

# Challenges for midwives: pregnant women and illicit drug use

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## KEY WORDS

Illicit drugs, pregnant, midwives, antenatal care

## ABSTRACT

### Objective

The purpose of the paper is to introduce illicit drug use as a societal problem and describes the response of the Australian Government. Specifically the paper examines the use of illicit drugs by pregnant women and the role of midwives in supporting these women throughout pregnancy and birth.

### Setting

Maternity services, specifically antenatal care clinics.

### Conclusion

In Australia the rate of pregnant women who use illicit drugs is escalating. These pregnancies are high obstetric risk with potential for harm to both the mother and the baby. Pregnancy however is seen as 'window of opportunity'; a time to provide education, choices and support. The literature describes that for health professionals working with pregnant women who are illicit drug users is challenging and for some health professionals their interaction can be negative. Australia advocates harm minimisation and encourages harm reduction strategies. Midwives are in a position to implement these strategies within the maternity setting. Further research is recommended as well as professional development programs for midwives to upgrade knowledge and cultivate engagement skills to enable appropriate and positive interaction with pregnant women who use illicit drugs.

## INTRODUCTION

Illicit drug use is a major societal problem that puts increased demands on community, judicial and health services (Wright and Walker 2007; Burns et al 2006; Jos et al 2003). Midwives, health professionals and community members alike are challenged when confronted by illicit drug use and more so when the user is pregnant. Women who are pregnant and use illicit drugs are considered high risk and require sensitive responses that are appropriate to meet their needs (Wright and Walker 2007). Increased maternal and foetal morbidity is associated with illicit drug use (Abdel-Latif et al 2007). Service provision is complicated by the legal, social and environmental problems as well as a prevalence of negative attitudes of health professionals that provide the services (NSW Department of Health 2006; Armstrong 2005). Women who are pregnant and use illicit drugs sometimes find it difficult to access traditional referral services to maternity care. They often present late in pregnancy for antenatal care, or wait until in labour to access health services and are unlikely to disclose their drug use (Wright and Walker 2007; Bartu et al 2006; Scully et al 2004). This paper presents a brief overview of illicit drug use in Australia, the strategies adopted by the Australian government to manage illicit drug use, and profiles pregnant women who are illicit drug users. Also featured is the current challenging role of midwives working with pregnant women who are illicit drug users.

### How big is the problem in Australia?

The National Drug Strategy has produced a number of reports from a series of surveys, conducted in 1985, 1988, 1991, 1993, 1995, 1998, 2001, 2004, 2006 and 2009 (data not yet available). The survey questionnaires ask about drug related knowledge, awareness, attitudes, use and behaviours. Population sample comprises of persons 14 years and over. The results present a statistical profile of both illicit and licit drug use throughout Australia (Ministerial Council on Drug Strategy 2004). Burns (2006) suggests criminal prosecution or for pregnant women, the fear of losing custody of the child may distort the

measurements from these national studies. Accurate data on the prevalence of illicit drug use is limited. It has been suggested the stigma and consequences associated with using illicit drugs may prevent users from disclosing their addiction. Therefore, household random controlled surveys measuring population health behaviours are problematic and unreliable when it comes to illicit drug use (NSW Department of Health 2006). Illicit substance use in Australia significantly contributes to illness and disease, injury in the workplace, violence, crime and breakdown in families and relationships (Degenhardt et al 2009; Dowdell et al 2007; Burns et al 2006; Tuten et al 2004). Estimates of social and economic cost of licit and illicit drug use in 1998-1999 was \$34.5 billion dollars with substances such as tobacco and alcohol contributing more than 82% of the cost and illicit substances making up the remaining 17% (AIHW 2005).

