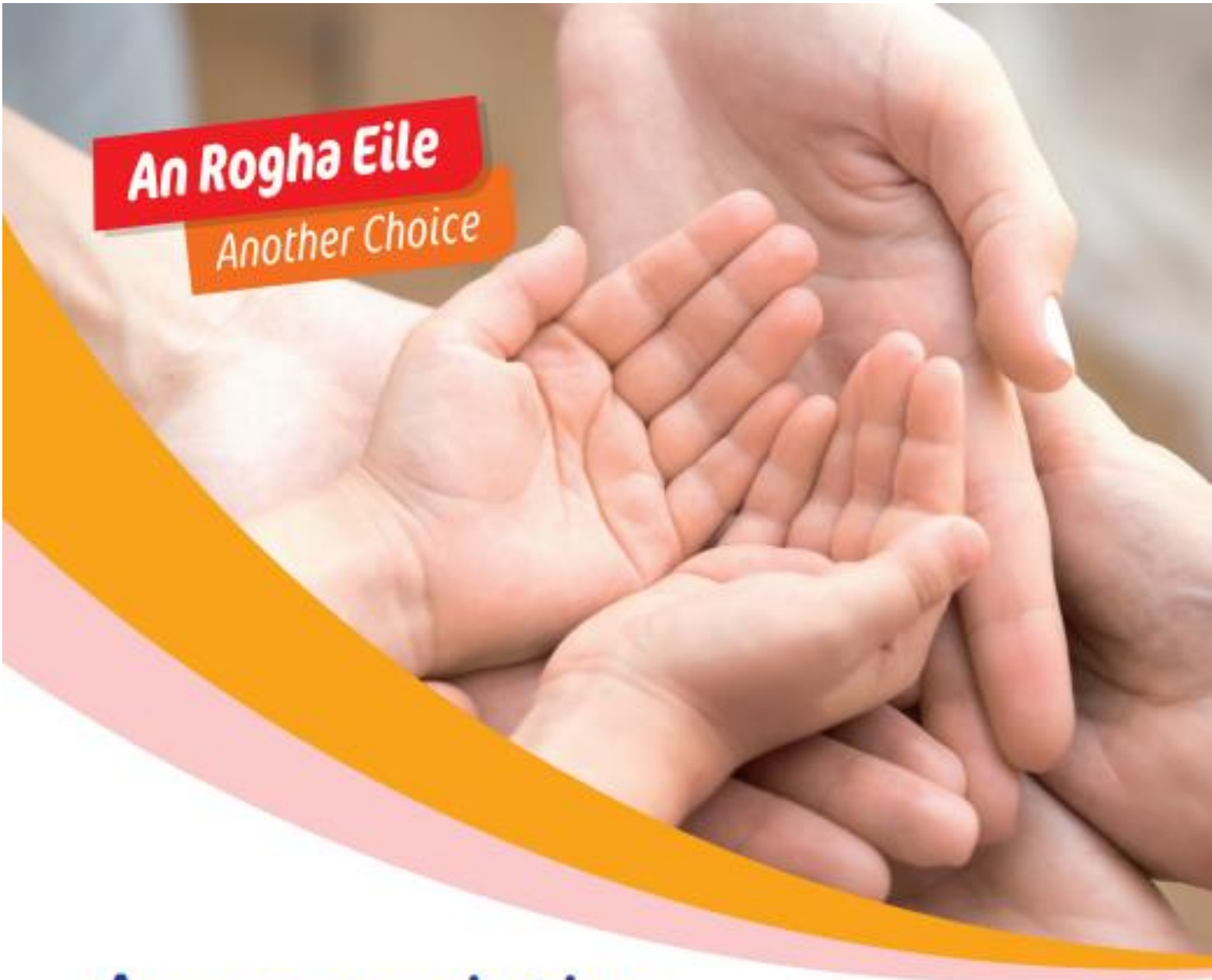

An appreciative enquiry of **family health support**

Presented to:

FINGLAS CABRA
LOCAL DRUG & ALCOHOL TASK FORCE

LinkAge Consultancy
Linking People, Practice & Policy

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1. Foreword

An Rogha Eilé commissioned LinkAge Consultancy to undertake this piece of research. The main purpose of the research was to document the data that was compiled by the Family Health Project, the work practices of the Project and make recommendations on the future development of the Project. It is hoped that this appreciative enquiry will highlight the need for additional community pre- and post- natal care for marginalised, vulnerable parents and their families.

I would particularly like to thank Dr. Debra O'Neill, Principle Consultant, for her devoted time, effort, and support throughout the process. I would also like to thank Dany El Amin, Senior Researcher and Project Manager with LinkAge Consultancy for her contribution in this piece of research. A particular thanks to Finglas Cabra Local Drug and Alcohol Task Force who funded this piece of research. A special thanks to Mary Heffernan, Family Health Worker for her continuing hard work in supporting and meeting the needs of mothers and fathers affected by substance use.

A word of thanks to all those who participated in the research. Your input and one to one discussions with Dr. Debra O'Neill were, and continue to be, invaluable to the Family Health Project in helping to inform the work of the project going forward. As such, I plan to share the findings and recommendations contained in this report with key stakeholders, where relevant. Fundamentally, the function and success of the Family Health Project operates on the on-going collaboration and support from various key agencies. I would like to thank all clinical and community care organisations that continue to work closely with the Family Health Project.

This report is dedicated to John Bennett, former Coordinator of Finglas Cabra Local Drug and Alcohol Task Force who sadly passed away in August 2023. John played an instrumental role in shaping the organisation's vision, values, and success as well as advocating strongly for the need of this piece of research.

Michelle McNally

Interim Coordinator, Finglas Cabra Local Drug and Alcohol Task Force , March 2024

2. Executive Summary

The evidence suggests that women are less likely to engage in problematic substance use than their male counterparts, but we have also seen the prevalence of drug use, among women aged 15– 34 years, double between 2002/03 and 2019/20 from 4.2% to 8.4%. This could be the result of the significant increase in the use of cocaine among women aged 15-24 years, up from 1.10% in 2002/2003 to 4.5% in 2019/2020. Across Europe women now make up about 20% of all new patients in specialised drug treatment programs and about 25% of all individuals with major problematic substance use. For many, being a woman with problematic substance use provides a double stigma, being a pregnant woman or a mother, creates very complex challenges.

In response to very specific unmet needs the Family Health Project, instigated by the Finglas Cabra Local Drug and Alcohol Task Force (FCLDATF), was set up in 2022 to provide services to women and their families, focusing on the pre-and post-natal support period. This is regarded as a time when many women, living with problematic substance use, seek support for the first time and are in contact with health services for an extended period. In addition, this period is observed as both an opportunity and a barrier. An opportunity: to seek treatment and support for their recovery, a barrier; as it may bring them into contact with official child protection agencies and health care professionals, many of whom have risk assessment responsibilities for the welfare of newborn and existing children.

In order to explore the impact of the project a transformation mixed method investigation was conducted. A quantitative analysis of service users (n=70) retrospective data (2022-2023) was undertaken, in addition to qualitative interviews with a nested sample of service users (n=13) and external service providers (n=12). These interviews provided a deep dive into the lived experiences of those engaged with the service. It also provided feedback on the project from the perspective of external agencies and stakeholders. The findings highlighted the importance of the service which positively impacted on the quality of life of those who sought support and help at a time of great need and vulnerability. The characteristics of the service users, provides testimony of the unique holistic support required and also the need for individual trauma informed care.

The majority of the service users were female (86%), including 3 grandmothers, who collectively represented 155 children under the age of 18 years. Nearly 50% of these children were in state care, and 42% were under 4 years old. Despite the current housing crisis, 73% of clients described themselves as

being in stable accommodation, with 37% of the women living alone with their children. This is more than double the national average for single parent households. A further 8.5% lived in a mixed household with their family of origin. At the time of presentation to the service 36% of the women were pregnant.

Of the seventy service users who sought support, over 48% had a history of childhood sexual abuse. Considering research findings, that 1 in 20 children in the UK have been sexually abused (NSPCC, 2021), this figure is extremely high. On further investigation it was also discovered that nearly 33% had been raped, 74% had been sexually assaulted and over 67% had been abused by their intimate partner. The findings suggest that there is a significant association between the number of service users who were subjected to childhood sexual abuse and intimate partner abuse as adults. Considering this level of trauma, it is not surprising that 48% (n= 33) of service users were diagnosed with a mental health condition, and nearly 75% of those were living with a diagnosis of depression. This is in keeping with international evidence which suggests a correlation between mental health and problematic substance use.

Prior to accessing the service, individuals described themselves as desperate, suicidal, misinformed and at rock bottom. The service intervention has changed their quality of life considerably. Post intervention individuals described themselves as actually living, confident and hopeful. The service provided was bespoke to each individual, timely and flexible. The Family Health Worker provided practical daily crisis interventions, from facilitating maternity appointments and advice to support with child access and treatment options. The external service providers acknowledged the benefits of the service, which enabled them to focus on their core area of responsibility, knowing that daily care and support was being maintained in the community. The Family Health Worker was identified as a connecting bridge between many of the services, operating in a truly multidisciplinary and collaborative way. Her independence was also considered an invaluable factor to external agencies, acting as an advocate, mediator and negotiator in very complex systems which were described as *"not very integrated or flexible".* Stakeholders identified the growing need for this service across their area of operation, as they had witnessed the growing number of pregnant women with problematic substance use which required gender specific treatment, support and aftercare.

The building of trust between the service user and the Family Health Worker benefited everyone concerned and was a critical element of the support. The connection with the Family Health Worker provided a solid foundation for building relationships with other organisations including health care,

schools, treatment and recovery support. As a result, the service user was more open to accessing additional services. From the external service providers point of view, this relationship of trust, enabled them to have focused conversations with the service user in a safe space, were they were supported and engaged, for everyone's benefit.

The service provided by the Family Health Worker was described as critical and one that should be available in all Community Health Organisations (CHOs) areas, as stakeholders understood it was not available in other areas. The service offered a real opportunity to end the cycle of family trauma and problematic substance use, as it was rooted in a philosophy of harm reduction and was trauma informed. It also provided an intervention at the earliest possible time in a child's life, at birth. The service is also in keeping with the ethos of the National Drug Strategy (2017) which holds that recovery is personal. The service is also targeted at a marginalised group identified in that strategy being women who harmfully use drugs, including those who are pregnant or have children (Reducing Harm, Supporting Recover, 2017-2025, p.44).

3. A Community Response to a National Challenge

It has been twenty-five years since Local Drug and Alcohol Task Forces (LDATF) were established and subsequently informed Ireland's first National Drug Strategy (2001-2008). Initially LDATFs were formed as a response to the growing challenges faced by individuals, families and communities affected by drug use in vulnerable areas but eventually they led to the establishment of Regional Drug and Alcohol Task Forces (RDATF), addressing the growing nationwide problem. In the proceeding twenty-five years communities have built resilience and social capital, contributing their wealth of knowledge and experience, as key stakeholders, to the complex challenges of growing substance use in their communities. Over this period Finglas Cabra LDATF have continually engaged in multi-agency multi-sectoral consultations as a means to address the causes and local consequences of drug and alcohol use.

Unfortunately, the heroin epidemic which triggered the development of Finglas Cabra LDATF in 1997 has not dissipated (Corbett et al., 2023). The problematic use of drugs and alcohol remains a very complex issue and one that remains a significant health and social challenge in communities. One in four Irish adults report using illegal drugs in their lifetime placing Ireland at number four for cocaine and cannabis use in Europe. While the use of opioids continues to grow, heroin still accounts for 38% of all entries to treatment centres in Ireland today (Corbett et al., 2023). It also remains the most commonly used illicit

drug in Europe and is responsible for much of the health burdens caused by illicit drug use (European Monitoring Centre for Drugs and Drug Addiction, 2023).

Examining the combined population of the 18 Electoral Divisions (ED's) in the Task Force area is 57,665 (CSO, 2022), 33,984 in Finglas and 23,681 in Cabra. South Finglas is also classified as very disadvantaged relative to national averages making it economically, one of the poorest places in Ireland (CS0, 2022). 7 electoral divisions in the Task Force area are rated disadvantaged and 6 are marginally below the national average for relative deprivation (CSO, 2022). The Annual Report (2019) from Finglas Cabra Local Drug and Alcohol Task Force identified two distinct groups of substance users in the area engaged in a complex culture of polydrug use, an older habitual user group (40+ years) and a younger recreational user group (16-40 years). Across the community in 2019 it was reported that 479 individuals were receiving methadone treatment, 30% of which were female (Finglas Cabra Local Drug & Alcohol Task Force, 2018, Finglas Cabra Local Drug & Alcohol Task Force, 2020). Research tells us that females are less likely to use illegal drugs than their male counterpart, however the prevalence of drug use among females aged 15–24 years and 25–34 years was found to have doubled between 2002-03 to 2019-20 from 4.2% to 8.4% (Mongan et al., 2021). The National Drug and Alcohol Report (2021) reported a significant increase in the use of cocaine among females aged 15-24 years, up from 1.10% in 2002-2003 to 4.5% in 2019-2020 (Mongan et al., 2021). Women were also more likely to report recent use of opioid pain medication than men (36.8% versus 27.3%), with the most common age group being 35–64-year-olds at 34.9%.

