, abuse, misuse, dependence and addiction

In this report, terms ‘substance use’ and ‘substance misuse’ will be used to include both licit and illicit substances. Substance misuse, as defined by the World Health Organization, is the ‘use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications’ (World Health Organization, 1994, p. 45). The term is preferred in the belief that it is less judgmental than other terms such as ‘addiction’ and ‘abuse’.

The terms ‘substance abuse’ (defined in *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM–IV), as ‘a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) criteria, occurring within a 12-month period’) and ‘substance dependence’ (defined in DSM–IV as ‘a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) criteria’) have been replaced in the 5th edition (DSM–5) by combining the DSM–IV categories of substance abuse and substance dependence into a single disorder. In order to be diagnosed with substance use disorder, the client must now meet at least two of the 11 criteria for the diagnosis. A minimum of 2–3 criteria is required for a mild substance use disorder diagnosis, while 4–5 criteria are diagnosed as moderate, and 6–7 are diagnosed as severe (American Psychiatric Association, 2013).

The terms ‘substance’ and ‘AOD’ (alcohol and other drugs) will be used interchangeably throughout the report to refer to both licit and illicit substances ingested by the mother.

2.5.2 Parental and maternal

The term ‘maternal’ will be used throughout this report because of the focus on substance use in pregnancy and on the period immediately after the birth of babies, and because of the lack of research on the impact of substance use by fathers in this context. The literature on the impact of substance use on male sperm and associated impacts on the foetus has predominantly focused on the impact of substance use on male fertility.

2.5.3 Foetus and the unborn child

Child protection legislation in Australian jurisdictions frequently use the term ‘unborn child’ as opposed to ‘foetus’. In this report, the term ‘foetus’ will be used, except in relation to jurisdictional legislation and policy where the term ‘unborn child’ is used.

2.6 Exploring the legal status of the ‘unborn child’ versus the pregnant woman

There is considerable debate around the legal status of the ‘unborn child’ and whose rights take precedence – those of the foetus or of the pregnant woman. A public debate recently took place in the *Journal of the Royal Society of Medicine*. On the one hand, Currey, Stoll and Chastonay (2013, p. 428) argued:

There is a definitional oversight in which the life of the child is inadvertently cut into two: the fetus or the ‘child inside’ and the ‘child outside’ the womb. This segmented definition should be replaced by a new inclusive way of thinking about ‘the unborn child’. The world has to be reminded that traditionally birth ... began from the time of conception, when a mother bears a new life – a life at considerable risk.

On the other hand, McCormick (2014) argued:

Perhaps it was unintentional, but this editorial raises some potentially unacceptable policies ... Elevating the value of the fetus above that of the mother has untoward consequences, as we on this side of the Atlantic well know. Such approaches permit, even encourage, abusive treatment of pregnant women and abrogation of their human rights in the name of protecting the ‘unborn child’.

The preamble to the United Nations Convention on the Rights of the Child (1989), to which Australia is a signatory, states that ‘the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth’. It is likely that, for emotional and moral reasons, the vast majority of society would agree with the proposition that mothers ought to care for and protect their unborn children (Do & Mapulanga-Hulston, 2013). However, it is questionable whether those same members of society would agree with the imposition of a broad, legally enforceable duty of care on expectant mothers, when armed with knowledge of the consequences that may flow from breach of such a duty. For example, if a duty of care were to be imposed on expectant mothers, any action taken by pregnant women, irrespective of how mundane this may be, could be subject to judicial scrutiny, and it would be extremely difficult to identify the circumstances in which mothers would have breached their duty to their unborn children (Do & Mapulanga-Hulston, 2013).

Meurk, Lucke and Hall (2014) have observed that there is a growing body of legal decisions arising from actions taken in attempts to impose medical treatment on pregnant women. They discuss the tendency to make pregnant women's bodies the subject of state surveillance, particularly in countries such as the United States and Finland, where women can be subject to compulsory commitment and/or incarceration if their AOD use is deemed to be potentially harmful to the foetus. This kind of regulation of women can be seen to grant certain legal rights to foetuses, where the rights of the foetus are deemed superior to those of the mother, and the state's assumed authority to protect the foetus overrules the interests of the mother (Meurk et al., 2014). Criminalisation of maternal substance use threatens women's autonomy, and the status of women as equal citizens who are entitled to protection under the law may further jeopardise infant health and wellbeing, may lead women to avoid antenatal care, may unfairly target already-marginalised groups, and does not necessarily prevent substance abuse among women (Zizzo, Di Pietro, Green et al., 2013).

In Australia, the current position is that pregnant women do not owe a duty of care to their unborn children (except in the limited circumstance of road accidents), meaning that the mothers' rights are superior to those of their foetuses. This position does not negate pregnant women's need to consider how their actions affect the development of foetuses (Do & Mapulanga-Hulston, 2013). What is clear is that the rights and needs of both pregnant women and foetuses are critically important, and ethical and legal positions need to be considered, in addition to their health needs.

3. Findings

The findings are structured by the four key research questions. Existing research evidence, reviews of the jurisdictional policies and practices, and key stakeholder interviews are used to answer each of those questions.

3.1 Research evidence on the outcomes of maternal screening for AOD use on pregnant women, their partners and their babies, and on the impact of statutory notification to child protection services

The purpose of screening for substance use in pregnancy is to identify potential substance misuse problems that may affect women and their foetuses. Such screening enables decisions to be made as to whether further assessment on the frequency and quantity of substance use needs to be undertaken, and to determine an appropriate intervention response.

The intervention response may take the form of referral to treatment, and may involve reporting to child protection services, due to concerns that pregnant substance-using women may not be able to safely care for their newborns. These responses have emerged from evidence that particular substances ingested during pregnancy can have adverse impacts on the development of foetuses, as well as evidence of an association between poor parenting, child maltreatment and maternal substance misuse.

Pregnancy has been described as the opportune time to address maternal AOD use: studies have found that interventions provided at this time of heightened motivation to change have the potential for stopping or reducing AOD use not only in the woman, but also in the home environment (Anthony, Austin & Cormier, 2010; Suchman, Pajulo & Mayes, 2013).

The following sections explore the issue of maternal screening for substance use in pregnancy, how screening is undertaken, and briefly examine best practice in identification and screening protocols in pregnancy, underpinned by discussion of the impacts of AOD use in pregnancy. The impacts of screening during pregnancy and the health and child protection system responses will also be examined, although research is limited on the direct outcomes of screening for AOD use in pregnancy.

3.1.1 How many women use substances in pregnancy?

Problematic substance use clearly harms the health of users (Degenhardt & Hall, 2012). Globally, fewer people use illicit drugs than use alcohol (roughly one-tenth), while tobacco use is far more widespread, and so its contribution to disease burden is greater than that for alcohol or illicit drugs (Degenhardt & Hall, 2012). Compared to other countries, Australia has a high rate of burden of disease attributable to illicit drug dependence, and among the highest prevalence of opioid dependence worldwide (Degenhardt, Whiteford, Ferrari et al., 2013). In Australia, the most recent data on trends in drug use have reported that tobacco and alcohol use has decreased; heroin, cannabis and cocaine use has remained stable; and while use of methamphetamine has remained stable, recent use of the form ice/crystal has increased (Stafford & Burns, 2014). There are significant gender differences in prevalence

of substance use and dependence, with lifetime prevalence of exposure for all categories of substances higher for males than for females in almost all societies and cultures (Degenhardt & Hall, 2012; Lev-Ran, Le Strat, Imtiaz, Rehm & Le Foll, 2013; Steingrímsson, Carlsen, Sigfússon & Magnússon, 2012).

The prevalence of any substance use (including cigarettes) by pregnant women has been estimated at upwards of 25 per cent in the United States (Havens, Simmons, Shannon & Hansen, 2009). However, pregnant women use significantly fewer substances than other women of child-bearing age and tend to reduce use as they progress through their pregnancy. Havens and colleagues (2009) analysed data from pregnant (n=1800) and non-pregnant women (n=37 527) aged 15–44 years who participated in the 2002 or 2003 United States' National Survey on Drug Use and Health, and found that the prevalence of substance use was significantly lower for all types of substances among pregnant women, compared to non-pregnant women. The most prevalent substance used by pregnant women was cigarettes (18.9%), followed by alcohol (10%) and cannabis (3.7%). Poly-substance use was reported by 6.1 per cent of pregnant women (Havens et al., 2009).

Licit drug usage, such as alcohol and tobacco use, in pregnancy has been estimated in Australia using the National Drug Strategy Household Survey. In the latest survey, an estimated 11.7 per cent of women reported smoking during pregnancy, with pregnant women under 35 years more likely to smoke (Australian Institute of Health and Welfare, 2011). The majority of pregnant women either reduced their alcohol consumption while pregnant (48.7%) or abstained (48.9%). The proportion of pregnant women abstaining during pregnancy increased in 2010 (statistically significantly from 40 per cent in 2007 to 48.9 per cent in 2010), as did the proportion of breastfeeding women abstaining. However, around half of all pregnant women reported some alcohol use during pregnancy (Australian Institute of Health and Welfare, 2011). A re-analysis of the 2005 National Drug Strategy Household Survey data found that while alcohol use in pregnancy was reported by around one-third, the majority reported low-level/occasional use of alcohol. However, significant numbers were exposed to three or more drinks on one occasion or to most days in utero (Hutchinson, Moore, Breen, Burns & Mattick, 2013).

United Kingdom studies have estimated the prevalence of illicit substance use in pregnant women between 0.75 per cent and 0.11 per cent (Goel, Beasley, Rajkumar & Banerjee, 2011). Estimates from the United States are higher, and it has been reported that more than 4.4 per cent of pregnant women misuse one or more illicit drugs during pregnancy (Wendell, 2013), with recent increases in estimates. Between 1999 and 2008, prevalence in America increased for narcotic- and hallucinogen-affected live births and neonatal drug withdrawal syndrome, but decreased for alcohol- and cocaine-affected live births. Maternal substance abuse at delivery showed similar trends, but prevalence of alcohol abuse remained relatively stable (Pan & Yi, 2013).

In Australia, Abdel-Latif and colleagues (2013) used hospital records and AOD service usage records to identify a total of 879 illicit-drug-using mothers from 62 682 pregnancies. This equates to 1.4 per cent (95% CI 1.3–1.5) of the total births in public hospitals in New South Wales and the Australian Capital Territory in 2004 affected by maternal drug dependency, a figure comparable to their previous estimates that 1.3 per cent of all pregnancies are affected

by perinatal drug use. Earlier estimates by Burns, Mattick and Cooke (2006), analysing 416 834 live births in New South Wales over a five-year period (1998–2002), found that 1974 pregnancies (0.47%) had an opioid ICD–10AM diagnosis recorded, 552 a stimulant-related ICD–10AM (0.13%) and 2172 a cannabis ICD–10AM diagnosis (0.52%).

Estimates from the 2004 Australian National Household Drug Survey (Australian Institute of Health and Welfare, 2005), which found that 2 per cent of women admitted to using illicit drugs (other than cannabis; 6% including cannabis) when pregnant or breastfeeding in the previous 12 months, were slightly higher than in other studies and may be explained by differences in methodology. Abdel-Latif and colleagues (2013) also found regional differences in illicit drug use patterns: compared to urban mothers (n=764), significantly fewer mothers from rural areas (n=115) admitted to illicit drug use in pregnancy. In terms of specific drug types used in pregnancy, Abdel-Latif and colleagues (2013) found that cannabis (66%), opiates (including 39.7% methadone) (46.8%), amphetamines (23%) and polydrug (16.4%) exposure were the most common. The majority of these illicit-drug-using mothers (82.3%) also smoked tobacco, while 136 (15.5%) drank alcohol.

3.1.2 Screening

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Screening for use of AOD in pregnancy is an important part of prevention (Seib, Daglish, Heath et al., 2012). Screening evaluates the possible presence of a particular problem, whereas assessment defines the nature of the problem, diagnosis and specific treatment recommendations (Haug et al., 2014).

As an important part of prevention, screening for AOD use in pregnancy is well established as having implications for public health. Assessment of current use may help predict future use. For example, previous alcohol consumption use by pregnant women has been found to be the strongest predictor of prenatal alcohol use (Chang, McNamara, Orav & Wilkins-Haug, 2006), and current smoking status has been found to identify women likely to use other substances during pregnancy (Saitz, Svikis, D’Onofrio, Kraemer & Perl, 2006).

The public health concept of screening has remained unchanged since the 1968 World Health Organization definition: ‘to discover among the apparently well who are in fact suffering from disease’ (Terplan, 2012). Similarly, Dawe, Dingle and Loxton (2013) say that ‘screening instruments are best thought of as a way of “flagging” that there are other important problems that may need either or both (1) further assessment, and/or (2) inclusion in a treatment plan’. The World Health Organization principles of population screening can be summarised as having: validated screening tests; availability of treatment; client and societal acceptability; and a balance of benefits to harms at a population level (Terplan, 2012).

Typically, screening includes self-reporting of substance use, review of substance use history and medical records, observation and drug testing. Screening instruments should be brief, easily administered, and scored and developed for use across a range of settings (Dawe et al., 2013). Other strategies are more invasive and have some limitations. For example, blood tests are likely to identify only long-term use through damage to the liver, while urine toxicologies detect only recent use and cannot detect frequency or amount of AOD usage (Anthony et al., 2010). These tests will be discussed in subsequent sections.

3.1.3 Purpose of screening

The purpose of screening for substance use in pregnancy is to identify potential substance misuse problems that may affect pregnant women and their foetuses. Such screening enables decisions to be made as to whether further assessment on the frequency and quantity of substance use needs to be undertaken, and to determine appropriate intervention responses.

Intervention responses may take the form of referral to treatment and involve reporting to child protection services because of concerns that pregnant substance-using women may not be able to safely care for their newborns.

In this section, the issues related to the impact of substances ingested by pregnant women, on both the women and the developing foetuses, will be explored, which is predominantly a health response, with subsequent sections focusing on the issues related to the substance-using parents' care of babies once born, which is predominantly a child protection response. Of course, child protection services are also concerned with the healthy development of the foetus, and the health sector has a role in ensuring adequate parenting for new infants as they grow.

3.1.4 Identifying potential substance misuse problems affecting a woman and her foetus

A major purpose of screening is to minimise harm and improve outcomes for both mothers and children (Jones & Kaltenbach, 2013). Screening may identify the type and amount of substances ingested during pregnancy in conjunction with a psychosocial history, and provide assessment and treatment to reduce morbidity and mortality (Jones & Kaltenbach, 2013). Screening assesses what substances have been ingested, which may transfer from a pregnant woman to her foetus through the placenta, and in what amount, stage and circumstances.

a. Direct impacts of substance use on a woman and her foetus

There is evidence that substance use during pregnancy can affect the developing foetus. Drug-exposed pregnant women may experience a range of obstetric complications, including gestational diabetes, placental insufficiency, post-partum haemorrhage, spontaneous abortion, pre-term birth and lower gestational age (Anthony et al., 2010). Children with prenatal substance exposure are at increased risk for premature birth, low birth weight, impairment in state regulation and arousal modulation, and especially with opioid-exposure withdrawal symptoms (Abdel-Latif et al., 2013; Burns et al., 2006; Jones & Kaltenbach, 2013).

However, few longer-term effects have been found: besides maternal alcohol use, a birth defect syndrome has not been described for illicit substances or prescription drugs of abuse (Holbrook & Rayburn, 2014). Furthermore, other causes of adverse pregnancy outcomes are likely to also exist within substance-using populations.

b. Factors other than alcohol and other drugs impacting on development of the foetus

Infants and children develop within the context of complex social and environmental conditions which also influence functional and behavioural capacities, making it difficult to ascertain a drug-specific effect on developmental processes (Bandstra et al., 2010). Specific drug effects may be difficult to determine because women have ingested a range of substances before being aware of their pregnancies. Substance(s) effects may also be impacted by factors such as the rate of drug metabolism and excretion in mothers, as well as their general nutrition and health status (Anthony et al., 2010).

Substance use is associated with a number of other factors that can also have an impact on the development of the foetus. Some groups of women remain vulnerable to continued substance use in pregnancy, including those who are unemployed, single and experiencing possible current psychopathology (Havens, Simmons, Shannon & Hansen, 2009). Burns, Mattick and Cooke (2006) found that births among substance-using mothers were more likely to be among women who were younger, had a higher number of previous pregnancies, were Indigenous, smoked heavily and were not privately insured. These women also presented later in their pregnancy to antenatal services and were more likely to arrive at hospital unbooked. Similarly, many of the mothers identified by Abdel-Latif and colleagues (2013) originated from socially disadvantaged backgrounds, which in itself is an independent risk for perinatal complications. The drug-using mothers in their study were younger than the average Australian mother, were more likely to be teenagers, and were more likely to experience domestic violence and single parenthood. Psychiatric co-morbidities affected almost half of the women in their cohort, also an independent risk factor for poorer perinatal outcomes (Abdel-Latif et al., 2013).

High prenatal stress, malnutrition and untreated maternal psychiatric disorders can themselves increase risk of developmental disabilities in children (Thompson, Levitt & Stanwood, 2009). During prenatal development, the foetus is particularly vulnerable to the effects of a broad range of environmental exposures, with consequences that can persist into infancy, adolescence and adulthood. In particular, maternal distress during pregnancy, in the form of exposure to chronic or acute stressors, depression and/or anxiety, can influence both foetal and infant behavioural and physiological outcome measures. For example, antenatal depression and anxiety symptoms predict increased behavioural reactivity and cortisol in response to novelty in infants, higher resting cortisol throughout the day among adolescents, and a reduction in grey matter density in the prefrontal cortex (Monk, Spicer & Champagne, 2012).

3.1.5 Who is screened?

One of the major questions to be addressed in relation to identifying substance use in pregnancy is whether all pregnant women should be screened (universal screening), or only those who are already identified as substance users (targeted screening). Furthermore, in relation to screening for substance use in pregnancy, screening the substance use of fathers in addition to that of mothers needs to be considered.

a. Universal versus targeted screening of pregnant women

There are debates in the literature over whether or not screening for substance use (and other risks) should be offered to all pregnant women (universal screening) or limited to those deemed at risk (targeted screening). In the context of AOD screening in pregnancy, universal screening means that every pregnant woman is asked about her substance use.

Universal screening is most respectful of the principle of justice and minimises the risk of stigmatising and stereotyping those population groups viewed to be at risk (Zizzo et al., 2013). It is recognised that many women under-report their AOD use during pregnancy due to stigma and the fear of adverse consequences (Haug et al., 2014).

When screening is not universal, it has been found that certain women – typically those who are poor and from marginalised groups – are targeted for screening and/or disproportionately reported to child protection services (Haug et al., 2014). Substance use among women of higher socioeconomic status may not lead to the same responses as for women from more marginalised groups (Anthony et al., 2010). Universal screening has the potential to reduce stigma and the adverse consequences of targeted screening, particularly on child protection outcomes (Haug et al., 2014).

Universal screening is likely to identify risky substance use that might otherwise be missed. Women may not report behaviours related to medical risks in pregnancy because they were unaware of the significance of these behaviours (McNamara, Orav, Wilkins-Haug & Chang, 2005). Similarly, health and medical professionals may have difficulty in identifying problematic substance use without the assistance of a screening tool (McNamara et al., 2005). Alcohol poses special challenges in that it is often treated differently by the medical profession and by child protective agencies than are illegal substances, although it may be more damaging (Drescher Burke, 2007).

Furthermore, substance-using pregnant women are already less likely to access antenatal care, which may lead to adverse health and developmental consequences for the baby and more complicated hospital stays (Anthony et al., 2010; Jones & Kaltenbach, 2013). Universal screening provides assurance that women's needs will be identified and services provided (Anthony et al., 2010). Asking direct questions to pregnant women makes it more likely they will be provided with appropriate support (Terplan, 2012).

Universal screening for substance use in pregnancy is currently recommended by organisations and professional groups. The American College of Obstetricians and Gynecologists (2008) committee opinion addresses the ethical rationale for universal screening for at-risk drinking and illicit drug use, and considers that there is an ethical duty to screen all pregnant and post-partum women for substance use. A recent Canadian review recommended that all pregnant women and women of child-bearing age be screened periodically for alcohol, tobacco and prescription and illicit drugs use (Wong, Ordean & Kahan, 2011). The recent World Health Organization's *Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy* (World Health Organization, 2014) and the Australian *National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn* (New South Wales Department of Health, 2006) suggest that all pregnant women be asked about their alcohol and other drug use.

Routinely asking *all* pregnant women about substance use, including alcohol, via a checklist of issues to address during antenatal care, and asking within the context of health and everyday behaviour are strategies that help to normalise screening and ensure greater consistency (Bradley, DeBenedetti, Volk et al., 2007).

b. Does universal screening lead to better outcomes for pregnant women and the foetus?

A universal screening approach is predicated on the supposition that more (net) harm can be prevented by focusing on the majority who are less seriously involved in harmful AOD use rather than through interventions that target smaller proportions of high-risk substance users. However, the extent to which this is realised is not clear. In the child protection context, it contributes to the presumed connection between a positive drug test and poor parenting (Anthony et al., 2010).

Debates over the costs and benefits of universal and targeted screening often revolve around its cost-effectiveness and the economic implications (Anthony et al., 2010). The costs of universal screening include the time it takes to complete instruments and the potential waste of scarce resources (Anthony et al., 2010). In addition, universal testing forces health care providers to assume sometimes conflicting roles of both the caregiver and the investigator (Drescher Burke, 2007).

Some authors argue that universal testing is too costly and unreliable to justify it, that an imperfect toxicology test may result in the reporting of mothers and infants with false positive tests to child protective services and result in unnecessary and intrusive social services. Similarly, they argue, false negatives will be overlooked, and families needing services will not receive them (Anthony et al., 2010; Berger & Waldfogel, 2000).

While there are some examples of good practice in different contexts nationally, Burns and Breen have reported that screening for substance use in pregnancy is currently not universal and there is little consistency in screening practices in Australia (Burns & Breen, 2013). For example, in a Western Australian study, researchers identified an estimated 15 per cent of

pregnant women who were drinking at moderate levels (defined as greater than two and less than five standard drinks on a typical occasion) were not being identified by health professionals because they were not being adequately screened during pregnancy (Colvin, Payne, Parsons, Kurinczuk & Bower, 2007).

The evidence is also lacking that universal screening reduces targeting and disparities in service delivery. A recent review found that the available research does not support the claim that universal screening for AOD use in antenatal care reduces racial disparities in child protection reporting at delivery (Roberts & Nuru-Jeter, 2011).

There is inconclusive evidence that the identification through universal screening of women who are AOD users in pregnancy leads to more effective treatment and better outcomes. Although some substance use can be addressed through brief interventions and minimal services, long-term substance use disorders require specialist treatment that may not be available (Anthony et al., 2010). Both health and child protection staff have reported in previous research that there is insufficient treatment available and that this is a major barrier to effective screening (Drescher Burke, 2007). A lack of funded AOD treatment places, particularly treatment places that appropriately address women's specific needs and which cater for pregnant women and women with children, has also been identified in Australia (Breen, Awbery & Burns, 2014).

c. Screening partners

Little is known about the patterns of substance use of fathers of unborn children, despite evidence from studies of pregnant women that substance use by men may (i) reduce women's ability to desist from substance use during pregnancy; (ii) increase the probability that women will return to use postpartum; and (iii) increase the risk of adverse child outcomes (Bailey & Sokol, 2008; Seib et al., 2012).

Paternal smoking has been found to be predictive of maternal smoking during pregnancy, but paternal alcohol use is not predictive of maternal alcohol use in pregnancy (Peadon, Payne, Henley et al., 2011). Bailey and Sokol (2008) set out to describe the association between pregnancy and patterns of binge drinking, daily smoking, and marijuana use among young fathers of unborn children, and pregnant women, from a community sample. They found that men's rates of binge drinking and marijuana use were unaffected by the pregnancy of their unborn child. Pregnancy decreased the probability of substance use among women, but substantial proportions of women users of cigarettes and marijuana used these substances during pregnancy. Many of the women who desisted from substance use while pregnant returned to use after their child was born.

Peadon and colleagues (2011) found that while most women said that it would make no difference to their behaviour, approximately one-third of women stated that if their partner did not drink alcohol during pregnancy, they would be less likely to drink themselves. Chang and colleagues (2006) suggest that knowledge about healthy pregnancy behaviours may exert greater impact if it is shared by pregnant women and their partners.

d. Screening infants

Maternal and neonatal characteristics including prenatal visits, neonatal behaviour, and birth weight identify some infants affected by maternal substance use, but do not reliably identify all exposed infants. To address the issue of under-identification of substance-exposed infants, the analysis of infant biomarkers has recently been considered: these tests may identify children at risk for deficits earlier and assist in targeting interventions (Hicks, Tough, Premji et al., 2009). However, it is unclear under what circumstances screening should be performed, how and when testing is performed and with which groups, how results should be used, whether informed consent from a mother is required, and whether it is ethical to obtain a neonatal sample without consent when it identifies maternal behaviour (i.e. de facto test of mother) (Hicks et al., 2009). Hicks and colleagues (2009) examined the conditions under which mothers would consent to AOD screening of their infants and to identify predictors of consent by surveying postpartum women in three large Canadian hospitals. The majority of women supported universal screening for AOD exposure as part of routine care, and almost all would consent to the screening of their own infant. Almost all women agreed that screening was appropriate if effective intervention was provided for mother and child, but less than 20 per cent agreed if no intervention was provided (Hicks et al., 2009). However, a more recent study examined the willingness of mothers in a high-risk obstetrics unit to participate in voluntary testing of meconium screening and long-term developmental follow-up of positive cases through an existing public health program. The participation rate in this screening program was significantly lower than when testing had been conducted anonymously. The authors concluded that, despite the potential benefits of such screening programs, maternal unwillingness to consent, likely due to fear, embarrassment and guilt, may limit their effectiveness (Zelner, Shor, Lynn et al., 2012).

3.1.6 Who is undertaking the screening and what is the uptake?

Initial discussions about their pregnancy and substance use may take place with women's general practitioners. Most women will attend antenatal appointments at stages throughout their pregnancy, the first generally between 12 and 16 weeks. Antenatal visits usually take place in hospital or primary health care settings, with antenatal checks conducted by obstetricians, general practitioners and midwives.

The majority of the literature about the delivery of screening is from literature on screening for alcohol use in pregnancy. Health professionals have an important role to play in the prevention of prenatal alcohol exposure. Studies have shown that screening can be delivered effectively within a routine antenatal visit by prenatal staff (Kennedy, Finkelstein, Hutchins & Mahoney, 2004). Some research on self-administered and computer-administered instruments has found that they elicit more accurate responses than face-to-face interviews in both the general population and pregnant women specifically (Haug et al., 2014).

Health professionals in Western Australia have identified a need for educational resources about the effects of alcohol use in pregnancy (Elliott, Payne, Haan & Bower, 2006; Payne, Elliott, D'Antoine et al., 2005). A survey of health professionals in Western Australia in 2002 showed that, of those who cared for pregnant women, only 45 per cent routinely asked

about their alcohol consumption, and only 25 per cent routinely provided pregnant women with information about the effects of alcohol on the foetus (Payne et al., 2005). Similarly, a more recent study found that Dutch midwives' alcohol advice required improvement with regard to screening, knowledge about mechanisms and consequences of antenatal alcohol use, and the involvement of partners in alcohol advice during pregnancy (van der Wulp, Hoving & de Vries, 2013). Burns and Breen (2013) interviewed clinicians treating pregnant women with problematic alcohol use. The clinician interviews supported evidence from the literature that while the prevalence of alcohol use disorders in the population is higher than disorders related to illicit drugs, the reverse is noted in specialist treatment services; problematic alcohol use in pregnant women is rarely seen. They highlighted the fact that, despite work aimed at improving the detection of alcohol use, screening and referral rates remain low (Burns & Breen, 2013).

In response to the findings in Western Australia, the Alcohol and Pregnancy Project (2006–08) provided a broad spectrum of Western Australian health professionals with educational resources to inform them about the prevention of prenatal alcohol exposure and foetal alcohol spectrum disorder, the aim being to change practice and increase the proportion who routinely asked pregnant women about alcohol use, and who routinely provided pregnant women with information about the consequences of drinking alcohol during pregnancy (Payne, France, Henley et al., 2011). The evaluation found that the educational resources were effective in producing a 31 per cent increase in the proportion of health professionals who routinely provided pregnant women with information about the consequences of drinking alcohol during pregnancy. One hundred per cent of the settings adopted the project, it reached 96.3 per cent of the target population, was implemented as intended, and the resources were maintained (Payne et al., 2011). Long-term outcomes of these changes in health professionals' practice are expected to contribute to a reduction in prenatal alcohol exposure and in the prevalence of foetal alcohol spectrum disorder.

