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Developing a model of care for Substance Use in Pregnancy and Parenting Services

Research 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
PAF	Perinatal and Family
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

Executive summary

Substance-using mothers often experience high levels of disadvantage, poverty, homelessness and unstable housing, unmet health needs and mental health problems (Taplin & Mattick, 2013). A significant proportion of these women have been subjected to domestic violence, and physical and sexual abuse in childhood (Taplin & Mattick, 2013) and have minimal social support. Research suggests that childhood abuse is likely to continue to negatively affect women throughout their life course (Berlin, Appleyard, & Dodge, 2011). Furthermore, substance dependence in mothers is a leading cause of child maltreatment (Comiskey, Milnes, & Daly, 2017; Onigu-Otite & Belcher, 2012; Schaeffer, Swenson, Tuerk, & Henggeler, 2013), and the impact of misuse of alcohol and drugs during pregnancy may have a significant bearing on the health and social development of the child (Ludlow, Evans, & Hulse, 2004; O'Leary, Nassar, Zubrick, Kurinczuk, & Fowler, 2010). The provision of drug and alcohol treatment and other interventions for pregnant women and mothers with substance use issues has the potential to break the intergenerational cycle of disadvantage and improve health outcomes for both the mother and the child (Ashley, Marsden, & Brady, 2003; Fowler, Rossiter, Sherwood, & Day, 2015; Niccols, Milligan, Sword, et al., 2012). However, significant structural and social barriers exist for women in relation to accessing care, and many are reluctant to engage with health services during pregnancy because of stigma, guilt and fear of losing custody of their children (Fowler, Reid, Minnis, & Day, 2014).

Substance Use in Pregnancy and Parenting Services (SUPPS) are specialist programmes that provide interventions before, during or after pregnancy, to ensure better outcomes for women with substance use disorders and their children. There is a need to identify evidence-based models of SUPPS service delivery in order to meet the complex needs of this group of women.

Project aims

During 2018, a research project was conducted in Sydney Local Health District (SLHD), to examine the existing evidence for a SUPPS model of care (MOC) and to develop an evidence-based, locally-appropriate model for SLHD.

Methodology

In Stage One of the project, a review of the literature was undertaken to identify effective non-pharmacological and psychosocial interventions for pregnant women and mothers with substance use issues. Stage Two of the project involved conducting semi-structured in-depth interviews with 38 staff in SLHD. While SUPPS and hospital-based services were a focus of the research, representatives of other services linked with SUPPS, with a key role in service delivery, were also included. Participants were selected on the basis of their willingness to participate and their role, ensuring that all aspects of service delivery and the diversity of clinical disciplines involved, were represented. Frontline staff and managers from the following services participated in interviews: Drug Health Services (DHS), Women and Babies services at Royal Prince Alfred Hospital (RPAH), SUPPS and Perinatal and Family Drug Health Services (PAFDHS) teams at RPA and Canterbury Hospitals, Child and Family Health, community services, Family and Community Services (FACS) and non-government organisations (NGOs). Interview data was analysed to identify themes related to key components of the MOC, including guiding principles, examples of effective services and interventions, recommended referral pathways and barriers to service delivery.

Stage Three involved conducting a workshop with stakeholders to obtain feedback on the findings of the research and the draft MOC.

Findings

Literature Review

A review of the peer-reviewed literature published between January 2008 and December 2018 was conducted to:

- identify non-pharmacological interventions utilised in SUPPS; and
- examine the evidence for the effectiveness of non-pharmacological interventions in order to inform the development of the SLHD MOC for SUPPS.

A total of 31 randomised controlled trials were identified, involving interventions including contingency management, brief interventions, motivational enhancement therapy and interviewing and attachment-based interventions. However, study quality was generally poor and given that most research was conducted in the US in disadvantaged African-American communities, the generalisability of findings to the Australian context was unclear.

The review highlighted the limitations of the existing evidence base for SUPPS and therefore, the limited capacity for findings to inform development of the SLHD MOC in a meaningful way.

Qualitative data

Guiding Principles

Three guiding principles for the MOC were identified by participants: client-centredness; integrated care; and harm reduction. Participants also highlighted four overarching practice approaches that were considered integral to the MOC: promoting engagement with clients, trauma-informed care (TIC), continuity of care and advocacy.

Effective service design

Strategies for promoting engagement were an important component of effective service design. Staff emphasised the centrality of building trust and rapport to facilitate disclosure of substance use-related issues. A non-judgmental, non-punitive approach was considered critical to building trust, as well as transparency regarding staff's mandatory reporting responsibilities. Staff highlighted the value of the Pregnancy Family Conferencing (PFC) programme for reducing assumptions of babies into care after birth. 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 the unborn child.

Maintaining continuity of care when a client moves in and out of hospital was one of the most commonly identified priorities in relation to the MOC. For many participants, the concept of continuity of care equated with continuity of staff, so the client could have the option of contacting familiar trusted staff when seeking assistance or support. Where staff from more than one service were involved, effective, timely information exchange was crucial. Many staff suggested that to facilitate continuity of care, workers involved in providing community follow-up after discharge needed to begin building a relationship with a new client antentally. A dedicated SUPPS midwife was also suggested to facilitate ongoing engagement in antenatal care.

Making services more client-centred required recruitment of staff with the right competencies, adopting a partnership approach to working with clients, enhancing trauma-informed work practices, and making services more accessible by adopting flexible approaches to service provision. For example, staff suggested reducing waiting times for antenatal care, providing drop-in services and being non-punitive when clients missed appointments. Outreach was also identified as a more accessible, non-threatening form of service delivery.

Possum Playgroup at RPAH was highlighted as a valuable part of service delivery. The playgroup offers a unique form of parenting and peer support for clients who do not feel comfortable participating in mainstream playgroups for fear of being judged regarding their substance use. In addition, Possum Playgroup could help maintain continuity of care for clients after the birth of the child, and was one of few avenues available for follow-up of babies by staff from neonatology, newborn care and community paediatrics.

Effective service delivery was also reliant on the capacity of staff to make referrals to agencies outside the health service. A number of service gaps hindered referral pathways. Staff reported that additional free drug and alcohol counselling was needed. In addition, lack of residential rehabilitation beds, public housing and support services for women after a child is assumed into care, also compromised service delivery.

To meet the needs of Aboriginal clients, the availability of Aboriginal workers with the capacity to provide intensive follow-up, more Aboriginal-specific rehabilitation services and refuges, prioritising Aboriginal clients for access to opioid substitution treatment (OST) and the involvement of Aboriginal community members and case workers in child protection matters, were considered important. In the Canterbury area in particular, provision of outreach services may be more effective for providing substance use-related support for Muslim and Arabic-speaking clients, in response to the significant stigma associated with substance use in this community. Data suggested that further research regarding the complex factors influencing engagement of these two populations with services is warranted, in order to inform decision-making about effective service design.

Barriers to service delivery

Data revealed three primary barriers to service delivery: lack of consensus regarding outcomes and scopes of practice; challenges with staff collaboration, intra and inter-agency cooperation, communication and knowledge sharing; and the need for appropriate institutional support and opportunities for clinical reflection.

Trust and engagement were considered the cornerstones of successful outcomes for clients. However, staff varied considerably in their perceptions of how far to go to engage with SUPPS women and how to practically apply continuity of care. Due in part to historical differences and different policies governing staff from different disciplines within the SUPPS/PAFDHS team, these inconsistencies had the potential to have a negative impact on a client’s engagement with a service, and to cause frustration and stress. According to some staff, too much ‘hand-holding’ would create or exacerbate dependence in a vulnerable client and potentially, skew the focus onto maintaining engagement rather than child protection, to the detriment of the child’s well-being. Other staff emphasised the importance of keeping the same familiar faces directly involved with clients wherever possible, to maximise engagement with the client and continuity of care from the antenatal period to post-delivery. Handover of clients to other staff meant clients would have to build trust with the new person all over again. Responding to crisis calls from clients was another policy area where opposing approaches to continuity of care were apparent, including to what extent clients can maintain contact with the same hospital-based worker after discharge.

Barriers to effective staff and service collaboration included fragmentation and siloing of services, a hospital-centric approach to service delivery, weak partnership structures, role ambiguity, limited trust, a 'hero' mentality among some staff, ineffective referral pathways and miscommunication. Conflict between staff and duplication of work was frequently reported at times when multiple staff members were working with the same client. Misunderstandings between inpatient hospital staff and community teams were a commonly reported cause of frustration. Difficulties with information sharing, including lack of integrated electronic referral systems, was also identified as a barrier to service delivery. To aid in this regard, staff suggested transdisciplinary practice and cooperation be modelled at all levels of leadership.

A strong need to establish formal agreements and shared policies between partner services, and for better processes around information sharing, referral pathways and community follow-up, were also identified. Improving staff's understanding of the diverse service goals across agencies, embedding collaboration into everyday work practices and allocating adequate staff resources and time to support effective mechanisms for information exchange, would also address barriers to collaboration. A perinatal coordinator was suggested to maintain continuity of care and oversee referral pathways between hospital and community.

Many staff felt unsupported in providing the types of care required to work in a trauma-informed, client-centred way. Work intensification was a significant problem for staff dealing with high-needs clients. Work intensification can arise if there is a mismatch between expectation of service delivery and size of case load. The need for health service managers to recognise the taxing nature of these roles was highlighted by many participants. A large proportion of staff articulated the need for more support and debriefing opportunities in light of the challenging work performed. The biggest obstacles to supervision and reflection was time constraints. Improving staff access to formal and informal support, supervision and reflective practice would act as a protective mechanism for staff against stress and burnout.

Governance and resources

As discussed, fragmentation and siloing of services created barriers to integrated service delivery. While the clients of SUPPS may require particular forms of support and assistance related to their substance use, it is recognised that they are also part of a broader population of vulnerable families in SLHD considered a priority group for hospital and community-based service provision. The suggestion was made that successful service delivery was best supported by a diverse leadership team representing stakeholders across hospitals, services and disciplines. A shared vision, commitment to resource sharing, clear goals, clinical indicators and accountability processes, were also considered necessary. It was reported that community and non-government organisations may also have a role within such a governance structure.

A districtwide approach to funding and governance, overseeing a consistent MOC across SLHD, would enable not only integrated service delivery but also efficient, targeted and equitable use of resources.

Adequate resourcing of services, including medical coverage, would assist in ensuring the provision of quality care as well as reducing staff turnover and burnout. Such an integrated service structure would also need a consistent name.

Clearly articulated and measurable outcomes for SUPPS need to be established, to facilitate monitoring and evaluation as well as to guide resourcing, staff recruitment and clinical practices. In addition, the development of appropriate data collection systems and academic leadership for SUPPS were suggested to inform service delivery and re-establish a focus on research in this area.

Feedback workshop findings

The feedback workshop identified key issues to be addressed in order to translate the MOC into practice. The outcome of the workshop was to work towards establishing working groups for each of these issues.

Conclusions and recommendations

The research identified guiding principles, practice approaches, strategies and interventions relevant to the SUPPS MOC for SLHD. The literature review highlighted the limitations of the existing evidence base for SUPPS and therefore, the limited capacity for findings of the review to inform development of the MOC in a meaningful way. The strength of the research methodology adopted for the project lies in the qualitative data obtained from in-depth interviews with staff. As well as exploring staff's perspectives of what should be included in the MOC and barriers to effective service delivery, the interviews provided opportunities to understand why staff held these views. In this way, data revealed the structural, institutional and individual-level drivers of these perspectives and the organisational context in which the MOC is embedded. Findings will inform the MOC, as well as the way forward in terms of translation into practice.

Against a backdrop of limited research evidence supporting particular interventions for SUPPS, the data-informed MOC developed through the project serves as a locally-appropriate guide for service provision in SLHD but in many ways, is only a starting point. The MOC needs to remain a live document and be viewed as a work-in-progress, that can be adapted to reflect an emerging evidence base and the changing context in which SUPPS and related programme operate.

A strong theme of the data was that several aspects of SUPPS-related policy and practices in SLHD were contested. Service delivery was at times heavily influenced by the preferred approaches of the staff involved rather than SUPPS-specific policies or set referral pathways. While the dedication and personal qualities of staff, and flexible approaches to care provision, were often among the greatest strengths of services, competing staff priorities and opposing philosophies could create inconsistencies with the potential to negatively impact on staff well-being and outcomes for clients. As a result, the MOC informed by the research requires further refinement prior to implementation, subject to consensus being reached regarding particular issues. Resolution of some of the barriers to effective service delivery was beyond the scope of this research and addressing them will require the input of relevant stakeholders.

Seven major recommendations arose from the research.

1: Shared governance over a dedicated SUPPS team

- A governance group comprising representatives from Drug Health, Social Work, Women and Babies, Child and Family Health and other community services. This may warrant pooling of all SUPPS-related resources, to support staff operating under a SUPPS-specific vision, scope of practice and overarching framework. Funding enhancements may be required.
- Operationalising shared governance including agreeing on leadership and other roles and responsibilities of group members.
- Measurable outcomes for SUPPS agreed upon by the governance group.

2: A districtwide model of care for SUPPS

- A consistent MOC for SUPPS and related programmes across SLHD to maintain continuity of care between RPA and Canterbury Hospital, to enable integrated service delivery and efficient, targeted and equitable allocation of SUPPS-related resources.
- A consistent name for SUPPS and related programmes in SLHD.

3: A consistent scope of practice

- Consensus regarding clinical practices in the following areas: promoting engagement with clients; continuity of care; and collaboration within and across agencies.
- Regular meetings of SUPPS and related teams for ongoing reflection around best practice.
- Explore options for reducing inconsistencies in ways of working across Social Work and Drug Health at RPA, including employment of a Social Worker directly under Drug Health.

4: Enhancing collaboration

- A less hospital-centric approach to service delivery to facilitate effective knowledge sharing, referral pathways and communication across agencies. This involves establishing better referral pathways to the community and general practice as part of antenatal care and improving ways of involving community workers during a client’s inpatient stay.
- Employment of a perinatal coordinator to coordinate and oversee continuity of care and referral pathways.
- The development of formal processes for identifying a key worker. This involves staff reflecting on who has the best relationship with a client, and other staff providing wrap-around support for the key worker.
- Regular intra and inter-agency meetings to build trust and networks between professionals and organisations.
- The development of policies around how to collaborate across agencies, including the establishment of formal agreements and shared policies between partner services.

- Flexible work practices and the allocation of sufficient time to facilitate collaboration.

- Processes and digital technologies that aid in more effective sharing of information.

5: Effective service delivery

- Flexible, client-centred service delivery. This includes:
    - Soft entry points, non-threatening, indirect and informal services
    - Warm (and/or facilitated) referrals
    - Services that encourage “drop-ins”
    - Outreach
    - Reduced waiting times.

- Reducing the number of psychosocial assessments for new SUPPS clients, as part of trauma-informed care. For example, nominating one staff member to undertake and then disseminate a thorough psychosocial assessment.

- A greater focus for SUPPS and related programmes on postnatal support. The role of inpatient staff at RPA in providing outpatient care or outreach, and the duration of follow-up, requires clarification. More opportunity for RPA staff to follow up with families post discharge is recommended, to maintain consistency in the MOC across the district.

- Evaluation of, and sustainable funding for, Possum Playgroup.

- The need for more Aboriginal workers to provide intensive follow-up, more Aboriginal refuges and residential rehabilitation programmes. Priority access to OST, as well as greater involvement of Aboriginal community members and case workers in child protection matters, is also recommended.

- More research to inform SUPPS service delivery for Muslim and Arabic-speaking clients in the Canterbury area.

- Ensuring adequate medical coverage for SUPPS and related programmes.

- Employment of a SUPPS midwife at RPA (in addition to the existing Indigenous midwife).

6: Workforce sustainability

- Increased institutional support to prevent burnout. This involves a greater acknowledgement from management of the challenging issues and vicarious trauma faced by frontline staff.

- Adequate supervision, mentoring and induction support for staff, opportunities for support and debriefing after critical incidents, and better contingency planning for staff turnover.

- Providing ongoing training and mentoring, particularly in trauma-informed care and working collaboratively.

- Developing processes for evaluation and reflective practice to ensure accountability and best outcomes for clients and move away from a crisis-driven MOC.

7. Measuring outcomes, data collection and research

- Integrated data collection systems to facilitate monitoring and evaluation, capture screening and longitudinal tracking data in relation to maternal and child outcomes, and inform service planning, staff recruitment, policy and resource allocation.
- Academic leadership of SUPPS to address the lack of SUPPS-related research and to inform the MOC and policy development.

Research Report: Developing a model of care for Substance Use in Pregnancy Services

Introduction

As health inequalities for individuals living in pervasive social exclusion continue to grow (McLachlan, Gilfillan, & Gordon, 2013), the complex and interrelated issues that contribute to poor outcomes for people experiencing disadvantage have become the focus. Service initiatives designed to address the complex nature of social exclusion and inequality need to be developed (Eastwood, 2017; Grace, 2015).

Substance use for mothers and pregnant women is associated with a distinct constellation of risk factors. Severe disadvantage and social exclusion is likely to persist through familial generations (Saunders, Naidoo, & Griffiths, 2007; Vinson & Rawsthorne, 2015) and often includes adverse social, mental and physical health issues, limited social capital, and problematic substance-use (Price-Robertson, 2011). Women experience particular vulnerabilities in relation to their general health, mental health and the social consequences of problematic substance use compared to men, and their health and well-being often deteriorate more rapidly (Milligan et al., 2010). Substance-using mothers often experience high levels of disadvantage, due to poverty, homelessness or unstable or unsafe living situations, unmet health needs and high rates of mental health problems (Taplin & Mattick, 2013). A significant proportion of these women have been subjected to domestic violence, and physical and sexual abuse in childhood (Taplin & Mattick, 2013) and have minimal social support. Research suggests that childhood abuse has ongoing negative affects throughout a person’s life course (Berlin et al., 2011).

Substance dependence in mothers is a leading cause of child maltreatment (Comiskey et al., 2017; Onigu-Otite & Belcher, 2012; Schaeffer et al., 2013), and the impact of misuse of alcohol and drugs during pregnancy may have a significant bearing on the health and social development of the child (Ludlow et al., 2004; O'Leary et al., 2010). However, substance use alone does not correlate with child maltreatment. Previous research reveals that it is the social determinants of health and disadvantage intertwined with problematic drug use that create adverse social and health outcomes for children (Dawe & Harnett, 2007).

The provision of drug and alcohol treatment as well as other interventions for women with substance use problems who are pregnant or parents, has the potential to break the intergenerational cycle of disadvantage and improve health outcomes for both the mother and the child (Ashley et al., 2003; Fowler et al., 2015; Niccols, Milligan, Smith, et al., 2012; Prendergast, Messina, Hall, & Warda, 2011). Although women who use substances are less likely than men to access drug or alcohol treatment over their lifetime (Greenfield et al., 2007), pregnancy often presents a window of opportunity for women to seek assistance with addressing their substance use (Fowler et al., 2014). However, significant structural and social barriers exist for women in accessing such services due to stigma, guilt and fear of losing custody over their children (Fowler et al., 2014; Stringer & Baker, 2015).

Substance Use in Pregnancy and Parenting Services (SUPPS) are specialist programmes that provide timely interventions before, during or after pregnancy, to ensure better outcomes for women with substance use disorders and their children. SUPPS offer antenatal and post-natal care, outpatient follow-up and home-visiting, assist pregnant women in planning for discharge from hospital to ensure continuity of care after birth, and address issues related to parental substance use that may impact on the newborn child or the mother. SUPPS have also been found to increase women's access to social support and offer much needed guidance and encouragement in relation to parenting and the mothering role (Fowler et al., 2014). The women accessing SUPPS are likely to be dealing with more than one form of disadvantage and experience multiple and complex barriers to individual well-being, community participation and service access. These types of contextual factors have many implications for service design.

In SLHD, SUPPS provide care to women across two socioeconomically diverse regions which include pockets of severe social disadvantage. Although there exists an overlap of risk factors across the areas where RPA and Canterbury Hospitals are located, there are significant differences between the two populations. DHS in inner-city Sydney services a high population of Aboriginal women while Canterbury Hospital provides services to a more multicultural population including a significant Arabic-speaking community. Although drug and alcohol issues are highly stigmatised within mainstream Australian culture, such stigma may be heightened for individuals from a Muslim background, which compound the barriers and difficulties experienced by Australian Muslims with substance use issues (Unlu & Sahin, 2015).

The aim of this research was to develop a sustainable and equitable service model for pregnant women or mothers who use substances. This report presents the findings in relation to stakeholders, service providers and staff perceptions of the most effective way to provide SUPPS and related programmes in SLHD.

Methodology

Two data sources informed the development of the MOC: a literature review and semi-structured in-depth interviews with SLHD staff involved in delivering SUPPS-related services.

Literature Review

A review of the peer-reviewed literature published between January 2008 and December 2018 was conducted to:

- identify non-pharmacological interventions utilised in SUPPS; and
- examine the evidence for the effectiveness of non-pharmacological interventions in order to inform the development of the SLHD MOC for SUPPS.

A total of 31 randomised controlled trials were identified, involving interventions including contingency management, brief interventions, motivational enhancement therapy and interviewing and attachment-based interventions. However, study quality was generally poor and given that most research was conducted in the United States in disadvantaged African-American communities, the generalisability of findings to the Australian context was unclear.

The review highlighted the limitations of the existing evidence base for SUPPS and, therefore, the limited capacity for findings to inform development of the SLHD MOC in a meaningful way.

Interviews

Semi-structured in-depth interviews were conducted with SLHD staff engaged in SUPPS-related service delivery. A purposive sampling frame was chosen where participants were recruited based on pre-selected criteria such as their work role and clinical discipline (Coyne, 1997). While SUPPS and hospital-based services were the primary focus of the research, representatives of other services linked with SUPPS, with a key role in service delivery, were also included. Chain referral sampling (also known as snowballing) was also used as a recruitment strategy. Research participants suggested other staff or services whose views should be included in the study.

A topic guide was developed for interviews, exploring key themes such as: key concerns about the current MOC, facilitators and barriers to effective service delivery, gaps or breakdown points in the system, and suggestions for improving service provision. The semi-structured nature of the interviews enabled the researchers to explore additional issues emerging during interviews relevant to the aims of the study.

A total of 38 participants were interviewed, 32 individually and on three occasions, in pairs. Most interviews were approximately one hour in length (range: 33 to 107 minutes). Frontline staff and managers from the following services participated in interviews: DHS, Women and Babies services at RPAH, SUPPS and PAFDHS teams at RPA and Canterbury Hospitals, Child and Family Health, community services, FACS and NGOs. Eleven staff approached by the researchers declined to participate or did not respond to invitations within the timeframe allocated for data collection.

With one exception, interviews were digitally recorded and transcribed verbatim. One participant declined to be recorded but was willing for notes to be taken during the interview. All interview data was read by both researchers. Data were coded using NVivo. Initial codes were broadly based on the five primary interview questions. Both researchers (HC and MM) independently coded the first five interview transcripts and then met to compare their analyses and emerging codes, in order to develop a consistent coding framework. Following this, each researcher independently coded 15 of the remaining interviews and read the other's coding and analysis. Once all data was analysed, both researchers collaborated to finalise the codes and identify key themes. A workshop was conducted with key stakeholders to obtain feedback on the findings of the analysis and further inform the MOC and its translation into practice.

Ethics approval for the project was obtained from SLHD Ethics Review Committee (RPAH Zone).

Qualitative Findings

Section 1: Guiding Principles for the Model of Care

Participants identified three guiding principles for the MOC:

1. Client-centredness
2. Integrated care
3. Harm reduction

1. Client-Centredness

The majority of participants referred to client-centredness as a primary component of the SUPPS MOC. In a health care context, client-centredness relates to the dynamics of professional-client interactions, particularly the inclusion of clients in decisions regarding their care. Emerging in the 1960s, in parallel with the political changes of that time, client-centredness represents a shift away from expert-driven models and medical paternalism towards an approach that recognises a patient's right to autonomy and choice when it comes to the conduct of health care (Hughes, Bamford, & May, 2008). Among participants, client-centredness was about taking the time to engage with clients in order to understand their goals and assist in developing a plan for achieving them.

> *I think client-centeredness again takes time. You need to have the time to actually get to know your clients and allow for a trust to develop. Client-centred means to me, in theory, that it should be client goals you're moving towards. It's about what's important in their life rather than what we, as health professionals, may see as more of a priority. So, it's about having the big picture while understanding that actually this is the client's life. It's their life. They should be making the choices about their life with the understanding that they know – everyone knows that they have an understanding of the consequences of their actions. Just because that's our goal doesn't mean it's necessarily theirs and perhaps if we help them with some of their earlier goals, perhaps we'll move together towards what we see as more of a priority. They're very much caught in the present, not the future. (Frontline staff)*
>
> *Being really flexible, you know, how and when and where you meet, validating the experience is massive, so always listening to them, their take on it, their story and their back story. [W]hat's worked for them in the past, what they're prepared to do, what's led them to this, what are their kind of stresses or factors that maybe led them where they're at now. It can really be valuable stuff, what their experiences are with services and what their goals are, what do they want that's not imparting what they should be trying to do. (Frontline staff)*

Some participants felt client-centredness was best supported by a partnership approach, where the expertise of all parties involved was recognised. According to this approach, clients were considered experts in their own health.

> *What I understand better is the idea of a partnership with your client. When I trained as a doctor and the way I train our doctors is it's a partnership. They [the client] are an expert in their own child's health, they're an expert in their own health to some degree, and you're also an expert and so it's valuing their opinions about what's going on with their child or what's going on with their pregnancy, and then you obviously carry some expertise as well. (Manager)*

However, some staff questioned just how client-centred services were, particularly in hospital settings where approaches sometimes privileged biomedical expertise or health professionals' preferred clinical practices over the client's voice.

> *Whatever we call it, whether it's person-centred or partnership-centred or strength-based, it's probably not happening here, and it's because we're working on an expert model where you are the expert, not recognising that the patient is also an expert in their own health. So it's about that parent control between the clinician and the client. (Manager)*

> *I think sometimes the multidisciplinary team dynamics takes no-one into account, what the client actually wants. They just like, "Okay, this is how we've done it for a long time" rather than advocating for the actual client. (Frontline staff)*

Advocacy for clients, who were typically a disadvantaged group, was often considered a critical component of a client-centred approach, to allow a client's voice to be heard. Some participants expressed concerns about how well staff advocated for clients and highlighted the need for greater accountability for, and evaluation of, this important aspect of their work role. In addition, a lack of established mechanisms for gathering client feedback was reported to be a problem.

> *So it's about advocating a little bit more for these women and I don't think the organisation know how to do that. (Frontline staff)*

> *I hope our practice is client-centred but I don't think there's anything built in to the position. We're not asking clients – obviously you can measure it from the way clients engage with people in a way, and the outcomes that they have, but there's nothing actually built in to the position that says these clients have to have a voice here. It's totally reliant on you as a worker to kind of get the feedback from your clients yourself. (Frontline staff)*

> *I guess it's just a more client-centred approach because we're not just talking about how the clients are going, we're talking about what we're doing with the client and what's effective, and if something isn't working, then we all should know about it. And if something is really working that is running well to it, then we can draw that strength and that positive gain. (Frontline staff)*

Some clients needed more advocacy than others. According to one participant, there were inequalities in clients' access to care. More articulate or assertive clients could receive a different standard of care compared to those less adept at speaking out regarding their needs.

> *We're finding that women who are really articulate, whether or not they have a higher education, will receive a different type of service. It can go either way; decisions affect the safety of a child, safety seems to be downplayed when the woman is more articulate. (Manager)*

Client-centredness was also shaped by staff's varied perceptions of who was the priority client. Most participants subscribed to the view that a client's family relationships were key considerations when seeking to understand a client's issues within the context of their personal circumstances. During interviews, staff often referred to family-centred practice. However, many participants reported prioritising the woman or children. For example, for midwives, the woman was often considered the priority. While the well-being of the unborn child was important, it was the woman who was situated at the centre of care provision.

> *I think it's about person-centeredness and being holistic. I worked in paediatrics before I was a midwife, so we're very family-centred, whereas in midwifery, we're more woman-centred. But I think people just have to remember that we're a woman-centred model and that's what we're here for. (Frontline staff)*

Many participants reported that Drug Health staff focused on the woman, first and foremost.

> *A lot of this comes – it's drug health driven. It's the women rather than the families. The families are important too, but it's just a different focus. (Frontline staff)*

FACS workers and Drug Health staff were often reported as having different clients, the former prioritising children and the latter, women.

> *FACS think that we just care about the women and the drug use, and it's their job to care about the child. So, it's my job to advocate for the lady, as well as her baby, and to see what the end result is. (Frontline staff)*

According to some participants from neonatology, post-natal care, paediatrics, Child and Family Health, their focus was on the babies.

> *So I would usually meet the women postnatally. So, ____, she's one of our nurses, so we kind of work together as a team. She tries to meet these women antenatally, if she can, but she's not employed fulltime, and she's a neonatal nurse primarily. That's not a dedicated funding position – should be, but it's not. And then together, one of us usually sees the women and babies after the baby is born. So, my primary interest is the babies and the families. I always start with the baby and then work back, whereas I think most of the adults, obstetricians, they start with the mum and work down. So, our focus is – I interact with the mum after I've seen her baby. (Frontline staff)*

> *Our reflective function needs to be more focused on the baby. I mean, the baby and the whole family. So there's a lovely diagram of whatever on the outside, and the baby is in the middle. So the baby with the family around the baby and then, our services should be around the outside of that. For me, the baby is the centre,*

> *because that's where I come from. And I think if we can actually focus these families on their baby, then that's worth a million things. (Frontline staff)*
>
> *But I think child and family nursing is both very, only because they have open cases for both mum and babies, so we're very much work with more the baby by that time, the family nurses, I think, work for both ways. (Frontline staff)*

It was often staff in community-based services who prioritised families.