While opioid use has become less common in pregnancy in the last decade up to 2019, the use of cocaine and cannabis in pregnancy is increasing (Corbett et al., 2023). Alcohol use in pregnancy remains a problem, with Ireland in the top five globally for alcohol use during pregnancy (Department of Health, 2017). Sadly, the statistics can only report those who access services and supports. A focus group of local service providers in 2018 reported that the majority of individuals using drugs are not in contact with treatments and supports (Finglas Cabra Local Drug & Alcohol Task Force, 2018). This limitation contributes to the difficulty in estimating the number of local children at risk of potential adverse effects, or indeed the scale of the actual problem (Galligan and Comiskey, 2019). However, it is known that women make up 18% of drug users in Ireland, the majority of which are of childbearing age (Aspa, S. 2017).

This figure is fairly consistent with Europe, where women make up about 20% of all new patients in specialised drug treatment programs and about 25% of all individuals with major substance use issues. For many, being a woman and a substance user provides a double stigma. A number of national strategies including the National Drug Strategy (2017), Sláintecare (2018) and Healthy Ireland (2013) have all advocated for supports to make more positive changes around health and well-being in marginalised communities. These supports are particularly relevant for high-risk groups, including women living with problematic substance use and especially those who are pregnant.

Despite the challenges, it is during periods of pregnancy or on the occasion of becoming a parent that women are more likely to seek therapy and are more open to receive care (European Monitoring Centre for Drugs and Drug Addiction, 2022). Pregnancy and parenthood are therefore seen as an ideal opportunity for women using drugs to consider a different path or a different way. An Rogha Eilé, is the Family Support Service offered by the Finglas Cabra LDATF. The service offers a safe space for parents and family members to build resilience, ultimately helping them to cope with the impact of addiction in their family.

In 2022 an application for funding was made under the Community Enhancement Fund, Health Service Executive, to augment the current services with an additional pre-and post-natal health and social care initiative in Community Health Care Organisation 9 (CHO9). The service would provide additional community-based services for a very marginalised group, pregnant women, and their children from 0-8 years old. The Family Health Worker would provide specific psychosocial supports, although initially it was expected that the role would primarily be of a clinical nature. The main objectives of the programme were to provide supports to those women and their children who had not previously accessed services. It was anticipated that the service would complement the existing services offered by the Liaison Midwife Service in the Rotunda Maternity Hospital and the residential service offered by Coolmine Therapeutic Community in Ashleigh House. Additional aims and objectives of this Family Health Project are outlined in Section 5.2.

As an expanding part of the Family Support Service, this report provides an appreciative enquiry into the support delivered by the Family Health Project and the impact it has had on service users and stakeholders alike. This aspect of the Family Support Service, An Rogha Eilé, complements the overarching services which focuses on a marginalised and vulnerable group of young women, their children, their families, and their communities.

One quarter of a century later, the Finglas Cabra LDATF is firmly embedded in local government structures as a key interagency body, tasked with the implementation of the National Drug Strategy (2017) at a community level. Finglas Cabra LDATF provides support to the community by analysing and monitoring local drug use trends, developing, and evaluating support services which are evidenced based and aligned to the National Drug Strategy (2017), implementing a health-led, harm reduction approach towards working with mothers, children, and families.

4. Reviewing the Literature on Parental Substance Use

While no formal systematic literature review was conducted for this report, the authors acknowledge that the body of evidence in relation to women and substance use is extensive and well documented scientifically. The Health Research Board, the European Monitoring Centre for Drug and Drug Addiction and many reputable academic journals provide an abundance of scientific evidence and information on substance use among women. Research in the area of drug and alcohol use during pregnancy however is less extensive. One European study estimated that between 6.5% and 11% of women with problematic substance use get pregnant or give birth annually (Gyarmathy et al., 2009). In the Irish context, Corbett et al. (2023) reported that of the 82,669 women who delivered in a Dublin city maternity hospital between 2010 and 2019, 525 (0.6%) were engaged in opiate or substance use. Corbett et al. (2023) also found that this marginalised group of women had a number of complex pre-pregnancy vulnerabilities including homelessness (11.6%), a history of psychiatric disorders (66.3%) and the vast majority were single parents (92.3%). The health implications for this group are also reported. They were found to have higher rates of maternal and perinatal ill health as well as higher rates of mortality, all of which required specialist antenatal services (Corbett et al., 2023).

The number of additional variables at play with substance use in pregnancy is complex and may include domestic abuse, complex trauma, mental health difficulties, as well as housing and financial instability, all of which impact on the welfare of existing or newborn children in the family (Taylor and Kroll, 2004, McFarline et al., 2023, Kroll, 2004). Given this evidence, it is reasonable to suggest that early interventions and community-based support services, which focus on changing behaviours and harm reduction (Barber, 2015), are critical for the wellbeing of children in such families. Further evidence suggests that the provision of interagency trauma informed community services are critical for the successful outcomes of such service delivery (McFarline et al., 2023).

The challenge however remains that in many studies the voices of the children remain silent (Kroll, 2004). Reports suggest that one in eight children in the USA live with a parent who misuses alcohol or drugs (Lipari & van Horn, 2017). In the United Kingdom, 22-30% of children live with a parent who drinks to a hazardous level and 8% of children live with a parent who uses drugs (Duffy, Shaw, Woolfall, & Beynon, 2010; Manning, Best, Faulkner, & Titherington, 2009). Delivering services to service users with complex care needs is demanding. One of the challenges identified in the literature is the burnout or emotional exhaustion experienced by support staff (McFarline et al., 2023). An identified gap in the literature is the impact working in a trauma informed environment can have on staff in addiction services. This gap in the research was particularly noted when children had been taken into state care (Huggard et al., 2017). The potential impact is escalated where staff are involved in both the removal of children and the provision of support for parents, which would suggest that a separation of support services is an optimal situation (McFarline et al., 2023). While there are challenges in resourcing and delivering services to parents with problematic substance use, their children and families, the literature also identifies several specific challenges for women in accessing services during pregnancy due to a complex range of gender specific influencing factors.

4.1 Service needs and response frameworks

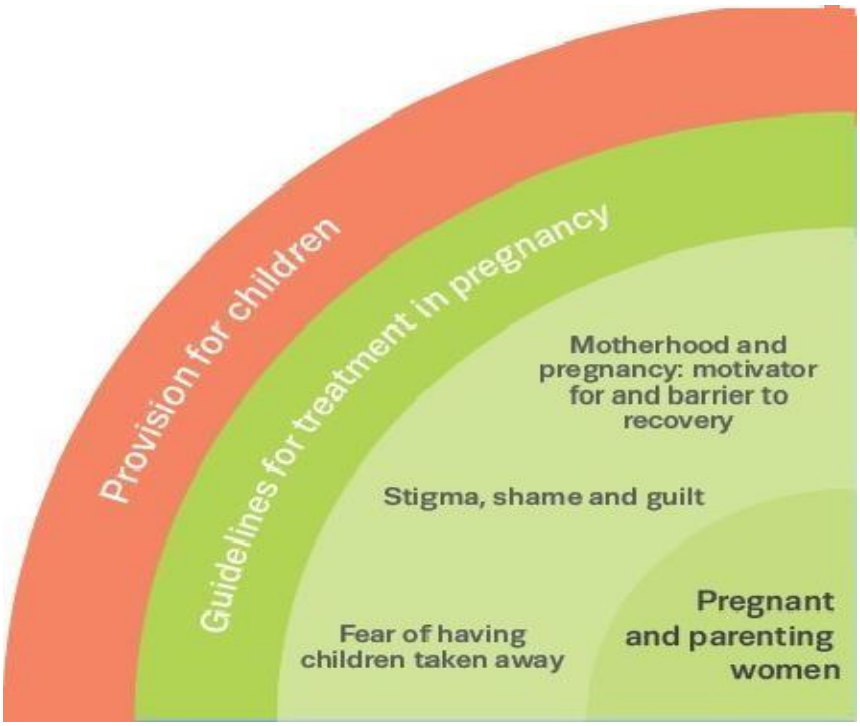
We have already seen that the estimated lifetime prevalence of illicit drug use in the female population of Ireland is 18% versus 36% for men (Arpa, S. 2017). This gender gap however is narrowest between younger adults under the age of 25 years. The available research would suggest that men and women who use drugs differ in their social characteristics, including the pattern and consequences of their drug use, and their level of addiction (European Monitoring Centre for Drugs and Drug Addiction, 2022a). Therefore women, with their traditional roles of mothers and caregivers, have different needs. This is not always acknowledged by service providers, and services remain predominantly male orientated. The evidence reports that gender specific challenges are over and above those experienced by men with problematic substance use. For some women, the issues may act as obstacles to seeking, engaging with, entering and remaining in treatment. Nevertheless, regardless of the gender challenges and the access barriers, women still comprise 20% of all specialised treatment entrants in Europe (EMCDDA, 2016a). Women were also more likely, then their male counterpart, to have a family member or partner living with addiction (Jones et al., 2007; Tuchman, 2010).

Given the high levels of trauma and self-stigma experienced by women who use drugs, it is imperative that services are welcoming, non-judgmental and practice a trauma-informed approach providing women with a physical and emotionally safe environment (European Monitoring Centre for Drugs and

Drug Addiction, 2022b). This should include general services and healthcare services accessed by all women (pregnant and non-pregnant) who use substances. In addition to general services for women, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has identified four subgroups of special vulnerable women who use substances who have specific needs. Pregnant and parenting women are one group, women in prison are another, women involved in sex work and women from ethnic minorities are the third and fourth group, respectively. The recommendations across all four groups of women are centred on the same approach.

1. Gender specific research, monitoring, and intervention.
2. Access to mental health services
3. Provisions for children (all women)

} Trauma informed services



Interventions Targets Women in General.

Specific Interventions for Group

Issues concerning cohort.

Figure 1 Service Needs and Reposes For Pregnant and Parenting Mothers

4.2 Principles and guidelines for interventions

In addition to the framework provided by the EMCDDA, the World Health Organisation (2014) identified a number of cross cutting principals which underpin best practices in the identification and management of problematic substance use in pregnancy include the following:

1. **Prevention** – requires a multiagency, multidisciplinary approach to the provision of information and a health-care system which implements prevention strategies and supports

healthy choices about substance use among women of childbearing age supporting a healthy home and social environment.

2. **Safeguarding against discrimination and stigmatisation -** requires services to be delivered in a non-discriminatory, non-judgemental way , which are flexible, person centred, and which promote family, community, social support and inclusion. This can be achieved by fostering strong links with available childcare, employment, education, housing and other relevant services.

3. **Ensuring access to prevention and treatment services** - specialised services for women with problematic substance use should be recognized as an important component of the health system and needs to be available proportional to the clinical need. The service should take into consideration the childcare needs of women when considering the accessibility of their services.

4. **Providing multiagency comprehensive care –** pre- and post-natal services for women with problematic substance use should have a level of comprehensiveness that matches the complexity and multifaceted nature of problematic substance use and their service needs.

5. **Respecting individuals' autonomy-**. The autonomy of pregnant and breastfeeding women should always be respected. Women with problematic substance use need to be fully informed about the risks and benefits, when making decisions about their health care.

4.3 The evidence on barriers to accessing service.

However, even when the services provided are optimal and accessible, the traditional role of women, which stigmatise drug use, acts as a barrier to service seeking behaviour. Other identified barriers are more intense for pregnant women and mothers in active addiction who require gender specific interventions and support for their children as detailed in the evidence. The research would suggest that the main barriers of stigma and discrimination are interlinked with other barriers as detailed below. The stigma that comes with having a child removed from a mother's care may impact future pregnancies and future child custody because of continued substance use. The relationship that a woman has with her partner, husband or father of her children, and their drug use, can also impact on her drug use and recovery as highlighted in this section.

4.3.1 Discrimination and stigma

Unlike other identified risk factors associated with child welfare, there is a very specific stigma and shame associated with parental substance use, for women. Escalated shame and societal stigma, surrounding substance use for pregnant women, can make it difficult for them to seek help or disclose their substance use to healthcare providers. While pregnancy may be an opportunity for women to reconsider their substance use, their pregnancy may also be the very barrier which prevents them from seeking help, at a time when their prenatal health is of utmost important (McLafferty et al., 2016, Steele et al., 2020). Women who use substances during pregnancy may face legal and social consequences, such as the loss of custody of their children or even criminal charges. It is often assumed that good parenting and substance use are not compatible, however the findings from the study by Roy (2023) would suggest this is not always the case. Roy (2023) reported that *"while some children are at significant risk of harm others are not and may be better supported through non-statutory services"* (Roy, 2023, p.1) at an earlier stage.