3.1.7 Identifying substance use in pregnancy

Identification of women using substances in pregnancy is essential to preventing or minimising harm. Ideally, a validated screening tool is used to assess the AOD consumption of all pregnant women in the context of a routine prenatal assessment. Screening women of reproductive age before pregnancy may encourage them to change their AOD consumption to reduce the risk of a substance-exposed pregnancy. The evidence suggests that screening for AOD use in primary care has a range of benefits and can reduce harm.

A recent report from the National Drug and Alcohol Research Centre (Breen, Awbery & Burns, 2014), titled *Supporting Pregnant Women Who Use Alcohol or Other Drugs: a review of the evidence*, in addition to the World Health Organization's *Guidelines for Identification and Management of Substance Use and Substance Use Disorders in Pregnancy* (World Health Organization, 2014) and New South Wales Health's *National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn* (New South Wales Department of Health, 2006) provide an overview of best practice in identifying substance use in pregnancy. A detailed discussion of screening tools used to identify substance use in pregnancy has not been undertaken in this report.

3.1.8 Child protection response to positive screening of substance use in pregnant women, and the impact of a statutory notification to child protection services

The previous section discussed the role of screening for substance use in pregnancy as a way of identifying concerns about the impacts of the ingested substances on women and the development of their foetuses. A positive screen for substance use in pregnancy may also lead to a report or notification to statutory child protection services, commonly called a prenatal report. A prenatal report is likely to lead to a detailed and extended assessment of pregnant women's current presentation and history, as to their future ability to safely parent once their babies are born. A pre-birth assessment of significant risk of child maltreatment may trigger additional treatments and supports, as well as child welfare and statutory child protection interventions.

This section of the report provides an overview of the existing evidence about (i) the impacts of substance use on the ability of the parent(s) to safely care for their newborn and on their parenting; (ii) prenatal reporting; (iii) pre-birth risk assessments; (iv) methods of identifying substance use in the child protection context; and (v) child protection responses including removal of a baby from the parents' care. An attempt has been made to ascertain the numbers of babies removed from their parents' care at birth, or soon after birth. It must be noted, however, that there is little research evidence or data on the number of babies removed because their mothers have been assessed as unable to safely care for them at birth, nor on whether the involvement of child protection and other services leads to increased support for pregnant women. This lack of data makes it difficult to determine the impacts of statutory notifications, or child protection involvement more generally, on pregnant women, their partners and their babies.

a. Evidence on child maltreatment and parental substance use

Parental substance use may be investigated by the child protection system to assess the risks of child abuse and neglect. Although substance use and treatment are higher among males than females (Australian Institute of Health and Welfare, 2013), much of the research around parental substance use and its impacts on children has focused on mothers, partly because of the concerns related to prenatal substance use, but also because women are more likely than fathers to be the primary carers of their dependent children (Stewart, Gossop & Trakada, 2007).

A significant body of research has found that parental substance misuse is associated with child maltreatment, and that parental substance use is a common characteristic of families involved with the child protection system. Families in which AOD use is present are more likely to come to the attention of child protection services, be re-reported, have their children removed from their care, and have them remain in out-of-home care for long periods of time (Barth, Gibbons & Guo, 2006; Gregoire & Schultz, 2001; Smith & Testa, 2002; Street, Whitlingum, Gibson, Cairns & Ellis, 2008). Parental substance misuse is common in child protection practice and plays an important role in determining child removal (De Bortoli, Coles & Dolan, 2013).

Limited research has examined the impact of different types of illicit substances on parenting and children. As Dawe and colleagues comment, the direct effects of the substance being used are likely to influence the quality of parenting provided for the child. Opioids, for example, may be more likely to be associated with child neglect, while substances such as amphetamines and cocaine, which are associated with serious disturbances of mental state, including sub-clinical symptoms of psychosis and hostility, may be more likely to result in physical abuse (Dawe et al., 2006). Heavy drinking can be associated with supervisory neglect in parenting practices, such as leaving a child where he or she may not be safe (Freisthler, Johnson-Motoyama & Kepple, 2014).

There is a lack of clear evidence as to the impacts of substance use alone on parenting, and the extent to which substance use places children at risk of maltreatment is not well understood (De Bortoli et al., 2013; Taplin & Mattick, 2014). Studies have attempted to determine whether parents with more extensive substance-use histories are more likely to be involved with child protection services due to child abuse or neglect than those with a less extensive substance-use history. Studies have generally found that when other factors are taken into consideration, the extent of the substance use is less important than other co-occurring factors (Gilchrist & Taylor, 2009; Grella et al., 2006; Taplin & Mattick, 2013). Among mothers in treatment for substance use problems, those involved with the child protection system are more likely to have mental health problems, particularly depressive symptoms, be younger mothers, have more children, have greater economic problems, have a history of homelessness, sex work or incarceration, live with a substance user and have fewer social supports (Gilchrist & Taylor, 2009; Grant, Huggins, Graham et al., 2011; Grella et al., 2006; Grella, Needell, Shi & Hser, 2009; Laslett, Room & Dietze, 2014; Nair, Black, Schuler et al., 1997; Taplin & Mattick, 2013). Furthermore, the greater the number of adversities, the less likely they are to be caring for their children (Gilchrist & Taylor, 2009; Grella et al., 2006).

Substance-using parents have greater levels of life stressors, often including trauma and abuse histories of their own, which may manifest in unresponsive and punitive parenting styles (Suchman et al., 2013). It has been suggested that the association between substance use and child maltreatment can be largely explained by the high levels of psychopathology in substance-using populations, and that parental substance misuse may in fact be a marker for mental health problems, which has a stronger association with child maltreatment (Dawe et al., 2006).

Research in this area is complicated by the definitions of child abuse. Although there is variability as to what constitutes child abuse internationally, differences in legislation across Australia defining a 'child in need of protection' provide similar thresholds for substantiated abuse or neglect requiring intervention (Holzer & Bromfield, 2010). In most research, reports/notifications, substantiations and entry into out-of-home care are used as proxy measures of child abuse rather than outcomes involving child harm or parenting quality. Official child protection outcomes are favoured because they are clearly documented despite being associated with limitations and biases (De Bortoli, Coles & Dolan, 2014).

The majority of the research on parental substance and child protection involvement uses either administrative data or data collected as part of a larger study to document the extent of child protection involvement among substance-using parents in treatment, generally reporting the number of children removed from their care as the only child protection outcome. Studies using administrative data to estimate the extent of substance use among those already involved with the child protection system have found that substance use is a commonly identified risk factor: for example, using administrative records, parental substance misuse has been identified in approximately 70 per cent of all children entering care in two Australian studies, one of which was a national study (Delfabbro, Fernandez, McCormick & Kettler, 2013; Jeffreys, Hirte, Rogers & Wilson, 2008). However, prevalence estimates are highly variable and range from as low as 11 per cent to as high as 79 per cent (Young, Boles & Otero, 2007). Part of this variability can be explained by differences in samples and in the definition, assessment and recording of substance use. One study, for example, reviewed 639 child protection files where the child was removed and found there was evidence of parental substance use in 79 per cent of cases. However, only 16 per cent of these were clinically diagnosed and in only 33 per cent of cases did caregiver substance abuse contribute directly to the child's removal from the home (Besinger, Garland, Litrownik & Landsverk, 1999; Taplin & Mattick, 2014).

b. How many substance-using women are caring for children?

Limited data are available on the extent to which substance-misusing adults are parents, or are caring for their children or other children, or on the nature of their substance use, particularly in terms of children's exposure to substance use and the direct effects on the parenting they receive.

Dawe and colleagues (2006) analysed data from the 2004 National Drug Strategy Household Survey and estimated that, based on the number of children aged 12 years or less living in Australia, 13.2 per cent or 451 621 children were at risk of exposure to binge drinking in the household by at least one adult; 2.3 per cent or 78 691 lived in a household containing at least one daily cannabis user; and 0.8 per cent or 27 370 lived in a household with an adult who uses methamphetamine at least monthly and reports doing so in their home. Estimates of other substance use among parents living with children were too small to be made with confidence.

c. Prenatal reporting

Health professionals working in antenatal services see pregnant women when they present to these services and are in the best position to screen women for substance use in pregnancy. Health professionals, as well as being concerned about the healthy development of the foetus and the mother's health, have a role in raising concerns about the ability of mothers and their partners to parent their babies once born, and the subsequent safety of the babies.

Largely due to concerns about the impact of substance use on parenting and the associated risks of child maltreatment, and to some extent influenced by the increased focus on alcohol use and its impacts on the developing foetus, Australian jurisdictions have in recent years introduced into their child protection legislation the prenatal reporting of 'at-risk' mothers. The aim of this legislation in most cases is to provide a mechanism whereby certain professionals can report their concerns to child protection services and to guide the provision of family supports to minimise future child protection involvement.

Differences and similarities exist in the legislation, policies and practices in relation to prenatal reporting across Australia. The common elements which aim to provide a legislative basis for earlier intervention with pregnant women include: (i) identifying risk in the perinatal period; (ii) commencing the process of addressing protective concerns by engaging 'at-risk' mothers prior to birth; and (iii) reducing crisis-driven interventions. The legislation, policies and practices will be discussed in greater detail in Section 3.3.

d. Pre-birth risk assessments

Obstetric services in most countries play a critical role in the identification of at-risk infants and in initial decision making to activate the formal service system, either through notification to statutory child protection or through referral to health or child and family welfare services. The professional groups most involved with decisions during this assessment time, and in pre-birth child protection interventions, are child protection or welfare officers, social workers and midwives. It is important to note that there are significant professional and ethical tensions with the different approaches to care by different professions. A much-reported tension is between the risk management approach within a child protection framework where the focus is on the safety of the child, and the health system focus on the health of the mother and development of the foetus. One of the difficulties of pre-birth screening and risk assessments is that the interventions have been contextualised within frameworks that have evolved to protect children rather than the foetus (Hodson & Deery, 2014).

However, assessments and interventions often tend to focus too narrowly on either substance abuse or child protection issues. As a result, there may be significant gaps in service systems in terms of both the knowledge and skills to identify the broad range of client problems and to provide the comprehensive services to address them (Marsh, Smith & Bruni, 2011). Not all infants exposed to substance use in pregnancy will become involved with child protection services. For some women, pregnancy may be a 'window of opportunity' where behavioural changes are motivated by health concerns for the foetus, or out of fear of child removal (Anthony et al., 2010; Burns et al., 2006; Forrester & Harwin, 2008).

Professional groups, in conducting pre-birth risk assessments, need to consider a multitude of complex issues and work as a multi-agency team to consider the impact of these issues on babies' health and wellbeing (Hodson & Deery, 2014). The role played by hospital-based services in the identification of risk requires a focus on the collaborative activity, as well as on the skills and knowledge needed by health professionals and child protection officers to conduct risk assessments in tertiary contexts for substance-using pregnant women (Tsantefski, Parkes, Tidyman & Campion, 2013). Tsantefski and colleagues (2013) found that obstetric services, such as antenatal clinics, were skilled in assessing risk factors but that accurate risk assessment did not necessarily lead to appropriate outreach, follow-up and ongoing collaboration. In some cases there was continuing exposure to the risks identified in pregnancy, including substance use and domestic violence, and inadequate follow-up of infants after discharge from hospital. The management of risk includes a focus not only on pregnant women, their partners and foetuses, but also on their engagement with the service system. A good outcome of interventions for substance use in pregnancy has been described as: 'continuous maternal care of the infant, drug use that was manageable or had ceased, and absence of domestic violence' (Tsantefski et al., 2013: 5).

e. Assessing substance use of partners and fathers

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There is limited information on the parenting status of men with substance use problems. We know that substance use, substance use problems, and treatment for substance use problems are all much more common among men than among women (Australian Institute of Health and Welfare, 2013). Among drug users in treatment, around half are parents, but fathers are much less likely than mothers to be the primary carers of their dependent children (Stewart et al., 2007). When fathers are primary carers, their substance use affects their ability to parent in the same way it affects the mothers' ability.

Intimate partner violence may be a co-occurring issue, particularly where there is problem drinking (Foran & O'Leary, 2008) or opioid dependence (Moore, Easton & McMahon, 2011). When opioid-dependent fathers have been compared to other fathers generally, there were significant differences found in (i) their economic resources to support family formation; (ii) patterns of pair bonding; (iii) patterns of procreation; and (iv) parenting behavior (De Bortoli et al., 2014; McMahon, Winkel & Rounsaville, 2007).

De Bortoli and colleagues (2014) have called for further research to improve our understanding of how the wider family support network alters the risk of abuse or child protection involvement in the context of substance use in pregnancy. Given a newborn's heightened vulnerability, assessing short-term risk is crucial (De Bortoli et al., 2014).

f. Using biomarkers to test for substance use in pregnancy

Health professionals will identify the presence of substance use in pregnant women and may report to child protection services. Child protection services will generally rely on information provided to them by health services, but they may request independent verification of substance use by requiring drug testing of pregnant women and parents who are considered 'at risk'. In many instances, an infant in the United States would be reported only if the child or the mother tested positive at the time of birth, and not necessarily if the mother used substances at some time during the pregnancy unless such usage was known to services (Young et al., 2007).

Drug tests can be performed on samples of the blood, breath (currently alcohol only), urine, saliva (more precisely, oral fluid), hair and sweat. The methods differ in their windows for detection of drug ingestion. Hair and sweat testing are generally used to detect use over a period of weeks or months. Urine tests detect use during previous days or weeks, depending on the type of substance, while oral fluid testing detects use within a shorter period of hours or days (Australian National Council on Drugs, 2013).

In 2006, a review of the literature on the costs and utility of parental drug testing in the child protection context was undertaken (Wood, Mattick, Burns & Shakeshaft, 2006) and made a number of recommendations about best practice:

- Drug testing is limited in its ability to determine dependence and/or impairment in relation to parenting ability; however, drug testing may have some utility in leading to treatment and/or confirmation of self-reports of use.
- Urine or hair testing are the recommended methods of drug testing in the context of child protection. The use of frequent urine testing, which is best conducted on a random basis, is a preferred method, but is expensive. Less expensive is hair testing, as hair can be easily harvested and analysed in Australia for a long observation window.
- The use of frequent (weekly or more often) regular, monitored urine testing is one best-practice model with good reliability and validity. Hair testing has significant benefits that should be weighed up in terms of convenience and the desired window of observation. Both are best-practice and reliable methods for assessing the extent of ongoing illicit drug use.
- Given the evidence (albeit limited) on the role of drug testing assisting in management of parents with problematic drug use patterns and children at risk, hair testing seems to be a viable and useful tool for management of these cases, although hair testing is currently not common practice in drug treatment agencies and is mainly used in the workplace and for court purposes.
- It has been suggested that the therapeutic relationship between caseworker and client may be jeopardised if the caseworker is also the person responsible for collecting the specimen for drug detection. For this reason, it seems preferable that a third party be responsible for collection.

Drug test results provide biological information at a particular point in time, but without contextual information on the substances detected, or on other issues that may be relevant. The potential for over- or under-detection of substance use or assessment of risk based solely on drug tests is evident (Testa & Smith, 2009). The use of biomarkers such as blood tests and urine toxicologies cannot be a substitute for good clinical rapport and management. In the area of pregnancy, the consequences of screening are far-reaching, with the possibility of removal of one's child a real possibility (Darke & Burns, 2012).

Little information is reported on the extent to which drug testing is used by the child protection system, although one New South Wales study (Taplin & Mattick, 2014) reported that 34.5 per cent of mothers in opioid pharmacological treatment had been required post-birth to provide urine samples for drug testing by child protection services, usually at a pathology laboratory and up to three times per week.

g. How many women who use substances during pregnancy are reported to child protection services?

In recent years in Australia there have been large numbers of families involved with the child protection system. In 2012–13, there were 272 980 notifications made to child protection services about 184 216 Australian children (35.5 per 1000 children), with abuse or neglect substantiated for 40 751 children (7.8 per 1000 children) (Australian Institute of Health and Welfare, 2014).

In relation to prenatal reports, the Australian Institute of Health and Welfare publishes data from six jurisdictions on the number of 'unborn children' for whom child protection reports are substantiated, although substantiating a child protection report seems problematic until the child is born. Table 1 shows that 1427 'unborn children' had substantiated reports of abuse in six jurisdictions, plus another 4356 children under 12 months of age nationally, constituting more than 14.25 per cent of all children with substantiated abuse (Australian Institute of Health and Welfare, 2014). There were 294 320 children under 12 months of age in 2012 (Australian Bureau of Statistics, 2013).

Table 1: National data on notifications re ‘unborn children’ and children <12 months, 2012–13

Jurisdiction	‘Unborn child’	Children <12 months	Total children (0–17yrs)
NSW	846	1513	16 236
VIC	8	1305	10 048
QLD	443	642	7149
WA	85	214	2686
SA	-	364	1836
TAS	44	77	918
ACT	1	71	494
NT	-	170	1204
Total	1427	4356	40 571

Source: Australian Institute of Health and Welfare, *Child Protection Australia 2012–13*, Table A8.

These data have a number of limitations, however. Firstly, it is unclear how abuse is substantiated in relation to an ‘unborn child’; and secondly, the reasons for these substantiated reports are not publicly available.

No data are reported by the Australian Institute of Health and Welfare on the number of notifications or reports by the age of the child, which means no national information on the number of child protection reports is available. New South Wales provides greater detail via their Annual Statistical Reports and includes information on the number of ‘unborn children’ reports. Table 2 shows the number of ‘unborn children’ concern reports and the reports where a risk of significant harm (ROSH) has been identified (around two-thirds of children and young person (CYP) concern reports) over the past three years. There has been some increase in the number of concern reports.

Table 2: New South Wales data on ‘unborn child’ reports, 2010–13

Year	‘Unborn children’ in CYP concern reports	‘Unborn children’ in ROSH reports	‘Unborn children’ in ROSH reports as % of all ‘unborn children’ in CYP concern reports	‘Unborn children’ as % of all ROSH reports
2010–11	3268	2240	68.5	3.7
2011–12	3304	2171	65.7	3.5
2012–13	3636	2389	65.7	3.7

Source: http://www.community.nsw.gov.au/docs_menu/about_us/docs_data.html: Table A4vi

There were 98 508 births in New South Wales in 2012. This means that 33.2 pregnant women/births per 1000 (or 3.3%) were the subject of CYP concern reports, and 22.7 per 1000 (or 2.3%) were the subject of ROSH reports (Australian Bureau of Statistics, 2013). The only other publicly available data on prenatal reports and interventions were available from Western Australia where, in 2012–13, 266 babies were involved in pre-birth meetings, with 69 babies requiring a subsequent protection application.

Limited research has explored the extent of reporting of substance use in pregnancy. One Australian study (Abdel-Latif et al., 2013) identified 879 (1.4%) drug-using mothers from 62 682 births. Child-at-risk issues were raised in 354 (40.3%) of the infants of drug-using mothers, with 149 (17.0%) infants already having other siblings living elsewhere, not with the mother. Another study by Wu, LaGasse, Woules et al. (2013) compared patterns of antenatal care among mothers who used methamphetamine during pregnancy and non-using mothers in the United States and New Zealand, and evaluated associations among maternal drug use, child protective services (CPS) referral, and inadequate antenatal care in both countries. Methamphetamine use during pregnancy was associated with lower socioeconomic status, single marital status, and CPS referral in both New Zealand and the United States. CPS referral for drug use comprised 40 per cent of all referrals in the United States, but only 15 per cent of referrals in New Zealand.

Street and colleagues undertook a prospective cohort study in the United Kingdom comparing child protection outcomes over the first five years of life in a group of children born to drug-using mothers recruited during pregnancy (cases) and a group of children matched for gestational age, chronological age, maternal neighbourhood and place of delivery whose mothers made no such declaration of problematic drug use (controls). Half of the children born to the drug-using mothers who received perinatal input were subject to child protection interventions by age five years, a threefold increase over controls from similar socioeconomic circumstances. They observed that risk was almost certainly higher for those drug-using women who do not seek help during pregnancy (Street et al., 2008).

h. How many women who use substances during pregnancy have their infants removed from their care?

The most intrusive of the interventions by the child protection system is the removal of a child from the care of its parents.

In Australia, 40 549 children were in out-of-home care in 2012–13, an increase in both the number and rate of children in care in recent years; 34.3 per cent of all children in care in 2012–13 were Indigenous. In 2012–13, 11 341 children were admitted to out-of-home care (mostly infants and younger children) and 9360 were discharged (mostly older children and young people). The only Australian data available on entries into out-of-home care by age report on infants under 12 months of age, so the number of removals soon after birth are not able to be determined.

Table 3 shows that 17.4 per cent of all children admitted to out-of-home care in 2012–13 were under 12 months of age, a rate of 6.5 children per 1000 on average. Jurisdictions varied to some extent in the rate at which infants were removed and admitted into care, with the rate in the Northern Territory around twice that of other jurisdictions.

Table 3: Number and rate of infants admitted to out-of-home care (OOHC), 2012–13

Jurisdiction	Children <12 months admitted to OOHC*	Population of children aged <12 months in December 2012 (ABS, 2013)	Rate admitted to OOHC per 1000 popn
NSW	618	95 370	6.5
VIC	446	75 865	5.9
QLD	452	62 266	7.3
WA	202	33 626	6.0
SA	126	20 220	6.2
TAS	48	6173	7.8
ACT	30	5343	5.6
NT	49	3922	12.5
Total	1971 (17.4%)	302 785	6.5

Source: Australian Institute of Health and Welfare, *Child Protection Australia 2012–13*, Tables A26, A46

*Note: 488 children <12 months (24.8% of admissions) were discharged from out-of-home care in 2012–13; of those admitted to out-of-home care in 2012–13, some will be discharged at older ages or in subsequent years.

Limited data are available on the number of women using substances during pregnancy who have their infants removed from their care at, or soon after, their birth. Table 4 shows that, in 2012–13, 505 infants nationally were admitted to out-of-home care within one week of their birth, and 851 within one month of their birth.

Table 4: Number of infants admitted to out-of-home care within one week and one month of birth, 2012–13

Jurisdiction	Children ≤ 7 days admitted to OOHC*	Children ≤ 31 days admitted to OOHC*
NSW	182	327
VIC	60	132
QLD	151	221
WA ^{a, b}	68	87
SA	23	46
TAS	11	18
ACT	5	8
NT	5	12
Total	505	851

*Data provided by Australian Institute of Health and Welfare

- a In Western Australia infants are placed into care for a variety of reasons, not just because of parental alcohol and other drug use. Therefore, the numbers in the table are not an accurate reflection of how many children were placed into care because of parental alcohol and drug use.
- b The Department works with parents and significant family members to return children to the care of their family, where possible. Therefore, the numbers of children do not accurately reflect the number of infants who remained in care for a long period or until 18 years.

*Notes:

1. This table counts children who were admitted to out-of-home care in less than or equal to 7 days after birth and less than or equal to 31 days after birth, during the year ended 30 June 2013.
2. Each child should be counted only once in each of the specified counting periods. However, a child may be counted in more than one counting period: for example, a child who was admitted to care in less than or equal to 7 days after birth, would be counted in both the ' ≤ 7 days' period and the ' ≤ 31 days' period for that year.
3. Age of child refers to age at time of first admission.
4. Children admitted to out-of-home care on their day of birth are counted as being one day old. This may have a subsequent impact on the count of children included in the ≤ 7 days or ≤ 31 days categories.
5. Children for whom date of birth was unknown have been excluded from this table.

Most of the available data does not report the reasons for removal, so the contribution of substance use in pregnancy is not able to be determined from these data. Even if substance use is identified as a reason for reporting or removal of a child, we know that the use of administrative data to estimate the extent of substance use among women involved with the child protection system leads to highly variable prevalence estimates ranging from 11 per cent to 79 per cent (Young et al., 2007). Part of this variability can be explained by differences in those included and in the definition, assessment and recording of substance use (Taplin & Mattick, 2014).

Two recent Australian studies explored the child protection involvement of substance-using mothers in treatment. Taylor and colleagues found that, of 139 women engaged with a perinatal drug health service in Sydney, approximately one-third (35.3%) reported past child protection involvement with other children, and over half (58.9%) had at least one previous child in kinship or foster care (Taylor, Hutchinson, Rapee et al., 2012); 19 neonates (13.7%) were assumed into care at or before discharge. Taplin and Mattick (2014) interviewed 171 mothers in opioid pharmacological treatment. Most of the mothers (63.7%; n=109) said that one or more of their children had been reported to child protection services within the past 16 years, with the most common reason being for substance use (including alcohol) (65.1%). Fifty-six women (32.7%) had at least one child in out-of-home care (n=99) at the time of interview, nearly half of whom (n=42) had been removed immediately or within weeks of their birth. Among the younger children, higher proportions had been removed at birth than among the older age groups, suggesting that increasing proportions of babies are being removed at birth in New South Wales. Another Australian study by Abdel-Latif and colleagues (2013) identified 879 (1.4%) drug-using mothers from 62 682 births. A total of 66 (7.6%) of these infants of drug-using mothers were placed in out-of-home care.

In France, Simmat-Durand and colleagues followed up 167 children born alive from 1999 to 2008 whose mothers used at least two substances at the beginning of their pregnancies. At the follow-up in 2010, 25 children had been immediately separated or removed from their mothers at discharge from the maternity hospital, while 41 children had been separated altogether (Simmat-Durand, Genest & Lejeune, 2014).

From these few studies, it appears that around 10 per cent (range 7.6–15.0%) of the babies of mothers who use substances in pregnancy have their babies removed from their care around the time of birth, and that having had previous babies removed at birth increases this risk.

i. Is there further child protection involvement after the removal of a baby?

Recent research has focused more closely on recurrence in the child protection system, particularly when infants have been removed at birth.

A recent paper presents the initial findings of a feasibility study that has captured the scale and pattern of *recurrent* care proceedings. Broadhurst and colleagues (2014) have arrived at a first estimate of prevalence, confirming that recurrence is a *sizeable problem* for the English system. Based on cases that completed during the observational window 2007–13 (calendar years), 7143 birth mothers appeared in 15 645 recurrent care applications concerning 22 790 infants and children. Initial observations are that the spacing between recurrent care proceedings is very short. Where episodes of care proceedings follow in swift succession, most likely prompted by the birth of another infant, this affords mothers little opportunity to effect change. The authors suggest that, unless the ‘status quo’ is tackled, it is difficult to envisage how vulnerable birth mothers can exit this cycle (Broadhurst, Harwin, Shaw & Alrouh, 2014).

Grant and colleagues (2011) found only four published studies that examined recurrent childbearing among substance-abusing mothers. In all these studies they found high rates of subsequent substance-exposed infants. Ryan and colleagues, for example, reported that 94 per cent of the 151 subsequent substance-exposed infants born during their study period were the offspring of women who had had a prior substance-exposed infant (Ryan, Choi, Hong, Hernandez & Larrison, 2008). Smith and Testa (2002) found that families involved with the child welfare system due to prenatal substance abuse were more likely to have subsequent allegations compared to families involved in the system due to other child maltreatment allegations, a finding largely attributable to mothers who had subsequent births with accompanying substance-exposed infant allegations. These researchers even suggested that a substance-exposed infant allegation may have predicted subsequent prenatal drug use (Smith & Testa, 2002). Taplin and Mattick (2014), in their study of mothers on the New South Wales opioid treatment program, found that once one baby had been removed at birth, the woman’s subsequent children were also removed at birth. These high rates of recurrence point to the need to intervene with the mothers in such a way that the rates are reduced.

3.1.9 Key findings from this section

- Parental substance use can affect children developmentally from the point of conception, after birth and across the lifespan. Pregnancy has been described as the opportune time to address maternal AOD use, but represents a brief window within which to address ‘the multiple intersecting and complex issues that led to substance use initiation and continuation’ (Jones & Kaltenbach, 2013).
- The purpose of screening for substance use in pregnancy is to identify potential substance misuse problems that may affect pregnant women and their foetuses. This then enables decisions to be made as to whether further assessment on the frequency and quantity of substance use needs to be undertaken, and to determine appropriate intervention responses.

