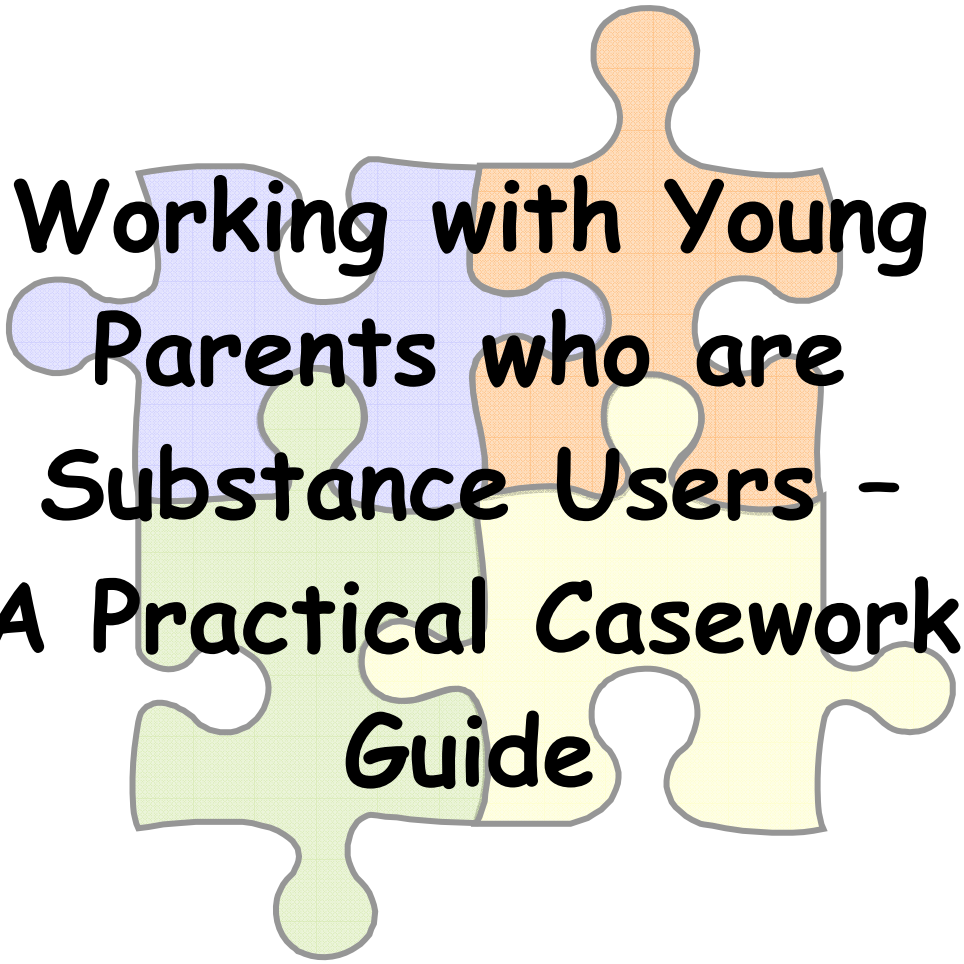

Working with Young Parents who are Substance Users - A Practical Casework Guide

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Table of Contents

SECTION 4 – PREGNANCY and BIRTH

SECTION 5 – PARENTING

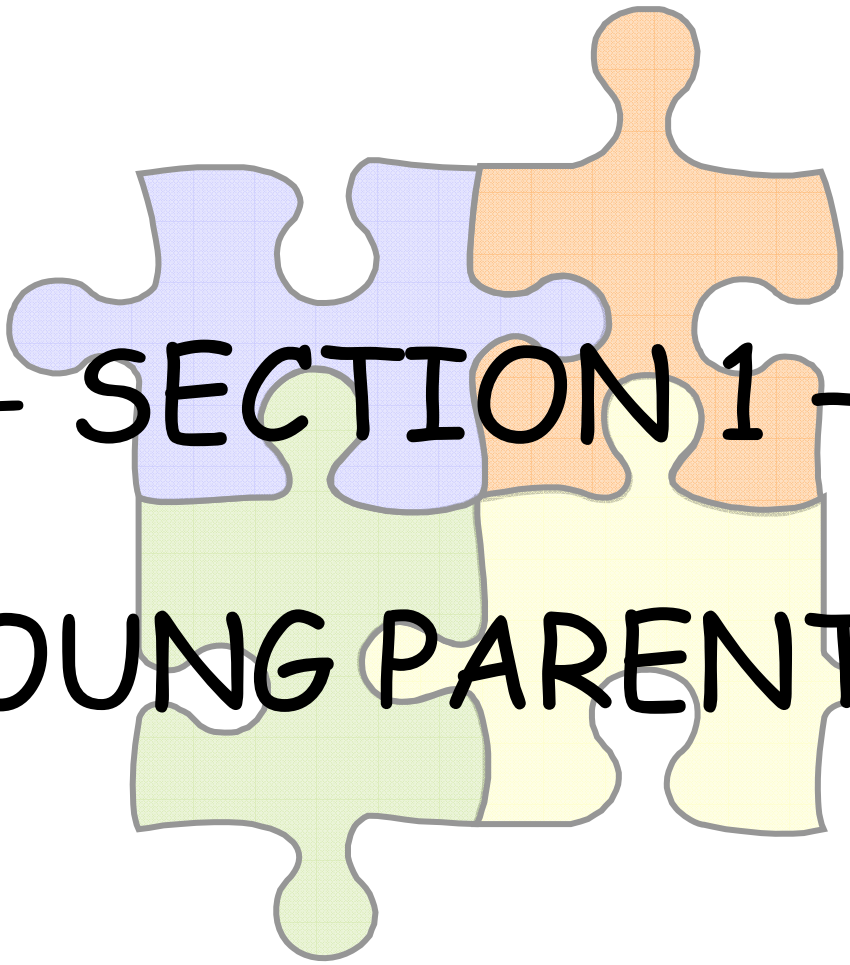
INTRODUCTION

The Youth Substance Abuse Service is a state wide drug treatment service for young people aged 12-21 who are experiencing significant problems with and due to their alcohol and/or drug issues. It works from a holistic perspective, and uses several direct care approaches to engage and work with young people. These include outreach, residential detoxification, day programs, health workers, and rehabilitation. The YSAS Young Parent's Project (YPP) was established in 2004 with a National Illicit Drug Strategy grant, in response to an increasing client group presenting for drug treatment. YSAS identified that around 10% of presenting clients were pregnant or parenting, and that it was a group who had quite specific issues and challenges apart from their substance use that needed to be dealt with in a holistic, systemic way. There was a significant lack of services that catered for young parents with substance use issues and it was noted that they were especially susceptible to negative parenting behaviours and as a result, protective involvement. This is a primary concern for clients, many of whom have been subject to statutory involvement themselves, and regard DHS with suspicion, anger and resentment.

This guide was written to assist workers to work effectively with this client group, minimise harm to the young people and their children and maximise their outcomes. It is not meant to be exhaustive, but to cover issues and knowledge that needs to be considered in a thorough, effective case plan. It also contains contact details for other programs and resources that may be helpful. Young parents with substance abuse issues often present as challenging, frustrating and damaged, and have multifaceted issues. They may be resistant to involvement and be reticent about engaging with services. Engaging this group can be difficult, but once established can have a huge positive impact on the young person's life.

Whilst it is a mistake to make mass generalisations about young parents with substance use issues, there are certainly many common themes that are displayed. Being a parent at any age is a challenging task, but it is certainly magnified for this group that faces not only the challenges of youth, but also lack of resources, life experience and support. Substance use and parenting at a young age can often be the end result of traumatic life experiences and multigenerational patterns.

The factors that lead a young person to problem substance use often predispose them to other challenges (such as homelessness, family breakdown, mental illness and challenging behaviours) all of which need to be addressed to help the young person move forward and achieve their goals. YPP works with young parents aged 12-25, and focuses on their role as parents as well as their substance use issues. The main objective of the project is to provide an intensive outreach based service that enhances young people's positive parenting capacity and provides family support and drug treatment simultaneously.



- SECTION 1 -

YOUNG PARENTS

THE YOUNG PERSON

Adolescence and early adulthood is a time of multidimensional development and change. As well as the obvious physical maturation, the individual also goes through social, emotional, moral and intellectual development. Several factors impact on these developmental areas, mainly family, peers, media, culture and school.

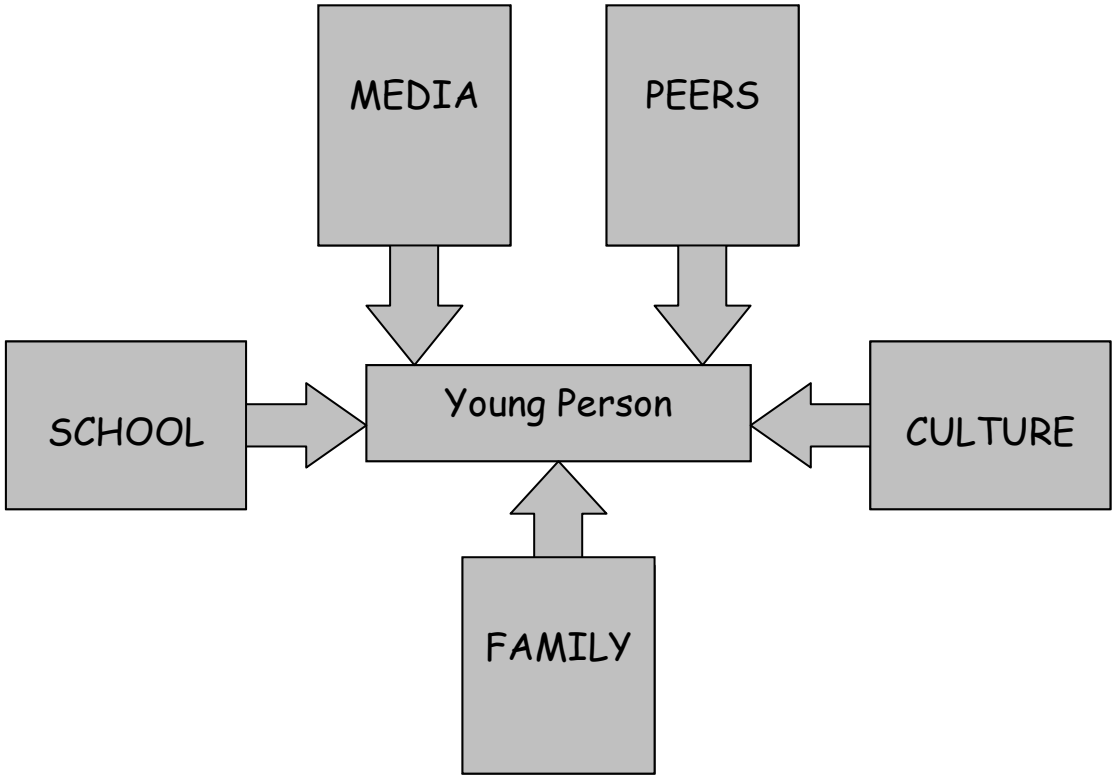


Figure 1 – Factors impacting on normal adolescent social and emotional development

Intellectual development concerns the way we organise information and acquire knowledge. One of the best known theories on intellectual development is Piaget's, which breaks up intellectual development into four stages. In the same way that individuals develop physical motor skills in a set order (and cant start a stage until they have finished the last one), Piaget believed that each successive stage builds and expands on the previous one. Adolescents fall into the formal operations stage, where abstract and speculative thinking develops[1].

Moral development is the knowledge of what is right or wrong, and relies on intellectual development. It is only at this developmental stage that the individual is able to understand interpersonal causality – how their behaviour affects the physical and psychological wellbeing of others

Social development concerns the individual and how they relate to others. In childhood, the individual is predominantly focused and dependant on family. This develops during adolescence and early adulthood through the individual seeking and consolidating their identity, to independence and interdependence on peers.

Emotional development revolves around the development of self esteem, gender identity, where the individual fits in and their self concept. Relationships and their effect on the individual change, and they develop appropriate feelings and reactions to situations.

Peers play a crucial role in a young person's social and emotional development and identity formation. This is especially the case for young people who have limited ties with their families, community, school or cultural background, all of which would usually have a large role. For many young people who have substance abuse issues, been in care or had histories of abuse and trauma, the relationship they have with peers can often be a familial replacement. Group culture can dictate appropriate behaviour, attitudes, values, morals and relationships. They also play a large role in the development of attitudes in relation to gender, sexuality, self esteem and acceptance.

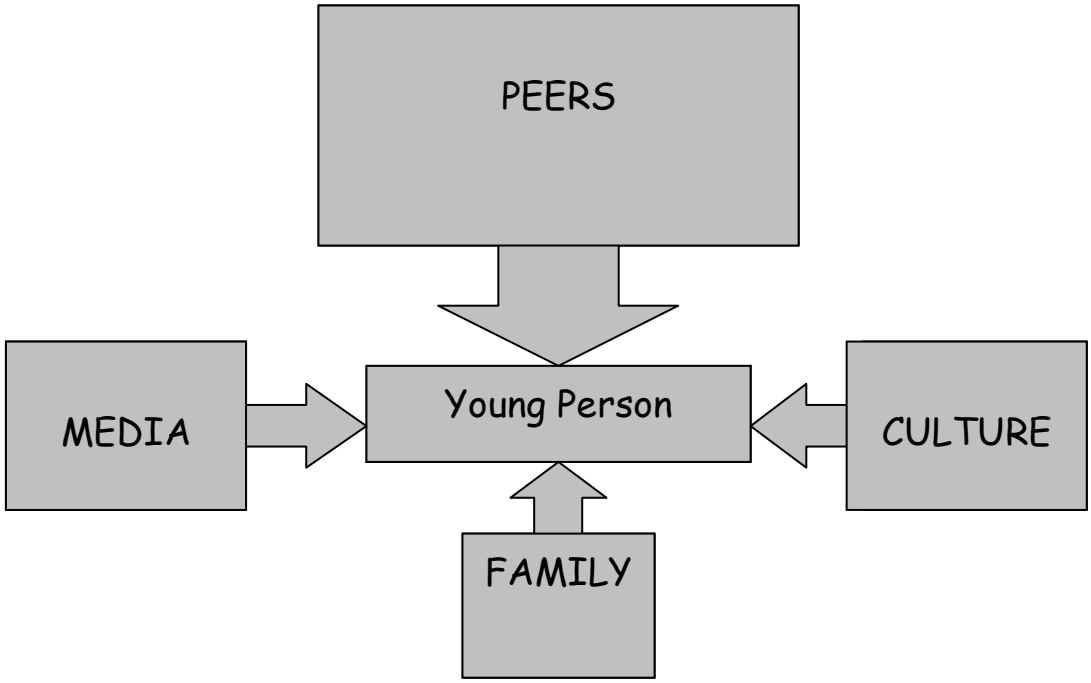


Figure 2 – Factors impacting on an adolescent's social and emotional development, if they do not attend school and have limited contact/support from their family

Young people who have experienced difficult environmental factors (such as being in care, childhood trauma etc.) can experience role confusion. This occurs when the roles that the young person has (such as son, brother, friend etc.) have not been clearly established, and there may be conflict between the expectations of different roles, or the expectations in a single role change. This interferes with identity development, and the young person may struggle with a sense of who they are, where they fit in and what is expected of them.

THE YOUNG PERSON AS A PARENT

As well as the challenges presented by their age and substance use, young parents face issues they are often hugely unprepared for. The life experiences that lead some young people to problematic substance use can provide them with self-preservation skills, but they often lack the social, maturational and parental proficiencies required to appropriately prepare them for parenthood.

There are multiple factors and correlates that can lead to pregnancy at an early age. The following information is based on studies conducted in the United States, but illustrates the complexity of the impacting factors on pregnancy

Figure 3 – Causes and Correlates of Teen Pregnancies[2]

Individual, Family and Neighbourhood Characteristics
• Low educational aspirations (1/3 of teenage mothers drop out of school before becoming pregnant) • Alcohol and drug use • Early initiation of sexual activity • Raised in poverty • Raised by single parents • Raised by parents with low educational attainment • Reside in communities with high rates of poverty, welfare use and single mother households
Sexuality Decisions
• Lack of knowledge about reproduction and contraception • Limited access to family planning and health services • Inadequate ability to foresee and be prepared for sexual activity
Psychological Processes
• Girls who lack adequate emotional support and stability may look to early sex and motherhood to provide emotional closeness • Have experienced sexual abuse and forced sexual intercourse prior to their early initiation to sex and teenage pregnancy

Whilst the factors influencing and leading to early pregnancy are many and varied, the consequences are even more far reaching. From the perspective of the mother (who is in most cases the primary caregiver), parenthood impacts on every facet of her life – from the practical and financial to less defined aspects such as feelings of self and relationships with family and peers. It also impedes a number of important psychological tasks of adolescence and early adulthood. Coley and Chase-Lansdale state that "parenthood, with its continual demands and responsibilities, can leave little time for exploration and appropriate individuation in areas of normative teen concern such as peer relations, dating, schooling and career choices."[3]

Mission Australia surveyed staff working in their family service programs across Australia as to what were seen as the major issues facing families using their services. The top 8 responses were –

- Financial issues
- Breakdown of relationships inside the family unit
- Isolation (physical and social)
- Lack of parenting skills
- Housing/accommodation issues
- Unemployment, or under employment
- Alcohol and other drug issues
- Mental illness[4]

These are all issues that face young parents, and are often the issues that lead young people to develop substance abuse issues and become parents themselves. Environmental factors play a huge role in choices that young people make and directions they pursue. Being brought up in an environment characterised by unemployment, chaos, poverty and drug use will certainly predispose most children to follow this pattern as it is all they know. They will often have no positive role models in their family or peer group. Whilst many young people do break away from this cycle, a much larger percentage does not, as their family and friends live in this culture as well. If you are not expected to finish school, or get a job, there is little motivation to do so. The issues listed above also impact on each other – if there are financial issues, this can lead to family breakdown and isolation. Mental illness can cause homelessness and unemployment. These issues can become normalised, a cycle that can be extremely difficult to break and leads to long-term welfare dependency and service involvement. Once established, this pattern continues, as the individual does not develop effective management strategies, and becomes increasingly reliant on services and workers. Most workers will be familiar with clients who go from one crisis to another, and are aware of how exhausting this is for not only themselves, but the burden it places on other services, the client's support system and families.

There have been many studies on the effect of drug use on parenting. Some of the main points identified are –

- Poor parenting skills, due to an increased risk of being abused themselves and having been badly parented. There may be unresolved childhood issues which should be dealt with before the parent can be a positive role model to their children[5]
- The drug seeking, use and consequent effects (irritability, drowsiness, altered mood, impaired judgement etc.) limits the parent's ability to adequately care for and supervise their children[6]. This can include the financial impact of substance use.
- Certain substances (and consequent use) lead to higher incidents of specific types of abuse. For example, alcohol use has been linked with physical abuse, and cocaine to sexual abuse[7]
- An increased risk of emotional difficulties, mood disorders, psychiatric issues etc. which negatively impacts on their ability to parent[8]

The reasons for young people having children are quite separate from the actual instance of becoming pregnant. Continuing a pregnancy is a decision based on many factors, the least of which considered by the potential parent/s usually being financial or emotional capacity. Most young people have an unrealistic view of parenthood, and don't understand the true complexity and long-term impact of having children. Rather, the focus is on the short term "now" factor, the attention and the "warm and fuzzy" aspect of babies and children. The issues that face young mothers (or young pregnant women) are quite different from those that face young fathers.

Young Mothers

For most young women, discovering they are pregnant is an extremely stressful event. Whether they are in a relationship or not, there are a number of factors that need to be considered. Do they want a baby? Do they have the supports they will need? How will they afford it? Can they cope with a baby? Whilst family, friends, workers and partners can give their opinion, the final decision rests with the mother. Around 50% of teenage pregnancies result in a termination. There are many reasons why a young person would continue a pregnancy, but most of the young people presenting to the YPP program have identified that their reasons fall into the following categories -

Family
Many young parents involved in the YPP identified that their own experiences in childhood and adolescence have been quite traumatic. There may have been incidences of abuse, statutory involvement, neglect, emotional distance from parents or real or perceived betrayal or abandonment. As a result of this, some clients identified that they have had children (via planned pregnancy or the continuance of an unplanned pregnancy) to start their own families. Their motivation has been to not repeat the mistakes of their own parents, and to create a positive family unit that they may not have had the experience of before.

Money
One of the more unexpected outcomes of the government's $3000 baby bonus has been as an added incentive for some young (and not so young) people to have children. Although most parents will acknowledge that having children is a very expensive exercise, the short-term benefits of $3000 (especially for those on a centrelink allowance) can sometimes outweigh the long term reasoning for procreating. Whilst not so much a reason to have a baby, it has had the effect of tipping the balance in favour of continuing a pregnancy for some clients.

Love
Some young people identified that motherhood is something they have always identified as being important to them. Pregnancy (whether planned or unplanned) was seen as a positive event, and there was no doubt that they were going to continue it. Many of these young people looked forward to having something that was theirs and something to love and care for.

Control
For many young people, becoming pregnant is just another issue in their already convoluted, issue-laden lives. These issues often lead to young people having several workers, and statutory involvement. If the situation or behaviours are serious enough, this can lead to the young person leaving home and becoming transient or residing in self found placements, or being removed from home and relocated to foster care or a residential unit. A common theme identified by YPP clients who have been subject to statutory involvement was that while they were pregnant, it was one of the only things they had control over – all their other life decisions were being dictated by DHS, workers or family. For most of these young women, the pregnancy was one thing that they could hold on to, and know that no one could take it away from them. Whilst the decision of whether or not to continue the pregnancy is always going to be a difficult one, most of these young women identified that whilst their decision to keep the baby in retrospect was not an educated one, it gave them a "reason to be" and a purpose that they felt they did not have at the time. When asked if they would make the same decision again, most of the young women stated that they would still want to have children, but would not have one so young or whilst their lives were so chaotic. All of the subjects had underestimated the amount of pressure that

would be placed on them after the birth by DHS/workers/family, and the difficulty of raising and being responsible for a baby.

Other reasons identified for continuing a pregnancy were –

- Not believing in terminations
- Too late for a termination
- Not the baby's fault, will deal with it

In deciding to continue a pregnancy (and enter into parenthood), most young mothers rarely receive the level of financial, emotional or general support that they anticipate. Even if the father initially expresses an ongoing commitment to support, this is often not followed through due to a breakdown in the relationship between the parties (or there not being an established relationship at all), questions around paternity, and already existing levels of poverty. Many young fathers-to-be can also withdraw from the process when they begin to realise enormity of the situation. Unlike the mother-to-be, who is physically aware of and confronted by the pregnancy every day, the young father can often find it easier to unengage than deal with the situation. Unlike several decades ago, the social stigma of being young, pregnant and unmarried is no longer enough to encourage the couple to marry. While in terms of the realistic long-term functionality of the relationship this is a good thing, it often translates to a lower level of support for the mother.

Even if supported by a partner, the pregnancy process can be very difficult for the young pregnant mother. For most of those involved in YPP, their partners viewed the pregnancy as "the mothers' responsibility", and they rarely played any part in the antenatal process.

Young Fathers

One of the main difficulties for young fathers (or potential fathers) is that in most cases, they have no control over the situation. The decision whether or not to keep the baby is ultimately up to the mother, and whatever the decision, there is often a high level of resentment if the opinions differ. In many cases the parents do not have an established relationship, and the pregnancy (and decision whether to continue or not) can lead to conflict. If the pregnancy is continued, there are many factors that need to be considered.

Many young fathers have conflicting emotions about being a parent, such as– feeling that parenthood has been forced upon them; relationship issues with the child's mother; blurred parenting roles; and subsequent relationships. With the current rising numbers of single parent family units, most of which are made up of single mothers, the young father may have had very limited male role modelling. This can impact not only on their ability to be an effective father, but also a supportive partner. If they are in a relationship, there may be early offers of assistance and continued support, but these often never come to fruition. Unlike the mother, who is unable to remove herself from her condition, the father is able to distance himself both emotionally and physically from the situation. This is certainly not the case in all situations, but the reality of most sexual/romantic relationships in adolescence and young adulthood is that they do not last as the parties involved are still growing and maturing as individuals. Most people who work with/parent/have engaged with young people will understand that they have a very limited conception of the requirements of sustaining a relationship, especially considering the enormous pressure that having a child puts on the connection.

A group not often considered is young single fathers. While groups for young mums are relatively widespread, often these do not cater for young fathers. While only making up a small proportion of single parents, young fathers are even more disadvantaged as they often have not had the previous involvement or experience with babies/children that most females have. Traditionally, females are more involved in the care and rearing of children in their own family or that of their peers. This allows them to develop skills and responses in relation to parenting, and behaviour can be modelled in response to mothers they have observed. Males, who are not necessarily involved in the care and rearing of children, often do not have the opportunity to pick up these skills. This is not to say that young fathers cannot develop the skills required to raise children, just that they may require extra support and education in relation to parenting.

Outcomes of Early Parenting

In a study and literature review conducted by Patsy Littlejohn, several factors were identified that impacted on the outcomes of young mothers and their children. One important point that she notes is that *"…poor parenting, often associated with young mothers, has been shown to be due more to social and economic deficits, rather than to age per se."*[9] A recurring aspect in the study was that although young parents are certainly overrepresented in terms of different facets of marginalisation, these issues are not dictated by their situation or age. With appropriate support and services, the young parents' outcomes can be just as positive as later age parents. Put another way, it is not the age of the parent that dictates their outcome, but the resources they have and support they receive.

Other factors discussed in the study were –

Accommodation
Homelessness was identified as the major unmet need for young pregnant or parenting women. It was also a factor in unplanned pregnancy, as it negatively impacted sustainable contraception and the high levels of rape of young homeless women. Some studies found that the overcrowding and frequent moves common to young pregnant and parenting women correlated to lower educational achievements of their children, and that periods of unstable (and unsuitable) housing were common for young women while they were pregnant and for the first two years after they gave birth. It was also identified that while a high number of survey participants (75%) lived with their mother at the time of the birth, this level dropped dramatically to 25% during the five years after birth.

Income and Employment
Most young mothers' sole income is centrelink payments, up to 60% of which may be used to pay for rent or accommodation. Working part time to supplement their income is often not viable, due to losing a proportionate amount of benefits because of their wage, having to pay for childcare or not having appropriate supports that can care for their children. Their lower educational level can often have a significant impact on being able to find suitable employment.

Education and Employment
Young women who continue their pregnancy rarely complete their education. The decision to obtain a termination is more frequently made by young women who are enrolled in school, have never dropped out or who are doing well in their studies and have higher educational aspirations. Studies in the United States have shown that some young women from low socioeconomic backgrounds choose early childbearing as they perceived it to be *".. an alternate life course that promotes their social and cultural survival and enhances personal development"*[10]

The points made above make it clear that to improve the outcomes for young parents (more specifically, young mothers), it is essential that their access to educational and vocational supports and services needs to be encouraged and facilitated. This point is not missed by young parents – one YPP client stated that "…after worrying about how to afford food and nappies, find good housing and trying to be a good parent with a family who doesn't support me and friends who are more interested in getting stoned, there is no time for me. I don't have space in my head to think about going back to school. I need to work out how the hell I'm going to afford food! School's just not an option at the moment, and I can't see that changing any time soon."

This is a common state of affairs. In terms of Maslow's Hierarchy of Needs, the lower levels (food, shelter) have to be appropriately addressed before any higher needs can even be considered.

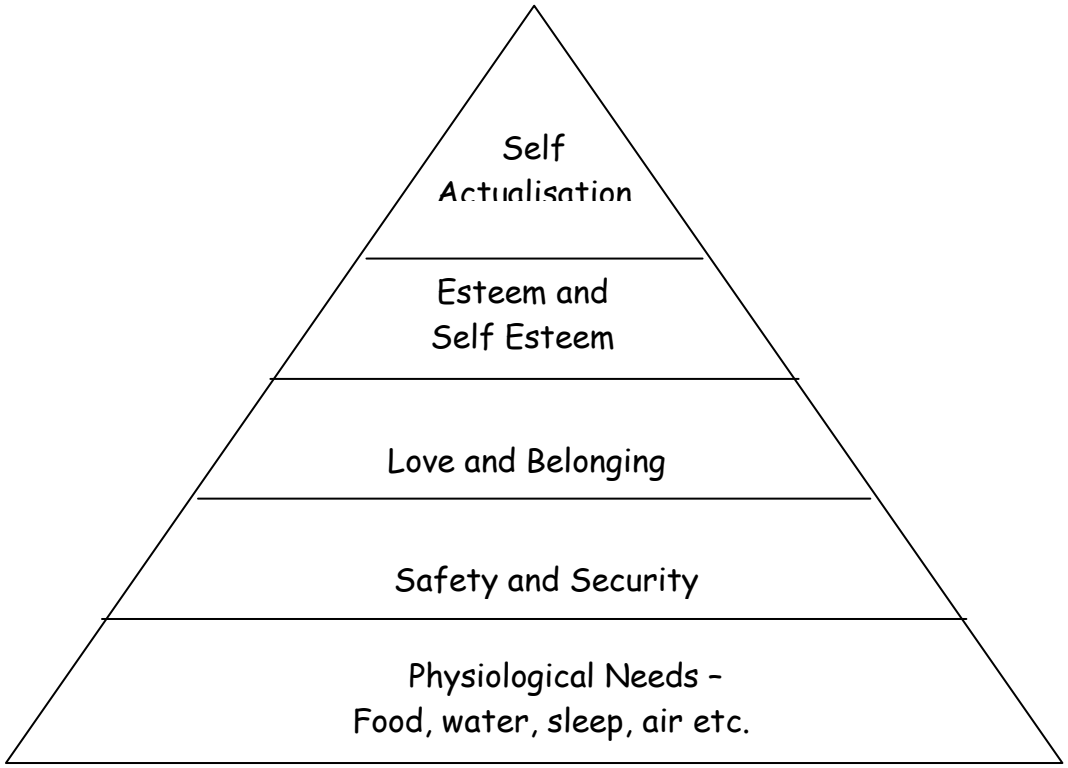


Figure 4 – Maslow's Hierarchy of Needs

THE YOUNG PERSON AS A SUBSTANCE USER

What causes a young person to use substances? Why do some young people indulge in age appropriate "experimental" drug use, and others develop long term substance use issues? While there is no definitive answer, there are patterns of behaviour and key issues that arise during the human development process (both environmental and genetic) that can predispose an individual to maladaptive patterns of behaviour (such as substance use).

The early years of development are some of the most important, as there is substantial brain development. This process is incredibly important, as it is when the physical pathways of the brain (neurons) are established. Spooner and Hetherington (2004) found that some of the key concepts in early human development are –

- Stress – prolonged stress is detrimental to health and wellbeing
- Essential to positive and healthy brain development and the prevention of a range of problems are –
    - Resilience
    - Self regulation
    - Human relationships and attachment
- Parents usually play a crucial role in development
- Each stage of life has a series of developmental tasks, the achievement of which is essential for healthy development. The transition from one life stage to the next involves a period of adjustment during which support is needed and the individual is more receptive to assistance than at other times.[11] :

They also found that two important features of early development are that-

- The development of children who do not receive the nutrition and stimulation necessary for development in the early months and years will be significantly impeded.
- During the early development years, significant and repeated stressful events can affect neural development (brain pathways) and the development of other body systems (such as the immune system). This system response to stress is called the allostatic load, and can impact upon the stress response for life[12].

The last point explains how events such as child abuse can lead to substance use and challenging behaviours in later life. The interaction between developmental processes and environmental factors also directly impacts on the likelihood of an individual developing substance use issues. Examples of risk factors across the life course include –

- Conception – genetic predisposition
- Gestation – drug use in pregnancy
- Neonatal and infancy – difficult temperament
- Preschool – early behavioural and emotional disturbances
- Primary school – inability to self regulate emotions and behaviour

- High school – exposure to drugs and drug using social contexts

In 2004, the National Drug Research Institute and the Centre for Adolescent Health released a monograph on the prevention of substance use, risk and harm in Australia. It put forward four key influences of parents' drug use during pregnancy and early childhood –

- Breast fed babies of drug using mothers ingest small quantities of the drug via breast milk
- The children of parents with impaired control and/or other signs of drug dependence are more likely to suffer from neglect and other forms of abuse
- Parental patterns have a strong influence children's drug use as young adults via modelling
- As a result of parents smoking, passive smoking presents a risk to children

These influences can affect physical development (in utero and in childhood) and later emotional development

It also presented other factors, both risk and protective, that can influence or predispose an individual to substance use. These are not predictive, and having risk factors does not dictate that the individual will use substances and go on to harmful drug use, but they are common themes among persons who do abuse substances.

Figure 5 – Risk and Protective Factors in Substance Use[1314]

	Risk Factor	*Protective Factor*
Individual Influences	• Aggression in childhood • Conduct disorder • Favourable attitude to drug use • Mental health issues • Unemployment • Sensation seeking and adventurous personality • Young people who are rebellious against adult authority and alienated from dominant social values	• Shy and cautious temperament • Social and emotional competence • Easy temperament in early childhood • Impulse control
School Influences	Early school failure Not completing secondary school Drug availability	Anti drug use policies
Peer Influences	• Relationship with peers who use substances • Delinquency	• Academic competence

Community Influences	• Low involvement in activities with adults • Availability of drugs • Favourable parental attitudes to drug use • Community disadvantage and disorganisation	• Strong neighbourhood attachment • Religious involvement
Family Influences	• Maternal smoking and alcohol use prior to birth and environmental tobacco smoke • Family history of criminality or anti-social behaviour • Being born or raised in a family experiencing extreme economic deprivation • Parent-adolescent conflict • Parental alcohol and drug issues • Inconsistent parenting • Parental rules permitting drug use • Being born or raised in a sole parent household • Child neglect and abuse • Lack of parental supervision	• Being born outside Australia • Attachment to the family • Low parental conflict • Parental communication • Getting married • Parental monitoring

Poulson, in his article on protecting infants and young children at risk, states that "*Children who are healthy, temperamentally easy, and developmentally competent, who are born into families that can provide rich relationships, appropriate expectations, and low environmental stress, tend to develop the internal resources that allow them to easily cope with the demands that are a part of all children's lives. These resilient children develop the internal self-regulation to respond to and recover from environmental challenges. They achieve a repertoire of responses, and have the flexibility to respond in a manner that matches the situation in context and intensity. Resilient children accomplish transitions smoothly and easily. They recover from stressful events in a period of time that matches the traumatic significance of the event. Stress and distress responses do not linger.*"[15] This presents quite clearly the role of parents in adequately preparing their children with the behavioural and temperamental skills required to adequately deal with life experiences and events, and the environment conducive to this skill development. Conversely, if parents do not have the capability or capacity to provide the family environment conducive to effective skill development, then this environment will contain the factors that the child is unable to effectively deal with, such as stress, poor relationships and inappropriate expectations.

