ATTACHMENT CH 4

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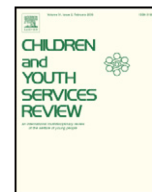

Infant risk and safety in the context of maternal substance use

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A B S T R A C T

Substance-exposed infants are extremely vulnerable due to biological, environmental and systemic risk factors that commence in pregnancy and are compounded by the postnatal caregiving environment. Substance-dependent mothers face unique challenges in caring for an infant while managing drug use or pharmacotherapy. The vulnerability of infancy therefore requires thorough assessment of risk and a prompt response from service providers. Drawing upon a prospective case-study of twenty women accessing a specialist alcohol and other drug obstetric service, this article explores the factors which contributed to infant risk or safety from the perinatal period to the end of the infant's first year. Data sources included structured interviews with counsellors and child protection workers and semi-structured interviews with mothers. The findings demonstrate continuing exposure to risk identified in pregnancy, including substance use and domestic violence, and inadequate follow-up of infants after discharge from hospital. The ability of an obstetric provider to conduct accurate risk assessment was evident. In addition, a sub-group of infants at higher risk of removal from maternal care was identified. The argument is made for a differential response by the service system to ensure women in greatest need are provided with extensive support when infants are most vulnerable and mothers most open to help.

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1. Introduction

All infants, due to total dependence on a caregiver to meet their needs, are vulnerable. Substance-dependent infants are extremely vulnerable due to biological, environmental, economic and systemic risk factors often beginning in pregnancy and compounded by the postnatal care-giving environment (VCDRC, 2000). Substance-dependent mothers face unique challenges in caring for infants while managing drug use or pharmacotherapy. This complexity in the mother/infant dyad requires thorough assessment of risk and a prompt response from service providers. Consequently, many substance-exposed infants are brought to the attention of child protection services in the perinatal period, particularly prior to discharge from hospital when vulnerability is heightened. Once they enter the child protection system, infant cases are more likely to be substantiated and to result in placement in out-of-home care where they tend to remain longer than other children (Zhou & Chilvers, 2010).

While perception of risk is ubiquitous in child protection practice, few studies report how risk is experienced and enacted (Stanford, 2010 p. 1067–1068). Equally, limited attention has been given to the subjective experience of substance-dependent women involved with child protection services (Davies & Krane, 2006). This article draws upon a prospective case-study of twenty women accessing a specialist alcohol and other drug (AOD) obstetric service. Two perspectives are presented: those of service providers and mothers to demonstrate the need for a differential response to risk when problematic parental substance use has been identified in the perinatal period.

2. Literature review

Data from the U.S. (Havens, Simmons, Shannon, & Hansen, 2009), the U.K. (Crome & Kumar, 2007) and Australia (Bartu, Sharp, Ludlow, & Doherty, 2006) indicate that approximately 5% of women use substances during pregnancy; although underreporting by women, and limited screening by hospitals, suggests these estimates are likely to be lower than actual rates (Anthony, Austin, & Cormier, 2010). Substance-use frequently continues in the postnatal period, and together with mental health problems and domestic violence, is present in the majority of notifications to child protection services in Australia (Council of Australian Governments, 2009), the U.K. (Forrester & Harwin, 2008) and the U.S. (Blythe, Heffernan, & Walters, 2010). Annual reviews of the deaths of children known to Child Protection conducted in the state of Victoria, Australia, repeatedly demonstrate that infants under twelve months of age are most likely to come to harm (VCDRC, 2000, 2012). While they vary in scope and approach, particularly in relation to mandatory reporting of unborn infants, where differences are found across and between countries, child protection systems generally seek to intervene early when in-utero substance use has been identified; the response, however, can vary greatly. For example, U.S. federal law mandates notification of infants exposed to in-utero substance use. Although the intent is to support pregnant women, there is potential in some states for prosecution on the grounds of child abuse (Drescher Burke, 2007). Child

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protection systems in Australia are also operated by individual states and territories, with differences in mandatory reporting requirements; child protection policy nevertheless reflects an underpinning philosophy of harm reduction. The aim is to improve pregnancy outcomes, prevent or ameliorate the severity of parenting difficulties, assist mothers in recovery and reduce the need for involvement with statutory child protection services (Anthony et al., 2010). This approach is also evident in the U.K. where the policy response is to promote access to alcohol and other drug treatment, mental health services and parenting education for mothers (Gilchrist & Taylor, 2009). Obstetric services therefore play a critical role in the identification of at-risk infants and in initial decision-making to activate the formal service system, either through notification to statutory child protection, or through referral to child and family welfare services (Campbell, Jackson, Cameron, Smith, & Goodman, 2000). However, questions have been raised regarding the requisite skill and knowledge of professionals other than child protection workers in conducting risk assessment (VCDRC, 2000).

