Model of Care: Substance Use in Pregnancy and Parenting Services

Sydney Local Health District

Final Report

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List of Abbreviations

ALO	Aboriginal Liaison Officer
CFHN	Child and Family Health Nursing
CNC	Clinical Nurse Consultant
CNS	Clinical Nurse Specialist
DHS	Drug Health Services
FACS	Family and Community Services
HCL	Hospital Consultation Liaison
HFHC	Healthy Families Healthy Children
HHAN	Healthy Homes and Neighbourhoods
MOC	Model of Care
NAS	Neonatal Abstinence Syndrome
NGO	Non-Government Organisation
OST	Opioid Substitution Treatment
PAFDHS	Perinatal and Family Drug Health Service
PFC	Pregnancy Family Conferencing
RPAH	Royal Prince Alfred Hospital
SLHD	Sydney Local Health District
SHHV	Sustained Health Home Visiting
SUPPS	Substance Use in Pregnancy and Parenting Services
TIC	Trauma-Informed Care

The SUPPS Model of Care

Background

Historically, Sydney Local Health District (SLHD) were among the leaders in the field of drugs in pregnancy services, largely due to the pioneering work of Dr Edith Collins who established the first drugs in pregnancy service in Australia at Crown Street Hospital in the late 1970s (Saunders, 2007). Collins continued this work at Royal Prince Alfred Hospital (RPAH) after Crown Street Hospital closed in 1983. With two social workers and a nurse, she ran an effective team that provided cutting edge medical care, including access to opioid substitution treatment (OST) and treatment for neonatal abstinence syndrome (NAS), as well as an empathic approach to service provision for a highly disadvantaged group of women (Saunders, 2007). However, when Edith Collins retired in 1993, the service was gradually defunded.

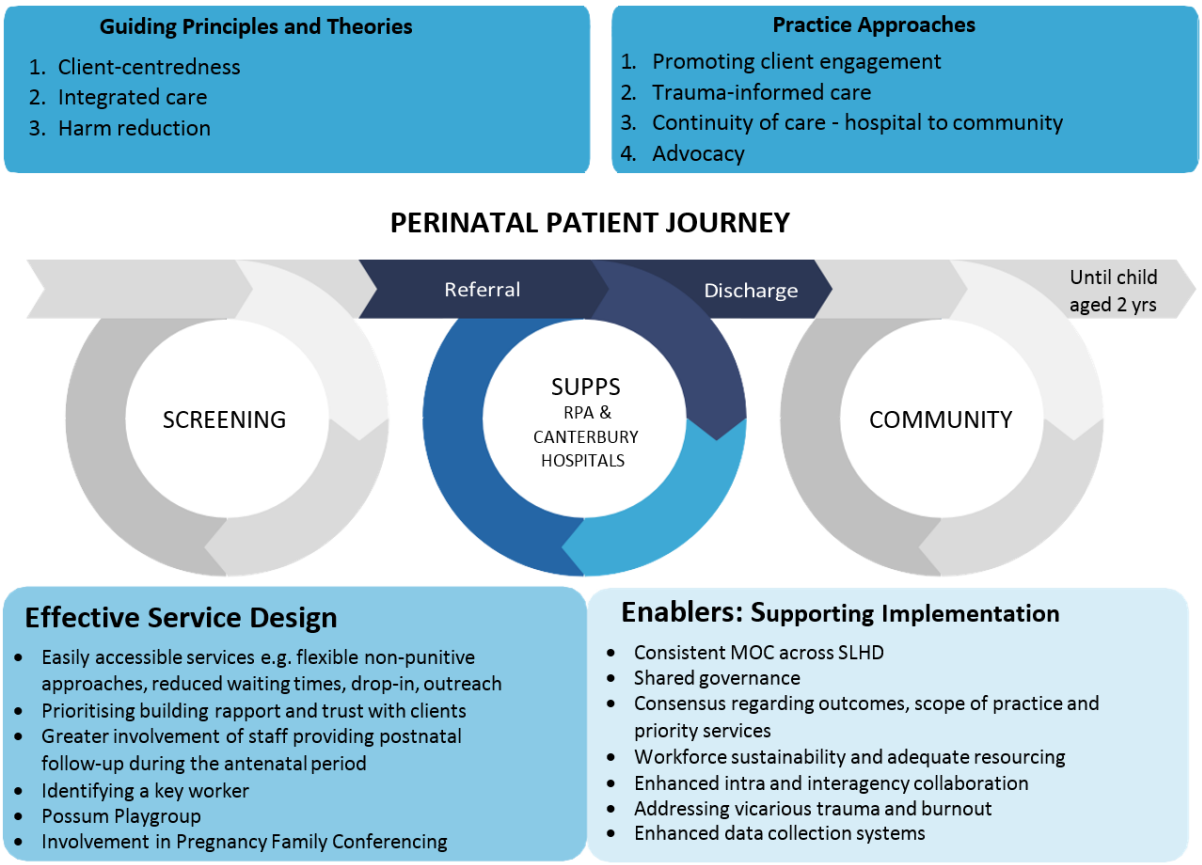
In 2004, the Perinatal and Family Drug Health Service (PAFDHS) was established at RPAH, staffed by a Clinical Nurse Consultant (CNC), a part-time Registered Nurse and a Perinatal and Family (PAF) Social Worker. Since its inception, there has been strong commitment to both Nursing and Allied Health involvement in the PAFDHS service. Drug Health funded the Nursing positions. However, at that time, Drug Health lacked the capacity to provide Allied Health staff with the necessary supervision and line management. As a result, the RPAH Social Work Department funded and managed the PAFDHS Social Work position.

