

Philosophy of care – a recovery focus

Exclusion, risk and personal aspirations

People who have problems with substance use are some of the most socially excluded and high-risk members of our society. When compared to mainstream society:

- **They are more likely to experience significant mental illness**
- **They are more likely to suffer a premature death**
- **They are more likely to be homeless**
- **They are more likely to be unemployed, often having failed to complete their education**
- **They are more likely to have criminal justice involvement**
- **Women are more likely to die in childbirth, to have low birth weight babies and to experience family planning problems**
- **They are more likely to be the subject of concerns regarding the welfare of their children**

It is important to recognise, however, that problem substance users share their general life aspirations with other members of society. In response, local commissioners must ensure that everyone has access to essential care, treatment and rehabilitation services which recognise this. Holistic assessment needs to take cognisance of the person's family, children, education and employment, housing and legal position and their aspirations around these areas. Health care interventions may be an integral part of the care package and access should follow a full clinical assessment covering physical, mental, sexual and reproductive health, diet and dental health.

Parental substance use does not always preclude the possibility of effective parenting. However, in order to minimise the potential harm to both, the unborn and any children, services and professionals involved with people with problem substance use should pro-actively encourage the discussion of contraceptive needs and plans for children. Medical and social treatments of substance use will increase fertility. All of these aspects of an individual's life must be regarded as essential areas to be addressed in all care packages.

2.2.7 Maternity care

Due to the high rate of co-existing morbidity associated with substance use, pregnant women with problem substance use have potentially high risk pregnancies. As recognised by *Why Mothers Die* (2) they require obstetrically-led multi-disciplinary care embedded in maternity services that attempts to address all their medical and social problems within a single setting. Those with opiate dependence should be provided with substitute prescribing, usually with methadone although if women are stable on buprenorphine there is no need to change. Those with benzodiazepine or alcohol dependence should be provided with a long acting benzodiazepine short-term to cover withdrawal. Though there is no reliable evidence that opiate detoxification during pregnancy is medically unsafe and some evidence that it is safe (3) it is rarely appropriate. The dose of substitute medication may need to change

according to external factors. Blood levels decrease during the third trimester but there is no evidence that this correlates with reduced pharmacological activity and no need to routinely increase the dose. Urine toxicology screening during pregnancy does not influence maternity management. If women use drugs illicitly in addition to prescribed medication they may benefit from an increase in the dose of prescribed medication.

Pregnancy affords an ideal opportunity for opportunistic care including cervical cytology. All pregnant women are routinely offered antenatal screening for HIV infection since interventions are available that will reduce the risk of maternal to child transmission. No such interventions have been identified in the management of women with HCV infection who are polymerase chain reaction (PCR +ve) so the routine offer of antenatal screening is not indicated. Since treatment during pregnancy is contraindicated, women rarely attend specialist HCV services during pregnancy. The diagnosis can lead to loss of stability so testing out with pregnancy is often more appropriate. Good communication between agencies involved in care is essential throughout pregnancy and after delivery; women should be managed according to national guidelines (4) with antenatal multi-agency planning meetings held as directed.

Women with problem substance use should receive adequate intrapartum analgesia.

Opiate dependence does not preclude the use of opiate analgesia during labour and if the standard dose proves inadequate it can be increased. It is important to recognise that methadone as prescribed for opiate dependence will not provide intrapartum analgesia nor will opiate intrapartum analgesia provide adequate opiate substitution.

For women on opiate substitute medication, opiate intrapartum analgesia if prescribed, should be given in addition to and not instead of methadone. Breast feeding will reduce the severity of neonatal withdrawal symptoms and consequent need for treatment of the neonate and should be encouraged for all drug using women with the exception of those who are HIV +ve. Having HCV PCR +ve status is not a contraindication to breast feeding.

In common with those from socially disadvantaged backgrounds or with unstable lifestyles, women with problem substance use should be offered effective, appropriate contraception (often using long acting reversible progestagen contraception via implant or intrauterine device) commenced prior to postnatal discharge.

Issues and solutions: Maternity care

1. Substance users have potentially high risk pregnancies and should have access to obstetrically led multi-disciplinary care.
2. Clear guidance exists regarding appropriate care of their substance problem and pregnancy – practice should reflect this.
3. Good practice in multi-disciplinary/multi-agency care is essential in maximising outcomes.

Above taken from -

1. *“Essential Care: a report on the approach required to maximise opportunity for recovery from problem substance misuse in Scotland”* Scottish Government SACDM Integrated Care Project Group, Essential Care Working Group January 2008
2. *“Why Mothers Die”*: Report on confidential enquiries into maternal deaths in the United Kingdom, RCOG Press, London 2004
3. .Hepburn, M. (1997) Drugs of Addiction. *Advances in Perinatal Medicine, Parthenon Publishing*. F. Cockburn, Ed. Carnforth Chapter 18, 120-124.
4. *.Getting Our Priorities Right: Good Practice Guidance for working with Children and Families affected by Substance Misuse.* (2003) Scottish Government. <http://www.scotland.gov.uk/Publications/2003/02/16469/18705>