Concern with the reliability of risk-assessment has resulted in widespread use of risk assessment instruments to guide decision-making. Yet, even with the use of standardised instruments which have become central to child protection practice (Gillingham, 2006), variability in the appraisal of risk and confidence in performing assessments have been noted amongst child protection workers. Regehr, Bogo, Shlonsky, and LeBlanc's (2010) study of 96 Canadian child protection workers found that worker variables including age, level of stress and ability to engage family members correlated with confidence in performing assessments rather than the level of risk assessed. This finding has significant implications for infant practice in the context of maternal substance use. Concern for vulnerable infants is likely to increase worker anxiety and drive risk-averse practice, particularly after high profile media events of serious harm to infants or children (Connolly & Smith, 2010). Substance-dependent parents in the U.K. have been noted to resent child protection intervention if they perceive it to be based on judgement rather than evidence about parenting practices and to be more likely to respond with antagonism (Buchanan & Corby, 2005). Faced with confrontational behaviour, workers are more likely to assess child risk as higher, as noted amongst participants in LeBlanc, Regehr, Shlonsky, and Bogo's (2012) Canadian study. The association between substance use and violence noted in U.K. child protection samples (Stanley, Miller, & Richardson Foster, 2012) is likely to further contribute to a 'culture of fear' pervading practice (Davies & Krane, 2006) leading to a spiral of mutual mistrust between parents and workers that may paradoxically leave the most vulnerable infants and children most exposed to risk. Studies conducted in the U.K. indicate that when domestic violence combines with the secrecy, resistance, denial and hostility that often characterises interactions between substance-dependent parents and service providers, workers may be more inclined to avoid contact with families (Forrester & Harwin, 2008) or to direct attention to mothers rather than the perpetrator of violence (Stanley, Miller, Richardson Foster, & Thomson, 2011). For their part, mothers experiencing domestic violence may be reluctant to ask for help for fear of being directed to separate from partners as noted in the U.K. (Stanley et al., 2012) and Australia (Walsh, 2002). It has been proposed that the concept of 'readiness to change' understood in relation to alcohol and other drug use may be applicable in situations of family violence (Hegarty, O'Doherty, Gunn, Pierce, & Taft, 2008; Humphreys, Thiara, & Skamballis, 2011); the process of intervention may, therefore, be an important factor in outcomes in relation to both substance use and family violence.

Various approaches to managing risk in child welfare have been recommended including improved engagement with parents (Darlington, Healy, & Feeney, 2010; Davies & Krane, 2006) and increased interagency collaboration in infant practice when maternal substance use has been identified (McGlade, Ware, & Crawford, 2012). The perinatal period has been referred to as 'a window of opportunity' in which women re-evaluate domestic violence (Pulido, 2001); many strive to become abstinent or, at the very least, to change their drug habits, as reported in Mayet, Groshkova, Morgan, MacCormack, and Strang (2008) and Radcliffe's (2011) U.K. studies. It is also a time when preparedness by mothers to be honest with health care providers, in the best interests of the infant, has been noted by Australian obstetric services (Phillips et al., 2005). The perinatal period may, therefore, be an ideal time to engage substance-dependent women in working towards an improved trajectory for themselves and their infants.

3. Method

3.1. The policy and practice context

There is no legal mandate in Australian legislation to support intervention with unborn babies but duty of care is considered imperative. Some child protection systems are able to receive reports for the purpose of support to expectant women but concern must be for the infant's wellbeing in the postnatal period (Mathews, 2008). Despite potential to intervene early in the development of problems, the Australian practice response to substance use in pregnancy is inconsistent with some hospitals notifying all newborn infants and others using discretionary powers. Child protection responses to infants deemed at risk prior to birth are similarly inconsistent (Wickham, 2009).

The present study was conducted in the State of Victoria which has mandatory reporting requirements for specific professional groups including the medical profession. Alternatively, reports can be made to community-based intake for vulnerable families not requiring a statutory response. Since the enactment of new legislation in 2007, Victoria has been able to formally receive notifications of unborn infants. In the absence of other concerns, substance is not considered sufficient grounds for notification in the pre or postnatal period. Victorian policy guidelines encourage health care providers to notify the statutory Child Protection service when women who have lost the care of previous children present at an obstetric service as this is considered a significant risk factor in child maltreatment. Case-planning meetings are generally held for all neonates considered at risk prior to discharge from hospital. Family Group Conferences are not mandated and are held at the discretion of Child Protection workers. The study was located at the Women's Alcohol and Drug Service (Women's ADS) at the Royal Women's Hospital, the state's largest provider of health services to pregnant women and newborn infants. Approximately 60 women access the service each year, half of whom who are brought to the attention of Child Protection in the pre or postnatal period on a case-by-case basis.