The National Drug Strategy Household 2004 survey found that more than 2.5 million Australians aged between 15-64 years had used illicit drugs in the last 12 months, approximately 15.3% of the population (AIHW 2005). The survey results estimated there were 200,000 dependant users. The most common illicit drug used was cannabis (AIHW 2005) and more recently there has been a significant increase in the use of psychostimulants (methamphetamines, crystal methamphetamines and other related substances) (WHO 2004; Wouldes et al 2004; Australian Bureau of Criminal Intelligence 1998; Hando et al 1997; ). 'Ecstasy' (the common name for the illegal synthetic drug called methylenedioxymethamphetamine [MDMA]) is in third position on the list as the most widely used illicit drug in Australia, with as many as 456,000 people admitting to having used this drug at least once and bingeing being a great concern (AIHW 2005). Heroin use has been decreasing since 1999, but significant death, injury and illness from this illicit drug is seen as the third common cause of death among 25-35 year olds (AIHW 2005). Inhalant and volatile substance use such as petrol, glue and some aerosols are found to be more prominent in Aboriginal and Torres Strait Islander communities

(AIHW 2005). Poly-drug use is the norm among illicit drug users and often involves a cocktail of alcohol, prescription and illicit drugs (AIHW 2005).

Australia's National Action Plan on Illicit Drugs 2001 to 2003-4 revealed several observations which included; a minority of the population use illicit drugs which represents a significant global burden of disease, death and crime (Degenhardt et al 2009). The report concluded that initiation to drug use occurred in the early teens and that more females are participating in illicit drug use which confirms the findings by Turner et al (2003). The number of pregnant drug users is nevertheless difficult to quantify (AIHW 2005). It is however assumed pregnant drug users are most often poly drug users combining both illicit and prescription drugs. In addition, where they live will have an influence on the drug of choice (NSW Department of Health 2006).

#### **Australia's drug 'problem' management strategy**

Managing illicit drug use has been a challenge for governments globally over the past 30 years (Ministerial Council on Drug Strategy 2009). Australia is party to a number of international treaties, working in collaboration with the United States of America (USA), Canada and the United Kingdom (UK) to combat drug production and trafficking of illicit drugs (Ministerial Council on Drug Strategy 2009). The Australian Government developed and implemented a national drug strategy in 1985, which includes a cooperative relationship between all states and territory governments and non government sectors. The main aim was to reduce supply, demand and harm (Ministerial Council on Drug Strategy 2004), with the primary focus for 2005-2010 on opioid use, specifically the prevention of premature death or infectious disease and provide treatment options (Ministerial Council on Drug Strategy 2009). For the future 2010-2015 there will be concentration on the significant rise in poly illicit and licit drug use (Ministerial Council on Drug Strategy 2004).

The basis of Australia's drug strategy since 1985 has been harm minimisation. Ritter and Cameron (2005) state firmly that contrary to some public opinion "Harm minimisation does not condone drug

use" (p 5). It aims to reduce drug related harm by improving the health, social and economic outcomes for the community and individuals with a wide range of approaches. There is certainly confusion over the use of terms whether it be harm minimisation or harm reduction, Ritter and Cameron (2005, p 6) define harm minimisation as a philosophical approach, and harm reduction as the specific interventions adopted to limit use. Ritter and Cameron (2005) maintain that harm reduction is failing the illicit drug using population as it may reduce harm but does not always reduce use. They conclude that a harm minimisation approach can be construed as contradictory with drug law reform that aims to reduce drug use, drug trafficking, and related crimes (Ritter and Cameron 2005).

Australia's drug policy highlights four main features; harm minimisation, comprehensiveness of the approach including education, partnerships between health, law enforcement and education agencies, as well as affected communities, business and industry and finally, all levels of governments work within this framework providing a balanced approach (Ritter and Cameron 2005). In a more positive light, Burrows (2005) asserts that in the Australian context, models that aim to reduce harm are working well. Allman et al (2007) maintain that harm minimisation strategies reduce health and social care service costs compared to the use of punitive measures.