Two groups of disadvantaged persons that are disproportionately represented in the criminal justice system and have a higher rate of drug related problems than the general population are children of sole parent families and Aboriginal and Torres Strait Islander peoples. Relative to

other children, children raised in sole parent families have been shown to have five times the rate of emotional, behavioural, social and academic problems[16].

The factors listed above do not just give a context to substance use in young people, but are also salient points regarding the risks young substance using parents are subjecting their children. This brings in a maladaptive dynamic that can be very difficult to break, but is also very common – that of multigenerational patterns. When working with the parents, casework involves dealing with issues that have been entrenched for years – effectively, the worker is conducting damage control and trying to minimise or prevent further problems. The damage is already done. This is not to say that young people (and even old people) are unable to overcome their issues, just that it is harder to address the longer the issues has been there. How many times have you engaged with a client and wished that you had got them earlier, before the issues impacted upon them so much? Working with young parents, you have the next generation of potential clients right there – you can't get earlier than that. So one of the more effective casework processes in working with young parents who use substances is helping them to stop their issues negatively impacting on their children, which can lead to them using in the future. As stated in the Preventing Drug Use Guide (US Dept. of Health and Human Services) "*For young children already exhibiting serious risk factors, delaying intervention until adolescence will likely make it more difficult to overcome risks. By adolescence, children's attitudes and behaviours are well established and not easily changed*".[17]

A very important factor that should not be underestimated is young people's peers. During adolescence, young people move away from the family and towards their peers. Instead of wanting parental approval, young people want peer acceptance. Parental advice is discarded in favour of peer opinion. Boundaries are tested, freedom explored, and young people see themselves as bulletproof. This stage may also be the first time young people are exposed to drugs and drug use. Experimentation, rebellion and risk taking, (staples of the typical teenager's life), coupled with exposure to substances, less parental supervision and a desire to be accepted by peers can lead to issues impacting on physical, emotional and mental health. Levels of substance use differ according to the individual. A normal part of adolescent psychological development is experimenting and risk taking. Experimental substance use is part of the rollercoaster ride of adolescence, and uusually resolves itself naturally. Other young people's experimentation can develop into longer term issues, where the use escalates in both frequency and type of substance used.

From the evidence and research, it is quite evident that there is a clear correlation between developmental trauma and stress and substance use in later life. Substance use may be identified by the young person as a way to feel normal, to escape reality or to stop the bad thoughts and feelings, but the common thread for problem substance use is that it is just a way of dealing with stress and other issues. The young person may not understand this – they just use because it makes them feel better in an undefinable way. What starts as a way to escape can develop into a dependence they have no control over.

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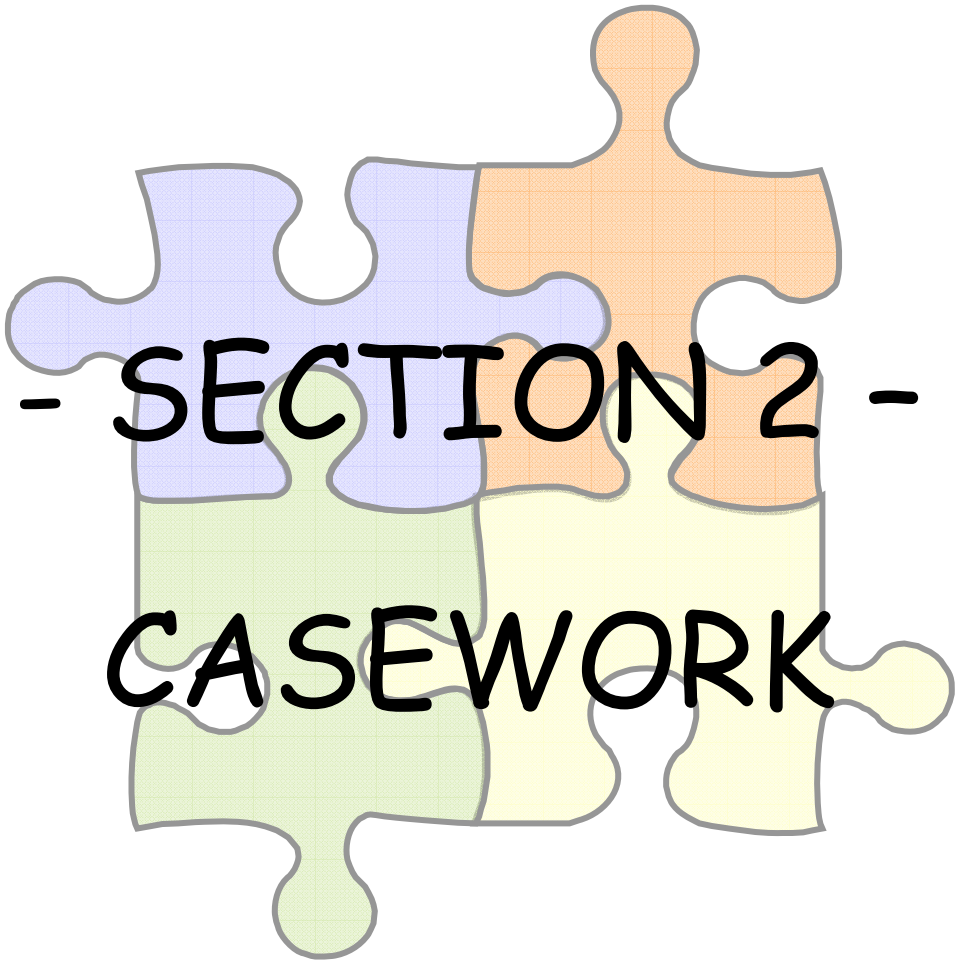
[16] Spooner, C. & Hetherington, K. ibid 2004.
[17] US Department of Health and Human Services. Ibid, 1997.



- SECTION 2 -

CASEWORK

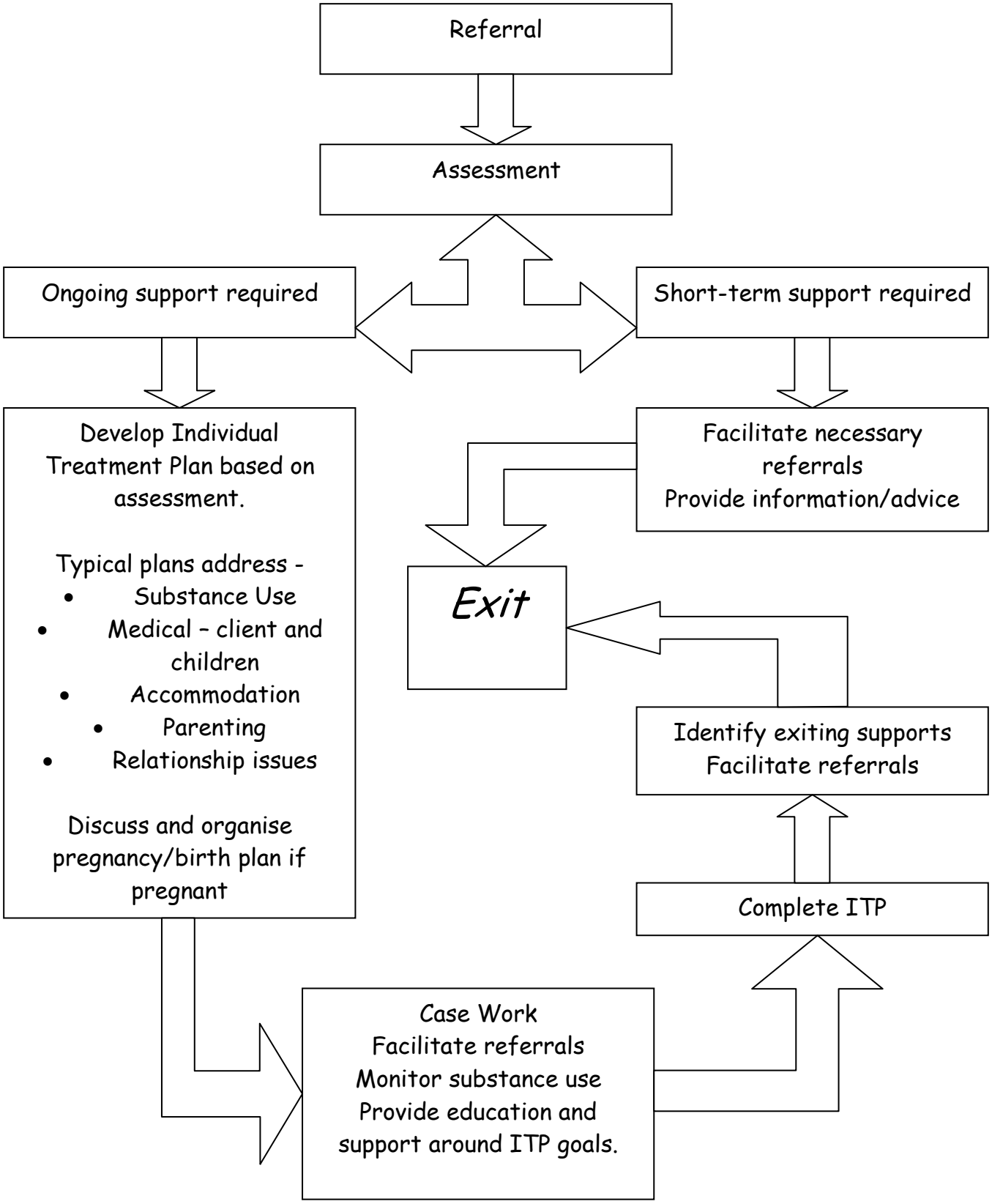
THE YOUNG PARENT'S PROJECT

As briefly discussed in the introduction, the YSAS Young Parent's Project was established to cater for a significant percentage of clients that were presenting for drug and alcohol services. Intake and assessment identified that around 10% of clients were either pregnant or parenting, and there were few services that dealt with both of these issues concurrently, particularly for the age group targeted by YSAS. Managing one's substance use while pregnant or parenting presents huge issues to the client base, especially when their life situation is also impacted upon by other negative factors and experiences.

The main focus of the project was to develop an effective framework that caters for young parents, helping them to concurrently address their substance use issues and parenting education. The ultimate goal is to help young people provide a safe, loving environment for their children, and minimise the likelihood of statutory involvement. The YPP also subscribes to the YSAS approach of looking at young people holistically – their substance use is not the problem, just a symptom of life experiences, issues and trauma. Helping young people identify and address these issues helps them to move past their problem behaviours and grow as individuals.

Most of the young parents involved in the program have a very limited understanding of parenting, and the effect that a child will have on their life. Whilst many may have had younger siblings or spent time with friend's children, the full impact of having a baby to look after full time is not considered. This is also compounded by the young person's current developmental stage – seeing themselves as in control, "grown up" and able to deal with anything. The reality of parenting tests their coping skills, sense of self, identity and relationships with others amongst other things. Young parents also find themselves in receipt of good intentioned (and usually differing) advice around child rearing, parenting and discipline, which can lead to confusion, inconsistency and frustration. All of these factors then influence their level of substance use, and the cycle continues.

Figure 6 - Young Parent's Project Pathway of Care



THE CASEWORK PROCESS

Practical Information

There are many practical aspects that need to be considered to ensure that young parents are catered for effectively. Having a properly equipped office and car can facilitate the casework process by reducing parent stress and lessening distractions. Providing an environment that is engaging to both parents and children can be an engagement method in itself. Many young parents do not actively seek services that they can link in with, so providing information on local programs, facilities and services in the local area that are appropriate is important.

Small children find appointments boring, and keeping them entertained and busy will enable their parents to concentrate on the content of the session rather than the behaviour of their children, and their impact on other people. If clients see that their children's behaviour is having a detrimental effect on others in the office, they may be less likely to engage with the service or attend appointments. So, to this end, the goal is to have a space in the office designated as "child friendly'.

This may be an already existing client area, or a room set up specifically for this purpose. Children are by nature noisy and curious, so ensure that the allocated area is away from staff workspaces and confidential information. Clients with older children may not like to discuss certain issues in front of them; so being able to settle the children in front of the television or in a playroom can be more conducive to effective casework. If possible, having another staff member keep an eye on the children would also be helpful.

Due to the often chaotic lifestyles of young parents with substance use issues, having a kitchen equipped with a microwave (for bottle warming) and snacks is a great idea, as there will inevitably be times where the children (and clients) have missed meals or arrive at the office hungry. If program funding allows, it may also be of value to have a stock of emergency hampers for clients, as getting practical assistance from crisis centres usually involves a lengthy wait in a waiting room.

If part of casework involves transporting clients, it is essential that you have access to a car seat/booster seat so the child/ren can be transported as well. Keeping a first aid kit, baby wipes and snacks such as dry biscuits in the glove box can also be a good idea.
Some good things to have…

In the "Child Friendly" Area

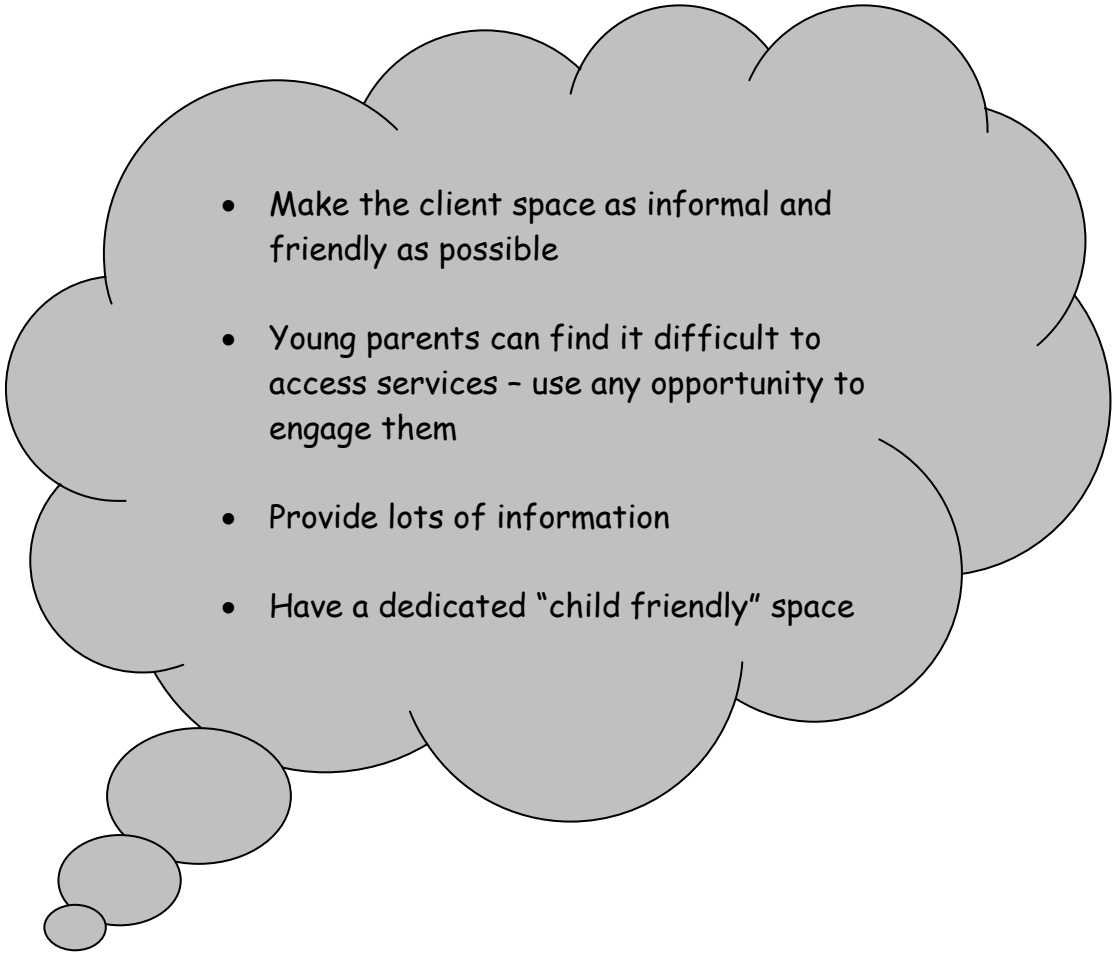
- Toys
- Books
- Blackboard + chalk
- Kids DVD/video
- Colouring-in books
- Textas
- Pencils

In the Kitchen

- Biscuits
- Fruit Juice
- Cordial
- Muesli bars
- Bread
- Jam/vegemite
- 2 Minute noodles
- Baked beans
- Tinned spaghetti

In the Car

- Car seat
- Booster seat
- Baby wipes
- Biscuits


Make the client space as informal and friendly as possible
Young parents can find it difficult to access services – use any opportunity to engage them
Provide lots of information
Have a dedicated "child friendly" space

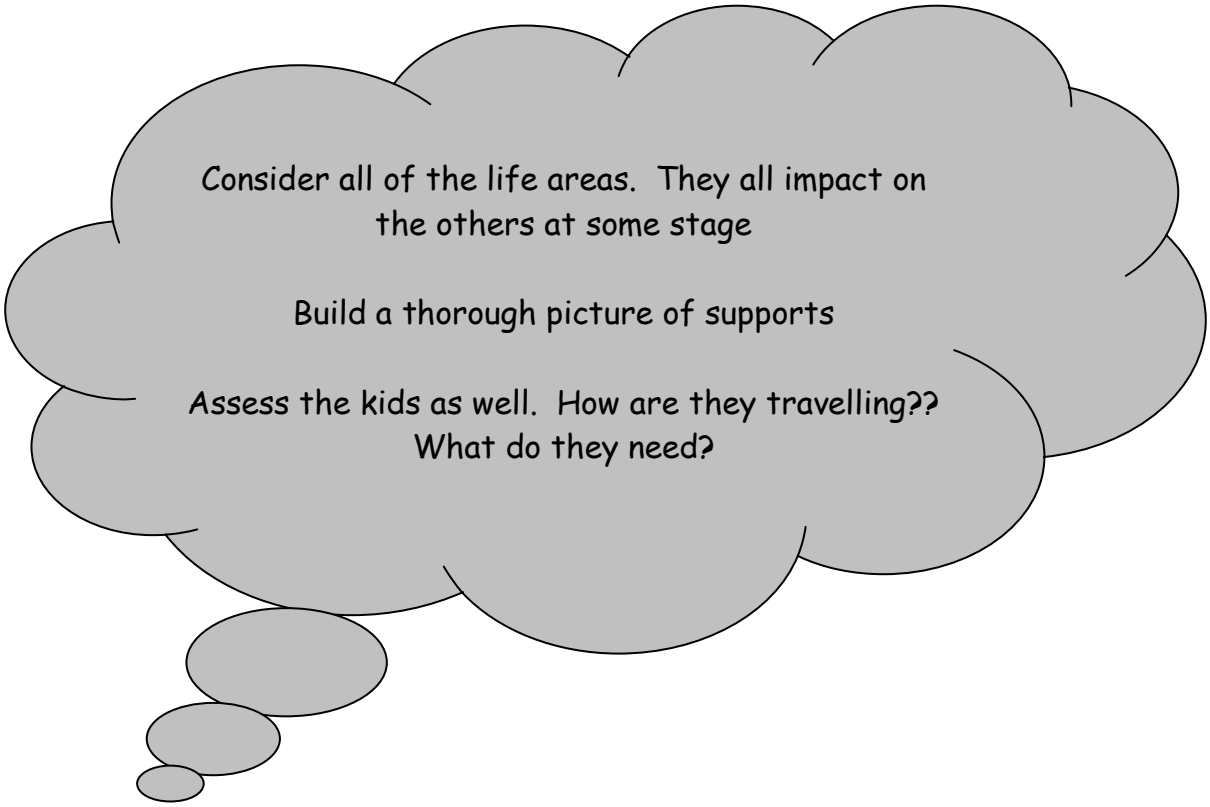
Assessment

The assessment process is one of the most important facets of casework. A thorough assessment will establish not only the client's details and background, but also patterns of substance use, underlying factors, other issues and areas in need of development. It should not just cover the program area (such as housing, drug and alcohol etc.) but all facets of the client's life. More information builds a more thorough picture of the client, and assists in developing a more effective intervention. The assessment period is also the first real opportunity to engage with the client, explain the service and establish a rapport. It may become apparent during the assessment process that the program/service is not appropriate. In this case, it is always better to facilitate a referral to a more appropriate service (and support until the referral is accepted) than engage the client in a service that may not be suitable. In terms of voluntary clients, assessing their motivation to engage and participate in the casework process is also important – participation due to coercion or outside influences will almost certainly negatively impact the young person's outcomes and motivation.

Areas covered in the YSAS youth assessment tool are –

- Substance Use
- Emotional/Mental Health
- Physical Health
- Relationships
- Family
- Supports
- Accommodation
- Legal and Statutory Issues
- Education and Vocation
- Leisure and Recreation

Most workers will find that it is often the unrelated issues that have the largest direct impact on the presenting issues. The information gathered in the assessment process is used to develop an individual treatment plan (ITP), in consultation with the client. The ITP is a list of goals that the client would like to achieve during their episode of care, and how and when they are going to do this. The goals can cover several different areas, and must be achievable. One of the biggest mistakes to make when developing an ITP is to include goals that are impracticable or unrealistic, as this leads to the client losing confidence in themselves, and negatively impacts on their willingness to engage again.


Consider all of the life areas. They all impact on the others at some stage
Build a thorough picture of supports
Assess the kids as well. How are they travelling??
What do they need?

Engagement

YPP is a voluntary program, and workers engage with the young people in a variety of settings. Whilst the project is primarily outreach based, many appointments are conducted on a "drop in" basis. Other methods used to engage and work with clients are transporting them to appointments, taking them grocery shopping, home visits and opportunistic contact.

YSAS works from a harm minimisation perspective, and this equates in casework to workers engaging with clients in a "helping you to keep yourself safe" role, rather than a "you must stop using substances" role. Education forms an important facet of casework, and is conducted informally. Information and pamphlets are accessible to clients, and posters and other resources are displayed. The client group responds well to this approach, and most actively seek out assistance. Many past clients will drop into the office to catch up with workers, and discuss how things are going for them. Workers have a genuine concern for clients, and this is acknowledged and appreciated by the client group. Often they will seek assistance for issues other than drug and alcohol, as they find the service, and workers, safe and approachable.

Another approach YPP uses is honesty. Workers are very clear with young people about the nature of involvement and that their children's safety and wellbeing is the top priority. If the worker witnesses a source of concern, this is addressed with the young person. A recurrent theme (and ongoing stressor) for many young parents is the threat of DHS getting involved, and the fear that they will be labelled a bad parent or have their children removed. Many young parents have had statutory involvement themselves, and their experiences often lead them to regard DHS with suspicion and anger. Clarifying with young parents what leads to a notification being made, and being available to assist them to deal with issues before they become problematic, is an important part of engaging and working with young parents.

There are instances where it is necessary to make notifications to DHS regarding concerns for the children's health and welfare. When young parents engage with YPP, part of the intake includes having a discussion with them around behaviours and reasons that can lead to notifications, and that the first priority of the workers is to ensure the safety and wellbeing of the children. The young people usually accept this, and workers ensure that they understand that workers are there to help them manage their substance use and parenting, and hopefully deal with problems before they become protective concerns.

- Develop a collaborative relationship with young parents. They know what they need more than anyone else
- Establish an up front method when dealing with parenting issues. Beating around the bush doesn't help anyone
- Let the clients know that your number one priority is the children's wellbeing and safety and theirs should be too

Casework

The YPP project aims to take a care team approach to casework. Identifying all parties (other workers, family members, health professionals, consultants) and their roles is an integral part of planning effective and thorough interventions.

The initial care team meeting would usually be held after assessment at the beginning of casework. It should involve all parties (including clients) if possible, and be held somewhere the clients feel comfortable. This may be at the office, client's home or another venue. The care team approach should be discussed with the client, and they should agree on who is invited. Sometimes there is a concerned family member wanting to be included, but the client does not want them involved. Consulting the client about who they would like to participate increases the chance that they will be more compliant. If there is statutory involvement, the DHS worker will instigate this process and the client may not have a choice of who attends.

. The aims of the care team meeting is to-

- Clarify everyone's role
- Address service gaps
- Designate tasks and responsibilities
- And if necessary, allocate a case manager

Depending on how well the young person is engaging with services and coping generally, this may be the only care team meeting required. More complex clients may require regular meetings. It is important for the care team to be communicating regularly about issues that arise, compliance and how the client is travelling. All participants can then address any issues identified, and casework is more consistent. This also reduces the chance of the clients playing workers off one another, and worker collusion. Having an allocated case manager (if there is not already one involved from DHS or case contracted to a community service organisation) provides a central point of contact and they hold the responsibility of coordinating the other care team members.

It is important for the client to be actively involved in this process – not consulting with them, or assuming compliance and understanding will usually result in the client not cooperating as they don't feel they own or control the process.

ITP's need to be reviewed regularly with the client and with a supervisor, to monitor progress and relevance of goals set. Often during the casework process, goals will have to be adjusted or changed completely as circumstances can change or the goals may no longer be appropriate. It is imperative that the goals identified in the ITP be achievable and realistic – it is always better to set small "baby step" goals, rather than large "big picture" goals, as client motivation and self esteem can be negatively impacted if goals are not achieved. Discussing ITP's with supervisors or peers also lends another perspective and may offer solutions or methods that have not yet been considered.

An important aspect of casework is identifying the young person's support networks. Like the quote "it takes a village to raise a child", young people need all the help they can get raising their children. Different supports can provide different assistance, and talking to the young person,

and their networks can clarify what help each can offer. This is simplified by making an ecogram for clients.

The ecograms following are for a fictional young person, Emma, and her daughter, Chloe. The first identifies their familial/peer supports, and the second includes roles the different supports play. Ecograms can also include workers, day/child care, and other organisations/agencies.

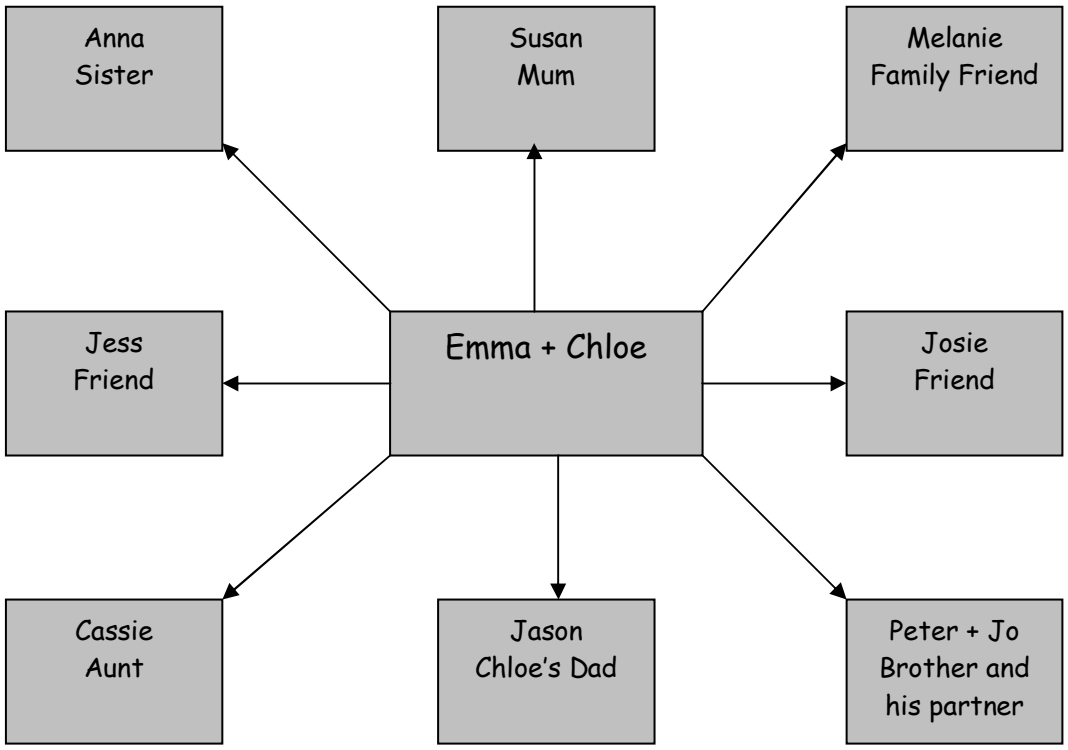


Figure 7 – Ecogram of Supports

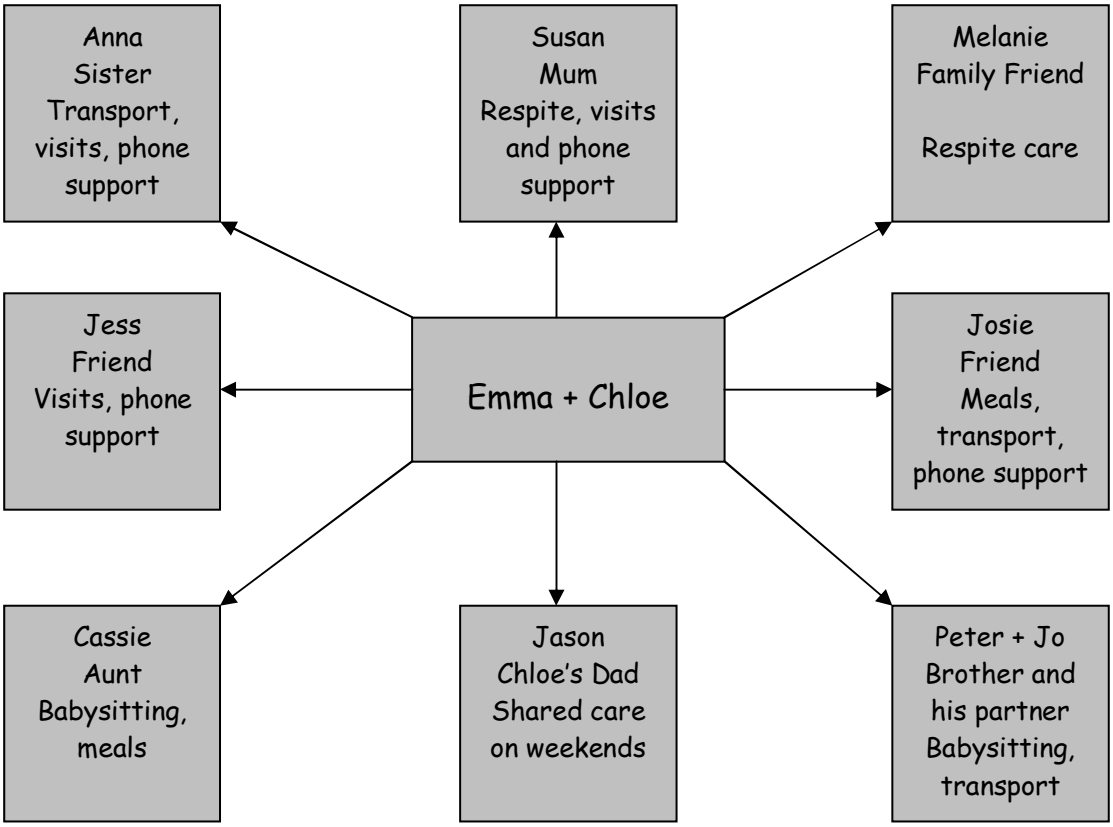
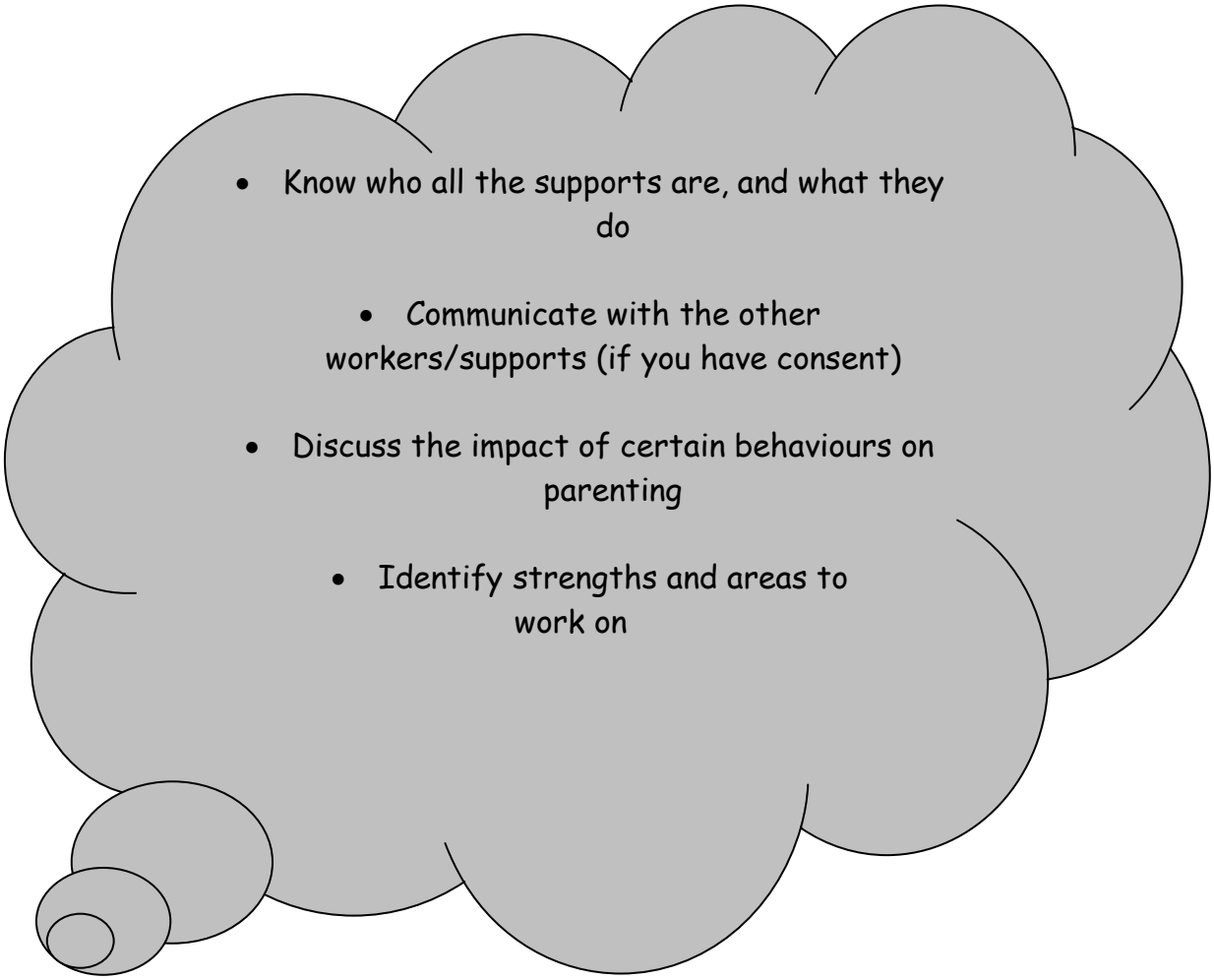


Figure 8 – Ecogram of Supports and their roles

Young parents can easily think that they are on their own dealing with their children, and feel isolated and overwhelmed. Having a list of support persons, their roles and contact numbers is a great tool to have on the fridge, as it presents support options and is a proactive way of circumventing crisis situations. People who are tired and stressed find it difficult to think rationally and constructively, so having a list of options

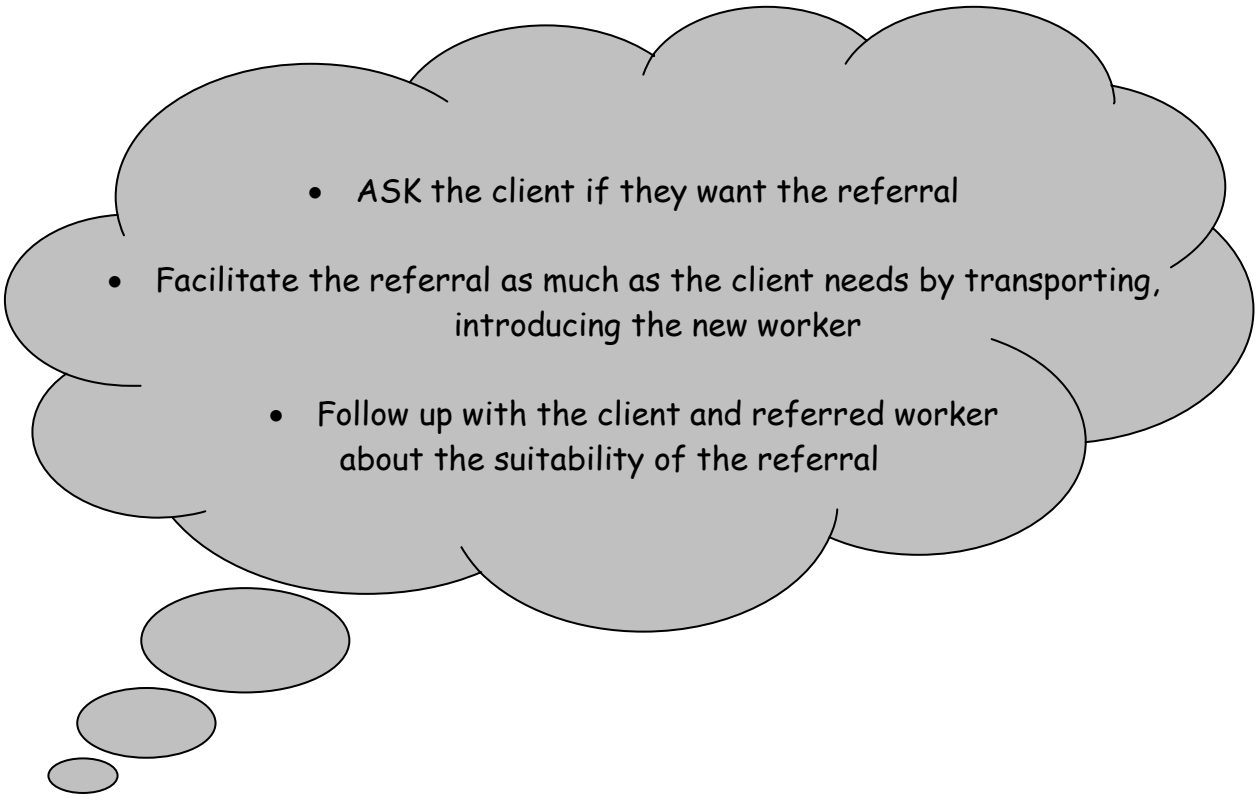

• Know who all the supports are, and what they do
• Communicate with the other workers/supports (if you have consent)
• Discuss the impact of certain behaviours on parenting
• Identify strengths and areas to work on

Referrals

Due to the multidimensional issues presented by young parents with substance use issues, any involvement will probably necessitate referrals to other programs and services. If the young person already has a number of workers involved, they may not want another person intruding in their lives. There may be issues that they feel they are not ready to deal with, or others that they feel have priority, that will dictate the type of referral. Exploring their options, rather than assuming what they will need, is an important facet of casework. It may be clear to the worker that the client would benefit from the involvement of a worker/program to deal with a specific issue, but if they are not ready or willing to deal it at this stage, the referral will be a waste of time not only for the young person, but the workers as well.