While the PAFDH Service was based at RPAH, the CNC also covered Canterbury Hospital when required. However, the high demand, complex caseloads and limited resources at RPAH often precluded this from happening. In addition, Canterbury Hospital did not provide the specialized medical interventions available at RPA for pregnant women who use substances. Most pregnancies among this group were considered ‘high-risk’ and women would need to deliver their babies at RPAH, even if they resided in the Canterbury area. The primary need for PAFDHS was at RPAH but given resource constraints, it remained a predominantly inpatient hospital-based service, with a minimal level of outpatient follow-up provided by the CNC.

In 2017, a Substance Use in Pregnancy and Parenting Service (SUPPS) was established at Canterbury Hospital, with New South Wales (NSW) Ministry of Health funding enhancements. A Social Worker and a Clinical Nurse Specialist (CNS) position were funded and managed by Drug Health. In contrast to PAFDHS at RPAH, SUPPS at Canterbury provides both an inpatient and outreach service for clients. This disparity in the models of care across SLHD have presented challenges in maintaining continuity of care and equity in terms of access to services when women move between the hospitals to deliver at RPAH.

In 2017, the NSW Ministry of Health also funded research aimed at developing an evidence-based model of care (MOC) for SUPPS in SLHD (Moensted & Coupland, 2018). The MOC outlined in this document is informed by the findings of that research.

Overview of SUPPS



Eligibility criteria

Women residing in SLHD who use substances and are pregnant or parents of children up to two years of age.

Aims of SUPPS

The research that informed the development of the model of care highlighted the need for key SUPPS stakeholders to reach agreement on clearly defined programme outcomes. Staff identified the following outcomes for consideration:

- Maximise maternal and child health outcomes, during pregnancy and after delivery
- Address women's needs in relation to substance use
- Maximise the number of women who retain child custody after birth and in the long term
- Retain or enhance mother-child relationships, including when out-of-home care placement has been ordered
- Support the development of effective parenting skills to facilitate optimal child well-being and development outcomes
- Provide access to relevant information, assistance and support in relation to the effects of substance use, in general and during pregnancy, and services available.

Staffing

SUPPS encompasses a core team of four full-time staff who work solely in this clinical area, as well as a number of hospital-based and external services with linkages to this team. The SUPPS core team is based in two sites: Royal Prince Alfred Hospital (RPAH) and Canterbury Hospital. At RPAH, the SUPPS team includes a CNC funded by Drug Health and a Social Worker funded by the RPAH Social Work Department. At Canterbury Hospital, the SUPPS team includes a CNS 2 and a Social Worker, both funded through Drug Health Services.