- These intervention responses may take the form of referral to treatment and involve reporting to child protection services, due to concerns that the pregnant substance-using women may not be able to safely care for their newborns.
- Infants and children develop within the context of complex social and environmental conditions that also influence functional and behavioural capacities, making it difficult to ascertain a drug-specific effect on developmental processes (Bandstra et al., 2010).
- Parental substance misuse can be associated with child maltreatment and is a common characteristic of families involved with the child protection system.
- Mothers with an AOD problem who are involved with the child protection system are more likely to have mental health problems, be younger, have more children, have greater economic problems, have a history of homelessness, sex work or incarceration, live with a substance user and have fewer social supports. The greater the number of adversities, the less likely they are to be caring for their children.
- Although the evidence is limited, universal screening for AOD use in pregnancy (including tobacco) is recommended: it reduces the targeted screening of marginalised groups, stigma and the under-identification of AOD use in pregnancy. Screening should be undertaken by health professionals in a non-judgmental manner at antenatal visits.
- Australian jurisdictions have in recent years introduced into their child protection legislation the prenatal reporting of ‘at-risk’ mothers, the aim of which is to provide a mechanism for reports of concerns to child protection services and to guide the provision of family supports to minimise future child protection involvement.
- A reported professional and ethical tension in risk assessment is between the risk management approach within a child protection framework where the focus is on the safety of the child, and the health system whose focus is on the health of the mother and the development of the foetus.
- Available data on prenatal reporting are limited. In 2012–13, 1427 ‘unborn children’ had substantiated reports of abuse in six Australian jurisdictions, plus another 4356 children under 12 months of age nationally (Australian Institute of Health and Welfare, 2014). Only New South Wales publishes more detailed data. In New South Wales, 2389 ‘unborn children’ were assessed at risk of significant harm in 2012–13. Definitional differences and the use of ‘reports’, ‘substantiations’ and ‘entry into out-of-home care’ as proxy measures of child abuse and neglect, rather than outcomes involving child harm or parenting quality, are an issue.
- It is estimated that around 10 per cent (range 7.6–15.0%) of the babies of mothers who use substances in pregnancy are removed from their care around the time of birth (see Section 3.1.8h).

3.2 Research evidence on best practice in the management of pregnant women using AOD in relation to child protection risks

3.2.1 AOD treatment responses to the identification of substance use in pregnant women

Detailed discussion of specific treatments provided for substance use and dependence (such as pharmacotherapies and counselling) is not within the scope of this report. However, a brief overview of the treatment types found to be the most effective with pregnant substance-using women is provided. Also discussed are the process and service system contexts of AOD treatments; namely, how treatment may be delivered to improve outcomes for pregnant substance-using women, as identified in the literature.

Although there is limited evidence about the outcomes of screening in terms of increased support for pregnant women and increased safety for their foetuses once born, screening can lead to an increasing range of responses, from brief interventions to linking women to AOD treatment, generally provided by the health system. The following section will outline the major responses.

a. Brief interventions

Following on from a screening outcome that shows risky substance use, a brief intervention involves the engagement of a client in a short conversation, providing feedback and advice, usually undertaken by a health professional in a hospital or community health setting.

There is good research evidence for brief interventions as an effective approach to reducing alcohol use. The positive effects of brief interventions have been well documented in the literature. In a systematic review of 22 randomised control trials examining the effects of brief alcohol interventions, subjects offered brief interventions significantly reduced their alcohol consumption in comparison to other groups (Kaner, Dickinson, Beyer et al., 2007). The evidence is not as strong in relation to brief alcohol interventions with pregnant women. However, brief interventions have been found to be a promising strategy for reducing alcohol-exposed pregnancies (Chang et al., 2006; Floyd, Sobell, Velasquez et al., 2007; O'Donnell, Anderson, Newbury-Birch et al., 2013; Seib et al., 2012). A minimum, one-session intervention involving personalised assessment, feedback, motivational interviewing and contraceptive advice could be beneficial in reducing the risk of an alcohol-exposed pregnancy, while a longer intervention is likely to have a more robust effect (Ingersoll, Ceperich, Hetteema, Farrell-Carnahan & Penberthy, 2013).

There is less research into the effects of brief intervention for drugs other than alcohol, both for the general population and for pregnant women (Breen et al., 2014). For pregnant women with AOD dependence or disorders, the most appropriate interventions include specialised treatment services with a comprehensive bio-psychosocial approach. An exception is tobacco. There is strong evidence for the effectiveness of smoking cessation programs for pregnant women and these can be delivered in routine antenatal care (Flenady, Macphail, New, Devenish-Mears & Smith, 2008). Brief interventions providing integrated motivational

interviewing content and contraceptive advice have been found to be effective in reducing the risk of alcohol-exposed pregnancies in non-pregnant women, in randomised controlled trials in the United States and South Africa (Floyd et al., 2007; Ingersoll et al., 2013; Rendall-Mkosi, Morojele, London et al., 2013). Further research is needed on the design of these interventions, the skills needed, the length and frequency of the intervention, the mode of delivery and the long-term outcomes (Breen et al., 2014).

b. Motivational interviewing

Motivational interviewing is a style of brief intervention that focuses on a person's readiness to change their behaviour. It uses an empathetic, collaborative and reflective counselling approach with the intention of motivating change and addressing any resistance or ambivalence that someone may be feeling about changing their behaviour (Jones & Kaltenbach, 2013). Motivational interviewing aims to clarify the person's motivation for change in their own language and to develop goals, and has been found to be effective in reducing problematic alcohol consumption in women (Jones & Kaltenbach, 2013).

Pregnancy may provide the ideal opportunity and motivation for behaviour change around substance use and can be assisted via motivational interviewing accompanied by the appropriate treatment and support (Lui, Terplan & Smith, 2008). Project CHOICES is a model of motivational interviewing for AOD use integrated with contraceptive advice. Developed in the United States, the Project CHOICES model provides four brief motivational counselling sessions and a contraceptive appointment to non-pregnant women of reproductive age. The model has been tested in randomised controlled trials and shown to be effective in reducing the risk of an alcohol-exposed pregnancy (Floyd et al., 2007; Ingersoll et al., 2013).

c. Treatment for substance use problems

Pregnant women who are assessed as being dependent on substances are likely to be referred to treatment, which may take the form of pharmacological treatment (when the woman is dependent on opioids), residential treatment or counselling.

In any discussion of best practice treatment approaches to pregnant substance-using women and their families, it is important to note that treating women during pregnancy represents a short period within which to address 'the multiple intersecting and complex issues that led to substance use initiation and continuation' (Jones & Kaltenbach, 2013). The perinatal period has been referred to as a 'window of opportunity' in which women re-evaluate their domestic situations, particularly where there is violence, with motivation to possible abstinence from substance use or at least to minimise substance use (Tsantefski et al., 2013).

Substance-dependent mothers face unique challenges in caring for their infants while managing drug use or pharmacotherapy (Tsantefski et al., 2013). Most substance-use treatment services are focused on treating the individual substance user, with less regard for the children and family. Efforts to change this focus are being implemented in Australia, such as the work being undertaken by the National Centre for Education and Training on Addiction. One United States study highlighted the balance between the need to provide low income and AOD-dependent women with the health care and safety that they themselves require, while understanding that they are expected to also provide for their babies (Flavin & Paltrow, 2010).

Treatment programs for substance-using pregnant women need to address survival needs such as housing, food and financial problems, as well as physical health (both obstetrical and general health), psychological health, social functioning, relationships and social supports (Jones & Kaltenbach, 2013). There is also a greater awareness that services and programs should be informed by recognition that most substance-using women in treatment have a history of trauma (Jones & Kaltenbach, 2013). Treatment should be multidisciplinary, comprehensive and collaborative in scope, use coordinated and evidence-based strategies that incorporate support, and comprehensive health and social services that are responsive to women's needs (Marsh et al., 2011). Some authors recommend that treatment comprise a comprehensive network of accessible, non-judgmental, non-punitive, culturally- and gender-specific services that includes provision for the care of the mother–baby dyad as well as partners and other children (Velez & Jansson, 2013). Other authors emphasise the need for all contacts within the treatment setting to be therapeutic; that is, reinforcing, optimistic, supportive and respectful (Jones & Kaltenbach, 2013).

In a Public Policy Statement on Women, Alcohol, Other Drugs and Pregnancy, the American Society of Addiction Medicine (ASAM) (American Society of Addiction Medicine, 2011) recommended that high-quality, affordable and culturally competent substance-use treatment services should be readily available to pregnant and parenting women and their families. Pregnant women and their partners should be offered the highest priority for admission to available treatment slots. The treatment components of the ASAM recommendations include:

- opioid agonist therapy for women dependent on illicit opioids
- family-centred treatment, including education and treatment of domestic partners
- evaluation and case management for substance-exposed children
- childcare and transportation
- adequate and appropriate facilities for the outpatient and continuing care phases of treatment
- perinatal care that is non-judgmental and sensitive to special needs
- facilitation of maintaining the family unit and mother–child unit, with consideration of alternative arrangements as needed
- child protection services as alternative placement when there is active substance-use disorder and absence of others able to fulfil the parental role
- collaborative, interdisciplinary relationships and consultation among primary care, obstetric, family medicine, and midwife practices with addiction treatment providers
- preservation of the physician–client relationship in regard to confidentiality and reporting laws
- screening, evaluation, treatment planning, and case management for co-occurring mental illness and personal history of prenatal alcohol exposure, foetal alcohol spectrum disorder, or foetal alcohol syndrome
- reproductive and contraceptive counselling, including the effects of alcohol, nicotine, and other drugs on pregnancy and foetal health.

d. Does treating the mother's substance use improve child outcomes?

Although substance misuse is one of the primary reasons that parents become involved with the child protection system, there is surprisingly little empirical research that examines the relationship between substance abuse treatment and child protection outcomes (Green, Rockhill & Furrer, 2007; Grella et al., 2009). Studies have most often focused on the role of treatment completion, which judges report using as a key factor in reunification decisions; custody status and overall family functioning have rarely been included within evaluations of substance abuse treatment outcomes (Grella et al., 2009; Karoll & Poertner, 2002). As Barnard and McKeganey comment, children have only rarely been the direct focus of interventions, with the assumption that they will derive indirect benefit from the support offered to their parents (Barnard & McKeganey, 2004).

Where the outcomes for children have been considered, findings are mixed (Grella et al., 2009). On the one hand, Green, Rockhill and Furrer, in a longitudinal study of 1911 women who had children placed in care, found that when women entered treatment more quickly, spent more time in treatment, or completed at least one treatment episode, their children spent fewer days in foster care and were more likely to be reunified with their parents (Green et al., 2007). Smith found that, in a sample of 159 substance-abusing families with at least one child in substitute care, about 50 per cent of parents completed at least one episode of substance abuse treatment, and that treatment completion was a strong predictor of the likelihood of reunification, even after controlling for parents' self-reported drug use and quality of parenting practices, among longer-term child welfare cases (Smith, 2003).

On the other hand, Gregoire and Schultz (2001) showed that there was a relatively low rate of treatment completion (less than one-quarter) among parents referred to substance abuse treatment from child welfare, and that treatment non-completion was strongly associated with continued substance abuse and eventual loss of parental rights. While parents who completed treatment were more likely to be reported by their caseworkers as 'clean and sober', they were no more likely to have custody of their children or to retain their legal parental rights (Gregoire & Schultz, 2001). In another study using case records, compliance with court-ordered substance abuse treatment was found to not affect either the likelihood of subsequent reports of child abuse or the duration of child welfare services received (Rittner & Dozier, 2000).

Barth, Gibbons and Guo undertook a secondary analysis of data from the National Survey of Child and Adolescent Wellbeing, a longitudinal study intended to answer a range of questions about the outcomes for abused and neglected children and their involvement in the child welfare system. From their nationally representative sample of 5501 children whose families were investigated by child protection services for child maltreatment in the year 2000, cases with any indication of carer substance misuse (n=1101) were selected. They found that families that enter substance abuse treatment have higher re-report rates; this may be because the families are more troubled, but also because they experience greater agency surveillance during the service period, thus increasing the likelihood of a subsequent report (Barth et al., 2006).

3.2.2 Interventions aimed at improving the substance-using mother's ability to safely care for her child

From previous reviews of the literature in this area, one of the strongest messages is the need for a coordinated service response in addressing parental substance misuse in a child protection context. There is some evidence that combining family-based interventions with drug treatment services has positive effects on children of substance users when it builds family routines and promotes strong bonds to non-drug-using family members. Other studies have found that re-abuse and re-entry to care for children are less likely the more time, assistance and supports that families receive (Taplin & Mattick, 2011).

a. Shared and collaborative decision making

Case planning, case management and family group conferencing are all strategies aimed at bringing services together with families, to discuss decisions and strategies with the aim of working collaboratively to reduce risks to children.

Case plans and safety plans

The development of a case plan that incorporates a safety plan is the first stage in any comprehensive intervention with substance-using pregnant women (Jones & Kaltenbach, 2013). Jones and Kaltenbach suggest that there are some key elements that need to be incorporated for their successful engagement with service interventions. These include: (i) woman-led and -owned case plans; (ii) priority given to addressing basic survival needs; (iii) involvement in decisions about any treatment intervention, such as opioid agonist medication or medication-assisted withdrawal (benzodiazepines); (iv) assessment of mood disorders after a period of stabilisation of drug use; (v) monitoring of the case plan; and (vi) recognition of the capacity of women to address goals and to break down goals into those that are realistic and can be managed (Jones & Kaltenbach, 2013).

In the context of child protection outcomes for substance-using pregnant women, case plans and safety plans can influence their early engagement with specialists, as well as with the broader service system. One study involving a specialist AOD service in Australia found that early engagement of pregnant women in case planning could lead to the avoidance of a crisis response, coordinated planning before birth for the care of the infant, and timely referral and links to services. Many of the women interviewed in this study reported a fragmented and uncoordinated response to substance use treatment and in the early period after discharge from hospital (Tsantefski, Humphreys & Jackson, 2011).

In Australia, case planning meetings are generally held for all neonates considered to be at risk prior to discharge from hospital. However, a small-scale qualitative study of a major provider of obstetric services to substance-dependent women in Victoria (the Women's Alcohol and Drug Service and the Royal Women's Hospital) found that the implementation of case plans

required resources that were not available. Mothers highlighted the lack of detoxification and rehabilitation programs or continuity of support for the family unit following infant discharge from hospital. In the context of child protection, it is noteworthy that, in the absence of appropriate services, surveillance leading to removal is more likely than family support (Tsantefski et al., 2011).

Case management

Case management in the context of substance-using pregnant women has been described as a comprehensive, coordinated continuum of services to optimise recovery of the aspects of women's lives that have been affected by substance use, which advocates on behalf of the women and enhances the women's advocacy skills. It involves the solving of practical problems with the active participation of women, and aims to overcome barriers to services and coordinate services across systems.

The literature supports case management as an integral part of a comprehensive treatment plan for substance use disorders in pregnant women (Jones & Kaltenbach, 2013). It has produced positive outcomes for vulnerable substance abusers facing multiple barriers, including pregnant women and mothers of young children, building on the knowledge that women have historically not responded well to traditional substance abuse treatment models that focus on abstinence alone, without incorporating services for problems in other areas (Dauber, Neighbors, Dasaro, Riordan & Morgenstern, 2012).

Case management is broad in concept and practice but specific elements have been identified in the literature as key principles toward a best practice model of care for pregnant women. These elements include: (i) establishment of rapport at intake; (ii) reaching out to pregnant women to maintain engagement, including home visiting; (iii) undertaking an assessment of women's needs, which can also enhance the trust and relationship between service provider and client; (iv) linking women to appropriate services; and (v) advocacy on their behalf (Jones & Kaltenbach, 2013).

A recent United States study, with a sample of 302 substance-dependent mothers recruited from welfare offices and their 888 children, examined the impact of 'intensive case management' (ICM) on child protection system involvement. The findings showed an initial reduction in child protection reports but no clear benefits of ICM over usual care. In addition, a lower proportion of children were removed from participants in the ICM condition compared to usual care, but this effect decreased over time. Overall, however, they found minimal benefits from case management in terms of child protection outcomes but it was effective in the areas of treatment, engagement and abstinence (Dauber et al., 2012).

Family group conferencing

Family group conferencing (FGC) is a family-led decision-making process that provides parents, extended family members, children/young people, child protection workers and service providers with an opportunity to come together for the purpose of discussing and developing strategies that will protect the safety and wellbeing of the children/young people. Conferences are typically facilitated by a neutral third party (facilitators) who ensures that all participants have an opportunity to speak, are listened to and remain focused on the needs of the children. In addition to empowering families to develop strategies, FGC also aims to improve relationships between child protection agency professionals and family members, to provide a culturally appropriate means of resolving child protection concerns, and to rebuild family ties, especially in families that may have stopped communicating or drifted apart (Boxall, Morgan & Terer, 2012; Chandler & Giovannucci, 2009).

Family group conferencing has been mandatory practice in New Zealand since 1989, when it was introduced to better address the practice issues experienced by Indigenous people that did not reflect the importance of their kinship networks (Connolly & Smith, 2010). In other countries, including Australia, the use of FGC is largely at the discretion of child protection workers. Australian child protection laws come under the jurisdiction of individual states and territories; all except one jurisdiction have implemented or conducted trials of FGC with significant variation in implementation (Tsantefski et al., 2011).

Research into the effectiveness of FGC has been generally positive. Previous evaluations of FGC programs operating in Australia and overseas have found: (i) the majority of families have been able to develop appropriate family plans that address the identified child welfare concerns and meet the requirements of the child protection agency; (ii) families are more likely to engage in services identified through conferences; (iii) children/young people have increased contact with their extended family; and (iv) families report an improved working relationship with the child protection agency (Boxall et al., 2012).

Further, while the cost-saving benefits of FGC are less clear, there is some evidence that FGC programs either generate some cost-saving benefits or are no more expensive than traditional care and protection processes (Boxall et al., 2012). Despite evidence that there are some benefits from FGC, there has generally been a low uptake of the model in Australia (Harris, 2008).

The literature has noted the tensions that emerge when two very different discourses attempt to integrate the 'democratic', participatory discourse of FGC versus the legalistic, bureaucratised discourse of conventional child welfare practice (Ney, Stoltz & Maloney, 2013). Delivering FGC needs an awareness of how power operates in this context and the potential for discourses that are incompatible with FGC objectives and values (Ney et al., 2013). Challenging and changing existing power relations and structures can be difficult to achieve (Tsantefski et al., 2011).

Family group conferencing with pregnant ‘at-risk’ women and their partners

There is limited research focusing specifically on the effectiveness of FGC with ‘at-risk’ pregnant substance-using women. In Western Australia, an evaluation was undertaken of interagency early intervention in the form of pre-birth planning using the New Zealand model of FGC in conjunction with the Signs of Safety Assessment and Planning Framework. The Signs of Safety Framework is used to assess safety in partnership with family members to address child abuse and neglect concerns (Turnell & Edwards, 1999). The Western Australian evaluation involved a sample of 31 mothers who participated in pre-birth planning using FGC and the Signs of Safety Framework (Hunter, 2009). The evaluation found that both mothers and professionals considered the pre-birth planning meetings underpinned by FGC principles to be a more effective and consistent process overall, the framework improved communication and planning during the trial, and there was better engagement with families. The authors also reported that it was not always possible to engage with the mother early enough to allow adequate time for the pre-birth planning process, and there was a need to increase the cultural responsiveness of the model to ensure that the Aboriginal kinship networks were incorporated (Hunter, 2009). It has been suggested that the discretionary use of FGC severely limited the engagement of the extended family at a time not only of heightened infant risk, but also of increased maternal and parental motivation for change, and limited the valuable opportunity for early intervention and prevention afforded by pre-birth notification (Tsantefski et al., 2011).

b. Co-location of services – integrated antenatal and substance abuse treatment programs

In addition to the strategies discussed above, services may be brought together or physically co-located to ensure more collaborative working arrangements aimed at reducing the risk to the child. These are commonly integrated treatment programs.

Integrated programs – that is, programs that integrate onsite pregnancy, parenting or child-related services with substance use treatment – have been developed to address the barriers to accessing care, and the unique needs of pregnant women who misuse substances (Niccols, Milligan, Sword et al., 2012). Within these models, the needs of women in relation to their substance use, wellbeing, mental and physical health (including antenatal care), and the needs of their children (including parenting interventions) are addressed by the provision of specific services. Integrated programs may differ in the number of services offered and the degree to which they are integrated from a process perspective, including the ways in which agencies work together, service linkage, cooperation, coordination and partnership (Milligan, Niccols, Sword et al., 2011). Substance-using women require integration of obstetric and specialist treatment services including education in caring for newborns, particularly with neonatal abstinence syndrome (Jones & Kaltenbach, 2013).

A review of the literature on integrated substance abuse and child welfare services for women found that improvements in service utilisation and outcomes were made when substance abuse and child welfare services were integrated, with women remaining in treatment longer and being more likely to reduce substance use and reunify with their children (Marsh et al., 2011). Grella and colleagues found that mothers who were treated in programs providing a ‘high’ level of family-related or education/employment services were approximately twice as

likely to reunify with their children as those who were treated in programs with 'low' levels of these services (Grella et al., 2009). In their study of 160 mothers who had delivered a substance-exposed infant, Huang and Ryan reported that mothers who received residential treatment combined with other community-based transitional programs (including outpatient, intensive outpatient, recovery homes, and methadone maintenance) were significantly more likely to achieve reunification compared to mothers who received only inpatient residential treatment (Huang & Ryan, 2011). The client-provider relationship has also been found to be an important element and reasonably consistent predictor of retention in treatment, but an inconsistent predictor of post-treatment substance use (Marsh et al., 2011).

One of the early integrated programs was Early Start, introduced in 1990 in northern California as an obstetric clinic-based perinatal substance-abuse intervention program. This program provided pregnant women with screening and early identification of substance use problems, early intervention, counselling and case management by a clinical therapist with expertise in substance abuse – the Early Start specialist. The Early Start program diagnosed and scheduled those identified as having substance use problems for Early Start appointments linked with their perinatal appointments. The program's unique feature was that the Early Start specialist was co-located in the prenatal clinic, as an integral part of the perinatal care. Co-location promotes easy access to services and client compliance (Armstrong, Gonzales Osejo, Lieberman et al., 2003).

Milligan and colleagues undertook a meta-analysis of studies evaluating the impact of integrated programs on birth outcomes. They found that, compared to women with substance abuse issues not in treatment, women in integrated programs had infants with significantly higher birth weights, larger head circumferences, fewer birth complications, positive toxicology screens, and low birth weight classifications. Women in integrated programs also attended significantly more prenatal visits and had significantly fewer pre-term births than women in non-integrated programs (Milligan et al., 2011). Furthermore, in a systematic review examining the effectiveness of integrated programs for mothers with substance abuse issues, Niccols and colleagues found that the limited available evidence supports integrated programs as being associated with improvements in parenting skills (Niccols et al., 2012).

In summary, meta-analyses of integrated programs show their positive impact on maternal mental health and birth outcomes and, in qualitative studies, women stated that integrated programs helped them to gain insight into intergenerational influences on parenting, to strengthen emotional bonds with children, and to use positive discipline techniques. However, the findings related to improvement of parenting skills, which has been shown to reduce the risk of child maltreatment, are fewer. Even though the advantage of integrated programs over addiction treatment-as-usual may be small, it could have a potentially large impact on the associated financial and human burden in this vulnerable population (Niccols et al., 2012).

c. Home visiting

Home visiting programs are an early intervention strategy providing a range of structured services to young children and their family in their home environment, usually by a professional service provider. Home visiting programs encompass a wide variety of strategies and service elements. However, they all emphasise the importance of parental behaviour in influencing the lives of children and the importance of the home environment as an opportune place for providing services. The observation of family dynamics and environment enhances a better understanding of families' needs and opportunities for service interventions. Interventions may include case management, referrals to existing community services, parenting and child education, and the provision of social supports to women and their families, prenatally and postnatally. Home visiting programs are most effective with lower socioeconomic groups, when nurses and/or other professionals deliver services to families instead of paraprofessionals, when services are comprehensive in focus, the program model is adhered to and families' multiple needs are targeted (Olds, Kitzman et al., 2004; 2007; 2014).

Participation in home visiting programs for 'at-risk' families has been shown to be effective for improving children's cognitive and behavioural outcomes (e.g. Peacock, Konrad, Watson et al., 2013). However, few home visiting programs have been able to significantly improve pregnancy outcomes and reductions in child maltreatment have been found for some models, but not for others.

Western Australian researchers recruited 152 illicit-drug-using mothers at 35–40 weeks gestation from Perth's King Edward Memorial Hospital and randomised them after delivery to a home visiting group or to a control group. The home visiting group received eight home visits, parenting support, and breastfeeding and child development education, while the control group had telephone contact at two months and at six months and no additional support. In both groups substance use reduced in pregnancy but increased by six months post-partum (Bartu, Sharp, Ludlow & Doherty, 2006).

A recent systematic review published by the Cochrane Collaboration focused on whether there was potential for improving outcomes for pregnant and post-partum women with an AOD problem via home visits (Turnbull & Osborn, 2012). The authors found that, although individual studies reported a significant reduction in involvement with child protection services, there was insufficient evidence to recommend the routine use of home visits for pregnant or post-partum women with an AOD problem (Turnbull & Osborn, 2012). Similar findings have been reported by Tsantefski and colleagues, who found evidence that home visits after births increased the engagement of women in drug treatment services, but there were insufficient data to indicate if this improved the health of the baby or mother (Tsantefski et al., 2013).

d. Additional or ancillary services to address the needs of substance-using pregnant women

Parenting interventions

Experience in early relationships with parents is known to be crucial for the child's brain development as well as for cognitive, emotional and social development (Cicchetti & Toth, 2009). Substance-use dependence reduces the rewarding value of caregiving and renders parents particularly vulnerable to stress, especially in the perinatal period. The outcomes may be a lack of response to infant cues (leading to neglect) or responding inappropriately to infant cues, which may lead to abuse or a combination of these responses. Many programs for substance-using pregnant women and new mothers use strategies that provide support and education based on the need to address the demands of parenting, as well as the problems of the substance use itself (Suchman et al., 2013). Without improvement in a substance-using mother's capacity to recognise and respond sensitively to a child's emotional cues, other interventions may do little to strengthen the mother-child relationship (Pajulo & Kalland, 2013; Suchman, DeCoste, Castiglioni et al., 2010).

However, attendance alone is not sufficient to improve parenting capacity. 'Simply arguing that a parent has attended an "evidence based" parenting intervention does not equate to an improvement in the capacity to provide a responsive and nurturing environment for children' (Dawe & Harnett, 2007, p. 388).

A small number of parenting programs have been developed for substance-using parents, some of which engage women prenatally.

e. Contingency management

Contingency management is an empirically supported intervention for substance dependence (Petry, Alessi & Rash, 2013). Contingency management has the 'greatest depth and breadth of empirical data' to support its use in changing substance use behaviours of pregnant women (Jones & Kaltenbach, 2013). Contingency management treatments are based on learning and conditioning theories that aim to alter the environment by arranging ways that make substance use less attractive (Jones & Kaltenbach, 2013). The theoretical basis for interventions and treatments needs to be operationalised through comprehensive programs that treat substance use disorders in pregnant women incorporating strengths-based, supportive, professionally respectful and affirming interventions. There is also evidence regarding the efficacy of treatments for substance use disorders during pregnancy showing that a combination of treatments are most successful (Jones & Kaltenbach, 2013).

Haug and colleagues (2014) recently reviewed the literature on the use of contingency management with pregnant women. They reported that, in general, contingency management approaches have shown effectiveness for improving retention and drug abstinence among substance abusers in treatment, thereby allowing clients to benefit from other components of clinical services. Contingency management is of particular relevance during a

time-limited window of opportunity such as pregnancy, in which longer treatment duration results in better maternal and infant outcomes. Contingency management interventions have consistently been shown to improve retention in drug abuse treatment and access to prenatal services for pregnant women, but with less promising effects on substance use. The cost of contingency management programs makes clinical application challenging in community-based treatment clinics. Moreover, stigma and related negative public perceptions of paying women to abstain from substance use during pregnancy are often difficult to overcome (Haug et al., 2014).

f. Residential treatment programs for substance-using mothers

Pregnant women are often granted priority admission into residential treatment and immediate access when a bed is available. Residential treatment programs have been developed specifically for substance-using pregnant and parenting women, focusing on simultaneously treating the substance use and supporting the mother–baby relationship. Collaboration between treatment providers and onsite nursing resources are important components of the residential treatment of pregnant women. Residential and inpatient treatment offers a safe environment for stabilisation, structure and intense support for recovery. Additionally, important and intensive early work to support the mother–child relationship within a safe residential treatment context is valuable from the babies’ developmental viewpoint and for the mothers’ future solutions and collaborative capacity (Pajulo, Pyykkönen, Kalland et al., 2012).

Pregnant women who live in drug-using environments may especially benefit from residential versus outpatient treatment (Haug et al., 2014). However, women who have other child and family responsibilities may prefer community-based programs rather than residential programs.

Research suggests that women become more engaged, obtain greater benefit from treatment, and have higher retention when they are permitted to bring their children into the residential treatment setting (Haug et al., 2014). Women in residential treatment with their children have better outcomes across multiple areas of psychosocial functioning (i.e. drug abstinence, employment, child custody, and involvement with continuing care and support groups) at six months after discharge than women who do not bring their children to treatment. Moreover, improved behavioural and emotional functioning at 6 and 12 months after residential treatment was found among children who attended residential treatment with their mothers (Haug et al., 2014).