> *Well I don't think it was built into the original design. But I think there's been some discussion over the last couple of years, probably pushed a bit by us, that in fact they need to involve the wider family group. And I think that FACS New South Wales has been starting to look at that, and starting to bring that into the discussion as well. [T]hey have now realised that the strengths are actually in other family members, and they're actually networking – they're actually mapping the families and working out where the strengths are in the family groups, and then using those strengths to support the clients. (Manager)*
>
> *So I think it [SUPPS] needs to be patient and family-centred and it needs to operate from a point of view of what is it that the family needs and what are their goals and what are their requirements from the healthcare system. (Manager)*
>
> *We're quite unique in that space. Challenges in our role are linked a lot to that not too many, if any other services – they may be aware of the needs of the other family members or the impact of the parent on what's happening with the children, but it's not to say that they would take steps to just take that really holistic whole of family view. So, it's quite a new space. (Frontline staff)*

Some participants highlighted that focusing on families also included providing services for fathers, not just mothers and children. The gap in service provision for fathers was highlighted by some staff who emphasised that fathers were still part of the family unit, even when there were domestic violence concerns.

> *Lots of services say they're child and family but they're not, they're mother-child. So, when we say we're whole of family, we're whole of family and we'll put just as much effort into care coordinating a father than we do a mother, partly because we know that there's so many services out there that will support the mother. Probably less services will support the dad so sometimes we do put more effort into supporting fathers. But that's another thing that concerns me. When we say we're a child and family, we are; we're child and the whole family. And when it comes to domestic violence and really complicated domestic violence relationships–it's not just black and white, you need to stop a father from seeing his child. (Manager)*
>
> *But in my head, I will be going I want to explore all avenues for everybody because we've gotta find placement for this baby and even if dad's not gonna be with mum, we want dad to be the best dad he can be and just to tell dad to go to counselling and to go to his GP to sort out his very complicated health problem*

> *isn't enough. He can't do it. He's crying when he comes here. He's beside himself. He doesn't know what to do. (Frontline staff)*
>
> *People would do anything to avoid working with the dad. So then you'd be like "No, you need to work with the dad. If he's at the home and he's part of the family, you can't avoid him. And if you're scared of him, imagine how mum and her kids are. (Manager)*

Participants did not indicate that these varied perceptions of 'the client' had a negative impact on the care clients received. However, there is potential for these disparities to influence the way staff in different services collaborate and view their roles (See Section 3B: Challenges with collaboration).

Overall, client-centredness was clearly considered integral to the MOC. However, data suggested this did not always translate into client-centred practice. Further research on barriers to client-centred practice may be warranted, to inform the development of policies and practices that serve to embed client-centredness in service delivery. In particular, making the partnership approach work, in terms of strategies for negotiating the intervention plan when health professionals' and clients' priorities conflict, requires further investigation.

2. Integrated care

Many participants identified the need to provide integrated health services that were easily accessible for clients, and to ensure professionals from different disciplines, hospital departments or services, work together effectively to deliver care (King & Meyer, 2006). In theory, integrated health care represents a client-centred approach to service delivery, designed around the needs of individuals, their families and communities. Integrated health service delivery has been defined as:

> *An approach to strengthen people-centred health systems through the promotion of the comprehensive delivery of quality services across the life-course, designed according to the multidimensional needs of the population and the individual and delivered by a coordinated multidisciplinary team of providers working across settings and levels of care. It should be effectively managed to ensure optimal outcomes and the appropriate use of resources based on the best available evidence, with feedback loops to continuously improve performance and to tackle upstream causes of ill health and to promote well-being through intersectoral and multisectoral actions (World Health Organization, 2016).*

The delivery of integrated care has been identified as a key NSW government health priority (NSW Legislative Assembly Committee on Community Services, 2018; NSW Ministry of Health, 2018). In the context of services for pregnant women with substance use issues, ideal integrated care models take an ecological approach (Milligan, Usher, & Urbanoski, 2017), bringing together substance use treatment programs, antenatal care, perinatal coordination, place-based hubs, parenting programmes, and child and family health initiatives (Blakely & Bowers, 2014; Eastwood, 2017; Goler, Armstrong, Taillac, & Osejo, 2008; Milligan et al., 2010). This kind of model is designed to reduce barriers to women engaging with services (Eastwood, 2017), reduce maternal substance use (Milligan et al., 2010), and enhance parenting skills (Niccols, Milligan, Sword, et al., 2012). However, while research suggests integrated programmes may be effective in reducing maternal substance use, such programmes were not associated with significantly more reductions than non-integrated programmes

(Milligan et al., 2010). Further research is needed to ascertain the effectiveness of integrated care for this population of women. In addition, the absence of an evidence-based theoretical model for integrated care, or a common understanding of how services should be offered, hinders the implementation of this promising approach (Lynham, 2002; World Health Organization, 2016). Systemic barriers related to funding and documentation, and professional barriers, including staff understandings of substance use disorders and the effects of trauma, also act as barriers to integrated care (Blakely & Bowers, 2014).

Participants described integrated care as a synthesis of health and social care, where recognition by service providers of the impact of the social determinants of health (Graham, 2004) underpinned the way services were provided.

> *I'm on a bit of a bandwagon at the moment about health and social care. So we gotta actually move from just thinking within health, which is a euphemism for disease and physical health – and actually thinking about health and social care. It's also about social determinants of health, about social inclusion. So we need to restart thinking about that social domain, and what is that social domain actually about in this biopsychosocial domain? So how are they all interacting with each other? (Manager)*

> *Integrated care is actually having a true understanding about the social determinants of health. An example of that would be a social work counsellor who's counselling one of my clients. Mum and child have mental illness. Mum is on Job Start so that means she's supposed to work somewhere between 25 to 30 hours per week to actually get the equivalent money from the government. She rents privately. She goes to charities for bills support. But the psychiatrist is only available one day a week and realistically only half a day a week and the counsellor herself is only available three days a week. And unfortunately, those three days a week coincide with mum's working hours. So, we had a discussion the other day. This worker has actually reported the mother to FACS for medical neglect. And so, we had a discussion about the child not turning up to her appointments, some of which is definitely the child's mental health and the mum just can't get the kid out of the house. So, just having an understanding of how challenging it can be to parent these children that flat-out refuse when they're older. You can't bolt them in the car seat like when they're three anymore. It's a matter of negotiation to get her out the house. So, making a 9:00 AM appointment is setting her up for failure. At one stage I was given the answer, "Well, if it was important to her," i.e. mum, "She'd get her there," and I went, "Well, actually, if we consider if she doesn't go to work, she doesn't get paid, she doesn't put food on the table and she's at risk of being evicted 'cause she doesn't pay her rent. (Frontline staff)*

In SLHD, both RPA and Canterbury Hospitals have sought to adopt an integrated care approach for providing perinatal care for women with substance use disorders. A range of departments and services are involved, including Drug Health, Women and Babies, Social Work, Neonatology and Child and Family Health. With integrated care a centrepiece of the MOC, further investigation of specific barriers to integrated care in the SLHD context would assist in identifying strategies for ensuring the effectiveness of this service model.

3. Harm reduction

Harm reduction was the third principle reported by participants to be fundamental to the MOC for SUPPS and related programmes, particularly in relation to child protection and what constitutes a risk of harm to children. Harm reduction is one of three pillars of the Australian Drug Strategy, aimed at reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community (Department of Health, 2017) 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. The defining features are the focus on the prevention of harm, rather than on the prevention of drug use itself, and the focus on people who continue to use drugs.”*

Harm reduction-based services can facilitate engagement of people who use drugs in health services by reducing the stigma associated with drug use (N. Lee & Petersen, 2009). Improvements in clients’ social functioning and quality of life, and changes in substance use, have also been reported as outcomes of harm-reduction programmes (S. Lee & Zerai, 2010). In the context of SUPPS programmes, the philosophy of harm reduction is demonstrated by a shift in attitudes away from assumptions that abstinence is always an absolute requirement for maintaining custody of babies and children. Health workers’ perceptions of substance use can be readily shaped by judgemental paradigms that often associate substance use with “loss of the ability to care” (Benoit et al., 2014). Framing substance use in this way does little to shift perceptions away from condemnation and the “stigma life sentence” of addiction (Lloyd, 2010). Socio-structural factors that limit women’s options for mitigating the potentially harmful impacts of substance use need to be acknowledged (Graham, 2004; Roberts & Pies, 2011) and there is inherent unfairness in a system that expects disadvantaged women to provide their unborn children with safety and health care when women themselves are unable to access it (Flavin & Paltrow, 2010).

Many participants emphasised that for some women, abstinence was not a realistic goal and that reducing drug use may be enough to reduce potential risks to the child’s welfare.

> *Abstinence may not be the main goal at all. It’s not realistic and you're just setting them up to fail, and it’s not even the main issue. (Manager)*
>
> *That’s very subjective as to what’s considered good parenting. And the other tension with that is we also work in drug and alcohol from a harm minimisation point of view. So people would say no drug use is the ideal but that’s not necessarily the way drug health operates and so that creates a tension between how do you work with parents from a harm minimisation framework when you’ve got children in the picture. So, it not might be not be about enabling safe drug use because you might need to actually do more than use safely. You might actually have to reduce your use or not use at all. (Manager)*

Drug Health staff were frequently advocates for harm reduction, and the view that pregnant women with substance use problems, who have appropriate treatment and supports in place, could fulfil the motherhood role.

> *It's not about having them abstinent because sometimes abstinence doesn't work for everybody but it is about that harm minimisation model and we talk to FACS about that as well. Decreasing cannabis use so that you're not smoking a gram a day to maybe a couple of cones to be acceptable. Or instead of injecting, you're actually now on OTP [opioid treatment programme]. It's about step by step working towards abstinence. But it's okay that they're not abstinent from the very get go and that is a huge part of our role in SUPPS because not everyone is drug-free. (Frontline staff)*

> *You know, trying to shift that focus, especially in the children's space. We often get people asking us how much drugs or what drugs and how much is it okay for a parent to use, and we change their way of thinking, that it's not about what and how much. It's about how does that drug use impact someone's parenting? So trying to shift their way of looking at things as well. (Frontline staff)*

Drug Health staff were arguably more familiar with the concept of harm reduction. Some participants felt other disciplines were less accepting of this approach and more comfortable with expectations that mothers remain abstinent.

> *I think drug and alcohol get that harm minimisation model, but it's our outside influence, maternity services, child and family health that don't have an understanding of harm minimisation because they think that a good parent is a non-drug using parent so anything in between does not work. And I've had midwives say to me, "I don't think this baby should go home" "Why?" "Well, you know, she is still smoking a cone or she's on methadone. What if she overdoses? She gives the baby some methadone to keep her quiet?" And I often say these mums love their babies no different to any other woman that's on this ward and they should be treated like every other woman on this ward, and that's what we advocate all the time. (Frontline staff)*

Maternity, social work, child protection and Drug Health staff reported that there had been a shift in FACS' approach to harm reduction and this had resulted in less babies being assumed into care.

> *I've been here for long enough now that I've seen lots of our families now taking their babies home, whereas five years ago, without even thinking about it, assumption of care. And lots of that has been through a change in FACS' interests, and threshold levels as well and you've gotta be pretty much an axe murderer to have – to lose your child now, or have serious DV to lose your child. And even then, you can still be a murderer and keep a child – we've seen that in the last six months here. So, their threshold is so high now. (Frontline staff)*

> *So, I mean last couple of years, it's been the case. I think more recently we've [FACS] been a bit more creative. We're sitting with harm or risk much more than*

> *we used to, much more. For example, when drug health hears that a client's used, then that's part of recovery, whereas in the past, when we've heard that our client used, we're thinking immediate risk or potential safety risk. That's changed now. We're sort of a bit more aligned with the fact that the parents will relapse, they'll slip, they'll fail – as long as we are able to have a safety plan and support people around that and that also depends upon what actual danger or harm has been vested upon the child, so – but we're much more open to sitting with that sort of risk. (Frontline staff)*

Previous research also suggests that adoption of a harm reduction approach enhances collaboration between addiction and child welfare services (Drabble & Poole, 2011).

Harm reduction as a guiding principle of the SLHD MOC for SUPPS is a step in the right direction towards resisting stigmatising representations of women who use substances, and the provision of accessible services that reflect the everyday realities of clients' lives.

Practice approaches embedded in the model of care

In addition to the three guiding principles, participants highlighted four practice approaches that were considered integral to the MOC:

I. Promoting engagement with clients;

II. Trauma-informed care;

III. Continuity of care: referral pathways from hospital to community; and

IV. Advocacy: responding to stigma and discrimination.

Promoting engagement with clients

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 (Fowler et al., 2014; Stringer & Baker, 2015). Promoting engagement with women was one of the main themes in the interview data when it came to effective approaches to service delivery. Pregnancy and antenatal care could provide a window of opportunity to engage with women regarding their substance use, in the context of other priorities associated with their motherhood role (Fowler et al., 2014). Some participants believed pregnancy could be a catalyst for change.

> *I think most of the women do wanna change and this is a good opportunity for them and I think we have to remember that this is often the reason that they change their habits or whatever. It's because they're pregnant and whether they know – they've had babies before that have been removed from their care and they don't want that to happen again. (Frontline staff)*

> *I think pregnancy is a great window. Women are so motivated during pregnancy. We've seen some women making some incredible changes in a short period of time, but then sustaining those changes. (Frontline staff)*

> *There's a patient who's had a baby and is on the ward at the moment who has previous history of drug use. The pregnancy gave her the opportunity to stop drug-using and become a mother. She thought, "I now have something else that's more important to me than the drugs". When people come in and they're having say, a detox on the ward, an inpatient detox, they're very, "I am so motivated. This is gonna change my life". (Frontline staff)*

Engagement was considered crucial to building a relationship of trust, where the client would be willing to disclose her substance use.

> *I think it's really important especially with this SUPPS position because it's case management up to two years postnatally, so you need to build that relationship. You need to build that trust that the patient will be able to tell something to you, or to trust you about all the history, about what's going on, especially if they have lapsed or relapsed. Because if they're hiding something, it's going to be hard for us to give them advice or to refer them to the proper services that they might need to in terms of the history. (Frontline staff)*

According to some participants, the absence of engagement or a therapeutic relationship could directly affect outcomes for mothers and babies. Without engagement, a notification would be made to FACS soon after a woman's substance use issue was identified and the child would be assumed into care soon after birth.

> *Historically, if you do file reviews, no one engaged them [women], no one developed a therapeutic relationship. Basically, they just went, made a report, and then brush our hands of things, and no obligations. And all of these babies, it's so sad, were removed. Because nobody did any work and because all the onus was on FACS. (Frontline staff)*

The existence of the SUPPS programme meant women had a mechanism for demonstrating to FACS that they were engaged with support for their substance use.

> *Because use in pregnancy was often FACS-related for us, because there wasn't that SUPPS intervention. Having a SUPPS program, I feel decreases those referrals or shows to FACS that, "You know what, they are engaged in support. They are seeing workers in an ongoing way. They are showing signs of improvement and differences in their urines and everything else." So that's a massive positive, I feel, for our FACS referrals. (Frontline staff)*

Engaging with clients also enabled staff to obtain a clearer understanding of the context of a client's actions, particularly their substance use, before a report to FACS was made.

> *I know that there's the eternal debate because you've got people who, they're mothers themselves who are also clinicians and they just have a very zero tolerance to any kind of drug use and just go, "No, a report needs to be made". Whereas you've got other staff who's like, "Oh, well, let's kind of just take a couple of steps back and try and engage them first and try and understand what's*

> *going on.” Yes, that might be an option further down the track, but not sort of the go-to position. (Manager)*

Often it was the social determinants of health that shaped a client’s ability to access services. For example, the reason why a client did not attend an antenatal appointment may have been a lack of resources or child care options, rather than lack of commitment or responsibility.

> *I do say to them, “If you don’t intend to turn out for your antenatal appointment, if you’re using all the stuff and you’re not doing all the stuff that you’re meant to be doing, of course that’s gonna be reported.” But it’s about giving them a bit more hope and finding out what’s actually going on. “Why didn’t you turn up for your antenatal appointment?” You might find that’s because they’ve got four kids at home and they’re all sick or on school holidays and they didn’t have the money to get to the hospital. So it’s about communication and not just assuming the worst and then picking up the phone and calling FACS where some inexperienced clinicians will just go, “Oh, well they didn’t turn up for antenatal, I’m gonna report that to FACS” without having those conversations. (Frontline staff)*

Promoting and maintaining engagement of clients in health care requires strategies and services specifically designed to support this goal. According to participants, promoting engagement was fundamental to developing trust between staff and clients and facilitating a client’s involvement in antenatal care. Aspects of service design that support engagement, and the need for shared understandings among staff regarding how to engage with clients, will be discussed further in Section 2A in Service Design, p.33).

Trauma-informed care

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, use of a strength-based approach (Fenton, Walsh, Wong, & Cumming, 2015) and opportunities to rebuild control (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)*

Trauma-informed care was considered by some participants to be “at the core” of drug and alcohol work.

> *So knowledge of trauma and trauma-informed care should be a core of drug and alcohol work which we do try and do. And I don’t think that there are disciplines that actually fully understand that. I don’t think that enough people are aware of that and it comes down to an individual’s clinician, their background, their knowledge and it shouldn’t. (Frontline staff)*

Participants from all disciplines and service contexts were keenly aware that experiences of trauma were common among women with substance use problems.

> *It is hard to parent as a single parent and it's very easy to escape when you've got a history of being raped or tortured because these stories, women would not just use drugs because they thought, "Oh, this might be fun." I would say "Well, today I've worked with a woman who was stalked, kidnapped and tortured. So now she uses substances to wipe that out of her memory. I can understand that because that's stuff that I would never wanna remember. A girl who is gang raped by 10 people, how do you ever forget that? That's just horrific. A woman who's trying to raise a family and keep it all together because her parents were never together, that she's happy to have a partner who beats the crap out of her so she can say she has a family, and so she takes benzos everyday so she doesn't have to feel the pain. (Frontline staff)*
>
> *So I think that's important, to be respectful and I think – and also as you said with your point about patient-centeredness and not taking account of the complexity, I think that a lot of society might expect these women to behave in a certain way and just expect them to lift their game and behave in this mother way. But society forgets about the trauma that a lot of these women have. They just don't think about that because many of them have not encountered anything like what the women have gone through. (Frontline staff)*
>
> *Often these women have had traumatic births in the past. I think many of them have traumatic childhoods where horrible things have happened to them and I think birth often brings out those memories for a lot of these women, like examinations and things like that. (Frontline staff)*
>
> *I've worked with some absolutely amazing FACS workers and I've also worked with some FACS workers who perhaps are still working at the old model and still a little bit too judgemental without understanding the impact of childhood trauma on the way that the adults are, and the additional fears and anxieties that come when you're a parent, you're pregnant, and being retriggered by all that stuff that happened in your past. Every mum-to-be is anxious and fearful of what it will be like. But when you've been, in a lot of cases, parented dysfunctionally, or there's been abuse in your own childhood by external family members or friends or whatever. Having a real understanding of how that complicates even a normal pregnancy and how at times that women may go towards drugs. I can certainly have an understanding of why some women tend towards just taking a timeout with drugs. It's not right, but I have an understanding why they would try and dampen their own anxieties about that and dampen their own – how triggered they themselves are. (Frontline staff)*

Trauma from negative past experiences with FACS was also well-recognised among participants.

> *There's obviously the trauma history in regards to their interactions with the department in the past, with family and community services. (Frontline staff)*

Trauma-informed care, as an example of a client-centred approach to practice will be discussed further in Section Two, in relation to effective service design.

Continuity of care: referral pathways from hospital to community

Most participants highlighted the importance of continuity of care, to provide a seamless transition between hospital and community services, and follow-up until the child was aged two years. However, some staff reported that there was a tendency to focus on the antenatal period rather than what happens after a woman is discharged into the community with her baby.

> *She's going home with the baby. "Whew! It's all over. We don't have to worry about anything now. She's gone home." So there was no thinking about what happens next. And so I think that the most critical time for her may well be when she gets home with her baby. She's probably got a partner and the man might have been supportive during pregnancy, but when she gets home and things are completely different and he doesn't handle this transition to adult parenthood very well and he goes off the rails and he's not there to support her, all sorts of things happen postnatally. And we have just crossed her name off the list and she's got no support from us. (Manager)*
>
> *I'm guessing that there's a lot more focus in the antenatal period. And then postnatally I'm guessing that there's probably intensive follow-up initially and then it kind of weans off. What's the ideal? (Manager)*
>
> *I think that there's a good pathway antenatally. I think in hospital, it works okay but it's after five days and they're sent home, that's for me where the big problem lies. I think in hospital, it's all right, because it's under our roof, but when – and then when they go home, we miss – we lose people and they're not going to other services 'cause there are no other services. So, they're just dropping out of health. (Frontline staff)*
>
> *And continue on that support post-delivery because there is a period of critical time once they go home that we tend to forget about and where they can fall apart because there's been all these intense help and structure in place and everyone walks away and then they're going, "Oh shit. I'm gonna do this on my own now," and that can be overwhelming. (Frontline staff)*

The need for improved networking and referral pathways between hospital and community-based services will be further discussed later in the report (see Section 3B: Challenges with collaboration).

Advocacy*:* Responding to stigma and discrimination

> *We're constantly seeing huge stigma and discrimination internally [in the hospital] and externally [in the community]. (Frontline staff)*

Many participants highlighted the need to respond to the stigma associated with substance use for pregnant women, by educating staff in hospital-based and community services.

> *You're still hear "What's that junkie doing looking after that baby" around the tracks every now and then. So, there's a lot of education. I do some education with people, with staff in the nursery as well, and on the postnatal ward. People have come with their own construct. (Frontline staff)*
>
> *It is obviously a lot of judgement. I just don't think people are exposed to education around – they see what they see, what's right in front of their face but they don't see the back story. They don't understand. They might hear what the tenets of addiction are but they don't understand what dependency really is and how profound it is as a disease and what drives that mother. (Frontline staff)*
>
> *Educating other services. Over the last five years, I've done a lot of education to midwives. I've done a lot of education with FACS. Going out there, it's about you're putting your face out there and getting them to have a bit of an understanding about what you do to support these women. And in the early days, we were often referred to as junkie lovers and I hate the word junkie, anyway, but it was not about being what they called a junkie lover, it's about being an advocate to educate, not only just these families but also all the other people that are supporting these families because we all want the same thing. (Frontline staff)*

Among Drug Health participants, their role as advocates for clients also included participation in discussions aimed at determining to what extent a client's substance use would impact on their parenting ability. Drug Health staff provided guidance regarding what kinds of supports should be put in place.

> *A lot of the time, it's historical drug use, which means it's not currently active. But, it still makes people scared and anxious and nervous and think that these ladies should be in rehab. Again, it's my job to advocate, "Actually, that's not necessary, at the moment, and it's not appropriate. There are other supports we could put in place." (Frontline staff)*
>
> *But most of our job actually became advocating for her that she didn't have an [substance use] issue, or if she did have one, it wasn't something that required a punitive approach. (Frontline staff)*

At times, FACS sought the expertise of Drug Health staff to inform their decision-making in relation to child protection.

> *I think it's a really interesting question because I think it's a case by case basis answer, but also, it's about what drugs they are using and how they impact on their ability to parent. I hope that FACS workers are guided by their drug health experts. I guess the expectation is in regards to what's in the best interest for that child and what will constitute that mum behaving in a way that will then allow her to protect this baby. (Frontline staff)*

Research highlights that the factors associated with parenting capacity among women who use substances are yet to be identified and this hinders collaboration between child protection and addictions services (Drabble & Poole, 2011). However, some authors have emphasised the need to shift the gaze from parental substance use to improving the determinants of health affecting the harms associated with substance use, including housing, isolation, food insecurity and exposure to violence (Drabble & Poole, 2011; Roberts & Pies, 2011).

Summary

The guiding principles and practice approaches reported by participants have been summarised in this chapter. The three identified guiding principles were client-centredness, integrated care and harm reduction. Participants highlighted promoting engagement with clients, trauma-informed care, continuity of care and advocacy in response to stigma and discrimination as four practice approaches that need to be embedded in the MOC. The following sections will outline participants' perspectives regarding the key aspects of effective service design, how to improve collaboration and continuity of care between hospital and community services, and governance issues that influence the MOC.

Section 2: Effective Service Design

Participants recommended a number of strategies and programmes that should be included in the MOC as part of effective service design. These were summarised into five categories: strategies for promoting engagement, more client-centred approaches, Possum Playgroup, involvement in Pregnancy Family Conferencing and services for specific populations.

A. Strategies for Promoting Engagement

Initial contact

Participants emphasised the importance of creating a warm and welcoming environment when clients came into contact with a service for the first time.

> *The important thing for us is that first moment they walk in a building and not to necessarily just focus on all the administration stuff. That can be a real stressor, to walk in and see an uncaring and unsmiling, unsympathetic person. And that's not to say that they're all – that everyone that works there are like that. But they [clients] go a lot by that very first moment even before they've got in to tell their story, that's how they're treated. (Frontline staff)*

Many clients had experienced the stigma associated with substance use and anticipated being judged and discriminated against when they accessed a service. Against this backdrop, a positive reception from staff could really make a difference in terms of promoting engagement.

> *A lot of them know there's already a lot of judgement and stigma because they use drugs and that people often see them as having a drug use issue not as a human being separate to that. So, I think that's the big thing that puts people off. The focus is always on ice or whatever they're using. And it's actually why you are here? You've got this appointment, let's make the most of the time here. And people who work in the health system, if you don't get a smile from someone when you walk in or an acknowledgement, that can make a big difference. That can make so much difference to someone. (Frontline staff)*

First impressions of the physical environment could also shape clients' expectations of how they would be treated. Cleanliness and tidiness could be interpreted as signs of respect.

> *Well, the physical environment – so, a respectful, clean, and comfortable environment. Now, downstairs [OST clinic] is reasonably new and it's pretty good, but I think just being mindful of what the environment looks like when you're bringing someone into the [consulting] rooms, clean and tidy. Is there a clean sheet on the bed with a clean pillow? There's no hazardous waste lying around. The waiting room is clean and comfortable. (Frontline staff)*

A gentle approach to engaging with clients was sometimes the best way to engage and build rapport in the early stages. Providing practical assistance could present opportunities to engage with women and build trust. For example obtaining equipment for the baby after discharge, or completing work development orders for clients were very well received.

> *Even all the baby equipment for all the baby's needs as well, so we already are ordering something, because sometimes you need to bribe. I know I'm not supposed to say it, but sometimes you need to bribe the pregnant one to engage with you. [B]ecause sometimes when they hear about drug and alcohol, they don't want to engage but once that you said that we also provide this service, if you have any fines, we can do a work development order, and they're like starting to engage with you because they say, "Oh, they will help me with this. They will provide this service". (Frontline staff)*

The provision of food was highlighted as something that clients valued and would encourage women to regularly attend a service.

> *I know food is a drawcard, like seriously. If there were things that they could eat while waiting in the waiting room and things like that. [A]nd truthfully, it would possibly be their only thing that they've had that day, especially with some young people that we worked with. So having food, or even for just like little, I don't know I'm just trying to think, like cupcakes, things like that, that would be – but the environment has to be friendlier. (Frontline staff)*

Building trust

A non-judgmental and non-punitive approach was highlighted by many participants as crucial for promoting engagement with clients.

> *I think it's just about empathy and understanding and being non-judgemental. I think that's the most important thing probably and just I think remembering that they're here now and they're – all women want a positive outcome. Everybody wants that. So, we've just gotta help them along a little bit sometimes and be understanding and be nice to them. I think often women feel very judged when they come in to hospital and – yeah, just the way people sometimes speak to them. And I think you just have to remember to treat that person the way you'd expect to be treated. (Frontline staff)*
>
> *I think they've got to feel that they're not gonna be told off and we're not gonna be punitive when they arrive. (Frontline staff)*
>
> *If mum is very unwell with some illness and the impact of that on her children, i.e. difficulty getting up in the morning, difficulty getting little ones dressed or fed, difficulty getting them to school, her inability to answer the multiple messages that come through the day that – a normal part of a mum's life that she's just exhausted by her illness and that there is often a comorbidity with depression and mental illness in her as well. So, just taking that bigger picture view rather than judging and blaming and saying a parent is uninvolved or not interested or whatever, actually looking for the reasons behind that and what sort of integrated support we can offer to that parent because there's often other ways of thinking about things. (Frontline staff)*

> *A lot of these families have slightly chaotic lives, so it is trying to keep [them] engaged with these services, and I think it's the recognition from all our services. Some are better than others, I think. Because I think for a lot of our services, they have a three-strike rule, where if you don't turn up for the third time –the three-strike rule doesn't really work very well, I guess, with a lot of the families. (Frontline staff)*

Responding to child protection matters was a core component of SUPPS service delivery and heavily influenced clients' willingness to engage with staff. However, clinicians' mandatory reporting responsibilities could make it difficult for them to gain the trust of clients.

> *But sometimes that relationship it can be damaged if you've done a child protection report as well. (Frontline staff)*

> *It's a challenging one. Particularly when – if you do have to report families to DOCS [FACS], how do you do that in a patient-centred way? (Manager)*

Some clinicians delegated responsibility for mandatory reporting to social workers in order to preserve the relationship they had built with a client.

