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The Royal Women's Hospital (The Women's)

Submission to Inquiry into the impact of illicit drug use on families

The context of the Women's

The Women's has a commitment to providing leadership and advocating for and influencing women's health policy and services at a state, national and international level.

We are a major provider of services to women. In 2005/06 we provided 150,677 occasions of service in outpatient clinics, 32,477 inpatient stays, 28,379 attendances in emergency and almost 6,000 babies were born at the Women's.

We work within a public health model of care which recognises that women's life experiences, economic and social situation impacts on their health and their ability to access health care.

The Women's Alcohol and Drug Service

The Women's Alcohol and Drugs Service (WADS) is a department of the Women's, which provides specialist midwifery and obstetric care as well as drug and alcohol counselling for pregnant and post natal women. Initiated in 1988, the service is now a state-wide model that provides intensive clinical care for women with complex AOD use issues, professional education and training including universities, and support for clinicians throughout Victoria via secondary consultation and mentoring. WADS staff work very closely with the Women's Psychiatric Services in the provision of clinical care.

WADS convenes the Chemical Dependency Units (CDU) resource group that represents the eight other Melbourne and metropolitan maternity hospitals that conduct specialist pregnancy care clinics for women with AOD use.

WADS is represented on the SIDS working group at the Victorian Office of the Child Safety Commissioner. In June 2006, WADS was included as an example of best practice in service delivery in the National Child Health and Wellbeing Reform Initiative.

National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn

The Women's Alcohol & Drug Service was a key participant in the development of the *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn* and authors of background papers to the guidelines. The service was nominated by the Victorian Department of Human Services as their representative on the Steering Committee.

The nationally agreed clinical guidelines are based on currently available evidence, developed through a rigorous process in which international and Australian research literature was reviewed by experts and consensus achieved. The guidelines were endorsed by the Ministerial Council on Drug Strategy on 2nd December 2005. They were developed with funding and support of Australian federal, state and territory governments under the Ministerial Council on Drug Strategy.

The national clinical guidelines recommend a harm minimisation approach to the management of drug & alcohol issues in pregnancy. They emphasise the importance of multidisciplinary pregnancy care that meets the physical, psychosocial, AOD and mental health needs of the pregnant women, and the safety and health for the developing fetus and the newborn.

Of relevance to this submission, the guidelines discuss the need for accessible, responsive service systems and service providers and health professionals with up to date knowledge and expertise in AOD pregnancy work. They recommend specific and timely interventions to address issues such as homelessness, domestic and intimate partner violence, access to withdrawal services appropriate for pregnant women, mental health services, mother-baby units, residential & home based parenting support services and long term family supports.

Recommendation

> ***Based on the 'National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn', we recommend a harm minimisation approach to the management of drug & alcohol use issues in pregnancy.***

Harm Minimisation in Pregnancy care and Breastfeeding

Internationally and in Australia, the harm minimisation approach underpins care of pregnant women and breastfeeding women with drug & alcohol use.

This applies in particular to opioids where methadone maintenance treatment (MMT) is universally considered the 'gold standard'. MMT is associated with improved pregnancy outcomes, improved fetal development and infant birth weight. The majority of pregnant women and new mothers who access WADS and the other 8 Melbourne metropolitan Chemical Dependency Maternity Units, have heroin dependencies or are on a MMT program.

There is consistent evidence that methadone alleviates the risk to the growth of the fetus that is associated with heroin use, and reduces the risk of infant death where women have been successfully stabilised on MMT.

The safety of withdrawal from opioids, especially rapid withdrawal, in pregnancy has not been established and is associated with a high risk of relapse. Methadone is regarded as a safe option for use in pregnancy or breastfeeding because its safety has been demonstrated over more than 20 years of use. Emerging evidence from Europe also supports the safety for pregnancy and the fetus of the use of buprenorphine maintenance treatment, an alternative to MMT. Buprenorphine is becoming more widely used in Australia although in the absence of robust evidence for use in pregnancy. Buprenorphine is available on its own or combined with naloxone which is thought to reduce the incidence of misuse of buprenorphine.

