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SPECIAL ARTICLE

# Caring for substance abuse pregnant women: The role of the midwife

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**ABSTRACT**

**Background:** Drug addiction during pregnancy and postpartum period is undoubtedly connected to maternal and fetal morbidity. Accordingly, there is a great need of proper approach, support and health care provision of addicted women during this special phase of their lives.

**Aim:** The aim of this review was to explore evidence based practices for caring for substance abuse pregnant women by midwife.

**Methods:** A thorough literature research was performed in different nursing and medical databases such as Medline, Embase, Cinahl and Cochran Library, using relevant with this review keywords.

**Results:** Motherhood concerns health professionals of various specialities, who require special training and studies regarding drug addiction and its consequences for the mother-to-be as well as the fetus. A sufficient supporting network aiming to addicted women's care and treatment throughout pregnancy and postpartum period can be created only with the state's contribution.

**Conclusion:** The creation of sufficiently organized health care centers, which are made especially for addicted pregnant women's support and are staffed with interdisciplinary teams, is more than necessary.

**Keywords**: Drug addiction, dependence, pregnancy, postpartum, health professionals.

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## INTRODUCTION

Maternal drug abuse can affect pregnancy outcomes as well as childhood health and development[1]. Children born to women who used substances during pregnancy are at greater risk for prematurity, low birth



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weight, impaired physical growth and development, behavioural problems and learning disabilities[2]. Women who use substances may also have other health-related issues, such as mental health problems and a history of physical or sexual abuse and usually have special medical needs, poor nutrition and relationship problems (including domestic violence) lacking meaningful social support[3,4]. Although the incidence of substance abuse varies among pregnant women depending on race, age and geographical differences[5] it is estimated around 10% of the pregnancies[1,3].

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs such as cocaine, opiates, amphetamines, cannabis ect. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state[6].

**Effects of substance abuse in pregnancy and postnatal period**

Outcomes in relation to abuse of specific illicit substances are difficult to determine as the majority of studies have focused on single drug use even though poly-drug use is common[7]. The use of substances such as tobacco, alcohol, and illicit drugs during pregnancy has been associated with significant health risks and poor outcomes for both the mother and fetus[8]. Illicit drug use during pregnancy is associated with spontaneous abortion, low birth weight, preterm delivery, placental abruption, congenital abnormalities, fetal compromise, hypertensive episodes, and thromboembolic events[9]. However Hepburn argues that few of the commonly used drugs directly affect pregnancy and that the adverse outcomes are mainly caused by associated factors with drug abuse like smoking, poor diet, stress and chaotic lifestyle[10]. Furthermore the associated legal, social and environmental issues involved interfere with the ability of the mother to care for her child after delivery.

Newborn infants experience the affects of maternal drug abuse mainly postnataly, or secondary to pregnancy complications. Such infants are at higher risk of drug withdrawal at birth,

admissions to neonatal intensive care units, longer hospital stays, and neonatal death. In addition children with prenatal drug exposure can have developmental, learning, and behavioural problems[7].

**Management of substance abuse women in pregnancy**

Being pregnant can inspire women to stop using tobacco, alcohol, and illicit drugs. Studies suggest that many patients experience additional motivation during pregnancy to consider and initiate certain positive health behavioural changes[5]. The desire to have a healthy baby often gives impetus to give up drug habits and pregnancy is seen as an opportunity for a new beginning, especially when child protection issues are considered[11]. Hepburn and Elliott showed that staff attitudes were more important to clients than medical aspects of care; in all cases pregnancy provided a strong motivation for change[12]. The first obstetric visit is often regarded as an opportunity for medical providers to counsel or intervene on a number of behavioural health issues. However pregnant drug users often feel that traditional health care is not accessible to them[13]. In fact they tend to seek midwifery/medical care rather late, mostly when in labour and they usually do not admit to their drug addiction. They also have difficulty using traditional systems of care. Services are not accessed for a number of reasons: fear of losing custody of children; fear of forced treatment or criminal prosecution; lack of treatment readiness; coexisting mental illness; guilt and denial or embarrassment regarding their substance use[3].

On the other hand negative attitudes of health care providers and responses that stigmatize women can deter them from accessing care. Health care professionals might lack not only the knowledge and skill to identify substance use, but also familiarity with available resources and therapeutic management[14]. To be effective, antenatal care should be appropriate to women's needs, easily accessible and the woman should be involved in the planning of care. It has been recognised that providing special services to attract and retain pregnant drug users into antenatal care can help to address their complex problems[9]. The systems that work best are multidisciplinary in nature, with specialist input from obstetricians, midwives, paediatricians, health visitors, social workers, drug counselors and other agencies that offer support to the individual concerned[12].

The importance of comprehensive, coordinated and individualized services



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provided by a multidisciplinary team of professionals who are supportive, non-judgemental and nurturing has been widely acknowledged. Myles argues that the obstetric and neonatal outcomes appear significantly better where a dedicated service is provided for pregnant drug dependent women than in studies of cohorts of pregnant drug dependent women where no specialist service exists[15].

## Model of care

It is clearly stated in the literature that the specialists service for pregnant drug using women should involve a variety of expert professionals in order to provide effective individualised care[1,3,11,18]. A multi-disciplinary team consisting of a specialist drug liaison midwife, an obstetrician, a community psychiatric nurse from the statutory drugs service; a social worker and a drugs worker and a voluntary drugs service, should work together to provide counselling and social support. In addition local hospitals should offer detoxification and a designated space should always available for women in need of shelter.

