

Effective Interventions Unit

Integrated Care Pathways Guide 8: Drug Misuse in Pregnancy and Reproductive Health

WHAT IS THE PURPOSE OF THIS GUIDE?

This is the eighth in a series of guides on developing and implementing Integrated Care Pathways (ICPs). This document is not an ICP. It is a 'guide' which can assist agencies to develop local ICPs for specific processes and procedures involved in the management of problem substance use during different phases of the reproductive health cycle. These should be consistent, evidence-based and appropriate to the needs of the individual and their family.

WHO SHOULD READ IT?

Those involved in commissioning, planning, delivering and evaluating care to problem substance users who are expecting a baby.

DEFINING THE POPULATION

Much has been written about the risks of physical, psychological and social harm associated with drug and alcohol use during pregnancy. This guide refers mainly to the care of those who have significant problems related to substance use, such as dependency. The guide addresses drug and alcohol use. However, the risks associated with smoking during pregnancy are also recognised.

The precise nature and extent of problem substance use during pregnancy is unknown as reliable statistics are difficult to obtain. Approximately one third of pregnant women smoke.¹ Around 20% of women of reproductive age exceed the recommended weekly limit of alcohol consumption.² Illicit drug use is common in a smaller proportion of the population. Statistics on drug misuse in pregnancy are available from the Scottish Morbidity Record - maternity discharges collected by ISD Scotland, although it is accepted that these are under-reported.³

PHILOSOPHY OF APPROACH

Planning and delivery of health and social care during pregnancy should focus on the needs and safety of the woman and baby. However, a wider supportive family-centred approach will encourage the best possible outcomes. It is particularly important to engage fathers in the assessment and care process. The fears and aspirations of problem substance users who are expecting a baby should be taken into account when planning and delivering their care. Some women may be reluctant to engage with services through fear of child protection issues. Local ICP development groups should consider providing service information leaflets about what local services are available and what local agencies do, and do not do.

GUIDANCE FOR MANAGING PROBLEM SUBSTANCE USE IN PREGNANCY

In 2001 the Scottish Executive launched *A Framework for Maternity Services in Scotland*⁴. It set out principles and practice for modern, responsive and effective maternity services. In 2002, the direction of maternity services was outlined in *Implementing a Framework for Maternity Services in Scotland*⁵.

There is a range of policy and guidance documents which outline standard professional practice for the management of high risk pregnancies. Local areas produce local guidelines and protocols to meet local circumstances and needs. The recently published (November 2004) UK-wide report, *Why Mothers Die*⁶, outlined findings and recommendations which are relevant to all health and social care professionals responsible for the planning and delivery of integrated care to pregnant and recently delivered women.

This Guide contains information on:

- Defining the population
- Guidance for managing problem substance use in pregnancy
- What is reproductive health?
- Mapping current practice
- Who should be involved?
- Choosing your topic
- Defining the desired outcomes of care
- Designing the pathway
- Flowchart and menu of documents
- Next steps and other resources
- Acknowledgements

¹ Taylor DJ. *Alcohol Consumption in Pregnancy*, Guidelines and Audit Sub Committee of the Royal College of Obstetricians and Gynaecologists, 2003

² Scottish Executive, *Plan for Action on Alcohol Problems*, 2002

³ Common Services Agency, *Drug Misuse Statistics Scotland 2004*, 2004

⁴ Scottish Executive, *A Framework for Maternity Services in Scotland*, 2001

⁵ Scottish Executive, *Implementing a Framework for Maternity Services in Scotland*, 2002

⁶ Royal College of Obstetricians and Gynaecologists, *Why Mothers Die 2000-2004 - Confidential enquiry into maternal and child health: improving the health of mothers, babies and children*, 2004

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OTHER RELEVANT DOCUMENTS

- *Getting our priorities right: good practice guidance for working with children and families affected by substance misuse*, Scottish Executive, 2003
- *Hidden harm: Scottish Executive response to the report of the inquiry by the Advisory Council on the Misuse of Drugs*, Scottish Executive, 2004

WHAT IS REPRODUCTIVE HEALTH?