In pregnancy, mono buprenorphine (Subutex) is still considered the safest option as buprenorphine with naloxone (Suboxone) potentially causes adverse pregnancy outcomes. We are concerned that as Suboxone becomes increasingly popular with pharmacies, there will be limited supply and access to mono buprenorphine which is considered safer in pregnancy.

Access to methadone or buprenorphine treatment is problematic for women as there is limited availability of practising prescribers and dispensing services especially in rural areas and outside major cities. Women often have to travel daily from town to town to access treatment which becomes increasingly difficult as pregnancy progresses, and with a new baby. Access to transport and the cost of travel is also prohibitive.

If doctors and pharmacists had more education around addiction and management of addiction in their general university training, they may be more willing to treat drug dependent pregnant women and parents of children.

The cost of pharmacotherapy places an unfair burden on women who generally have financial difficulties. Women who are making enormous lifestyle and health care changes to provide a safe and stable pregnancy for the developing fetus, and a safe environment for their new baby, struggle to finance their medical treatment. MMT and buprenorphine should be cost free for pregnant and breastfeeding women, and parents of young children.

Recommendation:

- ***Pharmacotherapy be subsidized and provided cost free to pregnant women, breastfeeding women and parents of young children.***
- ***That mono buprenorphine (Subutex) remain accessible to pregnant women as an alternative to methadone.***
- ***That access to pharmacotherapy prescribers and dispensing pharmacies be increased, in particular in rural areas.***

High Risk Pregnancies and Babies

Women attending WADS for pregnancy care are likely to have mental health issues, multiple substance use, and social complexities including but not limited to homelessness, legal, financial, relationship, isolation, and violence issues.
These women also have a pregnancy at high risk of complications and the babies are at risk of health complications and withdrawal after birth. Without long term ongoing family supports, the children are at risk of developmental problems. Child protection services are often involved with these families, and there is a likelihood of mother infant separation.

Working within a maternity care environment in hospitals, most providers and hospitals struggle to provide the intensive multidisciplinary care that is necessary for good pregnancy and infant outcomes. Maternity and neonatal wards and birth suites, and the midwives, medical staff are not equipped or trained to cope with the difficult and challenging behaviours that is frequently associated with drug and alcohol use. The experience of WADS in the state-wide training program is that one of the frequently requested sessions is around managing challenging behaviour.

Recommendation:

> ***Pregnancy care providers and maternity hospitals be adequately resourced and supported to provide intensive, accessible and holistic care for pregnant women and new mothers who have AOD use issues and mental health issues.***

Children under the age of 2 who are known to child protection are over represented in infant deaths attributed to SIDS. Illicit drug use in the family is a risk factor for SIDS.
These high risk families are hard to reach using mainstream health promotion methods. Families must be supported to develop a safety plan. Effective health promotion methods have to be in place in pregnancy with follow up once the baby is home to ensure that the baby has a safe sleeping environment. Visiting midwife services (domiciliary) and Maternal & Child Health home visiting nurses are well placed but under resourced to deliver this support.

Recommendation:

> ***Home visiting services should be available to view the sleeping environment of babies when they first leave hospital, particularly in the high risk family groups.***

Use of Legal Substances

In addressing the questions being examined by the inquiry we would first like to state our concern at the exclusion of legal substances such as tobacco and alcohol and illicit use of prescription drugs.

Recommendation:

> ***Future enquiries and responses into drug use include alcohol, tobacco and illicit use of prescribed drugs.***

Tobacco

The risk factor responsible for the greatest disease burden fro women of child bearing age in Victoria, after intimate partner violence is tobacco smoking. Tobacco smoking contributes to higher drug-related morbidity and mortality than both alcohol and illicit drug use combined. The impact of direct and environmental tobacco smoking on the health of women, the unborn baby and the developing child is well researched and documented and contributes to a broad range of complications. Nicotine is described as being as addictive as heroin and cocaine.

Women who are more likely to smoke are women of child bearing age, from the most disadvantaged population, and significantly higher amongst Aboriginal and Torres Strait Islander women. Women from all of these high risk groups attend the Women's and WADS.

