Drug use in pregnancy

Sex, drugs and fact 'n' fiction

Drug use in pregnancy is risky. It can and does adversely affect the health of both mother and child. However, it is extremely difficult to study the effects of illicit drugs on pregnant women and the foetus, as it is impossible to recreate the scientifically controlled environment of the laboratory in such delicate circumstances. It is therefore difficult to determine the precise actions or effects of individual drugs on the baby before and after birth.

Partly because of this lack of information, the 'medical management' of pregnant drug users tends to be based on rigid guidelines, and inevitably results in equally rigid 'social management'. Both medical and social management in turn are influenced by moral attitudes. Consequently, there is no shortage of advice on how to care for pregnant drug users and their children, but much of this advice has little basis in fact and such evidence as does exist is often ignored.

The Glasgow Women's Reproductive Health Service (WRHS) is in a unique position to provide some of that evidence. Since 1990, it has provided a city-wide service for women with severe social problems, among which of course is drug use. The service has cared for more than 600 pregnant drug users and our approach speaks for itself: we work hand in hand with social services, and yet more than 95 per cent of babies go home in their mothers' arms.

While the experience thus gained cannot fill all the scientific gaps, it does allow for a study of different approaches to medical management as well as a closer examination of some of the myths surrounding drug use in pregnancy to see how they stand up to scrutiny. This article seeks to challenge the strongest of these myths.

Drug-using women don't turn up

It is reported that pregnant drug users often fail to attend for care until late in pregnancy or they present for the first time in labour. Despite some recognition that inappropriate and insensitive services are to blame,1 the fault is still widely considered to lie not with the services but with the irresponsibility and inadequacy of the mother. Prior to the establishment of the WRHS, few pregnant women reported drug use to Glasgow Royal Maternity Hospital and in such cases, late booking after 20 weeks gestation was common.

Women give many reasons for non-attendance. For a start, service design is often seen as inappropriate — geographically as well as administratively inaccessible, with no opportunity for self-referral as all referrals must come through GPs. Furthermore, drug-using women have many demands on their time. Caring for families, dealing with social problems and financing a drug habit take precedence over routine antenatal checks which confer little apparent benefit. A major factor for many women, subsequently confirmed on formal assessment, was staff behaviour. Fear of encountering judgemental staff attitudes was often given as a primary reason for non-attendance.4

The WRHS took these worries into account, and is consequently accessible through any route, including self referral. Coupled with a philosophy which recognises drug use as a problem but does not condemn women for using drugs, this service has encouraged steadily increasing numbers of pregnant women to volunteer a history of drug use and to book earlier in their pregnancy. The service now cares for around 100 pregnant drug-using women each year, a third of whom attend by self-referral.

The current average booking gestation of 14 weeks is the same as the hospital average.

by

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Summary

There is very little scientific information on the effects of drugs on the foetus. This lack of knowledge has led to rigid 'medical and social management' of pregnant drug users. This article examines some of the precepts of this management and finds them to be dangerously faulty.
and the total number of attendances for an individual woman is invariably much greater. This experience confirms that with appropriate services appropriately delivered, drug-using women will attend and attend early for care.

All down to the drugs
Maternal drug use during pregnancy is widely reported to cause higher rates of mortality and morbidity among babies. While this is undoubtedly the case, such outcomes cannot be attributed to illegal drug use alone—the use of legal drugs and socio-economic deprivation will also play a part. In the WRHS we have actually found that rates of preterm delivery and low birthweight among drug-using women are lower than among non-drug-using women with social problems, and are comparable to rates among women from similar backgrounds who have no major social problems.

It is common practice to use the baby’s condition at birth as an indicator of whether or not a drug-using woman should get custody of her child. This approach is not only scientifically unsound but is also illogical. It is more stressful to care for a small premature baby, and the drug-using woman who has a sick child should receive not punishment but sympathetic support.

Detox is too dangerous
Antenatal detoxification is regarded as even more dangerous than continued drug use, with “cold turkey” detoxification reported to cause death of the foetus. Maintenance therapy throughout pregnancy is therefore widely advocated.

Pregnant drug users can attend early, regularly and frequently

But in our experience most drug-using women attending the WRHS are keen to stop or reduce their drug use during pregnancy. They have therefore always been given the choice of both maintenance therapy and detoxification at any speed, any stage of pregnancy, any number of times or in any combination.

The first 300 drug-using women who delivered in the service included 164 women who underwent opiate detoxification in hospital one or more times at gestations from 5 to 39 weeks, 64 of whom underwent “cold turkey” detoxification. Rates of fetal death, preterm delivery and low birthweight were lowest in the “cold turkey” detox group, higher in the methadone detox group and highest among women who did not undergo detoxification.

These groups were self-selected and the impact of other variables is unquantifiable, so the results do not indicate that detoxification is safer than maintenance. However, the excellent outcomes in the detox group do indicate that antenatal detoxification is not unduly hazardous to the foetus and that it can be undertaken at any speed and at any time.