The most important referrals made when working with young pregnant or parenting clients is those to medical support and intervention. This may be to midwives, doctors, hospitals and antenatal classes. Many clients presenting to YPP have little or no medical supervision, or have had no consistent medical care. It is common for medical issues not to be addressed (including chronic conditions such as asthma) and for pregnancies to be quite progressed before care is sought.

Finding geographically appropriate, youth friendly services is extremely important, as if the clients can't easily get there, or find the doctor/midwife etc. judgemental or unfriendly, they just won't go. Actively assisting in the referral process by transporting them and (if they want) sitting in on the first meeting to introduce them will assist them to engage with the service.



Exiting

Ideally, exiting should occur after the client has completed or achieved most (if not all) of the goals identified in the treatment plan. Clients cease involvement for many reasons, and exits may be planned (goals achieved, planned moving out of area, significant change in circumstances) or unplanned (an unplanned move out of area, incarceration, missing persons, no contact). Due to the chaotic lifestyle of many substance-using parents, unplanned exits are common.

In each case, there are several tasks that need to be completed.

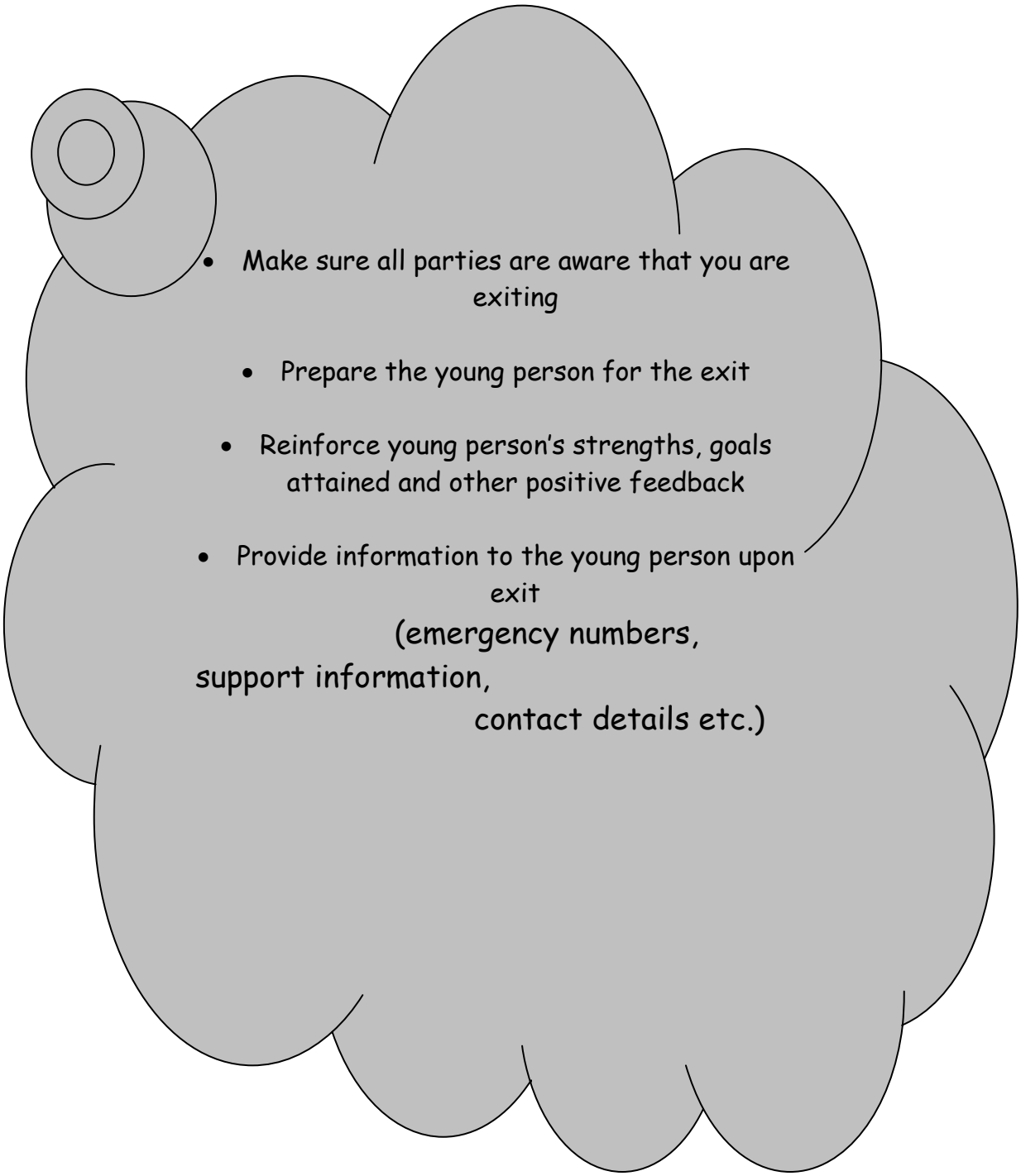
For a planned exit

- Let the other members of the care team know of your withdrawal
- Facilitate planned referrals
- Provide details of other appropriate services
- Have a planned exit appointment,
    - Review the gains, client strengths and improvements.
    - Review the care plan, supports and routines
    - Give the client any information they may need
    - Let the client know how/if they can re-access the service
- Send client a letter notifying them they have been exited from the program, and how they can access their file under Freedom of Information

For an unplanned exit

- Notify care team members of your withdrawal
- If possible, have an exit interview (or telephone conversation) about their involvement, gains, strengths etc. Review care plan, supports and routines
- If possible, send an exit letter to the client along with other service information, and how/if they can reengage with the service.

It is important that the clients are prepared for and have identified supports when you exit. Clients can get very dependant on workers and services, and an ill planned exit can cause clients to revert to unconstructive behaviours and subvert coping strategies.


• Make sure all parties are aware that you are exiting
• Prepare the young person for the exit
• Reinforce young person's strengths, goals attained and other positive feedback
• Provide information to the young person upon exit
(emergency numbers, support information, contact details etc.)

LIFE AREAS

Health

A recurrent issue when working with young substance users is that of health care. The lifestyle led by problem substance users can lead to a plethora of health issues, including malnutrition, STI's, blood borne infections, poor personal hygiene and poor dental health. Many young people doctor shop, and due to no continuity of care, have little knowledge of their medical history. They are reticent to access medical treatment unless it is urgently required, and often the medical access is via hospital outpatients, which have little or no follow up treatment. Free medical clinics (bulk billing) are often understaffed, and due to the financial necessity of seeing large numbers of patients, don't have the time or resources to have in-depth consultations. This take-a-number approach, coupled with young people only accessing doctors on a needs basis and their reticence to discuss their substance use due to fears of being judged, leads to only superficial medical intervention. The chaotic lifestyle led by many substance users also impacts on their ability to attend (and remember) scheduled appointments.

A research report conducted by Wyn and Stewart (1991) found that in regards to obtaining medical attention, young women felt –

- That they were being judged – especially in regards to sexual health issues, contraception and/or STI's
- That their needs and concerns were not taken seriously
- That their privacy was not always ensured or respected for a range of reasons.[1]

To improve both long and short term health outcomes, YSAS try to link young people into youth-friendly medical services. Many youth centres now offer visiting medical professionals such as doctors, midwives, dieticians etc. They may work from the service on set days per week, and often the young person does not require an appointment. Linking a young person in with a medical professional they feel they can trust, and can access free of charge and on a drop-in basis, can dramatically increase their level of engagement and willingness to attend. Being located in an environment where the young person already feels comfortable adds to the convenience of the service, and the youth friendly staff can diminish any feelings of being judged.

Dental care is another area that is neglected by young people – day to day dental hygiene is not seen as a priority, the public dental service has long waiting lists, and treatment can be expensive. Even if placed on a waiting list, the young person's transience often means they do not receive correspondence around scheduled appointments. Being able to act as a contact for the young person in this situation can ensure they are alerted to appointments regardless of where they are living.

Many of the client group do not brush their teeth daily, and are unaware of the dental problems that can be caused by substance use. This ranges from the effects of a dry mouth (tooth decay) to grinding teeth. These issues can lead to more serious longer-term health problems, so encouraging clients to brush regularly, drink lots of water and (if possible) providing toothbrushes and toothpaste is very important.

HEALTH

Link the young person in with appropriate, youth friendly medical supports they can access independently

Encourage good dental hygiene, and provide water (and if possible dental care supplies)

Encourage the young person to have regular medical check ups and address any concerns

Nutrition

A common issue with young parents is their (and their children's) nutrition. Homelessness, a chaotic lifestyle, poverty and poor modelling all can negatively impact on eating habits. Many young people with substance use issues not only lack basic cooking skills, but also do not eat regularly or nutritiously. Meals often consist of fast food, and they may only eat sporadically. Drug use places stress on a person's body, so the need for healthy, nutritious food is even greater.

The substances being used by a young person can also affect their eating habits. Some of the nutritional related effects of substance use include –

- Increased need for vitamins and minerals
- Loss of appetite
- Use of drugs in place of meals
- Forgetting to eat
- Inability to afford food
- Cravings or "the munchies"
- Constipation or diarrhoea
- Nausea and vomiting[2]

A balanced diet includes food from the five food groups – breads and cereals; fruit and vegetables; meat and alternatives; milk and dairy; and fats and sugar. The recommended daily consumption of these groups for young people is -

Food Group	*Serves*
Breads and Cereals	Minimum of 5
Fruit and Vegetables	Minimum 3 fruit Minimum 3 vegetable
Meat and alternatives	Minimum of 1
Milk and Dairy	Minimum of 3
Fats and sugar	Maximum of 3

Figure 9 – Recommended Daily Serves of Food Groups for Adolescents

As well as eating a balanced diet, young people should also drink lots of water, as this helps the body to stay hydrated.

The concept of healthy eating and nutritional needs may be completely foreign to young people. For many clients of YPP, food is something that stops hunger, rather than provides essential nutrients. The relationship between food and health may not have been recognised, and choice of food has more to do with convenience than requirements. Many young people do not have

experiences of eating three meals a day, or of a balanced diet. Changing their perceptions and educating them on the benefits of food groups, nutritional needs and food preparation is extremely important.

One of the factors contributing to eating habits identified by YPP participants is convenience – chips, takeaway, soft drinks and fried food are all quickly and easily obtainable. Food is not prepared and eaten, but bought "on the run". Nutritional content is not a factor in food choice, rather "the munchies" and cravings dictate purchases. Many young people do not shop for food (i.e. – at supermarkets), rather buy food on a meal-by-meal basis. This not only leads to a diet high in fat, sugar and empty calories, but is also more expensive. The transient lifestyle led by many young people is not conducive to preplanning meals or food storage, and substance use can lead to them forgetting to eat.

Some points that are valuable to discuss with the young person are –

- What is their knowledge of nutrition?
- What sort of things do you need to eat to stay healthy?
- What sort of things can you keep in your bag to eat, rather than getting takeaway?
- How do you cook cheap, tasty meals?

Taking the young person grocery shopping on pay day, and spending some time cooking some easy meals is a good way to foster rapport building, but can also build their life skills. Providing fruit and plenty of water at the office for young people to access can improve their eating habits, and encourage them to make more nutritious decisions around food choices. Information on the importance of nutrition and regular meals should be provided, as well as discussing how to integrate good eating strategies into the young person's routine.

NUTRITION

Encourage the young person to include more fruit and vegies into their diet

Establish an eating routine

Show the young person how to cook some quick, easy and cheap meals

Provide information about the importance of nutrition, particularly for substance users and children

Take them supermarket shopping, and identify some convenient food choices that are transportable (preserved fruit snack packs,

Mental Health and Dual Diagnosis

Among substance using young people, a disproportionately large number also present with mental health issues. Dual diagnosis is a term used for individuals who have both substance abuse and mental health issues. Research conducted by the National Youth Affairs Research Scheme found that up to 50% of people with mental health problems have concurrent substance use issues, and is was common among homeless young people[3]. The incidence of depression in clients presenting to YPP is approximately 50%, a significantly higher amount than the 9.5%[4] of the general population (in a one year period). Other issues commonly presented are anxiety (20%) and bipolar (10%), with eating disorders, psychosis and conduct disorders also prevalent. The question as to whether the substance use causes mental illness or vice versa is a contentious one, but the two factors directly impact each other. It is no coincidence that many young people with mental illness also use substances – most clients presenting with mental illness report that using helps them deal with their issues, or at least gives them respite from negative thought patterns and behaviours

Research conducted by Mather et al (1999) found that there are two broad groups of young people with dual diagnosis issues –

- Those with clinically significant mental illnesses such as schizophrenia, bipolar disorder and major depression who self medicate with alcohol and illicit drugs to lessen the distressing symptoms of their illness

- Those with borderline personality and anti-social personality disorders or anxiety exacerbated by excessive use of substances such as alcohol, marijuana, amphetamines, cocaine and heroin.[5]

Some common mental illnesses and syndromes that young people present with (apart from substance related disorders) are –

- Anxiety disorders (obsessive compulsive disorder, panic disorder, post traumatic stress disorder)
- Psychosis (often schizophrenia related)
- Mood disorders (depression, bipolar disorder)
- Eating disorders (bulimia, anorexia)
- Conduct disorders (attention deficit hyperactivity disorder, conduct disorder, oppositional defiance disorder)
- Personality disorders (borderline personality disorder)

There are four factors that should be considered which impact on mental illness in young people –

- Biological factors (is there a family history of mental illness?)

- Psychological factors (does the young person's personality or way of thinking increase risk? Eg. - Do they have low self esteem or do they have unrealistic expectations)
- Social issues and factors (are they homeless or do they face financial hardship?)
- Developmental factors (how is the young person cognitively functioning? Adolescent brains are still developing)[6]

A mental illness can also have other effects that impinge on the young person. These can include –

- Side effects of medications (i.e.- gaining weight, drowsy)
- Suicide and self harm (cutting/burning)
- Violence and aggression (verbally/physically attacking people, breaking things)
- Disorganisation and poor self care (not bathing, not eating, not attending school/job)
- Deterioration in mental/physical state (noticeable changes in physical/mental presentation)
- Exposure to trauma (experience of psychosis or treatment may be traumatic)
- Stigma of mental illness (may think they will/actually be rejected by peer group)[7]

These four factors need to be taken into account when dealing with mental illness in young people. Young people can also be very difficult to diagnose as their brains are still developing and changing. It is also common for young people to resist any involvement of mental health professionals, as they don't want to be seen as "mental" or "mad", or recognise that they have a mental illness. Being diagnosed can be an immense struggle for young people as it affects the way they see themselves. Adolescence is a time when young people are developing their own identity and going through intense social and emotional development[8], so a mental illness can have a huge detrimental effect on this process as it affects the way young people see themselves and how they think others perceive them. Being seen as different or odd can have a calamitous effect on the young person's self esteem, and adolescents are notoriously misinformed about many things, including mental illness.

Engaging young people with dual diagnosis issues, working with them effectively, and identifying barriers to service provision has been the subject of a research report conducted by the National Youth Affairs Research Scheme. Some of the service provider recommendations they came up with were –

- Dual diagnosis should be recognised by service providers in youth accommodation, drug and alcohol and mental health as a common occurrence rather than an exception.

- Drug and alcohol, youth accommodation and mental health services need to implement screening tools that appropriately cover dual diagnosis as part of the assessment process for all clients

- Service providers need to adopt a youth friendly, client centred approach for the target group. This includes creating a youth friendly environment, non-punitive punishments for

antisocial behaviour and non-compliance and encouraging meaningful involvement of young people.[9]

If a young person is displaying behaviours that pose a risk to their own or other people's safety, they will need to be assessed by a Crisis Assessment Team (CAT). Depending on how cooperative the young person is, these can be conducted either by presenting at a hospital emergency department, or by an outreach CAT team. The demand for CAT team services is large at the best of times, so there may be a long wait. If the young person is displaying symptoms that are less acute it is a good idea to consult a general practitioner
The Child and Adolescent Mental Health Service (CAMHS) can assess young people aged to 18 years, whilst adults fall under the general category. CAT teams can be contacted via local hospitals. Contact details of CAMHS and other mental health services are listed in the services guide.

MENTAL HEALTH

Know how the young person's substance use could affect their mental health

Have a management plan in place for dealing with certain behaviours or circumstances

Liaise with other workers to ensure an integrated, consistent approach

Discuss with the client how to manage their illness, and support them to take an active role in its management

Identity

One theory regarding adolescent identity development is Josselson's Process of Individuation, as described in Damon's "Social and Personality Development". He proposes that during adolescence and early adulthood, the major psychosocial task is the development of a personal identity. Up until this stage in development, the main focus has been very egocentric in the individual. Adolescence brings with it the need to define who we are and how we fit in. Identity development is a twofold process and is impacted on by both internal and external factors[10]. The internal, psychological role is to establish and understand "who I am". The external, social role is to establish and understand "where I fit in". This process is usually resolved by the age of 22.

The process of individuation can be broken down into four phases –

Differentiation
Where the adolescent starts to move from parental omniscience to seeing themselves as different and separate from their parents. This is often displayed as parental rejection, and the questioning of parental authority

Practice and Experimentation
In this stage, adolescents move away from parents and towards their peer group. They also engage in boundary testing, challenge parental authority and think of themselves as bulletproof.

Rapprochement
Rapprochement is a psychological response to the adolescent separating themselves from the parents/family unit and towards their peers. This level of autonomy (while not without its benefits) can be overwhelming for the adolescent, and they can feel pain and anxiety about parental acceptance and love. This often leads the adolescent to restate themselves as active family members.

Consolidation
Consolidation is the final stage of individuation. By this stage, the adolescent has experienced both autonomy and rapprochement with the parental unit, and can balance up the experiences of both. This stage involves the establishment of a formal sense of identity, and where the individual fits in their world[11].

Becoming a parent at an early age (and whilst these very important psychological processes are occurring) can have a strong influence on this process. The tasks of parenting can impede the process by putting the focus on another individual, rather than working through these issues. In terms of the process of individuation, the young person may not complete the stages properly or remain stuck in one stage for longer than usual as they are (by necessity) dealing with being a parent rather than discovering how they fit into their family/peer group and community. Delaying the tasks of adolescence and early adulthood can lead to long term issues, as the young parent is unable to define themselves as a person, but rather someone else's parent. To assist them to complete the normal psychological tasks, it is important for young parents to still be able to engage with others as a young person, and not just a parent. This may be via spending time with peers and family while their children are in childcare and engaging in age appropriate (rather than role appropriate) groups and activities.

A crucial point to be remembered by not just workers, but also family and the community is that even though the young person is a parent, they are a young person first. Many people assume that if someone has a child they are an adult (as defined by the role). Young parents are not adults – they are young people who have children. It should not be assumed that they have an adult's understanding, or an adult's sense of responsibility – having a child does not mean that the young person is psychological developed. They still need the support, care, attention and boundaries that any adolescent and young adult need.

IDENTITY

Encourage the young person to identify something they can do for themselves, that doesn't involve them as a parent

Remember that although they are parents, young people are still developing emotionally and psychologically

Ensure the young person gets some positive feedback

Encourage young people to retain, and use, their supports for respite. Everyone needs time to do their own thing, even if it's just an hour a week

Education and Training

As discussed in previous chapters, it is just as, if not more so, important for young parents to pursue education/training options as other young people. Parenthood (for parents of all ages) can reduce an individual's sense of self from "myself as a person" to just "parent". Continuing to pursue education/training goals is not only beneficial for sense of self, but it also improves longer-term educational/vocational opportunities.

Although in terms of improving outcomes for young parents education is a crucial factor, it may also be something that young parents do not see as being very important on a day-to-day basis when they are too busy trying to survive. In terms of young people who are parenting and have substance use issues, it is also common for them to have a very chequered past in terms of school attendance and engagement. Some of these identified by YPP clients include –

- Previous negative school experiences (bullying/feeling "over disciplined")
- History of truancy and school refusal
- No expectations from their family/peers to attend
- Feeling singled out – particularly if the home situation has made it difficult for them to complete homework or they have been financially unable to afford to attend trips, camps or have basic school supplies/uniform
- Not coping with the highly structured environment and behavioural expectations
- Not feeling engaged due to multiple relocations of the family or moving from placement to placement (either foster care or extended family)

So even though education is crucial in terms of improving long and short-term outcomes, the young person may not even want to return to education.

For those who do want to continue their education, there are impacting issues that can make this incredibly difficult. Although parenting certainly creates issues in terms of time, time management, priorities and finances, working through these to even attend for an hour a week can not only improve the individuals sense of self, but also provides a necessary break from the role of parent. Many TAFE's and training organisations have their own childcare centres, which can be accessed by students. Neighbourhood houses, community centres, city councils and private day care centres are some other options that vary in cost. The demand for childcare places is usually quite high, so enrolling as early as possible should alleviate access issues. If formal childcare is not a feasible option, maybe there are responsible family members or friends that would be able to assist on a regular basis. Both state and federal governments recognise the need for young people and low-income earners to continue their education, so being in receipt of centrelink benefits can significantly reduce fees and associated costs. Different training providers run courses specifically for young people and young parents, and can also offer pastoral support to participants.

EDUCATION

Explore the flexibility of local courses offered by TAFE, schools, neighbourhood houses, RTO's etc. Some may offer day care or flexible hours.

Even if returning to study is not possible at the moment, explore with the young person what their goals are, and how to get there

For pregnant clients who are still at school, talk to the school about ongoing options such as a modified timetable or them posting out schoolwork

Accommodation

Accommodation, or lack thereof, is a huge problem for young people. To make things even more difficult, the factors that lead to homelessness (such as family breakdown, family conflict, unemployment etc.) can also contribute to the development of mental health issues and substance use. Conversely, mental health issues and substance use can lead to homelessness as the young person may have limited finances, coping skills or motivation.

Homelessness in its various forms falls under three categories –

Primary homelessness – People with no accommodation, such as living on the streets, or in squats.

Secondary homelessness – People whose accommodation is not stable or long term – staying with friends, hostels, shelters, and moving frequently.

Tertiary homelessness – people who are living in boarding houses for 13 weeks or longer[12]

Young people, and young parents, fall into all three of these categories. An estimated 4.663 12-18 year olds were homeless on Census night 2001. In Victoria, 35% of the homeless population were aged 12-24, and 13% were children 0-12 accompanying adults[13]. That's nearly every second homeless person in Victoria being under 24 years of age.

Being homeless also makes service provision difficult, as it is more important to the young person to find accommodation (often a few nights at a time) than attend appointments, and the accommodation they find may not be as accessible geographically. Not being able to find a client is certainly a barrier to good service provision, as casework can only be delivered on an opportunistic (and often sporadic) basis. Young people with mental illness, substance abuse issues (or both) can find it very difficult to access housing, as they may not meet the criteria around being in a day program, having independent living skills or self care skills. Many youth housing programs are based on share housing, which also may mot be appropriate due to cross contamination, conflict and criminal activity. Having children, and ensuring that they reside in a safe, protective environment, is another complicating factor, as few programs can cater for children. There are many young people with children who are homeless, and while they may not be sleeping on the street, are staying in places that are not suitable environments for children. Moving around a lot, and residing in other people's accommodation (where the young parent has no real control over the environment) further impacts on their ability to have a routine for the children, which in turn negatively affects the children's behaviour, body clock, moods and stability.

There is a huge demand for youth housing, certainly more than is available. Waiting lists are often long, criteria can be very strict, and places are often out of the young person's preferred area. This alone can lead to the young person being geographically distanced from their support networks and lead to feelings of isolation and loneliness. Private rental can be difficult to obtain, particularly by the client group, as most real estate agents are reticent to lease to young people without references, most of who are dependant on income from centrelink. Sometimes the only option is to explore all of the young person's supports (or potential supports). There may be extended family members or family friends that would be able to accommodate the young person that they had not even considered.

Even if the young person manages to obtain housing, often sustaining it can be just as difficult. Not paying the rent, not maintaining the property and problem visitors/guests are three issues that often lead to eviction. Many young people have no appropriate modelling around maintaining housing. Paying rent or bills are not a priority, and once they get behind, find it difficult if not impossible to catch up. Many new occupants also find themselves supporting several friends, which may lead to noise complaints, property damage and eventual eviction. Monitoring client's accommodation and educating them on the responsibilities inherent to renting/tenanting is an important facet of casework. Few young people can adequately manage their money, so setting up direct debit facilities (such as centerpay) can help them to manage their money effectively, and ensure that they don't fall behind in rent and bills.

There are several accommodation programs aimed specifically at young people, and many of these can accommodate children. Different programs work from different models, so services on offer can range from general support in finding housing to providing actual properties. The accommodation on offer could vary from a share house with staff on site 24 hours to much more independent living. Almost all programs require the young person to actively participate, which may entail attending regular meetings or sessions, personal development/education, accepting certain involvements or remaining in employment or training. Due to the high demand placed on and the nature of these services, the intake and assessment period can be quite intensive. Waiting lists of varying lengths also often apply. Due to different funding provisions and accommodation models, some programs may not be able to accommodate couples. This is particularly evident in crisis accommodation, where availability changes on a daily basis and some facilities cater for only one gender. Most young people have unrealistic expectations regarding housing,

ACCOMMODATION

Discuss with the young person their responsibilities, and work out a budget with them

Organise centrepay to pay rent and utilities if they are on benefits

Many accommodation programs require participants to play an active role even when on the waiting list. Support clients to meet these commitments, as many include living skills development and education

Explore accommodation options they may not have considered, including friends and extended family

Social Relationships

Parenting affects all areas of a young person's life, and social relationships are no exception. Pregnancy often motivates many young people to cease or cut down their substance use, and this can place a huge pressure on relationships – often the young person realises that the only way to cease use is to remove themselves from the peer group. This is especially evident among groups where substance use plays a large part of interaction, and the "drug culture" is firmly established. Totally withdrawing from a primary peer group is an extremely stressful option, and is understandably difficult to do.

Identifying supports and social relationships, discussing how they can be fostered and supporting the young person to access them independently can improve the young person's connectedness and outcomes, as this independent network provides an important role in how well young parent's cope and how they deal with issues.

Young parents tend to include their children in all activities without taking their needs into account. Some activities may not be appropriate for children - maybe because it is late at night or they haven't packed any food; or as can be common with young parents with substance use issues, exposing the kids to criminal activity, drug use and substance related behaviours. The people that the children are exposed and lack of adequate supervision is also of concern – often young parents leave their children in the care of people they do not know well just because it is convenient. Establishing with the young parent which people are responsible and can keep their children safe is important.

Particularly if the young parent has independent accommodation, helping them to develop rules for their house is a proactive means of promoting the health and wellbeing of themselves and their children. An intrinsic part of the substance use culture, particularly for transient young people, is the loyalty to their friends. As accommodation can be sporadic, young people with accommodation often find themselves hosting several of their homeless friends and the residence becomes an "open house" of sorts. In situations like this, the young person has no control over their environment. Encouraging the young parent to assert their right to provide a safe and nurturing environment by making rules (and actually following through with enforcing them) gives them more control over their environment and significantly lowers risk. Strategies such as keeping the doors locked so people can't wander in and out, not necessarily opening the door every time someone comes over can also be effective.

Some rules could include -

- acceptable visiting times (not after 9pm etc.)
- what is not acceptable behaviour
  - swearing
  - drug use in/around the house
  - dealing
  - criminal activity
  - fighting etc.
- who is and isn't allowed at the residence
- not allowing people to bring their friends/acquaintances etc. over
- who is and isn't allowed to stay

Using the networks available for young and new parents is another way to increase the young person's supports and number of social relationships. Joining a local young parent's group, crèche or other parent specific group is a good way to meet others going through the same stuff, and who are able to offer friendship and support in an informal way. Help the young person to find one they are comfortable in, as many young parents feel judged and uncomfortable, and prefer a youth – specific service.

SOCIAL RELATIONSHIPS

Encourage the young person to maintain social links

Support the young person to access leisure and recreational options. Increase their connectedness

Help the young person to identify peers that are supportive/not supportive, safe/not safe etc, and how this fits into keeping their children safe.

Discuss ways the young person can build their networks to include their children

Family Relationships

The relationship between young substance using parents and their families is often complex and conflictual. If they have a history of statutory involvement, the connection with their family may be limited due to a history of trauma and abuse, or removal from the family. A common thread for many YPP clients is that from early adolescence their peer group has taken on a pseudo family role. Often families have not been protective, supportive or nurturing, and the young person has had a large amount of independence and autonomy from an early age. When they go on to have children, the young parents have had very little positive modelling from family, and have gained most of their parenting knowledge and ability from peers.

Although family may not have provided a safe, nurturing environment to the young person, they are still an important facet of their lives. Often there may have been many years of disjointed contact – where the young person has been alternatively accepted and rejected by their family. Parents may have chosen a partner over the young person, or there may be conflict between the new partner and young person. Another common issue is of parents who endow their children with adult responsibilities and autonomy, and cease actively parenting when the young person is not emotionally or developmentally mature enough to take on these tasks. This is often compounded by the parents having unreasonable adult expectations of the young person, and holding them accountable for their immature decisions and choices.

When young people have children, this may be the first time that they actively reconnect with their families. Their family may be able to offer valuable support to the young person, or the relationship could continue to be conflictual and issue ridden. Supporting the young person to exercise self care and preservation when reengaging with their family is an important function, as often there may be unrealistic expectations of both parties. Individuals may assume or believe that other people have changed, or have taken on more role appropriate behaviour. Issues that may have arisen in the past are not always resolved, and can re-emerge.