Underreporting of smoking in pregnancy is common practice and the intervention programs that are in place have variable outcomes. Maternity and parenting support services and practitioners must be provided with knowledge and resources to assist pregnant women and families in successful intervention programs.

Recommendation:

> ***Pregnancy care providers are resourced and educated in the implementation of smoking intervention and relapse prevention programs for pregnant and breastfeeding women and parents of babies and children.***

There is some evidence that nicotine affects the metabolism of some antipsychotic medications, and therefore quitting may contribute to a change in mental stability. A pregnant woman who is prescribed antipsychotic medications and wishes to quit should do so in consultation with the psychiatrist.

At least 30 percent of people seeking smoking cessation treatment may have a history of depression. Some may suffer an increase in symptoms after quitting. Ongoing relapse prevention advice may help to reduce relapse rates especially in environments with pregnant women, babies and children.

Alcohol

Developmental and health problems in the unborn baby and developing child that range from severe to mild are classified as Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Spectrum Disorder.

The number of pregnant women in Australia who consume alcohol at risky levels is not known often due to non disclosure. Alcohol consumption is common amongst Australian women, with about a third of women reporting drinking at least weekly and this most commonly in women of child bearing age. For women who drink at unsafe levels and become pregnant the risk is highest often before the woman knows that she is pregnant and before the first missed menstrual period. There is no consistent approach to accurately determine levels of alcohol consumption.

Recommendation:

> ***A systematic approach be developed to discussing and addressing alcohol consumption in all pregnant women and mothers of young children, including the use of a reliable assessment tool.***

In Australia an abstinence approach has not been taken due to high levels of anxiety this may cause in the event of an unplanned pregnancy. Many women may drink some alcohol during early pregnancy before they are aware they are pregnant, without harmful consequences. A Harm Minimisation approach is adopted and is in keeping with the NH&MRC guidelines.

No completely safe level of alcohol use has been determined. Further research is required to provide women with evidence based advice around safe alcohol consumption in pregnancy. Women, when informed, may chose not to drink alcohol if they are planning to become pregnant or once they know they are pregnant.
Women are encouraged to reduce overall alcohol intake, to avoid binge drinking, and to never become intoxicated. This also applies with breastfeeding.

Recommendation:

> ***A Harm Minimisation approach to alcohol consumption in pregnancy, should be adopted, until sound research indicates that alcohol intake outside of the guidelines levels supports otherwise.***

Education regarding safe levels of alcohol intake during pregnancy should be targeted at young women and continued throughout the childbearing years.

Recommendation:

> ***Discussions around alcohol drinking in schools should include information on the risks of drinking in pregnancy.***

Use of Prescription Drugs

In our experience there is a high incidence of using medication as the first line of treatment for conditions such as depression, anxiety and ADHD. In particular, the medication is often used in isolation from other forms of proven therapies such as groups, counselling or family supports. Often the reliance on prescribed medication and self medication with prescribed medication and alcohol is because of a lack of resources such as housing, adequate income, childcare, access to education, meaningful work and other opportunities for self advancement.

Addressing the Specific questions posed by the Inquiry

- **The financial, social and personal cost to families who have a member (s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders**

Given our particular expertise around supporting pregnant women and women with young families, our experience demonstrates that illicit substance use must be considered in the psycho social context of the lives of women and their families.

What this means is that to effectively address the impact on families it is necessary to address the underlying issues which may create or perpetuate a dependence on illicit drugs. In other words there seems little point in treating opioid dependent women who are victims of ongoing violence and aggression, homeless, and/or unemployed with MMT or buprenorphine without also providing material supports and counselling.

The primary focus in our work is the mother and baby. We are continually frustrated by the lack of resources to support women to remain the primary carer for their baby in the long term. Very often, even where child protection is involved, mothers are able to take their baby home. However where there are no long term and consistent family supports in place, in the longer term they are often unable to continue to care for the child. They are also at high risk of relapsing into their previous drug culture and lifestyle

In what could be seen as a grotesque twist, too often we witness women who have been abused within their families as children, and have relied on drugs or alcohol as a way of dealing with that trauma, who then have their children removed and placed in the care of the very families who abused the parent. Thus they suffer the double burden of guilt of not being able to care for their children and being all too aware of the potential for their child to be come the next generation of victims. Where possible the safest option for the child may be to support the mother to have her children in her care.