The SUPPS core team work closely with obstetricians, neonatologists, addictions specialists and midwives, as well as Family and Community Services and a number of community-based services (see Referral pathways and service linkages section p13).

Governance

With the exception of the SUPPS Social Work position at RPAH, funded by the Social Work Department, Drug Health Services provides governance, clinically and administratively, for SUPPS in SLHD.

Prioritising shared governance to enhance integrated care

The complexities of providing accessible services to disadvantaged women who use substances have proved challenging for policy makers across the health and community sectors, particularly in relation to maintaining continuity of care. An Inner West Sydney Child Health & Wellbeing Plan was developed in 2016 and led by SLHD with partners in the region, as a region-wide approach to supporting collaborative work across agencies to provide services for vulnerable children and families, including parents with substance issues (SLHD, 2016). With a commitment to establishing a collective vision, governance and collaboration framework the Plan was built on a formalised partnership between SLHD, NSW Family and Community Services (FACS), NSW Department of Education, Central and Eastern Sydney Primary Health Network (CESPHN) and the Inner West Collaborative Practice Management group (Shaw & Caffrey, 2017). Other SLHD programmes integrated into the Plan include Drug Health Services, Pregnancy Family Conferencing (FACS and SLHD), Community Health Child and Family Health Services including Community Paediatrics "Branches" clinics for at-risk children, Maternity Services and Allied Health interventions. In addition, the Healthy Families Healthy Children (HFHC) Steering Committee was established in recognition of the importance of shared governance to enhance integration of service delivery across multiple agencies, including those with linkages to SUPPS.

The key demonstration project of the plan is the Healthy Homes and Neighbourhoods (HHAN) integrated care programme, which aims to meet the needs of families with complex health and social issues through care coordination, and strengthening sector capacity. HFHC has developed a harmonised Sustained Health Home Visiting (SHHV) programme across SLHD, building on its universal service base to streamline service delivery for all families, with particular investment in the child's first five years of life (Shaw & Caffrey, 2017). Eligibility for the programme was expanded beyond Ministry of Health specifications to include vulnerable families, or those at increased risk of poor maternal, child health and development outcomes, and those with low English proficiency. Eligibility was also extended to provide up to six weeks post-delivery follow-up for mothers newly referred to the service.

The Pregnancy Family Conferencing (PFC) is a voluntary antenatal programme introduced in 2012, jointly funded by FACS and SLHD. The programme brings families, FACS and local health district staff together with an independent facilitator to finalise a plan that reduces risks to the unborn baby and assists in reducing assumptions into care. PFC ensures transparency regarding the responsibilities and expectations of all parties, as well as clarity regarding the supports that need to be put in place for the client. Recently, there has been expansion of the PFC Programme to include postnatal conferencing.

Working towards operationalising shared governance for SUPPS

As the above section detailed, a number of important changes have taken place as SLHD moves towards more effective integration of SUPPS. Through the Inner West Sydney Child Health & Wellbeing Plan, establishment of the HFHC Steering Committee, and more recently, the First 2000 Days Framework (NSW Ministry of Health, 2019), the district has demonstrated its firm commitment to shared governance of SUPPS in order to reduce fragmentation and siloing of services. However, there is more work to be done in operationalising shared governance and in ensuring this translates to changes further down the line where service provision takes place. It is acknowledged that successful service delivery is best supported by:

- a shared vision for SUPPS, commitment to resource sharing, clear goals, performance indicators and accountability processes; and
- a diverse leadership team representing stakeholders across hospitals, services and disciplines, including community and non-government organisations.

The model of line management for SUPPS staff is still to be decided by the SUPPS governance group, with the option of discipline-specific line management operating in parallel for the provision of mentoring and supervision, if needed. The SUPPS governance group is responsible for resolving any conflicts arising between stakeholders or discipline-specific line managers.