4.3.2 Partner with problematic substance use

In addition to discrimination and stigma, women with problematic substance use are more likely to have a partner with the same problem (Jones et al., 2007; Tuchman, 2010). As women place a high value on their relationships, a partner with problematic substance use can contribute to the start, the escalation, and the relapse of their female partners drug use (Bloom et al., 2003; Grella et al., 2008; Neale et al., 2014; Arsova Netzelmann et al., 2015). Women are also at a higher risk of blood-borne infections from their intimate partners (Roberts et al., 2010) and are at an increased risk of violence (Neale et al., 2014; Benoit and Jauffret-Roustide, 2016). Where partners are also using substances or alcohol this can also exacerbate the risk of abuse. Emotional, sexual and physical abuse have all been linked to substance use (Kroll, 2004). A partner with problematic substance use may also be more resistant to, and less supportive of, their partner's treatment and recovery, making women feel they will damage their relationship if they become drug free (UNODC, 2016). Farrell (1999) reported that women in Ireland are more likely to engage in risky behaviours than their male substance using counterpart. They are also more likely to have a substance using partner (74%) and have a drug related health problem including mental health (Farrell, 1999, Steel).

4.3.3 Lack of gender specific services

Another major barrier to accessing services and specialised clinical treatment during pregnancy is the lack of gender specific services. The evidence has already noted several specific challenges for women in accessing services, but women may also have specific care needs as mothers and primary carers (Niccols et al., 2012). Research has shown that women who use substances may have difficulty providing stable environments for their children, fuelled by severe economic and social problems, such as lack of affordable housing and homelessness. The decision to access residential detox or seek treatment support may not be an option if they are the primary carer of their children without family supports. The research shows that programs with prenatal care or childcare were associated with improved outcomes in substance use, mental health, birth outcomes, employment, and health (Ashley et al., 2003). A review of publications by Orwin et al., 2001, reported that enhancing "women-only" addiction treatment services, which include prenatal care or therapeutic childcare, add value above and beyond the effects of standard women-only programs. This is an opportunity to break the cycle of substance use, social exclusion and abuse experienced by the current generations of mothers with problematic substance use.

4.3.4 Fear of loss of child access.

In addition to their relationship with partners, the most important relationship for women is with their children. Children can play a central role in issues surrounding women's drug use and recovery (Grella, 2015, UNODC, 2004). The evidence recommends that interventions should promote healthy connections with children, family members, significant others, and the community (Bloom et al., 2003). While family involvement is an important aide to treatment and can enhance drug treatment affectiveness (Greenfield et al., 2007; Espinet et al., 2016; Selbekk, 2016; Slesnick and Zhang, 2016), it is the distress of the loss of custody of children that is the greatest fear for women living with substance use. The relationship with Tusla Family Agency, according to service users interviewed, did not inspire trust, confidence or seeking help. It was described as the last resort for most women.

4.4 Summary of evidence & best practices

Alcohol and substance use during pregnancy is a significant global public health concern that can have a range of negative outcomes for both the mother, the child, family, and the community. Women who are impacted by illegal substances during pregnancy are at a higher risk of experiencing health complications such as premature birth, low birth weight, and infant developmental delays. Substance use during pregnancy can also have a lasting impact on the child's physical and mental health. The evidence would also suggest that adults with problematic substance use have a number of pre-existing vulnerabilities including unresolved childhood trauma and mental health conditions. In addition to existing vulnerabilities, for women, domestic violence has also been shown to escalate during pregnancy and in the post-natal period (McFarlane et al., 2002). While supporting women, living with problematic substance use during pregnancy, it is essential to plan for the future health supports and well-being of both the mother and the child. While these facts speak for themselves the research has found that there are significant barriers for those living with substance use when accessing supports. These barriers include fear of stigmatization, community judgement, drug debt intimidation, threats of violence, not knowing what supports are available. In addition, the principal barrier is the fear of having a baby or child taken into state care. All these factors will be explored further in the qualitative enquiry.

Ultimately in order to address these barriers, affective interventions require a comprehensive approach which addresses the physical, emotional, and social needs of the mother and the child. Healthcare providers, policymakers, and community organisations must work together to provide access to treatment and support services which are flexible, rights-based, and person-centred. It is also recommended that stakeholders should distinguish between substance use, alcohol use, and mental health conditions (Kroll, 2004). The myriad of challenges experienced by families living with problematic substance use is complex. Organisations must work to reduce the stigma and shame surrounding substance use during pregnancy through education and information sharing. It is essential to prioritise the health and wellbeing of women and children to ensure a healthy and happy future for all, breaking the cycle of substance use and its associated social problems.

While healthcare during pregnancy is clearly important, it is of equal importance to support children and families *"further upstream"* to prevent generational and community problems escalating. Postnatal appointments and developmental check-ups are an ideal opportunity to reach those who need support and also provide an opportunity for screening for domestic abuse (O'Brien Green, 2021), childhood trauma, and for providing information and general support advice. This is the role and the service gap

filled by Finglas Cabra Local Drug and Alcohol Task Force (FCLDATF), An Rogha Eilé, and in particular the aspect of the programme which deals with pregnant women, their children, and their families.

5. An Rogha Eilé – Another Choice

The aptly named An Rogha Eilé (another choice), is the overarching Family Support Service, within the FCLDATF which in the last two years (2022-2024) has continued to expand its work by supporting pre-and-post-natal women with problematic substance use through their Family Health Project. The focus of the Family Health Project is.

- To support women who do not access adequate support services for themselves and their children.
- To respond to the complex needs of women in relation to pregnancy and other women's health issues.
- To provide targeted interventions aimed at women to reduce health related harms.
- To empower women to engage with local supports and to take care of their own health.
- To increase opportunities for women to link in with health services increasing their own health literacy.
- To support and positively influence women with treatment and recovery goals, improving their health and quality of life.

While the intervention initially had a strong health focus only, operationally the support is complex and includes housing, school, child custody and access problems, mental health, domestic violence, childhood trauma, and several multidisciplinary challenges which could not easily be addressed with a clinical approach. The programme also works to promote greater understanding, knowledge, and awareness of the needs of pregnant women and young parents at an interagency level. This is achieved through building relationships across sectors and organisations, working in essence as a multiagency caseworker for the benefit of the service users. The intervention builds on the success of general family support services in the area, providing this target group with specific bespoke, applied services.

5.1 Vision and mission

The new intervention is guided by the overarching ethos of the Finglas Cabra Local Drug and Alcohol Task Force whose principal vision is of

"a community where all are working together with belief and confidence to resolve drug issues positively" (Finglas Cabra Local Drug & Alcohol Task Force, 2018)

To deliver this vision the Task Force provides a welcoming, non-judgemental, harm-reduction oriented service for parents and families. This vision is further enhanced by the additional support provided for pregnant women and post-natal mothers, ensuring the future health of mother and child who are supported as a unit. The support is offered on a one-to-one and group basis and in the case of this intervention all women were first time users of services in the area.

5.2 Aims and objectives.

The aim of the Family Health Project is to develop and expand specific services for young adults and their children in the community. The intervention is mainly concerned with those who are not supported by existing services and are experiencing problems as a result of substance use (Department of Health, 2012). This cohort have previously been identified in the National Drug Strategy (2017) under action 2.1.21 (Figure 2) which highlighted the gender inequality in women accessing and remaining connected to community support service (Department of Health, 2017).

Women in addiction and their children have been identified as having complex needs with many contributing variables. Women in this group are more likely to have experienced domestic abuse, either in their family of origin or with their intimate partner, have unresolved childhood trauma and abuse and have at least one mental health condition (Department of Health, 2017). This evidence is born out in the retrospective data analysed in Section 7.1.

No.	Strategic Action	Delivered by:	Lead Agency	Partners
2.1.21	Respond to the needs of women who are using drugs and/or alcohol in a harmful manner.	a) Increasing the range of wrap-around community and residential services equipped to meet the needs of women who are using drugs and/or alcohol in a harmful manner, including those with children and those who are pregnant; and b) Developing interventions to address gender and cultural specific risk factors for not taking up treatment.	HSE	DOH, DATFs

Figure 2 Strategic Action 2.1.21 Reducing Harm , Supporting Recovery 2017-2025 p, 44.

The intervention is designed to support the development of the mother-baby relationship, but also to increase the active engagement of the mother with community services and supports. This is achieved by reducing the specific barriers experienced by women in addiction, who lack confidence, knowledge and are worried when accessing services and supports.

In addition to supporting women, as detailed in the National Drug Strategy (2017), through the pre- and post-natal stages of their pregnancy, the additional service dovetails into the wider Family Support Service, which supports individuals and families with their parenting roles, family stressors and the complex social challenges which result from substance use. A number of evidenced based models and programmes are currently used to deliver this service including:

- Parenting under Pressure (PUP)
- 5 Step Method
- Non-Violent Resistance
- Triple P (Positive Parenting Programme) & Triple P Fearless

This support also includes access to treatment and recovery services, signposting to housing, support with child access, facilitation with maternity services and the development of sustainable coping and parenting skills which will benefit the individual, family, and community long term (Section 7.1). The journey to services had been different for all individuals who accessed the supports of An Rogha Eilé (Family Support Service). The obstacles in our patriarchal culture often prevent women from seeking the most basic information to support their parenting role.

6. Research Methodology

The aims and objectives of this report is to provide *an appreciative enquiry* to highlight the work of the Family Health Project over the last two years since its inception in 2022. The report will

- Document the achievements of the project through the perspective of service users, service providers and external stakeholders.
- Document the retrospective data that has been gathered by the project and is highlighted in Section 7.01

- Document the work practices of the project through the qualitative findings of the stakeholder and team interviews as reported in Section 7.3
- Make recommendations on the future development of the project through the integration of the evidence-based literature, quantitative and qualitative findings as outlined in Section 8.00

The semi-structure interviews sought to establish the impact of the Project on the service users, their children, and their family relationships. The qualitative interviews also explored the service users' reason and expectations in coming to the service and their experience of accessing the service.

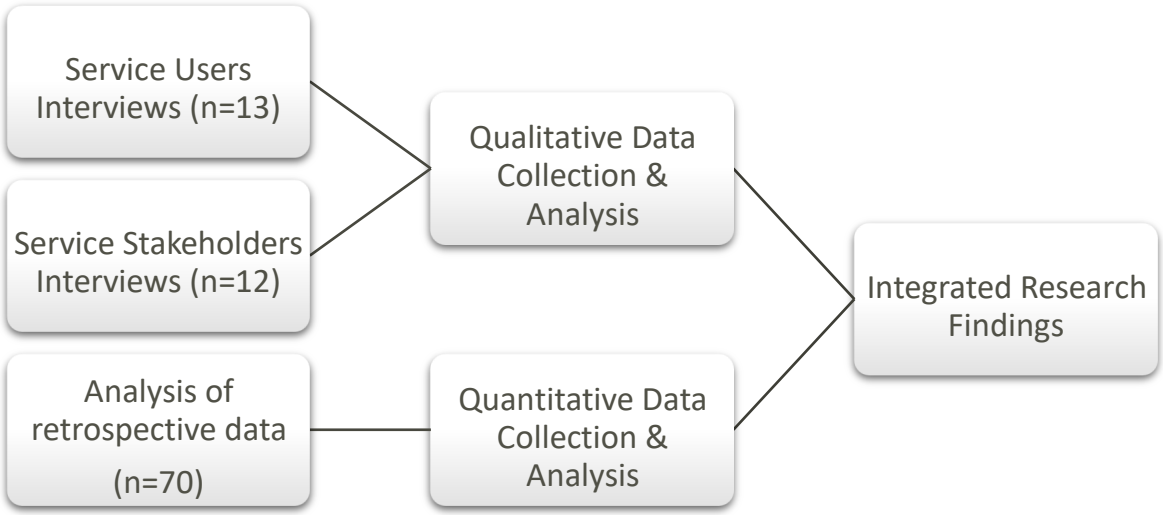


Figure 3 Research Design & Methodology

7. Findings From The Enquiry

The findings from the enquiry are reported quantitative and qualitative over the two main participating groups, the service users (n=13) as well as the stakeholders and team members (n=12). The retrospective data provides a quantitative analysis of the seventy service users who have accessed services over the period being explored. The qualitative data analysis provides a thick and rich narrative of the service users lived experiences allowing individual cases and experiences to be explored. The qualitative data collected from the stakeholders allows those lived experiences to be explored through the lens of the service providers, adding their perception of the service provided. The integration of the data sets inform the recommendations and conclusion in Section 8.

7.1 Retrospective data analysis – (2022-2023)

Between January 2022 and November 2023 seventy clients, 64 women and 6 men, accessed the service representing 174 children. Nearly 83% of service users were mothers, 14% were fathers and 3% were grandmothers providing care to grandchildren. The mean age of both mothers and fathers was 35.7 years, with the youngest parent being 18 years old (male), the mean age of all participants was 35.63 years (SD 8.50).