3.2. Research design

The overall aim of the study was to understand the trajectory for substance using women and their infants in the first 12 months of the infant's life and the role of the service system in responding to their needs. The research question addressed in this paper is: What risk and protective factors influenced outcomes among substance-exposed infants at infant age 12 months and how did the service sector, particularly the statutory child protection service, respond? The study was a mixed-method prospective case-study with two units of analysis: communication and collaboration between the Women's ADS and CP in the perinatal period and a twelve-month follow-up of individual women accessing the Women's ADS.

Data sources were:

1) The Women's ADS Client Assessment Tool which lists client demographics, psychosocial and risk assessment conducted by staff as routine intake procedure and case notes made after each contact with women accessing the service.
2) Structured interviews with Women's ADS counsellors to understand assessment of risk in infancy and corresponding referral pathways for each participating woman and her infant.
3) Structured interviews with CP workers to ascertain infant progress through the child protection system from notification to the making

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of Court Orders in cases of substantiated abuse/neglect and referrals made on behalf of each family. Both services were asked to report on the extent and quality of their mutual collaboration in the perinatal period.

4) Semi-structured interviews were held with service users. Women were asked about their experiences of a specialist AOD obstetric service and any other services they used, including CP. Women were also asked about their experiences of caring for a substance-exposed infant, their social network, substance use and the availability and helpfulness of formal and informal support.

Data were collected in three phases. Women's ADS staff members were interviewed at infant age six weeks. CP workers and participating mothers were interviewed at infant age six weeks, six months and twelve months. The study generated 54 interviews with mothers. Twenty interviews were conducted with Women's ADS counsellors. Twenty interviews were also conducted with CP workers ranging from three interviews regarding each participating mother/infant dyad to one only for one mother and her infant. Notes were taken during structured-interviews with Women's ADS and CP workers and presented in the form of answers to questions that guided the study. Semi-structured interviews with mothers were tape-recorded and thematically analysed manually. Emerging patterns were sought to draw out similarities and differences in experiences (Ryan & Bernard, 2000). Ethics approval for the study was provided by the University of Melbourne Human Research Ethics Committee (Approval No: 030702.1).

3.3. Participant description

There were three categories of participants: Women's ADS staff (n = 2), CP staff (n = 18) and service users (n = 20). A total of 51 women accessed the Women's ADS during the six month recruitment phase of the study. Twenty-two women agreed to take part in the study. Two women were lost to follow-up prior to the first interview. Among the remaining 20 women, eighteen participated in phase 2 interviews and 16 at phase 3.

With the exception of one woman who reported heroin use exclusively, all women were polydrug users. Pregnancies were largely unplanned; ten women were having their first baby. Among the remaining women, the majority had lost the care of older children. Half of the women reported depression during pregnancy and half had attempted suicide at some stage of their lives. Eight women were single. A third of the women reported domestic violence during pregnancy. Approximately half of the women disclosed past physical, sexual, emotional and verbal abuse. Their partner's drug use was problematic for approximately half of the women. Five women had involvement with child protection in their own childhood. Educational attainment was generally very low and all but one woman relied on social security payments. Housing instability or transience was high. Approximately half of the women faced legal charges; a third had been incarcerated at some stage, three during the pregnancy that resulted in the birth of the infant who was the subject of the current study. The mean age was thirty years. Sixteen women were non-Indigenous Australian, one woman was Australian Indigenous, three women were European and two were Asian. Comparison of demographics and descriptive variables with previous research (Kelly, Davis, & Henschke, 2000) indicates that the women in the present study were highly representative of mothers accessing the Women's ADS.

4. Findings

The following section reports the reasons for and the number of notifications made by the Women's ADS to CP in the perinatal period and outlines individual women's involvement with CP at each study phase.

4.1. Identification of risk in the perinatal period and ensuing CP involvement

Two women came to the Women's ADS with pre-existing CP involvement. Ten notifications were made by the Women's ADS in the perinatal period, four prior to the birth of the infant (Table 1). Two to eight risk factors per mother/infant dyad were identified by Women's ADS counsellors, these were: continuing maternal substance use (n = 10); older children out of maternal care (n = 6); intimate partner violence (n = 9); and unstable accommodation associated with domestic violence (n = 9). While continuing maternal substance use was the most frequently cited reason for notification, no woman was notified for substance use in the absence of other concerns. One notification was investigated and closed; the remainder resulted in further protective investigation and intervention. Amongst four mother/infant dyads, CP involvement ended by the second phase of the study (infant age six months). The remaining women had CP involvement until the conclusion of the study. At phase 2, one further infant was notified. An additional infant was notified at phase 3. In all, 14 of the 20 women who participated in the study beyond initial recruitment were involved with CP in their infant's first year: just over half lost the legal care of their infant (n = 8). Three of these mothers retained daily or regular care by residing with the infant's grandparents who had legal care of the infant; the remaining five infants were lost to maternal and familial care.