Illicit drug use during pregnancy is a serious public health and welfare issue for the Australian Government that consumes valuable health care resources and contributes to infant mortality and morbidity (Abdel-Latif et al 2007; Fraser et al 2007; Bartu et al 2006). Pregnant women who also use illicit drugs typically have high support needs and present with a combination of risk factors (Moore 2003).

Australian and UK research suggests that interventions that address illicit drug issues alongside maternity services are useful in improving outcomes for mothers and their babies especially in reducing or stabilising illicit drug use (Dawkins et al 1997; Dowdell et al 2007). Programs that have shown effectiveness with pregnant and parenting mothers

who use illicit drugs are usually based on long term and intensive support for the whole family (Gruenert et al 2004).

### **The profile of the pregnant women who uses illicit drugs**

The number of pregnant women who use illicit drugs is not well known despite increased awareness that drug misuse and abuse has an impact on maternal and child wellbeing. Surveys undertaken in New South Wales (NSW), the Australian Capital Territory (ACT) and the National Household Drug Survey 2004 on populations aged 14 and over, suggest that up to 6% of all pregnancies, are affected by illicit drug use (Abdel-Latif et al 2007). Drugs of choice that pregnant women use included; heroin, cocaine, cannabis, and benzodiazepines (Turner et al 2003).

Scully et al (2004) found in their study that pregnant women who use illicit drugs are frequently poly drug users, with a high percentage using long term prescription drugs to treat anxiety and/or depression. It is understood that illicit drugs affect the growing foetus and also that licit drugs can be additive and cause harm to the developing baby (Hepburn 2004; Turner et al 2003). Carter (2002) maintains that in the USA an estimated 5.5% of pregnant women use illicit drugs during pregnancy. She asserts that 18% of American pregnant women consume alcohol during pregnancy and approximately 20.4% smoke cigarettes throughout pregnancy yet society is tolerant of licit drug use during pregnancy and intolerant of illicit drug use; even though both are iatrogenic to growing fetuses (Lyons 2002).

Pregnant women who are known to use illicit drugs are stigmatised and face severe consequences that can include incarceration and sometimes removal of children following birth. Carter (2002) maintains that these women are labelled as immoral and seen as deficient caregivers.

Pregnant women in the USA who also use illicit drugs, have limited access to available resources (Jos et al 2003). If these women present for antenatal care, they are required to participate in drug intervention programs. Jos et al (2003) claim that these women

are often single mothers with multiple children who have minimal or no financial support from the father(s) of the children.

Many women who use illicit drugs are socio-economically disadvantaged and may experience co morbidities of varying degrees (Adams 2008). These include gynaecological problems, mental illness, emotional or sexual abuse. In addition, they may live in poverty and/or be homeless. Such women generally have not completed school, are unemployed or lack employment skills, and have limited access to transport and childcare. Adams (2008) argues more than two thirds of the pregnant women who abuse illicit drugs are living in domestic violence.

Hepburn (2004), a UK based researcher found that women who use illicit drugs are repeatedly alienated from available financial resources, social support services and health care. She claims such women are unlikely to attend health care services until late in pregnancy because they may not realise they are pregnant, or they lack motivation and/or understanding about the benefits of antenatal care, and may be mistrustful of government agencies. This mistrust is related to a fear of legal ramifications, having unborn and or other child/ren removed, and display feelings of shame because they use illicit drugs (Adams 2008; Hepburn 2004; Jos et al 2003). DeVille and Kopelman (1998) believe women who are known to be users of illicit drugs experience public scrutiny during pregnancy; increased criticism of their capacity to protect their growing foetus and their capabilities to care for the baby once it is born are doubted.