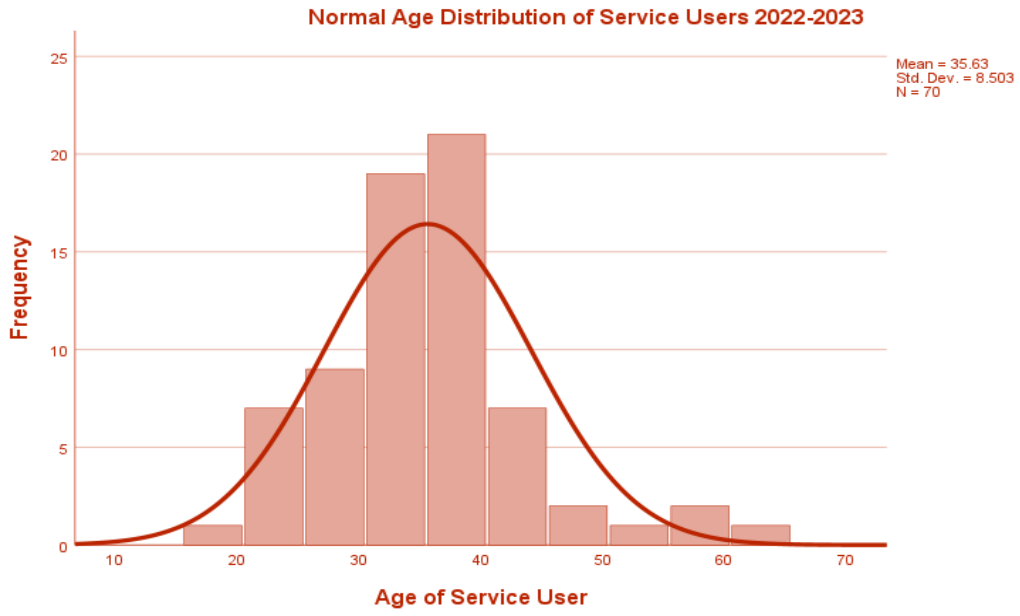


Figure 4 Frequency Distribution Showing Age of Service User

In total 94% percent of service users described their ethnicity as white Irish, and 5% self-described as Irish Travellers. Nearly 75% of service users had completed secondary education with 8.6% attending university or college. While nearly 9% of service users were married (n=6), only two of them were mothers. The majority of mothers, 71%, were either single or recently separated. This resulted in 37% (n=20) of mothers living alone in single parent household with their children. This is considerably higher, more than double, that of the national average which is 15.55% (Department of Children, 2024). Almost 13% (n=9) of service users were living alone, with their children in care, with a further 8.5% living in a mixed household with member of their family of origin. A further 20% of all service users were residing with their partner and children.

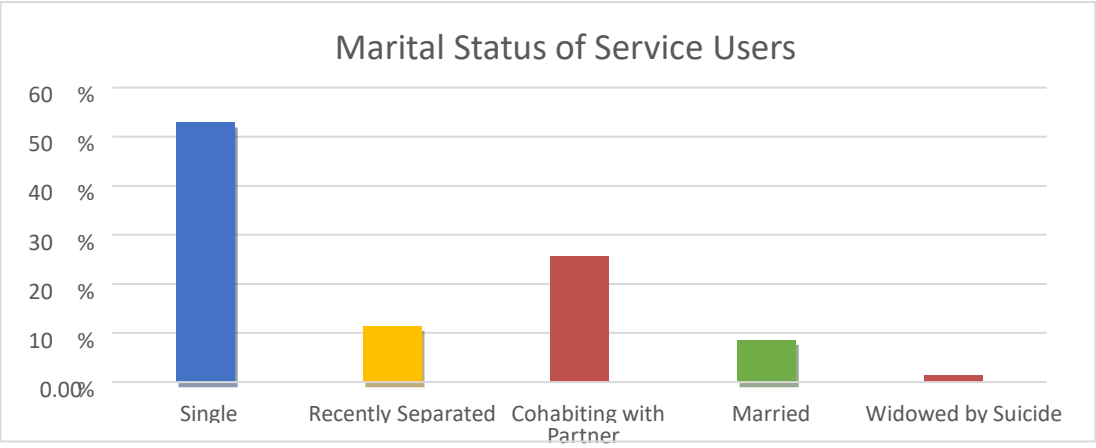


Figure 5 Marital Status of Service Users 2022-2023

Most of the service users were in stable accommodation (73%), 18.6% were clarified as homeless (n=13), 1 was in a treatment centre and 5 were in supported or assisted housing. The service users were equally divided between Finglas and Cabra, with a very limited number from Blanchardstown.

Employment Statues of Service Users 2022-2023

		Frequency	Percent	Cumulative Percent
Valid	Homemaker	23	32.9	32.9
	Unemployed	29	41.4	74.3
	Employed	12	17.1	91.4
	CE Scheme	2	2.9	94.3
	Disability	3	4.3	98.6
	Self Employed	1	1.4	100.0
	Total	70	100.0	

Table 1 Employment Status of Service Users 2022-2023

Of the seventy, first time service users, who accessed the Family Health Project, 41.4% were unemployed, nearly 33% self-described as a homemaker, 17% were in employment with a further 4.3% were receiving disability payment. A further 3% were on a community employment scheme. Of the 64 female service users who presented seeking support, 39% were pregnant at time of assessment (n=25) but 32% (n=8) miscarried

prior to delivery. This also concurred with the statements provided by other stakeholder who indicated that they had witnessed an increase in the number of pregnant women seeking support.

Inspecting referrals, the majority were self-referrals or via family and friends (n=28), including 5 which were pregnant at the time of seeking support. The highest number of referrals of pregnant women came from the HSE, Cuan Dara Treatment Centre (n=11), The Dove Clinic (n=3) and one via the Public Health Nurse. This is a prime example of interagency collaboration and demonstrates the level of confidence service providers have in the Family Health Project. It has enabled them to pass the baton from the treatment / detox / maternity hospital phase to the more sustainable community-based service. The level of referrals from Tusla is further evidence of this relationship of trust.

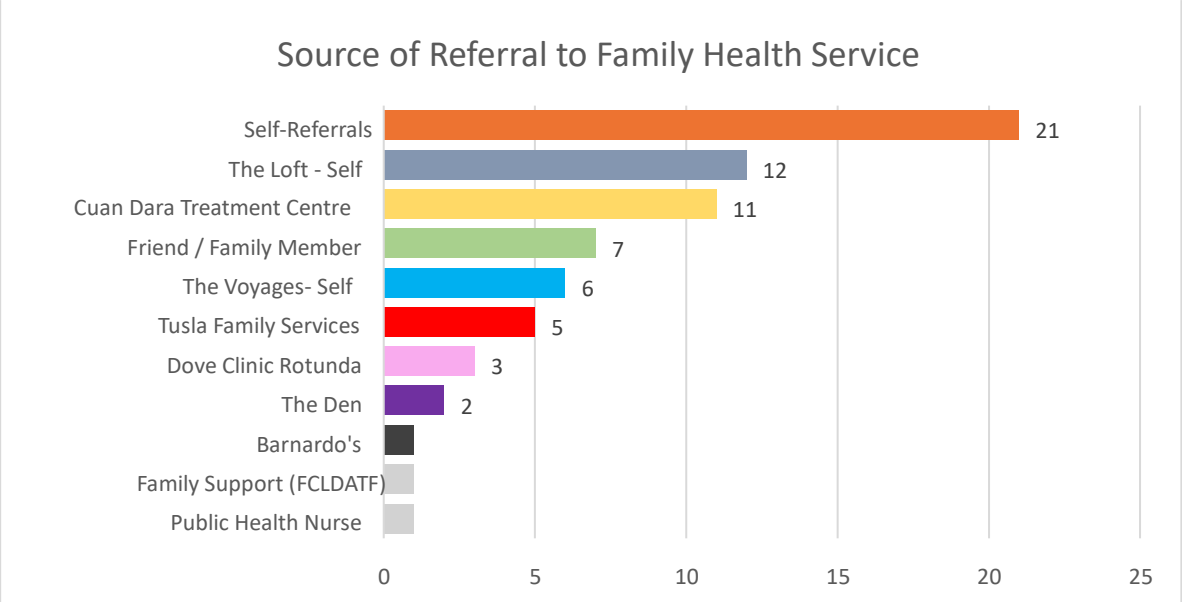


Figure 6 Source of Referrals to Family Health Project

Of the 174 children represented by the service users, 155 were under 18 years and 19 were over 18 years. Just over 52% (n=86) of children lived with the service user. This indicates that nearly half of all children born to parents (mainly mothers) affected or engaged in substance use are in the care of the state. This is a very high percentage of children in relation to the population of 1,218,567[1] children under 17 years.

Nationally, Tusla reported that 9,744 children[2] (under 17 years) were in state care which equates to 0.80% in January 2023[3]. It is difficult to qualify a relative percentage with the number of variables and the lack of comparable information, however this variance needs further investigation. The evidence would suggest that living with a parent who is engaged in substance use, is in and of itself, not necessarily an indication of neglect. The literature reviewed for this report suggests that better supports, like the Family Health Project, at an early stage, like 0-8 years, provided better outcomes for children. In fact, the poorest outcomes were reported by those who had multiple interventions and were continuously referred to Children's Social Care (UK) over a period of two years. While parental substance use is certainly one of the main worries in providing safe, consistent, physical, and emotional care for children (Cleaver et al., 2011), it is not the only concern. Roy's (2023) study reported that more than half of the children living with parents with problematic substance use did not need social care interventions and were not at risk of harm. In the cohort of service users, it was found that sixty-nine children were formally in state care, thirty formally in the care of another family member, and over half were in state foster care.

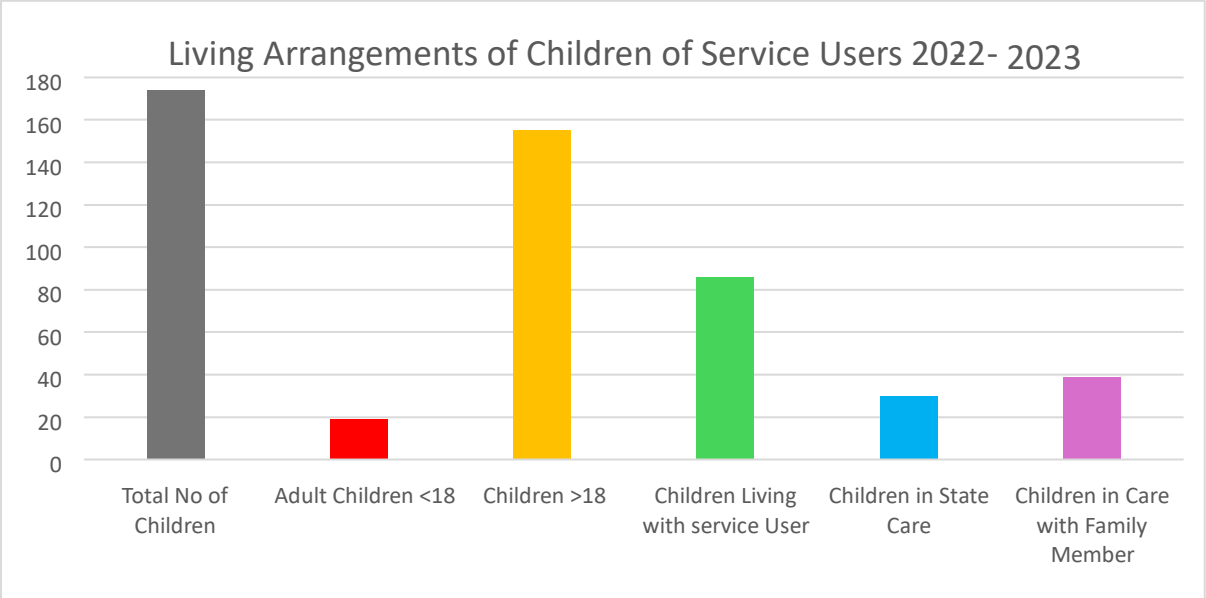


Figure 7 Living Arrangement of Service User's Children 2022-2023

In line with the international evidence, the service users had very specific health and complex support needs. While 38% (n=27) were supported by the parent of their children, 64% had family of origin support,

2 CSO Population by single year age 2023 2 CSO population by single year age 2023

3 [3]January 2023 was provided by Tusla from the National Childcare Information System (NCCIS)

but 11% of single mothers had no family or partner support at all. At the time of delivery and medical emergencies the Family Health Worker was often the only support. Mental health featured heavy for service users, confirming international evidence, 48% (n= 33) were diagnosed with a mental health condition. Nearly 75% were living with a diagnosis of depression (Figure 8). This is in keeping with international evidence in relation to the correlation between mental health and substance use.

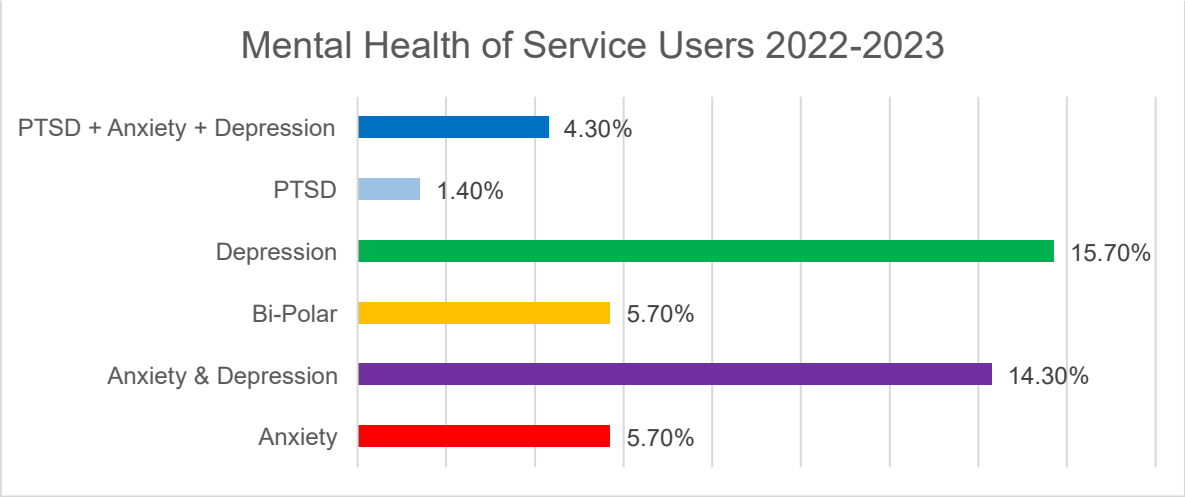


Figure 8 Mental Health of Service Users 2022-2023

Of the service users who presented seeking support in 2022-2023, over 57% (n=40) had a family history of substance use (14% history unknown). Over 25% had grown up in a home where their parent(s) were engaged in substance use and 10% of their siblings also had problematic substance use. While over 4% of service users' current partner was engaged in substance use, 7% had a previous partner who was engaged in substance use. Just over 4% of service users were now impacted by the substance use of their son /daughter and 37% of service users were on a methadone programme when they first sought support.