The formation of five working groups will represent a starting point for translating the MOC into practice, focusing on the following five areas:

1. Governance
2. Data collection systems
3. Output metrics
4. Team building
5. Consistent referral pathways.

Guiding Principles of the MOC

The belief that pregnancy can be a catalyst for change is a fundamental principle underlying the SUPPS model of care. Intrinsic to the model is that this population of women deserve the best possible chance to embrace motherhood and retain custody of their children. With access to drug and alcohol treatment, multidisciplinary interventions, support and assistance, there is potential to break the intergenerational cycle of disadvantage (Ashley, Marsden, & Brady, 2003). To support such aims, there are three guiding principles of the model of care client-centredness, integrated care and harm reduction.

Client-Centred Care

Client-centredness relates to the dynamics of professional-client interactions, particularly the inclusion of clients in decisions regarding their care. This approach represents a shift away from expert-driven models and medical paternalism towards an approach that recognises a client's right to autonomy and choice when it comes to the conduct of health care (Hughes, Bamford, & May, 2008).

Client-centredness is best supported by a partnership approach where the expertise of all parties involved is recognised. Clients are considered experts in their own health, with a right to have their needs and priorities incorporated into the development of a treatment plan. Transparency, honesty, equality and advocacy for clients, who typically come from a background of disadvantage, trauma and/or social marginalisation, is central to client-centredness.

Client-centred care is demonstrated by taking the time to engage with clients in order to understand their goals and assist in developing a plan for achieving them. In different service settings, variation may exist in terms of who is considered the primary client when it comes to supporting families, women and/or children. However, all staff recognise that whether the mother or the child is the priority, they will be viewed in the context of family relationships.

Integrated Care

The delivery of integrated care has been identified as a key NSW Ministry of Health priority (NSW Ministry of Health, 2014). SUPPS adopts an integrated care model, bringing together substance use treatment programs, antenatal care, parenting programmes and child and family health initiatives (Milligan et al., 2010) (Goler, Armstrong, Taillac, & Osejo, 2008; Milligan, Usher, & Urbanoski, 2017) (Blakely & Bowers, 2014). In SLHD, a range of departments and services are involved, including Drug Health, Women and Babies, Social Work, Neonatology, Community Paediatrics, Healthy Homes and Neighbourhoods (HHAN), residential rehabilitation programmes, non-government organisations (NGOs) and Child and Family Health.

In the context of SUPPS, integrated care seeks to reduce barriers to women engaging with services, reduce maternal substance use, enhance social and health outcomes, improve parenting skills and promote child well-being (Milligan et al., 2010; Niccols et al., 2012). This model represents a synthesis of health and social care, where the impact of social determinants of health is recognised.

Harm Reduction

The International Harm Reduction Association defines harm reduction as "policies, programmes and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop" (Harm Reduction Australia, 2019). Harm reduction is also one of the three pillars of the Australian Drug Strategy, its defining feature being the focus on prevention of harm, rather than on the prevention of drug use itself (Department of Health, 2017). Examples of harm reduction interventions include access to OST and needle and syringe programmes, blood-borne virus prevention, screening and treatment, peer education and access to programmes to reduce drug, alcohol or tobacco use during pregnancy (Department of Health, 2017). Harm reduction involves the active resisting of stigmatising representations of women who use substances at a service level, and can facilitate engagement of people who use drugs in health services (Lee & Zerai,

2010). Improvements in clients' social functioning and quality of life, have also been reported as outcomes of harm-reduction programmes (Lee & Zerai, 2010).

In the context of SUPPS in SLHD, the philosophy of harm reduction is demonstrated by focusing on reducing the harms associated with substance use as well as whether or not a woman is able to maintain abstinence. Abstinence, particularly in the short term, may not be a realistic goal for some clients. Wherever possible, services seek to find ways to reduce risks to a child's welfare by putting in place additional supports for women so they can fulfil the roles of motherhood.

Practice Approaches Integral to the Model of Care

Four overarching practice approaches are integral to the model of care: promoting engagement with clients; trauma-informed care; continuity of care from hospital to community contexts; and advocacy.