At the conclusion of the study, no woman unknown to CP in the perinatal period was subsequently notified (some were known to the service through involvement with older children). This finding could be read in one of two ways. Either, accessing a specialist AOD obstetric service predisposes women to notification to CP or that the Women's ADS conducted comprehensive, differential and accurate risk assessment. Consideration of the circumstances of infant removal suggests the latter interpretation is correct. With the exception of one infant who remained in his grandmother's legal care throughout the study time-frame, all infants separated from mothers were removed following police activity in relation to family violence or conflict, crime committed by mothers, or in one instance, a road accident in which both parents were substance-affected with children in the car.

4.2. Intersectoral collaboration in response to risk in the perinatal period

While the assessment of risk and protective factors in the perinatal period is generally a process focused on the mother (and her partner), the management of risk includes engagement with the service system. A strong engagement with the service system can be a protective factor, while lack of engagement and a poor service system response constitutes a risk. The ability of the Women's ADS to identify risk in the perinatal period and to begin the process of addressing protective concerns

Table 1
Notification and involvement with Child Protection by study phase.

Participant	Phase 1	Phase 2	Phase 3
Kim	Open	Closed	Closed
Alison	Not notified	Not notified	Open
Lily	Open	Closed	Unknown
Julie	Open	Open	Open
Sienna	Open	Open	Open
Elizabeth	Open	Open	Open
Belinda	Open	Open	Open
Diana	Open	Open	Open
Tess	Not notified	Open	Open
Janice	Open	Closed	Closed
Ava	Open	Closed	Closed
Ruth	Open	Open	Open
Natasha	Open	Open	Open
Sharon	Open	Open	Open
TOTAL	12	9	10

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through engaging mothers prior to notification was highly valued by CP. As reported by a CP Manager:

> We really have got a very good practice model with the Women's ADS and the work that needs to be done with substance-using mothers, so the Women's ADS very clearly spell out and articulate for the mother, their concerns, their desire or need to notify to protect are discussed upfront with the mothers…It's an excellent model of practice and it has worked very, very well.

From the perspective of CP workers, collaboration was helpful in engaging mothers and their partners in the development of safety plans or in devising alternative case-plans in the event of parental non-compliance. Planning meetings were held prior to infant discharge from hospital for all infants brought to the attention of CP, except one. These meetings did not have the structure of formal Family Group Conferences and inclusion of fathers, extended family or community-based organizations was minimal. Early identification of risk did, nevertheless, contribute to case-planning including decisions to initiate Children's Court action and to activate referral pathways. As one CP worker noted:

> Given the crux of the information, this was vital at the beginning. The richness in information provided enough detail to proceed with the case.

There was almost unanimous agreement among CP staff and Women's ADS counsellors that timely referrals and service links resulted from intersectoral collaboration. From a Women's ADS counsellor:

> CP put really good supports in place. They really tailored the action-plan to the woman's needs.

While professional communication and collaboration was highly valued by both CP and the Women's ADS, contact between services was limited to the period between notification and infant discharge from hospital. In addition to service links initiated by CP, the Women's ADS made 96 referrals for 18 women. In some instances, several referrals were made to different agencies for the same type of service. CP also actively referred women to mental health, alcohol and other drug treatment and domestic violence and family support services across each phase of the study. The following section reports women's use of services throughout the infants' first year and their perspective of intersectoral collaboration.

4.3. *The response of the wider service sector and parental engagement*

While the Women's ADS was able to accurately identify which women needed further support, service mapping in interviews with mothers revealed a fragmented and uncoordinated response to substance-use and early parenting post discharge from hospital. Women concurred that the Women's ADS and CP worked well together but generally noted poor communication and collaboration with the wider service sector and between service providers and service users. Ava described her experience:

> The level of communication that went on between CP when we went for an assessment at (residential parenting assessment and skill development service), they, the lady that was doing the assessment said, "Oh, so, what? You are coming in tomorrow or something?" We'd been waiting ages for this placement and we thought, Oh my God, they haven't done anything yet. They weren't communicating with us at all.

Good professional collaboration, which was largely limited to the perinatal period, was valued by women but was experienced as alienating, threatening, even conspiratorial if they felt excluded from discussions.

> It's a bit scary because I've heard her talking on the phone, and yeah, she's like a spy for CP, so I don't trust her. (Natasha)

Despite extensive activity by the Women's ADS in the perinatal period, engagement with services tended to be superficial and not well sustained: Women were reluctant to keep appointments made on their behalf and service providers failed to provide assertive outreach. Support to women with neonates at imminent risk of removal was largely confined to residential parenting assessment and skill development services which provided minimal long-term support. Service use was slightly higher among women with CP involvement which, as noted above, continued throughout the infant's first year for some mother/infant dyads. However, with the exception of two women attending the same family support programme, CP referrals to a range of services including domestic violence counselling and alcohol and other drug treatment for mothers, and men's behaviour change programmes for fathers, also failed to result in meaningful engagement to help either parent overcome barriers to effective and safe parenting. Some women actively resisted services they believed to be closely aligned to CP. Ruth noted her partner's lack of compliance with a Children's Court directive to attend what she referred to as an "anger management" course:

> He went for two goes and then he stopped. It hasn't looked good on his behalf.