The correlation between childhood trauma and violence is clear in the vast body of literature and will be explored further in the findings from the nested sample of service users interviews in Section 7.2. However, a review of the retrospective data from 2022-2023 provided some thought-provoking findings. Of the seventy service users who sought support, over 48% had a history of childhood sexual abuse. Considering research reports that 1 in 20 children in the UK have been sexually abused (NSPCC, 2021) this figure is overwhelming. On further investigation it was also discovered that nearly 33% of service users were raped as adults, 74% had been sexually assaulted and over 67% had been subjected to intimate partner abuse. The findings show a significant association between the number of service users who were subjected to instances of childhood sexual abuse and intimate partner abuse.

7.2 Findings from Interviews with service users

In total 11 individual service users, plus one couple, were interviewed on a one-to-one basis between October and December 2023 (n=13). The mean age of the participants was 37 years, with the youngest being 25 years and the oldest being 65 years. Almost 77% of participants described their ethnicity as white Irish, with 23% self-describing as Irish Traveller. All participants except one were born in Dublin. All contributing mothers described themselves as single (N=9), two married and one single grandmother attended on behalf of their families and the participating couple described themselves as engaged (N=2). The levels of education varied across participants with only one participant receiving no schooling following the death of both parents, and two siblings at a young age (Figure 9). Over 34% of participants started second level education, with 17% completing their Leaving Certificate.

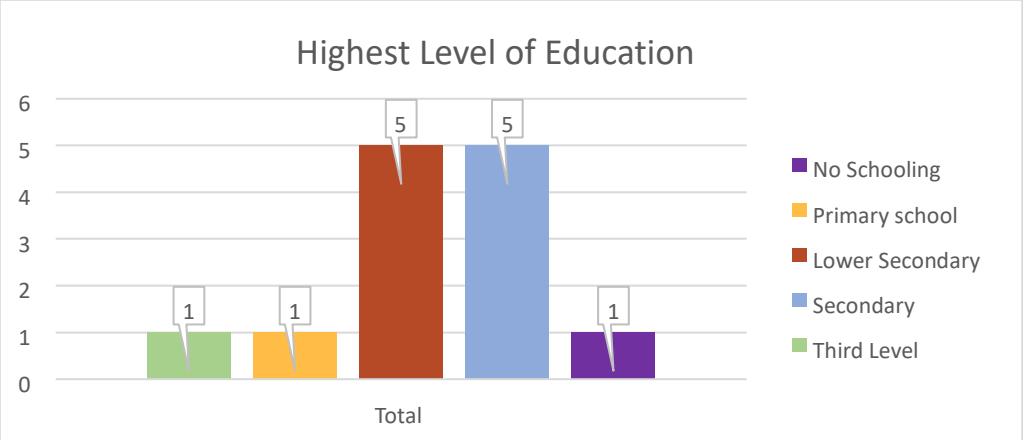


Figure 9 Highest Level of Education of Interviewed Service Users

For 31% of participants, heroin was their first experience of an illegal substance while cannabis was the first substance experienced by 46% of participants. Looking at when participants were first engaged in the use of illegal substances, the average age was 15.6 years (Figure 11). Of the participants who had self-reported being engaged in the use of heroin, the average age of their first experience was 22 years with the youngest being 15 years and the oldest being 33 years (Figure 10). This indicated a very young age when access to drugs were first available to this cohort.

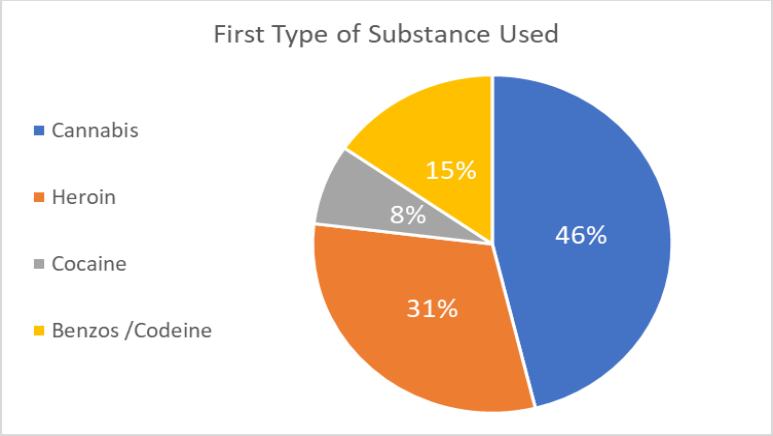


Figure 10 First Substance Used

Of all participants who reported ever using cocaine (n=8), the average age of first use was 16.5 years, which represented 50% of self-reported users. This was much younger than the average age of those who first experienced heroin. Crack cocaine was the domain of older substance users who first used the substance at 42 and 38 years respectively (n=2). Participants were also asked about traumatic childhood experiences; the Adverse Childhood Experiences Scale (ACES)[4] was used.

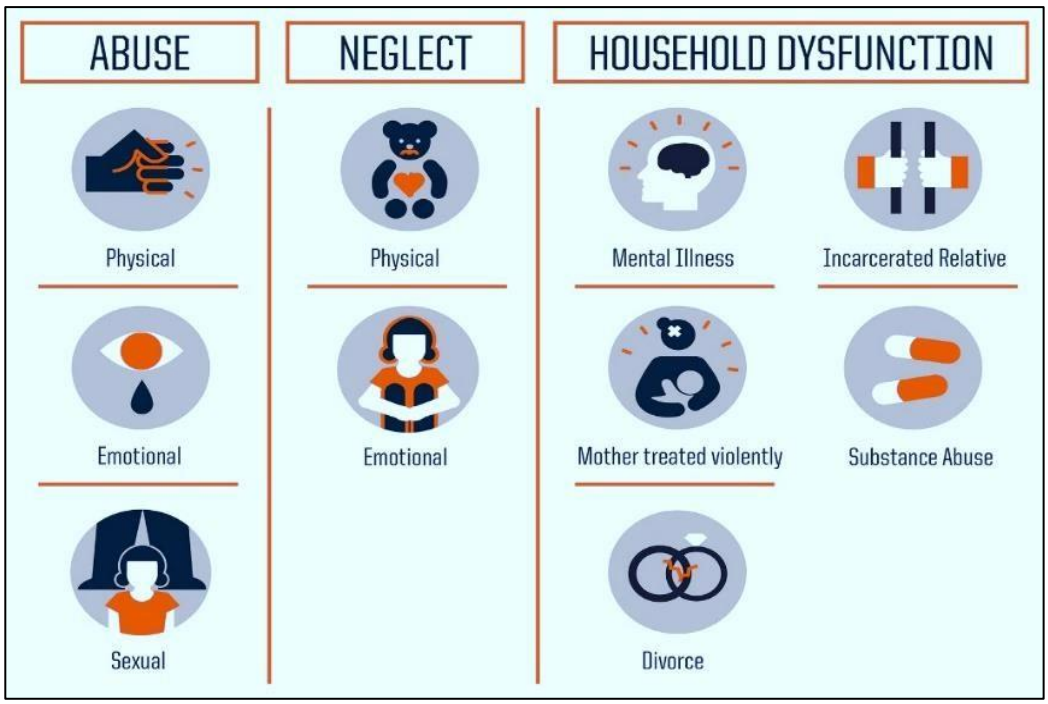


Figure 11 Adverse Childhood Trauma Scale - Groups of Trauma[5]

[4] Source: NPR, ACEsTooHigh.com. This ACEs Quiz is a variation on the questions asked in the original ACEs study conducted by CDC researchers.
[5] [5] Source: Centres for Disease Control and Prevention Credit: Robert Wood Johnson Foundation

Participants were asked ten questions about common traumatic experiences that occurred before their 18th birthday. The questions were divided into three groups which indicated abuse, neglect, and household dysfunctionality in their family of origin (Figure 12). A "yes" answer scored one on the ACES, a "no" scored zero. Evidence suggests that higher ACES scores often correlated to challenges in later life, including higher risks of certain health problems i.e., addiction. While a full analysis of ACES scores compared to other variables is beyond the scope of this report, it appears that some participants with very high score (8-10) on their ACES first experienced drugs at a very young age (10 and 13 years). This is related to sexual abuse in the top scorers, with Morton et al. (2023) arguing that there is a clear connection between substance use in women, childhood trauma and abuse.

It should be noted, however, that some children develop resilience and have the ability to overcome serious trauma and hardship while others do not. Research would suggest that some children are more genetically disposed to being more sensitive to adversity than others. The validated ACEs, while a reputable and established instrument to measure childhood adverse events, provides no insight into whether an individual child is more or less sensitive to adversity and asks no questions about protective relationships. The evidence reports that the most common factor among children who show resilience is at least one stable, responsive relationship with a supportive adult.

In total the interviewed participants represented parents (n=10) or grandparents (n=3) of 26 children under the age of 19 years (Figure 13) and two young adults aged 21 and 26 respectively presenting with complex support needs. In addition, one participant was pregnant at the time of the interview. Nine of the participating parents had some or all their children in care (n=21). This figure characterised over 80% of children represented. Nine of these children were placed with family members, mainly with grandparents or fathers; two grandmothers participated in the interviews.

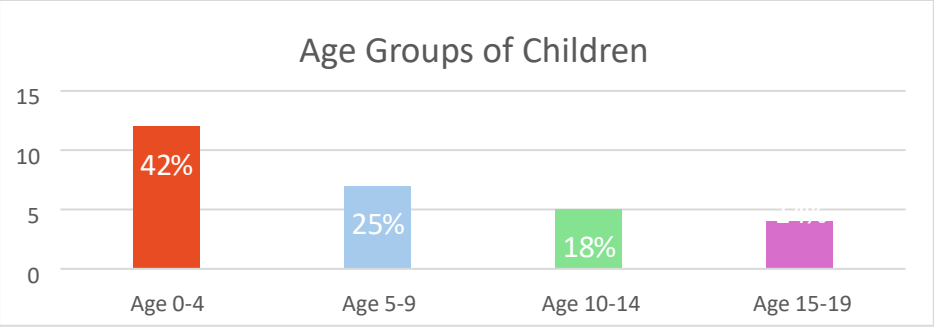


Figure 12 Age Group of Children Represented

7.2.1 Benefits of Service

The benefit of the service provided to such a vulnerable group of women and their children cannot be easily measured, and may have a long-lasting impact on individuals, their children, families, and the community. While stigma and other challenges act as barriers to accessing services (Section 7.2.5), the first impression of the service was overwhelmingly positive and welcoming. The main benefits as perceived by the participating service users are outlined below (Section 7.2.1.2 – 7.2.1.5). Their benefits are also confirmed by external professional stakeholders in Section 7.3. The summary below (Section 7.2.6.) compares the lived experience of the service users before and after the service intervention. The findings from the external stakeholders speaks positively about the benefits to their service delivery and their experiences of the service (Section 7.3).

7.2.1.2 Rebuilding Relationships of Trust

All participants spoke about a relationship of trust and the importance of trust in accessing and embracing support services. As a result of experiences with professionals in authority, most service users described themselves as distrusting prior to accessing the service.

"my trust has always been broken, so finding someone to trust again was hard, [Name] (Family Health Worker) always reassures me…… sometimes you can be in a dark, dark place, but you can get out and there is support out there. You just have to be patient". (Service User #08 Interview Transcript)

The relationship of trust was built on openness and honesty, the advocacy and reassurance provided by the service ensured that the communication was honest which was important in accessing and introducing additional necessary services.

"The hardest thing was explaining about my drug use, I thought I was going to be judged again but I wasn't, so I felt more open to tell her everything. I could talk to [NAME] , the way I wouldn't have been able to talk to other people. Yeah, she was one person I could trust".

(Service User #013, Interview Transcript)

"Yeah. Yeah, I'm getting emotional, out of everybody that I've kind of worked with, [NAME] is the only person I've had that kind of trust and relationship with, I never really had a relationship with a professional person before." (Service User #06, Interview Transcript)

The rebuilding of a trusting relationship was the critical component of the service and the relationship development ultimately impacted on other external support services also. This was further detailed by service providers in their interviews.