Young parents need all the constructive support they can get, and the family can be an important source of this. While family members may not fulfil roles the young person expects of them, identifying just what support they are able to provide is a valuable tool. Exploring what the young person wants in the way of support from their family, and then looking at realistically what they can expect can reduce future stress and conflict due to unrealistic expectations. Mum might not be able to perform the function of stereotypical grandmother, but can provide support in other ways. If appropriate, and the young person agrees, involve family members in case planning and decision making. Some parents can be very concerned about their children's substance use coupled with parenting, and play an active and protective function in their lives. Working effectively with them, with the young person's consent, can be an effective case work mechanism. One benefit of this involvement is that the support continues after workers exit. The worker's function in this arrangement is two-fold, in that they are also providing support to the parents. This is a good way of initiating management strategies that can be implemented in the future, and helps the family develop effective approaches to their children's behaviour and situations.

FAMILY R'SHIPS

Encourage the young person to have realistic expectations of the support they can expect from family

If appropriate, involve the family in decision making processes and case planning

Encourage the young person to practice self care and self preservation when dealing with their families. It may be in their best interests to take a step back, or only allow limited involvement

Household

Household management (especially when there are children involved) can be challenging for high functioning, well resourced individuals. One of the main reasons why young people with substance abuse issues are unable to maintain their accommodation (if they are lucky enough to have accessed suitable housing) is they have had no positive role modelling in. Some common reasons young people are evicted are noise, problem behaviour (often by guests, invited or not) and property damage.

Talking to young clients about aspects of household management that many take for granted is a great way of making an informal inventory of their skills and needs. Cleaning, routine, eating well and general organisation are four areas the project has identified are often issues for young people – they may have an understanding of how they think they should be done, but lack the skills and knowledge to adequately execute them. Finding out what they think is actually involved in cleaning a house/good nutrition/appropriate bed times (instead of assuming that everyone knows how to clean a toilet/prepare a nutritious meal/get a child to bed before midnight) Changing their perception of these tasks also is very important – instead of seeing these tasks as "things to get around to" (i.e. – reactive), getting organised and having a routine can make things easier for them (proactive). This can be a difficult switch for young people to make, especially as many have a lifetime's experience in being reactive instead of proactive. Breaking tasks down into manageable chunks also minimises the overload factor – instead of talking about cleaning the whole house once a week (which is overwhelming for most people!) designate a task (or room) a day. Small baby steps are a lot more achievable.

HOUSEHOLD

Discuss the young person's knowledge around cooking and other household management skills

Break down big jobs into smaller tasks

Talk to the young person about making the house child safe. This includes things like cupboards, drawers, medicine, weapons, substances and paraphernalia

Encourage them to make house rules around visitors (both long and short term), noise and behaviour, and follow through with them

Finances

One of the main ongoing issues for young parents (and most families) is managing finances. Most participants are reliant solely on centrelink benefits. Budgeting on such a limited income is difficult at the best of times, but even more so if the young person has limited maths comprehension and an already chaotic lifestyle. A common issue in the substance using cohort is that often payments are spent within a day or two of receipt, spent either paying back money already owed, or lending to peers. The young person may not have had positive financial role modelling, or be firmly stuck in the "I'll have fun today, and worry about tomorrow later" mindset.

Encouraging young people to pay for essentials first can assist in maintaining their accommodation, utilities and household necessities, such as food. Organising centrepay from their centrelink allowance is a great way of doing this – rent, bills etc. are paid automatically every pay day. Knowing where and how to shop, and what to buy when you are there is also important. In terms of grocery shopping, bills can be significantly reduced by purchasing home brand items and staying away from pre packaged food. A bit of investigation can save heaps of money on whitegoods, baby stuff, household goods and clothes. Shopping around and buying things when they are on special are also ways of saving money. Other things can be put on layby, which breaks up the cost into more manageable amounts. Ebay, op shops, the classifieds, the Trading Post and discount retailers are all great options to investigate.

FINANCES

Organise centrepay to pay rent and bills

Draw up a budget. Make it realistic, or it won't work

Refer to a financial counsellor. They have some great ideas about money management, and can help if young people get into debt

Investigate cheaper options for household goods, clothes, food etc. Some places offer great discounts

Show the young person how to "smart" food shop.

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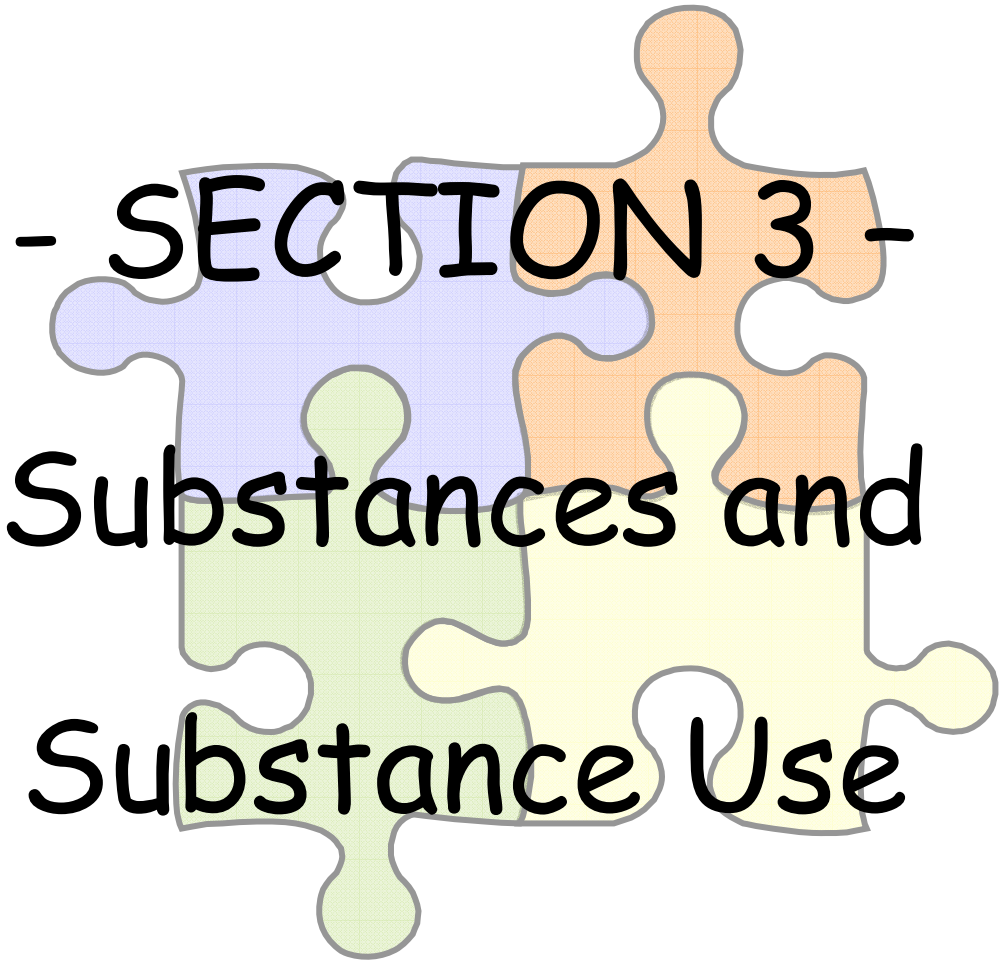

- SECTION 3 -

Substances and Substance Use

INTRODUCTION

Substance use is an issue that, despite increasing expenditure on drug prevention, has escalated markedly particularly in the last 40 years. An example of this is that 3% of people born between 1940 and 1954 had used cannabis by age 21, compared to 59% of people born between 1975 and 1979[1].

In terms of parenting, substance use directly impacts an individual's capacity to care for a baby or small child. This occurs on multiple levels – purchasing substances affects finances; being substance affected impacts on attention, patience, alertness and responsiveness; the lifestyle affects routine, etc. etc.

Prenatal exposure to substances has far reaching and ultimately a negative impact on the foetus. These can include the cognitive, academic, speech, and language delays, as well as the better-known physical and intellectual delays.[2] These negative influences can are also impacted by the ongoing role the environment plays on the child's development. If the mother has not ceased substance use during pregnancy, it will probably continue after the birth, and the negative implications of this include impaired parenting, ability to provide adequate nutrition (including breast milk), lowered levels of stimulation and interaction and impaired bonding. So whether the effects are the result of nature or nurture, the result of these is a very tangible negative effect on the baby's physical, cognitive and psychosocial development.

The following table details effects of prenatal and environmental parental illicit drug use on children, as found via several studies. It is important to note that these effects are only ones documented thus far, and the full longitudinal effect of illicit drug use has not been fully explored.

Figure 10 – Illicit Drug Use and the Effect on Children Pre and Post Birth

	Prenatal Exposure (Pre Birth)	*Environmental Factors (Post Birth)*
Physical	• Increased risk of SIDS • Increased risk of neurological deficits • Underdeveloped muscle tone • Poor reflexes • Trembling hands • More special needs in physical development • Persisting delays in gross and fine motor development	• Increased risk of motor development delay, possibly due to decreased stimulation and appropriate play • (Can lead to poor self esteem and lack of self confidence)
Cognitive	• Below average range in cognitive functioning • Lower IQ and attention span • Difficulties with articulation, identifying pictures and expressive language • Lowered hand/eye coordination abilities • Higher levels of learning difficulties	• Difficulties with academic achievement • Negative impact on speech development • Alters self concept • Fear that they will have D & A issues like parents
Psychosocial	• Difficulty interacting with peers • Became quickly frustrated • Resist attaching to new adults and peers • Increased impulsivity and antisocial behaviour • Inability to cope with changes to environment and routine • Emotional mood swings • Increased difficulties with group interactions and instructional environments • Difficulty initiating independent play • Lowered self esteem • Irritability	• Affects the way children think, interact and feel about themselves, others and society • Negative effect on social and emotional skills • Develop anti social behaviours as a survival skill • High levels of inner tension • Feelings of hostility and depression • Difficulty trusting others • Difficulty with interpersonal relationships • Fear of abandonment • Separation anxiety • Fear of losing parent/carer • Fear of being left alone • Collecting and hoarding food • Intense fear of sirens and police • Inappropriate sexualised behaviour • Sleeping difficulties • Aggression towards other children and adults • Post traumatic stress disorder • Bedwetting • Parentification (where the child takes on the role of parent)

Harm does not result just from the effects of drugs, but also the interactions between the drug, the individual and the environment.

Substance abuse is defined in DSM-IV-TR as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12 month period –

- Failure to fulfil major role obligations
- Use in situations in which it is physically hazardous
- Recurrent substance related legal problems
- Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance [3]

CLASSES OF DRUGS

Drugs (including alcohol) are divided into classes depending on what their effect is on the Central Nervous System (CNS). The three classes are –

- *Depressants*
- *Stimulants*
- *Hallucinogens*

Depressants slow down the central nervous system – i.e. – breathing, heart rate, metabolic rate. Typical depressants are alcohol, tranquillisers, opiates, cannabis and inhalants.

Stimulants speed up the central nervous system – the heart rate and breathing speed up, blood pressure rises and metabolism increases. Stimulants include tobacco, caffeine, amphetamines, cocaine and MDMA.

Hallucinogens change the way information is processed by the brain. Users may report seeing music or tasting colours and hallucinating. Hallucinogens include LSD, magic mushrooms and certain doses of cannabis.

Poly substance users can place themselves at a greater risk than single substance users because of the interaction between the drugs on their central nervous system. This effect can often be more severe than either drug on its own.

These interactions fall into three categories –

Addition – an interaction that involves the sum total of the effects of both drugs (using a mixture of depressants/stimulants or hallucinogens)

Potentiation – the interactions resulting in a response greater than the combined effects of the original drugs (using either depressants or stimulants)

Antagonism – when the taking of one drug inhibits the effect of another. For example, administering Narcan to overcome a heroin overdose.

Using two depressants (such as alcohol and tranquillisers) has a potentiation effect - a much larger depressant effect on the CNS that can lead to respiratory failure. The opposite can occur if two stimulants are used (i.e. - ecstasy and speed) the CNS can speed up to an unmanageable level. Using two different types of substance (a depressant and a stimulant etc.) is still risk taking behaviour, but is much safer than using two depressants or stimulants. It is important to educate users on these interactions, and encourage them to exercise harm minimisation strategies in relation to substances used concurrently.

ROUTES OF ADMINISTRATION

Most substances can be administered in different ways. How a substance is taken has a direct effect on how quickly it is absorbed by the body, and subsequently, the length and degree of intoxication. Common routes include –

- ingestion (alcohol, pills, tablets, mixed with food)
- intravenous (heroin, speed)
- sniffing (cocaine)
- smoking (cannabis, tobacco)
- inhalation (chroming, petrol sniffing)
- anal insertion (suppositories – some amphetamines, cocaine)

Administering intravenously and via inhalation, sniffing and smoking will have a more immediate effect than if a substance is introduced via ingestion or anal suppository as it enters the blood stream/airways almost immediately. For example, the duration of action for crack when smoked is ½ - 2 hours, compared to 1/4-1/2 hour if snorted.

DRUG TOLERANCE

Drug tolerance is when the user needs increasing doses to achieve the desired effect. There are four types of tolerance –

Pharmokinetic
The presence of a drug in the blood stream causes the liver to produce enzymes used to metabolise the substance. Through use, the body becomes more efficient at this, and more of the substance is required to gain desired effect.

Pharmacodynamic
Receptors in the brain respond to the continued presence of a drug by either increasing in number or reducing their sensitivity to the substance. Again, more substance is required for the user to be effected.

Behavioural
If a user has been using a particular substance for a period of time, they can get used to dealing with the effects. Additionally, tolerance is greater in the environment where the habit was developed. This suggests that people are more at risk of overdose in unfamiliar surroundings.

Cross Tolerance
If a user has developed a tolerance to one drug, they will also have an increased tolerance to other drugs in its class. An example of this would be that a heroin user would also have an increased tolerance to pethidine and opium.[4]

An important factor to consider in relation to tolerance is that it can change drastically in certain circumstances, and this must be taken into account. The risk of overdose can increase exponentially if these factors are not considered. These factors can include –

- Losing weight
- Not using for a period of time
- Being on a methadone program

This point is clearly illustrated by how a person's alcohol tolerance is lowered after they have lost weight, and the incidence of overdose in heroin users who inject the same amount they were using after a break as they did before.

HARM MINIMISATION

Harm minimisation is the official policy concept underpinning national and state public health strategies in relation to drug use. It has three principles –

- Supply reduction – reducing the production and distribution and consumption of drugs
- Demand Reduction – reducing the demand, and therefore consumption via drug education, health promotion programs and other strategies
- Harm Reduction – reducing the risks associated with drug use, without necessarily reducing consumption.[5]

Whilst supply and demand reduction is more of an organisational approach (police, harm reduction is more street level, based on providing resources and education. Harm reduction focuses on minimising risk to drug users, rather than preventing them from using drugs. Some harm reduction programs include needle and syringe exchanges, methadone/buprenorphine, and peer education.

The five main sources of harm resulting from substance use are –

- Acquisition – actually getting the substances
- Administration – how you take the substances can be risky – IV use, chroming with a garbage bag etc.,
- Intoxication – what the substances do to your body and brain while using
- Behaviour associated with intoxication – increased risk taking behaviour, aggression, clumsiness etc.
- Withdrawal – the physical and mental process of withdrawal

Harm reduction strategies can be developed to cover all of these points, and aims to reduce the level of risk posed by substance use, and increase the user's safety and wellbeing. The three main principles that underpin all harm reduction strategies are –

- For users not to be alone when they are using alcohol or drugs, and ensure that medical assistance can be contacted if required
- If substance affected, be with people you trust
- Do not use substances in an environment that may be dangerous if intoxicated (railway tracks, roofs, waterways etc

STAGES OF USE

Substance use, and the motivation and pattern of use, differs depending on the user. Classifying use patterns is important in the identification of the problem and method of dealing with levels of use. Essentially, the stage that the client is in will dictate which strategies will be used in their Individual Treatment Plan and casework.

The framework used by YSAS to categorise young people's dependence, is Prochaska and Di Clemente's "Stages of Change" (1986)[6]. In this framework, the worker looks at the young person's substance use history, motivation to use, motivation to cease use and other impacting factors to classify them into six categories. As well as classification, the worker encourages clients to move through the stages of the model. These categories, and their relationship with each other, are set out below.

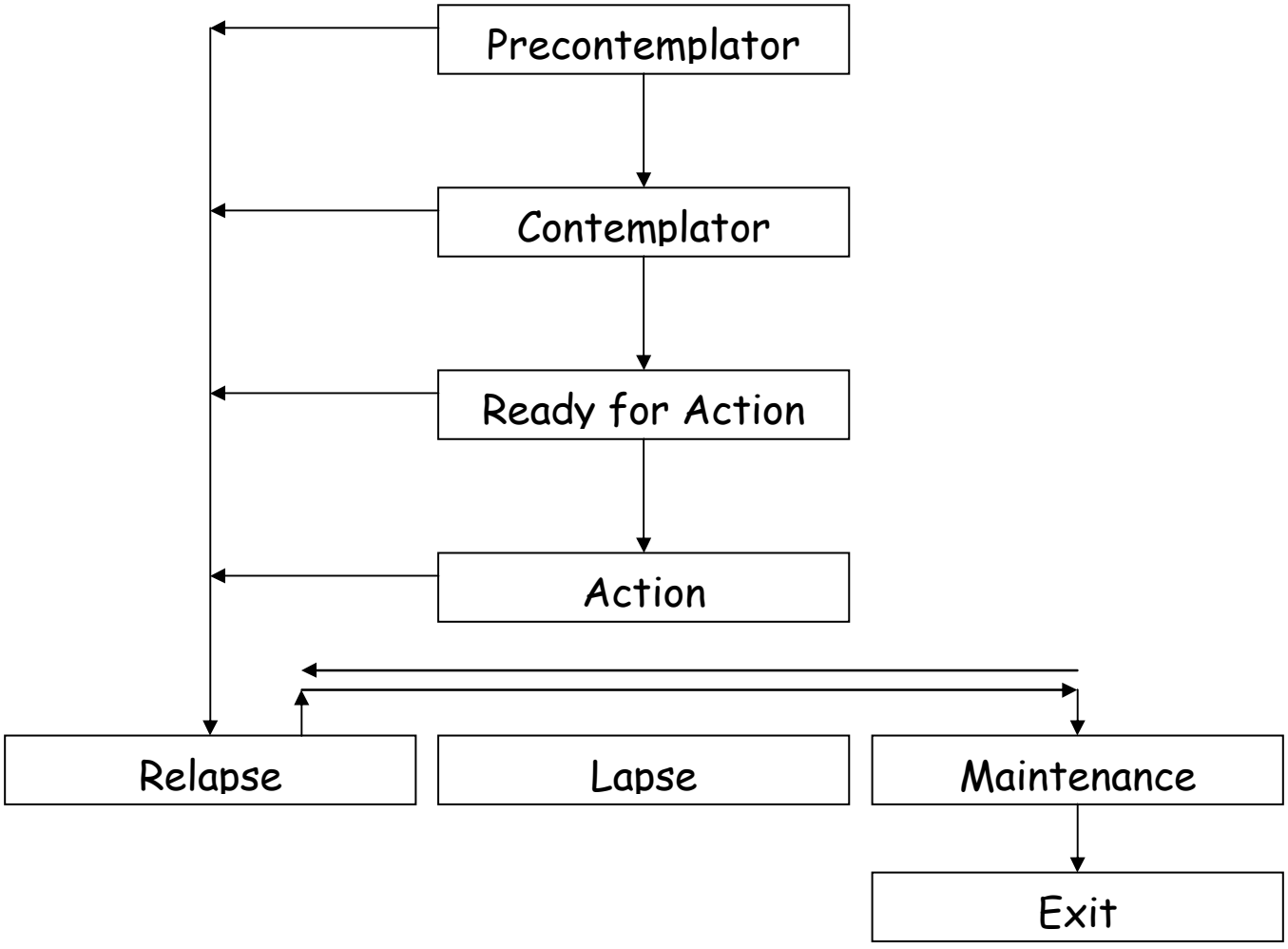

Figure 11 – Stages of Use

Precontemplator
Precontemplative users are happy with their level of use. They discount other's beliefs and opinions about their use, and are unconcerned about any potential negative affects. The positives of their behaviour outweigh any negatives.

Casework for a young person at this stage would include education, harm reduction strategies, awareness raising, and establishing the worker/service as somewhere the young person can engage with if their substance use becomes a problem to them in the future.

Contemplator
A contemplative user is aware that the negative consequences are outweighing the positives, and their substance use is starting to impact on them achieving their goals. They can be quite ambivalent about their level of use.

Casework strategies will include harm reduction, education, and discussions around the positives and negatives of substance use. Contemplators may stay in this stage for extended periods of time.

Ready for Action
If a young person is ready for action, they are aware that with their substance use, the negatives clearly outweigh the positives. They believe that change is necessary.

Strategies used in "ready for action" clients are giving the client education and options on how they can reduce/stop their use so they can make an informed choice. It is important that these options be available to the young person – if they decide on a course of action, and cannot move forward into it, they can regress to the contemplation stage very quickly
.
Action
Young people in the action stage have decided on a course of action, and are actively involved in changing their use. This is a stage where issues that have been previously been masked or suppressed by substance use can arise, and the young person may find that they have a big hole in their life without drugs.

Strategies used include supporting the young person in dealing with their issues, encouraging them to access and participate in other pro-social activities and helping the young person to see the gains they have made. Some young people may go back to the ready for action or contemplative stage after action – workers should reassure the client that they have not failed, and it sometimes takes several attempts to successfully move into the action stage.

Relapse
Relapse is a stage where the young person has ceased substance use, then returned to it. (A lapse is a one off short-term relapse – eg. A weekend binge). The reason the young person returns to substance use may be boredom, high stress levels, etc. Relapse is very common, and the young person should be reassured that they have not failed, and can stop using again.

Tasks during relapse include education, working out plans for high-risk situations, identifying people/places/events that can increase risk of substance use, and discussing positives/negatives of use.

Maintenance

Young people in the maintenance stage have successfully ceased their problem substance use, and have sustained the change for a period of time. They no longer identify as having a substance use issue. People are classed as maintainers for up to five years, by which stage they have totally detached physically and emotionally from old habits.

Casework tasks for young people in the maintenance stage include working out plans for high risk situations, help them deal with stresses that may revert them back to drug use and identify recreational options to help them remain substance free[7].

Figure 12 - A QUICK GUIDE TO SIGNS OF INTOXICATION AND OVERDOSE

Depressants		
Drug	*Intoxication*	*Overdose*
Alcohol	• Slurred Speech • Loss of Inhibitions • Relaxation • Changeable mood • Aggression • Talkative • Effusive	• Nausea • Vomiting • Coma • Slow and shallow breathing • Alcohol poisoning can lead to death
Cannabis	• Red Eyes • Poor concentration • Increased appetite • Relaxation • Short Term memory deficits • Reduced motor coordination	• Confusion • Hallucinations • Anxiety or panic • Detachment from reality • Decreased reaction time • Paranoia
Opiates	• Feelings of wellbeing • Sleepiness • Lack of coordination • Blurred vision • Chatty	• Slow and shallow breathing • Pin point pupils • Blue lips and fingernails • Convulsions • Unresponsiveness
Benzodiazepines	• Feelings of wellbeing • Giggling • Bumping into things • Blurred vision • Excitability	• Unconsciousness • Coma • Slurred speech • Poor coordination • Increased lethality if mixed with alcohol or other drugs
Inhalants	• Red around nose/lips • Paint around nose/lips • Poor concentration • Feelings of invincibility • Vomiting • Paint on hands/clothes • Distinct smell on breath • Thirsty	• Increased risk taking behaviour • Sudden sniffing death • Disorientation • Unconsciousness • Visual distortions • Convulsions

Stimulants		
Drug	*Intoxication*	*Overdose*
Amphetamines	• Restlessness • Decreased appetite • Increased smoking • Excessive sniffing • Increased motor activity (tapping, pacing) • Large pupils • Increased confidence	• Strokes • Heart failure • Seizures • High body temperature
Cocaine	• Self confidence • Busy behaviour • Decreased appetite • Excessive sniffing	• Seizures • Heart attack • Brain Haemorrhage • Kidney failure • Stroke • Repeated convulsions
Ecstasy	• Dilated pupils • Relaxed • Increased feeling of closeness with others • Anxiety and paranoia	• Very high body temperature • High blood pressure • Hallucinations • Elevated heart beat • Heart attack • Brain Haemorrhage

Hallucinogens		
Drug	*Intoxication*	*Overdose*
LSD	• Dilated pupils • Hallucinations • Jaw grinding • Reduced appetite • Stimulated • Anxiety	No deaths have been reported from LSD, but injuries have occurred from increased risk taking behaviour and using LSD in conjunction with other substances

DRUG PROFILES AND EFFECTS

The following tables contain information covering the substance, effects (on the user, pregnancy and breastfeeding), harm minimisation strategies, and intoxication management.

Intoxication management includes strategies that should be used if the young person is presenting as intoxicated. Appropriate medical assistance should be sought at all times if the young person is presenting with symptoms corresponding to overdose. Many young people engage in poly substance use, so symptoms of intoxication may not fall neatly into one substance description. Engaging the young person in dialogue about what they have taken, how much, how long ago and how they are feeling is an important part of assessing their mood, perception, orientation and level of consciousness. These strategies should not be substituted for medical advice and attention.

When dealing with intoxicated clients, always be aware of personal safety and likelihood that the young person may be aggressive, non compliant and confused about what is happening. Consider where you are and who is around when dealing with these situations – responses will differ depending on if you are at the office or in a client's home. Some young people may become agitated when medical assistance is offered or organised. There are significant duties of care issues when dealing with intoxicated (and possibly overdosing) clients, and these should always be weighed up when dealing with any situation. If it is decided that an ambulance will be called and the young person is opposing this, let the dispatcher know that the ambulance may require police accompaniment.

ALCOHOL	
Drug Class	Depressant
Also Known As	Grog, booze, tinnies
Routes of Administration	Ingestion
Duration of Effects	Dependant on amount consumed
Effects on User	
Short Term	
• Slurred speech • Loss of inhibitions • Magnifies moods • Increased risk taking behaviour • Reduced pain and anxiety • Can cause unconsciousness and hangover	
Long Term	
• Can cause damage to heart, brain, central nervous system, pancreas, stomach, liver • Can cause death	
Withdrawal Effects	
• Flushing and sweating • Tremors • Anxiety and sleep disturbances • Headaches • Nausea, vomiting and diarrhoea • Confusion and delirium • Hallucinations • Dehydration	

Effects in Pregnancy and After Birth

Prenatal Effects

- Increased risk of miscarriage and stillbirth
- Premature birth
- Reduced birth size and weight

Infant Effects

- Foetal Alcohol Syndrome
- Foetal Alcohol Effects

General Harm Minimisation Strategies

- Provide information about standard drinks
- Eat before and while drinking
- Avoid shots or rounds
- Alternate alcoholic drinks with non alcoholic drinks
- Drink slowly, and put glass down between sips

Pregnancy Harm Minimisation Strategies

- The foetus is most sensitive to alcohol in the first few weeks after conception and the last trimester, so limit alcohol intake during pregnancy, but particularly during these periods
- Although doctors state there is no safe level of alcohol use during pregnancy, it is thought that having one standard drink infrequently is OK.

Breastfeeding Harm Minimisation Strategies

- The alcohol level in breast milk is the same as the blood alcohol level. Drinking large amounts can change the taste, and potentially decrease infant intake. Do not breastfeed within two hours of having a drink, as neonates' brains are highly sensitive to alcohol, and try not to have more than one standard drink. If you plan on having a big night, express milk beforehand to use.

Intoxication Management Strategies

Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.

Don't engage the client in potentially emotive conversations.

Diffuse any aggressive behaviour.

Don't challenge the client regarding their alcohol use or presentation. This is not the time to address these issues.

Observe for any difficulty breathing

If the client becomes unconscious, put them into the recovery position, check airways, breathing and circulation. Obtain medical assistance if necessary.

CANNABIS	
Drug Class	Depressant
Also Known As	Dope, grass, weed, pot, hash, reefer, herb, mull, buddha, ganja, joint, stick, bucket, cones
Routes of Administration	Ingestion, smoking
Duration of Effects	Up to 5 hours, depending on method of ingestion
Effects on User	
Short Term	
• Relaxation • Laughter • Increased appetite • Loss of concentration • Slowed thinking and reaction time • Decreased balance and coordination • Bloodshot eyes	
Long Term	
• Respiratory complications • Decreases concentration and memory • Increased heart rate • Panic attacks • Can induce psychiatric problems	
Withdrawal Effects	
• Insomnia • Anxiety and restlessness • Irritability • Lethargy • Cravings	

Effects in Pregnancy and after Birth

Prenatal Effects

- Reduced birth size and weight
- Premature birth
- Foetal distress and delivery complications
- Increased risk of neurobiological abnormalities

Infant Effects

- Increased risk of behavioural problems
- Increased risk of delayed development
- Increased risk of illness

General Harm Minimisation Strategies

- Encourage user not to be alone when using
- Develop strategies in relation to decreasing potential anxiety and pains
- Educate user on safer administration routes (eg. – eating rather than smoking)
- Discuss planning use before using

Pregnancy Harm Minimisation Strategies

- Cannabis readily crosses the placenta and can remain in the body for up to three months. There are no known effective harm minimisation strategies

Breastfeeding Harm Minimisation Strategies

- THC (the active ingredient in cannabis) is easily transferred to the baby and can accumulate in the baby's fatty tissue. Therefore, there is no safe level of use.
- Do not smoke around the baby, and keep inside smoke free
- Change clothes, wash hands and wait for at least one hour after smoking before feeding baby. Smoking should be avoided around the baby to reduce the chance of SIDS

Intoxication Management Strategies

Cannabis intoxication resolves itself within ½ an hour to 4 hours.

Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.

Some people exhibit signs of paranoia, anxiousness and auditory/visual hallucinations. Reassure the client and encourage them to relax.

INHALANTS	
Drug Class	Depressant
Also Known As	Chroming, sniff, huff, gas, glue
Routes of Administration	Inhalation
Duration of Effects	Around ½ an hour
Effects on User	
Short Term	
• Feelings of happiness • Relaxation • Drowsiness • Large amounts can cause unconsciousness and sudden death	
Long Term	
• Liver, kidney and brain damage • Risk of suffocation from asphyxiation • Choking on vomit • Can cause hearing loss • Optic atrophy • Nerve cell destruction	
Withdrawal Effects	
• Irritability and depression • Anxiety • Nausea • Dizziness • Tremors	

Effects in Pregnancy and after Birth
Prenatal Effects
• Increased risk of spontaneous abortion • Increased risk of foetal growth retardation • Premature birth • Increased risk of malformations, including cleft palate and microcephaly
Infant Effects
• Increased risk of developmental delays
General Harm Minimisation Strategies
• Encourage user to use smaller plastic bags (so user cant put it over their head) • Use in a well ventilated area • Encourage user not to use alone • Encourage user not to spray inhalant directly into mouth
Pregnancy Harm Minimisation Strategies
• As the active ingredients in volatile substances are fat soluble, they readily cross the placenta. There is no safe level of use while pregnant
Breastfeeding Harm Minimisation Strategies
• Do not use until baby is fed and settled. • Do not use for at least two hours before feeding, and change clothes to ensure baby is not exposed to fumes • Wash hands, face and brush teeth before handling baby to reduce risk

Intoxication Management Strategies

Contain client to a safe area with low stimulation – dim lights, quiet, away from people, etc.

Encourage the client to drink lots of fluids.

Diffuse aggressive behaviour

Do not engage the client in potentially emotive/challenging conversation

Keep the client as calm as possible. Do NOT attempt to physically remove the bag/can, or engage the client in any situation which may lead them to become overstimulated/excited.

Monitor the client's breathing.

If the client falls unconscious, put them in the recovery position and monitor breathing, airways and circulation. Obtain medical assistance if necessary.

OPIOIDS AND OPIATES	
Drug Class	Depressant
Also Known As	Heroin, smack, scag, dope, H, junk, hammer, slow, gear, harry, horse
Routes of Administration	Ingestion, intravenous, smoking, sniffing
Duration of Effects	Injecting – 4-6 hours. Longer if smoked
Effects on User	
Short Term	
• Relief of pain and anxiety • Feelings of wellbeing • Decreased awareness of the outside world • Can cause vomiting, drowsiness, unconsciousness and death	
Long Term	
• High risk of overdose, HIV and hepatitis (if sharing needles) • Respiratory depression and arrest • Nausea • Confusion • Sedation	
Withdrawal Effects	
• Cramps, anxiety, vomiting, insomnia and pain • Yawning, runny eyes and nose • Diarrhoea • Muscle, joint, abdominal and back pain • Flushes and sweating • Dilated pupils • Goosebumps • Feelings of fear	

Effects in Pregnancy and after Birth

Prenatal Effects

- Increased risk of miscarriage or premature labour
- Increased risk of placental insufficiency
- Increased rate of breech presentation and foetal distress
- Increased risk of intrauterine foetal death
- Reduced birth weight and head circumference
- Increased risk of blood borne virus infection

Infant Effects

- Neonatal abstinence syndrome
- Increased risk of SIDS

General Harm Minimisation Strategies

- Encourage user to test for strength and purity
- Encourage user not to use alone
- Educate user about potential of overdose after having Narcan
- Educate user about harms of routes of administration and the impact on personal health

Pregnancy Harm Minimisation Strategies

- Substitution management (i.e. – the prescribing of methadone or buprenorphine) is the safest management of heroin addiction during pregnancy
- If withdrawal from opiates (including methadone) is to be attempted during pregnancy, it should occur during weeks 14-32 under close medical supervision

Breastfeeding Harm Minimisation Strategies

- As with heroin, small amounts of methadone and buprenorphine transfer via breast milk to baby. Your baby will need to be carefully monitored, and weaning should occur slowly as baby might experience mild withdrawal symptoms
- Do not breastfeed if intoxicated or HIV positive

Intoxication Management Strategies

Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.

Intoxication usually resolves in 4-6 hours.