Women-only residential treatment services are associated with increased length of stay compared with mixed-gender substance abuse treatment programs, and treatment focused on gender-specific needs results in longer stays and improved continuity of care (Ashley et al., 2003; Haug et al., 2014).

Women-only treatments

Drug treatment programs are often based on models that lack cultural sensitivity to minorities or women. For example, some people may find aspects of the initial involvement in these programs – such as self-disclosure, trust in virtual strangers, being urged to ‘surrender’ or admit they are ‘powerless’ – to be alien and culturally inappropriate (Wechsberg, Luseno, Karg et al., 2008). Copeland’s study of women who had ceased substance use without formal treatment found that the principal barriers to entering formal treatment services among this group included social stigma and labelling, lack of awareness of the range of treatment options, concerns about childcare, the perceived economic and time costs of residential treatment, concerns about the confrontation models used by some treatment services, and stereotypical views of clients of treatment services (Copeland, 1997).

Ashley and colleagues define substance abuse treatment programming for women as the delivery of services that (i) reduce women’s barriers to entering substance abuse treatment; and (ii) address the treatment needs specific to women. These investigators emphasise how services are delivered, in addition to the specific type or quantity of services (Ashley et al., 2003). Specifically, this consists of a nurturing and supportive group therapy environment, focus on self-worth, and a comfortable setting for women to discuss sensitive and painful issues (Haug et al., 2014; Marsh et al., 2011).

Comprehensive programs involving children that include specialised health and mental health services, and which offer practical help, have been shown to improve child welfare outcomes for AOD-using mothers involved with the child welfare system (Marsh et al., 2011).

3.2.3 Key findings from this section

- One of the strongest messages is the need for a coordinated service response in addressing parental substance misuse in a child protection context. There is some evidence that combining family-based interventions with drug treatment services has positive effects on children of substance users.
- There is some evidence that if pregnant women’s partners are encouraged by antenatal services to reduce their substance use, women are also more likely to reduce their substance use. Other family members may also be an important source of support.
- Following on from a screening outcome that shows risky or dependent substance use, a brief intervention, referral to pharmacological treatment (where women are dependent on opioids), residential treatment or counselling is recommended.
- The service response should be multidisciplinary, comprehensive and collaborative in scope, use coordinated and evidence-based strategies that incorporate support, and comprehensive health and social services that are responsive to women’s and children’s needs.

- There is little evidence on the extent to which pregnant women gain access to appropriate services in a timely manner.
- Treatment compliance increases the likelihood of reunification.
- Case planning, case management and family group conferencing are all strategies aimed at bringing services together with the family, to discuss decisions and strategies with the aim of working collaboratively to reduce risks to the child.
- The literature supports case management as an integral part of a comprehensive treatment plan for substance use disorders in pregnant women.
- Research into the effectiveness of family group conferencing has been positive, but there is limited research focusing specifically on its effectiveness with pregnant AOD-using women.
- Integrated programs, programs that integrate onsite pregnancy, parenting or child-related services with substance use treatment, address the barriers to accessing care and the unique needs of pregnant women who misuse substances. Meta-analyses of integrated programs show their positive impact on maternal mental health and birth outcomes, but limited improvements in parenting skills.
- A recent systematic review found that, although individual studies reported a significant reduction in involvement with child protection services, there was insufficient evidence to recommend the routine use of home visits for pregnant or post-partum women with an AOD problem (Turnbull & Osborn, 2012).
- Contingency management approaches have shown effectiveness for improving retention and drug abstinence among substance abusers in treatment, thereby allowing patients to benefit from other components of clinical services.
- Residential treatment programs for substance-using pregnant and parenting women focus on simultaneously treating the substance use and supporting the mother–baby relationship. Research suggests that women become more engaged, obtain greater benefit from treatment, and have higher retention when they are permitted to bring their children into the residential treatment setting (Haug et al., 2014).
- Women-only residential treatment services are associated with increased length of stay compared with mixed-gender substance abuse treatment programs, and treatment focused on gender-specific needs results in longer stays and improved continuity of care (Ashley et al., 2003; Haug et al., 2014).

3.3 Policies in Australian jurisdictions relating to the identification of maternal AOD use in pregnancy

This section identifies the current legislative and policy context in Australia with regard to the identification of maternal AOD use in pregnancy. It draws on consultations undertaken with key stakeholders as well as relevant material accessed online to identify the similarities and differences, along with the common approaches in legislation and policy across jurisdictions.

Current Australian policy and practice can be characterised as taking a clinical approach to managing substance use during pregnancy, which emphasises the health of the newborn rather than the enforcement of laws in relation to drug use (De Bortoli et al., 2014). This position can be contrasted with that in the United States where a zero-tolerance approach regards drug use as requiring a strong law enforcement apparatus and a drug policy that tends to punish the user. As part of this approach, all newborns exposed to illicit drugs through positive testing must be reported to child protection services, with responses ranging from service referral to punitive outcomes. In the United Kingdom, the approach to managing substance use during pregnancy appears to be similar to that adopted in Australia (De Bortoli et al., 2014).

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In 2005, South Australia was the only Australian jurisdiction that accepted notifications for unborn children, while other jurisdictions either recorded or investigated a notification (Western Australia, Queensland, New South Wales) or were considering legislation on prenatal reporting (Tasmania, Victoria, Australian Capital Territory) (Bromfield & Higgins, 2005). All jurisdictions progressively introduced legislation on prenatal reporting over the next few years. Prenatal reporting was introduced into legislation in the United Kingdom (2004) and the United States (2000) earlier than in Australia. The drivers for changes in child protection legislation in Australia were mainly in the aftermath of inquiries into child abuse following tragedies (e.g. Queensland Crime and Misconduct Commission, 2004), concerns in the United States about exposure to substance use in pregnancy and the presumption that such children have been abused or neglected and the mother's parental rights need to be terminated, and the United Nations Convention on the Rights of the Child (1989) which states that 'the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection, before as well as after birth'.

3.3.1 Australian legislation – overview of similarities and differences

A mapping of legislation across Australian jurisdictions with a focus on unborn reporting provisions and supporting policies found that differences have evolved in their statutory provisions and in their responses following an unborn child notification (see Appendix A for specific detail and legislation).

All jurisdictions, with the exception of the Northern Territory and South Australia, have legislation for reporting the unborn child to statutory authorities. Although South Australia and the Northern Territory have no specific provisions for unborn child reporting in their legislation, these jurisdictions have developed policies and practice guidelines for the management of reports including ‘high-risk infant alerts’ in conjunction with state and territory health and statutory child protection services (see Appendix A).

Tasmania has included prenatal reporting (*Children, Young Persons and Their Families Amendment Act 2009*, section 14) in the reporting requirements to child protection services for mandated reporters. The list of prescribed mandated reporters included in Tasmania’s child protection legislation, the *Children, Young Persons and Their Families Act 1997*, is extensive. It includes professionals such as medical practitioners and dentists similar to other Australian child protection legislation, but is more extensive in scope with the inclusion of employees and volunteers of all government-funded agencies that provide services to children.

All jurisdictions specify that a notification may be made to statutory child protection services prenatally without the consent of the parent. However, all other child protection interventions prenatally are voluntary; that is, requiring the consent of the pregnant woman. Another key feature of unborn reporting legislation is the intended aim of the reporting, which is stated to be generally non-punitive but rather aimed at providing opportunities for supportive interventions for better outcomes for children and pregnant women.

There are, however, differences in legislation across the jurisdictions, on the nature and thresholds for risk in the context of unborn reporting. For example, Queensland looks at harm initially, rather than causes of harm, and considers that it is the impact of a risk factor such as AOD use in pregnancy, not the presence or absence of AOD use, which would generate a report/notification.

Most jurisdictions have developed routine screening and assessment processes for biopsychosocial risks prenatally including for AOD use. This area of interest will be the subject of discussion later in this report. The known in-utero effects of AOD use in pregnancy have been and are currently gaining momentum, through increased awareness of foetal alcohol spectrum disorder for example, as significant drivers for health policies relating to screening and assessment for AOD use in the antenatal health policy. It is unclear, however, whether unborn reporting legislation and policies per se in the context of risk are influencing the development of structured screening and assessment protocols for antenatal care in maternity hospitals and in primary care. Nevertheless, screening and assessment of AOD use in pregnancy and most child protection policies that have identified AOD use in pregnancy as a high-risk factor for interventions are inextricably linked. Pre-birth notifications are common across jurisdictions and are reported to be increasing (see Section 3.1.8g).

a. Major features of each jurisdiction's legislation re prenatal reporting

A summary of the major features of each jurisdiction's legislation and policies is outlined below along with any planned changes.

In **New South Wales**, current legislation as outlined in the *Children and Young Persons (Care and Protection) Act 1998* provides for the making of a prenatal report where the child may be 'at risk of significant harm' when born. Of relevance to this discussion is a recent proposed amendment to the Act, the Child Protection Legislation Amendment Bill 2013 (expected proclamation date in October 2014), influenced by an increased emphasis on adoption. Under section 38A(1), Parent responsibility contracts (PRC), the scope of PRCs has been extended to include, under (b):

an agreement between the Director-General and either or both expectant parents whose unborn child is the subject of a pre-natal report under section 25 that contains provisions aimed at improving the parenting skills of the prospective parent and reducing the likelihood that the child will be at risk of significant harm after birth.

In addition, the legislated timeframes for decisions on returning children to their parents have become six months if a child is less than two years old, or within 12 months for a child over the age of two years. The implications in relation to PRCs where a prenatal report has been made in relation to parental substance use are that they will be required to attend and comply with treatment. Under the new legislation, it is likely that cases would go to court earlier than would previously have been the case. Some stakeholders consider that the new legislation may increase the number of removals at birth because of early court involvement.

The **Northern Territory** currently does not have legislation for reporting the unborn to statutory authorities. However, in 2010 a major review of the *Care and Protection of Children Act 2007* made recommendations that the Act be extended to enable the acceptance of a notification for an unborn child and to make provision for the care of the child once born (Northern Territory Government, 2010). In the recommendations for legislative review, there was support for the introduction of mandatory reporting for the protection of unborn children when the foetus is at risk of AOD use. This was seen as a logical step once unborn notifications provisions were provided in the Act. However, it was noted in the review that there may be unintended consequences for legislation of unborn reporting – as there is, for example, no known safe level of alcohol consumption during pregnancy, which may lead to a difficult and inappropriate plethora of notifications with the potential to further marginalise already-disadvantaged groups in the community. The legislative changes have not to date been introduced.

South Australia has no specific legislative provisions for reporting unborn children, but has developed policy and practice guidelines.

In the **Australian Capital Territory**, section 362 of the *Children and Young People Act 2008* provides for the prenatal reporting of an unborn child deemed 'in need of care and protection' following birth, based on a belief on reasonable grounds of anticipated abuse or neglect. The focus is currently on providing the optimal response to an unborn child report in terms of support, and whether child protection statutory responses are necessarily the best first

intervention. Information-sharing entities may report an unborn child and, as noted above, may do it without consent if it is deemed to be appropriate. A voluntary assessment may be undertaken and a referral made to a community service or provided with advice. If the pregnant woman does not consent under section 362(6) of the Act, the legislation allows the giving of prenatal information to the information-sharing entities; for example, to ACT Health if it suspects that the child may be in need of protection after birth.

In **Queensland**, section 21A of the *Child Protection Act 1999* provides for unborn children notifications and investigation if a reporter reasonably suspects the child may be in need of protection after their birth. There is also provision for the offer of help and support to pregnant women. The Act specifically states that the purpose of section 21A is ‘to reduce the likelihood that the child will need protection after he or she is born (as opposed to interfering with the pregnant woman’s rights or liberties)’. The recent Carmody Inquiry has been instrumental in instigating reforms of the child protection system (Queensland Child Protection Commission of Inquiry, 2013). The major development that has been noted from the Queensland reform is the greater consistency and uniformity of policies and guidelines around reporting of significant harm thresholds. The Inquiry report outlines provisions for unborn reporting in the circumstances that should result in prenatal reporting to child protection and support systems having an impact on good outcomes (Queensland Child Protection Commission of Inquiry, 2013).

In **Tasmania**, prenatal reporting requirements are outlined under section 13 of the *Children, Young Persons and Their Families Act 1997*. The current provisions came about under amendment of this Act in 2009, with the *Children, Young Persons and Their Families Amendment Act 2009*, whereby reporting of pregnant women became mandatory. This amendment has extended the statutory authority for unborn child reporting, and makes Tasmania the only state in Australia with mandatory provisions for unborn child reporting. Under section 14, any prescribed person must inform statutory child protection authorities of their belief, suspicion or knowledge that a child once born is reasonably likely to suffer abuse or neglect, or require medical treatment.

In **Victoria**, under section 29 of the *Children, Youth and Families Act 2005* a person may make a report, before the birth of a child, if they have a significant concern for the wellbeing of the child after their birth, and under section 32, referrals can be made to community-based child and family services about an unborn child. The aim is to support the pregnant woman and to collaborate to reduce risk to the unborn child.

In **Western Australia**, under section 33A of the *Children and Community Services Act 2004*, the chief executive officer of the relevant government department may make enquiries in order to determine actions to safeguard or promote the child’s wellbeing after the child is born, then must provide or arrange for the provision of social services, ensure that a meeting is arranged with service providers for case planning, or arrange an investigation to assess the likelihood that the child will be in need of protection after the child is born.

b. Risk assessment policies and guidelines

As discussed above, all jurisdictions have developed at least some level of policy, guidelines and procedures for reporting of unborn children, including the receiving and processing of unborn child reports; AOD screening and assessments, including the use of drug screens in child protection assessments; high-risk infant alerts and protocols between hospitals, AOD services and child protection services. All jurisdictions except one have developed protocols and pathways that distinguish, through risk assessment, the level of risk of AOD use and the nature of the risk factors that provide the appropriate pathway for the pregnant woman. Case management practice guidelines for prenatal reporting, such as in New South Wales Health's Child Wellbeing and Child Protection Policies and Procedures (2013), Tasmania's Department of Health and Human Services' guidelines on Unborn Children – Reporting Concerns about Safety and Wellbeing (2013) and Victoria's Department of Human Services' Reports Regarding Unborn Children (2013), provide a list of levels of risk factors that include substance use as a *specific* risk factor in assessment for child protection involvement.

In all jurisdictions, no specific thresholds of frequency or type of substance used in pregnancy exist for making an unborn child report or for child protection involvement. All jurisdictions have reported that most child protection interventions are instigated when there are multiple risk factors. Examples of risk factors that are commonly included in child protection guidelines, such as in Victoria's Department of Human Services protocols, as reason(s) for unborn child reporting across Australia include: (i) another child in the family previously suffering abuse, neglect or death while in the care of the parent; (ii) a sibling previously being removed from the care of either parent; (iii) where AOD use is likely to have a significant impact on the child's safety and stability after birth; (iv) where mental health problems are likely to have an impact on the child; (v) where domestic violence is present; and the likelihood that parental capacity is of concern because of (vi) the youth of the mother, or (vii) the presence of an intellectual disability. Additionally, a trigger may arise where the mother is the subject of a protection intervention or a protection order.

The issue of whether AOD use in pregnancy is a significant risk factor is not contested in the policies and practice across jurisdictions in child protection and health sectors. For example, resources that aim to support practitioners' work around the perinatal period include the following statement: 'the use of drugs by a parent or carer does not necessarily mean a child is at risk. Parenting capacities can vary as widely in substance-using parents as in non-using parents. Often substance-using parents express a desire to change to meet their children's needs and many can and do' (New South Wales Community Services' Parental Drug Testing Policy, 2009).

Nevertheless, although AOD use is stated as a separate risk factor in risk assessment protocols, all jurisdictions noted that AOD use in pregnancy *alone* is rarely a reason for the involvement of child protection services, but that the complexity and multiplicity of factors such as mental health concerns and domestic violence remain the priority for decisions on child protection statutory involvement. However, risk assessments include other factors, such as previous involvement with the child protection system.

3.3.2 Health screening policies and guidelines

This section provides an overview of the current screening policies and guidelines. Some examples of current policies, guidelines and screening practices are presented to address the major areas as noted in the introduction to this report. It is, however, not the purpose of this section to provide information and comparisons of screening processes per se, but to set a context for jurisdictional developments in this area with a focus on child protection. This section also identifies the views from participants about the pros and cons of universal health AOD screening for pregnant women and considers the emergent practice issues and responses from jurisdictions.

The identification and screening for AOD use in pregnancy across Australian jurisdictions are common for pregnant women in a variety of settings, but especially in antenatal settings in large maternity hospitals. There are key differences in the policies and practice of identification and screening protocols for AOD use in pregnancy across health and child protection settings. However, there is general agreement that identification and screening are advantageous to the foetus, the pregnant woman and her family; that the earlier the identification (including preconception) of AOD use the better the outcomes; and that the unintended consequences are generally related to the possibility of disengagement from the antenatal services and the risk of removals of babies at birth because of AOD use.

a. Common health service approaches across jurisdictions

Nationally agreed guidelines, such as the *National Clinical Guidelines for the Management of Alcohol and Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn* (2006) (under review), are intended to support a range of healthcare workers who care for and treat pregnant women with AOD use issues, their infants and their families. The guidelines provide a framework for the practice of identification and screening for AOD use in pregnancy, as well as for the management and treatment of women prenatally and postnatally, and their babies. This overarching framework has recommended screening but has not specified any particular structured or validated screening process requirements.

Policies and practice protocols have also been developed by all jurisdictions, which have consequently put into practice various ways of identification and screening for AOD use. One consistent theme in this context across the jurisdictions is the desirability for effective, consistent and structured brief interventions following an AOD screen that are acceptable to pregnant women.

All jurisdictions currently include some form of questioning about AOD use, and particularly about alcohol and tobacco. There was general agreement that the identification and screening for AOD use in pregnancy are worthwhile and should be universal for a number of reasons. The first is aimed at outcomes for a healthy pregnancy through the early identification of physical and psychosocial risk factors, such as medical conditions, mental health issues, especially depression and anxiety, domestic violence and financial disadvantage. The second, linked to the first objective, is aimed at ensuring a safe environment in utero and once born. In this context, identification and screening of risk factors such as AOD use in pregnancy are important.

All jurisdictions were supportive of the earliest possible screening of AOD use together with the repertoire of other risk factors, in order to engage appropriate services such as family support, parenting skills support and multidisciplinary case planning as required. This is an emerging priority across the jurisdictions.

b. Developments in screening practices

Some responses to the complexity surrounding prenatal substance use is evident in policy and practice developments across the jurisdictions, such as the utilisation of specific screening tools, policies for intersectoral collaboration (e.g. in Western Australia), shared responsibility for decision making, such as in the Australian Capital Territory, and training for professionals. These responses will be explored further through examples of policies and practice across the jurisdictions.

Screening tools

The most recent national initiative has developed protocols and resources for the identification and screening of alcohol in pregnancy with *specific* screening tools and requirements recommended in health settings. This initiative is an outcome of the 'Women Want to Know' project that is consistent with the National Health and Medical Research Council's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (National Health and Medical Research Council, 2009). The protocols and resources for health professionals were developed by the Foundation for Alcohol Research and Education. The resources include the alcohol screening tool AUDIT-C. In addition, online e-learning resources have been developed through the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Australian College of Midwives.

Some examples of tools used to screen a range of substances across the jurisdictions include the Australian Capital Territory's implementation of a validated screening tool for AOD use: ACT eASSIST. The screening tool is an electronic Alcohol, Smoking and Substance Involvement Screening Test developed by the Drug and Alcohol Service in South Australia and is an electronic version of the World Health Organization's ASSIST. The eASSIST tool is intended to screen for all levels of risky substance use, including tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants, sedatives, hallucinogens, inhalants, opioids and 'other drugs'. A risk score is obtained for each substance and falls into a 'low', 'moderate' or 'high' risk category, which then determines the type of intervention offered. The Australian Capital Territory version was developed in 2014 by the Alcohol Tobacco and Other Drug Association ACT and the Drug and Alcohol Service in South Australia and includes ACT-specific referrals and information.

In collaboration with the World Health Organization, South Australia Health uses the ASSIST tool for the assessment of AOD use and has developed an abbreviated version of it. This tool is currently being circulated for comment to hospitals. The ASSIST tool includes elements from the AUDIT-C. Positive acceptance of this tool has been reported by clinicians, who found that there was less pressure on the midwife if a standardised tool was used for assessment.

It is a priority across the jurisdictions to maintain the engagement of women in antenatal care, and it is hoped that the use of a validated tool may help with engagement by assisting midwives to feel more comfortable asking pregnant women about substance use.

Alternatively, Western Australia has introduced the AUDIT-C tool, which is administered up to three times during pregnancy, and includes guidelines that are used as an appendix to the Perinatal Hand Held Record (which is personally held by the woman). The use of the Hand Held Record has meant that women at the secondary and tertiary levels of care have earlier, and improved, access to tertiary services. If a woman scores high on the AUDIT-C, urinalysis and blood tests may be conducted voluntarily by the Health Department (urine in the first trimester and blood consequently). Information on its impacts is not yet available, as it was only introduced in 2013. However, it is reportedly very well received across health settings including in primary care. In practice, Western Australia has introduced universal screening that includes AOD use; stakeholders argue that this has greatly raised the awareness of clinicians (including general practitioners in shared care arrangements) of the issues surrounding AOD use in pregnancy and appropriate interventions. It is noted that Western Australia considers that the validated AUDIT-C is far better than having informal questions to assess substance use in pregnancy.

In other jurisdictions, a variety of screening tools are used to screen for AOD use in pregnancy.

Screening for specific substances

Alcohol

New thresholds recommending zero alcohol consumption in pregnancy were recently introduced in response to the lack of evidence on the safe levels of alcohol consumption in pregnancy (National Health and Medical Research Council, 2009). One example of a policy position on alcohol is the Tasmanian Alcohol Action Framework 2010–2015, which includes strategies for reducing alcohol use in pregnancy, based on the National Health and Medical Research Council advice guidelines on zero alcohol in pregnancy (National Health and Medical Research Council, 2009).

Consultations revealed that a major issue that has arisen across the jurisdictions is the potential for ‘mixed messages’ about alcohol use in pregnancy. An identified issue was that there are gaps in consistent information about the types and amounts of alcoholic drinks that are particularly harmful and equally about intermittent binge drinking.

There has been a great deal more information about the effects of alcohol in pregnancy in the media over the last few years, including public health campaigns and messages about in utero effects, that are also reinforced by messages from general practitioners and antenatal clinics. Stakeholders reported that a change has been noted in the understanding of alcohol and smoking effects in the community. Some jurisdictions have noted that alcohol use by pregnant women presenting to hospital settings is lower than expected, given the pervasiveness of social drinking, binge drinking and hazardous drinking generally in the population of women of child-bearing age. From our consultations the most commonly reported reason for low reporting of alcohol use among pregnant women is the associated stigma and guilt, which lead to concealment of their alcohol use in pregnancy.

Emergence of foetal alcohol spectrum disorder

The recent increased awareness of the effect of alcohol on the developing foetus and of foetal alcohol spectrum disorder has had an impact on jurisdictional policies. The Australian Parliament's inquiry into foetal alcohol spectrum disorder may have contributed to increased awareness of alcohol use in pregnancy (Australia. House of Representatives Standing Committee on Social Policy and Legal Affairs, 2012).

Many jurisdictions have responded to these issues via policy and practice changes as well as by developing specific training. In the Northern Territory there is currently a review into foetal alcohol spectrum disorder. The Western Australian Department of Health has developed a practice module containing a rationale for screening and the early detection of foetal alcohol spectrum disorder (Western Australia Department of Health, 2013). This module provides recommendations that include universal antenatal screening for alcohol consumption at first antenatal visit and at each trimester followed by brief interventions where indicated; the use of a standardised self-report questionnaire, the AUDIT-C, administered by a health professional; and the routine reporting of data on alcohol use during pregnancy for the maternity and child health information division with annual reporting in the Western Australian Government's perinatal statistics report (Western Australia Department of Health, 2013).

Generally, jurisdictions reported that although foetal alcohol spectrum disorder research and public health interest are accelerating and well developed, there is no screening tool for the diagnosis of foetal alcohol spectrum disorder, either in pregnancy or at birth, and no incidence data are available. All jurisdictions have noted that in their experience there is a low incidence and prevalence of foetal alcohol spectrum disorder in their clientele. It was also noted that, in the child protection sector, foetal alcohol spectrum disorder was not generally well understood.

Jurisdictions noted that, in practice, pregnancy can be a positive catalyst for change. However, it was also noted that clinicians who are not specialist AOD workers can tend to over-identify with pregnant women's feelings of guilt about substance use, and in particular with alcohol use. In relation to alcohol use, it was frequently noted that pregnant women wanted to know as much as possible about its impact on the foetus and the developing child. The information provided to the pregnant woman, however, was deemed inconsistent and sometimes inadequate.

Smoking

Screening for tobacco use in pregnancy is well developed across primary care and hospital antenatal settings in Australia. Public health campaigns and the less stigmatised nature of talking to pregnant women about smoking (compared to alcohol) have helped in providing effective universal screening for tobacco use in pregnancy. In some jurisdictions, brief interventions are undertaken when smoking is identified. Although smoking may be associated with the use of other substances such as alcohol, it is not in itself identified as a 'significant risk of harm' issue in the context of child protection.

Other substances

Another issue for policy makers and practitioners is that of changing AOD-use patterns in Australia. Most jurisdictions have noted that there has been a shift in the types of substances being used by pregnant women, which reflects the overall usage patterns and accessibility of particular drugs. Some have observed a shift toward the increased use of amphetamines and prescribed opiates, with benzodiazepines and polydrug use being common among pregnant women seen in specialist services. Concerns were raised by some tertiary hospitals about benzodiazepines such as Xanax and its effects on babies, particularly when there is polydrug use. The issue of over-prescription and 'shopping' for these drugs (benzodiazepines and anti-depressants) was raised by a number of jurisdictions. Some concerns were expressed about the changes in types of substances women were presenting with, and their effects on women's mental health (such as borderline personality disorders and post-traumatic stress disorders) and social problems, including domestic violence and homelessness. With amphetamines, in particular, there is also an increasing potential for complex psychiatric problems.

c. Views about universal screening

Most jurisdictions viewed universal screening not only as administering questions on AOD use to all pregnant women (which is currently the practice across all jurisdictions), but also as requiring additional elements: structured, standardised protocols, driven by more specific policies and procedural guidelines. Additionally, a need was identified for accessible pathology services for urinalysis testing (when required) as well as appropriate interventions and services following positive screens.

A number of jurisdictions reported that the implementation of a comprehensive universal screening policy would come at a high cost in terms of resources, yet it was seen as potentially advantageous in supporting practitioners in providing interventions. Some pressures noted by stakeholders include the capacity to fit additional screening processes into an already-busy antenatal visit; and in relation to drug testing, the capacity of pathology services to be able to cope with the extra demand on their services. Antenatal visits were reported to be of around 15 minutes in duration on average, with the exception of the initial visit, which is usually 90 minutes. It was reported that midwives can be affected by time restraints in their antenatal appointments and, as a consequence, some women's AOD use may not be identified.

There was support by stakeholders for more structured, validated and consistent approaches to screening for AOD use, together with the provision of brief interventions. Interest was shown for screening that has high sensitivity and specificity for the vast majority of pregnant women who use alcohol at low to medium levels. There was a consensus that interventions should provide benefits with appropriate information on harms and risks in a non-judgmental, supportive and timely way. Another recurring theme was the importance of pregnancy as a time for change and a motivator for the woman to focus on her unborn child, and provide the earliest opportunities for making changes to behaviours. There was general agreement, however, that policies and practice in this context need to be realistic, not expect major changes, and be responsive to the multiplicity and complexity of factors that impinge upon pregnant women.

3.3.3 Practice issues

a. Risk to relationships

There were a number of shared issues that emerged across jurisdictions, which were identified as affecting the identification of substance use in pregnancy. Although there was general agreement about the need to screen for substance use in pregnancy, a recurring theme of the consultations was the difficulty that some health practitioners, such as general practitioners and midwives, experienced in having conversations about AOD use with pregnant women. Many voiced concerns about the risk of compromising their practitioner–client relationship throughout pregnancy as a result of such conversations. Often the difficult questions tended to be avoided to help maintain relationships with pregnant women. A lack of consistency of skill level across the health and child protection workforce was also identified as an issue.

A professional tension was identified between maintaining a positive relationship between women and their practitioners throughout the pregnancy and postnatally (predominantly health practitioners, such as midwives), and in having to make decisions relating to the safety and wellbeing of the child once born (the statutory risk held by child protection authorities), although there is some overlap between the balancing of these risks. The literature also suggests that there is a need to identify risk at various stages throughout the pregnancy, as it appears that such assessments (for example, domestic violence, substance use) are not necessarily repeated later in the pregnancy. Again, a tension exists between the need to identify and respond to risk factors and maintaining the engagement of the woman throughout pregnancy.

b. Increased anxiety for pregnant women

Stakeholder interviews identified that one of the unintended consequences of AOD screening in pregnancy is the fear and anxiety that screening can generate in pregnant women as a consequence of discussing AOD use with them, particularly in relation to alcohol. Midwives reported that they were not keen to discuss alcohol use and foetal alcohol spectrum disorder generally, and that they used their common sense in assessments, particularly in discussing foetal alcohol spectrum disorder with women who may become stressed and over-anxious about their minimal use of alcohol during pregnancy and its potential effects.