The access to treatment for pregnant dependent women needs to be prioritised. The service focus on engaging the woman and have her access both prenatal and drug treatment services quickly, stabilize on oral methadone therapy, and address other health and social care issues as necessary. Stabilization of drug use should be the main goal of the treatment and women most of the times are encouraged to remain on oral methadone throughout their pregnancy. The option to detoxify as an inpatient or outpatient after the first trimester is normally given but women should not be pressured to reduce dose or to detoxify.

The members of the multidisciplinary team should have regular meetings and reflective discussions should be encouraged in order to develop the professional maturity to make informed decisions about the care offered. It is important to note the anxieties and need for ongoing support for such groups of practitioners, despite their level of experience in this area of work. It becomes evident that a close and strong communication in-between member of the members of the multidisciplinary team is essential. Interagency coordination is, however, challenging especially in situations where women, who feel increasing isolated, have a tendency to withdraw from potential supports or the development of nurturing networks.

Clinical impression indicates that many of the women relapse soon after giving

birth. They may be influenced by the misperception that the postnatal environment is much less important than the prenatal environment. In addition, if pregnancy is the primary motivator for treatment, mothers may place unrealistic expectations on the unborn child (e.g., that the child will serve to meet the mother's needs, such as creating someone to love her or making her life worthwhile); this could place inappropriate levels of responsibility on the child. This underscores the need for treatment programs to provide ongoing and aftercare services to women, particularly during the critical postpartum period[16] .

Most importantly, sympathetic and non-judgemental staff that has been trained to look after drug- and/or alcohol-using women must be available wherever the pregnant woman, her partner and her baby are likely to be cared for.

**The role of the midwife**

The role of the midwife is very significant as she may be the first professional a pregnant woman with substance abuse problems will visit when seeking maternity care. The booking visit when woman first come in contact with the maternity services is the most important. The midwife normally takes a detailed medical and social history. When the woman is referred by the social worker this booking process is less complicated. All midwives should be aware of the local facilities available for these women and refer them appropriately. This role becomes more complex when the midwife suspects drug abuse and the woman obscure such information. It is of highly importance to ask questions in the right manner so they do not seem threatening to the woman and build a trusting relationship with the woman. Stephany[17] argues that midwives have a vital role to play in improving the services available to pregnant addicts but first, they must recognize their own biases and be willing to re-examine the issues. As health care providers who choose to be "with woman," midwives must be on the addicted client's side as well as at her side.

As mentioned above specialised training is needed in order to care more effectively for these women. A specialist Drug Liaison Midwife would assist in the reduction of the stigma associated with the treatment of pregnant female drug users, ease access to care for pregnant dependent women and help maintain care pathways once established[18]. It is also suggested that the post would facilitate better communication and working relationships among the



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professional staff involved in the care of this patient population. However, in order to provide comprehensive assessment and care for these women community midwives need to acknowledge the inter-relationships of illicit drugs use, domestic violence and mental illness[19]. The specialist Drug Liaison Midwife as team leader would also create and co-ordinate a team of community midwives able to care effectively for pregnant substance abusers.

In the community, pregnant user's visits should be scheduled more frequently, even weekly because the positive relationships formed between the women and the midwives provide an opportunity to employ a case management approach to care[19]. Midwives should also work closely with the social worker and be thoroughly informed on these subjects, through continuous professional development, study days or guest speakers from treatment centers for example.

The needs of women should be central to the government's program in order to reform and invest in public services committed to address discrimination and inequality. When mental health care and drug treatment services are not responsive to the needs of women and their newborns with antenatal drug and alcohol exposure midwives should adopt a more pro-active role, by participating in campaigns to legislators and taking part in political action activities of their professional body in order to develop and reshape the public health agenda. Specific objectives of such agenda should include: improving nutrition, decreasing smoking, decreasing alcohol and drug use, encouraging breastfeeding, promoting dental health and encouraging physical activity, encouraging early and continuing antenatal care and promoting social and community support[20]. These services should offer a continuum of help to women, children and their families, including health promotion, harm prevention and early-intervention strategies, as well as appropriate treatment and follow-up support[21].

Health authorities grant health professionals the power to attempt to persuade women into changing their lifestyles. Midwives are in a unique position, in that they have an opportunity to establish and maintain a relationship with women over a long period of time. Furthermore midwives should be aiming on treating women sensitively and supportively when dealing with what is often a shameful personal behaviour.[23]

## Conclusion

The range of health, social and support services required by new mothers when they are using illicit drugs is extensive. Multidisciplinary collaboration and coordination is critical to engage and retain women in treatment and assist agencies in providing the needed scope of care for both mother and baby. Service providers should therefore focus on how we can encourage this vulnerable group of women to better utilise the existing services and resources available. Furthermore they should consider the environment in which the newborn will develop after birth, how antenatal care programs could address the special needs of postpartum women and what interventions might be offered to postpartum women that pick up when prenatal treatment ends.

The aim is to promote a coordinated approach so that women with a range of problems and needs feel confident that the departments and agencies responsible for providing help and support respond to their needs as a whole, rather than in isolation. Above all service providers in the full spectrum of services working with women and their families need to make these services welcoming, accessible, relevant and safe for women with substance-use problems. Continuity of care by a small number of community-based midwives who work within a multidisciplinary team, and who can develop positive relationships with women across the childbirth continuum, may be one strategy whereby this could be achieved.

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