The overall pattern of service use was characterised by some use of housing and crisis support services, particularly during pregnancy and the perinatal period to address immediate needs for safety and accommodation; there was variable but continuous engagement with General Practitioners and the Maternal and Child Health Service, both of which are universal, medically-oriented providers; and little engagement in AOD treatment, domestic violence counselling, mental health or family support services. Not one of the four men directed to men's behaviour change programmes engaged with a service. Among women, fear of infant removal was the most significant barrier to help-seeking or honest engagement with CP and the wider service sector. Sienna, among the most socially isolated women in the study, expressed reluctance to ask for assistance:

> I'd love to say to somebody, "I need help in this or that regard", but they're going to think that I'm not coping and that I can't look after her.

4.4. *Women's perspectives on risk in the perinatal period*

The perinatal period was a time of optimism and concerted effort by mothers and service providers. At this time, women were likely to share the professional perception of risk and to address risk factors which could jeopardise care of the infant: drug use and domestic violence. While some disputed the need for mandated intervention, women involved with CP theoretically acknowledged the important role the service plays in protecting women and infants, generally accepted the presence of significant family problems and understood why notifications were made. Most women reduced or ceased drug use, and, as directed by CP, five women agreed to separate from, or not to return to, relationships with violent men. Early interviews focused largely on initial assessment and monitoring by CP. Mothers expressed preference for pre-natal notifications and called for more active involvement before birth to prepare for the infant's discharge from hospital, engage men, and support both parents, particularly in situations of domestic violence.

> They could have started a little bit earlier, like three months earlier, or something, to get a bit more prepared and that in case people

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> need counselling for drugs and alcohol. They should get more supports for fathers, and that, some detox or something for them. (Natasha)

Women's expectations of and response to CP in the early days of the infant's life were largely determined by prior involvement: those without experience of a statutory service were generally more positive; parents with CP involvement in the lives of older children described heightened anxiety, learning to work collaboratively or knowing how to maintain a level of control over unwanted involvement through feigned cooperation. The requirement to 'prove' one-self featured in many early interviews. Mothers who remained in relationships with men who had used violence held high hopes for change in their partner in direct relation to fatherhood and were able to articulate benefits from involvement with both the Women's ADS and CP. Diana commented:

> I'm willing to give him a go and he hasn't stuffed up so far but the second he does, I'm not going to put up with shit anymore.

4.5. Managing risk in the context of continuing maternal substance use and domestic violence

All women retained infants in their care in the perinatal period while protective investigation was initiated; albeit, some infants were discharged from hospital to residential services while their mothers were assessed for parenting capacity and others were placed in the legal care of grandmothers. Despite good intentions and successful reduction, cessation, or changes in drug use patterns during pregnancy, and commitment to remain free of domestic violence in the perinatal period, 'the window of opportunity' slammed shut for many women by infant age six months. As the intervention unfolded, dichotomous perspectives between mothers eager to retain infants in their care, and CP workers charged with protecting infants and ensuring their wellbeing, emerged and resulted in mounting tensions and parental disengagement. In the tussle to protect, paradoxically, risk amongst some infants increased: all five women directed by CP to leave or not return to their partners in the perinatal period remained in, returned to, or formed new relationships with violent men; and several women attempted to conceal the resumption of illicit substance use. Elizabeth, who had lost the care of older children, described learning how to "play their game". She successfully avoided Children's Court action for a year by stating preparedness to comply with CP directives without real intent. As reported in interview:

> Now this week I'm supposed to provide three clean urines and they'll leave me alone but I haven't…so I will be lying to them and telling them I have to go somewhere.

Poor assessment by CP was seen to result in disruptive outcomes including unnecessary removal of infants and separation of couples which reduced the availability of support to mothers, strained relations between parents, and between parents and the wider family when called upon to care for infants. Several mothers considered CP a barrier to the creation or continuation of a family. Julie, who eagerly worked with the service in the perinatal period while her partner was incarcerated for assaulting her, later noted:

> It (domestic violence) happened once and that was it. He's never shown any violent tendencies for a long time. He just wants his family; that's what he wants. He realizes that now, you know.