If the client exhibits any of the following symptoms, put them into the recovery position, monitor airways, breathing and circulation and obtain medical assistance -

- Slow and shallow breathing
- Pin point pupils
- Blue lips and fingernails
- Convulsions
- Unresponsiveness

BENZODIAZEPINES	
Drug Class	Depressant
Also Known As	Minor tranquillisers. Brand names (valium, serepax, normison, rohypnol, Librium, mogadon)
Routes of Administration	Ingestion, intravenous, anally
Duration of Effects	Depends on substance used

Effects on User

Short Term

- Relief of anxiety and tension
- Lack of muscle coordination
- Blurred vision and drowsiness
- Lowered inhibitions
- Slowed pulse and breathing
- Lowered blood pressure

Long Term

- Depression and confusion
- Lack of muscle and speech coordination
- Impaired memory, coordination and judgement
- Respiratory depression and arrest

Withdrawal Effects

- Anxiety, tremors, insomnia
- Convulsions, aches, pains and numbness
- Sleep disturbances
- Depression
- Irritability, headaches and dizziness
- Hypersensitivity to noise, light and touch
- Impaired concentration and memory

Effects in Pregnancy and after Birth
Prenatal Effects
• Prenatal effects are unknown
Infant Effects
• Increased risk of respiratory depression • Decreased feeding • Decreased weight gain • Withdrawal symptoms
General Harm Minimisation Strategies
• Encourage user not to use alone • Educate user of risks of poly drug use • Educate user about side effects
Pregnancy Harm Minimisation Strategies
• Benzodiazepines readily pass through the placenta and affect the growth and development of the baby. Take only the prescribed dose • Withdrawal should occur slowly and be under medical supervision
Breastfeeding Harm Minimisation Strategies
• Depending on the dose, benzodiazepines can stay in your system for up to 24 hours. As the active ingredients readily pass into breast milk, it is advisable to formula feed. • May cause sedation and feeding difficulties if used in high or prolonged doses

Intoxication Strategies

Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.

Benzodiazepine intoxication resolves itself

If the client displays any of the following symptoms, place them in the recovery position, monitor airways, breathing and circulation and obtain medical assistance.

- Unconsciousness
- Coma
- Slurred speech
- Poor coordination

There is a chance of increased lethality if mixed with alcohol or other drugs

AMPHETAMINES	
Drug Class	Stimulant
Also Known As	Speed, pep pills, uppers, up, fast, crystal meth, ice, louie, goey, whiz, shabu
Routes of Administration	Ingestion, intravenous, sniffing, anally
Duration of Effects	4-8 hours
Effects on User	
Short Term	
• Increased heart rate and blood pressure • Decreased appetite • Feelings of euphoria and excitement • Increased activity	
Long Term	
• Rapid or irregular heartbeat • Can cause severe mental and emotional disturbances • Aggression • Headaches • Inability to sleep and restlessness	
Withdrawal Effects	
• Crash, exhaustion and depression • Irritability and anxiety • Psychotic phenomena • Depression and mood swings • Large appetite • Sleep disturbances and poor concentration • Cravings	

Effects in Pregnancy and after Birth
Prenatal Effects
• Increased risk of miscarriage • Increased risk of premature labour • Increased risk of placental abruption • Increased risk of foetal distress • Increased risk of limb malformation
Infant Effects
• Neonatal abstinence syndrome • Neonatal drowsiness and irritability
General Harm Minimisation Strategies
• Educate the user about the importance of using in a calm environment • Educate user about having plenty of rest, food and water while coming down • Educate user about potential harm of overuse
Pregnancy Harm Minimisation Strategies
• There are no known harm minimisation strategies for amphetamine use. Amphetamine use while pregnant is not recommended
Breastfeeding Harm Minimisation Strategies
• There are no known harm minimisation strategies for amphetamine use. Amphetamine use while breastfeeding is not recommended, as it causes irritability and disturbed sleep in infants.

Intoxication Strategies

- Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.
- Do not engage the client in emotive/confronting discussions – keep them as calm as possible
- Provide support and reassurance
- Diffuse any aggressive behaviour, and prevent the client from harming themselves or others
- Encourage client to drink water
- If the client develops seizures or a high body temperature, obtain medical assistance.

ECSTASY (MDMA)	
Drug Class	Stimulant
Also Known As	E, eccies, XTC, love drug
Routes of Administration	Ingestion, intravenous, anally
Duration of Effects	7-8 hours
Effects on User	
Short Term	
• Dilated pupils • Grinding teeth • Loss of appetite • Dry mouth • Tachycardia • Hot and cold flushes • Hypothermia • Water intoxication • Euphoria • Increased energy • Feeling close to others	
Long Term	
• Insomnia • Depression • Headaches • Muscle stiffness	
Withdrawal Effects	
• There are no known withdrawal effects	

Effects in Pregnancy and after Birth

Prenatal Effects

- Increased risk of miscarriage

Infant Effects

- There is currently no conclusive research on the effect of ecstasy on babies. It should not be assumed that ecstasy use is safe during pregnancy

General Harm Minimisation Strategies

- Educate user about importance of not overheating or over drinking
- Encourage user not to use alone

Pregnancy Harm Minimisation Strategies

- Ecstasy readily crosses the placenta, so there is no safe level of use or effective harm minimisation strategies

Breastfeeding Harm Minimisation Strategies

- Causes irritability in infants. Long term effects are unknown
- There are currently no effective harm minimisation strategies for ecstasy. Use while breastfeeding is not recommended

Intoxication Strategies

- Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.
- Provide reassurance and support to client
- Encourage client to drink fluids, but ensure intake is no more than 500ml per hour

TOBACCO	
Drug Class	Stimulant
Also Known As	Cigarettes, pipes, smokes, ciggies, butts, darts, fags
Routes of Administration	Inhalation
Duration of Effects	¼ - 2 hours
Effects on User	
Short Term	
• Increased heart rate • Increased blood pressure	
Long Term	
• Heart and lung disease • Cancer • Breathing difficulties • Bronchitis • High blood pressure	
Withdrawal Effects	
• Changes in sleeping patterns • Stomach/bowel disturbances • Cough • Increased appetite • Headaches • Agitation • Concentration loss • Muscle spasms	

Effects in Pregnancy and after Birth
Prenatal Effects
• Increased risk of miscarriage • Increased risk of premature labour • Reduced birth size and weight • Impaired placental function • Reduced foetal growth
Infant Effects
• Increased risk of SIDS • Increased incidence of asthma and respiratory conditions
General Harm Minimisation Strategies
• There is no safe level of smoking.
Pregnancy Harm Minimisation Strategies
• There are no effective harm minimisation strategies for using tobacco during pregnancy. Use is not recommended
Breastfeeding Harm Minimisation Strategies
• Babies are at a higher risk of SIDS if they are exposed to cigarette smoke. To reduce risk, have a smoke free home, and wash hands and change clothes after smoking and before handling baby. • Do not smoke while feeding baby (breast or formula), and wait 30 minutes after having a smoke before breast feeding • Nicotine is transferred via breast milk. High levels can cause vomiting, diarrhoea, irritability and increased heart rate in the baby

COCAINE	
Drug Class	Stimulant
Also Known As	C, coke, flake, snow, dust, white, crack, rock, freebase
Routes of Administration	Sniffing, smoked, snorted
Duration of Effects	Smoking – ½ - 2 hours, snorting – ¼-1/2 hour Injecting – immediate, peaks after a few minutes
Effects on User	
Short Term	
• Feelings of self confidence and power • Increased energy • Decreased appetite • Increased heart rate and blood pressure	
Long Term	
• Loss of concentration and motivation • Dizziness • Aggression • Mental disturbances • Erosion of the septum	
Withdrawal Effects	
• Depression • Intense cravings • Anxiety • Angry outbursts and agitation • Nausea/vomiting • Disturbed sleep and extreme fatigue • Muscle pain and shaking	

Effects in Pregnancy and after Birth

Prenatal Effects

- May cause bleeding
- Increased incidence of miscarriage
- Increased incidence of premature labour
- Stillbirth
- Lowered birth weight

Infant Effects

- May cause long term mental or physical effects
- Small number of foetal abnormalities have been reported (defects to brain, skull, heart, limbs and face)

General Harm Minimisation Strategies

- Educate client about potential health risks and the need to vary injection sites
- Encourage user not to use alone
- Encourage user to alter method of administration
- Educate user to potential side effects

Pregnancy Harm Minimisation Strategies

- Cocaine readily crosses the placenta, so use during pregnancy is not recommended

Breastfeeding Harm Minimisation Strategies

- Cocaine readily passes into breast milk. Can cause vomiting, diarrhoea, irritability and seizures. Long-term effects are unknown.
- There are no effective harm minimisation strategies for using cocaine whilst breastfeeding. Cocaine use is not recommended while breastfeeding.

Intoxication Strategies

- Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.
- Do not engage the client in emotive/confronting discussion
- Diffuse aggressive/violent behaviour
- Client may manifest symptoms associated with mental/emotional disturbances.
- Provide reassurance and support
- If the client becomes unconscious, has seizures, or develops a high body temperature, place them in the recovery position, monitor airways, breathing and circulation and obtain medical assistance

LSD and other HALLUCINOGENS	
Drug Class	Hallucinogen
Also Known As	LSD, acid, trips, tabs, PCP, angel dust, magic mushrooms
Routes of Administration	Ingestion
Duration of Effects	LSD – 10-12 hours PCP – 6 hours to several days
Effects on User	
Short Term	
• Hallucinations • Poor coordination • Paranoia • Sense of relaxation and wellbeing • Distorted body image • Distorted sense of space and time • Intense sensory experiences • Nausea • Panic • Anxiousness	
Long Term	
• Can increase risk of severe mental disturbances and flashbacks • Can impair concentration and memory	
Withdrawal Effects	
• No physical withdrawal symptoms have been observed	

Effects in Pregnancy and after Birth

Prenatal Effects

- Increased risk of complications
- Increased risk of miscarriage

Infant Effects

- Higher incidence of birth defects
- Long term behaviour and neurological effects have been observed

General Harm Minimisation Strategies

- Encourage user to develop strategies to deal with a bad trip
- Educate user on potential side effects
- Encourage user not to use alone or in environments that may be dangerous once intoxicated

Pregnancy Harm Minimisation Strategies

- There are no effective harm minimisation strategies for using hallucinogens whilst pregnant. Use is not recommended

Breastfeeding Harm Minimisation Strategies

Hallucinogens can be quite potent at low doses, and is stored in the fatty tissue of the baby. There are no effective harm minimisation strategies for using hallucinogens whilst breastfeeding

Intoxication Strategies

Place the client in a safe area with low stimulation – dimmed lights, quiet, away from people etc.

INJECTING DRUG USE – RISK AND REALITY

As discussed previously in this section, harm minimisation is an important factor to consider when using substances, particularly when injecting. Information gathered from the National Illicit Drug Reporting System (NIDRS) indicates that the mean age of a user first injecting was 18.14 years, and that the most common substances initially injected are heroin and amphetamines[8].

There are many serious health risks for injecting drug users. Overdose, virus transmission, damaged veins, and bacterial infection are just some of the physical risks of injecting, without taking into account drug induced risk taking behaviour, or impaired personal safety awareness. In some areas, 90% of injecting drug users has hepatitis C[9]. This is particularly concerning when the NIDRS study showed that approximately 25% of intravenous drug users have lent a used needle to another person in the past month, and 15% have borrowed a used needle. Participants in the NIDRS study identified 6 health problems related to their intravenous drug use, and 75% of respondents experienced at least one of these health issues –

Prominent scarring/bruising	-	47%
Difficulty injecting	-	49%
Dirty hit	-	17%
Thrombosis	-	10%
Overdose	-	7%
Abscesses/Infections	-	7%[10]

Other infections (apart from Hepatitis and HIV) include abscesses, cellulitis and septicaemia. Lack of medical intervention can lead to amputation, blood poisoning and vein collapse, deep vein thrombosis and death. Debris in the substance injected can block veins, affect the heart and cause veins to become infected. Utilising harm reduction strategies can reduce the likelihood of injecting problems, virus communication and overdoses, but this is still a high-risk activity.

Some safer injecting techniques….

- Always use a new, sterile needle and syringe
- Wipe down preparation area
- Do not share tourniquets or other equipment
- Put used syringes in a disposal bin (use a plastic container with a screw on lid if you don't have a yellow bin)
- Don't clean up anyone else's blood
- Don't mix your drugs
- Test a small quantity for strength and purity before injecting whole dose
- Vary injection site
- Do not inject into hands or feet – they have small vessels which can become blocked
- Do not inject into groin, as it may cause thrombosis
- If possible, use by another route (orally, smoking etc.)
- Find a safe place to use, and don't do it alone
- Use a pill filter to strain out any impurities
- Use a small gauge needle

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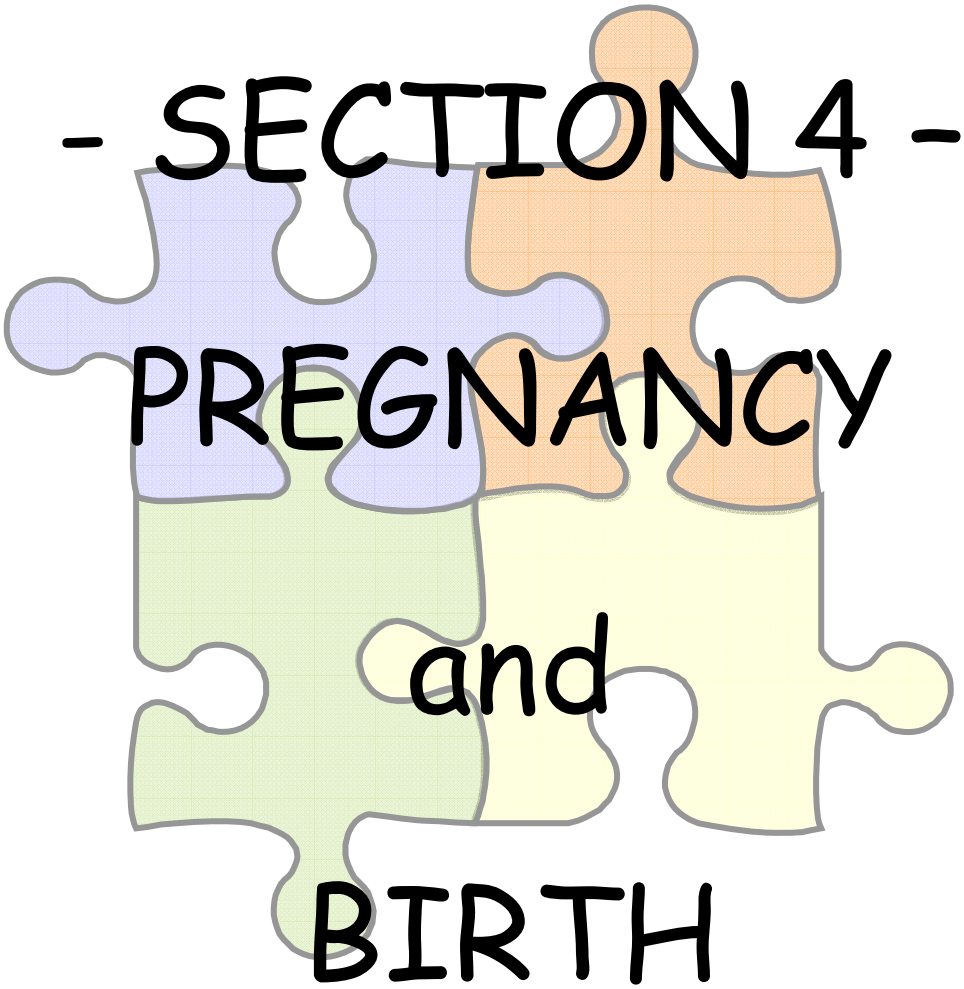

- SECTION 4 -

PREGNANCY

and

BIRTH

PREGNANCY SYMPTOMS

Following conception, the woman's hormone levels change enormously. This can cause the following symptoms. Most women will display at least a few (and sometimes all) of these to varying degrees.

- Missed period
- Morning sickness (nausea)
- Sore breasts
- Tiredness and fatigue
- Frequent urination
- Mood changes
- Food cravings
- Constipation
- Odd metallic taste in mouth
- Going off food
- Genital changes

As many of these symptoms can be caused by other factors (such as illness, stress etc.) it is best to see a GP for a pregnancy test. Many pregnancy tests can detect pregnancy as early as the first day of a missed period, and others from 7-10 days after intercourse. It is also worth noting that "morning sickness" affects 50-66% of all pregnant women, and does not occur just in the morning. It will usually resolve after the first trimester when the hormone levels settle a bit.

PREGNANCY OPTIONS

Once pregnancy is established, there are several options available. These should be explored fully, and the potential parents should be given as much information as possible to ensure an informed choice. Positives and negatives need to be weighed up, and the best interests of the parents and child to be taken into account. The young person may be getting pressure from family, friends, workers, their partner etc. but it is crucial that the final decision is theirs alone.

Depending on how far along the pregnancy is, options may be limited (such as the morning after pill, which is only effective for up to 5 days after intercourse). Pregnancy counselling is available from many agencies (such as Family Planning Victoria).

Deciding not to continue the Pregnancy

Emergency Contraceptive Pill
In the case of unprotected sex or contraception malfunction (such as a condom breaking or a missed contraceptive pill), the Emergency Contraceptive Pill (ECP) can be used. It is available by prescription from general practitioners, and is most effective if used within 72 hours of intercourse, or up to 120 hours (5 days).

Termination
A termination needs to be done quite early in the pregnancy, usually in the first trimester (before 12 weeks). It is usually only a day procedure, where the woman is anaesthetised (either local or general) and a small tube is inserted into the womb and the foetus is sucked out. The physical, mental and emotional aspects of termination need to be explored, and counselling is recommended.

Continuing the Pregnancy

Keeping the Baby
Keeping the baby is a huge decision, especially for a young person. It is important that they are well informed about what parenthood entails, and that they are prepared for this life-changing event.

Adoption/Fostering
Some young women decide to continue the pregnancy, but then foster or adopt their baby out. This option can be chosen when the mother (and father) decides that they may not be ready either physically or mentally to care for a child. There are specific agencies that deal with fostering and adoption. If fostering is chosen, the mother can have ongoing contact with their child via visits etc. In some cases this arrangement can occur with adoption, but it depends on the legal requirements and arrangement with the agency and adoptive parents.

MANAGEMENT OF SUBSTANCE USE DURING PREGNANCY

As discussed in a previous section, substance use during pregnancy can be hazardous for both the mother and the foetus. Most substances are teratogenic (toxic for the foetus), as they readily cross the placenta into the foetus' blood stream. Abstaining from substance use would be the ideal response, but this is not always a realistic expectation. It is important for both the mother and the baby's health that any substance use be discussed with a health professional in the context of the pregnancy. Due to the stigma, illegality and several other factors, many problem substance users do not disclose this information to their health professionals. Doctors will not inform police about illicit drug activities/use, and should be non judgemental about dealing with individuals who display substance use issues. Especially in pregnancy, health professionals need to know all pertinent details that have an impact on patient's health, and it helps to develop a care plan that takes the patient's circumstances into account.

Provide education and information around the impact of substance use on the pregnancy and the importance of if not ceasing, at least reducing their substance use. Harm reduction strategies should be discussed with the young person, and while they may not see cessation as a short term plan, establish what they want to do with their substance use. Some harm reduction strategies that could be implemented (if they aren't already) are -

- Reduce amount used
- Change the route of administration to a less harmful one
- If on heroin, transfer to the methadone or buprenorphine program
- Switch to lower alcohol alternatives
- Adjust using pattern (maybe start later in the day, finish earlier in the evening)

More harm reduction strategies are discussed later in this section.

TESTS AND SCANS

Blood Tests
Blood is removed from arteries in the arm. This should not hurt (but may be uncomfortable) and should only take a few minutes. Blood can be tested for a number of things, and gives a good indication to how your pregnancy is going, and what is happening to your body.

Ultrasound Scans
Ultrasounds use sound waves to see what is happening inside your body. They produce pictures of the baby, and from these pictures the doctor can tell what sex the baby is, how it is developing and be able to detect some potential problems. Some hospitals/radiographers are equipped with newer ultrasound machines which give a three dimensional image.

Vaginal Swabs
Vaginal swabs are conducted to test for Group B Streptococci (GBS) bacteria, which lives in the vagina and anus. A large cotton tip is inserted into the vagina and anus, and this is then tested. You can do these yourself, or they can be conducted by a nurse/midwife/doctor. If you have GBS, you will be given antibiotics during labour to reduce risk to the baby.[1]

Urine Tests
Urine tests are used to detect protein, glucose and other levels. These involve urinating into a cup, which is then tested by the doctor/midwife.

Physical Examinations
During physical examinations, the midwife/doctor will feel your stomach to check where the baby is and how big it is and listen to its heartbeat. Sometimes (depending on what is going on) a vaginal exam may be conducted. A physical examination should not be painful, but may be a little uncomfortable when your stomach is being palpated.

Chlorionic Villus Sampling (CVS)
Conducted in week 10-12, it is like a pap smear. Cells are taken which can be tested for genetic abnormalities such as Down's Syndrome, cystic fibrosis and thalassaemia. Results are usually available in 2-3 weeks.

Amniocentesis
This test is conducted in weeks 14-18. It tests for chromosomal abnormalities, inherited disorders and neural tube defects. A small needle is used to withdraw some fluid from the amniotic sac. Results are available in 3-4 weeks.

Maternal Serum Test
This test is conducted in the 16th-18th week. It tests for neural tube defects and birth defects, and is done via a blood test.

PREGANCY CARE

Many young women who present to YPP have received little or no prenatal care up until this point. Whilst in most cases the pregnancy has been confirmed by a doctor, they have not returned for follow up care. This can be due to a number of factors, but whatever the reason, is concerning due to the health risks it poses to the young person. Even if they have engaged with medical services, few disclose the fact of (or the extent of) their substance use. Many young people are misinformed about the role of statutory bodies such as DHS, and are concerned that these factors will lead to unwanted intervention. Some reasons stated by clients as to why they had not obtained medical intervention were –

Not wanting to be judged because of their pregnancy
Expecting a lower level of care due to their substance use
Not wanting to deal with the pregnancy (don't have the "head space")
No knowledge of appropriate local services
Unsure of whether to continue the pregnancy or not, and not wanting to engage with services until they had made up their mind

There are several hospitals that offer prenatal care for young women, including those that have issues including substance use. These are staffed by approachable, professional staff, who have a high level of commitment to their client group. Some local agencies (such as youth resource centres, community health centres and day programs) also offer midwives and doctors that focus solely on providing quality health care to marginalised groups. These services are usually free, and have the benefit of working from easily accessible (and "youth friendly") premises.

Medical history and involvement is explored in depth in the assessment process of YPP, and options are discussed with the young person. Some young people opt for the "one stop shop" option presented by hospital programs such as the Young Women's Clinic at Monash Medical Centre, and others decide to attend the midwife and doctor at the local youth services and book in with the local hospital. This is up to the individual, and all referrals are fully supported by workers. The worker also plays an active role in facilitating referrals, and will usually attend at least the first appointment with the young person, depending on the level of support required. Pregnancy is a time of immense pressure, stress and fear for the young person, so providing information and reassurance is an important part of casework. Many young people worry about different issues, and may not express these to others, so making information available at all stages and discussing the effects of substance use, what happens in different stages of pregnancy, what will happen during labour and after the birth is crucial. All young people have fears that what they are going through/feeling/what their bodies are doing may not be normal, and exploring their concerns is important for their physical and emotional wellbeing.

For those young people who have had their pregnancy confirmed but are unsure of what to do, or are finding it difficult to comprehend, can often find it easier to ignore the issue or sometimes leave it to a point where they no longer have to make a decision but find it made for them. Continuing a pregnancy just because they felt unable to make a decision, or because they were too concerned about the potential reactions of family/friends/partners often leads to resentment, more fear and feelings of their lives being out of their control. Presenting options at all stages, and going through the positives and negatives of continuing offers them the opportunity to take some control over the situation and their bodies.

Irrespective of the reasons to continue a pregnancy, all young people react differently to the situation. Some immediately take on the maternal role, and begin to nest and prepare for the birth. Others tend not to take an active role, and leave the preparation to the last minute. Many feel overwhelmed by the imminent intense life change, and want to take advantage of the time they have left to be themselves. Pregnancy, and their attitude to the birth and beyond is an individual thing.

NUTRITION DURING PREGNANCY

Nutrition is crucial to good health (as discussed in previous sections) but it is even more important during pregnancy. The young person not only has to provide enough nutrients for herself, but also for the developing baby. A lack of nutrients and kilojoules can cause health problems for both the mother and baby. Nutritional needs also differ, with an increased need for folate, iron, protein, calcium and vitamin C.[2]

Food Group	*Number of Serves*
Bread and Cereals	4-8
Fruit	2
Vegetables	5
Dairy	2-3 (4 when breastfeeding)
Meat	1-2
Extras	1-2

Figure 13 – Recommended Daily Serves of Food Groups during Pregnancy

Nutrient	Eat More
Folate	Dark green leafy vegies (spinach, broccoli, cabbage, asparagus etc.) Legumes (chickpeas, beans) Wholegrain breads and cereals Vegemite, marmite
Iron	Meat Chicken Fish
Protein	Beans Nuts Milk Peanut butter
Calcium	Milk Yoghurt Cheese
Vitamin C	Citrus fruits Broccoli Capsicum Pineapple Strawberries

Figure 14 – How to Eat More Nutrients during Pregnancy

There are also some foods that should not be eaten during pregnancy due to Listeria, a bacteria that can have harmful effects on a pregnancy. Foods that should be avoided include –

- Soft cheese (camembert, brie etc.)
- Pate
- Manufactured meat, including ham
- Packed salads
- Salad bar salads
- Cooked diced chicken
- Soft serve ice cream
- Thick shakes
- Cold and raw seafood (smoked salmon, oysters etc.)

The average weight gain during pregnancy is around 13 kilos. In the first three months, weight gain is around 0-1.5 kg per month, and this increases to around 2 kg per month for the last 6 months of pregnancy. Too little weight gain can lead to low birth weight babies, while too much can lead to high blood pressure and/or gestational diabetes.

WHAT HAPPENS DURING PREGNANCY?

First Trimester

0-12 weeks

The Baby
At 12 weeks, the foetus is around 7 cm long. Its heart started beating at week 5, and all of its internal organs have formed. The hands and feet have developed fingers and toes, and it can swim around. It has vocal cords, can make facial expressions and clench and unclench its fists and hands.

The Mother
The foetus is too small yet to be felt by the mother, even when it is moving around a lot. Morning sickness and tiredness may be an issue. Other effects can be drowsiness and mood changes due to the fluctuating hormone levels. Weight gain should be around 0-1.5 kg per month.

Second Trimester

12-24 weeks

The Baby
At 24 weeks the foetus is around 33 cm long. It can hear muffled sounds from outside the mother, and can open and shut its eyes. The foetus has eyelashes and eyebrows, and the gender can be determined with an ultrasound. The mother can feel when it has hiccoughs, and it is moving around more.

The Mother
The mother will notice that the foetus is moving around a lot. They tend to sleep while the mother is active, and wake up and move around at night and when mum has a rest. Morning sickness should have resolved, and tiredness improved. The mother will notice increased weight gain, and may get swollen ankles and hands due to fluid retention. Discomfort may also be experienced, as the expanding uterus can cause indigestion and constipation. Some women will get varicose veins and haemorrhoids. Weight gain should be around 2kg per month.

Third Trimester

24-40 weeks

The Baby

At 38 weeks, the baby is around 51 cm long. Its body has caught up with its head, and looks more in proportion. The baby breathes amniotic fluid into and out of its lungs. At the start of the trimester, the baby will be in the breech position, where it sits upright in the uterus. In the last weeks, it will spend most of its time asleep, and will usually move into the "head down" position ready for birth.

The Mother

During the last trimester, the baby takes up nearly all the available room in the womb. Moving around, sleeping and sitting can be uncomfortable, and the baby can kick, punch and turn a lot. You may be able to distinguish body parts as they press against the stomach wall. Due to pressure on the bladder, the mother may need to urinate frequently. In later weeks, the mother may experience Braxton-Hicks contractions, which are essentially fake labour pains. Weight gain should be around 2kg per month.

LABOUR and BIRTH

Labour can be one of the most frightening aspects of pregnancy. While many mothers enjoy being pregnant, and look forward to having their children, labour is something that very few actually look forward to. This is mainly due to the pain (and the act of squeezing something so large out of an opening that small). Being prepared will not make the process any less painful, but knowing what is going on, what the stages of labour are and what happens in each stage should take away some of the "fright" value. As the due date draws closer, there will be a lot of movement around the baby. This is a normal part of the baby getting ready for birth, and does not necessarily mean that the birth is imminent.

There are three signs that indicate labour has started. These are –

The Show Appears
The show is a mucous plug that seals up the cervix. For this to be expelled signals that the cervix is stretching and labour will start soon. Occasionally it may be expelled weeks before the real birth.

Waters Break
While in the uterus, the baby is contained in a sac filled with fluid. In the initial stages of labour, the pressure in this sac increases and the sac pops. This may be a sudden gush of fluid or a slow trickle.

Contractions Start
Contractions occur when the uterus starts to contract, and work to push the baby down the birth canal. These can be quite painful, and are usually initially quite irregular. When they are coming regularly every 10 minutes or so, contact the hospital - contractions may start and stop, or be very irregular, and can sometimes go for hours before they regulate and move closer together. .

Many women experience Braxton-Hicks contractions, which are where the uterus contracts at intervals. It is often mistaken for labour, but is in effect only practice for the real thing.

If any of these occur more than three weeks before the baby is due, seek appropriate medical attention.

Labour is divided into three stages, which are defined by the passage of the baby and afterbirth. Attending antenatal classes will prepare most parents-to-be for the labour and birth experience.

First Stage of Labour
The first stage is defined by the cervix (the lower entrance to the uterus) dilating enough for the baby to fit through. The first stage can be the longest, as it can take several hours for the cervix to dilate enough. Pushing is not encouraged during this stage, as the baby cannot pass through the undilated cervix, and this can cause swelling which can impede the process[3].

Second Stage of Labour
At the start of the second stage, the cervix is dilated to 10cm and the uterus and vagina have formed one birth canal. At this stage, the baby is still in the uterus. During the second stage, the pushing begins. This pushing combined with the uterine contractions, act to force the baby out of

the uterus and down the birth canal. When babies reach full term, most are positioned upside down with their head above the cervix - this ensures that the biggest part of the baby (its head) comes out first. Second stage finishes after the birth of the baby.[4]

Third Stage of Labour

The third stage involves the expulsion of the placenta. There may still be some contractions, and some mothers do not even notice that they have passed the placenta. The doctor or midwife will check to see if the placenta is complete (as pieces not expelled can cause complications) and see if any stitches are required. After the birth (and during third stage) the baby is examined and then usually placed with the mother. This assists in the bonding and attachment process.[5]

PAIN MANAGEMENT

There are several pain management alternatives available during labour. Usually these options are discussed during appointments with the medical professional (i.e.- midwife or doctor) during the latter stages of pregnancy. The mother's substance use, both previously and currently, needs to be taken into account when making decisions around the type and method of pain relief. If the mother has used psychostimulants (such as speed, amphetamines etc.) the use of ketamine as an anaesthetising agent should be avoided.[6]

Gas
The gas is a mixture of nitrous oxide and oxygen. It does not take away all the pain, but removes the edge. It is administered via a mask, which you hold yourself.

Pethidine
Pethidine is an opiate that is administered via injection. It can last for 2-4 hours. If it is given within an hour of delivery, it can make the baby sleepy and slow to breathe, but this is reversed by treatment.

Epidural
An epidural is a local anaesthetic injected around the spinal cord. It works well to block pain, and you are still alert. It can make it harder to push during the second stage of labour, and can cause low blood pressure, headaches and backache.

MEDICAL INTERVENTION

During the labour, it may be necessary for the midwife or doctor to perform medical interventions. These should be discussed with your medical professional during the pregnancy, so you understand what they are and why they are done.

Induction
Induction is when labour is started artificially. It may occur for a variety of reasons (such as pre eclampsia or the baby is in distress). It involves the doctor putting a gel near the cervix. The doctor may also put in a drip containing hormones, and break your waters.

Episiotomy
An episiotomy is a cut to the perineum (the piece of skin between the vagina and the anus). It is used to speed up delivery, or prevent the perineum tearing during birth. It is done under a local anaesthetic, and is stitched up after birth.

Vacuum Extraction
A vacuum extraction is used to help the baby move down the birth canal if it is having difficulty. A cup shaped instrument is inserted into the vagina and placed on the baby's head, which creates suction. The doctor is then able to manoeuvre the baby out. The baby may have a red mark where the vacuum was used, but this will heal by itself.

Forceps
Forceps are like a big pair of tongs, and are used for the same reason as a vacuum extraction. They are inserted and placed around the baby's head, and then the baby can be extracted. Like the vacuum extraction, the baby may have red marks where the forceps were used, but these marks resolve by themselves.

Caesarean Section
A caesarean is conducted for various reasons – the baby may be in distress, you are at risk or your pelvis is too small. An incision is made in the abdomen and the baby is removed via this cut. It may result in a longer hospital stay, and can be uncomfortable for a few days.

WHAT TO BUY

While baby stuff can be really expensive, it can be done on a budget. Don't go overboard buying every gadget and device either – these take up space, cost money, and are usually unnecessary. Some good ideas are to –

- Check out the op shops for baby clothes, cots, prams etc.
- Some councils lend out baby car capsules etc. Contact them to see if they can help you out.
- See if you have any friends or family that can "hand down" baby stuff to you
- Don't buy too many baby clothes – babies grow really quickly, and will grow out of most things within weeks!
- Check out ebay
- Use sorbolene cream for moisturising, nappy rash etc. It's really cheap and effective.

So what to buy? Listed below are the "essentials" – things that will definitely be needed.

Clothes

- 6 singlets
- 6 jumpsuits
- 2 cardigans
- a hat
- 6 pairs socks
- 6 bibs
- 4 cotton wraps

Bathing

- Sorbolene cream
- Baby wash
- 6 face washers
- 4 bath towels
- baby nail scissors

Bedding

- Cot mattress
- 2 mattress protectors
- 3 sheet sets

- 4 cot blankets

Changing

- Changing mat (this can be put on a bed/floor etc. if you don't want to purchase a changing table)
- Nappy bin
- Nappies (either disposable or cloth)
- Baby wipes

Other Things

- Baby car seat (check that it meets the safety standards and is fitted properly)
- Pram (it's worth it in the long run to get one that converts into a stroller)
- Cot (This should comply to Australian Standards as well)
- Bottles, nipples and steriliser (if formula feeding)
- Nappy bag (you can use a back pack or any bag large enough)
- Dummies

POTENTIAL PREGNANCY/INFANT COMPLICATIONS

Foetal Alcohol Syndrome/Effects

FAS (Foetal Alcohol Syndrome) is now regarded as the leading (and most preventable) form of non-genetic intellectual handicap[7].