Promoting Engagement with Clients

Relationship-based practice is a key approach for staff seeking to assist marginalised individuals and the centrality of trusting relationships for good client outcomes is frequently highlighted in the literature (Perlman, 1979; Potter & McKinlay, 1982; Trevithick, 2003). However, pregnant women and mothers with substance use problems are often reluctant to engage with health and community services due to lack of trust, negative past experiences with services and concerns about being reported to FACS and having their baby assumed into care (Clark, Dee, Bale, & Martin, 2001; Stengel, 2014; Stone, 2015).

Pregnancy and antenatal care can provide a window of opportunity for services to engage with women regarding their substance use, in the context of other priorities. Engagement is considered crucial to building a trusting relationship where the mother is willing to disclose her current circumstances, priorities and concerns regarding substance use. Absence of meaningful engagement or a therapeutic relationship can directly affect outcomes for mothers and babies. The SUPPs programme provides a mechanism for demonstrating to FACS that women are engaged with support for their substance use, increasing their chances of retaining custody of their children. Engaging with clients also enables staff to obtain a clearer understanding of the context of a client's actions, particularly their substance use, before a report to FACS is made.

Trauma-Informed Care

Given the high prevalence of trauma among SUPPS (Cohen & Hien, 2006) clients, good client outcomes rely on staff operating from a trauma-informed care approach when dealing with clients. Trauma-informed care (TIC) refers to service approaches designed to respond to client trauma (Marcellus, 2014). The key principles of TIC include trauma awareness, emphasis on safety, opportunities to rebuild control and use of a strength-based approach (Hopper, Bassuk, & Olivet, 2010). TIC is designed to be both preventative and rehabilitative (Yeager, Cutler, Svendsen, & Sills, 2013) and has been defined as "a strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010, p.82). An emphasis on staff

training, combined with TIC-specific mentoring, ensures that staff learn the best possible way to assist clients affected by trauma.

Continuity of Care from Hospital to Community

The concept of continuity of care as a well-recognised contributor to health has been identified as crucial when working with marginalised groups (Barker, Stevenson, & Deeny, 2017), including in the drug and alcohol field (Kim et al., 2007). Within SUPPS, continuity of care involves providing a seamless transition in service delivery as clients move between hospital and community settings. Maintaining a client's engagement in health and support services may require ensuring the same trusted workers provide the service over time, or that referrals to other services be made. Collaboration between staff within and across agencies, clear referral pathways and effective mechanisms for information sharing are vital to ensuring continuity of care can be maintained.

Advocacy

SUPPS staff play a key role as advocates for clients' health, social, legal and economic rights. In response to the stigma associated with substance use and discrimination against SUPPS clients, this role often promotes a shift in focus away from parental substance use per se. Instead discussion focuses on how a client's drug use is problematic and ways to improve the determinants of health influencing the harms associated with substance use, including housing, isolation, food insecurity and exposure to violence (Drabble & Poole, 2011; Roberts & Pies, 2011). Having an advocate can also be an important transformative experience that contributes to the participants' sense of empowerment and being able to take control over their life (Day & Moensted, 2018).

Advocacy also involves educating other staff in hospital-based and community services in response to stigma and discrimination against SUPPS clients. Drug Health staff in particular, are involved in raising awareness of the principles of harm reduction, providing guidance regarding whether or not a woman's substance use requires intervention, and what kinds of supports may need to be put in place.

Overview of Services Provided through SUPPS and related services in SLHD

Antenatal and postnatal care (inpatient and outpatient)

- Case management
- Collaboration with FACS regarding child protection matters
- Parent education and provision of written resources
- Inpatient detoxification and stabilisation
- Opioid substitution treatment
- Smoking cessation programmes
- Drug and alcohol counselling
- Residential rehabilitation
- Referrals to Department of Housing
- Mental health care
- Midwifery
- Pain management in labour and postnatally
- Neonatology
- Newborn care

- Possum Playgroup
- Referrals to Dandelion Service
- Referrals to community services for long term follow-up
- Referrals to legal services
- Contraception

Community-based care

The role of the SUPPS core team

To promote continuity and equity in service provision across the district, an extension of the PAFDHS role at RPAH to include outreach follow-up until the child reaches two years of age has been suggested. At present the service is primarily an inpatient service. The Social Worker and CNC provide outpatient follow-up for up to four weeks post discharge.