Women who are able to maintain a drug free lifestyle and have their children in their care are those who are well supported by their immediate families, and where there are sufficient community long term resources in place to enable that to happen.

Recommendation:

> ***More intensive long term family supports should be made available for high risk women and families especially those with AOD and mental health issues.***

• The impact of harm minimisation programs on families

While harm minimisation is recognised as effective practice, amongst generalist health care providers and community services, there is little understanding of this approach to care. This means that health care providers can often respond ineffectively and without sensitivity to women who present and may seek help.

One of the major barriers to women seeking support for substance use during pregnancy is that the mother's fear of judgemental attitudes by health care providers prevents her form accessing pregnancy care. Research conducted at The Royal Women's Hospital, published in March 2005, demonstrated that 65% of pregnant women with drug and alcohol dependence cited fear of 'being treated differently by staff because of drug or alcohol use' as a reason for not attending pregnancy care.[1]

This is particularly important to consider when a woman is pregnant as being pregnant can be a critical stage for a woman to assess her drug use and begin to make positive changes. The development of a good relationship between a pregnant woman and her health care provider can be significant factor in maximising outcomes for the mother and baby. This will require clinicians to develop specific skills and expertise.

Recommendation:

> ***The committee consider the National Clinical Guidelines For The Management Of Drug Use During Pregnancy, Birth And The Early Development Years Of The Newborn which recommends that: All clinicians need training in the specific skills required to engage vulnerable groups in care.***[2]

• Ways to strengthen families who are coping with a member (s) using illicit drugs

As we have noted, community supports provide the key to strengthen the ability of AOD dependent mothers to be the primary cares of their children. The Child First system being established in Victoria, offers the hope of such supports being strengthened and being more readily accessible.

While we work from a harm minimisation perspective, we find that services set up to assist women to develop the capacity to care for their children in the long term and develop parenting skills, such as Tweddle Child & Family Health Services, and the O'Connell Family Centre exclude women who use

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[1] P. 38 Lost Opportunity or Lifeline? Women with substance use issues and their perceptions of the barriers to pregnancy care. Mary Catherine Tobin Published by WADS, The Royal Women's Hospital March 2004

[2] P. 5 National Clinical Guidelines For The Management Of Drug Use During Pregnancy, Birth And The Early Development Years Of The Newborn, Commissioned by the Ministerial Council on Drug Strategy under the Cost Shared Funding Model, NSW Department of Health, 2006

any form of drugs. Thus women who are successfully working towards stopping their addiction are unable to access services that could be of most benefit to them, their partners and their children.

Commonly when women first come to us they will identify violence by their partner, or other family members as a contributing factor to their substance use. However, they are excluded from access to safety in the form of women's refuges because of their substance use. Therefore their children are also potentially left in unsafe circumstances.

Recommendation:

> ***One of the critical strategies for facilitating mothers being able to successfully care for their children is the establishment of services which are accessible to women with substance use issues and their children.***

This access would then enable mothers and babies to remain together and improve mother infant attachment which is critical to the long term improved outcomes for the whole family and have a significant impact on breaking the generational cycle of illicit drug use.

Partners of pregnant women with AOD use and other family members who they live with, frequently also have drug or alcohol dependency. For the pregnant women to successfully address her drug use issues and parent her baby safely, the partner also needs to be able to have AOD counselling. This may also mean attending a withdrawal service. Referral and access is often difficult to achieve in the short time available with the pregnancy. Women with AOD use are not always aware that they are pregnant until late, or may be reluctant to attend for pregnancy care so the timeframe for the partner to address his dependency is also limited.

Recommendation:

> ***Partners and family with drug and alcohol dependency be given priority access to drug treatment and withdrawal services.***