For a diagnosis of FAS, symptoms need to be recorded in each of the following categories –

- Prenatal and or postnatal growth retardation (weight, length, head circumference
- Central Nervous System involvement (neurological abnormality, developmental delay, intellectual impairment)
- Facial abnormalities (with at least two of the following symptoms – head circumference below the third percentile, narrow eye slits, flat and long upper lip, under developed mid face, flattened nose bridge)

Infants who display some of these symptoms, but not enough to constitute a diagnosis of FAS (i.e.- symptoms do not cover all three categories), are diagnosed as having Foetal Alcohol Effects (FAE) / Alcohol Related Birth Defects (ARBD) or Alcohol Related Neurodevelopmental Disorder (ARND).

If the embryo is exposed to alcohol in the first eight weeks after conception, it can result in intellectual impairment while exposure later in the pregnancy may affect growth and behavioural/cognitive development. The mortality rate of infants with FAS is 3.5 times the normal rate.[8]

There is still some controversy over the quantity and frequency of alcohol exposure that is required to produce FAE/FAS/ARND. Exposure to large amounts of alcohol does not always lead FAS. There are a number of other factors that appear to increase the risk. These include –

- Genetic predisposition
- Low socioeconomic status
- Drinking patterns
- Age when started drinking/how long drinking
- Maternal nutrition and health
- Smoking
- Loss of traditional culture

Management of FAS

As the main effects of NAS (other than facial abnormalities and growth retardation) are developmental delay and intellectual impairment, management of this condition will most likely be the same as other children with these issues. Developmental milestones can be reached, but will probably take longer and necessitate more individual attention and stimulation. As FAS occurs while the baby is still in the womb, the symptoms are the end product of damage already done. Apart from more intensive attention, there are no medical interventions that would be effective in

improving or curing this syndrome. Children with symptomatic intellectual and developmental impairments may require ongoing assistance in some areas, such as at school and with independence skills.

Neonatal Abstinence Syndrome

The use of opioids, benzodiazepines, alcohol and barbiturates during pregnancy can cause a withdrawal syndrome in neonates, referred to as NeonatalAbstinence Syndrome (NAS, or Neonatal Withdrawal Syndrome (NWS). It is estimated that approximately 60-90% of babies born to dependant women will be affected by NAS to varying degrees.[9] The severity of NAS depends on the type, dosage and frequency of use of the particular drug/s, and the ability of the neonate to metabolise the particular substance. Symptoms are usually displayed within 24-72 hours after birth, and may last up to several weeks.

Some of the physical symptoms of NAS that an affected baby may display are –

- Irritability
- Hyperactivity
- Hypertonicity (increased muscle tone and rigidity)
- A continuous high pitched cry
- Inability to settle or sleep after feeds
- Excessive sucking
- Poor feeding ability
- Regurgitation and vomiting
- Diarrhoea
- Poor weight gain or weight loss
- Respiratory depression
- Increased pulse and heart rate
- Temperature instability
- Seizures
- Repetitive sneezing, yawning, hiccups
- Increased appetite[10]

Management of NAS

Severity of NAS is scored on a withdrawing-scoring chart and the neonate is medicated accordingly. Medication is weaned off as tolerated, and aims to manage the symptoms of withdrawal to lessen infant distress. This process often necessitates the neonate being placed in a humidicrib, and involves a longer than usual hospital stay. In terms of mother/infant bonding, the first few days and weeks are the most important. It is therefore crucial for the mother or primary caregiver to spend as much time as possible with the baby at the hospital, even if they have already been discharged. Talking with the nurses and midwives about this can assist with the process and ensure that mum is kept up to date with information and progress. It has also been shown that the more time a baby (particularly a withdrawing baby) has with the primary caregiver (in most cases the mother) the faster they recover and better the outcome. Skin to skin contact is preferable, but discuss this with the midwives in the unit.

Babies displaying moderate symptoms will not necessarily require medical intervention, but the symptoms can be managed by using the following strategies –

- The baby should be kept in a low stimuli environment – quiet, dimly lit, soft music and stable, warm temperature
- Swaddling the baby will assist with any tremors and restlessness
- The baby should be handled gently at all times
- Change the nappy frequently
- Use a dummy
- Feed on demand – small amounts frequently will often stay down better
- Change baby's clothes often if they are sweating a lot

As with detoxification for adults, once the symptoms are resolved there should not be any ongoing problems.

Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS) is the sudden and unexpected death of a baby. It is the most common cause of death of babies between 1 month and 1 year old. Most babies who die of SIDS are under six months[11]. The rate of SIDS has dropped by 84% since 1990, due to the introduction of the "Reducing the risk of SIDS" initiative, which give medically endorsed guidelines that minimise the risk. The incidence of SIDS is now only 1 in 2000 babies born, and deaths are more likely to occur during winter than summer[12]. The use of some substances prior to or during pregnancy (such as tobacco and opiates) can lead to a higher rate. If the mother smokes tobacco during pregnancy and after birth, the risk of SIDS doubles, quadrupling if the father smokes as well.

How to reduce the risk of SIDS

- Don't put bumpers, doonas, pillows, soft toys etc. in the cot
- Keep baby's bedroom (ideally the whole house) smoke free
- Settle baby to sleep on it's back
- Make sure baby sleeps with their face uncovered
- Do not let baby sleep in same bed as others (children/adults)
- Never sleep baby on soft mattresses, couches, beanbags or other very soft surfaces
- Make sure covers/sheets etc are not loose in the cot
- Make sure baby is not too hot or too cold

Where baby is placed to sleep in the cot is also important – to reduce risk, the baby should be placed with their feet at the end of the cot, rather than their head. The following diagram illustrates how to do this -

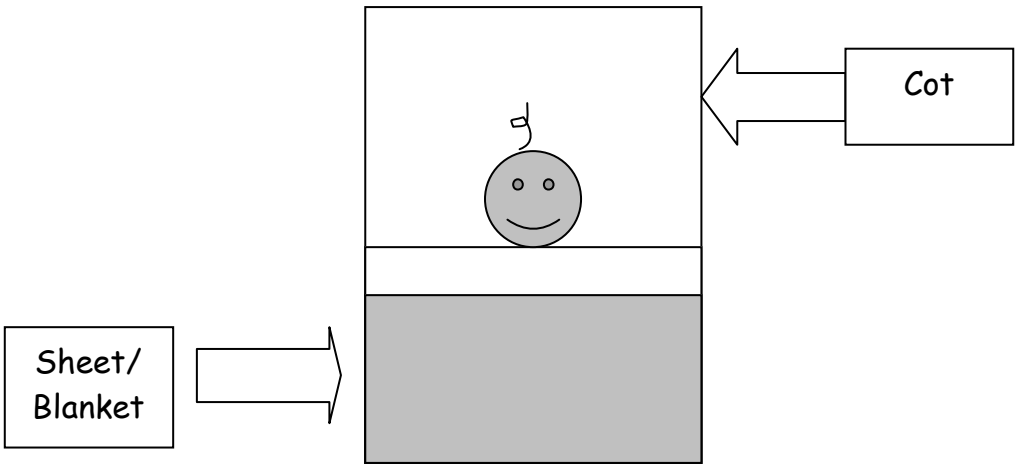

Figure 15 – Correct Settling Positions for SIDS Prevention

SEXUALLY TRANSMITTED INFECTIONS

Incidences of sexually transmitted infection (STI) transmissions dropped dramatically in the late 80's and early 90's (most likely as a response to the AIDS epidemic), but have risen continually since 1995. This is thought to be because of several factors – people are becoming complacent about safe sex; individuals are starting to have sex earlier and more individuals are engaging in high-risk behavior, such as concurrent partners. [13]

Young people, particularly those who engage in high-risk behaviours such as substance use, have a high rate of infection. As young people can be reticent about seeking medical attention, and many individuals do not display any symptoms of infection, the rates of transmission are very high. Many infections are only picked up via routine tests during pregnancy. The table below details how STI's interact with pregnancy and birth.

Figure 16 - STI Interactions with Pregnancy and Birth

Infection	Risks to Mother	Risks to Baby	Method of Transfer
Gonorrhoea	Can result in ectopic pregnancies, and lead to Pelvic Inflammatory Disease (PID) which can cause infertility	Can result in premature birth, stillbirth and eye infections	Can transfer in the birth canal during delivery
Chlamydia	Can result in ectopic pregnancies and Pelvic Inflammatory Disease	Can cause pneumonia, eye infections or blindness	Can transfer in the birth canal during delivery
Trichomoniasis	Can cause fallopian tube damage	Can cause premature birth and low birth weights	Can transfer in the birth canal during delivery
Bacterial Vaginosis		Can cause premature birth and low birth weights	Can transfer in the birth canal during delivery
Syphilis	Can cause miscarriage	Can cause stillbirth and congenital syphilis, which can result in mental and physical problems	Can cross placenta during pregnancy and can transfer in the birth canal during delivery
Human Papilloma Virus (HPV)	Can lead to genital cancer. Warts in birth canal can cause delivery complications	Warts can develop in the baby's throat which will require surgery	Can transfer in the birth canal during delivery, but rare.
Hepatitis B	Can cause significant damage to the liver	Unless treated within an hour of birth, 90% of babies will become a carrier for life	Can transfer in the birth canal during delivery
Herpes	Severe outbreak in the first trimester can cause miscarriage	Foetus is at higher risk if herpes is contracted during pregnancy, and can lead to neonatal herpes	Can transfer in the birth canal during pregnancy, and rarely cross the placenta
Human Immuno deficiency Virus (HIV)	HIV develops into AIDS	HIV develops into AIDS	Can cross the placenta during pregnancy and can transfer in the birth canal during delivery

Hepatitis C

Hepatitis C is a highly infectious, blood born virus that affects the liver. Of all new infections, 90% are the result of the sharing or reuse of drug injecting equipment (syringes etc.) contaminated with infected blood, and 10% result from other risk behaviours which involve blood to blood contact, such as mother to baby transmission, tattooing/piercings and needlestick injuries[14]. Hepatitis C is not classified as a sexually transmitted infection as it is transferred via blood-to-blood contact. It is estimated that between 51-54% of injecting drug users are infected with Hepatitis C.

The risk of transmission from mother to baby (vertical transmission) is around 2%-5%. This is increased if the mother is in an acute phase of hepatitis infection, has serious liver damage or has high levels of the virus in her blood. If the mother is also infected with HIV, the transmission rate increases to 16%.

All babies born to Hepatitis C positive mothers will test antibody positive at birth – within 18 months, 92-95% of babies will clear their mother's antibodies and test negative.[15] Having the antibodies do not mean that the baby has hepatitis C or is immune to it – antibodies are produced by everybody when they are exposed to the hepatitis c virus[16]. There are also levels of the virus in breast milk, but the levels are too low to be thought a transmission risk. Mothers who are Hepatitis C positive can breastfeed safely, but do not feed if nipples are cracked or bleeding, as there may be blood expressed in the milk.

Nutrition also needs to be taken into account when living with Hepatitis C. Eating healthily can –

- Help relieve some of the symptoms (such as nausea)
- Boost the body's immune system
- Provide the necessary nutrients to regenerate liver cells
- Reduce the risk of other diseases[17]

Human Immunodeficiency Virus (HIV) / Acquired Immune Deficiency Syndrome (AIDS)

Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms and infections resulting from damage to the immune system caused by infection from the Human Immunodeficiency Virus (HIV). HIV is transmitted via contact of bodily fluids (blood, semen, vaginal fluid, breast milk or preseminal fluid) with mucous membranes or the bloodstream[18]. This transmission can be caused by unprotected sex, blood transfusions, contaminated syringes, mother to baby (vertical transmission) or contact with infected bodily fluids. The instance of actual transmission depends on the infectiousness of the carrier and the susceptibility of the partner. Sexually transmitted infections (STI's) increase the susceptibility of individuals as they have a detrimental effect on the normal skin barrier (via ulceration or irritation). There is no known cure for HIV or AIDS, but there are treatments that can slow the progression of the condition.

AIDS was first recognised in 1981, since which time around 25 million people have succumbed to the disease. The World Health Organisation (WHO) estimates that approximately 40 million people are currently living with the disease. WHO devised a staging system for HIV sufferers, breaking up the condition into four stages -.

Stage I-	HIV is asymptomatic, and not categorised as AIDS
Stage II-	Includes minor mucocutaneous manifestations and recurrent upper respiratory tract infections
Stage III-	Includes unexplained chronic diarrhoea for longer than a month, severe bacterial infections and pulmonary tuberculosis
Stage IV-	Includes toxoplasmosis of the brain, candidiasis of the oesophagus, trachea, bronchi or lungs and Kaposi's sarcoma. This stage indicates the development of HIV into AIDS.

Without medication, the median time for HIV to develop into AIDS is approximately 9-10 years, with the median survival time after diagnosis of AIDS being 9.2 months. These times are greatly increased when the individual is medicated, but the condition is still ultimately fatal.

Vertical transmission can occur during the last few weeks of pregnancy or during childbirth. Without treatment, the transmission rate is around 25%, but this is reduced to 1% if retroviral treatment is used. Current studies recommend that infected mothers be treated with retroviral medication, have a caesarean section and formula feed to minimise the potential for infecting the baby. It is also recommended that HIV positive mothers should not breastfeed, as this can increase the risk of transmission by 10-15%[19].

The damage that HIV does to the immune system leaves it vulnerable to infections that would not normally present a problem to an individual with a health immune system. Sufferers do not die from the condition itself, but rather from the infections or malignancies that occur because of the compromised immune system. The body is unable to fight bacteria, viruses, fungi or parasites, and there is an elevated risk of developing cancers and opportunistic infections.

Postnatal Depression

Postnatal depression (PND) occurs in the months following childbirth, and usually develops gradually. It is a form of clinical depression, and if left untreated, may last for several months, and recur after subsequent pregnancies. Mild to moderate cases of PNS are sometimes mistaken for the "baby blues", a common and short-lived condition that develops in the days after birth and are related to the mother's hormones being slightly unstable. The baby blues usually resolve naturally as the hormone levels stabilise. PND is the most common psychological complication of childbirth, and affects around 15% of childbearing women. PND is caused by a combination of physical, psychological and social factors. Some identified factors that are associated with an increased risk are –

- A personal history of depression
- Depression during the current pregnancy
- Difficulties in the relationship with the partner
- A lack of practical and emotional support
- An accumulation of stressful life events[20]

Some of the symptoms of PND are:

- Feeling inadequate and a failure as a mother
- Having a sense of hopelessness about the future
- Feeling exhausted, empty, sad and tearful
- Feeling guilty, ashamed or worthless
- Experiencing anxiety or panic
- Fear of the baby
- Fear of being alone or going out
- Insomnia or excessive sleep
- Appetite changes
- Decreased energy and motivation
- Inability to cope with daily routine
- Not looking after personal hygiene
- Ideas about suicide
- Inability to think clearly or make decisions
- Lack of concentration or poor memory[21]

Not all of the symptoms will be evident in any given case of PND, but if the mother is feeling low or has lost pleasure in normal activities and is displaying or feeling four (or more) of the above symptoms for at least two weeks, then it is advisable to seek medical attention as a diagnosis of

clinical depression (PND) is likely. Mothers may feel ashamed about their feelings and be unwilling to seek help, but it is important for their own mental and physical health that they are assessed and treated for PND. PND can cause issues within the family and even relationship breakdown.

After diagnosis, there are several treatment avenues that may be explored. Each case is different, and it may be trial and error to see which combination of therapies is most effective. Some of the options are-

- Counselling
- Psychotherapy
- Group Treatment
- Support Strategies
- Medication

Doctors and other health professionals will be able to provide detailed information and referrals to appropriate practitioners/programs.

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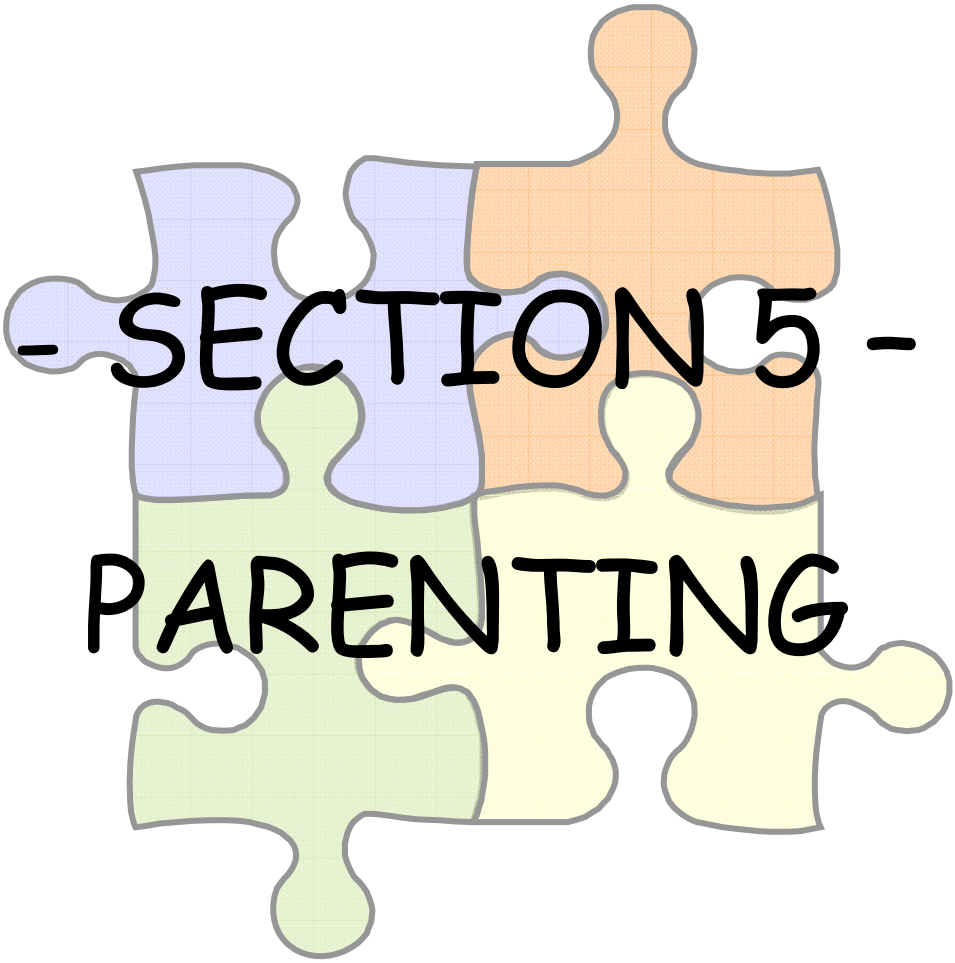


- SECTION 5 -

PARENTING

PARENTING – WHAT IT MEANS TO YOUNG PEOPLE

Having a baby may be the first time in a young parent's life that they have had to think of, and look after someone other than themselves. This is not only dependent on their current developmental stage (as even well adjusted, well supported young people can struggle conceptualising parenthood and the responsibility) but is also compounded by the young person's life experiences. Factors leading to a young person using substances (such as mental health issues, homelessness, family conflict, protective concerns) often result in them being alienated from/not supported by their family, having lowered community connectedness and being less able to access services and support. These factors force the young person to focus on self-preservation and basic needs, rather than other "normal" age appropriate tasks. It is also a common mistake for family/friends/workers to see the young person as an adult (and have adult expectations of them) just because they have a child, and not recognise that they are still developmentally and emotionally immature.

Many young mothers in the YPP program identified that giving birth highlighted the difference from "me" to "us". During the pregnancy, a large amount of positive attention is focused on the mother. This, for many of the client group, was very rewarding. After the birth, the attention switches immediately to the baby. Some mums found this to be really difficult – when paired with the fluctuating hormones, normal baby blues, and sleep deprivation etc, the situation felt overwhelming.

The shift in conceptualisation, from "me" to "us" can be really difficult for many young people. Accepting a baby/child's limitations and focussing on what the child needs rather than what the parent needs is for some really difficult. Having a baby will affect all aspects of their lives – from relationships with their family and peers, to accessing recreation/education options and mobility. Some new parents can have feelings of resentment and frustration about the impact on their lives, but these feelings can resolve once options are explored and new ones present themselves. Babies and children should not totally change the parent's life, but aspects will need adjustment. Discussing with the young person different ways they can still access recreation/training, see friends' etc. can help prepare them for the inevitable changes, rather than overwhelming them. For their own mental health and wellbeing, it is really important for the parents to still have their own pursuits, so they can remain a "person" rather than just a "parent". This will usually require organisation with supports (such as parents, friends, childcare) to help the young parent with regular babysitting or other help.

Another factor that is common with young parents is that they may no longer be in a relationship, if they were in one at all to start with. This can (and often does) lead to a high level of conflict between the parties, as the child may be the only thing that the mother and father have in common. The choice to keep the baby is ultimately up to the mother, and this can lead to feelings of anger and frustration from the father, who may either resent being placed forcibly in a role he does not want, or being excluded from the process if the mother wants to raise the child alone. Young people rarely have the maturity or emotional ability to make these decisions rationally, or see the ongoing impact of their choices.

It is really important for the parents to work out a parenting plan, either formal or informal. A parenting plan, covering the main aspects of parenting tasks, and responsibilities, sets out who does what. Clarifying these issues sooner rather than later, and having roles defined, will hopefully improve the communication and positive interaction between the parents.

PARENTING EXPERIENCES

Most young parent's knowledge and perception of parenting depends solely on their own experiences. There is a common assumption that if someone has a child, they know how to be a parent. Exploring with young parents the concept of parenting, what it means to them and what sort of parent they want to be is invaluable for both their own development and the welfare of their children. Many young parents identify that they don't want to parent like their own parents, but are unsure of what the alternative is. Identifying a parenting role model (this may be a friend or relative, or even someone on TV) and exploring what their idea of an "ideal parent" is can help the young parent to identify characteristics and traits they would like to incorporate into their own parenting method.

Some points that are good to explore are –

- How were you parented?
- How did your parent/s show you they loved you?
- How would you do things differently?
- How were you disciplined when you were a child?
- Would you do things differently?
- What do you want for your children?
- What type of environment would you like them to grow up in?
- Is there something you wanted your parents to do more with you when you were a child? (eg – playing, conversation, hugs/kisses)
- Is there someone you think is a good parent? (friend, relative etc.)
- What do they do that you like?

Frustration, lack of sleep, isolation and responsibility can often lead young parents to lose the "big picture" of their parenting ideals, and get lost in the little things. Taking anger out on the children, seeing their misbehaviour, as a personal attack and having unrealistic expectations are all quite common occurrences for young parents. Developing a support network is extremely important for the short and long term welfare of both parent and child.

PARENTING STYLES

There are countless schools of thought regarding parenting and the best way to bring up children. It is doubtless that all have their relative merits, and that different approaches work in different situations. Most parents will confirm that they have been in receipt of good intentioned (and usually unsolicited) parenting advice offered by everyone from family to strangers on the street. This advice is usually conflicting, and it can be difficult for parents to filter the good advice from the bad. As many young parents are eager to prove themselves as capable, this can often translate to them parenting to meet the expectations of who they are with. For example, the children may be over disciplined at nana's house but allowed to misbehave when visiting friends, as nana has higher expectations of the children's behaviour and the parents' control. This inconsistent approach has a hugely detrimental effect on children's behaviour, as they are never sure what's allowed in any given situation.

A common factor with most young parents who present with substance issues is a chaotic lifestyle. As many clients are not involved in a day program, employment or other regular, structured activity, they often lack a regular routine. While this may not be an issue for the client when they have no children, trying to effectively raise kids with no pattern or routine can be frustrating and difficult. Babies and children need routine to understand their environment, and to know what happens when. Children need regular meals and sleep to regulate their body clocks, and find these processes soothing and comforting. This also extends to activities and people – having people coming and going from the house at all hours of the day and night (as well as posing a potential risk to the health and safety of the child) can be confusing, and the child can find it difficult to form appropriate attachments to people. Living in an environment where they are subjected to irregular, inconsistent meal times, bed times etc. results in the child becoming frustrated, tired, hungry and fussy.

Having a defined parenting style and approach also empowers young parents to take control of their parenting role, rather than relying on unsolicited (and often conflicting) advice, and offer their children consistent boundaries, rules and expectations. Children learn by testing boundaries, and inconsistent expectations and rules lead to inconsistent behaviour. If children know they can get away with something 4 times out of 5, they will continue the behaviour, but if a boundary is consistent they will know after attempt 2 or 3 that this behaviour is not rewarded.

Positive Parenting

Positive Parenting is a program developed by the University of Queensland, aimed at providing a simple, consistent and effective approach to parenting. It is endorsed by the Department of Human Services, and is supported by a range of parenting tip sheets (available via the Victorian Parenting Centre). The approach is appropriate for children of all ages, and is designed to "…promote children's development and manage children's behaviour in a constructive and non-hurtful way."[1] One of the main benefits of this approach is that it is a thorough framework encompassing all aspects of parenting that young people find easy to understand and implement, and encourages them to be consistent when dealing with their children. Positive Parenting is made up of 6 areas of parenting development which are underpinned by 5 key principles

The five key principles are –

Ensuring a Safe, Interesting Environment

- Childproof the children's environment
- Children should be supervised at all times
- Always know where your children are and who they are with
- Teach children personal safety and safety rules
- Provide a stimulating learning/playing environment

Creating a Positive Learning Environment

- Spend time with your children
- Involve them in daily activities
- Use encouragement and positive attention
- Reward good behaviour
- Be available to talk and interact
- Be interested in what your children are doing

Using Assertive Discipline

- Act quickly when children misbehave
- Be consistent when responding to children's bad behaviour
- Teach children how to behave in an acceptable way
- Remain calm when children misbehave
- Avoid name calling, threatening, smacking or yelling
- Use logical, consistent consequences

Having Realistic Expectations

- Don't expect perfect behaviour
- Have realistic expectations of yourself as a parent
- People make mistakes
- Know the developmental stage of your children

Taking Care of Yourself as a Parent

- Well adjusted children need well adjusted parents
- Take care of yourself as a person, as well as a parent

The 4 areas of parenting development are –

Developing a positive relationship with your child

- *Spend quality time with your child* - this involves actually engaging with your child and interacting with them
- *Talk to your child* - involve your child in conversation and encourage them to communicate with you. This encourages your child to develop social, conversational and speech skills.
- *Show* affection – hugging, kissing, touching and holding show children they are loved and cared for. It also helps children to form secure bonds and show affection themselves. Talk to them about appropriate affection (i.e. – with family as compared to strangers).

Encouraging desirable behaviour

- *Use praise* – using praise and positive attention when your child is behaving well encourages them to continue the good behaviour.
- *Give children attention* – a smile, wink, praise, or actively paying attention to your child shows them you are pleased with their behaviour.
- *Give your child engaging activities* – encourage children to play independently by providing activities and toys.

Teaching your child new skills or behaviour

- *Set a good example* – children learn by watching. Setting a good example teaches children what is expected and how to behave.
- *Ask, say, do.* – Use this approach when teaching new skills. Teach one step at a time. For example – making cereal. Ask the child "what do we do first?" if the child does not know, say "first we put the cereal in the bowl". If the child does not understand, do – help them to pour the cereal in the bowl. Repeating processes like this, and encouraging children to participate in the process helps them to learn.

- *Behaviour Charts* – charts are great when encouraging children to practice new behaviours, skills or tasks. It gives children a sense of achievement, and they can see how they are doing. Negotiate the rewards with the child when you start the chart, and make sure that the behaviours are well defined and positive (eg. – staying in own bed all night, speaking nicely).

Managing Misbehaviour

- *Establish Clear Ground Rules* – children need to know what is expected of them and how they should behave. Establish house rules, and make sure they are fair and easy to understand.
- *Using Directed Discussion* – when a child breaks a rule, tell them what they have done wrong, explain why their behaviour is a problem, ask they what they should have done and that they practice the correct behaviour next time.
- *Planned Ignoring* – use planned ignoring for minor problem behaviour such as being silly, whining etc. Kids love all attention (even negative attention), so ignore the child when they are displaying these behaviours. The behaviour may get worse before it gets better (as they try harder to grab your attention). When the child stops the problem behaviour and starts to behave, praise them for being good.
- *Give Clear, Calm Instructions* – to do this, get your child's attention, tell them what to do/what is expected, give them time to cooperate, praise them for cooperating, repeat the instruction if necessary and take action if they don't cooperate.
- *Logical Consequences* – use consistent, logical consequences for bad behaviour. Act straight away. Explain why their behaviour is not acceptable, what you are doing and don't argue the point with them.
- *Quiet Time* – in response to bad behaviour, remove child to a quiet place (usually in the same room as the problem behaviour) explaining why their behaviour is unacceptable. Use quiet time for one minute for each year eg. – 5 minutes for a 5 year old.
- *Time Out* – this is the same process as quiet time, but the child is removed to a quiet room/space where they are alone and there are no stimuli. Using a bathroom or a spare room (not their own bedroom, where there is lots of things to play with) can be effective.

Family survival tips

- *Work as a team*
- *Avoid arguing in front of children*
- *Get support*
- *Have a break*

The main points to remember are –

Be consistent

Establish rules

Keep your children safe

Model good behaviour

Explain consequences

Be clear, calm and firm

Play with and enjoy your children

Parenting is a difficult task, and having plans and strategies to deal with behaviours (as opposed to dealing with each situation in an arbitrary way) can not only help improve children's behaviour, but empower parents to feel in control of the situation.

Another issue that many young (and not so young) parents face is other people disciplining their children. In some instances this is unavoidable – in day care or school settings, the caregivers have a responsibility to address problem behaviour. In terms of friends, family or other people, discussing with them how you deal with certain behaviours can improve the consistency in a child's environment. This may be particularly important if you share care of the children (such as with a partner) or they have regular time with other adults. Agreeing on consequences and rewards can minimise conflict between parties.

Sleep deprivation is another issue that all new parents face – new babies can wake as often as every hour and a half, and it may take an hour or more to settle them back to sleep. Encourage parents to sleep whenever they can – usually this is when the baby is asleep. Getting an hour or two here or there during the day can take the edge off.

Parent self care is also an important facet – all the parenting education in the world is of no comfort when your baby has been screaming for hours and you feel dangerously close to losing control. Having a contingency plan to deal with situations when you are angry, sick, tired or frustrated can reduce risk to the child, and give the parent an opportunity to walk away and regain control. One method of dealing with situations like this is to -

- Put the child somewhere safe (such as a playpen, in their cot etc.)
- Close the door
- Walk away
- Do something you have identified that relaxes you (having a cigarette, having a coffee, ringing a friend etc.)

Parenting is a 24/7 responsibility, and even when using an effective framework can be difficult. There are many community organisations and programs that are available to assist with parenting, behaviour issues, parental support etc. Some of these are listed in the Services Directory section, and others can be located by contacting local information centres, maternal and child health care nurses, doctors and community organisations.

SINGLE PARENTING

A large percentage of YPP clients are single parents. The circumstances leading them to have children did not always occur in a committed relationship, or the relationship may have broken up during the pregnancy or after the children were born. Raising a child as a sole parent is an incredibly daunting prospect, and with already limited supports, can get overwhelmingly hard. Around 90% of single parents are mothers[2]. Due to the 24hour commitment of single parenting, having regular respite is important to factor into a routine. This can range from a few hours at daycare, an afternoon with an appropriate carer to a weekend with grandma. Ideally it needs to be regular and flexible, both to offer an opportunity to be themselves and not just a parent, and a physical break from caring for the kids.

The following points are important for any young parent, but even more so for the single parent –

- Establish a daily and weekly routine that includes some time out for the parent
- Identify all supports and the way in which they act as a support
- Communicate with supports (subject to consent from the young person) and encourage them to actively support the young person
- Develop management plans with the young parent – plan for scenarios that will occur at some stage. These could include for if the young person gets sick, feels they can't cope, feeling out of control, using substances. Who are they going to call? Where do the kids go? How do they keep themselves, and the kids, safe?
- Make a list of contact numbers for crisis services
- Provide the young person with positive feedback about their parenting, and act as a safe sounding board for them

PARENTS WHO DON'T HAVE CUSTODY

Whether it's because of a relationship break-up, losing custody or other reasons, just because the young parent does not have custody doesn't mean they don't want involvement in the children's upbringing. There may be high levels of anxiety and stress around the relationship with their ex-partner, or anger at having had custody taken away, and this often leads young people to display behaviours more challenging than usual. In most cases, it is because the young person feels powerless in the situation, and may forego seeing their children because of the stress it causes them. If they are separated due to the kids being removed, the young person often does not understand the process and legalities of DHS involvement. The resulting anger and hostility is not helpful in reinstating their custodial rights, and only gives further evidence that they may be unsuitable to parent their children at this point in time.

Some other tasks that can assist the young person are -

- Encourage the young person to continue a relationship with their children, and make them the priority.

- Encourage the young person to develop a relationship with the ex-partner (if this is appropriate) and place the importance on the kids, not the issues in the past.

- Discuss ways the young person can be involved in their kid's lives. Regular access, phone calls, letters, regular communication can help develop their relationship

- Encourage the young person to work with DHS if they are involved, rather than against them. In most cases, the ultimate goal for them is to return the child to the parent's care.

ATTACHMENT AND BONDING

One of the most important developmental tasks, and one that can impact on all interpersonal development in an individual's future, is bonding and attachment. The baby starts to bond with the mother as soon as it is put on her chest after birth, and is a process that continues with her, and other primary caregivers, in the period of time following birth and into childhood. How the caregivers interact with the infant, and the environment the infant is reared in, is incredibly important physically, emotionally and psychologically, as the repercussions of trauma and ineffective attachment and bonding can last a lifetime.

Illustrating the importance of effective bonding and attachment, the following table lists some possible negative outcomes if this process is adversely affected.

Nature of caregiver/child adversity	*Manifested as*	*Behavioural problems in child's later development*
Interference with attachment behaviour	Separation from caregiver coupled with poor quality social interactions during the separation and vulnerability on the part of the child	Acute distress syndrome (e.g. – severe psychological reactions during separations)
Conflictual interpersonal relations	Family conflict, caregiver/child disharmony	Conduct disorders in interactions with adults and peers
Lack of meaningful social experiences	Impoverished social environment, little or no social stimulation	Infant/child not meeting intellectual developmental milestones
Insecure early attachment	Caregiver not interacting with or being cold towards infant (especially if infant is displaying behavioural difficulties as result of illness, premature birth and caregiver is not taking this into account with interactions)	Affectionless psychopathology, does not connect or relate well to others. Attachment disorders

Figure 17 - Lasting consequences of Different Types of Adversity in Caregiver/Child Relations during Infancy[3]

In terms of parental substance abuse (and the incidence of Neonatal Abstinence Syndrome), these factors can have a definite detrimental effect on not only caregiver/infant bonding, but also the long-term emotional and intellectual development of the infant. A premature infant (or one suffering NAS) will probably spend some time in a humidicrib or Paediatric Intensive Care Unit, resulting in physical separation of mother and baby. If the mother does not actively spend time with the infant while it is receiving special care, the bonding and attachment process is compromised, and can result in acute distress syndrome and affectionless psychopathology.