Reproductive health encompasses a 4-phase cycle of care:

- **Pre-conception** – the planning for pregnancy with emphasis on good health and consistent support.
- **Pregnancy** - the 9-month period of pregnancy care involving women and their partner, with emphasis on quality and continuity of care.
- **Childbirth** – the achievement of a positive birth experience to meet the care needs and expectations of the woman and her partner; and the safe delivery of the baby.
- **Postnatal and parenthood** – the provision of postnatal care to baby and the woman and her partner to facilitate the transition to parenthood.



Remember ... reproductive health represents a total package of care

CHOOSING YOUR TOPIC

The package of care should be divided up into bite-sized chunks, each representing a specific process or procedure with a defined start and end point. The table below outlines some examples only.

Phase of care	Issue	Specific Process or Procedure (Subject of ICP)
Pre-conception and reproductive health	Problem drug using women who are not menstruating.	Management of contraception for opioid dependent women who are not menstruating.
Pregnancy care	Engaging opiate dependent women into antenatal care.	Substitute prescribing.
Childbirth	Management of pain during labour.	Provide adequate pain control, if needed; and medication (e.g. methadone), if due.
Postnatal and parenthood	Parenting support.	Delivery of multi-disciplinary family support plan.

MAPPING CURRENT PRACTICE

ICP Guide 2 provides information on why mapping current practice is important and how this should be carried out. The ICP development group should consider what questions they want answered from this process. For an ICP on pregnancy these might include:

- Can maternity services refer directly to specialist drug and alcohol services?
- Do specialist substance misuse services have a policy in place which fast-tracks referrals of pregnant problem substance users and their partners? If not, should this be considered?
- Are ante-natal clinics hospital based or can they be accessed via local health centres?
- What screening and assessment processes and tools are currently used?
- What are the current monitoring and evaluation processes and who is responsible for these?

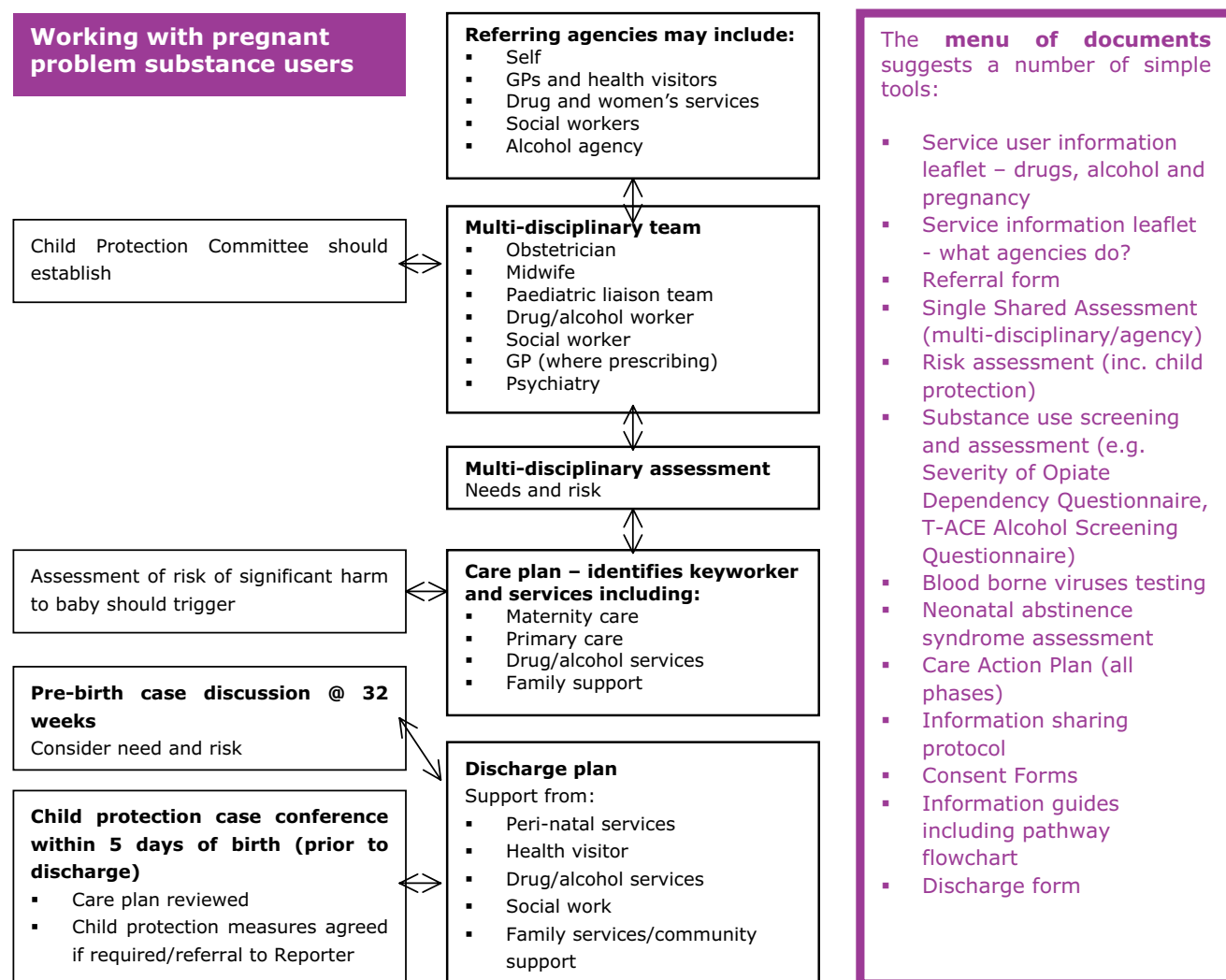
The results of the mapping process should help the ICP development group to identify what needs to be done and who needs to be involved in the process.