For their part, CP workers noted women's failure to provide urine screens, the presence of men who came to their attention following acts of violence against mothers, parental failure to comply with directives and maternal recidivism to crime. CP workers also observed that among infants with older siblings no longer in maternal care, the reason for removal of infants in the present study was strikingly similar to those that resulted in prior child loss: maternal drug use, exposure to domestic violence and crime, a finding confirmed in interviews with mothers. Notably, only Diana, who retained the care of her infant throughout the study time-frame, described her infant as at risk of exposure to domestic violence. A highly-experienced CP manager assumed responsibility for case-management due to worker safety concerns regarding a man with an extensive history of violence towards women. Diana's quote illustrates the benefits of CP involvement when engagement with mothers has been established:

> They kept her safe, at least for now…Knowing that CP is still helping me and, you know, need be, they'd get me out of there like that (clicks fingers), which they've got to do.

Although women were acutely aware of being monitored by CP and other service providers, they did not resent this intrusion in their lives, as such: involvement with the service system, including CP, was experienced as both a risk and an opportunity for assistance. What they did resent was monitoring without encouragement or support; monitoring without children in parental care; or monitoring that focused exclusively on mothers. It is noteworthy that all four 'first-time' mothers with CP involvement commented on the discrepancy between the level and type of support they anticipated and what they received. When support did not match expectation, they became disillusioned and less willing to accept the service. While they argued for support for their partners, women also described repeated unsuccessful attempts at engagement with fathers by CP and minimal or outward compliance by men. The approach by individual workers was considered an important factor in engagement. Efforts by older and more experienced CP workers were particularly valued. These workers were more likely to attempt to work with both parents, including those where there was domestic violence, and to be proactive in linking women with services. As a result, women were more prepared to accept monitoring. Julie reported:

> She (older worker) was the one who helped me. She was always coming down, and you know, checking on me and all that.

By the end of the study several women described resignation to an outcome predetermined by CP, outward compliance with, and resistance to, a range of directions including referral to services, or biding time until Children's Court Orders expired and CP withdrew, leaving the situation, essentially, unchanged. Ruth explained:

> Well, the Protection Order ran out and there wasn't much they could do about it…they've got nothing new to go on.

Women called for inclusive, family-centred practice, improved collaboration among service providers and support for parents for reunification of infants and children to their care. Perhaps paradoxically, increased monitoring, on the condition it came with support, including counselling for alcohol and other drug use and domestic violence for both parents, was proposed as a viable alternative to infant removal.

4.6. Differences in outcome among individual women and their infants

Outcomes among this group of mothers need to be understood on an individual basis. Retaining or losing care of the infant in the first year postpartum was not determined solely by whether a woman was subjected to domestic violence or used substances; the interplay between factors related to the woman, her partner, the wider family and the service response were critical. As mentioned above, of the twenty-women participating in the study beyond initial recruitment, fourteen experienced CP involvement in their infant's first year, eight lost the legal care of the infant, and among this eight, five infants were lost to the

family. A 'good' outcome was operationalized as continuous maternal care of the infant, drug use that was manageable or had ceased, and absence of domestic violence. The term 'mixed' accounts for women who lost legal but maintained daily care by residing with the infant's grandparents. There is little doubt that without the availability of familial support these infants would have been among those placed in foster care and outcome would therefore have been considered poor. Approximately half of the women did well with their infant, six did poorly, and outcomes among the remaining three women for whom there is data were mixed. Although Elizabeth maintained the care of her infant until infant age 12 months, the outcome was considered poor due to an escalation in drug use and the formation of another relationship marred by domestic violence. Table 2 lists the key descriptive variables in this study and outcomes for individual women and their infants.

Among the women with good outcomes, seven were first time mothers; the remaining three were able to demonstrate ability to provide adequate care of the infant under changed circumstances. Overall, women who did well were those who: were able to significantly alter their substance-use patterns, either by ceasing to use, reducing frequency or changing their drug of choice; were not subjected to or managed to escape domestic violence; felt well-supported; and did not experience child protection involvement in their own childhoods. Women who did well tended to have partners for whom drug use was either not problematic or less problematic than their own or to have left their partners during the time-frame of the study.

Conversely, women who did poorly were more likely to be in relationships characterised by domestic violence and to not have been able to control their drug use. Some of the latter group of women lived with men with problematic substance use and others did not. By far, the variable most likely to be associated with poor outcome was the mother having experienced out-of-home care in her own childhood. Four of the five women who lost daily care of their infant by the conclusion of the study had experienced childhood sexual assault and had been removed from parental care as adolescents. These women remained in high risk situations; during adversity, they lacked sufficient familial support to buffer them from circumstances leading to loss of the infant. Current practice intervention was also insufficient in helping them overcome barriers to effective and safe parenting.