These issues affect both the mother/caregiver and infant, which in turn impact upon the other. An infant who is not bonding and attaching will display challenging behaviours such as increased crying and problems settling and feeding. These issues can lead to mothers feeling frustrated, angry and like they are failing as a mother, which can manifest as coldness towards the infant and less interaction. These behaviours then negatively affect the infant, and develop into an unconstructive cycle.

THE IMPORTANCE OF PLAY

One of the most important aspects of parenting (and one that is often neglected) is play! For children, play is crucial for effective socialisation, development, attachment and creativity. Play does not have to be expensive - as many parents will know, children often get more enjoyment out of the wrapping paper and the box it came in than the present. Using things that are already around the house, and encouraging children to use their imagination is a free way of engaging with your children, tiring them out and encouraging their creativity. Children learn things like sharing, counting, movement and expression from playing – the more fun they have, the more they learn!

Many parents underestimate the value of playing, and see it as something that they just don't get around to doing. Getting down on the floor and involving yourself in their activities encourages bonding and close relationships.

Some play ideas are –

- Join a toy library – for a small fee each year, you can borrow heaps of toys – and swap them over when they get boring!

- Save old Tupperware containers and kitchen utensils. Let the kids have their own cupboard and encourage them to play with their stuff while you are cooking.

- Save food boxes (cereal, biscuits etc.) and play shops. This also helps them develop numeracy skills.

- On trips, play games like "count the … (red cars, motorbikes, etc.) It helps pass the time and they don't get so bored.

- Play games like tag, chasey and kick – to – kick to tire kids out. It doesn't matter if you can't kick or run fast – kids are more interested in you participating than how good you are.

- Make everything into a game. Turning chores like getting dressed, cleaning their room and doing the shopping into a competition will make them more cooperative, and hopefully speed up the process. Kids love to "win" and be the fastest – use this to your advantage.

CHILD DEVELOPMENT

Developmental Milestones

Although all children have their own "growing up plan" and will differ from other children of the same age in some respects, generally speaking child development occurs in a fairly standard order. Children may master one set of skills quite early and others quite late, and babies that are the same age may not be able to do the same things. There is little we can do to speed up the developmental processes, but certain conditions can drastically slow developmental processes. Some of these include –

- Lack of stimulation
- Poor diet
- Inadequate health care
- Lack of love and attention

Even if there is no physical neglect or abuse, a lack of stimulation, love, touch and attention can result in a child

As discussed in previous chapters, exposure to illicit substances in utero can affect the physical, emotional and cognitive development of babies and children. Some of these effects may not be evident at birth and only recognised later in development. Some of the behaviours and signs that a baby or child is not developing appropriately are listed under "things that may indicate a developmental delay". These signs should not be used to diagnose or label a child as developmentally delayed, rather be used as a cue for the child to be assessed by a specialist practitioner. If any of these or other behaviours raises concern, consulting your GP, a paediatrician or early childhood professional is highly recommended. An early diagnosis can improve outcomes for these behaviours, and certain issues can be easily rectified by changes to environment, routine or stimuli.

Things you can do

There are many things and activities that you can do with your child to help them develop. Activities listed in this section are designed to stimulate interest, participation and development in the appropriate areas. Children are naturally curious, interested and interactive, so including them in appropriate activities and conversation will provide them with vital stimulation and learning opportunities. Developing social skills is also very important, and children learn from modelling observed behaviour.

Things that may indicate developmental delay

There are certain behaviours (or lack thereof) that can indicate that a child is not developing at the normal rate. Although all children develop differently, it is usually within a fairly standard range. If a child is presenting with these signs, it is always a good idea to consult with a professional, such as a GP, or early intervention worker. Addressing these concerns early can make all the difference, and it may just be a case of providing the child with more stimulation or adjusting their routine.

0-3 Months

Developmental Milestones

- Can lift up head briefly when placed on stomach
- Reacts to sudden movement or noise
- Makes noises
- Can follow a moving object with their eyes
- Can stare at objects
- Smiles when played with
- Grasps small objects if placed in baby's hand
- Blink at bright lights
- Open and shut hands
- Kick legs

Things you can do

- Tummy time – put baby on stomach to strengthen muscles
- Smile and talk to baby often
- Hang a mobile over baby for stimulation and interest
- Move baby from room to room
- Let baby watch people and activities
- Give baby rattles and soft toys

Signs that may indicate a developmental delay

- Unusually floppy or stiff body
- Muscle tone or power is obviously different from one limb to another
- Fingers are always in a tight fist
- Not being startled by noise
- Not watching faces by 2-3 months
- Difficulties feeding (outside normal range)
- Very long periods of crying and settling difficulties

3-6 Months

Developmental Milestones

- Lifts head and chest when placed on stomach
- Tries to roll over
- Sits with some support
- Kicks legs and moves actively when placed on back
- Looks at hands and fingers
- Tries to reach and hold objects
- Seems to know familiar objects and is happy to see them (parent's faces, bottle)
- Makes babbling sounds
- Sometimes laughs and chuckles
- Turns head towards sounds

Things you can do

- Put baby in different positions in cot
- Hold baby in sitting position
- Give baby small toys to play with
- Hold baby in front of mirror
- Talk to baby – copy noises and praise baby
- Interact with baby – talk, sing, play music

Things that may indicate a developmental delay

- Muscle tone or power unusually high or low
- Fingers not extending spontaneously
- Arms and legs held flexed most of the time
- Not following activities with eyes
- Lack of adequate weight gain
- Does not seem to recognise mother/father or other carers
- Shows a lack of interest in surroundings
- Doesn't startle at loud noises
- Doesn't look for where a sound is coming from
- Doesn't vocalise at all

6-9 Months

Developmental Milestones

- Baby can sit unaided
- Can roll from/to stomach and back
- Can creep forward on stomach
- Can rock back and forth on knees
- Can reach for and hold items
- Can put objects in mouth
- Knows strangers from family
- Can feed themselves solids (biscuit/rusks)
- Can respond to own name
- Looks at person speaking
- Begins to play simple games (peek a boo etc.)

What you can do

- Help baby sit up
- Put baby in a playpen with toys
- Introduce finger food (toast, biscuits, banana)
- Talk to baby about what you are doing and name objects
- Play simple games
- Expose baby to different sounds and experiences
- Include baby with your activities. This is important for socialisation

Things that may indicate a developmental delay

- Not smiling or laughing out loud
- Inability to grasp, hold or shake things
- Not reaching for objects and putting them in their mouth
- Not turning to you when you call their name
- Not wanting to try solid foods
- Inability to make range of sounds
- No eye contact
- Not showing pleasure when seeing familiar people
- Seeming not to recognise mother or other carers

9-12 Months

Developmental Milestones

- Pulls self to sitting/standing positions
- Creeps or crawls (this may be backwards at first!)
- Picks things up with thumb and forefingers
- Places objects in and out of containers
- Understands simple words
- Pays attention to simple commands (no, give it to me etc.)
- Copies sounds and words
- Gives affection and love (kisses, hugs)

What you can do

- Tell baby the names of things throughout the day
- Let baby play and explore in a safe environment
- Ask baby to hand you items, and praise them
- Play games (rolling a ball, pat a cake)
- Look at picture books with baby
- Give a lot of love and attention

Things that may indicate a developmental delay

- Doesn't show pleasure in seeing familiar people
- Doesn't show anxiety when separated from main caregiver
- Is not sitting by 9-10 months
- Is not starting to move around
- Is not interested in new objects
- Babbling has not become more complex
- Doesn't babble in 'conversation' with others

1-2 Years

12-15 Months

Developmental Milestones

- Begins to walk by themselves
- Can feed themselves
- Talks nonsense words
- Can play by themselves
- Understands more words

Things you can do

- Walk hand in hand with baby
- Let baby practice climbing and moving around in a safe environment
- Let baby use its own cups, cutlery etc.
- Encourage baby to play with toys, books etc.
- Involve baby in day to day activities
- Talk to baby about things

15-18 Months

Developmental Milestones

- Can walk independently
- Can build with blocks
- Can scribble with crayons
- Can imitate simple words
- Recognises simple objects
- Can imitate actions
- Begins to ask for help

What you can do

- Take toddler on walks
- Colour with toddler
- Read out loud, and give child books
- Get child to point out objects, people etc.
- Let child help you with simple tasks
- Praise child when they tell you they need to be changed

18-24 Months

Developmental Milestones

- Can run, climb stairs and throw a ball overarm
- Improved motor skills – can do simple puzzles
- Uses many words and can tell you about wants/needs
- Knows themselves in the mirror
- Likes music
- Will often say no to requests, certain foods and bedtime

What you can do

- Take child on walks,
- Go to playground
- Give child simple puzzles
- Talk about things with child. Encourage them to name objects
- Allow child to make simple decisions
- Praise child for using bathroom and staying dry
- Do not punish child for toileting accidents
- Provide music and stimulation for your child – other children, interactive DVD's etc.

Things that may indicate a developmental delay (1-2 years)

- Doesn't show awareness of different people
- Doesn't show a preference for familiar people
- Doesn't show separation anxiety
- Isn't walking yet
- Not walking steadily (especially if the child has a limp)
- Isn't babbling often
- Isn't starting to use meaningful words
- Doesn't listen when others are talking to them
- Is still mostly silent when playing
- Isn't able to point to objects when they are named
- Uses signs, grunts or gestures only when they want something

2-3 Years

Developmental Milestones

- Can use up to 50 words
- Become more social and wants to play with other children
- Starts to recognise changes in routine
- Begins to change speech depending on who they are talking with
- May create an imaginary friend
- Interested in how boys and girls are different
- Interested in why people do things
- Asks lots of questions
- Have difficulty distinguishing fantasy from reality
- May have tantrums and be impatient

What you can do

- Read aloud to them and talk about the pictures
- Provide a range of toys and encourage your child to play
- Talk and show an interest in what they are doing
- Give them individual attention whenever you can
- Encourage them to safely explore their world

Things that may indicate a developmental delay

- Frequent tantrums
- Doesn't play with adults or older children
- Doesn't play imagination games
- Is mostly in their own world rather than interacting with others
- Can't run smoothly
- Has a limp
- Is unable to safely climb stairs or on to low furniture
- Is far more active or less active than peers
- Is not yet feeding themselves most of the time
- Is not using words to let others know what they want
- Is not talking clearly enough for the primary caregiver to know what they want

3-4 Years

Developmental Milestones

- Can jump, run, kick a ball etc.
- Can help to dress/undress themselves
- Can speak in short sentences
- Knows some colours, shapes, animals, own name
- Can pay attention to activities for longer periods of time
- Can balance on one foot
- Can ride a tricycle
- Can put shoes on
- Brushes teeth with some help
- Can copy simple shapes and use scissors
- Can repeat nursery rhymes
- Knows difference between 'big' and 'little'
- Plays well with other children
- Start to explore their bodies
- Socialises well, and has independent friendships

What you can do

- Encourage child to dress themselves
- Listen to and talk to your child
- Read simple stories
- Teach body parts
- Let your child use paints, clay etc.
- Praise child for using the toilet
- Put aside time for your child to play with other children
- Praise your child for their efforts
- Take your child to parks, playgrounds.
- Continue to name unfamiliar objects
- Encourage child to explore and play
- Encourage child to tell stories and explain pictures
- Encourage your child's imagination – dress ups, make believe etc.

Things that may indicate a developmental delay

- Doesn't interact with other children or with adults through play
- Is excessively aggressive or withdrawn with other children
- Plays in repetitious, stereotyped ways
- Is less physically capable than other children of the same age
- Doesn't become toilet trained and reliably dry
- Starts wetting again after being dry during the day
- Still speaks unclearly or is not talking in sentences
- Is unable to follow verbal instructions
- Is not talking during play

CHILD HEALTH

After leaving the hospital, the Maternal Child Health Nurse is linked in with the mother. The MCHN monitors the health and development of the baby and how the mother is coping up until the baby's second birthday. Depending on the situation, this service may visit at home, or implement a more intensive service. In assessing how well the mother is coping and parenting, the nurse can refer out to appropriate services or access resources that may assist the family unit.

In addition to the MCHN, parents should have access to medical professionals such as general practitioners for their children

Rather than accessing random doctors clinics, encourage young parents to link in with an appropriate, consistent, doctor or practice. This continuity will hopefully lead to better health outcomes, as general health and medical conditions can be monitored, and a thorough medical history built up.

Keeping the child's yellow book in a safe place is also important – all of their medical information is in it, as well as developmental milestones, immunisation dates and growth information. If some YPP clients are worried they will lose it, workers photocopy the document and keep it in their file.

Because children attract lots of paperwork – medical information, reports etc.- encourage the parent to have a box or file that all child related information can be kept. This information is always required at some stage, and keeping it all in one place (where it won't get lost) is important. Because it can be difficult to keep this information secure if the family unit is transient, keeping the box accessible at another location (such as with a worker, family member etc.) may be a good idea.

Infant/Child Nutrition

Breastfeeding vs. Formula

Although some substances can be transferred to baby via breast milk, the benefits of feeding with breast milk will usually outweigh the detrimental affect of the substance. Breastfeeding encourages a very close bond between mother and baby, and contains certain enzymes and antibodies that help babies' immune systems to develop. The choice to breastfeed or use formula is an individual choice, but options should be discussed with the midwives while in hospital to ensure a well-informed decision. The National Health and Medical Research Council's Dietary Guidelines for Children and Adolescents in Australia specifies that "Exclusive breast feeding to the age of six months gives the best nutritional start to infants"[4]

	Breastfeeding	Formula Feeding
Positives	• It's free • It's always ready • The most nutritious choice • Always the right temperature • Contains immune system - building enzymes and antibodies	• Dad can feed the baby • Mum doesn't have to omit certain foods from her diet • Timing and frequency
Negatives	• Need to express if mother wants to drink alcohol • Timing and frequency • Have to limit caffeine • Can't eat certain foods	• Sterilising • Cost • Needs to be heated

Figure 18 – Positives and Negatives of Breast/Formula Feeding

Some of the Council's other recommendations include -

- Support and encourage exclusive breast feeding up to 6 months of age
- Highlight the importance of introducing complementary foods form 6 months, together with continued breast/formula feeding until 12 months
- If breastfeeding is discontinued before 12 months, choose an appropriate formula, and ensure it is mixed and sterilised properly
- Reduced fat milk should not be given to children under 2 years of age
- Too much cows milk after 12 months can cause iron deficiency[5]

Solids should be introduced at around 6 months. Signs that indicate a baby is ready to try solids are –

- Interested in food eaten by others
- Chewing on things
- More hungry
- Has good control of head and neck when supported to sit up

Food should be pureed or mashed to start with, and solidity increased as the child can tolerate.

Parents should be encouraged to carry age appropriate snacks such as fruit, cut up vegetables, sandwiches, cheese etc. when out and about. This is also a lot cheaper than buying snacks, and can regulate the eating times of children. This has a positive effect on children's behaviour, as most children respond to hunger with grizzly, bad behaviour.

Encourage young parents to plan ahead for their (and their children's) needs for the day - take enough food and drink, and keep enough basic stuff in the kitchen to make a meal or two in case of emergency. Nutrition is important for everyone, and ensuring that their kids are getting enough vitamins and minerals (and not filling them up on sugar and junk food) improves health outcomes.

Dental Health

Good dental health needs to begin even before the first teeth appear. Good teeth are essential for good speech, health, digestion and looks. It is a good idea to get into the habit of wiping baby's mouth out with a soft cloth until their teeth appear, and then brushing them twice daily with a baby toothbrush and paste. When the child is old enough, teach them how to brush their own teeth and limit high sugar snacks. The most important time to brush teeth is before bed, otherwise food sits around the mouth all night and can easily develop into cavities.

It is recommended that children see a dentist just after their first teeth appear. This enables the dentist to discuss and monitor good dental hygiene, and can often pick up problems before they become more serious (and more expensive). As dental health can be an area that is neglected by the young parent, provide education on the benefits of dental care for both themselves and their children, and the impact it has on their general health.

RISK ASSESSMENTS

The Victorian Risk Framework (VRF) provides a framework for assessing a client's immediate needs and risk assessment. It was developed by the Department of Human Services, and provides a thorough process for identifying both the level of immediate safety and future risk for young people. The process involves information collection (from several sources), which is then analysed according to the four key dimensions –

- Severity of believed risk
- Vulnerability of the client to risk
- Likelihood of risk continuing or recurring
- Existing client strengths

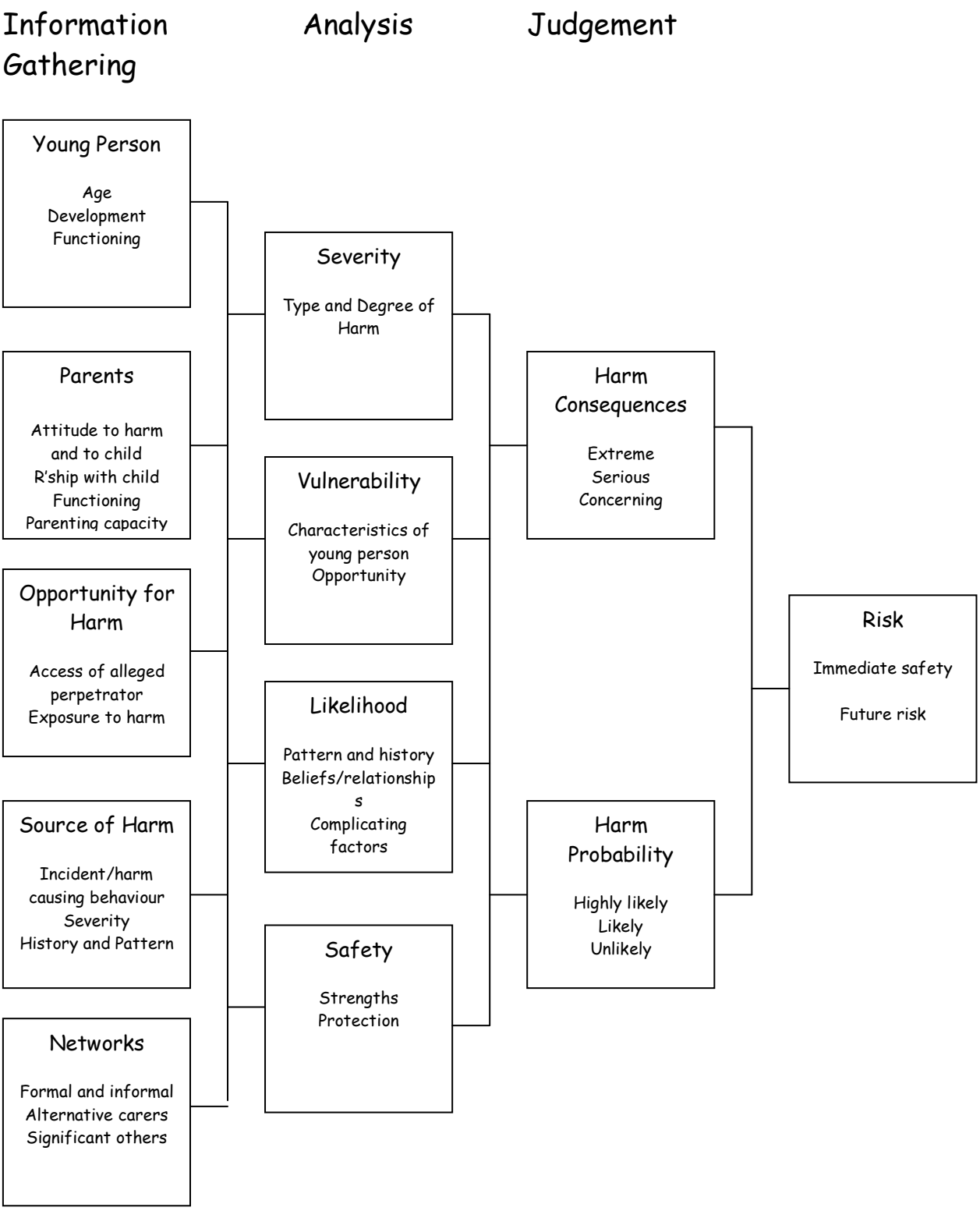
Risk level judgement should evaluate the degree and probability of both the current and potential risk, and take into account actions that are taken to reduce the risk both in the current situation and in the future. The process results in the worker being able to make a decision regarding the level of risk, and implement an appropriate response.

In the context of this client group, risk assessments are valid for both the young parent and their child/ren. Depending on the level of risk, strategies can be put into place to minimise this (but requires the young person/person allocated tasks to cooperate and fulfil their role). More severe risks may require a notification to be placed with the Department of Human Services. Further information on Departmental involvement can be found under Section 5 – Parenting.

Risk assessments, and the reasons why they are being conducted, need to be discussed with the young person at all stages. Clear communication regarding what the worker identifies is a risk, why this is a risk, what can be done about it and who is going to do something about it are all important points. Young parents also need to be able to identify risks for themselves and conduct their own informal risk assessments. Often risks raised by the worker will not have been seen as problematic for the young person.

Raising awareness of risky situations and behaviour can improve safety for both the young person and their children. Most young parents are fiercely protective of their children, and want to keep them safe. Risk education is one way of identifying potential issues and addressing them before they become more serious. For example, young people involved in the drug subculture are often part of a (usually large) loose social group. People may be known only by their first or nicknames, and substance use and criminality are common elements. Many (and in some cases, most) of this group are homeless. If an individual has access to accommodation, there will often be guests coming and going at all hours of the day, and several peers couch surfing. This is a generally accepted facet of the subculture, and members tend to look out for one another – the other members rely on whoever has accommodation, money, drugs etc. For young parents in this culture, they may not be aware of the risk they are placing their children in by having a constant parade of peers through their house. Recognising that virtual strangers in the house, drug use, intoxicated persons and criminal elements can pose a serious risk for the health, safety and wellbeing of children is an important step in keeping them safe.

Figure 19 - Victorian Risk Assessment Framework



DHS INVOLVEMENT

Having DHS involved is one of the most stressful events for any parent. For young parents (many of whom either are, or have had statutory involvement) this fear is further exacerbated by their own or other people's experiences. Most young people regard DHS with a high level of suspicion, resentment and hostility. One of the reasons for this is the loss of power – the power to make decisions directly affecting their family has been removed, and their lives are open for scrutiny in what is a very invasive process. Rather than viewing the involvement as helping them to change maladaptive situations or behaviours, it is seen as criticism, meddling and unwanted attention. Often, parents will not approach or engage with services that may assist them as they assume this will lead to them coming to the attention of DHS.

The instigation of the Mandatory Reporting law has lead to a dramatic increase in the number of notifications to DHS. Putting aside all the negative press and public opinion, the foremost function of DHS is to protect children. An intrinsic part of this is responding to notifications – alerts raised by individuals regarding their concern for the welfare of a child. These notifications are followed up by an investigation process, and depending on the severity of the presenting issues, pursued. This may result in voluntary involvement, an order, an undertaking or withdrawal. This process is detailed below in the flowchart.

If DHS feels that the presenting factors warrant an order being made, they must collect evidence that is then presented at court, and make a recommendation regarding further involvement. The family is also able to retain legal advice, and challenge this process. The magistrate hears both sides, and then makes a judgement regarding the outcome. This may result in an order, warranting ongoing DHS involvement; an undertaking not requiring involvement; or no ongoing involvement. Orders and undertakings are made for a specific length of time (usually 6 months – 2 years). If the family can prove to the court that the child is not at risk anymore, the order can be revoked. For an order to be extended, DHS has to present their case to the court, and again the family have the option of retaining legal representation and opposing this. If an order is about to expire and DHS do not think there are grounds to extend, the order is left to lapse.

For DHS to lodge a court application for a protection order, evidence must be presented in one or more of the six listed grounds –

- That the child has been abandoned by his or her parents, and after reasonable enquiries the parent cannot be found AND no other suitable person can be found who is willing or able to care for the child

- The child's parents are dead or incapacitated and there is no other suitable person willing and able to care for the child

- The child has suffered, or is likely to suffer, significant harm as a result of physical injury and the child's parents have not protected, or are unlikely to protect, the child from harm of that type

- The child has suffered, or is likely to suffer, significant harm as a result of sexual abuse and the child's parents have not protected, or are unlikely to protect, the child from harm of that type

- The child has suffered, or is likely to suffer, emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged and the child's parents have not protected, or are unlikely to protect, the child from harm of that type

- The child's physical development or health has been, or is likely to be, significantly harmed and the child's parents have not provided, or are unlikely to provide, arranged or allowed the provision of, or are unlikely to provide, arrange or allow the provision of, basic care or effective medical, surgical or remedial care

Factors that commonly lead to DHS involvement for the client group are –

- Leaving the children to be cared for by unsuitable persons (risk of physical or sexual abuse, neglect)

- Lack of appropriate supervision (i.e – when substance affected)

- Not obtaining adequate medical care

- Neglect (leaving the child in the cot all day, inadequate nutrition)

- Physical or emotional abuse

- Not providing adequate and safe accommodation

Most of the client group live in constant fear of DHS involvement, and often do not access services (such as medical, for fear of being notified on. Most young people are misinformed about the function and motives of DHS, and what grounds can lead to them becoming involved. As part of the casework process, workers discuss with clients in practical terms what can lead to involvement, and also bring to their attention any areas of concern that the worker may have noticed during the episode of care. This "honesty policy" is discussed with the clients at the assessment and intake stage, where the client is also made aware of the worker's duty of care obligations. The child's health and safety is the number one priority, and if circumstances necessitate the worker making a notification, this is discussed with the client. Discussing grounds that lead to notifications, and the responsibility of the worker to ensure the wellbeing of the child BEFORE any issues arise is an important proactive step.

There are several different orders and undertakings that are can be imposed -

Custody to the Secretary Order
Custody to the Secretary Order (CtoS) is an order granted by a magistrate, usually for a period of 12 months. This order means that the custody of the child has been granted to DHS, and they have the power to decide where the child lives and make day to day decisions regarding their care. The parents still retain legal guardianship of the child.

Custody to Third Party Order
Custody to Third Party Order (CTPO) is an order in which custody of the young person is granted to another person besides parents and DHS (other family member, family friend etc.).

This person has the power to make day-to-day decisions regarding the young person's care, but the parents still retain legal guardianship.

Guardianship to the Secretary Order
A Guardianship to the Secretary (G to S) order is made by a magistrate and grants both custody and guardianship to DHS. This order allows DHS to make all decisions in relation to the young person, such as where they live, permission to travel, which school they attend etc. Guardianship orders are usually made for 12 months, and require all parties to return to court to extend the order.

Interim Protection Order
An Interim Protection Order (IPO) is made by a magistrate, and means that the young person has been placed under the temporary supervision of DHS for a period up to three months. The young person usually lives at home during this time, and DHS will work with the young person and their parents to develop plans to ensure the health and wellbeing of the young person.

Supervised Custody Order
A Supervised Custody Order (SCO) is an order made by a magistrate. It involves a third party (expended family, family friend etc.) having custody of the young person, but the parents retain guardianship. The magistrate believes that there is a good chance of family reunification, and a DHS worker will work with the young person and their family.

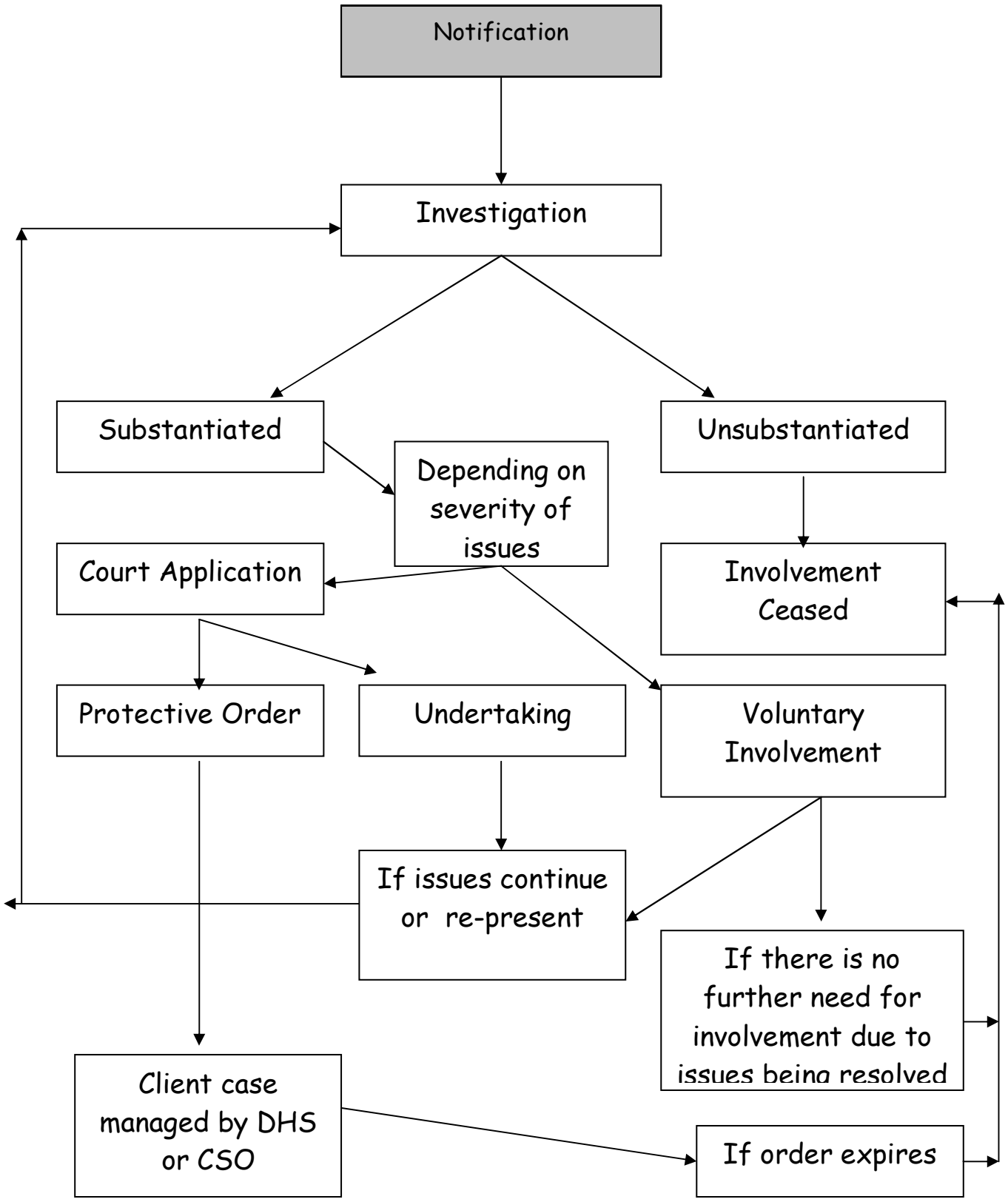
Supervision Order
A Supervision Order (SO) is made by a magistrate, usually for 12 months. The young person will most likely still reside at home, but they and the family must meet the conditions of the order, and accept assistance from DHS. The court can revoke the order if the issues that lead to the order being taken out are resolved, and the young person is not at risk anymore.

Undertakings
An undertaking is a protective order made by the magistrate. It is an agreement in writing between the magistrate and the young person/their guardian to do or not do certain things (these are specified in the order). Undertakings are usually made for 6 months. If you believe that the factors that lead to the undertaking have been resolved, you can apply to the court to have the undertaking revoked. Undertakings do not involve ongoing involvement of DHS.

Families can also have voluntary involvement with DHS. This involves the family accepting assistance from DHS, and working towards minimising risk and harm to the young person. Depending on the severity of the risk, if a family is compliant and willing to accept voluntary involvement, the matter may not be pursued to court.

All orders have guidelines and timelines which must be followed by DHS. The main aim of DHS involvement is, if possible, to reunify children with their families. In some situations, this does not occur due to the child still being at risk, regardless of the intensity or length of involvement. Order reviews, reports and other entailments (such as the Looking After Children document) follow a set timeline, and the families should be an important part of this process.

Figure 20 - Flowchart of DHS Intervention



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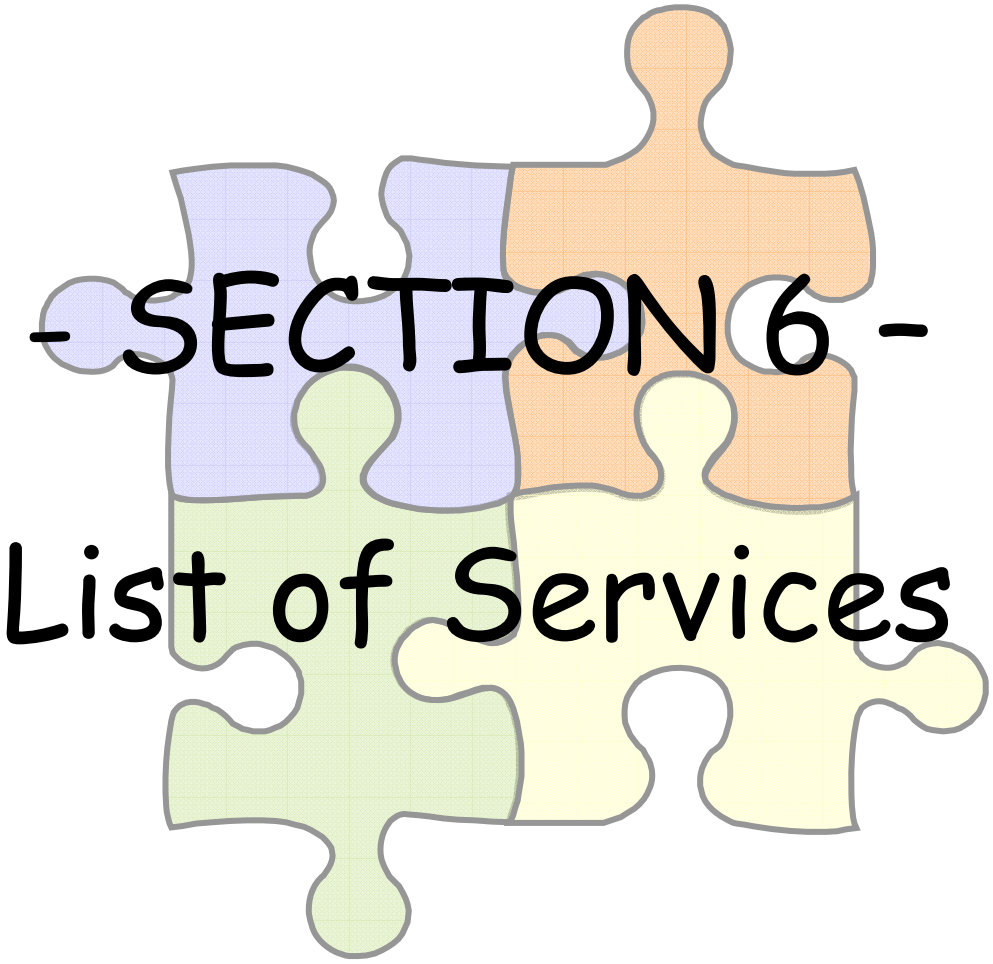

- SECTION 6 -

List of Services

Please note that this guide only covers the Southern Metropolitan region and the Latrobe Valley sub region. It is not exhaustive and does not list all programs and services, but is a good place to start. More agencies and programs can be found in the telephone book, local community directories and on infoxchange. Check with individual services about their referral processes and intake criteria, as all differ depending on what they offer and their program focus.