> *It was actually very difficult whereas I never did that. I have always left it to social work. That's their job and mine is to remain a good support. (Frontline staff)*

> *I mean it's a very deliberate strategy because if you wanna maintain a relationship – basically, I can tell you that if I wrote a letter to take away your driver's license because I saw you in a consult and I made a decision that you shouldn't have a driver's license, that's the end of our therapeutic relationship. You're never gonna come and see me again. And I can sugar-coat it and talk you into it and send you flowers, but if I took away your driver's license, you're gonna kind of hate me for it. And so, we have to I think be clear about the effects of doing something that the patient doesn't like. Acknowledge that that's the end of that particular therapeutic relationship from the patient's perspective and move on. Get another clinician involved. (Manager)*

Those participants who worked closely with clients highlighted the importance of transparency and honest disclosure of their mandatory reporting responsibilities.

> *It's about safety yes, and I'm always upfront with the mums I work with and I will say, "Hey I'm a manager, a reporter. I have to report anything you say that puts you or your baby at risk. (Frontline staff)*

> *Before we even do the child protection, on our first assessment with the patient, we always inform them about us, our role as a mandatory reporter. But sometimes, of course, they're not that happy once that you've done the report. But once that you explained to them about the role of the community services, being involved in the care of her and the unborn baby, and sometimes they realise that they need that support as early as possible. (Frontline staff)*

In order to assist clients as much as possible, staff encouraged clients to disclose substance use and engage with FACS around child protection issues.

> *I'm not here to judge you. I'm not putting on your shoes and having to walk in them. That's something that you have to do but I'll give you the best go at supporting you as long as you're honest with me because if I know what I've got to deal with, I can fight alongside you but if things pop out because you haven't told me. (Frontline staff)*

> *I basically said to her, "Look, I know that this is a situation. I know you've got kids in care. I bet you're really scared about meeting me and all of these people [FACS]. It's 11:15. Intake for Jarrah House closes in 20 minutes. Can we call them right now? Because you haven't had antenatal care and you've got kids in care. The bottom line is, they're gonna want you to go to rehab. Can we get on the phone?" Now a week later, this girl - FACS didn't end up coming out 'cause we have a good relationship with them, but it's like everything is built on these relationships that are so fickle, like not fickle, but one person leaves and they stop. And so, I knew the manager there and I'm like, "Look, I don't think she's gonna leave the hospital. She's beautiful with the baby. She wants to breastfeed. She's doing all this. Yes, her kids are in care. Let me put a plan in. If she tries to leave, they will call – they'll escalate" and they agreed. And then a week later, she's doing well on the ward, she goes home with her baby now. In April, I think she called me for a letter, and she was still with her baby so it'd been like, six months. (Frontline staff)*

Often staff had to reassure clients that substance use or relapse did not necessarily mean their child would automatically be assumed into care.

> *I'll also come to you and say, 'What the hell's happening? We need to talk about this because FACS will get involved. So what's happening?'" Because I wanna know what's going on for them to have had a lapse or something. It's not just about ringing, picking up the phone and saying, "FACS, hey you need to come and remove this baby because mum's just had a lapse," but it's about really looking at and seeing if everyone's safe and then making sure that there's more supports to continue that safety. (Frontline staff)*

> *I mean sometimes they do hide, especially when they lapse. They're scared, especially, if they have a child protection issues. When they lapse, they think that that's the end of it. They're [FACS] going to remove the child straightaway but they don't realise that they can still do something to prevent the removal of their children. (Frontline staff)*

> *It's always that FACS are gonna take the babies. One of the big ones – and that's why they won't divulge drug use because then mandatory report goes in, and then they go, "That means taking my babies," whereas my view generally is that you are better off to disclose it. So sometimes we talk to them about maybe you should start telling them [FACS] that you do take a bit too much meth or*

> *whatever, so now I've booked myself into drug and alcohol counselling. 'Cause generally, it's always gonna come out, especially if they're pregnant. I would rather it get out when they're four, five months pregnant and we can address the issues as opposed to when the baby is born, the baby starts withdrawing, everyone goes, "What the hell is going on with this bub?" Mum has been on meth throughout the whole pregnancy. We need to take that baby. But they're very scared, very scared to put their hand up. I've had clients who've been clean and have started very, very minor drug use, but have said, "Look, I'm starting to struggle a bit." And I'm like, "Well, you need to go back and have some counselling". But they're too scared to do that because then they think that that means that FACS will say, "Oh, you're using," whereas it's a good thing to do drug and alcohol counselling 'cause that keeps you off the drugs. But they're too scared. And so, they'll fall over, start using drugs, and then it's just all – goes downhill. (Frontline staff)*

Many clients had had children assumed into care in the past, and had negative perceptions of FACS as a result.

> *The FACS organisation has changed and we do know that, but FACS in the past had the reputation as being quite punitive and judgmental. And so, a number of these women have had past engagement with FACS either in their own childhood or through previous pregnancies. So, I think the notion of working with FACS is not understood by the families. FACS is still seen to be big brother coming down hard and parents' first thought when FACS were involved is, "They're gonna take my kids," and so I think FACS have a huge cultural shift to make as well– rather than, "They're gonna take my kids," it's gonna be – "We're gonna help you keep your kids," and that needs – they've got a lot of work to do. (Frontline staff)*

In community settings, maintaining engaging with disadvantaged and potentially vulnerable clients in the long term presented its own set of challenges. Participants from Healthy Homes and Neighbourhoods (HHAN) identified wraparound care models (Walker, Bruns, & Penn, 2008) as more appropriate to this setting, where "persistent engagement" through outreach was accepted as a long term strategy for building trust with clients.

> *I was aware that wraparound models had been used in adolescents, for drug-using adolescents and youth, and how long it can take to build that trust and empathy, and that may not happen in the first two visits. It might not even happen the first 10 visits. Healthy Families America actually got a set of principles. This has been around for a long time, this stuff. And talked about persistent outreach, persistent engagement until they [clients] actually engage. So Healthy Homes and Neighbourhoods was designed around some basic ideas of empathy, wraparound, persistence, not giving up, staying in there for the long haul, and family group conferencing. Not just giving six months and then stopping, but actually being in for the long haul. (Manager)*

Approaches to engaging with clients, that did not reflect the financial and social realities of clients' personal circumstances, were criticised by some participants, particularly those working in community settings. For example, attempts to follow-up clients who missed appointments by leaving messages on their mobile phones was considered by some participants to be inadequate when clients may not be able to afford to listen to voicemail.

> *An understanding that if you leave voicemails for these clients and they don't have the capacity to set their phone up correctly, actually they pay a charge to listen to their voicemail and they actually can't afford to listen to their voicemails. So, writing endlessly in medical records notes of "attempts to contact the patient, unsuccessful – discharged", is just not looking at the big picture and not taking a holistic view and not looking at social determinants of health. (Frontline staff)*

One participant highlighted the value of a soft entry approach to build trust with clients in the community. Soft entry approaches prioritise taking opportunities to develop a non-stigmatizing trustful rapport to facilitate discussion of harmful substance use (Allan & Campbell, 2011). According to this participant, proving her value to clients by intervening to "make the system work for them" was one example of this approach.

> *And I think it's really beneficial that we take a really soft-entry approach. I can Band-Aid a crisis and develop some trust by setting up things for the kids, which are too hard for them to access sometimes, meaning even getting past paediatric receptionists sometimes is too confronting so their kids don't get appointments. By establishing, almost proving myself that I can make the system work in their favour, that develops some trust. (Frontline staff)*

Acknowledging small successes and being non-judgmental were also important for maintaining engagement with clients and working towards long term goals.

> *But being in there long-term and just getting to know them and not judging them very much, showing them that I'm doing my best not to judge. Sometimes life is really shitty and sometimes they've done their best. Just keeping on focusing that you did really well. "Isn't that great? No, stop there. Don't think of all those other negative things. Let's just celebrate this one moment right here". They really struggle to get past that feeling of being overwhelmed by how many negative things or bad things or challenging things are happening. Let's just take a moment out to focus on a "yay" moment. (Frontline staff)*

Continuity of workers to maintain engagement

Many participants believed that giving clients access to the same worker over time, if that was who they trusted, would help keep clients engaged with health and community services. The strongest support for this approach was from participants involved in antenatal and post-natal inpatient care.

> *One of the big, big issues in public health is the lack of continuity and this group of patients who we want to stay engaged in our system and will drop out at a chance, continuity builds relationships and that's how we keep people in our system. We've had a number of mums come through this service, through PAF two or three times now, either second or third baby, and they're ,"Right, where's ____ [social worker? I wanna talk to ____[social worker]. Where's _____*

> *[nurse]? Yep, I know ____ [doctor] because baby number one was in the nursery. So it's the team and continuity. I think a different person antenatally, a different person in hospital, a different person postnatally, a different person at playgroup, referral – that never ever works, not even in low-risk patients. That's a disaster. (Frontline staff)*
>
> *If somebody has a stillbirth, I've come and seen them, scanned them, counselled them, it's more appropriate for me to continue looking after them even though someone else [a different obstetrician] might be allocated. I think there probably needs to be a bit more flexibility for that. (Frontline staff)*
>
> *It's not enough for mothers and children or pregnant women. They need consistency of care. So I think that works well. You need that role, and I know across the road, the antenatal, they're trying to get the same midwife for these clients 'cause they don't turn up otherwise if there's someone different. (Frontline staff)*

Continuity of care was described by some participants as the gold standard for midwifery, so women had a good chance of seeing the same midwife during antenatal care, delivery and postnatally. There is currently an Indigenous PAFDHS midwife employed at RPA. Obstetricians and midwives highlighted the need for a non-Indigenous PAFDHS midwife to maintain provide continuity of care for all PAF clients, who frequently had histories of trauma and mistrust of health services.

> *I think having that continuity is really important. You just have to invest some time at the beginning to build up a rapport and some trust and I think it's really beneficial. To have a different person that they see each time, I think can be really detrimental. In midwifery we talk about continuity of care and the gold standard is a model that provides continuity. So, at RPA, we have a group practice model where women see the same midwife antenatally and they've got a good chance of seeing that midwife during labour and postnatally definitely. I think the women who are part of the PAF clinic would really benefit from a continuity model where they can be supported in labour by somebody that they've already met. I think they often have a distrust of hospitals and I just think they would really benefit from seeing somebody that they've met before. (Frontline staff)*

A PAFDHS midwife was also needed to help maintain the focus of care on the client's experience of pregnancy and preparing for motherhood, as well as substance use-related issues.

> *The non-indigenous ones that don't have any midwifery input which means they are somehow robbed of some of the most normal elements of having a baby, which is having a midwife healthcare for you. The continuity of care that a single midwife from one of these clinics can provide is important. You need to have the opportunity to form a quality relationship, particularly if you're a vulnerable or disadvantaged person and that's what our group is. So if they knew there was a number they could ring to get hold of a midwife, if they knew that she knows their story and that she'll link them with all these other people, as time goes by that*

> *she might be able to be there at their birth and she's a phone call away after they deliver. That she would see them on the postnatal ward. I think this would encourage better attendance, better outcomes in general and help women not feel as fearful of the whole process as if it's a medicalised thing. They're all mums, the same as anyone else and they have some extra elements going on in their life that we need to address. Other mums get to have a midwife and have the benefits of that and it seems a shame they're not getting it. I know my [indigenous] women like to ring up and get hold of me any time they like. I know they like seeing me adding on to the story from last week and midwives traditionally have been a safe place for women. They have that role. They're on your side. They're on your team. They want your baby to get well. (Frontline staff)*

According to one participant, this role would need to involve a small team of midwives, in order to provide on-call cover, particularly to support women during childbirth.

> *I think to have somebody look after them in labour that they've already met, I think would be so beneficial for these women, and some postnatal follow up as well. You'd need a team of midwives to be able to do that 'cause it would need some on-call. So, it would be a small team of midwives that could see all of these women. (Frontline staff)*

Extending this midwifery role to home visiting for a period after the birth was also suggested.

> *I mean home visiting after the birth, so that person could really be the midwife. I think it would be possible because it'd just be really helpful for the women to just know that there's someone who is going to visit them each week, in that first six weeks and maybe there'll be other services that they're keen to into, but to have this known person who they totally trust would be nice. (Frontline staff)*

> *I think the problem is that we are looking after people in a little snapshot, so you see them once a week, or once fortnight, or once every three or four weeks in a clinic for five or ten minutes, and then you say, "Cheerio." So how much influence are you gonna have? They come in and they have their baby, or even if they're in the inpatient detox, so they come in and you see them for a number of weeks, it's still a very short time. And then they've had their babies and they go home and one thing I'm not clear about is how much community support [is available]. In the UK women are encouraged to go home as soon as is practical after they've had a baby, and they are seen by a midwife for ten days every day after they go home. It's absolutely mandatory. It's written in law that that has to happen and then there's an early childhood nurse will take over and they actually go to the home to visit. (Frontline staff)*

Concerns about maintaining continuity of care after clients were discharged from hospital were also raised by many participants, particularly how to maintain engagement with mothers in order to monitor the health and well-being of babies.

> *We were losing quite a lot of them [babies] to follow up in terms of newborn care follow-up, neonatal follow-up, developmental follow-up. For babies that have mums who have been Hep C positive or Hep B positive, who need to have a further testing later down the line to make sure that they haven't contracted Hep C in a vertical transmission. A lot of babies clear the Hep C so they're not necessarily going to get it, but you need a blood test to see, and then appropriate referral for Hepatology. So, we've been losing quite a lot of those babies because their parents, they're quite chaotic. And because they would come back to clinic, maybe. If they didn't get there, then everyone was really too busy, there was no one support [person] to really chase them up for their baby stuff. And then, they went off into the community and who knows what happened to them then. (Frontline staff)*

Possum Playgroup at RPA provides staff with opportunities for maintaining engagement with clients and monitoring babies' health and well-being. This will be described in more detail later in this report (see Section 2C: Possum Playgroup). A district-wide approach to post-natal follow-up, particularly for neonatal abstinence syndrome (NAS), was suggested. Participants reported that there were limited mechanisms in place at Canterbury hospital, compared to RPA.

> *They lack paediatric buy-in at Canterbury and there's no playgroup. So, should playgroup run as a district-wide service? Maybe, I don't know. It's gonna need some serious support if it's to run as a district wide thing. Should they just set up the same model over there? I don't know. But we could do a lot of things together, I think, postnatally for this group of women. So there's a new head of paediatrics starting at Canterbury next week – in two weeks. So they've just – the head of paediatrics has been there for 30 years, so he's just retired. So there's someone knew and young and energetic – is coming in to the area and they struggle to – they hardly ever manage neonatal abstinence there. (Frontline staff)*

> *A real gap, or a real difference is in the way that women are supported there with their babies. So the baby support through Canterbury, we hardly ever get to see them. We don't know whether they have follow-up. We don't know whether they – unless they get to the nursery, or somebody actually refers them to a paediatrician who knows whether they get any follow-up? (Frontline staff)*

At the time of data collection, the absence of a NAS clinic at Canterbury Hospital had an impact on the follow-up of clients after discharge.

> *At Canterbury, they don't have any NAS clinic which is one of the gaps as well. They don't have that follow-up appointment after they're discharged from the clinic or from the hospital, follow-up in terms of NAS withdrawal. When we spoke with the doctor over there, he did mention if they need to do a follow-up then they will do it. But they're not required to have follow-up. Here [RPA], once the baby has been monitored for the NAS during admission or during hospital admission, they will automatically have some follow-up at the NAS clinic. But at Canterbury, if they don't think that they don't need to, they won't do any follow-up. They started to have a follow-up appointment at the paediatric ward. They're*

> *starting to have that follow-up after discharge from the newborn care but it's not really a NAS clinic, the same as here, because they [clients] also don't have anyone to call. ____ [Nurse] is doing that community service as well for newborn care. At Canterbury they don't have that, so they don't know who they going to call when that baby isn't settled. (Frontline staff)*

These findings raise the question of how best to utilise resources available within the district to ensure systematic follow-up of mothers and babies can occur, to maintain engagement with clients and continuity of care. However, community follow-up also relates to collaboration between staff and services involved in inpatient and community care. Factors affecting collaboration and referral pathways across agencies will be discussed in more detail later in the report. (see Section 3: Barriers to Effective service delivery).

Flexible approaches to hospital admissions

Some participants reported that flexible ward admission procedures offered another valuable mechanism for engaging clients in care. Sometimes clients were admitted quickly onto wards for inpatient detoxification. A client's inpatient stay in the Emergency Department or on the post-natal ward, could also be extended in the interests of either the client's health or that of her unborn child.

> *We wouldn't ever discharge a woman like this [pregnant with substance use issues] early before all bases are covered and that she's safe and the child is safe. Referrals have been made because they're, what we would call a complicated patient really. So it's not a simple thing. You would make allowances for a patient like this. We have a medical unit we call which has recently just moved upstairs because we're renovating. So that's our short 24-hour ward where patients go in and wait for reviews or discharges, things like that. (Nurse 7)*

> *The [post-natal] ward is bloody amazing. I can call them and say, "This woman is homeless and she is at risk of relapse. Do you mind just having her for a few days just so we can engage her." (Social worker 1)*

Summary

Participants identified a range of approaches to promoting engagement, as part of effective service design: a non-judgmental, gentle approach, transparency regarding mandatory reporting responsibilities, wraparound care in the community, soft entry approaches, continuity of workers involved in community follow-up, and flexible ward admission procedures.

B. More Client-Centred Approaches

Client-centredness was highlighted by many participants as a key component of the MOC (See Section 1: Guiding Principles). Effective service design included increasing client-centredness in a number of ways: appropriate staff selection, partnership and trauma-informed approaches with clients, flexible appointment times, reducing waiting times for antenatal care and outreach models of service delivery.

Staff selection

Selection of staff with the right attitudes, expertise and experience was a recurring theme in the data. In services where building relationships with clients was so central to successful outcomes, the staff providing the services were the critical foundation for effective service delivery.

Many participants emphasised the need to select staff who were passionate about working in this area and genuinely cared about their clients. Often this was demonstrated by staff being willing to put in "extra effort" and be client-centred in their work practices.

> *Just professionalism. That's what I just loved about ___ [social worker] and ____ [midwife], is exactly like this, it's not, "Oh, it's four o'clock, I'm going home," it's like, "I got a patient who really needs to be seen," "Oh yeah, where is she? What can I do to help?" The public health system so benefits from those people. (Frontline staff)*

> *When this service was flying along and no one was getting missed and PFCs [Pregnancy Family Conferences] were happening, it was because there were passionate people in it every step of the way who really cared about these women and who could see them – who were making a difference to families. (Frontline staff)*

> *The selection of staff to work in these kind of areas, you need people that are keen to put in a bit of extra effort, be a bit persistent, follow up. (Frontline staff)*

> *It's an area you work in 'cause you're passionate about the area. It's not – you can't work in this area if you don't give a crap basically 'cause it shows and our clients are the best bullshit detectors ever and they'll spot it like if it's not genuine, without a doubt. (Frontline staff)*

Working with this group of clients required a particular approach, given clients' significant distrust of health professionals and the stigma associated with substance use, particularly by pregnant women and mothers. One participant described this as a competency for working with Drug Health clients.

> *I think the biggest thing that I find with these women is that they just see through you like that. If you don't care, if people go in there and there's a little bit of this, a little bit of that and the way the questions are asked, there's a bit of judgement… they've [clients] got to really feel comfortable and safe. I mean it's the same as cultural competency. The fact is you've got to have a cultural competency to work with drug health patients, people who've often experience difficult interactions. (Frontline staff)*

Many participants reported that some staff lacked the necessary competencies for this kind of work. and were unsuitable because of their lack of empathy and judgmental attitudes. Education could go some way to building staff capacity in working with Drug Health clients but in some cases, it would not be enough.

> *Our guys [clients] get a better understanding when you're on their side. It doesn't take a lot. In fact, you just got to be on their side. They'll forgive you, but a lot of*

> *people just aren't on their side and they put up barriers and I think there needs to be a weeding out of people that don't really want to work there. I don't think it's an area you should just come along just to pay your bills. Some people don't have the empathy that they really need to have and people aren't selected based on their capacity for empathy or their genuine willingness to wanna help people in this. (Frontline staff)*
>
> *I think you've got all different types of people in the ward, haven't you? There are some people that just aren't suitable to work in these kind of areas, because their attitudes and opinions and the way they approach people are probably a bit more harmful. I think most people could be trained and educated, but some people can't. (Frontline staff)*
>
> *I suppose some empathy and some – being non-judgemental I think would be the most – and I don't think it's for everybody, that role. (Frontline staff)*

The need for staff to have life experience was frequently raised as crucial for understanding the complex needs of their clients and for developing realistic expectations of success.

> *From a client point of view, when you've come up through the school of hard knocks and your caseworker is 22 and comes from the middle class and has all the really good intentions, but really doesn't have the true understanding of how hard it is from day to day, sometimes unrealistic expectations or judgement can creep in there because they don't, it takes years to understand well. It takes experience to understand the why. (Frontline staff)*

Some staff questioned whether new graduates and young staff were best placed to work in this area. The need to ensure there were more experienced staff working within the same team was highlighted as one strategy for supporting younger staff.

> *I'd say you have to have experience. A lot of the workers [in particular services], there's a huge turnover of staff, and the staff are all quite young. And they come from I think predominantly social working backgrounds. So there's a real dearth of experience, and there's a huge turnover. I'm talking about one agency now but I think that's the case for a lot of these agencies. They're dealing with families that have been through a lot. You need to have some life experience to be able to actually –nothing wrong with the 22-year-old but you need to have some experience in the broader team as well, so I think that's what is missing a lot. (Frontline staff)*

Working in the SUPPS teams required a diverse skill set informed by expertise in a range of areas, not just drug and alcohol.

> *But also life experience. I'm not fresh out of uni and just settling into my first role. I've been in nursing for 20 plus years and in those years I've had a number of different roles which I've chosen because they complement each other. So I've worked as a midwife. I've worked as a child and family health nurse. I've worked as a primary health nurse. I've worked as a palliative care nurse. I've worked in*

> *the corrective services with high risk women. I've worked with adolescents in custody and down in the community. So, it all blends together because when women front up, they don't just have the issue of "I'm using drugs and I'm pregnant," they also have the issue of "My child is attending juvenile justice because they've got picked up for stealing a pushbike." "My 15-year-old daughter may be having sex with an older person and I'm scared she's gonna get pregnant." "I'm not coping with sleeping so I am using some extra benzos on top of my methadone" and "My partner's beating me." (Frontline staff)*

The combination of experience with substance use and child protection was highly recommended, given the major role of staff in working across both these areas.

> *So in working with families, having a bit more understanding about, I guess, child protection aspects, perinatal conferencing aspects, child and family aspects not just drug and alcohol. It's [child protection] a major part of my role; it's supporting these women to make changes to prevent what's already occurred in their lives before and recently, we've been getting women who've had four, five, six children removed, go home with their last child and doing fairly well out there in the community. But if you put them in a model where they're with the clinician that doesn't know what they're doing then you've just done them a massive disservice. You might as well just tear all the work that's been happening for the last five years. In my experience I've had some people come and relieve who have significant drug and alcohol experience but if you don't have that health experience of family, substance use in pregnancy experience, you do tend to struggle a little bit and you can still come across in a punitive way and it's not about being punitive. Some inexperienced clinicians will just go, "Oh, well they didn't turn up for antenatal, I'm gonna report that to FACS" without having those conversations. (Frontline staff)*

These findings have implications for recruitment and staff selection practices. In addition to selecting staff on the basis of criteria in relation to qualifications and experience, data highlight the need to ensure staff attitudes and life experiences are also aligned with work in this area.

A partnership approach

As discussed previously (see Section 1: Guiding Principles), a family partnership approach was suggested as an effective way to increase client-centredness when working with clients.

> *I've been a long-term supporter of something that we call family partnership, and that's the way we train our clinicians in community health and child and family, and that is a partnership relationship. This person-centred care has come along and I will say I'm just a little bit suspect about what it really means and whether it's just a platitude. So, let me try and work this through. I think if you're working in a partnership where you're recognising the client as being an expert in their own health, and that works better for me. (Manager)*

As part of recognising clients as partners, some staff emphasised the importance of ensuring clients were actually present at key meetings regarding their care.

> *I think that's where we've got it wrong to be honest and I think that's where it just needs to be turned on its head, that if you truly want it client-centred, the meeting is about the client and the client's present. So if you truly want to empower, I mean, I only work with vulnerable families so if you truly want to empower somebody to make a change, you bring them on that journey with you. They don't even know what they've discussed at these meetings. (Frontline staff)*

> *It's not efficient and it enables rumours, misinformation, gossip. So you fell pregnant and you used, right? You're discussed with social care, you'll be discussed with drug health and if you've got mental health, they might discuss you at the mental health meeting. And if you're young, they'll discuss [you at] the young parent's meeting as well. So, potentially, we'll discuss you at four meetings and you don't actually know that those meetings are happening and you don't even know what they're deciding about you then somebody has to go back and tell you what they decided about you. (Frontline staff)*

Trauma-informed care

TIC was identified by participants as a practice approach that was integral to the MOC (see Section 1: Guiding Principles). As part of a more trauma-informed approach, reducing the number of workers involved in a client's care was suggested. Many participants felt clients could become overwhelmed by contact with a large number of staff.

> *They have a lot of services involved with some of them. They can be really overwhelmed because not everyone is giving the same information in terms of each service. Of course, they have different scope or different boundaries or limitations about their service. (Frontline staff)*

> *I think sometimes there's too many people in their lives and they're just overwhelmed. I know everyone is trying to help. I just think everyone's got their own agenda and there's sometimes too many people. You could have a drug health nurse here and have your drug and alcohol counsellor, a social worker, then you could have one of the NGOs involved in your life and you could have FACS. It's a lot of people in your life trying to tell you what you need to do and it all gets confusing. And then they don't know how to prioritise like, "I got this appointment, I got this appointment, I got this appointment." Okay, we need to cut back on all of that. If it is drug use stuff, then keep seeing a drug and alcohol counsellor. It's number one. Keep engaged with the drug health nurse, do that, but then the rest is just gonna have to slide. (Frontline staff)*

> *One of the fundamentals of this population, I think, is their difficulty in forming and maintaining relationships. So, I think you want to minimise the number of therapeutic relationships that you're asking them to form. So, if they can get used to one nurse and/or social worker and/or doctor, then try and maintain that link as long as it's reasonably possible, other than when special skills are required. (Manager)*

The impact of clients' past experiences of trauma was well recognised by participants. However, the extent to which service delivery and clinical practice was trauma-informed was questioned.

> *I think everyone in the team has an awareness of what trauma is but I just don't know. I think it's just really hard to have a uniform approach with different disciplines. Everyone tries to be as trauma-informed as possible but I don't know how trauma-informed everyone involved in the client's care is. For these women, retelling your story to an obstetrician, doctor, midwife, social worker, drug health worker, psychiatrist, is that trauma-informed? (Frontline staff)*

> *A lot of their treatment is focused on the mother's addiction and all of that kind of stuff, but not necessarily on her psychological wellbeing, her past trauma, and her parenting ability. So I want to focus on the parenting aspect. So while they're focusing on her addiction, getting her off her addiction, supporting her addiction, but what about her efficacy to be a parent and learning parenting skills? And are they also thinking about the relationship between her and her partner? So, those relationship issues. So they might be thinking bio-psychological but they're not necessarily bio-psychosocial. So they may not be looking at the family function issues, the wider connectiveness to society issues, how she's tracking with her own grief and her own trauma. (Manager)*

> *It's the power imbalance that re-traumatises and re-triggers, and I don't think they acknowledge how much we do that as a service. (Frontline staff)*

The need to reduce the number of times a client had to re-tell their trauma history was raised by many participants.

> *They [clients] can be anxious because it's going to be a new environment and they're going to see new staff and they're going to do another assessment. They're going to repeat all the history again. Sometimes they feel overwhelmed with that and they can be frustrated repeating the history all over again and again and they can be guarded about what they're going to say and what they're going to disclose as well. Of course, they haven't built any relationship at that stage. (Frontline staff)*

> *Having to retell their story over and over again. And that's something that is frustrating across all health care, for everybody, every patient really. Particularly for these women who have had very traumatic lives to keep having to retell things that could be quite hard for them. (Frontline staff)*

It was argued by one participant that a trauma assessment was unnecessary as it could be assumed that the vast majority clients would have experienced trauma.

> *Sometimes I work with people and I have absolutely no idea what's happened in their childhood in lots of ways. One of the clients I've worked with with two pregnancies, she just came and saw me one day in the office with her baby and she was like, "Oh, I never told you but my uncle raped me," from the ages of this and this, and I never knew that about her. But I didn't need to know because all I*

> *needed to do was address the drug health issues and make sure that she's engaged with someone that can work with her therapeutically. I just have to make the assumption that most of my clients have had that. (Frontline staff)*

Having one staff member complete a detailed psychosocial assessment, including the client's experiences of trauma, and disseminate this to others involved in the client's care was suggested. This would avoid re-traumatising of clients, and increasing their frustration.

> *Is it possible that we do, even at the beginning of someone's antenatal care, could we do a massive big assessment with them that includes medical history and drug and alcohol and psychosocial history, could we do that? That's antenatal-focused? And then we all use that assessment to inform what we do. Who would do that assessment, I don't know. (Frontline staff)*

> *If someone presents from ____ [residential rehabilitation programme], I don't to do a whole bloody assessment about their lives because that would re-traumatise them. I just need to engage them in terms of talking about FACS, prenatal family conferencing but particularly what to expect after birth and when FACS will come in and how we're going to support them. I can get information from the _____ [residential rehabilitation programme] worker and, of course, I need to know what's been used in the pregnancy but I don't need to do that assessment because what's the point? And it would be awful for the client to go to every service and be like, "Okay, this is my life story again." (Frontline staff)*

Who would be best placed to carry out the psychosocial assessment would need to be negotiated. Data suggested staff may not necessarily trust the assessments of others. According to one participant, including more questions regarding financial stress, poverty and social connectedness would strengthen the psychosocial assessments currently being done.