5. Discussion

This study documents a productive partnership between CP and the Women's ADS at a time of heightened infant vulnerability prior to discharge to home or to alternative care. The study demonstrates capacity by a specialist AOD obstetric provider to conduct accurate risk assessment operationalized as consensus with CP and by examination of the outcomes of a twelve-month follow-up which revealed that no woman unknown to CP was brought to the attention of the service within this time-frame. The findings therefore confirm that 'there appear to be fairly good systems for identifying concerns around babies born to drug-using mothers' (Forrester & Harwin, 2006 p. 331). Decisions made by the Women's ADS in the perinatal period were important in determining pathways to service provision but did not adequately impact on the effectiveness of the child protection system as a whole. Despite accurate identification of risk in infancy, referrals without assertive outreach, poor collaboration between service providers beyond the Women's ADS and CP and lack of follow-up of vulnerable infants in the community were evident: the same gaps in communication and collaboration among professionals are repeatedly identified as contributing factors in the deaths of children known to CP in Victoria (VCDRC, 2000, 2006, 2008, 2012).

The ability of the Women's ADS to engage a population of women who typically have low-levels of trust in service providers created opportunity for early intervention. However, the call by women, including those notified prenatally, for even earlier intervention suggests the response is still largely crisis-driven and reactive (VCDRC, 2008 p. 32). Rather than being risk-averse, CP 'took a stand for their clients' (Stanford, 2010 p. 1074) and initially gave all women, including those who had lost care of older children, an opportunity to parent the new infant. However, the initial response, referral to parenting assessment and skill development and other services, led to monitoring of mothers (Zhou & Chilvers, 2010) without translating into increased long-term support for families. Fear of infant removal and women's attempts to protect the relationship with the fathers of their infants overrode engagement (VCDRC, 2006). Service use by men was largely non-existent, even when mandated. As the 2006 Victorian Child Death Review notes, referral is not of itself an intervention (VCDRC, 2006). Without CP involvement there was little long-term case-management

Table 2
Key descriptive variables in who did well and why.

Participant	Out-of-care in own childhood	Primi-gravida	Older children out of maternal care	Drug use in study time-frame	History of domestic violence	Domestic violence in study time-frame	Sole parent at end of study	Infant in maternal care at end of study	Outcome (mother retaining care)
Bonnie		✓			✓	✓	✓	✓	Good
Kim			✓	✓	✓		✓	✓	Good
Alison			✓	✓	✓			✗✓	Mixed
Lindsay		✓						✓	Good
Lily				?	✓	?	?	?	Unknown
Julie		✓		✓	✓			✗	Poor
Sienna	✓		✓	✓	✓		✓	✗	Poor
Lena		✓		✓				✓	Good
Marie		✓					✓	✓	Good
Elizabeth			✓	✓	✓	✓		✓	Poor
Belinda			✓				✓	✓	Good
Christy		✓		✓				✓	Good
Diana		✓		✓	✓	✓		✗✓	Mixed
Tess	✓		✓	✓	✓	✓	✓	✗	Poor
Janis				✓				✓	Good
Ava		✓		✓			✓	✓	Good
Ruth		✓		✓	✓	✓		✗✓	Mixed
Natasha	✓		✓	✓	✓		✓	✗	Poor
Miranda		✓					✓	✓	Good
Sharon	✓		✓	✓				✗	Poor

Legend: ✓ = Yes; ✗ = No; ? = Uncertain; and ✗✓ = Mixed.

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to coordinate service delivery or to assist women address the psychosocial issues discussed during pregnancy with Women's ADS counsellors, which could be interpreted as indicative of the need for notification, a conclusion based on a potentially erroneous assumption that substance-dependent women must be mandated to ensure service use. Universal use of the Maternal and Child Health Service and General Practitioners indicates willingness to access non-stigmatizing services directed to the wellbeing of infants.

The women in this study were a heterogeneous group who presented at the Women's ADS with different psychosocial profiles that elevate risk of disruption to caregiving: a history of childhood trauma, depression, social isolation, domestic violence, poverty and poor or unstable housing. By six months postpartum it was evident that not all women were willing or able to give up drug use. Similarly, not all women in situations of domestic violence wanted to leave their relationship (Stanley et al., 2011) and directing parents to separate largely proved ineffective (Stanley et al., 2012). This was a critical time for loss of infants to maternal care. It is highly likely that a longer study-time frame would have recorded greater numbers of infants entering the child protection and out-of-home care system (Forrester & Harwin, 2008). The finding that women most likely to lose the care of the infant were those who had experienced placement in out-of-home care in their own childhood confirms research conducted with substance-dependent women in the U.K. (Gilchrist & Taylor, 2009). Without familial support, or appropriate service provision, this sub-group of women was unable to safely retain infants in their care. As it is not possible to fully eliminate risk (Gambrill & Shlonsky in Shlonsky & Friend, 2007), the harm reduction approach underpinning the AOD sector has been proposed as a means of working with families where there is domestic violence (Shlonsky & Friend, 2007). Both are long-term problems (Stanley et al., 2011); in combination, they are serious cause for concern.