CRISIS SERVICES

Service Name	***Service***	***Telephone***
Police, Fire, Ambulance	Emergencies	000
After Hours Child Protection Notifications	24 hour line for reporting child abuse	13 12 78
Australian Breastfeeding Assoc.	Advice and support around breastfeeding	9885 0653
CareRing	24 hour counselling and support	13 61 69
Directline	24 hour counselling advice and referral for drug and alcohol issues	1800 888 236
Domestic Violence and Incest Resource Centre	Information and referrals for victims of DV and incest	(03) 9486 9866
Family Drug Help	Support and referrals for family/friends of people with drug issues	1300 660 068
Family Drug Support	Information and support for families affected by drugs	1300 368 186
Lifeline	24 hour counselling line	13 11 14
Maternal & Child Health Line	24 hour advice line	13 22 29
Parentline	24 hour parenting advice and support	13 22 89
Poisons Information	24 hour poison advice line	13 11 26
Pregnancy Counselling Australia	Pregnancy counselling	1300 737 732
Pregnancy Help Line	Pregnancy counselling and options	1300 139 313
SIDS and Kids Australia	24 hour crisis bereavement support	1800 240 400
South East Centre Against Sexual Assault (SECASA)	Sexual assault counselling and support	9928 8741
Syringe Disposal Help Line	Information and advice on syringe disposal	1800 552 355
Women's Domestic Violence Crisis Line	24 hour crisis line	1800 015 188

DEPARTMENT OF HUMAN SERVICES

Service Name	*Telephone*	*Fax*	*Address*
DHS - Cheltenham	(03) 8585 6000	(03) 8585 6004	,4-10 Jamieson St., Cheltenham
DHS - Frankston	(03) 9874 3100	(03) 9784 3288	431 Nepean Hwy, Frankston
DHS – Dandenong	(03) 9213 2111	(03) 9213 2414	122 Thomas St., Dandenong
Crisis Line - Child Protection Notifications	13 12 78		

DRUG AND ALCOHOL SERVICES

Service Name	*Address*	*Telephone*
Bridge Program	12a Chapel Street, St Kilda	(03) 9521 2770
Central Bayside Community Health Service	335 Nepean Highway, Parkdale	(03) 8792 2337
Inner South Community Health Service	10 Inkerman Street, St Kilda	(03) 9534 8166
Ngwala Willumbong (Koori Specific)	93 Wellington Street, Windsor	(03) 9510 3233
Odyssey House	81-85 Barry Street, Carlton	(03) 8341 1600
Peninsula Drug and Alcohol Program	Frankston Community Health Service, Hastings Road, Frankston	(03) 9784 8100
South Eastern Alcohol and Drug Service	106 Cleeland Street, Dandenong	(03) 8792 2337
Taskforce Community Agency	421 South Road, Moorabbin	(03) 9532 0811
Windana	88 Alma Road, St Kilda	(03) 9529 7955
Youth Substance Abuse Service	12 Keys Street, Frankston	(03) 9770 5622
Youth Substance Abuse Service	39a Clow Street, Dandenong	(03) 9701 3488

MATERNAL AND CHILD HEALTH NURSE PROVIDERS

These are the contact numbers for each local government areas' Maternal and Child Health Care Coordinators. Contact your local coordinator to locate your closest Maternal and Child Health Care Facility.

Local Government Area	*Telephone*	*Fax*
Bayside City Council	(03) 9599 4444	(03) 9598 4474
Cardinia Shire Council	(03) 5945 4249	(03) 5941 3784
City of Casey	(03) 9705 5200	(03) 9704 9544
City of Glen Eira	(03) 9524 3404	(03) 9523 0339
City of Greater Dandenong	(03) 9767 0809	(03) 9767 0818
City of Kingston	(03) 9581 4585	(03) 9581 4501
City of Port Phillip	(03) 9209 6360	(03) 9645 7629
City of Stonnington	(03) 8290 1670	(03) 9521 2255
Frankston City Council	(03) 9784 1888	(03) 9781 3117
Latrobe Valley	(03) 5128 5672	
Mornington Peninsula Shire	(03) 5986 0303	(03) 5986 6696

HOSPITALS

Please note that not all of the medical facilities listed below have midwifery suites or emergency departments. Please contact your local GP or medical professional to discuss delivery locations and options.

Service Name	*Address*	*Telephone*
Calvary Health Care – Bethlehem Limited	476 Kooyong Road, Caulfield South	(03) 9596 2853
Caulfield General Medical Centre	260-294 Kooyong Road, Caulfield	(03) 9276 6000
Cranbourne Integrated Care	140 Sladen Street, Cranbourne	(03) 5990 6789
Dandenong Hospital	David Street, Dandenong	(03) 9554 1000
Frankston Hospital	Hastings Road, Frankston	(03) 9784 7777
Kingston Centre	Warrigal Road, Cheltenham	(03) 9265 1000
Monash Medical Centre	246 Clayton Road, Clayton	(03) 9594 6666
Monash Medical Centre	867 Centre Road, East Bentleigh	(03) 9928 8111
Rosebud Hospital	Point Nepean Road, Rosebud	(03) 5986 0666
Sandringham and District Memorial Hospital	193 Bluff Road, Sandringham	(03) 9921 1000

ACCOMMODATION SERVICES

Service Name	*Address*	*Telephone*
Bayside Share Accommodation	Suite 10, Level 1 54-58 Wells Street, Frankston	(03) 9783 2959
Hanover	224 Thomas Street, Dandenong	1800 183 183
Peninsula Youth and Family Services	Ross Smith Avenue, Frankston	(03) 9783 4500
Southern Directions	2a Station Street, Moorabbin	(03) 8531 2000
WAYSS		(03) 9791 6111
Windana		(03) 9529 7955
Melbourne Youth Support		(03) 9614 3688

PARENTING SERVICES

Service Name	*Address*	*Telephone*
Anglicare	1161 Point Nepean Road, Rosebud	(03) 5982 2586
Anglicare	38 Bakewell Street, Cranbourne	(03) 5995 0866
Bayside Support and Information Centre	Rear 37 Albert Street, Mordialloc	(03) 9555 6560
Connections	56 Robinson Street, Dandenong	(03) 8792 8999
Connections Prahran Family Resource Centre	274 High Street, Prahran	(03) 9521 5666
Good Shepherd	1 Church Street, Hastings	(03) 5971 9444
Oz Child	433 South Road, Bentleigh	(03) 9553 4822
Parentzone	Nepean Highway, Frankston	
Queen Elizabeth Centre	53 Thomas Street, Noble Park	(03) 9549 2777
Southern Community Centre	1-12 Chesterville Road, Cheltenham	(03) 9502 3763
Southern Family Life	197 Bluff Road, Sandringham	(03) 9598 2133
Uniting Care Connections	105a High Street, Cranbourne	(03) 5996 2611
Windana	39a Clow Street, Dandenong	(03) 9529 7955
Yarraman Family and Children's Centre	33 Joffre Street, Noble Park	(03) 9767 0820

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GLOSSARY

A

Abstinence
Refraining from using substances.

Adolescent Egocentrism
A characteristic of adolescent thought in which they conceptualise themselves as the centre of the world – everything is thought of in terms of what it means to them, and how it will affect them.

Agonist
A drug that binds to and activates receptor sites. The substance mimics naturally occurring chemicals which stimulate receptors in the brain.

AIDS
See HIV

Amniocentesis
When a small amount of amniotic fluid is extracted through the abdomen for testing.

Amniotic Fluid
The fluid surrounding the foetus in the uterus.

Amphetamines
A class of drug that acts as a stimulant to the central nervous system. Effects include increased awareness, faster heart rate, greater energy, elevated blood pressure, loss of appetite and exaggerated behaviours.

Analgesics
Painkillers that do not produce unconsciousness.

Antagonist
A drug that binds with receptor sites in the brain, producing no pharmacological response but blocking the actions of agonists for that receptor.

Antenatal
Before birth and delivery.

Antibiotics
Substances capable of destroying bacteria and other germs.

Antibodies
Protein produced by the body to fight germs, bacteria or foreign bodies.

Apgar Scale
An assessment conducted after birth on the newborn of heart and respiratory rate, muscle tone, color and reflexes. Used to determine if they need specialist medical care after birth.

Apnoea
Interrupted breathing. Can occur in preterm or low birth weight babies.

Assessment
The process of compiling a client's history (including drug and alcohol use, medical, social, etc.) to develop a clear picture of issues, presenting problems and impacting factors.

Attachment
An emotional bond between a person and other people, animals, or objects. Produces a desire for contact, and distress during separation.

Attention Deficit Hyperactivity Disorder
A behavioural issue usually found in children, characterised by excessive activity, inability to concentrate, impulsivity and sometimes aggressive behaviour.

Authoritarian Parenting
A style of parenting in which the parents set definite rules and limits and punish misbehaviour. Authoritarian parents do not communicate well with their children and can be seen as severe.

Authoritative Parenting
A style of parenting in which the parents set limits, but provide guidance and are willing to listen to their children. Authoritative parents communicate well with their children.

B

Barbiturates
A group of drugs that have a sedative/hypnotic effect. Not often seen in Australia.

Benzodiazepines
Drugs used as anti-anxiety, anti-epileptic and muscle relaxant medications. There is significant potential for dependence in a short time. Eg – Valium, Xanax, Ativan.

Binge
An episode of intense or excessive alcohol/drug use. Results in intoxication or overdose.

Brachycardia
A slow heart rate.

Braxton Hicks Contractions
Contractions of the uterus. Often mistaken for real labour, they are the muscles contracting in preparation.

Breathing Reflex
A normal reflex that ensures an adequate supply of oxygen by breathing in and out without conscious effort.

Breech Birth
When a baby pushes through the birth canal bottom first, rather than headfirst. Accounts for 3% of births.

Buprenorphine
A pharmacotherapy used as a maintenance treatment for opioid dependence. Acts as a partial opioid agonist and antagonist – blocks the effects of other opioids, and reduces withdrawal symptoms.

C

Caesarean Section
When a baby is delivered via an incision in the mothers' abdomen wall rather than via the birth canal.

Cannabis
Generic term for the various psychoactive preparations of the marijuana plant. Cannabis is a depressant (at low doses) on the central nervous system, and a hallucinogen at higher doses. The active ingredient is 9 tetrahydrocannabinol. Use is associated with increased appetite, euphoria, anxiety, sleepiness and lightness of the limbs. Can be eaten and inhaled/smoked.

Central Nervous System
Made up of the spinal cord and brain, it is responsible for the coordination and control of bodily activities and the interpretation of information from the senses (sight, hearing, smell, etc.).

Cervix
The lower entrance to the uterus.

Child Abuse
Maltreatment inflicted on children by parents and other caregivers. Includes physical, sexual and emotional abuse, as well as neglect of the child's basic needs.

Chroming
The process of inhaling vapours from paint/spray cans. Usually can is sprayed into a plastic bag and inhaled.

Cleft Palate
A congenital abnormality of the roof of the mouth.

Cocaine
A drug that has a stimulant effect on the central nervous system. Derived from the coca plant. Produces euphoria, wakefulness and anxiety. Can be injected, ingested and inhaled.

Cognition
The mental process in which an individual obtains knowledge and becomes aware of their environment.

Colostrum
Milk expressed after birth for several days. Rich in protein and nutrients.

Co morbidity
When an individual has both substance use issues and mental health issues. The interaction of these two issues can have serious negative consequences for the individual, and require accurate assessment and treatment.

Conception
The fertilisation of the egg by the sperm, and its implantation in the uterine wall.

Congenital Abnormality
An abnormality or deformity arising from a damaged gene, the adverse effect of certain drugs or the effect of certain diseases during pregnancy.

Contractions
The regular tightening of the uterine muscles, dilating the cervix and pushing the baby down the birth canal.

Cooperative Play
A method of playing which involves sharing toys or taking turns.

Cravings
A strong desire or urge to use drugs, usually during withdrawal or when "hanging out". Symptoms are both physical and psychological, and can occur long after the cessation of drug use.

Critical Period
A stage in prenatal development (the first eight weeks) in which all of the major organs and body structures are forming, and most vulnerable.

D

Defence Mechanism
Behavioural or thought patterns that protect the individual from internal or external stimuli, thoughts or actions that may cause extreme distress.

Delirium Tremens
An acute psychotic state occurring after the cessation or reduction of alcohol consumption. Characterised by confusion, disorientation, agitation and tremors.

Dependence
When a person has a strong desire to use substances, and cannot control their use despite detrimental effects. Physical dependence includes an increased tolerance and physical withdrawal symptoms when use is discontinued.

Depressants
A group of substances which have a depressant effect on the central nervous system. Includes alcohol, benzodiazepines, small doses of cannabis and opiates.

Depression, Respiratory
When newborn babies have trouble breathing.

Detoxification
The process of withdrawing from a substance. May or may not involve medication.

Developmental Theory
A statement of hypotheses and principles that offers an explanation or theory on human development.

Doctor shopping
When individuals attend multiple doctors to obtain larger quantities of prescription medication.

Drug
Any substance that a) has the capacity to alter biochemical or physiological processes, tissues or organisms, or b) has the potential to prevent or cure disease, or enhance physical or mental welfare.

Drug Interactions
When two or more psychoactive drugs interact. This occurs in three ways – antagonism (where one drug cancels out the effects of another); potentiation (when the drugs combine and increase the effects of each other); and interference (when one drugs interferes with the effects of another).

Dual Diagnosis
See co morbidity.

E

Eclampsia
High blood pressure and other symptoms during pregnancy. Can be very serious.

Ecstasy
See MDMA

Ectopic Pregnancy
A pregnancy which develops outside of the uterus. Can be serious and life threatening.

Embryo
The developing baby, from day 10 after conception until week 12.

Engagement
The process of developing a rapport with a client for the purposes of casework.

Epidural
An anaesthetic which is injected into the lower spine and blocks feeling from below the waist. Commonly used during labour.

Episiotomy
A surgical cut in the perineum to enlarge the vagina during birth.

F

Fine Motor Skills
Skills using the small muscles and small movements, usually by the hands and fingers. For example, writing, tying shoelaces.

Foetal Distress
A shortage in the oxygen supply to the foetus. Can result from numerous causes.

Folic Acid
A form of vitamin B that should be taken during pregnancy to reduce risk of abnormality.

G

Gestation
The length of time between conception and delivery.

GHB
Gamma Hydroxybutyric Acid. Classed as a party drug and date rape drug. A synthetic version of a naturally occurring substance. Has a depressant effect on the central nervous system.

Gross Motor Skills
Movements and physical skills using large muscle groups and coordination. For example, running, riding a bike.

Gynaecologist
A doctor specialising in female medicine.

H

Habituation
The process where a particular stimuli becomes so familiar that it no longer evokes a response.

Haemorrhage
Excessive bleeding, usually internally.

Half Life
The time it takes for a drug's concentration in the blood to reduce by 50%. Drugs with a short half-life have a higher and faster "peak" (i.e. – heroin).

Hallucinogens
Drugs which cause hallucinations and altered states of consciousness. Effect on the central nervous system involves disturbances in thought and perception. Eg – LSD, high doses of cannabis.

Harm reduction
Aims to reduce drug related harm at an individual and community level. Recognises that drug use is and will continue to be an issue, and focuses on reducing physical and social risks of use. Initiatives include standard drinks, methadone, syringe programs.

Harm minimisation
A broad strategy aimed at reducing substance related harm for the individual and society. Has a threefold approach – demand reduction, supply reduction and harm reduction.

Hepatitis C
A slow acting virus impacting the liver. 75% of persons infected will develop a chronic infection. 25% will clear the virus, but remain a carrier.

Heroin
An opium derivative produced by modifying morphine. Is usually injected, inhaled or ingested.

HIV
Human Immunodeficiency Virus. Usually transmitted via sharing infected injecting equipment and via unprotected sex. HIV develops into AIDS.

Holistic Development
A view of human development signified by looking at individuals and their issues as a whole, and the interaction between the physical, cognitive and psychosocial aspects.

Hormone
A chemical in the blood which stimulates various organs to action.

Hydrocephalus
A congenital abnormality in which the baby's head is swollen with fluid.

Hypertension
High blood pressure. In pregnancy, this can reduce the baby's oxygen supply.

I

Illicit drugs
A drug whose possession, sale or use is prohibited by law. This includes heroin, cocaine, cannabis etc.

Induction
The process of artificially starting labour.

Inhalants
A group of psychoactive substances that have a depressant effect on the central nervous system. Includes petrol, spray paint, glue, paint thinners. Usually inhaled via a plastic bag.

Intervention
Any method used to assist or intervene in an individual's behaviour, functioning or life.

Intoxication
The acute effects of a substance taken on a single occasion that produces physical and behavioural changes. Intoxication occurs when the level taken exceeds the individual's tolerance.

J

Jaundice
A common condition in which the liver cannot break down red blood cells. Causes skin to go yellow, and is easily treated.

K

Ketamine
Commonly used as an animal tranquilliser, ketamine has a stimulant effect on the central nervous system.

Ketosis
The accumulation of lactic acid in body tissues.

L

Lanugo
The fine soft body hair on foetus'. This falls out soon after birth.

Lapse/Lapse-Relapse Cycle
Using drugs for the first time after a period of abstinence. A lapse is a temporary state of use (such as one occasion, or a weekend binge) and relapse is when levels of use return to previous levels, or is uncontrolled.

Licit Drugs
A drug whose possession, sale or use is not prohibited. Eg – tobacco, alcohol, benzodiazepines.

Low Birth weight Baby
A baby who weighs less than 2.5 kg at birth.

LSD
Lysergic Acid Diethylamide. A hallucinogenic substance whose use can induce psychotic states. LSD is taken by ingestion, and is also called acid and trips.

M

Maintenance
A stage of behaviour change, where a user actively tries to remain abstinent. May also include the use of a pharmacotherapy agent, such as methadone or buprenorphine.

Meconium
The first contents of the baby's bowel after birth. It is dark and sticky.

Methadone
A synthetic opioid agonist. Predominantly used as a pharmacotherapy maintenance agent for individuals with an opioid dependence. Taken daily in liquid form.

MDMA
3,4-methylenedioxymethamphetamine. Also known as ecstasy, it is a hallucinogenic substance that is taken orally.

Miscarriage
When a pregnancy ends in a natural abortion (expulsion of the foetus), usually before week 10.

N

Neuro-adaptation
The process of the brain adapting to the presence of a substance. This process leads to tolerance (where increasing amounts of a particular substance are required to maintain the substances desired effects) and cravings (when the substance is not present).

Neuro-transmitters
Chemical messengers that either start or stop an action. Psychoactive substances can behave like neurotransmitters, and are either agonists (where the substance mimics the natural neurotransmitter and starts the action) or antagonists (where the substance takes the neurotransmitters place, and stops the action).

Narcotic
A drug which induces a state of altered consciousness and stupor. Eg – morphine, heroin.

National Drug Strategy
A venture between federal, state and territory governments as well as the non-government sector. It aims to minimise the harmful effects of drugs on Australian society.

Neonatal abstinence syndrome
The condition affecting newborns exposed to certain substances during pregnancy, and are now withdrawing. Managed with medication and extra care.

Neonatal period
The first four weeks after birth

Neonatal death
When a baby dies within four weeks of being born.

O

Oedema
Fluid retention, which causes body tissues to swell.

Opioid/Opiates
Opioids are a class of drug (both naturally occurring and synthetic) which have a depressant effect on the central nervous system. Opioids are legitimately used for pain management.

Overdose
When the amount of a substance taken significantly exceeds an individual's tolerance. Depending on the substance taken, effects can range from psychosis to respiratory depression. Can result in death.

P

Palpation
Feeling the baby through the mother's abdominal wall.

Party Drugs
A group of drugs that are predominately used in the pub/club/dance scene. Eg – ecstasy, GHB, ketamine.

Pelvic Floor
The muscles that support the uterus and bladder.

Perinatal
The period from 28 weeks gestation to one week following delivery.

Perinatal death
When a baby dies in the perinatal period.

Perineum
The area between the vagina and the anus.

Pharmacotherapy
The use of prescribed medications to address problem substance use. Can be used to alleviate withdrawal symptoms, as a maintenance substitution or reduce cravings. Also known as substitution therapy.

Pituitary Gland
The gland controlling hormones responsible for menstruation and stimulating the milk glands.

Placenta
The organ which develops in the uterus and supplies the foetus with all necessary nutrients.

Placental Insufficiency
When the placenta is inadequate for taking care of the foetus.

Polysubstance use
The use of more than one substance, either concurrently or sequentially.

Postnatal
After the birth.

Post Partum
After the delivery.

Pre Eclampsia
Condition prior to the development of eclampsia. Characterised by high blood pressure.

Preterm labour and birth
The event of labour and birth occurring before 38 weeks gestation.

Prevention
Actions designed to cease or delay the uptake of drugs or reduce further problems.

Psychoactive Drugs
Any substance which alters mood, cognition and behaviour.

Psychostimulant
See Stimulant.

R

Relapse/Relapse Prevention
A relapse is when an individual returns to substance use after a period of abstinence. Relapse prevention is strategies for dealing with high risk situations that may lead to relapse behaviour.

Rhesus Factor
A feature of red blood cells. Mothers and babies must all be tested, as complications can arise if the mother is Rh- and the baby is Rh+. Once established, this can be treated.

S

Sedative/Hypnotic
Sedatives relieve anxiety and reduce central nervous system activity. Includes benzodiazepines and barbiturates.

Show
A discharge of blood stained mucus. Occurs at the start of labour.

Sudden Infant Death Syndrome
SIDS is the sudden, unexpected death of a baby from no known cause. Safe sleeping strategies have reduced risk by 70%.

Stillbirth
The delivery of a dead baby after week 28 of pregnancy.

Standard Drink
Any alcoholic drink containing 10 grams of alcohol. Used to ascertain drinking patterns and alcohol ingestion.

Stimulants
Any substance that activates, enhances or increases central nervous system activity. Includes amphetamines, caffeine, nicotine and cocaine.

Substance Use
Self-administration of a psychoactive substance. Substances can be smoked, inhaled, ingested, injected etc. Occurs in various patterns, to varying degrees. The act of using a substance.

Supply Reduction
Harm reduction strategies aimed at disrupting the production and supply of illicit drugs. Also refers to laws surrounding the use of licit substances such as tobacco and alcohol.

T

Teratogen
Any substance which can cause physical defects in the embryo.

Termination
An artificially induced abortion before week 28.

Thrombosis
A blood clot in the heart or lung.

Tolerance
The ability of an individual to moderate the effect of a substance. Regular use usually increases tolerance, and more substance needs to be used to obtain the desired effect.

U

Uterus
The hollow organ in which the foetus develops and grows.

V

Vernix
The white substance which covers the foetus while in the womb.

Vertical Transmission
When in the process of pregnancy, a mother infects the foetus with a condition. Eg – AIDS, hepatitis.

W

Withdrawal Syndrome
A range of physical and psychological symptoms that occur when an individual ceases or significantly reduces their substance use. The length and seriousness of effects depend on the substance used, amount used and how long the individual used it for.

Z

Zero Tolerance
A policy aimed at stopping individuals from using substances by imposing harsh punishments for even small offences.

INDEX

C

F

G

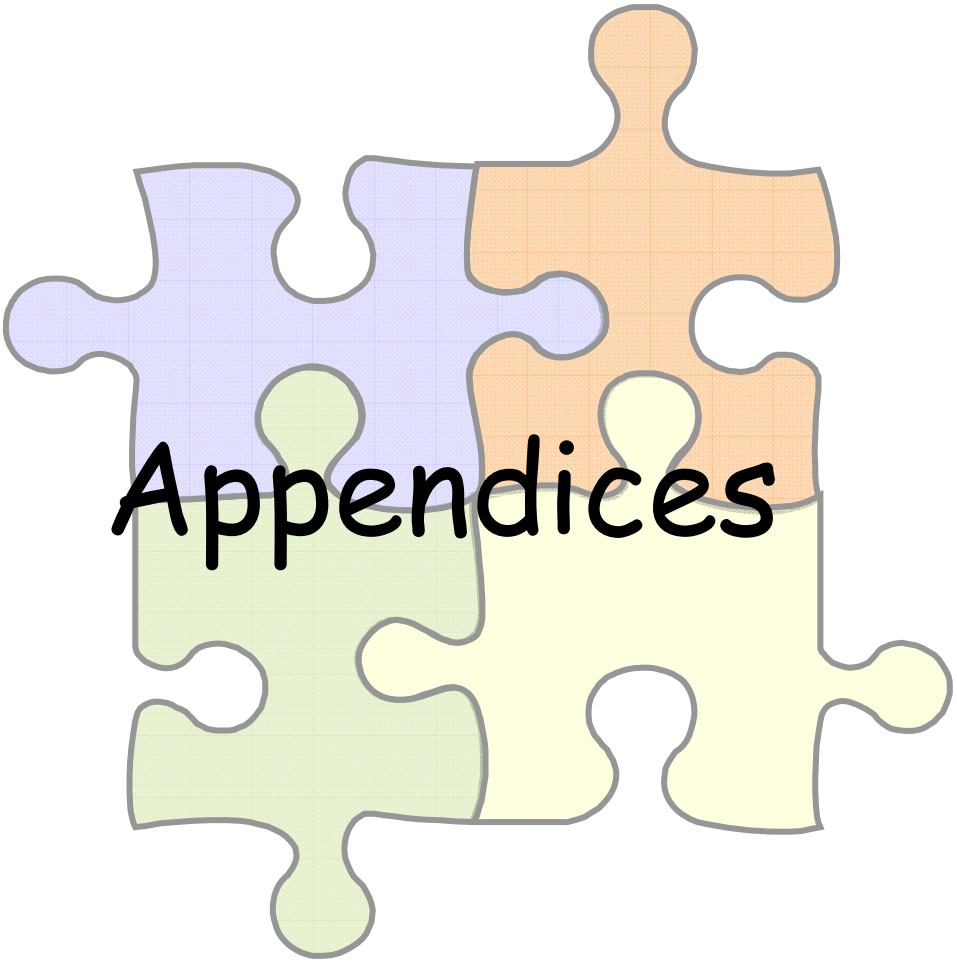
H

I

N

O

P



Appendices

Appendix 1 –
Suggested Pregnancy Medical Schedule[1]

Week	Visit	The Tests
7-10	1	Blood Group, Rh and antibodies Full blood examination Rubella HIV Hepatitis B Syphilis Urine test for asymptomatic bacteriuria Physical examination, including blood pressure Down's syndrome testing will be offered
12-15	2	Discuss results of previous tests Complete any unfinished tests or physical exam Serum screening tests Discuss 18-20 week ultrasound scan for any anomalies Measure blood pressure, check uterine size
18-20	3	Complete any unfinished tests Discuss any results Measure blood pressure, check uterine size Discuss blood sugar test for next visit
26-28	4	Discuss any results Complete blood sugar test Measure blood pressure Check baby's heartbeat, size and position If Rh negative, check FBE and Rh antibodies
32	5	Discuss any results Measure blood pressure Check baby's heartbeat, size, position and movements
34-36	6	Measure blood pressure Check baby's heartbeat, size, position and movements If Rh negative, check FBE and Rh antibodies
38	7	Measure blood pressure Check baby's heartbeat, size, position and movements
40	8	Measure blood pressure Check baby's heartbeat, size, position and movements
41-42	9	Measure blood pressure Check baby's heartbeat, size, position and movements Measure blood pressure Discuss foetal monitoring, CTG and ultrasound if baby is still not delivered Discuss induction Possible vaginal examination

Appendix 2 –
Immunisation Schedule

Age	*Immunisation*
Birth	Hepatitis B
2 Months	Diphtheria/Tetanus/Pertussis/Polio Haemophilus Influenzae Type B Hepatitis B Pneumococcal
4 Months	Diphtheria/Tetanus/Pertussis/Polio Haemophilus Influenzae Type B Hepatitis B Pneumococcal
6 Months	Diphtheria/Tetanus/Pertussis/Polio Pneumococcal
12 Months	Measles/Mumps/Rubella Haemophilus Influenzae Type B Hepatitis B Meningococcal C
18 Months	Chickenpox
4 Years	Diphtheria/Tetanus/Pertussis Measles/Mumps/Rubella
Year 7	Hepatitis B Chickenpox
Year 10	Diphtheria/Tetanus/Pertussis
Non – immune women	Measles/Mumps/Rubella

Appendix 3 –
Sample Pregnancy And Child Assessment Form

YSAS Young Parent's Project
Pregnancy and Child Assessment Form

Date Completed	

Children

Please fill out a separate sheet for each child.

Child's Information	Name	
	Date of Birth	
	Current Age	
Day program	School/Day Care	
	Contact Person	
	Contact Telephone	
	Address	
	Days Attended	
	Other Programs attended	
	Contact Person	
	Contact Telephone	
	Address	
Health	Health Issues	
	General Practitioner	
	Contact Telephone	
	Immunisations up to date?	
Other issues	Behavioural Issues	
	Other identified issues	

DHS Involvement

DHS Worker		Orders	
Office		Conditions	
Contact Telephone		Expiry Date	

Other Involvement

Agency	Program	Worker	Telephone	Nature of Support

Pregnancy

Due Date		Substances used during pregnancy	
Antenatal Midwife/Doctor			
Contact Telephone		Current medications (including prescribed)	
Address			
Nominated Hospital		Medical conditions/pregnancy health issues	
Contact Telephone			
Address		Pharmacotherapies	
General Practitioner		Pharmacotherapy provider	
Contact Telephone		Contact telephone	

Supports

Name				
Relationship				
Contact Telephone				
Address				

Appendix 4 –
Substance Use Diary

Substance Use Diary

	Monday	*Tuesday*	*Wednesday*	*Thursday*	*Friday*	*Saturday*	*Sunday*
What did I use?							
How much did I use?							
What time did I use?							
How did I feel before I used?							
How did I feel while using?							
How did I feel after?							
How did I sleep?							
Did I use more or less than usual?							
Any negative physical or mental effects?							

Appendix 5 –
Sample Pregnancy Appointment Record

Pregnancy Appointment Record

My due date is:

	With Who?	Telephone	Appointment Date	Appointment Time
Midwife				
Obstetrician				
Ultrasounds				
Blood Tests				
Other Tests				
Antenatal Classes				
Other Appointments				

Appendix 6 –
Sample Birth Care Plan

Birth Care Plan

My due date is:

When I go into labour, I need to call:

	Who?	*Contact Number*
Hospital		
Partner/Family Member		
Support Person		
Worker		
If I go into labour during the day, my children will stay with		
If I go into labour at night, my children will stay with		

Things I need to have packed and take into hospital with me are:

Things for Me	*Things for the Baby*	*Other stuff*
Health Care Card	Clothes	Magazines
Pyjamas	Blanket	Camera
Comfy clothes (truckies etc.)	Nappies	Money for phone etc.
Shampoo/ Conditioner		Contact phone numbers
Deodorant + other toiletries		
Maternity pads		
Dressing Gown		
Maternity bras & nursing pads		
Slippers		
Undies		

Appendix 7 –
Sample "Important Numbers" Sheet for Pregnant Clients

Important Numbers

In case of emergency		**000**	
Pregnancy Information			
	Name	*Telephone*	*Organisation/Address*
Midwife			
Obstetrician			
Maternity Hospital			
General Practitioner			
Dispensing Pharmacy			

Other Supports			
	Name	*Telephone*	*Organisation/Address*
Drug and Alcohol			
Accommodation			
Counsellor			
Legal			

Appendix 8 –
Sample "Important Numbers" Sheet for Parenting Clients

Important Numbers

In case of emergency	**000**
Parentline	**13 22 89**
Maternal and Child Health Care Line	**13 22 29**
Poisons Information Line	**13 11 26**

Information			
	Organisation	**Telephone**	**Address**
Day Care/School			
Hospital			
General Practitioner			
Chemist			

Other Workers			
	Name	**Telephone**	**Organisation/Address**
Drug and Alcohol			
Accommodation			
Counsellor			
Legal			
Other			

Other Supports		
Name	**Telephone**	**Address**

Appendix 9 –
A Quick Guide to Positive Parenting

A QUICK GUIDE TO POSITIVE PARENTING

The 5 Key Principles of Parenting

Ensure a safe, interesting environment

Create a positive learning environment

Use assertive discipline

Have realistic expectations

Take care of yourself as a parent

The 4 Areas of Parenting Development

Developing a positive relationship with your child

- *Spend quality time with your child*
- *Talk to your child*
- *Show affection*

Encouraging desirable behaviour

- *Use praise*
- *Give children attention*
- *Give your child engaging activities*

Teaching your child new skills or behaviour

- *Set a good example –*
- *Ask, say, do.*

- *Use Behaviour Charts*

Teaching your child new skills or behaviour

- *Establish Clear Ground Rules –*
- *Using Directed Discussion*
- *Use Planned Ignoring*
- *Give Clear, Calm Instructions*
- *Use Logical Consequences*
- *Use Quiet Time*
- *Use Time Out*

Family survival tips

- *Work as a team*
- *Avoid arguing in front of children*
- *Get support*
- *Have a break*

And Remember…

Be consistent

Establish rules

Keep your children safe

Model good behaviour

Explain consequences

Be clear, calm and firm

Play with and enjoy your children