Submission No 18

CHILD PROTECTION AND SOCIAL SERVICES SYSTEM

Organisation: Kamira Alcohol and Other Drug Treatment Services Inc.

Date Received: 11 December 2020

Submission: Inquiry into child protection and social services system

About Kamira

Kamira was established in 1982 on the Central Coast of New South Wales. It was created in response to the growing need for residential alcohol and other drug treatment for women with children in NSW.
Kamira is a registered charity with a governance committee comprised of women from our community. It receives funding from NSW Ministry of Health, and the Commonwealth Department of Health and Ageing, and HNECC Primary Health Network.
Kamira is an accredited health services organisation through the Australian Council of Healthcare Standards
Kamira is located within a beautiful purpose built building on the grounds of Wyong Hospital

OUR PURPOSE
Kamira provides a place of enduring value for women and families to support them to thrive beyond alcohol and other drug dependency.

WE BELIEVE
Everybody has the right to access quality treatment. That building healthy and strong attachment between family and significant others is essential to achieving generational impact.

SERVICES OFFERED
Kamira provides residential treatment for pregnant women, women with or without children, and their family and significant others.

To learn more please visit our website: www.kamira.com.au or contact Kamira's CEO: Catherine Hewett [redacted]

Submission –

As a frontline treatment provider, Kamira is well positioned to comment on the inadequacy of current interventions and responses for vulnerable children and families, that these can lack co-ordination, and are indeed under resourced. More concerning are the same inadequacies for the over represented population of Aboriginal women and pregnant women, for whom the generational impacts are enormous.

In 2019 Kamira received 638 requests for treatment from women and were able to admit 51(8%). Up to 98% of women seeking residential alcohol and other drug treatment services are currently involved with DCJ or have themselves been involved as a vulnerable child (NSW Specialist Womens AOD treatment services) Kamira prioritises pregnant and Aboriginal women.

In the same year, Kamira admitted 16 pregnant women (31%) and 15 Aboriginal women (30%). It is important to note that there were far more than 16 pregnant women requested treatment but due to the 4 month waitlist and the time limitations of the pending baby's delivery, many requests for treatment don't progress to the assessment stage.

Kamira identified pregnant women as a population in urgent need of enhanced services 5 years ago when a dramatic increase was experienced in the referrals made by DCJ case managers.

It is not uncommon for pregnant women to have lengthy involvement with DCJ and Out of Home Care. For many, they have had multiple children removed (some exceeding 8) and unfortunately, this can be their first admission into residential treatment.

Three years ago for the first time in 36 years, the primary drug of concern for women requesting treatment shifted from alcohol to 'ice'. Most pregnant women seeking treatment at Kamira are using 'ice' throughout their pregnancy and are denied treatment due to a lack of treatment beds.

Ice use in pregnancy

Internationally, methamphetamine use in pregnancy is an increasing problem, with strong indications that the problem will continue to grow.[1] In the US, for example, amongst pregnant women using substances, it is the primary substance for which treatment is sought.[2] Australian SUPS units are seeing increasing numbers of pregnant women who are using methamphetamine, or have used methamphetamine while pregnant[3] – usually in conjunction with other substances such as tobacco, alcohol and opioids.

Due to polydrug use, isolating the impact of methamphetamine on foetal outcomes has been difficult, however, a combination of human and animal studies has been able to demonstrate significant adverse foetal and neonatal impacts, and show a high risk of longer term adverse impacts on child development. These include higher rates of intrauterine death, foetal distress, prematurity, foetal growth restriction, and neurobehavioral effects. Although few newborns with prenatal exposure to methamphetamine will require pharmacological intervention for amphetamine withdrawal, symptoms including jitteriness, drowsiness, and respiratory distress have been observed.[4]

Methamphetamine is a neurotoxin with adverse impacts on foetal central nervous system development, creating a risk of a range of cognitive and behavioural deficits, with probable lifelong impacts.[5] These effects appear to be dose respondent. A recent case study showed dramatic impacts on an infant's brain development, apparently as a consequence of chronic heavy methamphetamine use by the mother.[6] The brain had a complex malformation, with a massive left lateral ventricle dilatation (in effect, the left side of the brain had failed to develop).

At Kamira, we have recently had a resident mother and baby, where the mother was a heavy methamphetamine user throughout her pregnancy. The baby has been

1 Wouldes, T., et al (2019) Stimulants: How big is the problem and what are the effects of prenatal exposure? Seminars in Fetal and Neonatal Medicine Vol 24 (2), 155-160

2 Marcela, S., et al (2019). Stimulant Use in Pregnancy: An Under-recognized Epidemic Among Pregnant Women Clinical Obstetrics and Gynecology, Vol 62(1), 168-184.