"For one particular service user I felt trust was a big thing for her, I definitely know that this particular client would not be linked in with me right now, and I wouldn't be in a position to support her right now had [NAME] not established that trust and developed that groundwork beforehand."
(Stakeholder Interview ST008 Project Worker, Pos. 40)

One participant described how, because of the support she received, following a rape and assault, she was able to trust An Garda Síochána and was able to tell them what had happened. The same participant also described how she now *"trusted her doctor and even her psychiatrist,"* which would not have previously been the case. Another participant with a seriously ill child struggled to confide in and trust the advice of doctors before the Family Health Worker's support.

"It's a serious heartache when you see your child in pain, you have to put your trust in the doctor's hand, and I couldn't do that because I couldn't trust them. I couldn't trust what they were saying that they were leading me down the right route" (Service User #08)

The same participant went on to describe her new-found trusting relationship with nurses, physiotherapist, speech and language therapist and radiologist, all because of learning to trust the Family Health Worker. This also gave her a boost in her own confidence and ability which was echoed by other participants.

"She never leaves me alone, in a good way. I can always ring her. I have a great relationship with her. I know I can always turn to her. She never judges. I trust her 100%" (Service User #014)

"Meeting [NAME] and building a bond and a relationship, someone you can actually trust, you know saved my life, having someone to talk to and I probably wouldn't have given social workers a chance. I understand how where they are coming from. I need time to recover and time to myself".
(Service Users #015 Interview Transcript)

"when I told her I can't and it was just, she was calm, and she told me I can do it. Because we got to a stage where I really trusted her then and I was really down in the dumps, and I would tell her I can't do it and I would just feel like throwing in the towel and she would tell me I can do it".

(Service User #014 Interview Transcript, Pos. 17)

7.2.1.3 Practical Daily Supports

While the parenting programmes, either in groups or one-to-one, were seen as invaluable it was the day-to-day practical ad-hoc support which many young parents reported as having contributed to their recovery, parenting, attendance at healthcare meetings, support with child access and other family supports. This support was particularly valuable in its flexibility and was essential for service users who had no family or community support. These ad-hoc supports included shopping for necessary appliances for a new home, attending Tusla and medical appointments, preparing for baby's arrival, and arranging school meetings for school going children.

" The parenting classes and then everything else kind of followed. [NAME] has come to TULSA meetings with me and stuff like that. So, it's more the support you know and there's someone in your corner that can see like, you're willing to try and you want to try and that would have been the main thing for me". (Service Users #012, Interview Transcript)

"[NAME] helped me with secondary school applications for my son , it's hard because he has ASD, and she brought me out to the school and helped me explain".

(Service Users #012 interview Transcript)

Both the service users themselves and the service provider who engaged and referred to the Family Health Worker also spoke about the element of reassurance and advocacy across multiple agencies.

7.2.1.4 Advocacy and Reassurance

While the service-built empowerment and confidence in young mothers and women, in the early stages of support the Family Health Worker advocated on behalf of clients who found themselves in complex situations with multiple other professional agencies.

"she came like when I was kind of confused about my addiction when I relapsed. She came into the Rotunda (Maternity Hospital) with me asked for advice on what I could do next. (Service User #06 Interview Transcript, Pos. 227)

"I don't actually know what to do , it's just because I knew there was something wrong with my child and I was like, the doctors thought they knew best I suppose. That having someone professional with me saying like how I felt was really important." (Service User #06 Interview Transcript, Pos. 215)

Gentle reassurance in times of crisis was also a critical support and one that was also recognised by other service providers. The reassurance allowed service users to remain in recovery and maintain their health care.

"[NAME] reassured me, to let me know that he is still in my care. You know that, just to kind of hold back, I will get him back. I just have to kind of hold on, she got me into treatment and kept reassuring me". (Service User #16 Interview Transcript, Pos. 251)

This reassurance and advocacy were particularly beneficial when children were ill, in complex medical situations or subject to care orders.

"The going back and forth and reassuring me that I had someone on my side that could understand what they were all trying to say because at the moment. I was still learning about his illness.

(Service User #08 Interview Transcript, Pos. 35)

In the same way that trust in the Family Health Worker spread to other professionals, the building of confidence and the reassurance enabled the service users to access other services as witnessed by other service providers and relayed in their interview.

"it's about having somebody just to tell you how much confidence they have in you, to stand up for yourself. You know, because sometimes someone just needs a little nudge. They just need someone to sit there with them and tell her you can do this. We practise this. Let's go. Do you know and just give them the bit of boost they need" (Stakeholder Interview, Addiction Counsellor #ST012, Pos. 129)

7.2.1.5 Access to Treatment & Multiagency Care

The interviews with the service users and the service providers provided evidence of the importance of the building of trust and confidence and the impact it had on most external agencies and healthcare providers. From liaising with the paediatric nurse to the Tusla Social Worker, and from the addiction counsellor to the treatment centre manager, the role of the Family Health Worker was viewed universally as one of *multiagency case worker*. The independence and focus on the service user's needs, enabled the Family Health Worker to work across organisations and services, opening doors and negotiating where other agencies could not. The knowledge and network of connections exceeded that of any other community service, as relayed by both family members and service providers.

"I knew we needed help, but I did not know what help we needed, [NAME] came up with things I would not have thought about. So, I had to talk to a social worker and [NAME] said write things down, so she also got

me help from the school, the school, actual used to come up to the house, she gets everyone working together."
(Service User #011, Interview Transcripts)

"She basically helped me out when I did not know what to say on the phone, or when I was in meetings, it did not matter who it was, they knew her and trusted her and I trusted her, so she could open doors and have conversation that we could not"
(Service User # 002 Interview Transcript)

"She did everything to help us and there was no one else who cared or tried to help."

(Service User #007 Interview Transcript)

The impact on other agencies and multiagency working is further evidenced in the findings from the stakeholder interview in Section 7.3.2

7.2.2 Summary of Service User Findings

In summary the service users were predominantly female and single mothers, in their late twenties or early thirties with over a decade of substance use, which started in their mid-teens. The majority had experienced tragic bereavement or loss, violence and trauma, abuse, and neglect, with a history of substance use in their family of origin and different levels of dysfunctionality. The service was described as welcoming and non-judgemental. The relationship of trust built with the Family Health Worker opened access to other services. Practical examples of support included attending Tusla meetings, preparing the service user for these meetings, attending and negotiation pre-and post-natal healthcare support, assisting with children's health requirements, signposting to housing, treatment, counselling, and other service needs. The role of advocate and mentor was made possible by open, honest, and supportive conversations, sharing information, and providing practical interagency communication and mediation. The support of family members, especially during a crisis, was often only minimum, including miscarriage, unplanned hospital admissions, emergency healthcare for children, abuse, and violence.

All the participants (n=13) experienced a positive improvement in their wellbeing, mental health, and quality of life as a result of the service intervention (Figure 13). Participants were asked to describe themselves in one word before and after the intervention. The positive improvements can be clearly seen in the word cloud below which represent the participants self-descriptions prior to and following the Family Health Project intervention (Figure 13).

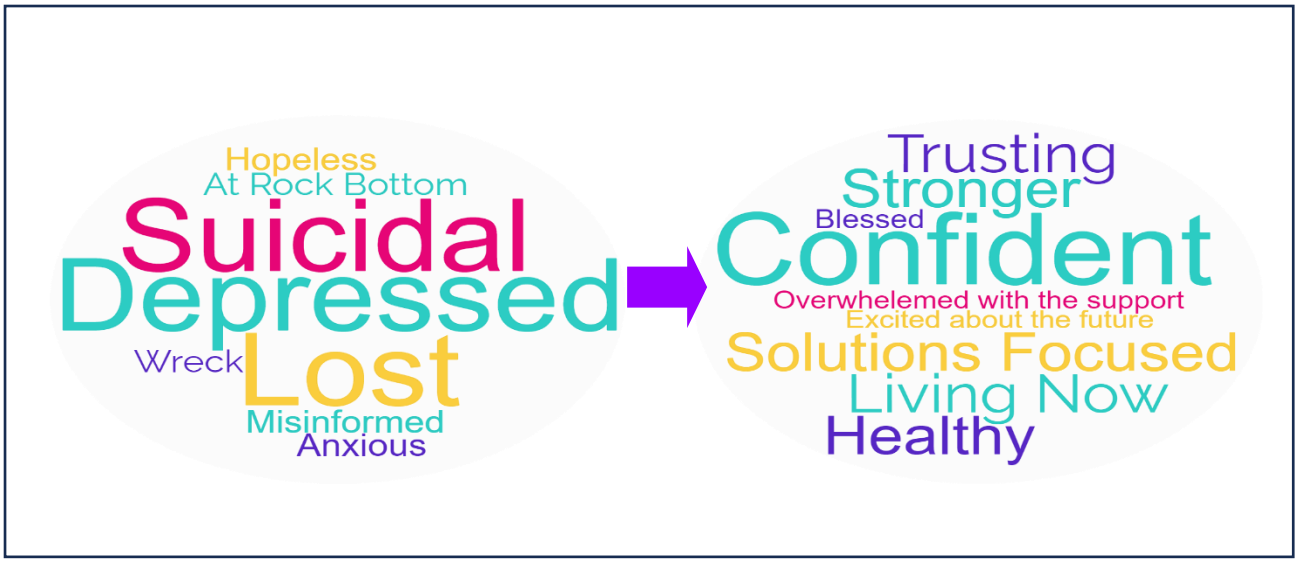


Figure 13 Self-Description Pre & Post Intervention

"The service helped me as a mother, as a human being, even how to look after myself again. To shower again to be honest. To dress again, to eat again. It goes a lot deeper. It started off with PUP ((parents under pressure) but so many things have happened after that."
(Service User #013 Interview Transcript, Pos. 62)

Additional service users advised that their relationships with their children/grandchildren had improved through evidenced based parenting programmes and communications, delivered on a one-to-one basis (11%) and in groups (44%). Nearly 10% of the seventy service users who accessed the services in this period had also accessed the 5 Step Programme. This structured and evidenced based programme supports family members affected by a relative's drug and/or alcohol use. It acknowledges the significant stress and challenges that family members often face when dealing with a loved one's addiction. The approach aims to empower family members by providing them with practical strategies and support to cope with the situation more effectively. Of the other programmes and brief interventions which were available nearly 4% of service users conducted a Drug Audit and smaller numbers attended the Non-Violent Intervention Programme, Triple P Programme and/or a multiagency Méitheal meeting.

Table 2 Service Users Self-Description before and after service intervention

	Prior to Family Support Intervention 	**After Family Support Intervention** 
SU04 Interview Transcript	I was totally lost	I'm finding out who I am now, finding out who (name) is. I kind of lost myself from a long, long time, but now I'm finding to like who I am again and being able to sit in my own company, that was a big, big thing for me.
SU06 Interview Transcript	I was lost.	I am blessed.
SU07 & SU02 Interview Transcript	My anxiety was through the roof. I was suicidal.	I feel overwhelmed with what work she is doing for us. With the motivation she has given to us.
SU08 Interview Transcript	I was a nervous wreck. so many temptations to use again.	I don't really think about myself at all, I only think about them (children)
SU11 Interview Transcript	I was a total wreck, a wreck!	I'm getting the help I need. I'm ok. I can look at things now that I can do, and I can look at the help. I can see solutions.
SU12 Interview Transcript	Depressed. Rock bottom / no way out	I would say I am living now. I am not sitting around anymore.
SU13 Interview Transcript	Hopeless, not having any information	I could not have conversations with people, it has done an awful lot for me. I have a lot more confidence than I did. Even health wise with my teeth. I am going to the dentist. I am a good mother today; I am a lot healthier. It is amazing.
SU14 Interview Transcript	On the edge, If the river Liffey were outside my back door, I would be floating in it. I just could not go on, I was suicidal. I just thought there was no one there to help me.	When my grandkids were getting help that was good for me. So, I was more at peace with myself.
SU15 Interview Transcript	Depressed, very depressed. Very suicidal	It has made me realise a lot; I am seeing the world completely differently. I am excited. I have things to look forward to.
SU16 Interview Transcript	Lost. Total lost and nobody cared.	I have an awful lot of guilt and shame and disgust. More disgust because I have let myself go. But I know I am strong,

7.3 Findings from stakeholder interviews

Interviews with external and internal stakeholders (n=12) were conducted between September and October 2023. External stakeholders included team members from Tulsa (Child and Family Agency), Crumlin Children's Hospital, Focus Ireland, Barnardo's, Cuan Dara (HSE), Coolmine (Therapeutic Residential Treatment Centres) and FAST (Finglas Addiction Support Team). The specialist Liaison Midwife service in the HSE Maternity Hospital was not available to participate. The referring professionals included a social worker, counsellor, specialist paediatric nurse, parental advocates, project workers, case manager and a child & family support network coordinator (n=9). In addition, three internal team members from Finglas Cabra LDATF were also interviewed. On average interviews lasted 50 minutes. All participants signed a consent form and received a Participant Information Leaflet (PIL). Depending on the referring individual or organisation the reasons for referral to the programme was varied. Stakeholders considered some service users to be *"high risk,"*

7.3.1 Impact on Women and Children

Historically, Hogan (1997) noted that little is known about the social and psychological effects on children of parental drug use: *'the main focus of existing research in Ireland has been on prenatal chemical exposure of children to drugs rather than on postnatal social exposure'* (Hogan, 1997: 4).