> *I think there're some questions that we're not currently asking that we want to add in. One is around financial stress and poverty and the other one is around social connectiveness and social networks. So there might be a few others that we should add into the history taking that's actually being taken antenatally. So there's some work to be done to make sure that we've – we can strengthen the psychosocial assessments that are being done currently, and that there's a digital system to organise that and then there's a coordinator. (Manager)*

This issue will be discussed in more detail in a subsequent chapter, in the context of barriers to staff collaboration (see Section 3B: Challenges to collaboration).

Making services more accessible- flexibility with appointment times

> *Flexibility isn't something that we're renowned for in health. (Manager)*

Making services more accessible through more flexible arrangements with appointment times was recognised by many participants as a strategy for increasing client-centred practice. Appointment scheduling needed to reflect what was realistically possible for clients.

> *In health, we talk about person-centred care. If you look at the person in the context of their world, if you're a drug health client and you're a high flying lawyer and you're on methadone, you got to pick up your methadone at seven o'clock in the morning. There's no point saying to you, "Oh, look, if you wanna be in the methadone program, you have to turn up here at 11 o'clock" 'We don't do that. That's ridiculous. We say in the context of your life, how do we help you live your life better? We organise for you to pick up your methadone at 7:00 AM at the chemist on your way to your high-flying court case. So, why is that different for parents? Because for people who come in our doors who are parents, that's a huge thing in their life. So therefore, if you also organise for them to pick up their methadone when it's not impacting on their parenting responsibilities, you're helping them. If you actually are transparent and are acknowledging and are working with parents around how do they keep their children safe while they manage their substance abuse, you're actually helping them in the context of their life. (Manager)*

Some staff tried to make themselves available on a drop-in basis or when women presented in a crisis.

> *Women may miss appointments, may present in a crisis. Some of the visits are ad hoc, so it's about dropping what you're doing and then dealing with the crisis to prevent a bigger crisis down the road. People do rebounce back. It's not "I'm sorry, you had a two o'clock appointment, you didn't come at two o'clock, it's now quarter past two. I can't see you. We'll have to reschedule for next week." It doesn't work that way. Most of drug health understands that framework because none of our clients do tend to come at appointment times but we can be flexible to a degree. I mean, if you are a full doctor's clinic, they need to know that the doctors work a little bit different but, as for us, we can flex things around a little bit. I've put off a meeting to go and see a client. That's more important. (Frontline staff)*

However, particularly for medical staff, the logistics of providing a drop-in service presented challenges.

> *In terms of flexibility of service, people talk about flexible appointments, drop-in kind of thing and yes, I think that would be ideal. But I guess the problem is that things are pretty tight. There are not a lot of doctors, not a lot of appointments schedules available. And also, part of my understanding about trying to support people with drug health is to try to introduce structure – giving structure and routine and things like that. So, trying to encourage that is also beneficial. I think generally, definitely for pregnant women and with families, we try and be as flexible as we can and don't rouse on people if they turn up late. (Frontline staff)*

Clients often had a number of appointments in different places and their attendance was scrutinised, particularly by FACS. Many participants felt it was unrealistic to expect that women would never miss appointments given their other responsibilities and limited transport options.

> *For these women, particularly if they've got FACS involved, they've got so much going on, so many expectations being placed on them that they're trying to manage a diary that's chock-a-block and then things going pear-shaped. On that day, the kid gets sick or something happens with housing, so they – and they haven't got money on their phone, so they can't ring. And also, the other thing is a lot of people we see downstairs have been on their own since they're quite young. So, they've often not learnt a lot of life management skills anyway. So, to suddenly expect them to be perfect at managing a diary and getting to various places is a bit unrealistic. (Frontline staff)*

> *I just think there's lots of appointments, especially if you got other kids, it's like a lot of dragging kids around, and then you miss one and then they go, "Oh my God! I missed an appointment," and FACS will go, "You've missed an appointment. Why?" and I think that's tough. I just think it's a massive commitment to come here every day [to get dosed] and they don't have cars, so it's putting toddlers and babies on public transport and getting here, it's not easy. (Frontline staff)*

> *These girls have so many appointments and are scrutinised. They're amazing and they've got their daily dossier. Some of them go by public transport to halfway across Sydney, and they're back, and they've got small babies, and they do it in all sort of weather. (Frontline staff)*

Reducing waiting times for antenatal care

Integrated care for pregnant women with substance use issues typically includes the provision of antenatal care and addiction management under the one roof (Blakely & Bowers, 2014; Marcellus, MacKinnon, Benoit, Phillips, & Stengel, 2015; Milligan et al., 2010; Milligan et al., 2017; Morris, Seibold, & Webber, 2012; Niccols, Milligan, Smith, et al., 2012; Toner, Hardy, & Mistral, 2008). The PAF antenatal clinic at RPA has adopted an integrated care approach, enabling clients to see a multidisciplinary team comprised of an obstetrician, midwife, social worker and Drug Health nurse, on a single visit. For many clients, this is their first contact with the service and for staff, the clinic presents an important engagement opportunity. However, participants reported that this approach could result in considerable waiting times for clients. On a given day, a client could expect to be at the clinic for hours and this time would be extended if the obstetrician was called away for a delivery.

> *For a lot of these women, they see a doctor or midwives and they have to wait, and they see the social worker, then they see the drug health person, then they go for a scan, then they come back to us waiting for someone to look at the scan. So they do see a number of people and it really is a whole afternoon. I don't know whether patients' expectations are too high given that it is a public health service and we do see multiple numbers of patients, that they have to accept, you're not paying for this, you do need to see all this number of people, so that we can help you get through the pregnancy and take your baby home at the end of it all. It will take all afternoon. Is that fair to expect them to do that? And especially as – particularly the women who are stabilised on methadone, they may have a job, they might not wanna wait around all afternoon. That might be okay as a one-*

> *off, but – and what if you're doing a job where you only get paid if you're physically there? (Frontline staff)*
>
> *If our women downstairs didn't have to line for three hours for an appointment which is so sad on a Wednesday, some people are seen that they don't attend appointments. But if you've got two kids and they're lining up for three hours, a lot of people can't wait around. (Frontline staff)*
>
> *I think that's such a shame, 'cause they already have a distrust. A lot of them are Aboriginal women and they don't like coming to hospital and they do have a bit of a distrust and – yeah, they're just not happy to hang around in a waiting room and I think that's a shame. Sometimes I don't even realise that they've gone. You call their name and they're not there. Sometimes the obstetrician will be running late, they might've had an emergency Caesarean or something that they've had to do, so they're just running a little bit late. When I say a little bit, it can be significant. (Frontline staff)*

Staff were keen to explore options for increasing client-centredness by reducing waiting times. The idea of a group assessment process was suggested by one participant.

> *I sometimes wonder if we were all in a room at the same time with the patient. We know that with certain patients, they're gonna dash off if they're not seen quickly. So, do we need a different model? We need a model that's more convenient for the patient and for us. (Frontline staff)*

Rationalising which members of the antenatal team clients needed to see a client for each visit was suggested by obstetricians, as a way to reduce the time clients spent at the clinic.

> *Communication with each other, making sure that we're not overwhelming the patients, so that they don't feel that every time they come, they're spending the whole afternoon here seeing multiple numbers of people. That we rationalise who they need to see at each visit, whether we can see them less frequently, but more effectively. Unless there's a specific obstetric reason for them to come every week or every however often they need to be seen, and do they always need to see an obstetrician? (Frontline staff)*

However, if a client would not have regular contact with an obstetrician, a midwife would need to be available as a consistent contact person for clients. The midwife could have a coordinating role, with the capacity to follow-up clients after missed appointments and stop them "falling through the cracks".

> *Making sure that people don't fall through the cracks. If they don't turn up, that we have a system of contacting them. Although they see a number of different people, if we can coordinate it such that they feel that they don't have to see everybody every visit, having a midwife that they can contact if they're in difficulty or they need help. (Frontline staff)*

As discussed previously, having a dedicated midwife for pregnant women with substance use issues was also suggested to maintain engagement and continuity of care during pregnancy and after the birth of the child (See Section 2A: Strategies for promoting engagement).

Some staff also questioned whether Drug Health involvement in the PAF clinic was necessary or an efficient use of staff's time. According to one participant, discussing substance use issues could intrude on or overshadow a client's experience of antenatal care. Completing the drug health assessment at a different time meant clients could enjoy just being "an expectant mum" when they attended the antenatal clinic.

> *I also think it [antenatal care] should just be about the ladies' physical and maternal health. I think there's plenty of space downstairs. There's plenty of clinical rooms. There's plenty of time where we can link in, from a drug and alcohol, social work, FACS point of view, and not intrude on their antenatal care. I think it's quite unfair that these ladies don't get that experience, where it's just about their ultrasound, or their… being an expecting mum. And then, discreetly, I can make a phone call. ____ [The social worker] can make a phone call. A few of the mums are on methadone, anyway so I could see them here at ___ [hospital]. And, it doesn't have to intrude on their antenatal care. But, it's all this, "Oh, it's a one-stop shop. They won't come to any other appointments." I would rather see the drug health side of it separate. Or, not included in their antenatal appointment. I think all women deserve the joy, or the ability, to be looked after for nine months, antenatally. (Frontline staff)*

Given the existing time constraints of the antenatal clinic, it was felt that there was often inadequate time for doing a drug health assessment and it would be best to arrange the appointment for another time.

> *It's not clear, a lot of the time, why you're there. And, the slots – they have, maybe, ten or 20-minute slots. But, that's to see everyone. But how you can have a meaningful conversation, even just from a drug health point of view? You can't, in that timeslot. I think the most ladies I've ever seen have been three on a Tuesday afternoon. So, the list looks huge. But, when you break it down and look at it properly, there's indigenous or social work requirements. There's domestic violence. Not always active drug and alcohol. And, I actively refuse to see some ladies because I don't think it's necessary. If somebody's booked in and they've got a history of cannabis use and haven't used anything for three years, I'm not going to – I don't think it's appropriate. (Frontline staff)*

Data highlighted some of the challenges of making integrated care work effectively in this context, without having a negative impact on clients. The best practice approach for the MOC, including the potential role of a dedicated PAFDHS/SUPPS midwife, requires further consideration and consensus among all staff who are involved in the antenatal clinics at RPA and Canterbury hospital.

Outreach

> *There's huge benefits I think to that home-visiting where someone comes and knocks on your door and says, "How are you?" and that's how it should be. Women shouldn't be coming back here to the hospital or any sort of service based in the hospital. (Frontline staff)*

For decades, outreach, as a model of service delivery, has been considered an effective way to make health and community services more accessible for marginalised or disadvantaged populations who use substances (Bradshaw, Pierce, Tabrizi, Fairley, & Garland, 2005; Cortis, 2012; Coyle, Needle, & Normand, 1998; Fisk, Rakfeldt, & McCormack, 2006). Participants highlighted the importance of outreach services during the antenatal period and to follow-up and maintain engagement with clients, rather than expecting them to come back to hospital for care.

> *I keep preaching on about outreach. You can see the benefits to it. To be able to do that longitudinally over a period of time, that kind of outreach, that kind of model is just so valid. I think the work that we can do as opposed to a centre-based service is so much better, we can do so much more. (Frontline staff)*

> *Outreach services. I think RPA have done some good things with their teams. So, when you've got social work, paediatrics – all the follow-up services, but they don't have outreach to pregnant mums and after. I think it's really, really important. It's a problem getting people to the hospital for antenatal care. If they've got a relationship with someone, it's easier. I think dedicated outreach social workers, even drug health staff is really important. (Frontline staff)*

> *So being flexible and going to the home like SUPPS would shows that it's not through [clients'] lack of wanting to be here. It's capacity. So I think that just flexibility in practise, it's quite old school, our hospital approach, and just being flexible is a great new concept. (Frontline staff)*

> *I think outreach would be ideal. That's why we [NGO] have such a success because we go out to their [clients'] homes. If we had to rely on them coming to us, it wouldn't happen, no way. (Frontline staff)*

Participants reported that home visits were advantageous for both clients and staff. Clients could feel more comfortable and "cared for" when seen in their home environment.

> *Home visit as well, that's what they [clients] love as well. Someone is seeing them and they said that someone is caring for them about their needs, their lifestyle. (Frontline staff)*

> *A big one [problem] is people having to come in to the hospital. Services need to be more outreach where people are more comfortable. (Frontline staff)*

> *That's the part I'm loving about SUPPS, because they can go to the houses and they can do that additional research, I guess, in a sense and see what it is instead of us relying on their [client's] word and they've got the capacity to build a*

> *fantastic rapport. They're in somebody's home, people feel comfortable at home. (Frontline staff)*

Home visits were more convenient for clients but also provided opportunities for staff to observe a client's parenting approach in a natural setting.

> *Because some of them, they won't be able to attend a court hearing or appointments because of maybe transport, or they're not well or something like that. So at least we will be able to go there and do a home visit and see how they're going and we can monitor the environment as well, where they live. Which is really good for me to monitor the patient in terms of how they're capable of looking after the baby, or how they manage their social issues because at least you can see it, you can visualise it when you do the home visit. (Frontline staff)*

> *If you've got outreach and you've got a nurse out there doing it, they can spot all of that kind of stuff, have a quick – everything looks reasonably normal in the household with babies, with stuff everywhere, but everyone seems fine. (Frontline staff)*

Outreach was particularly effective for monitoring babies who may be experiencing withdrawal.

> *Because when you visit, especially the postnatal one, when you visit after delivery, you will also monitor if the baby is settled, especially with the NAS withdrawal, with the neonatal abstinence syndrome withdrawal. (Frontline staff)*

Drug Health Services currently funds three outreach services, including the Assertive Community Management Team, the Assertive Community Outreach Team, and the SUPPS program at Canterbury Hospital. However, the lack of drug and alcohol services provided through outreach, including relapse prevention, was reported by some participants

> *There's no help for new parents. They don't – it's not set up really well because all of the other NGOs and stuff will come to the house, FACS will come to the house to meet you, do all that kind of stuff, but your drug health stuff isn't dealt with in-home. You're the one having to get out and do it, whereas everyone else will come to you. (Frontline staff)*

> *I don't know of a lot of services who do outreach in the house, specifically for drug use and relapse prevention. Usually, I think from memory, mums continue engagement with the hospital in regards to those things and then they have family support coming to the house. I know now at Canterbury, there's going to be outreach and that's definitely going to be a super plus. (Frontline staff)*

The outreach model also enabled workers to facilitate a client's engagement with other services in the community. Many clients could be reluctant to access services, particularly for the first time. When staff accompanied clients for the initial visit, it could increase the client's confidence, reduce their anxiety, and make it more likely that the client would engage with services again in the future.

> *We offer that community support. If you're engaging with the pregnant woman and you want to link them in, obviously you do have to go to hospital for certain appointments. The worker has the capacity to take people to that first appointment to meet with the new person. It's always scary going somewhere for the first time, so having that, to do that hand-holding service. This week I'm walking someone from their house to the hospital for their first meeting, 'cause they can't access trains or busses due to some past trauma. So we're walking 400 metres to make it there. It don't seem like much but it's probably a huge factor. (Frontline staff)*
>
> *So it's not doing things for them. It's through accompanying them or going to Centrelink with them and sitting with them for two hours, knowing that their anxiety would prevent them from sitting for two hours. Therefore they might make it through the door of Centrelink, which is a huge step for some clients, but the capacity to sit in a crowded waiting room, waiting for your number to be called is beyond the most of our clients. If you don't get things done at Centrelink, the impact of years of your life as a result of that is huge. (Frontline staff)*

At times, participants acted as a communication bridge between staff and clients. For example, when a client was admitted to hospital, the presence of the outreach worker could assist in making sure staff and the client were communicating effectively.

> *I also know that without me being there, the parents very much struggle to feel that they're not being judged. I have to go there. I have to be there. Some health staff only want to talk directly to me. So I have to work very hard to get mums and/or dads into that conversation sometimes. It's really interesting. It's like, [the hospital staff member] "Oh, you know the family well." "Actually, she's right here". I have to look the part and talk to them on a professional health level, and just provide that bridge between an anxious, distressed parent, often with issues of articulation and fear of authority and a health professional. So I find that incredibly helpful to be that bridge. The client rings me, sobbing, saying such and such has just gone off in an ambulance with a police escort. I can say, "Okay." I can rearrange things 90 percent of the time. I can be there to be that bridge while we get you – deescalate the adult and their natural anxiety and stress and provide that bridge between what's actually happening in the home versus the medical world. So, I don't know how we make that process better, but it certainly is required in my opinion and it certainly helps with the ongoing communication in so many ways. (Frontline staff)*

This role did not usually involve multiple visits.

> *I don't need to keep going back to the hospital, I've found. I need one intensive, maybe two or three-hour period where I'm allaying mum or dad's anxiety to the point where they can communicate and it's almost like I'd proven that the health staff are nice and worth talking to. So I've just facilitated that communication bridge. So, yeah, it may be one intensive, "I'm here." So, just communicating that*

> *it's a progressive thing and they're trying. Stop the judgment, they're trying. And from then on, things seem to move more quickly, more smoothly. (Frontline staff)*

The SUPPS service at Canterbury Hospital currently has the option to provide outreach up until the child reaches two years of age. This is not the case at RPA. At this hospital, a degree of follow-up is provided by a Clinical Nurse Consultant (CNC) on an outpatient basis. However, the social worker role is an inpatient one and it is Social Work policy to refer clients to other services rather than asking them to return to the hospital for outpatient care. In the interests of maintaining continuity of care, many participants supported the outreach role of SUPPS workers who had built rapport with the client during their hospital admission or as part of antenatal care. It was suggested the Canterbury approached be adopted at RPA.

C. Possum Playgroup

Possum Playgroup, in its current form, was established in 2016 and is held once a week in the RPA OST clinic. The service received a NSW Health Award for the contribution it made to the lives of patients.

> *[Possum Playgroup] probably been the best addition to the whole PAF service, I would say, in the last five years. It won a NSW Health Award actually, for contributions to patients. So, it's been recognised in the state as being useful and we know it's useful. And you only have to go there for a few weeks and see some of the families that were all in there and you can see that it's a safe place that adds value. (Frontline staff)*

The playgroup played a unique role for some clients who would never have been willing to attend a mainstream playgroup because of concerns about being judged and the stigma related to substance use.

> *They're not going to go down to an open play group. I think they feel like they're exposed and quite vulnerable and that people maybe know that they're taking drugs or their previous history. You know that paranoia? Probably been judged before and would have an understanding of that. (Manager)*
>
> *A lot of them are reluctant because they feel like they're going to be judged. Then when they get there [Possum Playgroup], they think, "This is amazing, there's another mom that's my age who is going through the same things." But it's just that initial getting them there, that is the real challenge, especially for the young mums that have had drug and alcohol issues. They really struggle because they do feel like they're going to be judged. (Frontline staff)*
>
> *The Possum Playgroup, we sort of started a year and a half, nearly two years ago. It came about because we were identifying that we were not keeping up with these people, that we were not providing them with a good service once they've had their babies. So, they weren't engaging in other playgroups in the general community, because they felt stigmatised and not able to relate to those people, felt very judged, and didn't want to go. So, they were socially quite isolated, and their children, therefore, were socially isolated. (Frontline staff)*

Possum Playgroup ostensibly operates like any other playgroup, but with professional input from staff from Drug Health, Midwifery, Newborn Care, Tresillian and Social Work. As well as guidance in relation to parenting and child development, clients can access support from each other as well as staff, in an informal, non-judgmental environment. The playgroup also provides some clients, who have babies in temporary care arrangements, with an opportunity to spend time with their child, without being under the direct scrutiny of FACS.

> *The key ingredients are that we try and meet the women where they're at, in an informal way. I think that's really important. It's why they keep coming back. We try and not make them feel like they're doing it badly, and to make it feel like a friendly and safe place for them, so that they can relax. Because they're just so scrutinised and we need somewhere where they're not scrutinised. (Frontline staff)*

> *What we provide there is an avenue where these women feel safe and not judged, can turn up and talk about nutrition for their children, can talk about drug and alcohol issues if they've had some cravings or – I've had people turn out and go, "Hey, I just ran into a friend and I think she's using. Do you mind if she comes and starts coming to Playgroup?" And then they link in immunisation, just weighing the baby, make them feel safe. And sometimes some of the mums actually come because it's a moment that they get some care, like time with their baby without FACS. So, FACS will drop their babies off and they'll sit there and FACS aren't allowed to sit in there with them while they're with their babies because it's not right for the other women. I think it's quite trauma-invoking and people can't just be who they are. Just to ask questions that they feel someone else may judge them for. We had one woman who doesn't cook. She's never been shown how to cook and then some other women were talking about recipes and then she said, "Look I'll cook for you and cook you some meals" and then they started chatting and there was all these recipe exchanges, so it's just an avenue where like-minded people with similar experiences can come together or bring other women that they know into it to gain some support as well. So it's really important for them. But also, I think that they like that support. So they've known you throughout the pregnancy but post pregnancy, they don't have to come every week. But they'll rock up because they wanna show off their child and say, "See? Look, I'm still doing really good" and they rock up Christmas time, we throw massive Christmas parties and they all get gifts and hampers and they feel special, and the kids feel special. That's priceless. When you've got a child come up to you and say, "This is the best Christmas ever," because some things are really silly and miniscule for us but it's everything to them. (Frontline staff)*

The playgroup has adopted an integrated care approach, where a range of services can be provided for clients in the form of a "one-stop-shop".

> *So, the playgroup was really designed as more of a one-stop shop for them. So, we thought if we could get many services available across a lot of disciplines in one spot, then we can actually use that to model behaviour in terms of family*

> *dynamics, model discipline, model engagement, really, with their children, and attachment. So, that was the reason we really started. It gave the mothers some social contact where they felt relaxed. It was a very safe space, and they felt okay with the people who were there. Food. And access to a lot of services so both nongovernment and government organisations. So, there's a Tresillian nurse, we run in partnership with Tresillian. So, we have child and family, well baby information there all the time with a professional who is there to just chat with the women. On the surface, it looks like nobody's doing anything except playing with babies and doing stuff, but then if you look around, you'll see the Aboriginal liaison and midwife will actually be talking to one or maybe two people. And one of the Drug Health counsellors would have walked in and be talking to someone else. The Tresillian nurse would be asked some questions to another mum. (Frontline staff)*

Immunisation and developmental checks for babies have also been integrated into the playgroup's activities.

> *We know why they aren't immunised now because they haven't been engaged anywhere. The patients will come to playgroup 'cause it's non-threatening. They will come a lot actually and they would way rather go to playgroup than clinic or PAF clinic. (Frontline staff)*

Training and education classes have been part of the playgroup programme, aimed at skill development for clients.

> *You know, nutrition, we have all healthy food. There's no sweets and stuff like that. No soft drinks. We get first aid comes in every couple of weeks and teaches us different things about burns and choking so they all get to do first aid. We've had cooking classes so we've taken them down to Charles Perkins and they're all cooking so they can just learn to just do some simple stuff that their parents may not have done with them when they were growing up, so they can then model that to their children as they get older. (Frontline staff)*

> *We've had the dental people come. We got a private company called CPR Kids who come and actually donate their time for free now. (Frontline staff)*

Self-defence classes have also been a successful and very popular component of what is offered through the playgroup.

> *We also had martial arts self-defence classes for a long period of time as well. There was a really huge uptake for it because I think it empowered women. These women have been threatened most of their lives and abused and it just gave them something to focus on and really put some power behind being strong women and give them hope that they can raise their children to then be strong children. It's really good seeing them really concentrate and focus some of that anger. (Frontline staff)*

However, education sessions were not always the most effective way to get clients to participate. According to one participant, clients needed the chance to “have a say” regarding the content of the education programme.

> *They’ve got some sort of purchase on it, some say on what happens there. Things like, I might say to them the first day that people come, “What would you like to talk about?” So, they’ll decide between themselves and you can suggest various things, and then we will look for that provider to come in to talk to them about that. (Frontline staff)*

Sessions needed to be limited in length. Clients did not always feel comfortable speaking up and asking questions during information sessions, and preferred a more informal and interactive approach.

> *We find that trying to get somebody to stand up and talk about a subject is not a good way to do it. They're all keen for information, but they don't like to actually ask the question in a group that often. So, I think when we do have people who come to present something, we find that the attention span – they just walk with their feet after 35-40 minutes, and that’s fine. They’re allowed – going out for fresh air, or just going out to – they just don't want – just can't concentrate for any longer than that. (Frontline staff)*

However, arguably the primary focus of Possum Playgroup was on role modelling parenting to clients and facilitating social skill development for children.

> *So Possums, it is there to support mums on different things but there is a focus about modelling good parenting for children. So it’s mums who’ve never had people model just normal social behaviours. This mum comes and her baby is almost two and when her baby first started moving around, her baby used to smash all the other babies like really violently. She is used to being in an adult world so didn’t really have an understanding of children. But I would sit there and when she was near a baby, I would sit there and I would say to the mum, you know, it’s really important for them to know that they can still interact with children so I would model, like “Pat. Gentle, gentle” and you know that talking, what we would do with our kids. So you’d see her over time, she would start like that but then she’d still smack last, ‘til now, she goes up to kids and she hugs them and likes to share and she’s like talking and it’s a pleasure to see that development over time because then you know these kids are actually getting some vital structure and also mums are getting that vital support that they never had growing up. (Frontline staff)*

Food was also provided and donations of second-hand baby clothing were distributed, when possible.

> *Food. We need to feed them. That’s actually what gets them to come, I think. (Frontline staff)*

The playgroup was also one of few available avenues for staff from neonatology, community paediatrics and newborn care to follow up clients and their babies post-delivery. According to staff, clients were not necessarily willing to return to the hospital to attend a clinic appointment.

> *I think in hospital, it works okay 'cause but it's after five days and they're [mother and the baby] sent home, that's for me where the big problem lies. And playgroup has been a way of keeping people engaged in the system. It's the only way we've got really of maintaining engagement with the families. (Frontline staff)*

Staff who ran Possum Playgroup nurse sought to engage with clients during their pregnancy or on the hospital ward or nursery, to build rapport and facilitate the client's engagement with the playgroup after discharge from hospital.

> *Normally, what I would do is try and meet people antenatally or perinatally when they come into hospital to have their babies and then talk to them about coming over to the Playgroup afterwards. Talking about follow up for their babies, people that are likely to have their babies come to the nursery for any period of time. So, there's going to be a separation of mother and baby for some period, because they have a medical condition, because they're preterm, because they're likely to be withdrawing a lot, and in this hospital, you can't really have a very withdrawing baby with their mother on the ward. So, what I found is that if you can actually get the mums to come down to the nursery to meet a few of the staff, they actually feel better about spending time in the nursery, and they don't feel quite so judged, and the staff actually responds to that too. So, it's much easier to engage them and then to actually form a relationship with them, which means you're much more likely to see them in follow-up. (Frontline staff)*

The idea of incorporating evidence-based parenting programmes into Possum Playgroup was also raised by some participants. While participants appeared generally supportive of parenting programmes like "Parenting Under Pressure", or "Circles of Security", using Possum Playgroup as the context for running these programmes could detract from its other important functions.

> *I just don't think we can do it there. It does have a value in itself, and I think that it'd be wonderful, but again, I think it's a little bit tangential to the real aim of the playgroup. It shouldn't be some rigid sort of program that we do every week, because I think that's how those things fall apart. I wouldn't want in the time I'm relaxing with my kids every week to be doing some rigid thing every single week. I'm not very comfortable with that. Jill It demands that you are all sitting around and actually doing a program. I would like that to be a bit separate from playgroup. (Frontline staff)*

There was not a similar playgroup in the Canterbury area and some participants expressed concerns about the lack of other mechanisms for follow-up of babies.

However, while many participants reported that Possum Playgroup was a very effective programme for clients, it was "not for everyone".

> *It's the only way we've got really of maintaining engagement with the families if they engage in it, and the thing is, playgroup is not the answer for everyone. We were having this discussion last week actually. It is for a lot of the families, but it's not for everybody. So, some women I think find it too overwhelming or too intrusive, or not the scene they like to be at, or below them, a whole lot of reasons. (Frontline staff)*

The number of clients and children attending on any given week, varied considerably, according to some participants.

> *We've had anywhere from four families to 23 families turn up at any one time. (Frontline staff)*

> *Not enough women come. Three today. (Frontline staff)*

A small minority of participants questioned the value of Possum Playgroup given the time involved for staff and lack of clarity regarding the playgroup's intended function.

> *I don't know what it's [playgroup] meant to be doing. We can't document anything about women being there, which concerns me, when some of them are mandated by FACS to be there. We should be. They've got four or five clinicians. We're getting paid a lot of money for two hours, to stand there, and we're not really doing anything. It's all about eating cake. I don't quite get it. I think, in a church hall, it would be fabulous, on a voluntary basis. But, from a health service? I don't get it. (Frontline staff)*

Some participants with direct involvement with Possum Playgroup highlighted the need to shift the focus of the playgroup programme away from the mother's substance use problems and onto the child's development. It was suggested that an additional staff member for the playgroup be funded by Women and Babies at RPAH rather than Drug Health, towards this end.

> *It's all about the babies, them as mums, and having a lactation person there, and a social worker, and Tresillian nurses, and all the other people that ____ [nurse] gets to come. It's got nothing to do with the fact that they use heroin. It's because they're a mum with a newborn. I think removal of playgroup from drug health, I think would be good. It comes back to my whole thing that the drug-using women are a part of it, but they're not all about it and postnatally, it's about the family, not about the methadone. It's just the perspective that we come from. I think it's just about family-centred care. It's not about the baby of a methadone-using mother. (Frontline staff)*

> *That was the gap in service that I saw. It's the babies – that we need somebody there to actually advocate for them all the time. The balance is just the other way. I have put in a brief to the Women and Babies' executive for a whole new position, which would be based in Women and Babies, not in Drug Health. That's part of having recency of practice with babies and being very connected with the maternity stuff, being baby-focused rather than being adult-focused. I think going forward, and if you're going to look at the service long-term, you need somebody*

> *who can actually work in Women and Babies and in the nursery, run the follow-up clinic in the nursery, and also, the Developmental Paediatric Clinic afterwards. The Drug Health people – the parent drug health staff do really beautifully with that overall overarching drug health services for the mothers, but that's for the women. (Frontline staff)*

Overall, participants felt Possum Playgroup was effective but the programme is yet to be formally evaluated.