Linkage with other community-based services

- Care coordination (HHAN)
- Parenting and family support (SHHV, NGOs, residential rehabilitation)
- Child developmental checks (Child and Family Health)
- Allied Health interventions (Child and Family Health)

Key Aspects of Effective Service Design

Strategies for promoting engagement of clients in care

Promoting engagement of women in antenatal and postnatal care is a key priority of the model of care. Engagement is achieved by adopting a range of client-centred strategies for building trust and rapport, including adopting flexible approaches to service delivery that make services and support as easy to access as possible.

Client-centred strategies include:

- Creating a warm and welcoming service environment, including the physical environment;
- Adopting a non-judgmental, non-punitive approach;
- Providing information about drug and/or alcohol treatment or detoxification options, as well as reassurance that substance use per se may not automatically be grounds for having their child assumed into care;
- Transparency regarding staff's mandatory reporting responsibilities;
- A partnership approach to working with clients, where clients are acknowledged as experts in their own health and circumstances;
- Ensuring client are present at key meetings regarding their care;
- Continuity of workers over time, if possible;
- Early referral (during antenatal care) to FACS and agencies best placed to provide long-term follow-up in the community to allow clients and staff to build trust and rapport prior to delivery of the baby;
- Identifying a key worker to reduce confusion for clients; and
- Minimising the number of psychosocial assessments required, to avoid re-traumatising or causing frustration for clients.

Making services as easy to access as possible is achieved by:

- Minimising waiting times for antenatal clinic visits;
- Appointment scheduling that reflects clients' everyday realities and the social determinants of health;
- Providing drop-in services;
- A non-punitive approach when clients miss appointments and ensuring staff have sufficient time to follow-up women who have missed an appointment;
- Facilitating a client's engagement with other services in the community e.g. acting as an initial communication bridge; and
- Outreach rather than outpatient follow-up.

Ensuring staff collaboration and continuity of care

Maintaining continuity of care is a fundamental priority of the MOC and is predicated on effective intra and interagency staff collaboration, and formalised partnerships between all agencies involved. In SLHD, SUPPS-related care traverses antenatal and postnatal follow-up until the child reaches two years of age, and includes a range of hospital, government and non-government, and community-based services. The SUPPS MOC recognises the importance of a less-hospital-centric approach to service delivery and the need to take a long-term view of continuity of care and follow-up of women in the community. This includes embedding shared goals and policies pertaining to work and referral practices to enhance integrated care.

Strengthening continuity of care between hospital and community-based services involves:

- Identifying a worker for clients to contact by phone in the event of a crisis after discharge from hospital (e.g. relapse to drug use);
- Referral to services to provide ongoing parenting support in the form of outreach, POSSUM Playgroup, residential rehabilitation programmes, intensive family support programmes and other community-based services; and
- Referral to services focusing on child development and well-being until the age of two years, including NAS clinics and Child and Family Health.

To ensure continuity of care, mechanisms for enhancing intra and interagency staff collaboration and operationalising shared care plans include:

- Collaboration across agencies modelled at the leadership level;
- Staff familiarising themselves with formal intra and interagency policies and practices regarding roles and work practices;
- Consistent SUPPS-related referral pathways;
- Regular networking opportunities for staff from different agencies to:
    - gain a better understanding of others' roles and enhance role clarity
    - engage in multidisciplinary clinical reflection and debriefing to problem solve more effective work practices, build trust and enhance interagency collegiate support;
- Effective systems for information exchange between agencies, including electronic referral systems;

- Adequate staff resources to support effective interagency communication and collaboration; and
- Opportunities to build capacity for transdisciplinary practice, where appropriate.