The special care nursery
It is common practice for babies of drug-using women to be routinely admitted to the special care nursery even in the absence of specific medical problems. This is often justified on the grounds that the babies require observation for signs of withdrawal which in turn require treatment.

Following the opening of a dedicated ward for the WRHS, all babies have remained with their mothers unless they have medical problems which necessitate admission to the nursery. We have found mothers to be just as diligent as staff in watching for signs of withdrawal and have not found the presence of symptoms per se an indication for treatment nor treatment an indication for admission to the nursery. Overall fewer than one in five babies have required admission to the nursery and many of these have required admission for reasons unrelated to maternal drug use.

Treatment is given only to babies who
are obviously unwell, including those considered at risk of convulsions or with unacceptable weight loss. However, treatment of opiate withdrawal with methadone or morphine can take longer. Given the current common pattern of polydrug use, the use of substitute drugs can be less effective than simply treating any symptoms by using phenobarbital as an anticonvulsant and as a sedative to improve feeding.

Some babies exhibit withdrawal symptoms which are disproportionate to maternal levels of drug use. Closer examination suggests that a common factor in a number of these severe cases has been maternal use of dihydrocodeine. We have therefore felt justified in warning drug-using women of the potential dangers to the newborn baby of using dihydrocodeine in pregnancy.

Permanent damage

The precise nature and pattern of withdrawal symptoms in the baby depend on the exact drug and the mother’s pattern of use. Symptoms due to methadone withdrawal, for example, usually develop several days later than those due to heroin and are widely regarded as more severe. While withdrawal symptoms may exacerbate or be exacerbated by other problems such as prematurity we have only occasionally seen opiate withdrawals last longer than 7-10 days.

It is reported that babies of drug-using women may have later developmental abnormalities and behavioural problems. However, as already discussed, the presence of other contributory factors including social circumstances together with an absence of accurate drug histories makes it impossible to attribute specific effects to drug use let alone to specific drugs. Reporting is inconsistent and may itself be influenced by other factors. For example, in Canada the additional allowances payable to parents fostering children with developmental problems might be expected to ‘affect perceptions’.

We are currently studying information from routine health visitor follow-up of babies born to all the women attending the WRHS. This follow-up goes up to school age and to date, there are no apparent differences between babies of drug-using and non-drug using women.

Breast feeding is out

Drug-using women are often told they should not breast feed their babies because the drugs pass into the breast milk and on to the baby. While chaotic drug use by the mother will, if she breast feeds, result in the baby receiving erratic drug doses, the baby of a woman on a stable dose will simply continue to receive the same drug it received in utero – no different from the approach used by those who give babies substitute opiates as treatment for withdrawal symptoms.

In the WRHS we believe that the advantages of breast feeding vastly outweigh any possible disadvantages and routinely recommend breast feeding to drug-using women. It is not only generally beneficial (including offering protection against cot death) but is also specifically helpful in preventing and reducing the severity of withdrawal symptoms. Unfortunately, breast feeding is culturally unpopular among women attending the WRHS, but we are beginning to see a slight but encouraging take-up.

So it's just plain sailing?

Of course not! Just as with non-drug-using women things can go wrong. All professionals will from time to time have to help women cope with a bad pregnancy outcome and this is likely to occur more frequently when looking after drug-using women. While women have a right to be told about the effects of drug use on their pregnancies it can be difficult to find the correct balance between giving them the necessary information to allow behavioural change and predisposing them to intolerable guilt if things go wrong.

Helping women to cope with the inevitable but hopefully infrequent bad social outcome may be less familiar and more daunting for health care staff. In this situation the temptation to deny any responsibility should be resisted.

When necessary the decision to remove a baby from the mother’s custody should be a joint one involving not only all the relevant services but also the mother herself who must be helped to recognise this as not simply a knee-jerk reaction to her drug use per se but as a consequence of her failure to control that use. Such insight may make attempts at behavioural change seem more worthwhile and help persuade her that any subsequent pregnancy should preferably be deferred until such change is achieved.

So what is the truth?

Pregnant drug users are portrayed as difficult to contact, hostile, uncooperative and as inadequate parents, while their children are regarded as irrevocably damaged by their mothers’ deviant behaviour. Working with them is undoubtedly demanding.

Even when all goes well there are often recurrent setbacks and crises which require long term intensive support. However, our experience in the WRHS has been quite different from the stereotypical image.

When provided with non-judgmental services which take account of their views and needs, pregnant drug users not only attend but attend early, regularly and often much more frequently than women without social problems. So while caring for drug-using women during and after pregnancy may be a stressful and at times apparently thankless task, the enormous scope for improvement can make it very rewarding for all concerned.

We have found pregnant drug users to be similar to non-drug-using women in their concern for their babies’ welfare and motivation towards behavioural change in the babies’ interests. Pregnant women will readily accept treatment or act in a particular way in the interests of their unborn child. However while they want concise information they also have the right to accurate information. Where accurate information does not exist, dogma based on anecdote should not be substituted. Rather than imposing scientifically unsound regimes we should allow women to make decisions about their own medical and social management based on the best available information. We would all do well to remember the very real limitations of available knowledge.

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