> *We're doing the whole thing in other [work] time and people say, "You need to do some research on the playgroup." And yes, I know we need to do research, but we've hardly got time to run the playgroup, who's going to do this research? (Frontline staff)*

In addition, the need to review the funding for the programme was highlighted in order to ensure the sustainability of the programme in the future. Currently some staff attend the group in their paid work time while others contribute considerable hours on a voluntary basis, particularly when preparing for the meeting.

> *It takes a bit of organising and I'm a little concerned with my team lately, because funding-wise, we were started with a one-off grant from a group called Little Wonders, who support the nursery and they gave us a $4000 grant when we were going to set this up. We put in briefs for the playgroup and various other things. So, it was it was funded by an outside group that funds things for the nursery so not from anything from Drug Health. And then, it wasn't really their target focus. They're not actually directly funding us anymore. So when _____ [previous manager] was here, we actually went and spoke to her and said, "Look, these are the figures for the year and this is what we're going to need going forward." And so, she signed off on $6,000 a year, just for those sorts of things. That's nothing, the $6,000 a year to run the playgroup. None of the staff are funded for this so we all just fit it in, in our other work time. Now, for me, that means taking me out of my job and the nursery have actually agreed that I can come and do this but it really puts a bit more pressure on my colleagues in the nursery who are transporting babies and supporting families with preterm – otherwise non-drug health families in the nursery. (Frontline staff)*

The need for a larger, designated space was also suggested.

> *The space itself is getting too small. And what we really need, if we're going to move forward with it and actually make this something that is part of the service that is going to have some longevity is a space that actually fits the purpose a little better. (Frontline staff)*

D. Continued involvement in Pregnancy Family Conferencing

Identifying and responding to child protection concerns is a key component of SUPPS service delivery. Participants working directly with clients were often involved in the PFC programme, jointly funded by

SLHD and FACS. Participants reported it was an effective way to reduce assumptions into care. PFC was introduced in 2012, as a voluntary antenatal programme with the following aims:

- To bring families, FACS and local health district staff together with an independent facilitator to finalise a plan that reduces risks to the unborn baby;
- To ensure transparency regarding child protection concerns and FACS workers' expectations in relation to a client's behaviour change and supports that need to be put in place;
- To reduce assumptions into care at birth; and
- To target the over-representation of Aboriginal children in the child protection system (Tayebjee, 2016).

Outcomes of the programme appear promising. Over the period July 2016 to June 2017, there were 19 participating families and 68% of babies remained in the care of at least one parent when they left hospital. The majority (75%) of Aboriginal infants remained in the care of their parents and, of those babies assumed into care, 50% left hospital to an identified kinship placement (Tayebjee, 2016).

Participants highlighted the success of PFC for some clients and the need for continued funding for this programme in the future. The strength-based approach of PFC was seen as powerful for many clients who rarely focused on, or received feedback on, their strengths.

> *During the [PFC] process, we discuss their strength, the family's strengths, their hopes and dreams in regards to this baby and the family, and the worries. We really focus on the child protection concerns, and then we case plan based on those worries and those strengths. Many times this is the first time families hear what's okay with them, like what's going well within their lives because it's so strength-based. Especially from FACS. Many times caseworkers will say, "You know, you're doing this really well and this really well and this really well. It's only this bit we are worried about so how can we help you?" So, from that perspective, it's just a different way of working. (Frontline staff)*
>
> *Actually, a lot of our clients have never had anyone tell them that they're doing a good job or they're trying hard. (Frontline staff)*
>
> *My aim is to get the strengths massive in that meeting, so overwhelmingly massive. So the clients go, "Oh, actually I'm quite good at something. I've only got to deal with the drugs and with other stuff and actually, bingo." (Frontline staff)*
>
> *[They think] "Oh, somebody actually cares about me and they actually see my potential. They don't see me as not being worthwhile". (Frontline staff)*

However, participants also reported that the programme's effectiveness could be undermined by late referrals to PFC, resulting in less time for clients to engage in the process. In SLHD, 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. Early engagement of women in

PFC during the antenatal period is the ideal (Tayebjee, 2016) and if possible, FACS like to hold three PFC meetings prior to the child's birth.

> *We have three of them [PFC meetings] and they've now moved into postnatal conferences as well. So by the third prenatal meeting we'll know what's gonna happen, right? So there's no surprises unless between that conference and birth of the baby, something drastic has happened – for example, if a mum uses significantly. So, we'll know by the third conference what we're gonna do based upon what's preceded. I will have a discharge meeting at the hospital with all services and all supports. And then I will start referring off to a new caseworker over a couple of weeks or so. There'll already be things in place like an NGO with a home-visiting service. Mum might still be required to do drug testing. So she's still busy. And that will be ongoing and we'll be doing safety risk assessments, case plans. (Frontline staff)*

However, participants reported that often, only one meeting could be held. A client's participation in PFC was often viewed by FACS case workers as a demonstration of the client's commitment to making changes.

> *Participation [in PFC] shows you there is some level of commitment [from the client] to do something different. Sometimes there is not enough time. (Frontline staff)*

Delayed presentation for antenatal care or delays in FACS opening a case could reduce a client's opportunities for participation in PFC. FACS's policy states that PFC cases will only be opened after 20 weeks gestation. According to some staff, delays in opening a case and late referrals to PFC, could disadvantage clients.

> *The client says she's pregnant eight to 16 weeks or something, then it gets referred to FACS. It may be a bit delayed for it to open, and then once it's opened, they're gonna refer. So, the ones that I'm having are being referred the first 13 to 32 weeks pregnant, way too late. How do you demonstrate change? (Frontline staff)*
>
> *I mean FACS drive me nuts. I mean most of them are alright. It's just their policy. They don't open a matter until they're [the client is] like 20 weeks or 22 weeks or whatever. If there's lots of stuff to deal with, and the clients just get so super anxious, "I gotta meet with FACS. I don't know what's going on." I've done it a few times when there's just heaps of stuff so I force FACS to open a matter early, so we can get everything [organised]. So that works really well sometimes, but that's frustrating that you have to do that. (Frontline staff)*

Participants identified PFC as an effective programme that could be expanded. However, staff also noted that PFC involved a considerable time commitment from staff involved. In addition to meeting with clients and collaborating with other health professionals, PFC meetings could take hours.

> *But that preparation takes a huge amount of work. (Frontline staff)*

In order to support continued staff and client participation in PFC, staff needed the time and resources to carry out this role.

> *They have a lot of patients here at the moment but for one nurse to deal with that is really heavy because we also need to attend PFC meeting, PFC which is our family conference and that one, it takes at least five hours for the first meeting. That is only for one patient. Can you imagine if you have 38 patients, how are you going to deal with that? (Frontline staff)*

Expansion of the PFC programme will have resourcing implications for other services involved in the process.

E. Service gaps affecting core service delivery

There were three main gaps in service delivery identified by participants: access to free drug and alcohol counselling at RPA, residential rehabilitation places, and support services for women after a child had been removed and as they worked towards restoration.

Free drug and alcohol counselling

Relapse prevention counselling (Bowen et al., 2014) and access to drug treatment are considered key intervention for drug dependence (NSW Health, 2014). However, at RPA, there were times when it was not possible to access free counselling.

> *Sometimes it's hard to access [drug and alcohol] counselling because their capacity at RPA, it's really difficult. Sometimes, it's a zero availability within the counselling, even the outpatient one. In Canterbury, they have a few vacancies which is good. But for the counselling, it depends if it's public or private because most of our patients doesn't have money to pay for a private psychologist. (Frontline staff)*

Residential rehabilitation

Residential rehabilitation programmes provide clients with the opportunity to address substance use-related problems, to be removed from a home situation where domestic violence is present, to enhance their parenting skills and to demonstrate to FACs their commitment to making changes that will reduce the potential risks to children (Iachini et al., 2015; Pajulo et al., 2011). For some clients, not being able to enter rehabilitation could mean their child is taken into care. According to participants, clients could be referred to residential rehabilitation postnatally and sometimes, antenatally. However, places in residential rehabilitation were not necessarily available at the time they were needed. One participant described finding a vacancy for a client was like "winning the lottery".

> *I think one of the biggest challenges in the role, apart from all the politics, is the lack of residential rehabs. You're literally winning a lottery. If you had a bed in a residential rehab, if it only takes a number of weeks, you're like, "Oh my God." If you have an unbooked women present to the hospital, as soon as she's in delivery ward, I am like, "Okay, I'm just going to ring every possible service". One of the women we had just had a C-section and she was like, "Do I really have to do this*

> *[make a referral] right now?" I'm like, "Yes, you have to do it". They only have intakes on Wednesday, Thursday, Friday and they're super strict. (Frontline staff)*

In addition, eligibility criteria could restrict access to residential rehabilitation, particularly when a client was in OST or would need to bring children.

> *It's so hard to get a better residential rehab and especially with an 18-month-old in her care. (Frontline staff)*

Residential rehabilitation programmes in SLHD differ in terms of their eligibility criteria, their programmes and in terms of cost. Data suggested an increase in capacity of rehabilitation programmes in SLHD was needed to meet demand. However further research to examine the effectiveness of current models of care within these programmes is also needed, to inform the establishment of appropriate referral pathways.

Access to public housing

Limited availability of public housing could also have a negative impact on clients, particularly their options for responding to FACS concerns in relation to child protection. For example, housing availability heavily influenced accommodation options for clients after the birth of the child and whether clients could remove themselves from an unsatisfactory living environment (e.g. when domestic violence is an issue). Without housing, some clients may be unable to meet FACS' expectations and could not retain custody of their child.

Processes for applying for housing, including accessing temporary accommodation, could place onerous burdens on pregnant women. According to one participant, access to housing should be "non-negotiable" for this group of pregnant women.

> *I really want to do research about the lack of one residential rehabs but also housing for women, and families with drug health issues and what we could do as a system in terms of addressing that. Some of the pregnant women we've worked with have to present to Department of Housing every couple of days because they've been in temporary accommodations so they stay in a hotel and then every three days, they have to present to Department of Housing and prove that they're looking for private rental and Department of Housing will only house them for 28 days and after that it's outside guidelines and so then services have to advocate for these families. The mum can be like heavily pregnant and you still have to get all these support letters and blah, blah, blah, whereas one of their things is, I think if that was a policy that if a woman's pregnant, it's non-negotiable with housing. (Frontline staff)*

Support services for women who have a child taken into care

For many clients, the experience of having their child taken into care was traumatic and it was not uncommon for relapses to substance use to occur, at least for a period of time. Participants highlighted the lack of services available to support women during this period, including providing assistance to those who wish to work towards restoration.

> *Another thing that was really challenging with the PAF position is particularly the gap in service for women that didn't go home with their baby. So, actually, what*

> *would happen is if they left the hospital, they didn't have a child with them so, Intensive Family Support Services wouldn't take them either. FACS might help them a bit but FACS just took their babies so, they're not gonna engage with them. There's no wraparound service unless they have an acute mental health issue, that's willing to engage them and they would then maybe call us in the crisis and we weren't meant to provide that support. We actually didn't have a service to refer to in that instance, to provide them with ongoing care because they don't have a kid with them so, there's no support for that person. (Frontline staff)*

Summary

While SUPPS and hospital-based services were the priority focus of the current study, service gaps that exist in the broader service context were important to highlight given their influence on SUPPS core service delivery and their potential role in meeting the needs of clients. Participants suggested more free drug and alcohol counselling be made available at RPA, or elsewhere in SLHD. It is also hoped that the need for better access to public housing, more residential rehabilitation places and services for women after a child is assumed into care, can be highlighted through this research and that this evidence can inform future service resourcing and planning at a district level.

F. Services for specific populations

> *So how are we looking after Aboriginal women and how are we looking after women from non-English speaking backgrounds, and refugee women and people who recently immigrated to Australia? (Manager)*

Cultural considerations for the MOC were identified by some participants, in relation to two specific populations:

- Aboriginal clients at Royal Prince Alfred Hospital
- Moslem/Arabic-speaking clients in the Canterbury area.

Aboriginal clients

According to Census data, there are 4875 Aboriginal people residing in SLHD (Australian Bureau of Statistics, 2012). Aboriginal residents in SLHD experience considerable disadvantage compared to non-Aboriginal residents including poorer health, more difficulties accessing appropriate health services and lower life expectancy (Sydney Local Health District, 2015). In 2010/11 the rate of alcohol attributable hospitalisations for local residents was considerably higher for Aboriginal people than non-Aboriginal people (1,727 per 100,000 compared with 604 per 100,000). In 2010 only 48% of Aboriginal women in SLHD attended an antenatal visit before 14-weeks gestation, compared to 70% of non-Aboriginal women. A similar pattern is reflected at the 20-week gestation mark (72% and 90% respectively). In 2009/10, Aboriginal women were also more likely to have a pre-term birth (8.2% compared with 6.7%). Fifty-four percent of Aboriginal women in SLHD smoked during pregnancy in 2010, compared to 7.5% of non-Aboriginal women (Sydney Local Health District, 2015).

Racism and discrimination, negative past experiences with services, socio-economic disadvantage, lack of Aboriginal health services, dislocation from cultural support systems, poor communication with health care professionals and lack of transport options have been identified as barriers to health service access for Indigenous people (Aspin, Brown, Jowsey, Yen, & Leeder, 2012; Davy, Harfield, McArthur, Munn, & Brown, 2016; Reibel, Morrison, Griffin, Chapman, & Woods, 2015).

In the current study, staff highlighted a number of barriers to engaging Aboriginal clients in health care. According to one participant, Aboriginal clients were unaware of what forms of assistance and support were available.

> *They don't know what they're entitled to. It's hard for them to navigate the system. They don't know what's available". (Frontline staff)*

Maintaining engagement with clients could be very challenging. The strength of kinship ties meant Aboriginal clients often left SLHD for weeks at a time because of family responsibilities in regional or rural areas. According to one participant, this made follow-up of clients difficult.

> *It just doesn't work because they fall through the cracks. They do have extra business and the clinic system says you need to get your eyes checked and we'll book you in for an appointment. But that day, somebody in someone's mother country dies, and they go up there for about three weeks and come back, they've got so much else going on. You need relentless follow-up for these kids. (Frontline staff)*

The sustainability of long-term support and care arrangements was also raised as a challenge in terms of maintaining engagement.

> *I mean they've got the MECSH program, they've got Yana Muru, which is the Aboriginal home-visiting service. Their early childhood stuff is reasonably good. As long as there's a team, 'cause what happens, you get all these great case plans. It looks fantastic but too complicated to begin with, too many things in it, and you can see it just drifting off and off and off and things just falling away. The sustainability part of it is really important. I think we all fail in that. (Frontline staff)*

Previous research has identified a range of strategies for promoting engagement of Aboriginal clients in health care including involving family members in care planning to support service access, providing Aboriginal services, employment of Aboriginal case workers, continuity of care by known and trusted care providers, assistance with transport and appointment reminders (Davy et al., 2016; Reibel et al., 2015).

In the current study, the need for more Aboriginal-specific services was identified.

> *Need Aboriginal dedicated rehabs or refuges. There are none in SLHD. For women or men. (Frontline staff)*

Aboriginal clients needed to be prioritised for access to OST given their reluctance to engage in relapse prevention counselling.

> *Aboriginal people need to be prioritised to access [drug] treatment. Aboriginal people don't attend relapse prevention counselling. [Why?] It's the shame and feeling they're going to be judged. (Frontline staff)*

Responding to the financial hardship experienced by many clients, by providing food, second-hand clothing or bedding, could promote engagement as well as making a difference in the everyday lives of clients.

> *Whatever you have [gets handed out], bedding, towels, clothes, food, like sandwiches. I start the day by going into the [OST clinic] waiting room, "Does anyone need anything?" There's all types of people. (Frontline staff)*

Meeting clients at Aboriginal services and in their local community could maximise cultural safety for Aboriginal clients and promote engagement.

> *So we have a meeting at _____ [Aboriginal service] to start with, pre-pre and then we have the [pregnancy family] conference in the local community here and mum keeps the baby. So she engages really well. She's quite capable of voicing her own opinion. She just needs to feel culturally safe and supported, and she engaged in all of that. (Frontline staff)*

The involvement of Aboriginal workers was highlighted as important for building trust.

> *We had the first meeting with _____ [social service agency] here a few weeks ago and the Aboriginal support worker and myself went to that meeting. _______ [social service agency] is saying, "But she's not engaging with us. She's not doing what we're asking her to do." So we're going, "Aren't you using any Aboriginal people to help her to deal with this because she just thinks you're FACS." (Frontline staff)*

Drug Health Services employs an Aboriginal Case Worker, Aboriginal Project Officer and an Aboriginal Magistrates Early Referral Into Treatment (MERIT) clinician. There is an Aboriginal PAF midwife employed at RPAH.

Participants from child protection agencies recognised the need to work more effectively with Aboriginal families, and the potential value of involving Aboriginal workers, or community representatives, in relation to child protection matters.

> *We are trying. We are asking the Aboriginal community what they think the best way to include an Aboriginal worker is in this process. Now, family and community services, they now have Aboriginal caseworkers consultants, I think it is, and so what we are doing, what we are gonna try to do is in every Aboriginal case, any Aboriginal family that is referred to the program, we are trying to have a consultation with them and see whether they can either support the family from before the conference, like the first meeting takes place and explain the program from a cultural perspective, or whether they can participate in meetings. We're still sort of developing that area, that role, and we need to. Definitely we need to get better at working with Aboriginal families. (Frontline staff)*

FACS were reported to be very aware of the cultural sensitivities around child protection for Aboriginal clients given the intergenerational impact of government policies between 1910 and 1970 that resulted in the forced removal of Aboriginal children from their families that led to the Stolen Generations (Commonwealth of Australia, 1997).

> *It's foremost. I think we're very conscious about it, sometimes over-conscious in some respects. If we need to remove an Aboriginal child, there's a lot of processes that we go through, which is important. Consultation with the community could be better and I think they're setting up community hubs where there's consultation. With Aboriginal families, the rate of removals are higher but the rate of family placements generally is better. We try and get that as much as possible. The problems are that sometimes the apple doesn't fall far from the tree. So, it's difficult to get Aboriginal family members to care for them when we assess them, but their family networks are huge. So, we've got something called "Family Finding" where we try and locate family because speaking with Aboriginal clients, they can be the most desperate, down situation, but there's no Aboriginal client who cannot name four generations of their family including cousins. It doesn't matter how removed they are, they can do it. So, it's obviously very strong and we seek to place [within family networks] as much as possible. We seek to consult as much as possible, but it's really difficult in the community as well. The level of distrust and like the grape vine is pretty strong. (Frontline staff)*

If at all possible, FACS workers consulted Aboriginal community elders and sought to place a child taken into care within family or social networks. However, the limited availability of elders and the lack of capacity within families to assume care of a child could make this approach very challenging to implement.

> *I would like to get sort of elders involved where we can make sort of joint decisions and they – because I find really difficult to engage Aboriginal clients with Aboriginal sort of elders in the community. They – I mean a lot of them are transient. They live here as well. It's really difficult to get other people on-board. [Kinship ties] they're strong, but they're also fractured and so what I find is that families tend to come along when the child's removed. So, when we're seeking support, no one really wants to get involved. They say they wanna get involved and often it's a case of lots of families don't put their money where their mouth is. They say heaps about what they'll do. We have plans with people, the family members. When the baby is born, they just disappear, but when a child is removed, then they all come and say, "Why didn't you seek our support? We were there." (Frontline staff)*

Muslim/Arabic-speaking women in the Canterbury area

> *Particularly for the Canterbury area, how do we reach into those communities? Particularly the Arabic-speaking community? There's a lot of distrust against the government in that community. So how do we provide help to them? (Manager)*

According to Census data, 43% of residents in SLHD speak a language other than English at home, almost twice the level of NSW as a whole (22%). Within SLHD, Canterbury Local Government Area (LGA) has the highest proportion of people (64%) speaking a language other than English and the two most common languages spoken include Mandarin (28,712 people) and Arabic (26,665 people). Most Arabic speakers in SLHD live in Canterbury LGA (Sydney Local Health District, 2015).

Drug and alcohol use is highly stigmatised in Muslim communities (Unlu & Sahin, 2015) and Muslim clients were very reluctant to engage with a worker from a drug and alcohol service, or a mental health service. As a result, the social work department received a large number of these referrals.

> *There're a lot of different things that don't work, because of our different cultures in our community which you have to adjust to. Because of culture, a lot of women don't want to be seen by a mental health worker and they don't want to be seen by a drug and alcohol worker which means our referrals are very high. So our birthing rate was 1800, I think, last year and the amount of referral was over 400. So that's 25% of the community here, we're getting some type of paper referral. We've got a high population of Muslim people, which are agreeable to social work but they would decline mental health and drug and alcohol. So then if we're to have a small meeting and introduce them separately, I think, we could get around that stigma that's just about time management, a lot of the time and communication. (Frontline staff)*

According to one participant, the outreach model for drug and alcohol services was more culturally-acceptable.

> *To have a particular service who can go to the home works a lot better for a lot of our women. And I think most women are more agreeable to a home visit, especially if they've got kids and things like that. It just looks like another early childhood nurse or somebody coming to visit instead of your drug help worker. (Frontline staff)*

Given the stigma associated with substance use in Muslim communities, involvement of Muslim midwives in services for clients with substance use issues was not necessarily the most effective option.

> *As positive as it is that we've got a lot of Muslim midwives downstairs who work in our clinic, it can work against them as well. So, they're doing their book-in appointment and it's fantastic but then they're not going to tell them anything about the drug or alcohol use, because they know them from the community and it's a very close-knit Muslim community and they would not disclose. (Frontline staff)*

Summary

Participants identified a number of strategies and existing programmes that should be included in the SUPPS MOC. Strategies identified for promoting and maintaining engagement included: a welcoming and non-judgmental approach by staff, advocacy and support for clients to engage with FACS and PFC, focusing on the client's motherhood experience as well as their substance use, providing continuity of workers over time and involving community workers who will provide follow-up in antenatal care. More client-centred practices included selection of the right staff for SUPPS roles, ensuring clients were present at key planning meetings, adopting a partnership approach, reducing the number of psychosocial assessments clients were subjected to, being flexible with appointment times, reducing waiting times at the antenatal clinic and adopting outreach models for service delivery. Possum Playgroup and PFC were two programmes staff identified as beneficial for clients, however, staff needed to be adequately resourced to continue to be involved. Service gaps affecting service delivery were identified in three areas: free drug and alcohol counselling, residential rehabilitation and support services for women after a child is removed from her care.

Key features of effective design for specific populations of clients were also identified. To meet the needs of Aboriginal clients, the availability of Aboriginal workers, staff capacity to provide intensive follow-up, more Aboriginal-specific rehabilitation services and refuges, prioritising Aboriginal clients for access to OST and the involvement of Aboriginal community members and case workers in child protection matters, were considered important. In the Canterbury area in particular, provision of outreach services may be more effective for providing substance use-related support for Muslim and Arabic-speaking clients, in response to the significant stigma associated with substance use in this community. Data suggested that further research regarding the complex factors influencing engagement of these two populations with services is warranted, in order to inform decision-making about effective service design. Research needs to involve representatives of these communities in the design and implementation of the research.

Data also highlighted a number of areas where consensus among key stakeholders needs to be reached in order to refine service design for the MOC. These areas included:

- The need to employ a non-Indigenous PAF midwife at RPA to enhance continuity of care
- Should SUPPS teams at RPA and Canterbury hospitals adopt a consistent approach in relation to policies regarding outreach, NAS follow-up and referral to other services?
- How to reduce client waiting times at the PAF antenatal clinic
- The future funding plan for Possum Playgroup and whether a similar service should be established at Canterbury Hospital.
- To what extent are services and staff approaches trauma-informed in practice? While staff were aware of the impact of experiences of trauma on clients, the extent to which trauma-informed care was reflected in practice was questioned. This finding suggests staff may benefit from further training in relation to TIC, and that further research may be needed to identify ways in which services could be designed and implemented in more trauma-informed ways.

Further research is also needed in a number of areas focused on:

- Barriers to client-centred practice and effective integrated care
- Factors influencing engagement of Aboriginal, Muslim and Arabic-speaking clients with substance use issues in care

- Possum Playgroup
- The effectiveness of residential rehabilitation programmes and how best to integrate them into the SUPPS MOC.

There were two barriers to service delivery that emerged strongly in the data: barriers to engagement with clients and barriers to staff collaboration and continuity of care. These barriers will be discussed in detail in the following section.

Section 3: Barriers to Effective Service Delivery

This section outlines some of the challenges involved in providing services to a highly socially disadvantaged group of women and their children. Issues and suggestions raised by staff concerning how to implement an effective inter-disciplinary collaborative MOC is also outlined in this section.

An emerging evidence base for the effectiveness of integrated, trans-disciplinary, cross-sectoral service delivery to address the needs of vulnerable populations suggests benefits include enhanced patient satisfaction, increased perceived quality of care and access to services (Baxter et al., 2018). However, the realising of such an approach in practice is fraught with difficulties. This section will focus on three major themes that emerged as areas that could both facilitate or hinder good service outcomes. These included:

A. Lack of consensus regarding outcomes and scopes of practice guiding the service
B. Challenges with collaboration; inter and intra-agency cooperation, communication and knowledge sharing
C. The need for appropriate levels of institutional support and more opportunity for clinical reflection.

A. Lack of consensus regarding outcomes and scope of practice guiding the service

A lack of consistent ideology of practice was mentioned as inhibiting collaboration. In some cases, limited understanding of another person's position or lack of a shared therapeutic approach precluded good quality care. The latter was particularly problematic and tackling this lay at the heart of effective transdisciplinary services. This was a challenge for intersectoral and inter-agency service delivery, but also across disciplines and within hospital departments.

A tension that was repeatedly highlighted in the data related to the nature of the work performed, which in many cases resulted in role conflict for staff. This role conflict related to situations where worker knowledge and attributes were in conflict with organisational guidelines of the SUPPS services, for instance in terms of the interpretation of engagement, interpretation of continuity of care, or trauma-informed care.

A large proportion of staff we interviewed articulated a need for more reflection and a shared body of understanding in relation to operating in ways consistent with continuity of care and relationship-focused practice.

> *Well, I think the team, but it's the patients too and it's the families because we got to such a good point where families were getting three perinatal family conferences, and they were engaging, and they were coming back, and they were supported, and then they were being followed-up, and they were being cared for, and I think providing care is– that's our job – is to care for people and I feel like the system is stopping us caring for these people. Oh, sure, we can care for them in hospital for five days. Wow, that's great. These people need care for a long period of time and I just don't feel that we've got it. We're kind of – we're getting it antenatally, even though fractured team is not gonna help that. We can do it in hospital because they're under our roof, but I think as soon as they walk out the door, it becomes very difficult to keep caring and to keep it managed and I –*

> *yeah, I just don't know that managers in social work or drug health perhaps recognise that importance. (Frontline staff)*

The quote above relates to understandings of how workers facilitated and motivated change in clients, and when and how personal and professional boundaries were overstepped. For instance, the outreach component of SUPPS and the ability of SUPPS workers to be able to do community follow-up after the mother goes home with her baby, was mentioned time and time again, as not just big service gaps, but also areas where staff felt that there might be a mismatch between what staff felt was needed to ensure good outcomes for the women and babies, and what staff from an institutional level felt being supported to do. The inflexibility of services in this regard was lamented by many staff members, as the current work practices was felt in violation with their own professional judgements about good care.

In the following examples, the workers had to navigate and prioritise the immediate risk to and needs of the mother and the involved children, with organisational constraints, in order to guide their actions.

> *It's good to have policy to back you up but you need, as a worker, as a clinician, you need to have the skills to advocate because you just lose all sense of – it would all be so helpful to have a model of care to say, "Actually, we do see clients in this situation," rather than having to always negotiate. I've been negotiating as a worker, I'm exhausted. I mean those two cases, I am absolutely distressed by them and there was no support, but the whole time I was fighting – I was always dealing with kind of the trauma that my client was facing but then also thinking, "Oh God, I'm going to get in trouble for seeing these people." (Frontline staff)*

In the absence of consistency of practice across departments many staff felt they were forced to individually advocate for each client, to be able to deliver the type of care they felt was appropriate and necessary.

Of particular concern in this regard was the inconsistencies in ways of engaging and working with clients between Social Work and Drug Health at RPA. There were fundamental differences in the premises upon which Social Work and Drug Health viewed and defined their service delivery, workforce development and outcomes related to referrals and continuity of care. Workers collaborating across departments often had to work within these contradicting policies. The following section will outline these contestations as they contributed to significant inter-personal conflict, staff distress and ultimately was felt to impact negatively on service delivery. Resolving these tensions was a main priority for staff working within the SUPPS team and across hospital departments.

Facilitating engagement: client vulnerability or self-responsibility?

Promoting and maintaining engagement with clients was identified as a practice approach integral to the MOC. Staff reported that clients were reluctant to engage with services because of mistrust of staff and negative past experiences with services, or fear of having their child removed if they disclosed their drug or alcohol use. It was often pregnancy or admission to hospital that brought clients into contact with health services, not a client's desire to engage or seek assistance. Creating relationships of trust with clients was the absolute cornerstone of successful outcomes. Without trust and rapport, staff could do little to support clients.