The harm reduction approach accepts that recovery from addiction is typically a non-linear process involving cycles of change with likelihood of relapse (Prochaska, DiClemente, & Norcoss, 1992). The concept of 'readiness to change' has recently been considered in relation to women experiencing intimate partner violence. Hegarty et al. (2008) report that returning to a violent relationship, or to an earlier stage of readiness, is part of the process of leaving abusive partners and that most women only slowly come to the realization that their partner will not change. It is now understood that organizational cultures and contexts also facilitate or impede external elements associated with the change process for women and children subjected to family violence (Humphreys et al., 2011).

There is no doubt the infant was a catalyst for change in the perinatal period. The 'window of opportunity' in which women re-evaluate substance use and violent relationships (Pulido, 2001) may have remained open longer with continuity of care (Phillips et al., 2005). According to the women in this study, protective intervention needed to commence earlier (Wickham, 2009) and to continue well beyond the perinatal period. CP was considered potentially helpful, but without engagement of mothers as clients in their own right, professional collaboration was seen to exacerbate parenting difficulties (Davies & Krane, 2006) and to undermine relationships between parents, between fathers and infants and between parents and the wider family. Women with prior experience of child protection were able to negotiate their way through the child welfare system (Radcliffe, 2011). The findings lend support to Darlington et al.'s (2010) contention that women with histories of child protection involvement are more likely to respond with caution or outright hostility which seriously hampers the ability to conduct a thorough assessment and to intervene effectively. The present study also demonstrates that, depending on the extent of trust generated between service provider and mother, experience can also lead to acknowledgement of the need for change and positive help-seeking behaviour and improved infant safety or, just as readily, in greater ability and willingness to conceal problem behaviours including uncontrolled substance use and domestic violence, thereby increasing risk to the infant. Organizational factors, including readiness to work with parents, are therefore of critical importance if harm reduction is to be safely applied in relation to parenting of vulnerable infants. Consideration also needs to be given to the wider social context in which substance use and domestic violence occur.

External intervention helped to prompt insight (Hegarty et al., 2008) in the perinatal period, but the women most vulnerable to losing care of their infants, those with histories of trauma in childhood and adolescence (Gilchrist & Taylor, 2009), resumed substance use and returned to, remained in, or formed new relationships with violent men, all of whom, with one exception, were problematic substance-users. Leaving an abusive relationship and overcoming substance-dependence require more than motivation; much is dependent upon the availability of resources within the informal network and the service sector. As an alternative to infant removal, the mothers in this study recommended increased monitoring of infants provided it occurred with support to whole families, including services to help men address violence and substance-use, and called for improved collaboration between services and between services and parents. These recommendations, and the finding that most referrals by the Women's ADS were not actively followed up by women or service providers, suggests the need for assertive outreach to bridge the gap between obstetric and community-based services.

A differential response in child protection practice needs to do more than determine referral pathways: it needs to be transformative; this could only occur with genuine engagement which relies on establishment of a trusting relationship. A trusted key professional could monitor infant safety and wellbeing, coordinate services (McGlade et al., 2012) and provide advocacy for parents involved with child protection (Darlington et al., 2010). This may help alleviate some of the hostility directed towards child protection workers by parents anxious about child removal (Buchanan & Corby, 2005), reduce the anxiety experienced by child protection workers in high-risk situations (Connolly & Smith, 2010) and enable more accurate risk assessment (LeBlanc et al., 2012) including perpetrator risk assessment to allow for a more nuanced intervention (Humphreys, 2007) with options beyond separation of couples (Stanley et al., 2012). Conversely, increased support to mothers may enable some to parent alone rather than resorting to relationships with men who are violent. As substance-dependent parents are often resistant to service involvement, a comprehensive model of care with home visits and interventions focused on substance-use and domestic violence would be required (Forrester & Harwin, 2006). The key worker would need understanding of addiction and requisite skills for effective intervention in domestic violence. Appropriate service provision would need to be intensive and of sufficient duration to address the needs of all family members. It would, therefore, be comparatively expensive but it may help to break intergenerational cycles of involvement with statutory services and removal of infants and children from parental care through improved, timely and appropriate support.

6. Conclusion

The present study demonstrates accurate assessment of at-risk substance-exposed infants by a specialist AOD obstetric provider and supports research identifying a sub-group of infants at increased risk of separation from mothers. The longitudinal method illustrates that practice is hamstrung by reliance on statutory services to monitor and intervene and that the current response does not lead to resolution of the issues that bring infants to the attention of child protection. If we are to restore the client's place in human service intervention, and uphold parental rights to care for infants and the rights of infants to remain safely with parents, scarce resources need to be targeted to the most vulnerable mother/infant dyads, men need to be engaged as fathers and a relationship with a trusted professional needs to be established to ensure effective child welfare practice.

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