However, we do know that without gender specific post-natal services children are separated from their mother if their mothers wish to pursue a detox or treatment programme.

"There's nothing after Ashley House. So, you have a woman who's in homelessness and she goes into Ashley house. She has her baby back, she can go home, but there's very little support for her and her baby to access the day care programmes, or for her follow up treatment to keep them engaged and stuff like that. So, there's and then the child childcare has, especially since COVID childcare, is just like hens' teeth" (Service Provider #07, Interview Transcript)

The very limited number of mother and child places in treatment centres means that often mothers have to choose between surrendering their babies and entering treatment. Service providers spoke of criteria for entry to the limited spaces also and how the Family Health Worker was able to navigate the *"system"* and connect with other agencies in a way which they could not. The independence of the Family Health Worker was also noted on several occasions.

"We take people in, we meet them in very, very poor condition, often physically, mentally, emotionally, spiritually, financially when anything has happened, and it's gone wrong. The Family Support Worker meets them where they're at, alongside us, and then takes them to the next place, that we can't go because we're here. This is residential, that's our position. Like we had a lady leave this morning and she's gone to Kildare where there is no Family Health Worker to connect her in to" (Service Provider #05, Interview Transcript)

Stakeholders in general found the impact on women and children of the service far exceeded their expectations. The fact that the Family Health Worker was not tied to any specific agency gave a degree of flexibility which was recognised as invaluable by those who had to operate within the confines of their agency remit.

"There's public health nurses and there's GPS and there's doctors and so on , like that. But there's no one that's kind of going out on those missions and helping, I suppose. And that's what I found so great about that programme".

(Service Provider #02, Interview Transcript)

The confidence that the service provided to women in the post -natal phase was seen by several stakeholders as really important during the early stages of the baby's development.

"things like getting to a meeting can be difficult, intimidating, upsetting. They didn't have that one person there to kind of, you know, be a cheerleader for them, someone who will remind them of the meeting is going to be happening, someone to go with them, someone to prepare for the meeting with them, but the Family Health Worker can " (Service Provider # 10)

The support and the rapport built with the Family Health Worker during the pregnancy means that trust is implicit between her and the young mothers. Stakeholders discussed the change in the young mothers, on the basis of the preparation and encouragement supplied by the Family Health Worker. Healthcare professional also described the support they received from the Family Health Worker, they reported that meetings was less confrontational, more productive and produced more focused results. The service providers had total confidence in the Family Health Worker.

"the baby was basically in the care of all the family, cared for by everybody and nobody in one sense, which is really sad. Everyone was trying their best, and I actually don't think they would have managed at all without the Family Health Worker. So, she basically was the point of contact for me to bring the baby into the hospital anytime care was needed".

(Stakeholder Interview ST009, Pos. 5)

The positive impact witnessed by the stakeholders was observed across all areas, including health, housing, financial management, confidence and in other areas of parenting and recovery planning.

7.3.2 Impact on Other Agencies

There was certainly evidence from other agencies that the support of the Family Health Worker enabled them to focus on their own role in the provision of care services. Many service providers described their own role as quite restrictive. They described how they were *"unable to cross discipline lines or statutory roles."* Access to the Family Health Worker provided a degree of flexibility that they just could not provide, but still required. From the Family Health Worker's point of view, she did not always have access to the same services directly, which could be frustrating.

"You need a supported childcare place, and you know that the PHN can put in for or two places, but you can't. I have to go to them to get them to set it up, which is time consuming and doubles the work" Family Health Worker.

On the other hand, from the pre-natal care to the post-natal appointments, the Family Health Worker was very much viewed as part of the community care team, with service providers discussing their very positive, professional relationship with the Family Health Worker.

"Mom was using drugs heavily while she was pregnant and didn't have stable accommodation. We were really, really concerned about her and the baby, when she returned home from hospital [NAME], would remind Mom about her antenatal appointments, she'd have it written down in her diary. Sometimes she'd be at the appointments with mum. I suppose it really helped me in the way that, you know, I was able to do a safety plan, then knowing Mom was going to the appointments." Stakeholder Interview #002
it's a really good service because you can see people who may have not had the confidence to go into an addiction service that they can be met in their home, and they can be worked with for baby steps to get them to that place. So, I do think that's really positive. (Stakeholder Interview #12)

The same stakeholder describes how the Family Health Worker facilitated her to do what she needed to do, because the relationship was already established with the service users. This was an advantage as this relationship building was not always possible in statutory agencies because of high levels of movement within the sector and changing roles. The stability of the relationship, between the service user and the

Family Health Worker requires constant contact, which is not possible for all agencies. In the meeting situation the help and support of the Family Health Worker was also noted.

"I suppose sometimes, there has been different conversations I've had to have with a particular mother and [NAME] was able to, I suppose, to ground the mum in those kind of meetings and help I needed as well. She helped me to try and get my point across so that I'm not overreacting or coming across reactive. She was able to make it a little bit easier for the service users to understand because they had times and trust , you know like all of us, we can react to situations (Stakeholder Interview ST008, Pos. 34)

Trust would have been a major challenge for agency engagement with service users. Trust for this vulnerable cohort is critical in-service seeking behaviour, especially where children are involved. Building a relationship of trust with the Family Health Worker opened the door for other agencies.

"I very much felt that the interventions that [NAME] used with the service users, and I mean even the customer herself, would say she was using the intervention skills during that time period. And so yeah, it's been very beneficial having that kind of interagency communication and support (Stakeholder Interview ST008, Pos. 36)

7.3.3 Impact on the Community

The availability of Family Health Project and Family Support Services provides numerous benefits to the community, impacting various characteristics of community life and well-being. According to the evidence of service providers it's the community base and community awareness which provided the most impact.

"You know that is coming from the ground up. That it's coming from word of mouth, that it's coming from people talking with people, people participating in the community and then the community being very aware and the visible of the services in the community (Stakeholder Interview #ST004)

1. **Reduction in Crime**: Access to drug treatment services can lead to a decrease in drug-related crime within the community. When individuals struggling with substance abuse receive appropriate treatment and support, they are less likely to engage in criminal activities to support their addiction, such as theft or drug trafficking.

2. **Improved Public Health**: Drug treatment supports can contribute to better public health outcomes by reducing the spread of infectious diseases associated with substance abuse, such as HIV/AIDS and hepatitis. Treatment programs often include initiatives like needle exchange programs and access to testing and treatment for blood-borne diseases.

3. **Economic Benefits**: Effective drug treatment services can lead to economic benefits for communities by reducing healthcare costs associated with substance abuse-related illnesses and injuries. Additionally, individuals in recovery are more likely to become productive members of society, contributing to the workforce and economy.

4. **Strengthening Families**: Drug treatment supports can help families affected by substance abuse by providing counselling, education, and resources to improve family dynamics and relationships. Stronger family units contribute to the overall stability and well-being of the community.

5. **Prevention of Substance Abuse**: Prevention efforts are often integrated into drug treatment programs, aiming to educate individuals and communities about the risks associated with substance abuse and provide strategies to prevent future problematic substance use.

6. **Increased Social Cohesion**: Communities with accessible and effective drug treatment supports often experience increased social cohesion as individuals and families affected by addiction receive support and guidance. This can foster a sense of belonging, support, and mutual aid within the community.

7. **Reduced Healthcare Burden**: By addressing substance abuse issues at the root through treatment and support services, communities may experience a decrease in the burden on healthcare systems related to emergency room visits, hospitalizations, and other healthcare services utilized by individuals with problematic substance use.

Overall, drug treatment support services play a crucial role in addressing substance use issues and promoting the health, safety, and well-being of communities. They contribute to a range of positive outcomes, including reduced crime rates, improved public health, economic benefits, stronger families, and increased social cohesion.

7.4 Summary of Key Findings from Service Providers

The service providers felt that the Family Health Worker provided practical daily support to individuals in the programme, going above and beyond her job requirements. She helped with tasks such as shopping, attending appointments, and writing letters. She also provides emotional support by connecting individuals

with counsellors and mental health doctors. The Family Health Worker helped with school applications for children with ASD and supported individuals during moves. She guided new mothers through addiction services and provided disability advocacy. The Family Health Worker meets individuals where they are, including at home, and provides reminders and preparation for meetings. Overall, the Family Health Workers' support is crucial in helping individuals navigate difficult situations and improve their daily lives.

7.5 Barriers to access services

The barriers identified by the service users participating in the qualitative interviews were in line with the international evidence in relation to the provision of support to families living with substance use in the communities (Section 3.3). The lack of **gender specific services** especially for detox and treatment was seen as a high-level barrier for women accessing services. While the Family Health Worker did access any available services one expecting father expressed his concern.

"She was the only girl there pregnant with 10 men and every time she went down to the kitchen, they would follow her. It wasn't the place for her, she did not feel safe." (Service Users #07)

His partner also expressed similar views and in addition added that,

"Definitely should have a detox centre just for women. There are no activities, nothing about a birth plan or parenting or caring for babies. Absolutely nothing" (Service Users #02)

Another area identified by several service users was the lack of childcare facilities at day programmes, AA meetings and other community support facilities, which is also considered a gender specific barrier as mothers and grandmothers are traditionally still considered the main source of childcare. It was universally accepted that this was a real barrier which prevented mothers from accessing services and could also be linked to the reluctance in entering detox and treatment services.

"Childcare is the main thing because it's hard when you have kids and you have to mind them all the time. My main thing is recovery and it's very hard when you have a child and a newborn and there is nowhere to put them until the meeting is over" (Service User #03)

"I have nobody to mind the kids. I'm not flexible. If you want me to come to a meeting I have to come with the kids, same with this appointment, same with a nurse, doctors. I don't have babysitters, I'm a single mam, when I come, they come too" (Service Users #08)

"I couldn't go into a treatment centre before because of childcare, like especially for my autistic child as well. It is hard, childcare is probably the one thing. I have to do my meetings online because when the two kids came home, I was lost. I needed to get to a physical meeting. Yeah, that's probably the one I'd change is the childcare" (Service Users #12)

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Even when participants had a partner, they were not necessarily supported with childcare when they needed to attend meetings and support programmes. This was common. Service users were often estranged from their family of origin and did not have their support or assistance with childcare. The reasons for this were varied.

"I haven't spoken to my mam in nearly two years. I'm worried about her constantly because I'm not there. My mum at the moment is in severe addition, heroin drug addict and alcohol. And I know that sounds crazy. She's gone. She won't get help, she won't go to meetings, she won't go to doctors, she is completely gone. She just isn't home. I have to stay away; it brings me to a lower place that I was, and I don't like that feeling" (Service User #08)

While ensuring access to gender specific services outside the Finglas Cabra LDATF Family Support programme is beyond the scope of the organisation, advocating for such services is a critical part of ensuring that services meet the needs of service users. Stigma and discrimination were also identified as an external barrier to accessing services and is concurrent with the international literature. The very positive experience that service users had accessing the services was contrary to the reported stigma and discrimination experience with health care services and Tulsa Family Services. Self-stigma was also evident with one service user commenting.

"Like I could be wrong because I'm an addict and people look down on me, so I could be wrong in what I'm feeling" (Service Users #06)

"Even as an addict, this family support programme does not judge you…. All I've even had was people, judge, judge judge" (Service Users #013)

"I was kind of scared of being judged "she can't mind these kids" I didn't know what to say, I was afraid of saying too much. But the Family Health Worker was friendly. I could tell her more, you know what I mean, and she understands……. and taught me a lot. I was afraid, social workers were going to take him. He is only 11, he has special needs" (Service User #011)

"you feel hopeless, what's the point. That's the attitude you come out with having dealt with them, well I've tried and there is no point trying again, health care is not for everyone" (Service Users #08)

"[NAME] sat in the hospital with me for hours, with my (Service User #06)

"she would have pushed for things for me also when I felt I was not being heard" (Service Users #016)

"[NAME] came to one of the appointments with me and she came like when I was kind of confused about my addiction when I relapsed, she came into the maternity hospital with me asked for advice, on what I do next " (Service User #06)

"I'm not saying she made me spend my money, but she knew what I needed for the new house and the money I had been given, and she knew I needed a cooker. She was there every morning to go shopping. And I did, I got everything that we needed" (Service Users #013)

While the service and support were truly person-centred and flexible, evaluating projects which vary in terms of activities, sector, target clients etc. essentially demand a mixed approach involving inspection of quantitative data and qualitative data assessment. The true impact of the outputs and results of the programme would require a scientific study design with a control group and a relatively large sample size, which would be incompatible with the cost and characteristics of these projects. However, the summary of the service user findings reported below and the before and after narrative in service users' own words provides evidence of a change in quality of life and a more positive outlook for all concerned.

8. Recommendations from Exploration

One of the overarching objectives of this report is to make recommendations about the future activities and operations of the Family Health Project, Finglas Cabra LDATF, and in particular the elements which target pre-and post-natal mothers and babies. As evidenced in the stakeholders interviews the number of pregnant women presenting at services with problematic substance use is increasing. The fact that the service has provided support to 25 pre-and-post-natal women and their families in the last 24 months is testimony to the growing need and the objective identified in the National Drug Strategy (Section 5.2.). The external service providers also pointed to a gap in areas where this service is not provided. This targeted service has applied evidence-based support and adapted to the changing needs of the most vulnerable group of substance users at a time of additional health and social care needs.