At times, participants differed in terms of how far they would go to promote engagement with clients, and in their perceptions of a client's vulnerability versus self-responsibility. Some staff placed more onus of responsibility on clients to actively engage, compared to other staff who felt this approach did not go far enough and went to greater lengths to seek engagement. There was a tension between these approaches, caused by different understandings of what constituted "spoon-feeding" versus facilitating when it came to engagement. Perceptions of a client's readiness to change underscored some participants' approaches to intervention.

> *There's that whole kind of rhetoric in some drug health staff where it's like people have to wait until they're ready. Give them the numbers for rehab and if they don't call them then they're not ready to do it. You don't wanna spoon feed people all this stuff and it's actually like – it's BS. People like to be helped and I know some dickhead invented that policy so that they could get away with handing the people a piece of paper [a brochure instead of engaging]. (Frontline staff)*

> *People talk about motivation and engagement, and 'they didn't engage enough'. Whereas I just don't think that us, as services, think "Why didn't they engage?" Why is the onus on them to engage when we're the skill professionals? (Frontline staff)*

Engaging women from this hard-to-reach group was considered a distinct skill. Staff competency in this area was crucial to ensure good outcomes for clients. Some staff reported that clients could be blamed for "not engaging", rather than shifting the focus onto what the health worker had done to foster engagement. Some participants called for greater accountability regarding how far staff went to promote engagement.

> *Say for example, I sit down with someone and I interview them in a way that doesn't foster engagement and they get up and walk out of the room. And then they decide, "You know what? I don't wanna have this antenatal care. I don't think this is great." Or they just see the doctor and they don't engage with social work or the drug health CNC and all of that. And then it gets to nine months, they haven't done anything, they haven't changed, they haven't gone into rehab, they haven't fixed their housing situation, they're still sex working, and then FACS come in and have to do an assessment and there's nothing that's changed. That first worker could go, "That woman just didn't engage." But how do you measure that if they stop coming, if they stop engaging? How do you know that maybe is on us rather than on these women? (Frontline staff)*

Engagement with women was crucial as it could affect outcomes in relation to assumptions into care. One participant described the difference good engagement between staff and a client could make when negotiating with FACs regarding a woman's readiness to be a parent. If rapport and trust had been established, clients disclosed more about their circumstances and service providers had more information to inform planning in relation to child protection.

> *I'll tell you about the issue that I had today. You hear about them [clients], whether it's through a health service or a GP, that somebody's using significant*

> *amount of drugs, is pregnant in the community. If we just wait and do nothing, and maybe someone makes a report to FACS, because no one's engaged this woman. And then they [FACS] come in, how do you expect a woman, one, that's just had a baby; two, that's already scared of FACS probably. And then FACS come in and interview them and try and talk to them about safety and insight, and these people are so scared to communicate with FACS 'cause they're worried FACS is gonna take their baby. FACS, in turn, needs to see insight and they have a person sitting in front of them that's not communicating and has no advocate and so, they go, "Well, she's not agreeing. She's not talking. She's won't talk to us. She's gone up in a huff and gone out and sworn and all that; so, obviously, she's not ready to have a child with her." The difference if they have a worker, where I can say, "Look, she's spoken to me about the domestic violence or she's already going to rehab", before they arrive, we can have made that happen. But that wasn't happening consistently and so, of course, the outcomes were different. (Frontline staff)*

Staff who went further to engage with SUPPS women highlighted the need to capitalise on the opportunity to build a relationship with a client. However, from the point of view of some participants, some staff went too far, describing their approach as "wanting to save" or be a "hero".

> *So, that's another thing that concerns me, is that I don't know how to summarise that. And I'm not 100% sure if that is but I'm starting to think, is it a bit of a, "I wanna save", which of course, you coming into a profession where you wanna save people and help people but do we need to have a bit of 'no heroes' policy here where we just share it? (Manager)*

Concerns about staff's lack professional boundaries and staff creating dependence in clients, were also raised. According to one participant, seeing a client several times a week could also make staff "lose sight of" child protection issues.

> *I think what I've seen in the time I've been here is that people develop relationships with people in the antenatal periods, they've become very attached to the women and lose sight of the children, because they don't have a relationship with the child. So, whilst people are mindful of child protection, if they've got a good relationship with the woman, that clouds the judgment and also, I think from a dependency point of view, people have seen women quite frequent and create a bit of dependence there and I think for clients that are using substances, you need to be really careful. Their vulnerability's all around dependency so, you don't wanna create them being dependent on you as well. So, I think it's about empowering women and advocating for women but not seeing them three times a week or not seeing the – it's – there needs to be probably more guidelines about frequency of appointments. (Manager)*

Maintaining continuity of care: a consistent approach between Social Work and Drug Health

The concept of continuity of care is a well-recognised contributor to health that has been identified as crucial when working with marginalised groups (Barker, Stevenson, & Deeny, 2017), including in the drug and alcohol area, where individual relationships have been identified as especially important

(Kim et al., 2007). Therefore, the ability of the staff to work holistically and respectfully with clients was highlighted as a crucial element to ensure successful outcomes.

Data reflected two separate camps when it came to the concept of providing continuity of care. There were sometimes different policies governing staff from different disciplines, within the SUPPS/PAF team. For example, many staff highlighted the opposing approaches of the Social Work Department who fund the PAF social worker, and other staff, including many from Drug Health. From a social work perspective, data revealed that continuity of care did not have to translate into the same worker being involved with a client over time. Continuity of care was predicated on good handover of information between workers and services.

> *From what I've read and my experience, you can have continuity of care, but it doesn't have to be the same worker all the way through the journey necessarily. One worker can work with the family for a certain amount of time and then there'll be a handover to another worker and I think if you do that well, it can work really well. I don't think it necessarily has to be the one worker and I think that's a bit problematic because that's a lot on one worker. If they're the kind of sole support for that family, I think that's a lot. (Manager)*

Concerns about staff burnout underscored the social work approach. A "circle of support" made up of a team of staff with the necessary skills, was considered preferable to having one staff member carrying full responsibility for a client. The staff member most engaged with the client should be part of that circle of support, but if that person was on leave or otherwise unavailable, there would be other staff in the circle available to address the client's concerns and provide continuity of care. Those within the staff circle could support each other and help prevent staff burnout.

> *It needs to be the one that has that rapport and trust already established. If there is a worker that exists, then yeah. I think everyone thinks it's challenging, but it is possible to build a kind of circle of support for that woman of more than one worker that can be there for her, and I think that's important for the workers as well as for her because if she can't get a hold of one or one goes on holidays or something, at least there's other people. Those workers can support each other as well as that person [client] has a network of supports, not just one. (Manager)*

Efficient use of available resources was also a driver of this approach. The PAF SW position was considered largely an inpatient role. It was inevitable that clients would need to be referred on to community-based services, because of the limitations in hospital-based resources for client follow-up.

> *Just with regards to continuity of care, I think continuity of care means different things to different people. So, some people see continuity of care as "this woman must have the same relationship with the same professionals all the way through." Continuity of care can also be, "this woman has a relationship with the health service and sees a select bunch of professionals whose skills set it is" and then there's a transition because each service can't continue working with a family from nought to 18. So, it's also handing over from one service or one worker to another so that people don't necessarily feel abandoned or rejected, it's "this is when my role ends, I'm gonna introduce you to this person who's gonna*

> *pick up" and having therapeutic endings with people as well and smooth transition. So, I think, yeah, it does mean different things for different people. (Manager)*

However, other staff, often from Drug Health but also obstetrics, midwifery and neonatology, approached continuity of care differently. These participants stressed the importance of keeping the same familiar faces directly involved with clients wherever possible, to maximise engagement with the client and continuity of care from the antenatal period to post-delivery. Handover of clients to other staff meant clients would have to build trust with the new person all over again. Staff known to the client could act as a bridge between clients and new workers, but only to a limited extent. Staff vouching for each other, however, did not necessarily mean the client accepted the assertion that a new person could be trusted.

> *We're dealing with a cohort of people who have had many people say, "Oh, you can trust me." Do you know what I mean? That's bullshit. So, even me, like if someone came up to me and said, "Hey, I've got this clinician. You just gotta trust her," like why should I trust her? I've never met her. Does she know my story? Is she gonna be as helpful as the people I've already been working with the majority of the time? Why would I trust her? Is she gonna have a different personality to the people I've already worked with? And I've already seen that before where they might be harsher and not tolerate some of the things that are in those grey areas that you can work with. And then next thing I know I'm being told I can't take my baby home. (Frontline staff)*

Trust is a key issue for people with substance use histories and staff emphasised that clients were unlikely to seek advice, especially when pregnant, from a person or service they did not have an established relationship with or some other relevant link (such as warm referral from a trusted worker or a friend in the community). Staff noted that these relationships with clients took time to develop and were nurtured through continuity of care. It was to be expected that once clients came to trust particular staff, they were likely to seek out those staff in the future, for support during challenging periods.

> *Acknowledging that when you engage women that are vulnerable and isolated in a pregnancy, there's a good chance that they might call you in six months. And as long as your contact with them in six months is centred around linking them in with appropriate support, that you can take that call and that you might be able to do a one-off intervention with them and that they're gonna call you again in six months. (Frontline staff)*

These different approaches to continuity of care were particularly apparent in circumstances where clients who had been discharged from hospital were in crisis and called inpatient staff they knew and trusted in order to seek assistance and support. Participants reported that social work policy at that time was that the client should not re-engage with the impatient social worker but be referred on to another service. Some staff argued that referring clients in a crisis to a different, unfamiliar service was not appropriate and was a barrier to continuity of care and engagement.

> *If you asked any of my clients at that time, "Do you want a different social worker?" they would've been, "hell no!" If people contacted the social work department, when I had a day-off they were told, "____ is no longer your social worker." So I had another client whose child committed suicide. She [also] had a baby in her care and she started using. She contacted me after the suicide and I think then we referred her to rehabilitation again. And then she was discharged and she relapse again but she called me on my day off to say, "Can I come and see you. I've relapsed." They said, "____ is not your social worker. I don't know why you're calling." Lucky she called me again and said, "They told me but I really need to see you". At that stage she was using heroin. But also they [different social worker] didn't know anything about this woman and they just tell her like, "____is not your social worker," rather than reading her notes, looking at actually this is a really vulnerable time, she's got a new born baby in her care. Her child just committed suicide. (Frontline staff)*

The role of inpatient hospital staff in providing follow-up for clients after discharge was contested by participants. However, many believed providing continuity of care after discharge helped maintain clients' engagement with services, particularly in the absence of other familial and social supports.

> *Even if it's out of hours, phoning someone because they need some assistance – who else are they gonna phone if they need help? They may not even be in touch with their families anymore. So, having maybe a crisis line or someone that they can contact if they feel that they're falling off the wagon again. (Frontline staff)*

> *I think face to face is very important because I think that the woman needs to know that it's not like you've gotten to a door and someone said, "See you later. There you go." And then that woman thinks that service has just let them go. And having some regular catch ups is quite important to see the clinician's still there if they need to, face to face. (Frontline staff)*

These tensions could lead to significant stress for workers and decreased work-satisfaction. Participants' accounts suggested some staff felt immense pressure when they felt forced to comply with departmental policies they did not agree with and that they believed would lead to poor outcomes for the client.

> *It takes long to get clients to engage in a hospital service and then to not be able to provide that support during that really significant period [relapse post discharge] that they're really struggling with, it's so difficult. (Frontline staff)*

One participant explained there was a tension between adhering to policy and child protection responsibilities.

> *We were going against management in order to meet our child protection obligations to clients. Basically a memo was sent out to say that if anyone is six weeks postnatal, that you have to get permission prior to having contact. If they contact you, you should say to them, "Let me call you back, and call the manager" even if they called from a payphone or private number, or they've rocked up to see you in the hospital, you should be like, "I need to check this out with my*

> *manager" and not be able to provide a crisis response. And still, that hasn't been clarified. It's almost a little bit like don't-ask-don't-tell, where I have people that do contact me postnatally and they might be in a crisis or there might be domestic violence. I might go, "Okay, I'm gonna refer you to this service" or "I'm gonna link you with this support" or "I can write a letter." Technically, I'm not meant to be doing that but the other option – the alternative is turning people away that may go on to have more children and so you're not doing early intervention. (Frontline staff)*

Competing discourses and scopes of practice were identified as a tension across departments. Staff expressed that the theories used to guide their practice and serve as explanatory frameworks differed across departments, and many staff expressed defensiveness when their guiding theories were challenged. Other difficulties pertaining to working across disciplines involved differences in norms, working patterns, values and decision-making processes that shaped the ways departments functioned. Employment of a social worker funded by Drug Health was one potential solution highlighted by participants, that may resolve the problems associated with competing approaches, particularly to policies regarding maintaining continuity of care. In addition, a dedicated multidisciplinary SUPPS team supported by a shared governance structure was suggested as a strategy for enhancing continuity in clinical practices.

> *I think it should have a specific social worker, a specific drug health worker, a specific neonatal nurse, and a specific paediatrician in hospital assigned to it at RPA. Should be the same thing at Canterbury and then a discussion between those two sides about who looks after the postnatal or after they go home. So I think antenatally, same social worker, and that's what worked really well here for a couple of years. I really do advocate for continuity of care and a focus on the family rather than the drug use with a dedicated team. PAF alone, that's a big thing for this hospital, and lots of hospitals do have that now, but dedicated stream where you get the dedicated obstetrician and social worker and drug health worker, I think that's a big thing for these families 'cause they [the team] get buy-in early. (Frontline staff)*

Summary

Participants varied considerably in their perceptions regarding how far to go to engage with SUPPS women and how to practically apply continuity of care. Due, in part, to historical differences and different policies governing staff from different disciplines within the SUPPS/PAF team, these inconsistencies had the potential to have a negative impact on the woman's engagement with a service. To limit conflict in these instances involves articulating consistent principles of practice.

Trust and engagement were considered the cornerstones of successful outcomes for clients. However, data revealed that there were inconsistencies in staff approaches to maintaining engagement and continuity of care. Inconsistencies were evident among staff within the same team, or staff within the same clinical discipline, causing frustration and stress. Some participants believed a failure to engage appropriately would lead to more assumptions of children into care. According to other participants, too much "hand-holding" by staff would create or exacerbate dependence in a vulnerable client and potentially, skew the focus onto maintaining engagement rather than child protection, to the detriment of the child's well-being. Responding to crisis calls from clients was another policy area where opposing approaches to continuity of care were apparent, including to what extent clients can maintain contact with the same hospital-based worker after discharge.

Fundamentally, these tensions around the interpretation of continuity of care and engagement relate to what type of MOC SLHD seeks to offer. Specifically, is the primary focus of SUPPS services the mother's addiction or also her psychological wellbeing, past trauma, parenting ability, challenges around housing and domestic violence? Is the SUPPS MOC aimed at crisis intervention or aimed at relationship-building, continuity of care and two-year follow-up? As time and resources are finite, a decision needs to be made regarding what type of SUPP services are required. The model should then be supported with adequate resources and staffing, as well as clear policies and work practices. Closing these gaps will be critical if jobs are to better reflect the resources available and established service priorities.

Clarity around theoretical underpinnings and a shared understanding of the meaning of concepts such as engagement and continuity of care was suggested by participants, achieved through more opportunities for reflective practice. However, reflective practice is a proficiency that is cultivated and refined. Enabling workers to reflect on their practice cannot be done via supervision alone. Being able to articulate one's own developmental approach and strategies, as well as reflect on their appropriateness, cannot be achieved without a commitment from the organisation in terms of time and resources. As such, allocating time for regular meetings earmarked for reflection around best practice frameworks for working with SUPPS women is important to ensure that staff are able to share knowledge and reflect on what works.

B. Challenges with collaboration, inter and intra-agency cooperation, communication and knowledge sharing

Collaboration

The importance of effective collaboration and the numerous barriers and facilitators of effective collaboration were emphasised by a vast majority of staff and service providers. The majority of informants spoke about the importance of services and practitioners working together in a coordinated and client-focused way to appropriately respond to the often complex support needs of clients.

> *That could be a full-time job between doing all of this, doing relentless follow-up, being involved in the paediatric follow-up clinic, the neonatal follow-up clinic, their in-hospital care, their antenatal care, and playgroup. And it's a journey – a patient journey, isn't it? You meet them antenatally, and then they wander along through this and you give them some education. They meet a few people and they have good antenatal care. They start to focus on their babies, hopefully in that point, so you can talk to them a lot about that. They get to feel like they're a critical part of – or an integral part of the treatment team, if their baby needs any treatment and that they're the carers, they're the competent parents. And then, they move through – and they support it afterwards, followed it up, go to playgroup, have community supports around them, and then finally, the aim is not to keep them in playgroup 'til their 50s, but to actually just send them off happily into the community; happy, well, and functioning, on a level that they*

> *weren't able to or couldn't see before with all the little bells and whistles along the way. So – and definitely, you can't do that in silos. (Frontline staff)*

Several staff expressed deep commitment to working across services and sectors in acknowledgement that good outcomes relied on working together. Despite general acknowledgement of the importance of working as an integrated inter-sectoral team, the realisation of such a goal was at times difficult, due in part to the complexity of working within the Health Service and across sectors.

> *I think generically, one of the things that anybody who works in health who comes across child protection issues struggles with is just the complexity of the work and the need to collaboratively work with other services because nobody can do it alone and that's particularly challenging in the health system because mostly clinicians have a role – you come to me for X, I'll provide you that X. I fix it. It's not a situation where we're working with a lot of other people often external to our agency to provide that fix-it service to you. And of course, people in health work in multidisciplinary teams within health all the time and there's all the usual communication, hierarchy, power issues that come with that. Well, take that idea and multiply it out into the interagency context and you've got all those issues at play. People don't understand each other's roles. There are trust issues. People don't understand the legislation because the legislation that allows information exchange between agencies. (Manager)*

> *I think some of the multidisciplinary team does not want things to change. They like to be into their silo and have the expertise in their silo. (Frontline staff)*

The goal of intra- and inter-sectoral collaboration was often compromised by a wide-spread fragmentation of services and services operating in silos. The following section will provide more details on the types of collaboration barriers staff mentioned as impeding good service delivery for SUPP services.

Barriers to collaboration

As mentioned, collaboration was identified as one of the most important factors needing to be improved to enhance the effectiveness of SUPPS services. Effective inter- and intra- service cooperation is influenced by multiple factors such as coordination, partnership models, preparedness to share power and information, challenges to professional identity, competing goals and agendas across services and lack of reconciliation of different ways of working (Grace, 2015). The need to formalise partnership models across services and sectors was highlighted as a method of ensuring better service integration. Shared plans need to be operationalised and implemented across agencies to be effective, and this could, at times, be challenging.

> *If you were to say, "Okay, you need to collaborate and you need a shared care plan, for example, with the MECSH nurse in the community and someone in the antenatal space in the hospital. Who is FACS going to contact in that pathway? Would they contact the – so, FACS wanted to have a discussion or a meeting, are they going to contact the community nurse or are they going to contact someone in the hospital? Just because that process is there, it doesn't mean that that*

> *information is going to get distributed to both. I don't know, there're just a lot of barriers there. But if they want to collaborate, and we've seen excellent examples of that in both RPA and Canterbury, that flow of information and communication, and the respect for each other's role just happen. (Manager)*

The importance of greater consistency in how staff work with clients and communicate, prioritise concerns and give information to clients across sectors and services, was stressed by participants. This referred to services working together towards shared goals and outcomes and eliminating confusion for clients by providing consistent messages regarding priorities and concerns. However, aligning services to achieve a shared partnership model and facilitating the effective linking of services was inhibited by a lack of clearly defined outcomes and goals. Priorities were hard to negotiate for staff which had the potential to cause confusion for clients. The importance of giving a unified picture in terms of what clients need to do to ensure good outcomes was highlighted.

> *So things have changed over the years for good reason and in a positive sense, but there's still a lot of work to be done and that's where models of care, but not just within your own health service but being consistent with other health – in line with all health services is really important so we're giving the same picture. (Frontline staff)*

Overwhelmingly the need for clearly identified SUPPS programme goals and outcomes, was highlighted by staff. As described, conflicting perspectives around core service delivery and outcomes of the SUPPS program was found to negatively impact on staff and create a significant amount of tension, interpersonal conflicts and duplication of work. And ultimately had the potential to affect the outcomes for clients. In this regard, staff lamented the minimal managerial commitment towards developing and supporting such a shared partnership model. In the absence of such commitment, staff questioned whether the current collaboration barriers could be easily resolved.

> *What could be done? Maybe a bit of – some sort of authorising environment or even a bit of a managerial push "You must work with the community, this is the pathway, and these meetings need to occur." I know we've got perinatal family conferencing, and it's held up really high, but it's just a meeting. Why can't that sort of way of working exist outside of the PFC pathway because not everyone wants to access PFC. We can still have those meetings for other families who might not be eligible for PFC.* (*Manager)*

A suggestion in this regard involved transdisciplinary practice and cooperation being modelled to a higher degree at a leadership level. At a provider-to-provider level, several factors were identified as impacting on collaboration such as cooperation being highly personality-driven and relationship-driven, as opposed to being supported by institutional processes. This will be elaborated on in the sections below.

Trust, relationships and referral pathways

Trust emerged as a major theme impacting on the success of the SUPPS programs. This relates both to trust between service providers, agencies and workers, and trust between workers and clients. Many staff mentioned that cross-sectoral cooperation, for instance between health social services such as Child Protection, or between health and community services, was highly reliant upon the establishment of good relationships between individual workers. Below is a quote from a service provider detailing how access to residential rehabilitation relied on relationships within the network of staff members.

> *Ringing up rehabs and trying to get them a bed sooner. When you don't have a relationship with a rehab, you're just another name and they just go "Just tell the woman to ring. Tell the woman to ring." But over the time we've developed such good relationships with the residential rehabs so sometimes you can get them straight from hospitals right into a rehab or even if you're lucky, prior to – if you've got them really early while they're pregnant so then they are actually showing FACS that they're actually doing change, addressing their drug use issues to say, "Hey, I really do want my child at home in a safe manner" but that takes time to develop those relationships. (Frontline staff)*

It seems that good collaboration is driven by staff attributes, rather than established institutional procedures. Creating good working relationships with other workers, although crucial to ensure good outcomes, was a time-consuming activity. Below is a quote from a front-line hospital worker detailing how she creates and sustains relationships with community providers.

> *You know, being a pain in the ass sometimes. Over the years just constantly ringing, knocking on their doors, just like lobbying on their doorstep saying, "Hey this is me and this is what I can do. This is what type of relationship I'd like to have with you", and then constantly keeping in touch with those people. (Frontline staff)*

Respondents told us that trust between vulnerable women and service providers very often was built through bridging relationships, that is other trusted services, other trusted workers, or peers in the community.

> *"Oh, someone from ____ [residential rehabilitation programme] has come with another mum who comes to playgroup from _____." So this is often what happens. We just get randoms rock in from rehabs 'cause the rehabs know that we're useful and there's a nurse there and there's a paediatrician there, or one of the other mums is going, so go and meet some other mothers and there's some food and clothes and stuff. (Frontline staff)*

Trust also relates to workers' willingness to refer a woman, with whom they had built a good relationship, on to another service or other workers. The risk here could be that a referral to a worker that did not meet expectations could jeopardise the relationship built between the original worker and the women.

> *I just don't refer to services I don't trust. I don't refer to services that I've had a poor experience with the work. I'm like, "No." The services are only as good as the workers but most of – I've really tried to make an effort to get to know how people work in particular services. […] And so I was always a bit hesitant. If I was referring clients to that service or clients were coming from that service, in the back of my mind, I was like, "I need to build that," and not trusting their assessments. (Frontline staff)*

Inconsistent referral pathways between the hospital, community and NGO services, meant that sometimes successful referrals were dependent on 'who the workers know'. In some instances, there was a tendency to rely on networks of proven or trusted colleagues rather than set pathways for referrals. As a result, turnover of staff could jeopardise the workings of the whole network.

> *I guess, the biggest barriers, it's been when you have a new worker who's maybe not across the process from FACS so someone who's not the usual prenatal case worker, and then they don't have the same relationship with the workers. So, I guess, when you don't have that trust, where you're not used to sharing that information. (FACS 2)*

According to community service providers and NGOs, RPA appeared hospital-centric, with weak links and inconsistent referral pathways to the community and NGO services.

> *It was one client that I had that started off at Canterbury on our psychosocial meeting out there, was transferred to us because of the significance of drug use, and she was admitted to detox sort of thing, and my attempts to speak with social workers and basically get a formal referral – 'cause we do have to have that formal referral. We can't just go, "Hey, we'd be great in this space." That just never happened despite discussions directly with that social worker. It seemed to be reluctance and almost like, "No, we got it covered. Don't worry." So I don't necessarily think health departments – be they sexual health or drug health or endocrinology or whatever, I don't think we're very good at working with each other or accepting that we can all live happily in a space together. (Frontline staff)*
>
> *I work in community. I get the feeling, and things might have changed, but I get a feeling that RPA is very good at supporting the families, the babies for a certain amount of time, but then after that, I think they could possibly make more effort in terms of referring them to mainstream, or specialised for that particular purpose, community-based services. (Frontline staff)*
>
> *The hospital and the community do not talk. When someone is in hospital, they're in the hospital, they'll have the care and that's it; when someone's in the community, that's it. So there's no handover or transition or anything. Just not checking notes, not communicating, not answering questions. (Frontline staff)*

The inadequate communication between hospital services and community providers was echoed in many interviews with hospital staff. Additionally, many health staff expressed frustration regarding the inconsistencies in their health colleagues' willingness to work collaboratively. Staff felt that the hospital culture in many ways worked against collaboration, and that some staff might find it challenging to work in a more collaborative manner.

It was suggested that some staff might be reluctant to let go of control if they had to work in a more collaborative way. Another aspect of collaboration and referral pathways related to the relationship between the clients and the workers. As mentioned in the sections above, engagement was a crucial issue for this group of women. Seeking to safeguard a relationship or to establish trust with a client, led some staff to work against other services, for instance by advocating for the client against the advice of other services. This was a major concern for many workers, as they feared losing the relationship with the women, when they to go against her immediate priorities and wishes. In this context, where relationships, trust and having a good reputation in the local community could either facilitate or inhibit engagement, staff needed to juggle both relationships with clients as well as with other professionals, and this came with certain challenges.

> *But I don't know if that collaboration is occurring. Well, is it good? I think it is definitely in some instances but not all the time. And then the relationship with the client, yeah, we all forget about that, don't we? And does everyone just have a separate relationship and do we play each other off with the clients as well? And that's that hero mentality coming off with "The client relates to me mostly. They told me about this, did they tell you about that?" (Manager)*

> *I think the main thing about relationship is that child protection is fractured. So when they talk about a village to raise a child or – relationships and participation, working together – it's really fractured and I truly believe that is the main impediment to child safety that everyone's thinking about the child, about what's safe for the child, but no one's really ultimately working together as a whole. So, myself, RPA, a few rehabs, a few other services work well together. When it's just us, much easier. When it opens up to other services, it becomes difficult – it's a harder task and we just don't share the same culture and don't share the same views about safety and the focus is different as well. So, that's a real difficulty. No service wants to be known for helping remove a child. Even once, they'll get a reputation. Particularly in the Aboriginal community. Once one child is removed and they feel the service has assisted, then that service will be – for lack of a better word, blacklisted and no service wants to be in that position. (Frontline staff)*

Staff spoke of one-sided agency and a type of hero mentality, where workers advocated fiercely for their clients but often worked in a vacuum, cut off from colleagues and support. A potential consequence of this approach was that referrals to other relevant services were not made, and staff could seek to take on more than they could handle and feel unsupported in doing their job.

> *But I think sometimes in one of our big hospitals, in that perinatal space, there's a little bit of a hero mentality. I know in my team, if someone wants to help them with a case, they're like, "Please, come help me with this case. I need everything I can get." Whereas, we've got some colleagues who just wanna push everybody like, "I'll manage this for now." without thinking long term. But once that mother gets discharged from the hospital, what are you going to do? You should be connecting with people in that community now, establishing a relationship, sharing that care with the community staff member. I don't understand why they're not making their jobs easier. And the only thing I can put it down to is are they wanting to be a bit of a saviour? I don't know. (Manager)*

This section has highlighted several tensions relating to cross-sectoral and service level cooperation. As collaboration is highly reliant on the establishment of good relationships between individual workers, such partnerships are vulnerable to the impact of staff turnover or to staff resisting working in collaborative ways. Lack of dedicated time within current workloads further inhibited successful inter-agency collaboration. Limited accountability for workers who do not work collaboratively and a culture of working in siloes were highlighted as major barriers in this regard. The following section will provide details on how miscommunication and limited willingness to share power and knowledge impacts negatively on service delivery.

Communication issues and sharing of power

At the core of many collaboration difficulties lay issues around communication both at a provider-to -provider level and between services. Limited appreciation of different service goals and workplace cultures were also mentioned as barriers to effective collaboration.

> *I think interagency communication is key and understanding as well, I think when things don't go well is when information is not shared appropriately, openly amongst workers, and when there is – yeah, because when there is that misunderstanding and FACS is asking for one thing and the workers don't see that – other workers don't see the point of what's happening there, I think there is a breakdown in that communication and hence in trust. And so, that's when I see that process having problems. (Frontline staff)*
>
> *And I guess the other problem I see with the service is that the team are doing a good job amongst themselves, but it's the communication out that is the problem. (Frontline staff)*

The different NGOs and community services having different goals and criteria also added to the miscommunication. Professionals lamented a lack of understanding in relation to this and described significant time invested trying to understand the different services and roles of other professionals. Below is an example where a respondent discusses inconsistencies and misunderstandings on the subject of care coordination and service provision.