Australian pregnant women who are illicit drug users have a similar profile to those reported in the international literature. Turner et al study (2003) found that illicit drug users were more likely to have depression and used a combination of both illicit and licit drugs. Bartu et al (2006) general description of the pregnant illicit drug user is socially disadvantaged, having chaotic lifestyles (Wouldes et al 2004) and accessing antenatal services late in an unplanned pregnancy. Nevertheless, there is limited information about the characteristics and health needs of the

Australian women who use illicit drugs in pregnancy (Burns et al 2006). In general terms, Burns et al (2006) large study found women to be younger than the general population having babies, smoked, presented late to antenatal services or in labour and more likely to have a premature baby requiring neonatal intensive care, which was exacerbated when women used opioids.

### **Neonatal outcomes**

Infants of mothers who use illicit drugs during pregnancy are significantly more likely have lower birth weight, head circumference and gestational age at birth with a preponderance for prematurity (Abdel-Latif et al 2007). Abdel-Latif et al (2007) found that maternal illicit drug use accounts for more than 6% of premature critically ill babies in neonatal intensive care unit in NSW and the ACT. In conjunction with these early problems the infant is then exposed to a number of potential risks. Evidence demonstrates that parents who use illicit drugs are linked with a raft of chronic life conditions (Dawe 2007). These may include parental psychopathology, socioeconomic disadvantage, social isolation and violence. Infants at potential risk are those whose mothers are young, have a low level of education and early age of onset of illicit drug use together with serious environmental risks, homelessness, lack of safety from violence, poor nutrition (Dawe 2007; Cousins 2005). Protective factors are required to be in place for the mother and infant in order for the infant and the subsequent child's resilience to grow (Resnick et al 1993). Thus pregnancy is an ideal window of opportunity for intervention (NSW Department of Health 2006). This opportunistic time offers to support women to make positive decisions about their own and their infant's wellbeing. Resnick et al (1993) suggests there is a significant protective factor against the risk of harm to the babies when mothers are emotionally and socially connected to their families.

### **Pregnancy 'a window of opportunity'?**

Research demonstrates that maternal child health outcomes are enhanced exponentially if women access antenatal care throughout pregnancy (Bartu

et al 2006). Antenatal care provides opportunity for service providers to offer health education, prevention and intervention designed to promote positive obstetric and paediatric outcomes. Pregnant women who use illicit drugs and who present for antenatal care are directed to services to minimise harm from drug use to themselves and the growing foetus. Although women who use illicit drugs and are pregnant often present late for health care, this is the time when they become visible to maternity services (Klee 1998). Studies from the USA (NSW Department of Health 2006) and UK (Klee et al 2002) and Australia (Burns et al 2006; Moore 2003) concur. Daley et al (1998) refer to this time not as a 'window of opportunity' but more a 'revolving door'. Illicit drug dependence is chronic with relapse seen as a real possibility (NSW Department of Health 2006). Dowdell et al (2007) supports the recommended 'National guidelines for management of drug use during pregnancy, birth and the early development years of the newborn' (Ministerial Council on Drug Strategy 2004) as a useful manual for both midwifery and other health professional practice when working with pregnant women who use illicit drugs. Midwives practice includes antenatal, intranatal and postnatal care. Practice is developed within professional, ethical and legal frameworks. Midwives are responsible for working within these boundaries and develop life skills appropriate for midwifery practice and the provision of women's centred care. Pelvin (2006, p. 223) identified some of the many 'life skills' required to work with women in partnership and collaborate with them and other professionals.

Klee et al (2002) suggests, midwives engagement with these women is the key to enable such change to occur. It is known that foetal toxicity can occur in the first trimester with outcomes of foetal abnormalities, whilst foetal growth and development is particularly important in the third trimester as well as the high risk of premature birth (Abdel-Latif et al 2007). Engaging with these women is crucial as they can be given vital information on the effects of illicit drugs on their baby's health as well as their own, be provided with specialised drug support in terms of

pharmacological regimes, and connect with services that will assist in their future parenting role (NSW Department of Health 2006).

One of the greatest fears for women who are pregnant and use illicit drugs is the possibility that their baby will be removed from their care (Burns et al 2006; NSW Department of Health 2006). The challenge for midwives and health professionals who work with these women is to make appropriate and sensitive notifications to protect the yet-to-be-born (Jos et al 2003).