Conveying to a woman the risks associated with substance use was recognised as difficult, especially when referral pathways and supports may not be available. This lack of services and supports was recognised as a critical issue in clinical settings. Some stakeholders questioned the value in screening for substance use and other risk factors when interventions may not be accessible or are non-existent, and that it may simply result in increased stress and anxiety. Raising anxiety and distress in a pregnant woman may affect her experience of pregnancy or exacerbate an existing mental health problem. These stakeholders were strongly of the view that the identification and screening of AOD or any other risk factors in pregnancy should cause no additional harm.

c. Need for holistic assessment – screening for risk and assessing for need

One of the strongest messages from the literature is the need for a coordinated service response in addressing parental substance misuse in a child protection context. Interviewed stakeholders acknowledged that AOD problems are highly prevalent among vulnerable groups who often experience multiple disadvantages, requiring a holistic assessment of need that reflects the known impacts of AOD and other risk factors and cross-sectoral responses. Stakeholders were concerned about the group of pregnant women with multiple risk factors, experiencing serious domestic violence, mental health problems, intellectual disability and AOD use. They were seen as the most vulnerable and most likely to have impaired parenting capacity, to be unable to safely care for their baby, and to come to the attention of child protection authorities.

A view voiced by stakeholders interviewed across jurisdictions was that AOD issues often fade into the background as these disadvantaged women and families have higher, more urgent needs, such as homelessness, domestic violence and serious nutritional issues, which may take priority. These cumulative disadvantages and risk factors are too complex and intertwined to separate for targeted screening and interventions for AOD alone, and require strong, intersectoral collaborative approaches.

Collaborative working is also reflected in jurisdictional policy and practice activity in the development of cross-sectoral memorandums of understanding. For example, in Western Australia, policy and practice have been developed specifically relating to effective partnerships for early interventions following the reporting of an unborn child (see Appendix A). In Tasmania, advances have been made through public health policies, including *Working in Health Promoting Ways: a strategic framework 2009–2012* (Tasmania Department of Health and Human Services, 2010), which focuses on the importance of a collaborative approach to public health issues such as AOD use in pregnancy. Intersectoral and collaborative ways of working are evident in the practice models and pathways discussed in the pathways section below.

d. Training

Training to increase staff confidence in screening, to become familiar with new screening tools and to update knowledge of the effects of particular substances has been used by jurisdictions to respond to some of the above issues. Continuity of training, increasing the skills base and education of the workforce are seen as key strategies in being able to identify and promote a broader understanding of how to address AOD use and other issues, resulting in increased support for pregnant women.

As an example, Alcohol Tobacco and Other Drug Association ACT, supported by the Australian Capital Territory Government, has provided workshop and training opportunities to support health and community services workers to build their capacity to better identify and respond to AOD issues. The drivers for this initiative included workers' lack of confidence in raising AOD issues with clients, and a lack of knowledge about referrals and follow-up with specialist services. In Tasmania, a Foetal Alcohol Spectrum Disorder Placement Support Training Program has been established: the goal of this project was to develop a foetal

alcohol spectrum disorder training program to build the capacity of service providers in the child protection sector to provide support to those who care for individuals living with and affected by foetal alcohol spectrum disorder. This pilot project has also raised awareness of the in utero effects of alcohol in pregnancy (Russell, Eaton & Petersen-Williams, 2013).

3.3.4 Key findings from this section

- Current Australian policy and practice can be characterised as taking a clinical approach to managing AOD use during pregnancy, which emphasises the health of newborns rather than the enforcement of laws in relation to drug use.
- Six jurisdictions have legislation for reporting an unborn child to statutory authorities. Those with no specific provisions in their legislation have developed policies and practice guidelines. Only Tasmania has mandated prenatal reporting.
- Most jurisdictions have developed routine screening and assessment processes for biopsychosocial risks prenatally including for AOD use. Antenatal services are generally the first contact.
- All jurisdictions reported that most child protection interventions are initiated when there are multiple risk factors, and that substance use in isolation is not necessarily a trigger for child protection involvement.
- Recent initiatives have had a strong focus on reducing the use of alcohol in pregnancy following the adoption of new guidelines by the National Health and Medical Research Council's *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* (2009).
- Some lack of understanding and consistency in relation to the identification and advice around alcohol use in pregnancy was reported in the consultations, plus reports of staff's limited understanding of diagnosis and prevalence of foetal alcohol spectrum disorder.
- The AOD screening tools known as ASSIST and AUDIT-C are used and recommended by several jurisdictions.
- A recurring theme of the consultations was the difficulty that some health practitioners experienced in having conversations about AOD use with pregnant women. Many voiced concerns about the risk of compromising their practitioner-client relationship and increasing stress and anxiety.
- A lack of consistency of skill level across the health and child protection workforce was also identified as an issue by those interviewed, with suggestions for training.
- A lack of referral pathways into treatment and support services was identified through the consultations.
- The need for a coordinated service response in addressing parental substance misuse in a child protection context, having holistic assessments and services to address multiple disadvantages, and the need to work collaboratively were all emphasised in the consultations.

3.4 Pathways into AOD treatment services, support services and statutory child protection services for parents and their unborn children

This section provides an overview of the common pathways for pregnant women into treatment and support. It begins with a discussion of the common existing antenatal pathways and specialist AOD responses before examining the existing interaction between pregnant substance-using women and statutory child protection services.

3.4.1 Professional guidelines for the management of AOD use

The Royal Australian and New Zealand College of Obstetricians and Gynecologists in its College Statement, *Substance Use in Pregnancy* (2013), states that AOD use in pregnancy is a common and important issue in maternity care; patterns of substance use before pregnancy are important considerations, as such use commonly carries into pregnancy. The policy advises that the key considerations following a positive antenatal screen for substance use should be a broad psychosocial assessment to understand the reasons for AOD use, and to help to address the substance use, providing sensitive counselling and referral to AOD multidisciplinary service programs and/or mental health services. The College has developed specialised training modules that may be undertaken by practitioners, such as information about AOD use, treatment of withdrawal and the involvement of partners and other family members. Additionally, information is outlined on the circumstances when a pre-birth child protection notification may be appropriate.

The Australian College of Midwives has also developed specialised modules outlined in the *National Midwifery Guidelines for Consultation and Referral* (2013). A key focus for midwives is on the continuity of care that is provided to pregnant women and the importance of building a strong and supportive relationship with pregnant woman throughout their pregnancy. Stakeholder consultations strongly supported this focus of the Australian College of Midwives. Stakeholders emphasised that antenatal screening by midwives supports women's potential to change in pregnancy and any concerns they may have for their babies. In the Australian Capital Territory, the midwife asks: 'Aren't you worried about the baby?' and responds to each woman's circumstances.

The Royal Australian College of General Practitioners produces a wide range of clinical guidelines for the screening and management of AOD use in pregnancy and specifically for comorbidity – AOD use and mental health issues. Most recently, the College, along with other groups, has been involved in the publication of guidelines and resources in conjunction with the Foundation for Alcohol Research and Education's 'Women Want to Know' public health campaign (2014).

3.4.2 Common practice for identification and referral

This section documents the common pathways, policy and practice for responding to pregnant women who use AOD, as reported in the interviews with stakeholders. The discussion includes mainstream antenatal care (midwives and obstetricians) and primary health care provided by general practitioners. Women with substance use problems are generally referred to specialised AOD services, discussed below.

a. Mainstream health service pathways

As discussed, pregnant women with substance use issues are generally identified at the time of booking in at the first antenatal visit, at which time their medical history, alcohol, smoking and illicit drug use are assessed, along with other health and psychosocial issues. In most jurisdictions there are clear guidelines around the provision of information and brief interventions on alcohol, tobacco and other drugs. However, not all jurisdictions have standardised responses and this is an area that has been identified as requiring further development.

Self-reported smoking in pregnancy at the first antenatal visit is often followed by information and referral for nicotine replacement therapy. With regard to alcohol, if the woman's consumption of alcohol was greater than the National Health and Medical Research Council's guidelines, it is likely that a brief intervention would be conducted, particularly with women who are consuming at low to medium levels. However, referral pathways for women who self-report AOD use, especially alcohol use, at low to medium levels are limited; a positive screening presents a potential dilemma.

If a woman has been identified via the antenatal substance use screening and there are concerns, a referral could be made to a specialist drug-use-in-pregnancy service. Most jurisdictions have commented that there is significant under-reporting of AOD use and other social issues (e.g. domestic or family violence). Midwives and others interviewed made the point that women need to feel safe and supported in this sensitive area of disclosure.

b. When referrals are made to specialist AOD services

Most jurisdictions have a triage system from the first antenatal visit assessment. In most pathways, practice reflects the policies of early identification, engagement and collaborative safety planning to reduce both medical and social risks.

In the majority of jurisdictions, policies identify the point at which substance use in pregnancy warrants a referral for specialist interventions in either AOD-in-pregnancy services or specialist social work services in hospital settings such as Royal Prince Alfred and Westmead hospitals in Sydney or King Edward Memorial Hospital for Women in Perth. In South Australia, for example, stakeholders reported that a referral would occur if there is self-reported (i) daily cannabis use greater than four cones per day; (ii) opioid dependency or current opioid treatment; (iii) any other illicit drug within the past three months; and/or (iv) alcohol consumption greater than two standard drinks per day. Any of these responses may result in a referral to the Drug and Alcohol Service South Australia.

In New South Wales, midwives reportedly refer to a specialist service, such as the Drug Use in Pregnancy Service at Westmead Hospital in Sydney, if a pregnant woman self-reports any alcohol use, such as 1–2 drinks per day, smoking and/or use of other drugs. Women may also be referred when there is identified anxiety about pre-conception alcohol use. However, it was noted that the majority of women who are referred to a specialist assessment following identification of AOD use are women on an opioid treatment program.

Some referrals to specialist AOD-in-pregnancy services in hospital settings are generated from emergency departments. However, most women are identified through the antenatal visit's screening and assessment processes. General practitioners may also refer to specialist services if AOD use in pregnancy is a concern.

Once referred, a pregnant woman's substance use is further assessed by the tertiary AOD-in-pregnancy service.

Significant concerns were expressed about substance-using pregnant women presenting late to antenatal services. Some women have been noted to arrive at the hospital in labour having had no antenatal care. The issue of late presentation or presentation in labour has been noted by all jurisdictions as an outcome of the stigma, fear of child protection involvement, lack of access to primary health care, and chaotic lifestyles that are often associated with AOD dependence.

3.4.3 Case planning – a health service response

In many jurisdictions, once concerns about AOD use in a woman's pregnancy have been identified and she has been referred to specialist AOD services, a case plan is developed by the health services and other services are initiated in an effort to reduce further risk to the foetus. A caseworker may be appointed from the specialist AOD team or, if the woman does not already have one, from the opiate treatment program. Multidisciplinary specialist AOD teams may include: specialist AOD workers (often nurses); an AOD caseworker; a social worker; midwifery/birth unit personnel; a mental health professional; an obstetrician; nursery staff; and specialist neonatologists. In most *tertiary* hospital maternity settings (e.g. Westmead Hospital), management plans are developed through the multidisciplinary team at around 24–36 weeks gestation for the AOD-using pregnant woman. The plan is initiated at around 20 weeks or earlier in other jurisdictions, such as at King Edward Memorial Hospital in Perth.

3.4.4 Specialist AOD-in-pregnancy services

Many tertiary maternity hospitals provide specialist AOD services for pregnant women. The key issue in this context is early engagement of pregnant women in services that respond to the often multiple needs they may experience in pregnancy. Integrated treatment programs, such as substance use in pregnancy services, have been found to improve outcomes for the child, improve service utilisation, and decrease the risk of mothers' substance use (Marsh et al., 2012). Stakeholders pointed to some evidence of the success of specialist AOD pregnancy services. For example, the Substance Use in Pregnancy and Parenting Support Service, operated by Barnardos in the Illawarra region of New South Wales, noted that their antenatal visit attendance rates are equal to other mainstream clinics, indicating that they have managed to reduce the rate of late presentations to antenatal care among substance-using women.

Below is an example of a specialist substance use in pregnancy service that reflects an integrated model of practice.²

An example of a specialist substance-use-in-pregnancy service

The Western Australian Newborn & Drug and Alcohol Service (WANDAS) is a specialist AOD-in-pregnancy clinic situated at King Edward Memorial Hospital for Women in Perth. This tertiary hospital has a specialist multidisciplinary team that provides comprehensive and intensive support to AOD-using pregnant women.

Midwives are heavily involved with WANDAS, together with hospital social workers, child protection staff, clinical psychologists and medical obstetric services. Women are screened and referred to the service, and other issues such as housing are also addressed. This involves a pre-management plan. Where a care plan is established, women are seen early in their pregnancy via primary or secondary service referrals. Referrals are often from a general practitioner, an outreach service or from other services, such as a hostel for homeless women. It is an advantage that referrals are *not* required to access the specialist service. However, women are required to be connected with a general practitioner. Services incorporate social work, psychiatric and parent education services with midwives often conducting parent education.

In Western Australia, 31 000 women out of the total births of 32 000 women who present to antenatal clinics per annum have screening as part of their care. WANDAS' clients are seen for longer than are other pregnant women, and up to 250 clients per year are seen within the specialist service. Women see a social worker and a midwife at every visit. An obstetrician may see them around 4–5 times during their pregnancy, and a feature of the service is prenatal 'continuity of care' by the midwife.

WANDAS does not recommend complete abstinence during pregnancy, as it is believed that it is unrealistic within this short period. The recommendation is that these women are given the highest levels of support to stop AOD use if they can. Most specialist AOD services in hospital settings around Australia are linked to opioid treatment programs. Video links are sometimes used to communicate remotely to the central specialist services.

3.4.5 Prenatal reporting – child protection involvement

As described in previous sections, all Australian jurisdictions have developed at least some level of policies, guidelines and procedures for reporting of unborn children, including the receiving and processing of unborn reports; AOD screening and assessments, including the use of drug screens in child protection assessments; high-risk infant alerts and protocols between hospitals, AOD services and child protection services. Although unborn reporting policy varies across jurisdictions leading, not surprisingly, to considerable differences in the responses from child protection authorities to the reporting/notifications, all jurisdictions aim to intervene early and offer voluntary support to the pregnant woman and her family.

² Women who are not significant users or dependent users can also be seen by the Western Australian Newborn & Drug and Alcohol Service, with less intense provision of services for this group.

a. Prenatal reporting responses – providing voluntary family support

In the previous sections, the legislative basis for prenatal reporting and child protection involvement when substance use has been identified in pregnancy is outlined. It is, however, useful to provide some examples of prenatal reporting policy and practice responses across the jurisdictions.

Current child protection practice in the Northern Territory considers that, where a report identifies that an unborn child would be at risk of harm or in need of protection at birth, a family support case is created. Support is provided to the pregnant woman to reduce potential risks and to allow planning to take place with other agencies for appropriate care and protection once the child is born. However, a child protection report can be created only when the child is born.

In Queensland, the Department of Health's Protecting Children and Young People Policy states that all reports relating to an unborn child are to be discussed with the health service's child protection adviser or liaison officer prior to a report being made to the Queensland Government's Child Safety Services centres. This includes the initiation by Child Safety Services of unborn child 'high-risk alerts', which may occur where there are significant protective concerns about the unborn child and the parents have refused to participate or be engaged in an assessment of their circumstances.

Victoria's Department of Human Services has developed comprehensive policy guidelines and protocols for child protection that have a significant focus on collaboration across sectors, particularly the AOD and other health services and child protection services (Victoria Department of Human Services, 2002). The *Children, Youth and Families Act 2005* establishes two pathways in Victoria for people to report or refer an unborn child where they have 'significant concern for the wellbeing of the child after his or her birth'.

In Tasmania, amendments in 2009 for new provisions to the *Children, Young Persons and Their Families Act 1997* provided the Department of Health and Human Services with the ability to receive information concerning unborn children and to enable effective planning prior to the birth of a child who could be at risk. Reports are made through Gateway Services or Child Protection Services (see Appendix A). Tasmania is the only jurisdiction that requires mandated reporters to report an unborn child at risk. The pathway following a prenatal report in Tasmania, for example, is the offering of an assessment and family support services to the mother and other family members, Intensive Family Support Services, AOD, mental health or disability services. In effect, this pathway reinforces service supports as an *initial response* to prevent child protection service responses being the first line of intervention.

All jurisdictions identify specific risk factors in their risk assessment frameworks that may lead to a notification of an unborn child, including significant AOD abuse by the caregivers (mother and/or other). Stakeholders noted that there are limited data on the numbers of unborn child reports across the jurisdictions, and no available data on the *specific* factors (including AOD use) that may have led directly to an unborn report and/or substantiation. Therefore, it may be difficult to identify any specific factor that led to an unborn report or substantiation. Furthermore, a number of jurisdictions have noted that this is an area where specific data would be highly beneficial to further understanding of the impacts of legislation (and policies) on identification of AOD use in pregnancy and reporting of unborn children.

b. Drug use testing (urinalysis) to monitor AOD use

Antenatal drug screening via urinalysis is undertaken by the health sector, which necessitates a certain amount of collaborative activity and information sharing required between health and child protection sectors. Child protection policies and protocols that guide the use of urinalysis (including prenatal screening) include the description and purpose of screening by urinalysis, the circumstances in which requests occur, and the utilisation of the results in case planning and risk and needs assessments. In Victoria, child protection guidelines stipulate the use of urinalysis in conjunction with an AOD assessment in order to regularly monitor and assess the parents' level and type of substance use and their commitment and capacity to change.

Prenatal urinalysis screening is done with the consent of the pregnant women and in the context of potential support and monitoring. Once the baby is born, voluntary engagement is still the desirable course with regard to drug testing. However, if it is considered necessary by child protection authorities, the case would be taken to court and an order sought requiring drug screening via urinalysis. In Victoria, for example, the court would specify the type and the frequency with which urinalysis is required.

Urinalysis and other drug tests are a consequence of antenatal screening that has identified the use of substances in pregnancy. Urinalysis testing in jurisdictions such as Victoria and the Australian Capital Territory requires specialist AOD services to be available to child protection services to interpret the results. Most jurisdictions provide telephone consultancy services that assist practitioners in other sectors with AOD use information and interpretation of test results and specialist referral pathways. The New South Wales Drug Testing Policy prescribes consultation with the Clinical Issues Unit if there is AOD use involvement in pregnancy.

The purpose of drug testing is to confirm abstinence or to gather information on AOD use, which may be used as evidence in court. It is, however, currently difficult to establish the level of evidence of AOD use around cumulative harm that courts accept following birth, and this has been a point for education and training of magistrates through child protection services about child development and the impact of trauma and AOD on the foetus and the baby. Some jurisdictions noted that if court orders require complete abstinence following birth, one single positive result through drug testing can initiate a child protection response. Many jurisdictions commented that a more ideal situation would be to take a holistic approach.

Two key issues were raised in response to the use of urinalysis results to inform decisions about child protection involvement. Firstly, the interpretation of AOD use screening by child protection services has been identified as an issue, particularly the difficulty in interpreting meaningful results from pathology laboratories, which depend on dose, timeframes and the type of substance used. The second is the impact of false negatives and false positives in the results. Policy and stakeholders reported that, as a result, urinalysis results are rarely used as the sole factor in deciding a child protection response, both prenatally and postnatally.

c. Example of a pathway for prenatal reporting

Below is an example of a pathway for the intake and assessment phase for a prenatal report from Victoria’s Department of Human Services: *Protecting Victoria’s Children: Child Protection Practice Manual* (p. 3).

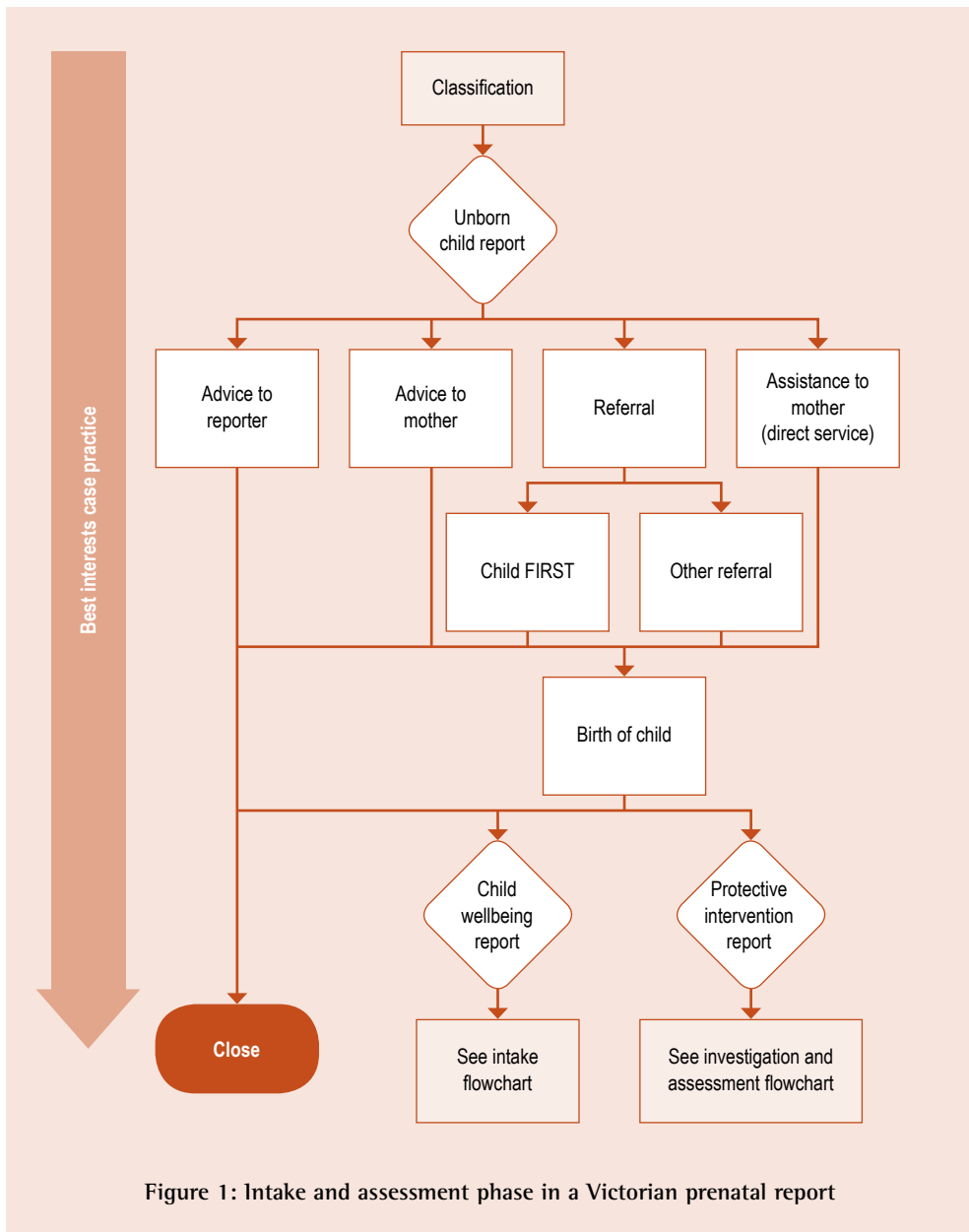


Figure 1: Intake and assessment phase in a Victorian prenatal report

d. Engagement with services and information sharing prenatally

It is important to note that, while a child is in utero, no jurisdictional legislation or policies provide for statutory powers to investigate harm or risk of harm, including the ordering of drug testing, until the child is born. With the important exception of sharing information about mothers and unborn children across information-sharing entities such as child protection, welfare and health services, all interventions including drug testing require the consent of the mother until the child is born. However, policies and guidelines across the jurisdictions enable the mobilisation of support and treatment services for pregnant women and their families, including child protection support and assistance that are not specifically statutory protective interventions.

Stakeholders in all jurisdictions reported that the mother's and/or family members' decision to actively participate in the support services offered (or not) is a key factor in the risk assessment undertaken upon the birth of the child, and this determines any subsequent child protection interventions.

e. Planning and decision making for early support

Also noted across most jurisdictions is the importance of early identification and the involvement of child protection services if potential harm during pregnancy could result in a report. It was generally agreed that the earlier that child protection services became involved in this context the better that outcomes could be achieved, as there would be more time to support women to enable them to address the risk factors. However, in a number of jurisdictions, the child protection authority does not always start its involvement early in the pregnancy. Stakeholders commented that their involvement at a later stage is more likely to result in crisis-driven interventions and decision making. It was noted that the major outcome of identifying and screening for AOD use in pregnancy should be the early engagement of supportive services.

Within at least two jurisdictions, prenatal case conferencing was used as a strategy to plan and implement support for pregnant women. One example of a tertiary maternity hospital in Sydney using this approach aimed to hold three case conferences during pregnancy. The aim is to have pregnant women work with health and child protection services and return home with their babies, with community-based support services already in place.

Throughout the jurisdictions, the need was noted for the child protection and health sectors to collaborate through regular meetings and support. Collaborative working was enhanced by implementing strategies such as liaison officers working together across sectors, co-location of health and child protection personnel, joint policies, and having a memorandum of understanding between agencies. For example, involvement by maternity hospital social work departments was identified as an important factor in reaching and engaging substance-using pregnant women in services.

The early engagement of substance-using pregnant women with antenatal and support services, including child protection involvement, is seen as a critical factor for better outcomes for unborn children, their mothers and families. Early engagement and support for substance-using pregnant women do not always occur, however. A factor that was reported as reducing the likelihood of early intervention in pregnancy was the overwhelming and competing priorities within the child protection system concerning children who have already been harmed or are at risk of harm. In addition, the multidimensional and complex nature of pregnant substance-using women was seen to reduce the likelihood of early intervention. Some stakeholders reported that in this group of women the complexity of medical risks can often overwhelm other risks, and the medical risks take priority. Also mentioned in the consultations as a barrier to early engagement in services was the high level of unrealistic engagement and/or expectation of change from pregnant women and their families within a short timeframe.

Stakeholders mentioned the need for information on the number of mothers who take up the offers of prenatal support and on the outcomes of early prenatal reporting.

f. Examples of early engagement programs

Differences exist across jurisdictions as to the ideal time for making a prenatal report and triggering a child protection intervention: report times range from 12 weeks gestation (in a New South Wales pilot program discussed below) to around 20 weeks in most jurisdictions.

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Western Australian outreach program for Indigenous substance-using pregnant women

An outreach program for Indigenous substance-using pregnant women operating from Perth aimed to engage women early, and was reported as being effective for the early and maintained engagement of Indigenous women in antenatal care and for having good neonatal outcomes. Outcomes from this outreach program that were reported through the consultations include: linking women to antenatal services continuously through the pregnancy; reducing the tension around assessment; improving access to support services; meeting women in their own space; pre- and post-natal conversations about baby care and personal care; and the capacity to link with local medical services, such as diabetes services. This program's funding has not been continued, however, and the outreach strategy is now confined to pregnant incarcerated women. Some information regarding the approach to engaging vulnerable populations of pregnant women is contained in the Western Australian Department of Health's Strategic Plan for the Aboriginal Maternity Services Support Unit (2010–13).

Early engagement pilot program in New South Wales

A second example describes a collaborative project conducted between the Metro Central Office of New South Wales Community Services and the Sydney Local Health District using family conferencing to promote early engagement and interagency planning with pregnant women and families at risk of their newborns entering out-of-home care at birth (Hurley & George, 2013). This pilot program, now implemented as a permanent program, received several unborn child referrals per week regarding pregnant women with multiple risk factors.

As part of this program, a case conference is initially held with the family when the woman is 12–15 weeks pregnant, the first of three meetings. Case plans are developed for support and goals are set as to what needs to change. A review is held at the second meeting to see how the woman is progressing with meeting her goals. The final meeting is held 2–3 weeks before birth and the mother is informed of the decision made by the child protection service – whether she will take her baby home or if there will be an ‘assumption of care’ (Family and Community Services New South Wales). Women may be referred to a program such as Brighter Futures, an early intervention program with significant child protection involvement, which provides close monitoring and support to mothers and families, especially during the first three months post-birth.

A major dilemma in child protection has been whether to inform pregnant women when a decision has been made to remove their babies at birth, prior to their giving birth. This has been in the context of the possibility that women may abscond. The experience of the Central Sydney program has been that women do not abscond or disengage from the program and that it was rare (possibly only in the case of serious mental health issues) for women not to be told about child protection decisions for removal.