> *One of the things that we've created is services who do care coordination. But then, we're all confused about what care coordination does. And then what happens for some services is they're care coordinators and they actually end up being service providers, but they say they're care coordinators. And then the service next door to them is saying, "But if you're gonna see the family three times a week, why am I going?" And then, the care coordinator actually says, "Oh, no, we have to go 'cause we're care coordinating, 'cause we have to have a relationship with the client to care coordinate." So I think there's a lot of confusion around that. (Manager)*

In many instances miscommunication resulted in over-servicing the clients. A majority of service providers mentioned that the clients often had involvement with a significant number of services, and were required to attend numerous meetings at the hospital as well. This often resulted in confusion and could overwhelm clients, especially in instances where different staff provided different information and had varied priorities. Staff requested a greater level of cooperation and prioritisation of which services and professionals the clients were required to see, to avoid overwhelming clients.

> *They have a lot of services involved with some of them. Some of them, they can be really overwhelmed because not everyone is giving the same information in terms of each services. Of course, they have different scope or different boundaries or limitation about their service. (Frontline staff)*
>
> *I think sometimes there's too many people in their lives and they're just freaking overwhelmed and I know everyone is trying to help. Everyone's got their own agenda and what they need to do and I think there's just sometimes too many people and they just get – you could have drug health nurse here and have your drug and alcohol counsellor, social worker, then you could have one of the NGOs involved in your life and you could have FACS. It's a lot of people in your life trying to tell you what you need to do and that it all gets confusing and then they don't know how to prioritise like, "I got this appointment, I got this appointment, I got this appointment." Okay, we need to cut back on all of that. (Frontline staff)*

Difficulties with information sharing, particularly lack of integrated electronic referral systems, were also identified as a barriers to collaboration. Enhanced data integration systems that facilitate effective communication between workers was suggested, as the current electronic communication system makes it difficult to track women's progress through the health system and to keep all workers involved with the client informed.

> *The electronic medical record, is a nightmare, really, to navigate. […]. The problem with – there's a lot of advantages of EMR, but the disadvantage is that everything is all over the place. So, if you're trying to track what's been going on for somebody, you got to look in lots of different sort of spots. Need to add quote source. (Frontline staff)*
>
> *So, it's because in the hospital, they're cared for by the hospital teams and so how those teams properly link in with community teams. And it's hard for them because there are so many community teams that patients could come in. So, if the patient can't tell them – and there's different systems for documenting. So the way the hospital – the Canterbury maternity department documents is different to RPA, and its different to drug health's system. (Manager)*

Staff felt that better data sharing and management systems would aid in this regard, as well as strengthened policies around information sharing. The following section will provide details on how limited role clarity, duplication of services and rigid occupational boundaries act as barriers for collaboration.

Role conflict and occupational boundaries

Other barriers for working collaboratively across departments included role ambiguity and concerns around professional identify. It seemed some staff feared that transdisciplinary practice might diminish their own sense of professional status and devalue their expertise. This manifested as a resistance to working outside what was considered the scope of their professional practice, combined with a sense of protectiveness when other staff appeared to overstep work boundaries. One manager expressed a general frustration that was evident in many of the interviews:

> *But what that takes is professional maturity from the workers to be able to step in and out. And sometimes in our workforce, we don't have that because sometimes we're too busy gate-keeping. So, we struggle between saying we've got too much work to do and gate-keeping by keeping clients out of the system, and then when clients are in the system, we struggle with being able to share the work or having – feeling we have to do everything. So, I don't know. Will we get a happy balance? I don't know how you solve that one either. (Manager)*
>
> *I think we've all got to get over this business of talking about our patches. It is the clients' patch, and it's up to us to actually nurture that patch, and make it into a really productive one. And it's been interesting working across disciplines because there is – there's quite a – there has not been that cooperation often. (Frontline staff)*

A general lack of clarity around how a successful, operational transdisciplinary service delivery model might look further impeded staff willingness to collaborate. For many workers, the notion of transdisciplinary practice threatened their sense of control and professional expertise.

> *In the transdisciplinary model, you're still the physiotherapy expert. They'll still go to you for the ultimate – but you allow the others to do some of your trade as well and that's where willingness to give away some of the parent control. (Manager)*

Tensions over occupational boundaries also related to trust. In cases where workers did not really know or trust other workers, they were less willing to delegate and share the work associated with clients. As mentioned, this could mean several staff did the same psycho-social assessment, wasting both their own and the clients' time, and potentially expecting the client to re-tell their story over and over again.

> *Essentially maybe drug health don't have to do their own assessment. Maybe they just need to just go through the psychosocial assessment the social worker has done and perhaps just confirm things and then give their drug health information and all, whatever they need to do. (Frontline staff)*
>
> *Speaking for my FACS colleagues, if I'm a FACS worker, I don't want the drug health worker to do my job. I wanna do my job and I want you to deal with the drug health issues because I don't understand what they are. And I need you to provide me that expertise so that I can do my job. (…) And it's about everybody else being clear that we have a different role and that it's okay, and it's actually a good thing. If I go to see the psychiatrist, I want them actually to help me with my mental health problem. (Manager)*

It appeared there was a tendency for staff and disciplines to protect what they saw as their turf instead of responding to the needs of the client using a more holistic and team-based approach. This could result in over-servicing the clients.

> *Sometimes the thing that we do in – when we join up all different services for all the different families – sometimes we over-service people. And there is that – it's a blurry boundary and people don't have the courage to go – well, actually, you and I have similar roles and Mrs. Bloggs is connected, for whatever reason, better to you. So maybe there's not a role for me here. (Manager)*

As discussed, conflicts regarding role clarity and occupational boundaries often resulted in a double up of assessments and over-servicing of clients. Staff spoke about a lack of procedures around role clarity, or procedures that were unworkable or poorly-implemented. Levels of trust between professionals and services also contributed. Workers were less willing to make use of an assessment undertaken by a service or a worker they did not trust, which in many cases, may have been both reasonable and a sound professional judgement. In some cases, however, such duplication of services and assessments became a source of conflict between workers.

> *So, for example, at that meeting, the midwife says all families need to come to me as early as possible for booking in so I can do the complex health and psychosocial assessment on them, right? That would scare most of my clients off straightaway. She says I do sort of really in-depth assessment, right? My personal view of that is if they're involved with other agencies, all you need to do at that booking-in visit is book them in and check the baby. You will trust my information or you'll trust the Aboriginal member health person's information around the psychosocial stuff. You don't need to touch them. You'll just look on the MR [medical record] and get all that from there. Why would you need to interrogate somebody on their first visit where they're really vulnerable around their background? You would trust your colleague's views on that. (Frontline staff)*

Our research highlighted interpersonal issues between professionals and within organisations as impacting on client care. Lack of clarity of case management responsibilities, or reliable procedures around how to identify a key worker for a new client was often a source of tension. However, in instances where services and workers had built a relationship and were able to collaborate, less over-servicing of the clients and more delegation occurred.

> *All the other services, like rehab, like Guthrie House, like Kathleen York, I feel like we all know exactly what we need to do it. If someone presents from Guthrie, I don't do a whole bloody assessment about their lives because that would re-traumatise them. I just need to engage them in terms of talking about FACS because at Guthrie they will talk to them about that but talking about their experience at the hospital and what to expect and prenatal family conferencing, but particularly what to expect after birth and when FACS will come in and how we're going to support them. I can get that information from the Guthrie House worker and, of course, I need to know what's [substances] been used in the pregnancy but I don't need to do that assessment because what's the point and it would be awful for the client to go to every services and be like, "Okay, this is my life story again." (Frontline staff)*

> *I think that you might be more productive to identify the needs and the opportunities for meeting the needs. And if there's an overlap of three services providing the same thing in the same area, then to some extent, we are left with having a choice and that's also not necessarily a bad thing. You got a choice of where you go to do your shopping, which supermarket you go to, and that's a good thing because if some place was consistently selling rotten apples or whatever, you were dissatisfied with them for whatever reason, you just somewhere else. And so, I'm not uncomfortable with there being overlap in choice, as long as we meet the needs of our clients. (Manager)*

A related concern is what staff described as limited accountability for workers when clients abscond or do not engage well with services. It was felt by many staff members that there was a tendency to blame the clients for not engaging as opposed to reflecting on what the service could have done better. Participants were concerned that there were no structures in place to pick up bad practice and then respond to improve it.

> *There needs to be some guidance around that this role does include, like, early engagement, flexibility of care, continuity of care, linking in with services, assisting with the linking of services like facilitating – like contact with FACS, being in every single meeting with community services, where possible with the perinatal family conferences. So, we're all on the same page, we'll know what's going on. All these things that needs to be said, that's what you have to do. So, if somebody doesn't do these things then they're not doing their job. (Frontline staff)*

> *I think it's just like maybe the theoretical underpinnings of what we're doing doesn't get discussed in those meetings. There's nothing wrong with that but it's something I would like to talk about a bit more. (…) I think it could lead to more accountability about the models and frameworks that clinicians are using with clients. (Frontline staff)*

The need for more reflexive practice and explicit frameworks around how staff should engage with clients was requested by several staff members. Some staff suggested that RPA lacked policies or checklists around what was expected when the service engaged with a new client, such as offering inpatient detoxification, checking that clients had appropriate housing, and were referred to legal and community services.

In summary, this section has detailed the significant challenges around role conflicts, occupational boundaries, duplication of work and interpersonal issues staff spoke about during the interviews. There were of course critical exceptions to this, and many examples where communication and collaboration occurred seamlessly and staff showed deep dedication to working in a collegial way.

Collaboration between inpatient and community services

Engagement in the long term was considered critical, in relation to making a sustainable impact on parenting capacity, child development and family functioning. Staff underscored the importance of collaboration across hospital, community and NGO services. However, the crises-driven system often did not allow for the type of communication and information sharing that NGO and community workers felt was most appropriate. This posed challenges for continuity of care and treatment planning for staff and clients.

> *And another, I think, key concern would be how we get a good crossover interface between the SUPPS staff and inpatient services, so that when a client who's seeing the SUPPS staff and they're primarily community-based – go in to hospital, how those staff can continue to provide care for patients in hospital because traditionally, their care then falls onto other staff in the hospital, so sometimes, there's lack of continuity and treatment planning and stuff becomes challenging. (Manager)*

Often clients had multiple care providers, many of whom were unaware of one another's role or involvement. A significant communication gap happened when clients who were receiving care from community teams, such as Canterbury SUPPS, were admitted to hospital.

> *Basically when the patient goes into hospital, they then fall under the care of the nurses and the social workers in the hospital. So, if the nurses and the social worker in SUPPS have a treatment plan in place, the staff in the hospital all of a sudden might not know that exists. They might develop their own treatment plan and make a different decision. They might not be aware SUPPS is involved because they haven't looked thoroughly through the medical record 'cause it's long and hard to do that. Then everyone's responsible for providing that care and support in the hospital, not SUPPS. So, it creates an opportunity for someone's treatment plan to be changed and just things to be missed. They may or may not contact SUPPS. It has been an issue when, for example, the mother might deliver and DOCS was called in and so there might already have been a treatment plan put in place with DOCS but the hospital team might not know that. They might not have seen the treatment plan and so they might contact DOCS through a different avenue and then something different might happen to the family because of that. (Manager)*

Misunderstandings between the community teams and the inpatient hospital social work department were a frequently mentioned source of frustration. Staff being unaware of care-plans, and communication being missed was frequently cited. As the quote above highlighted, miscommunication could lead to negative outcomes for the clients.

Role clarity and blurred boundaries relating to where one worker's role stopped and another's began was mentioned as a source of tension between services and individual workers.

> *The issue is not regarding the nursing or midwife but I think it's more on the social worker issue, if this patient is already engaged with us, previously even before going to RPA, and we provide all the support already, we organised housing, we organised all the connection or all the services around, what do you think the in-patient social worker will do or what are they still going to do? But it depends if they have occurrences during admission or maybe crisis during admission, and then maybe they will provide that one, but the other bit has already been organised. (…) I mean we can inform them that we organised everything already.*

> *So we just go into liaise with the inpatient social worker about the plan – I mean, of course, they can change the plan if they want to but it really depends on the patient as well if the patient will agree on that. (Frontline staff)*

In instances where community clients were admitted to hospital, significant negotiation and communication was required to ensure smooth hand-over and good quality care. This however was complicated by current workloads and further compounded by the difficulties tracking clients' progress through the current electronic communication system.

> *I think there needs to be a good understanding between the community teams and the – probably mostly the social work team – they are most likely to do things that impact upon discharge. Where the nursing and the medical teams are likely just to do what needs to be done right now to deliver the baby sort of thing. So that there's an understanding that SUPPS is also working with the patient and they need to be part of the treatment planning for their inpatient stay and discharge. And there needs to be a clear understanding of how the inpatient services document and use the medical records system. And our staff, SUPPS staff need to make sure that they're following that system, so that anything they're doing is gonna be found by inpatient staff 'cause there's far many more of them. And I think we really need to clearly understand what their avenues are for communicating and we need to build relationships too. (Manager)*

In light of the significant communication issues between community staff and inpatient staff, greater acknowledgement by all staff of the collaborative effort required to ensure women have a positive experience in their meeting with Health services was requested. Staff also suggested other ways to improve collaboration, and these are outlined in the following section.

Facilitators of collaboration

On the topic of role ambiguity and issues around occupational boundaries, to ensure successful collaboration professionals should avoid making assumptions about the guiding frameworks of other professions, be willing to stop seeing their profession as experts and instead focus on establishing joint expert interventions (Coates, 2015). Joint training across individual disciplines has further been identified as an enabler of interdisciplinary collaboration as it provides the building of a common language (Glueck, 2015).

Strategies that facilitate inter-agency collaboration include strong leadership and shared vision; partnership models; building trust between professionals and organisations; enhanced data integration systems; and regular evaluations of effectiveness (Eastwood, 2017; Grace, 2015). These suggestions were echoed by staff and service providers across sectors. In light of the barriers to collaboration described in the previous sections, this section outlines staffs' suggestions on how collaboration might be improved.

In recognition that effective service delivery requires a commitment to collaboration across all levels of department management through to the practice of staff involved in direct service delivery, the recommendation was made that transdisciplinary practice and cooperation be modelled at a leadership level.

> *So it's leadership and authorising environment, even on top of leadership. So, like I said with the RPA example, not only is there no leadership in that room when you've got the Drug Health CNC, the Aboriginal midwife, the social workers, there might be Healthy Homes and Neighbourhoods, and Child and Family Health nursing, there's no leadership. I feel there's no leadership. But there's also no – if no one can tell each other what to do in that space, there's no authorising environment at all. (Manager)*

Many informants highlighted the need to develop better process mechanisms and frameworks, including establishing formal agreements and shared policies between partner services, to better support collaboration and referral pathways.

> *We need to be very clear on everyone's roles, so how we all interrelate and what our responsibilities are and how we work with NGOs. We need to have clear guidelines about NGOs and when we will refer to NGOs as opposed to when we refer to SUPPS and things are a bit clearer. (Frontline staff)*
>
> *Issue for a lot of major incidents in hospitals, communication between teams. I think that SUPPS need to have a really clear understanding of how inpatient services operate and they need to work with them to find out how SUPPS can fit into that, and that's probably what needs to happen. (Manager)*

Improving the general understanding of the diverse service goals and governance structures across professions and services was also identified as a meaningful way to achieve effective collaboration. Mandating all staff involved with SUPPS clients to increase their general knowledge regarding their colleagues' roles and the services available, as well as cultivating a greater respect and understanding of other clinicians' expertise, were also suggested. This would also enable staff to work across silos.

> *They don't wanna find out. Sometimes I get grumpy at my own department because people will sit there in a team meeting every Monday morning and then say "I don't know what the rest of you guys do." I said "Well you've been here 12 months. Why don't you try and find out what they do?" (Manager)*
>
> *And you do some education that way but I think working, providing a bit more education is important in this health district to have that understanding of something different to your discipline; so, harm minimisation, drug and alcohol relapse addiction background to be working with these families. So, I think we need to work a bit more harder on that. (Frontline staff)*

In terms of assisting staff to work across departments and agencies and cultivate a better understanding of the diversity of working cultures and agendas, the suggestion was made for greater sharing of staff across and within organisations, such as staff doing secondments or rotations between hospital and community settings.

> *Service redesign, so there's maybe joint management between community hospitals. Placements, having hospital staff do a secondment in the community or do a rotation so we do understand each other's roles better – I get frustrated that my staff, I think, don't necessarily see it from a hospital clinician's perspective.*

> *They've got to work to policy as well as we do. So sometimes it's not a personal thing if they're being inflexible, it's a policy in the hospital. So, the rotation might help make that more apparent so we're more understanding and then together, we might be able to escalate something that could lead to policy change. (Manager)*

As mentioned in the sections above, effective cooperation can place additional pressure on available resources and time, and may not be compatible with existing models of job design. In this regard, flexible work practices, the allocation of sufficient time to facilitate collaboration and supporting staff to be able to negotiate priorities with multiple stakeholders and agendas was suggested. This includes embedding collaboration into everyday work practices, for instance by allocating adequate staff resources, allocating time for teams to problem solve and debrief cases, timely handover from one provider to the next and supporting effective mechanisms for information exchange. Several staff members requested regular network meetings across agencies to build trust between professionals and organisations. Mutual respect and willingness to collaborate was generally fostered when workers were familiar with each other, as illustrated in the quote below:

> *If I think about a social worker and a nurse in my own team who just did not want to work together; I put them in the same setting, they did not wanna work together at all and it was a nightmare. And then, something happened, I felt like it was overnight and they're just working together beautifully now. And I think what has happened, it's got nothing to do with me, it's got nothing to do with processes, it's just to do with two of them. One of them has done something with the client that the other one has gone, "Whoa!" I can see the value in what you've just said and what you've just done and vice versa," and then, they sort of almost proven each other's worth. (Manager)*

A greater acknowledgement of the personality-driven nature of this work from management was recommended. This involved a commitment towards recruiting staff with strong interpersonal skills and a willingness to build relationships across departments, combined with a commitment to open and honest communication. It was further suggested that competencies around collaboration across and within agencies be better acknowledged in performance review.

Processes for identifying a key worker were also recommended. This involved staff reflecting on which professional across the services and agencies had the best relationship with a client and consequently was best placed to act as the main worker. This could also involve other workers providing wrap-around support for the key worker, as the participant below suggests:

> *There's so much you can do without engaging with the client. If you wrap support around the person who's got the relationship with the client, you don't necessarily always have to wrap around the client, but wrap it around the person who is working with the client so then they have access to your knowledge. I mean, some of my team, that's what they wanna do. They don't always wanna engage with the client because it's not sustainable and they'll burn out. So, they're really happy when there's a case manager from wherever who's happy to communicate with them. The client is still our client, the client knows they're our client, we might call them every now and then but we're not the one seeing them*

> *all the time, but we're definitely benefitting from our service because we're supporting the key worker. (Manager)*

Effective processes around information sharing, referral pathways and community follow-up were also requested. In terms of how to facilitate effective knowledge sharing and communication across agencies, a less hospital-centric approach to service delivery was recommended. This involved establishing referral pathways to the community as part of antenatal care and improving the current ways of involving community workers during a client's inpatient stay.

> *And you've got to look at the whole picture and I think the hospital is seeing just a bit of a picture, so how can they expand their mind to see that pulpit? They have to work with community. (Frontline staff)*

More appreciation of the information needs and requirements across services was also recommended, to ensure that treatment and discharge planning involves all relevant workers. This includes the development of better procedures for information sharing, and education of staff of the importance of following such procedures. To overcome some of the communication issues and improve referral pathways, in particular from the hospital to the community, the suggestion was made that a perinatal coordinator be employed to oversee continuity of care from hospital to community.

> *One of the early projects that I was lucky to implement in Liverpool was perinatal coordination, and that was funded by family and community services as a pilot study as part of their early intervention program. And it worked really well because you had a dedicated clinician who wasn't trying to provide therapeutic input to patients, she just trying to make sure that the system worked, that all those that will have a need were linked into the right services and that they were then followed through. The coordinator is linking all the services together and has also got a prenatal, postnatal brief. The idea was that the perinatal coordinator would stay in touch with these women from when they first presented to the first birthday of the child, and it was all done by phone call. So it was just to make – so an engagement by phone call. And if they didn't like that person we'd linked them with, we would find them somebody else. (Manager)*

Enhanced data integration systems and processes that aid in the sharing of knowledge were also suggested. This included staff familiarising themselves with the appropriate medical record system to ensure that staff working in the community understand how best to make use of these resources.

Summary

In summary, the development of a more outcomes-based approach, instead of the current service-based approach, that in many ways further exacerbates the current tendencies to work within silos, was suggested to aid collaboration across agencies and disciplines. This involves a greater acknowledgement of our shared responsibility for the welfare of vulnerable families and management being seen to actively work to change the culture of working in silos, and mandating staff to work together.

Trust and collaboration emerged as two major themes that could both facilitate good outcomes or undermine the good that could have come from SUPPS interventions. Barriers to effective collaboration included weak partnership structures, limited trust, communication issues, unproductive processes and policies guiding the work, ineffective referral pathways and miscommunication.

In regard to processes best suited to support an integrated approach, staff suggested transdisciplinary practice and cooperation being modelled at a leadership level; establishing formal agreements and shared policies between partner services; better processes around information sharing, referral pathways and community follow-up; improving the general understanding of the diverse service goals across services; and embedding collaboration into everyday work practices by allocating adequate staff resources and time to support effective mechanisms for information exchange. The potential role of a perinatal coordinator also needs to be considered.

C. The need for appropriate levels of institutional support and more opportunity for clinical reflection

Many staff felt unsupported in providing the types of care required to work in a trauma-informed, client-centred way. Aspects of work design, such as client-load and opportunities for debriefing, in particular, felt inconsistent with a more relationship-focused MOC, as the following sections will discuss.

Work intensification, vicarious trauma and burnout

Work intensification was a significant problem for workers dealing with high-needs clients. Work intensification can arise if there is a mismatch between expectation of service delivery and size of case load. Empirically this is reflected in situations where service expectations in terms of the level of engagement the workers are expected to deliver on, does not match the resources and time allocated to the workers. Two workers reflect on this dynamic below.

> *And then for the staff, I think there is a problem with having enough staff. And the PAF team is a multidisciplinary team that includes obstetricians, paediatricians, neonatologists, social work, nursing, drug health nursing, and also nursing from neonatal as well. So there's quite a big team and then potentially you could almost look at family and community services as all kind of part of that too in a way, 'cause they're often involved a lot. So, I think the team is a really good team, but it's a bit thin on the ground, I think in terms of enough people. And they do a very important role, but being so thin on the ground I think there's a big risk of burnout and things like that. So, that's my concern about that team that they're doing a very good role. (Frontline staff)*

> *But again, it's a time issue for the staff that are involved. We can't actually see everybody and do everything with everybody. We need more staff, we need dedicated staff to actually be able to move between various bits and be flexible. (Frontline staff)*

As mentioned in the sections above, workers often had to reconcile competing and contradictory policies and determine a solution on the basis of clients' needs. Staff spoke of feeling unsupported and undervalued for the high-demand work that they perform. These tensions are not adequately addressed through institutional processes and often go unrecognised within the sector. The need for management to recognise the taxing nature of these roles was highlighted by many participants. A large number of respondents described not being adequately supported by a manager or staff member with the appropriate level of knowledge relating to women, babies and drugs. We found extreme cases of support workers not having the opportunity to debrief following particularly acute episodes. The following extract is one example of how intense the work can.

> *I used to go home and I would think about it. It would keep me up at night. Did I do the right thing? Did I forget something? Because you take on such overwhelming responsibility that this family's gonna be okay, that this baby's going to live in a safe environment. And I've had a couple of cases where I've had a couple of babies die and you do take that personally and I'd go home and cry all the time but then when the child death review team comes and looks at all your stuff and you realise you're actually doing an okay job and you could – when you sit back and you look at it and dissect it all, you can justify why you made some of the choices that you made. (Frontline staff)*

Reconciling working emphatically and professionally with vulnerable women and children is best supported by ongoing reflection and enquiry concerning one's own beliefs and values. If the knowledge base of a team or an individual is not being developed with input from external sources there is a danger that, at best, skill levels will stagnate and, at worst, poor practice will be perpetuated. A large proportion of the employees we interviewed articulated a need for more support and debriefing opportunities in light of the challenging work performed.

> *It's really hard when they have someone being removed from your care. Even though you know already that it will happen and you know that it's going to be good for the baby. It depends on where the baby will be going. But, still, it's really hard for the staff member to accept that it will happen. I think in this job, they need to have some debriefing as well especially if they have some child protection issues but they don't have any debriefing. The child has been taken away and you will feel upset but no one will talk to you if you're okay. (Frontline staff)*

> *You've got to feel that you're supported in the work that you do. And I think that means probably good supervision and good leadership and people taking an interest in what you do and giving you appropriate feedback if you need to improve certain things. So, the supervision and leadership I think needs to be really strong, so that – particularly if a staff member is starting to go through some difficult times that they have an opportunity to talk to someone about it and ideally, intervene before things would get worse or staff need to move on or get really unwell. (Frontline staff)*

The biggest obstacles for supervision and reflection we encountered in the interviews were time constraints, and staff operating without formal support structures and colleagues. Below a worker reflects on the difficulty of not having any immediate colleagues with whom cases could be discussed.

> *If there was someone else that was there then there would be two people seeing the caseload together where you sit, meet and you chat and talk about, "Okay well I did this, do you think that's the correct pathway," so you just bounce stuff of each other to be able to do that but management do not encourage that over the years and the people that have tried to help have just not been recognised and have moved on. (Frontline staff)*

Workers were more likely to point to ongoing peer supports and team meetings as means of improving their support and debriefing opportunities, than monthly clinical supervision.

> *[We need] time for meetings and time for professional development. And if you feel like you're being communicated with, then you feel like people are noticing what you're doing, that they value you. (Frontline staff)*

Reflection can also protect against vicarious trauma, stress and burn-out.

> *I mean for this position to be working, you're also going to check if your staff is physically well, emotionally well, or something like that to be able to provide the support to them because it's really complex patient. (Frontline staff)*

> *So that's why it's so important to have someone help you in a role like this because you take on so much of that story that as much as you try and not have what they call vicarious trauma, you just still have an aspect of it. (Frontline staff)*

Supervision and de-briefing are vital tools for anyone working with highly vulnerable clients. Work intensification and working in isolation were two very common elements of work that were identified as diminishing the capacity for workers to build on their practice and share their own learning. Several participants described informal arrangements outside formal work arrangements that they used to debrief with other workers and solve problems.

> *So, over the last five years I've worked with some really amazing people that aren't within my own team. I know that they – here at drug health, they say that I have a team but there's no "I" in team so – but I worked with some brilliant people who have made it very easy and we have supported each other for the last five years to get up and keep doing what we've been doing. But, unfortunately, what's happened with that team is over the last six months, people have moved around and so the support has diminished a little bit and you notice that, so it does impact on you to start having headaches or sleepless nights trying to regurgitate stuff in your mind a little bit. (Frontline staff)*

Below is a quote from a worker reflecting on the significant inter-agency collegial support she received.

> *I think there're amazing workers in this area. I think that they're so much open, that people get advice from each other all the time. One of the FACS managers from Central emailed me the other day saying, "I've got this mum in this predicament. What do you think?" and I have nothing to do with that client but I*

> *think that there is that kind of – and I think if they do that to me, then I feel okay to be vulnerable with them and get advice from them. (Frontline staff)*

Work intensification is evident at critical points, particularly among front-line workers. This has the effect of inhibiting reflective practice and the capacity to gather outcomes data that might assist the service undertaking evaluations and benchmarking for future planning. These were also examples where networks of informal support within and across services and agencies acted as protective barriers against staff burn-out.

Summary

Lack of reflective capacity at the organisational level was evident at the level of job design. The key barriers to workplace learning are work intensification which diminishes the time available to workers and managers to reflect on their practice, to give and receive feedback, to locate and use knowledge from outside sources and to engage in processes to review learning opportunities and work processes. Staff working in isolation or experiencing limited collegial support further curtails opportunities for mutual learning and support from colleagues and mentoring. In this context, effective SUPPS programme delivery corresponds with the right level of staff mentoring, support and debriefing and generally that staff feel that they are supported and acknowledged in their work.

Recommendations in this regard relate to providing appropriate ongoing training, mentoring, professional developmental opportunities and education to inform client-centred theory and practice frameworks. In particular, the need for training in areas such as trauma-informed care and the skills associated with working effectively as part of a collaborative team, were identified.

Conclusion

A strong theme from the data was that core service delivery and the intended outcomes of SUPPS were contested. A shift towards more trauma-informed, client-focused care, places emphasis on empowerment and reflective practice, and greatly shifts expectations of service delivery standards. This involves a greater acknowledgement that engagement is broader than simply referral pathways and service access, but also involves the fostering of relationships to ensure clients' continued participation in services. Despite this shift, notions of engagement and continuity of care remain contested as they are implemented on the ground, with significant flow-on effects on work design. Other barriers to effective collaboration related to limited trust between services and workers, communication issues, and concerns regarding professional identities, role clarity and occupational boundaries.

A critical challenge for SLHD is to design, implement and support mechanisms and new ways of organising work that overcomes those barriers. The skills required of SUPPS front-line workers were a combination of support and education encompassing how best to support women's development. Such work requires a high degree of clinical skill, emotional labour and empathy when carried out in a respectful and principled manner and is a significant factor in making SUPPS work at times both emotionally draining and rewarding. Workers must have or develop attributes and skills that facilitate clients to make significant changes, consistent with the principles of person-centred practice and empowerment. Supervision is a vital tool in the development and retention of such skills, especially given the complex interpersonal work involved in the work. Reflective practice, whether formal or informal, promotes a questioning culture and encourages self-investigation. This allows workers to share common values, theoretical understandings, skills and practice principles. Reflective practice is essential in developing collaborative negotiation involving different perspectives. Improving staff access to formal and informal support, supervision and reflective practice would further develop a learning culture across departments and act as a protective mechanism for staff against stress and burnout.