### **Child Protection**

In Australia illicit drug use is a contributing and predicting factor in child abuse with more than 30% of the parents known to child protection, either as a recipient of care as a child themselves or through previous pregnancies (Cousins 2005). Protecting children is mandated by the Australian Government. In all jurisdictions of Australia "... some level of legislation requiring the compulsory reporting to state and territory child protection and support services of harm due to child abuse or neglect" exists (AIHW 2006). In Victoria, illicit drug use alone without other risk factors is insufficient for notification to child protection services.

There are challenges to the providers of maternity services, they are asked to comply with mandatory reporting requirements while trying to maintain a therapeutic relationship (NSW Department of Health 2006). It is felt by some providers that if the report is punitive or lacks feedback or communication from child protection on the outcomes of a case, there is an reluctance to notify the next time that abuse is suspected (Vulliamy and Sullivan 2000).

### **Health Professionals view**

A review of the literature revealed many health professionals hold stereotypical views and have negative attitudes towards women who use illicit drugs (Adams 2008; Wright and Walker 2007; Scully et al 2004; Grafham et al 2004; Jos et al 2003; Norman 2001; McLaughlin and Long, 1996; Corse et al 1995). These views, argue McLaughlin and Long (1996), hamper relationships between

health professionals and women but also impede the progress women make during the pregnancy and birth and the early postnatal period.

Norman (2001), Corse et al (1995) and McLaughlin and Long (1996) identified that nurses found it difficult and not satisfying to work with clients who use illicit drugs. Scully et al (2004) contend that negative perceptions increased when the illicit drug user was a woman and she was pregnant. Grafham et al (2004) agree, arguing that generalists prepared health professionals including nurses and midwives working with drug users found the work with this group stressful and believed that insufficient resources are made available to up skill them. Women who use illicit substances are viewed as 'tainted, blemished and polluted' (McLaughlin and Long 1996, p. 284). More importantly, and more damning, is the linked perception that illicit drug users are of weak personality; in some way corrupt and flawed (Norman 2001); fulfilling the idea that illicit drug users are prone to criminality, violence and manipulative. McLaughlin and Long (1996) found that the majority of nurses interviewed in a study in 1992 suggested that drug users constituted a threat to society; further perpetuating and reflecting the fear beliefs of society. Mental health nurses, drug and alcohol nurses, social workers were found to have a more positive attitude, greater knowledge and understanding of illicit drug users. Grafham et al (2004) study, highlighted the role of this group of professionals was seen by others as a 'soft option' and regarded at times negatively by other health professionals.

Health professionals are not immune to the societal norms and are influenced by their own backgrounds. Life-long attitudes and beliefs systems are difficult to change especially when they are seen as going against the tide of overwhelming and dominating practices, policies and beliefs in the community in which they live (Lyons 2002).

### **CONCLUSION**

Illicit drug use among pregnant women is increasing in Australia. Pregnancy is seen as high risk to both the mother and the infant but it is also an

opportunity to support women, adopt lifestyle changes to optimise positive health outcomes for themselves and their children. The literature supports engagement with women who use illicit drugs and advocates for a philosophy of harm minimisation and harm reduction strategies. There are opponents to harm minimisation and support for punishment and control. Commentators have rejected these latter strategies as harmful to the community as it alienates and stigmatises segments of the population and does not provide pathways towards recovery and acceptance. Evidence confirms that health professionals find it confronting to work with illicit drug users, particularly pregnant women and require special staff development skills to overcome these challenges. Midwives in particular are in an advantageous position to make a difference and support mothers who want to make changes. Further research is necessary to explore what it is like for midwives to work with women who use illicit drugs. Knowing more about these experiences will shed light on the complexities of this special relationship and inform contemporaneous midwifery practice.

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