In a small-scale evaluation of the program, it was found that 75 per cent of the families accessing the program had substance use issues, and many were on opioid treatment programs. Domestic violence was also a reason for reporting. Twenty-four women were referred to the pilot: ten women were referred between 12–20 weeks gestation; five between 21–28 weeks; and nine between 29–36 weeks (Hurley & George, 2013). Of the 24 who had given birth by the end of the evaluation, 16 infants were reported to be in the care of their mothers, nine were assumed (removed) into care, and a further three infants have since been removed. Service providers reported that the pilot achieved a 50 per cent reduction in the removal of babies from women who had been reported prenatally.

The level of engagement of the pregnant women with this program appeared to be a factor in making decisions about whether to remove the baby at birth, or for the baby to go home with the mother. Anecdotally, it has been noted that if the situation was identified as unsafe for the baby, it was likely that the mother would have disengaged from the program by the third meeting during her pregnancy. The strengths of the Sydney pilot were that: early engagement could lead to health and child protection services collaboration with parents around case planning; it avoided crisis responses at birth; and it could reduce the trauma to mothers and families, as well as to health and child protection personnel. The program aimed to coordinate planning for the care of the infant during pregnancy. In summary, early engagement appeared to reduce the risks and reduce the number of infants assumed into care.

g. Planning, case management and collaboration across sectors

In most jurisdictions there is a level of pre-birth planning that may cover the spectrum from informal case meetings, shared information and provision of support, to providing formal protocols that include case conferencing, family group conferencing, and family decision making (see Appendix A).

Most jurisdictional policies and practices in relation to AOD-using pregnant women have a position on case and safety plans. There are many different examples noted across jurisdictions of policies identifying pathways following identification of AOD use, which include case management and linkages to specialist and community services. However, it was often reported that there are gaps and a paucity of community-based supports for substance-using women, with at times less than exemplary case management, mainly due to limited resources. Many women have no case plan and no way of asking for support, notwithstanding the policy and guideline positions of all jurisdictions, whose aim is to be supportive of substance-using mothers. At times, case reviews are reportedly not conducted, although they were seen as an integral part of case management, especially for the most vulnerable groups.

Collaboration across health and child protection sectors

As discussed, jurisdictional policy and practice point to the need for health and child protection sectors to work better together to support pregnant women, to increase positive outcomes for mothers and babies after birth, and to contribute to the decrease in removals of babies at birth.

Most jurisdictions have some form of joint decision-making processes, and some jurisdictions such as Western Australia have developed a bilateral policy for interagency collaborative processes when unborn or newborn babies are identified as being at risk of abuse or neglect. In Western Australia, the bilateral schedule is between the Department for Child Protection and Family Support and the Department of Health. It aims to facilitate interagency collaborative processes across the sectors in this context, and is part of a memorandum of understanding developed in 2013 between the sectors. The processes include pre-birth interagency meetings and 'interagency protection and care planning meetings', to develop safety plans with the purpose of progressing the post-birth decision made regarding care and management of newborns and mothers within the hospital setting, in a manner that causes the least distress for newborn babies, their mothers and other clients and staff.

Strong collaboration across the sectors is also a major strategy of the Western Australian Signs of Safety framework. This framework seeks to engage women prenatally to reduce the number of child removals at birth, with a shared message and goal that if they wish to take their babies home, they are supported through shared case and safety planning processes. In this approach there are opportunities to engage family members who may also need to support mothers to care for their babies at home (Western Australia Department of Child Protection, 2011). An evaluation of the first year of using Signs of Safety meetings in pre-birth planning with pregnant mothers facing high-risk situations showed a 30 per cent reduction in child removals for this cohort and a significantly improved working relationship between the Department of Child Protection and Western Australia's primary maternity hospital, the King Edward Memorial Hospital for Women in Perth (Turnell, 2013).

The South Australian new practice casework model, based on the Solution-Focused Casework approach, ensures a stronger collaborative approach across sectors (the Solution-Focused Casework approach originated in the AOD sector and was used for relapse interventions). The model promotes a sense of continuity in the client, which will help maintain positive behaviours.

One further area for collaboration across sectors, discussed in the consultations, is the joint commitment to cross-disciplinary training, education and support of staff across the sectors. In Victoria there has been an emphasis, for example, on training around attachment theory and the neurosciences and the impact of neglect of children, which is essentially a focus on parenting roles and capacity. The ability to stay connected with the baby is the focus, equally for fathers and partners, and the impact of domestic violence on the mother-child dyad.

h. Child protection responses – removal of babies

For women reported to child protection services during pregnancy, stakeholders reported that removals at birth were more likely to occur when there was not enough change demonstrated by the mother before the birth. However, it was also acknowledged that the gestation period may not provide enough time to show change if there was a significant history of AOD use or domestic violence.

Some stakeholders were of the view that earlier involvement of child protection services prenatally, and increasing mothers' engagement with services, were resulting in fewer babies being removed by their service.

Health professionals are generally strong advocates for pregnant women, while having a strong commitment to the safety of infants. It is acknowledged that there is a threshold for risk and harm, and that the legislation is there to protect children. However, there is still ambivalence voiced by some stakeholders, who are concerned about the particularly distressing effect on mothers and families of the removal of a baby at birth. Several stakeholders reported that when removal does occur, the impact on the mother and also on the midwives is enormous. There have been reported situations where it has been necessary to provide security in the hospital because of the reaction by the partner to the removal of the baby.

As most jurisdictions agree, providing sustained early intervention services prenatally has the best chance of decreasing removals at birth. It was also pointed out that if support and case planning are prematurely terminated, outcomes will be poor and there is an increased possibility that the baby will be taken into care at a later date. There are some reports of removals increasing by six months post-birth, supporting the need for longer-term support.

A number of jurisdictions noted that the likelihood of removal is higher if another child has already been removed from the family.

Key points that have been noted to contribute to the decrease in removals at birth are better collaboration and relationships with the health sector, and a reduction in the tensions and conflicts that can arise between stakeholders who may hold different views, such as different foci on family deficits versus protective factors. The New South Wales Central Sydney pilot, for example, demonstrated reduced conflict overall, earlier assessments and a greater clarity around the reasons for child removal.

3.4.6 Key service and program models

This section identifies some of the key service and program models, such as intensive support programs, residential programs and other forms of family support. Examples of existing programs are discussed, as well as common issues that emerge in providing support and treatment to substance-using pregnant women.

A strong theme that emerged from the consultations was the fear that substance-using pregnant women, particularly those with complex issues, have of child protection involvement. This fear was identified as a critical barrier to women accessing support and treatment, and affects the level of disclosure of substance use, which relies on the development of a trusting and supportive relationship with clinicians (e.g. midwives) and specialist AOD staff who play a major role in identification and screening of AOD use in pregnancy through the antenatal period.

A specific role of non-government AOD specialist services, such as Odyssey House in Victoria, was seen to be in assisting pregnant women to understand the child protection system, to help overcome their fear of child protection involvement and, in some cases, the possible consequences of the removal of their baby at birth. In this approach there is an emphasis on advocacy and working closely with women to help them regard child protection services as a source of assistance (including the development of parenting skills, practical support and accessing treatment) and to reframe their involvement in order to achieve better outcomes for themselves and their babies. However, this advocacy can be more difficult in situations when there has been previous involvement with the child protection system.

During consultations, stakeholders at Odyssey House in Victoria identified elements they considered to be best practice programs in AOD use in pregnancy in the context of child protection, which included: (i) offering a women's discussion group on mother–infant attachment; (ii) supporting the intensity and longevity of service engagement; (iii) focusing on building trust in the client; (iv) supporting the client to engage with other sectors and agencies; (v) providing training and education particularly about the science of brain plasticity and emotions; (vi) providing mindfulness training to help the mother connect with her baby; (vii) helping women to recognise when they are emotionally disconnected; (viii) teaching women to minimise the use of threats; and (ix) meeting a woman's practical needs, such as providing a cot or a baby bath.

As discussed, strong intersectoral partnerships and responsive programs are essential to provide the intensive sustained support that is required, beginning in pregnancy, and for some families, until the child is five years old. However, some jurisdictions have noted that it is difficult to find support services for substance-using pregnant women, particularly where there are no local specialised programs. When this is the case, pregnant substance-using women are encouraged to access mainstream supportive interventions programs, such as the Northern Territory's Strong Women: Strong Babies.

a. Specialist intensive support programs

One of the aims of intensive programs for AOD use in pregnancy is to ensure that collaborative and holistic services are provided, aimed at maintaining the mother–baby dyad, and for the baby to go home with the mother. The provision of intensive sustained interventions with high-risk pregnancies, which include AOD use as a major risk factor, has been identified as a necessary part of tertiary AOD maternity pathways. The Substance Use in Pregnancy and Parenting Support Service in the Illawarra region of New South Wales, noted earlier, is an example of integrated perinatal care that begins at 20 weeks with collaboration across health and child protection sectors, and may include other support services such as parent groups, playgroups and education about foetal alcohol spectrum disorder. Staff working in teams are seen to play a strong advocacy role, with the focus on the mother–baby dyad but also including partners and families in their service provision.

b. Residential programs

As discussed, residential treatment programs have been developed specifically for substance-using pregnant and parenting women. There is a simultaneous focus on treating the substance use and supporting the mother–baby relationship. Although pregnant women are often granted priority admission into existing residential treatment and immediate access when a bed is available, a lack of residential facilities for AOD-using pregnant women and families has been noted as a significant gap across jurisdictions. Where these programs exist, there were reported to be delays in access due to high demand. Additionally, there was a stated need for more local residential programs to maintain a family within their local area.

The report of the inquiry into protecting vulnerable children in Victoria (Cummins, Scott & Scales, 2012) made key recommendations to improve responses to meet the needs of vulnerable children. As a consequence, a four-bed residential mother–baby unit for high-need intensive interventions, through the Uniting Care ReGen agency, has been funded and is currently being developed, and due to open in 2015. This initiative is a response to the identified gap for programs that enable babies to stay with their mothers, while the mothers undergo detoxification/withdrawal from substance misuse. This unit will support women with babies under 12 months as well as pregnant women. Stakeholders identified that in some jurisdictions, such as in South Australia, there are no *specific* residential programs for pregnant AOD-using women. In that state, however, a 30-bed hospital-based inpatient unit will admit women at up to 28 weeks in their pregnancy with referral to an obstetric setting when required.

3.4.7 Need for ongoing support

There was agreement that AOD-exposed families who experience multiple issues (e.g. violence, mental health issues, disability) need a wraparound service from birth until the child is aged five years, thereby covering the transition to school and increasing the chances of improved outcomes for the children. Programs such as these are improved by having continuity of care, which at present is not always available.

A major issue arising from the consultations is that AOD-using women require ongoing support following the birth of their babies. Antenatal services and specialist services, such as the Western Australian Newborn & Drug and Alcohol Service and the Substance Use in Pregnancy and Parenting Support Service in New South Wales, aim to link and maintain women to services and programs within the community on a longer-term basis. The Victorian program Kids in Focus, a specialist child parenting and family support service for highly vulnerable families where parental AOD use is an issue, aims for sustainable supports and networking for their clients from pregnancy and birth to 13 years of age.

Across jurisdictions most family support programs were reported to begin postnatally. However, some programs provide antenatal interventions particularly when there are other children involved who are of concern to child protection services. The Western Australian Best Beginnings program is an example of an intensive home visiting program for vulnerable families which engages with the mother and family from three months prior to the birth, until the child is aged two years, although few visits are provided during pregnancy. Best Beginnings involves collaboration between the health and child protection sectors and trained health nurses who have a small caseload but who also have a role as consultants.

3.4.8 New models for intervention and support

Victoria has recently commenced a three-year pilot of a Family Drug Treatment Court, the first in Australia (De Bortoli et al., 2013). The aim of the Victorian pilot is to provide support and services to substance-using parents, prevent child maltreatment, and promote family reunification. The Family Drug Treatment Court pilot, modelled on those in the United States and the United Kingdom, is intended to ensure timely judicial decisions through coordinated services, provision of substance use treatment, and increased judicial oversight. This approach depends on court-based collaboration among child welfare agencies, substance use treatment providers, the legal system, and other community agencies (Boles, Young, Moore & DiPirro-Beard, 2007). Pilots of pre-birth assessments of pregnant women whose expected babies are likely to be made subject to care proceedings have recently begun in the United Kingdom. Pre-birth involvement recognises the benefits of early intervention with pregnant women who have substance misuse problems in order to lengthen the time available to effect change before their babies' birth. These pre-birth assessments raise their own unique legal issues and assessment complexities and it can be difficult to engage the women after their babies have been born, if the Family Drug Treatment Court has recommended the baby's removal in order to ensure the child's safety (Harwin, Ryan, Tunnard et al., 2011).

The Cradle to Kinder program in Victoria operates for a family with children up to four years of age and begins prenatally. Referrals can be made through Child FIRST (Child and Family Information, Referral and Support Teams) across the state. The program is a collaborative family support program incorporating case conferencing and partnerships with families to develop plans for improved outcomes. Cradle to Kinder is a recently implemented program which is yet to be evaluated. The initial phase of the project (February to June 2013) has focused on the development of the evaluation.

a. Co-location and liaison models of intervention – promising practice

A strategy for building greater collaboration and coordination across sectors is improved and shared training. In South Australia, a trial aimed to co-locate the Drug and Alcohol Service SA and Families SA to work alongside family preservation and reunification staff. The objectives were to increase the level of knowledge and skills of workers across sectors, to better address AOD issues, and to improve client access to AOD services. Stakeholders commented that AOD clinicians provided an educative role for child protection staff through jointly working on cases and provided training on ASSIST (the AOD screening tool). Stakeholders also reported positive outcomes of the project as AOD clinicians were being used effectively to link families who were the subject of unborn child notifications and plans, and clinicians succeeded in diverting the parents from the child protection system.

3.4.9 Key findings from this section

- Identification of any substance use issues at the antenatal visit results in referral to a specialist drug-use-in-pregnancy service where further assessments are then undertaken.
- No jurisdiction's legislation or policies provide for statutory powers to investigate harm or risk of harm until the child is born. With the important exception of sharing information about mothers and unborn children across information-sharing entities (such as child protection, welfare and health services), all interventions including drug testing require the consent of the mother until the child is born. However, policies and guidelines enable the mobilisation of support and treatment services that are not statutory protective interventions.
- Prenatal urinalysis screening is undertaken with the consent of the pregnant women and in the context of potential support and monitoring. Policy makers and stakeholders reported that urinalysis results are rarely used as the sole factor in deciding upon a child protection response, both prenatally and postnatally.
- Concerns were expressed about AOD-using pregnant women presenting late to antenatal services, seen as a product of the stigma, fear of child protection involvement, lack of access to primary health care, and chaotic lifestyles.

- The early engagement of substance-using pregnant women with antenatal and support services is seen as a critical factor for better outcomes for unborn children, their mothers and families. Early child protection involvement allows more time to support women to address their risk factors.
- Actively participating in the support services offered (or not) and demonstrating change are key factors in any subsequent child protection interventions at birth.
- Stakeholders expressed concern about the particularly distressing effect on mothers and families of the removal of a baby at birth.
- Stakeholders were concerned that if support is prematurely terminated, outcomes will be poor and there is an increased possibility that the baby will be taken into care at a later date. There were some reports of removals of babies increasing by the time six months post-birth was reached, supporting the need for longer-term support.
- Case management, although supported across jurisdictions, was not always undertaken. Within at least two jurisdictions, prenatal case conferencing was used as a strategy to plan and implement support for pregnant women.
- The need for cross-disciplinary training, education and support of staff, and better collaboration and relationships across sectors and services were identified.
- A lack of comprehensive accessible services, for pregnant substance-using women, particularly residential services, was also identified as an issue.

4. Implications for policy and practice

The aim of this project was to examine the outcomes of identifying AOD use during pregnancy on women, their partners and their children through existing evidence and current jurisdictional policy and practice. Concerns about the extent (that we know of) that AOD plays in reducing the safety and wellbeing of children and the impact of AOD on the developing foetus have led to the increased screening of women for problematic AOD use and the developing of new responses by child protection authorities. The report has focused particularly on the outcomes of this screening activity and the current legislative, policy and practice responses to pregnant women identified as using substances. Unfortunately we are unable to make any extensive comment on how partners and their wider family are responded to in this context as there is limited attention paid to them, the main focus being on pregnant women.

Most jurisdictions screen for a range of issues including AOD use in pregnant women; and most jurisdictions have pathways for responding to women, including some specialist services. All jurisdictions specify that a prenatal notification may be made to statutory child protection services without the consent of the parent where there are concerns for the foetus. However, all other child protection interventions delivered prenatally are voluntary, requiring the consent of the pregnant woman. Another key feature of prenatal reporting legislation is the intended aim of the reporting, which is stated to be generally non-punitive and is aimed at providing opportunities for supportive interventions aimed at improving outcomes for children and mothers.

In general, what has been highlighted across jurisdictions is the difficult balance between risk and protective factors on the one hand, which may be tipped towards the removal of a baby at birth or later; and maintaining the dyad relationship, which evidence suggests is critical to the health, wellbeing and development of the infant.

The following section outlines the key implications arising from the report, which include a consideration of the implications of screening for AOD use, and what is required to increase the engagement of, and better support for, at-risk pregnant women in this context, to prevent involvement with the child protection system.

4.1 Screening for risk but assessing for need

All jurisdictions ask pregnant women about their levels of AOD use but some jurisdictions have more formal screening processes than others. In some jurisdictions there is considerable effort being expended on identifying AOD use, but with little consistency or commitment to providing a response. Some ambivalence around the need to intervene in relation to low-level alcohol use was expressed in particular. Smoking was recognised as a problem in pregnancy, as was the use of other drugs such as benzodiazepines, although there seem to be limited responses to these issues. Although generally supportive, stakeholders pondered the focus on a universal screening approach because of the level of resources required to implement such a strategy and the limited capacity to provide differentiated responses.

The reviewed literature and examples from practice indicate that a more holistic and ongoing assessment process is required to be most effective in engaging women with complex needs, and to better identify particular issues such as mental health, homelessness and violence. There is only limited evidence that women receive the services they need and that increased identification through screening may contribute to the targeting and further stigmatising of marginalised women, such as those already known to services. Although the literature suggests that there is a need to identify risk at various stages throughout the pregnancy, it appears that such assessments (for example, domestic violence, substance use) are not necessarily repeated later in the pregnancy.

Simply put, screening for AOD risk on its own appears to be of limited benefit. It requires two further elements: greater attention to building and maintaining partnerships with key services (discussed further below); and the increased availability of specialist treatment services for women. Some jurisdictions noted that it is difficult to find support services for substance-using pregnant women, particularly where there are no local specialised programs available, including in larger cities.

4.2 Integrated systems of support

Child protection involvement appears to be working more effectively where child protection workers are active participants in a more integrated and collaborative working arrangement with health authorities.

Jurisdictional policy and practice, along with the research evidence, point to the need for health and child protection sectors to work together better, to support pregnant women, to improve outcomes for mothers and babies after birth, and to contribute to reducing the number of removals of babies at birth. Women with issues such as AOD misuse, domestic and family violence, and mental health issues are also more likely to face other difficulties, such as homelessness and severe financial disadvantage. This complexity and multifaceted disadvantage require strong intersectoral partnerships and responsive programs to provide the intensive sustained support that is required, beginning in pregnancy. As the level of family vulnerability and complexity of issues increase, so too does the need for services to work more closely together (Winkworth & White, 2011).

There is evidence from the international literature that when substance abuse and child welfare services worked together, there was better engagement of women with services, women attended more prenatal visits and experienced fewer birth complications, which led to improved outcomes for babies (Marsh et al., 2011; Milligan et al., 2011). A review of the effectiveness of family interventions where parents were already involved in AOD treatment concluded that, along with developing a trusting working alliance with the parent, successful outcomes were dependent on agencies working together with child protection services and a wide range of other services to resolve multiple problems. Working together in this way can help 'build trust' and provide 'a clear rationale' for intervention (Dawe, Harnett & Frye, 2008, p. 11). It is a case of working together to redirect negative pathways for children when risk factors are high and protective factors need to be strengthened (Winkworth, McArthur, Layton & Thomson, 2010). Indeed, preliminary evaluation findings from some local models being developed appear to be replicating some of these international findings (e.g. New South Wales inner city pilot).

4.3 Engaging women, engaging early and staying engaged

The literature and the consultations raised concerns about possible negative outcomes that can occur as a result of prenatal reporting to child protection. Negative outcomes for women may range from disengagement from or avoidance of health services, later presentations at antenatal care, and increased marginalisation, through to an increased involvement with the child protection system. There was a strong sense from the consultations that AOD-using mothers are difficult to engage because of fear of child protection involvement. All jurisdictions made the point that interventions can be provided prenatally only with the consent of the mother, so child protection services take a back seat until the baby is born. Late presentations at antenatal services, as well as carrying significant obstetric risks, mean that there is a very short window in which pregnant substance-using women can demonstrate the change that child protection services require to assess them as able to safely care for their newborns.

Participants also identified a professional tension in maintaining a positive relationship between women and the health practitioners (predominantly midwives) throughout the pregnancy and postnatally, and in child protection practitioners having to make decisions relating to the safety and wellbeing of children once they are born.

It was acknowledged that most pregnant women are motivated to improve their health and reduce their AOD use to ensure a healthy baby, and that this could be a period when engagement may be more successful. This issue of engagement is evident in other areas of supportive service provision, where some families with multiple complex issues do not take up the offer of services because they have had previous negative experiences, feel ashamed about asking for help, have insufficient information about services to access them, or because they are too overwhelmed to do so. There are some emerging models, such as the pilot program in New South Wales, where engagement with pregnant women is occurring as early as possible and is leading to promising results in terms of outcomes for mothers and their babies.

There is some evidence that early engagement in services and strategies such as case conferencing and family group conferencing are promising mechanisms to develop sustainable plans to support women to safely care for their newborns at home. Unless support is continued for longer periods of time there is some evidence that women may have their babies removed later as supports drop off. There are some good examples of antenatal services and specialist services within Australia that aim to link and maintain women to services and programs within the community on a longer-term basis.

4.4 Lack of data on prenatal reports and removals at birth

In attempting to determine the number of pregnant women and their families who are identified or screened for AOD use in pregnancy and/or affected by prenatal reporting and removals of their babies by the child protection system at birth, it became apparent that limited data are available. Data reported by the Australian Institute of Health and Welfare include the number of infants under one year of age admitted to out-of-home care in each jurisdiction and limited information on substantiated abuse related to ‘unborn children’. Information published by New South Wales shows that a high proportion of prenatal reports are made (3.3 per cent of all pregnant women in New South Wales were reported to child protection services in 2012–13). Anecdotally, many of these women are reported and their babies removed because of maternal substance use issues, with an over-representation of illicit-drug-using women in opioid pharmacological treatment. No information is published, however, on the reasons for prenatal reports, the removals of infants, or on the longer-term outcomes. Without such data and longitudinal research on the impacts of prenatal reporting and removals at birth, we are unable to make assessments about the outcomes from these policies and practices.

4.5 What will be the future prenatal legislation, policies and practices?

Currently, Australian legislation and policies around prenatal reporting are focused on the early identification of risk in pregnancy and the provision of appropriate services and supports. The extent to which this is realised in practice is unclear.

There are emerging indications of a weakening of this supportive focus in some Australian jurisdictions and a leaning towards the more punitive responses evident in the United States. In some American states there is a tendency to make pregnant women's bodies the subject of state surveillance, and women can be committed or incarcerated if their AOD use is considered potentially harmful to the foetus. In this context the rights of the foetus are deemed superior to those of the mother and the state's assumed authority to protect the foetus overrules the interests of the mother (Meurk et al., 2014).

In recent years there have been a number of government inquiries into past welfare practices in Australia, including *Bringing Them Home: the 'Stolen Children' report* (1997); *Lost Innocents: Righting the Record: report on child migration* (2001); and *Forgotten Australians: a report on Australians who experienced institutional or out-of-home care as children* (2004). Most recently the report of a Senate committee inquiry, *Commonwealth Contribution to Former Forced Adoption Policies and Practices* (2012), whereby mothers and their now-adult adopted children were separated as a matter of social policy, led to recent governments apologising to those affected and stating that it should never happen again. Furthermore, recent studies have highlighted recurrent childbearing among substance-abusing mothers and the issue of repeat involvement with the child protection system, including the removal of multiple children within a short period of time (Broadhurst et al., 2014).

The focus of any policies and practices should be on ensuring that every pregnant woman and developing foetus are healthy, and that every child has a right to be safe and well cared for. However, there is also a duty to support women with substance-use and mental health problems, to take into account the multiple problems and disadvantages that many of these women experience, and to provide them with adequate services and supports to give them realistic opportunities to change and to parent their children.

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6. Appendices

Appendix A: Mapping of legislation, programs and services by jurisdiction

This Appendix provides online mapping of child protection legislation, child protection and health policies and guidelines, key pathways, programs and services in the context of identification of AOD use in pregnancy and prenatal (unborn child) reporting of child abuse and neglect.

An overview for the Australian Capital Territory, New South Wales, the Northern Territory, Queensland, South Australia, Tasmania, Victoria and Western Australia is provided below.

(a) Child protection legislation and policies

1. Australian Capital Territory

Key variables	
Legislation / statutory authority	<i>Children and Young People Act 2008 (ACT)</i> Care and Protection Services, Community Services Directorate
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	Yes. Section 362 of the above Act provides for prenatal reporting of an unborn child deemed 'in need of protection' following birth and based on a belief, on reasonable grounds, of anticipated abuse or neglect. Voluntary assessment; provision of a range of voluntary support services; referrals with consent giving prenatal information to a prenatal information sharing entity, e.g. health facility and vice versa. The purpose is to assist the pregnant woman to reduce the likelihood of need for care and protection intervention but also to protect the woman's human rights. However, consent may be waived if on reasonable grounds the unborn child is deemed to be in need of care and protection when born.