Section 4: Governance and resources

Fragmentation of services

Fragmentation of services has been highlighted as a significant barrier to staff collaboration and integrated service delivery (see Section 3B: Challenges to collaboration). Participants also reported that fragmentation of services reflected siloing at the governance level.

> *Every time we set up another department, we have another silo. So all these workers are all coming from a different structure, and they're all reporting to a different governance structures, right? And at that higher level, there is dysfunction, so pussyfooting around about our relationship with mental health, pussyfooting around about our relationship with chronic and whatever aged care stream, pussyfooting around our relationship with Women's and Children's Health. So there's that structural issue up there which they feel down at the clinical level. (Manager)*

While a range of departments and services were involved in delivering SUPPS-related care, a more coordinated approach was recommended.

> *Fragmentation occurs. The obstetrics, the perinatal chaps, the neonatologists, every department you can think of that contributes to this either does so half-heartedly or even if they do so with enthusiasm, it's not a coordinated effort. (Manager)*

At the service level, having different line management of staff who worked within the same team, policy inconsistencies and lack of consensus regarding scopes of practice, created policy further opportunities for fragmentation of service delivery (see Section 3: Barriers to effective service delivery).

> *We've got two different departments providing two different perspectives, two different types of service. (Manager)*

The fact that there were two different models of care for SUPPS/PAF teams operating within SLHD was a concern for many participants.

> *Another key concern would be that we have different models of care across the district for how families with substance use and pregnancy and young children are managed. (Manager)*

The presence of different models of care at Canterbury Hospital and RPA could create inequalities, where access to services was influenced by residential postcode or which hospital a child was born in, than by the needs of families.

> *I guess, concerns around not having a consistent model of care that can just make sure that all women get the same service between RPA and Canterbury but also something that's in line with other LHDs as well because we should all be consistent in what we offer so that if you're transferring from one hospital to another, that you're gonna get offered the same level of care. (Manager)*

> *A lot of it is still a post code lottery, you know, it's where you live. There's no consistency across the district for people accessing services. When we're out at Canterbury we just can't get over there's 10 services at Redfern to every one over there. There's just nothing out there, whatsoever. (Frontline staff)*

In addition, scope for staff working across the district to make efficient use of resources would be undermined by having different models of care operating in each area.

> *If RPA becomes really busy and the Canterbury side isn't and we want Canterbury staff to pick up some of the caseload for us, it's a challenge to do that with the social workers because they work differently according to different models and they're providing slightly different care and they're doing it through different reporting lines. But from a nursing point of view, we could probably do it quite easily because it's far more closely related, the way they're working. (Manager)*

Several managers suggested that to reduce fragmentation and maintain equity of service provision within SLHD, the teams operating at Canterbury and RPA should both adopt the same MOC and call themselves by the same name, that is, SUPPS rather than PAF.

> *I think in the last few weeks, the Drug Health executive team has discussed this a couple of times, and we've decided that we should call all of the services by the term SUPPS. So, we should rename the RPA team. We should have some meetings with social work to explain that to them and we should get their buy-in. The way Canterbury is doing it is superior because Canterbury is doing what the ministry want them to do and the ministry has had a lot of concentrated planning around this area and have come up with a pretty decent approach. (Manager)*

From a governance standpoint, it was also suggested that SUPPS become better integrated with other related services, including Healthy Families Healthy Children and General Practice.

> *SAPS should not be an island on its own.   It's gotta have legs. It's gotta be supported on some legs and we gotta figure out what those legs are. One of those legs is Healthy Families Health Children, and the other leg is integrated care, and it's attempts to try and engage general practice. (Manager)*

A shared governance structure to oversee integrated SUPPS service delivery and, potentially, shared resources, was also suggested. Senior managers, or clinicians, representing all services involved in providing care should be part of this governance group to facilitate more direct communication and between key stakeholders. SUPPS should be thought of as an integrated service network rather than a funding stream.

> *I know the chief executive believes in the matrix system, but we don't seem to have the systems in place enough to bring task groups together to work on a problem, identify who's gonna be the lead, and let that person be the lead and we all look to the lead. That idea of being able to bring task groups together, how to work as a team. So that's why I've said before, I like the military approach of forming a task group and someone's in charge of that task group, and I can give my resources to that group, and I don't, then, try to control them when they're in*

> *the group. So I don't know whether we're willing to go down that route. If you've got a socially high-risk team and mental health allocates the CNC and 10 hours a week of a psychiatrist and 10 hours a week of registrar and so and so. When they're in that team, they belong to that team. They're a part of the culture of that team and the team leader is in charge. (Manager)*

> *There's no substitute I don't think for some cohesive planning, where people spend some time in the same room to talk, thresh these issues out, 'cause you can't do it for them and I can't either. Teresa Anderson, who's the boss of the health district, can't do it for everybody either. She can facilitate people getting together, but people that work for different governance and people have different perspectives, be they medical and social and this and that, they're gonna have to communicate with each other. (Manager)*

One manager suggested the services provided under the shared governance structure should be given a new name, rather than using SUPPS.

> *We need to get rid of the SUPPS name and the HHAN name, throw them all together into one team and get them to rename themselves. (Manager)*

The Healthy Families Healthy Children Steering Committee was formed in 2016 in recognition of the need for a more integrated approach to service delivery in SLHD and to create a shared governance structure for services targeting pregnant women and mothers with substance use problems. This forum is a valuable starting point for moving towards efficient and integrated service delivery.

Efficient use of resources across SLHD

It was more than two decades ago when the first drugs in pregnancy service in New South Wales was established at Crown Street Women's Hospital in Sydney, under the stewardship of Edith Collins. When Crown Street and RPA merged, the service moved to RPA. However, over time, funding for the service and its four staff was lost and has never been adequately re-established.

> *The RPA approach has evolved historically because it was the best approach. In the the 1980s and '90s the first drugs in pregnancy service in New South Wales, possibly Australia was at the Crown Street. Crown Street Hospital moved to RPA, to the King George V building, and that service came with it, run by Edith Collins. Edith Collins established and led a separate little subgroup with four staff, two social workers, nurse, and herself, and they did a great job in getting this group of women through their pregnancy successfully. But over time, Edith Collins herself retired and the team disintegrated. And so, we went from having the best service to having none at all. And it was very difficult to get anything re-established because the funding was distributed elsewhere. So, that became an area where we were really quite deficient and nobody's been able to successfully re-establish it. That's really what it comes down to. (Manager)*

Creating a case for increased funding is challenging because the population of women with substance use problems delivering babies in SLHD is small relative to the total number of women who give birth each year. In addition, this group of women often have complex needs and substance us remains highly stigmatised.

> *The challenge, I think, for this group of patients is three particular things. Firstly, the complexity is high. The number is relatively small. If there's 50 or 75 or even a hundred such women passing through the system at RPA each year, that's a hundred out of 6,000 [births]. That's how many deliveries there are. That's just RPA. It's another three or four thousand at Canterbury. So, it's needle in a haystack stuff. (Manager)*

> *Again, it's the stigma. This isn't an exciting group of patients. This isn't ED who seem to get funding for everything. These are really risky patients where I think we can do so much, so many things. (Frontline staff)*

The cost of providing follow-up support for clients for up to two years, and what form that follow-up could take given available resources, is currently unknown.

> *I think one of the biggest things that's gonna be hard in SUPPS is how do you really provide ongoing care and support for people for two years and not hit capacity within the service. And so, what does that really look like? Is that care coordination? Is that case management? Because the clinicians are gonna get overloaded very quickly. So I think what will be important is how realistic we are about what we want clinicians to offer and what does that really mean in terms of resourcing. If that's not possible, then how do we do it with what is possible? (Manager 2)*

It was often frontline staff who reported that current staff resources were not adequate, to get the work done and also prevent staff burnout.

> *Resources are very low, so that's staffing. At one stage I had 45, nearly 50 women on my list and I cannot physically see that so it was unachievable. They might have three antenatal and 10 postnatal families and I've got about 27 at the moment. I've just had a few births but I was carrying up to 45 to 47 women antenatally and then I'm still about 10 postnatal families so it just doesn't make sense. (Frontline staff)*

> *I think there is a problem with not having enough staff. And the PAF team is a multidisciplinary team that includes obstetricians, paediatricians, neonatologists, social work, nursing, drug health nursing, and also nursing from neonatal as well. So there's quite a big team and then potentially you could almost look at family and community services as all kind of part of that too in a way, 'cause they're often involved a lot. So, I think the team is a really good team, but it's a bit thin on the ground, I think in terms of enough people. And they do a very important role, but being so thin on the ground I think there's a big risk of burnout and things like that. So, that's my concern about that team. (Frontline staff)*

Funding for adequate specialist medical coverage for SUPPS was also considered necessary.

> *Third area of concern is medical support, medical engagement. It's very important that there is adequate medical coverage where it's relevant for the patients. And it's been a problem here at RPA with the service not choosing to consult the doctors. At Canterbury, I have yet to see what's going on in that domain, 'cause they've only just really started, but I think the problem there is more likely to be that they don't have adequate medical staff to respond to these consultations. I would not be surprised if that was the concern, although it hasn't come to me as a concern just yet. So, there's really a lot of fragmentation at the RPA side, far too much. I think that would require probably an academic, medical, or clinical lead, like a senior expert specialist role. At least I would've thought half time would be required. (Manager)*

According to participants, while the recent funding enhancement from the NSW Ministry for Health for Canterbury Hospital addressed an area of unmet need in that local area, a mismatch between funding levels and where patient demand is highest in SLHD has also been created. Participants were concerned that there are now more resources at Canterbury when most of the workload was at RPA. A district-wide approach to SUPPS funding, along with consistent models of care, was recommended.

> *Currently and historically, at least three quarters of the workload was at RPA and until the latest SUPPS enhancement, there were – a hundred percent of the resources were at RPA. So, Canterbury was, in fact, under-resourced. The one position we had at RPA was supposed to visit Canterbury periodically, but usually didn't. Subsequent to the funding enhancement, the problem has reversed with all the resources or the vast majority of the resources now based at Canterbury whilst most of the patients are based at RPA. So, that means that there's a lot of interest and support and cohesion for the Canterbury clients, but actually no interest at all in what's going on at RPA, like none. So, I feel it's very important we adopt a district-wide approach. (Manager)*

An absence of data to measure outcomes of the SUPPS programme, or to evaluate its effectiveness, also makes it difficult to plan and resource the programme. The need for clearly defined service outcomes and access to data for monitoring and evaluating services will be discussed in the following section.

Measurement of outcomes

Participants highlighted the importance of putting in place data collection systems for monitoring and evaluating the effectiveness of SUPPS services.

> *The team are doing a good job amongst themselves, but it's also data collection, evaluation, planning, improvement. All that kind of stuff is not happening systematically and I think that's something that could improve the service. All the staff, they're in the midst of it, all so busy with their day-to-day that it's hard for them to step back and plan and reflect and also collect some data. I mean, I know that the EMR collect very basic – I mean, you enter data into to your medical record and so, potentially it's all there, but again, it's not terribly accessible to summarise and reflect on what you're actually doing. So data, in terms of clinical data, having a coherent medical record, but also research and*

> *evaluation data. Data just to be able to reflect on what's happening. How many people have been seen in the last month or six months and what were the outcomes? Did we do any good? (Frontline staff)*

One manager reported that research in the area of substance use in pregnancy had diminished since there was no longer an academic head for the SUPPS programme.

> *A need for academic and clinical leadership. The next concern is that we've had a history of interest in research in this area and RPA led some of the early research in the drugs in pregnancy space in Australia and our current service is not data-driven or research-orientated. It's really very problematic and very frustrating to me. So, there's no academic lead in the position anymore. (Manager))*

Systematic data collection was also lacking.

> *As an example, people have to enter their data into the computer, so you know how many patients they've seen and they've never done that. They've never been willing to do it. We've never had decent data collection. (Manager)*

The need for clearly articulated programme outcomes, that were routinely evaluated to provide greater accountability for staff, was also reported. As well as maternal and child health-related outcomes, participants often identified keeping families safe and together wherever possible, as a key outcome for SUPPS.

> *I want families to have safety around them and be able to go home and those kids not be another statistic, not come through the cycle. "My mum was bummed down. My dad was never around so what's the point? I'm gonna be unemployed. I'll just be in and out of care." It's about keeping families together safe, that's what I wanna see and that should be the outcome for us. (Frontline staff)*
>
> *I suppose ideally we want people who are having children to then be able to sustain looking after those children in an environment that's suitable. So that would mean stabilised say, substance use and attentive parenting. I mean, ideally, that's what you want and you wanna keep kids in families. You want the kids to be safe and being raised in a way that's meeting their developmental needs. (Manager)*

Collecting data on assumptions into care was considered an important indicator of service effectiveness.

> *I think the lack of accountability that we had as a service and the lack of measurable outcomes. For me, that was one of the major things. At RPA, people said when I started the role that they just took babies at this hospital and if clients present they didn't really have an opportunity to take their babies home. Hopefully, these things have changed but I don't know. We don't know. There was nothing to say how many assumption of cares happened per year, how many FACS reports we made. I know anecdotally from the FACS caseworkers that when I started I made more reports but we don't, as health, it's crazy, we don't actually*

> *keep statistics on that. There's not even like a baseline outcome – if when things go wrong, if there's an assumption of care and maybe I haven't done my job properly, maybe I didn't like that woman very much and just didn't provide her a very good service, there's nothing to say – what did health do and what could we have done differently, and is there something that we can change about our practice. There's absolutely nothing in-built in the job at all in terms of that. I really think having some outcomes that you have to tell people about, some place that we have to get to the end of 2018 and say, "This is how many babies were assumed to the care." (Frontline staff)*

However, other measures of longer-term outcomes were also needed. Less assumptions of care at birth was not always an indicator of success. Identifying whether referral of clients to residential rehabilitation post-delivery leads to better results such as fewer assumptions into care was also needed.

> *The social worker was extremely proactive, reduced the amount of assumption of cares. So, like the terminology is less assumptions of care, increased success. That's one way of looking at it but also, some of that is "You are gonna lose your baby unless you go to rehab" so, they then get into rehab. They go into rehab but there's no evaluation done as to what happens after the rehab, if they've successfully completed that and are they still safe. Do they go home with the baby or do they still lose the baby down the track? Some of the ones that we've seen have been absolutely chaotic. (Manager)*

In the case where children were assumed into care, collecting data regarding what services the client accessed was also considered important for monitoring staff practices and guiding future service provision.

> *So, with outcomes for families, I guess, we've gotta make sure that we're not just looking at mums going home with their babies is the only best outcome. That some women are not ready to parent or might not have that available to them at that time due to their trauma and their issues that are going on, but the outcome should actually be what happens with them afterwards as well. Did they have services involved? Did they get to rehab? Did they get out of a DV relationship? Did they have support? Minimise their drug use, address their health issues, and that those two outcomes should be as important as each other because having their baby go home with them isn't the only outcome. (Frontline staff)*

Identifying to what extent services were reaching their target population in SLHD was also highlighted as a key goal for monitoring and evaluation.

> *The early identification of all women. To me, that's taking a population-based approach and identifying all the women who could potentially benefit from a SUPPS program, not just those who've been referred late in pregnancy to Drug Health. I think that a lot of those mums don't declare their situation when they're booking in, and the very busy midwives across the road don't necessarily ask the right questions or spend the time to dig – to get to those questions. (Manager)*

> *I think trying to get a baseline of who are the mothers who identified as having drug use [issues], because that's all we can really go by. We acknowledged that a number of mums, lots of mums probably, who do partake in drugs, don't disclose that, so we don't know about that. But even amongst the ones who do disclose, someone needs to have that baseline, or that denominator. So that was one of the things that we identified from that work that we did that there was actually no database to capture that baseline figure at RPA. And who owns that? Is it drug health that owns it, or is it the neonatologist that owns it? So I think it's important to have that data, to know how well we're managing in terms of follow-up for these families, because without that data, we have no idea how we're doing. (Frontline staff)*

> *If you look at the vulnerable families in Sydney Local Health District, are they all connected to someone in this space or are we all just seeing the same people and fighting about it? There's a whole lot of families who aren't engaging at all because we are putting all of our effort into fighting over this cohort of families. (Manager)*

A digital system for identifying women needing SUPPS services, and for longitudinal tracking of child development and well-being, was suggested.

> *So I know I'm talking bigger than SUPPS here but SUPPS has a nest within that. With the right training of the staff, we can have a digital system to identify them, and we have a person to coordinate them. On the digital side, there was an attempt here to develop a REDCap database. It was developed by this team, what's it called? PAF, by a staff specialist from neonatal. I stepped back from this for a couple of years and I'm not sure whether they still use it. But I think we've got some ideas about how we could go forward. It needs to be a digital solution. (Manager)*

> *I guess, that longitudinal tracking. We need some database to track them. I think if you're thinking purely about Sydney LHD, the electronic medical record that we use that's called CERNA, whether that can be used to track these families. When I say track them, it would be nice if we can just track these individual babies and children once we know that they've been born. How do we track them if we don't have that baseline data? I guess I'm trying to go back to the importance of the baseline data, of being able to track these babies that turn into children. [A]nd therefore, how do we keep track of these vulnerable mums and babies? (Frontline staff)*

In summary, the lack of clarity regarding outcomes creates challenges to undertaking evaluations of short and long-term goals of the SUPPS programme. In particular, data needs to be collected to determine:

- Outcomes: If there is a difference in health and social outcomes, for mothers and babies who engage in SUPPS services,

- Referral pathways: If existing care pathways translate to proactive engagement with other health and community services.

Summary

Fragmentation and siloing of services has created barriers to integrated service delivery. A shared governance structure, specifically for SUPPS and related services, was recommended to embed a more integrated approach at the leadership level. Successful service delivery was best supported by a diverse leadership team representing stakeholders across hospitals, services and disciplines. A shared vision, commitment to resource sharing, clear goals, performance indicators and accountability processes, was also necessary. It was suggested that community and non-government organisations have a role within such a governance structure.

A districtwide approach to funding and governance, overseeing a consistent MOC across SLHD, would enable not only integrated service delivery but also efficient, targeted and equitable use of resources. Adequate resourcing of services, including medical coverage, would assist in ensuring the provision of quality care as well as reducing staff turnover and burnout. The new integrated service structure also needs a consistent name.

Clearly articulated and measurable outcomes for SUPPS also need to be established, to facilitate monitoring and evaluation and also guide resourcing, staff recruitment and clinical practices. In addition, the development of appropriate data collection systems and academic leadership for SUPPS were suggested to inform service delivery and re-establish a focus on research in this area.

Section 5: Feedback workshop discussions and recommendations

A workshop was conducted in November 2018 as a mechanism for obtaining feedback from key stakeholders regarding the findings of the research. Managers from a range of SUPPS-related services across SLHD participated in the workshop, involving a presentation by the researchers who conducted the study and discussion facilitated by the academic lead of the project.

Overall, stakeholders were in agreement that the research findings had highlighted a range of issues that needed to be addressed, as part of developing a MOC for SUPPS across SLHD. The presentation generated discussion in five main areas:

1. The benefits of a districtwide SUPPS MOC, to enhance consistency of clinical practices in SLHD and improve integration of services, particularly when clients move between RPA and Canterbury Hospital. Clarity and consistency regarding scopes of practices in relation to postnatal follow-up were also needed, as well as a consistent name for the programme in SLHD.
2. Efficient use of resources. Findings suggest more resources are needed for SUPPS but at this point, it needs to be recognised that applications for funding enhancements will require clearly defined service outcomes and evidence, in the form of relevant data. There is currently a significant data 'gap' to inform resourcing, policy and practice. Enhanced data collection systems and evaluation need to inform future service development. The need to provide equitable access to care across SLHD (RPA and Canterbury Hospitals) and optimizing the use of existing staff are two key considerations.
3. The need to improve staff collaboration to enhance continuity of care, particularly from antenatal care to the community. Small steps to address this issue have already been initiated within some services. For example, the Canterbury SUPPS team attends the PAF meeting at RPA and are invited to Child and Family nursing review meetings. The need to establish a key worker for clients rather than having multiple staff involved was discussed. However, inter-agency team building was an important pre-requisite to implementing this approach.
4. Using the MOC to ensure service delivery and referral pathways are guided by evidence-based policies and practices, rather than relying on individuals. The issue of high staff turnover and staff burnout needs to be further examined with a view to enhancing workforce sustainability. The impact of vicarious trauma on staff needs to be acknowledged, with appropriate use of medical and psychiatric resources in supporting staff.
5. Leadership of the SUPPS programme. Shared governance of SUPPS was recommended, with no single department having full ownership of SUPPS. Governance and resourcing need to be shared between a range of stakeholders to share responsibility for service outcomes. Line management of staff should be to this SUPPS-specific governance group, as long as staff also have the option of putting in place mechanisms for connecting with discipline-specific supervision. In situations where there are conflicting approaches to service delivery, the shared governance group should be charged with responsibility for ensuring a final resolution is reached.

The outcome of the workshop was that there were five issues to address as a starting point:

- Governance
- Data collection systems
- Output metrics
- Team building
- Referral pathways.

The formation of five working groups to respond to these issues was recommended. It was anticipated that additional strategies would be needed, subject to the full recommendations outlined in the final project report.

Conclusions and Recommendations

The research identified guiding principles, practice approaches, strategies and interventions relevant to the SUPPS MOC for SLHD. The literature review highlighted the limitations of the existing evidence base for SUPPS and therefore, the limited capacity for findings of the review to inform development of the MOC in a meaningful way. The strength of the research methodology adopted for the project lies in the qualitative data obtained from in-depth interviews with staff. As well as exploring staff's perspectives of what should be included in the MOC and barriers to effective service delivery, the interviews provided opportunities to understand why staff held these views. In this way, data revealed the structural, institutional and individual-level drivers of these perspectives and the organisational context in which the MOC is embedded. Findings will inform the MOC, as well as the way forward in terms of translation into practice.

Against a backdrop of limited research evidence supporting particular interventions for SUPPS, the data-informed MOC developed through the project serves as a locally-appropriate guide for service provision in SLHD but in many ways, is only a starting point. The MOC needs to remain a live document and be viewed as a work-in-progress, that can be adapted to reflect an emerging evidence base and the changing context in which SUPPS and related programme operate.

A strong theme of the data was that several aspects of SUPPS-related policy and practices in SLHD were contested. Service delivery was at times heavily influenced by the preferred approaches of the staff involved rather than SUPPS-specific policies or set referral pathways. While the dedication and personal qualities of staff, and flexible approaches to care provision, were often among the greatest strengths of services, competing staff priorities and opposing philosophies could create inconsistencies with the potential to negatively impact on staff well-being and outcomes for clients. As a result, the MOC informed by the research requires further refinement prior to implementation, subject to consensus being reached regarding particular issues. Resolution of some of the barriers to effective service delivery was beyond the scope of this research and addressing them will require the input of relevant stakeholders.

Seven major recommendations arose from the research.

1: Shared governance over a dedicated SUPPS team

- In order to create consistency between organisational structures and core service delivery goals, it is recommended a shared governance structure over the extended SUPPS team working across hospital departments be developed. This could include representatives from Drug Health, Social Work, Women and Babies, Child and Family Health and other community services. This may warrant the pooling of all SUPPS-related resources, working as one team and operating under a SUPPS-specific vision, scope of practice and overarching framework.

- Operationalising shared governance will need to include agreeing on leadership and other roles and responsibilities of group members.

- The MOC needs to be supported with adequate staffing, resources, policies and work practices that reflect the objectives of the SUPPS programme. Funding enhancements may be required.

- Measurable outcomes for SUPPS need to be agreed upon by the governance group. Outcomes in relation to the extent of women's engagement in care, services provided, maternal and child health, assumptions of children into care, at birth and in the longer term, and reunifications, were suggested.

2: A districtwide model of care for SUPPS

- A consistent MOC for SUPPS and related programmes across SLHD is needed to maintain continuity of care between RPA and Canterbury Hospital, to enable more integrated service delivery and efficient, targeted and equitable allocation of SUPPS-related resources across the district.

- A consistent name for SUPPS and related programmes in SLHD is also recommended.

3: Consistent scope of practice

- The lack of consistency of practice within the SUPPS programme was found to negatively impact on staff and create tension, interpersonal conflicts and duplication of work. Consensus is needed regarding the following aspects of SUPPS service delivery:

    - Promoting engagement with clients
    - Continuity of care
    - Collaboration within and across agencies

- Regular meetings of SUPPS teams for ongoing reflection around best practice frameworks, is recommended to ensure that staff are able to share knowledge and reflect on what works.

- In light of the inconsistencies in ways of working across Social Work and Drug Health it has been suggested that a Social Worker be directly employed under Drug Health in the SUPPS team at RPA. This option warrants consideration.

4: Enhancing collaboration

- A less hospital-centric approach to service delivery is recommended to facilitate effective knowledge sharing, referral pathways and communication across agencies. This involves establishing better referral pathways to the community as part of antenatal care and improving ways of involving community workers during a client's inpatient stay.

- Employment of a perinatal coordinator is suggested to coordinate and oversee continuity of care and referral pathways.

- Improving the general understanding of the diverse service goals and governance structures across professions and services is recommended as a meaningful way to achieve effective collaboration. This includes increasing the general knowledge of all staff involved with SUPPS clients regarding others' role and the services available.

- Attendance at regular intra- and inter-agency network meetings across agencies is important to assist in building trust between professionals and organisations.

- The development of policies around how to collaborate across agencies and hospitals is recommended, to facilitate better service coordination and integration. This includes the development of enhanced process mechanisms and frameworks, including the establishment of formal agreements and shared policies between partner services, to better support collaboration and referral pathways.

- Flexible work practices and the allocation of sufficient time to facilitate collaboration are also needed to support staff to negotiate priorities with multiple stakeholders.

- The development of more formal processes for identifying a key worker is recommended. This involves staff reflecting on who has the best relationship with the client, and other staff providing wrap-around support for the key worker.

- Processes and digital technologies that aid in more effective sharing of information are also recommended.

5: Effective service delivery

- The degree to which SUPPS and related services are able to meet the needs of clients relies to a large extent on service delivery being offered in a flexible way. In this regard, a focus on flexible models of service delivery that accommodate the often unpredictable lives of families unable to commit to “timetable” type appointments is recommended. This includes:

    - Soft entry points, non-threatening, indirect and informal services
    - Warm (and/or facilitated) referrals
    - Services that encourage “drop-ins”
    - Outreach
    - Reduced waiting times.

- To adopt a more trauma-informed approach, a policy regarding who does the psychosocial assessment for new SUPPS clients is needed. It has been suggested that one staff member do a thorough psychosocial assessment that other hospital and community staff can then refer to, rather than expecting the client to retell their story several times to different workers.

- A greater focus on postnatal support in the community is needed. The role of inpatient staff in providing outpatient care or outreach, and the time frame for follow-up, needs to be clarified, and consistent across SUPPS teams in SLHD. More opportunity for RPA staff to follow-up with families post discharge is recommended, to maintain continuity of care.

- The need for evaluation and sustainable funding of Possum Playgroup has been identified.

- The need for more Aboriginal workers to provide intensive follow-up, Aboriginal refuges and residential rehabilitation programmes was highlighted. Priority access to OST, as well as greater involvement of Aboriginal community members and case workers in PFC and other programmes focusing on child protection matters, is recommended.

- More research is needed to inform SUPPS and related service delivery for Muslim and Arabic-speaking clients in the Canterbury area. Outreach models have been suggested as a worthwhile approach that acknowledges and responds to the stigma associated with substance use in these communities.

- Ensuring adequate medical coverage for SUPPS and related programmes is also recommended.

- To assist in maintaining continuity of care from the antenatal period to postnatal community support, employment of a SUPPS midwife (in addition to the existing Indigenous midwife) in the antenatal clinic is recommended.

6: Workforce sustainability

- Increased institutional support to increase staff work satisfaction and prevent burnout was recommended. This involves a greater acknowledgement from management of the challenging issues faced by frontline service providers and a recognition of the risk of vicarious trauma for staff.

- Effective SUPPS program delivery requires the right level of staff mentoring, support and debriefing and generally that staff feel supported and acknowledged in their work. Adequate supervision, mentoring and induction support for new staff, opportunities for support and debriefing after critical incidents, and better contingency planning for staff turnover, was recommended.

- Providing ongoing training, mentoring, professional developmental opportunities and education to inform client-centred theory and practice frameworks is recommended. In particular, the need for training in areas such as trauma-informed care and the skills associated with working effectively as part of a collaborative team were identified.

- Developing processes for evaluation and reflective practice to ensure accountability and best outcomes for clients is recommended to ensure continued learning as an institution and move away from a crisis-driven MOC.

7. Measuring outcomes, data collection and research

- There is a lack of systematic data collection in relation to SUPPS outcomes and service delivery that can be used to inform governance, management, and resourcing. Measurable outcomes for SUPPS need to be agreed on by the governance group, and data collection systems put in place to facilitate monitoring and evaluation, and inform service planning, staff recruitment, policy and resource allocation.

- To what extent SUPPS services actually reach the intended target group in SLHD remains unclear. The development of integrated digital systems for capturing and storing screening and longitudinal tracking data, on women and children in SLHD, are recommended to assist in estimating the size of the SUPPS target population, the reach of service delivery and longer-term client outcomes.

- Academic leadership of SUPPS was highlighted as important for addressing the lack of SUPPS-related research in Australia and internationally, and to inform policy development and service delivery.

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