Possum Playgroup

Possum Playgroup offers a unique form of parenting and peer support for clients who do not feel comfortable participating in mainstream playgroups. An integrated care approach has been adopted, where a range of services, training and information sessions can be provided for clients in the form of a "one-stop-shop". The playgroup operates ostensibly like any other playgroup but includes professional input from staff from Drug Health, Midwifery, Newborn Care, Tresillian and the Social Work Department. A primary focus is on modelling parenting skills to clients and facilitating social skills development for children. Clients can access information and support from each other as well as staff, in an informal, non-judgmental environment, including in relation to their substance use and relapse prevention. The playgroup may further provide clients with babies in temporary care arrangements with an opportunity to spend time with their child, without being under the direct scrutiny of FACS.

In addition, Possum Playgroup can assist in maintaining continuity of care for clients after the birth of the child, and providing an avenue for follow-up of babies by RPAH staff, Neonatology, Newborn care and Community Paediatrics. The CNC nurse from Newborn Care runs the playgroup and often starts engaging with women during their antenatal care to encourage their involvement in the playgroup once their baby has been born.

Involvement in Pregnancy Family Conferencing

As discussed previously (see Governance p.5-6), PFC is a voluntary child protection programme jointly funded by SLHD and FACS that aims to bring families and staff from different agencies together with an independent facilitator to develop a plan for reducing risks to a client's unborn child. Given that responding to child protection matters is a core component of SUPPS service delivery, the SUPPS core team work closely with FACS and are often involved in the PFC programme.

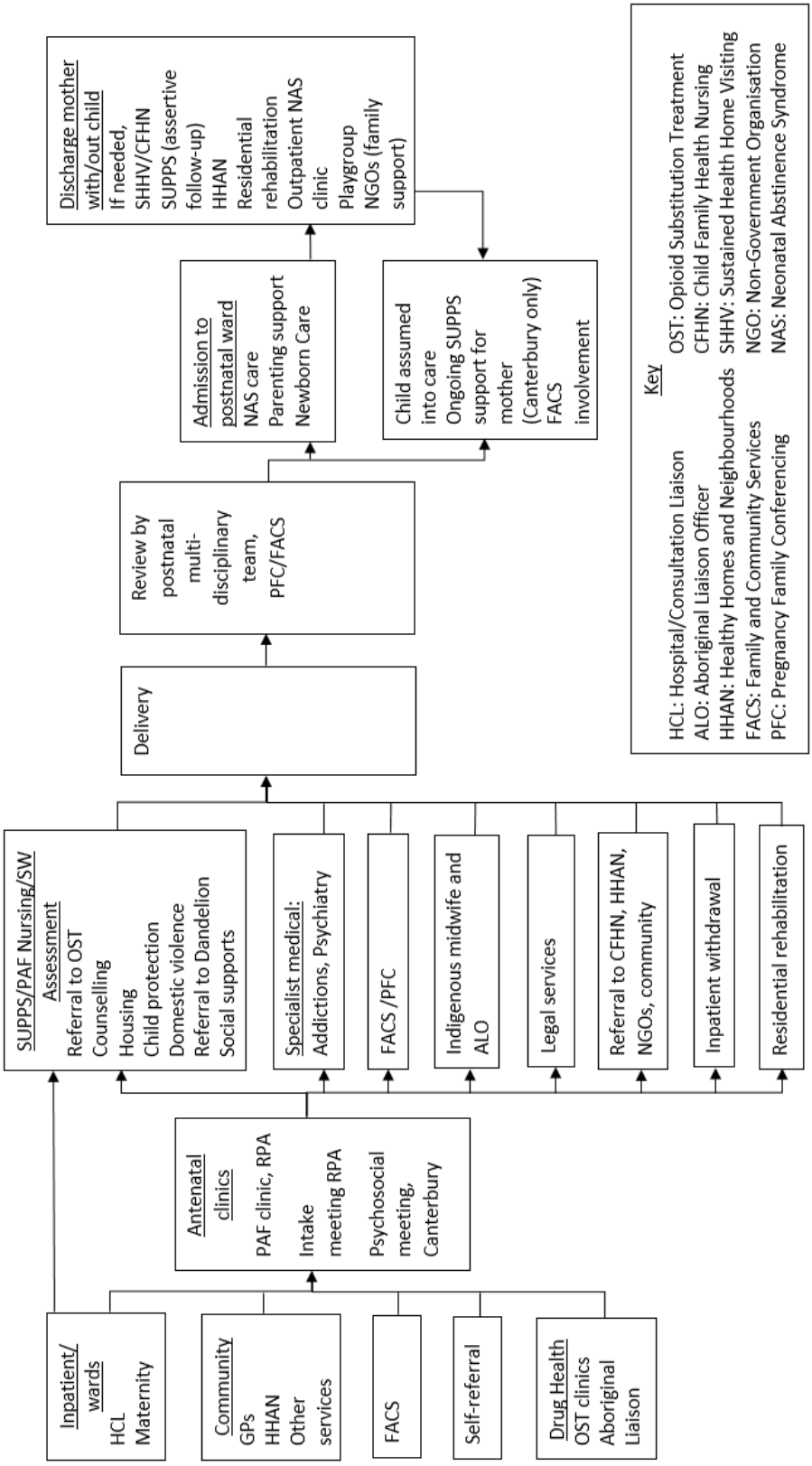
Early engagement of women in PFC during the antenatal period is the ideal (Tayebjee, 2017) and when possible, FACS prefer to hold three PFC meetings prior to the birth of the child. FACS's policy states that PFC cases will only be opened after 20 weeks gestation. Once child protection concerns have been reported to FACS, a case worker is allocated to meet with the client and their family to discuss their participation in the PFC programme.