3 https://www.abc.net.au/news/2015-10-02/increasing-number-of-pregnant-women-seek-help-for-ice-addiction/6821880

4 Smith, L, Yonekura, M L, Wallace, T, Berman, N, Kuo, J and Berkowitz, C. 2003. Effects of prenatal methamphetamine exposure on fetal growth and drug withdrawal symptoms in infants born at term. Journal of Developmental Behavioural Pediatrics, 24: 17–23.

5 Vand Dyk et al (2014) Maternal Methamphetamine use in Pregnancy and Long-Term Neurodevelopmental and Behavioral Deficits in Children, Journal of Population Therapeutics and Clinical Pharmacology Vol 21(2):e 185-e196.

6 Maya-Enero, S. (2018) Central nervous system malformation associated with methamphetamine abuse during pregnancy, Clinical Toxicology, 56 (8), 795-797.

diagnosed with agenesis of the corpus collosum. This condition is associated with developmental delays, and a range of cognitive problems.

Maternal outcomes are also poor and substantially worse than those for opioid affected births. Methamphetamine use in pregnancy is associated with cardiovascular disorders and hypertension complicating pregnancy and severe maternal morbidity and mortality. [7] Affected births have been observed to have high rates of preeclampsia, placental abruption, preterm delivery and caesarean delivery.[8]

In addition, women who use methamphetamine in pregnancy typically face a range of other problems, including socio-economic disadvantage, being a victim of domestic violence or sexual violence, polydrug use, unplanned pregnancy, STIs, and physical and mental health problems.[9]

Due to the highly adverse impacts of methamphetamine use on babies and mothers, there is a clear need to increase treatment availability and options for pregnant women, and to get women into treatment as soon as possible.

Complex needs of women misusing substances in pregnancy

Pregnant women who use illicit drugs or misuse alcohol are frequently polydrug users, and most also smoke tobacco,[10] with many using long term prescription drugs to manage pain or treat anxiety and/or depression.[11] Their living situations are usually precarious, characterised by homelessness or housing instability, domestic violence, poor mental and physical health, complex trauma histories, poverty and prior child removals.[12] Aboriginal women are over-represented amongst pregnant women with problematic substance use, and face a range of additional risks and barriers to treatment.[13]

Barriers to care

[7] Admon L., et al (2019), op. cit.
[8] Ibid.
[9] Wouldes (2019), op. cit.
[10] Duong C, et al. (2017). op cit.
[11] Miles, M.et al. (2010). Challenges for midwives: pregnant women and illicit drug use. *Australian Journal of Advanced Nursing* 28(1).
[12] Duong C, et al. (2017). op cit.
[13] Breen, C, et al. (2014) op cit.

Infants and children are removed prior to the provision of alcohol and drug treatment. Coercion into treatment can present in many forms and self reports from mothers in treatment detail the fear of having their child removed as the most significant motivator to engage in treatment. This opportunity is denied if a child is removed prior to treatment.

Women who use alcohol or illicit substances in pregnancy are stigmatised and have legitimate fears of judgmental responses or that their baby will be removed post-delivery. These fears, combined with comorbid mental health issues and other disadvantages, mean that women with problematic substance use are likely to have little or late antenatal care and avoid disclosing their substance use to health professionals.[14]Additional barriers faced by Aboriginal pregnant women include a lack of culturally safe services, mistrust of health services, and high rates of child removals from Aboriginal mothers.[15]

<u>The costs of no treatment</u>

Substance use in pregnancy is associated with a wide range of harms to babies including: stillbirth, preterm birth, perinatal death, low birth weight, intra-uterine growth retardation, birth defects, neurological and cognitive deficits and foetal alcohol syndrome disorders.[16] Children exposed to substances in pregnancy are also at substantially increased risk of a range of health, behaviour and learning problems, leading to poorer academic and employment outcomes.

The additional, and often lifelong, health and support needs of children damaged by substance misuse in utero, creates considerable economic costs.[17]

If a pregnant mother does not enter treatment, she faces the following risks post-delivery of her baby:

- newborn babies are removed from their mothers three days post-delivery and placed into Out Of Home Care (OOHC) services. Other children currently in the mother's care are also placed in OOHC.

[14] ibid.

[15] Lee, K.S.K., et al. (2014). Better methods to collect self-reported alcohol and other drug use data from Aboriginal and Torres Strait Islander Australians. *Drug and Alcohol Review,* 33(5).

[16] Cook, Jocelynn L. et al. (2017). Epidemiology and effects of substance use in pregnancy, *Journal of Obstetrics and Gynaecology Canada,* 39(10*)*.

[17] Goler NC, et al. (2012). Early start: a cost-beneficial perinatal substance abuse program. *Obstetrics and Gynaecology*. 119(1):102-10.

