Lifeline Project Ltd.

Risk & Response

Tackling drugs to build a better Britain

Update Number 2: Pregnancy, Birth & Postnatal Services

1. Introduction

This update briefly examines some of the issues regarding drug use during, and immediately after, pregnancy both for mother and baby, and suggests some interventions and practice in answer to these issues. For the purpose of brevity, this newsletter will concentrate on female drug users as mothers; however, it should not be forgotten that other family members' and carers' drug use can also have a significant impact on children.

In 1995 the Department of Health published a snapshot of 89 maternity services for drug users in England & Wales. It highlighted the need for obstetric and maternity staff to undergo specialist drug training in areas where there was high drug use and for two-way referral procedures between maternity services and drugs services. A number of health authorities now employ 'Drug Liaison Midwives' (the title differs in different areas) who have both knowledge of drug use and midwifery and often act as advocacy workers for pregnant drug users as well providing specialist support. 'Drug Using Parents: Policy Guidelines for Inter-agency Working' produced by LGDF & Scoda (1997) was written to outline good practice in statutory and non-statutory agencies and to emphasise the need of inter-agency work in order to provide appropriate services for children and their drug-using carers. It recommends:

- Written policies and guidelines about the support provided to pregnant drug users and drug using parents;
- Wide dissemination of policies to specialist and generic agencies;
- Health and local authorities to have a shared strategy for developing and jointly commissioning services;
- Plans for drug using parents and their children should separately identify children's and parents' needs.

Although these guidelines were published in 1997, not all areas have implemented them in full.

1.1 Risk Factors

As children of drug users, individuals may be open to a wide range of risk factors, not least future development of drug use themselves, and agencies have a statutory duty to protect vulnerable children where possible; however, drug use of any form (including alcohol and tobacco) is not necessarily an indicator of bad parenting per se. Some parents are able to control their substance use and reduce the potential impact it may have on their children: for example only using drugs when their children are being cared for by someone else; not allowing any drugs in the home; ensuring the child's needs are met before money is spent on drugs. Once a child is born, it may not only be the carers' drug use itself which has a negative effect on the child, but also the range of social and environmental risk factors to which they are exposed (and indeed which may have led to their parents' drug use).

The extent to which children of drug-users might be at risk can be estimated by a number of indicators, which might include (and this is by no means an exhaustive list):

- drug user is the mother;
- continued drug use throughout pregnancy;
- heavy/poly-/chaotic drug use;
- longer period of drug use;
- lack of drug-free social networks for main carer;
- young mothers;
- previous children in care;
- poor parenting skills.
- presence of other risk factors

Assessments of risk and interventions must therefore focus on other factors as well as drug use, in order to impact on the potential risk a child is exposed to.

1.2 The Role of Maternity & Obstetric Services

The table below indicates very briefly, the key stages of maternity and obstetric interventions available to all pregnant women once they have presented to a primary care service as pregnant.

Stage of Pregnancy	Key Maternity Appointments
Pregnancy confirmed	Referral to hospital.
12/13 weeks	Meet midwife. Scan. Midwife dates pregnancy & obtains detailed history inc. drug use. Tests for Hep B, syphilis &, depending on the hospital, possibly HIV.
19/20 weeks	Scan to check for any abnormalities usually at antenatal clinic.
28/32/34weeks	Visit GP if receiving shared care for the pregnancy.
36 weeks	See consultant weekly from now if it is first child or any problems. If not return for birth or one week after due date if overdue.
Birth	Discharge from hospital varies according to health of baby & whether it is 1st child.
Ist weeks after birth	Midwife visits at home every day for up to 10 days — if baby is not fully fit can continue to visit for up to 28 days. Health Visitor takes over when midwife stops.
6 weeks after birth	Visit GP.

The level of input a woman will actually receive from professionals depends on her medical/gynaecological history, whether it is her first pregnancy, and how healthy she is.

2. Pregnancy

Pregnancy can be a particularly high motivator for women to control their drug use; many women and their partners use pregnancy as a reason either to reduce or to stabilise their drug use.

2.1 Issues

From conception, drug use will have an effect both on the woman's health and on that of the foetus. Pregnancy for chaotic poly-drug users will often be unplanned and, given the erratic lifestyle of many poly-drug users, may go unnoticed for several weeks or even months. This coupled with the fear of forced social services intervention often results in late presentation at primary care services to confirm pregnancy. Even when women have had their pregnancy confirmed, many will refuse to inform their drugs service (assuming that they are currently receiving any treatment) and/or attempt to conceal their drug use from maternity services.

It is difficult to accurately predict the effects of drug use on the foetus because:
- self-reported drug use is often lower than actual use;
- women may minimise their drug use, only report the main drug used, or use on top of opiate substitutes;
- street-bought drugs may vary widely in terms of their actual content of the active ingredient and what else they may have been mixed with.

2.2 Interventions & Practice

- Extra scans at 28 and 34 weeks to check the development of the foetus.
- Nutritional advice including that specifically for the side-effects of some drug use eg. constipation
- Screening for blood-borne viruses and testing for STIs that may be passed to baby during birth
- Additional support to attend appointments
- Support and advice in preparing home environment

These last two interventions are particularly important given the chaotic lifestyle of many polydrug users.

3. Birth

This section refers to the period when a woman enters hospital in labour to the point where the baby is born. It is assumed that any woman who is known to use drugs and is in contact with health services would be encouraged to attend hospital for birth.