Outcomes of the PFC programme appear promising. However, PFC meetings, as well as the preparation of these meetings, involves a considerable time commitment from staff.

Involvement of Aboriginal Workers

SLHD has a significant Aboriginal population, particularly in the Redfern/Waterloo area, in the City of Sydney and in Marrickville. In seeking to respond to the needs of this sizable population, Drug Health Services employs an Aboriginal Case Worker, Aboriginal Project Officer and an Aboriginal Magistrates Early Referral Into Treatment (MERIT) clinician. There is also an Aboriginal PAF midwife employed at Royal Prince Alfred Hospital.

Referral pathways and service linkages



Workforce Sustainability

Staff selection for SUPPS

In services such as SUPPS, where building relationships with clients is central to successful outcomes, selection of staff with the right attitudes, expertise and experience is crucial. The following characteristics are considered priorities among the core SUPPS team:

- Being passionate about working with SUPPS women;
- Being empathetic and non-judgmental regarding women who use substances;
- Being client-centred and willing to work in partnership with women and other services;
- Having life and work experience rather than being a new graduate; and
- Experience in drug and alcohol work as well as child protection.

Building and retaining staff knowledge

Providing ongoing training, mentoring, professional developmental opportunities and education to inform client-centred theory and practice frameworks is integral to optimal service delivery. This includes ongoing training and mentoring in areas such as drug and alcohol, trauma-informed care, child protection, relationship-focused practice and working collaboratively in interdisciplinary teams.

A commitment to support processes for evaluation and reflective practice to ensure accountability and best outcomes for clients ensures that RPA and Canterbury Hospital keep learning as an institution and move away from a crisis-driven model of care.

Addressing vicarious trauma and staff burnout

Management of SUPPS recognise the challenging issues faced by frontline service providers and the risk of vicarious trauma. In seeking to prevent staff burnout, induction support for new staff is provided as well as adequate supervision, mentoring, and opportunities for support and debriefing after critical incidents, as needed. Contingency planning for leave cover and staff turnover is also recognised as a strategy for promoting staff well-being and minimising the impact of the resulting disruption on work teams.

Measuring outcomes, data collection and research

For monitoring and evaluation purposes, and to assist in guiding resourcing, staff recruitment and clinical practices, measurable outcomes for SUPPs is vital. The development of integrated digital systems for capturing and storing screening and longitudinal tracking data, on women and children in SLHD, is a priority issue. This needs to be supported by strengthened academic leadership to inform service delivery and enhance research output in this area.

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