Key variables	
Is unborn child reporting mandatory?	No. While not mandatory, the policy and guidelines support practitioners in the reporting of the unborn child.
Related legislation	<p><i>Adoption Act 1993 (ACT)</i></p> <p><i>Human Rights Act 2004 (ACT)</i></p> <p><i>Human Rights Commission Act 2005 (ACT)</i></p> <p><i>Public Advocate Act 2005 (ACT)</i></p> <p><i>Family Law Act 1975 (Cwth)</i></p> <p><i>Mental Health (Treatment & Care) Act 1994 (ACT) (under review)</i></p>
Policies, guidelines, reporting, intake and assessment	<p><i>Keeping Children and Young People Safe: a shared community responsibility.</i> Community Services, ACT Government, 2012.</p> <p><i>Child, Youth and Family Services Program Service Delivery Framework: 2011–2015.</i> Community Services, ACT Government, 2012.</p> <p>‘Child, Youth and Family Gateway’ (prenatal – 18 years) – Information, Engagement and Coordination Service; use of the Common Assessment Framework.</p> <p>The Act makes provision for reporting an unborn child as a voluntary report and consent must be received from the pregnant woman (see above). However, if the pregnant woman does not consent to assistance and if the Director-General suspects on reasonable grounds, and considering the woman’s human rights, that the child once born may be in need of care and protection, the Director-General may give prenatal information to or ask for prenatal information from a relevant organisation(s).</p>

Key variables	
Services, programs and pathways	<p>Unborn child notifications are received by the Prenatal Support Team within the Centralised Intake Service. The Prenatal Support Team provides support for the family up to 28 days postnatally. The team is responsible for conducting appraisals/investigations upon birth as necessary. Prenatal liaison officers (2) liaise with hospitals and other health services in relation to the unborn child.</p> <p>Prenatal Support Team (to 28 days postnatal): Responsible for deciding whether the child is <i>safe</i> to be discharged from hospital to the home or not. Provides a collaborative approach using case conferencing to provide a multidisciplinary coordinated service.</p> <p>Care and Protection Services Family Work Team</p> <p>Child, Youth and Families Services Program: A service delivery framework for community organisations funded to provide early childhood and support services to vulnerable and in-need children, young people and their families in the ACT.</p> <p>Child and Family Centres: Four centres across the ACT provide support programs (including pregnancy AOD use), early intervention through a multidisciplinary service from pre-birth to 8 years.</p> <p>Substance Use in Pregnancy Support at the Canberra Hospital provides support and care for pregnant women who are on opiate replacement therapy and/or who use drugs or alcohol and also specialised care for their babies.</p> <p>IMPACT program: The Integrated Multi-agencies for Parents and Children Together program is designed to strengthen service provision through integrated and collaborative practice and supports being offered to women who are pregnant or families with children less than 2 years of age, and who are clients of Mental Health ACT and/or are receiving opioid replacement therapy.</p>

2. New South Wales

Key variables	
Legislation / statutory authority	<i>Children and Young Persons (Care and Protection) Act 1998</i> (NSW) Department of Family & Community Services (FACS) Child Protection Legislation Amendment Bill 2013 (NSW)
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	Yes. Section 25 of the 1998 Act provides for reports concerning unborn children where the child may be ‘at risk of significant harm’ when born. The intention of the legislation is to allow assistance and support to be provided to the expectant mother to reduce likelihood that a child when born will need to be placed in ‘out of home care’. To provide early information that a child who is not yet born may be ‘at risk of significant harm’ subsequent to birth. The Child Protection Legislation Amendment Bill 2013: Under the amendment to section 38A, Parent Responsibility Contracts are extended to include either or both expectant parents whose unborn child is the subject of a prenatal report under section 25, which contains provisions aimed at improving the parenting skills of the prospective parents and reducing the likelihood that the child will be at risk of significant harm after birth.
Is unborn child reporting mandatory?	No. Reports related to an unborn child are not mandatory. While reports are not mandatory, those with mandatory responsibilities are required to consider the benefits for the mother and to an unborn child of making a report. This is to enable Child Safety Services and other agencies to mobilise services for the benefit of the mother and the child or enable Child Safety Services to prepare appropriate statutory/protective intervention following the birth of the child (Family and Community Services Mandatory Reporting Guide).
Related legislation	<i>Children and Young Persons (Care and Protection) Amendment (Parent Responsibility Contracts) Act 2006</i> (NSW) <i>Child Protection (Offenders Registration) Act 2000</i> (NSW) <i>Commission for Children and Young People Act 1998</i> (NSW) <i>Ombudsman Act 1975</i> (Cwth) <i>Family Law Act 1975</i> (Cwth) Children and Young Persons (Care and Protection) Amendment Bill 2009 (information to Children’s Guardian and Director-General) <i>Children Legislation Amendment (Wood Inquiry Recommendations) Act 2009</i> (NSW) <i>Privacy and Personal Information Protection Act 1998</i> (NSW) <i>Health Records and Information Privacy Act 2002</i> (NSW)

Key variables	
Policies, guidelines, reporting, intake and assessment	<p>Child Wellbeing Units (CWU) Family Referral Services</p> <p>Child Wellbeing and Child Protection – NSW Interagency Guidelines: ‘Child Wellbeing Units’.</p> <p>Intake for unborn reports: Six government agencies where there is a Child Wellbeing Unit practitioner’s report to CWU. ‘Risk of significant harm’ threshold – report to the Child Protection Helpline.</p> <p><i>New South Wales Mandatory Reporter Guide</i> (2014); Mandatory Reporters Guidance Assessment Tool CSS.</p> <p>Safe Start Strategic Policy – Families NSW: supporting families.</p> <p>Structured Decision Making System used when there are concerns for the welfare of an unborn child once born.</p> <p><i>Keep Them Safe</i> is a framework that reflects the legislation to strengthen the role and capacity of the non-government sector in providing services to children. <i>Keep Them Safe: a shared approach to child wellbeing</i> (2009): whole-of-government, five-year plan following report of special commission of inquiry into child protection services in NSW (2008).</p> <p><i>Brighter Futures Caseworker Manual</i> (6th ed., 2010).</p> <p>Aboriginal Maternal and Infant Health Strategy (AMIHS): antenatal and postnatal assessments and interventions direct pathway to <i>Brighter Futures</i> (2010).</p> <p>Aboriginal Child Youth and Family Strategy</p> <p>Wellnet information-sharing computerised system</p> <p>Parental Drug Testing Policy (2009): informs the Children’s Court on the removal of children or restoration. The trigger is ‘serious and persistent’ use of drugs. (Alcohol is not included in this policy.)</p> <p>Families NSW whole-of-government (health education, community services, NGOs) initiative for pregnant women and specific strategies to address the needs of vulnerable families; Family Services volunteer home visiting and playgroups.</p> <p>The Legislative Framework for a Partnership Approach to Child Protection in NSW.</p>

Key variables	
Services, programs and pathways	<p>Families NSW offers a wide range of early intervention and prevention programs statewide including: universal health home visiting (but not antenatally); Safe Start; the Positive Parenting Program ('Triple P'); whole-of-government, community-based volunteer home visiting; playgroups; family workers.</p> <p><i>Brighter Futures</i> is a community-based government program for vulnerable families. Early intervention: pregnancy up to 8 years of age where there have been concerns reported to FACS. Voluntary.</p> <p>Drugs in Pregnancy programs: Safe Start – psychosocial assessment questions through Department of Family and Community Services.</p> <p>Child Protection Case Conferencing (CPCC) planning and coordination of service activity.</p> <p>NSW Government expanded AMIHS to 31 teams in locations across the state to provide priority referral to the Department of Community Services' Brighter Futures early intervention program. Aims to improve the health of Aboriginal women during pregnancy and reduce mortality rates for Aboriginal babies.</p>

3. Northern Territory

Key variables	
Legislation / statutory authority	<p><i>Care and Protection of Children Act 2007</i> (NT)</p> <p>Department of Children and Families</p>
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	<p>Legislation does not include unborn children in categories for notifications and statutory interventions. However, if there is a belief on reasonable grounds for a notification under Care and Protection Policies (see below), a notification about an unborn child can be made to care and protection.</p> <p>A major review of the <i>Care and Protection of Children Act</i> in 2012 made a recommendation (No. 112) that the Department extend the Act to enable acceptance of notifications for unborn children, and to make provision for the care of the child once born and that this change should be incorporated into the Act. NT Government is considering new legislation for punitive responses to alcohol use in pregnancy.</p>

Key variables	
Is unborn child reporting mandatory?	The Act does not have provisions currently for notifications to be made about unborn children (see above).
Related legislation	<p><i>Information Act 2006</i> (NT)</p> <p><i>Disability Services Act 2004</i> (ACT)</p> <p><i>Criminal Code Act 2006</i> (NT)</p> <p><i>Family Law Act 1975</i> (Cwth)</p> <p><i>Stronger Futures in the Northern Territory Act 2012</i> (Cwth)</p> <p><i>Adoption of Children Act</i> (NT); <i>Adoption of Children Regulations</i> (NT)</p> <p><i>Care and Protection of Children Act 2007</i> (NT) (provisions relating to child protection)</p> <p>Care and Protection of Children (Mediation Conference) Regulations (NT)</p> <p>Care and Protection of Children (Placement Arrangement) Regulations (NT)</p> <p>Care and Protection of Children (Screening) Regulations (NT)</p> <p><i>Guardianship of Infants Act</i> (NT)</p>
Policies, guidelines, reporting, intake and assessment	<p>Centralised Intake Service, Department of Children and Families</p> <p><i>NT Families and Communities Policy and Procedures Manual Casework Manual</i> (2010)</p> <p><i>Child Safety and Wellbeing Plan 2012: key strategies and actions</i> – multi-agency, whole-of-government plan.</p> <p><i>Strong Aboriginal Families, Together</i> (2011) – policy and guidelines.</p> <p><i>Care and Protection Policy and Procedures Practice Manual</i> allows for a referral to be accepted on an unborn child. A family support case can be created and support and planning services provided.</p> <p>The <i>Child Protection Operations Manual 2</i> (2008) states that:</p> <p>Reports made before the birth of a child which identify risks to the child after birth should be recorded on CCIS [the Community Care Information System] and referred to an NTFC [Northern Territory Families and Children] work unit for follow-up, if appropriate. The purpose of recording these reports is to allow assistance and support to be provided to the family to reduce the likelihood of the child being harmed after birth. The work unit may need to plan child protection action in advance of the birth and liaise with maternity services.</p>

Key variables

Policies, guidelines, reporting, intake and assessment (continued)

General control measures relating to alcohol abuse but specifically directed at pregnant women are those in the *Alcohol Reform (Prevention of Alcohol-Related Crime and Substance Misuse) Act 2011* (NT).

The Northern Territory Ombudsman's report *A Life Long Shadow: report of a partial investigation of the Child Protection Authority* (2011) recommended that:

an immediate change be made to the Operations Manual from: 'the work unit *may* need to plan child protection action in advance of the birth and liaise with maternity services' to 'the work unit *must* plan a child protection action in advance and must liaise with maternity services when there is a foreseeable risk to the wellbeing of an unborn child'.

Additionally the report recommends that:

There needs to be co-operation between RDH [Royal Darwin Hospital] and CIT [the Central Intake Team] to establish a mechanism whereby when a baby is born there is immediate monitoring and support for a family whose history of caring for children or lifestyle factors known to the CPA [Child Protection Authority] indicate a risk to the wellbeing of the unborn.

Information Sharing Guidelines (2012): A Safe Territory.

AOD policy: *Alcohol and Other Drugs Strategic Direction 2009–2012* – priority action area targeting alcohol and other drugs.

Stronger Futures in Northern Territory Policy: a ten year commitment to Aboriginal people in the Northern Territory (2012): a joint Commonwealth/NT program with strategies for enhanced safety, health and wellbeing of children and families which includes the Stronger Communities for Children Program.

Indigenous Family Safety Agenda (2010): addresses program development for alcohol abuse; completion of project to improve referral & intervention processes to families affected by AOD use involved with the child protection system (under the National Framework for Protecting Australia's Children).

Tune in to Little Ones: a resource kit to help Office of Children & Families staff focus on vulnerable infants (neonatal abstinence syndrome, AOD, foetal alcohol syndrome disorder and toxic stress included).

Key variables	
Services, programs and pathways	<p>Department of Children and Families: child protection is currently aiming to adopt the Signs of Safety Practice Framework developed in WA (2013).</p> <p>Program and service pathways through <i>Stronger Futures</i> roll-out, e.g. antenatal care for domestic violence and alcohol abuse.</p> <p>Implementation of the Structured Decision Making System (Safety, Family Strengths and Needs and Risk Assessment and Reassessment) tools across all service centres.</p> <p>Community Child Safety and Wellbeing Teams: child protection professionals living and working in remote Aboriginal communities.</p> <p>Community Child Safety and Wellbeing Teams: establishment of interagency hospital-based child safety and wellbeing units. This initiative was a recommendation of the report of the board of inquiry into the child protection system in NT (2010): <i>Growing Them Strong, Together: promoting the safety and wellbeing of the Northern Territory's children</i>.</p> <p><i>Stronger Futures in Northern Territory Policy</i>: joint program (see above) with the federal government also includes funding for partnerships across sectors.</p> <p>Introduction of an information-sharing framework under the legislation.</p> <p>Multi-agency Assessment and Coordination Teams in Darwin and Alice Springs to provide interagency responses to hospital admissions of child and family at risk.</p>

4. Queensland

Key variables	
Legislation / statutory authority	<i>Child Protection Act 1999</i> (Qld) Department of Communities, Child Safety & Disability Services: Child Safety Services (CSS)
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	Yes. Section 21A. There are provisions in the Act for unborn children notifications and investigation if a reporter becomes aware of risk or reasonably suspects harm. There is also provision for offer of help and support to the pregnant woman. The Act states that the purpose of the section of the Act is to reduce the likelihood that the child will need protection after he or she is born (as opposed to interfering with a woman's rights or liberties).
Is unborn child reporting mandatory?	No. While reports are not mandatory, there is provision for mandated reporters to report their concerns to CSS about the potential risk of harm to a child following their birth. Section 21 of Act enables CSS to take appropriate action when it suspects an unborn child may be at risk of harm after birth. CSS can initiate an 'unborn child high-risk alert'.
Related legislation	<i>Commission for Children and Young People and Child Guardian Act 2000</i> (Qld) <i>Education (General Provisions) Act 2006</i> (Qld) <i>Public Health Act 2005</i> (Qld) <i>Adoption of Children Act 1964</i> (Qld) <i>Family Law Act 1975</i> (Cwth) <i>Queensland Civil and Administrative Tribunal Act 2009</i> (Qld) <i>Hospital and Health Boards Act 2011</i> (Qld) (Disclosure of information)

Key variables	
<p>Policies, guidelines, reporting, intake and assessment</p>	<p><i>Child Safety Practice Manual (CSS)</i></p> <p>Notifications of unborn children at risk are made to CSS for investigation and referral and for support services.</p> <p>Child Safety Services policy on Investigation and Assessment</p> <p>Protecting Queensland Children: policy statement and guidelines on the management of abuse and neglect in children and young people 0–18 years (includes prenatal). Includes guidelines on needs assessment and follow-up; and parenting: for example, life management skills and other practical assistance for pregnant women who use substances.</p> <p><i>Queensland the Smart State: putting families first (2000):</i> Queensland Government.</p> <p><i>Parental Substance Misuse and Child Protection: intervention strategies.</i> Department of Child Safety (2007).</p>
<p>Services, programs and pathways</p>	<p>Family CARE Home Visiting Program: an initiative with Mental Health and Alcohol and Drug Service and Queensland Health’s Domestic Violence Initiative providing home-based support for vulnerable families.</p> <p>Parents under Pressure (PUP) program for clients of the opioid dependence program.</p> <p>Intensive Family Support Services, e.g. New Families Program Brisbane including antenatal care.</p> <p>Helping Out Families Initiative (roll-out 2014)</p> <p>Enhanced Health Home Visiting Service</p> <p>Ngarramam Intensive Home Visiting Service, Indigenous Child Health Team</p> <p>Child Health Centre initiative aims to improve antenatal, perinatal and paediatric care through better service integration, clinical partnerships and programs such as Family CARE Home Visiting Program.</p>

5. South Australia

Key variables	
Legislation / statutory authority	<i>Children's Protection Act 1993 (SA)</i> Families SA, Department of Education and Child Development
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	No. There are no <i>specific</i> provisions for reporting, assessment or interventions for unborn children. However, notifications to Families SA can be made. Changes have been made to policy and guidelines to support practitioners in the reporting of unborn children, the management of reporting and interventions.
Is unborn child reporting mandatory?	No.
Related legislation	<i>Adoption Act 1988 (SA)</i> Children's Protection Regulations 2010 (SA) <i>Family Law Act 1975 (Cwth)</i> <i>Family and Community Services Act 1972 (SA)</i>
Policies, guidelines, reporting, intake and assessment	Families SA: Intake Child Abuse Reporting Line (CARL); centralised intake. Children, Youth and Family Services policy: Infants at Risk Policy, Procedures and Standards (2005): outlines how the reporting of unborn children should be managed. All notifications are to be reported to Families SA Child Protection if the unborn child is assessed as being at risk once born. Families SA redesign: <i>Brighter Futures</i> – solution-focused casework policy and practice. <i>Keeping Them Safe: SA Government's Child Protection Reform Program</i> : enhanced prevention and early intervention strategies. <i>Child Protection Manual (2008)</i> : Families SA. <i>Keeping the Child in Mind: child protection practice and parental mental health (2011)</i> : SA Department of Families and Communities – chapters on the impact of mental health disorders on children (inclusive of substance abuse).

Key variables	
Service, programs and pathways	<p>High Risk Infant Service: identification of risk for early intervention.</p> <p>Interagency networks are in place to identify high-risk pregnant women and their families and coordinate support and counselling services prior to the birth of the infant.</p> <p>Stronger Families, Safer Children Program to support families in contact with child protection and care system; targeted early intervention; intensive placement prevention reunification services.</p> <p>Strong Start: a program that helps first-time pregnant mothers to care for their babies.</p> <p>Partnerships across government departments and NGOs through continued implementation of 'Information sharing: guidelines for promoting the safety and wellbeing of children, young people and their families' (ISG).</p>

6. Tasmania

Key variables	
Legislation / statutory authority	<p><i>Children, Young Persons and Their Families Act 1997</i> (Tas)</p> <p><i>Children, Young Persons and Their Families Amendment Act 2009</i> (Tas)</p> <p>Department of Health and Human Services</p>
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	<p>Yes. Section 13 of the <i>Children, Young Persons and Their Families Act 1997</i> provides for reporting on reasonable grounds of concern for an unborn child when an adult suspects that, once born, the child would be likely to suffer abuse, neglect or be in need of medical attention due to the mother's (or other's residing) behaviour (domestic violence/AOD). The provision for notification is stated for prevention purposes. Notifications are from mandated persons but there is no legal authority until the child is born.</p> <p>The report by the Commissioner for Children on <i>Child Protection Services in Tasmania</i> recommended the amendment of the legislation to allow for the taking of a notification of unborn children. It states that notifications of unborn children should be treated as if the unborn child was a born child for all other purposes of the Act.</p> <p>The Act provides for reports to be made for unborn children at 'risk of significant harm' under section 25, whose birth mother has not engaged with support services in order to eliminate or minimise the risk that gave rise to the report.</p>

Key variables	
Is unborn child reporting mandatory?	<p>Yes, mandatory reporting of unborn child on reasonable grounds. Tasmania has included unborn reporting (2009 amendment) in the mandated reporting requirements to child protection services for mandated reporters.</p> <p>The list of prescribed mandated reporters included in Tasmania’s child protection legislation, the <i>Children, Young Persons and their Families Act 1997</i>, is extensive. It includes professionals such as medical practitioners and dentists similar to other Australian child protection legislation, but more extensive in scope with the inclusion of employees and volunteers of all government-funded agencies that provide services to children.</p>
Related legislation	<p><i>Ombudsman Act 1975</i> (Cwth)</p> <p><i>Family Law Act 1975</i> (Cwth)</p> <p>Children and Young Persons (Care and Protection) Amendment Bill 2009 (Tas) (information to Children’s Guardian and Director-General)</p> <p><i>Family Violence Act 2004</i> (Tas)</p> <p><i>Misuse of Drugs Act 2001</i> (Tas)</p> <p><i>Mental Health Act 2013</i> (Tas)</p> <p><i>Alcohol and Drug Dependency Act 1968</i> (Tas)</p>
Policies, guidelines, reporting, intake and assessment	<p>Gateway Services: notification of neglect and abuse to the community-based child protection worker. This service is NGO-operated – community-based intake services or child protection intake; referral and support through Gateway Services.</p> <p><i>Keeping Children Safe: a shared responsibility</i>: operated by Disability, Child, Youth and Family Services. New reporting threshold for prevention and early intervention.</p> <p>Unborn Child Reporting Policy: intake reports to either child protection services or Gateway Services (NGO consortium). Its aim is to provide discussion of issues and referral and support services to avoid involvement of child protection statutory services.</p> <p>National Framework for Universal Child and Family Health Services (2011): Australian Government Department of Health (includes antenatal and child safety).</p> <p>Kids Come First project – early years including antenatal: Tasmanian Department of Health and Human Services.</p>

Key variables	
Services, programs and pathways	<p><i>Our Kids: our present and our future: strategic policy framework</i> (2002): Tasmanian Department of Health and Human Services.</p> <p>Tasmania’s Department of Health and Human Services has implemented a CU@home program for young pregnant women 15–19 years of age. This is a voluntary universal support, intensive home visiting program that begins prenatally up to 2 years of age.</p> <p>The major pathways in the community sector are to the child health centres that provide home visiting and support to vulnerable women and to AOD services in each region.</p> <p>Tasmania Family Future Program: City Mission Hobart</p> <p>Small Steps Program – supported accommodation for young mothers: Anglicare.</p>

7. Victoria

Key variables	
Legislation / statutory authority	<p><i>Children, Youth and Families Act 2005</i> (Vic)</p> <p><i>Child Wellbeing and Safety Act 2005</i> (Vic)</p> <p>Department of Human Services</p>
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	<p>Yes. Section 29 of the <i>Children, Youth and Families Act 2005</i> has provisions for notifications to be made about unborn children if it is deemed a significant concern. Section 32 of this Act provides for referrals to be made to community-based child and family services about an unborn child. The aim is to support the pregnant woman and to collaborate to reduce risk to the unborn child.</p>
Is unborn child reporting mandatory?	<p>No provision for mandated reporting until the child is born.</p>
Related legislation	<p><i>Working with Children Act 2005</i> (Vic)</p> <p><i>Children’s Services Act 2005</i> (Vic)</p> <p><i>Commission for Children and Young People Act 2012</i> (Vic)</p> <p><i>Family Law Act 1975</i> (Cwth)</p> <p><i>Family Violence Protection Act 2008</i> (Vic)</p>

Key variables

Policies, guidelines, reporting, intake and assessment

Reports can be made either to Child Protection (CP) or to community-based Child and Family Information Referral Support Teams (Child FIRST). The Act establishes two pathways for people to report or refer an unborn child where they have 'a significant concern for the wellbeing of the child after his or her birth': confidential reports to child protection authorities (sec. 29) and referrals to Child FIRST – Child and Family Information, Referral and Support Teams (sec. 32) to be made about unborn children and stipulates the type of responses that may be provided.

Victorian Risk Framework

The Act allows anyone to contact the CP Child First before the birth of a child, e.g. a hospital may contact CP indicating that an expectant mother has a serious drug problem that is likely to place the newborn at risk. The CP or family service provider offers support information in partnership with relevant agencies for effective planning.

The intent of the legislation is to prevent future harm and reduce the likelihood of child protection intervention after the child's birth by working earlier and in partnership with the mother and appropriate support services to address the need or risk factors. The guiding principle is one of supportive interventions rather than interfering with the rights of the pregnant woman.

Guide for Assessing Parental Substance Use (Department of Human Services, 2000).

Protecting Victoria's Children: Child Protection Practice Manual: reports of children in specific circumstances.

Brighter Futures Caseworker Manual (2010)

Protocols exist between Protective Services, Victorian drug services, and the Victorian Association of Alcohol and Drug Agency (VAADA).

Protocol between Drug Treatment Services and Child Protection for working with parents and other drug issues (2002).

Parental Substance Abuse: Guidelines for Protective Workers (1994, reviewed in 2000). Specialist guide for assessing parental substance use (Department of Human Services).

Supporting Parents, Supporting Children: a Victorian early parenting strategy. Services providing specialist support to vulnerable children and families from pregnancy to pre-school (Department of Human Services, 2010).

Key variables	
Services, programs and pathways	<p>The Child First community-based support service is directly linked to notification of the unborn child.</p> <p>High Risk Infant Program: case conferencing – a community-based child protection worker organises case conference. Following birth, a CP worker may make application to the Children’s Court if they consider that a child is in need of protection.</p> <p>Cradle to Kinder program provides early intervention and longer-term intense antenatal and postnatal support for vulnerable expectant mothers.</p> <p>Supporting Parents, Supporting Children: a Victorian Government early parenting strategy with specialist intervention teams; expanded family group conferencing and Aboriginal family decision making.</p> <p>Best Start: whole-of-government policy (Department of Human Services and Department of Education and Training).</p> <p>The High Risk Infant Program must be consulted in all unborn reports received by child protection.</p> <p>Child protection workers are encouraged to work with maternity services and other professionals to help with antenatal plans for the unborn safety stability and development after birth.</p> <p>Every Child Every Chance: a Victorian Government initiative. These 2006 reforms aimed to create a more integrated system of child development and family services that focus directly on child health, safety and wellbeing with an emphasis on prevention and early intervention across the sectors.</p>

8. Western Australia

Key variables	
Legislation / statutory authority	<i>Children and Community Services Act 2004</i> (WA) Department of Child Protection
Prenatal reporting (Does the statutory authority accept notifications for unborn children?)	Yes (Reform 2010, section 33B). The reform of the <i>Children and Community Services Act 2004</i> provides for the Department to record a notification and to conduct an assessment to plan for the safety of a child once born. The CEO of the Department may cause inquiries to be made before the child is born. Then the CEO must: provide or arrange for the provision of social services; and ensure that a meeting is arranged with service providers for case planning and investigation to assess likelihood that the child will be in need of protection after birth.
Is unborn child reporting mandatory?	No provision for mandatory reporting until the child is born.
Related legislation	<i>Parental Support and Responsibility Act 2008</i> (WA) <i>Family Court Act 2004</i> (WA) <i>Adoption Act 1994</i> (WA) <i>Family Law Act 1975</i> (Cwth) <i>Child Care Services Act 2007</i> (WA)
Policies, guidelines, reporting, intake and assessment	Department of Child Protection and Family Support: child abuse intake to district child protection departmental offices with referral to interagency teams. <i>Identifying and Responding to Child Abuse and Neglect: a guide for professionals</i> . Department of Child Protection. <i>The Signs of Safety: Child Protection Practice Framework</i> . (2nd ed., 2011): Department of Child Protection. <i>Family Support (Responsible Parenting) Framework</i> . (Rev. ed., 2013): Department of Child Protection and Family Support. The Signs of Safety framework is a comprehensive approach to child protection assessment and interventions. It is strengths-based and expands the investigation of risk to encompass strengths and signs of safety that can be built upon to stabilise and strengthen the child's and family's situation. It provides a format for undertaking a comprehensive assessment for both danger and strengths/safety.