3.1 Issues

Entering hospital for the birth may present women with a number of worries: the fear of stigmatisation and poor treatment from medical staff because they are drug users, particularly where drug use has continued through pregnancy; fear that they will be exposed as a drug user on admittance to hospital, whether this is to other patients, their own family and friends or both; the fear that their baby will automatically be transferred to a special baby care unit at birth in case it exhibits withdrawal symptoms – which in itself will risk exposure of the woman as a drug user to other patients.

Where women use throughout their pregnancy, entering hospital can present problems in obtaining substitute medication, such as methadone, and where women continue to inject, obtaining clean injecting paraphernalia. Continued use can also present issues regarding pain management for women who may be concerned about receiving insufficient medication to control their pain and/or the potential for overdose if they continue to use their drug of choice on top. Women who use opiates will have a much higher tolerance of painkillers and consequently need more to achieve an effect. The need to disclose drug use in order to receive appropriate pain management can lead to concerns about confidentiality and, again, possible disclosure to friends and family.

3.2 Interventions & Practice

- All staff should ensure that they work with all patients in an objective and non-judgmental manner.
- Women's drug use should be confidential and not discussed on open wards or in the presence of family/friends.
- Unless the baby exhibits withdrawal symptoms, mother and baby should be kept together.
- Risk of vertical transmission should be discussed with individuals prior to labour and assessed by experienced obstetricians. After birth, midwives should explain any risks associated with breastfeeding and ensure that women know how to bottle-feed, where necessary.
- Discreet dispensing of methadone in consultation with the woman's drug worker to ensure that the dosage is correct - dispensing should attempt to follow the woman's preferred pattern of consumption. Women should be made aware of where they can obtain clean works or staff should consult with the drug worker to ensure adequate provision for the woman's withdrawal is made.

4. Postnatal/Neonatal

Whether remaining in hospital or returning home straight away, having a new baby can be extremely stressful: for some women the added stress can make it even more difficult to control their drug use or abstain from use; for others, keeping busy with a new baby means that they do not think about drug use.

4.1 Issues

The most obvious issue after birth is withdrawal for the baby, symptoms usually present 24 to 72 hours after birth. Where the baby withdraws, it will be kept in hospital on a special baby care unit and often mothers will be allowed to remain as in-patients until the baby is well enough to return home. A second issue for women, especially those having their first child, is the wide number of professionals who become involved after birth. It can be very confusing and each professional's remit is not always clear. Perhaps the most oft forgotten issue for women and the potential source of longer-term problems is the return home, this is especially pertinent for women who have poor social networks, social networks which revolve solely around drug use and/or no family nearby.

4.2 Interventions & Practice

- Increased monitoring of mother and baby, including a prolonged hospital stay where necessary. It is important to keep mother and baby together on the postnatal ward where possible to improve bonding between mother and child.
- All professionals involved in mother's and baby's care need to explain their role carefully to the mother and ensure that they communicate effectively with each other and share information.
- Support upon return home from midwife and health visitor. Referral to voluntary schemes (where they exist locally) that support new mothers either within their own homes or via regular group meetings.

CASE STUDY: BRIGHTON*

Brighton Oasis Project

This voluntary sector project provides a range of services for women who use drugs, including specific work with pregnant clients. Oasis employs a part-time maternal health drugs worker who is a qualified midwife. Her work includes:

- Taking referrals from GPs, health visitors and social services in addition to self-referral
- Outreach including home visits and accompanying clients to antenatal & other relevant appointments
- Advising on sexual health and wellbeing
- Advising on detox procedure and outcomes for mother and child
- Advocacy on behalf of clients
- Providing extended postnatal support for up to six months
- Facilitation of a pregnancy and postnatal support group

The project has confidentiality and child protection policies and works within the same legal framework as statutory services. Attendance rates and client take up of counselling and cr che facilities are good. The service is independent and provides a complementary service to statutory health care.

Brighton Multi-disciplinary Working Group

The working group started meeting after a multi-disciplinary workshop 18 months ago that looked at the issues of drug use during and after pregnancy. It meets monthly to discuss the issues raised by ante- and neonatal drug use and develop a way forward. Representatives from paediatrics; community and hospital midwifery services; child protection; health visiting; social services; substance misuse team; and the Oasis Project all sit on the group. It is currently developing guidelines for work with pregnant drug users to ensure consistency of service across professions and clients and is in the process of setting up a hospital based one stop shop .

* It is the intention of the case studies simply to illustrate current work. Additional case studies will be used for the final project report and suggestions for these are welcomed. Please contact Paul or Karen at the address below.

5. Conclusion

The priority should be the welfare of the woman *and* her baby. Agencies need to consider their health and welfare before any sanctions for substance use. Interagency communication and work is vital in providing appropriate services which meet the substance use needs of the mother; her health/pregnancy needs; and the health needs of the baby. Joint training is needed to ensure appropriate non-stigmatising responses, child welfare agencies need drug awareness training and drug services need child protection training. Shared understandings regarding information sharing and confidentiality are especially important in facilitating multi-agency work.

Further Reading: Fiona Harbin & Michael Murphy (eds) 2000 'Substance Misuse and Childcare' RH Publishing
LGDF & Scoda 1997 'Drug using Parents: Policy Guidelines for Inter-agency Working'

6. Update Number Three

The next Update will be sent out to you in December and will focus upon drugs and the 'Sure Start years' (0-4 years). If you have any comments to make in relation to this or any other issue, please contact us, we would be happy to hear from you.

7. Contact Details

Risk & Response is being carried out by the Research Department of Lifeline Projects. The key staff currently working on the project are:

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