The Family Health Worker in the Finglas Cabra Local Drug and Alcohol Task Force provides a flexible, non-judgemental support which advocates, navigates, and communicates service users' needs across services

and disciplines at a time when evidence suggests they are more susceptible to engaging with healthcare services, perhaps for the first time.

8.1 Recommendations

Regardless of the direct benefits, we know that the benefits of interventions do not simply accrue to those with problematic substance use and their families but to the community at large and to future generations. The challenge is measuring the impact of such a multifaceted project, while the National Drug Strategy looks at population level outcomes, this report explores the human lived experience of individuals and the potential impact on the quality of life for those individuals , their children, families and community.

The overarching identified service needs are in line with international evidence; services should be non-judgement and welcoming. The language used in this regard is critical and impacts on the social and community acceptance of those living with problematic substance use. In the case of those who are pregnant, the services should be gender responsive. Complementary interventions should address the issues facing women, incorporating their specific needs into all aspects of intervention design and delivery, including structure and organisation, location, staffing, programme development, approach, and content. Once a less stigmatised, gender specific, respectful service is designed this ringfenced resource should be available across all Family Support Service teams to address the growing need and current gap in services according to the evidence. At a more project specific level, the following practical recommendations have been extracted from the data with a view to improving the current service and futureproofing the upscaling of services to other areas.

1. Access to Childcare.

Recommendation for Practice - One of the principal barriers for this cohort when accessing services is access to childcare. With the majority of service users being single parents, the mother and child must be viewed as a single unit in the provision of support. This is not the case with fathers and children. So, whether it is residential detox, a *Parents Under Pressure* group meeting or addiction services day programmes, childcare must be provided for in order to remove this very specific and real barrier. While this service is currently provided by the Family Health Worker in emergencies, *where possible*, a standard drop-in service should be available to all mothers and parents in order for them to attend to their own health care needs at this most vulnerable time. This remains one of the main recommendations of service users when asked about additional supports or services.

Supporting Evidence: Across Europe in the last decade there has been calls for the integration of childcare facilities and treatment centres (EMCDDA, 2012). The earlier National Drug Strategy in Ireland previously considered the implications for children of such shared facilities and the risk of further stigmatisation children of those who live with problematic substance use (Department of Health, 2001). There is the opportunity for subsidised childcare to be provided locally which is available in other areas including parts of Dublin (EMCDDA, 2012). Alternative gender specific services which are provided by SOAL (www.saolproject.ie) look at the holistic needs of women and their children. In order to address this barrier to services mothers and children must be viewed as a unit when seeking treatment in particular, but especially during period of pre- and post-natal health care needs. The National Reducing Harm, Supporting Recovery (Department of Health, 2017 p. 45) identifies the support needed for the mother-baby relationship, and while the strategy specifically recommends the expansion of the Drug Liaison Midwife (DLM) support, the evidence of this report would suggest that the psychosocial supports are more holistic and more responsive to the many needs of the service user which are not covered by a clinical approach alone. In fact, the delivery of social outcomes in the National Drug Strategy are highlighted in several areas.

2. Standard Referral Process

Recommendation for Practice – While one of the strengths of the Family Health Project is the flexibility and the unique person-centred approach to providing supports, the main request from service providers was for a standard referral form. While the current approachability was certainly appreciated and commented on by external service providers, a number indicated that a simple referral form would enhance *"their records"* and also provide a *"more formal link into the service."* There is no doubt that this best suits the record keeping and risk management of external agencies. It may also act as a record of the informal communications and referrals directed to the Family Health Worker. However, it is critical that communication and interagency exchanges continue at their current high level and relationships are maintained even if the referral becomes more formal.

Supporting evidence:

The evidence suggests that once an informal referral is activated a more structured process should be introduced (O'Reilly, Lawless 2023). This referral process should activate a care plan which will support and encourage the service users at each stage of their engagement and recovery as outlined in the National Drug Strategy, Reducing Harm, Supporting Recovery 2017-2025. This national strategy which describes recovery as a *"personal matter*" (Department of Health, 2017 p.35) must also ensure that critical access to services, and the current effectiveness of the response is not tied up in hierarchal red tape once referrals become more formal.

3. Measuring and Tracking Outcomes

Recommendation for Practice – While progression to detox, stabilisation and/or treatment are very important milestones for the service user, it is recommended that additional information and outcomes are captured at baseline and on exiting the service. This important information could be related to quality of life (QOL), progression or engagement in training. *My Journey Travelled Scale*™[4] or other measurement instruments could also be used as a baseline measurement and a way by which to measure quality of life progress. Other collected data could include the number of facilitated engagements with other services and agencies, improvement in patterns and levels of substance use, or participation and satisfaction levels with evidence-based parenting programmes. An additional research role would greatly benefit the Family Health Project at this stage, providing vital information for the upscaling of the project.

Supporting evidence: The evidence suggests that improving parenting skills and capacity improves outcomes for children. Measuring and tracking outputs shows a reduction in the actual costs of service provision, including a reduction in costs of providing foster care, emergency room visits, medical and enhanced healthcare provisions and ultimately the cost of social services delivery (Niccols et al, 2012, Roy, 2022). The National Drug Strategy also indicates that a performance measurement should be developed to strengthen the delivery of initiatives and to improve outcomes. A set of indicators should be agreed in this regard.

4. Resource Management

Recommendation for Practice – While there was no evidence of stressors in the current Family Health Project, it is recommended that duplication of the service into other CHO areas could benefit from external professional supervision. The level of vicarious trauma and everyday stressors could lead to burn out and the loss of experienced trained professionals who work in addiction. This would be particularly useful if the services were being upscaled or expanded into other areas, and this supervision could form part of the process and support offered to team members.

Supporting evidence:

Evidence suggests that the rate of burn out among those who are working in the area of addiction services is very high. There are a number of reasons, including the personal determination to fix the situation in complex and inherently stressful situations (McFarline et al., 2023). Working in alcohol and drug recovery services can have a long-lasting emotional impact of the role of service providers and managers. This level of stress could be managed using a validated traumatic stress instrument for example (STSS) Bride et al. 2004.)

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https://www.pobal.ie/app/uploads/2020/01/My-Journey-Form-1.pdf

8.2 Conclusion

Harm reduction strategies encompass a broad array of interventions aimed at minimising the negative health and social associated with problematic substance use, both for individuals impacted by substance use and for the wider community. Generally, these interventions range from providing sterile needles and syringes through needle exchange programs to offering drug testing facilities, overdose prevention measures, and drug consumption rooms. The overarching goal of harm reduction is to mitigate harm rather than eliminate substance use entirely. The service provided by the Family Health Worker in Finglas Cabra Local Drug and Alcohol Task Force is in line with the harm reduction approach in a more subtle, holistic, and individual way.

When it comes to the measurement of outcomes, the National Drugs Strategy (2017) typically operates with population-based objectives. This means that the interventions funded by the government to address substance use issues are designed to have an impact at the societal level rather than solely targeting individual behaviour. By intervening across multiple domains of society, such as healthcare, education, law enforcement, and social services, these strategies aim to create a comprehensive approach to addressing substance misuse. While these high-level objectives address the bigger picture, they appear to do little to support the day-to-day challenges of a new mother (father or grandmother) struggling with addiction in a poverty trap, judged by the very professionals assigned to provide support.

While, the National Drug Strategy recognises that addiction and recovery is a personal matter, the evaluation of local, grass root responses, to problematic substance use is also necessary, to ensure a positive impact at a population level. This involves assessing changes in key indicators such as rates of drug-related deaths, HIV and hepatitis infections, crime rates, healthcare utilization, and social outcomes. By analysing this population-level data, policymakers and public health professionals can determine the effectiveness of harm reduction interventions and identify areas for improvement. However, the most appropriate method to measure these outcomes, at an individual level, would be the use of a quality-of-life measurement scale like *Quality of Life* (QoL)[5] , *My Journey; Distance Travelled Tool* ™[6], or a post-natal depression scale, of which there are many.

[5] [5] https://www.who.int/tools/whoqol/whoqol-100

[6] *My Journey is a validated tool which measures soft skills relevant to employment, education and training, and personal development.*

Nevertheless, it is important to recognise that the evaluation of harm reduction strategies can be complex due to various factors, including the dynamic nature of substance use patterns, the diversity of populations affected, and the interaction of multiple interventions over time. Needless to say, by continually monitoring and adapting interventions based on evidence, policymakers can work towards reducing the overall burden of substance use on both individuals and society as a whole, as is the case with the Family Health Project in the Finglas Cabra Local Drug and Alcohol Task Force area.

The challenge however remains, that capturing the full scope of the harmful effects of substance use through indicators is complex. Substance use can manifest differently across various populations and contexts, making it difficult to create a comprehensive and universal applicable list of indicators, measurements, and outcomes. One reason for the variability in lists of indicators is the multifaceted nature of substance use and its impact on individuals, families, and communities. Substance use can lead to a wide range of consequences, including physical health problems, mental health issues, social disruption, economic burden, and law enforcement challenges. Moreover, these impacts may vary depending on factors such as age, gender, socioeconomic status, cultural background, and the type of substance being used. This is evidenced in the current level of violence and intimidation deeply rooted in some communities.

Attempting to measure the overall impact of problem substance use not only requires the identification of the various elements impacted, but the elements must also be combined and weighted in a meaningful way. However, determining how to assign weights to different indicators and how to aggregate them into a single measure of *"overall problem substance use"* can be subjective and contentious. Different stakeholders may prioritise certain indicators over others, based on their perspectives, values, and priorities. In addition, measuring impacts at the individual level is challenging because substance use affects not just individuals but also their children, families, and communities. The Family Health Project has endeavoured to examine in detail each individual case, provide the supports to overcome the daily channels , which ultimately cause roadblocks on the route to “personal recovery” which may be different for everyone. In this regard the Family Health Project is based on several overarching principles and practices.

1. **Long-term Impact:** Sexual abuse can have lasting and profound effects on addiction and mental health. Survivors have been shown to struggle with various psychological issues such as PTSD, depression, anxiety, and issues related to trust and authority. The level of adverse childhood events cannot be discounted when dealing with this vulnerable cohort of parents and their children. The Family Health Project has applied a holistic lens when supporting those women and their children affected by substance use, meeting individuals where *“they are”.*

2. **Access to Trauma-Informed Support:** Directly linked is access to trauma-informed, evidence-based interventions. Trauma informed practices should be sensitive to the unique history of individuals, their lived experiences and their current life situations. The Family Health Project, backed by scientific research, supports and understands the pathway to trauma recovery. The service is responsiveness and flexibility, ensuring that the past experiences of the service users remain part of their holistic care journey.

3. **Supportive non-judgemental care:** It is vital that the support provided is non-judgemental and does not compound the service user's sense of stigma. This support includes believing their story, validating their feelings, and providing resources for help and healing. While the Family Health Project provides a safe and trusting space, unfortunately, many service users do not receive such responses from state agencies, which can exacerbate their trauma and mistrust. The Family Health Project has built bridges and trust in an interagency way which includes the individual at the centre of the process, empowering and building additional relations of support in the community, and building their own health literacy.

4. **Proportionate Care:** It's essential that service users receive care that is proportionate to their needs. This may include a combination of advocacy, mentoring, therapy, support groups, clinical support , and other resources tailored to the individual's situation. The individual supports may also include (but are not limited to) signposting for housing, welfare entitlements, support with child health, post-natal appointments, advice and support in relation to child protection, liaising with Tusla, schools and explaining often complicated processes to those who may have literacy challenges.

5. **Developing Evidence Base:** All in all, more research is needed to identify evidence-based interventions to support developmental trauma recovery, particularly in women engaged in substance use. This research can help identify effective strategies for addressing the complex needs of survivors and ensure that they receive appropriate care.

In summary, capturing the full extent of harmful effects of substance use for individuals and determining how to provide comprehensive support and interventions is a complex task. It requires considering the diverse range of impacts across different populations and contexts, as well as the challenges associated with aggregating and weighing indicators to reflect the overall problem of substance. The vision of the current National Drug Strategy (2017) is an Ireland where……

"every person affected by substance misuse is empowered to improve their health wellbeing and quality of life" (Department of Health 2017 p. 16)

This vision is directly supported by the Family Health Worker at the Finglas Cabra Local Drug & Alcohol Task Force which ultimately supports the future health of the unborn child and the future generations of the community.

8.3 Limitations of the Research

This report provides a snapshot of the Family Health Project in the Finglas Cabra Local Drug and Alcohol Task Force area. It is not intended as a scientific evaluation but rather an enquiry into the characteristics of service users seeking support and their experience of the services received. As a mixed method study the data is intended to provide both the breath of quantitative retrospective data analysis and the depth of personal lived experiences.

8.4 Acknowledgments

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DISCLAIMER:

The views expressed in this report are those of the authors and do not necessarily represent the views of the Finglas Cabra Local Drug and Alcohol Task Force.

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