Key variables	
<p>Policies, guidelines, reporting, intake and assessment (continued)</p>	<p>Department of Health /Department of Child Protection. Bilateral schedule: interagency collaboration processes when an unborn or newborn baby is identified as at risk of abuse and/or neglect, 2013.</p> <p><i>Aboriginal Services Framework</i>. (Rev. ed., 2012): policy on assessment and investigation procedures; policy on neglect. Department of Child Protection.</p> <p><i>Casework Practice Manual</i>: Department of Child Protection and Family Support.</p> <p>AOD issues – urinalysis testing: to guide child protection workers in using AOD urinalysis as a means of determining a parent’s or carer’s substance use, this policy does not specify use for pregnant women.</p> <p><i>Better Care, Better Services: standards for children and young people in protection and care</i>. Department of Child Protection.</p> <p>Working Together Resource Kits developed with drug and alcohol services and the Department of Child Protection.</p> <p>Interagency early intervention pre-birth memorandum of understanding uses the Signs of Safety framework and establishes a model of collaborative and inclusive pre-birth planning meetings as well as a range of written protocols and resources to guide agencies and workers on its application.</p> <p><i>Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015</i>. Western Australia Drug and Alcohol Office.</p>
<p>Services, programs and pathways</p>	<p>Best Beginnings intensive home visiting program: home visiting service for families of new infants; referral before birth up to 2 years.</p> <p><i>The Signs of Safety Child Protection Practice Framework</i> (2011): Signs of Safety pre-birth planning meetings; Signs of Safety home visiting.</p> <p>The Kids in Focus program’s overall aim is to provide support to children and their families in order to minimise the harmful effects of parental substance misuse on child wellbeing and to strengthen family resilience through a range of interventions and activities. The secondary aim is to build capacity within the family relationship service providers and other sectors in better addressing the needs of target group children and their families. This will include a Telephone Advice Service for service providers. Similar programs also exist in other jurisdictions.</p>

(b) Health legislation and policies

1. Australian Capital Territory

Key variables	
Legislation / statutory authority	<i>Children and Young People Act 2008</i> (ACT) ACT Health
Policies, guidelines, referral, intake and assessment	<p><i>Child Protection Policy</i> (2008): ACT Health.</p> <p>Under section 362 of the <i>Children and Young People Act</i>, if an ACT Health employee in their dealings with a pregnant woman suspects or believes that the child who may be born as a result of the pregnancy may be in need of care and protection, a prenatal report may be made to Care and Protection Services. It covers an unborn child, child or young person at risk of abuse or neglect (ACT Health staff should consult if necessary and use clinical judgment to report or not).</p> <p>Information sharing with a prenatal information-sharing entity, e.g. hospital, may be conducted without the consent of the pregnant woman.</p> <p><i>The ACT Opioid Maintenance Treatment Guidelines</i> (2012): ACT Health.</p> <p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn</i> (2006): commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by health care practitioners working with pregnant women experiencing AOD problems.</p> <p><i>National Antenatal Care Guidelines</i> (2012). Module 1: Australian Government Department of Health.</p> <p><i>National Framework for Universal Child and Family Health Services</i> (2011): Australian Government Department of Health and Ageing.</p>

Key variables	
Services, programs and pathways	<p>Antenatal clinics/shared care – information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p>IMPACT program provides support for families, for a pregnant woman or a woman who has children under 2 years of age and who is experiencing opioid dependency or has mental health issues. If not eligible, pregnant women may be referred to a clinical nurse consultant at the AOD program.</p> <p>Alcohol and Drug Program Consultation and Liaison Service</p> <p>Alcohol and Drug Program, ACT Health</p> <p>Alcohol and Drug Foundation ACT (ADFACT)</p> <p>Community Health Helpline</p> <p>Queen Elizabeth II Family Centre</p> <p>Alcohol and Drug Service: substance use in pregnancy support team.</p> <p>Women’s Information, Resources and Education on Drugs and Dependency (WIREDD)</p> <p>DIRECTIONS ACT – provides information, interventions, counselling, referral, support, detoxification and rehabilitation services; Althea Wellness Centre – primary health care program for AOD users.</p> <p>ACT specialist hospital-based services to Canberra Hospital.</p> <p>Antenatal clinics – mental health assessment, perinatal assessment, domestic violence and AOD issues; self-management information and resources; brief interventions and/or referral to AOD specialist services.</p> <p>Opioid treatment services, ACT Health Alcohol and Drug Program.</p>

2. New South Wales

Key variables	
Legislation / statutory authority	<p><i>Children and Young Persons (Care and Protection) Act 1998</i> (NSW) Department of Family and Community Services</p> <p>The Child Protection Legislation Amendment Bill 2013 will be incorporated into the current 1998 Act</p> <p>NSW Health</p>
Policies, guidelines, referral, intake and assessment	<p>Under child protection legislation, health workers are mandated reporters of risk of harm for children under 16 years. It is not mandatory to make a prenatal report but the existence of any previous prenatal reports must be taken into account when assessing risk of harm. Assessment of risk of harm and the decision to make a report to the Department are at the discretion of the individual health worker but this may be influenced by discussion at multidisciplinary case meetings. Every health worker may report unborn children where it is suspected they may be ‘at risk of significant harm’ after their birth.</p> <p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn</i> (2006): commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by all health care practitioners working with pregnant women who are experiencing AOD problems.</p> <p><i>National Framework for Universal Child and Family Health Services</i> (2011): Australian Government Department of Health and Ageing.</p> <p><i>Neonatal Abstinence Syndrome Guidelines</i> (2013): these NSW Health guidelines are mandatory for health staff; they cover prenatal screening, identification of opioid use; referral to case manager; referral to substance use in pregnancy services; collaboration with AOD services and antenatal care providers.</p> <p><i>Nursing and Midwifery Clinical Guidelines</i>: identification of and responses to AOD issues for the pregnant woman. Assessment and screening are required to be holistic, quantified and documented, as well as physical examination, signs of drug use and administration, and signs of withdrawal.</p> <p><i>NSW Health Review of Substance Use in Pregnancy Services</i> (2009): Mental Health and Drug and Alcohol Office.</p> <p><i>Keep Them Safe: a shared approach to child wellbeing 2009–2014</i> (2009): a whole-of-government five-year plan aimed at improving health, safety and wellbeing of children and young people in NSW; the NSW Government’s response to the Report of the Special Commission of Inquiry into Child Protection Services in NSW (2008) on accessing and receiving services they require.</p>

Key variables	
Policies, guidelines, referral, intake and assessment (continued)	<p>Safe Start provides psychosocial risk assessment, depression screening for all women as part of a comprehensive health assessment conducted prenatally by a midwife at the booking appointment or first presentation; includes core psychosocial questions and domestic violence questions or self-administered questionnaire (for self-administered; not for domestic violence) and the Edinburgh Depression scale.</p> <p>Child Wellbeing and Child Protection Policies and Procedures for NSW Health (2013). Child Wellbeing and Child Protection NSW Interagency Guidelines and other agreed interagency procedures provide health workers with direction on information exchange, high-risk birth alerts, and prenatal reporting.</p> <p>Child Wellbeing Units are staffed by child protection workers who provide advice and support to health workers for reporting and follow-up. Aboriginal Assessment Officers are also available at the Child Wellbeing Units.</p> <p>Needle and Syringe Program Guideline (2013): NSW Health.</p> <p>Maternal and Child Health Primary Health Care Policy (2010): NSW Health.</p> <p>Domestic Violence – Identifying and Responding: Policy Directive (2006): NSW Health.</p> <p>Opioid Treatment Program: Clinical Guidelines for Methadone and Buprenorphine Treatment (2006): NSW Health.</p> <p>Aboriginal Maternal and Infant Health Strategy (2005): NSW Health.</p> <p>Nursing and Midwifery Management of Drug and Alcohol Issues in the Delivery of Health Care (2007): NSW Health.</p> <p><i>The Health of Children and Young People in NSW: report of the Chief Health Officer</i> (2014): NSW Health.</p> <p>Information sharing: NSW Health & Department of Family and Community Services Opioid Treatment Program – responsibility for children under 16 years; prenatal reporting.</p> <p>NSW established a Substance Use in Pregnancy Advisory Group to oversee the development and implementation of the recommendations of the Review of Substance Use in Pregnancy Services by NSW Health (2009), resulting in the publication of <i>Clinical Guidelines for the Management of Substance Use during Pregnancy, Birth and the Postnatal Period</i> (2014).</p>

Key variables	
Policies, guidelines, referral, intake and assessment (continued)	<p><i>National Antenatal Care Guidelines</i> (2012). Module 1: Australian Government Department of Health.</p> <p>Supporting Families Early Package policies include:</p> <p>Maternal and Child Health Primary Health Care (2010)</p> <p>Safe Start Strategic Policy (2010)</p> <p>Improving Mental Health Outcomes for Parents and Infants: Safe Start Guidelines (2010): NSW Government, Mental Health and Drug and Alcohol Office.</p>
Services, programs and pathways	<p>Antenatal clinics/shared care – identification of AOD/screening by self-report; information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p>Maternal and neonatal intensive care discharge services; Universal Health Home Visiting program; Sustained Health Home Visiting program; specialist child health nurses.</p> <p>Continuity of care with maternity, neonatal, paediatric, family care cottages, child and family health units through case conferences and exchange of information.</p> <p>Drug and Alcohol Specialist Advisory Services (DASAS)</p> <p>Drug Use in Pregnancy Service (DIPS) at King George V Hospital is integrated with the obstetric antenatal clinics.</p> <p>MotherSafe – specialist referral service at Royal Hospital for Women; comprehensive counselling service for women and health professionals concerned about exposures during pregnancy.</p> <p>Opioid Treatment Program</p> <p>Pregnancy and Parent Support Service (SUPPS)</p> <p>NSW Health has been piloting screening programs in antenatal and emergency departments of acute hospitals for domestic violence.</p> <p>Sex Workers Outreach Project – includes pregnant women.</p> <p>Drug and Alcohol Multicultural Education Centre</p> <p>Chemical Use in Pregnancy Service (CUPS)</p> <p>Drug and Alcohol Specialist Advisory Service (DASAS) and Alcohol and Drug Information Service (ADIS) for community information, counselling, referral and support.</p> <p>Mental Health & Drug and Alcohol Office and the Primary Health and Community Partnerships Branch collaboration in NSW Health.</p>

3. Northern Territory

Key variables	
Legislation / statutory authority	<p><i>Care and Protection of Children Act 2007</i> (NT) Department of Health and Families</p>
Policies, guidelines, referral, intake and assessment	<p>The Child and Youth Health Strategy Unit</p> <p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn</i> (2006): commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by all health care practitioners working with pregnant women who are experiencing AOD problems.</p> <p><i>National Antenatal Care Guidelines</i> (2012). Module 1: Australian Government Department of Health.</p> <p><i>National Framework for Universal Child and Family Health Services</i> (2011): Australian Government Department of Health and Ageing.</p> <p><i>Health Promotion Strategic Framework 2011–2015</i> (2011): Northern Territory Department of Health – includes strategies for prenatal screening for AOD.</p> <p><i>The National Aboriginal Health Strategy</i> (1989).</p> <p><i>The Health and Wellbeing of Northern Territory Women</i> (2005): Northern Territory Department of Health and Community Services.</p> <p>Alcohol and Other Drugs Program: Priority Action Area 3: Targeting Smoking, Alcohol and Substance Abuse. Northern Territory Department of Health.</p>

Key variables	
Services, programs and pathways	<p>Antenatal clinic brief intervention for AOD (self-reporting).</p> <p>Antenatal clinics/shared care – information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p>Antenatal clinics: Darwin and Alice Springs hospitals’ use of alcohol self-reporting and support during first visit and 36-week gestation.</p> <p><i>Grog – Making the Change</i> (2010): a general screening and assessment tool for alcohol that also includes pregnancy and babies.</p> <p>Referral to AOD services and child and family nurses for universal home visiting assessment.</p> <p>Models of care for NT Maternity Services Caseload Team – continuity of antenatal and postnatal care.</p> <p>AOD Awareness and Family Recovery Program, Department of Health and Community Services.</p> <p><i>Stronger Futures in the Northern Territory</i> (2012). Australian Government Department for Families, Community Services and Indigenous Affairs.</p> <p>Stronger Communities for Children program (2012): Australian Government Department for Families, Community Services and Indigenous Affairs.</p> <p><i>Strong Women, Strong Babies, Strong Culture Program: information for Strong Women workers, government and non-government professionals.</i> Northern Territory Department of Health and Families.</p> <p>Healthy Pregnancy, Healthy Baby program – support and information service.</p> <p>Growth Assessment and Action program: Northern Territory Department of Health, Maternal and Infant Health.</p> <p>7 Steps to Safety initiative: Northern Territory Department of Health and Community Services, Office for Children and Families.</p> <p>Specialist hospital-based services at Royal Darwin Hospital.</p> <p>Drug and Alcohol Clinical Advisory Service (DACAS) for health professionals and Alcohol and Drug Information Service (ADIS) for community information, counselling, referral and support.</p> <p><i>Stronger Futures for the Northern Territory:</i> joint program that includes improved maternal and child health outcomes as key strategies with whole of federal government involvement, e.g health, education, employment etc.</p>

4. Queensland

Key variables	
Legislation / statutory authority	<p><i>Child Protection Act 1999</i> (Qld)</p> <p><i>Public Health Act 2005</i> (Qld) (no specific provision for reporting of <i>unborn child</i>; however, the legislation links this Act with the <i>Child Protection Act 1999</i> (see below))</p> <p>Department of Health</p>
Policies, guidelines, referral, intake and assessment	<p>Queensland Health's Child Safety Unit has a policy on information sharing. Section 1590 of the <i>Child Protection Act 1999</i> specifically includes the giving of information before the child is born that is relevant to the protection and welfare of the child after he or she is born. In the reporting form for health professionals there is a question: Are you aware of any risk of harm to the child? The alleged risk after the child is born should be provided. It is not a requirement of the reporting process to inform the parent/carer that a 'child' report has been made.</p> <p>Clinical Guidelines for Mandated Reporters</p> <p><i>Child Abuse and Neglect Education Module: responsibility, recognizing and reporting: a resource for the interdisciplinary team</i> (2013): Queensland Health.</p> <p><i>Neonatal Abstinence Syndrome: maternity and neonatal clinical guidelines</i> (2013): Queensland Government. For use by all health professionals in public or private maternity services; coordinated antenatal assessment and management including the development of a care plan.</p> <p>Maternity and Neonatal Clinical Guidelines (2010): Queensland Health.</p> <p>Protecting Children and Young People policy states that all reports relating to an unborn child are to be discussed with the health service child protection adviser or child protection liaison officer prior to the report being made to Child Safety Services (CSS).</p>

Key variables	
Policies, guidelines, referral, intake and assessment (continued)	<p>Unborn Child High Risk Alert (when there is no consent from the pregnant woman) remains confidential to CSS. It is the responsibility of the admitting midwife to undertake the relevant inquiries associated with these alerts, by accessing the toolkit and to facilitate advice to CSS when the woman presents at the hospital for delivery.</p> <p>Child Safety Services: consent required for referral and support; and when child is deemed to be in need of care and protection. CSS offers ongoing support through a support plan.</p> <p><i>Child and Youth Health Practice Manual for Child and Youth Health Nurses and Indigenous Child Health Workers (2007):</i> Queensland Health. Key prevention early detection and early intervention; home visiting ICARE antenatal care, domestic violence and maternal mood disorder.</p> <p><i>Queensland, the Smart State: Putting Families First (2000):</i> Queensland Government.</p> <p><i>Dual Diagnosis Clinical Guidelines: co-occurring mental health and alcohol and other drug problems (2010):</i> Queensland Health.</p> <p>Queensland Opioid Treatment Program: clinical guidelines (2012): Queensland Health.</p> <p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn (2006):</i> commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by all health care practitioners working with pregnant women who are experiencing AOD problems.</p> <p><i>National Antenatal Care Guidelines (2012).</i> Module 1: Australian Government Department of Health.</p>

Key variables	
Services, programs and pathways	<p>Antenatal clinics/shared care: AOD screening; information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p>Screening in antenatal services, 12–18 weeks: social history; Safe Start: tobacco, alcohol and other drugs cessation.</p> <p>Structured maternal interview during antenatal assessment; maternal counselling for AOD use at each maternal visit. Self-management for majority with information and AOD use resources; brief interventions as appropriate and referral to AOD specialist services.</p> <p>CHAMP specialised antenatal clinic, Mater Mothers’ Hospital, to provide care to pregnant women with substance use issues.</p> <p>Alcohol, Tobacco and Other Drug Services (ATOD): provides assessments, interventions, planning, case management, counselling, residential treatment and referral as required.</p> <p>Antenatal Day Assessment Services (ANDAS): Queensland Health. Multidisciplinary clinic for alcohol and substance use: comprehensive maternity care by a multidisciplinary team for women with complex needs including AOD, mental health and comorbidity.</p> <p>Post-discharge from maternity service or hospital: AOD support and liaison with community AOD agencies.</p> <p>Opioid Treatment Program (methadone or buprenorphine) as standard treatment for opioid-dependent pregnant women.</p> <p>Education regarding the safety of opioid replacements in pregnancy/lactation (Maternity and Neonatal Clinical Guideline).</p> <p>Alcohol and Drug Information Service: 24-hour specialist alcohol and drug service for health professionals and community.</p>

5. South Australia

Key variables	
Legislation / statutory authority	<p><i>Children's Protection Act 2003 (SA)</i> Department of Health (SA Health)</p>
Policies, guidelines, referral, intake and assessment	<p>Child Abuse Report Line (CARL): Families SA – centralised intake.</p> <p>South Australian Paediatric Clinical Guidelines: for substance use in pregnancy.</p> <p><i>Alcohol, Tobacco and Other Drugs: clinical guidelines for nurses and midwives (Version 3, 2012).</i></p> <p>South Australian Perinatal Practice Guidelines (2013), SA Health: (i) Substance use in pregnancy; (ii) Women with significant psychosocial needs. Policy on screening for alcohol stating that pregnant women following brief interventions and requiring further follow-up should have a full assessment of alcohol intake with validated screening tools T-ACE, TWEAK or AUDIT.</p> <p><i>A Framework for Primary Health Care for Aboriginal People (2011):</i> SA Health.</p> <p><i>Aboriginal Health Care Plan 2010–2016 (2010):</i> SA Health.</p> <p>Healthy Start (SA Department of Human Services): Healthy Start is an initiative funded by the Australian Government under the Stronger Families and Communities Strategy.</p> <p>Aboriginal Families Study: Antenatal Care (Policy brief #1, 2013) – translating evidence from the Aboriginal Families Study to inform policy and practice; compares data compiled by SA Pregnancy Outcome Unit in 2010.</p> <p>Aboriginal Family Birthing Program: SA Health.</p> <p>Alcohol Treatment Guidelines for Indigenous Australians (2009): development and implementation in SA of national guidelines.</p> <p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn (2006):</i> commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by all health care practitioners working with pregnant women who are experiencing AOD problems.</p> <p><i>National Antenatal Care Guidelines (2012).</i> Module 1: Australian Government Department of Health.</p>

Key variables	
Policies, guidelines, referral, intake and assessment (continued)	<p><i>National Framework for Universal Child and Family Health Services</i> (2011): Australian Government Department of Health and Ageing.</p> <p><i>Australian Guidelines to Reduce Health Risks from Drinking Alcohol</i> (2009): National Health and Medical Research Council.</p> <p><i>Fetal Alcohol Spectrum Disorders: a guide for midwives</i> (2006): Drug & Alcohol Services SA.</p>
Service, programs and pathways	<p>Antenatal clinics/shared care: AOD screening; information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p>South Australian Perinatal Practice Guidelines: screening for alcohol of all pregnant women; advise a full assessment of alcohol intake be undertaken with a validated screening tool such as T-ACE, TWEAK or AUDIT.</p> <p>Drug and Alcohol Counselling Service SA</p> <p>Drugs in Pregnancy Information Line</p> <p>Community Midwives Program</p> <p>Pregnancy Advisory Service</p> <p>Drug and Alcohol Services SA (DASSA). The DASSA Obstetric Unit is a specialist service for substance-using pregnant women and their partners from conception until birth. It provides assessment, treatment, education, support and advocacy services to ensure safe outcomes.</p> <p>Alcohol and Drug Information Service (ADIS)</p> <p>Specialist hospital-based services at the Women’s and Children’s Hospital, Adelaide.</p> <p>Early Links Program: early intervention designed to systematically identify pregnant women facing risk or adversity and to consider the implications for their unborn infant (SA Health & Flinders Medical Centre).</p> <p>Opioid Treatment Program</p>

6. Tasmania

Key variables	
Legislation / statutory authority	<p><i>Children, Young Persons and Their Families Act 1997</i> (Tas)</p> <p><i>Children, Young Persons and Their Families Amendment Act 2009</i> (Tas)</p> <p>Department of Health and Human Services</p>
Policies, guidelines, referral, intake and assessment	<p>Kids Strategic Policy Framework: Department of Health and Human Services</p> <p><i>Alcohol, Tobacco and Other Drug Services: Future Service Directions 2008/09–2012/13</i> emphasises the proposed strategy for a three-tiered system of provision of services that places the primary health care system – mainstream health and human services – as a key access and treatment point for pregnant women with AOD and all other groups.</p> <p><i>Alcohol, Tobacco and Other Drug Services: Future Service Directions 2012–2013</i> emphasises the role of primary health care services and hospitals and child and family services, including NGOs, to include brief interventions for AOD and referrals in all assessments of pregnant women.</p> <p>Specialist treatment and extended care services: Department of Health and Human Services.</p> <p><i>Tasmanian Drug Strategy 2013–2018</i></p> <p><i>Child Health and Parenting Service Strategic Plan 2009–2014</i> (2009): Department of Health and Human Services.</p> <p><i>Tasmanian Psychostimulants Action Plan 2007–2009</i> (2007): Department of Health and Human Services.</p> <p><i>Tasmanian Alcohol Action Framework 2010–2015: Rising above the Influence</i> (2010).</p> <p><i>Everybody's Business: a strategic framework for implementing promotion, prevention and early intervention approaches in averting alcohol, tobacco and other drugs use</i> (2013): Department of Health and Human Services.</p> <p><i>Tasmanian Opioid Pharmacotherapy Program: policy and clinical practice standards</i> (2012): Department of Health and Human Services.</p>

Key variables	
Policies, guidelines, referral, intake and assessment (continued)	<p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn</i> (2006): commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by all health care practitioners working with pregnant women who are experiencing AOD problems.</p> <p><i>National Antenatal Care Guidelines</i> (2012). Module 1: Australian Government Department of Health.</p> <p><i>National Framework for Universal Child and Family Health Services</i> (2011): Australian Government Department of Health and Ageing.</p>
Service, programs and pathways	<p>Antenatal clinics/shared care: information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p>The Tasmanian Alcohol and Drug Service is a treatment, information, education and community-based service of the Department of Health and Human Services.</p> <p>Specialist hospital-based services at Royal Hobart Hospital.</p> <p>The tertiary end is the Specialist Treatment and Extended Care Services of the Department of Health and Human Services. This futures document also states a priority in establishing primary health care brief interventions for the screening and assessment of AOD use.</p> <p>Drug Education Network</p> <p>Opioid Treatment Program</p>

7. Victoria

Key Variables	
Legislation / statutory authority	<p><i>Children, Youth and Families Act 2005</i> (Vic) Department of Human Services</p>
Policies, guidelines, referral, intake and assessment	<p><i>Vulnerable Babies, Children and Young People at Risk of Harm: best practice framework for acute health services</i> (2006): Department of Health – unborn reporting within acute hospital settings; since this policy, unborn reporting has increased significantly and created the opportunity for early support and assistance to be provided to pregnant women whose child may be at risk of harm <i>during</i> and after birth.</p> <p>Health Acute Services: Protective Services Division of Department of Human Services.</p> <p><i>Victorian Alcohol Action Plan 2008–2013: 'Restoring the Balance'</i> (2008): Victorian Government.</p> <p>Child First: Child and Family Information, Referral and Support Service in partnership with the Department of Human Services team and NGOs.</p> <p>Prenatal referrals allow for a wellbeing report to be made for early engagement with families with consent.</p> <p><i>Working with Families</i> (Clinical Treatment Guidelines for Alcohol and Drug Clinicians, no. 11): Turning Point Alcohol and Drug Centre.</p> <p>Pre-birth case conference teams within hospitals and community services: pre-birth multidisciplinary case conferencing.</p> <p><i>Guide for Assessing Parental Substance Use</i> (2000): Department of Human Services.</p> <p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn</i> (2006): commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by all health care practitioners working with pregnant women who are experiencing AOD problems.</p> <p><i>National Antenatal Care Guidelines</i> (2012). Module 1: Australian Government Department of Health.</p> <p><i>National Framework for Universal Child and Family Health Services</i> (2011): Australian Government Department of Health and Ageing.</p> <p><i>Capability Framework for Victorian Maternity and Newborn Services</i> (2010): Department of Health.</p> <p>Royal Women's Hospital Melbourne: antenatal pathway for drug use in pregnancy with clinical guidelines.</p>

Key Variables	
Service, programs and pathways	<p>Antenatal clinics/shared care: AOD screening; information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p>The Women’s Alcohol and Drug Service (WADS), Royal Women’s Hospital Melbourne, provides information and multidisciplinary care for pregnant women with AOD use and their infants. Provision of clinical services, education, support, voluntary and professional services statewide.</p> <p>Every Child, Every Chance program: strong partnerships between professionals prior to birth of a child for conferencing, coordination, planning and supports.</p> <p>Child First: Child and Family Information, Referral and Support Service in partnership with the Department of Human Services team and NGOs.</p> <p>Healthy Mothers Healthy Babies Program: especially for pregnant women who experience difficulty accessing antenatal and postnatal care services; addresses maternal risk behaviours and provides support during pregnancy: Department of Health.</p> <p>Royal Women’s Hospital, Drug and Alcohol Services Unit: management of opioid withdrawal.</p> <p>Drug and Alcohol Clinical Advisory Service (DACAS): specialist alcohol telephone consultancy service for health professionals: Turning Point Alcohol and Drug Centre.</p> <p>Alcohol and Drug Information Service (Direct Line)</p> <p>Victoria has employed 16 mental health workers (FYE) in rural and regional Victoria to provide early assessment support and referral to pregnant women at risk of experiencing perinatal mental health problems.</p> <p>Maternity Outreach Support Service: Sunshine Hospital targets women with a high-risk pregnancy and complex physical and psychological care requirements. Also provides midwifery care model to incarcerated pregnant women.</p> <p>Safekids@health (2011): a practice forum for health services to share solutions for improving the health, safety and wellbeing of vulnerable children at risk of child abuse and neglect.</p> <p>Specialist hospital-based services at Royal Women’s Hospital.</p> <p>Odyssey House Victoria: Kids in Focus: a support service for vulnerable families where a parent has an AOD problem.</p> <p>Yakapna Family Healing Centre: a residential program for vulnerable Indigenous families, Njernda Aboriginal Corporation.</p> <p>Opioid Treatment Program</p>

8. Western Australia

Key variables	
Legislation / statutory authority	<p><i>Children and Community Services Act 2004</i> (WA)</p> <p><i>Family Court Act 1997</i> (WA)</p> <p>Department of Health</p> <p>Drug and Alcohol Office</p>
Policies, guidelines, referral, intake and assessment	<p>King Edward Memorial Hospital Perth, Women and Newborn Health Service: O&G Clinical Guidelines: Antepartum Care, section 1.5: Substance Use in Pregnancy. Department of Health</p> <p>Child and Youth Health Network: Fetal Alcohol Spectrum Disorder Model of Care. Department of Health.</p> <p><i>Alcohol and Other Drugs Assessment: Clinicians' Booklet</i> (& form) (2011): Drug and Alcohol Office.</p> <p><i>Western Australia Community Program for Opioid Pharmacotherapy: clinical policies and procedures for the use of methadone and buprenorphine in the treatment of opioid dependence</i> (3rd ed., 2014): Drug and Alcohol Office.</p> <p>Drug and Alcohol Office: management of programs for opioid-dependent women; assessment by an AOD midwife; psychosocial assessment – domestic violence; mental health problems.</p> <p><i>A Brief Guide to the Assessment and Treatment of Alcohol Dependence</i> (2012): Drug and Alcohol Office.</p> <p><i>National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn</i> (2006): commissioned by the Ministerial Council on Drug Strategy under the cost shared funding model. The guidelines were intended for use by all health care practitioners working with pregnant women who are experiencing AOD problems.</p> <p><i>National Antenatal Care Guidelines</i> (2012). Module 1: Australian Government Department of Health.</p> <p><i>National Framework for Universal Child and Family Health Services</i> (2011): Australian Government Department of Health and Ageing.</p> <p><i>Drug and Alcohol Interagency Strategic Framework for Western Australia 2011–2015</i> (2011): Drug and Alcohol Office.</p> <p>Memorandum of Understanding: Department of Child Protection & Drug and Alcohol teams.</p>

Key variables	
Service, programs and pathways	<p>Antenatal clinics/shared care: AOD screening; information resources; brief interventions and referrals to specialist AOD treatment services and programs.</p> <p><i>Antenatal Shared Care Guidelines for General Practitioners</i> (5th ed., 2014): Women and Newborn Health Service, King Edward Memorial Hospital, Perth. These clinical guidelines recommend the use of short and full screening tools: AUDIT-C for pregnant women for alcohol screening. This tool has been validated for pregnancy.</p> <p><i>Fetal Alcohol Spectrum Disorder Model of Care</i> (2010): Department of Health – screening programs will provide opportunities to prevent FASD and provide early intervention for pregnant women with alcohol problems and children diagnosed with FASD.</p> <p>Telethon Institute in Western Australia has developed a resource making use of the screening tool AUDIT followed by a brief intervention.</p> <p>Screening for alcohol use during pregnancy and infants and mothers registered with the Women and Newborn Drug and Alcohol Service (WANDAS).</p> <p>Antenatal screening for alcohol consumption – <i>Fetal Alcohol Spectrum Disorder Model of Care</i>: Department of Health.</p> <p>Western Australia has established a continuity of antenatal care model for women with serious mental health problems. This partnership model ensures the woman maintains contact with a caseworker, psychology medicine provider/midwife and obstetrician. The WANDAS provides outreach services to incarcerated women.</p> <p>Next Step Drug and Alcohol Services: Clinical Advisory Service: 24-hour phone service for GPs and health care professionals seeking information and advice on alcohol and other drug treatment.</p> <p>Specialist hospital-based services at King Edward Memorial Hospital, Perth.</p> <p>Antenatal Chemical Dependency Clinic: obstetric and neonatal services for women and families; multidisciplinary with a focus on healthy parenting.</p> <p>Referral to WANDAS clinical midwifery consultant and obstetric consultant and social worker.</p> <p>Alcohol and Drug Information Service</p> <p>Statewide Maternity and Newborn Services (Obstetrics, Midwives and Maternity Hospitals)</p> <p>Opioid Treatment Program</p>

Appendix B: Key stakeholder interview list

Key stakeholder group (n=9)	Representative
Substance users group representative (1)	New South Wales Users and AIDS Association (NUAA)
Residential family drug treatment service provider (1)	Kids in Focus, Odyssey House, Victoria
Antenatal service provider to substance-using pregnant women, including midwife representatives (3)	Westmead Hospital Drug Use in Pregnancy Service Royal Prince Alfred Hospital Drugs in Pregnancy Service Women and Newborn Drug and Alcohol Service (Western Australia)
Non-government family support service (2)	Barnardos Australia Substance Use in Pregnancy and Parenting Program (Illawarra)
Child protection prenatal service (1)	Pilot perinatal family conferencing service for at-risk newborns: Central Sydney Community Service Centre, New South Wales Department of Family and Community Services
General practitioner (1)	Member of the Royal Australian College of General Practitioners' Drug and Alcohol Committee

Interviews with policy makers: Another 24 interviews were undertaken with policy staff members working in the prenatal reporting area from statutory child protection services and health departments, in each of the eight states and territories.³ In some jurisdictions several interviews were conducted (e.g. six in one jurisdiction).

³ In one jurisdiction, a health response was not obtained, and in a second jurisdiction no child protection/welfare response was obtained, despite multiple attempts to contact the nominated departmental interviewees.

Appendix C: Project Reference Group

Member	Organisation
Professor Margaret Hamilton	Australian National Council on Drugs
Emeritus Professor Dorothy Scott AOM	Australian National Council on Drugs
Dr Delyse Hutchinson	National Drug and Alcohol Research Centre, University of New South Wales
Professor Sharon Dawe	School of Applied Psychology, Griffith University
Dr Stefan Gruenert	Odyssey House, Victoria
Professor Virginia Schmied	School of Nursing and Midwifery, University of Western Sydney
Professor Morag McArthur	Australian Catholic University project team
Dr Stephanie Taplin	Australian Catholic University project team
Dr Giovanna Richmond	Australian Catholic University project team