DESIGNING THE PATHWAY

Each ICP should be based on evidence of effective practice and local needs assessment (see *Guide to Needs Assessment*, EIU, 2004). The actual structure of the pathway will be influenced by the availability of resources locally, in particular the range and capacity of services and the skills, knowledge and experience of staff within the different organisations involved.

FLOWCHART AND MENU OF DOCUMENTS

The flowchart below is outlined in *Good Practice Guidance for working with Children and Families affected by Substance Misuse: Getting our Priorities Right* (Scottish Executive, 2003). It provides a multi-agency framework that can be adapted and built upon to reflect local factors and actual needs and risks involved.



NEXT STEPS AND OTHER RESOURCES

All EIU documents and ICP guides can be viewed on: www.drugmisuse.isdscotland.org/eiu

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WHO SHOULD BE INVOLVED?

The table below suggests the professions that should be involved in developing and implementing an ICP for reproductive health. Maternity care should be family-orientated, with the woman remaining at the centre of the decision making process about her care. Care should be obstetric led although much of the care can be delivered by trained midwives.

WHO?	WHY?
Obstetrician/ Gynaecologist	Trained in management of all aspects of pregnancy and childbirth including managing high risk pregnancies and those with complications.
Neonatologist/ Paediatrician	Trained to manage the medical needs of the new born infant. Role in managing babies with Neonatal Abstinence Syndrome.
Midwife	Trained to manage low risk pregnancies. With additional training, midwives contribute to the management of obstetric led high risk pregnancies.
Health Visitor	Trained to manage child, family and public health matters. Role in antenatal and postnatal care. Role in supporting vulnerable families where children are in need or at risk.
General Practitioner	Trained to provide general medical care and often 'enhanced' care for problem substance users, for example, substitute prescribing. Often confirm the pregnancy. Role in providing reproductive health and pregnancy care.
Pharmacist	Trained to ensure medicines are properly prescribed and dispensed, and used safely to best effect. Role in dispensing and supervising the self administration of methadone. Role in providing needle exchange.
Social Worker	Trained to support parents to enable them to look after their children. Use compulsory measures of care only when this is absolutely necessary for the child's care and well-being. Role in antenatal and postnatal child care risk assessment.
Substance use specialist	Trained to provide a range of treatment, care and support options (interventions) to problem substance users.
Liaison Psychiatry	Trained to provide support to women suffering from post-natal affective disorders, and their families.
Others e.g. voluntary sector workers, etc.	Others who have or could have a treatment, care and support role to play with the family.

DEFINING THE DESIRED OUTCOMES OF CARE

The outcomes of care should reflect the stated aim of the ICP. An example is outlined below:

Aim	Specific Process or Procedure (Subject of ICP)	Outcome
To support parents to look after the baby.	Delivery of multi-disciplinary family support plan.	Woman and partner/family supported and caring for baby.