- continuing problematic use of drugs and alcohol, placing themselves and children at significant risk of harm, minimising chances of rescinding OOHC orders
- higher rates of parenting stress and difficulties coping
- significant risk of homelessness / housing instability
- domestic violence perpetuates and escalates
- criminal behaviour in order to maintain drug use continues and escalates
- deteriorating physical and mental health
- long term cognitive impairment, due to alcohol and other drug use as well as acquired brain injury resulting from violent interactions and accidents
- further unplanned pregnancies, where mother and child are at risk
- unemployment and poverty.

Best practice care for pregnant women using alcohol and other drugs

The best outcomes for babies are achieved through programs which integrate substance use treatment with antenatal care and parenting services.[18] Babies born to women in integrated treatment programs have fewer birth complications and higher birth weights, as compared to those in no treatment. At the time of delivery, these women are more likely to have negative toxicology screens.[19]

Women are also more likely to use treatment services that are non-judgemental, women centred and culturally safe.[20]

Their Futures Matter

Numerous efforts were made by NSW Specialist Womens AOD treatment services to engage in conversations regarding the over representation of DCJ clients in AOD treatment services. Unfortunately, only one somewhat unproductive meeting was held. It would appear that treatment services did not lay within the brief of this program

[18] Milligan, K., et al. (2011) Birth outcomes for infants born to women participating in integrated substance abuse treatment programs: A meta-analytic review. *Addiction Research & Theory*.19(6).
[19] ibid.
[20] Breen, C, et al. (2014). op cit.

Kamira welcomes the inquiry into child protection and social services system and offers its support for any further exploration of the issues raised in this submission.

Case Study 1:

The Child and Family Team at Kamira has such a crucial role in being a safe, non-judgemental place for the mothers to learn about good enough parenting, based on a relationship with their children and develop enduring healthy attachments.

Sarah came to Kamira with her one -week old baby boy Johnny in January. After the comprehensive assessment with Sarah, it became clear that Sarah needed some guidance and support to understand her baby's developmental needs, to identify his cues and respond to him in a more nurturing way.

The Child and Family Team offered Sarah and her baby, psycho-education and explained to her the developmental needs of babies through different stages. Initially Sarah found it difficult to agree with the guidance provided. For instance, when Johnny was at an age where solid foods are not yet recommended she interpreted possible mirroring behaviour as Johnny asking to eat solid food. However, she had an "aha" moment when she realised it could have been mirroring behaviour and there was a shift noticed in her for being more open to other possibilities and suggestions.

Sarah was also guided into physical nurturing touch through Infant massage. The Child and Family Team provided lots of moments of gentle promptings such as asking questions like *"What do you think Johnny might be saying to you right now"*, to make her aware of possible cues. Sarah had another "aha" moment when she was guided into reflecting on her behaviour when she was laughing at a crying Johnny. Sarah came to the realisation herself that this could be confusing for Johnny and that she rather needs to *"be with him"* and responding to his need rather than laughing at him.

Over time through many micro moments of gentle promptings and guidance, Sarah has learnt to be empathetic to Jonny's behaviour and to respond to him in an appropriate nurturing manner.

Sarah was also open to learn from the Circle of Security course. She participated well in group and keenly explained to new group members what the course was about. Sarah was able to apply the information in her relationship with her son Johnny. After a few months at Kamira, the FACS worker stated that he saw a significant change in Sarah and she also became like a "role model" to the other mothers in the house.

Sarah is currently living with her 9-month-old baby in the Blue Mountains and is doing very well.

CASE STUDY 2

'Michelle' was 34 year old Aboriginal woman. She came to Kamira pregnant.

She was a poly substance user since early adolescence. Her main substance was cannabis and she also injected heroin and methamphetamine.

Her father was a substance user and she experienced childhood neglect, physical and sexual abuse and was bullied at school.

She had 5 other children who were no longer in her care but had no DCJ involvement with her current pregnancy due to her coming to Kamira.

Michelle wanted to work on her rage, anger and aggression and this was the main focus of interventions. She also identified grief and loss as issues and wanted to improve her current relationship.

Michelle presented with elevated anxiety and depression. Her mood regulation was co-case managed through psychological treatments offered at Kamira and referral to medical practitioners for medication review. This was particularly important post the delivery of her baby, a high risk time for depression.

Michelle had her baby after being at Kamira for 5 months and DCJ were not involved after the baby's birth.

While she was at Kamira she improved contact with her other children and her mother. She engaged in the Infant Massage program, Attachment based play therapy, my children and me program, and completed the Circle of Security group program.

She was referred to Brighter Futures, Wesley Housing, Yerrin Aboriginal Medical Services, a counselling service and she connected to a Women in Recovery group.

MF continues in recovery to the present, 18 months after discharge.